Rotherham Better Care Fund Plan

September 2014

Local Authority
Rotherham Metropolitan Borough Council

Clinical Commissioning Group
Rotherham Clinical Commissioning Group

Date agreed at Health and Wellbeing Board
18 September 2014

Date submitted
19 September 2014

1) PLAN DETAILS

a) Summary of Plan

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**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Rotherham Clinical Commissioning group**
By	Chris Edwards
Position	Chief Officer
Date	18 September 2014

Signed on behalf of the Council	**Rotherham MBC**
By	Martin Kimber
Position	Chief Executive
Date	18 September 2014

Signed on behalf of the Health and Wellbeing Board	**Rotherham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Cllr John Doyle
Date	18 September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

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	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2013 – 2015.
A3	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
A4	**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.
A5	**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.
A6	**Communication Plan**	Plan for continued consultation and engagement with service users, patients and providers.
A7	**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.
A8	**BCF 'Plan on a page'**	2 page document which demonstrates how the BCF actions align with the health and wellbeing strategy and outcome measures.
A9	**Workstreams delivering savings**	Table showing the workstreams through which QIPP savings are being delivered.

A10	**Governance Framework**	Diagram demonstrating the decision making structure, as well as the framework for delivery and performance.
A11	**Healthwatch Rotherham – Better Care Consultation**	Healthwatch Rotherham report based on findings from consultation carried out December - January 2014.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

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

The Health and Wellbeing Strategy and four strategic outcomes described above have been developed based on the evidence in the local Joint Strategic Needs Assessment (JSNA). The JSNA tells us about the demographic and socio-economic changes occurring in the local area and the needs of local people as a result of this. We understand that we don't just need to focus on single health and wellbeing issues, but we need a cultural change to the way we work and deliver services which address the needs of local people in a holistic way. The focus on preventative activities alongside appropriate support and treatment will also help address the demographical challenges ahead. Our strategy was therefore created as a step-change to realise this vision for Rotherham, and the BCF plan will contribute significantly to this.

b) What difference will this make to patient and service user outcomes?

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.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

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; Community Occupational Therapy 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 HWB.

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 HWB, 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.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Rotherham has a strong record of joint commissioning between health and social care. We have a joint commissioning framework and governance structure which incorporates joint needs assessment, supply mapping, market analysis, pooled budgets and performance management. This has prepared the way for these new developments in integrated care which will support people with complex needs to remain independent in the community. Services that are already subject to joint commissioning and/or pooled budget arrangements include:

The Rotherham Intermediate Care Service (RICC)
RICC delivers community-based recuperation, recovery, rehabilitation and re-ablement services, supporting individuals who have a combination of nursing, therapy and mental health needs. The main aim of the service is to maximise independence and re-integrate into local communities.

The Rotherham Occupational Therapy Service
The Rotherham Occupational Therapy Service provides support on activities of daily living, ensuring that patients achieve the highest level of independence. The service helps prevent deterioration and minimises loss of function caused by illness or disability. It reduces the risk of admission to hospital by ensuring that people are living in a low risk physical environment where they can function autonomously. The service empowers patients so that they maximise their potential to engage in meaningful and productive activities/occupations

These services deliver health and social care outcomes. They perform well within a robust joint performance management framework.

Despite these successes current models of care are not designed for the health challenges of today. The ageing population, changing disease burden, and rising expectations demand fundamental change. Care outside hospitals needs to be strengthened whilst hospital care itself must be improved with 7 day working. The overriding priority must be a greater integration of services across health and social care, extended use of pooled budgets and a robust joint commissioning framework.

The Better Care Fund provides a major opportunity to drive forward integrated care. BCF offers an opportunity to deliver an evidence-based approach to investment. It has the potential to offer better value for money, a more cohesive model of care and better outcomes for people. The Better Care Fund acts as a stepping stone to the longer term transformation of services. The requirement that local plans should be part of a five-year strategy for local health and social care services from 2015 will be a helpful spur to look beyond the immediate short-term pressures and develop a shared vision of what future local services should look like.

The Better Care Fund will support the aspiration that all people with a long-term condition should have a personalised care plan which is accessible, available electronically and linked to the GP health record. Patients will be able to access self-management materials

and information so that they are empowered to manage their own condition. Effective implementation of the Better Care Fund will support the use of telehealth services to monitor conditions, deliver tele-coaching and promote self-care. The Better Care Fund will support data sharing across the local health economy. Rotherham's BCF Action Plan places a responsibility on local health communities to ensure that hospital and GP data is comprehensively connected within the next two years.

Wider prevention and public health initiatives will align to the BCF services to maximise opportunities to improve the health and wellbeing of the ageing population. The transparent links between the services and pathways will aim to keep Rotherham people healthier for longer.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

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 actions within our plan 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.

Our overall plan includes the following key milestones:

- To develop an effective S75 agreement/pooled budget, consistent with BCF guidance.
- To include in this a risk sharing agreement and dispute resolution protocol to ensure that the key principles and outcomes of the BCF are embedded within the S75 agreement.
- Using the governance framework set out in appendix 10, all partners will monitor the BCF plan effectively. The Operational Group and Strategic Task Group reporting up to the Health and Wellbeing Board will ensure that the plans are delivered through the various workstreams put into place.
- The Health and Wellbeing Board will receive quarterly progress reports, holding partners to account, scrutinising and monitoring plans and offering challenge to the delivery of the BCF actions.

b) Please articulate the overarching governance arrangements for integrated care locally

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 Health and Wellbeing Board will have overall accountability for the BCF plan, they 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 framework shown in Appendix 10 demonstrates the decision making structure and how the BCF plan will be delivered through the various groups.

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.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The management and oversight of the delivery of the BCF plan has been delegated to the BCF Strategic Task group, chaired by the HWB chair and including senior representatives from both the council and CCG.

The BCF Task group role is to:

- Monitor delivery of the Better Care Plan through quarterly meetings
- Ensure performance targets are being met
- Ensure schemes are being delivered and additional action is put in place where the plan results in any unintended consequences.
- Make strategic decisions relating to the delivery of the plan
- Report directly to the HWBB on a quarterly basis.

The Strategic Task Group is supported by the BCF Operational Officer Group, which has been meeting since April 2014. The Operational group is made up of the identified lead officers for each of the BCF actions within the plan, plus other supporting officers from the council and CCG. The Operational group meets monthly and reports directly to the Task group.

The Operational Group role is to:

- Ensure implementation of the BCF action plan
- Implement and monitor the performance management framework
- Deal with operational issues, escalating to the Task Group where needed

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	**Scheme**
1	Mental Health Service
2	Falls Prevention
3	Joint call centre incorporating telecare and telehealth
4	Integrated rapid response team
5	7 day community, social care and mental health provision to support discharge and reduce delays
6	Social Prescribing
7	Joint residential and nursing care commissioning, quality and assurance team
8	Learn from experiences to improve pathways and enable a greater focus on prevention
9	Personal health and care budgets
10	Self-care and self- management
11	Person-centred services
12	Care Bill preparation
13	Review existing jointly commissioned integrated services
14	Data sharing between health and social care
15	End of Life Care

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions
Introduction of the Care Act will result in an increase in cost of care provision from April 2015, impacting on social care services and funding	5	4 £0.850m	20	Working group established and initial impact assessment undertaken of the potential effects of the Care Bill. The Lincolnshire Model, as agreed by ADASS, is being populated and provides evidence of potential demand for additional assessments (including carers' assessments and respite) in 2015/16 of approx. £0.850m. Other models are also been populated.
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	3	3 £0.750m	9	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 is 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	1	1	2	Task group has agreed the most appropriate governance structure for BCF, which includes the HWBB as the accountable body and has been agreed by HWB
Failure to achieve planned savings will create financial risks for the respective parties	3	5 £1.250m	15	Performance management framework via the System Residence Group in place to monitor progress throughout 2014/15 to ensure targets are achieved.
Shifting of resources could destabilise current service providers.	2	4 £0.880m	8	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. CCG received Quality Impact Assessments 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.
Risks to CCG capacity and conflict of interest if the CCG takes on responsibility for primary care	2	2	4	The CCG is weighing up these risks against the opportunities and the risks of not taking on responsibility and will develop a delivery plan that mitigates against the risks and delivers the benefits

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The contingency plan and risk sharing approach is set out as follows:

(i) A risk pool of £1.5m - £2m has been included in the BCF financial plan to mitigate the risk of non-delivery of the non-elective savings requirement which is to dampen down growth and demand (rather than reduce admissions from 2013/14 outturn). The risk pool is also in place to support any unintended consequences of successful initiatives on other parts of the system eg demand created from improved case management.

(ii) A financial governance process is in place and the financial monitoring and performance information is to be provided at monthly operational group meetings and quarterly at Director and Member level. The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified where appropriate as part of the planning cycle for both Health and Social Care in totality.

(iii) The CCG has a robust plan with regards to keeping emergency admissions within affordable levels and has been very successful since 2011. All local stakeholders are key players in delivering these plans through the System Resilience group. The CCGs contracts with providers specify that marginal tariff will apply if admissions exceed 11/12 rates, admissions above that rate will be funded at 30% of tariff, NHS England will manage through the System Resilience Group how the remaining 70% should be best invested to reduce admissions.

(iv) All local stakeholders are members of the System Resilience Group. This plan has been approved by the Task Group, comprised of Health and Wellbeing Board members and will be formally approved by the Board at its next meeting.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

These plans align with other developments within Rotherham through being consistent with and in line with the Joint Health and Wellbeing Strategy. The plans outlined in the BCF clearly build on existing good practice and evidence based services including jointly commissioned and delivered services such as the Intermediate Care Service. Personal Health Budgets are currently being delivered through the Continuing Health Care process in partnership with the Local Authority and are a sound foundation for the extension of and delivery of personal health budgets in line with the recent announcements regarding Integrated Personal Commissioning. Personal Health Budgets build on a number of existing initiatives, including those in the Better Care Fund including : person centred one page plans, social prescribing initiatives, self-care and self-management and the extension of assistive technology to include telehealth and digital assistance.

The GP Case Management Service has been designed to support many of the new initiatives in Rotherham. It uses a system of risk stratification which was used initially to identify those most at risk of admission to hospital. It has been successful through bringing all stakeholders, including customers, carers, GP's, voluntary sector and adult social care together and has been very successful in demand avoidance activity and signposting people to alternative activity in the community. It is now being extended to include people with long term conditions and people over 75. The person centred on a page plan will ensure that the views of customers as expressed in the set of 'I' statements remain at the heart of every new development.

Other than the BCF operational group and task group, there have been no new groups or processes established. The governance framework for the BCF is integrated with the delivery of Health and Wellbeing Strategy and Joint Commissioning initiatives, ensuring alignment across the health and social care economy. A specific housing strategy for older people and people with complex needs is being developed in line with the Health and Wellbeing Strategy and will incorporate assistive technology, use of Disabled Facilities Grant and specific projects that are being developed by Strategic Housing Services.

Aligning to the Health and Wellbeing Strategy also ensures our plan is in line with public health initiatives which focus on prevention and reducing need, for example the ageing well agenda, which is an important element of the whole system approach we want to achieve. Public health will provide information to relevant BCF groups to maximise improvement through partnership working.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

All schemes relying on CCG funding are included in the Rotherham 2 year operating and 5 year strategic plan. The plan has had favourable feedback externally and local clinicians have agreed that whilst challenging it is clinically deliverable.

The CCG with stakeholders is just starting the process of refreshing the 2 year plan to

include 17/18 this refresh will take the BCF as a basis for plans in relevant areas.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG is currently consulting with members and stakeholders which additional responsibilities to propose to NHS England. It is likely that the CCG will wish for some additional co-commissioning or delegated responsibilities for primary care. If this transpires this will help the delivery of the BCF plan - for example, the further development of the case management pilot will be simplified by this. Additional local responsibilities will also help mitigate some of the risks around BCF particularly with regards to hospital admissions because it would give local flexibilities over care pathways that include both primary and secondary care.

Primary care co-commissioning is being discussed at Rotherham GP Members' Committee and Governing Body in September. This paper has a full consideration of the risks of taking on delegated responsibility and also the risks of not doing so. In September /October it is being discussed with all member practices at locality meetings, attended by CO and GPMC chair.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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 restrict access to services including 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. If the planned investment arising from CCG efficiencies does not occur there is a risk that this will prevent adult social care from receiving the investment needed to deliver against specific commitments such as seven day working, integrated fast response services, and re-commissioning of jointly commissioned services.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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 Integrated Community Equipment Service are all fully integrated health and 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, re-ablement, intermediate care and Social prescribing – 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 re-ablement 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 re-ablement 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. Any reduction in investment would result in potential delays for access to assessment, reduction on volume and quality of services that currently support independence such as RICC Intermediate Care Centre and other impacts that would increase pressure on NHS services and performance against

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£13m has been allocated to protect social care which includes all of the nationally prescribed funding sources.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The council has established a Care Act Steering Board which takes an inclusive planning approach – each workstream has a broad membership and will utilise the experience of customers, third sector and independent sector providers. There is a specific workstream on customer and carer engagement which will ensure that people are informed, engaged and consulted. This builds on the Making It Real initiative within the council which has had success in developing co-production approaches and ensuring that customers

remain at the heart of all we do. There have been awareness raising presentations on the Care Act 2014 to the Adult Planning Board. Learning Disability Partnership Board, Shaping the Future provider engagement events, Health and Wellbeing Board, Cabinet and Chief Executive Leadership Board. The delivery plan addresses every section of the Care Act 2014 Part 1 including: advice, guidance and information, assessment eligibility and transition, safeguarding, commissioning, workforce, carers, IT, legal and policy, customer engagement.

v) Please specify the level of resource that will be dedicated to carer-specific support

The current Carer's Grant of £500,000 delivers support that provides carers with a break. In addition, a significant number of services that are delivered to customers, i.e day services, also provide carers with a break. Carers' assessments are incorporated into the mainstream social work activity. Specific services to carers include: carers' centre, carers emergency scheme, Caring For Carers Mental Health Service.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There have been no changes to the original financial plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

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.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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).

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

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.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

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.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Rotherham uses the Healthnumerics risk stratification tool. It measures the expected health care utilisation of an individual or population and identifies patients of highest risk of chronic admission in a 12 month period. The Risk Stratification Tool takes data from multiple sources including primary and secondary care. It does not currently use social care data.

The Rotherham Case Management programme assumes that there is a high degree of correlation between the cohort of patients identified on the risk stratification tool and their level of social care need. We have joint processes in place to plan the care of these patients. The GP practice adopts the role of lead professional. Care planning is carried out by a Multi-Disciplinary Team, which incorporates specialist social workers. This ensures that health and social care plans are consistent and complementary. The social workers are funded through Re-ablement Grant and are specifically responsible for supporting the case management programme.

The risk stratification tool only uses health data to identify risk. Although this is a good proxy for social care need there are people who require a joint approach to care planning who are not flagged on the risk stratification tool. Social workers and GPs are able to make professional judgements on vulnerable adults who would benefit from a case management approach.

This joint approach to case management targets resources on the patients with the greatest need and allows for prioritisation of community based preventative care. It supports strategies to reduce emergency admissions and delivers better patient outcomes whilst driving down costs.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

GP practices in Rotherham are working towards the top 5% of those at risk having a case management plan in place. There are currently 6675 patients who have a plan (this represents approximately 2.67%).

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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 we engaged with service users and the public in the development of the April 2014 BCF submission, including:

- Healthwatch Rotherham were commissioned by the Health and Wellbeing Board to consult with the local community and engage them in the envisaged transformation of services, which took place 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

Healthwatch Rotherham has supported the Rotherham Health and Wellbeing board to capture the views of the public in relation to the principles of the BCF through an initial consultation and report published on the 20 February 2014 (appendix 11). The principles of better joined up care through health and social care was used to facilitate this piece of work. The findings of the Healthwatch report have been used alongside other consultation and public intelligence to inform the BCF action plan. As a member of the Health and Wellbeing Board, Healthwatch agreed the action plan submitted initially in February 2014 and with the final plan submitted September 2014.

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.

Rotherham agencies held a Rotherham wide engagement event 'Working together' on 16 July 2014; this covered the whole health community strategy, opportunities and challenges and was attended by 150 members of the public and representatives of organisations. The event included general discussion on the health community's level of ambition and overall strategy and specific workshops on Better Care Fund Projects such as mental health, integrated working and social prescribing.

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.

You Said, We Did…

Through the service user, patient and public engagement described above, we have been able to identify a number of common areas which local people have told us are important to them and areas for improvement, these include:

- 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

We have used this information to inform the actions which will be delivered through the BCF plan in Rotherham and develop the set of 'I Statements' which will be used to monitor our performance of these. We want to ensure that the things that are important to local people, such as being central to decisions about their care, having access to services when they need them, feeling safe and not having to repeat themselves to numerous agencies, is at the heart of our plan for integration and we will continue to engage local people to ensure we continue to meet their needs.

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

Future engagement and consultation planned from September 2014

We have developed a consultation and engagement plan (appendix 6), which has been used from the start of this process and will ensure continued engagement and communication as we move into transition and implementation of the BCF plan.

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 8 and 'What will the BCF deliver for the people of Rotherham' Appendix 7).

No further consultation and engagement has taken place specifically on BCF by Healthwatch following on from the initial report in January. However the nature of the work carried out by Healthwatch is linked to the vision of joined up health and social services and they will continue to gather views from the public and feed themes and trends into the health and wellbeing board priority areas, and to the BCF action leads. Further detail on some of the specific work to be carried out by Healthwatch to feed into the BCF actions is described in appendix 6.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

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 Rotherham, Doncaster and South Humber Mental Health Trust (RDaSH)) 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 The Rotherham Foundation Trust (TRFT), 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 residential and nursing care homes; community therapy: equipment; and enabling services; intermediate care; and services for older people with mental health problems. The Rotherham System Resilience Group (formally the Urgent Care Group) has 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 9 shows the workstreams through which the QIPP savings are being delivered.

This revised template was shared with Rotherham’s main acute and mental health providers on Tuesday 26 August (TRFT and RDaSH).

ii) Primary care providers

The plans requiring health funding were fully consulted on with local primary care providers as part of developing the 14/15 Rotherham commissioning plan. This BCF plan is an integral part of the CCGs plans for 15/16 and will be consulted on with all member practices in September/October through the GP Members Committee and through the Chief Officer and GP Members Committee chair visiting all locality meetings.

iii) Social care and providers from the voluntary and community sector

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: BCF06).

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.

The council has a well-developed process for engagement with adult social care providers and has an ongoing programme for the year, called Shaping the Future, which includes engagement to explore the implications of BCF and the Care Act. A presentation to adult social care providers took place on the 7 May 2014, which brought together both pieces of work and resulted in a co-produced action plan for the year. The Market Position Statement for Older People's services (Appendix 5) 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.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

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, treats people with the same needs more consistently and deals 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.

ANNEX 1 – Detailed Scheme Description

Scheme ref no. BCF01
Scheme name: Mental Health Service
Overview of scheme
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.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
The mental health liaison service will be provided through a multidisciplinary team working to support people with mental health problems including dementia who attend the acute hospital for treatment and/or in a crisis. The team will also work in partnership with care homes, the Police, other health and social care providers, and general wards in the hospital. Its minimum function will be to reduce admissions into acute hospital 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 people with mental health problems including older people and people with dementia. • 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
The key success factors including an outline of processes, end points and timeframes for delivery
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.
- 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

Measures

- Admissions to residential and care homes
- Avoidable emergency admissions
- Patient/service user/ carer experience
- Emergency readmissions
- Use of compulsory powers in MHA

Finance

£1.1m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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.

Expected Impact

- By April 2015 the mental health liaison service will be recruited to and fully established and retrospective analysis been carried out to establish historical and post intervention trajectories for the 4 outcomes measures for the cohort of people with mental health problems

- April 16 – first full years outcomes – trajectory will be dependent on analysis work referred to above
- April 2019 – scheme will have been revised according to evaluation; if successful there will be a switch in emphasis of funding from acute mental health liaison to investment in more upstream prevention services.

Scheme ref no. BCF02

Scheme name: Falls Prevention

Overview of scheme

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.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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

The key success factors including an outline of processes, end points and timeframes for delivery

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

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance
£0.9m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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.

Expected Impact

April 16	Integrated Falls and Bone Health Service is established
April 17	Reduction in fragility fractures for people >55years against trajectory
April 19	Reduction in fractured neck of femur against trajectory
April 2021	Falls and Bone Health Service extends its role to support people <55 years

Scheme ref no. BCF03

Scheme name: Joint call centre incorporating telecare and tele-health

Overview of scheme

A coordinated response is provided to individuals' needs and an increased use of assistive technologies to support independence and reduce hospital admissions.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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.

The key success factors including an outline of processes, end points and timeframes for delivery

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

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance

This will require scoping of the existing service and a transfer of funds

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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.	
Expected Impact	
April 2016	Care Coordination Centre and Rothercare are co-located and working together through joint protocols
April 2017	Reduction in number of falls related A&E attendances against trajectory
April 2019	CCC and Rothercare are fully integrated with single management structure
April 2021	40% increase in the number of people who have Rothercare across Rotherham with substantial proportion having an integrated telehealth/telecare package

Scheme ref no. BCF04

Scheme name: Integrated rapid response team

Overview of scheme

A coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

We will enhance the current Fast Response Service so that it incorporates social workers, re-ablement 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.

Measures

- Admissions to respite care in residential care homes
- Effectiveness of re-ablement
- Delayed transfer of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency hospital re-admissions

Finance
£1.2m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Expected Impact

2016 Effectiveness of re-ablement increased to 90%. Hospital length of stay down 1%
2017 Effectiveness of re-ablement increased to 91%. Hospital length of stay down 2%
2019 Effectiveness of re-ablement increased to 92%. Hospital length of stay down 3%
2021 Effectiveness of re-ablement increased to 93%. Hospital length of stay down 5%

Scheme ref no. BCF05

Scheme name: 7-day community, social care and mental health provision to support discharge and reduce delays

Overview of scheme

Appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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.

The key success factors including an outline of processes, end points and timeframes for delivery

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.

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Delayed transfer of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance
£4.8m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

2016 Community nursing, Care Coordination Service and ALOC operating 7 days/week
2017 Significant reduction in OOH hospital admissions for people with LTCs
2019 Fully integrated Health and Social care Services OOH services 7 days/week
2021 Fully integrated community and primary care OOH services 7 days/week

Scheme ref no. BCF06

Scheme name: Social Prescribing

Overview of scheme

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.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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.

The key success factors including an outline of processes, end points and timeframes for delivery

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.

Measures
- Admissions to residential and care homes
- Effectiveness of re-ablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Initial headlines from evaluation:
Patients and Carers
- 1,607 local people referred to the Social Prescribing Pilot
- 1,118 onward referrals to community based services
- 83 per cent made progress towards self-management
- 38 per cent had fewer A&E attendances
- 40 per cent had fewer in-patient stays
- 47 per cent had fewer outpatient appointments
- £350,000 in additional welfare benefits claimed
- General improvements in wellbeing, mental & physical health, isolation and independence

Public Sector
- 20 per cent reduction in A&E attendances
- 21 per cent reduction in in-patient stays
- 21 per cent reduction in outpatient appointments
- Potential well-being value of £742,000 in the first year post-referral
- Improvements in patient satisfaction
- Potential wider savings for primary and social care
- Up to £148,000 contribution by volunteers

Voluntary Sector
- £1m investment in VCS service provision
- £30,000 in additional funding accessed (figure tbc)
- Opportunity to innovate and deliver health outcomes for the first time
- Highlights the potential for micro-commissioning with local infrastructure as the accountable body
- Improved sustainability of small organisations
- Improved collaboration and partnership working
- Stimulates social action through the creation of new groups and activities

- National spotlight on their work

Finance
£0.6m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Expected Impact

Results from the first evaluation indicate that the benefits for the cohort who receive social prescribing will be:
April 2016 - Potential cost reductions of £415,000 in first year post referral

- 20 per cent reduction in A&E attendances
- 21 per cent reduction in in-patient stays
- 21 per cent reduction in outpatient appointments

April 2021 - Potential cost reductions of £1.9 million, post referral

Scheme ref no. BCF07

Scheme name: Integrated residential and nursing care quality assurance team

Overview of scheme

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.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

What are we trying to achieve?

Approximately 1,700 people 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 quality assurance service that fulfils the following functions;

- Integrated care home quality assurance arrangements in place

- Increased monitoring of nursing care standards
- Earlier response to health related safeguarding alerts and contracting concerns
- Improved standards in care homes, resulting in fewer CQC compliance actions and warning notices
- Reduction in the number of contracting and safeguarding concerns
- Safeguarding through a more pro-active, preventative and co-ordinated approach
- Reduced admissions to hospital
- Improved hospital discharges
- Reduced cost of significant service failure
- 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.

The key success factors including an outline of processes, end points and timeframes for delivery

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 quality assurance 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 integrated quality assurance 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.

Measures
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions
- Reduction in the number of contracting and safeguarding concerns
- Reduction in CQC compliance actions and warning notices

Finance

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

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Expected Impact

2016 A&E attendances from care homes reduced by 1% against trajectory
2017 A&E attendances from care homes reduced by 2% against trajectory
2019 A&E attendances from care homes reduced by 3% against trajectory
2021 A&E attendances from care homes reduced by 5% against trajectory

Scheme ref no. BCF08

Scheme name: Learn from experiences to improve pathways and enable a greater focus on prevention

Overview of scheme

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.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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

The key success factors including an outline of processes, end points and timeframes for delivery

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.

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance

£0.03m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Expected Impact

2016 Development of an integrated health and social care risk stratification tool
2017 Introduction of an integrated health and social care plans for community
2019 Integrated health and social care plans in place for high risk patients
2021 Introduction of integrated health and social care teams

Scheme ref no. BCF09

Scheme name: Personal health and care budgets

Overview of scheme

Individuals are provided with the right information and feel empowered to make informed decisions about their care.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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.

The key success factors including an outline of processes, end points and timeframes for delivery

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.

Measures
- Admissions to residential and care homes
- Effectiveness of re-ablement
- Patient/service user experience

Finance
£1.6m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Expected Impact

Roll out of personalisation service – all domiciliary Continuing Healthcare patients will have a right to have a PHB from 1 October 2014.

Roll out of personalisation service to all SEN children.

NHS mandate sets an ambitious objective that people living with long term conditions who could benefit should have the option for a personal health budget, including a direct payment, from April 2015. Further NHS England guidance expected in due course.

Scheme ref no. BCF10

Scheme name: Self-care and self-management

Overview of scheme

Individuals are provided with the right information and support to help them self-manage their condition/s.

Professionals are equipped with the right skills to enable self-care / self-management and promote independence.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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.

The key success factors including an outline of processes, end points and timeframes for delivery

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.

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance
£0.05m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Expected Impact

April 2016 Integrated patient skills programme in place for people with long-term conditions and being utilised fully by primary care, social care and community health services

April 2017 Workforce development programmes have created an organisational ethos which focuses on self-management

April 2019 35% of people on chronic disease registers have attended patient skills programme

April 2021 50% of people on chronic disease registers have attended patient skills programme

Scheme ref no. BCF11

Scheme name: Person-centred one page plan

Overview of scheme

Each individual has a single, holistic, co-produced one page plan , 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.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
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. The GP case management project funds additional clinical time in primary care to case manage patients at highest risk of hospital admission (as identified by the risk stratification tool), all patients in nursing and residential homes and links to work to provide additional GP support for all patients over 75. Community nursing and social workers are refocused to provide input into patient reviews. This builds 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
The key success factors including an outline of processes, end points and timeframes for delivery
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. **Measures** • Patient/service user experience **Finance** £2.5m
How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care
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.

Expected Impact

- April 2016 – the person centred one page plans will be available to people on the GP case management process
- April 2015 - case management of 12,000 patients in Rotherham at highest risk of admission to hospital
- April 2017- person centred one page plans will be embedded in practice and available to anyone who wants one
- April 2019 (three years after 2015/16)
- April 2021 (five years after 2015/16)

Scheme ref no. BCF12

Scheme name: Care Act 2014 preparation

Overview of scheme

Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The Care Act 2014 presents 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.

The key success factors including an outline of processes, end points and timeframes for delivery

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.

Measures

- The Care Bill will impact on all BCF outcome measures

Finance
£0.3m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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.

Expected Impact

- by April 2016 the Care Act 2014 will be fully implemented including the Care Funding Reforms , the new services and approaches in place will be supporting the strategic Health and Wellbeing outcomes of prevention and early intervention and a reduction in dependence , increase in independence for people
- By April 2017 the new legislation will be fully embedded and social care services will be sustainable and able to support the Health and Wellbeing Strategy and BCF ambitions
- April 2019 (three years after 2015/16) safe services will be delivered
- April 2021 (five years after 2015/16) safe services will be delivered

Scheme ref no. BCF13

Scheme name: Review existing jointly commissioned integrated services

Overview of scheme

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.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

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.

The key success factors including an outline of processes, end points and timeframes for delivery

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.

Measures
- All integrated services impact on BCF outcome measure/s

Finance
£7.9m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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.

Expected Impact
April 2016 All services currently funded under S256 and S75 reviewed and reconfigured April 2017 All services included in the Better Care Fund have been reviewed and new services re-commissioned. Those services that are no longer strategically relevant or performing poorly have been decommissioned April 2019 Services commissioned under BCF are fully integrated across health and social care April 2021 BCF is expanded to incorporate new service from health and social care. Existing BCF services deliver fully integrated health and social care packages

Scheme ref no. BCF14
Scheme name: Data sharing between health and social care
Overview of scheme
All providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
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.
The key success factors including an outline of processes, end points and timeframes for delivery
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.

Measures

- Delayed transfer of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance

£0.3m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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.

Expected Impact

April 2016 – NHS Number available in social care systems for all people on GP Case Management Process
April 2017 – NHS Number recorded in social care system for 12,000 patients in Rotherham at highest risk of admission to hospital
April 2019 (three years after 2015/16) - Ability to view information securely across networks
April 2021 (five years after 2015/16) – Ability to update information across networks

Scheme ref no. BCF15

Scheme name: Community End of Life Care pilot

Overview of scheme

Investment in enhanced community end of life care services by Rotherham Hospice to augment the current day hospice /Inpatient Patient Unit services with hospice at home

provision.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The scheme is similar to successful schemes operating in numerous other districts. Rotherham has invested non-recurrently in this area for the last 18 months and outcomes to date are being evaluated at system wide event on 22 October 2015.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?
Rotherham hospice will provide a community end of life care team that will provide care and support to patients and their carers. This includes a 7/7 service and 24/7 advice line working in partnership with other providers such as GPs and district nurses.

Who will benefit?
Service provided to an average of 34 patients at any one time totalling more than 400 patients per year.

Measures
- Avoidable emergency admissions

Reduction of hospital admissions for EOLC patients by 330/year
- Patient/service user experience

Percentage of patients in the scheme receiving care in their preferred place over 80%
Overall percentage of people dying not in an acute hospital to be more than 50%
- Emergency readmissions

No more than 20% of the EOLC Hospice at Home register patients to have a hospital admission. This will have a substantial impact on re-admissions for this cohort.

Finance
£0.8m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. The Community End of Life pilot is an important part of the Rotherham 2014-2016 Commissioning plan where there is an explicit commitment to evaluate its impact in October 2015, this will be an event with RMBC and the CCG together with all other health providers in Rotherham. 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.

Expected Impact

April 2016: We has some confidence in predicting that the outcomes detailed above 9360 avoided admissions, more than 50% of all Rotherham residents people dying not in an acute hospital) will be maintained if the level of investment is maintained. Future annual evaluations will show if there is scope for improving outcomes for the same level of investment or if there is a compelling case for increasing the level of funding. In this case the expected outcomes in future years will be amended.

April 2017: expected outcomes as in 2016 unless evaluation suggests increased outcomes or increased investment is prioritised.

[ANNEX 2 – Provider commentary]

Name of CCG	NHS Rotherham Clinical Commissioning Group
Name of CCG Accountable Officer	Chris Edwards
Signature (electronic or typed)	CEdwards.
Name of Provider organisation	The NHS Rotherham Foundation Trust
Name of Provider CEO	Louise Barnett
Signature (electronic or typed)	LBarnett

For CCG to populate:

Total number of non-elective FFCEs in general & acute **[see E.C.4 of planning guidance]**	**2013/14 Outturn**	23,200
	2014/15 Plan	23,200
	2015/16 Plan	23,200
	14/15 Change compared to 13/14 outturn	0
	15/16 Change compared to planned 14/15 outturn	0
	How many non-elective admissions for the CCG is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions for the CCG is the BCF planned to prevent in 15-16?	0

For Provider to populate:

	Question	Response
1.	**Do you recognise the planned non-elective (general and acute) admissions data for 14/15 and 15/16 submitted by the CCG?**	YES
2.	**Do you agree with the data submitted for the impact of the BCF in terms of planned in non-elective (general and acute) admissions 15/16 compared to 13/14 outturn and planned 14/15 outturn?**	YES
3.	**If you answered 'no' to Q.2 above, please explain why you do not agree?**	N/A
4.	**Can you confirm that you have considered the resultant implications on your organisation?**	YES

[ANNEX 2 – Provider commentary]

Name of CCG	NHS Rotherham Clinical Commissioning Group
Name of CCG Accountable Officer	Chris Edwards
Signature (electronic or typed)	CEdwards.
Name of Provider organisations	Rotherham, Doncaster and South Humber Mental Health Trust
Name of Provider CEO	Christine Bain
Signature (electronic or typed)	Approved via email

For CCG to populate:

Total number of non-elective FFCEs in general & acute **[see E.C.4 of planning guidance]**	**2013/14 Outturn**	N/A
	2014/15 Plan	N/A
	2015/16 Plan	N/A
	14/15 Change compared to 13/14 outturn	N/A
	15/16 Change compared to planned 14/15 outturn	N/A
	How many non-elective admissions for the CCG is the BCF planned to prevent in 14-15?	N/A
	How many non-elective admissions for the CCG is the BCF planned to prevent in 15-16?	N/A

For Provider to populate:

	Question	Response
1.	**Do you recognise the planned non-elective (general and acute) admissions data for 14/15 and 15/16 submitted by the CCG?**	N/A – RDaSH does not provide these services.
2.	**Do you agree with the data submitted for the impact of the BCF in terms of planned in non-elective (general and acute) admissions 15/16 compared to 13/14 outturn and planned 14/15 outturn?**	RDaSH notes and agrees the 'Expected Impact' on the Mental Health Scheme along with on page 28 future specifications and targets for this service which are likely to change significantly.
3.	**If you answered 'no' to Q.2 above, please explain why you do not agree?**	NA
4.	**Can you confirm that you have considered the resultant implications on your organisation?**	When considering the Mental Health Service Scheme, and the need to, as a minimum function, reduce admissions into the acute Trust, through the 'Key

		Objectives' and 'Expected Impact' for the Scheme, RDaSH would also seek to understand the inter-operable connection for patients with dementia associated in the *'Joint assessment and accountable lead professional for high risk populations'*, in the following areas: • Patients at risk of hospitalisation. • Case management programme. • Use of risk stratification tool • In order to build on existing arrangements for joint patient management. RDaSH notes the following schemes and in particular the 'Expected Impact' and look forward to the future integrated system: • Falls prevention • Integrated rapid response team • 7-day working Social prescribing