This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

Association

Finance - Summary

##

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	£ 19,646	£ *18,350*	£ *19,646*
BCF Total		**£ 23,099**	**£ 20,318**	**£ 23,316**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

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 achieved)		
	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)		
	Maximum support needed for other services (if targets not achieved)		
Delayed transfers of care from	Planned savings (if targets fully		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to 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	£ 1,128		£ 400		£ 1,128		£ 400	
BCF02 - Falls prevention	RFT	£ 903		£ 320		£ 914		£ 320	
BCF03 - Joint call centre incorporating telecare and telehealth	RFT/RMBC	*In year workstream to inform future BCF				*In year workstream to inform future BCF			
BCF04 - Integrated rapid response team	RFT/RMBC	£ 1,226		£ 435		£ 1,226		£ 435	
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	RFT/RMBC	£ 4,802				£ 4,802			
BCF06 - Social Prescribing	Voluntary Sector	£ 605		£ 214		£ 605		£ 214	
BCF07 - Joint residential and nursing care commissioning and assurance team	RCCG/RMBC	*In year workstream to inform future BCF				*In year workstream to inform future BCF			
BCF08 - Learn from experiences to improve pathways and enable a greater focus on prevention	RFT/RMBC	£ 27				£ 27			
BCF09 - Personal health and care budgets	RMBC	£ 1,643				£ 1,643			
BCF10 - Self-care and self management	RFT	£ 50				£ 50			
BCF11 - Person-centred services	Primary Care	£ 3,239		£ 1,148		£ 3,239		£ 1,148	
BCF12 - Care Bill preparation	RMBC	£ 275				£ 275			
BCF013 - Review existing jointly commissioned integrated services	RMBC	£ 7,938				£ 7,938			
BCF14 - Data sharing bewteen health and social care		£ 250				£ 250			
Disabled Facilities Grant	RMBC	£ 1,013				£ 1,219			
Total		£ 23,099	£ -	£ 2,517	£ -	£ 23,316	£ -	£ 2,517	£ -

Association

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

Template 1 provides further details of how our BCF plans will enable Rotherham to achieve the metric targets and these will be monitored monthly through our operational group.
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - We plan to reduce admissions rate 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 4%.
Delayed transfers of care from hospital per 100,000 population (average per month) We plan to reduce delayed transfers rate by 7%
Avoidable emergency admissions (composite measure). We plan to reduce avoidable admissions by 15% over the 5yr strategic planning period with a 3% reduction in 2014/15.
Emergency readmissions - there is a plan to reduce the rate of emergency readmissions where clinically appropriate by 4%. 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 budgets provision 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

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

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

Please complete all pink cells:

Metrics		Baseline*	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
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	86.70	N/A	90.00
	Numerator	110		117
	Denominator	130		130
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	124.6	119.9	114.8
	Numerator	2282	2207	1415
	Denominator	203503	204480	205444
		Apr 2013 - Dec 2013 (9 months) 9	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	2634.8	1193.9	1368.3
	Numerator	6807	3115	3570
	Denominator	258352	260908	260908
		Apr 2012 -Mar 2013 (12 months) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
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 measure to be used *(State time period and select no. of months)* 1	N/A	National measure to be used *(State time period and select no. of months)* 1
Local measure *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*	12.1	11.9	11.6
	Numerator	2290	2995	2934
	Denominator	18932	25250	25250
		Apr 2013 - Dec 2013 (9 months) 9	*Apr 2014 - Mar 2015 (12 months)* 12	*Apr 2015 - Mar 2016 (12 months)* 12