Appendix 2 Rotherham Better Care Fund Action Plan

Ref.	Scheme	Outcome	Action	Measure/s	Finance	Lead
Prevention and Early Intervention (PE) – Rotherham people will get help early to stay healthy and increase their independence						
PE1 We will co-ordinate a planned shift of resources to high dependency services to early intervention and prevention						
BCF01	**Mental Health Service**	A jointly agreed plan which results in a reduction in formal, high intensity use of services (including acute services and police intervention) and a greater investment in community-based and primary care preventative activity which addresses mental health issues much earlier on. This new service will be 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.	Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention. Increase funding available for social care packages including short term support time and recovery packages provided through Direct Payment, to enable where appropriate a link with personal health budgets to support longer term recovery .	Admissions to residential and care homes Avoidable emergency admissions Patient/service user experience Emergency readmissions	£1.1m .	**Deputy Chief Officer CCG** **Strategic Commission ing Manager, RMBC**
BCF02	**Falls prevention**	Older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance to help prevent them.	Review the falls service to ensure its primary focus is delivering a preventive community-based service, as well as targeting those most vulnerable, who are most at risk of fracture neck of femur.	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions Patient/service	£0.9m	**Head of Urgent Care and Long-term Conditions, CCG**

				user experience Emergency readmissions		
BCF03	**Joint call centre incorporatin g telecare and tele-health**	A coordinated response is provided to individuals' needs and an increased use of assistive technologies to support independence and reduce hospital admissions.	Undertake a scoping exercise to identify efficiencies and improvements in practice that can be delivered though integrated / joint working between the Rothercare Community Alarm Centre and the Care Coordination Centre. Review the service to incorporate increased use of assistive technology and extended use of telehealth and tele-coaching to support people to stay at home, and explore increased use of assistive technology to reduce costs within mainstream social care services including domiciliary care and residential care	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions Patient/service user experience Emergency readmissions	This will require scoping of the existing service and a transfer of funds	**Head of Urgent Care and Long-term Conditions, CCG** **Director of Health and Wellbeing, RMBC**
PE2 Services will be delivered in the right place, at the right time, by the right people						
BCF04	**Integrated rapid response team**	A coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.	Implement a joint approach to an integrated rapid response service, including out of hours, capable of meeting holistic needs of identified individuals to reduce hospital admission. Incorporate community nursing, enabling and commissioned domiciliary care, to be funded the through the BCF to protect social care services from the impact of additional community based support packages.	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions	£1.2m	**Head of Urgent Care and Long-term Conditions, CCG** **Strategic Commission ing Manager, RMBC**

			Additional assessment time (social care support) to be provided through the BCF as part of the response, in order to enable throughput through the Fast Response service, either into funded packages or through the social care prescribing offer into community based prevention activity.	Patient/service user experience Emergency readmissions		
BCF05	**7-day community, social care and mental health provision to support discharge and reduce delays**	Appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.	Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health. This will require an increase in social work support to support discharge, and increases in domiciliary care funding for packages to protect social care services. Fund a pilot project, social care staff working with Community Nurses to intervene early to avoid admission to hospital and residential care, supported by the outcomes of the project identified at BCF06	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions	£4.8m	**Head of Urgent Care and Long-term Conditions, CCG** **Adult SS Service Manager, RMBC**
Expectations and Aspirations (EA) – All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community						
EA1 We will ensure our workforce routinely prompt, help and sign-post people to key services and programmes						

BCF06	**Social Prescribing**	The need for more formal care services is reduced, creating an opportunity to shift investment into community activity that fosters independence and encourages local people to participate in their community. This service won a National Award from NHS England for best practice and will transform services from being reactive to a pro-active multi agency approach for Rotherham patients with high needs.	Review social prescribing service to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstream this service subject to findings.	Admissions to residential and care homes Effectiveness of reablement Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions	£0.6m	**Assistant Chief Officer, CCG**
BCF07	**Joint residential and nursing care commissioning and assurance team**	Reduction in the cost of contract compliance increased monitoring of nursing standards, reduced admissions to hospital and improved hospital discharges. Reduced cost of significant service failure and safeguarding though a more proactive/ preventive/ coordinated approach.	Implement a joint approach to a single LA and CCG team whose purpose is to commission and assure quality of service in residential and nursing care homes, with clear links to GP case management and an integrated response from health services.	Avoidable emergency admissions Patient/service user experience Emergency readmissions	This will require a review of existing services and creation of a jointly commissioned/ managed team supported by but not necessarily funded by the BCF	**Head of Urgent Care and Long-term Conditions, CCG** **Strategic Commissioning Manager, RMBC**
EA2 We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions						

BCF08	**Learn from experiences to improve pathways and enable a greater focus on prevention**	A shift in investment from high-cost, high-intensity users of health and social care, to low cost high impact community initiatives which focus on prevention. A co-produced (between health, public health and social care) risk stratification tool to identify high intensity users.	Undertaken a deep dive exercise conducted on cases of high social care and health users. Map the journey through health and social care services to identify opportunities to improve pathways and explore where better preventative action earlier on may help avoid or delay access to health and care services in the future. Carry out a full evaluation of Rotherham's risk stratification tool, and develop a mechanism for identifying high intensity users of health and social care services.	Admissions to residential and care homes Effectiveness of reablement Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions	£0.03m	**Head of Urgent Care and Long-term Conditions, CCG** **Director of Health and Wellbeing, RMBC**
Dependence to Independence (DI) – Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances						
DI1 We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and sel-care						
BCF09	**Personal health and care budgets**	Individuals are provided with the right information and feel empowered to make informed decisions about their care.	Commitment to giving personal budgets to as many people as possible, and will develop our plans to do this. Extend our current plans for personal health budgets, working with patients, service users and professionals.	Admissions to residential and care homes Effectiveness of reablement Patient/service user experience	£1.6m	**Head of Contracting and Service Improvemen t, CCG** **Adult SS Service Manager, RMBC**
BCF10	**Self-care and self-management**	Individuals are provided with the right information and support to help them self-manage their condition/s.	Develop self-care and self-management, working with voluntary and community groups to co-design, co-develop and co-	Admissions to residential and care homes	£0.05m	**Head of Urgent Care and Long-term**

		Professionals are equipped with the right skills to enable self-care / self-management and promote independence.	produce improved health and care outcomes, including the areas of transitions from young people's services into adult care. Develop patients and practitioner skills programmes that can be implemented across health and social care. Development of integrated workforce development programmes and risk management courses aimed at promoting an ethos of self-management. Develop specialised psychological support services for people with long term conditions so that they are better able to self-manage their condition.	Effectiveness of reablement Avoidable emergency admissions Patient/service user experience Emergency readmissions		**Conditions, CCG** **Director of Health and Wellbeing, RMBC**
DI2 We will support and enable people to step up and step down through a range of statutory, voluntary and community services appropriate to their needs						
BCF11	**Person-centred services**	Each individual has a single, holistic, co-produced assessment, meaning they only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery. This approach will transform the way patients with high needs access services and will ensure more joined up working between health and social care.	Develop and implement a person centred, person held plan, in partnership with key stakeholders.	Patient/service user experience	£3.2m	**Head of Urgent Care and Long-term Conditions, CCG** **Director of Health and Wellbeing, RMBC**

BCF12	**Care Bill preparation**	Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service.	Identify the cost and activity pressures resulting from the implementation of the care bill, including increased assessments, carers assessment and support, information advice and guidance capacity, and resulting administrative and operational costs. Develop a plan to meet these pressures.	The Care Bill will impact on all BCF outcome measures	£0.3m	**Director of Health and Wellbeing, RMBC**
Long-term Conditions (LTC) – Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life						
LTC1 We will adopt a co-ordinated approach to help people manage long-term conditions						
BCF13	**Review existing jointly commission ed integrated services**	All jointly commissioned services provide value for money and are aligned with the BCF vision and principles. Where services are not efficient and effective, a plan is developed to de-commission/re-commission as appropriate.	Undertake a project to review all existing S75 and S256 agreements and pooled budget arrangements. KPMG (both organisations' External Auditors) to provide independent view. Where this will impact on current services being provided, ensure that social care is funded to ensure that the current levels of outcomes being met are maintained. This will be achieved through an increase in the appropriate budgets ie residential care, home care	All integrated services impact on BCF outcome measure/s	£7.9m	**Chief Finance Officer, CCG** **Strategic Commission ing Manager, RMBC**
LTC2 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						
BCF14	**Data sharing between health and**	All providers have access to integrated person-held records, which include all health and social	Develop portal technology to share data in a secure way that is in the best interest of people who use	Delayed transfer of care	£0.3m	**Customer Relationship Manager,**

	social care	care plans, records and information for every individual.	care and support. Use of the NHS number as a unique identifier across health and social care will create the starting point for the development of shared IT capacity.	Avoidable emergency admissions Patient/service user experience Emergency readmissions		**CCG** **Systems Development Manager, RMBC**