BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

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.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

Rotherham Health and Wellbeing Board

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

At a local level Rotherham Place has been working in a collaborative way for several years to transform the way it cares for its population of around 265,800 [Census 2021]. The Rotherham Place Partnership [formerly the Integrated Care Partnership (ICP)] has been in place since 2018 and is responsible for the delivery of the Integrated Health and Social Care Plan and Better Care Fund Plan (2022/23). The Rotherham Place activity is also aligned to our newly formed NHS South Yorkshire Integrated Care Board (SY ICB) including ensuring governance processes support decision making at Place and at SY ICB (where appropriate).

The Rotherham Better Care Fund (including IBCF) continues to provide a substantial funding stream to some of our key priority workstreams within Urgent and Community Transformation, surge and winter planning and is aligned to other funding streams such as Ageing Well. The Plan also supports elements of the Health and Wellbeing Strategy (A Healthier Rotherham by 2025) including commitments to support unpaid carers, people with autism and learning disabilities and to tackle health inequalities.

The governance arrangements through Rotherham Place ensure that all partners across NHS Trust, Social Care, Housing / DFG Leads, Mental Health, Public Health, Primary, Independent and the Voluntary and Community Sector are engaged in the development of the Place Plan and BCF Plan, with several task and finish groups in place under an overarching operational and executive meeting structure.

Outcomes for the Rotherham population are jointly agreed and all partners are committed to a whole system partnership approach. The SY ICB Commissioning Plan aligns with the Joint Health and Wellbeing Strategy (A Healthier Rotherham by 2025) and the Integrated Place Plan and sets out, as a key partner, how we will support their delivery.

The Council, South Yorkshire ICB and NHS England work closely together to ensure that all commissioning plans (including the BCF Plan) 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 c£500K to spend on winter pressures across partners.

How have you gone about involving these stakeholders?

The Directorate Leadership Team of the Council and Place Executive Team have been involved in the development of a BCF Plan 2022/23 including commissioning, adult care and integration, public health, housing, finance, performance and intelligence and legal services. The BCF Operational and Executive members have also been fully consulted in the BCF planning process as well as members of the Health and Wellbeing Board (HWB). The HWB consists of Elected Members, Chief Executive, Chief Officers and Directors from the Council, South Yorkshire ICB and The Rotherham Foundation Trust (TRFT), Housing, Public Health, Safeguarding, NHS England, GP's, South Yorkshire Police, Voluntary Action Rotherham (VAR) and Healthwatch. Age UK Rotherham, community health services, in-house and independent sector care home providers have also been involved in the BCF planning process.

Executive Summary

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Key Priorities for 2022-23

The Rotherham Place Partnership: Health and Social Care Place Plan delivers a set of 'place' key priorities, which are aligned to the Health and Wellbeing Strategy which aims to transform mental health, learning disability, urgent care and community care services.

Prevention, early intervention and the integration of health and social care services are the focus of the Place Plan and Better Care Fund Plan, to transform the way services are delivered. These Plans in Rotherham have increased community care over recent years to improve better outcomes, improve flow through the system and reduce inefficiencies. Health and social care transformation programmes include developing alternatives to entering services or hospital admission and facilitating discharge. The Place Plan and Better Care Fund Plan provide an opportunity to build on this to take a more holistic and integrated approach across physical and mental health, social care and the voluntary and community sector to develop and embed an integrated model of care. This model supports individuals and their carers and focuses much more on prevention. Narrowing inequalities and targeting resources towards areas of greatest need is a principle of the Health and Wellbeing Strategy.

The Population Health Management (PHM) is currently defining a cohort to focus on and designing a PHM intervention that is person centred, considering what is important to that cohort and how better outcomes can be achieved, in comparison to the wider population. Key forums have been established such as Rotherham Office of Data Analytics (RODA) steering group and ICS discussion group to ensure strong likes across the Place and the ICS to support the PHM approach.

The workstreams of the Urgent and Community transformation group (aligned to BCF and Ageing Well funding streams and Rotherham's Prevention and Health Inequalities strategy) are as follows:

Workstream 1: Sustaining People at Home

The aim of this workstream is to develop an integrated health and social care Multi-Disciplinary Team (MDT) tiered level of care model which supports more people to remain/return to living in their own home as independently as possible and for as long as possible. Projects include:

1. Development of a prevention and anticipatory care model in localities to support those with long term conditions and unplanned exacerbations aligned to Ageing Well priorities

2. Development of a frailty and acute respiratory virtual ward for those who would otherwise be in an acute bed, supported by remote monitoring technology

3. Development of our urgent community response, growing referral numbers and ensuring a minimum 2 hour response at least 70% of the time

4. Developing alternative pathways to conveyance to and admission from our emergency department

Workstream 2: Integrating a Sustainable Discharge to Assess Model (Priority 4)

This builds on the Discharge to Assess model implemented during Covid. The aim is to target specific barriers to effective discharge, including those highlighted in the 100 day challenge, and enhance integrated working across acute and community health and social care. Planned activity includes

1. Targeted acute ward by ward activity to reduce numbers of people with no right to reside and long length of stay including pilots of criteria led discharge, a reduction in TTO errors and duplication and increased usage of the discharge lounge
2. MDT working to improve patient outcomes and streamline discharge planning and reduce length of stay across our community bed base
3. Streamlining our integrated discharge team processes and systems and clarification of roles and responsibilities particularly in relation to weekend working

Workstream 3: Enhanced Health in Care Homes (Priority 5)

1. Developing and embedding the care home offer for the above projects to ensure equity of provision. Activity includes developing our care home pathways to reduce avoidable conveyances and admissions
2. Improving MDT working including GP led MDTs and access to specialist services
3. Developing use of technology including remote monitoring and a shared care record
4. A jointly commissioned approach to standardising and streamlining care home specifications

Key Changes since Previous BCF Plan (2021/22)

The BCF Plan also reflects the wider priorities within the Place Plan through supporting the transformation of mental health, learning disability, urgent care and community care services.

The key changes since the last BCF plan are as follows:

- 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 and Integrated Rapid Response to support community services (hospital avoidance/effective discharge)
- Funded brokerage to provide support over the weekend to facilitate hospital discharges.
- Recruited Public Health Specialist (and admin. support) for the programme management of the Prevention and Health Inequalities Strategy.
- A programme of training sessions to support people with dementia and their unpaid carers
- New service specifications to reflect the ideas and learnings from the market engagement exercise to improve residential, community and housing support for people with mental health and / or learning disabilities.

All these schemes mentioned above are BCF funded.

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. This is underpinned by 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 2022/23 will be approved by the Health and Wellbeing Board which consists of Elected Members, Chief Executive, Chief Officers and Directors from South Yorkshire ICB 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 South Yorkshire Integrated Care Board.

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 South Yorkshire ICB.

- 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 Section 75 agreement for 2022-22.

Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

Joint Priorities for 2022-23

Please see Executive Summary for detail of our joint key priorities for 2022-23 and changes to our approach in supporting the transformation of mental health, learning disability, urgent care and community care services.

Approaches to Joint / Collaborative Commissioning

RMBC and SY ICB have a proven track record of successful joint / collaborative commissioning which is managed by the BCF Executive Group which act as a key decision-making forum on areas of common interest and joint priorities across the health and social care community. There is a joint performance management framework in place which includes the monitoring of BCF funded schemes, development of pooled budget arrangements for integrated services, supporting the development of joint strategies and service reviews, facilitating stakeholder engagement and incorporating the views of service users, carers and service providers.

The Adult Social Care Pathway already includes whole system requirements to 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 Adult Care target operating model is based on people being supported via their social, community, housing, 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.

Rotherham Place fully recognise that individuals need to be at the centre of the adult social 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 has also resulted in a stronger understanding of what care is currently being provided and whether or not this is the most appropriate, with increased reviews and oversight, specifically with a recovery model that requires close working with the provider and individuals.

An initiative that the Place is looking at currently is to further develop our proportionate care approach, recognising the challenges with workforce across the social care sector, particularly home care. Single Handed or Proportionate Care is an ethos which asks if the person's needs can be met by one carer. With use of specific equipment, adaptations and techniques it is usually possible to enable someone to maintain their dignity and reduce their need for formal care. The benefit to the person and across the systems are being increasingly recognised across stakeholder groups. These benefits include a more strength based, person centred approach, recognised the least intrusive options for care, and improved relationships with the individual, carer and family. It

also supports the national shortage of care hours available within the system and can release some funding to reinvest in essential care.

Funding has been approved to provide specialist training to colleagues across the Reablement pathway including Occupational Therapists, Reablement Coordinators and Trainers from the Care Provider network. The Council and South Yorkshire ICB Commissioning are working collaboratively together to increase the range and availability of equipment available to support this approach. The aim of care and support is 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, DFG Leads, South Yorkshire ICB, 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 Adult Social Care operating model are as follows:

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

The Integrated Discharge Team are undertaking a review to ensure that the ways of working in the team fully support the updated national discharge guidance and make best use of the MDT staff resource, reduce duplication and improve the persons discharge experience. The Council remains committed to a seven day week service, recognising the pressures faced by the acute trusts.

The Reablement Service have a new registered manager and are reviewing rotas and IT solutions to improve efficiencies and increase face to face time to support more people to be optimised across adult social care and support increased independence. The ability to reable more people as soon as possible is a core commitment to improve outcomes for greater independence for individuals and to ensure that social care provision, which is increasingly harder to source is challenged to those who need it most.

The Reablement Service are working closely with the Integrated Rapid Response Service and are working on system integration to support case management. Once this is in place, then they will be co-locating with health colleagues to support more integrated working during 2022/3. The Place system is exploring posts to work across both services on a generic job description. Recruitment is also being looked at due to recruitment challenges, along with looking at apprenticeship opportunities. This recognises that currently the pull of the NHS is greater than social care and aims to address issues with recruitment and on-going vacancies.

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

The Council, along with partners, are continuing to focus on a strengths-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.

There are some good examples of the use of the BCF as a pooled budget to support our approach to hybrid roles as a means of mitigating workforce challenges. For example, we have joint roles employed by The Rotherham Foundation Trust that work into the Council supporting both Health and Social Care (and vice a versa) in areas such as discharge, capacity management and transformation / integration of services through the Urgent and Community Transformation workstream.

The Place system is working across health and social care to recruit roles that are able to deliver across the pathway into urgent response and reablement / intermediate care as demand arising and to support where there are market challenges across the borough for care and support at home.

Implementing the BCF Policy Objectives (national condition four)

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

The BCF funding enables people to stay well, safe and independent at home for longer and provides the right care in the right place at the right time. The BCF funded services will support delivery of these objectives

The aim of care and support is 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 and provide personalised care and support planning based on a 'what matters to me' conversation.

The utilisation of the Better Care Fund 2022/23 is based on the experiences, values and needs of our service users, patients and carers. To demontrate the outcomes local people want from better integrated, person centred services, a number of “I statements” based on their testimonies have been defined. The ambition is for provider responses to be captured in the form of “We” statements and

linked to the Provider Assessment and Market Management Solution (PAMMS) during regular contract monitoring returns. The Rotherham Health and Wellbeing Boardholds the responsibility for the Better Care Fund plan and will work towards achieving these outcomes:

'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 wellbeing.

'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.

'I feel safe and am able to live independently where I choose' - People want to stay independent and in their own homes 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.

To demontrate the outcomes of a better integrated, person centred services, a number of "We statements" include:

'We have conversations with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments".

"We work with people to make sure that their personal plans promote wellbeing and enable them to be as independent as possible".

"We make sure people feel safe and comfortable in their own home, which is accessible, with appropriate aids, adaptations, technology and medical equipment".

Work has been ongoing in 2021/22 in relation to the Provider Assessment and Market Management Solution (PAMMS) which is an on-line commissioning toolkit to support market shaping and oversight responsibilities and assesses the quality of care delivered by providers. This will ensure better data collection, analysis and reporting to increase care quality and mitigate risks of provider failure. CQC registered adult social care providers will be completing their Quality Assurance self-assessments during 2022/23.

The RMBC Insight system also provides a wealth of "live" performance data in how many individuals are being supported by adult social care commissoined services.

BCF funding contributes to the Rotherham 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 daily oversight across Place and escalation levels (Opel).

The Rotherham pathway for discharge home is in line with the national target at c.95% and, although the Length of Stay (LOS) has fluctuated recently due to challenges with Covid pressures, the Place have maintained a reasonable level of performance.

There is a joint approach to discharge planning within Rotherham. The Place system have recently self-assessed against the 100 day challenge and have incorporated actions from this self-assessment to our ongoing discharge workstream across Place.

The initial self-assessment against the High Impact Change Model led to the establishment of the Rotherham integrated health and social care discharge team and a range of process and system service improvements. The Place is now in the process of reviewing the Discharge to Assess (D2A) model post Covid including carrying out a self-assessment against the revised 2019 model. Significant progress has been made against 7 of the 9 domains with further work planned and are active in all 9.

Significant progress has been made in relation to:

Capacity and Demand: The Rotherham Place has developed an acute clinical command centre which provides full visibility of patient flow, in real time, to, through and out of the acute hospital and into the community setting to enable effective decision making at strategic, operational and patient level. This work has been short-listed for a Health Service Journal award in 2022. The escalation wheel is currently being developed to reflect community services. A daily report circulated to all partners shows OPEL levels of escalation. In parallel the Place has developed a capacity and demand tool for discharge pathways and have a mature escalation ladder.

MDT Working - The Rotherham Integrated Discharge Team (IDT) has a blend of nursing and social care staff who work closely with therapists, community rapid response services and continuing health care. There is a well-established contract with Age UK for hospital after care support and have recently set up a pilot with a Voluntary and Community Services (VCS) social prescriber link worker who in- reaches into the emergency department for admission avoidance and facilitates discharge. The next phase is to set up an integrated community hub which will in reach into IDT to support more people home.

Home First /D2A model – The Rotherham integrated discharge model provided a strong foundation to implement the national D2A model at the start of Covid. Discharge pathways were aligned and therapy and Continuing Health Care (CHC) staff were seconded into the team during Covid to enable all assessments to be carried out in the community which remains standard practice unless there is benefit to conducting assessment in hospital to ensure the correct pathway is followed. Age UK provided a safety netting service with follow up calls for all pathway 0 patients discharged from hospital during Covid. If the patient or family did not respond this was followed up with a home visit. This work was aligned to the Age UK hospital after care service.

Flexible Working - Within Rotherham there is a 7 day discharge service which includes the integrated discharge team, brokerage and dispensing. However, issues remain particularly in relation to the ability of care homes and home care to accept discharges over the weekend. Commissioners are working with providers to address this. Where discharges cannot be completed over the weekend, arrangements are planned through the weekend for early discharge Monday morning.

Trusted Assessments - IDT allocate the most appropriate worker to co-ordinate the discharge of a patient according to their needs and there are elements of trusted assessment in place to support effective flow through MDT working. However, more can be done and Commissioners have initiated

a conversation with care home providers to discuss developing a trusted assessor role for discharge to care homes.

Choice - The Deputy Chief Nurse has carried out extensive work to improve communication and engagement with patients and their supporters. This includes banner stands on wards and an information pack for each bedside. In preparation to the end of Scheme 2 funding, the Place system has reviewed all discharge communications including those for self-funding patients. New information leaflets are under development for our commissioned community beds. The Place system is developing pilots across 4 wards to review how discharge planning is carried out including criteria led discharge. This work will include ensuring patient and family are fully engaged in the process.

Discharge to Care Homes - Rotherham has carried out 2 self-assessments against the enhanced health in care homes framework which is one of our key urgent and community Place priorities. Each care home has an allocated GP. Commissioners are working with GP practitioners to develop a proportionate continuum of care appropriate to the needs of the individual. The physical and mental health care homes teams provide proactive support and training. The teams worked closely with Public Health and Commissioners throughout Covid to ensure Care Homes were up to speed and supported with all aspects relating to infection control, provision of PPE and regulatory requirements as well as allocation of additional monies.

Domains identified as requiring additional development include:

Early discharge planning in line with the 100 day challenge work is planned to ensure a mandatory discharge date is set for all patients within 48 hours (the Rotherham Place currently have c 80% uptake) and for complex discharge planning to begin earlier.

Housing - Discussions are underway to more proactively engage housing services in discharge planning at an earlier stage including submitting daily data to our capacity dashboard and attendance at MDTs. The Council is developing an Assistive Technology strategy to provide alternatives to care

From a strategic perspective Discharge Planning is one of the 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.

The Rotherham Place system is in the process of revising governance arrangements and aligning them to the SY ICB Urgent and Emergency Care Alliance Board. The previously known A&E Delivery Board will merge with the Urgent and Community Transformation Group to become the Rotherham Urgent and Emergency Care Group and will cover both performance and transformation.

Cross system working is well embedded in IDT, with at least twice daily MDT (including community / reablement), twice weekly Length of Stay (LoS) MDT and reviews of stranded patients based on the Emergency Care Improvement Support Team (ECIST) model.

The Rotherham Place has increased capacity within IDT and ensure cover over weekends with an 8.00 am to 8.00 pm approach in place. There is a Discharge Doctor on site to support weekends.

Capacity has been increased within community services to ensure 7 day discharges are facilitated 8.00 am to 8.00 pm 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.

To embed the changes made and to meet the new national discharge guidance the Place system has reviewed the discharge processes and pathways including the community bed base facilities, culminating in a Discharge Action Plan that is currently being implemented. This includes targeted activity with wards to improve flow of pathway 0 patients and between acute, community and the integrated discharge team for pathway 1 and 2 patients. There is a specific focus on early discharge planning particularly to address complexity in a timely way.

The Rotherham model of an integrated intermediate care, reablement / recovery pathway is well established which supports effective patient flow. 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.

The Rotherham Place system wants 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.

The community unit with nursing / therapy has 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 Intermediate Care, Reablement and Urgent Response.
The integrated intermediate care offer delivers better outcomes which also includes collaborative integrated commissioning between adult social care and South Yorkshire ICB to support this. Integrated commissioning of discharge services will continue to support safe and timely discharge and continue to embed a home first approach so that people are discharged to their usual place of residence with appropriate support This includes primary, community and social care services are being delivered to support people to remain at home or return home following an episode of inpatient hospital care

These services have seen an increase in resources to provide sufficient capacity to meet the demand (increasing no. of complex cases requiring additional support). The Council have also increased the number of providers on the jointly commissioned home care framework (home first) 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 hospital.

Additional reablement co-ordinator / support workers in adult social care will increase capacity to deliver both discharge/admission avoidance.

The brokerage function has also been increased to cover weekends to support hospital discharges.

The above BCF funded services improves the discharge process from hospital and ensures that people get the right care at the right time.
.
Rotherham is working across Place and ICS partners to share knowledge and develop our capabilities in understanding and addressing Health Inequalities and Population Health Management (PHM).

Place partners meet monthly as a Prevention and Health Inequalities Enabler Group, chaired by the Director of Public Health. This group leads the multi-agency approach to address Prevention and

Health Inequalities across Rotherham, linking to the wider South Yorkshire system. This has included developing Rotherham's partnership strategy and plan around prevention and tackling health inequalities, looking at the whole population and the individual.

This Enabler group is supported by a data sub-group which meet to establish a network across Place to share knowledge and learning in relation to Health Inequalities Data. This group has considered a wide range of intelligence by aspects of inequality including urgent care frequent attenders, waiting list recovery, deprivation by geography and disease prevalence.

The Rotherham Place system is working to develop a Rotherham Office of Data Analytics (RODA) as a Place wide capability in analysing and interpreting Public Health Management and Health Inequality data, supporting the Place wide Health Inequality and Prevention Group work programme. It is anticipated that RODA will generate insight into areas such as the inclusive restoration of services and population segmentation. Rotherham is actively engaged in the South Yorkshire PHM work programme to develop insight into South Yorkshire communities and share best practice. Rotherham is also actively working with Sheffield University to consider how to gain better insight into PHM.

Rotherham has strongly engaged in the national Place Development Programme co-sponsored by NHS England and the Local Government Association. As part of this programme the Place have undertaken a series of externally facilitated Action Learning Sets, to test out a PHM approach. This programme has generated a wide range of quantitative and qualitative knowledge and insight on Health Inequalities, acting as a foundation for a work programme to address these.

The Place system has 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 resources funded through BCF and working with partners to review/audit access to acute care for those with long Covid. Physical and mental health needs are rising, it is 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.

The Rotherham Place is 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. The Rotherham Place has 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

Supporting Unpaid Carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Rotherham Health and Wellbeing Board's (HWB) vision is for Rotherham to be a carer friendly Borough. There are around 30,000 informal carers providing unpaid care in Rotherham. The Carers Strategy – *The Borough That Cares* has been co-produced with carers, carers organisations, colleagues across the Council, Health and the voluntary sector and has been signed off by the HWB. This is 'live' document which will be updated on an ongoing basis to reflect required actions and activity. The carers voice is embedded throughout the framework.

The Strategic Framework (2022-25) sets out a vision for working with and supporting carers, it also provides an action focused road map for how the Rotherham Place will achieve this change directly with carers. Over the next three years, the Place system will work to deliver the actions, and will continue to put carers at the heart of this process through their direct involvement in *The Borough That Cares* Strategic Group.

The purpose of the strategic framework is to ensure carers can live well, be active and have fulfilled lives. It recognises that carrying out an unpaid carer role can be rewarding and life affirming.

The Council Plan also shows priorities that we work with health and community partners to provide accessible, high-quality services for adults with support needs, including those with disabilities, older people and their carers

The Better Care Fund currently has a budget allocation of around £600,000 to provide support to a range of Carers Support Services. The BCF funding to support carers will be reinvested this year to provide dedicated resources to oversee implementation. An investment will be made to increase the number of carers assessment / carers direct payment to provide carers breaks and support to carers as per the requirements of the Care Act duties and the BCF Planning Requirements 2022/23. This approach is aligned to the priorities of the Carers Strategy and the BCF NHS minimum contribution will be used to improve outcomes for unpaid carers.

The Better Care Fund currently provides funding for a Carers Emergency Service which is available for a period of up to 48-72 hours when substitute care is necessary as a result of any sudden or unplanned event that incapacitates the unpaid carer and it would be unsafe to leave the cared for person without support. The service is free of charge and provides peace of mind for unpaid carers registered to the scheme who are undertaking regular and substantial care of vulnerable adults should informal replacement care and support be unavailable. The plan is to host the service in the Integrated Rapid Response Service which is also financed by the Better Care Fund.

The Better Care Fund also currently provides funding for home care and support services for unpaid carers provided by Crossroads Care Rotherham who provide support to people who live with or receive support from an unpaid carer. The specialist nature of this service provider means that they are able to provide support to connect unpaid carers to relevant statutory or voluntary services. Expected outcomes for eligible unpaid carers and the person that they care include improving quality of life for unpaid carer and the person they care for, enabling unpaid carers to enjoy a life outside their caring role, achieving greater independence for the unpaid carer, having an improved sense of carer wellbeing, mental and physical health, reduce carer isolation, increase local community, voluntary sector, and social enterprise involvement, maintaining/increasing the independence for

person being cared for and by sustaining the unpaid carer increasing the chances of the cared for person to remain at home for longer.

A significant range of support that aligns with the outcomes of the Carers Strategic Framework is currently provided by Crossroads Care which includes carers groups, carer activities and events, complementary therapies and volunteering opportunities. Conversations are underway between the Council and SY ICB in relation to the financial sustainability of the services provided by Crossroads. Officers are actively exploring further options for funding, looking at possibilities through the Better Care Fund. The draft funding proposals for 2022/23 are currently being developed and will need to be approved by the BCF Executive Group

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social 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 2022-23 and is a member of the Health and Wellbeing Board (HWB) and BCF Executive Group.

Both the HWB Board and BCF Executive Group includes representatives from South Yorkshire ICB 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

Adult Social Care, Housing and Public Health Services work collaboratively together in responding to the Care Act (2014) requirements in order to prevent, reduce or delay care and support needs and to support the role of carers to continue their caring role.

The Housing Strategy (2022-25) 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.

The Housing Strategy focuses on increasing the supply of affordable housing, both through new build and from bringing empty homes back into use. The Council will be carrying out a "Where do you want to live?" survey in 2022 to capture the current and future housing needs and aspirations of residents. Surveys are also conducted of people who have moved into new Council built homes and feedback is used to inform the future development of schemes. 10 bungalows have recently been completed in the South area of Rotherham. The plan is for more bungalows to be built and purchasing of additional bungalows from private developers to support people with accessibility needs to continue to remain living in the community. The plan is also to maximise the use of aids, adaptations, and assistive technology to support independence in the home to meet the needs of a range of people and support the creation of mixed communities. This supports the principles of Home First.

Extra Care Housing in Rotherham is currently based across three sites providing 108 units. Each site provides accommodation aimed at enabling people to remain independent within their home for longer. Extra care housing combines a safe secure environment in a community setting and is seen as a way forward to provide older people with their own high-quality accommodation, with access to housing related support and personal care when required. The Council is keen to expand supported housing options for older people so that they can remain living in the community.

Council owned housing stock is also ageing, and it is essential that investment continues so that the Council can 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 strategy sets out a clear direction for aiming to increase the overall number of homes through the creation of new housing, as well as continued investment to making the best of existing homes and communities. Council priorities are focused on the right homes to meet the needs of Rotherham's people which need to be safe, comfortable, affordable and energy efficient.

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 Disabled Facilities Grant (DFG) provides funding for Housing to support 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.

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 2022/23. Grant approvals range from £1,000 to around £80,000 and in exceptional circumstances has been as high as £120,000.

Following release of the Government's White Paper – 'People at the Heart of Care: Adult Social Care Reform White Paper' which was modified in March 2022. This focussed on 'Providing the Right Care, in the Right Place at the Right Time'. This gave more people the choice to live independently and healthily in their homes for longer. It included updated guidance advising Local Authorities on the efficient and effective delivery of DFGs, including more flexibility on the areas and amount of spend.

This ensures that people can quickly access the adaptations they need, in a way that is co-ordinated with other practical support they receive. The Council now applies discretion to larger more expensive projects such as major internal conversions and extensions to meet this need. A clear case is made that by providing the adaptations, the customer can live independently for longer in their home and cost savings are made in terms of long-term care requirements from the NHS.

The Disabled Facilities Grant (DFG) also provides funding for community equipment to enable and support people with their daily living activities which are supplied by our Integrated Community Equipment Service delivered by an independent sector provider. Mandatory functions for DFG are always considered annually before continuing to agree funding for community equipment.

The IBCF currently funds a project lead for Assistive Technology and Occupational Therapy. The role of Occupational Therapy (OT) to support the prevent, reduce and delay agenda within Adult Social Care and Housing is well established, and the impact of extended roles are also being increasingly recognised. The DFG is also used to fund assistive technology equipment.

The Council is funding a further 1 x full time equivalent Community OT to support the increasing caseload of the service. The postholder has taken a lead, alongside the commissioning team, in a review of the current service offer, including benchmarking with other Adult Care based services regionally. The recommendations from the review are now being taken forward with the Community OT Service providers and other stakeholders to ensure effective and efficient use of the OT resource.

The postholder is also now working with the provider on a more imminent recovery plan to arrest and address increasing waiting times due to vacancies within the service. The post is also supporting adult social care to better utilise care technology. There is a wide range of Technology Enabled Care (TEC) 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.

A relaunch of the Assistive Technology Champions scheme has started to raise awareness across teams and develop new ideas for better utilisation of the Technology Enabled Care currently available. Links have been made with corporate customer services and communications teams to further raise the profile within the Digital Strategy workstreams. The post holder undertook a LGA / Rethink Partners Leadership Programme in 2021/22, alongside a senior sponsor, which resulted in a review of the current structures around the Technology Enabled Care vision in Rotherham. Work is ongoing to develop a structure fit for the future, on which a TEC Strategy can be based.

There is also a Remote Monitoring Pilot in operation with Care Homes in relation to monitoring vital signs which has been extended for a further year until 31st March 2023. 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 BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Changes from Previous BCF Plan

There is a recognition by the South Yorkshire ICB that tackling Health Inequalities (HI) is integral to everything the system needs to do to keep people healthy and independent and reduce statutory service demand.

Rotherham's Prevention and Health Inequalities Strategy and Action Plan: 2022-25 was agreed in 2022 by the Place Board and endorsed by the Health and Wellbeing Board. This strategy is focussed on supporting people in Rotherham to live well for longer through driving prevention-led approaches across health and social care. Through working in partnership, the aim of the strategy is to:

- Improve the overall health and wellbeing of the Rotherham population when compared with the England average.
- Reduce health inequalities within Rotherham, including within our most deprived communities as well as between protected characteristic and other inclusion groups.
- Manage, delay, and prevent future demand for our health and social care services.
- Support the delivery of other agendas, including our economic strategy for the borough, by ensuring more people in Rotherham are healthy and empowered.

Delivery of the strategy is focussed on five main priorities:

1. Strengthening the Place understanding of health inequalities. Work around this priority is centred around data and intelligence, which links with the further detail around population health management outlined above.
2. Developing the healthy lifestyles prevention pathway. This priority is focussed on the factors closely associated with disability-adjusted life years in Rotherham, such as smoking, obesity and alcohol.
3. Supporting the prevention and early diagnosis of chronic conditions. This includes cardiovascular disease, diabetes respiratory disease, cancer, and mental health conditions.
4. Tackling clinical variation and promote equity of access and care for underserved groups.
5. Harnessing partners' collective roles as anchor institutions to address health inequalities.

Additionally, the strategy sets out the local approach to delivering the Local Authority's priorities under the Equality Act and NHS Core20Plus5 framework. This means that as part of the programme, partners have committed to addressing inequalities for:

- Those living in the 20% most deprived communities of England according to the Indices of Multiple Deprivation (IMD). In Rotherham this accounts for 36% of the population.

- A number of inclusion groups include:
  - Ethnic minority communities
  - Gypsy, Roma and Traveller communities
  - People with severe mental illnesses

- People with learning disabilities and neurodiverse people
- Carers
- Asylum seekers and refugees
- Those in contact with the criminal justice system

An action plan is in place to deliver against the strategy and progress is overseen by the Prevention and Health Inequalities group. The group includes representatives from the Council, NHS South Yorkshire ICB, TRFT, RDaSH, Primary Care and the Voluntary Sector.

The BCF has also been utilised to partly fund a Public Health Specialist who is responsible for programme management of the Prevention and Health Inequalities Strategy and reporting into the Place Partnership and Health and Wellbeing Board. The BCF also partly funds an Administrative Assistant to support and arrange meetings relating to the programme.

Health inequality remains an issue for the Learning Disability client group and Neurodiverse people that will continue to be addressed. It is still evident that people in these client groups are dying at an earlier age than within the general population. Continued reviews of early deaths through the LeDeR Programme influences future practice around health and aging well. The LeDeR programme has now been extended to review early deaths in people who are neurodiverse.

Work has been undertaken across Rotherham to ensure that Annual Health Checks are completed in a timely manner by local GP's and people are aware of and have access to appropriate health screening services.

Support and information for the individuals and service providers is regularly distributed around accessing Annual Health Checks, promoting healthy lifestyles and healthy choices. Future Care and Support contracts both in Care Homes, Supported Living and Day Opportunities will continue to focus on reducing these inequalities and improving the lives of people with Learning Disabilities and Neurodiverse People in Rotherham.

How these inequalities are being addressed through the BCF plan and BCF funded services

Rotherham Prevention and Health Inequalities Strategy includes an aim to improve access to social prescribing (BCF funded scheme) for ethnic minority communities. The plan is to deliver a programme to promote social prescribing amongst ethnic minority communities and increase referrals from clinicians.

Breathing Space is also a BCF funded scheme and the aim is to reduce the health burden of chronic respiratory disease in Rotherham. The plan is to restore diagnosis, monitoring and management to pre-pandemic levels in 2022/23, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets for asthma registers and spirometry checks and COPD registers for adults and children.

The Council have also refreshed the Equality, Diversity and Inclusion Strategy and Objectives (2022/25) which set out the ambition to create an inclusive borough for people to live, work and enjoy. A borough where no-one is left behind and where all are welcome and treated fairly. The aim is to ensure no-one is held back and that regardless of age, disability, race, sex, religion or belief, gender re-assignment, sexual orientation, marriage and civil partnership, pregnancy and maternity that people can achieve.

Rotherham's Joint Strategic Needs Assessment (JSNA) identifies the current and future health and wellbeing needs of Rotherham's local population. Data to inform commissioning is obtained from the JSNA, Census, POPPI and PANSI, ongoing consultations and engagement activities, feedback from individuals and targeted or specific health assessments. The JSNA also details Rotherham's diverse communities, their needs, and the aspirations of all partners in addressing these identified gaps in provision and used to identify commissioning priorities and areas of health inequalities to target interventions. An Equality Analysis is also carried out when commissioning significant changes to service to identify the potential impact on individuals to ensure that equality duties are met and that changes benefit individuals.

The Council will look to advance equalities through their third-party contracts and this is now included in a commissioning toolkit, tender documents and contract documentation. The Council will also focus on the way services are designed, commissioned, and delivered and contributes to ensuring that the needs of diverse communities are served and that nobody is excluded from accessing services.

Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered

The Council collects and analyses information from internal and external data sources including the Indices of Multiple Deprivation (IMD) to better understand the make-up of their communities. This range of data sources are shared through the Rotherham Data Hub.

The Market Position Statement provides an overview of the opportunities available to providers and presents the Council's future strategic priorities and upcoming procurement opportunities. It also aims to provide the background information and context to support any future business proposals. It outlines the number of people we support through commissioned services, predicted future demand and overall commissioning intentions. The "live" data is supplied by Insight on the number of individuals supported by adult social care commissioned services which is the Adult Social Care case management system.

Services are encouraged to use the data available for service planning, commissioning, decision making and preparation of strategic documents such as the Joint Strategic Needs Assessment and contracts / service specifications. The data is also used to assess the health needs of the local population. Housing is a wider determinant of health and has a significant impact on the wellbeing of our residents.

Any actions moving forward that can contribute to reducing these differences in outcomes

The Council will also be launching a commissioning toolkit for commissioners, contract managers and suppliers. The toolkit will address equalities through social value in the commissioning and procurement of services and managing external contracts. The Council will also ensure new in scope contracts are in line with Living Wage accreditation.

South Yorkshire ICB has also produced an annual report for 2021/22. This shows that Equality and Diversity is central to the work of the ICB to ensure there is equality of access and treatment within the services that they commission. The ICB is committed to embedding equality and diversity values into its commissioning processes that secure health and social care for our population, and into our policies, procedures and employment practices. The ICB's vision is "Your Life, Your Health, Better Health and Care for Rotherham People".

Healthwatch Rotherham have produced an Annual Report in 2021/22 which shows that information has been gathered about health inequalities, by liaising with people whose experiences are often not heard. The reports examined how services have been affected by Covid-19, how health and social care services are moving digitally and longer waiting times for appointments has affected the patient experience for Rotherham residents. This included examining mental health services for both young people and adults, which showed there are limited mental health services commissioned for young people in Rotherham, in particular digital services. In response to these key findings, the Council commissioned the digital mental health service 'Kooth' to provide its digital services to young people in the area. This has benefited lots of young Rotherham residents, allowing them to access anonymous support and resources digitally.

Healthwatch have also identified that there have been difficulties accessing GP appointments and have completed an "Accessing GP services" report to highlight the need for change within this process. Healthwatch has made links with other services to ensure patient options are taken into account and will continue to share information to provide continuous feedback to services. The report found that many patients wished for a greater availability of face-to-face appointments, which the Covid-19 pandemic had drastically reduced. A lack of face-to-face appointments risks digitally excluding people, and can greatly affect those hard of hearing, those who have English as an additional language/cannot speak English and those with communication difficulties.

Healthwatch have also completed a Dentistry report after a huge increase in client enquiries surrounding a lack of dentist appointments due to the Covid-19 pandemic, which resulted in dental services not being able to see patients due to the nature of their work. Healthwatch contacted all dental practices and compiled a list of which dentists were taking on patients and which had waiting lists to join. Healthwatch also recommended that dental practices update their information on the NHS England 'Find a Dentist' tool, to ensure patient information is accurate and up-to-date.

Additionally, Healthwatch were contacted by the South Yorkshire ICB, who commissioned them to write a report looking into how Rotherham residents found the three lockdowns, how they accessed health and social care services and what they would change. The report found that residents' experiences of lockdown differed drastically, with some using the time to spend with family and focus on self-care, and others feeling isolated and frightened. Some residents really struggled with a lack of face-to-face GP and hospital appointments, particularly older people who struggled with technology and were used to seeing somebody in person. For others, the anxiety of going out and mixing with others when Covid-19 was at its height would be too much for them, so they appreciated the option of having telephone and video medical appointments that they could access from the safety of their homes.

Healthwatch will also be liaising with services such as Rotherham Ethnic Minority Alliance (REMA) who is the infrastructure support organisation for the Black and Minority Ethnic Voluntary and Community Sector for Rotherham. REMA provides immigration advice for asylum seekers and refugees, community navigators to provide settlement support for BAME communities, Roma Drop-in for advice and signposting and volunteering to provide a pathway into work or new experiences to help open other avenues in life. The aim is to identify any themes and trends they are seeing in their service. Healthwatch plans to ensure they are reaching all communities, and ensure their voices are heard in health and social care issues.

Healthwatch also holds monthly 'Let's Talk' events via Zoom on different topics including dementia awareness, accessing dentistry, perinatal mental health, cancer awareness and COPD/TB awareness. Guest speakers with knowledge in these fields attend and this also allows a Q&A opportunity for attendees. These events give professionals and members of the public information about local support services available, and how to access them.

Healthwatch holds a monthly stall at Rotherham Hospital, to interact with the public about their experiences, as well as working with the patient experience team on the wards to support patient feedback surveys. Other engagement that has taken place includes visiting a number of care homes, GPs and dental practices in Rotherham, spreading awareness of Healthwatch and building contacts that can support future work. Healthwatch has become involved in local community groups such as 'Social Supermarket' and older people groups. Healthwatch is also planning to develop links with harder to reach communities, to build good relationships and receive feedback on their experiences within health and social care.

BCF Funded Schemes which Reduce Health Inequalities

BCF funded schemes which reduce health inequalities includes:

- 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).

- Project support for the implementation of Population Health Management (PHM) priorities

The above BCF funded schemes are included in the BCF Section 75 Agreement which will be signed off by the Health and Wellbeing Board.