Rotherham Better Care Fund Plan

April 2014

Local Authority
Rotherham Metropolitan Borough Council

Clinical Commissioning Group
Rotherham Clinical Commissioning Group

Date agreed at Health and Wellbeing Board
3 April 2014

Date submitted
3 April 2014

Final Version 3.4.14

Finance

Minimum required value of BCF pooled budget	2014/15	**£20,101,000.00**
	2015/16	**£20,318,000.00**
Total agreed value of pooled budget:	2014/15	**£23,099,000.00**
	2015/16	**£23,316,000.00**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Rotherham Clinical Commissioning group**
By	Chris Edwards
Position	Chief Officer
Date	3 April 2014

Signed on behalf of the Council	**Rotherham MBC**
By	Martin Kimber
Position	Chief Executive
Date	3 April 2014

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	3 April 2014

1. Plan Details

1.1 How we have engaged health and social care providers in the development of this plan, and the extent to which they are party to it

The Rotherham health and social care community has a strong track record of working together in partnership to achieve meaningful change for local people. We can evidence that we continuously work with people using services, to understand and learn from them, and to improve their experience. Their views and experiences are reflected in this plan.

Against this backdrop and using principles already established it is easy to see how our partnership around integration can be developed, strengthened and sustained.

Health providers

The Rotherham Health and Wellbeing Board has representation from the main local health providers (Rotherham Foundation Trust and Mental Health Trust) and the voluntary sector (Voluntary Action Rotherham) from the launch of the Board in 2012. They are each represented at board meetings, and their contribution has been embedded through the key theme groups, and the ongoing discussions regarding BCF. This involvement has ensured they have been engaged right through the process and are fully signed up to the principles and vision of the BCF, whilst being aware of the potential impact on services and the local community.

Healthwatch Rotherham are key partners at the board, bringing added value and independence through their direct relationship with the voluntary and community sector (VCS), and with people using services.

In addition to this, the BCF has been embraced by The Adults Partnership Board (APB), 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 (Rotherham, Doncaster and South Humber Mental Health Trust) and the voluntary/community sector. The Adult Partnership Board agrees commissioning plans which address outcomes identified in the local Health and Wellbeing Strategy, examines national policy and directive and conducts impact assessments for Rotherham, making recommendations about commissioning priorities to the Health and Wellbeing Board. The APB has a key role in overseeing performance on jointly commissioned services including: registered nursing care homes; community therapy: equipment; and enabling services; intermediate care; and services for older people with mental health problems. The Rotherham urgent care working group, including its task and finish groups have cross system membership, and the BCF outline plans have been considered carefully at this forum. These discussions will continue as the action plans are shaped and revised, and developed into detailed implementation.

Local health providers understand that Rotherham CCG has identified a range of services which will be transferred into the BCF, and that the commissioning arrangements, including future specifications and targets for these services are likely to to change significantly. Locally the BCF will affect services delivered by Rotherham

Foundation Trust (RFT) and key voluntary sector partners. All provider organisations have expressed a willingness to work under the new commissioning framework, recognising the potential opportunities to improve outcomes for Rotherham people. RFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved.

Key local healthcare providers have been engaged through monthly clinically led QIPP (Quality, Innovation, Productivity and Prevention) groups where pathway redesign, innovation and efficiency are key deliverables. Therefore the clinical areas where savings are planned from acute care have been generated over the last twelve months from a multi-disciplinary group of clinicians and officers of the CCG, local authority and appropriate provider. Appendix 11 shows the workstreams through which the QIPP savings are being delivered.

Voluntary sector providers

Rotherham commissioners have a long established relationship with the local voluntary and community sector (VCS), both as partners in working to improve social capital locally, and directly as provider organisations. Commissioners engage formally through the Council Contracting for Care and Provider Forums, partnership and consultation meetings; and through the Adult Social Care Consortium and Health Networks. The VCS has a strong local voice with elected members and trust boards, and are seen as true partners where opportunities for not-for-profit organisations and charities to unlock funding streams not accessible to public services present themselves. We understand the remit and the influence of the VCS extends far beyond that of our public services and interfaces with people in our communities who do not use statutory services and who arrange their own care.

Voluntary sector partners have engaged with us variously in delivering a wide range of services, some of which are included in our BCF plan and form part of integrated care pathways in stroke, dementia care, carer support, and crisis services for people with mental health problems, We see the BCF as a catalyst and enabler to embed voluntary sector services into other condition specific care pathways, and maybe more importantly, as a key partner in prevention and early detection - signposting and offering advice and support to people who may be at risk of needing acute interventions, and offering more sustainable and meaningful activity to offset or delay entry into health and social care pathways. The BCF plan supports this specifically through the social prescribing project (Action Plan reference: BCF05).

Social care providers

Rotherham Council formally commissions social care services from over 100 independent providers delivering registered care (care homes and domiciliary care services) and smaller scale specialised services, and operates a robust framework of contract management and quality assurance (including gathering intelligence from and working closely with CQC and other commissioners) to make sure that services are safe, good quality, relevant, and value for money. In addition, growing numbers of customers purchase their own support services directly using Direct Payments, and these service providers are regulated through formal review arrangements with appropriate and proportionate scrutiny. The council operates a risk register and applies appropriate incentive to contracts with providers to encourage innovation, added value, and high standards, and has a good record of positive engagement with the sector.

Local social care providers – the full range of independent sector organisations - have been engaged specifically on the implications of the BCF and to better understand some of the issues and good practices already taking place. This was undertaken using an online survey circulated to a wide database of local providers, consisting of those who are already engaged in work with commissioners, and those who are registered on the Rotherham E-Marketplace (Connect to Support), and holding a round-table discussion for a smaller group. The round-table provided an opportunity to use their experiences to explore potential solutions and enabled providers with a local focus to engage with the priorities for the BCF plan. A number of common themes have been identified which have informed the plan (see Appendix 1).

1.2 How we have engaged patients, service users and the public in the development of this plan, and the extent to which they are party to it

Our Better Care Fund vision is based on our Health and Wellbeing Strategy and on what Rotherham people have told us is most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon, and a "right first time" principle applies to the delivery of services whether they are provided directly by us or commissioned. We engage with inspirational local people in a number of forums, both formally brokered (eg the Council's Customer Inspection Team; the Rotherham Learning Disability Partnership Board; Rotherham Speak Up) and informal (eg Rotherham Older People's Forum, the Carers4Carers Mental Health Support Group; and Tassibee Womens' Group) to understand the barriers for local people in accessing the most appropriate support, staying safe; and keeping well. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

Specifically service users and the public have been engaged in the development of the BCF submission, including:

- Healthwatch Rotherham - 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
- 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

Responses from a range of consultation exercises and surveys previously completed have also been collated, and used 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, 'Making It Real' Programme consultation in 2013, which assisted with developing Rotherham's "I" statements; 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 Council consults with and recruits customers for all major social care commissioning exercises, and undertakes rigorous customer evaluation to establish quality in the registered care sector. 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, bringing 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.

Our local NHS Provider Trusts have robust, monitored, and publicised arrangements that consult with and seek participation from people using their services, families and friends.

Through the service user, patient and public engagement described above, 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 independent sector health and social care providers

Further information regarding the specific outcomes from all of the consultation activity can be found in Appendix 1.

1.3 Future engagement and consultation planned from April 2014

We have developed a consultation and engagement plan (appendix 8), which has been used from the start of this process and will ensure continued engagement as we move into transition and implementation of the BCF plan.

The council has a well-developed process for engagement with adult social care providers and has an ongoing programme for the year which includes engagement to explore the implications of BCF and Care Bill. A planned presentation to adult social care providers on the 7 May 2014 will bring together both pieces of work and will result in

a co-produced action plan for the year. The Market Position Statement for Older People's services (Appendix 6) has been published and provides clear direction for existing and new providers, this will be updated and evaluated periodically, and an additional position statement will be available later in the year that will scope activity and intentions across all adult care sectors and with close collaboration with health commissioners.

We have produced two public-facing documents which we will use to share with local people our plans, how they align with our local priorities and what our proposed changes will mean for local people ('Plan on a page' Appendix 10 and 'What will the BCF deliver for the people of Rotherham' Appendix 9).

1.4 Related documentation

Ref.	Document or information title	Synopsis and links
A1	**Findings from consultations**	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.
A6	**Market Position Statement for Older People**	The Market Position Statement has been developed by Rotherham Council to inform current and potential providers of social services in the borough of the direction of social care services for older people over the next few years.
A7	**Risk Register**	Detailed log of risks and mitigating actions which will be used to monitor and review the

		impact of the BCF plan and identify any unintended consequences,
A8	**Consultation Plan**	Plan for continued consultation and engagement with service users, patients and providers.
A9	**What will the BCF plan deliver for the people of Rotherham**	A public document which provides an overview of the BCF planned schemes, 'I Statements', and case studies demonstrated the what the changes will mean for local people.
A10	**BCF 'Plan on a page'**	2 page document which demonstrates how the BCF actions align with the health and wellbeing strategy and outcome measures.
A11	**Workstreams delivering savings**	Table showing the workstreams through which QIPP savings are being delivered.
A12	**Governance Frameworks**	Diagrams demonstrating the decision making structure, as well as the framework for delivery and performance.

2. Vision and Schemes

2.1 Our vision for integrated health and care services for 2019

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

Local 'I Statements'

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.

Customer experiences will be closely monitored throughout the delivery of the BCF action plan via the 6 'I statements'. This will involve the council's Performance and Quality Team contacting relevant service users and patients, upon delivery of each of the BCF actions and obtaining their views regarding service/s they are receiving. This will help us to see the real customer journey and to learn and improve service delivery based on customer feedback.

Through surveys, telephone and face to face interviews, the team will develop a number of case studies, to identify the positive and negative impacts that the BCF plan has had on customer experiences. Rotherham Council has in place a Customer Inspection Service, with individuals who are customers and experts by experience. This group will support the assessment of the impact of the BCF plan and help us to see the implementation through the eyes of the customer. These experts by experience will also help us to identify where further improvements are needed. All feedback will be used to further enhance and improve the customer experience.

Our vision – a customer perspective

As a result of the changes we will make, we expect that 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.

Integrated commissioning

To achieve this, we have agreed a number of actions that will begin this journey and result in changes short and medium term. We have a tradition of shared commitment to delivering joined up services, as demonstrated by our well-established Joint Adult Community Mental Health Services; Joint Learning Disability Service; Joint Residential and Nursing Care Service, and a joined up approach to Safeguarding of Vulnerable People; Intermediate Care Service; Stroke Recovery Services; dedicated Step- Up/Down placements; and Integrated Community Equipment Services, all supported either by pooled budgets and/or partnership agreements overseen by dedicated joint commissioning staff. Currently the majority of commissioning activity is undertaken separately by experienced officers in the council (including Public Health) or in the CCG (and colleagues in the Regional Commissioning Support Unit), though key partner decisions, broad commissioning intentions; and efficiency programmes are shared through our joint consultation forums: the Adult Partnership Board; Chief Executives Group; Rotherham Partnership Board; and HWBB.

Our longer term, 5 year plan, will see health and social care teams working in an increasingly integrated way and our commissioning plans aligning more comprehensively to meet the priorities set by the HWBB, to achieve maximum efficiencies, preserve service quality, and reach beyond critical, acute or “eligible” social care to impact on the prevention agenda. 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 scope and routinely share information on commissioning activity, share respective commissioning plans and timetables, align wherever possible, and develop joint market facilitation arrangements so that market providers receive a consistent and transparent message from the Rotherham health and social care community. Our integrated approach extends to public health services; complimentary public health activity focuses on primary prevention and supporting and developing the healthy ageing agenda. The synergy between BCF and public health will help to maximise the improvements across the pathway from prevention to early diagnosis/help.

2.2 Our aims and objectives for integrated care and how the fund will secure improved outcomes in health and care in Rotherham.

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	
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	
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	
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	
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**
- **N2 Effectiveness of reablement**
- **N3 Delayed transfers of care**
- **N4 Avoidable emergency admissions**
- **N5 Patient and service user experience**
- **L1 Emergency readmissions**

The 4 vision themes and objectives of the health and wellbeing strategy described above are being delivered through a set of workstreams, jointly led by the council and CCG. The proposed schemes to deliver the BCF described in the following section will form part of this broader work and contribute to achieving these objectives. Although the BCF plan is only part of the picture, we feel it will significantly contribute to the strategic outcomes that the Health and Wellbeing Board have already signed-up to through the local strategy, which is why we have closely aligned the two pieces of work. By ensuring the BCF plan is closely aligned to the objectives of the Health and Wellbeing Strategy, we are able to identify specific funded activity that will improve outcomes for local people through a better integrated system, which will ultimately help us to achieve our vision.

2.3 A description of our planned changes

Achieving our vision will mean significant change across the whole of our current health and care landscape. Commissioners and providers welcome the opportunity 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.

The local BCF action plan is transformational and signifies a major shift in the way we commission health and social care services. For example:

- The development of an integrated Rapid Response Service is one example of how the BCF will ensure a consistent and integrated response to people who have an urgent need.
- By responding quickly with the full range of support we will be better able to reduce hospital admissions and delay admission to residential care.
- An integrated falls and bone health care pathway will reduce the impact of falls related injuries and save costs further down the care pathway.
- Finally the introduction of person held care record will ensure that health professionals can make informed decisions about treatment options and most the appropriate place of care.

An 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 put in place the following schemes:

BCF01 Mental Health Service

The mental health liaison service will be provided through a multidisciplinary team working to support the care of older people with mental health needs and younger people with dementia. The team will work in partnership with care homes and general wards in the hospital. Its minimum function will be to reduce admissions into mental health wards by supporting people effectively in the community, and also to support timely discharges from hospital.

We have identified the following key objectives for developing the service.

- Improve the provision of mental health liaison across CAMHS, Adults and Older People services
- Reduce avoidable emergency admissions and re-admission to The Rotherham NHS Foundation Trust (TRFT).
- Reduce the number of admissions and length of stay for older people with dementia or adults with mental health problems.
- Improve outcomes and patient experience for people with mental health illness accessing TRFT.
- Raise the profile and increase awareness of mental health and dementia within TRFT as an aspect of holistic health.
- Improved compliance of TRFT with the legal requirements of the Mental Health Act (2007) and Mental Capacity Act (2005).
- Improve access to mental health services through 7 day working.
- Improve parity of esteem.
- Ensure people with mental health problem receive the right treatment in the right location at the right time

How will we do this?

- Commission a 7-day a week with extended hours (9.00am – 8.00pm) for mental health liaison service for adults with mental health problems and older people with dementia.
- Raise the profile and awareness of mental health within TRFT as an aspect of holistic health. This will be achieved through the increase prominence of mental health services at TRFT and the delivery of training programme to TRFT staff.
- Ensure there is effective liaison and improved pathway of care with other parts of the health / social care system, including Rotherham GPs, Crisis and inpatient teams (TRFT, Woodlands, Swallownest etc.), specialist mental health teams (adult and older people), social services, emergency service and non-statutory agencies, Alcohol Liaison service, Substance misuse services.
- Pilot the introduction of an additional CAMHS consultant into the service to support 7/7 working.
- Provide expert advice on capacity to consent for treatment in complex cases, including advice regarding the use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).

Who will benefit?

Customers will benefit from being provided with more skilled and appropriate support when they do need to experience a hospital admission, and will also benefit from having care provided to them where they live. The coordinated assessment and care plan should result in more person centred care and better outcomes for people using services. Those who will benefit include:

- People with dementia and their carers
- Adults with mental health problems and their carers
- Children and young people with mental health problems and their carers
- Staff in TRFT, RDaSH, social care and working in the Emergency Care Centre
- NHS England interface with Rotherham services, such as RDaSH, social care and TRFT

BCF02 Falls Prevention

Rotherham will set out a systematic approach to falls and fracture prevention. We have identified four key objectives for developing the service

1. Improve patient outcomes after hip fractures through compliance with core standards
2. Respond to a first fracture, through falls and fracture services in acute and primary care settings
3. Early intervention to restore independence, through falls and fracture care pathways
4. Prevent frailty, promote bone health and reduce accidents through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards

How will we do this?

Engaging all key partners to comprehensively scope and apportion lead responsibility for the actions needed, and establish an intelligence network to collect evidence to be presented at a bi-yearly clinic around falls prevention, pro-actively engaging care sector providers through the Shaping the Future Forum. To link this work to the Dependence to Independence Workstream and the partnership approach around risk management.

- Identifying patients presenting with fragility fracture and assess them to determine their need for bone active therapy to prevent future osteoporotic fracture
- Ensuring that people at high risk of falls and fracture are given comprehensive assessment and evidence based intervention
- Introducing a care management pathway with clear lines of referral for an integrated approach to bone health, fracture liaison and falls prevention
- Reducing year on year increase in falls that result in hospital admission and serious injury and to reduce the numbers of people who sustain fractured neck of femur following a fall.

Who will benefit?

There will be separate care pathways for each of these cohorts;

- People at risk of an injurious fall — Primary and community care
- People who have had a recent fragility fracture — A&E and Fracture Clinic
- People with an injurious fall who have complex needs — Case management

BCF03 Joint call centre Incorporating telecare and telehealth

This workstream provides a joint vision for the development of telehealth and telecare services in Rotherham. It sets out the principles for care pathway development, maps current telecare provision and puts forward proposals for joint commissioning activity.

The overall objective of developing a joint telecare/telehealth strategy is to optimise the care of patients with long term conditions. Rotherham MBC and Rotherham CCG recognise that technology is an enabler for optimisation but not the whole solution. Pathways should be developed in conjunction with national guidelines and strategies for the management of long term conditions. All pathways should be systematically reviewed with clinicians in order to draw on their local expertise.

How will we do this?

Rotherham CCG and Rotherham MBC will work to together to develop telecare prescriptions for GP Practices participating in the case management programme. We will introduce integrated telecare and telehealth packages which can be offered as part of a self-management programme for patients with a long term condition. We will scope the potential for development of a joint telecare/telehealth hub. Specifically we examine the potential for combining the Rothercare Service with the Care Coordination Centre.

Who will benefit?

The main benefit of this initiative is its potential to deliver improvement in outcomes for people who have a high dependency on health and social care services. A combined approach to care coordination, telehealth and telecare allows local practitioners to maintain contact with vulnerable patients. It can help improve the reach of health and social care, supporting those who are often 'invisible' from main acute services.

This initiative is more likely to ensure that intervention is early and appropriate. It makes more efficient and effective use of available clinical teams by reducing unnecessary home visits. It involves people far more in the management of their own healthcare and could lead to significant reductions in A&E usage and unplanned admissions

BCF04 Integrated Rapid Response Service

Rotherham will extend the current Fast Response Service so that it is capable of meeting the holistic needs of adults with long term conditions who experience an exacerbation. The new service will incorporate community nursing, social work support, enablement and commissioned domiciliary care. The main aims of the service will be to;

- Prevent avoidable admission to hospital for people with long term conditions
- Support discharge from hospital for those who are medically stable
- Ensure that patients receive the most appropriate level of care that can meet their needs
- Ensure that patients receive seamless care that is patient focused and clinically safe
- Provide a service from 7am until 2am, 7 days a week including bank holidays
- Ensure safe and effective handover of care to mainstream primary and community services.

How will we do this?

We will enhance the current Fast Response Service so that it incorporates social workers, reablement workers and it will work in a streamlined way with commissioned domiciliary care providers. The new Integrated Rapid Response Service will assess patients who are medically stable but need additional support to remain at home. The service will meet all the health and social care needs of eligible patients for up to 72 hours at which point there will be a hand-off to mainstream services.

Under this enhanced service model the GP will retain overall medical responsibility for patients. The team will have access to the Fast Response beds located at Lord Hardy Court. If it is not possible to meet the needs of the patient at home, the Integrated Rapid Response Service will be able to arrange transfer to one of the Fast Response beds for recovery and recuperation.

Who will benefit?

In order to qualify for support from the Integrated Rapid Response Service the patients has to be 18 years or over. They have to have a Rotherham GP and they must be medically stable at the time of referral.

The patient may require rehabilitation. They may be a falls risk or have poor mobility. Patients who require IV Therapy would be eligible for the service as would those experiencing an exacerbation of a medical or long term condition.

BCF05 Seven day community, social care and mental health provision to support discharge and reduce delays

Rotherham will extend current provision so that appropriate services are available 7 days/week. This will enable timely discharge from hospital and avoid unnecessary admissions to hospital or residential care.

Emergency care should not be used when patients would benefit from care in other settings. We will ensure that community health and social care services deliver a high quality, responsive service both in and out of hours. We will focus on improving diagnostics and urgent care. Through good partnership working, we will ensure that community services deliver a high quality, responsive service both out of hours. We will ensure that when someone has an urgent care need out of hours the quality of health provision is maintained and that patient outcomes are good.

How will we do this?

Rotherham will review and evaluate existing arrangements against potential increase in demand arising from 7-day working across community, social care and mental health. We will increase social work capacity and, through jointly agreed specifications, we will commission future domiciliary care capacity, to support discharge at weekends. We will enhance and integrate out of hours services, and review commissioning arrangements, so that they are more responsive.

Who will benefit?

7 day services have the potential to drive up clinical outcomes and improve patient experience through, reducing the risk of morbidity and excess mortality following weekend admission in a range of specialties. Case studies reveal the potential for:

- improved quality, efficiency and innovation through

- Admission prevention;
- Speed of assessment, diagnosis and treatment;
- Safety and timing of supported discharge;
- Reduced risk of emergency readmission;
- Better use of expensive plant and equipment;
- Avoidance of waste and repetition
- Service rationalisation to enable safe consultant staffing levels.

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 put in place the following schemes:

BCF06 Social prescribing

The social prescribing project has had a successful start and has been recognised nationally as good practice. The plans included in the Better Care Plan will extend availability. The project acts as a portal for health professionals to access voluntary and community support services, to enable existing third sector providers and groups to complement the formal support that people with long term conditions receive. They are able to provide flexible, appropriate services that help people to self-manage.

How will we do this?

Through funding community navigators, employed by VAR, the local community and voluntary service, people with long terms conditions are able to access through their GP the following services:

- Condition management programmes: education, managing pain and fatigue, healthy eating, exercise, emotional support, support to self-care, understanding care pathways, self-help groups.

- Health and wellbeing: craft groups, music sessions for people with dementia, community garden projects, peer support groups, healthy cooking clubs, walking groups, specialist yoga and assistive technology support.

- Employment, education or wider community participation: one to one support, group work, social activities, training, apprenticeship s, support to access community facilities, travel support, community transport.

The service employs dedicated workers whose role includes liaison with providers and support to enable referred patients to access the prescribed service. This may include a

short period of one to one support to access available services, taking someone to a self-help group or organised activity.

Who will benefit?

GPS will benefit from being able to support patients to follow through on self-help activities. Customers will benefit from being able to access a wider range of support that enables them to regain or gain independence, and the community benefits from having a wider range of people actively engaged. The third sector is fully engaged into patient care pathways. It contributes to a reduction in formal social care packages and reduces admission to hospital.

BCF07 Joint residential and nursing care commissioning and assurance team

What are we trying to achieve?

Approximately 1500 Rotherham people live in care homes in Rotherham, under a diverse set of funding arrangements. Rotherham currently has more available placements than demand requires, and this suggests a degree of fragility for the sector. The intention of this workstream is to develop a joint approach towards quality assurance of residential and nursing care homes. Rotherham CCG and Rotherham MBC will work closely to develop an integrated care home support service that fulfils the following functions;

- Reduce A&E referrals, ambulance journeys and hospital admissions from residential care
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives
- Review health aspects within care homes and ensure they are contract compliant
- Improve communication and align local routes for delivering improvements in care home standards and quality.

How will we do this?

Rotherham will carry out a review of existing services to examine where joint working arrangements can best apply. We will explore the potential for developing an integrated Care Home Support Service, incorporating the current functions of the team with responsibilities for contract compliance. Health and social care staff will work closely together to improve quality and monitor performance. Where the team identifies issues with care quality or where a training need is identified for staff, the service will directly intervene. Interventions can include; the development of remedial improvement plans, co-ordinating tailored training programmes and case management support for complex residents.

Who will benefit?

The development of an integrated Care Home Support Service will ensure that care home contracts are monitored effectively and that health related concerns are properly picked up within the local authority contracts. Residents will benefit because quality and performance issues will be identified early, enabling Homes to take remedial action before concerns regarding safeguarding start to arise. Care Home Providers will benefit from a unified approach to contract monitoring and a consistent message from commissioners. They will understand better the local intentions, which will assist them to make positive and informed business continuity decisions in a local market that is under the development of this type of integrated support provision will support good practice and protect residents.

BCF08 Learn from experiences to improve pathways

We want a clearer understanding of the journey through health and social care services for people with long term conditions. We want to answer the following questions about our local services:

- Is our care proactive, holistic, preventive and patient-centred
- Are people playing an active role in their care? Are they engaged, informed and empowered?
- Do health and social care professionals adopt a partnership approach with their customers
- Are clinicians competent in supporting shared decision-making and goal setting
- Can we reduce duplication of input between health and social care
- Is the risk stratifications tool identifying high intensity users of health and social care services
- Is there a link between care planning for individuals and commissioning for local populations
- Do we have a diverse range of quality providers to call on that allow sufficient choice and flexibility to meet the specialist needs and preferences of people in our communities

How will we do this?

We will gain this understanding by:

1. Undertaking a deep dive exercise which maps the care pathway of a specified number of high intensity uses of health and social care services, using customer journey tools to enable a better understanding of the customer experience of services.
2. Carrying out a full evaluation of the risk stratification tool and developing a mechanism for identifying high intensity users of health and social care services
3. Involving customers and carers in refreshing the JSNA so that demand is better understood and partners have as much intelligence as possible on which to base their commissioning activity.
4. Health and Social Care Market Facilitation Programme

Who will benefit?

This piece of work will ensure that we are targeting resources at the correct cohort of people. It will inform plans to reduce duplication within care pathways and it will support a partnership approach to care delivery. It will promote partnership working between the patient and health & social care professional. It will also support partnership working on a case and individual level between health and social care services.

What 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 put in place the following schemes:

BCF09 Personal health and care budgets

The council has a positive record in delivering personalised services, including personal budgets and direct payments. Collaborative work between the Council, CCG, and CSU has resulted in the early delivery of personal health budgets for people in receipt of fully funded health care, so the health and social care economy is on track to deliver personal health budgets by 1st April 2015. Through the Better Care Fund, it is our aspiration to continue to deliver on these agendas and to extend our current plans to a wider group of individuals, ensuring that they have choice and control.

How will we do this?

As the personalisation agenda is rolled out, the CCG will review its the payment mechanisms for community services to ensure that where patients choose alternative services over commissioned services, the CCG does not pay twice. Where commissioned services are no longer required we will seek to decommission services without destabilising existing providers. There is potential for a much wider range of providers which require the appropriate oversight to ensure quality requirements are being achieved, and RMBC and the CCG will work together to present a consistent approach to the care market, and develop streamlined and flexible contract management arrangements.

Over the next year we will roll out training to offer personal health budgets (PHB) to all patients in receipt of a domiciliary Continuing Healthcare package, including notional budgets. We will monitor the impact of PHB roll out on expenditure. We will hold stakeholder development sessions to build strong partnerships between RMBC, Rotherham CCG and Commissioning Support Unit colleagues. Finally we will develop a service level agreement with RMBC, subject to agreement of final costs.

Who will benefit?

Customers and their families will benefit from being able to choose the way in which their services are delivered, offering increased choice and control. Service providers will benefit from positive engagement with customers and the ability to work in a more person centred way.

BCF10 Self-care and self-management

The purpose of this workstream is to ensure that self-management is embedded in all aspects of health and social care. A good system of self-management will support the development of knowledge, skills and confidence in self-care support. Health and social care services should support people with long term conditions to actively participate in care planning. Care plans should include actions for the person receiving support aimed at improving or maintaining their condition. High-risk patients with long term conditions should have a person held record, which includes their care plan. Case managers should ensure planned follow up on goals. Scheduled appointments should be in place to plan care, treatment or support.

Some specialist teams such as the Home Care Enabling Service, Intermediate Care , Falls Service, Breathing Space and the Community Stroke / Neurological Conditions Teams and community matrons are built on an ethos of self-management. These services have the clinical systems in place to support self-care. However many mainstream health services still focus on direct support rather than support with self-management.

How will we do this?

Rotherham will evaluate the current patient skills programme and reconfigure. We will bring all self- management programmes under a single banner “Rotherham Patient Skills Programme”. We will extend the current patient skills programme so that it supports patients on the GP case Management Programme. We will develop specialised psychological support services for people with long term conditions, so that they are better able to self-manage**.**

Rotherham will set up a local self-management network, responsible for promoting self-management and acting as an interface between the statutory, voluntary and independent sectors. We will develop a multi-agency practitioner development programme, equipping works with the skills to assist in self-management. Finally Rotherham will introduce a person held record for people with a long term condition, enabling them to monitor their condition and track the progress of their care plan.

Who will benefit?

Every person in Rotherham with a long-term condition should have an opportunity to participate in a collaborative care planning process with effective self-management

support. People who recognise that they have a role in self-managing their condition, and have the skills and confidence to do so, experience better health outcomes. With effective support and education, evidence shows that these skills can be developed and strengthen, even among those who are initially less confident, less motivated or have low levels of health literacy. Professionals gain new knowledge and skills, leading to greater job satisfaction.

BCF11 Person-centred one-page plan

Each individual in contact with services will have a person-held one page plan that informs them, their family and professionals involved with their care of their story, their plan and what they can do to keep themselves healthy, safe and living in the community. It will outline about what is important to that individual, Building on the success of the case management pilot, which has seen every person in the pilot being provided with a care plan that is held in the home, the document will be agreed with the customer and will be developed in line with current best practice
How we will do this

How will we do this?

We work with customers and patients to develop an agreed format. This will then be tested with a small group of customers and once the result is effective and meets customers' needs, will be rolled out through the case management process, through social work assessments and other routes.

Who will benefit?

Customers will only have to tell their story once, and will be able to work with their GP or other professional on developing a plan that reflects their needs, and also includes their self-care or self-management plan, plus a plan that informs, when needed, other professionals to ensure that they receive the care they need where they need it. This plan will ensure that people's needs are met. The case management pilot has resulted in a number of people having person held plans in their homes, and this has been welcomed by the ambulance service who have found them useful and have been able to use them to support decision making – the person centred one page plan will build on this.

BCF12 Care Bill preparation

The Care Bill present significant challenges to the Local Authority and partners , in relation to a duty to provide effective advice, information and guidance services, extended rights for carers, statutory responsibilities for safeguarding adults, deferred payments and care accounts including new responsibilities in relation to people who fund their own care and an increased focus on personalisation. The council will identify the cost and activity pressures resulting from this new legislation.

How will we do this?

There is a Care Act Steering Board in place which has five workstreams each focussing on key elements of the Act, The Steering Board will work with customers, providers, and partners to determine the actions needed, and will then guide the action plans to deliver effective change by 1 April 2015.

Who will benefit?

The Care Act will ensure that there is a consistent approach nationally in relation to the eligibility for adult social care, portability of assessment, and the delivery of more personalised services., It will ensure that carers are supported. The action plan will ensure that staff needs for training, development and information are met at a time of significant legislative change.

What 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 put in place the following schemes:

BCF13 Review existing jointly commissioned services

All jointly commissioned services will be reviewed to establish if they provide value for money and are aligned with the BCF vision and principles. Where services are not efficient and effective, services will be reconfigured or decommissioned. There is a recognition that the shift from care in hospital to the community will impact on social care services. Where this impact is apparent the Better Care Fund will provide additional support to social care services through the service review process.

How will we do this?

Rotherham will develop a 3 year review programme for all services funded through the Better Care Fund. We will also develop a robust review process which enables commissioners to form a clear picture of the strategic relevance and performance of existing services. We will set out joint governance arrangements for making decisions on review recommendations. Finally we will put in place a proper performance framework for BCF services which demonstrates the effectiveness of services against BCF criteria

Who will benefit?

Reviewing the current portfolio of BCF services will ensure that there is proper alignment between health and social care locally. Commissioners from the local authority will have a direct influence over the configuration of services that were historically commissioned by health. Local Authority commissioners already have a good dialogue and contract

management arrangements with the care market and involve health partner commissioners in its engagement/ market facilitation programme, to present a united approach to commissioning and procurement of services wherever possible. The BCF presents an opportunity to understand more thoroughly the models and drivers for commissioners from each organisation and to improve future collaborative commissioning for the health and social care community.

All commissioned services can be realigned to deliver a combination of health and social care outcomes rather than being totally focused on the targets of a single organisation. This inevitably benefits the patient as it moves both CCG and Council commissioners towards a position where they are commissioning fully integrated health and social care services.

BCF14 Data sharing between health and social care

All Rotherham NHS correspondence uses the NHS number as primary identifier, and the council has a plan already in development to enable this to be used on social care systems. It is proposed that use of the NHS number as a unique identifier across all health and social care will create the starting point for the development of shared IT capacity locally. We aim to provide information sharing capacity between and across health and social care that is effectively governed and safe.

How will we do this?

Through the BCF there is a commitment to ensure that all providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. To enable this to happen we will develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Accompanied with effective use of new technology it will liberate practitioners and transform the way they work.

Who will benefit?

The BCF Plan has highlighted actions related to the use of technology and information that, if fully implemented, could deliver significant benefits to the health and social care economy. These benefits include improvements to quality and efficiency as well as patient experience and satisfaction.

As well as delivering efficiencies, there are also tangible benefits such as the improvements in the quality of care delivered, the accuracy of data collected, improved data flow between health and social care and the increased flexibility the practitioners have in managing their time and location of work.

The BCF Plan will ensure greater efficiency in accessibility of patient information. Increased accessibility will enable faster transfer of medical history in a medical emergency or when visiting a new practitioner. Researchers and public health authorities, with the permission and consent of the patient, will be able to collect and analyse up-to-date patient data. Such access is imperative in emergency situations, and also allows public health officials to easily conduct outbreak and incident investigations. Improved accessibility will also enable health care providers to reduce costs associated with duplicate testing, appointment reminders and laboratory results.

2.4 Our plan's impact on mental health services

The mental health liaison service is a key component of the BCF plan, which will be in addition to existing services and will transform how patients with mental health issues are treated in the Rotherham urgent care system. This will also improve patient experience and health outcomes

A key change in 2014 will be increased clinician to clinician discussions between CCG GPs and mental health service clinicians to ensure that quality improvements can still be made in the increasingly challenging financial situation.

There will be an increased focus on the mental health of people with other long term conditions. The Older people, Adults and Alcohol liaison services will be part of an increased emphasis on the mental health needs of people accessing acute hospital services. The GP case management, over 75s and social prescribing schemes describe the increased multiagency and voluntary sector inputs we will deliver to 20,000 people with long term conditions and who are at risk of hospital admission.

An action log was produced in December 2013 setting out details of as follows:

- An increased focus on quality for Rotherham residents in both adult services and CAMHS;
- Older and Adult Mental Health Liaison Services and Alcohol Services. These services which started in 2013 will be evaluated and enhanced if they provide value for money and deliver the required outcomes;
- Dementia
    - Achieving timely diagnosis and treatment and improving the care pathway, and reviewing scanner capacity;
    - Develop a one-stop clinic for dementia diagnosis;
    - Improving support to carers
    - Work with partners to review dementia day care service provision across health and social care
    - Social prescribing support is improving support to carers, it is helping more hidden carers to be identified and get support earlier
- Establish an adult autism diagnosis process
- Work to implement Mental Health Payment by results. This will require primary and secondary care clinicians to work together on benchmarking and care pathways;

2.5 What our changes will mean for local people

We have developed a set of personas and 'case studies' which demonstrate what the changes we are making through the BCF will mean for local people. These have been aligned to our 'I Statements' providing us a basis for monitoring our changes once the plan is full into implementation.

Case studies can be seen in Appendix 9, which we will also use to share with the public what our proposed changes are and what this will mean for them as patients, services users and/or carers.

2.6 How the BCF aligns to other local 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. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

2.7 Our timescales for delivery

We have identified lead officers for each of the BCF schemes in our plan, who will be responsible for developing more detailed action plans for each scheme, demonstrating the expected timescales and delivery mechanisms.

This will be supported by the BCF operation officer group, which will begin this work during its first meeting in April 2014.

We have identified the budget and where this will be spent during the transition year 2014/15, which will include reviewing a number of services to ensure the BCF plan is ready to be fully implemented from 2015/16.

2.8 Implications of our plan on the acute sector

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:

1. 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** in 2014/15 and the 5 year plans are as follows

QIPP Plans 2013/14	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
4% Efficiency	(8,750)	(8,993)	(8,993)	(8,993)	(8,993)

2. 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.

In addition to the £8.8m above, there are two key areas for acute savings:

Unscheduled Care – reducing avoidable admissions - £1.3m
Historically, Rotherham health community has been an outlier for emergency admissions to hospital. This is not fully explained by the higher than average levels of morbidity and

there is evidence that individual clinicians involved in hospital admissions such as GPs, ambulance staff, and accident and emergency doctors have different thresholds for admission. Whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting could be a better, safer option. The CCGs strategy provides 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. There are important links between this area and plans to improve community services such as further developing the care coordination centre and providing alternative levels of care.

Clinical Referrals - £3.4m
The CCG will continue its approach based on clinical leadership and peer influence. Work with GPs and referring clinicians and providers will ensure referrals and elective and non-elective procedures are kept within affordable limits. If the current consensual, educationally based approach continues to be successful it will mean that Rotherham can maintain short waiting times and avoid unnecessary restrictions on the numbers of types of procedures that are available to patients.
Key to the work is effective communication with all clinicians in Rotherham, by face to face meetings, working with GP localities and hospital specialists through the Hospital Management Team and Medical Staff Committee, educational events, monthly newsletters, top tips for important pathways and by providing benchmarking information.
Patient experience will be enhanced by improving the quality of referral information to consultants, high quality discharge letters back to GPs with advice and management plans.

Alternative ways of getting secondary care opinions such as expanding the current virtual haematology will be more convenient for patients. The changes will ensure that patients receive care as close to home as possible.

Details of how savings are to be invested is covered under section 3.1

Quality Impact Assessments (QIAs)

QIAs are an integral part of the annual planning cycle and are completed by the healthcare provider, proposed by the Chief Nurse and Medical Director and adopted by the Trust's Board. The Commissioner reviews the QIAs in advance and views are taken on board prior to the final submission. The CCG must also report through to NHS England the assurance level it has of provider efficiency savings and the extent to which quality and safety is optimised. This process will be completed in April 2014.

2.9 Governance arrangements 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 will be fit for purpose to ensure effective scrutiny, accountability and delivery.

The framework shown in Appendix 12 demonstrates the decision making structure and how the BCF plan will be delivered through the various groups.

The Health and Wellbeing Board will:

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

The BCF Task group will monitor delivery of the Better Care Plan through quarterly meetings, ensuring performance targets are being met, schemes are being delivered and additional action is put in place where the plan results in any unintended consequences. The Task Group will report directly to the HWBB.

2.10 Audit and assurance process

To provide an independent review of the BCF, including the source and use of the funds, a local audit and assurance process has been agreed. The final report of which will be shared with the respective members of both organisations and the Task Group.

Scope of the Audit: that the BCF has:

- Been developed with the national planning guidance in mind
- Is fit for the purpose, in that it clearly sets out indicative budgets for the CCG and RMBC and identifies those areas for which each party will have commissioning responsibility
- Provided a clear audit trail of where funds are invested in contracted services
- Provided a clear audit trail to substantiate claims made against the risk pool;
- Provided a clear audit trail supporting the financial reporting to the CCG, RMBC and BCF Task Group
- Reflected a diligent approach by both parties to quantify and manage current and future budgets and identify future risks
- Reflected good internal control.

3. National Conditions

3.1 Our local definition of protecting adult social care services

NHS savings of £7.6m will be used to fund transformation – this is illustrated in the table below:

BETTER CARE FUND 2014-15	EXISTING SOCIAL CARE	PROTECTING & TRANSFORMING SOCIAL CARE	EXISTING HEALTHCARE	PROTECTING & TRANSFORMING HEALTH-CARE	TOTAL
	£000s	£000s	£000s	£000s	£000s
Funded from Health	6,214	1,151	5,840		13,205
Additional funding from Health Savings		2,336		4,105	6,441
TOTAL from Health	6,214	3,487	5,840	4,105	19,646
Funded from Local Authority	3,305	148			3,453
TOTAL Funding	9,519	3,635	5,840	4,105	23,099

The savings are to be invested as follows:

- Growth monies of £1.3m have been allocated from NHS England for social care in 2014-15 which will be utilised to protect social care (£1.1m) and provide support to advice, Mental Capacity and IT (£0.2m);
- In relation to concerns around the impact of CCG transformation in mental health and integrated fast response, we have proposed a risk pool for 2014/15 to protect both parties against unintended consequences. This is estimated at approximately £x00k and will require auditable information in year to support the claims from either party;
- There is a potential unintended impact on the Occupational Therapy service of the successful social prescribing initiative which is estimated at £100k by RMBC colleagues;
- The transformation of the intermediate care residential beds including therapy services estimated at £320k;
- Support the development of 7-day working in social care by £240k to provide additional social work capacity to supplement the existing emergency duty support at weekends;
- For data sharing – both parties agreed to increase the allocation in this area in 2014/15; CCG contribution £250k and RMBC £148k;
- £511k for transformation of S256 care Individual case management of high risk patients and over 75s - £2.2m;
- Hospice at home - £771k;
- Social prescribing - £500k
- Mental Health liaison - £375k rising to £1m in 2015/16

There are a number of ways in which the Rotherham BCF will protect social care services. Firstly, services such as Community Occupational Therapy, Intermediate Care and The Rotherham Equipment Service are all fully integrated health social care services, which are measured against the adult social care outcome framework. Placing them under the umbrella of BCF will secure these services for the future, save costs further down the care pathway, and allow for growth in social care services where transformation in other parts of the system require it.

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

This approach will transform the way patients with high needs access services and will ensure more joined up working between health and social 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 BCF is used to support those care services which in turn protect the NHS.

3.2 How social care services will be protected within our plan

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 re-commissioned or de-commissioned 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.

The BCF will ensure we do not have to raise the eligibility criteria for assessment, care management, and commissioned support, 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.

3.3 Seven day services to support discharge

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 complement 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.

3.4 Information and data sharing

All Rotherham NHS correspondence uses the NHS number as primary identifier, and the council has a plan already in development to enable this to be used on social care systems. It is proposed that use of the NHS number as a unique identifier across all health and social care will create the starting point for the development of shared IT capacity locally.

Through the BCF there is a commitment to ensure that all providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. To enable this to happen we will develop portal technology to share data in a secure way that is in the best interest of people who use care and support.

The BCF Plan has highlighted actions related to the use of technology and information that, if fully implemented, could deliver significant benefits to the health and social care economy. These benefits include improvements to quality and efficiency as well as patient experience and satisfaction.

The BCF Plan will deliver improvements in data sharing across health and social care. Accompanied with effective use of new technology it will liberate practitioners and transform the way they work. As well as delivering efficiencies, there are also tangible benefits such as the improvements in the quality of care delivered, the accuracy of data collected, improved data flow between health and social care and the increased flexibility the practitioners have in managing their time and location of work.

The BCF Plan will ensure greater efficiency in accessibility of patient information. Increased accessibility will enable faster transfer of medical history in a medical emergency or when visiting a new practitioner. Researchers and public health authorities, with the permission and consent of the patient, will be able to collect and analyse up-to-date patient data. Such access is imperative in emergency situations, and also allows public health officials to easily conduct outbreak and incident investigations. Improved

accessibility will also enable health care providers to reduce costs associated with duplicate testing, appointment reminders and laboratory results.

We are committed to adopting systems that are based upon open APIs (Application Programming Interface).

All Rotherham NHS platforms are Information Governance Toolkit compliant and Rotherham CCG has achieved assurance on Caldicott 2 compliance in March 2014.

Underpinning the developments outlined above, the Health and Wellbeing Board has collectively signed up to an overarching information sharing protocol (appendix 5), which provides a framework for information sharing for all partner organisations.

3.5 Joint assessment and accountable lead 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.

Within the case management programme the accountable professional is the GP. In Rotherham the Case Management Programme places GPs at the centre of care coordination. Over the next 12 months we will transform community services to ensure that patients can access high quality, safe sustainable community services including multi-disciplinary community teams and specialist community services that target specific conditions.

We are embarking on a programme of integration across acute/community services and also across health/social care. This will ensure that packages are fully integrated and contain clear lines of accountability

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 Locally Enhanced Scheme (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.

The BCF Plan will deliver significant benefits through delivery of integrated services and joint assessment. The development of a joint assessment framework will help prevent harm and crises to individuals at risk. It will do this by promoting a shared understanding of risk amongst health and social care professionals. Case management processes, led by one person, will improve co-ordination, reduce duplication and support communication across organisational boundaries. The clear lines of accountability resulting from identifying a case manager will encourage creative approaches to assessment which are more person-centred. The benefits of shared assessment in hospital will include improved patient information on admission and better communication between wards. It will encourage holistic working and overcome professional boundaries. There will be an

improved understanding of other professional roles, increased expertise and improved decision-making through information sharing.

4. RISKS

We have set out below the most important risks that we believe are associated with the delivery of the BCF plan. This includes our 'mitigating actions plan' which demonstrates the agreed commitment to share the risks between both partners, and ensure robust arrangements are in place to identify and manage risks and unintended consequences.

These risks and mitigating actions will be managed by the BCF Task Group, which will meet on a quarterly basis to review the BCF plan, reporting to the Health and Wellbeing Board where necessary.

A more detailed risk register is included as appendix 7.

Risk	Risk rating	Mitigating Actions
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.
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	**Medium**	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. Both partners have agreed a 'risk pool' to form part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan will be monitored on a quarterly basis by the Task group, and any consequences will be reviewed. We will consider turning this risk green in-year based on this process if both partners are comfortable with progress.
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 HWBB as the accountable body.
Performance targets are unachievable	**Medium**	Metrics agreed following robust process testing for "statistically significant" impact and

		investments made through BCF where appropriate.
Failure to receive 50% of the pay-for-performance element at the beginning of 2015/16.	**Medium**	HWBB 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.	**Medium**	Performance management process in place, accountable to the HWBB
Shifting of resources could destabilise current service providers.	**Low**	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 CCG to receive Quality Impact Assessments in March from providers regarding their respective efficiency plans. Local authority will continue to engage with providers through the Shaping the Future events programme to ensure potential impact is understood and planned for.