Rotherham Better Care Fund Plan- DRAFT

March 2017

Local Authority

Rotherham Metropolitan Borough Council

Clinical Commissioning Group

Rotherham Clinical Commissioning Group

2017/19

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:	08/03/2017
Date submitted:	31/03/2017
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	31st March, 2017

Signed on behalf of the Council	
By	Sharon Kemp
Position	Chief Executive
Date	31st March, 2017

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor David Roche
Date	31st March, 2017

3. Vision for Adult Services

The integration work that brings together Rotherham Metropolitan Borough Council (know herein as the Council) and Rotherham Clinical Commissioning Group (known herein as the CCG) through the Better Care fund is a fundamental aspect of pooling budgets and resources to ensure that we have a robust alignment across the health and social care system in Rotherham. This opportunity enables us:

- To reduce duplication and target resources effectively and efficiently to impact on the lives of those that need it the most
- To ensure there is a greater impact on prevention
- To have a systematic approach to the sustainability of social care and health systems which shares responsibilities with partners, community and voluntary sector organisations, and supports residents to take control of self-care and self-management.

In order to deliver our aspirations of a fully integrated system across health and social care we have developed key strategic documents outlining our ambitions in the form of an Integrated Health and Social Care Place Plan and Sustainability and Transformational Plan (STP) which is a 5 year forward view.

The five joint priorities within the Integrated Health and Social Care Place Plan are as follows:

- Prevention, self-management, education and early intervention
- Rolling out our integrated locality model – "The Village" pilot
- Opening an Integrated Urgent and Emergency Care Centre
- Further development of a 24/7 Care Co-ordination Centre
- Building a Specialist Re-ablement Centre

Both these documents will identify key integration work, which will bring the opportunity to jointly commission services to deliver:

- joined up working practices and multi-disciplinary teams
- efficient and effective service pathways for people; which includes "step up" and "step down"
- reduce duplication and ensure targeted interventions which are value for money; where people get the right service, from the right place and at the right cost

The vision shared across Rotherham's health and social care is to ensure we have a fully integrated health and social care system in place now, but also fit for the future. Working in this way will support our vision "to support people and families to live independently in the community, with prevention and self-management at the heart of our delivery". This vision is contained within various strategic documents which encompass the transformational work that needs to happen in order to achieve a fully integrated health and social care system. We have worked collectively and developed our ambition through a period of transformation which is contained in the:

- Rotherham Integrated Health and Social Care Place Plan
- South Yorkshire and Bassetlaw Sustainability and Transformational Plan (STP)
- Better Care Fund Plan (BCF)
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Better Care Fund (BCF)

The Better Care Fund (BCF) provides us with an opportunity to further 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 an improved service and better quality of life. We will achieve this through a strong focus on implementing services which deliver early intervention and prevention as well as information and enablement. 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.

The BCF will enable us to implement effective joint commissioning services across the Council and CCG which will inevitably drive the integration of services. This will bring together specialists within multi-disciplinary working arrangements from primary care, social care, 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, and ensure that the discharge home and step up and step down approach is embedded so that people are well managed through the care system rather than it escalating to the point of crisis. We will ensure better information sharing between health and social care services. Service integration will be used as a vehicle to deliver "parity of esteem", whereby 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 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 View. The Forward View emphasises the need to develop new care models to support integration. A central theme of our plan is the further development of integrated service models, intermediate care services, locality teams, rapid response, carer support and first point of access.

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 Strategy and Rotherham's Integrated Health and Social Care Place Plan.

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. Social Prescribing
8. Broader use of new technology to support care at home
9. A financially sustainable model that targets resources where there is greatest impact

The impact of implementing the BCF Plan will improve patient and service user experience significantly. As a result of the changes we will make, we expect that all service users, patients and their family carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. We want to reduce the need 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 of its population, 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

There are also several new Public Health England fingertip guides available which outline Rotherham's position. These tools enable us to track progress and benchmark Rotherham's position against statistically similar areas. These are available at:

https://fingertips.phe.org.uk/profile/older-people-health

https://fingertips.phe.org.uk/profile/adultsocialcare

4.2 The South Yorkshire and Bassetlaw Sustainability and Transformational Plan

The South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformational Plan (STP) is now published, and can be found at the following website address: http://www.smybndccgs.nhs.uk/what-we-do/stp

Our STP sets out the vision, ambitions and priorities for the future of health and care in the SY&B region and is the result of many months of discussions across the STP partnership. Between December

2016 and March 2017, discussion will take place with staff in each partner organisation and local communities about the plan. In addition, work will take place with Healthwatch and voluntary sector partners to ensure input and views from a wide range of communities. The feedback will be taken into account and incorporated into the STP.

The five STP transformational initiatives are listed below and in section 10.2 of Rotherham's Integrated Health and Social Care Place Plan we describe Rotherham's direction for each of these five challenges:

- Urgent and Emergency Care
- Elective Care
- Cancer
- Children and Maternity
- Mental Health and Learning Disability

4.3 Rotherham Integrated Health and Social Care Place Plan

At a local level Rotherham's Health and Social Care Community has been working in a collaborative way for the past several years to transform the way it cares for its population of 261,000. Our aim is to provide the best possible services and outcomes for our population; we are committed to a whole system partnership approach, as we recognise that it is only through working together that we can provide sustainable services over the long term.

Our common vision is: ***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***

Our approach to transformation is based on a multi-agency strategy of prevention and early intervention of health and social care services and we recognise the importance of addressing the wider determinants of health. We aim to champion prevention and integration and establish a range of initiatives in Rotherham to serve as a proof of concept that can then be rolled out further across South Yorkshire and Bassetlaw.

Since the publication of the BCF Plan 2016-17, we have developed the Rotherham Integrated Health and Social Care Place Plan (Place Plan) which can be found at the following website address http://www.rotherhamccg.nhs.uk/rotherhams-place-plan.htm. This details our joined up approach to delivering five key initiatives that will help us achieve our Health and Wellbeing Strategic aims and meet the region's STP objectives. The five initiatives (see list below), aim to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services and achieve clinical and financial sustainability. Further detail of the initiatives can be found in our Place Plan.

1. Prevention, self-management, education and early intervention
2. Rolling out our integrated locality model 'the village' pilot
3. Opening an integrated urgent and emergency care centre
4. Further development of a 24/7 care co-ordination centre
5. Building a specialist re-ablement centre

Planning and delivery at an overarching STP level must be coordinated with planning and delivery at a local (Rotherham) level, as they represent different elements of the same system.

Rotherham partners view themselves collectively accountable for the health and wellbeing of our population and consider the Place Plan to be our framework for jointly providing acute, community and primary care services forming an integrated partnership. Our new governance arrangements will support us towards becoming an Accountable Care System, which will enable us to design and deliver services to meet the needs of our population and improve health and wellbeing outcomes, within agreed budgets.

We have developed an interactive infographic and animation, which can be found at the following website address: http://preview.beach-design.co.uk/nhs_rotherham/ that will be used across the health and social care system as a key tool in articulating how our five priorities are closely interlinked to deliver better, more accessible services in the coming years.

As well as the Rotherham Place Plan the CCG's Commissioning Plan remains the cornerstone of the CCGs strategic direction, and can be found at the following website address: http://www.rotherhamccg.nhs.uk/our-plan.htm

4.4 Rotherham Carers Strategy 2016-21

Rotherham's Carers' Strategy "Caring Together" (Appendix X) is a partnership strategy which sets out the intentions and actions necessary to support carers and young carers. We recognise that informal carers are the backbone of the health and social care economy. The ambition is to build stronger collaboration between carers and other partners in Rotherham, and formally start to recognise the importance of whole family relationships.

The strategy lays down the foundations for achieving these partnerships and sets the intention for future working arrangements. It aims to makes a difference in the short term and start the journey towards stronger partnerships across formal services for people who use services and their carers

"Caring Together" has been co-produced between Adult Services, Children's Services, Customer Services, Rotherham Carers groups, including Young Carers, the Voluntary Sector, Rotherham Doncaster, and South Humber Foundation Trust, The Rotherham Foundation trust and Rotherham Clinical Commissioning Group

4.5 Vanguards

Two new care vanguards have been developed to support the local health and care economy system. It takes the learning from nine PACS vanguards which are both central to the delivery of the vision of the NHS five year forward view. The success of this will include a core element of GP registered listed and a core GP practice at its core. The aim will be to improve the physical, mental and health and well-being and focus on reducing health inequalities for local residents. The two vanguards are:

1. Integrated Primary and Acute Care System (PACS) and
2. Multi-specialty Community Providers (MCPS)

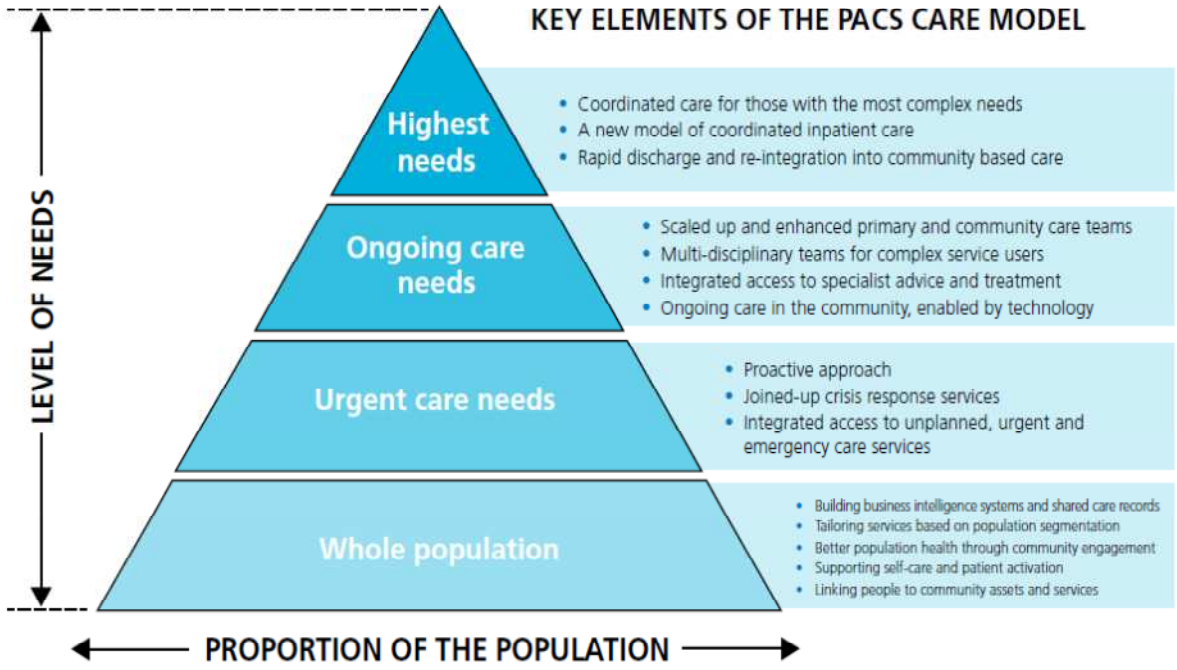
The PACS and the MCPS vanguards now cover 8% of England and nearly all sustainability and a transformational plan (STPs), involve population based accountable care models. Therefore, the national coverage of these models is to grow to 25% next year to 50% per cent by 2020. Linked to STPs, funding will be made available to support new sites from 2017/18 to achieve growth.

PACS

The PACS brings together health and social care providers with shared goals and incentives, which focus on best solutions for the local population. The current fragmented and complex contracting, funding and governance system within the NHS, and between NHS and Social Care, frustrates a focus on population health. Joining up services in a PACS allows better decision making and more suitable use of resources, with a greater focus on prevention and integrated community based care, and less reliance on hospital care. The PACS will:

1. Focus on prevention and health management. Better relationship and joined up working across health and social care services. PACS will connect people to community assets and resources to help keep people well, working with local government and the voluntary sector, using social prescribing
2. Provide urgent care that is integrated with primary care, community, mental health services and social care, reducing the need for emergency or unplanned interventions.
3. Ensure people with ongoing care needs receive more co-ordinated care, with more services in settings such as their own homes and community. It will deliver this through integrated, multi-disciplinary community teams, by linking hospital specialists to community based care, and making greater use of technology to deliver care remotely
4. Ensure those people with complex health needs are managed in the community. The PACS may reduce the number of hospital beds, with inpatient care only for those who need intensive or complex care.

The PACS care model operated at four levels of the population which is visualised below based on the population need. The diagram below summarises the key elements.



4.6 Joint Strategic Needs Assessment

The JSNA predicts a substantial increase in the number of adults with additional health and social care needs over the next five years. The JSNA shows that the population of Rotherham is at its highest ever level, at an estimated 260,800 in 2016. 50,800 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.

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 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 also has a significant part of its population with a learning disability. There are currently 724 Learning Disability customers aged over 18 accessing 1067 placements/service.

Rotherham has a higher rate of Adult Learning Disability customers per 100,000 head of population at 371.77 than neighbouring authorities and is ranked 28th Highest out of 152 local Authorities.(ref: SALT Return 15/16).

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 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.

4.7 Market Sustainability

The Market Sustainability report is based on the Cordis Bright framework which assists Local Authorities to support the adult social care market. The framework pulls various intelligence from various sources that is readily available to carry out an analysis of each market segment consisting of commissioning building based services (Residential and Nursing, Supported Living and Extra Care) and non-building based services (Domiciliary Care) for each client group.

This intelligence enables commissioners to develop a risk matrix with the market and ensure contingency planning is in place to reduce provider failure.

4.8 "Deep Dive" Reviews in 2016-17

As acknowledged in the BCF Plan 2016-17, significant work has been undertaken to complete 'Deep Dive' reviews on a number of identified BCF services. These were highlighted from the 2015-16 review as requiring further analysis for one or more of the following:

- Concerns over strategic relevance/fit for purpose
- Lack of a clear service specification
- Concerns over the performance of the service including; requirement to realign service priorities to meet emerging demand
- Lack of performance management framework

All reviews undertaken in 2016-17 have included key stakeholders from across the system including, where appropriate, patients and their carers. The reviews have led to changes in working practices, reconfiguration of services, improvements in the outcomes for the Rotherham population (i.e. reductions in waiting times for COT), flexibility in accessing services, integration of provision, reductions in bureaucracy and increase in efficiency.

The 'deep dive' reviews taking place in 2016-17 which were identified through the 2015-16 service review have involved changes in service provision. However, this has not impacted on the funding provided within the BCF as a whole. A robust monitoring tool has been developed to ensure that impact of each review is closely monitored through the BCF governance structure.

Some examples of the reviews undertaken are detailed below (not an exhaustive list);

Intermediate Care

There has been significant work undertaken in 2016-17 to further improve the intermediate care provision within Rotherham. The eligibility criteria have been widened, the service specification and referral/allocation criteria updated and the referral process streamlined. A decision was taken to close one of the 3 sites for intermediate care (provided by the Council, and jointly commissioned between CCG and the Council) in July 2016. The rationale for this was a move to a more wrap around integrated rehabilitation provision that was fit for purpose and strategically relevant. The number of beds has increased by 4 in this new model.

However, there are still issues with the service as it does not provide nursing care, which can be attributed to the delays with patient flow in the acute sector. CCG audits taken place in 2016 show that there are still a number 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% of 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.

Therefore, Rotherham Place Plan has an aspirational priority to consider options for the development of a Specialist Reablement Centre. The desire is to provide a single centre for all community intermediate care services would be a fully integrated provision. This would deliver economies of scale, broaden the range of people who can receive support and act as a vehicle for health and social care integration. This objective is likely to be delivered in 2018-19.

Community Occupational Therapy Services

The service review carried out on the Community Occupational Therapy Service shows that the service is performing well on the majority of key performance indicators but is struggling with the waiting times for assessment, due to the sharp rise in the number of referrals of older people living with long-term conditions living in the community. However, there are still a significant number of contacts which could be signposted to alternative services. For example, 555 assessments were terminated in 2015/16, 128 by adult social care, 104 by carer and 192 by client.

The Occupational Therapy Backlog group has been set up to address this issue and this has reduced the numbers from 599 in June 2016 to 135 in January 2017. The agreed rectification actions include:

- The Single Point of Access Team can issue equipment at first point of contact.
- Housing Repairs are able to directly issue lever taps, half step, grab rails and key safes.
- Home Improvement Agency to pick up on toileting assessments and tubular path rails.
- Support staff to start assessing for level access showers.
- The Adult Care Performance & Quality Team is currently exploring data requirements, with a view to reducing the amount of paperwork Occupational Therapists are required to complete for each assessment.

The Community Occupational Service review considers options for future development of the service, and therefore an options appraisal will be developed to consider future commissioning arrangements. The ambition is to integrate the service into the locality model and working closely with adult social care by providing additional resources into the Council's Single Point of Access by signposting potential or existing service users to alternatives services and to reduce home care packages by identifying alternative solutions to address needs.

4.9 Directory of Services

The Directory of Services (DoS) for BCF that came from the review in 2015-16 describes a new structure for categorising BCF funded schemes explained within the BCF Plan 2016-17. The schemes continue to be 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

The Directory of Services provides clarity on where BCF funding is currently being invested and the strategic relevance of each scheme. Commissioners have prepared an ongoing review schedule, a monitoring tool and review template, which were used throughout 2016-17 and will continue to be used where appropriate. The next steps are:

(i) To develop a Memorandum of Understanding (MoU) between the Council and the CCG to clearly define the expectations of each service area where there is no service specification in place which are funded through the Better Care Fund.

(ii) To continue undertaking a series of individual reviews on services where there are funding or performance issues or where there are concerns regarding strategic relevance.

(iii) For commissioners to continue to monitor and review progress of reviews throughout 2017-19

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.

The Council is currently conducting a review of adult social commissioning to achieve an increasingly strategic and corporate approach by 2017/18, this is interconnected with the CCG restructure and will incorporate several new joint commissioning posts across adults, children's, mental health and learning disabilities. In order to underpin the desired model there will need to be a skilled workforce that is sufficiently structured and resourced to deliver key commissioning priorities. Integrated commissioning in Rotherham will need to align and embed the principles and approaches outlined in commissioning best practice guidance across public services. Commissioning activity needs to be targeted to tackle priorities in an integrated way predicated on a predetermined outcomes framework.

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.

There has been substantial investment in additional community services supporting the BCF Plan over the past 2 years. The continued investment through the CCG's 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

Current models of care are not designed for the health challenges of today. Rotherham is currently intending to move towards and Accountable Care System in order to deliver the Integrated Health and Social Care Place Plan. 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 ** Performance data as at November 2016*

KPI	Performance 16/17	Target 16/17
People >50 years attending A&E with a fragility fracture	98/month	111/month
No. of people over 55 with a fractured neck of femur	19/month	23.0/month
No. of GP referrals to the Medical Assessment Unit	205/month	265/month
No. of unscheduled admissions of patients >65years	839/month	730/month
No. of long stay patients over 14 days	68/month	212/month

A focus on community services has helped to support the other parts of the system (acute) in dealing with the increasing demand presenting at the front door. For example the performance against KPI No. of long stay patients over 14 days has significant improved since 2015-16 from an average of 86 per month to 66 in 2016-17 to date. The BCF Plan 2017-19 will be instrumental in supporting further initiatives to reduce attendances.

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 which, reduced in 2015-16 to 401 people. In Quarter 2 2016/17 110 older people had been admitted to permanent residential care. 537 adults were in receipt of day care in 2015/16, compared to 644 the previous year. In 2015/16 we saw a slight increase to 86.1% in the proportion of adults who received home care enablement services who 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, with a predicted out-turn of 664 in 2016/17. 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. It is predicted this is likely to increase to around 600 in 2016/17.

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. Single points of access i.e. The Care Coordination Centre
3. Locality Based Community Nursing Teams including the integrated locality pilot

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. The CCG and the Council 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 19 days. There are currently 54 beds across the borough, with an element of this for social care assessment, commissioned jointly by the CCG and the Council. The Intermediate Care Residential Service accepts admissions 7 days/week.

Pathway 3: Discharge to Assess

Pathway 3 provides a 24/7 nurse-led care model 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.

The CCG and the Council 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.

Winter Pressures Initiatives

In autumn 2016-17 as part of the system wide response to Winter Pressures two further initiatives were agreed through the A&E Delivery Board as follows;

1. 10 nursing care beds at Ackroyd House (independent sector provider) providing short term support for patients who have passed the acute phase of illness and no longer require consultant led care, but who need a further short period of nursing led support prior to returning home. This pathway is overseen by the Rotherham Foundation Trust in collaboration with the Council and partners.

   The desired outcome for patients is that they return home within a 10-14 day period of admittance, within this time the MDT will have identified any appropriate support is needed to enable this transfer to take place. A trusted assessor model is also used to facilitate timely discharge.

2. 12 beds at Woodlands (RDaSH) providing a short term placement for patients with physical conditions and cognitive issues to:
    - Facilitate recovery in a more conducive environment with input from specialist expertise
    - Assess needs to facilitate discharge
    - This option could be tested over the winter and, if successful, developed as a pathway modelled on some of the benefits of discharge to assess approaches.

6.2 Care Coordination Centre

The Care Coordination Centre (CCC) has been a key vehicle for delivering BCF outcomes.

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 requires 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 funded through the BCF, they continue to be key vehicle for delivery of the 2017/19 BCF programme. The current service model incorporates 7 community nursing teams serving GP practice populations. The teams service geographical clusters of GP practices.

Over the past 2 years there has been significant investment in community nursing to deliver more effective leadership and clinical supervision, create an environment where nurses can safely care for patients with a higher level of need and reduce administrative burden. 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 work in 2016-17 to pilot an integrated locality is providing insight into the opportunities and challenges for roll out across the health and social care system. This work will take place throughout 2017-18.

7. Integrated Commissioning

It is now universally recognised that health and social care services need to be much better co-ordinated around the individual to ensure that the right care is offered at the right time and place to promote better outcomes. This can only be achieved through greater integration of services. It is clear that commissioning has a key role to play in developing integrated services, and that the ongoing separation between the health and social care systems is a major obstacle to achieving better outcomes for individuals. People often require health and social care services at the same time so ensuring an integrated approach to how services are commissioned including jointly commissioning, planning and reviewing services.

The adequacy of current commissioning arrangements is also called into question by the development of the new delivery models proposed in the Forward View. All of these models will require fundamental changes to commissioning so that there is a much more strategic and integrated approach to the planning and use of resources, both within the NHS and between the NHS and local government.

With this in line Rotherham's health and social care system will focus on integrated commissioning activities in the following areas:

7.1 Joint Commissioning and Fee Setting of Domiciliary Care/Residential & Nursing Home/Continuing Health Care Placements

The Council currently contracts with 8 domiciliary care organisations on a framework agreement for a 3 year period until 31st March 2018, with an option to extend for a further year until 31st March 2019. There is also a block contract financial agreement in place for the 'night visiting' service. The Community and Home Care Service Framework respond flexibly to changes in demand. Providers appointed to the framework currently deliver around 12,800 hours of home care per week to approximately 1,166 people.

The Council has been consistent in its approach with the contracted sector and has awarded an inflationary uplift each year, however in 17/18 a discretionary uplift has been included rather than an inflationary one. There is no nationally prescribed formula for calculating care, but there is a Funded Nursing Care (FNC) rate prescribed by the Department of Health. Currently, both the CCG and the Council commission domiciliary care differently and each area has set rates. Both parties already liaise regarding fee setting, but there is recognition that the CCG and the Council need to develop a joint and consistent approach to fee commissioning and fee setting for domiciliary care providers.

The Council is currently working with a neighbouring authority (Sheffield) to redesign the home care provision and develop a model that is effective in preventing hospital admission/premature admission to a care home environment. This will require a workforce with enhanced skills/increased responsiveness to change in need i.e. a trusted assessor approach that involves home care providers in

the assessment process to prevent waiting times and address duplication issues. The model will promote enabling and will require allied health professionals to work alongside the home care providers and collaborate to achieve good outcomes for the people who use services. In this model Assistive Technology and Health technology i.e. monitoring of BP/Blood Glucose will be a feature and the administering of medication and this will be an integrated model. Consideration will be taken throughout the lifetime of the BCF plan as to how we will promote home carers to work more closely with District Nurses. The locality pilot in the Village provides an opportune time for this to be piloted as part of the review of the model prior to full roll out.

In relation to CHC funding for nursing care homes the Council and CCG have begun discussion to understand the risks associated with the current costing model; this includes but is not exclusive to market sustainability, reputational and financial risks. Together we will examine the options to realign the CHC rate so that it reflective of the increases Nationally in FNC since 2016-17.

7.2 Medication Administration in Care Homes and for People Receiving Care at Home

The administration of medication in care homes and to people receiving care in their own homes is dependent on the medication policies of the individual care agencies. Both RMBC and the CCG have agreed to undertake the development of a joint commissioning policy that will ensure greater flexibility in the administration of medicines whilst guaranteeing patient safety. This is a complex multi-agency problem that will need the full co-operation of all stakeholders to agree a way forward.

Rotherham Council, Clinical Commissioning Group and the Rotherham Foundation Trust will work together to review the medication policy for domiciliary care services. They will develop a business case to upskill care workers to administer medications which will reduce the burden placed on District Nurses and Pharmacists. The initiative will support safe hospital discharge, help prevent admissions to residential care and acute hospital beds and support appropriate and safe administering of medication in the community to help people stay at home longer.

7.3 Personal Health Budgets/Direct Payments

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual. It is planned and agreed between the individual and the local CCG. This is a different way of spending health funding to meet the needs of an individual.

Co-produced, personalised care and support planning is at the heart of making personal health budgets work well. The plan helps people to identify their health and wellbeing goals, working with their local NHS team, and sets out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

Adults eligible for NHS Continuing Healthcare and children in receipt of continuing care have had a right to have a personal health budget since October 2014. There is a longer term objective to widen the availability of personal health budgets to others who could benefit. In line with the rest of the country, the most significant demographic change occurring in Rotherham is the growth in the number of older people. 18.8% of the population are aged 65 and over but this will raise to a projected 20.7% by 2021.

The Integrated Personal Commissioning (IPC) programme was formally launched in April 2015 as a partnership between NHS England and the Local Government Association. IPC is a new approach to joining up health, social care and other services at the level of the individual. It enables people, carers and families to blend and control the resources available to them across the system in order to 'commission' their own care through personalised care planning and personal budgets. IPC also supports people to develop their knowledge, skills and confidence to self-manage through partnerships with the voluntary and community sector (VCSE), through community capacity-building and peer support.

IPC is one of the key steps towards delivering the NHS Five Year Forward View. It supports the Joint improvement, integration and personalisation of services, building on learning from personal budgets in social care and progress with personal health budgets.

Each demonstrator site is working with one or more of the following groups who typically have high levels of need from both health and social care:

- Children and young people with complex needs, including those eligible for education, health and care plans.
- People with multiple long-term conditions, particularly frail older people
- People with learning disabilities with high support needs, including those who are in institutional settings or are at risk of being placed in these settings.
- People with significant mental health needs, such as those eligible for the Care Programme Approach (CPA), or those who use high levels of unplanned care.

The goals of IPC are:

- People with complex needs and their carers have better quality of life, and can achieve the outcomes that are important to them and their families
- Prevention of crises in people's lives that lead to unplanned hospital and institutional care
- Better integration and quality of care.

Rotherham CCG will closely monitor the learning from demonstrator sites in order to develop its own integrated personal commissioning approach.

The Local Offer

There is an expectation that Personal Health Budgets should expand towards 1 in 1,000 people, this equates to approximately 260 people in Rotherham. The national pilots have demonstrated that benefit from a PHB derives from the level of need rather than particular diagnosis or condition. The planning guidance for 2015-16 allows local flexibility on which groups will be offered personal health budgets.

Continued consultation on this Local Offer will help determine our priorities for the future expansion; this will be partly dependent on the freeing up of resources to fund budgets.

Plans are in place through existing target groups and projects, which in part is increasing the uptake of Personal Health Budgets in groups where we already have an agreed process. From 2017 onwards plans will be developed in line with the analysis in the table above of benefits to individuals which will be included in the Local Offer. Current targets of expansion will be monitored by the BCF Operational and Executive group.

There is also opportunity to jointly develop the approaches between the CCG and the Council for personal budgets and self-directed support, which is part of the Adult Care Improvement Plan. The membership of the CCG PHB working group (working on development and governance) is being expanded to include the Council with a view to rolling out PHBs to the wider population.

7.4 Learning Disability High Cost Care Packages

Residential Care

This service provides care commissioned for people with Learning Disabilities by the Council and relates to Adult Service Users in both long term and short term care. The primary objective of the service is to achieve the outcomes identified by the process of Community Care Assessment, detailed in the consequent Support Plan and agreed with the Service User and any named third party.

Supported Living Schemes

Supported Living schemes are seen as a viable and value for money alternative to care homes, with the potential to provide a more personalised approach and better outcomes for people.

Supported Living establishments provides people with somewhere to live with their own front door and is usually for 1-6 people with domiciliary care provided either by the accommodation owner, or by another provider chosen by the service user. Choice and control is key, with quality monitored by commissioning to ensure a good standard of care.

Domiciliary care is provided in communal supported living establishments, in hub-and-spoke models of clustered supported living, and in people's own family homes.

The main outcomes are:

- Enhancing quality of life for people with care and support needs through promoting independent living skills
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support.
- Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.

All Learning Disability residential homes and supported living are contract monitored by the Council using a quality monitoring framework. The Rotherham LD Partnership Board is actively involved in

service redesign and strategy development. Rotherham Transforming Care Board oversees this work locally to ensure tasks are kept on track.

The current service in Rotherham is moving towards the promotion of independent living but is still heavily reliant upon residential care. Further work will need to be undertaken to support adults to make different choices and to optimise their independence in a safe way i.e. supported living.

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The current service offer in Rotherham is moving towards promoting independence, but is still heavily reliant on a residential care rather than independent living approach. Further work will need to be undertaken to support adults to make different choices and to optimise their independence in a safe way i.e. supported living.

The Council will work to commission a new provider for the people living in supported living schemes at John Street and Oak Close which is currently being provided by the NHS Mental Health provider (RDaSH) via a competitive tender process. Full analysis is required to understand how this should be commissioned. All relevant stakeholders will be involved in the process.

Oak Close is a Supported Living Scheme for people with learning disabilities situated in the North of the Borough. The scheme comprises of 16 purpose built, self-contained apartments that were built in 2015, together with an additional four beds in a house also on the site. The property is owned by South Yorkshire Housing Association and the service is run by and CQC Registered with RDaSH.

John Street is a Supported Living Scheme for people with learning disabilities situated in the South of the Borough. The scheme comprises of three five bedded bungalows totalling 15 beds. The property is owned by South Yorkshire Housing Association and the service is run by and CQC Registered with RDaSH.

The Supporting Living market is small in Rotherham with only 7 providers. We want to engage with more person centred, value for money and good quality providers. The Council is currently exploring the opportunity to work in partnership with Sheffield City Council to develop and ultimately procure a supported living framework covering both areas from April 2017. We have a very similar supply base and a shared border so there are potential efficiencies from this approach in terms of economies of scale and consistency.

Direct Payments

Direct payments allow people with learning disabilities between the ages of 16 and 65 years, to have more choice and control over their day-to-day life through flexible care arrangements. Instead of the council commissioning their care services, the money is given to an individual to buy the care they need and they choose the kind of support that is right for them.

The following are some examples of how people have used direct payments to meet their assessed needs:

- Employing a personal assistant to support and help with everyday living skills agreement with a care agency to purchase help with personal care
- To buy a piece of equipment
- Support to access the local community, such as leisure and social activities
- Help with caring, such as respite care and taking a break from caring
- Assistance to access further education and employment opportunities.

Support and advice is also available for individuals to support them with all aspects of managing their direct payments including:

- Help with recruiting and employing staff and agencies
- Support and advice in employment law
- Developing appropriate contacts of employment
- Advice and support to sort out any difficulties you may have with your employee
- Calculate holiday entitlement, notice and redundancy pay to your employees
- Payroll support

7.5 Mental Health Section 117 placements

The legal responsibilities placed on Health and Social Care Services by Section 117 of the Mental Health Act 1983 requires Local Clinical Commissioning Group and Local Authority's Social Services, in conjunction with voluntary agencies, to provide aftercare for patients admitted under Section 3, 37, 45A, 47 and 48. This includes patients given leave of absence under Section 17 and any other section of the mental health act which entitles patients to provisions for aftercare under section 117 of the act.

After-care services must have both the purposes of meeting a need arising from or related to the person's mental disorder and reducing the risk of a deterioration of the person's mental condition and accordingly reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder.

The principles of self-directed support will apply to section 117 after care services including Personal Health Budget and Integrated Health and Social Care Budgets

8. Prevention and Early Intervention

8.1 Shaftesbury House/Short Stay Project

We have developed a "Short Stay" Project at Shaftesbury House from November 2016, which provides support through enablement and housing for a maximum of up to six weeks. The purpose of this project is to provide a safe, appropriate and short term housing support for people who are unable to return home to their own home, providing time and a period of adjustment after a change in their health or social care needs.

This scheme contributes to the BCF metrics by facilitating hospital discharges, avoiding unnecessary admissions to respite and residential care provides a safe environment to facilitate a short-term risk assessment due to high falls risk or cognitive impairment and provides a period of enablement that cannot be delivered in the person's own home.

8.2 Review of Therapy Services

The Rotherham Foundation Trust currently employs a large number of therapists working in the acute and community sector as follows:

- Domiciliary Physiotherapy
- Musculoskeletal Services
- Stroke and TIA service
- Falls, Fractures and Bone Health
- Integrated Rapid Response
- Breathing Space – beds, community rehab, domiciliary rehab
- Integrated Neurorehabilitation
- Cardiac Rehabilitation
- Community Occupational Therapy
- Intermediate Care – residential, community rehab team, day service rehab.
- Community Unit
- Waterside Grange – Discharge to Assess beds
- Hospital

Therapy is essential to the prevention and early intervention priority, Rotherham has a wealth of therapy services across community and acute however, at present there is no consistency in approach to therapy provision, integration and performance particularly on waiting times. As such therapy as a cross cutting service provision has been identified as an area of review for 2017-19, to ensure that where appropriate therapists are integrated into the locality way of working i.e. community locality teams, are able to provide flexibility in the cohort of patients they see and provide a more effective and efficient working arrangement across the services.

9. Adult Social Care Improvement Programme 2016-20

The Adult Social Care Improvement programme has been established to redesign the Rotherham arrangements for supporting the adult social care journey, to ensure Care Act compliance, provide better outcomes for customers and generate efficiencies/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.

The four key themes which have been identified:

- Prevention – This involves ensuring right information is available in all formats, that a range of options across the Borough that promote healthy lifestyles are available and increased use of digital channels.
- Integration – This focuses on future models for integrated health and social care teams, including hospital discharge team and mental health services, future role of configuration of

therapy across the Borough, integration of systems, sharing of data, information governance, understanding our people and place and future role of care homes.

- Care co-ordination – This will provide clarity on how the Care Co-ordination Centre forms part of a wider Single Point of Access for hospital admission.
- Maximising independence and reablement – This includes development of specialist reablement and recovery services, extra care supported living, best use of the Rotherham pound (CHC, joint funding, social care), working with providers and health partners to offer value for money, drive and manage the market, making sure there are the right support options available for people, personalisation of individual options, telecare/telehealth, internet, digital communication, skype/face time.

The Local Authority have also established regular Practice Scrutiny Groups which are held on a twice weekly basis to carry out quality assurance checks to ensure Care Act compliance, ensuring best value, effective use of resources and promoting better outcomes. The group is focusing on developing a strength based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised.

The Practice Scrutiny groups focus on greater promotion of the use of individual budgets via a direct payment provides strength based, focussed assessment on well-being and clear evidence of person's needs, eligibility criteria, support plans, completion of Continuing Health Care and Decision Support Tool checklists, alternatives to standard service provision and greater use of assistive technology.

Delivery of this programme in full is likely to take around four 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.

10. 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.

10.1 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 re-admission. This has enabled the targeting of case management on those who are likely to require intensive support further down the care pathway. It is expected that further opportunities will be considered to expand the current risk stratification model to support prevention and early intervention as this is key to promoting self-management and increased independence for longer.

10.2 The Rotherham GP 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.

10.3 The Social Prescribing Programme

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. Social prescribing is an approach that links patients in primary care with non-medical support in the community. The Rotherham social prescribing model particularly focuses on secondary prevention, commissioning services that will prevent worsening health for those people with existing long term conditions, and thus reduce costly interventions in specialist care. 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 re-ablement. VAR provide a one-to-one service to people on the GP Case Management Programme, motivating, signposting and supporting them to access services in the voluntary and community sector.

Rotherham CCG is also running a pilot within Mental Health. The Rotherham Social Prescribing Mental Health Pilot was developed to help people with mental health conditions overcome the barriers which prevent discharge from secondary mental health care services. It initially ran from April 2015 to March 2016 but has since been extended to March 2017. The service helps service users build and direct their own packages of support, tailored to their specific needs, by encouraging them to access personalised services in the community provided by established local voluntary and community organisations, and to develop their own peer-led activities.

Voluntary Action Rotherham, on behalf of NHS Rotherham CCG, co-ordinates both schemes. By connecting people with a range of voluntary and community sector-led interventions, such as exercise/mobility activities, community transport, befriending and peer mentoring, art and craft sessions, carer's respite, (to name a few), the scheme aims to lead to improved social and clinical outcomes for people and their carers; more cost-effective use of NHS and social care resources and to the development of a wider, more diverse range of local community services.

Within the Long Term Conditions service, participants are identified by GP surgeries using a risk stratification tool. Advisers discuss patients at risk of unplanned hospital admission within the integrated case management teams and patients identified as needing non-clinical means of support to improve their health and wellbeing are referred to the social prescribing scheme. Advisers then carry out a home visit to undertake a guided conversation to help patients identify what areas of their lives they would like to change/improve.

The services they connect people to are provided through contracts with a range of local voluntary and community sector organisations, including local branches of Age UK, Citizens Advice Bureau, Alzheimer's Society and Sense. As well as the services listed above, people can be linked to dementia services; advice and information; advocacy; sensory services; therapeutic services and community hubs based on an asset based community development (ABCD) model. Where the main providers are not able to meet a particular need or goal, advisers may spot-purchase more appropriate solutions.

The Mental Health Pilot is funded by NHS Rotherham Clinical Commissioning Group (CCG) and delivered in partnership between Rotherham, Doncaster and South Humber Foundation Trust[1] (RDASH) and a consortium of 17 local voluntary sector organisations led by Voluntary Action Rotherham.

Both services have been independently evaluated by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. Both evaluation reports are available here

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

10.4 Supporting People with Dementia

Rotherham has invested in a wide 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.

Dementia Enablement Service

The service is provided by Crossroads Care Rotherham (voluntary and community sector provider), which provides emotional support and respite breaks to carers of people with dementia. The service supports people with dementia to be more independent at home and in the community and aims to reduce inappropriate admissions to hospital or premature admission to long term residential care. The service is available on a 24 hours a day, 7 days a week basis. .

Dementia Enabling

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

[1] RDASH as historically provided mental health and learning disability services across South Yorkshire and North East Lincolnshire, but recently expanded its remit to include community services such as district nursing and health visitors.

Dementia Re-ablement Service

This service is also delivered by Crossroads Care Rotherham and is available for 6 weeks. The service aims to support hospital discharges, offers support to prevent admission to hospital/residential care and to prevent re-admissions to hospital. The service will work to re-establish routine and support the family/carer. The service is available on 24 hours, 7 days a week basis.

Discussions are ongoing around Dementia Reablement ceasing and being absorbed into Dementia Enablement but this has yet to be confirmed. The position will be clear by around January 2017.

Carer Support Service

This service is also provided by Crossroads Care Rotherham, which provides emotional support and respite breaks. The service aims to enable people to enjoy a life of their own alongside their caring role. It also helps to reduce social isolation and improve health and wellbeing. The service is available for 30 hours over a 10 week period.

Dementia Carers Resilience Service

This service is provided jointly by three voluntary and community sector providers which are Crossroads Care Rotherham, Alzheimers Society and Age UK. Each GP practice has a named link worker who identifies and supports carers of people with dementia. The service provides information, advice and practical support including respite care at home, as appropriate. When a carer is referred by their GP they are contacted by a Dementia Adviser within 5 days of the referral being received. An initial assessment of need is carried out. The period of support will be one month. Where appropriate, carers are then signposted to other organisations who can offer support e.g. Single Point of Access, aids and equipment, social activities, benefits checks for longer term support to be arranged, as required.

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.

The Alzheimers Society employs Dementia Support Workers who assist people with dementia and their carers to identify their needs and to access services. The workers give information, support and guidance and signpost service users and carers to other services for further support.

Community Cafes

The Local Authority have commissioned a new Community Café service from the voluntary sector since April 2016, which includes the development of 6 community cafes, providing support, structured activity, information giving, open discussion and social engagement in a group setting, at various locations in the community to support people living with dementia and their carers.

Community Cafes are a more informal version of Memory Cafes and are arranged by a Café Co-ordinator and attended by Dementia Support Workers

5 out of the 6 cafes are now established and fully operational as follows:

- The café at New York Stadium has a health/exercise programme to improve health and well-being
- Swinton has a social and creative programme with one to one activity for both carers and people with dementia
- Chislett Centre has an excellent network of community activity for service and carers to access and have been introducing those opportunities within the group.
- Kiveton Park is now well established within the community with 33 attending the first session in October 2016. The environment is set out well with an appropriate number of volunteers to support the activity.
- Rotherfed held its first café in November 2016, which offers an opportunity for people to eat together, as well as linking in other activities such as quizzes, games, speakers and opportunities to liaise with the dementia support worker for advice, support and guidance.

The sixth café will be located at the Methodist Church in Wickersley from January 2017. The dementia support worker is currently supporting the group to get the service fully operational.

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 delivered by the Alzheimers Society 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.

An enhanced service in primary care service for diagnosing dementia is in place to provide early access to services. This is separate to the Better Care Fund but closely links to its objectives.

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.

Memory Service - 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

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

There have been significant achievements since the last BCF plan in 2016/17.

We have reviewed some of the jointly commissioned services during 2016/17. The reviews have highlighted where BCF schemes are strategically relevant, those services that have performance issues and those that require further investigation in 2017/19.

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 (Appendix X).

We have now successfully matched around 5,495 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.

The Local Authority's new social care case management system (Liquidlogic) went "live" on 13.12.16, and this includes the facility to integrate with the NHS 'Patient Demographic Service' (PDS) , which will deliver the ability to quickly look up NHS numbers on the NHS spine and we will begin using the NHSN on our correspondence.

We are also working towards ensuring that better data sharing data includes ensuring that patients/service users have clarity about how data about them is used, who may have access and how they can exercise their legal rights. Significant progress is under way, with an expected full implementation date of 31st January, 2017, to ensure that we fully meet the national condition.

The work carried out includes The Proposed Consent Model was fully approved at the Rotherham Interoperability Group on 31st August, 2016. The Model states that the ability to access a patient's information may be done via implied consent for direct care. The public must, however, be effectively informed that the data is in use and have the option to object to their records (from any organisation) being shared. Access of a record must be done on the explicit consent of the individual for each episode of care, wherever this is possible (and practical).

Where a patient requires emergency treatment and is unable to give consent, or when a record is being reviewed in response to a test result when the patient is not present, a professional clinical decision can be made considering whether the duty to share or implied consent may be justified. Such access without explicit consent should be documented. This should be fully auditable and monitored accordingly.

A Communications and Engagement plan has been drafted and information will be made available in a variety of formats covering:

- The system "Rotherham Health Record" (RHR) that we will be using to share data
- How it works
- What information will be shared within it (details such as name, address, medication)
- Who will have access to it
- Reassurance on the security of the RHR (both technical within the system and organisational in terms of duty of confidentiality)
- How to opt out
- Who to contact with any concerns/queries

We have a 7 day social care working in place and embedded at the hospital with on-site social care assessment available to support patients. This has become "business as usual" from October 2016, following the implementation of a social care restructure. Support over the full 7 days is provided by the same core team, ensuring that there is consistency of process over this period. Additional support over and above the dedicated resources identified can be accessed through the out of hours service on an as needed basis.

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 Clinical Quality Advisor within the Care Home Support Service from February 2017. 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 and will improve the standard of care for residents. The Advisor will monitor quality standards of care and will undertake audits, reviews, assessments and provide advice, training and support to care homes. The Advisory will also work with the Local Authority contracting team and will contribute to co-ordinated patient pathways.

Through use of BCF we have commissioned 3 Adult Social Care Assessment beds to support discharge patients who require further assessments to optimise independence. All beds are designated to support hospital discharge for patients who require optimisation and further assessment and 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.

12. 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. Consideration of a specialist reablement centre incorporating intermediate care
6. A single health and social care plan for people with long term conditions
7. A joint approach to care home support
8. A shared approach to delayed transfers of care (DTOC)

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

Rotherham has high ambitions for being a cohesive community with strong partnerships and joined up support delivered around localities. Key to this is to ensure a good understanding of what the options are to support people appropriately to remain healthy, well and outside of services for as long as possible.

The vision for Rotherham Single Point of Access is for one hub that citizens of Rotherham who have concerns about their own, or others health and social care needs can contact. Citizens will receive immediate advice which will allow them to self-serve and if required further timely advice or intervention to prevent, reduce and delay needs and safeguard as necessary. The key features of this offer are that Rotherham citizens:

- Tell their story once and make every contact count;
- Are supported at each stage to maximise own strengths, assets and ability to self-manage / self-care;
- Receive just enough support to maximise independence and self-reliance;
- Receive the right care in the right place at the right time;
- That Rotherham health and social care professionals;
  - Can access a pool of knowledge and resources outside of their own profession, or local area of expertise;
  - Can appropriately advise customers / patients / service users how to access different parts of the system;
  - Can manage system demands and prioritise resources appropriately.

If the vision is achieved the single point of access should be able to facilitate citizens to access the most appropriate advice, onward referral to meet their needs and prevent reliance on acute services (i.e. prevention of attendance and admission to hospital).

What are we going to do?

There are a number of "services" across the system currently that provide some of the functions identified in the model however there are gaps in provision across the wider system response and differing entry points makes navigating services confusing. It is the intention of all partners to examine the options for extending the current Care o-ordination Centre discussed in 6.2 and to further integrate the Integrated Rapid Response service discussed in 6.1 with mental health, social care and enabling.

The single point of access cross cuts several Place Plan Priorities. It is a key to prevention and self-serves, has strong interdependency with the model of an enhanced care coordination centre, could maximise the benefits of a single reablement hub and provides solutions to support the emergency and urgent care centre. Crucially the localities model will not be sustainable unless demand is managed and dealt with more effectively and these resources can be prioritised.

The proposal is to phase this work, concentrating first on developing a single point of access for the out of hours response (integrated rapid response). The rationale for this approach is detailed below;

- Outside of standard working hours there is a significantly smaller set of services and is therefore easier to manage implementation
- A number of these services have already started to look at working more closely so there is willing and some progress towards this.
- Out of hours citizens often access a more intensive level of support e.g. residential care or hospital in order to ensure safety and if as system we can close this loop it would have significant positive outcomes.

The learning from bringing together the out of hours service can be used to shape the vision for what the wider single point of access model needs to achieve alongside the planned review of the Care Coordination Centre. It is the intention to expand the integrated rapid response service to provide an enabling function which will support discharge home ensuring that people are appropriately supported to reach their full rehabilitation potential in a more applicable setting (home) to inform the assessment (i.e. DST) and support process.

12.2 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 coordinated 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 have we done?

A fully integrated health and social care team has been piloted to support the Health Village. The team is co-located and supporting the same population as the current community nursing locality team. The team has a single line management structure and joint service specification. A portal has been developed that can store the integrated care plan and provide full visibility on the range of work being done on the individual. The Rotherham Health Record now imports the Virtual Ward flagged patients and displays them within its existing Patient Lists functionality. This is currently being assessed to see if it meets the needs of the MDT and once signed off it will be ensured that there is appropriate access for MDT staff.

The integrated health and social care team includes 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.

12.3 Development of preventative services that support independence

Rotherham has developed a "Healthy Ageing Framework" Reference to improve the health and wellbeing of the ageing community. The framework

supports 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

The Care Act (2014) "Guidance for Occupational Therapists", endorsed by ADASS, highlights that "It is critical that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. It is vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence and prevents needs or delays deterioration wherever possible. The statutory guidance also states that they must consider the principle of prevention from the first point of contact and throughout their ongoing involvement.

The Care Act also highlights that practitioners need to share their skills so that others can meet particular areas of need e.g. equipment provision. We need to work across other statutory and voluntary services to maximise capacity and reduce duplication.

We also need to have a greater awareness of what is available in our local area e.g. community assets which can help and support service users and/or their carers, for example charities, faith and social groups, health promotion and volunteer services..

What are we going to do?

The Community Occupational Service review considers options for future development of the service. The ambition is to integrate the service into the locality model and working closely with adult social care by providing additional resources into the Local Authority's Single Point of Access by signposting potential or existing service users to other alternative services and to reduce home care packages by selecting alternative solutions to address needs. An options appraisal will be carried out in 2017-18 to determine a new service model and future commissioning arrangements. The service will also form part of the overall review of all community therapy services in Rotherham.

Community Equipment

The Care Act (2014) stipulates that Local Authorities must provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement services, e.g. community equipment services.

These preventative type services also provides effective rehabilitation, improves quality of life, enhances their life chances through education and employment and 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.

What are we going to do?

We will review the Integrated Community Equipment Service and Wheelchair Service to ensure there is sufficient funding on a recurrent basis to respond to increase needs and demands. The review will focus on increasing needs, funding, risks, business continuity, identify savings or additional investment and customer experience to provide a service that is sustainable and fit for purpose.

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 will use with people across the health, social care and voluntary sector workforce. This tool 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. The tool had its soft launch in November 2016 and will be fully launched in early 2017.

Promoting physical activity

Public Health and partners have developed a post rehabilitation support for patients with seven long term conditions (Stroke, Cardiac, Heart failure, COPD, MSK, Falls, and Cancer). This research project started in November 2015 and provides 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 supports patients to access appropriate exercise activity in their local community. The service is 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
- Research project being externally evaluated by Sheffield Hallam University.

Over 500 patients have completed the programme in Year 1, resulting in some positive outcomes and excellent case studies. A short video has been developed to bring the project to life and this is available on http://www.rotherhamgetactive.co.uk/activeforhealth

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.

12.4 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.

12.5 Consideration of a Specialist Reablement Centre 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. In 2016-17 we have moved forward in this journey by flexing the eligibility criteria to our intermediate care (bed base), removing bureaucracy in the referral process and amalgamating provision across 3 sites to 2 to support effective integration of teams.

What are we going to do?

We will further review our intermediate care offer over 2017-19 considering other community bed based provision such as the nurse-led provision (Community Unit & Breathing Space) in conjunction with the review of hospital to home (Integrated Rapid Response). This is to ensure that services are future proof and fit for purpose. We will ensure that the right numbers of beds are commissioned to meet demand, more flexible eligibility criteria is in place, increased provision of services in the home and more choice of housing.

We will build on our intermediate 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 consider the options for merging existing intermediate care provision, including the Rotherham Intermediate Care centre (RICC) onto a single site, creating a specialist reablement centre. This is one of the key priorities contained with the Integrated Health and Social Care Place Plan. 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

12.6 Rotherham Carers' Strategy

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 have developed and approved a Carers Strategy "Caring Together". 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?

"Caring Together" is a partnership document recognising that Carers form an essential part of the overall health and social care offer within Rotherham and should have a voice in how they are supported. The strategy identifies 6 desired outcomes which have been developed with Carers:

1. Carers in Rotherham are more able to withstand or recover quickly from difficult conditions and feel empowered.
2. The caring role is manageable and sustainable
3. Carers in Rotherham have their needs understood and their well-being promoted
4. Families with young Carers are consistently identified early in Rotherham to prevent problems from occurring and getting worse and that there is shared responsibility across partners for this early identification.
5. Our children are recognised and safeguarded in their challenging role and receive appropriate intervention and support at the right time.
6. Children and young people in Rotherham that have young carer roles have access to and experience the same outcomes as their peers.

We will work collaboratively to commission services that meet the desired outcomes identified within the strategy.

12.7 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.

12.8 A Joint Approach to Care Home Support

An important part of our new integrated locality model of care and of ensuring there are appropriate care solutions in the community, is the transformation of our care home sector. Approximately 15% to 18% of emergency admissions into the hospital are from care homes and the length of stay for these people tends to be higher than for average admissions. Most people want to be cared for in their own homes and we know that this is best for their wellbeing. Partnership with the care home sector is therefore critical to reducing demand for acute services. Our aim is for:

- Fewer admissions from care homes into hospital
- Patient length of stay to be more proactively managed through technology (e.g. automated systems from providers to case management systems to alert on bed availability)
- Less people to be automatically placed in care homes when they could stay in their own home and be supported within their community

A&E attendances and admissions from care homes have increased on previous years, the predicted outturn is currently 1503 (data to Oct 2016) against a target of 1250. This has significantly improved in the last three months from an average of 136 per month from April to June 2016 to 112 in August to October 2016. The number of those admitted after attendances is high and reflects the increasing level of complexity and acuity in those that access emergency care. On a positive note the number of emergency admissions out of hours is predicted to be under plan at 5232 against a target of 8760.

To help us achieve this, we will further develop our **care home support service** linking medical staff into care homes and also linking in with mental health liaison services (described in Section 4.3.1) and with the integrated locality team. Currently physiotherapy assessment is carried out in the hospital ward and then another one upon admission to the intermediate care beds. We plan to introduce a 'Trusted Assessor' model to streamline the assessment – defined as one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.

We are also aware that a number of care home staffs remain uncomfortable in managing a care home resident who is frail and experiencing deterioration in their health due to an infection or dehydration. Whilst advance care plans can help inform decision-making, there is an important need to upskill staff in this sector with the assessment and practical skills to manage residents with higher acuity medical problems. We would like to develop a syllabus to help **upskill staff in some of our care homes** and for them to develop a subspecialty interest in higher acuity patients in order to reduce transfers to different levels of care and also to facilitate earlier discharge from hospital. One option being

considered is to increase opportunities for care home staff to work within the hospital and develop the necessary skills to take back within the care home setting.

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 CCG and the Council's 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.

12.9 A Joint Approach to Care Home Fee Setting – Residential/Nursing/EMI/FNC/CHC

The Local Authority currently contract with 35 independent sector care homes to support older people in Rotherham. This includes a range of care types including residential, residential EMI, nursing and nursing EMI placements.

The independent sector care home market supplies around 1,779 beds and accommodates around 1,593 older people.

The Rotherham NHS Foundation Trust (TRFT) are required to carry out timely discharge of patients from acute beds to alternative forms of care and prevent admissions to acute bed capacity. A solution to increasingly complex care needs would be to increase nursing type capacity in the independent sector care home market. The high levels of occupancy in nursing type provision mean that there is a requirement to work with the Rotherham independent sector market to incentivise immediate growth in this area.

With this in mind, the Local Authority and the CCG need to develop a joint approach to fee setting of care home placements for residential, EMI, nursing, FNC and CHC placements in light of the increase in the National Living Wage since April 2016 and the introduction of compulsory employers' contributions to pensions from April 2018.

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

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.

Rotherham CCG and its partners will monitor DTOCs through the A&E Delivery Board. A&E Delivery Board endorsed a Memorandum of Understanding (MoU) (Appendix X) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which was signed up to in 20161-7. 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. We have developed robust reporting systems which incorporate data on DTOC and other patient cohorts who have an impact on patient flow.

What are we going to do?

We are currently reviewing the effectiveness of the MoU through audits of particular ward discharge process which will inform any future iteration of the document. This robust review process will make further steps to embed the Trusted Assessor model and provide evidence of the need for discharge co-ordinators on each ward (currently being piloted) to support the Transfer of Care Team (which incorporates the Hospital Social Work Team).

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 which has been successful in supporting complex discharges 2016-17. 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. An example of success is that we have been able to reconfigure the provision of Keysafes from the local provider to ensure that complex patients can access a Keysafe within 24 hours of referral to expedite a discharge.

12.12 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	
	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
	Consideration of the development of a specialist reablement centre	

HWB Aim	BCF Priority	Impact on HWB objectives
	incorporating intermediate care	with long term health and disability needs
	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	

12.13 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	LEAD	Milestones 2016	Date
1	A single point of access into health and social care services; including the integration of Integrated Rapid Response		Project Group established of senior leads across CCG, Council, RDaSH, Primary Care	01.01.17 **Completed**
		Project Group	Scoping and planning expansion of services to other health and social care services	30.09.17
		Project Group	Agreement of expansion and service reconfiguration	31.10.17
		Project Group	Service reconfiguration begins	01.11.17
		Project Group	Evaluation of new models	01.04.18
2	Development of integrated health and social care teams		Development of project group – RDaSH, CCG, Council, VAR, TRFT senior leads	01/01/17 **Completed**
		TRFT – with partners	Development of Standard Operating Procedures, Job descriptions, process mapping	01.06.17
		TRFT - with partners	Analysis of demographics and population need across Rotherham and specific to locality area, to inform roll out model.	01.06.17
		External support	Evaluation of pilot	01.07.17
		Project Group	Roll out of the integrated locality teams across Rotherham	01.01.18

Priority	Description	LEAD	Milestones 2016	Date
		Project Group	Care Home transformation timecscales to be defined as part of project group	01.6.17
3	Consideration of a Specialist Reablement Centre incorporating intermediate care beds		Project Group established of senior leads across CCG, Council, RDaSH, Primary Care	01.01.17 **Completed**
		Project Group	Further review of Intermediate Care model incorporating Nurse-Led provision	31.05.17
		Claire Smith	Review of acute and community respiratory pathways	31.05.17
		Project Group	Proposals for future development of Reablement Centre	31.07.17
		Project Group	Service reconfiguration begins	01/01/18
4	Preventative services that support independence	Karen Smith RMBC	OT Review approved by BCF Executive	17.02.17
		Karen Smith RMBC	New service model agreed by BCF Executive	17.2.17
		Karen Smith RMBC	Project plan agreed for implementation of new service model	17.2.17
		Karen Smith RMBC	New service model fully operational	01.04.17
		Karen Smith RMBC Claire Smith CCG	ICES and Wheelchair Review approved by BCF Executive	23.05.17

Priority	Description	LEAD	Milestones 2016	Date
		Karen Smith RMBC Claire Smith CCG	New service model agreed by BCF Executive	23.05.17
		Karen Smith RMBC Claire Smith CCG	Project plan agreed for implementation of new service model	23.05.17
		Karen Smith RMBC Claire Smith CCG	New service model fully operational	01.07.17
5	Reconfiguration of the home care enabling service	Chris Corton RMBC	Home care enabling Review approved by Adults Transformation Board	31.07.16
		Chris Corton RMBC	New service model agreed by Board	31.07.16
		Chris Corton RMBC	Project plan agreed for implementation of service model	01.10.16
		Chris Corton RMBC	New service model fully operational	01.04.17
7	Single health and social care plan for people with long term condition	Dawn Anderson CCG	Scoping exercise completed on integrated care plan	01.09.16
		Dawn Anderson CCG	Develop common template for case management	31.11.16
		Dawn Anderson CCG	Develop IT solution for sharing care plan across systems	31.12.16
		Dawn Anderson	Implement integrated care plan for case	01.04.17

Priority	Description	LEAD	Milestones 2016	Date
		CCG	management	
8	A joint approach to care home support	Karen Smith RMBC	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
9	Shared Approach to Delayed Transfers of Care (DTOC)	Dominic Blaydon	Review of implementation of MoU through audit of a ward	01.03.17
		Dominic Blaydon	Review findings from pilot of discharge coordinator on one ward to link with Transfer of Care Team and recommendations for future model	30.06.17
		Dominic Blaydon	Examine assessment process to streamline and integrate functions of health and social care	30.06.17
		Dominic Blaydon	Further work to embed “trusted assessor” role to reduce duplication and improve patient flow	30.06.17

13 National Conditions

13.1 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.

13.2 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 from 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 2017/19 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.

Assistive Technology

Assistive Technology is one way which can support people to live independently in their homes/accommodation for as long as possible. Assistive technology promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with devices needed to accomplish such tasks. Examples of assistive technology include standing frames, text telephones, accessible keyboards, large print, Braille and speech recognition software.

We would like to encourage providers to think about technology devices which can be used to support people and their carers. The Local Authority will ensure for people who access support and services, assistive technology will be a consideration as an option identified in their support plan identified through the assessment process. This can also be used as a preventative measure to keeping people at home. Currently we support people with physical and sensory disabilities, and older and frail people through aid and devices.

There are many technology solutions which provide innovative and bespoke packages depending on the individual need and their family's needs and aspiration; this can be achieved through exploring a holistic approach to care and support. Rothercare (Local Authority 24/7 contact centre) is leading on assistive technology for Rotherham and will be identifying numerous ways of expanding the use of technological equipment.

The term "assistive technology" also includes technology that enables the use of automatic, remote monitoring of emergencies as they happen, as well as general practical equipment. The ranges of options are:

- raising an alarm through to a monitoring system in cases of emergencies such as falls, or
- standalone equipment which does not send signals to a response centre but supports carers through providing local alerts in a person's home, to let the carer know when a person requires attention.

The assistive technology is a crucial element of support for our clients especial for those with disabilities which will include sensory impairment. It enables people to still lead equal and independent lives, feeling safe in their own home, community and enable them to remain in the community.

13.3 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.. The 7 day social care working is now fully in place and embedded at the hospital with on-site social care assessment available to support patients. This has become “business as usual” from October 2016, following the implementation of a social care restructure. Support over the full 7 days is provided by the same core team, ensuring that there is consistency of process over this period. Additional support over and above the dedicated resources identified can be accessed through the out of hours service on an as needed basis.

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 2017/18. 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.

13.4 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 is now live. Early in 2017 we will be integrating the new system 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.

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 have developed a 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 (2016/18) 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. In addition GPs can view details of their patients who have been admitted to hospital, attended A&E and recently discharged patients. There is also the capability to see safeguarding flags.

The clinical portal has been made available in Rotherham Hospice allowing their clinicians to view secondary and community care records.

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 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. An inter-agency information sharing protocol that covers public sector organisations across South and West Yorkshire has been proposed as a successor to the current Rotherham information sharing protocol and this is currently undergoing approval across Rotherham's local partners.

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 Caldicott requirements via our submission to the IGSoC and via the IGToolkit

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

14. Measuring Success

14.1 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

	Metric	Numerator	Denominator
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 2017/19. 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 resulted in 68 fewer admissions compared to 2014/15. An outturn of 401 admissions equates to a rate of 819.52 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 2015/16 year end outturn was 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.

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.

14.2 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)

RMBC Corporate Plan

The Local Authority's Corporate Plan also measures:

A number of Key Performance Indicators from the Local Authority's Corporate Plan will be supported by the schemes funded by the Better Care Fund as follows:

- Number of people provided with information and advice at first point of contact (to prevent service Needs).
- Proportion of carers in receipt of carer specific services who receive services via self-directed support.
- Number of carers assessments completed.
- Proportion of new clients who receive short-term (enablement) service in year, with an outcome of no further requests for support.
- Number of adults with learning disabilities supported into employment, enabling them to lead successful lives.
- Improved satisfaction levels of those in receipt of care and support.

15. 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 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
6	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 approach	• 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
7	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

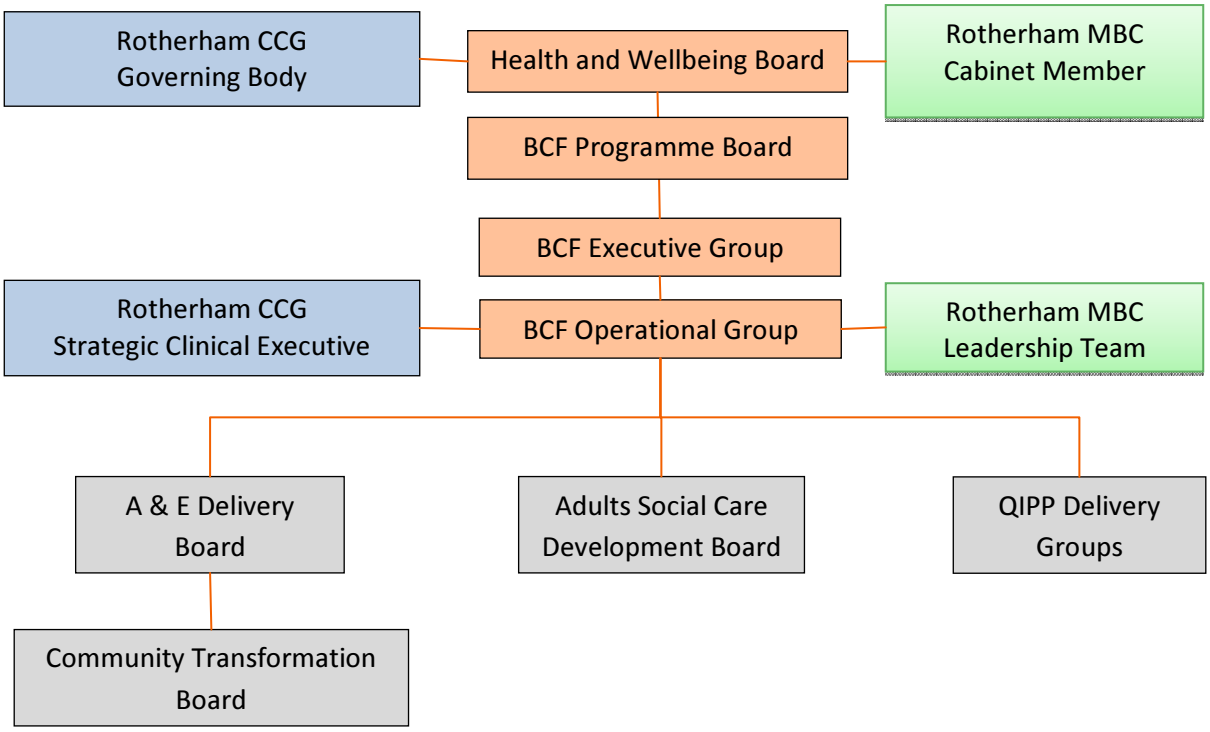
16. Governance Arrangements

16.1 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

16.2 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.

17. 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				
Consequence score				
1 Negligible	2 Minor	3 Moderate	4 Major	5 Extreme
Likelihood Score				
1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
Strategic Risks					
1	Poor alignment between service budgets and actual cost; resulting in overspend	4	3	12	The review process timetabled throughout 207-18 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

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
					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 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	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 2017/18 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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
7	Failure to achieve planned savings due to overspends in the system/ inability to meet targets will create financial risks (budget pressures) for the respective parties	3	5	15	Performance management framework via the A& E Delivery Board 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 17/18 programme. If 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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
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. 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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
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 A&E Delivery Board 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.
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. A& E Delivery board 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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
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.
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 2016-17 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

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
					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 viability issues due to loss of funding in one area, cause issues with performance against contracts.	2	4	8	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. CCG received Quality Impact Assessments from providers 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 2017-18. 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.

16. Contingency Planning and Risk Sharing

A risk pool of £500,000 has been included in the BCF financial plan for 2017/18 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 2015/16 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 2017/18.

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 2017/18.

The CCG has comprehensive plans with regards to dampening down growth of emergency admissions has been successful in previous years when compared to the national levels. All local stakeholders are key players in delivering these plans through the A&E Delivery Board. The way in which RCCG will contract for urgent and emergency care will change markedly in 2017. A new purpose built £12m capital development will open in July 2017 housing the new urgent and emergency care centre (UECC). This will bring the existing Walk-in-Centre service together with the ED to deliver a new service model with Advanced Care Practitioners and GPs as senior clinicians to prevent admission. The UECC business case was predicated on a reduction of 5 emergency admissions per day. To allow these changes to happen without financial consequence for TRFT, RCCG and TRFT have agreed to a block contract across urgent and emergency care at 2016/17 forecast outturn levels. This limits RCCG's financial exposure over 2017/18 and 2018/19. The threshold for the block contract is 2% higher than contracted activity levels. If activity reaches the 2% threshold, RCCG and TRFT will undertake a joint review of emergency activity.

All local stakeholders are members of the A&E Delivery Board. This plan has been approved by the BCF Executive Group, comprised of Health and Wellbeing Board members and will be formally approved by the Board at its next meeting.

17. Patient Engagement

Integration Locality Engagement

The integrated locality pilot commenced in June 2016 , to ensure patient engagement was central to the integration of community services within one locality and the impact this may have on Rotherham people. For example; streamlining of assessments, better communication, more effective support. Leading on from the consultation at the AGM is a focused workshop to take place at the next Patient Participation Group on the 6th December 2016. This will include a presentation to members on the purpose of the pilot and the expected outcomes and then several discussion groups looking at different questions relating to the service i.e. in- reach into hospital.

Rotherham CCG and its partners are also examining opportunities to involve an external organisation in the review of the pilot which will include evaluation of patient feedback to inform future commissioning arrangements. The evaluation is due to be completed by June 2017, with various participation to be planned in early 2017.

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.

We engage with local people in a number of forums, both formally brokered such as the the Council's Customer Inspection Team and Speak Up and informally, 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 experiences 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 a number of techniques, the team will measure the customer defined i-statements , to identify the positive and negative impacts that the BCF plan has had on customer experiences and help shape integrated services

The paper 'Working Towards Integration in Rotherham', presented to the Health and Wellbeing Board in February 2016 referenced the Better Care Fund in promoting and strengthening integrated working.

The Lead Executives identified a number of priorities for further development of integrated services including the development of a reablement hub, incorporating intermediate care beds. It was agreed at the BCF Operations Group to initially focus customer insight activity on Intermediate Care Services.

We engaged with a sample of 35 people in receipt of Intermediate Care Services between March and May 2016, through a telephone and postal survey. To supplement this, 81 customer journeys were mapped.

Survey results confirmed that 62% of people rated the service 'excellent', 21% 'good', 2% 'satisfactory' and 1% 'poor' (14% of people did not provide a rating). The customer journey mapping provided key information about referral routes in to Intermediate Care, reason for referral, length of stay, discharge information including destination and levels of re-admission to acute care. The results were reported to the BCF Operational Group and were accepted to be used by commissioners in the review of Intermediate Care Services.

Customer engagement will continue to be captured for services under the BCF umbrella; activities will be ordered in line with the action plan to ensure the customer insight informs the future shaping of services.

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 X).

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 X).

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 Provider Forums, partnership groups and "Meet the Buyer" events 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 and 2017-18.

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, A&E Delivery Board, Clinical Referral Management Committee and Joint Commissioning Performance Groups.

Table 7: Stakeholder Map

<table>
<tr><th>Stakeholder</th><th>Channels</th><th>Reporting</th></tr>
<tr><td>Service users / patients</td><td rowspan="2">Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.</td><td rowspan="2">No set reporting periods</td></tr>
<tr><td>Health watch</td></tr>
<tr><td>CCG Governing Body</td><td>Formal governance</td><td>6 monthly reports</td></tr>
<tr><td>Council, Cabinet and Scrutiny</td><td>Formal governance</td><td>6 monthly reports</td></tr>
<tr><td>Health and Wellbeing Board</td><td>Formal governance</td><td>6 monthly reports</td></tr>
<tr><td>MPs and Councillors</td><td>Briefings</td><td>Annual</td></tr>
<tr><td>NHS clinicians and staff</td><td rowspan="4">Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.</td><td rowspan="4">No set reporting periods</td></tr>
<tr><td>RMBC staff</td></tr>
<tr><td>Service providers</td></tr>
<tr><td>3rd sector organisations</td></tr>
<tr><td>Public</td><td>Website, newsletters and local publicity</td></tr>
</table>

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 2016/17, 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 2016/17 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. This investment remains in 2017/18, with a slight increase in overall funding within the BCF.

The detailed financial plans will be submitted in the tables but the movement between 2016/17 and planned BCF for 2017/18 is provided below:

Table 8: Summary of Financial Plan

			ADDITIONAL INVESTMENT			ALLOCATION OF POOLED BUDGETS		
	THEME	2016/17	RMBC	RCCG	2017/18 BCF PLAN	RCCG POOL	RMBC POOL	TOTAL
		£000s	£000s	£000s	£000s	£000s	£000s	£000s
1	MENTAL HEALTH SERVICES	790		1	**791**	**791**		**791**
2	REHABILITATION AND REABLEMENT	13,391		138	**13,529**		**13,529**	**13,529**
3	SUPPORTING SOCIAL CARE	3,682			**3,682**	**3,682**		**3,682**
4	CASE MANAGEMENT AND INTEGRATED CARE PLANNING	5,028		0	**5,028**	**5,028**		**5,028**
5	SUPPORTING CARERS	690		(40)	**650**	**650**		**650**
6	INFRASTRUCTURE (including Care Act)	242		0	**242**	**242**		**242**
7	RISK POOL	500		0	**500**	**500**		**500**
	TOTAL	**24,323**	**0**	**99**	**24,422**	**10,893**	**13,529**	**24,422**

Table 9: Summary of Investment Profile

	Service Area	2016/17 BCF £000	Additional costs	2017/18 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	**790**	**1**	**791**					Ok
Theme 2: Rehabilitation and Reablement									
2	Home Improvement Agency	75		**75**					Ok
3	Falls Service	432	12	**444**					Ok
4	Home Enabling Services	1,556	37	**1,593**					Under Review
5	2 SSO reviewing officers to fast track assessments during reablement	98		**98**					Ok
6	Community Stroke Service	175		**175**					Ok
7	Community Neuro Rehab	154		**154**					Ok
8	Breathing Space	2,256	88	**2,344**					Under Review
9	Expert Patient Programme	50		**50**					Ok
10	REWS	939	1	**940**					Under Review
11	Community OT	746		**746**					Under Review
12	Disabled Facilities Grant	2,119		**2,119**					Encorporates PSS adult services capital grant
13	Age UK Hospital Discharge	163		**163**					Ok
14	Stroke Association Service	50		**50**					Ok
15	Stroke Social Work Support	27		**27**					Ok
16	Intermediate Care Pool	4,531		**4,531**					Ok
17	Otago Exercise Programme	20		**20**					Ok
	Total	**13,391**	**138**	**13,529**					
Theme 3: Protecting Social Care									
18	Direct Payments	1,643		**1,643**					MOU in development
19	Care Act Implementation	700		**700**					Carer Strategy in place, now under review
20	Residential Care	274		**274**					MOU in development
21	Learning Disability Services	1,065		**1,065**					MOU in development
	Total	**3,682**	**0**	**3,682**					
Theme 4: Case Management and Integrated Care Planning									
22	GP Case Management	2,145		**2,145**					Ok
23	Care Home Support Service	267		**267**					Ok
24	Death in Place of Choice	788		**788**					Ok
25	Social Prescribing	750		**750**					Ok
26	Social Work Support (A&E, Case management, Supported Discharge)	1,078		**1,078**					MOU in development
	Total	**5,028**	**0**	**5,028**					
Theme 5: Supporting Carers									
27	Day Care Services	350		**350**					MOU in development
28	Carers Centre	100		**100**					Carer Strategy in place, now under review
29	Carers Support Service	200		**200**					Carer Strategy in place, now under review
30	Reablement – Crossroads	40	(40)	**0**					Paid directly to Crossroads, not part of BCF
	Total	**690**	**(40)**	**650**					
Theme 6: Infrastructure									
31	Joint Commissioning Team	49		**49**					Under Review
32	IT to support Comm Trans	193		**193**					Ok
	Total	**242**	**0**	**242**					
33	Contingency Fund	**500**		**500**					Managed in year
	Total	***24,323***	***99***	***24,422***					

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.
Appendix 12	**Community Transformation 2**	Presentation on Stage 2 of Transforming Unscheduled Care

Ref.	Document	Synopsis and links
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