BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Rotherham Health and Wellbeing Board

Health and Wellbeing Board(s)

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

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 267,000. With a mature Integrated Care System (ICS) in Place responsible for the delivery of the Integrated Health and Social Care Place Plan (2020-21).

Our Better Care Fund (including IBCF) provides a substantial funding stream to some of our key priority workstreams within Urgent and Community Transformation.

The governance arrangements through our ICS ensure that all partners across NHS Trust, Social Care, Mental Health, Primary, Independent and the Voluntary and Community Sector are engaged, with several task and finish groups in place under an overarching operational and executive meeting structure.

Outcomes for our population are jointly agreed and we are committed to a whole system partnership approach. The CCG's Commissioning Plan aligns with the Joint Health and Wellbeing Strategy (2018-25) and the Integrated Place Plan 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, within an identified Place fund of c600K to spend on winter pressures across partners.

How have you gone about involving these stakeholders?

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

In the refreshed Rotherham Place Reset Plan the following were identified as priority areas for Urgent and Community transformation group (aligned to BCF and Aging Well funding streams): Workstream 1: Prevention and Urgent Response -1. Front Door (priority 1) 2. Urgent Response Standards (priority 2) 3. Prevention and anticipatory care in localities: long term conditions and unplanned (priority 3). Workstream 2: Integrating a sustainable discharge to assess model (priority 4). Workstream 3: Enhanced Health in Care Homes (priority 5). These priorities include key actions such as: further development of our local Clinical Assessment Service (CAS) working with 111 and 999 to ensure urgent services are effectively managed through the Directory of Services (DOS) to reduce unnecessary conveyances to hospital and avoidable admissions. To pilot an integrated community hub for the triage of complex urgent and intermediate care and reablement this includes the co-location of social care reablement staff within Woodside (health building). After the implementation of the Integrated Intermediate care and reablement pathway in 2019-21 we have developed integrated service specs with KPIs/outcomes across the system, which will be signed off in year. We also want to develop further and embed the urgent 2 hour and reablement 2 day urgent standard and mandatory reporting. Although we have had an Integrated Discharge Team in place for a number of years due to Covid the guidance has changed to a same day discharge and we want to review our processes to remove any barriers, developing a business case for a sustainable model with the right workforce to meet demand. We will also seek approval and implementation of a discharge to assess community unit with nursing. Finally we have a number of key actions across the Enhanced Health in Care Homes/High Impact Change Model which include; Integrating MDTs: review of referral routes and signposting for residents and families, review of physical and mental health care homes team, Development of the Rotherham Health Record for Care Homes (following 4 milestones) - Care home view of existing information for health and social care practitioners/Expansion of information for health and social care practitioners/Pilot and roll out of care home view to care homes/Pilot and roll out electronic information capture by care homes to feed the Rotherham Health Record (RHR) care home view. We have a jointly commissioned Home Care service detailed through the Section 75 and part funded within the BCF, however, we want to align our commissioning of Care Homes across Health and Social Care (joint contracting/specifications). The key changes since the last BCF is further integration of community services including enhanced MDT working, training of Reablement staff to deliver Therapy plans, jointly commissioned Home Care provision including night visiting services, increase in providers on the framework to support demand, remote monitoring pilot in care homes established, ECHO e-learning platform in place for End of Life Care and other health related topics, new model for Intermediate Care (bed base reconfigured), increased the spend on the COT provision in year to support the demand profile, increased resources across Reablement, Rapid Response to support community services (hospital avoidance/effective discharge), funded brokerage to provide support over the weekend to facilitate hospital discharges

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

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 Better Care Fund Section 75 Agreement for 2021/22 will be approved by the Health and Wellbeing Board 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 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

The BCF Executive Group consisting 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.

The BCF Executive Group is supported by the BCF Operational Group which meets on a quarterly basis. 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 need

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, through the 2021-22 Section 75 agreement.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Please see Executive Summary for detail of our key priorities (joint) for 2021-22 and changes to approach. A new Adult Social Care Pathway was implemented by the Council 2019/20 which takes 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. We fully recognise that individuals need to be at the centre of the new care pathway, who need to self-manage their care, unless their requirements exceed the threshold. This means that people who have a care package will be re-enabled so that their needs are decreased, resulting in either a reduced or no care package, an increased level of independence and enhanced quality of life, that is healthier and more fulfilling for the individual. This will also result in a stronger understanding of what care is currently being provided and whether or not it is the most appropriate, with increased reviews and oversight, specifically with a recovery model that requires close working with the provider 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. This has required a strengthening of partnerships and collaboration with a wide range of key stakeholders including Public Health, Housing, CCG, Foundation Trusts and Mental Health Trusts, voluntary, community 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 four key themes of the new operating model are as follows:

1. Prevention 2 Integration 3. Care co-ordination 4. Maximising independence and reablement.

The Council along with partners are focusing on 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. With a 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,

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

BCF funding contributes to our Integrated Discharge Team (IDT) – funding posts such as the joint manager across health and social care and the capacity manager in The Rotherham Foundation Trust (TRFT) who provides our daily oversight across Place and escalation levels (Opel). Our discharge home is consistently higher than the national target at c.95% and our Length of Stay (LOS) has been one of the best in South Yorkshire and Bassetlaw (SYB) consistently for many months, although recent challenges due to continuing Covid pressures has increased our LOS slightly. We were asked this summer to present to NHSE Regional colleagues our integrated approach to discharges due to the recognition of our performance including weekend discharge rates. We have a joint approach to discharge planning. From a strategic perspective it is one of the 3 portfolio projects within our integrated Place Urgent and Community Transformation Programme. The Place Discharge Executive lead is the TRFT Head of Operations and TRFT Deputy Chief Operating Officer (COO). Discharge plans are co-developed with all Place partners and assured via the Place governance structure including an Executive Lead group comprising the Trust's Deputy Chief Executive, Deputy CCO and Community Division General Manager. Cross system working is well embedded in IDT, with at least twice daily MDT (including community/reablement), twice weekly LOS MDT and reviews of stranded patients based on the ECIST model. We have increased our capacity within IDT and ensure cover over weekends with an 8am-8pm approach in place. There is a Discharge Doctor on site to support weekends. We have also increased capacity within community services to ensure 7 day discharges are facilitated 8am to 8pm including increasing transport availability (week days/weekends to meet peak times in demand) and 7 day equipment access. However, there is some performance variation and seasonal spikes through the year. In order to embed the changes made and to meet the new national discharge guidance we have, in collaboration with Attain, reviewed the discharge processes and pathways including our community bed base facilities, culminating in a Discharge Action Plan that is currently being implemented. Our new model of an integrated intermediate care, reablement/recovery pathway is well established which supports effective patient flow. Our processes start with early discharge planning and management of patient transfers, through to community beds with additional discharge co-ordinators appointed across acute/community beds. We want to ensure patients receive right level of care and that processes are streamlined to speed up transfers and reduce duplication and gaps resulting from previous siloed working. Our community unit with nursing/therapy has recently been retendered to better meet the changing complex needs of our population. The BCF funds a number of community services across health and social care including Reablement/Urgent Response. These services have seen an increase in resources in 2021-22 to provide sufficient capacity to meet the demand (increasing no. of complex cases requiring additional support). We have also increased the number of providers on our jointly commissioned home care framework to support the demands on the care sector and are looking to employ a locum therapist to work in COT service to support the review of care packages, freeing capacity to provide better flow from the Acute Trust. Additional reablement co-ordinator/support workers in ASC will increase capacity to deliver both discharge/admission avoidance. The brokerage function has also been increased to cover weekends

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Strategic Director for Adult Social Care, Housing and Public Health is fully engaged in the planning and approval process for the BCF 2021-22 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 Disabled Facilities Grant (DFG) provides funding for the provision of aids and adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. Social Care and Housing Services work collaboratively together in responding to the Care Act (2014) requirements in order to prevent, reduce or delay care and support needs.

The DFG has provided funding for aids and adaptations for older people, people with physical disabilities and care needs, children and those living in owner occupied, private and social tenancies in 2020/21. Grant approvals range from a minimum of £1,000 and a maximum of £32,552.

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 and 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 and/or adaptations in their current home or re-housing to a suitable property that meets their needs. The IBCF currently funds a project lead for Assistive Technology and Community Occupational Therapy (COT). This post is currently working with Adult Social Care (ASC) colleagues to embed the COT provision (we are funding a further 1fte COT to support the increasing caseload of the service) within ASC to support the prevent, reduce and delay agenda. The post is also supporting ASC to better utilise care technology. There is a wide range of Technology Enabled Care equipment in use including exit sensors, GPS trackers and pre-set reminders enabling people with memory difficulties to remain safe and live their lives well, as well as several falls detection options. Robotic pets are also proving successful in reducing anxiety, purposeful walking and challenging behaviours. There is also a Remote Monitoring Pilot in operation to March 2022 with Care Homes around vital signs. The aim is to keep people out of hospital and reduce the length of stay in hospital if a person was to be admitted.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

There is a recognition at SYB and Place that Health Inequalities (HI) is integral to everything. Rotherham is working across Place and ICS partners to share knowledge and develop our capabilities in understanding HI and Population Health Management (PHM). We are working to develop a Rotherham Office of Data Analytics (RODA) as a Place wide capability in analysing and interpreting PHM and HI data, supporting the Place wide HI and Prevention Group work programme. We are anticipating that RODA will generate insight into areas such as the inclusive restoration of services and population segmentation. Rotherham is actively engaged in the SYB PHM work programme to develop insight into SYB communities and share best practice. Our Prevention and HI Group provides a multi-agency approach and formulates/leads on actions on tackling health inequalities by looking at the whole population and individual person. It focuses on helping people to get the best start in life, reduce harm from smoking, alcohol, obesity, improving cardio-respiratory health, mental health/well-being and early diagnosis and survival of cancer. The group includes the Director of Public Health, Commissioning, Public Health, CCG, GP Federation, Medicine Management, Intelligence, TRFT, Mental Health Trusts and Voluntary Action Rotherham (VAR). BCF funded schemes includes the Social Prescribing programme which provides interventions on tobacco, weight, alcohol, physical activity, obesity reduction, smoking cessation and diabetes prevention programmes. Breathing Space is also delivering respiratory services within the Right Care pathway. There are projects underway, focused on Frailty and Anticipatory Care including the use of external support to agree a capacity/demand modelling tool for community services (including urgent response 2 hour and 2 day reablement). We have also started to focus on the impact of the pandemic and taking a population approach to meeting those needs and preventing further demand. This includes our resource funded through BCF and working with partners to review/audit access to acute care for those with long Covid. As we are seeing both physical and mental health need rising, it is deemed timely to deliver a focused piece of work. This will include looking at risk factor prevalence, with a focus on cardio-vascular disease, diabetes, mental health. There will be a long stay audit taking place that looks at factors effecting long length of stay, establishing the facts about population, analysis of pre and post pandemic and targeted population including co-morbidities. We are also working on our Anticipatory Care model, the national ask is for systems to provide proactive health and care interventions for all ages. To be targeted at frailty, multiple morbidity and/or complex needs for people living in their own homes. The focus is on what is important to individuals and it is delivered and co-ordinated through cross system MDT working. We have allocated funding in year to scope the development, which will use population health and local data to identify those at risk by PCN/Offer, carry out a proactive needs assessment with individuals, provide personalised care and support planning based on a 'what matters to me conversation' and establish a digital MDT to agree what interventions the person needs