BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	18th September 2019
	LEAD OFFICER	Karen Smith, Strategic Commissioning Manager, Rotherham Metropolitan Borough Council and Rotherham Clinical Commissioning Group
	TITLE:	Better Care Fund Plan 2019/20

1. Background

1.1 The purpose of this report is to give the Health and Wellbeing Board an overview of the Better Care Fund Plan for 2019-20 and to note the contents.

1.2 The BCF planning template is in line with the 2019-20 Better Care Fund Policy Framework published in April 2019 and the Better Care Fund Planning Requirements 2019-20, which includes Key Lines of Enquiries (KLOE's) released in July 2019.

2. Key Issues

2.1 The BCF will continue to provide a mechanism for personalised, integrated approaches to health and social care that support people to remain independent at home or to return to independence after an episode in hospital.

2.2 The BCF planning and reporting has incorporated the utilisation of the IBCF and Winter Pressure Grants this year. Separate narrative plans have now been replaced with a single template that includes short narrative sections on the local approach to integration, plans to achieve metrics and plans for ongoing implementation of the High Impact Change Model for Managing Transfers of Care and Enhanced Health Care in Care Homes (EHCH) framework.

2.3 The BCF planning template (Appendix 1) covers our approach to:

- integrating care around the person, including prevention and self-care and promoting choice and independence;
- integrating services including joint commissioning arrangements, alignment with primary care services (including Primary Care Networks), alignment of services and the approach to partnership with the voluntary and community sector;
- integration with wider services e.g. Housing, the use of DFG funding to support the housing needs of people with disabilities or care needs, including arrangements for strategic planning for the use of adaptations and technologies to support independent living;
- system level alignment, including how the BCF plan and other plans align to the wider integration landscape e.g. ICS/STP plans and joint governance arrangements.

2.4 **Key Achievements since BCF Plan for 2017/19**

Key achievements since the publication of Rotherham's BCF Plan for 2017/19 are as follows:

	• The implementation of a new build Integrated Urgent and Emergency Care Centre (UECC) • Trusted Assessor model has been introduced in UECC to support admission avoidance to hospital • An Integrated Discharge Team is fully embedded in the Rotherham system and is driving down DTOC levels • Development of a more effective ambulatory care pathway to better support people with long-term conditions • Extension of social care prescribing service to support people with long term and mental health conditions. Extension of the Hospice at Home pilot for a further one year period to provide immediate advice and support for people living in community and care homes • Formal tender exercise completed to procure an Integrated Equipment and Wheelchair Service from 1.2.19, which is now delivered by an independent sector provider. • Care Co-ordination Centre (CCC), Unplanned District Nursing Hub, Integrated Rapid Response (IRR) and Community Therapies co-located which has brought together community services responsible for supporting people to remain at home. • Further development of the locality model by creating an affordable and sustainable integrated model aligned to the new primary care networks which will make the best use of resources e.g. high intensive users, MDT and case management reviews • Development of the Council's First Point of Contact team to promote independence through prevention and early intervention. This includes the secondment of an occupational therapist and pilots with specialist physical, mental health, reablement, safeguarding and community sector workers. This will continue to be based at the front door in a multi-disciplinary team, working to prevent further escalation of need through face to face and "immediate" interventions. • Reconfiguration of Rotherham Intermediate Care Centre to deliver the service in a person's home which provides therapy interventions and delivers programmes to facilitate independent living to clients who may otherwise need ongoing care packages, This is currently under review which will form part of the new offer for intermediate care and reablement.
2.5	**Enhanced Health Care in Care Homes (EHCH)** Key achievements over the last 12 months include: • Working to embed pharmacy teams into the health and social care system to support care homes and their residents with medicines optimisation. • Relaunch of red bag system to improve communication between care home, ambulance service and the hospital. • Development of an integrated health and social care training offer to support workforce development, in particular on areas such as hydration, nutrition, diabetes, respiratory, dementia, pressure areas and oral health. • Apprenticeships for trainee nurse associate are also being offered by South Yorkshire Region Excellent Centre (SYREC) to improve recruitment and retention of staff and development of career pathways. • A community physician is working with care homes will support delivery of enhance case management for those identified as at risk of hospital admission • All care homes are now registered on the NHS Capacity tracker system which provides regular 'live' updates on information, including current bed vacancies, placement costs, location, contact details and CQC ratings and supports hospital discharge planning.

- All care homes are now registered on the Data Security and Protection Toolkit and NHS mail system to ensure secure and efficient communication between hospitals, GP practices, pharmacies and care homes so that patient data is shared safely.
- Hospice at Home Care Home Pilot has now been extended until 31.3.20, which addresses both immediate advice and rapid response in emergency situations and the provision of education and supervision of front line care and residential home staff.
- Rotherham Health App has been developed which enables patients to make on-line GP appointments, view their records and order repeat medication. There is the potential to give care homes a dedicated portal to manage their residents and this would allow them to see discharge letters.
- CCG/BCF funding is continually provided to support the GP Local Enhanced Service (LES), Care Home Support, Advanced Nurse Practitioner, Mental Health Liaison Team and Clinical Quality Advisor to reduce emergency hospital admissions and improve quality standards.

2.6 **Lessons Learned**

Since the publication of Rotherham's BCF Plan for 2017/19, the lessons learnt include:

- A review of current services in 2018/19 identified an over-reliance on a large community bed base to provide Intermediate Care and Reablement. The development of a new integrated service across health and social care, which will rationalise the current 7 pathways into Intermediate Care and Reablement support services, to 3 core integrated pathways, thus improving patient/customer outcomes, is currently underway.
- The development of the Integrated Discharge Team (IDT) and an integrated MDT approach to discharge planning has consistently reduced DTOC levels. The monitoring of DTOCs now forms part of a system escalation processes. In order to embed the change and continue to reduce DTOCS, we are reviewing the IDT, with the aim of implementing a fully funded 7 day service in 2019/20.
- The OT and community sector workers in the First Point of Contact Team and the closer working relationships between the Care Co-ordination Centre and Integrated Rapid Response Service shows that integration and alignment has clear benefits to the patient/customer and to staff who become more knowledgeable of the wider health and social offer.
- There is a strong record of joint commissioning between health and social care and this has great benefits in terms of working in partnership, bringing together planning, funding and delivery of integrated services. Therefore, we want to further build on this framework and to develop an integrated commissioning hub in future.

2.7 **Income and Expenditure**

- The total Better Care Fund (BCF) for 2019/20 is £40.370m, an increase of £4.8m from 2018/19. This is due to increases in the additional and improved BCF grant (£2.6m), Disabled Facilities Grant (£0.2m), additional CCG investment (£0.6m) plus the new requirement to include the Winter Pressures Grant funding (£1.4m).

- Spending Plans continue to be allocated to the 6 themes and managed within 2 separate pooled funds, both the CCG and RMBC managing one pool fund each. This is in line with previous years and can be summarised in the table below:-

Budget 2019-20	2019/20 INVESTMENT		2019/20 SPLIT BY POOL		
BCF Investment	**RCCG SHARE**	**RMBC SHARE**	**Pool 1 RMBC Hosted**	**Pool 2 RCCG Hosted**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
THEME 1 - Mental Health Services	1,169			1,169	1,169
THEME 2 - Rehabilitation & Reablement	10,813	4,433	15,245		15,245
THEME 3 - Supporting Social Care	3,617			3,617	3,617
THEME 4 - Care Mgt & Integrated Care Planning	4,893			4,893	4,893
THEME 5 - Supporting Carers	600	50		650	650
THEME 6 - Infrastructure	241			241	241
Risk Pool	500			500	500
Improved Better Care Fund		12,710	12,710		12,710
Winter Pressures		1,345	1,345		1,345
TOTAL	**21,833**	**18,538**	**29,300**	**11,070**	**40,370**

2.8 **National Conditions**

Rotherham is fully meeting the 4 national conditions set within the Government in the BCF Policy Framework as follows:

(i) That the BCF plan (including at least the minimum mandated funding to the pooled budget specified in the BCF allocations and grant determinations), is signed off by the Health and Wellbeing Board (HWB) and by the Council and CCG.
(ii) A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution, in line with the uplift to the CCG's minimum contribution.
(iii) That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care.
(iv) A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans

2.9 **Maintaining Progress on Former National Conditions**

Rotherham continues to make progress towards the former national conditions contained within the BCF Plans in 2017/19 as follows:

(i) Develop delivery of 7 day services across health and social care
(ii) Improve data sharing between health and social care; and
(iii) Ensure a joint approach to assessments and care planning

BCF National Metrics

The BCF Policy Framework also sets out the four national metrics for 2019/20, which have been used in previous years as follows:

(i) Non-elective admissions
(ii) Admissions to residential and nursing care homes

	(iii) Effectiveness of reablement (iv) Delayed Transfers of Care (DToC)
3. Key Actions and Relevant Timelines	
3.1	The BCF planning template for 2019/20 is going through various stages of the approval process as follows: • Submission for Informal Feedback to ADASS/LGA Assurance – 2nd September • BCF Operational Group – 2nd September • South Yorkshire BCF Network Meeting – 4th September • BCF Executive Group – 5th September • Assurance of the Social Care Minimum Contribution to the BCF Template – 6th September • Informal Feedback received from ADASS/LGA Assurance – 13th September • Health and Wellbeing Board – 18th September • Submission to NHS England – 27th September • Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation - 30th October • Regionally moderated assurance outcomes to Better Care Support Team - 30th October • Cross regional calibration - 5th November • Assurance recommendations considered by Departments and NHS England - 15th November • Approval letters issued giving formal permission to spend (CCG minimum) week commencing 18th November • All Section 75 agreements to be signed and in place by 15th December
4. Recommendations	
4.1	That the Health and Wellbeing Board note the contents of the: (i) Documentation submitted to NHS England (NHSE) on 27th September 2019