Rotherham Better Care Fund

Planning template – Part 1

Local Authority
Rotherham Metropolitan Borough Council

Clinical Commissioning Group
Rotherham Clinical Commissioning Group

No boundary differences

Date agreed at Health and Wellbeing Board
11 February 2014

Date submitted
14 February 2014

Minimum required value of ITF pooled budget	2014/15	**£20,101,000.00**
	2015/16	**£20,318,000.00**
Total agreed value of pooled budget:	2014/15	**£21,838,000.00**
	2015/16	**£22,055,000.00**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Rotherham Clinical Commissioning group**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	**Rotherham MBC**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	**Rotherham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Cllr Ken Wyatt
Date	<date>

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This first draft submission reflects a number of ways in which health and social care providers have been engaged in the planning process for the Better Care Fund (BCF), and in developing our local priorities.

The Rotherham Health and Wellbeing Board includes the main local health providers (Acute and Community Foundation Trust and Mental Health Trust) as well as representation from the voluntary sector (Voluntary Action Rotherham), this has ensured that they are fully signed up to the principles and vision of the BCF and are aware of the potential impact on services and the local community.

In addition to this, full discussions on the BCF have taken place at The Adults Partnership Board, which acts as a commissioner / provider interface on jointly commissioned services. The board is coordinated jointly by the council and Rotherham CCG and includes representation from Rotherham Foundation Trust, RDASH and the voluntary/community sector. The board agrees commissioning plans which address outcomes identified in the local Health and Wellbeing Strategy, makes recommendations about commissioning priorities to the Health and Wellbeing Board, and oversees performance on jointly commissioned services. The Rotherham urgent care working group, which has cross system membership, has also reviewed the BCF outline plans. We intend to have further detailed discussions with providers before the final submission in April.

Local health providers understand that Rotherham CCG has identified a range of services which will be transferred into the Better Care Fund, and that the commissioning arrangements for these services are going to change significantly. Locally the BCF will affect services delivered by Rotherham Foundation Trust (RFT) and key voluntary sector partners and all provider organisations have expressed a willingness to work under the

new commissioning framework, recognising the potential opportunities. RFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved. Voluntary sector partners have already developed services which form part of integrated care pathways in stroke and dementia care, and we see the BCF as an enabler to embed voluntary sector services into other condition specific care pathways.

We have engaged with social care providers to raise awareness of the implications of the BCF and to better understand some of the issues and good practices already taking place. This has been done through an online survey and round-table discussion, using their experiences to explore potential solutions. A number of common themes have been identified which have informed the plan:

- There needs to be a greater focus on prevention and early intervention, with appropriate information and signposting to community-based services at a much earlier stage
- Better communication between agencies is needed to identify individuals who are most vulnerable and at risk of crisis (particularly in relation to mental health)
- Equipment, adaptations and support services need to be provided quickly before cases become critical and people reach crisis point
- Better 7-day (weekend) provision is needed to support discharge from hospital and transition between services
- We need more step up and step down beds to support transition between services
- Carers and workers need to have the right skills to deal with changes in care packages
- We need to reduce bureaucracy and make it easier for all providers to link up and work together
- GPs are often the first point of contact for people and commissioners need to work with GPs to ensure that preventative solutions are utilised
- Commissioners of health and social care need to communicate more and see the whole person (not just single issues in isolation) as well as the whole system, avoiding duplication
- We need more opportunities for people to engage in their community; reducing the reliance on more formal 'services' for social interaction

Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our Better Care Fund vision is based on what Rotherham people have told us is most important to them.

We have used a variety of methods to involve service users and the public in the development of the plan including:

- Better Care Fund consultation– Healthwatch Rotherham was commissioned by the Health and Wellbeing Board to consult with the local community and engage them in the envisaged transformation of services between December 2013 - January 2014
- RMBC Customer Inspection Group – During January 2014 Rotherham Council consulted with a group of mystery shopper volunteers regarding the proposed vision, priorities and their views of health and social care services

We have also collated responses from a range of consultation exercises and surveys previously completed, and used these to help shape our vision and priorities, including; Joint Health and Wellbeing Strategy consultation July – August 2012, ASCOF Adult Social Care User Survey 2011/2, Personal Social Services annual Survey of Adult Carers in England 2012/13, Health Inequalities consultation 2011 and staff consultation regarding the hospital admission to discharge process. In addition, the council continually works to improve services through customer insight activities and learning from customer complaints, ensuring that service users are at the heart of service delivery. The annual Local Account is also used to inform members of the public how the council is meeting the needs of service users and improving outcomes.

Rotherham CCG co-ordinates a Patient Participation Network that brings together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients' views from across the local health economy. As part of an exercise to develop the patients' view of the CCG's five year strategy, the network identified a number of priorities that could be addressed as part of the Better Care Fund Plan.

Through service user, patient and public engagement, we have been able to identify a number of common areas for improvement including:

- Patients and service users do not always feel central to decision making, they want to be in the driving seat when it comes to their own care
- Services, local groups and organisations are not accessible due to a lack of information and advice, availability 7 days a week and long waiting times
- There needs to be better education and information available for people, particularly those with long term conditions
- People often feel unclear of expectations regarding the service they should receive and customer pathways due to a lack of advice and support and conflicting information. They are also not always signposted to appropriate services. Better staff training and education is required
- There is a lack of communication and information sharing resulting in poor joined up working between patient/service user, family and carers, health and social care services, GP, hospital, providers and partners
- Service users feel that they have to chase health and social care professionals, causing delay in the delivery of care and support
- Service users and patients would like an allocated key worker/professional; inconsistency of workers makes individuals feel unsafe
- There needs to be more of a focus on preventative, community/home-based services to reduce the number of people going into hospital and residential and nursing care. Nursing services are also critical for home-based support.
- Better after care is required. Examples provided included people felt alone, socially isolated, found it difficult to access services, no support for carers who are left behind
- Service users have a level of distrust using external health and social care providers

Further information regarding the consultation can be found in Appendix 1.

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Ref.	Document or information title	Synopsis and links
A1	**Summary of consultation**	A summary of all the consultations which have taken place as part of the BCF planning and wider health and wellbeing agenda.
A2	**Rotherham Better Care Fund Action Plan**	Includes the detail and intended outcomes (including related 'I Statements') of the schemes to be delivered through the BCF, and shows how these align with the local health and wellbeing strategy priorities and objectives,
A3	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2013 – 2015.
A4	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
A5	**Overarching Information Sharing Protocol**	This protocol complements and supports wider national guidance, professional body guidance and local policies and procedures to improve information sharing across services in Rotherham. Signed up to by HWB September 2012.

1) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

The Rotherham Health and Wellbeing Strategy sets out our overarching vision to improve health and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to more integrated, person-centred working, to improve health outcomes for local people.

The Better Care Fund plan will contribute to 4 of the strategic outcomes of the local Health and Wellbeing Strategy:

- **Prevention and early intervention**: Rotherham people will get help early to stay healthy and increase their independence

- **Expectations and aspirations**: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

- **Dependence to independence**: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

- **Long-term conditions**: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

Our vision for integration is based on the experiences, values and needs of our service users, patients and carers. Through mapping these and understanding the journeys people take in and out of health and social care, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. From 2015/16 our Better Care Fund plan will work towards the following:

'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 only have to tell my story once'
Service users, patients and carers want all organisations and services to talk to each other and share access to their information, so that they only ever have to tell their story once.

'I feel part of my community, which helps me to stay healthy and independent'
People want to feel independent and part of their community and want organisations to provide better information and support to help them to do this, understanding that this reduces social isolation and avoids the need for more formal care services later on.

'I am listened to and supported at an early stage to avoid a crisis'
People want support, advice and information at an early stage to help them look after their mental health and wellbeing, avoiding the need for more intense, high-level services when they reach crisis point.

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

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

As a result of the changes we will make, all service users, patients and their carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. They will feel well and less likely to rely on acute services, resulting in a reduction in overall pressure on the hospital and health budgets. Although, when acute care is the best option for people, they are helped to move quickly back into their community when they are ready to do so. We will see a greater shift from high cost reactive care, to lower cost, high impact preventative activity.

To achieve this, we have agreed a number of actions that will begin this journey and result in changes short and medium term. However our longer term, 5 year plan, will see health and social care teams working in an increasingly integrated way. We will move to a whole-system commissioning model, which has services commissioned in line with our health and wellbeing strategy principles that are coordinated across all agencies to ensure they are person-centred and we maximise local spend. We will explore the benefits and efficiencies that can be made through having joint approaches to call centres, including an increased use of assistive technologies, and joint teams for commissioning and assurance.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

Our aim is for an integrated system, that provides care and support to people in their home or community, which focuses on prevention, early intervention and maximising independence. To do this, we have identified a number of key objectives set out in our health and wellbeing strategy which have been used to inform our plan. We have demonstrated below where these will impact on the specific outcome measures of the BCF:

To deliver our vision on Prevention and Early Intervention (PE)	
What we will do	**Related measures**
We will coordinate a planned shift of resources from high dependency services to early intervention and prevention	N1, N2, N4, N5, L1
Service will be delivered in the right place at the right time by the right people	N1, N2, N3, N4, N5, L1

To deliver our vision on Expectations and Aspirations (EA)	
What we will do	**Related measures**
We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes	N1, N2, N3, N4, N5, L1
We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions	N1, N2, N3, N4, N5, L1

To deliver our vision on Dependence to Independence (DI)	
What we will do	**Related measures**
We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care	N1, N2, N3, N4, N5, L1
We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs	N1, N2, N3, N4, N5, L1

To deliver our vision on Long-term Conditions (LC)	
What we will do	**Related measures**
We will adopt a coordinated approach to help people manage their conditions	N1, N2, N3, N4, N5, L1
We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual	N3, N4, N5, L1

Outcome measures (key):

- **N1 Admissions into residential care -** Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000
- **N2 Effectiveness of reablement** - Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
- **N3 Delayed transfers of care** - Delayed transfers of care from hospital per 100,000 population (average per month)
- **N4 Avoidable emergency admissions** - Avoidable emergency admissions
- **N5 Patient and service user experience**
- L1 Emergency readmissions

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

Achieving our vision will mean significant change across the whole of our current health and care landscape. Commissioners and providers will need to adapt and change the way they do things. The following actions demonstrate the commitment both the council and CCG have made to transforming services and working in a more integrated way for the benefit of Rotherham people.

A more detailed action plan is attached as Appendix 2.

What we want to achieve: Rotherham people will get help early to stay healthy and increase their independence

We will use the BCF to:

- Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention.
- Review the falls service to ensure its primary focus is delivering a preventive community-based service
- Implement a joint approach to an integrated rapid response service, including out of hours, capable of meeting holistic needs of identified individuals to reduce hospital admission.
- Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health.

What we want to achieve: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

We will use the BCF to:

- Review the social prescribing pilot to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstreaming this service subject to findings.
- Undertaken a deep dive exercise conducted on cases of high social care and health users, to identify opportunities to improve pathways, and explore where better preventative action earlier on may help avoid or delay access to health and care services in the future.
- Carry out a full evaluation of Rotherham's risk stratification tool, and develop a mechanism for identifying high intensity users of health and social care services.

Want we want to achieve: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

We will use the BCF to:

- Commit to giving personal budgets to as many people as possible
- Develop self-care and self-management, working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes,
- Develop and implement a person centred, person held plan, in partnership with key stakeholders.
- Identify the cost and activity pressures resulting from the implementation of the care bill and develop a plan to meet these pressures.

Want we want to achieve: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

We will use the BCF to:

- Undertake a project to review all existing S75 and S256 agreements and pooled budget arrangements.
- Develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Use of the NHS number as a unique identifier across health and social care will create the starting point for the development of shared IT capacity.

Aligning to other plans

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities.

Timeline

Feb – April 14: We will further develop our BCF action plan, setting out timescales, delivery leads and the specific governance arrangements for each scheme.

April 14 – March 15: We will undertake detailed planning to ensure the schemes in the action plan are implemented.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

NHS Rotherham CCG's share of the national efficiency challenge is around £80 million over five years and is referred to as QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

Provider QIPP; Efficiencies passed onto health service providers. For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given 2.1% uplift for inflation but are then expected to make 4% efficiencies. The efficiency requirement is **£8.8m**.

System Wide QIPP; NHS financial allocations are expected to rise by around 1-2% each year over the next 5 years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth will continue at around 6% a year because of the ageing population, rising expectations and new medical technologies. System wide QIPP programmes are the actions required to keep overall growth at an affordable 1-2% level rather than the historical 6%.

The Unscheduled Care QIPP target will be partially reliant upon the success of the BCF. The initiatives will provide more alternatives to hospital admission, treat people with the same needs more consistently and deal with more problems by offering care at home or close to home - value is **£2.5m**.

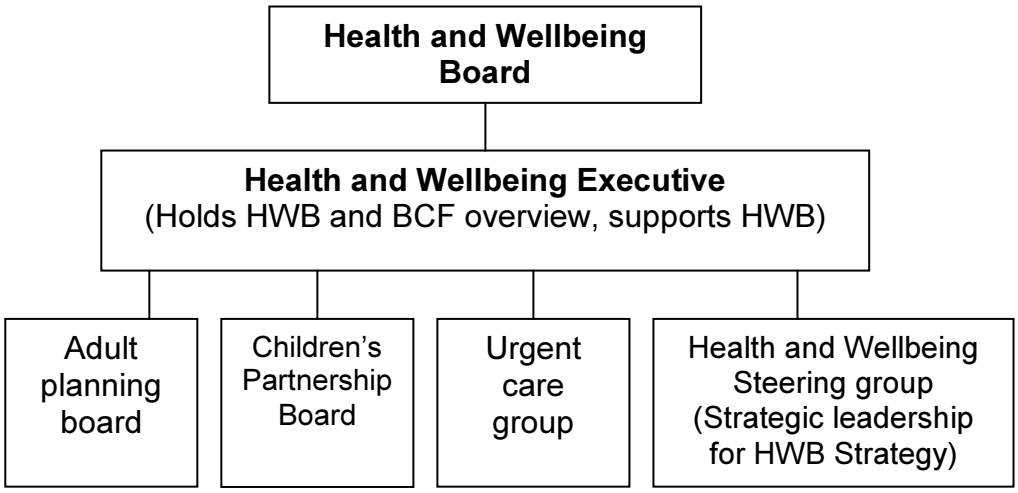
e) Governance

Please provide details of the arrangements in place for oversight and governance for progress and outcomes

The CCG and RMBC have co-terminus boundaries and already have a layer of governance and delivery mechanisms in place. There is clear agreement to the need to maintain a simple clear governance framework which does not add to the burden of any of the agencies or partnership mechanisms.

The delivery of the BCF will be fully integrated with the delivery of the Health and Wellbeing Strategy and as a result, the existing mechanisms with some adaptation should be fit for purpose to ensure effective governance, accountability and delivery.

The framework outlined below brings together the existing partnership and single agency arrangements into a coherent whole system approach and integrates the existing mechanisms to ensure that there remains a clear focus on the health and wellbeing strategy.



The Health and Wellbeing Board will:

- Monitor performance against the BCF Metrics (National/ Local) and receive exception reports on the BCF action plan
- Ratify the Better Care Fund Commissioning Strategy
- Ratify decisions on commissioning or decommissioning of services, in relation to the BCF

The HWB executive provides support to the board and holds the overview role for delivery of the BCF through the 4 key groups below.

Our final submission will include more detailed information about how the 4 groups will deliver the actions in the BCF plan.

Audit

The use of the funds and other finance issues arising will be audited with the final scope to be agreed by RCCG Chief Finance Officer and RMBC Finance Director.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Key to the delivery of integrated person centred services, in the context of reduced revenue and increased demand for health and social care services, is a core offer of social care services including:

- Advice, guidance and information sharing
- Preventive services such as telecare/assistive technology, reablement, intermediate care – all designed to support independence
- Ongoing care provision including personalised services which offer choice and control to the individual to enable them to lead as independent a life as possible
- Good quality domiciliary and residential care

It is known that cuts to social care services increase pressure on the NHS, and protecting the NHS is a key priority for central government. Without the support that is achieved through the Better Care Fund, social care reductions will negatively impact on the local NHS community. RMBC has taken the following actions to date:

- A rational approach to setting reasonable fees for provider services, including tackling high cost fees for learning disability residential placements and supporting the quality of care in older people's residential care services
- Increases in charges for care
- A greater use of reablement services that offer support to people to enable them to remain independent
- Implementation of personalised support, alongside effective commissioning of services

To date it is clear that these efforts have enabled the council to manage increasing demand due to demographic pressures – these approaches cannot be effective indefinitely, and in 2013/14 there are indications that demand, despite the actions taken to reduce demand through reablement etc, is beginning to increase significantly.

In order to prevent further cuts to services, it is essential that the Better Care Fund is used to support those care services which in turn protect the NHS.

Please explain how local social care services will be protected within your plans

The fund itself does not address the financial pressures faced by local authorities and CCGs. The Better Care Fund brings together the NHS and local authority resources that are already committed to existing core activity. The Better Care Fund will be used in the first instance to protect the funding to existing services, allowing the local council to maintain its current eligibility criteria, under Fairer Access to Care Services (FACS). Current services will be reviewed and evaluated to ensure that they address the key aims of the Better Care Fund. Where they are not seen to be delivering against this, they will be recommissioned or decommissioned and the funding reinvested in services that support improvements in health and wellbeing, independence, and prevents admission to care services or hospital, as well as information and signposting services for people who are not eligible for services, to prevent or delay their need for such services. Assessment, care management, and commissioned support for those who meet eligibility criteria needs to be maintained at current level, with the potential that this investment will need to increase to maintain the offer in the light of developing 7 day services and additional responsibilities that the Care Bill will bring when enacted in 2015.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

There is a commitment in our plan to the achievement of 7 day working in all parts of the health service, parity of esteem for people living with mental health issues and better care for people requiring integrated health and social care services. This is a key element in our contract negotiations with providers.

There is also a commitment from the CCG to support GP practices in transforming the care of patients aged over 75 in line with national planning guidance. This is being developed in year to compliment our strategy for vulnerable people which is also included in our plan.

Existing services, including out of hours support by social workers, access to enabling care and intermediate care, will be reviewed and strengthened where necessary in response to emerging patterns of demand.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All Rotherham NHS correspondence uses NHS number as primary identifier.

RMBC does not currently use the NHS number as primary identifier.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS Number can be recorded in SWIFT/AIS as a specific 'Other Reference' which then appears in the person's context banner in the most commonly used screens.

From May 2014, we will begin a piece of work with Northgate to use a facility provided by them to batch load NHS numbers into SWIFT/AIS. Steps in the process are as follows:

A script will be provided to extract all clients without a validated NHS number into the correct csv file format for submission. SWIFT Identifiers will be provided with names, address, data of birth and gender for matching purposes. This will initially be used for a bulk update and can then be run on an automated regular basis to pick up new clients or clients where the initial match attempt has failed (since their SWIFT details may be updated to achieve a match eg as part of data quality work). The file will be encrypted and transferred from the local authority server to the secure Northgate server via secure ftp.

Northgate has a secure server with an N3 connection to the NHS Spine who will run the client software on that server to submit each customer's clients in an encrypted file to the Demographics Batch Service. The returned file will then be transferred back to the local authority by sftp. Northgate will automate this process to run on a nightly basis and keep

records of runs. The returned file will identify those Persons for whom no match was found. We will have in place a process for dealing with those cases, eg checking & amending the demographic details and re-submitting.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

All Rotherham NHS platforms are Information Governance Toolkit compliant.

RMBC is committed to adopting systems that are based upon open APIs.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

All Rotherham NHS Organisations use the IG toolkit and provide annual assurance on this.

Rotherham CCG will complete assurance on Caldicott 2 compliance by 31 March 2014

The Rotherham Health and Wellbeing Board has jointly approved and signed up to an overarching information sharing protocol (appendix ..)

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

There is an initiative in place to improve the case management of the 5% (12,000) of patients at risk of hospitalisation which is key to our unscheduled care efficiency plan. In 2013/14 the pilot was solely for patients identified by a computer tool as being at the highest risk of admission to hospital. In 2014/15 the tool will still be used to identify the first 3% of patients eligible to be on the scheme. An additional 2% of each practices population will be eligible for the scheme, this will also include all patients in nursing and residential homes and other patients selected on the basis of clinical judgment.

In light of the planning guidance requirement to provide addition GP services for patients over the age of 75 the CCG will add an additional component to the LES to provide services for all 20,000 people in Rotherham over 75. The CCG will make the case management and over 75 services funding recurrent so that practices can make permanent appointments as the current shortage of locums is affecting the stability of current services.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Governance is deemed by NHS England not to meet requirements to deliver the BCF change	Medium	Task group to agree the most appropriate governance structure for BCF, which includes the HWB as the accountable body.
A lack of detailed data / baseline data means finance and performance targets are unachievable	High	Validated financial data from both organisations enabling interpretation and auditing of information. Performance Management Framework that includes SMART measures to evidence progress against improving outcomes
Shifting of resources could destabilise current service providers.	High	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. Assessment of the potential impacts on the provider to be collated as integral to the implementation plan
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	High	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from.
Failure to receive 50% of the pay-for-performance element at the beginning of 2015/16 due to the HWBB not adopting a plan that meets the national conditions by April 2014	High	HWB to ensure plan meets the national requirements and is fully adopted by April. Performance management framework in place to monitor progress throughout 2014/15 to ensure meet agreed targets.
Failure to receive the remaining 50% of the pay-for-performance element mid 2015/16 due to not meeting the in-year performance targets.	High	Performance management process in place, accountable the HWB
Introduction of the Care Bill resulting in an increase in cost of care provision from April 2015, impacting on social care services and funding	High	Working group established and initial impact assessment undertaken of the potential effects of the Care Bill.