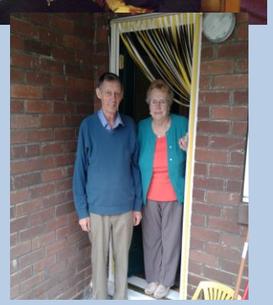
WHAT WILL THE BETTER CARE FUND PLAN DELIVER FOR THE PEOPLE OF ROTHERHAM

Better Care Fund Targets:

- *More people will have been supported to live independently in the community and the number of people admitted into residential and nursing care will have reduced*
- *We will have increased the number of people who are still at home 91 days after hospital discharg*
- *The number of people who are unnecessarily delayed from being transferred from hospital back into the community will have reduced*
- *Avoidable admissions to hospital will continue to be reduced*
- *Emergency re-admissions within 30 days of discharge will have reduced*



Better Care Fund Actions:

- ***BCF01*** *- Increased community based preventative support for people with mental health needs*
- ***BCF02*** *- A preventative community based Falls Service which targets those most vulnerable and those most at risk*
- ***BCF03*** *- Increased access to and use of assistive technology to support people to live independently in the community*
- ***BCF04*** *- A joint health and social care Rapid Response Team, including out of hours, providing a direct route to community based services and reducing the need for hospital admissions*
- ***BCF05*** *- A 7-day a week joint community, social care and mental health service which is there to promptly support people back into the community who need to be discharged from hospital*
- **BCF06** *- Increased use of voluntary and community based services by GP's, reducing the need for individuals to access formal care services and supporting independence*
- ***BCF07*** *- Improved standards in residential and nursing care through the development of a joint quality assurance team*
- ***BCF08*** *- Improved customer pathways as a result of listening to their experiences, providing better preventative services to support more people in the community*
- ***BCF09*** *- Increased the use of personal health and care budgets to help more customers have choice and control about the support they receive*
- ***BCF10*** *- Provided Information and support to help people-self-manage their conditions and stay independent*
- ***BCF11*** *- Each person has a single, health and social care plan which means they need to only tell their story once*
- ***BCF12*** *- Social Care Services meet the new requirements and demands of the Care Bill to ensure that people of Rotherham are supported when they need it most*
- ***BCF13*** *- Joint health and social care services deliver the best outcomes for the people of Rotherham*
- ***BCF14*** *- Customers see that health and social care information about themselves is shared and supports them to receive a better joined up service*
- ***BCF15 –*** *Investment in enhanced community end of life care services by Rotherham Hospice*

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Brian is a 65 year old man and lives alone in a rented property. Brian has recently retired under ill-health. He has suffered with bi-polar disorder for a number of years which affects his mood; sometimes he can feel very depressed whilst other times he is overactive. Brian's sister recognises that he is increasingly showing signs of depression so she takes him to see the GP.

Brian was referred to the Mental Health Liaison Team promptly by his GP to ensure he is supported early to prevent his health and wellbeing deteriorating and reaching crisis point. The service encourages Brian to be actively involved in his support plan which keeps him in control enabling him to manage his condition more effectively. Brian has a person held record which sets out his goals. Brian has a schedule of appointments with his support worker which encourages him to live independently and safely in the community. He is also supported to access a Personal Health Budget to meet his long term needs, giving him control over the care and support he receives. This prevents Brian from reaching crisis and ensures that his condition is managed in a way that promotes better quality of life.

Without intervention Brian would be prone to neglecting himself when feeling depressed. This would impact on his general health and wellbeing and quality of life. He would also become increasingly dependent on other crisis intervention services including the Police and A&E.

Brian said 'I am listened to and supported at an early stage to avoid *crisis.'*

Dorothy is 73 years of age and lives with her husband in their own property. Dorothy has recently suffered a number of falls due to dizziness. This has had a significant impact on the couple's quality of life and independence. At 11pm one evening Dorothy fell. Her husband knew to ring the out-of-hours number due to previously contacting Assessment Direct for information and advice.

The Rapid Response Team visits immediately to listen to both Dorothy and her husband's concerns. Dorothy's social care needs are assessed and it is recommended that she would benefit from some equipment to help her to move safely around the house. A number of referrals are made to specialist services to make sure Dorothy's health and wellbeing needs are met. This includes the GP for further tests to be undertaken to diagnose the cause of Dorothy's dizziness. A referral was also made to a team specialising in falls prevention - the community based Falls and Fracture Service due to her being at risk of future falls.

The specialist assessments resulted in Dorothy being provided medication to prevent her dizziness, a falls belt and several grab rails being installed around the house to help Dorothy to move safely and independently. Dorothy was also provided with Rothercare Alarm System to provide her and her husband with peace of mind and reassurance that support is just a call away. Dorothy received a 12 week exercise programme and information and guidance to prevent future falls and following this she attended a community exercise programme to help maintain her functional ability, strength and balance. Each intervention has prevented Dorothy from falling again and potentially being admitted to hospital.

Dorothy said 'I feel safe and am able to live independently where I choose.'

Emma is 42 years old and lives with her daughter who is her main carer. Emma has Multiple Sclerosis, which is a long term health condition. She was recently involved in a car accident. Emma was admitted to hospital to treat a broken leg and head injury. Emma is due to be discharged from the hospital back home.

The Social Care and Mental Health Community Team work 7 days a week to ensure Emma care and support needs will be met upon discharge from hospital. As Emma wishes to return home, the team recommends the Home Enabling Service. Emma is also referred to a specialist brain injury service.

Back home Emma receives support from the Home Enabling Service. The team helps Emma on a short term basis to mobilise safely and regain her confidence and independence. The Home Enabling Team and brain injury service recognise that Emma has ongoing care needs due to her brain injury and refer her for a social care assessment. Longer term social care support is provided to Emma through a jointly agreed support plan. This helps her maintain her independence and enable her to live at home, as she chooses. The brain injury service provides information and advice to Emma's carer to enable her to encourage Emma's recovery and provide practical day to day support at home. Without this intervention, Emma would have experienced a longer stay in hospital and as a result her long term health and quality of life could have been affected.

Emma said 'I am able to access information, advice and support

Harry is a full time Carer for his wife who suffers with dementia and has been feeling depressed and isolated. Harry is also worried about the couple's finances. This has meant that Harry has been making regular visits to the GP surgery as a coping mechanism.

Upon visiting the GP it was identified that Harry was at risk of a breakdown and the GP made arrangements for a Multi-disciplinary Team meeting (which includes various representatives including; GP, Voluntary Action Rotherham, Social Worker). The meeting resulted in Harry being provided with various information and advice about local support groups for those suffering with dementia and their careers and being signposted to financial support services.

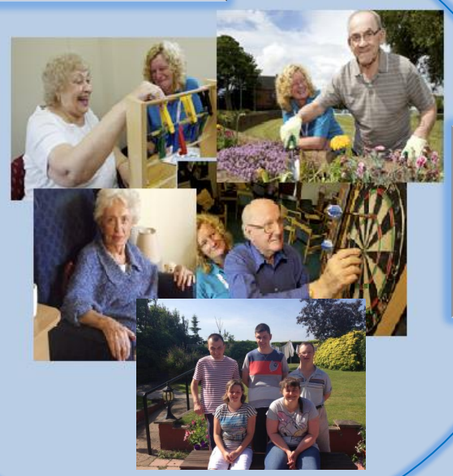
Harry and his wife now attend a regular dementia café and support sessions which have prevented them from feeling isolated and accessing formal care services. Harry also receives 3 hours respite a week, to allow him to socialise within the community and he no longer has concerns about their finances. Through the support received and self-help Harry and his wife have been able to stay independent and improve their health and wellbeing.

Harry stated 'I feel part of my community, which helps me to stay healthy and independent.'

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing' (BCF05, 08, & 12)

'I feel part of my community, which helps me to stay health and independent' (BCF06 & 10)

I am listened to and supported at an early stage to avoid a crisis' (BCF01 & 12)



'I am in control of my care' (BCF09, 10 & 11)

'I feel safe and am able to live independently where I choose' (BCF02, 04, 07 & 03)

'I only have to tell my story once' (BCF11, 13 &14)

Jackie is 35 and suffers from rheumatoid arthritis. Due to a long term condition Jackie spends a lot of time in hospital, which can last for several weeks. Jackie is at breaking point and wants to spend more time at home, managing her condition, so she contacts her GP for help.

Jackie's GP arranges for her to receive a joint health and social care assessment of her needs. During the assessment it is agreed that a personal health and care budget would provide Jackie with choice and control over the support she receives.

Jackie is involved in developing her support plan and provided with information regarding various local groups that could support her, to manage her condition. Discussions also take place regarding things that Jackie could do for herself, to reduce the support she requires, for example staying healthy.

Using the personal health and care budget, Jackie decided to appoint a personal assistant to support her with daily tasks and purchased a gym pass to improve her health and wellbeing. Jackie also attends a number of activities in her local community. Through involvement in self-managing her condition Jackie's health is significantly improved.

Jackie stated 'Through my personal health care budget I am in control of my care.'

George is 72 years of age and lives alone. George has diabetes and his health recently deteriorated, resulting in him being admitted to hospital. George is discharged from hospital and various support services are put in place.

Upon returning home George takes to his bed and is at risk of developing bed sores. The district nurse visits George and although she has never met him before, she has full access to his health and social care records and is able to make informed decisions regarding the treatments he requires.

6 weeks after discharge, a Social Worker visits George to review his care and support. During the review George says that he would like more support to help him within the community and it is agreed that a direct payment would give him the flexibility required, giving him more choice and control. The Social Worker has access to all George's records and works with him to develop a support plan, to meet all his longer term health and social care needs. The Social Worker develops a person centred plan which includes self-care/management to help George manage his condition.

George now has a managed direct payment which is paid directly to a provider and receives both home care and community support to help him with shopping and visiting the local café. Through improved joint working and data sharing George's customer/patient experience is significantly improved. Health and Social Care staff were also able to deal with Georges needs in a more timely manner.

George stated 'I only had to tell my story once.'