Rotherham Better Care Fund (BCF) Plan

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

Rotherham Health & Wellbeing Strategy Vision

To improve health and reduce health inequalities across the whole of Rotherham

Priority areas

- ***Prevention and Early Intervention (PE)***
- ***Expectations and Aspirations (EA)***
- ***Dependence to independence (DI)***
- ***Long Term conditions (LC)***

Strategic Outcomes

- ***PE –*** *Rotherham people will get help early to stay healthy and increase their independence*
- ***EA –*** *All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community*
- ***DI –*** *Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances*
- ***LC –*** *Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life*

Outcome measures

- ***N1 Admissions into residential care -*** *Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 (We will support more people to live independently in the community and reduce the number of people admitted to residential and nursing care by 12%)*
- ***N2 Effectiveness of reablement*** *- Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services (We will increase the number of people who are still at home 91 days after hospital discharge by 4%)*
- ***N3 Delayed transfers of care*** *- Delayed transfers of care from hospital per 100,000 population (average per month) (We will reduce the number of people who are unnecessarily delayed from being transferred from hospital back into the community by 7%)*
- ***N4 Avoidable emergency admissions*** *- Avoidable emergency admissions (We will reduce avoidable admissions to hospital by 3%)*
- ***N5 Patient and service user experience*** – tbc
- ***L1 Emergency readmissions (****We will reduce emergency re-admissions within 30 days of discharge by 4%)*

Rotherham BCF Plan Actions and Schemes

PE– Rotherham people will get help early to stay healthy and increase their independence

PE 1 – We will co-ordinate a planned shift of resources from high dependency services to early intervention and prevention (N1, N2, N4, N5, L1):

- *BCF01 – We will review Mental health provision (N1, N4, N5, L1)*
- *BCF02 – We will review the Falls prevention service (N1, N2, N4, N5, L1)*
- *BCF03 – We will deliver a joint call centre incorporating telecare and tele-health (N1, N2, N4, N5, L1)*

PE 2 – Services will be delivered in the right place at the right time by the right people (All outcome measures):

- *BCF04 – We will create an integrated rapid response service (All outcome measures)*
- *BCF05 – We will strengthen 7 day social care provision in hospitals (All outcome measures)*

DI – Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

DI 1 – We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care (All outcome measures)

- *BCF09 – We will develop personal health and care budgets (N1, N2, N5)*
- *BCF10 – We will develop self-care and self-management (N1, N2, N4, N5, L1)*

DI 2 – 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 (All outcome measures)

- *BCF11 – We will develop and implement person centred services (N5)*
- *BCF12 – We will make preparations for the implementation of the Care Bill (All outcome measures)*

EA – All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

EA 1 - We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes (All outcome measures):

- *BCF06 – We will review the Social prescribing pilot (All outcome measures)*
- *BCF07 – We will implement a joint residential and nursing commissioning and assurance team(N4, N5, L1)*

EA 2 - We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions (All outcome measures):

- *BCF08 – We will learn from experiences to improve pathways and enable greater focus on prevention (All outcome measures)*

LTC– Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

LTC 1 – We will adopt a co-ordinated approach to help people manage their conditions (All outcome measures)

- *BCF13 – We will review existing jointly commissioned integrated services (All outcome measures)*

LTC 2 - 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)

- *BCF14 – We will develop technology to share data between health and social care including use of the NHS number and shared IT capacity (N3, N4, N5, L1)*