Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Rotherham

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to): - Prevention and self-care - Promoting choice and independence	
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A new suite of Adult Care pathways will be implemented by the Council in Q3 of 2019/20. These pathways take into account whole system requirements to move to a position where elements of the system collaborate to fully explore the potential of individuals to become as independent as possible. The community support offer within the new model will be based on people being supported via their social, community and neighbourhood assets, through joint working with partners across Rotherham to allow people to access the support they need through a variety of more sustainable support networks. An extensive consultation exercise has been carried out over several months with key stakeholders/partners, with around 400 comments received to reshape the new pathways.

We fully recognise that individuals need to be at the centre of the new pathways with a stronger emphasis on encouraging and supporting people to self-manage their care. This means that people who have a care package will be re-abled so that their needs are decreased, resulting in either a reduced or no care package, an increased level of independence and an enhanced quality of life. This will also result in a stronger understanding of what care is currently being provided, with increased reviews and oversight, specifically with a recovery/reablement model that requires close working with providers and individuals. The aim of care and support should be for people to live the best life that they can, meaning living independently, in their own home when possible, utilising the assets and the people around them to do the things that make them happy and leading a fulfilled life.

Rotherham requires a new way of providing care and support to its people, placing the individual at the heart of decision making. The approach should fully utilise personal, social, neighbourhood and community assets, along with a transformed social care offer and this requires thinking differently about what people can do for themselves, ensuring that care and support is proportionate to need, with reablement being the focus at every step along the pathway and within every service. This will require partnering and collaboration with a wide range of key stakeholders including Public Health, Housing, CCG, Foundation Trusts and Mental Health Trusts, voluntary and independent sector to create more options for how care can be delivered through, for example, natural forms of support, universal services and community assets, as well as formal health and social care services.

The new pathways has been established to redesign the Rotherham arrangements for supporting a person's journey through adult social care, 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 DTOC rates.

4 key themes of the new pathways include:

1. Prevention – ensuring right information is available in all formats, that a range of options promote healthy lifestyles and increased use of digital channels.
2. Integration – future models for integrated health/social care teams, including hospital discharge team and mental health services, role and reconfiguration of intermediate care/reablement services, role of health and social care in relation to the development of the primary care networks (PCNs) and integration of systems, sharing of data, information governance, understanding our people and place and role of care homes.
3. Care co-ordination – across health and social care to resolve more issues at the first point of contact and ensure patients are effectively triaged to the right level of care, first time for effective admission avoidance and discharge and reduced reliance on primary and secondary services.
4. Maximising independence and reablement – includes development of a specialist integrated health and social care intermediate care/reablement/recovery service, Multi-Disciplinary Teams, trusted assessor working, development of core competencies to support generic cross health and social care roles, 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 utilising 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, thus increasing choice and control. 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 CHC and Decision Support Tool checklists, alternatives to standard service provision and greater use of assistive technology.

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

Commissioning high quality services that support the health and wellbeing of adults/older people is a key priority. This will only be achieved through the Council working in close partnership with Rotherham CCG to better identify and meet the needs of adults/older people; and to ensure that they are fully engaged in the commissioning process

Rotherham CCG has developed an IT strategy to ensure that the CCG and partners have the capabilities to fully support the delivery of key priorities identified within the CCG Commissioning Plan (2018-20) and also reflects the goal of the new national information framework to support the delivery of technology enabled, personalised care services. This remains the cornerstone of the CCG's strategic direction available at http://www.rotherhamccg.nhs.uk/our-plan.htm.

A new digital offer in Rotherham has been developed in 2019/20 which sets out a programme for transforming information for health and social care so that services could achieve higher quality care and improved outcomes for patients/customers. The commitment is to deliver improved digital access for people to healthcare services, their clinical records and other healthcare information and to improving the sharing of information between health and care professionals.
Rotherham CCG will ensure that patients/carers can participate as far as they want to in planning, managing and deciding about their care through extending the use of personal health budgets, promoting case management for people with long term conditions, continuing the voluntary sector commissioned social prescribing programme which is financed from the BCF, aiming to improve outcomes in terms of health, wellbeing, self-care, independence, Increase resilience of individuals and communities, support dependence to independence and reduce social isolation.
A new Rotherham Health and Wellbeing Strategy ("A Healthier Rotherham by 2025") sets out Rotherham's overarching vision to improve the health and well-being of its population, for people to continue to live fulfilling lives, actively engaged in their community and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board (HWB) 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 HWB supports collaboration and integration, has a role in breaking down barriers between agencies, focusing on getting the most out of the whole system, thus improving outcomes and reducing health inequalities. Work across the partnership to look at ways to improve/enhance the use of evidence-based programmes to reduce health inequalities, including: parenting programmes, sleep programmes, weaning, oral health programmes for both people living in the community and care homes and smoking cessation projects. The focus is on those children/young people who are most vulnerable: those who are looked after or on edge of care, adults with mental health conditions/physical/learning disabilities and those from the most deprived communities. BCF funded schemes contribute to reducing health inequalities through the provision of intermediate care/reablement type services, extension of social care prescribing service for people with mental health conditions, Community Occupational Therapy provides assessments for children/adults with complex needs, use of Assistive Technology/aids/adaptations which are accessible to all with a range of disabilities/health conditions. The Council also assists people from the most deprived communities to access support, including welfare benefit advice, through a number of voluntary sector organisations including Citizens Advice Bureau, Advice Centres, Age UK and Rotherham Ethnic Minority Alliance, which collaboratively work together as an "Advice in Rotherham Partnership" to deliver a "Single Advice Model" to help vulnerable residents. The BCF Plan contributes to priorities within the HWB Strategy: all people enjoy the best possible mental health and wellbeing, have a good quality of life, live well for longer and live in healthy, safe, resilient communities.
Rotherham ICP has formed a system wide steering group to examine the requirements for the development of a 'Rotherham Segmentation Tool'. Robust data is currently being collected across the partnership to support the development of the tool. Once achieved, analysis of the data will support how community provision identifies cohorts requiring care and support and deals with them in a multi-disciplinary approach.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

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The South Yorkshire and Bassetlaw Integrated Care System (ICS) is the local approach to delivering the national plan and sets out a vision of a better NHS, the steps we should take to get us there, and how everyone involved needs to work together. 25 health and care partners from across the region are involved in the ICS, along with Healthwatch and voluntary sector organisations. The ambition of the ICS is to enable everyone in South Yorkshire and Bassetlaw to have a great start in life, supporting them to stay healthy and to live longer. The plan is to invest in, reshape and strengthen primary and community services so that we can provide the support people in our communities need to be as mentally and physically well as possible. Mental health will be integral to our ambitions around improving population wellbeing.

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 around 263,000. We have now established a mature Integrated Care Partnership (ICP) which is responsible for the delivery of the Integrated Health and Social Care Place Plan (2018-20). This can be found at http://www.rotherhamccg.nhs.uk/rotherhams-place-plan.htm

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.

This details our joined up approach to delivering key initiatives that will help us achieve our Health and Wellbeing Strategic aims and meet the region's ICP objectives, Planning and delivery at an overarching ICP level must be co-ordinated with planning and delivery at a local (Rotherham) level, as they represent different elements of the same system.

Delivery of the Integrated Place Plan and CCG Commissioning Plan is underpinned and dependent on successful working with the Council, other key partners and stakeholders. There are great benefits from working in partnership, bringing together planning, funding and delivery of health and social care. We all aspire to reducing health inequalities and providing better care outside hospital. The CCG's Commissioning Plan aligns with the Joint Health and Wellbeing Strategy (2018-25) and the Integrated Place Plan (2017-19) and sets out, as a key partner, how we will support their delivery. The CCG, Council and NHS England work closely together to ensure that all commissioning plans are aligned so that together we deliver the maximum amount for each 'Rotherham pound'. This includes the System Wide Winter Plan developed annually.

The Rotherham ICP will focus on future models for integrated health and social care teams, including hospital discharge team and mental health services, future role and reconfiguration of intermediate care and reablement services across the Borough, the role of health and social care in relation to the development of the primary care networks (PCNs).

The Rotherham ICP will 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.

Rotherham partners view themselves collectively accountable for the health and wellbeing of our population and consider the Integrated Place Plan to be our framework for jointly providing acute, community and primary care services forming an integrated partnership. The governance arrangements support an Integrated Care Partnership arrangement, which enables us to design and deliver services to meet the needs of our population and improve health and wellbeing outcomes, within agreed budgets.

The Rotherham ICP works in partnership with the voluntary sector and the BCF currently funds the social prescribing programme which is an approach that links patients in primary care with non-medical support in the community. Rotherham currently has two social prescribing schemes in action, Long Term Conditions (LTC) and Mental Health (MH). The LTC social prescribing model 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. The MH scheme works with secondary care providers (Rotherham, Doncaster & South Humber NHS Foundation Trust) to help patients to discharge from statutory mental health 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, with Social prescribing initiatives featuring heavily in NHS national plans.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:

- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

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Rotherham Council is a Housing Authority, so we can confirm that the use of the DFG has been agreed with Housing Services. The Strategic Director of Adult Social Care, Housing and Public Health has been fully involved in the development and approval of the BCF plan for 2019/20 and is a member of the Health and Wellbeing 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. The DFG provides funding for the provision of aids/adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. Services work collaboratively together in responding to the Care Act requirements in order to prevent, reduce or delay care/support needs.

The DFG has provided funding for aids/adaptations for 252 people with physical disabilities, living in owner occupied, private and social tenancies in 2018/19, of which 60% were for people aged 65 years and over, 27% for people with physical disabilities and 13% for children. Grant approvals range from a minimum of £1,000 and a maximum of £32,552. The DFG also supports people being disharged from hospital with our indepenent sector housing contractors supplying minor fixings such as key safes, grab rails and stair-rails. The Housing Strategy (2019-21) aligns to the Integrated Place Plan and BCF Plan by supporting people to live at home for longer and has benefits for the individual's health, as well as a positive impact on health and social care budgets. Instead of providing everyone with the same service regardless of need, housing support or adaptations are tailored to the individual and used to empower people to make choices for themselves. Council owned stock is also ageing and it is essential that investment continues so that the Council is able to continue to provide good quality, safe and affordable homes in sustainable neighbourhoods that meet the needs of local people. As people's needs evolve, the Council will seek opportunities to make better use of its stock and consider conversions/adaptations to provide more suitable homes where appropriate.

The Council's Adaptations Policy aims to assist people in living independently through either the provision of equipment/adaptations in their current home or re-housing to a suitable property that meets their needs.

Telecare Project - The Council are currently working in partnership with an independent sector provider to implement and deliver an assistive technology pilot with a group of around 60 individuals. The DFG will fund the project costs which will be around £140,000 per annum. The pilot will test the concept of the benefits of this type of technology in achieving improved outcomes for older people, people with learning/physical/sensory disabilities, mental health and young people transitioning from young people's services and their carers, along with creating cost efficiencies by reducing demand and dependency on high cost services. This also forms part of our new intermediate/reablement offer by increasing opportunities for reabling individuals, supporting them to self-manage and to support unpaid carers and their families. This will include the use of SIM card, Amazon Alexa, sensors, video calling device and other add-ons eg epilepsy monitor.

Telehealth - NHS England has allocated a budget to spend on a pilot to introduce telehealth in two care homes in Rotherham. The aim is to keep people out of hospital and reduce the length of stay in hospital if a person was to be admitted. This is achieved through use of a kit/tablet in care homes that is linked to the GP surgery.

The IBCF funding is being used to employ a Programme Lead for Assistive Technology and Occupational Therapy for a one year period from 1.7.19. This post will develop an Assistive Technology strategy to enhance the local offer and better utilisation of technology solutions available to support people to remain independently in their own homes. They will also support the new Intermediate Care and Reablement offer to ensure effective therapy intervention across care pathways. The Programme Lead will conduct a performance review of the Community Occupational Therapy to ensure efficient and effective use of resources and to enable single handled care by establishing funding routes for specialist pieces of activities of daily living (ADL) equipment.

The contract for the Home Improvement Agency service has been extended for a 1 year period to support around 800 people living in poor/unsuitable housing and provide a point of contact to older, disabled and/or vulnerable to promote independent living and enable them to remain in their homes in greater comfort, security, safety and warmth. The service aims are to prevent homelessness, social exclusion, preventing falls and admissions to hospital.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	
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The BCF is closely aligned to the Integrated Care Partnership's Integrated Health and Social Care Place Plan and also closely links with the Health and Wellbeing Strategy, CCG Commissioning Plan and Housing Strategy. These all 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, public health, housing, community health services and the voluntary and community sector. Rotherham CCG will further expand community based services, reducing reliance on the acute sector. The CCG 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. The CCG and Council will ensure that there is 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. The CCG will ensure that the appropriate care pathway is selected to support both the patients' physical and mental health.

The Rotherham BCF Plan and the Integrated Health and Social Care Place Plan are consistent with the aims of the NHS Long Term Plan (2019) which emphasises the need to develop new care models to support integration and to provide enhanced health care in care homes to improve quality of life of residents. A central theme of our plan is the further development of integrated service models, integrated point of contact, rapid response, discharge service, localities, development of a reablement and intermediate care offer and co-ordinated approach to care home support.

Rotherham has a strong record of joint commissioning between health and social care. The CCG 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.

There are great benefits from working in partnership with partners and stakeholders, bringing together planning, funding and delivery of health and social care so that we can together deliver the maximum amount for each 'Rotherham pound'.

The BCF Section 75 Agreement for 2019/20 is on the agenda for future approval by the Health and Wellbeing Board (HWB) which consists of Elected Members, Chief Executive, Chief Operating Officer and Directors from CCG and the Council, NHS England, GP's, Voluntary Action Rotherham (VAR), Healthwatch. The key responsibilities of this group include:

- Monitor performance against BCF Metrics and receive exception reports on the BCF action plan
- Agree the BCF Commissioning Plan/Strategies
- Agree decisions on commissioning/decommissioning of services

The BCF Executive Group consisting of Chief Executives, Elected Members, Chief Finance Officers, Directors from both the Local Authority and the CCG. Key responsibilities include;

- Agree strategic vision and priorities
- Make decisions relating to the delivery of the plan
- Monitor delivery of the BCF Plan
- Ensure performance targets are met
- Ensure schemes are being delivered and actions put in place where the plan results in any unintended consequences.
- Report directly to the HWB on a quarterly basis.

The BCF Executive Group is supported by the BCF Operational Group. The Operational group is made up of 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 need

A financial governance process is in place and the financial monitoring and performance information is to be provided at 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 through a Section 75 pooled budget agreement.

Since the publication of Rotherham's BCF Plan for 2017/19, the following has been achieved:

- Implementation of a new build Integrated Urgent and Emergency Care Centre (UECC) to ensure that patients with urgent and emergency needs get the right treatment at the right time, in the right place, thus reducing hospital admissions.
- Integrated Discharge Team is fully embedded in the Rotherham system and is driving down DTOC levels through a single referral route for complex patients. The team consists of nursing, therapists and social care practitioners to ensure a holistic approach to complex discharges. The monitoring of DTOCs now forms part of a system escalation processes.
- Trusted Assessor model has been introduced in UECC to support admission avoidance to hospital and to facilitate early discharge from hospital.
- 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, to ensure that the service is modernised, fit for purpose and promotes value for money. This is now delivered by a 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 during an acute episode or be discharged home from an acute setting.
- 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 by developing stronger connections between health and social care e.g. high intensive users, Multi-Disciplinary Team and case management reviews.
- Development of the Council's First Point of Contact team to promote independence through prevention and early intervention. The Council have re-allocated resource to invest in developing expert non-qualified assessment officers, supported by robust access to qualified staff at the front door to resolve more issues at the initial point of contact. This includes the secondment of an OT and pilots with specialist physical, mental health, reablement, safeguarding and community sector workers.

There are further changes planned in 2019/20 due to the establishment of new adult care pathways, with the development of the “First Point of Contact” team. 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. The new adult care pathways will ensure that this team enhances the intermediate care and reablement team in Q3 of 2019/20, with re-alignment with the in-house reablement team.

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/service user outcomes.

• 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 customers/patients 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.