Rotherham Better Care Fund Plan

May 2016

Local Authority

Rotherham Metropolitan Borough Council

Clinical Commissioning Group

Rotherham Clinical Commissioning Group

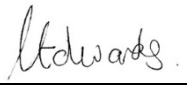
2016/17

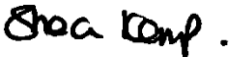
Contents

1. Plan Details

Local Authority	Rotherham Metropolitan Borough Council
Clinical Commissioning Groups	Rotherham CCG
Boundary Differences	The map in the attached document below shows that the geographical boundary of Rotherham MBC is co-terminus with Rotherham CCG.  Map of Rotherham.docx
Date agreed at Health and Well-Being Board:	20/04/2016
Date submitted:	25/04/2016
Total agreed value of pooled budget: 2016/17	£24,323,000

2. Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	
By	Chris Edwards
Position	Chief Officer
Date	3rd May, 2016

Signed on behalf of the Council	
By	Sharon Kemp
Position	Chief Executive
Date	3rd May, 2016

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor David Roche
Date	3rd May, 2016

3. Vision for Adult Services

The overarching vision for our health and social care services is to empower people to live independently in the community. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and better quality of life. We will achieve this through a strategy of early intervention and prevention. We will integrate services to improve the health and well-being of people in Rotherham. We will focus on information, prevention, enablement, rather than providing ongoing support which increases dependence and reliance on health and social care services. We will build resilience by empowering individuals, families and communities and provide better support for carers so that they can continue in their caring role.

We will develop effective joint commissioning arrangements which drive the integration of services. We will promote multi-disciplinary working between primary care, social care, mental health, community health services and the voluntary sector. We will expand community based services, reducing reliance on the acute sector.

We will streamline and simplify care pathways, providing better information, advice and signposting to the third sector for ongoing support. We will ensure that better information sharing between health and social care services.

Service integration will be used as a vehicle to deliver "parity of esteem". Integrated locality teams will incorporate mental health staff, working alongside health professionals whose focus is on physical health. Care planning and support will address the psychological and physical needs of the individual, recognising the huge overlap between mental and physical well-being.

We will ensure that staff working in the health and social care economy understands the specific needs of people with mental health and learning disabilities. We will do this through training and education, effective partnership working and integrated care pathways. We will ensure that the appropriate care pathway is selected to support both the patients' physical and mental health. Our vision is consistent with that set out in Rotherham's Mental Health Adults and Older People's Transformation Plan which is available at:
http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=103679

The Rotherham BCF Plan is consistent with the aims of the NHS Five Year Forward Plan. The Forward Plan emphasises the need to develop new care models to which support integration. A central theme of our plan is the development of integrated service models intermediate care services, locality teams, rapid response, carer support and first point of entry.

The overarching vision for Rotherham's BCF Plan can be translated into the following local priorities. These are aligned with the outcomes set out in Rotherham's Health and Well Being and Rotherham CCG's Commissioning Plan, CCG Operating Plan and Provider Plans.

1. An integrated health and social care delivery system which promotes joint working
2. An integrated commissioning framework with joint outcomes and service specifications
3. More care and support provided in people's homes
4. Integrated care planning that addresses physical and psychological wellbeing

5. Individuals and families taking more control of their health and care
6. Accurate identification and active case management of people at high risk of admission
7. Broader use of new technology to support care at home
8. A financially sustainable model that targets resources where there is greatest impact

The impact of the BCF Plan on patient and service user experience will be significant. As a result of the changes we will make, we expect that 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. Our expectations are reflected in the service users feedback collected on a regular basis; for example through the Friends and Family Test carried out across hospital and community services.

4. Evidence Base

4.1 Health and Wellbeing Strategy

The Rotherham Health and Wellbeing Strategy (2015-18) sets out Rotherham's overarching vision to improve health and well-being, enabling people to live fulfilling lives, to be actively engaged in their community and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to ensure the commissioning and delivery of services which are more integrated, person-centred, providing high quality care and accessible to all.

The Better Care Fund Plan contributes to the following strategic objectives identified in the local Health and Wellbeing Strategy.

- All Rotherham people enjoy the best possible mental health and wellbeing
- Healthy life expectancy is improved for Rotherham people and the gap in life expectancy reduced
- Rotherham has healthy, safe and sustainable communities and places.

The full Health and Wellbeing strategy is available at:

http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18

The Health and Wellbeing Strategy takes account of the local health and well-being needs identified through the JSNA which is available at http://www.rotherham.gov.uk/jsna/

4.2 Rotherham CCG Commissioning Plan

The Rotherham CCG commissioning plan is currently in final draft format and the Better Care Fund plans for 2016-17 have been incorporated, the 2015-19 plan incorporates a section dedicated to the Better Care Fund, plan on a page with reference to Joint Working as a key priority, BCF Metrics and Quality Premiums and can be viewed at http://www.rotherhamccg.nhs.uk/

4.3 Sustainability and Transformation Plan (STP)

Every health and care system across England has been asked to come together, to create its own ambitious local blueprint for accelerating implementation of the Five Year Forward View. The South Yorkshire and Bassetlaw STP covers populations living in Sheffield, Barnsley, Rotherham, Doncaster and Bassetlaw.

The five CCG local place-based plans (Rotherham CCG's Commissioning Plan and BCF Plan) will form the foundation of the approach we will take to developing our STP. Key local priorities within local plans include: out of hospital care, end of life care, children's and healthy lives, living well and prevention.

Complementing these, and based on knowledge of local need and challenges and national guidance, five transformation workstreams have been established for South Yorkshire and Bassetlaw. Each is being led by both a provider or local Chief Executive and commissioner Accountable Officer.

The five priority workstreams are:

- Urgent and emergency care
- Elective care and diagnostics
- Cancer
- Mental health and learning disabilities
- Maternity and children's services

4.4 Joint Strategic Needs Assessment

Rotherham's JSNA shows that the population of Rotherham is at its highest ever level, at an estimated 260,800 in 2016. 49,800 people are aged 65 or over and 5,700 are aged 85 and over. By the year 2020, the number of older people is predicted to increase to 54,200 and the 85 year and over age group will increase to 6,900.

There are now estimated to be 3,100 people over 65 living with dementia in Rotherham. 10,300 people aged over 75 live alone, half of all people in this age group. Around 4,000 older people experience significant loneliness on a daily basis. Two thirds of householders over 65 own their own homes, although the proportion reduces with age to 52% of those aged over 85.

An estimated 18,500 people over 65 (40%) need some help with domestic tasks and 15,200 (33%) need help with self-care. 18% of people over 65 need assistance with some aspect of mobility such as walking or climbing stairs. 41% of people over 65 have some form of hearing impairment and 9% have a moderate or severe visual impairment. Incontinence affects 19% of people over 65, rising to a third of those aged over 85 years.

The number of older people (65+) is projected to rise by 7,300 (15%) between 2013 and 2021 and the number aged 85+ is projected to rise by 1,500 (28%) by 2021. The number of people aged over 75 living alone is projected to increase by 2,100 or 20% between 2012 and 2020. The number of people over 65 who need help with domestic tasks or self-care is predicted to increase by 17% between 2012 and 2020. The number of people aged over 65 with dementia is predicted to rise from 3,100 in 2012 to 3,700 by 2020, a 19% increase. The number of people over 65 admitted to hospital after a fall is predicted to increase by 20% between 2012 and 2020.

The JSNA predicts a substantial increase in the number of adults with additional health and social care needs over the next five years. This prediction is made on a backcloth of substantial reductions in social care investment. Also, increases to the NHS budget are unlikely to keep pace with the rising demand for services. So this strategy is important. If the demographic challenge is to be met it will require a joint approach to commissioning service delivery. Effective joint commissioning can remove duplication, increase economies of scale and, through early prevention, reduce interventions further up the care pathway.

The health and well-being needs of the ageing population continues to increase as older people are likely to experience disability and limiting long-term illnesses and lower quality of life. The JSNA highlights that falls in older people are of a particular concern because of the risk of hip fracture and subsequent morbidity and mortality. We are below the national average for injuries due to falls in older people. Our Integrated Falls and Bone Health care pathway is crucial in improving patient outcomes, providing early intervention to restore independence and prevent frailty.

Rotherham's Market Position Statement highlights that there is a predicted increase of 25% for formal support required by 2020 and a 58% increase in demand by 2030, particularly for those people with conditions such as dementia, depression, mobility, hearing impairment, incontinence and diabetes.

The Market Position Statement is available at:

http://www.rotherham.gov.uk/downloads/file/959/market_position_statement_for_older_peoples_services_2014

The Rotherham BCF plan is aligned with all of the above emerging population needs. The services currently funded through BCF and all the local priorities focus on addressing the impact of the ageing population. Through a combination of integration, prevention and case management the BCF Plan can deliver better outcomes for the growing population of older people and reduce pressure on the local health and social care economy

4.5 Mapping BCF Services

The Rotherham BCF Programme recently completed a full review of services funded through the Better Care Fund (Appendix 1). The review considered the following criteria when assessing the current BCF service areas;

Strategic Relevance	Does the service address BCF metrics?
Service Specification	Is there a specification for this service?
Performance Framework	Is there a performance framework in place?
Performance Issues	Are there any issues relating to performance of the service?

The report made the following recommendations for each service area

Ok	Service exists, strategically relevant with evidence of good performance
Review	Service exists, realignment required on funding or performance issues
Reallocate	Funding is not linked to the service area identified and needs reallocating
Merge	Merge schemes that relate to the same service area

The service review has been successful in understanding areas of unmet need within Rotherham and areas of excellence across the health and social care economy. The review also identifies services which require more detailed review due to performance or quality issues. 18 service areas have been identified for further review. A number of others require a service level agreement and specification so that it is clear what they do and how they will be monitored.

4.6 Examples of Reviews

Social Prescribing

Patients with long-term health conditions are reaping huge benefits from being prescribed non-medical treatments by their doctors. We recognised two years ago that *'doing the same'* was not an option and wanted to find a different innovative way to commission services for people with long term conditions who were at high risk of hospital admissions. The service has received a national "Excellence in Participation Commissioner" award.

The service reduces inappropriate admissions into hospital, reduces attendances at GP practices and provides sustainability to the voluntary and community sector. The service also improves quality of life, reduces social isolation and moves the patient from dependence to independence.

A review in October 2015 of the Social Prescribing service assessed the strategic relevance of the service, the impact it is having, the benefits and improvements that patients felt and the impact on BCF outcomes. For example, in the case of non-elective patient admissions the review showed a 7% reduction in Finished Consultant Episodes (FCEs), an 11% reduction in Inpatient Spells and there was a 17% reduction in all A&E attendances across all patients (Appendix 2).

More than 2,000 patients with long-term health conditions, and at risk of hospital admission, have been referred for a social prescription. All 31 GP practices in Rotherham have signed up to the project.

The evaluation also found even better reductions in those aged 80 and under, and for those who engaged with voluntary sector-led activities over a sustained period. 82% of service users, regardless of age or gender, also reported a positive change in their well-being within four months of being issued with a social prescription.

This analysis provides an excellent case for the social prescribing service remaining within the BCF programme in future years. It demonstrates how outcomes can be improved for patients through the appropriate use of BCF funding.

Intermediate Care

This service review demonstrated that Rotherham's Intermediate Care Service is performing well across the majority of KPIs. There are, however, issues with the eligibility criteria, the lack of nursing/EMI resource and delays with patient flow. The review references CCG audits which show that there are still significant numbers of hospital admissions that could be redirected to intermediate care. For example, an audit carried out last year showed that 23% of MAU admissions were avoidable. 14% these patients were subsequently admitted to hospital despite the fact that they did not have an acute medical need. The audit concluded that 29% of MAU admissions could have been dealt with in

an alternative setting. The alternative settings identified included intermediate care services. The review also highlighted gaps in the eligibility criteria. Patients with 24/7 nursing needs and/or those with high levels of dementia are currently unable to access the intermediate care service.

The Intermediate Care Review considers options for the future development of the service. The ambition is to provide a single centre of excellence for intermediate care. This will deliver economies of scale, broaden the range of people who can receive support and act as a vehicle for health and social care integration.

4.7 Directory of Services

Appendix 3 sets out the Directory of Services (DoS) for BCF that came from the review. The BCF DoS describes a new structure for categorising BCF funded schemes. The schemes are grouped using the following themes.

1. Mental Health Services
2. Rehabilitation, Reablement and Intermediate Care
3. Supporting Social Care
4. Case Management and Integrated Care Planning
5. Supporting Carers
6. BCF infrastructure

A brief analysis of each service categorised under the BCF plan 2015-16 (BCF01 TO BCF15) compared to the new Themes 1-6 is set out in Appendix 4 The BCF Review and Directory of Services provide clarity on where BCF funding is currently being invested and the strategic relevance of each scheme. Commissioners have prepared a review schedule, a monitoring tool and review template. The next steps are:

(i) To develop service level agreements and specifications for those services that don't have them
(ii) Undertake a series of individual reviews on services where there are funding or performance issues or where there are concerns regarding strategic relevance.
(iii) Commissioners monitor and review progress of the reviews throughout 2016-17

Although the service review has re-categorised existing services there has been no initial negative impact on provision. Where changes in funding have been identified in the financial plan for 2016-17 they relate to existing funding that has been pooled into the BCF budget. It is likely that the 'deep dive' reviews of specific provision identified through the 2015-16 service review will involve changes to service provision. A robust monitoring tool has been developed to ensure that impact of each review is closely monitored through the BCF governance structure and is discussed in detail later in the plan.

5. Case for Change

5.1 Record on Joint Commissioning

Rotherham has a strong record of joint commissioning between health and social care. We have a joint commissioning framework and governance structure which incorporates joint needs assessment, supply mapping, market analysis, pooled budgets and performance management. This has prepared

the way for new developments in integrated care which will support people with complex needs to remain independent in the community.

Services that are already subject to joint commissioning and/or pooled budget arrangements include the Rotherham Intermediate Care Service, Community Occupational Therapy Service and the Integrated Community Equipment Service. All jointly commissioned services provide support on activities of daily living, ensuring that patents achieve the highest level of independence. All services help prevent deterioration and minimises loss of function caused by illness or disability. They reduce the risk of admission to hospital by ensuring that people are living in a low risk physical environment where they can function autonomously. The service empowers patients so that they maximise their potential to engage in meaningful and productive activities/occupations. These services deliver health and social care outcomes. They perform well within a robust joint performance management framework.

Rotherham has been successful in achieving a 20% reduction in non-elective admissions to hospital over the last 4 years. This enabled a substantial investment in additional community services supporting the BCF Plan last year. The continued investment through the Community Transformation Programme will improve outcomes for service users and prevent future increases in hospital admissions that would otherwise be expected from the demographic changes.

5.2 Development of New Care Models

Despite these successes current models of care are not designed for the health challenges of today. The ageing population, changing disease burden, and rising expectations demand fundamental change. For example the following community transformation performance indicators can be driven down further through effective implementation of the BCF Plan

Table 1: Community Transformation KPIs Influenced by the BCF Plan

KPI	Performance 15/16	Target 15/16
People >50 years attending A&E with a fragility fracture	99/month	118/month
No. of people over 55 with a fractured neck of femur	23.7/month	23.0/month
No. of GP referrals to the Medical Assessment Unit	229/month	261/month
No. of unscheduled admissions of patients >65years	664/month	730/month
No. of long stay patients over 14 days	86.7/month	213/month

Changes to the traditional models of care have already started to gain traction. For example, in 2014/15 469 older people were permanently admitted to residential and nursing care, compared to a predicted out-turn of 410 people in 2015/16. 537 adults were in receipt of day care in 2015/16, compared to 644 the previous year. This year 85.2% of adults who received home care enablement services were discharged without needing any long-term formal care from social care services.

We have increased patient utilisation of residential intermediate care from 587 in 2014/15 to 613 2015/16. This has been achieved within the same cost envelope. Similarly, in 2015/16 550 adults received community and day rehabilitation services in Rotherham, compared to 500 2014/15.

5.3 How Can the BCF Plan Support Development of New Care Models

The BCF Plan provides an opportunity to support the development of new care models. BCF has the potential to offer better value for money, a more cohesive model of care and better outcomes for people. The Better Care Fund acts as a "stepping stone" to the longer term transformation of services. The requirement that local plans should be part of a five-year strategy for local health and social care services will be a helpful spur to look beyond the immediate short-term pressures and develop a shared vision of what future local services should look like.

This will include the move towards Multi-specialist Commissioning Providers (MCP). A new care model outlined in the NHS Five Year Forward View, which sees GP group practices expand, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. The implementation of the integrated locality team pilot outlined in Section 10 Key Priorities is intended to examine the far wider range of care needed by registered patients through a multi-specialist team in order to acquire learning for future models.

6 Analysis of Out of Hospital Services

Rotherham has a range of high quality Out of Hospital Services which promote independence, prevent hospital admission and support hospital discharge. Out of Hospital Services fit into 3 main categories:

1. Admission Prevention and Supported Discharge Care Pathways
2. The Care Coordination Centre
3. Locality Based Community Nursing Teams

Our Out of Hospital Services support the reduction of avoidable non-elective hospital admissions and re-admissions. They promote 7 day working, facilitate timely hospital discharge and improve patient experience.

6.1 Admission Prevention and Supported Discharge Pathways

In Rotherham there are three admission prevention and supported discharge pathways. These are all supported by the Better Care Fund.

Pathway 1: Hospital to Home

Pathway 1 supports patients who are medically stable, but cannot be supported at home with generic health and social care services. Rotherham CCG and Rotherham MBC jointly commission an Integrated Rapid Response Service to support discharge and prevent admission for this cohort of patients. The Integrated Rapid Response Service operates 24/7, 7 days/week, providing short term therapy, nursing and social care support.

Pathway 2: Intermediate Care

Pathway 2 provides residential rehabilitation to patients who cannot return home. The aim is to maximise independence and optimise patients who do not have nursing needs. The Intermediate Care Residential service supports all patients on Pathway 2.

Intervention focuses on active enablement with view to maximising independence and returning home. The service is provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy and treatment.

The care plan sets out agreed rehabilitation goals and milestones. The service is time-limited, normally no longer than six weeks with average stay of 18 days. There are currently 50 beds across the borough, commissioned jointly by RCCG and RMBC. The Intermediate Care Residential Service accepts admissions 7 days/week.

Pathway 3: Discharge to Assess

Pathway 3 provides 24/7 nurse-led care for adults with complex care needs who are medically stable. The pathway is for patients who need a place to recover from an acute illness before an assessment can be made about their long term care needs.

Pathway 3 provides residential assessment and rehabilitation for patients with nursing needs. It also supports patients who trigger positive for the CHC checklist but have not yet had an assessment.

Pathway 3 services are delivered by The Oakwood Community Unit, Breathing Space Inpatient Beds and Waterside Grange Residential and Nursing Home.

Oakwood is a 20 bed nurse-led unit situated in the grounds of Rotherham District General Hospital. Work is currently underway to reconfigure the unit so that it is better able to meet the needs of Pathway 3 patients.

Breathing Space is a 20 bed nurse-led unit focusing on patients who have COPD and other respiratory conditions. It is both a step-up and step-down facility for this cohort of patients.

Rotherham CCG and Rotherham MBC also jointly commission, through BCF, 6 independent sector nursing home beds at Waterside Grange Residential and Nursing Home to support Pathway 3 patients.

The Community Unit, Breathing Space and Waterside Grange play a pivotal role in facilitating timely discharge from hospital for those patients who no longer require specialist acute care. All Pathway 3 services will receive admissions 7 days/week.

Figure 1 summarises the pathways that Rotherham currently operates for admission prevention and supported discharge.

Figure 1: Admission Prevention and Supported Discharge Pathways

Pathway 1: Hospital to Home

Integrated Rapid Response Service provides early supported discharge at home. Active in-reach into hospital, identifying patients who are medically stable and can be cared for at home. Delivered by an MDT for up to 6 weeks. Supported by specialist home care provider. Incorporates community rehabilitation.

Pathway 2: Intermediate Care

Intermediate Care provides residential rehabilitation to patients who can not return home. Aim is to maximise independence. Patients do not have nursing needs. Delivered by an MDT for up to 6 weeks. 50 community based beds

Pathway 3: Discharge to Assess

24/7 nurse-led care for adults with complex care needs who are medically stable. Delivered from The Community Unit and Breathing Space. Residential assessment and rehabilitation for patients with nursing needs. Supports patients who are preparing to undergo Continuing Health Care assessments.

6.2 Care Coordination Centre

The Care Coordination Centre (CCC) has been a key vehicle for delivering Better Care Fund outcomes in Rotherham.

The CCC acts as an access hub for community health services. On supported discharge the CCC holds a register of patients in an acute bed, whose medical episode is complete. It actively engages with the relevant community services to ensure that patients are placed on the right discharge pathway.

The CCC coordinates transfer to the relevant service. It monitors outcomes and identifies where there are capacity issues within each care pathway. The CCC supports the commissioning process by identifying where there is under and over-utilisation of services on each care pathway.

The CCC also receives all hospital based referrals for community nursing services. Transferring responsibility to the CCC for these calls will ensure that health professionals and patients are able to speak to a clinician about the most appropriate level of service. Figure 2 summarises the full functionality of the Care Coordination Centre.

Figure 2: Current Functions of the Care Coordination Centre

GP Support Service

Access point for GPs requre an alternative level of care for a patient. Advises on available range of services. Makes referrals, arranges placements and co-ordinates transport. Includes community pathway for suspected DVT.

Telehealth

Telehealth hub for patients with heart failure. Patients submit health data electronically. Collated and assessed to establish whether defined thresholds have been reached. Response coordinated.

Urgent Response Service

Single point of access for NHS 111 and the 999 ambulance service into alternative levels of care. CCC forms part of the YAS Pathfinder Project which supports ambulance crews when patients do not require A&E services

24/7 Service

Service will receive out-of-hours calls from patients and health professionals who require access to comunity health services or who have an urgent health need.

Supported Discharge

Service holds a register of patients in an acute bed, whose medical episode is complete. The CCC will actively engage with relevant services to ensure that patients are place on the right discharge pathway.

Single Point of Access for Community Nursing Referrals

Receive all hospital based referrals for community nursing services. The CCC carries out task allocation for all community nursing teams. Primary care referrals can be submitted to the CCC or direct to teams

6.3 Locality Based Community Nursing Teams

In Rotherham, our newly reconfigured, locality based community nursing teams support the transition from hospital to community. Although not currently funder through the Better Care Fund, they are a key vehicle for delivery of the 2016/17 BCF programme. The current service model incorporates 7 community nursing teams serving GP practice populations. The teams service geographical clusters of GP practices.

Additional resources have already been approved for investment into the community nursing service. New staff nurses have already been recruited and deployed. Clinical Team Leaders have been introduced to take responsibility for performance and quality. The new service model delivers better leadership and clinical supervision for staff, creating an environment where nurses can safely care for patients with a higher level of need.

The Community Transformation Team has worked with the provider to reduce the administrative burden on the community nursing service. Community nurses no longer responsible for completing Continuing Health Care assessments. There has been a full roll out of IT equipment for community nurses.

The focus on practice populations has supported partnership working between community and primary care. The service model uses an allocation formula which ensures equitable distribution of community nursing resources across the borough. Finally the service is now underpinned by a comprehensive service specification, a coherent system of governance and a robust performance management framework.

7. Adult Social Care Development Board

The Adult Social Care Development programme has been established to redesign the Rotherham approach to social care to ensure Care Act compliance, provide better outcomes for customers and generate savings. The programme direction is based on good practice nationally and pulls on resources regionally and further afield to support the delivery of improved outcome and best value. Five initial priorities have been identified:

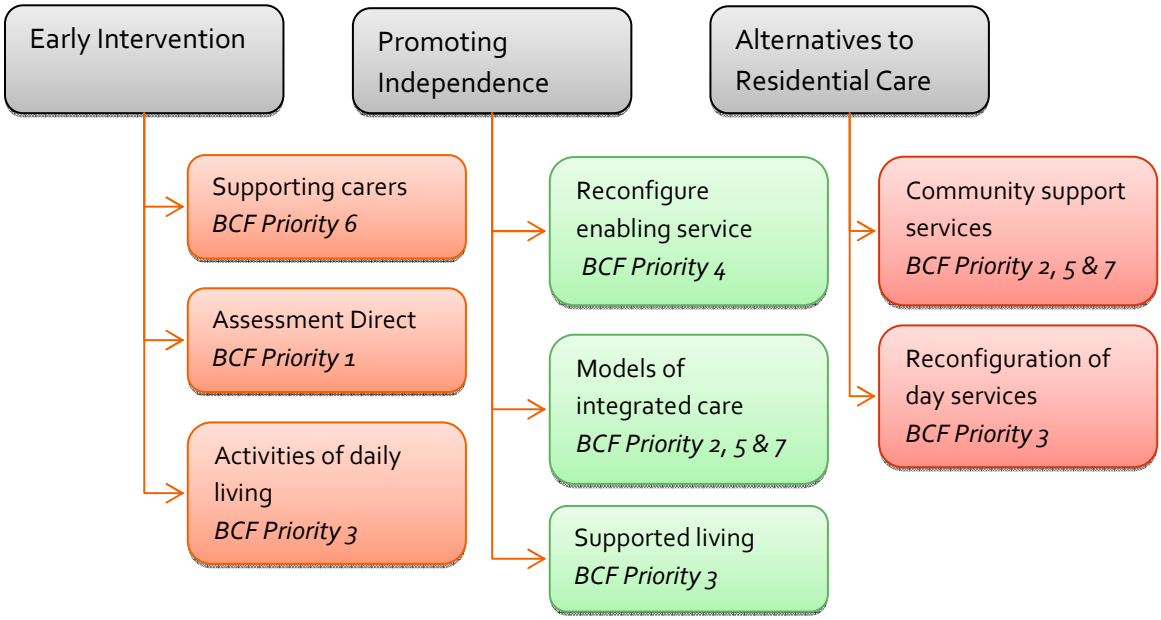
- Safeguarding
- Strategies
- Developing community assets
- The customer journey
- Alternatives to traditional care

Delivery of this programme in full is likely to take three to five years, the direction and scope of changes will need to be reviewed and reshaped through the programme. There are key decisions that will need to be taken around the size and shape of the in-house offer. Options will need to be worked up, consulted on and decisions made. Some changes which will improve the offer for the citizens of Rotherham are likely to cause significant concerns for customers already in the system and this need to be carefully balanced to ensure long-term sustainability. The timing of decision making will impact on the overall delivery of the programme. A development board consisting of partners within health and social care in Rotherham has been established to monitor delivery of the programme.

Changing adult social care cannot be done in isolation and this programme will have implications across the Council as well as a need to work closely with colleagues in the NHS and third sector to ensure that the programme acts collaboratively to improve outcomes for the citizens of Rotherham and support people to remain independent and connected for longer. Adult social care will need to develop better partnership arrangements with the independent sector to develop flexible and innovative options for the future. Resources from other areas that are further forward in this area of work are already being optimised and this will need to continue to do this as the programme progresses. It is vital that the programme develops and embeds a culture of co-production with people that use services and their families through regular use of experts by experience, working parties and involvement of customers in service design.

Figure 3 identifies the priorities of the Adult Social Care Transformation Programme that are most relevant to this plan. It also links each workstream to the relevant BCF priority (Section 10)

Figure 3: Summary of the Adult Social Care Programme and Links to the Better Care Fund



8. Improving Quality and Reducing Costs

This section of the BCF Plan considers some of the initiatives which have improved quality whilst at the same time increasing levels of efficiency. These initiatives support the reduction of avoidable non-elective hospital admissions and re-admissions. They promote 7 day working, facilitate timely hospital discharge and improve patient experience.

8.1 Risk Stratification

Rotherham has a well-established risk stratification tool, which uses a combination of primary and secondary care data to select the top 3% of the population who are at highest risk of hospital admission. This has enabled the targeting of case management on those who are likely to require intensive support further down the care pathway.

8.2 The Rotherham Case Management Programme

Having identified those people who are at greatest risk of being a high user of health and social care services, Rotherham' Case Management Programme places GPs at the forefront of care planning, self-management and care coordination. The main aims of the Case management Programme are;

- To reduce the unnecessary utilisation of secondary care services and therefore cost
- To facilitate improved quality and co-ordination of care in the community setting
- To improve the quality of care for older people
- To improve self-care by patients

The Case Management Programme is fully funded through the Better Care Fund. A key function of the programme is to empower GPs to act as care coordinators, taking overall responsibility for all health and social care input. The GP has a full understanding of the role of other parties in the care of an

individual patient. The Case Management Programme relies on the development of an integrated care plan which incorporates; medical review, analysis of social factors, exacerbation plans and place of care preferences. The integrated care plan is reviewed every 4 months and supported by regular MDT meetings with the full range of health and social care professionals.

8.3 The Social Prescribing Programme

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. Its main function is to make the wide range of 3rd sector services in Rotherham available to the GP Case Management Programme. Voluntary Action Rotherham (VAR) have been commissioned to employ a social prescribing team which maps voluntary and community services across the borough. The team will attend case management MDTs and link patients into services that promote community integration and reablement. VAR provide a one-to-one service to people on the Case Management Programme, motivating, signposting and supporting them to access services in the voluntary and community sector. The service addresses directly the unmet social needs that often evolve from the case management process. These needs are met before intervention is required from formal social care. The service promotes self-care, protects social care services and supports a holistic approach to care planning.

This initiative has recently been recognised nationally and is being recommended for inclusion in Sustainability and Transformational Plans (STPs).

8.4 The BCF Service Review 2015/16

Rotherham MBC and Rotherham CCG have carried out a joint review of all service areas funded through BCF. The review measured services against the following criteria;

- Strategic relevance of the cost centre or service specification to the Better Care Fund
- Performance against BCF metrics
- Whether the funding is being used for the service it was originally intended for
- Whether BCF funding for that service area is value for money
- Whether the service is fully funded by the BCF or is funded from other sources

The review of BCF services was completed in December 2015 and informed the development of a local BCF Directory of Services . The Rotherham BCF Directory has delivered a simpler, more coherent structure to the BCF programme. It includes the cost of each service, a brief description of what it delivers and how it supports achievement of the BCF metrics. Alongside this Rotherham has agreed a schedule of service reviews for 2016/17. These reviews will target services where there are issues around strategic relevance, performance or value for money. The reviews will make recommendations on;

- Whether service should continue to be commissioned
- Whether the service requires redesign
- Whether the service requires investment or disinvestment

8.5 Supporting People with Dementia

Rotherham has invested in a range of initiatives aimed at supporting people with dementia. Many of these are funded directly through the Better Care Fund. All of these services contribute to the evolving multi-agency approach to dementia care.

Carers Support Service

This is a domiciliary based care service provided in the persons own home. People are provided with 30 hours flexible support. They are then reviewed and assessed for ongoing support requirements. The service is available 24/7.

Dementia Enabling

This service offers personal care, assistance with medication, social stimulation and carer breaks. The service is available 24/7.

Dementia Reablement

This service is available for 6 weeks, can be extended to 8 weeks. The aim of the service is to support discharges, offer support to prevent admission to hospital/residential care and to prevent readmission to hospital. The service will work to re-establish routine and support the family/carer. Available 24/7.

Dementia Support Workers

Dementia Support Workers assist people with dementia and their carers to identify their needs and to access services. Give information support and guidance. Signpost and refer to other services.

Memory Cafes

Monthly Memory Cafes are provided across four areas along with two Singing for the Brain Groups. The service aims to help people to come to terms with their diagnosis, live well with dementia, offers choice through person centred support planning, reduces social isolation, increases access to information, helps maintain independence and life skills, improves and maintains health and well-being, helps maintain hobbies and interests and helps avoid crisis such as unplanned admission to residential or hospital care.

Carers Information and Support Programmes (CrISP 1 & 2)

CrISP courses are for carers, family members or friends of people with dementia to improve knowledge, skills and understanding. CrISP 1 is designed for recent diagnosis of dementia. There are four sessions covering understanding dementia, legal and money matters, providing support and care, coping day to day and next steps. CrISP 2 is designed for families, carers and friends of people who have been living with dementia for some time. There are three sessions covering understanding how dementia progresses, living with change as dementia progresses, living well as dementia progresses including occupation and activities.

Carers Resilience Service

This service is provided jointly by Crossroads Care Rotherham, Alzheimer's Society and Age UK. Each GP practice has a named link worker who identifies and support carers of people with Dementia. The link worker takes referrals and can provide information sessions to staff as required.

When a carer is referred by their GP they are contacted by a Dementia Advisor within 5 days of the referral being received. An initial assessment of need is carried out. The period of support will be 1 month. Where appropriate carers are then signposted to other organisations who can offer support e.g. Assessment Direct, aids and equipment, social activities, benefits checks.

Cognitive Stimulation Therapy (CST) Sessions

These are provided in the community and offered to all patients and families as clinically appropriate following diagnosis. Sessions are led by OT's and nurses from the Memory Service. Sessions are delivered in line with the 'Making a Difference' programme, but with the added option of including relatives/carers if appropriate.

Occupational Therapy

The Memory Service has dedicated OT resources. OTs contributes to MDT case discussions and reviews. In terms of their direct clinical work with patients and carers the OTs offer a range of assessments and interventions focusing particularly on promoting and maintaining safety, meaningful activity, independence and well-being. The OTs are involved in a range of ways, for example they work collaboratively with social care re assessment and provision of assistive technology and other equipment/adaptations. They carry out ADL home assessment and environmental safety and improvement work, give input and guidance on a wide range of therapeutic interventions to support health promotion, falls prevention, well-being and quality of life

Social Prescribing

This is coordinated by Voluntary Action Rotherham. The Memory Service and GPs can refer people with Dementia for referral/signposting to activities, services, befriending and other sources of support.

9. What has the Better Care Fund Achieved This Year?

There have been significant achievements since the last BCF plan in 2015/16.

We have reviewed all jointly commissioned services during 2015/16. The review has highlighted where BCF schemes are strategically relevant, those services that have performance issues and those that require further investigation in 2016/17.

We have developed a Directory of Services for BCF. The directory provides clear visibility to all key stakeholders on what services are funded. It provides a summary specification for each service, sets out objectives and describes relevance to the BCF metrics.

We are successfully matching adult social care records with their NHS number, providing a single identifier that can be used across health and social care. We have already started to look at how we can match records to improve the quality of joint commissioning. We are also identifying the highest cost individuals across the health and social care economy with a view to providing a more integrated and cost-effective service.

We have expanded the Mental Health Liaison Service. The service supports wards and care homes when delivering care to people who have mental health issues. It focuses on those parts of the health and social care economy that work with people who have a physical condition. One of the key aims of this service is to reduce admissions to hospital and to limit average length of stay.

We have developed an integrated falls and bone health care pathway. There is evidence that reducing the number of fragility fractures among people over 55 years has an impact on health and social care costs later in life. The integrated falls and bone health service tracks older people who have had a fragility fracture and offers follow-up support to reduce the risk of falls and osteoporosis.

The Better Care Fund has been used to maintain provision of social care. This includes the use of direct payments, residential care and social work in case management programmes. All social care domiciliary care providers are now contracted to respond to urgent hospital referrals over the weekend to facilitate discharge. The BCF Fund has supported the recruitment of a Quality Officer (Health) within the Care Home Support Service. This post is integral in ensuring that health issues are addressed when monitoring contract quality and performance. The post will work flexibly across health and social care.

Through use of BCF we have commissioned 7 Adult Social Care Assessment beds to support discharge patients who require further assessments to optimise independence. 5 beds are designated to support hospital discharge for patients who require optimisation and further assessment. 2 beds are designated for step-up provision to prevent hospital admissions. The step-up beds are used for patients who have a combination of health and social care needs but do not require rehabilitation within an intermediate care facility.

This year we have extended the eligibility criteria for intermediate care services. Patients who are unable to take part in rehabilitation can now be transferred to an intermediate care unit provided they have rehabilitation potential. There are 2 designated "delayed rehabilitation" beds within each intermediate care unit that can accommodate patients who are non-weight bearing, receiving pain management medication or recovering from illness.

We have recommissioned the social care prescribing service to provide people with long-term conditions access to voluntary and community sector support. This service helps promote self-management and community integration, thus reducing hospital admissions and reliance on social care. We recently established a mental health social care prescribing pilot creating opportunities for mental health service users to sustain their health and wellbeing outside secondary mental health services.

Using the Better Care Fund we have increased the number of adults receiving a Personal Health budget so that they can commission their own continuing health care support.

Finally, we have established a community end-of-life hospice team to support families and carers allowing patients to die in their place of choice. This also contributes to reducing hospital admissions.

10. Key Priorities: 2016-19

The BCF Executive has identified the following priorities for 2016-19. These include;

1. A single point of access into health and social care services
2. Integrated health and social care teams
3. Development of preventative services that support independence
4. Reconfiguration of the home enabling service and strengthening the seven day social work offer
5. A reablement hub incorporating intermediate care
6. An integrated carers support service
7. A multi-disciplinary rapid response service
8. A single health and social care plan for people with long term conditions
9. A joint approach to care home support
10. A shared approach to delayed transfers of care (DTOC)

10.1 A single point of access into health and social care services

The Community Transformation Programme supported the development of a Care Coordination Centre (CCC), which acts as a portal into community health services. The key functions of the CCC are;

- Coordination of supported discharge care pathway
- Single point of access into community nursing services
- Single point of access for GPs when supporting patients with an urgent health need
- Central referral point for NHS 111 into community health services
- Clinical advice on the availability of alternative levels of care for ambulance patients

The CCC works alongside two other points of access. Assessment Direct is the central referral point for all social care support. There are a number of access points into RDaSH, in-house NHS mental health provider.

Rothercare is a telecare hub, supporting older people who use the community alarm service. It also provides a range of equipment which supports vulnerable people in their own home. Closer links between this service and the monitoring functions of Care Co-ordination Centre will also form part of this work.

What are we going to do?

We will create a "triage" function within Assessment Direct which will deflect people who do not require formal social care into preventive services. The team will deal with health and wellbeing visits, assistive technology and some elements of safeguarding. Within this context we will strengthen links with the voluntary sector and promote joint working between the Local Authority and NHS.

We will provide a single point of access into all community-based health and social care services. This will reduce costs associated with several call centres. The new 24/7 call centre will be more accessible

for people who require support. They will not have to decide which organisation to contact. There will be one telephone number for everything. Most importantly, the new integrated call centre will support greater integration of health and social care pathways.

10.2 Integrated Health and Social Care Teams

Evidence suggests that integrated health and social care teams are likely to achieve better results than those that operate within strict organisational boundaries. The Kings Fund identifies some of the key characteristics of a successfully integrated team.

- Community-based multi-professional teams based potentially around practice populations
- A focus on intermediate care, case management and support to home-based care
- Joint care planning and co-ordinated assessments of care needs
- Named care coordinators who retain responsibility throughout the patient journey
- Clinical records that are shared across the multi-professional team.

What are we going to do?

We will develop a fully integrated health and social care team to support the Health Village. The team will be co-located and potentially support the same population as the current community nursing locality team. The team will have a single line management structure, joint service specification. It will incorporate named care coordinators responsible for supporting people with complex needs. We will develop a single portal that can be used across professional boundaries to store the integrated care plan and provide visibility on the full range of work being done with an individual. We will use the NHS Number to link records on this portal. We will develop a combined outcome framework which supports the strategic objectives of both the local authority and the CCG.

The integrated health and social care team will include community nurses, a community matron, social workers and allied health professionals. It will have a single point of access for all referrals. As well as focusing on structure, the process of integration will include a programme of relational transformation aimed out enhancing interpersonal relationships and breaking down cultural/ organisational barriers.

10.3 Development of preventative services that support independence

Rotherham is currently developing a "Healthy Ageing Framework" to improve the health and wellbeing of the ageing community. The framework will support the delivery of the ambitions within the RMBC Corporate Plan and Joint Health and Wellbeing Strategy. It will be used as a vehicle to optimise the impact of services and generate further investment through external funding applications. The framework and will help to ensure that Rotherham services work together seamlessly to create healthy, independent and resilient citizens.

Rotherham has a range of community services that focus on early intervention and prevention. These services promote independence by providing support with activities of daily living, physical activity initiatives, community equipment and community integration.

Occupational Therapy

National Institute for Clinical Excellence (NICE) Guidance – Mental Well Being and Older People (2008) concluded that occupational therapy and physical activity interventions actively promote the mental well-being of older people in the community. Occupational therapy enables people who have physical, mental and/or social care needs, either from birth or as a result of an accident, illness or ageing, to achieve as much as they are able to enhance their quality of life and maximise independence to their full potential. Department of Health guidance "Occupational Therapy in Adult Social Care in England" places emphasis on occupational therapy contributing to the health and well-being of the population in promoting self-reliance and resourcefulness for service users and their carers.

As the occupational therapy service works closely with health, social care, housing, education, employment, voluntary and the independent sector, this places the service in a key position to contribute to the delivery of a modern, personalised and integrated service.

Community Equipment

Audit Commission "Fully Equipped" guidance states that equipment for older people or disabled people provides the gateway to their independence, dignity and self-esteem. It is central to effective rehabilitation, it improves quality of life, enhances their life chances through education and employment and it greatly reduces morbidity at costs that are low compared to other forms of healthcare.

There is clear evidence that a good community equipment service

- Maximises a patient's ability to live independently
- Maintains health and improves quality of life.
- Reduces likelihood of further health problems (immobility, muscle contractures, pressure sores).
- Promotes social inclusion.
- Prevents accidents and falls-related admissions to secondary care.
- Reduces the need for 24 hour care from health and social care.
- Facilitates early hospital discharge as well as access to service in a planned way.

Activities of Daily Living Tool

We have commissioned an innovative web-based tool to help us to encourage people to maximise their independence by acting early. This is a nationally recognised tool which is in the process of being localised. The working title is "Iagewell-Rotherham", which we hope to use with people across the health, social care and voluntary sector workforce. This will help to link individuals to services or technology that will maintain their wellbeing and reduce the onset of ageing. The tool is strongly linked to the evidence on healthy ageing and the life curve and has been shown to deliver savings to the health and social care economy when embedded in our service delivery.

Promoting physical activity

Public Health and partners have recently been successful in winning a bid to develop post rehabilitation support for patients with seven long term conditions (Stroke, Cardiac, Heart failure, COPD, MSK, Falls, and Cancer). This project will provide tailored exercise programmes for patients post-rehabilitation. Patients on the programme will undergo condition specific group exercise activity aimed at optimising physical function and embedding a long term culture of regular exercise. The programme will also support patients to access appropriate exercise activity in their local community. The service will be accessible to GPs as part of the case management programme. It will also be available to patients on specific health care pathways. The intention is that referrals from health professionals will be made through the Care Coordination Centre.

The main elements funded by the programme include;

- 12 week condition specific group exercise programme
- Community buddies who provide individual support to patients requiring support with exercise
- Support with accessing appropriate exercise activity in the local community
- Targeted support for patients on the stroke, respiratory, falls and cardiac rehab, heart failure, MSK and cancer care pathways

What are we going to do?

We are committed to maintaining and improving these services despite the challenging financial framework within we operate. We will review our occupational therapy and equipment services so that they are fit for purpose. We will make best use of the resources available within Rotherham to include not just health and social care, but housing support. We will free up the occupational therapy service so that it provides more direct support to people struggling with activities of daily living. We will properly resource the equipment service so that it supports the work of the occupational therapy service. Finally we will continue to promote physical activity pathways for people who have had major health events.

10.4 Reconfiguration of the home enabling service

Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.

The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home. People using reablement experience greater improvements in physical functioning and improved quality of life compared with using standard home care.

Reablement is usually free for the first six weeks.

What are we going to do?

We will implement the outcomes of a recent service review, ensuring that the enabling service is fit for purpose and promotes value for money. The service will support people to maximise their independence using the "i-age-well" tool. We will ensure that the service is able to respond in a timely way to hospital discharges 7 days per week. We will rebrand the service so that it is incorporated into the intermediate care portfolio of service provision. We will link the service with

mental health services, providing important psychological support to people who struggle with motivation or depression.

10.5 A Reablement Hub Incorporating Intermediate Care

With an ageing population, people living longer with more long term conditions and a significant efficiency challenge we want to develop a more integrated approach to the provision of intermediate care services. This ambitious transformation of services will support our joint priorities of promoting independence, prevention of avoidable hospital admission and delayed discharges.

Our aim is to support recovery in a non-acute setting, enabling people to achieve optimum levels of independence. Building the right capacity and capability for an integrated intermediate care service is a key element in driving this forward.

What are we going to do?

We will develop a fully integrated intermediate care offer, with the right number of beds to meet demand, more flexible eligibility criteria, increased provision of services in the home and more choice of housing.

We will build on our intermediate day care offer to support more people to regain control over their lives based on self-determined outcomes enabling people to remain in control of their lives, promote their health and well-being and remain outside of statutory services.

We will increase options for move-on Extra Care Housing provision, incorporating access to telecare and telehealth service.

We will merge existing intermediate care provision, including the Rotherham Intermediate Care centre (RICC) onto a single site, creating a rehabilitation/ reablement hub. Eligibility criteria for the new intermediate care service will be extended to include:

- People with 24/7 nursing needs
- People with dementia
- People who require a period of recovery/recuperation

10.6 An Integrated Carers Support Service

The National Carers Strategy Carers sets out the strategic vision and outcomes for carers. It states that carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, while enabling the person they support to be a full and equal citizen.

The key outcomes associated with this strategy are;

- Carers are actively sought and identified
- Carers are provided with appropriate up-to-date information, advice and guidance
- Carers receive Carers Assessments
- Carers are engaged and supported to plan for the future
- Carers' wellbeing is improved through the provision of emotional support
- Increased knowledge, skills and behaviours for Carers through training and development
- Carers Receive Health Prescribed support when appropriate

We are currently developing a co-produced Carers Strategy "Caring Together" which is due to go to the Health and Wellbeing Board in June 2016. The plan focuses on three outcomes:

- Carers in Rotherham are more resilient and empowered
- The caring role is manageable and sustainable
- Carers in Rotherham have their needs understood and their well-being promoted

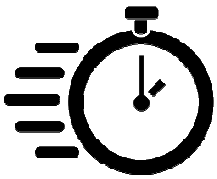
What are we going to do?

We will jointly commission an integrated Carers Support Service to support these outcomes. The service will incorporate health and social care professionals specialising in carer support, working in partnership with carers advocacy groups and third sector partners. The new service will provide information and advice on breaks from caring, lifestyle issues, family relationships, legal issues, employment and advocacy.

We will develop and Emergency Plan for Carers which sets out the support requirements for the cared for person if a carer is no longer able to offer support. Following assessment carers will be given a record of their needs and a copy of their support plan.

10.7 A Multi-Disciplinary Integrated Rapid Response Service (IRR)

The IRR service supports patients who are medically for discharge, can be cared for at home but are waiting for the appropriate health or social care package to be assessed and put in place. It also supports patients who are at immediate risk of hospital admission. The main interventions carried out by the IRR service include;



- Rapid MDT assessment and care planning
- Nursing intervention , including IV therapy if capacity allows
- Falls risk assessment
- Intensive rehabilitation services, including physiotherapy, occupational therapy and reablement
- Respite care e.g. due to carer breakdown
- Co-ordinating alternative levels of care

What are we going to do?

We will extend the IRR Service so that it incorporates social care.. The service will incorporate the following legacy services:

- Out of Hours Home Care Provider
- Care Home Support Advance Nurse Practitioners
- The Fast Response Service
- The District Nursing Twilight Service, Evening Service and Night Sister

The service will be accessed through the Care Coordination Centre. There will be a significantly stronger link between the out-of-hours social care services and renewed enabling service to ensure continuity of care and support

10.8 A Single Health and Social Care Plan for People with Long Term Conditions

When done well, care planning can be effective in improving the quality of life of people with long term conditions. Over the next two decades, shifts in demographics and disease management will result in a greater proportion of people than ever before, living well into their eighth and ninth decades of life. The majority of these people will also be living with at least one long term condition. Ensuring their care is well managed over the long term, including the approach to the end of their lives, will become an increasing challenge for the CCG and the local authority.

One major barrier to supporting this cohort of is the fragmented approach to care planning. Health and social care still have separate systems for preparing care plans. Although communication and connectivity has improved between health and social care professionals, they are hampered by a requirement to have separate care plans.

The Cochrane Review on integrated care planning found that it leads to improvements in physical, psychological and subjective health. Integrated care planning also affects people's capability to self-manage their condition. The studies showed that the effects were greater when it incorporated a single health and social care plan.

What are we going to do?

Rotherham will develop integrated health and social care plans for people on the long term case management programme. Now that social care and health records can be matched using the NHS number there is an opportunity to develop single care records and care plans. Using integrated care planning we can avoid duplication and multiple monitoring regimes.

10.9 A Joint Approach to Care Home Support

There are presently around 1,800 older people living in residential and nursing care homes in Rotherham. The number of residents is predicted to increase to 2,100 by 2020. This figure includes those residents that are financially supported by the Local Authority, self-funders and out-of-authority placements. Around 400 older people are admitted to residential care each year with complex needs.

Rotherham has a Care Home Support Service, funded through the Better Care Fund. The main aims of the Care Home Support Service are to:

- Ensure that the appropriate quality of care is provided in our residential and nursing homes
- Reduce A&E referrals, ambulance journeys and hospital admissions from care homes
- Meet the mental health needs of residents (via agreed Mental Health pathways)
- Develop personalised care planning residents at high risk of hospital admission
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives
- Ensure quality of health and social care is being provided in residential and nursing care homes through contract compliance and care home support

What are we going to do?

We will carry out targeted interventions on residential and nursing homes who are outliers on emergency admissions. We will support GPs in the case management of patients who are at high risk of hospital admission.

These patients will be allocated a Care Co-ordinator from within the Care Home Support Service. The Care Co-ordinator will combine advanced clinical nursing and therapy practice with the co-ordination of personalised and integrated care plans. The Care Co-ordinator, alongside the Case Manager, will be responsible for co-ordinating the journey through all parts of the health and adult social care system.

We will support residential and nursing homes in meeting the needs of residents with organic and functional mental health problems. We will conduct an annual mental health assessment of all care homes. The assessment will identify residents with depression and dementia. We will monitor these residents, ensuring that they are sign-posted to appropriate health and adult social care services for support. We will identify residents who have memory problems and ensure that they are referred to the Rotherham Memory Service for a comprehensive dementia assessment.

We will deliver an extensive and comprehensive training programme agreed with RCCG and RMBC commissioners. Training courses will include: safeguarding, communication and dementia, life story sessions, active ageing, Parkinson's disease, safe feeding, swallowing and positioning, peg feeding, falls management and prevention, diabetes, oxygen therapy, hand hygiene, chest infections/respiratory conditions, infection control, oral hygiene, continence, ophthalmic care, oral care, equipment assessment including installation, cleaning and maintenance and tissue viability including effective use of mattresses and pressure area care.

We will have clear protocols with Rotherham's integrated stroke care pathway so that patients discharged from the stroke unit into residential/nursing care receive continued support and are reviewed after 6 months. Such patients are likely to have substantially different needs from those who return to their own home so the focus of intervention will be different.

10.10 A Shared Approach to Delayed Transfers of Care (DTOC)

Within the Better Care Fund Policy Framework (2016/17) there are new National Conditions which all BCF programmes must action. One of these is the development of a Delayed Transfer of Care Action Plan (Appendix 5) and a locally agreed target for the reduction of DTOCS.

The number of recorded Delayed Transfers of Care (DTOC) from the December 2015 National DTOC report shows that 2.2% of transfers were delayed. This is significantly lower than the national average of 3.5%. There has been significant progress in the last 12 months to support the reduction in DTOCs within Rotherham.

The requirements around DTOC are considered within the Rotherham CCG's Operating Plans for 2016-17. Rotherham CCG and its partners will monitor DTOCs through the System Resilience Group. The System Resilience Group has recently endorsed a Memorandum of Understanding (MoU) (Appendix 6) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which has now been signed up to by all providers. The MoU covers DTOC and all other patients who are 'medically fit for discharge'. This figure for patients who are " medically fit for discharge" is usually higher than the DTOC figure, because it includes the following cohorts of patients

- Patients who require assessment for a new or existing care package (DTOC)
- Patients who need to have an existing care package restarted
- Patients who do not require a social care package
- Patients who may require a Continuing Health Care
- Patients waiting for an intermediate care or discharge to assess bed
- Patients who have been assessed as needing residential care but the actual home has not been selected.

The main purpose of the MoU is to ensure that patients are discharged as soon as they are medically fit and that they have the appropriate care packages in place which reduces the risk of readmission

What are we going to do?

We will develop robust risk sharing agreements relating to DTOC within the next quarter as part of further development of the MoU. We will also develop robust reporting systems which incorporate data on DTOC and other patient cohorts who have an impact on patient flow.

We will further develop our MoU through a robust review process. Future iterations will consider issues that expedite discharge, for example predicting times of discharge to enable effective community planning, the interfaces with integrated rapid response and management of MDT's for patients who change wards during their acute stay, effective discharges from Intermediate Care.

We will continue to work with partners through the "GP ward round" weekly meetings. This is a multi-disciplinary meeting which brings together front-line staff and senior managers to focus on facilitating discharges from hospital. The main aims of the meeting are to remove barriers to discharge and identify systemic issues that restrict patient flow. The "GP Ward Round is a key vehicle for achievement of BCF Metrics.

10.11 Relevance to The Health and Wellbeing Strategy

The BCF priorities will support the aims and objectives of Rotherham's Health and Wellbeing Strategy. Table 2 shows how the BCF priorities line up with those of the Health and Wellbeing Board.

Table 2: Relevance to Health and Wellbeing Strategy

HWB Aim	BCF Priority	Impact on HWB objectives
All Rotherham people enjoy the best possible mental health and wellbeing	A single point of access into health and social care services	• Improved support for people with enduring mental health needs, including dementia • Reduction in common mental health problems among adults • Reduction in social isolation
	Reconfiguration of the home enabling service	
	Integrated health and social care Teams	
	An integrated carers support service	
	Shared approach to delayed transfers of care (DTOC)	
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reduced	Preventative services that support independence	• Reduction in early death from cardiovascular disease and cancer • Improved support for people with long term health and disability needs
	Development of a reablement hub incorporating intermediate care	
	A multi-disciplinary rapid response service	
	A single health and social care plan for people with long term Conditions	
	A joint approach to care home support	

10.12 Milestones and Timelines

This section of the BCF Plan maps out the key milestones associated with the key priorities.
Table 3 sets out the key milestones for delivery of this strategy.

Table 3: Key Milestones

Priority	Description	Milestones 2016	Date
1	A single point of access into health and social care services	Service model agreed by BCF Executive	31.08.16
		Commissioning arrangements agreed	31.10.16
		Service reconfiguration begins	01.01.17
		Single Point of Access in place and operational	01.04.17
2	Development of integrated health and social care teams	Identify pilot locality	09.03.16
		Service specification agreed by CT Board	30.04.16
		Appoint locality manager	01.06.16
		Recruitment of team complete	01.07.16
		Integrated locality team starts to operate	01.08.16
		Evaluation complete	30.06.17
3	Reablement hub incorporating intermediate care beds	Intermediate Care Review approved by CT Board	30.06.16
		New service model agreed by CT Board	01.09.16
		Pooled budget arrangements agreed by CT Board	01.09.16
		Project plan agreed for implementation of service model	01.09.16
		New service model fully operational	01.06.17

Priority	Description	Milestones 2016	Date
4	Preventative services that support independence	OT and REWS Review approved by BCF Executive	31.08.16
		New service model agreed by BCF Executive	31.08.16
		Project plan agreed for implementation of service model	01.11.16
		New service model fully operational	01.01.17
5	Reconfiguration of the home care enabling service	Home care enabling Review approved by Adults Transformation Board	31.07.16
		New service model agreed by Board	31.07.16
		Project plan agreed for implementation of service model	01.10.16
		New service model fully operational	01.04.17
6	A multi-disciplinary carer support service	Service map of carer services	31.03.17
		Service specification agreed at BCF Executive	01.06.17
		Commissioning arrangements agreed	01.06.17
		New service operational	01.10.17
7	A multi-disciplinary integrated rapid response service	Service model agreed by BCF Executive	31.01.17
		Commissioning arrangements agreed	31.01.17
		Service reconfiguration begins	01.04.17

Priority	Description	Milestones 2016	Date
		New service in place and operational	01.09.17
8	Single health and social care plan for people with long term condition	Scoping exercise completed on integrated care plan	01.09.16
		Develop common template for case management	31.11.16
		Develop IT solution for sharing care plan across systems	31.12.16
		Implement integrated care plan for case management	01.04.17
9	A joint approach to care home support	Development of care coordinator role	01.04.17
		Introduction of annual mental health assessments	01.06.17
		Development of a targeted care home training programme	01.09.17
		Introduction of protocols for stroke patients in care homes	01.09.17
10	Shared Approach to Delayed Transfers of Care (DTOC)	Development of an MoU on management of patients who are medically fit for discharge	01.05.16
		Embed daily MDT meetings on medical wards	01.05.16
		Introduce "trusted assessor" role to reduce duplication and improve patient flow	.1.06.16

11 National Conditions

11.1 Supporting Social Care Services

Rotherham's BCF Plan supports social care in three ways;

- Ring-fencing resource in the BCF budget for social care activities that support health outcomes
- Supporting integration, reducing duplication and generating efficiencies that can be reinvested
- Enlisting the support of the 3rd sector through effective social prescribing

Ring-Fencing

Theme 3 of Rotherham's BCF Service directory is "Supporting Social Care " This identifies a range of social care services that are strategically relevant and performing well. Decisions on future funding can only be taken if agreed between RCCG and RMBC. More importantly there would have to be drift in relation to performance or strategic relevance to precipitate a decision to remove these services. There has been no reduction in the funding made to this category of service from the 2015-16 BCF plan, the main difference is how the services have been categorised into 6 new Themes as discussed earlier in the plan.

Supporting Integration

Rotherham's Better Care Fund Plan includes a range of initiatives which support joint working across health and social care. These include; integrated locality teams, the care home support service and social care assessment beds. All these initiatives support social care by using resources from partner organisations to achieve social care outcomes. For example, the integrated locality teams will be responsible for initiating and reviewing social care assessments. Social workers will be able to access therapists and other health care professionals to assist with these assessments, delivering a more holistic service and reducing duplication.

3rd Sector Support

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. The service protects social care because it intervenes early, before the need for formal care services. The Social Prescribing Service addresses directly those social needs that arise after significant life events; e.g. after loss of a partner or after diagnosis of a long term condition. The service promotes self-care, community integration and a holistic approach to care planning. There is local evidence that it has successfully reduced the cost of social care packages. Even where someone already has a social care package in place, the service can play a complementary role, reducing levels of dependence, maintaining engagement with informal support networks and boosting resilience.

11.2 Disabled Facilities Grant

The Disabled Facilities Grant is embedded within the 3 year Housing Investment Plan (HIP) which is approved by members. The funding is used for the provision of adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. This will include the provision of Assistive Technology in 2016/17 due to the ending of the PSS Capital Grant in March

2016. The Strategic Director of Adult Social Care and Housing has been fully involved in the development and approval of the BCF plan for 2016/17 and is a member of the Health and Wellbeing Board, BCF Programme Board and BCF Executive Group. Both the Boards and group includes representatives from the CCG including the Chief Officer and Chief Finance Officer. This ensures there is a joined up approach in improving outcomes across the health, social care and housing sector.

11.3 Delivery of 7 Day Services Across Health and Social Care

Health and social care both recognise the need to improve the process for planned hospital discharge for vulnerable adults. At any one time, there are a number of patients in an acute bed, whose medical episode is complete, but who are awaiting further assessment, initiation of a care package or decisions on choice of a care home placement. The following services, funded through BCF operate 7 days/ week.

Integrated Rapid Response Service (IRR)

The IRR service supports people who are unable to remain at home because they have a temporary health and/or social care need. The service supports people to remain at home until they have recovered or until a long term care plan can be put in place. The service operates 7 days/week, 24 hours/day. It provides immediate support to patients who exacerbate in the community and has access to community beds which are also available 7 days/week.

Intermediate Care

Intermediate Care Services in Rotherham now receive referrals 7 days/week. Historically hospital discharges could only take place during the working week. Extending the time frame for referrals supports timely discharge and can prevent admissions during the weekend. There is a specialist Mental Health OT and CPN which carry out assessments and management of mental health for individuals whose needs affect their function and ability to undertake rehabilitation. This service also covers the Integrated Rapid Response service.

Hospital Social Work Service

The Hospital Social Work team can now carry out social care assessments and co-ordinate packages of care 7 days a week. Domiciliary care providers are also now contracted to respond to urgent referrals on a 7 day a week basis, delivering urgent packages of care.

A 7 day community, social care and mental health pilot to support hospital discharge and reduce delays has now been operational since December 2015. The hospital and Hospital Social Work Team now provide a joint approach to assessments and care planning on a 7 days a week basis. This new pathway also reduces length of stay in hospital medical wards. We will carry out a review of this pilot at the end of March 2016, with the intention of ensuring that this becomes a permanent arrangement to continue to support discharge and admission prevention.

Rotherham Equipment and Wheelchair Service

A review of the Integrated Community Equipment Service will be carried out in 2016/17 which will identify demand for community equipment to facilitate hospital discharge, in particular over the

weekend. A review of the satellite office provision enabling practitioners to collect health and social care equipment will also be carried out.

Mental Health Liaison Service/Learning Disability

The Adult (including older peoples) Mental Health Liaison Service pilot will continue in 2016/17. This service is to be externally evaluated by Sheffield Hallam University (SHU) in 2016-17. This service in conjunction with the Crisis Team provides a 7 day service. There are also several other health and social care commissioned Mental Health and learning disability Services that provide 7 day services to support this agenda that are not currently part of the BCF programme but contribute to meeting the objectives of the BCF.

11.4 Improving Data Sharing Between Health and Social Care

Improved data sharing between health and social care is a national condition of the Better Care Fund. All BCF adult social care records now have an NHS number assigned. The health and Well Being Board has agreed that the NHS number be used as a primary identifier.

The new social care system will go "live" later in 2016. This will include a new facility to integrate with the NHS "Patient Demographic Service" (PDS) allowing access to NHS numbers on the NHS spine. Whilst we are awaiting for that facility to go "live" we will add new NHS numbers manually and continue to use the local informatics team matching bureau for batch processing.

An operational data sharing agreement has now been developed and agreed by the CCG and Local Authority (Appendix 7) which sets out how data can be seen, when and how the data will be used. This ensures that Information Governance controls are in place for information sharing in line with Caldecott 2.

The new social care system will go "live" later in 2016. This will include a new facility to integrate with the NHS "Patient Demographic Service" (PDS) allowing access to NHS numbers on the NHS spine. Whilst we are awaiting for that facility to go "live" we will add new NHS numbers manually and continue to use the local informatics team matching bureau for batch processing.

Training materials have been issued which demonstrate to practitioners in adult social care how to use the NHS number field. This includes mechanisms for maintaining the NHS number. A weekly report is issued to managers detailing the number of NHS numbers updated each week. Managers are reminded to encourage practitioners to check/complete the NHS number field, wherever possible.

We will continually improve data sharing between health and social care through the use of NHS numbers in all correspondence. The use of the NHS number is an important stepping stone towards our main objective, the rapid and easy exchange of data between health and social care.

Rotherham MBC's strategy "Your Digital Council (Appendix 8) highlights the continuing importance of a digital infrastructure. This includes "broadband, online services, access and skills". The strategy describes opportunities which digital offers and the dependencies that exist between a strong economy, social well-being and modernised public services. The strategy includes the following commitments:

- Partners will develop an NHS "Local Digital Roadmap", ensuring that all electronic health and social care records are interoperable and ultimately paperless
- NHS staff will have real-time access to local authority client data where it is appropriate and legal to do so
- Local authority staff will be able to access NHS systems where it is appropriate and legal to do so, creating a single view of the Rotherham citizen
- Partners will work together to create a common sets of standards, which support the sharing of data cross local services. This will be enhanced by the adoption of a common identifiers such as NHS numbers and unique property reference numbers.
- Partners will work together to develop a web portal that allows multiple data sources to be interrogated from one location

The CCG and Local Authority have long recognised the importance of open APIs (application programming interfaces) in facilitating data sharing between systems and we have a long standing policy of mandating that suppliers provide open APIs wherever possible. The new social care system includes access to open APIs. Similarly the NHS has written the provision of open APIs in to the current national contract for the supply of GP clinical systems.

One of the commitments of the Rotherham CCG IT Strategy (2015/16) (Appendix 9) is to develop a clinical portal that will integrate information from health and care services across the local health community. As the system is developed it will give professionals access to all the data and information they need to deliver safe, high quality care. We also aim to develop patient access to the portal allowing them a common view of their health information for Rotherham health and care services. Work on the clinical portal has been on-going since June 2015. A single view of a patient's secondary care information has been developed and this has been linked with risk stratification data to provide a system for GPs to view the hospital activity of their patients who are at a high risk of hospital admission.

The Detailed Care Record Service of the Medical Interoperability Gateway (MIG) has been developed for primary care data to be viewed in the clinical portal. GP Practices have been contacted with guidance on how to register to gain access to the clinical portal. Over the period of this plan we will develop the clinical portal to provide safeguarding and end of life information, ensuring information governance is place to ensure security and confidentiality.

We will carry out a feasibility study for development of the patient portal. This will a provide results tracker for chronic patients and an ability to sign-post patients to appropriate service.

The use of integrated records, information and technology will support the reduction of unnecessary non-elective hospital admissions, promote 7 day working, support out of hospital/community based services and facilitate timely hospital discharge.

A joint working group known as "Rotherham Health and Care Interoperability Group" is in place. The membership of the group includes clinicians, GP's, Directors, IT Programme Managers from the Local Authority, CCG, TRFT, RDaSH and Rotherham Hospice. This group is the "parent" to a subsidiary group which is the "Information Governance Sub-Group" which ensures that all aspects of data sharing are properly considered at every stage of the development of our Local Digital Roadmap (which the BCF will form an important part of).

An Overarching Information Sharing Protocol is in place – this is a Tier 1 agreement that was created through the Council's 'Corporate Information Governance Group' and has been adopted across the local partners. In addition we have a specific Tier 2 agreement relating to data sharing for the BCF initiative.

All relevant IG controls are in place and we are fully compliant. RMBC is accredited against the PSN code of connection. Further, the Council complies with and meets Caldicott2 requirements via our submission to the IGSoC and via the IGToolkit.

The Council has a nominated SIRO (this is the Strategic Director of Finance and Customer Services). We have an Information Governance escalation group and a IG Board where all IG decisions are made. There is an annual mandatory DPA training provision and an e-induction process is in place.

As part of our Local Digital Roadmap programme we have developed a communication and engagement plan (Appendix 10). This plan has yet to be formally signed off and the communication described within has yet to begin.

At the heart of all the communications on these issues is our desire to ensure that citizens are educated and comfortable with regards to the way their data is being used. Throughout the campaigns we will put the following principles front and centre:

- Explain to people why data is being shared between partners and how this will benefit everyone
- Ensure that local people have clarity about how data about them is used – this will include
- Description of the personal confidential data shared
- Description of the de-identified data shared on a limited basis
- Explain who may have access to their data (i.e. who we are sharing with)
- Explain how people can exercise their legal rights with regards to their data

12. Measuring Success

12.1 BCF National Metrics

As part of the Better Care Fund Plan we will measure against the national metrics and Rotherham's agreed local metrics. The BCF Policy Framework establishes that the national metrics will continue as they were set out for 2015-16. In summary these are:

a. Non-elective admissions (General and Acute)
b. Admissions to residential and care homes
c. Effectiveness of reablement
d. Delayed transfers of care

The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, are clearly identified in the BCF planning return. The detailed definitions of the other three metrics are set out in Table 4

Table 4 – BCF Metrics Definitions

	Metric	Numerator	Denominator
2	Admissions to residential and care homes	The sum of the number of council-supported people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year. Data from Short- and Long-Term Support (SALT) collected by HSCIC	Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection
3	Effectiveness of reablement	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move on/back to their own home who are at home 91 days after the date of their discharge from hospital.	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move back to their own home.
4	Delayed transfers of care	The total number of delayed days (for patients aged 18 and over) for all months of baseline period	ONS mid-year population estimate (mid-year projection for 18+ population)

Non-Elective Admissions

The metric reflects the overall CCG plan as submitted to UNIFY2 on the monthly activity template. The UNIFY2 submissions have been triangulated with current contract plans. There is the wider footprint of the South Yorkshire and Bassetlaw STP to take into consideration. The setting of CCG plans has been undertaken with consideration to previous year's activity levels, in the context of the 2016/17 financial challenge.

Delayed Transfers of Care (DTOC)

The Delayed Transfers of Care Plan is set to a level of realistic achievement within the financial challenge of 2016/17. Trend analysis has been undertaken prior to the setting of targets. The Delayed Transfers of Care Plan has set a target which is realistic within the challenges anticipated from demographic and service changes.

Permanent admissions of older people to residential and nursing care homes (per 100,000)

Rotherham MBC year end outturn for 2015/16 will show approximately 60 fewer admissions compared to 2014/15. An outturn of 410 admissions equates to a rate of 822 per 100,000. Further improvements through BCF initiatives will potentially deliver an additional reduction of 20

admissions next year giving an estimated total of 390 for the year. This results in an overall rate of 767 per 100,000. These figures take account of the increase in admissions rate resulting from the definition change in 2014/15. It also takes account of the estimated increase in the over 65 population for 2016/17.

Proportion of older people still at home 91 days after discharge from hospital into rehabilitation and reablement services

Rotherham MBC is projecting a year end outturn of 89.6%, which reflects an increased number of people benefitting from using rehabilitation and reablement services in 2015/16. This improves on our 2014/15 score of 83.5% but is just below our target of 90%. Rotherham MBC estimates that improvements to our service 'offer' will result in further improvement in 2016/17, making a target of 91% realistic. There is a need to strengthen our analysis on the longer term trend, in order to provide evidence based findings that support our projections.

In-patient Experience – proportion of people reporting poor patient experience of in-patient care

The 2014 score was published in late 2015 showed an improvement beyond the 2015/16 plan, with a score of 115.9. Current plan is to sustain this level of achievement. Numerator and denominator are not available until published nationally.

12.2 Impact on Local Metrics

Rotherham CCG Commissioning Strategy

The CCG Delivery Dashboard incorporates metrics which the BCF has an impact on:

- Number of patients admitted to hospital for non-elective reasons discharged at weekends/bank holidays
- Health related quality of life for people with long-term conditions
- Proportion of people being supported to manage their condition
- Proportion of deaths at home
- Hospital spells resulting from fall-related injuries patients aged 65 and over
- Additional years of life secured in conditions considered amenable to healthcare.
- All people over 65 or those under 65 living with long term conditions have their own co-ordinated care plan where the priorities set by the individual are supported by the care that they receive, resulting in improved health related quality of life.
- Emergency admissions and length of stay reduced by managing care more proactively in other settings.
- Proportion of people having a positive experience of care in all settings increased.
- Parity of esteem for people suffering with mental health conditions alongside those with physical health conditions.

RMBC Adult Social Care Metrics

A number of Key Performance Indicators from the Adult Social Care Outcomes Framework (ASCOF) will be supported by the initiatives identified in the BCF Plan as will some local performance measures and include the following:-

- Proportion of people using social care who receive self-directed support and those receiving direct payments
- A range of Service User and Carer survey ASCOF measures for example: reporting that they have a good quality life, the proportion of people who use services who feel safe, social care service users who feel they have control over their daily lives.
- Proportion of people aged 65 and over requiring social care support, plus impact on ASCOF relating to employment, settled accommodation, delayed transfer of care and rehabilitation measures.
- Supported housing placements - Learning Disability (18-64)

13. Impact Assessment

Table 5 provides a summary of the impact that BCF Change Programme will have on patients and the local health economy. We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce activity in acute care, reduce reliance on formal social care, increase access to primary and community services and improve outcomes for people with long-term conditions.

If we do not deliver activity reductions in acute and social care, we anticipate significant financial pressures in the local health and social care economy. We anticipate that the changes proposed will have a significant impact on community services. Statutory and independent providers of health and social care will be partners with us in delivering this Better Care Fund Plan.

Rotherham partners have a commitment to ensuring that the impacts of our local plans are understand throughout organisations.

Table 5: Summary Impact Assessment

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
1	Single point of access into health and social care services	• People can access the right care first time • Reduced duplication of assessments and visits to patient homes through better care co-ordination • Facilitates discharge and prevent unnecessary admission • Can respond to people who require support after using the community alarm system	• More controlled access to urgent care services • Reduces the time currently spent by the referrer in identifying and arranging appropriate care. • Improved access for professionals to a range of services. • Health professionals can make informed choices about the most appropriate level of care	• Non-elective admissions • Effectiveness of reablement • Delayed transfers of care
2	Integrated Health and Social Care Teams	• People don't have to re-tell their story every time they encounter a new service • People get the support they need because different parts of the system are now talking to each other • Home visits from health or care workers are combined	• Professionals can support patients to stay at home and minimise the need for hospital admission to hospital. • Increase in face to face clinical time. • Improved organisational reputation through delivering a responsive service and providing alternative to acute admissions.	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
3	A Reablement Hub Incorporating Intermediate Care	• Single rehabilitation coordinator who supports individual through whole care pathway • All therapists and carers on-site and accessible • More holistic approach to rehabilitation	• Generates efficiencies that can be reinvested • Reduced length of hospital stay for step-down patients • Greater impact on reducing hospital admissions because of increased use of	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
			step-up beds	care
4	An Integrated Carers Support Service	• Better access to benefits, information and advice • Reduction in social isolation for both carer and those being cared for • Improved health and well being	• Reduced likelihood of carer breakdown, which could lead to increase in costs of formal care • Care being used effectively as a resource to support people with long term conditions • Reduction in cost of social care packages	• Non-elective admissions • Admissions to care homes
5	A Multi-Disciplinary Rapid Response Service	• Immediate access to medical and social care support for those that have an urgent care need • Housebound patients can access the service • More likely to see and treat at home	• Reduction in number of unscheduled hospital admissions will release capacity in acute care • Reduced length of hospital stay for patients will improve patient flow in acute care • Team will support GPs to maintain high risk patients at home	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
6	A Single Health and Social Care Plan for People with Long Term Conditions	• One plan covering all aspects of care • Less confusion and duplication • Includes support with self-management and urgent response	• Greater visibility of what other professionals are doing • Reduces risks that arise from fragmentation of service • Reduction in bureaucracy	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement
7	A Joint Approach to Care Home Support	• More likely to see and treat at home • Single care coordinator who can support a resident throughout their stay • Better quality care and holistic	• Specialist team will have correct skill set to support people in residential care • Case management approach to care in residential homes • Better support for care home staff	• Non-elective admissions • Effectiveness of reablement • Delayed transfers of care

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
		approach		
8	A Shared Approach to Delayed Transfers of Care (DTOC	• Shorter hospital stay • Better quality care packages delivered in a timely manner • Reduced risk of readmission	• Better patient flow through the hospital • Reduction in cost of acute care • Reduction in readmission costs for RFT	• Delayed transfers of care

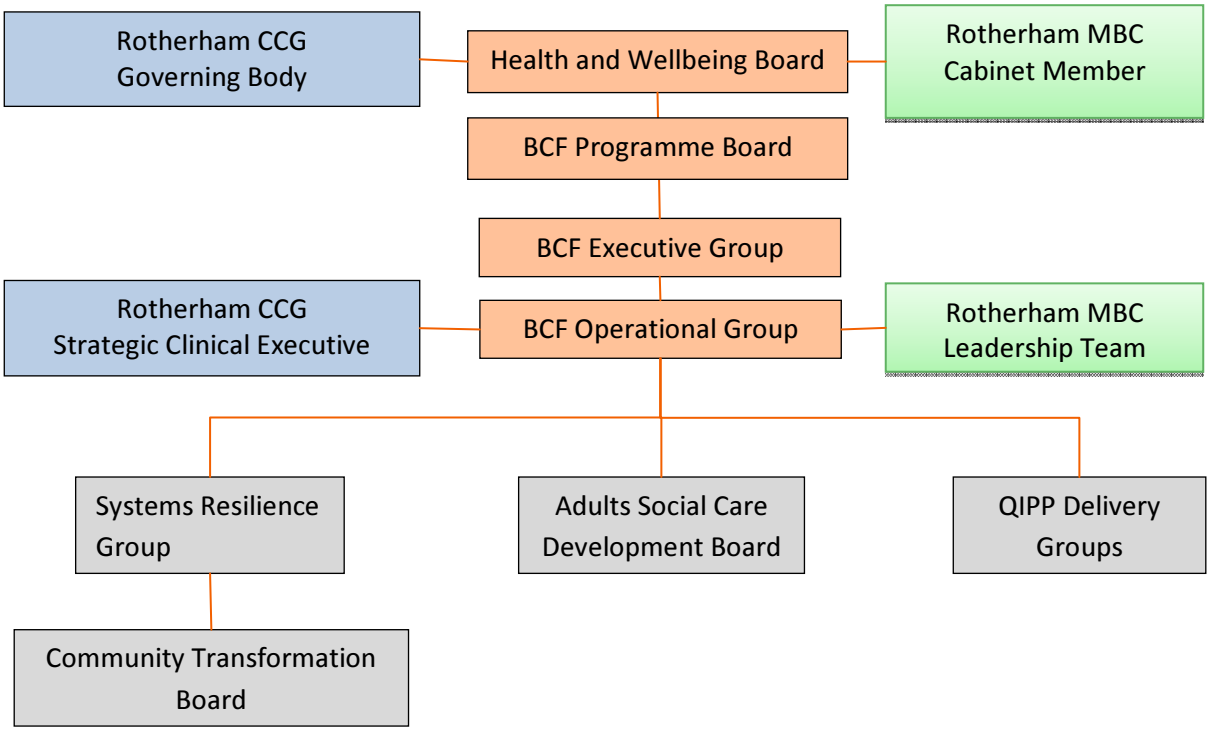
14. Governance Arrangements

14.1 Description of Current Governance Framework

The delivery of the BCF is fully integrated with the delivery of the Health and Wellbeing Strategy. In Rotherham the Health and Wellbeing Board has overall accountability for the BCF Plan.

Figure 4 sets out the current governance arrangements.

Figure 4: Current BCF Governance Structure



Role of Health and Wellbeing Board

Key responsibilities of the Health and Well Being Board include;

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

Role of BCF Programme Board

Key responsibilities of the Programme Board include;

- Agree strategic vision and priorities for the future
- Make decisions relating to the delivery of the plan

Role of BCF Executive Group

The BCF Programme Board is supported by the BCF Executive Group, which has been meeting since July 2015. Both Board and Group consist of Chief Executives, Elected Members, Chief Finance

Officers, Directors from both the Local Authority and the Clinical Commissioning Group. Key responsibilities of the Executive include;

- Monitor delivery of the Better Care Plan through quarterly meetings
- Ensure performance targets are being met
- Ensure schemes are being delivered and additional action is put in place where the plan results in any unintended consequences.
- Report directly to the Health and Wellbeing Board on a quarterly basis.

Role of BCF Operational Group

The BCF Executive Group is supported by the BCF Operational Officer Group which meets every 6 weeks. The Operational group is made up of the identified lead officers for each of the BCF priorities, plus other supporting officers from the council and CCG.

- Ensure implementation of the BCF action plan
- Implement and monitor the performance management framework
- Deal with operational issues, escalating to the Task Group where needed

14.2 Review of Governance Framework

During 2016/17 The Health and Wellbeing Board will review the current governance arrangements. The review will identify where there are areas of duplication and put forward proposals for a streamlined governance framework that incorporates all elements of the commissioning cycle.

The review will make recommendations on a joint performance framework so that we can build on the outcomes of the service review and continue to monitor the performance and strategic relevance of BCF funded services.

The review will incorporate the development of a full suite of combined health and social care metrics for those services that have been integrated. The new governance framework will show clearly where joint decisions are made. It is really important that there is full visibility in relation to the decision making process. A streamlined and coherent governance framework will speed up decision making and create a positive environment within which commissioners collaborate.

15. Risk Assessment

Table 6 provides a summary of the risks associated with the development of the Better Care Fund

Table 6: Major Risks to BCF Action Plan

Key:

Likelihood * Impact = Score
1 = Low Impact or Low Likelihood
5 = High Impact or High Likelihood
Maximum score 25

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
Strategic Risks					
1	Poor alignment between service budgets and actual cost	4	3	12	The review process timetabled throughout 2016-17 will ensure the alignment of budget with actual costs. Monthly budget monitoring is in place and reports are regularly taken to the Operational and Executive groups regarding finance and any risks which require mitigation.
2	Shortfall of resources to fund the priorities identified in the plan	3	4	12	As above. The review process will seek to identify areas where budgets can be appropriately aligned to BCF priorities; this may include reconfiguration of service provision in year.
3	BCF services are not fit for purpose	4	3	12	New governance and performance framework will highlight those services that are not performing and set out a new

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
					structure for performance management
4	The introduction of the Care Act will result in a significant increase in the cost of care provision onwards that is not fully quantifiable currently	4	4	16	The financial implications of the Care Act have been included in the financial plan (£0.7m) Work to address Care Act compliance is incorporated in Adult Social Care Development Board Programme. Various models have been populated and provided evidence of demand for additional assessments (including carers' assessments and respite) at an approx cost of £0.850m. This information ensured that sufficient funds were established in 2015-16 and remain in BCF for 2016-17.
5	Compliance with Mental Capacity Act (MCA) incorporating the Deprivation of Liberty Safeguards (DOLS)	4	4	16	New DOLS team developed with new team manager and seconded full time Best Interest Advisors x 4.
6	Operational pressures restrict capacity to implement key projects identified in the BCF Plan	4	5	20	Our schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. BCF Ops Group will oversee implementation of the 2016/17 programme, identifying areas where operational pressures are impacting on implementation and developing targeted strategies to free up the change process. Monitoring template in place for all BCF reviews and will be taken to Operational Group meetings to ensure early identification the risks associated with implementation/achievement.
7	Failure to achieve planned savings due to overspends in the system/ inability to meet targets will create financial risks (budget pressures) for the	3	5	15	Performance management framework via the System Resilience Group in place to monitor progress to ensure targets are achieved. Good forward planning with providers on activity reductions through regular contract performance meetings. BCF Operational Group will oversee implementation of the 16/17 programme. If

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
	respective parties				service improvements do not have the intended impact on hospital and care home admissions the BCF Operational Group will make recommendations on where service restrictions should apply, ensuring that the programme remains within budget.
8	Achieving savings in one area of the system, can cause unintended consequences of higher costs elsewhere.	3	3	9	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. Both partners have agreed a 'risk pool' of £500K which has been included in the financial plan to mitigate the risk of non-delivery of non-elective savings and social care packages. The "risk pool" forms part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan is monitored on a quarterly basis by the BCF Executive group, and any consequences will be reviewed.
9	Failure to meet the national conditions and performance outcomes agreed with NHSE	3	5	15	Joint governance arrangements and new performance framework will help mitigate this risk. Financial risk sharing is in place through the Risk Pool.
10	Lack of engagement from front line staff because do not buy in to the integration agenda or lack the skills	3	4	12	Changing organisational structure is not sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care. This issue will form part of individual implementation plans for new initiatives in 2016-17.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
					Strong links are in place with all partners communication teams to ensure that change management occurs in the most effective and transparent way.
11	Social care not being adequately protected	3	5	15	No change in 2016-17 to the services that were identified in the BCF plan 2015-16 as fundamental to the protection of Social Care. BCF governance groups to take regular stock-take on current state of social care provision. Regularly review strategies for how the BCF can be enhanced to protect key services, particularly those that support admission prevention and reductions in formal social care.
12	Governance arrangements are insufficient to make investment decisions, ratify the vision and deliver key metrics	3	4	12	Governance arrangements scheduled for review this year. Programme has clearly defined purpose. Full engagement at CEO level. Clearly defined process for decision making with appropriate scheme of delegation. Clear system for disagreement resolution. Rules on data and performance management agreed.
Performance Risks					
13.	*Non-elective target not met;* BCF Schemes do not deliver the planned reduction in non-elective admissions resulting in higher cost. This is complementary to the programme within the System Resilience Group which focuses upon avoiding emergency admissions amongst other wider system issues of the CCG.	4	5	20	BCF commissioning intentions and investment in a number of work-streams have already taken place in 2015/16 including Integrated Rapid Response, Care Co-ordination Centre. The focus on out of hospital services will continue in 2016/17 through the BCF plan including Integrated Locality Pilot, rehabilitation and re-ablement hub.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
14.	*Residential Care target not met;* BCF Schemes do not deliver a reduction in permanent admissions to residential care increasing costs to the LA. This may be due to delays in implementation of schemes i.e.	3	3	9	BCF Schemes aligned with Care Act (2014) and Joint Health and Wellbeing Strategy 2015-19. Change Management leads have been appointed to ensure successful implementation of projects that will complement the BCF objectives. Any delays in scheme progress will be mitigated by appropriate Working Groups including closer working relationships with Housing.
15.	*Delayed Transfers of Care (DTOC) target not met*; BCF Schemes do not deliver the planned reduction in DTOC which will result in higher cost to the CCG and/or The Rotherham Foundation Trust. This may be due to poor collaboration/ communication between health and social care staff or ineffective/ insufficient out of hospital services i.e. intermediate care.	3	3	9	Review of pathways from hospital to community to ensure that they meet patient demand and are fit for purpose is underway. Action planning taking place to reconfigure services as part of the review process. This includes development of social care assessment beds, changes to the hospital discharge team to support integration. System Resilience objectives complement the Better Care Fund objectives. Memorandum of Understanding in place which ensures a clear, effective integrated discharge process which considers both hospital and community and cross sector provision.
16.	*BCF schemes are delayed;* Delay in implementation of BCF schemes results in underspends, creates inefficiencies in service delivery and hinders integration. There is likelihood that targets will not be met if scheme implementation is delayed.	2	3	6	Regular reporting on progress of all BCF schemes through the BCF Operational and Executive Group Meetings to ensure that underspends are managed and risks mitigated through the risk share agreement. A review of BCF schemes has taken place which identified those schemes requiring a deep dive review to be undertaken in 2016-17.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
OPERATIONAL RISKS					
17.	*Data sharing between health and social care;* Target on number of patients with NHS identifiable number is not met. This is a national condition, in not meeting the target there would be significant impact on the ability for integration /communication.	2	3	6	The officer lead for this objective at RMBC has provided updates at every operational group meeting throughout the 2015-16 and has given assurance that this target has been achieved.
19.	*Community Services;* BCF schemes increase demand on community services resulting in increased waits for health and social care assessments/ services	3	4	12	The BCF has identified new funding for social care and this will be reviewed as part of the work plan for 2016/17. Investment in community transformation programme through the CCG in 2015-16 will provide more targeted resource into the community in order to better meet demand.
20.	*Rotherham Population;* Schemes not targeted at the right populations resulting in pressures on the acute services	1	3	3	Using Joint Strategic Needs Assessment, Commissioning Plans/Strategies to support rationale for scheme development – incorporating intelligence of local population and demand in to service specifications to target appropriate cohorts of patients. Review of service implementation takes place once a scheme is up and running. Performance, quality and outcomes regularly monitored through performance submissions and meetings with providers.
QUALITY RISKS					
21.	*Provider destabilisation;* Shifting of resources could destabilise current service providers. For example force	2	4	8	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. CCG received Quality Impact Assessments from providers

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
	viability issues due to loss of funding in one area, cause issues with performance against contracts.				regarding their respective efficiency plans. LA will continue to engage with providers to ensure potential impact is understood and planned for.
22.	*Carers;* Risk that BCF impacts negatively on the support and experience of carers leading to a reduction in the number of carers. Carers may not be supported to continue to care through the various services currently in place, or the new services implemented, i.e. 7 day support for adult social care. If they cease to care this could result in increased costs for the LA and CCG	2	2	4	Existing support for carers is delivered through a number of services including respite, short break, carers emergency scheme, carers centre, carers assessment officers. The risk that services may be disrupted through the transformation/ integration process was identified and a risk pool allocated to ensure that carers and customers could continue to access services that they need throughout the process of change in 2016-17. They would also be able to benefit from any new services delivered, through the BCF and Care Act implementation. A revised Joint Carers Strategy has been developed which will link in to the BCF and other strategic objectives for Health and Social Care. Revised Carers Handbook in place which will be launched at the Carers week in June 2016.

16. Contingency Planning and Risk Sharing

A risk pool of £500,000 has been included in the BCF financial plan for 2016-17 to mitigate the risk of non-delivery of the non-elective savings requirement which is to dampen down growth and demand (rather than reduce admissions from 2014/15 outturn).

The risk pool is also in place to support any unintended consequences of successful initiatives on other parts of the system e.g. demand created from improved case management. Financial monitoring of schemes is in place and risks materialising in year will be monitored and mitigated through the risk pool and expected slippage on new investment through BCF. Planned analysis completed and proposals for use of year-in slippage to support risks in BCF will be agreed through the BCF governance structure as appropriate.

Risks are to be supported by the fund through the CCG, with cases for additional support to be considered through the appropriate governance structure in 2016/17.

A financial governance process is in place and the financial monitoring and performance information is to be provided at monthly operational group meetings and quarterly at Director and Member level. The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified, where appropriate, as part of the planning cycle for both Health and Social Care in totality, with the introduction of a Section 75 pooled budget agreement from 2016/17.

The CCG has a robust plan with regards to keeping emergency admissions within affordable levels and has been very successful since 2011. All local stakeholders are key players in delivering these plans through the System Resilience Group. The CCGs contracts with providers specify that marginal tariff will apply if admissions exceed 11/12 rates, admissions above that rate will be funded at 30% of tariff, NHS England will manage through the System Resilience Group how the remaining 70% should be best invested to reduce admissions. Check this is still accurate with Keely/Louise??

All local stakeholders are members of the System Resilience Group. This plan has been approved by the Task Group, comprised of Health and Wellbeing Board members and will be formally approved by the Board at its next meeting.

17. Patient Engagement

Our Better Care Fund vision will enable us to deliver on our Health and Well-Being Strategy and vision. It is based on what Rotherham people have told us is most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon, and a “right first time” principle applies to the delivery of services whether they are provided directly by us or commissioned.

We engage with inspirational local people in a number of forums, both formally brokered (e.g. the Council’s Customer Inspection Team; the Rotherham Learning Disability Partnership Board; Rotherham Speak Up) and informal (e.g. Rotherham Older People’s Forum, the Carers4Carers

Mental Health Support Group) to understand the barriers for local people in accessing the most appropriate support, staying safe; and keeping well. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

Through the mapping of service users views and experience and understanding the journeys people take, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. The BCF Plan will focus on achieving the following outcomes for patients and service users.

'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 well-being.

'I only have to tell my story once'

People 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 pint.

'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.

Customer experiences will be closely monitored throughout the delivery of the BCF Plan via the 6 'I statements'. This will involve the Local Authority's Performance and Quality Team contacting service users and obtaining their views regarding the services they are receiving. This will help us to see the real impact of service reconfiguration and help us improve delivery based on customer feedback.

Through surveys, telephone and face to face interviews, the team will develop a number of case studies, to identify the positive and negative impacts that the BCF plan has had on customer experiences. Rotherham Council has in place a Customer Inspection Service, with individuals who are customers and experts by experience. This group will support the assessment of the impact of the BCF plan and help us to see the implementation through the eyes of the customer. These experts by experience will also help us to identify where further improvements are needed. All feedback will be used to further enhance and improve the customer experience.

An example of recent consultation which will be used to support BCF Planning in 2016-17 is the engagement event which took place in February 2016 (Appendix 11) with a focus on older carers, ran by Rotherham CCG and NHSE. It is anticipated that in conjunction with utilising this information as evidence of need to inform national planning, the intelligence emerging from this particular engagement activity will be used to inform the more local planning/development of carer support services. This fits in well with the recent development of a carers strategy and the priority identified in this BCF plan for an integrated carers service by 2019.

18. Engagement with Providers and Stakeholders

18.1 Evidence of Engagement

The Rotherham Health and Wellbeing Board has had consistent representation from the main local health providers (RDaSH) and the voluntary sector (Voluntary Action Rotherham). They are each represented at board meetings, and their contribution has been embedded through the key theme groups, and the ongoing discussions regarding BCF. This involvement has ensured they have been engaged throughout the process and are fully signed up to the principles and vision of the BCF Plan. Healthwatch Rotherham are key partners at the Health and Wellbeing Board, bringing added value and independence through their direct relationship with people who are using services.

Local health providers understand that Rotherham CCG has identified a range of services which now form part of the BCF. They are aware that the commissioning arrangements, specifications and targets for these services are likely to change significantly over the coming years. Locally the BCF will affect services delivered by Rotherham Foundation Trust (TRFT) and key voluntary sector partners. All provider organisations continue to express a willingness to work under the new commissioning framework, recognising the potential opportunities to improve outcomes for Rotherham people. TRFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved. This is reflected in the Community Transformation Programme underway where TRFT are playing a lead role (Appendix 12).

Local healthcare providers are engaged through monthly clinically led QIPP (Quality, Innovation, Productivity and Prevention) groups where pathway redesigns, innovation and efficiency are key deliverables.

Rotherham CCG is working in partnership with RDASH, transforming mental health services in the borough. Regular transformation events are taking place with commissioners, providers (independent/VCS), service users and carers on this programme (Appendix 13).

Rotherham commissioners have a long established relationship with the local voluntary and community sector (VCS), both as partners in working to improve social capital locally, and directly as provider organisations. Commissioners engage formally through the Council's Contracting for Care and Provider Forums. There is additional engagement through the Adult Social Care Consortium. The VCS has a strong local voice with Elected Members and Trust Boards. We understand that the remit of the VCS extends far beyond that of our public services. VCS acts as an interface with people in our communities who do not use statutory services and who arrange their own care.

Voluntary sector partners have engaged with us in delivering a wide range of services, some of which are included in the BCF Directory of Services. The sector forms part of integrated care pathways in stroke, dementia care, carer support, and crisis services for people with mental health problems. We see BCF as a catalyst, helping to embed voluntary sector services into condition specific care pathways. The sector is also a key partner in prevention and early detection, signposting and offering advice and support to people who may be at risk of needing acute intervention. The BCF Plan supports this specifically through the Social Prescribing Programme.

One example of good practice in relation to provider/stakeholder engagement is the "Meet The Buyer" events which included representation from across the health and social care sector. These events also included independent and voluntary sector providers responsible for delivering social care services. The purpose of the meetings was to consult on the Health and Wellbeing Strategy, the impact of the Care Act, Better Care Fund and the adult social care development programme.

Providers and stakeholders are fully sighted on plans to transfer resources from acute services to the community. This includes community assets and workforce requirements. Assessment of workforce and capacity issues resonates through provider operating plans and will be an integral part of all BCF service reviews which take place in 2016-17.

18.2 Provider/Stakeholder Engagement Strategy

This section of the Rotherham Better Care Fund Plan sets out the communication and engagement strategy for 2016/17. It includes a range of ways in which provider representatives, including front line staff, can be involved in the development, implementation and evaluation of our programme. Clinicians and other practitioners will play a key role alongside service users and carers in ensuring that the BCF makes a positive difference to people's lives. As well as providers there is great interest and enthusiasm from the voluntary and community sector, services users and carers, and representatives such as Healthwatch. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

We will build on existing approaches to develop a strong service user and community voice within the Better Care Fund. This plan sets out our basic communications and engagement objectives, identifies the stakeholders we hope to work with, and confirms our commitment to the adoption of co-design principles.

In Rotherham we have identified 6 themes which incorporate all existing provision and the key priorities.

Theme 1:	Mental Health
Theme 2:	Rehabilitation and Reablement

Theme 3:	Supporting Social Care
Theme 4:	Case Management and Integrated Planning
Theme 5:	Supporting Carers
Theme 6:	Infrastructure (including Care Act)

Our communication and engagement programme will be based around these key themes, creating service user and stakeholder strategies for each. The overall strategy will be based on the following principles;

Collaboration	Bringing together clinicians, staff, patients, service users and the community together as equal partners
Evidence-based	Co-design an evidence base which will support service redesign
Capability	Developing the capacity of patients, service users and the community to engage effectively in identifying needs, planning, procurement, implementation and evaluation.
Review	After redesign has been implemented, using stakeholders and service users to evaluate impact, monitor quality and support performance management

Table 7 sets out a local map of all stakeholders, channels of communication and how we will keep people informed. Funding for communications and engagement activity and support will be part of the programme costs for the Better Care Fund Programme and will be confirmed once further development work has taken place.

Over the next few months we will be briefing stakeholders on the journey so far – how the Better Care Fund has been put together and where it is going. We will then work with them to refine the programme and develop an approach for involving relevant people from all the stakeholder groups in the development of each theme.

The BCF Plan is fully consistent with our provider's operational plans. Chief Executives of The Rotherham Foundation Trust (TRFT) and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) (our two biggest health providers) support the Better Care Fund submission and clinicians and managers from TRFT and RDasH are fully engaged in delivery. TRFT and RDaSH are also members of the Health and Well-Being Board, Systems Resilience Group, Clinical Referral Management Committee and Joint Commissioning Performance Groups.

Table 7: Stakeholder Map

Stakeholder	***Channels***	***Reporting***
Service users / patients	Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.	No set reporting periods
Health watch		
CCG Governing Body	Formal governance	6 monthly reports
Council, Cabinet and Scrutiny	Formal governance	6 monthly reports

Stakeholder	*Channels*	*Reporting*
Health and Wellbeing Board	Formal governance	6 monthly reports
MPs and Councillors	Briefings	Annual
NHS clinicians and staff	Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.	No set reporting periods
RMBC staff		
Service providers		
3rd sector organisations		
Public	Website, newsletters and local publicity	

We will work with our provider partners adhering to best practice guidelines and relevant legislation (Health and Social Care Act 2012) to ensure that, when services change, we will engage, inform and consult. We will endeavour to secure the confidence of patients, staff and the public in change proposals. We will use NHS England's guidance for building proposals for major service change including the 'four tests'.

19. Funding Arrangements

Financial Risk Sharing and Contingencies

There is a risk sharing policy in the Section 75 Partnership Agreement (Appendix 14) and this has worked well in 2015/16, can be evidenced and has been audited twice in the last 12 months with significant assurance given on both occasions that the governance arrangements are in place and working within the framework and policies.

There will be two pools as in 2015/16 but the content and financial allocations have be re-classified following the review of the services in 2015/16. This change to the plan was approved by the BCF Executive Group on 16th March 2016.

Protection of Social Services

In 2015/16, all BCF schemes were reviewed and re-classified from 15 to 7 key themes. This included the definition of 'Protecting Social Care' which is embedded throughout the BCF themes.

Services funded through the BCF which help maintain essential social care services include Community based services, residential care, equipment and assistive technology, services for carers and 7 day social work support. More detail is shown in Table 9 including additional investments.

Total investment in social care has increased from £8.6m in 2015/16 to £9.3m in 2016/17, mainly in respect of equipment and adaptations and to meet additional cost pressures arising from the Care Act 2014.

The detailed financial plans will be submitted in the tables but the movement between 2015/16 and planned BCF for 2016/17 is provided below:

Table 8: Summary of Financial Plan

			ADDITIONAL INVESTMENT			ALLOCATION OF POOLED BUDGETS		
	THEME	2015/16 BCF	RMBC	RCCG	2016/17 BCF PLAN	RCCG POOL	RMBC POOL	TOTAL
		£000s	*£000s*	*£000s*	*£000s*	*£000s*	*£000s*	*£000s*
1	MENTAL HEALTH SERVICES	375		471	**846**	**846**		**846**
2	REHABILITATION AND REABLEMENT	12,532	166	482	**13,180**		**13,180**	**13,180**
3	SUPPORTING SOCIAL CARE	2,982			**2,982**	**2,982**		**2,982**
4	CASE MANAGEMENT AND INTEGRATED CARE PLANNING	4,842		254	**5,096**	**5,096**		**5,096**
5	SUPPORTING CARERS	670	50		**720**	**720**		**720**
6	INFRASTRUCTURE (including Care Act)	499		500	**999**	**999**		**999**
7	RISK POOL	1,416		(916)	**500**	**500**		**500**
	TOTAL	**23,316**	**216**	**791**	**24,323**	**11,143**	**13,180**	**24,323**

Table 9: Summary of Investment Profile

	Service Area	2015/16 BCF £000	Additional costs	2016/17 BCF £000	Strategic Relevance	Service Spec	Perf F/work	Perf Issues	Recommendation
		£000	£000	£000					
Theme 1: Mental Health Services									
1	Adult Mental Health Liaison	**375**	**471**	**846**					Incorporate CCG funding
Theme 2: Rehabilitation and Reablement									
2	Home Improvement Agency	60	15	75					Incorporate RMBC funding
3	PSS Adult Services Capital Grant	749	(749)	0					**Grant ended 2015/16**
4	Falls Service	275	152	427					Incorporate CCG funding
5	Home Enabling Services	1,556		1,556					Requires Specification and SLA
6	2 SSO reviewing officers to fast track assessments during reablement	98		98					Requires Specification and SLA
7	Community Stroke Service	175		175					Ok
8	Community Neuro Rehab	151		151					Review – performance issues
9	Breathing Space	2,064	160	2,224					Incorporate funding review
9	Breathing Space	2,064	160	2,224					Incorporate funding review
10	Expert Patient Programme	50		50					OK
11	REWS	634	170	804					Incorporates funding review
12	Community OT	753		753					Review
13	Disabled Facilities Grant	1,219	900	2,119					Ok
14	Age UK Hospital Discharge	158		158					Ok
15	Stroke Association Service	50		50					Ok
16	Stroke Social Work Support	27		27					Ok
17	Intermediate Care Pool	4,513		4,513					Review
	Total	**12,532**	**648**	**13,180**					
Theme 3: Supporting Social Care									
18	Direct Payments	1,643		1,643					Requires Specification and SLA
19	Residential Care	274		274					Requires Specification and SLA
20	Learning Disability Services	1,065		1,065					Review
	Total	**2,982**	**0**	**2,982**					
Theme 4: Case Management and Integrated Care Planning									
21	GP Case Management	2,200	(55)	2,145					Update BCF allocation
22	Care Home Support Service	264	51	315					Incorporate funding review
23	Death in Place of Choice	775	13	788					Incorporate CCG funding

Service Area		2015/16 BCF £000	Additional costs	2016/17 BCF £000	Strategic Relevance	Service Spec	Perf F/work	Perf Issues	Recommendation
24	Otago Exercise Programme	20		20					Ok
25	Social Prescribing	505	245	750					Incorporate CCG funding
26	Social Work Support (A&E, Case management, Supported Discharge)	1,078		1,078					Requires Specification and SLA
	Total	**4,842**	**254**	**5,096**					
Theme 5: Supporting Carers									
27	Day Care Services	350		350					Requires Specification and SLA
28	Carers Centre	100		100					Requires Specification and SLA
29	Carers Support Service	150	50	200					Incorporate RMBC funding
30	Reablement – Crossroads	70		70					Requires Specification and SLA
	Total	**670**	**50**	**720**					
Theme 6: Infrastructure									
31	Joint Commissioning Team	49		49					Review
32	IT to support Comm. Trans.	250		250					OK
33	Care Act Implementation	200	500	700					Requires Specification and SLA
	Total	**499**	**500**	**999**					
34	Contingency Fund	**1,416**	(916)	**500**					Managed in year
	Total	***23,316***	***1,007***	***24,323***					

20. Appendices

Ref.	Document	Synopsis and links
Page 3 **(embedded document)**	**Map of Rotherham**	This map was produced by Rotherham Borough Council to illustrate the 7 Area Assemblies across the borough
Page 4 **(web links provided)**	Rotherham Mental Health Adults and Older People's Transformation Plan	The plan sets out a plan on a page for the transformation of services to ensure people of all ages are able to live as normal and inclusive a life as possible. http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=103679
Page 5 **(web links provided)**	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2015 – 2016. http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18
Page 5 **(web links provided)**	**CCG Commissioning Plan 2015-19**	The Rotherham CCG Commissioning Plan 2015-19 http://www.rotherhamccg.nhs.uk/
Page 5 **(web links provided)**	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
Page 6 **(web links provided)**	**Market Position Statement for Older People**	The Market Position Statement has been developed by Rotherham Council to inform current and potential providers of social services in the borough of the direction of social care services for older people over the next few years. http://www.rotherham.gov.uk/downloads/file/959/market_position_statement_for_older_peoples_services_2014
Page 41	**RCCG Communication and Engagement Plan**	Rotherham CCG communication and engagement plan 2015-19 sets out how the NHS Rotherham Clinical Commissioning Group (RCCG), are committed to engaging, communicating and consulting with a wide range of audiences, using the right platforms and mechanisms. http://www.rotherhamccg.nhs.uk/Downloads/Publications/comms%20and%20engagement%20plan%20final%202015-16.pdf

Ref.	Document	Synopsis and links
Appendix 1	**BCF Service Review Programme**	The service review report sets out recommendations for the reconfiguration of the Better Care Fund. The report provides a breakdown of current funding identified within the BCF programme, overall cost of the service and costs that are covered through alternative funding streams.
Appendix 2	**Review of Social Prescribing Service**	Review details analysis, impact, outcomes, case studies, costs, and benefits.
Appendix 3	**BCF Directory of Services**	The BCF Directory of Services provides clarity on where BCF funding is currently being invested and the strategic relevance of each scheme.
Appendix 4	**Analysis of BCF Schemes**	Analysis shows re-categorisation of existing BCF schemes, showing no negative impact on provision
Appendix 5	**Delayed Transfers of Care Action Plan**	This is a local DTOC action plan which shows actions taken to delayed transfers of care from hospital.
Appendix 6	**Memorandum of Understanding**	Agreement between CCG, LA and Rotherham Foundation Trust which sets out roles and responsibilities in relation to hospital discharge for all patients who are medically fit for discharge..
Appendix 7	**Tier 2: Data Sharing Agreement**	An agreement between CCG and LA around sharing adult social care information with the Rotherham NHS Foundation Trust for the purpose of assigning NHS numbers to social care6records.
Appendix 8	**RMBC Digital Council Strategy "Your Digital Council"**	The Strategy shows the continuing importance of a digital infrastructure in Rotherham which includes "broadband, online services, access and skills to provide a modernised public service.
Appendix 9	**RCCG IT Strategy (2015/16)**	The strategy ensures that CCG has IT capabilities to support the delivery of its commissioning plan including the development of a clinical portal that will integrate information from health and care services .
Appendix 10	**Digital Road Map Communication and Engagement Plan**	A plan which details the benefits of a clinical portal and managing patients. Consultation with Healthwatch, community, voluntary sector and care homes.
Appendix 11	**Rotherham Engagement Event**	Presentation on evidence of need, with a focus on access to services for vulnerable carer groups.

Ref.	Document	Synopsis and links
Appendix 12	**Community Transformation 2**	Presentation on Stage 2 of Transforming Unscheduled Care
Appendix 13	**Rotherham Mental Health Transformation Event**	Paper showing updating on adult and older people's Mental Health transformation agenda.
Appendix 14	**Section 75 Partnership Agreement**	The agreement has been signed and agreed by CCG and Local Authority setting out commissioning intentions in the use of the BCF