Appendix 2. ROTHERHAM BETTER CARE FUND ACTION PLAN

Ref.	Scheme	Action	Outcome	Measure/s
HWB Strategy: (PE) prevention and early intervention – Rotherham people will get help early to stay health and increase their independence				
PE1 – We will co-ordinate a planned shift of resources to high dependency services to early intervention and prevention				
BCF01	Mental Health Service	Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention.	A jointly agreed plan which results in a reduction in formal, high intensity use of services (including acute services and police intervention) and a greater investment in community-based and primary care preventative activity which addresses mental health issues much earlier on. *'I am listened to and supported at an early stage to avoid a crisis'*	Admissions to residential and care homes Avoidable emergency admissions Patient/service user experience Emergency readmissions
BCF02	Falls prevention	Review the falls service to ensure its primary focus is delivering a preventive community-based service, as well as targeting those most vulnerable, who are most at risk of fracture neck of femur.	Older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance to help prevent them. *'I feel safe and am able to live independently where I choose'*	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions Patient/service user experience

				Emergency readmissions
PE2 – services will be delivered in the right place, at the right time, by the right people				
BCF03	Integrated rapid response team	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. Incorporate community nursing, enabling and commissioned domiciliary care.	A coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital. *'I feel safe and able to live independently where I choose'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
BCF04	7-day community, social care and mental health provision to support discharge and reduce delays	Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health.	Appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care. *'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions

				Patient/service user experience Emergency readmissions
HWB Strategy: (EA) All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community				
EA1 – We will ensure our workforce routinely prompt, help and signpost people to key services and programmes				
BCF05	Social Prescribing	Review social prescribing pilot to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstream this service subject to findings.	The need for more formal care services is reduced, creating an opportunity to shift investment into community activity that fosters independence and encourages local people to participate in their community. *'I feel part of my community, which helps me to stay healthy and independent'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
EA2 – We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions				
BCF06	Learn from experiences to improve pathways and enable a greater focus on	Undertaken a deep dive exercise conducted on cases of high social care and health users. Map the journey through health and social care services to identify opportunities to improve pathways and explore where better	A shift in investment from high-cost, high-intensity users of health and social care, to low cost high impact community initiatives which focus on prevention. A co-produced (between health, public health and	Admissions to residential and care homes Effectiveness of reablement

	prevention	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.	social care) risk stratification tool to identify high intensity users. *'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'*	Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
HWB Strategy: (DI) Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances				
DI1 – We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care				
BCF07	Personal health and care budgets	Commitment to giving personal budgets to as many people as possible, and will develop our plans to do this. Extend our current plans for personal health budgets, working with patients, service users and professionals.	Individuals are provided with the right information and feel empowered to make informed decisions about their care. *'I am in control of my care'*	Admissions to residential and care homes Effectiveness of reablement Patient/service user experience
BCF08	Self-care and self-management	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, including the areas of transitions from young people's services into adult care. Develop patients and practitioner skills programmes that can be implemented across health and social care.	Individuals are provided with the right information and support to help them self-manage their condition/s. Professionals are equipped with the right skills to enable self-care / self-management and promote independence. *'I am in control of my care'*	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions

		Development of integrated workforce development programmes and risk management courses aimed at promoting an ethos of self-management. Develop specialised psychological support services for people with long term conditions so that they are better able to self-manage their condition.		Patient/service user experience Emergency readmissions
DI2 – 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				
BCF09	Person-centred services	Develop and implement a person centred, person held plan, in partnership with key stakeholders.	Each individual has a single, holistic, co-produced assessment, meaning they only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery. *'I am in control of my care'* *'I only have to tell my story once'*	Patient/service user experience
BCF10	Care Bill preparation	Identify the cost and activity pressures resulting from the implementation of the care bill, including increased assessments, carers assessment and support, information advice and guidance capacity, and resulting administrative and operational costs. Develop a plan to meet these pressures.	Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service.	The Care Bill will impact on all BCF outcome measures
HWB Strategy: (LC) Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life				
LC1 – We will adopt a co-ordinated approach to help people manage long term conditions				
BCF11	Review existing jointly	Undertake a project to review all existing S75 and S256 agreements and pooled	All jointly commissioned services provide value for money and are aligned with the BCF vision	All integrated services impact

	commissioned integrated services	budget arrangements.	and principles. Where services are not efficient and effective, a plan is developed to de-commission/re-commission as appropriate.	on BCF outcome measure/s
LC2 – 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				
BCF12	Data sharing between health and social care	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.	All providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. *'I only have to tell my story once'*	Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions