Appendix 1

Better Care Fund

2017/19

Executive Summary

Local Authority

Rotherham Metropolitan Borough Council

Clinical Commissioning Group

Rotherham Clinical Commissioning Group

2017/19

1. Better Care Fund 2017/19

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. All of the partners involved in the Better Care Fund are committed to achieving 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 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 and reduce reliance on the acute sector.

The Rotherham BCF Plan is consistent with the wider integration agenda and encompasses the aims of the NHS Five Year Forward View, the local Integrated Health and Social Care Place Plan, Yorkshire and Humber Sustainability and Transformation Plan, Health and Wellbeing Strategy, Carers Strategy and individual organisations' strategies. 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 plan is also focussed on improving the management of transfers of care and reducing delays.

2. Local Priorities 2017/19

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 Wellbeing 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 integration work that brings together Rotherham Metropolitan Borough Council and Rotherham Clinical Commissioning Group 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.

3. Key Developments 2017/19

In order to deliver the local priorities the following developments will be focussed upon. These include:

3.1 ***A single point of access into health and social care services*** – one hub that citizens of Rotherham who have concerns about their own or others health and social care needs can contact to receive immediate advice.

3.2 ***Integrated health and social care teams*** – This team (community nurses, community matrons, social workers and allied health professionals) and has been piloted to support the Health Village. It 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.

3.3 ***Development of preventative services that support independence*** - The ambition is to integrate the Community Occupational Therapy service into the locality model, and working closely with adult social care provide 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.

We have also commissioned an innovative web-based tool to help us to encourage people to maximise their independence by acting early. The working title is "I-age-well-Rotherham", which will be used with people across the health, social care and voluntary sector workforce.

We have 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.

3.4 ***Reconfiguration of the home enabling service*** - We will implement the outcomes of a recent service review, ensuring that the service is fit for purpose, promotes value for money and is able to provide timely support to hospital discharges **7** days a week. The service will support people to

maximise their independence using the "i-age-well" tool. We will link the service with mental health services, providing important psychological support to people who struggle with motivation or depression.

3.5 ***Consideration of a Specialist Reablement Centre incorporating Intermediate Care -*** We will further review our intermediate care offer considering other community bed-based provision such as the nurse-led provision (Community Unit and 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 number 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. A further review and reconfiguration of intermediate care will include 'trusted assessor' approach to referrals.

3.5 **A Single Health and Social Care Plan for People with Long Term Conditions** - We will develop integrated health and social care plans for people on the long term conditions 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.

3.6 **A Joint Approach to Care Home Support -** 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. The Care Co-ordinator will combine advanced clinical nursing and therapy practice with the co-ordination of personalised and integrated care plans. We will support care homes in meeting the needs of residents with organic and functional mental health problems. We will deliver an extensive and comprehensive training programme agreed with CCG and the Council's commissioners. Build strong links with care home sector to enhanced health in care homes – trusted assessor, enhanced skills for staff, Clinical Quality Advisor. 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.

3.7 ***A Joint Approach to Care Home Fee Setting – Residential and Nursing Care Placements and Domiciliary Care-*** *T*he Local Authority and the CCG will develop a joint approach to fee setting of care home placements for residential, EMI, nursing, FNC, CHC placements and domiciliary care packages 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.

3.8 ***Development of a joint medication administration policy for people receiving care at home -*** 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.

3.9 ***A Shared Approach to Delayed Transfers of Care (DTOC) –*** There is a clear action plan to address this in 2017-19. We are currently reviewing the effectiveness of the Memorandum of Understanding (MoU) through audits of particular ward discharge processes. This robust review process will ensure that the Trusted Assessor model is embedded, 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). We have evaluated our local health and social care offer against the High Impact Change Model in 2016 and this contributed to the development of a local action plan delivered by the A&E Delivery Board members.

3.10 ***Reduction in the cost of Learning Disability high cost care packages and commissioning of sheltered housing to promote the independence of people with learning disabilities –*** 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.

3.11 ***Increase in the Uptake of People with a Personal Health Budget and Direct Payments -*** 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 to expand health budgets to groups which will benefit. 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.

4 National Conditions

The number of National Conditions has reduced from 8 to 4 for 2017-19 these include:

- **Condition 1- A jointly agreed plan**- A requirement for a jointly agreed plan, approved by the Health and Wellbeing Board. This includes that all minimum funding requirements are met, full involvement from other key stakeholders such as providers, housing authorities and the voluntary and community sector and that the CCG minimum contribution to increase, in line with CCG overall budgets. It also includes agreement on use of the Improved Better Care Fund (IBCF) funding to ensure that local social care provider market is supported and agreement on use of DFG funding.

- **Condition 2- Social Care Maintenance**- Real terms maintenance of transfer of funding from health to support adult social care. This applies to the CCG minimum contribution, uplift of minimum required contribution from 2016/17 baselines in 2017/18 and 2018/19 and local areas can agree higher contributions.
- **Condition 3- NHS Commissioned Out of Hospital Services**- Requirement to ring-fence a portion of the CCG minimum to invest in Out of Hospital services. This applies to the CCG minimum and covers any NHS commissioned service that is not acute care – can include social care. Areas are expected to consider holding funds in a contingency if they agree additional targets for Non-Elective Admissions (NEA) above those in the CCG operational plan.
- **Condition 4- Managing transfers of care (new national condition**). Ensuring people's care transfers smoothly between services and settings. This requires all local areas to implement the high impact change model which is also a condition of the Improved Better Care Fund.

5. Measuring Success – BCF Metrics

As part of the Better Care Fund Plan we will measure against the national metrics and Rotherham's agreed local metrics. New metrics are still in development including outcome metrics, user experience and process measures, but it is anticipated that the following metrics will still be measured.

- Non-elective admissions (General and Acute)
- Admissions to residential and care homes
- Effectiveness of reablement
- 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 the table below:

	Metric	Numerator	Denominator
1	Admissions to residential and care homes	Sum of the number of council-supported people (aged 65+) 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
2	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.
3	Delayed transfers of care	Total number of delayed days (for patients aged 18+) for all months of baseline period	ONS mid-year population estimate (mid-year projection for 18+ population)

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