Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Rotherham MBC	Y	3,453	1,968	3,670
NHS Rotherham CCG	Y	18,385	18,350	18,385
BCF Total		**21,838**	**20,318**	**22,055**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this

The BCF plans are based on robust methods of working which will be further enhanced by targeted investment to deliver the outcomes. Failure to reduce emergency admissions or social care costs will be mitigated in the first instance by any underspends in the BCF funds and CCG/RMBC contingency plans thereafter.

Contingency plan:		2015/16	Ongoing
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population	Planned savings (if targets fully	TBC	TBC
	Maximum support needed for other services (if targets not achieved)		
Proportion of older people (65 & over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other		
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other		
Avoidable emergency admissions	Planned savings (if targets fully achieved)	2,000	TBC
	Maximum support needed for other	600	
Patient / service user experience	Planned savings (if targets fully achieved)	208	TBC
	Maximum support needed for other	62	
Reduced Emergency Re-admissions	Planned savings (if targets fully achieved)	310	TBC
	Maximum support needed for other	93	

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
BCF01 - Mental Health Service	MH FT	1479		507		1479		507	
BCF02 - Falls prevention	RFT	903		310		914		310	
BCF03 - Integrated rapid response team	RFT/RMBC	610		209		610		209	
BCF04 - 7 day community social care and mental health provision to support discharge and reduce delays	RFT/RMBC	4186				4186			
BCF05 - Social Prescribing	Voluntary Sector	605		208		605		208	
BCF06 - Learn from experiences to improve pathways and enable a greater focus on prevention	RFT/RMBC	27				27			
BCF07 - Personal health and care budgets	RMBC	1268				1268			
BCF08 - Self-care and self management	RFT	50				50			
BCF09 - Person-centred services	Primary Care	3739		1283		3739		1283	
BCF10 - Care Bill preparation	RMBC	1351				1351			
BCF011 - Review existing jointly commissioned integrated services	RMBC	6607				6607			
BCF12 - Data sharing bewteen health and social care		0				0			
Disabled Facilities Grant	RMBC	1013				1219			
Total		**21838**	0	**2517**	0	**22055**	0	**2517**	0

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - We plan to reduce admissions by 12%
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services - We plan to increase these services by 6%.
Delayed transfers of care from hospital per 100,000 population (average per month) We plan to reduce delayed transfers by 14%
Avoidable emergency admissions (composite measure). We plan to reduce avoidable admissions by 15% over the 5yr strategic planning period which equates to an average of 3% per annum.
Emergency readmissions - there is a plan to reduce the rate of emergency readmissions where clinically appropriate. This is supported by community services which are currently being reviewed to ensure that seven day and locally designed services are in place.

A range of outcomes and benefits from our schemes will be provided via our action plans. All measures will benefit from aspects of :
- Integrated rapid response team - will provide a joint approach to an integrated rapid response service, ensuring a coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.
- 7-day community, social care and mental health provision to support discharge and reduce delays, ensuring appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.
- Social Prescribing pilot findings that deliver on prevention, avoidance and delaying access to formal care services with the outcomes of the need for more formal care services being reduced.
- Learning from experiences (of high social care and health users) to improve pathways and enable a greater focus on prevention that sustains users within the community.
- Care Bill preparations, will result in Rotherham adult social care being able to meet the increased demand and maintain / protect the existing level of service.
- Review existing jointly commissioned integrated services (S75 and S256 agreements and pooled budget arrangements) will deliver value for money for customers and provide effective services through de-commissioning/re-commissioning as appropriate.

In addition other actions will impact on specific metrics from the six national and local suite including outcomes resulting from our actions regarding:
- Review of Mental Health provision resulting in greater investment in community based and primary care preventative activity which addresses mental health issues much earlier.
- Falls prevention service improvements identify that where a person is more at risk of a fall, they are provided with the right advice and guidance to help them prevent it.
- Personal health and care budgetsprovision will be maximised to individuals so they are provided with the right information and feel empowered to make informed decisions about their care.
- Self-care and self-management working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, so that Individuals are provided with the right information and support to help them self-manage their condition/s.
- Person-centred services recorded on a person held plan (using NHS number) will mean individuals will 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.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National metric to be used

Each metric will have a performance management and assurance process in place. The overall performance management will take place at the Health and Wellbeing Executive (Holds HWB and BCF overview, supports HWB) and will be monitored by the Health and Well Being Board.

Each metric will have:

A designated senior lead ASC/Health operational manager, who will be responsible for delivery of the overall measure performance and has the 'power' to direct available resource to meet service demands within agreed limits.
An agreed action plan, with milestones and target delivery profiles
An appropriate frequency of reporting to Senior Management Teams/Executives/Boards etc
An agreed quality assurance of reported performance
An agreed remedial action plan process when a 'trigger' is activated
An agreed escalation process with sufficient 'power' to direct available resource to meet service demands within agreed limits
Satisfaction testing of outcomes achieved, which when coupled with any complaints learning will lead as appropriate to further improvements being factored into on-going arrangements

Permanent admissions - Delivery of this metric will be lead by Rotherham MBC
Reablement - Delivery of this metric will be lead by Rotherham MBC
Delayed Transfers - Delivery of this metric will be lead by Rotherham NHS
Avoidable emergency admissions - Delivery of this metric will be lead by Rotherham NHS
Emergency readmissions - Delivery of this local metric will be lead by Rotherham NHS

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	739.6	N/A	650.7
	Numerator	345		317
	Denominator	46645		48720
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	86.7	N/A	91.5%
	Numerator	110		119
	Denominator	130		130
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	126.6	109.1	104.7
	Numerator	256	223	215
	Denominator	202200	204480	205444
		(insert time period Apr 13 - Nov 13 [8 months]	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	499	484	528
	Numerator	2994	2,904	3169
	Denominator	6	6	6
		(April - September 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		National to be used	N/A	National measure not yet available - data for October 2015 to be provided.
		(insert time period)		*(insert time period)*
Emergency readmissions within 30 days of discharge from hospital (all ages) PHOF 4.11 NHSOF 3b - Note this is a local variation to national measure, and calculates from patients registered with a Rotherham GP, not local authority population.	*Metric Value*	12.10%	11.86%	11.60%
	Numerator	2290	2995	2934
	Denominator	18932	25250	25250
		April - December 2013	*April 2014 - March 2015*	*April 2015 - March 2016*