



Rotherham Better Care Fund

Local Authority

Rotherham Metropolitan Borough Council

Clinical Commissioning Group

Rotherham Clinical Commissioning Group

2017/19

Contents


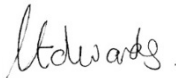
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Authorisation and Sign Off

Local Authority	Rotherham Metropolitan Borough Council
Clinical Commissioning Groups	Rotherham CCG
Boundary Differences	<p>The map in the attached document below shows that the geographical boundary of Rotherham MBC is co-terminus with Rotherham CCG.</p>  <p>Microsoft Word 97 - 2003 Document</p>
Date agreed at Health and Well-Being Board:	30/08/2017
Date submitted:	11/09/2017
Total agreed value of pooled budget: 2017/18	£32.390m
Total agreed value of pooled budget: 2018/19	£35.523m
Signed on behalf of the Clinical Commissioning Group	
By	Chris Edwards
Position	Chief Officer
Date	11 th September, 2017

Signed on behalf of the Council	
By	Sharon Kemp
Position	Chief Executive
Date	11 th September, 2017

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor David Roche
Date	11 th September, 2017

1. Executive Summary

A copy of the Better Care Fund Executive Summary is attached as [Appendix 1](#)

2. Vision for Integrated Health and Care for Adults

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

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
- Developing a Specialist Reablement Centregov

Both these documents identify key integration work to support the ambition of full integration by 2020, which is in line with the intentions set out in 2015 Spending Review and BCF Policy Framework. This 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”
- Reduction in 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

2.1 Better Care Fund (BCF)

The Better Care Fund (BCF) and Integrated Health and Social Care Place Plan provide 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 and Integrated Health and Social Care Place Plan 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, housing, community health services and the voluntary and community sector. We will further 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/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.

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://modern.gov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=103679>

The Rotherham BCF and the Integrated Health and Social Care Place Plan are consistent with the aims of the NHS Five Year Forward View which 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, 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 and the Integrated Health and Social Care Place 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.

3. Evidence Base

3.1 Health and Wellbeing Strategy

The Rotherham Health and Wellbeing Strategy (2015-18) sets out Rotherham's overarching vision to improve the health and well-being of its population, reablement of people to continue 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>

3.2 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 February and April 2017, discussions were held with staff in each of our partner organisations and local communities about the plan. We worked with local Healthwatch and our voluntary sector partners to ensure we have input and views from a wide range of communities. 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

3.3 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 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 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 (See Section 2) that will help us achieve our Health and Wellbeing Strategic aims and meet the region's STP objectives

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 Integrated Health and Social Care 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 system which will be used across the health and social care as a key tool in articulating how our five priorities are closely interlinked to deliver better, more accessible services in the coming years. This can be found at the following website address: <http://preview.beach-design.co.uk/nhs rotherham/>

As well as the Rotherham Integrated Health and Social Care 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>

3.4 Rotherham Carers Strategy 2016-21

Rotherham's Carers' Strategy "Caring Together" 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 make 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

The Carers Strategy “Caring Together” for 2016-21 can be found at the following website address: <http://modern.gov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=108721>

3.5 The Rotherham Plan 2025 (Housing and Community)

The Rotherham Together Partnership (RTP) has been developing a long-term plan setting out partners’ shared ambitions for the borough over the next few years. This Rotherham Plan is centred on five “game changers”:

- Building stronger communities
- Skills and employment
- Integrated health and social care
- A place to be proud of
- Town centre

This streamlined plan sets out the major areas of joint working and complements ongoing efforts to promote the many positive aspects of Rotherham.

The Rotherham Plan 2025 can be found at the following website address:

http://rotherhamtogetherpartnership.org.uk/downloads/file/7/the_rotherham_plan_a_new_perspective_2025

3.6 The Rotherham Foundation Trust Five Year Strategy

TRFT are currently developing a Five Year Strategy for their organisation the key themes are as follows:

- Patients Excellence in health care
- Colleagues Engaged, accountable colleagues
- Governance Trusted, open governance
- Finance Sound financial foundations
- Partners Securing our future together

The overarching vision is intrinsically linked to our STP and Rotherham Integrated Health and Social Care Place Plan priorities. TRFT set their main priorities as follows:

- We will continue as a thriving district general hospital
- We will build a reputation for innovation and quality care
- We will achieve a CQC rating of “good” or better
- We will be a sustainable and financially viable Trust

- We will collaborate with local providers on workforce and delivery
- We will have a strong emergency and urgent care function
- We will develop sub-regional specialist care centres
- We will provide a strong community health service offer
- We will integrate with health and social care partners

3.7 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 aim will be to improve the physical, mental health and well-being and focus on reducing health inequalities for local residents. The two vanguards are:

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

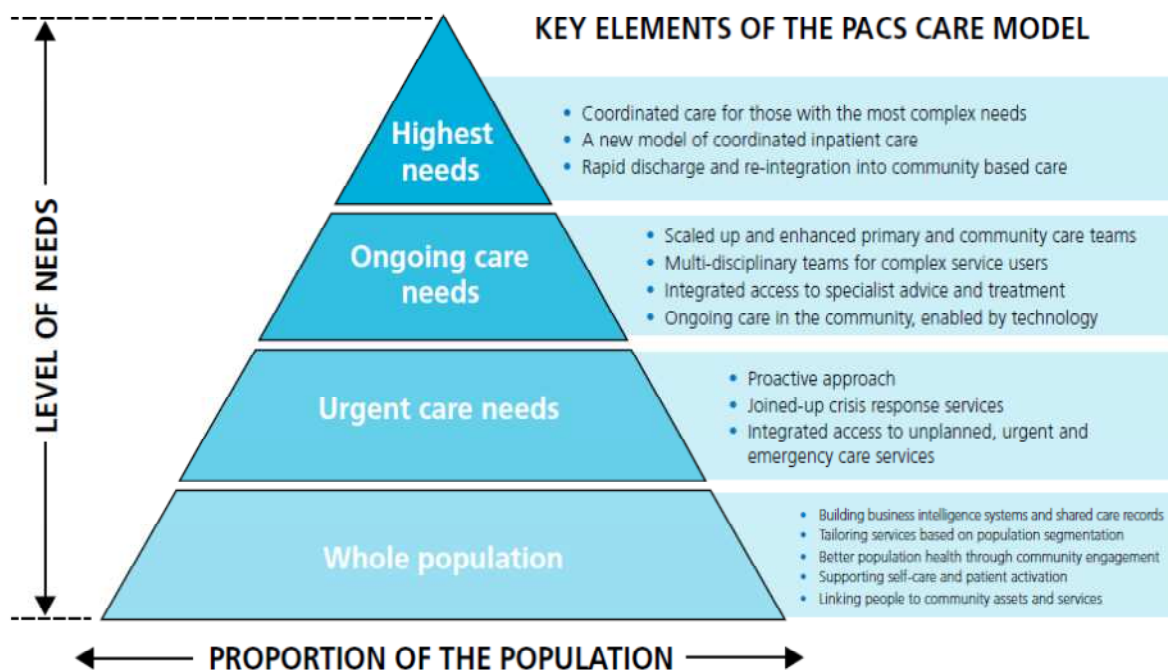
The PACS and the MCPS vanguards now cover 8% of England and nearly all sustainability and a transformational plan (STPs), involve population based accountable care models. Therefore, the national coverage of these models is to grow to 25% next year and to 50% per cent by 2020. Linked to STPs, funding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

3.8 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.



3.9 Accident and Emergency Delivery Plan 2017/18

The A&E Delivery Plan sets out the actions for the Rotherham A&E Delivery Board in relation to the key deliverables for Urgent and Emergency Care set out in NHS England's 'Next Steps on the NHS Five Year Forward View'¹⁷ published in March 2017 ([Appendix 2](#))

Urgent and Emergency Care (UEC) is one of the NHS's main national service improvement priorities and closely ties in with BCF priorities in reducing admissions to hospital and reducing Delayed Transfers of Care.

The key deliverables incorporate:

- Front door clinical streaming in A&E by October 2017.
- Good practice to enable appropriate patient flow.
- Joint work to ensure people are not stuck in hospital while waiting for delayed community health and social care.
- Specialist mental health care in A&E.
- Enhancement of NHS 111.
- Roll out of extended access to GP appointments.
- Strengthening support to care homes.
- Roll out of standardised Urgent Treatment Centres.

Strategic Vision and Key Deliverables

The need to redesign urgent and emergency care services in England and the new models of care which propose to do this are set out in the NHS Five Year Forward View and 'Next Steps on the NHS Five Year Forward View' (March 2017). The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, improving out of

hospital services so that we deliver more care closer to home and reducing hospital attendances and admissions. We need a system which is safe, sustainable and that provides consistently high quality. The vision of the Review is:

- For those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

3.10 Rotherham System Wide Escalation Plan 2017/18 (including Winter Planning)

The escalation plan sets out winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures (Appendix 3). The plan incorporates Rotherham's response to the National Cold Weather Plan which helps prevent the major avoidable effects on health during periods of cold weather in England.

Rotherham CCG, along with other local CCGs, is required to provide assurance to NHS England regarding year-round and winter planning across the Rotherham health and social care community. This plan also links closely with the BCF plan in reducing hospital admissions.

3.11 Joint Strategic Needs Assessment (JSNA)

The JSNA predicts a substantial increase in the number of adults with additional health and social care needs over the next five years.

The Rotherham BCF plan and Integrated Health and Social Care Place Plan are aligned with all of the 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.

The Joint Strategic Needs Assessment can be found at the following website address:

<http://www.rotherham.gov.uk/jsna/>

3.12 Market Sustainability

RMBC has produced a Market Sustainability report which uses the Cordis Bright framework to understand the risks associated with the current diminishing market place for adult social care. This looks at the local, sub-regional and regional market place and carries out benchmarking exercise around Residential, Nursing and EMI beds within the market place. This intelligence enables commissioners to develop a risk matrix with the market and ensure contingency planning is in place to reduce provider failure.

3.13 "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 Integrated Health and Social Care Place Plan have 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 which 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 2019-20.

Community Occupational Therapy Services (COT)

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 was set up to address this issues and this has reduced the numbers from 599 in June 2016 to 126 in September 2017. The agreed rectification actions included:

- 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.
- Support staff to start assessing for level access showers, straight stairlifts and ramps.
- Co-locating Occupational Therapy staff within the Local Authority's Single Point of Access to carry out all moving and handling assessments to reduce home care packages and to provide advice and information and signposting to alternative services.
- The Adult Care Performance and 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. The review also recommended the lead commissioner arrangements be assigned to CCG from the Council due to a slightly larger financial stake and an increased capacity through the joint commissioning function to lead this activity. The Better Care Fund Section 75 agreement with Rotherham CCG allows for the assignment of the Lead Commissioner responsibilities, which has been approved by the Better Care Fund Executive Group.

Extension of the current contracts for a period of up to 12 months will ensure that services can be redesigned, will allow time for the purpose and nature of future preventative services to be agreed in line with the Council's and CCG's Transformation programmes, Corporate Plan, Health and Wellbeing Strategy and the Better Care Fund Plan 2017/19. It will also ensure appropriate commissioning actions are taken to streamline services and ensure funding streams are appropriately placed.

3.14 Directory of Services

The Directory of Services provides clarity on where BCF funding is currently being invested and the strategic relevance of each scheme ([Appendix 4](#)). The schemes are grouped using the following themes:

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

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. 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.

Performance and quality is monitored through various formats including individual service Key Performance Indicators, performance and contract meetings with providers, friends and family testing, key stakeholder and service user feedback and quality audits/service reviews.

4. Case for Change

4.1 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 has conducted a review of adult social care 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. This new integrated commissioning structured is the back bone for delivering the aspiration of an integrated health and social care system by 2020. Services that are already subject to joint commissioning and/or pooled budget arrangements include 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 patients 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.

4.2 Development of New Care Models

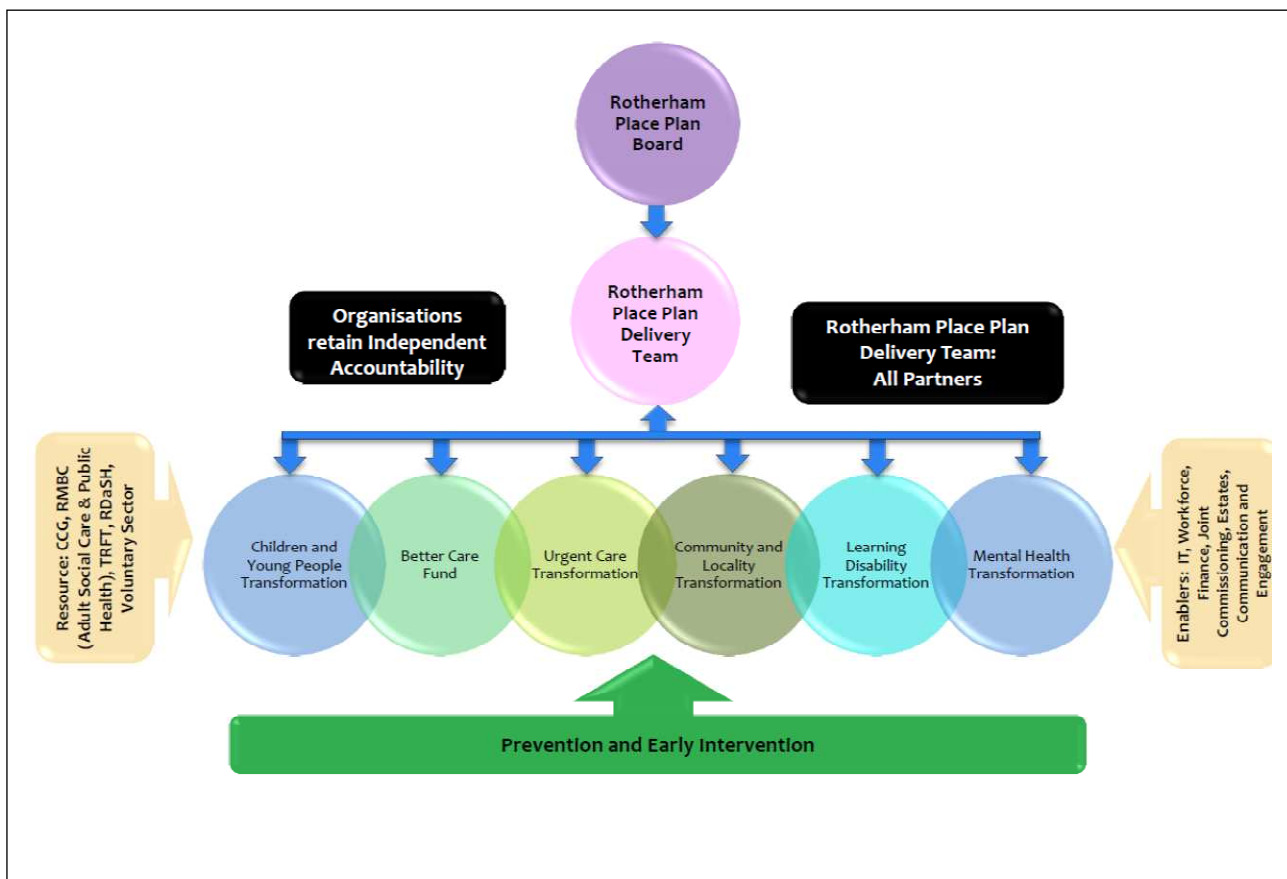
The term Accountable Care Organisation is gaining ground in the NHS and describes arrangements where groups of providers come together to jointly deliver new pathways of care in ways that maximise efficiency, reduce cost and improve patient experience and outcomes.

In Rotherham we view ourselves as collectively accountable for the health and wellbeing of our population. The Rotherham Integrated Health and Social Care Plan will be our framework for jointly providing Acute, Community and Emergency Primary Care Services. Our new governance arrangement enables us to work towards an Accountable Care System (ACS). The aim of an ACS is to design and deliver services to meet the needs of the local population and improve health and wellbeing outcomes, within an agreed budget.

The Rotherham Accountable Care System (ACS) model will include commissioners and bring important functions such as needs assessment, identification of priorities, service redesign skills, setting and monitoring outcomes and quality and engaging with public and professional stakeholders.

Workshops have been held (facilitated by Capsticks), to work through what an ACS might look like for Rotherham. The sessions have been attended by Executive Officers and Chairs from TRFT, RMBC, Rotherham CCG, RDaSH, Elected Members and Voluntary Action Rotherham. There is strong support from all partners for the development of an ACS, and work is taking place on the details.

Figure 1: Proposed Accountable Care System Governance



4.3 Community Transformation

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.

The BCF Plan 2017-19 and the Integrated Health and Social Care Place Plan will be instrumental in supporting further initiatives to reduce attendances.

Alongside this, the new Emergency Centre which opened in July 2017, will stream patients at the front door to alternative appropriate provision. This model is reliant on robust community provision that is able to rapidly respond with an integrated approach to care.

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 89.6% in the proportion of adults who received intermediate care and home care reablement services that were discharged without needing any long-term 24 hour care from social care services. In 2016/17 outturn has shown a slight decrease to 87.5% from the 2015/16 outturn of 89.6%. Although, the performance has shown a fall, a positive is that the total number of people using the service increased from 135 to 144.

This demonstrates the total number of people who are benefitting from increased rehabilitation beds capacity is on an upward trend. However, the service is being used for more complex people and this has made the target more challenging to achieve. In addition, the service has been offered to younger people and not all of these are able to be included in this measure, as only those over 65 fall within the definition. We have increased patient utilisation of residential intermediate care from 587 in 2014/15 to 613 2015/16, and this has further increased to 666 in 2016/17. This has been achieved within the same cost envelope.

Day Rehabilitation Figures for 2016-17

Rotherham Intermediate Care Centre Phase 1

169 patients/service users attended Phase 1 sessions in 2016/17.

The average length of intervention/input for Phase 1 in 2016/18 is 12 days (2 weekly sessions x 6 weeks)

Rotherham Intermediate Care Centre Phase 2

141 patients/service users attended Phase 2 in 2016/17.

The average length of intervention/input for Phase 2 in 2016/17 was 19 days

Table 1: Community Transformation KPIs influenced by the BCF Plan

KPI	Performance 16/17	Target 16/17	Perf 16/17 year-end	Target 17/18
People >50 years attending A&E with a fragility fracture	98/month	111/month	127/month (no data for March 17)	97.9/month
No. of people over 55 with a fractured neck of femur	19/month	23.0/month	37.3/month (no data since Nov 16 re transfer to Meditech)	23.3/month
No. of GP referrals to the Medical Assessment Unit	205/month	262.5/month	177/month	262.5/month
No. of unscheduled admissions of patients >65years	839/month	730/month	440.8/month	730/month
No. of long stay patients over 14 days	68/month	212/month	69/month	Not in either Community Perf Framework or Community KPI set for 17/19 contract

KPI Suite - Community Services and Integrated Pathways 2014/17 Rehabilitation and Reablement Performance Group		Target	Thres hold 2016/17	Predicted Out-Turn	Rag Rating	Apr-16	May-16	Jun-16	Jul-16
1	Bone Health, Falls and Fracture Service								
1.1	Number of patients attending A&E with a fragility fracture (>50 years).	Local	1175	1399	R	59	69	192	157
1.2	Number of patients presenting with a fractured neck of femur.	Local	280	264	G	17	28	18	35

KPI Suite - Community Services and Integrated Pathways 2014/17 ALOC Performance Group		Target	Threshold 2016/17	Predicted Out-Turn	Rag Rating	Apr-16	May-16	Jun-16	Jul-16	A
1	Care Coordination Centre									
1.2	Number of GF urgent admissions of MAJ	Local	3150	2124	G	216	195	207	209	
4	Integrated Rapid Response									
4.7	No. of emergency admissions for people > 65 years QOH	Local	8760	5289	G	422	459	426	454	

5. Prevention and Early Intervention

5.1 Shaftesbury House/Short Stay Project

We have developed a “Short Stay” Project at Shaftesbury House from November 2016, which provides support through reablement 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.

5.2 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.

5.3 Mental Health

The Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) are:

- Working closely with social prescribing mental health to support people with long term mental health conditions who have remained stable but require support in things like socialisation, vocational opportunities, art and crafts. This has supported people to move away from traditional secondary care services and to become more independent and integrated within their local communities.
- Developing their IAPT (Improving Access to Psychological Therapies) services to work with people with long term conditions, providing CBT focused therapy and working closely with colleagues in primary care to support physical and emotional wellbeing.
- Running physical health clinics for people with long term mental health issues in order to address the health gap in people on long term psychiatric medications. Our staff are providing GP's in primary care with physical health assessments for these patients in order to ensure parity of esteem and early intervention.

- Hospital liaison services, based at the District General Hospital are working closely with general nurses and medical staff to ensure “parity of esteem” for people with co-morbid physical and mental health issues. Mental health staff provides training and advice to the district general hospital in a variety of settings and across all age pathways.
- RDASH and TRFT have opened a hospital ward (12 beds) where RMN’s and RGN’s work together to support people with dementia who also have a physical health condition and would be supported better in a dementia friendly environment and not an acute hospital environment known as ‘Ferns’. This is a real opportunity to provide holistic care to patients that includes caring for their long term conditions in an integrated way.

6. 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. Contribution to social care services has some health benefit in that people are supported to live independently in the community and contributes to reducing hospital admissions/re-admissions and reducing Delayed Transfers of Care.

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 Council are focusing on developing a strength based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised. They will focus on greater promotion of the use of individual budgets via a direct payment, strength based, focussed assessment of well-being and clear evidence of a person’s needs. Consideration must be taken to eligibility criteria, support planning, completion of Continuing Health Care and Decision Support Tool checklists, alternatives to standard service provision and greater use of assistive technology. The Assistant

Technology offer will be extended to support self-care in the home, as part of the early prevention and personalisation agenda. This will build on the existing profile of telecare solutions available.

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 will 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.

7. 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.

7.1 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. The development of the IRR service includes mental health and learning disability urgent care provision and out of hours approved mental health practitioners.

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 21 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 per week. The RDASH Ferns pilot provides cognitive rehabilitation for people with dementia who are medically fit and can be discharged from the general hospital.

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 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 the 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 per week.

Figure 2 summarises the pathways that Rotherham currently operates for admission prevention and supported discharges

Figure 2: Admission Prevention and Supported Discharge Pathways



7.2 Winter Pressure 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:

7.3 Ackroyd House

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.

7.4 Woodlands known as "Ferns"

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.

7.5 Care Coordination Centre

The Care Coordination Centre (CCC) has been a key vehicle for delivering BCF outcomes. The expansion of the CCC is to provide a single point of contact for professionals and patients to call for

advice on the most appropriate level of care/appropriate pathways, which includes health, social care and mental health provision. 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 3: Current Functions of the Care Co-ordination Centre



7.6 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 which links with BCF commissioned services 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.

8. 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 mind Rotherham's health and social care system will focus on integrated commissioning activities in the following areas:

8.1 Joint Commissioning and Fee Setting of Domiciliary Care/Residential and 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 2017/18 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 reablement 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 blood pressure/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.

8.2 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.

8.3 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.

A co-produced, personalised care and support plan is at the heart of making personal health budgets work well, setting 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.

8.4 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. 'Forward View into Action- Planning for 2015-6' (NHS England) allows local flexibility on which groups will be offered personal health budgets. Information on requesting a PHB and our current plan for extending PHBs beyond continuing

healthcare can be found on the CCG website at <http://www.rotherhamccg.nhs.uk/personal-health-budgets.htm>

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 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.

8.5 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.

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 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.

8.6 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

9. 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.

9.1 Risk Stratification/Segmentation

Rotherham practices have used risk-stratification tools for the last 5 years to identify the top 3% of the population which 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. The local system is working with KPMG to further expand the current risk stratification/segmentation model to support prevention and early intervention as this is key to promoting self-management and increased independence for longer.

9.2 The Rotherham Long Term Conditions 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's 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.

9.3 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 reablement. 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.

Voluntary Action Rotherham, on behalf of NHS Rotherham CCG, co-ordinates both social care prescribing 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.

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

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

9.4 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 Reablement 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.

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 wellbeing, 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

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 wellbeing
- 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 55 attending between April to June 2016. The environment is set out well with an appropriate number of volunteers to support the activity.
- Winthrop in Wickersley has been set up during the summer months of 2017. There are rooms as well as gardens and garden type activities on offer which offers a different approach.

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.

10. 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 (See Section 3.10).

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

We 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.

As part of the placed based data modelling being undertaken with KPMG a set of 28,000 children's records have been sent securely (as part of a refreshed data sharing agreement) to colleagues in the TRFT for NHS number matching, once returned this will enhance Liquid Logic and other relevant databases even further.

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 falls rate has improved significantly over the last five years. The most recent data shows that 751 Rotherham people over 65 had an injury that was due to a fall in 2015/16, in comparison to 1,039 in

2011/12. The cost savings to the Rotherham Health and Social Care system for the falls that have been preventing over the last 4 years are close to £15m (using the mean rate), with an average annual saving of £3.6m. This has been calculated using the Kings Fund (August 2013) costings and using the actual number of falls from 2011/12 highest point.

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.

The Association for Public Service Excellence (APSE) have shortlisted Active for Health as a finalist for the 2017 Best Health & Well-being initiative (including social care) Service Awards. This is following a rigorous selection process from 310 submissions. The Service Awards presentation evening will be held at the end of APSE’s annual seminar 2017, which will be held in Oxford on 7 September, 2017. This achievement is another example of how fantastic the project is and a measure of the hard work by all involved.

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.

11. Key Developments for 2017-19

In order to deliver the local priorities the following developments will be focussed upon. 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 reablement 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 (DTC)

11.1 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 co-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 reablement.

The single point of access cross cuts several Integrated Health and Social Care 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 reablement 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.

11.2 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.

11.3 Development of preventative services that support independence

Rotherham has developed a “Healthy Ageing Framework” 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 the integrated 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 was fully launched in June 2017, and can be found at the following website address: <https://www.iagewellrotherham.co.uk/>

Promoting physical activity

Public Health and partners have developed an Active for Health programme which provides 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.

11.4 Reconfiguration of the home reablement service

The aim of re-ablement is to help people accommodate illness or disability by learning or re-learning the skills necessary for daily living. Although a focus on regaining physical ability is central, addressing psychological support to build confidence as well as social needs and related activities is also vitally important. People accessing reablement services experience greater improvements in physical functioning and improved quality of life compared with using standard home care (SCIE research). Reablement is usually for a period of up to six weeks and is free to the customer regardless of their means/assets.



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 are in the process of reviewing the Council's Re-ablement service to ensure that it is securing the best and most sustainable outcomes for our customers and that it is being accessed by those who would most benefit from the service. This promotes both best value for the expenditure involved and also contributes to wider health and social work management of need, minimising use of unplanned support in both sectors (including admission avoidance activities). There is a natural alignment with the role of therapists who prioritise function and adopt a clear strengths-based approach to the management of risk.

The overall review of the service is being completed in partnership with wider adult care services, The Rotherham Foundation Trust and their associated network of community provision. This will facilitate a merging with all parallel work-streams, exploring therapies and intermediate care provision, community health 'rapid response' services as well as the peripheral networks that exist in the community.

With a view to creating a customer experience that is more joined-up, efforts are being made to both map and communicate all the teams and services that are in place so that the person concerned is received by the right team, at the right place and is therefore able to achieve the right outcomes. All agencies engaged in working with people who present with social care and health needs are encouraged to consider reablement potential in the first instance to ensure that we are Care Act compliant in respect of preventing, delaying and reducing need. This promotes the independence and wellbeing of the person concerned as well as diverting inappropriate people away from costly and less-effective services. It is anticipated that this approach will incorporate services such as 'social prescribing' and 'early planning' as well as those teams and services that are more traditionally evident in this area.

There is energy and commitment across all organisations involved to ensure that services are efficiently and promptly configured to deliver timely change which accommodates this BCF agenda.

We will implement the outcomes of a recent service review, ensuring that the reablement 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.

11.5 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, reablement of 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 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 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, reabling 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

11.6 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, reabling carers to maintain a balance between their caring responsibilities and a life outside caring, while reabling 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.

11.7 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.

11.8 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 are now on a downward trajectory. To continue this trend 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 staff remains 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 build strong links with care home sector to enhanced health in care homes including trusted assessor, enhanced skills for staff and the role of the 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.

11.9 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.

11.10 A Shared Approach to Delayed Transfers of Care (DTC)

The number of recorded Delayed Transfers of Care (DTC) from the September 2016 National DTC report shows that 3.27% of transfers were delayed. This is lower than the national average of 3.5%. There has been significant progress in the last 12 months to support the reduction in DTCs within Rotherham, however it is recognised that our DTC have been steadily increasing. A trajectory has been agreed to ensure that we reduce our DTC levels back in line with national requirements which has been included in the DTC Plan submitted to NHS England on 21st July, 2017.

The national ambition (National Condition 4) is to ensure that all areas reach/maintain a level of more than 3.5% for all DTCs (health and social care).

In 2017, The Rotherham Foundation Trust reported DTC as follows:

January 2017	February 2017	March 2017	April 2017	May 2017	June 2017
4.1%	4.2%	6.0%	5.1%	5.9%	5.4%

This is an increasing trend against a relatively stable position prior to 2017, where figures were under the 3.5% target at circa 3%.

In response to the increase in DTC levels locally, the introduction of the national condition and in order to effectively plan Rotherham's future delivery model, an external evaluation of discharge processes took place in April 2017.

A two day review of current transfers of care was carried out by a senior advisor from the Care and Health Improvement Programme, Local Government Association and a Discharge Planning Manager from the University Hospitals of North Midlands NHS Trust. This has led to the development of a revised DTC action plan ([Appendix 5](#)). Significant progress has already been made to support more effective flow through the system. This includes:

- Project Initiative Plans to integrate the transfer of care team fully with hospital social work and therapy (building on the MoU).
- Appointment of an external consultant two days per week, every two weeks over the winter period (linked to the external review took place in April 2017) to support the Trust and partners in developing Standard Operating Procedures for identification of DTCs (health and social care) and the review of pathways to ensure consistent and streamlined approaches to discharge.
- Additional £400,000 within the Improved Better Care Fund (IBCF) for winter pressures that will support effective discharges in times of high escalation.

- Appointment to a DTOC lead for two years as part of the IBCF to drive the DTOC action plan forward

Rotherham CCG and its partners will monitor DTOCs through the A&E Delivery Board. The Board endorsed a Memorandum of Understanding (MoU) ([Appendix 6](#)) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which was signed up to in 2016/17. 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 an integrated discharge function with co-ordinators on each ward (currently being piloted).

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 "multi-agency" weekly meetings which has been successful in supporting complex discharges in 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. This is a key vehicle for achievement of BCF Metrics. An example of success is that we have been able to reconfigure the provision of key safes from the local provider to ensure that complex patients can access a key safe within 24 hours of referral to expedite a discharge.

The DTOC action plan will play a fundamental role in improving flow and is monitored on a continuous basis to ensure achievement of objectives with limited risk of slippage

11.11 Relevance to The Health and Wellbeing Strategy

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

Table 2: Relevance to Health and Wellbeing Strategy

HWB Aim	BCF Priority	Impact on HWB objectives
All Rotherham people enjoy the best possible mental health and wellbeing	A single point of access into health and social care services	<ul style="list-style-type: none"> • 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 reablement service	
	Integrated health and social care Teams	
	Shared approach to delayed transfers of care (DTC)	
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reduced	Preventative services that support independence	<ul style="list-style-type: none"> • Reduction in early death from cardiovascular disease and cancer • Improved support for people with long term health and disability needs
	Consideration of the development of a specialist reablement centre incorporating intermediate care	
	A multi-disciplinary rapid response service	
	A single health and social care plan for people with long term Conditions	
	A joint approach to care home support	

12. Key Milestones

Table 3: Key Milestones

Priority	Description	LEAD	MILESTONES	Date
1	A single point of access into health and social care services; including the integration of Integrated Rapid Response	Project Group	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	Project Group	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	30.09.17
		TRFT - with partners	Analysis of demographics and population need across Rotherham and specific to locality area, to inform roll out model.	30.09.17
		External support	Evaluation of pilot	01.07.17 to 01.12.17
		Project Group	Roll out of the integrated locality teams across Rotherham	01.01.18
		Project Group	Care Home transformation timescales to be defined as part of project group	31.01..18

Priority	Description	LEAD	MILESTONES	Date
3	Consideration of a Specialist Reablement Centre incorporating intermediate care beds	Project Group	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	31.12.17
		CCG	Review of acute and community respiratory pathways	31.06.17 Completed
		Project Group	Proposals for future development of Reablement Centre	31.3.18
		Project Group	Service reconfiguration begins	30.6.18
4	Preventative services that support independence	RMBC/CCG	OT Review approved by BCF Executive	17.02.17 Completed
		RMBC/CCG	New service model agreed by BCF Executive	31.12.17
		RMBC/CCG	Project plan agreed for implementation of new service model	31.12.17
		RMBC/CCG	New service model fully operational	01.04.18
		RMBC/CCG	ICES and Wheelchair Review approved by BCF Executive	31.12.17
		RMBC/CCG	New service model agreed by BCF Executive	31.12.17
		RMBC/CCG	Project plan agreed for implementation of new service model	31.1.18
		RMBC/CCG	New service model fully operational	01.04.18
		RMBC Reablement Team Manager	Complete a review of the in-house assessment and reablement service to determine its current efficiency and	31.8.17

Priority	Description	LEAD	MILESTONES	Date
5	Reconfiguration of the home care reablement service		effectiveness in relation to the management of demand	
		RMBC Reablement Team Manager	Implement an improvement programme linked to the evidence findings of the review	1.9.17
		RMBC Reablement Team Manager	Evaluate the improvement work in relation to the in-house service and produce a report for consideration to the Improvement Group and Improvement Board	31.1.18
		RMBC Reablement Team Manager	The Improvement Programme linked to the in-house reablement team must benchmark against best practice.	1.3.18
7	Single health and social care plan for people with long term condition	Primary Care Team CCG	Scoping exercise completed on integrated care plan	30.09.17
		Primary Care Team CCG	Develop common template for case management	31.11.17
		Primary Care Team CCG	Develop IT solution for sharing care plan across systems	31.12.17
		Primary Care Team CCG	Implement integrated care plan for case management	01.04.17
8	A joint approach to care home support	TRFT Care Home Support Service	Introduction of annual mental health assessments	31.12.17
		TRFT Care Home Support Service	Development of a targeted care home training programme	31.12.17
		TRFT Care Home Support Service	Introduction of protocols for stroke patients in care homes	31.12.17

Priority	Description	LEAD	MILESTONES	Date
9	Shared Approach to Delayed Transfers of Care (DTOC)	Associate Director of Transformation TRFT	Review of implementation of MoU through audit of a ward	01.11.17
		Associate Director of Transformation TRFT	Review findings from pilot of discharge coordinator on one ward to link with Transfer of Care Team and recommendations for future model	30.09.17
		Associate Director of Transformation TRFT	Examine assessment process to streamline and integrate functions of health and social care	30.09.17
		Associate Director of Transformation TRFT	Further work to embed “trusted assessor” role to reduce duplication and improve patient flow	31.10.17

13. National Conditions

13.1 National Conditions

There are 4 national conditions within the BCF plan for 2017/19 as follows:

- **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.
- **National Condition 4- Managing transfers of care (new national condition)** of the Better Care Fund (BCF) sets out the requirement to ensure 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 (IBCF).

13.2 Previous National Conditions

There were 4 previous national conditions in the 2016/17 BCF policy framework which will be continually monitored as follows:

- **A joint approach to assessments and care planning are taking place and, where funding, is being used for integrated packages of care, there is an accountable professional** - 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.

- **An agreement on the consequential impact of changes on providers that are predicted to be substantially affected by the plans** - 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. We now have an Accountable Care System governance arrangements in place with various sub-groups supporting transformation across the health and social care system, including the Acute and Community Transformation Group and BCF groups.
- **7 day working in hospital and community settings** - 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 are now working towards the development of an Integrated Health and Social Care Discharge Team at the hospital to increase in-patient experience, reduce admissions, delays to discharge, length of stay and to contribute to managing winter pressures.
- **Data sharing between health and social care care** - 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.

As part of the placed based data modelling being undertaken with KPMG a set of 28,000 children’s records have been sent securely (as part of a refreshed data sharing agreement) to colleagues in the TRFT for NHS number matching, once returned this will enhance Liquid Logic and other relevant databases even further.

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. An information sharing agreement (ISA) relating

to the Rotherham Health Record (RHR) has been drafted and is currently progressing through the Information Governance Boards of the organisations covered by the ISA, these are:

- NHS Rotherham CCG (RCCG)
- The Rotherham NHS Foundation Trust (TRFT)
- Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
- Rotherham Hospice
- Rotherham Metropolitan Borough Council (RMBC)

The sharing of personal confidential data into the Rotherham Health Record and the viewing of personal confidential data via the Rotherham Health Record are for the purposes of Direct Care only. Accordingly, the patient's consent to such sharing may be implied. Fair processing notices are required and the nature of the sharing will be communicated to patients by a variety of means, and all patients will have the opportunity to opt-out.

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

13.2 High Impact Change Model

Rotherham used the High Impact Change Model to self-assess the local position in 2016-17 and developed a Delayed Transfer of Care (DToC) action plan. This self-assessment was completed by the multi-agency effective patient flow group and was reported through to our local A&E Delivery Board prior to winter 2016-17. As a system we have recently commissioned an external review of the discharge processes and pathways by the LGA and NHSE. The outcome of which is as follows;

- Rotherham’s Delayed Transfers of Care are comparatively low. However there is an upward trajectory in recent months
- There is an energy, commitment and enthusiasm from staff to make improvements
- There are some examples of good practice on wards i.e. MDT approaches – but this is not consistent
- IT system Rotherham Care Record is best practice model
- Pathways out of hospital are confusing
- Planning around the individual was strong
- Lack of process for agreeing and signing off DTOCs

We have already developed a Memorandum of Understanding around better integrated discharge planning and have piloted 'Trusted Assessor' models in our services i.e. Ackroyd Care Home. We plan to further develop 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 in 2017-18).

A set of agreed actions have been developed that form part of the DTOC action plan for 2017-19 included in the BCF Plan 2017-1 as follows;

1. Implement an Integrated Discharge Team :
 - Would help with roles, responsibilities, clarity of teams.
 - Would help structure MDT's better, referral processes, working relationships
2. Agree Joint reporting and Data Set
 - System to have standard, single version of the truth
 - Some things get reported, some things unclear (non-acute delays)
3. Simplify Pathways (including Home First and DST's)
 - Too many pathways and need greater clarity
 - DST's need a better pathway and need to get them home where safe to do so
4. Awareness and Training
 - Understanding of DTOC's, Care act needs improving
 - Training for teams and awareness sessions
5. Escalation Process and Response
 - How do teams respond to pressures
 - Who does what, when and how does this get translated into de-escalation

All of these conditions have been included in the plan. There is an expectation that the national conditions are continued, although there will be no formal reporting requirements.

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 2016-17. In summary these are:

- 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 Table 4

Table 4 – BCF Metrics Definitions

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

Non-elective hospital admissions – The plan illustrated (within the BCF planning template) is the affordable level of non-elective admissions reflected in CCG contracts. The plan is a composite of shares of all the CCG’s plans covered by the HWB area. The definitions and shares used for this target are set nationally by the BCF programme.

The Rotherham CCG plan for non-elective admissions is built up from growth assumptions produced by analysing local data on previous trends and from the planned impact of relevant quality improvement and targeted intervention programmes which are all established.

Key schemes for 2017-19 include the opening of the Urgent and Emergency Care Centre - which aims to contain non elective growth through effective streaming of patients to the appropriate level of care - social prescribing, case management, hospice at home and 7 day working.

Non-elective activity and the impact of these schemes are monitored through a number of contractual processes and meetings.

No additional reductions have been planned in as part of BCF as the broader non elective plan already encompasses the key schemes impacting non elective admissions.

Delayed Transfers of Care (DTC)

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.

This plan is the number of delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). Delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. The definitions for this target are set nationally by the BCF programme.

There is currently no agreed target for April and May 2017. There are however clear expectations set out by September 2017 for DTCs, these are:

Not more than 9.4 people in total delayed in hospital per 100,000 adults, which equates to approximately:

- 2.6 people delayed in hospital per 100,000 adults due to social care
- 5.5 people delayed in hospital per 100,000 adults due to the NHS
- 1.2 people delayed in hospital per 100,000 adults jointly attributable

A provisional trajectory from July 2017 has been submitted to meet these expectations. The target figures displayed in the scoreboard are an indicative position between current performance and this trajectory.

The DTC trajectory has been developed and agreed across all partners (including health and social care providers), underpinned by an action plan, focusing on a universal home first approach and a more integrated discharge model. DTCs are a key issue for the A&E Delivery Board and a cross partner operational group is in place to work through individual DTCs.

The gap in delays to meet the national requirement is around 10 patients less delayed a day. The universal home first approach supported throughout the BCF investment themes such as Social Work Support and Home Enabling Services are aimed at addressing this gap.

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

In order to provide customers with greater independence and choice, admission to 24 hour care is provided only for those people who can no longer have their needs met by remaining at home in the community. Final year end admissions data as at end of March 2017 reflected 329 new admissions (or a rate of 663 per 100,000 per population). This was a significant improvement from the 401 admitted in 2015/16. The first quarter of 2017/18 shows 45 new admissions to date, which is below Quarter 1 target of 75. However, there is some 'recording lag' regarding current short stay admissions; which may need to transfer to permanent during the year. Planned in-year review of these admissions will enable a projection of total admissions to be included during Quarter 2 reporting onwards. The measure is currently rated 'on track' to be below target of 297 admissions by year end which is equivalent to a target rate of 589 admissions per 100,000 population. The target takes account of recent trend analysis and is realistic when considering demographic pressures. A range of the BCF initiatives/projects will contribute positively to this target reduction of 32 fewer admissions in 2017/18

and a further 10 fewer admission in 2018/19 include but especially the Initiative - Supporting the DTOC High Impact Change Action Plan and Initiative - Investment in additional re-ablement capacity.

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

This is an annual measure and collation of data is undertaken during January - March 2018 period to track service users who have been 'offered' (i.e. commenced) the service during October to December 2017, to identify those who were still at home 91 days following discharge from the service.

The 2016/17 outturn reflected a slight decrease to 87.5% from the 2015/16 outturn of 89.6%. Although, the performance has shown a fall, a positive is that the total number of people using the service increased from 135 to 144. This demonstrates the total number of people who are benefiting from increased rehabilitation beds capacity is on an upward trend, but the service is being used for more complex people and this has made the target more challenging to achieve. In addition the service has been offered to younger people and not all of these are able to be included in this measure, as only those over 65 fall within the definition.

A target of 88% has been set for 2017/18 and 89% in 2018/19, data will be collected using the same criteria in 2016/17. However, we anticipate that some planned changes to the service (through additional IBCF funding to increase our reablement service) should enable the performance to stabilise, if not improve, both in terms of 'offered' the service and those still achieving the outcome of being 'still at home' after 91 days after ceasing to use the service. The target takes account of recent trend analysis and is realistic when considering demographic pressures. A range of the BCF initiatives/projects will contribute positively to this target's improvement over 2017/18 and 2018/19 but especially the initiative – Supporting the DTOC High Impact Change Action Plan and Initiative – Investment in additional reablement capacity..

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
- 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/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 understood 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Non-elective admissions • Effectiveness of reablement • Delayed transfers of care
2	Integrated Health and Social Care Teams	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
3	A Reablement Hub Incorporating Intermediate Care	<ul style="list-style-type: none"> • Single rehabilitation coordinator who supports individuals through whole care pathway • All therapists and carers on-site and accessible • More holistic approach to rehabilitation 	<ul style="list-style-type: none"> • 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 step-up beds 	<ul style="list-style-type: none"> • Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
4	An Integrated	<ul style="list-style-type: none"> • Better access to benefits, 	<ul style="list-style-type: none"> • Reduced likelihood of 	<ul style="list-style-type: none"> • Non-elective

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
	Carers Support Service	<ul style="list-style-type: none"> information and advice Reduction in social isolation for both carer and those being cared for Improved health and well being 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> admissions Admissions to care homes
5	A Single Health and Social Care Plan for People with Long Term Conditions	<ul style="list-style-type: none"> One plan covering all aspects of care Less confusion and duplication Includes support with self-management and urgent response 	<ul style="list-style-type: none"> Greater visibility of what other professionals are doing Reduces risks that arise from fragmentation of service Reduction in bureaucracy 	<ul style="list-style-type: none"> Non-elective admissions Admissions to care homes Effectiveness of reablement
6	A Joint Approach to Care Home Support	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Non-elective admissions Effectiveness of reablement Delayed transfers of care
7	A Shared Approach to Delayed Transfers of Care (DTC)	<ul style="list-style-type: none"> Shorter hospital stay Better quality care packages delivered in a timely manner Reduced risk of readmission 	<ul style="list-style-type: none"> Better patient flow through the hospital Reduction in cost of acute care Reduction in readmission costs for RFT 	<ul style="list-style-type: none"> Delayed transfers of care

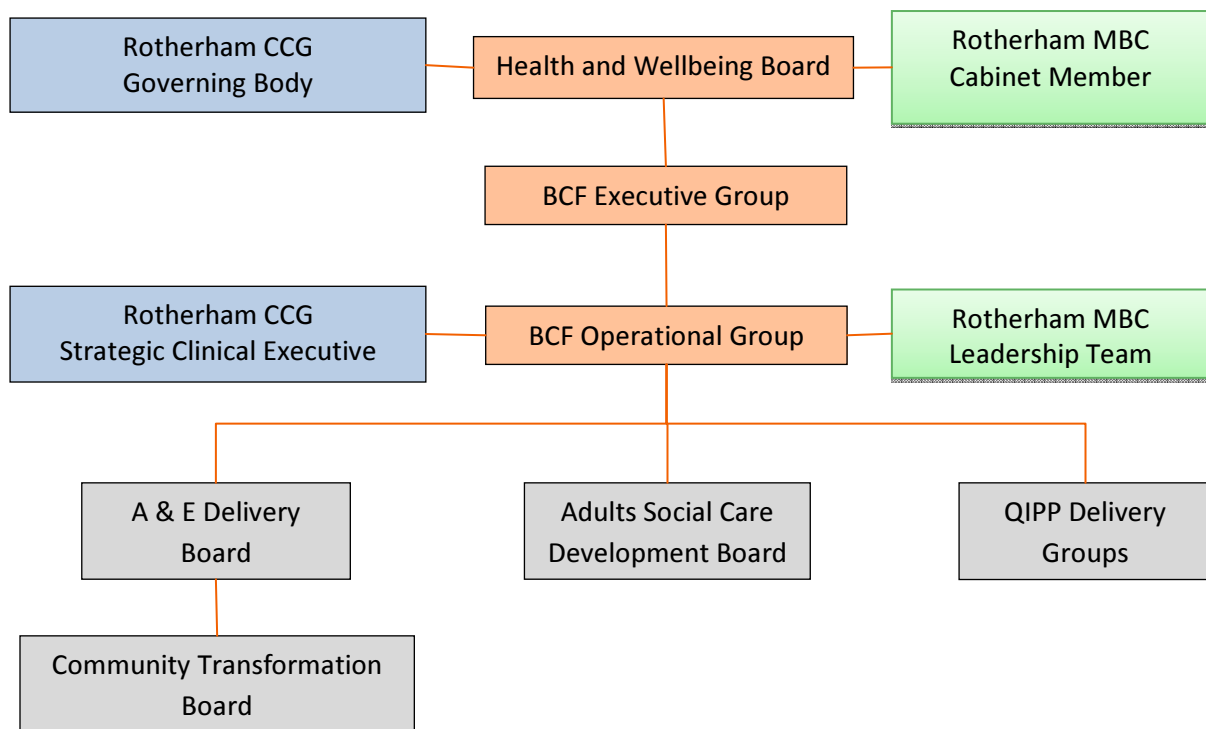
16. Governance Arrangements

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.

The Health and Wellbeing Board and BCF Executive Group have fully endorsed the BCF plan, planning template and narrative plan and all relevant stakeholders support the allocation of BCF and IBCF funding.

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 Executive Group

This group consists 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;

- Agree strategic vision and priorities for the future
- Make decisions relating to the delivery of the plan
- 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 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 current governance arrangements were reviewed and the governance framework shown in figure 4 was agreed.

17. Risk Assessment

Table 6 provides a summary of the risks associated with the development of the Better Care Fund. Risks have been assessed in partnership with key stakeholders and description of how these will be mitigated or managed operationally is detailed below:

Table 6: Major Risks to BCF Action Plan

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

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
Strategic Risks					
	Delay in provision of definitive guidance and confirmation of metrics leads to lack of time for implementation and monitoring	3	3	9	The programme is being monitored closely and the plan is continually updated to take account of changes in the Health and Social Care System.
	Poor alignment between service budgets and actual cost; resulting in overspend	4	3	12	The review process timetabled throughout 2017-18 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.
	Shortfall of resources to fund the priorities identified in the plan	3	4	12	As above. The review process will seek to identify areas where budgets can be appropriately aligned to BCF priorities; this may include reconfiguration of service provision in year.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
1	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
1	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.
1	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 of the risks associated with implementation/achievement.
1	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 is 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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
1	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.
1	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.
1	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.
1	Social care not being adequately protected	3	5	15	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.
Performance Risks					
2	<i>Non-elective target not met</i> ; BCF Schemes do not deliver the planned	4	5	20	Many of the schemes outlined in the plans from previous years have already been put in place and are

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
	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.				demonstrating outcomes. The focus on out of hospital services will continue in 2017-18.
2	<i>Residential Care target not met</i> ; BCF Schemes do not deliver a reduction in permanent admissions to residential care increasing costs to the LA.	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.
2	<i>Delayed Transfers of Care (DTC) target not met</i> ; BCF Schemes do not deliver the planned reduction in DTC 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.
2	<i>BCF schemes are delayed</i> ; 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	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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
	scheme implementation is delayed.				
OPERATIONAL RISKS					
2	<i>Community Services;</i> BCF schemes increase demand on community services resulting in increased waits for health and social care assessments/ services	3	4	12	New funding was identified and included in the plan for 2015-6 onwards and this is continually reviewed by the executive group.
2	<i>Rotherham Population;</i> Schemes not targeted at the right populations resulting in pressures on the acute services	1	3	3	Using Joint Strategic Needs Assessment, Commissioning Plans/Strategies to support rationale for scheme development – incorporating intelligence of local population and demand in to service specifications to target appropriate cohorts of patients. Review of service implementation takes place once a scheme is up and running. Performance, quality and outcomes regularly monitored through performance submissions and meetings with providers.
QUALITY RISKS					
2	<i>Provider destabilisation;</i> 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.
2	<i>Carers;</i> 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	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

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
	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 RMBC and CCG				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.

18. 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's plans to dampen down growth of emergency admissions have 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 all of the relevant boards.

19. Patient Engagement

19.1 Integration Locality Engagement

The integrated locality pilot became fully operational in June 2016. There was an initial consultation exercise to ensure patient engagement was central to the integration of community services within one locality and the impact this may have on Rotherham people. Leading on from the consultation there was a focused workshop at the Patient Participation Group in December..

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 December 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 point.

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'

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

'I feel safe and am able to live independently where I choose'

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

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.

This was followed by a targeted piece of work with people who had been in receipt 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.

19.2 Case Studies

Case Study 1 – Integrated Locality Team

On 30th May 2017, a letter was sent to the Integrated Locality Team, from a couple, thanking the therapists for the time and effort put in to reabling Mr J to get up and walk again, unaided. Mr J was referred in to the Integrated Team after deterioration following a stroke. He had been isolated to one room in his house due to his inability to move. It required three people to stand Mr J at this point. His deterioration resulted in him being placed in intermediate care, who referred him to the Community Occupational Therapist (COT) attached to the Integrated team, for a hoist to lift him. A multi-

disciplinary review took place to assess Mr J's needs and the case was to be managed by the Physiotherapy and Occupational therapists with input from the Team Social Worker in relation to the care he would require. The team rehabilitated Mr J from December 2016 and, as a result, he is now able to function without aids and reports being so much happier. He is spending time in the garden and has three outings planned for the summer, including to London and Llandudno. The team has reduced Mr John's social isolation, enhanced his mental well-being and overall quality of life. He is now able to attend medical appointments instead of requiring domiciliary visits, the risk of developing sores and District Nursing input has reduced dramatically, and his social care package will be reduced as a result.

Case Study 2 – Rotherham Active for Health – MSK Pathway (Rehabilitation and Reablement)

Client SE was referred to the Active for Health MSK programme after suffering from sciatica on two occasions. His GP referred him to a Physiotherapist who then referred him to the Park Rehabilitation Centre. After completing the NHS 12 week programme at Park Rehab he was recruited into the Active for Health MSK programme in April 2016. SE enjoyed the regular exercise and the opportunity to get out of the house (works from home) and get active along with other people who also suffered from back issues. He wanted to carry on with guided exercises and circuit training and welcomed the opportunity to continue this with Active for Health. Before joining the programme he was living in fear of succumbing to sciatica once again and moving carefully, "not really daring to exercise too hard in case my sciatica was triggered again". SE is now saying that "I am feeling fitter and am now more active than I have been for many years". "I am able to stretch further in all directions and can exert myself more before becoming out of breath. I also recover faster from cardio exercise and feel less aches and pains in my body". "My weekly MSK sessions have inspired me to exercise every single day; in the mornings I go through a stretch and in my lunch breaks I do a small workout and go for a short run. My sciatica has not returned and I am sure this is due to being a part of the Active for Health programme". The extension to the rehabilitation pathways in the NHS has enabled SE to increase his self-care and aid his rehabilitation.

Case Study 3 – Rotherham Active for Health – Stroke Pathway (Rehabilitation and Reablement)

Client JS suffered a stroke in which initially affected all his right side, leaving him with limited movement in his right arm. His wife explains how he was in a bed downstairs as he didn't have the mobility to get upstairs. JS started rehabilitation with the enablement team and Physiotherapy at Park Rehabilitation. JS was then referred to the Active for Health programme and has been attending for the last 10 months. JS has completed step 2 of the programme and has continued into step 3 where he attends on a weekly basis. When JS first started the programme he would attend in his wheelchair, and would exercise in his chair, from this he progressed to being out of the chair assisted by the instructor on a 1 to 1 basis with a walking aid, 10 months into the programme, JS is now talking part in the exercise independently with little instructor support. As a result of the programme, JS is now able to get upstairs to sleep, completes the full session with no walking aid and limited 1 to 1 support, walks independently around his home, his right side had improved greatly and he does not kick his leg out as much, his leg movement is more aligned. This has increased JS's independence, mental wellbeing and built upon the NHS rehabilitation pathway.

Case Study 4 – Rotherham Active for Health – Heart Failure Pathway (Rehabilitation and Reablement)

Client GM suffers with Heart Failure and is also completely visually impaired. Prior to starting Active for

Health he was virtually sedentary and very resistant to starting exercise. GM has been attending the cardiac class once a week at Aston Leisure centre since September 2016, after being referred from the heart failure nursing service. He has completed Active for Health step 2 and has now moved onto step 3 maintenance sessions and is said to be “loving it”. He has now increased self-confidence, reduced anxiety, increased his 6 minute walk test by 60m, reduced his Heart Failure symptoms on his health questionnaire, increased physical activity from 40 minutes 90 minutes a week and is now doing regular home programme with his wife as well as attending the follow on cardiac class. He is now that inspired from the team’s support that he wants to create his own voice programme to help other visually impaired clients. He has started narrating the home programme and will share with the team once complete. He has improved his confidence and rehabilitation through attending the sessions.

Case Study 5 – Rotherham Active for Health – Cancer Pathway (Rehabilitation and Reablement)

Client MT was diagnosed with cancer, which resulted in some of his thigh muscle being removed. MT was told that he might not be able to walk unaided again. Prior to the diagnosis, MT was active, he was keen to get back to his active lifestyle after following the operation. He picked up on the Active for Health programme at the walk-in centre and took it to his GP, who referred him to the programme. MT has been involved in the programme for over 10 months now and since starting the programme he feels more positive about himself and that he generally feels his wellbeing has improved. MR has said “I am no longer dependant up on his walking during sessions”, “I can now complete the full session with no support”, he finds it easier to walk, he has more confidence in his walking ability and less fear of falling, he has started gardening again and he enjoys socialising within the group and it has helped increase his confidence. MT has seen great improvements in his independence.

Case Study 6 – Intermediate Care Services

Client admitted to hospital due to TIA, slurred speech and marked weakness in the left upper limb. Client had reduced hip/knee control on the left and weakness of the left shoulder. Client was given an exercise programme to complete independently, and with the support from reablers. This was targeted around improving strength, stability and control around the left shoulder, lower limb strength and control around the left hip. Stairs assessment and practise was completed with 2 rails, client progressing to become independent. Kitchen assessment – completed meal preparation of cutting vegetables and lifting full casserole dish in and out of simulated oven. Support worker continued with the exercise programme given to the client. Client also attended gardening groups – this involved standing to re-plant seedlings using both hands. The support staff also took the client to the local shops where they purchased items for the gardening group from the gardening therapy fund – this aimed to promote community integration. The client was discharge to her own home following 18 days of rehabilitation and no referral to adult care for ongoing support as had gained full independence. On discharge the client was referred to the community stroke team for ongoing therapy. They were also provided with information for ongoing support from Rothercare and Age UK.

Case Study 7 – Intermediate Care Services

Client fell at home, admitted to hospital with hip fracture. Kitchen assessment completed around preparation of drinks and meals, client fatigued quickly. Assessment of washing, dressing and grooming activities assessed, client required assistance with lower half but progressed to becoming fully independent. Client was independent with chair transfers, required minimal assistance to lift legs onto bed, client given a sheet of chair based exercises to complete independently to increase strength and

mobility. Client progressed to being independently mobile with walking frame after 4 days and progressed to step practice with therapy staff as client had internal steps at the property. Support Worker provided ongoing support with standing exercise programmes. Client discharged home after 20 days of rehabilitation with a reablement package to assist with showering and to increase stamina during meal preparation. Client was referred to day rehabilitation to further increase confidence and practice outdoor mobility.

Case study 8 – Active for Health – Falls Pathway (Rehabilitation and Reablement)

The patient suffered a minor stroke, resulting in loss of peripheral vision in left eye and damaging the part of the brain effecting balance and sporadic episodes of dizziness. Following partner bereavement she gradually became withdrawn, disinterested and eventually stopped going out alone, fearing she would fall. The GP initially referred the patient to AFH, following a bad “dizzy spell,” leaving her unable to get out of bed for 15 hours. The patient started to attend the sessions and there was a noticeable change immediately. Her daughter stated “Amazing difference, even before the end of the initial 12 weeks”. “Even after the very first session, she was totally enthusiastic. There is a significant improvement in her confidence, she’s more mentally alert, her concentration has improved and she’s generally a much happier person”. “I genuinely believe my mum’s quality of life has significantly improved, way beyond mine and my sibling’s expectations and more importantly, my mum’s, due to this programme”. “It almost seems impossible such amazing results can be achieved in such a short space of time”. The family “feel more confident and less worried about leaving mum alone now, knowing she’s happier, having the sessions to look forward to”. She is now making her own way to the sessions and gaining independence, she loves the social time as she has made new friends and she is happy to encourage others to follow in her footsteps. The active for health sessions have aided rehabilitation from a fall and supported the patient move from dependence to independence.

20. Engagement with Providers and Stakeholders

20.1 Evidence of Engagement

The Rotherham Health and Wellbeing Board has had consistent and robust representation from Elected Members, Council, CCG, NHS England, General Practitioners, Public Health, main local health providers (TRFT and RDaSH), Police and the voluntary sector (Healthwatch and Voluntary Action Rotherham) which is currently being ratified by the Local Government Association (LGA).. 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.

We now have an Accountable Care System governance arrangements in place with various sub-groups supporting transformation across the health and social care system, including the Acute and Community Transformation Group and BCF groups.

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.

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.

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 is an integral part of all BCF service reviews.

20.2 Engagement with Regional/National Areas

The CCG and Local Authority regularly attends meetings such as South Yorkshire BCF Network meetings, STP Update Meetings, Urgent and Emergency Care Commissioning Steering Boards and Groups and take parts in teleconferences/webinars/seminars to sharing good practice and outcomes

both regionally and nationally. NHS Benchmarking Networks are regularly used to identify improvements in schemes funded by BCF and the commissioning team have recently taken part in the National Audit of Intermediate Care Services in July 2017.

20.3 Provider/Stakeholder Engagement Strategy

This section of the Rotherham Better Care Fund Plan sets out the communication and engagement strategy for 2017-19. 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. This is a continual process designed to ensure that the relevant stakeholder groups are briefed at the right time.

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

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

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

21. Funding Arrangements

21.1 Financial Risk Sharing and Contingencies

There is a risk sharing policy in the Section 75 Partnership Agreement ([Appendix 7](#)) 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.

21.2 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. The spend on social care has clear health benefits and supports the overall aim of the BCF plan in reducing hospital admissions, re-admissions, reducing Delayed Transfers of Care, reducing the number of admissions to 24 hour residential care and increasing the proportion of older people living in the community 91 days after hospital discharge.

Total investment in social care from the CCG minimum contribution has increased from £6.5m in 2016/17 to £8.1m in 2017/18, mainly in respect of equipment and adaptations and to meet additional cost pressures arising from the Care Act 2014.

This planned investment remains in 2018/19, with a slight increase of 1.9% in line with the overall increase in BCF funding. 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

BCF Theme	2016/17 Investment	Additional Funding	Total 2017/18	2017/18 Investment by Commissioner			2017/18 SPLIT BY POOL	
	£000	£000	£000	RCCG SHARE	RMBC SHARE	Total	Pool 1 RMBC Hosted	Pool 2 RCCG Hosted
THEME 1 - Mental Health Services	790	1	791	791		791		791
THEME 2 - Rehabilitation & Reablement	13,391	779	14,170	10,142	4,028	14,170	14,170	
THEME 3 - Supporting Social Care	3,682		3,682	3,682		3,682		3,682
THEME 4 - Care Mgt & Integrated Care Planning	5,028	11	5,039	5,039		5,039		5,039
THEME 5 - Supporting Carers	690	-40	650	600	50	650		650
THEME 6 - Infrastructure	242	-1	241	241		241		241
Risk Pool	500		500	500		500		500
Improved Better Care Fund	0	7,317	7,317		7,317	7,317	7,317	
TOTAL	24,323	8,067	32,390	20,995	11,395	32,390	21,487	10,903

Table 9: Summary of Investment Profile

BETTER CARE FUND - 2017/18			
			2017/18
SUMMARY OF INVESTMENTS	Funding Streams		Total
	RMBC	RCCG	
	£'000	£'000	£'000
THEME 1 - Mental Health Services			
Adult Mental Health Liaison		791	791
THEME 2 - Rehabilitation & Reablement			
Home Improvement Agency	15	60	75
Falls Service		444	444
Home Enabling Services		1,591	1,591
2 SSO reviewing officers to fast track assessments during reablement		98	98
Community Stroke Service		181	181
Community Neuro Rehab		156	156
Breathing Space		2,346	2,346
Expert Patient Programme		50	50
Otago Exercise Programme		20	20
REWS	92	1,293	1,385
Community OT	372	374	746
Disabled Facilities Grant	2,311		2,311
Age UK Hospital Discharge		158	158
Stroke Association Service		50	50
Stroke Social Work Support		27	27
Intermediate Care Pool	1,238	3,294	4,532
THEME 3 - Supporting Social Care			
Direct Payments		1,643	1,643
Care Act Implementation		700	700
Residential Care		274	274
Learning Disability Services:		1,065	1,065
THEME 4 - Care Mgt & integrated Care Planning			
GP Case Management		2,145	2,145
Care Home Support Service		267	267
Death in Place of Choice		789	789
Social Prescribing		760	760
Social Work Support (A&E, Case management, Supported Discharge)		1,078	1,078
THEME 5 - Supporting Carers			
Day Care Services:		400	400
Carers Support Service	50	200	250
THEME 6 - Infrastructure			
Joint Commissioning Team		49	49
IT to support Comm Trans		192	192
RISK POOL			
Risk pool		500	500
Improved Better Care Fund			
Sustainability/mitigation of service reduction/transformation	4,400		4,400
Information Sharing/System Development	360		360
Leadership capacity for system transformation	290		290
Discharge Pathways and Patient Flow	1,250		1,250
Market capacity/sustainability	955		955
Improved BCF Contingency Fund	62		62
GRAND TOTAL	11,395	20,995	32,390

21.3 Disabled Facilities Grant (DF)

The DFG is embedded within the 3 year Housing Investment Plan which is approved by members. The funding is used for the provision of adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. This will include the provision of Assistive Technology in 2017/19.

The 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 HWB 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

22. Improved Better Care Fund (IBCF)

Rotherham has been allocated a new grant allocation within the 2015 Spending Review and Spring Budget entitled "Improved Better Care Funding" (IBCF) via a Section 31 Grant from the Department of Communities and Local Government (DCLG).

The IBCF funding has not been offset against the contribution from the CCG minimum contribution, it is a new funding allocation which will meet adult social care needs, reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready, and ensuring that the local social care provider market is supported. This funding will enable Local Authorities to provide stability and extra capacity in local care systems. The grant funding will be pooled within the BCF Section 75 agreement and will be used to meet the National Condition 4 (Managing Transfers of Care).

Rotherham Council's total allocation for the IBCF is £7.318 million in 2017/18 and £10.104 million in 2018/19.

22.1 Grant Conditions of the Improved Better Care Fund

Agreement has been reached between all key stakeholders around the use of the IBCF money that will meet all of the grant conditions set out in the grant determination. These are as follows:

- Meeting adult social care needs
- Reducing pressures on the NHS – including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local care provider market is supported

22.2 Proposals for IBCF and BCF Investment in 2017/18

The proposals for priority areas for investment seek to both meet the grant conditions described above and achieve a balance between off-setting the adult social care budget pressures and strategic investments to achieve greater longer-term financial sustainability, contributing to Rotherham's Better Care Fund Plan.

The proposals for use of the £7.3m BCF funding in 2017/18 are structured as follows:

Investments to ensure the sustainability of adult social care and the local social care provider market

- Reform of care assessment and support planning
- Additional capacity to respond to increasing demand / complexity of care packages
- National Living Wage/Sleep-in Cover

Proposals that support the integrated health and social care priorities within the BCF Plan

- Supporting the DTOC High Impact Change Action Plan
- Investing in the leadership and management capacity to support integrated health/ social care
- Investment in additional reablement capacity
- Developing the Enhanced Care Worker role
- Expanding the Care Home Support Service

Collectively the proposals are designed to reduce the number of permanent admissions to residential and nursing care homes; increase the number of older people still at home 91 days after hospital discharge; reduce the number of delayed transfers of care from hospital; and reduce the total number of emergency admissions/readmissions to hospital. These proposals are expanded below.

22.3 Reform of care, assessment and support planning

Transforming the management, approach and delivery of care assessment and support planning is central to the Council's Medium Term Financial Plan and associated savings targets for adult social care. A detailed Adult Social Care Improvement Plan has been developed (June 2017) which sets out a comprehensive programme of work to strengthen governance; improve the front door to deal with demand better; improve assessment, support planning and review; invest in short term interventions; and re-design the care pathways for long term care and support needs.

The proposed impact of these changes will be stable and capable leadership; continued improvement in the quality and effectiveness of practice; strong and supportive partnerships; robust financial management; a compelling strategy for the workforce; and effective performance information and quality assurance.

Investment in the Improvement Plan will be required in 2017/18 – 2018/19 on an invest-to-save basis. Utilisation of the iBCF grant is appropriate and in line with conditions of use.

22.4 Additional capacity to respond to increasing demand/complexity of care packages

As set out in national policy documents such as the Five Year Forward View, the 2017-19 Integration and Better Care Fund Policy Framework, and Rotherham's Better Care Fund Plan, people are living much longer, often with highly complex needs and multiple conditions. Section 3 above describes the particular set of demand and budget challenges facing adult social care in Rotherham.

The availability of social care is a fundamental element of an effective, integrated health and care system. In the face of growing pressures on social care, additional investment is required to ensure and protect access to packages of care and placements for those who need them.

It is proposed to utilise the iBCF to ensure that those in need continue to receive social care support in the context of increasing volume, complexity and acuity, particularly older people and people with learning disabilities.

22.5 National Minimum Wage/Sleep-in Cover

Many funded packages of care for adults with learning disabilities, in both registered care services and in a person's own home include sleeping in provision. Such packages of care or placements require a member of staff to be present on site overnight to ensure that the person remains safe and has their needs met. However, the member of staff is permitted to sleep and only attend to any needs if required.

Recent case law has established that "sleep-ins" are covered by the National Minimum Wage (NMW) regulations. So even if a worker is allowed to sleep at work, if they are required to stay at their workplace all their hours are covered by NMW regulations.

This means if any worker is paid - on average – less than the National Minimum Wage over their pay reference period they will be entitled to a pay rise. Staff who are paid significantly above the NMW and who do sleep-ins are unlikely to be affected, because their pay will not fall below the NMW on average over the pay reference period.

It is proposed that an additional percentage premium will be added to any inflationary uplift to cover off all NMW changes including the impact of changes to the case law regarding sleep in shifts. New placements will also be made against this premium rate. Whilst this is a recurring cost pressure, this in-year pressure does meet the conditions for iBCF funding and the grant could be used to offset this.

22.6 Supporting the DTOC High Impact Change Action Plan

Rotherham's DTOC performance (all causes) is average at a regional level, masking variations in performance attributable to adult social care and NHS within Rotherham. A jointly agreed High Impact Change Action Plan has been developed (following an independent review of DTOC arrangements) to drive DTOC performance, linked to the third strand of the BCF Plan. The Council proposes to support the action plan using iBCF and BCF funding, including early discharge planning, integrated rapid response, developing the trusted assessor model with social care providers, building capacity of the seven day offer across acute/community services.

22.7 Investing in leadership/management capacity to support integrated health/social care

Together with the CCG, the Council is investing in a series of jointly appointed and funded Assistant Director posts within Children's and Adults services as part of the Joint Commissioning Arrangements strand of the Better Care Fund Plan. This includes a joint commissioning and performance role in Children's Services and three Heads of Commissioning covering Learning Disabilities, Adults and Mental Health.

22.8 Investment in additional reablement capacity

Additional capacity is required in reablement services to reduce delayed transfers of care. It is proposed that the local authority's reablement provision is extended so that it can support the development of integrated localities. The Health Village Pilot is currently developing a reablement service model, which combines the skills and capacity of community therapists and reablement services to reduce reliance on formal care services. By targeting reablement packages at people with social care packages we will be able to drive down the number packages and the unit cost.

22.9 Developing the “Enhanced Care Worker” role

To address the recruitment, retention and quality issues within the social care market, particularly domiciliary care, the Council proposes developing the Enhanced Care Worker role, together with health partners and providers. This will include the administration of medication, supporting community rehabilitation programmes and carrying out baseline health monitoring. As well as potentially widening the scope of support to customers, reducing multiple visits by multiple front line professionals, the role should enable greater integrated working with primary care.

22.10 Expanding the Care Home Support Service

It is proposed that the Care Home Support Service is expanded so that it is able to provide a broader range of support to care home residents. The team can deliver training programmes to care home staff on management of long term conditions, falls prevention, end-of-life care, nutrition/hydration and dementia. They can provide support to care home staff when someone has an urgent care need. These types of interventions will not only improve health outcomes of residents but also support retention of care home staff.

23. Appendices

Ref.	Document	Synopsis and links
Page 5 (embedded document)	Map of Rotherham	This map was produced by Rotherham Borough Council to illustrate the 3 locality areas in the North, South and Central area of the borough
Page 7 (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 8 (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 8 (web links provided)	Public Health England Fingertip guides	These guides enables us to track progress and benchmark Rotherham's position against statistically similar areas. https://fingertips.phe.org.uk/profile/older-people-health https://fingertips.phe.org.uk/profile/adultsocialcare
Page 8 (web links provided)	South Yorkshire and Bassetlaw Sustainability and Transformational Plan (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. http://www.smybndccgs.nhs.uk/what-we-do/stp
Page 9 (web links provided)	Rotherham Integrated Health and Social Care Place Plan	The Integrated Health and Social Care Place Plan details our joined up approach to delivering five key initiatives that will help us achieve our Health and Wellbeing strategic aims and meets the region's STP objectives. http://www.rotherhamccg.nhs.uk/rotherhams-place-plan.htm .
Page 9 (web links provided)	Infographic and Animation System	This will be used across the health and social care as a key tool in articulating how our five priorities are closely interlinked to deliver better, more accessible services in the coming years. http://preview.beach-design.co.uk/nhs_rotherham/
Page 9 (web links provided)	CCG Commissioning Plan 2016-20	The Commissioning Plan for 2016-20 sets out Rotherham CCG's vision for the next 4 years which includes our purpose, values and priorities and the CCG's contribution to delivering Rotherham's overall Health and Wellbeing Strategy.

Ref.	Document	Synopsis and links
		http://www.rotherhamccg.nhs.uk/our-plan.htm
Page 9 (web links provided)	Rotherham Carers Strategy 2016-21	The Carers Strategy sets out the intentions and actions necessary to support carers and young carers. http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=108721
Page 10 (web links provided)	The Rotherham Plan 2025 (Housing and Community)	The Rotherham Together Partnership (RTP) has developed a long-term plan setting out partners' shared ambitions for the borough over the next few years. http://rotherhamtogetherpartnership.org.uk/downloads/file/7/the_rotherham_plan_a_new_perspective_2025
Page 13 (web links provided)	Joint Strategic Needs Assessment	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
Appendix 1 Page 6	BCF Executive Summary	The BCF Executive Summary gives a brief summary of all strategic priorities contained within the BCF plan.
Appendix 2 Page 12	A&E Delivery Plan	The Plan sets out the actions for the Rotherham A&E Delivery Board in relation to the key deliverables for Urgent and Emergency Care
Appendix 3 Page 12	Rotherham System Wide Escalation Plan 2017/18 (including winter planning)	The escalation plan sets out winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures
Appendix 4 Page 15	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 5 Page 47	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 Page 48	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 Page 78	Section 75 Partnership Agreement	The agreement will be signed and agreed by CCG and Local Authority setting out commissioning intentions in the use of the BCF