Rutland Better Care Fund Programme

2023-25

Programme of the Rutland Health and Wellbeing Board

Contents:

1 Context and Governance

This document, combined with the Excel workbook 'Rutland HWB BCF Planning Template 2023-25', sets out the Rutland Better Care Fund (BCF) Programme for 2023-25.

The area covered coincides with the unitary Local Authority boundary of Rutland County Council, which is a 'place' as defined in the NHS Long Term Plan. Rutland falls within the wider health and care footprint of the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS)

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

Programme development has been led by the Integrated Delivery Group (IDG), involving all its members (RCC, LLR ICB, LPT, the Rutland PCN and Healthwatch Rutland).

VCS organisations including Citizens Advice, Mind, Age UK have been consulted and accepted the plan.

How have you gone about involving these stakeholders?

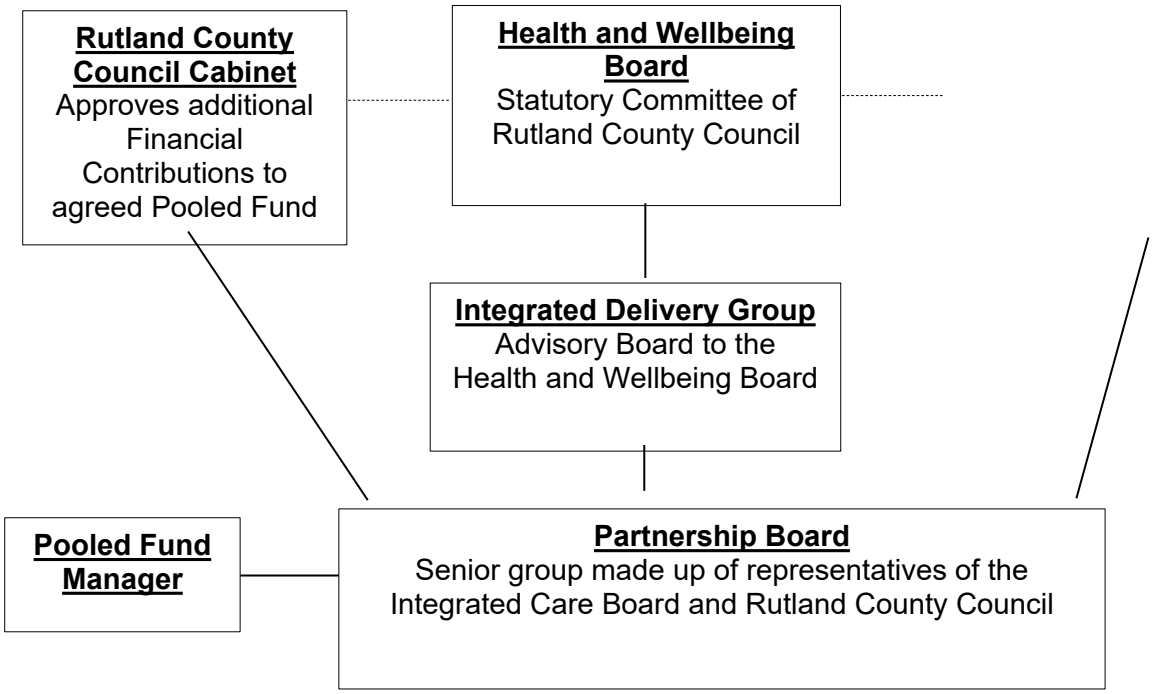
The IDG meets on a monthly basis. BCF reporting is provided at each meeting and consultation and planning with partners takes place.

Separate meetings have taken place with the ICB Deputy Chief Operating Officer for Rutland and Head of Commissioning.

The BCF Lead for RCC attended the Rutland Voluntary and Community Sector Networking Meeting. A presentation was given, and the group were consulted on the plan which was ultimately accepted. The involvement will continue to be facilitated through quarterly meetings with representatives from RCC and the VCS organisations. Consultation will take place on BCF planning and, in addition, on how RCC should be meeting the required standards of the Care Quality Commission.

There have been sessions held with colleagues from Leicester and Leicestershire at system level for consistency and to clarify interventions at this level.

Overall governance arrangements diagram:



The BCF programme is governed by, and has been developed under the leadership of, the Rutland Health and Wellbeing Board (HWB) which meets on a quarterly basis and brings together the following:

Rutland County Council (RCC) (members and officers, including People services and Public Health)
NHS Leicester, Leicestershire, and Rutland (LLR) – the LLR Integrated care board (ICB)
The Rutland Primary Care Network (PCN) on behalf of its constituent practices
Leicestershire Partnership Trust (LPT)
Healthwatch Rutland
Citizens Advice Rutland, on behalf of the wider Voluntary and Community Sector (VCS)
NHS England
Longhurst Housing Association, on behalf of the social housing sector
Leicestershire Constabulary
Plus other such persons as are appropriate to the Board's agenda

Quarterly reports on the progress of the BCF plan are provided to the HWB and are presented and discussed. To further improved governance, RCC will re-establish the BCF Partnership Board. The board will meet on a quarterly basis to with the purpose of ensuring that the Better Care Fund Plan achieves its aims and outcomes within the financial

contributions agreed by the partners. The BCF manager will provide financial and activity information regarding the performance of the individual schemes and will take decisions on the delivery of the schemes and the BCF plan based on that information. Attendees will include representatives from ICB, RCC including the Council's Leader or another appropriate Councillor.

2 **Executive summary**

Priorities are aligned with:

'People at the Heart of Care: Adult Social Care Reform' which focuses on areas such as access to the right quality care, at the right place and the right time; recognition and support for unpaid carers.

'Delivery plan for recovering urgent and emergency care services' with the aim of patients being seen more quickly in emergency departments and improved ambulance response time – through improvements across the health and social care system.

As in previous years, the BCF plan for Rutland for 23-25 reflects delivery against the established framework already in place for delivery of this across the Leicester, Leicestershire and Rutland (LLR) system. The Rutland plan and pooled budget continues to be utilised to progress current successful and enable new models of care.

The Rutland BCF plan and pooled budget continues to be utilised to expedite models of care through embedding already successful schemes and supporting new approaches. Priorities continue to be aligned to delivery of the Rutland Joint Health and Wellbeing Strategy (JHWS). The strategy focuses on the life course approach, with specific integration focus on Living Well with Ill Health and Inequalities. There are two new subgroups, the Mental Health Neighbourhood Group giving much needed focus to improvements in mental health and the Staying Healthy Partnership which is focussed on inequalities.

Priorities:
Prevention at all stages so preventing the need for primary or secondary care and preventing, reducing or delaying the need for social care provision through Home First, reablement, social prescribing, community health.

LLR are committed to implementing a cohesive model or intermediate care aligned to the NICE guidelines (2017). This will ensure a robust step-up and step-down offer of reablement, rehabilitation and recovery to support people to live as independently as possible at home. This is to improve whole system flow regarding hospital admission, stays and discharge. Discharge funding for reablement, staff retention, and at ICS level for expansion of the discharge hub and home first training.
Carers recognition, support and breaks including carers of people living with dementia

Expansion of technology, equipment and adaptations in the home

Capacity in the market for meeting need through personalised, quality services whilst promoting independence and asset based approaches

Falls prevention has had increased focus mobilisation of increased falls prevention strategy in Rutland and Falls Steering Group across System – already increased level of activity in these area which is aligned with the requirement for a new metric on falls leading to hospital admission.

National Condition 1: Overall BCF plan and approach to integration

With regard to joint commissioning, RCC are in the progress of setting up a Health and Care Collaborative with partners including ICB, Public Health and the PCN. This is looking to expand on section 75 arrangements, and will focus on prevention, access and expenditure around complex care as initial priorities.

Other joint commissioning arrangements include:

- A s256 agreement with the ICB for a contribution to VCS infrastructure support.
- A Service Level Agreement with Leicestershire Public Health who provide Public Health in Rutland, which includes a shared Director of Public Health. This provides economies of scale and shared knowledge and planning related to primary prevention services.
- Mental Health Wellbeing and Recovery Service, provide by P3, is jointly commissioned with the ICB, which supports people with less severe mental health issues.
- The advocacy services provided by POhWER are jointly commissioned with Leicestershire County Council

The BCF programme remains structured into four high level priorities as these continue to reflect national and local demand.

1. Unified Prevention: improving individual health and wellbeing, and the vitality of communities
2. Holistic health management in the community: services for people living with ill health, particularly those whose needs are complex, providing a range of 'home first' co-ordinated support tailored to the care needs of individuals, helping them to live well and, where possible, to sustain their independence
3. Hospital flows: reducing avoidable hospital admissions and ensuring prompt, safe and sustainable discharge
4. Enablers: support to the programme itself, alongside analytics, technology and communications and engagement

Access to primary care is a LLR priority as it is nationally. Communication around raising awareness of the Additional Roles Reimbursement Scheme (ARRS) and use of the NHS App is in place across the system.

Support for unpaid carers is also a joint priority. The **LLR Joint Carers Strategy 2018–2021 'Recognising, Valuing and Supporting Carers'** sets out eight key strategic priorities relating

to unpaid carers of all ages, and was developed jointly by the LLR local authorities and the (then) CCGs. It is currently being refreshed. The **LLR Carers Strategy Delivery Group** is in place to ensure awareness and support for carers continues to develop. Carefree, Mobilise and carer awareness training for PCN staff. Professionals across the system work together on Carers Week planning and facilitating events.

Joint commissioning has led to the establishment of a new MDT Facilitator, who acts a central point of information for health, care and the voluntary sector. See page 7 for further details of these roles.

Certain BCF funded services are continuing from previous years as they are successfully supporting progress with priorities of collaborative commissioning, a viable care market and further improving outcomes of those who require support with care. For this reason, the BCF will contribute towards funding of the senior commissioning, compliance and improvement officers.

The RCC Commissioning Team supports budget holders to commission high quality and value for money services and supports the County's care market. The team ensures the provision of services, facilities, and resources to help prevent, delay, or reduce the development of care needs. There must be easy access to information and advice so people can make good decisions about the potential care and support needed. The following activity is planned to ensure a wide range of high quality, appropriate services is commissioned.

- Collaborate with budget holders to understand where there are issues/challenges/weaknesses in care delivery and work to resolve these.
- Commission services efficiently and work with providers so we are aligned with our vision for care and that they are complaint in their delivery.
- Support the care market so it can meet local needs including proactive measures to detect emerging risks.

RCC will run a quarterly provider forum for homecare and care home providers to promote engagement, integration and:

- Give guidance and advice.
- Offer training opportunities.
- Communicate council priorities and local trends/needs.
- Facilitate peer support.
- Obtain feedback/views.

Work is being planned in line with DHSC to ensure we can receive Market Sustainability and Improvement Fund to further support the market.

There will be a newly developed RCC Compliance Lead, who will work as part of the Quality Assurance Team within Adult Social Care to take a lead role in managing the quality of the external care provider sector. They will lead on a programme of work which focuses on

compliance, improvements to quality of health, care and development of the provider sector. The role will also focus on providing assurance of effective local commissioned care services by driving service improvement, quality assurance and contract compliance. Alongside this they will work in partnership with local health partners and the voluntary sector on improvements to service provision. Ultimately working to ensure local market sustainability, advice and support to promote CQC regulatory compliance within the sector and to support positive outcomes for adults with care and support needs.

The Improvement Officers are new posts which support the leadership and implementation of key projects which improve compliance with statutory functions. They will take on activities such as facilitating co-production of services and support in areas such as learning disability, where people with lived experience are co-chairing the Learning Disability Partnership Board. They will lead on digital accessibility including the implementation of a social care referral portal. They are leading on the communication and engagement for a local project, in an area identified in the Joint Strategic Needs Assessment based on socio-economic deprivation and rurality/access to the community. This supports delivery of the Joint Health and Wellbeing Strategy, ensuring any projects incorporate priorities for both health and social care including integration.

Working with the Voluntary and Community Sector as partners is vital to support the health and wellbeing needs of the Rutland community. The BCF will fund the Vista contract which assists people with sensory impairment to continue to live as independently as possible. BCF also contributes to the funding of Citizens Advice in Rutland which gives vital information, advice, and support on many matters relating to welfare and wellbeing and is also making a large contribution to funds to develop the Voluntary and Community Sector Strategy, with the aim of amending and improving services in line with the needs and wishes of the population.

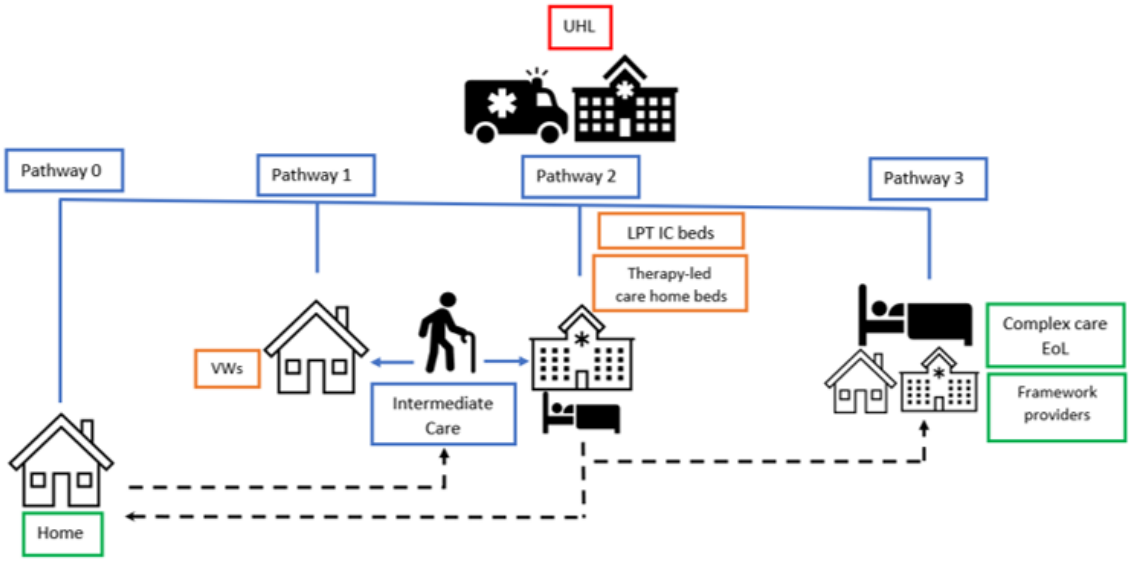
National Condition 2

BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

The LLR vision is to adopt a consistent Home First approach, underpinned by intermediate care, that ensures people are supported to remain independent, in their usual place of residence, for as long as possible. The vision will be achieved through the establishment of a refreshed ‘transfer of care’ hub with four distinct functions:

1. Ward-based MDT: patient facing clinical decision-making; implement criteria-led discharge
2. Integrated Discharge team: focus on complex discharges – through face to face reviews
3. Improve Intermediate Care and discharge pathways: ensure right care, right place, right time.
4. Establish a Transfer Control Centre: Building on the existing data hub to provide discharge, intelligence and operational coordination across the LLR system.

LLR Vision for Intermediate Care (University Hospitals Leicester – UHL)



*EoL = End of Life

Our home first offer helps deliver access a range of preventative and proactive services, deliver more care outside of hospital and closer to home and provide integrated, personalised, and holistic services. The table below is a summary of our Home First priorities and the developments that aim to meet the above priorities in addition to existing services described in previous years' plans, including outputs and outcomes. During the course of 23/25 we plan for our Unscheduled care hub, UCR, and our falls offer to become business as usual.

LLR Home first Priorities 23/24

No	Priority	Priority Description
1	Virtual Wards	Min 276 VW beds by March 24 80% occupancy by Sept 23.
2	Care Homes	Reduce conveyance rates from top 10 CHs by 25% by the end of March 24.
3	Urgent Community Response	80% for 2 hours and 2 days response by end of March 2024
4	Falls Management Tier 1 and Tier 2 falls response across LLR	Consistent falls offer across LLR by the end of March 2024 10% reduction in admissions from falls by the end of March 2024
5	UCCH	Reduce EMAS activity by 15% (from the stack)
		Increase referrals from 111, self referrals, PC and EMAS by 25%
6	Intermediate Care	Roll out step-up/step-down intake model by March 25.
		Increase P1 discharges and decrease P2 discharges by 20% by the end of March 24
7	INTs/ Community Health and Wellbeing Teams at Place	Formation and delivery of 9 (7) in the County CHWTs (INTs) across LLR by the end of March 2024
8	Carers	35,000 identified informal carers across LLR by the end of March 2024

A cohesive approach to BCF planning and delivery allows us, as a system, to continue to deliver our mature LLR out of hospital model based on a wrap-around care concept. The aim is to develop community teams aligned to the recommendations from the Fuller stocktake to ensure care is planned and delivered locally underpinned by a population health management approach.

The BCF contributes to roles within the Rutland Integrated Social Empowerment (RISE) Service focussing on social prescribing. This takes an Integrated Neighbourhood Team approach, enriching collaboration, and coordination across local partners; a personalised, asset- based approach, helping people to engage with what motivates them, and use this to drive changes that improve their physical and mental health and wellbeing. The aim of the service is to support people to maintain their independence, thereby helping to drive preventative practice and benefit those who may otherwise frequently attend primary or secondary health care services.

RISE receive referrals from a range of sources. They work with the local community and a wide range of health, social care, and voluntary sector professionals to ensure the optimum support is progressed. RISE holds between 40-60 active cases, receiving 80+ referrals each month.

RISE Core Principles

- Aim to increase people's control over their health and lives.
- A holistic approach focussing on individual need.
- Promotes health and wellbeing and reduces health inequalities in a community setting, using non-clinical methods.
- Addresses barriers to engagement and enables people to play an active part in their care.
- Utilises and builds on the local community assets in developing and delivering the service or activity.
- Working in a preventative pre-eligible way.

Rutland also has a new social prescribing website 'Joy', which has improved access to health and wellbeing services. The online system can be used by health and social care

professionals, the voluntary sector, and members of the public. This is a close collaboration between RCC, the four GP practices of the Rutland PCN, and the ICB through LPT.

There are other new initiatives which contribute to the vision of BCF. There is a Multi-Disciplinary Team (MDT) Facilitator who leads on multi-disciplinary neighbourhood facilitation and coordination, acting as a central point of information for health, social care and voluntary sector services and as a hub for coordinated collaborative working between partners. The facilitator has introduced a population health management approach to case finding, using algorithms to interrogate GP data to identify cohorts sharing characteristics that mean they are likely to benefit from the prevention and wellbeing services provided by the social prescriber link workers, PCN pharmacists, case coordinators, health coaches. The facilitator is also leading on the Anticipatory Care Project, supporting people with cognition issues and/or a new diagnosis of dementia.

BCF also funds the RCC Clinical Care Home Lead. She supports care home residents through co-ordinating MDT meetings with managers and staff, to identify issues early in order to reduce the need for social care and health contacts. She is leading on the implementation of WHZAN, a telehealth case which completes assessments and measures to detect signs of deterioration or illness which is shared with health. Also funded by BCF is the Brokerage Lead who works with social care staff and providers, to broker care on the service user's behalf in a person-centred way, to enable hospital discharge and following reablement.

There is a new Neighbourhood Mental Health Sub-Group of the HWB. The plan is for this to be established with a formal Terms of Reference. This recognises the significant need to more support for people with enduring mental health needs in Rutland. It is also an area of priority for JSNA work for 2023.

Seven- day therapy offer

In April 2021 RCC were successful in securing Ageing Well monies via a bid to provide a seven-day therapy offer supporting the D2A model. The resource identified as being required to deliver the improvement was 1.6 Occupational Therapists who were then recruited.

Data analysis of role performance - 2022.

Total Number of Referrals Received JAN 2022-DEC 2022	Total Number of Referrals requiring weekend intervention	Total Number of D2D cases	Total Number of Admission Avoidance
78	**23**	**60**	**18**

Without weekend therapy, delay to reablement commencing would have totalled 46 days for 2022. The impact for the person of a two-day delay to start reablement is a likely

decrease in their reablement effectiveness and possible increase in care need. The impact for staff is an increased workload pressure during Monday to Friday.

The current effectiveness of the reablement service is demonstrated by 75 of the 78 reablement cases had no ongoing care and support needs at the end of their reablement.

The 7-day working model is also a key driver in the work we do with the LLR Integrated Therapy Board and aligns social care with health. It positively impacts the resource available to health and a continued commitment to integration. We have created the roadmap for our neighbouring authorities to follow. Because this service is so effective, it is planned to continue for 2023-24.

At the request of the Allied Health Professions (AHP) and Clinical Director at LPT, RCC showcased the successful therapy integration roadmap to date as part of the National AHP week celebration. The presentation has since been shared at the ICS LLR leadership event.

Falls Prevention -The Rutland Offer

Personalised Falls Prevention Strategy for Care Homes

Premise for change

There are 10 times more hip fractures among older people living in care homes compared with older people living in other environments.
Whilst there is a significant amount of generic training and advice available it doesn't feel relevant to staff or residents and any impact quickly diminishes.
We should treat everyone as an individual regardless of where they live.

Aims

- Change the culture of practice to make falls prevention personal and embed in practice.
- Reduce preventable falls.
- Minimise the risk of serious harm for falls that cannot be prevented.
- Identify patterns of falls risk and create a personalised strategy for each care home

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Interventions

- Identify the key roles to make change happen.
  Each care home now has an assigned falls champion to liaise directly with dedicated falls prevention therapist.

- Collaboration at operation and managerial levels.
  Buy in to the vision is required at all levels across the organisations involved and communication, change management and promoting individualised care are key.

- Improve accuracy and incidence of reporting through guidance and joint working.
- Empower staff to feel they could help prevent falls.

Outcomes

- Care homes are requesting a falls prevention forum to network and share good practice.
- 53% reduction in safeguarding for falls.

Jan - April	Safeguarding for falls
2021	19
2022	21
2023	9

- Reduction in falls with injury

Period	No of reported Hip Fractures in Care/Residential Homes
July – December 2021	17 (6 Months)
January – December 2022	8 (12 months)

Community Offer Hip fracture data is now being collected more widely to ascertain the hip fractures rates across Rutland and not simply the most at high risk in care settings. This is to demonstrate the efficacy of our current therapy offer and identify any gaps.

Falls Recovery Service From consultation we have successfully established a direct referral route from the Falls Recovery Service into Adult Social Care Therapy. This will enable:

- Monitoring of the number of falls
- Early identification of those falling in the Community
- An offer of wrap around therapy services from our current offer which includes the Raizer Chair loan and a falls recovery training and equipment offer for formal and informal carers in the person's own home.

This will begin to address equity of service to those in the community, reducing preventable falls and minimising the risk of serious harm if falls do occur. This will reduce the need for a crisis response and hospital conveyance.

The LLR Falls Steering Group is an initiative at System level in response to the priority of falls prevention which is attended by a range of health and social care staff. The Ambition Statement is as follows:

We aim to work in partnership across health, social and voluntary care to improve the health and wellbeing of people at risk of or affected by falls living in the place they call home. We will develop a plan for and take action to ensure the system is equipped to deliver an

effective, accessible and equitable falls prevention and management offer across LLR which includes:

1. *Identification of falls risk and assessment*
2. *Addressing falls risk factors to reduce the risk falling.*
3. *Ensuring that specific falls incidents are effectively managed*
4. *Reducing impact of falls injury to reduce the associated distress, pain, injury, loss of confidence and loss of independence caused by a fall.*
5. *Reducing further falls after specific events*
6. *Recognise value in difference in service provision model across LLR where appropriate but ensure parity of access to services at each stage of the pathway across LLR*

National Condition 2 (continued)

Estimates of demand and capacity for intermediate care to support people in the community.

Metric targets have been jointly produced across LLR, with each area using the same methodology for target setting. This has been through a collaboration of representation from Mids and Lancs Commissioning Support Unit, LA's and ICB with targets and metrics agreed with all partners prior to formal governance sign-off. These have been added to the performance framework across LLR for joint delivery of outcomes related to activity to support timely discharge.

Estimates of demand and capacity have largely been made based on last year's usage. There was no unmet demand where people had to be offered support in a less beneficial service, due to there being insufficient capacity. There was low utilisation of community step-up beds last year. With greater usage of this provision in 2023-24, there is confidence that there should be no over utilisation of inappropriate bedded provision. Assumptions have been made that this will continue as there has been no reduction in provision of services such as MiCare and therapy led reablement. The Home First model continues to be further embedded which will serve to promote the efficient utilisation of support in people's own homes.

National Condition 3

BCF objective 2: Provide the right care in the right place at the right time.

Services which will impact on the following metrics:

- **Discharge to usual place of residence**

It is recognised that enabling people to return home after a hospital stay is a national challenge and there are issues such as an over-reliance on bedded pathways and transition to long-term residential care.

The approaches described below are in line with People at the Heart of Care: Adult Social Care Reform. MiCare is based on an innovative model of care which recognises the importance of planning for changing needs and focuses on prevention and health promotion.

The Home First approach is firmly embedded throughout LLR and working well in Rutland to promote discharge home as the primary and preferred discharge destination (see also page 8). The effectiveness of the Home First Model in Rutland and ensuring sufficient capacity through investing in community based provision, is reflected in data which includes an average of 96% of people who received reablement were still at home 91 days later (2022-23)

Working in conjunction with the wider LLR Discharge Hub, Rutland's MDT triages all requests for support with discharge.

The Integrated Hospital Team combines health and social care colleagues. It successfully supports transfers of care in an empowered and flexible way. Taking shared responsibility for discharges across health and social care colleagues continues to offer a more efficient and effective way to work. For example, having nurses working within the team makes transfer of care considerably smoother, ensuring that the medical needs of services users are supported appropriately on discharge. Working as a Multi- Disciplinary Team provides proactive case management of all P1, P2 and P3 discharges, therefore both the immediate and long-term care needs are supported in a timely fashion.

The Nurses complete Decision Support Tools for Continuing Health Care, arrange the support of those who have short term health conditions (non-weightbearing or delirium patients) and support the transition of those people who require long term health intervention. In accordance with D2A principles the Nurses complete Fast Track applications in the community, expediting discharges from the hospitals, meaning that people with short prognosis get to be in their preferred place for death. Discharge planning starts before the Home First form are received in many cases, as the Rutland Hospital Team are aware of Rutland patients in hospital before they are Medically fit for discharge, having access to Etrack in Peterborough City Hospital allows for proactive triage and anticipates the support needs of pre-discharge patients, streamlining the associated workload. This is something that the Discharge Team will look to emulate with University Hospitals of Leicester over the coming months.

Alignment with D2A facilitation as part of the Adult Social Care Discharge Fund.

The Adult Social Care Discharge Fund was used to fund additional block booked reablement beds in a residential nursing home to facilitate timely discharges. The reablement was delivered by RCC therapists who were available at point of discharge and throughout the patient journey. Additional community capacity was secured through additional funding to retain staff in the MiCare service – see below for service description.

The plan for the Discharge Fund for 2023-24 includes two D2A beds in a residential home in Rutland. These will be used flexibly for any type of D2A need including assessment and reablement. This is based on learning from the previous discharge fund where wrap around and night- time domiciliary care was not utilised, and beds specifically commissioned for reablement although used effectively when there was need, were not fully always utilised. Beds have also been jointly commissioned across LLR. These will utilise the RRR model (Rehabilitate, Reable, and Recover) D2A services, supporting Pathway 2 discharges. At ICS level, the fund is also to be used for training purposes.

It has been recognised that there has been low usage of Step- Up beds throughout 2022. Rutland Memorial Hospital was closed for some months during this period due to structural repair work being required. Therefore, beds were not accessible for Step Up. In addition, there was low usage across LLR and whilst the location of these beds is not optimal for Rutland residents, there could still be potential. This has been considered within the demand and capacity section of the plan. Work is required across LLR regarding utilisation of these beds. These beds can also support with Pathway 2 discharges. However, there is no significant capacity issue affecting Pathway 2 hospital discharges for Rutland. Data shows a very good rate for the proportion of older people who were still at home 91 days after discharge from hospital into reablement. This has hit 96% which demonstrates effective planning and utilisation of Pathway 1 discharges and no over reliance on Pathway 2.

The Rutland Integrated Hospital team historically has strong retention of staff and is currently fully staffed with experienced practitioners and managers including In Reach nurses. Recruitment is therefore not an issue and there is no impact on discharge planning. There are occasional complex discharge cases which require and multi-disciplinary approach with a wide range of professionals' input. Due to excellent localised collaborative working, we can quickly respond and identify appropriate care plans. Whilst placements in Rutland can have their challenges due to home closures and Local Authority fee rates not being accepted, we have remained able to place within Rutland, albeit some have chosen homes outside of the Rutland boundary.

It is recognised that therapists are best placed to manage the functional and environmental risks of returning home. A 7-day service enables RCC to have a therapist triage daily and appropriately designate to P1 or P2 pathway. Rutland Joint Strategic Needs assessment 2018 reported a high and rising level of frail and ageing population. To manage domiciliary care capacity effective routes in to reablement remains our best defence. The above D2A context and motivations for delivery, validated by positive data supports continued investment in the 7-day therapy model for RCC.

MiCare

A creative approach to outcome focused care that tailors support to service users' goals and wishes rather than time and task orientated care in the person's own home. It was developed based on the principles of the Buurtzorg model with small neighbourhood teams integrated health and care provision. The service aims to help people in Rutland to remain

independent and living at home for as long as possible and supports the system flow, providing the right care in the right place at the right time.

The service provides support 7 days a week on a 24 hour basis. On average Micare hold 15 cases per day (7 cases of reablement, 2 safety net, 1 crisis response, 3 complex care, 1 end of life) Micare supports hospital discharges and has on average 40 – 45 cases per month.

Values:

- enable and promote independence
- people are involved in any decisions relating to the service
- people have a service which adapts and changes to meet their needs, preferences and wishes.
- listen, work flexibly and respond to how people want to be supported.
- integrate care and support across health and social care, linking to other specialist and voluntary sector services and the local community

Types of support:

- Reablement—Time limited, therapy led assessment Programme and goal setting with a mixture of health, therapeutic care interventions. **Reablement**, starting within 2 days of referral, is also primarily delivered by Micare, which follows the NICE guidance on intermediate care as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care".

Average length of stay on reablement is 22-25 days while maintaining 80 – 100% effectiveness (acscof)

- SafetyNet—Short Term Care. Support whilst longer term care is sourced

Average stay on safety net is 10 – 21 days

- Crisis response—2 hour response to Rutland residents experiencing a social care crisis, preventing unnecessary residential care or hospital admission. They also provide a **step- up crisis response service** offering short-term care and support following a referral via health or social care emergency routes to reduce the risk of unwarranted hospital admission e.g due to a health crisis, a temporary inability to transfer, risks following a fall or a carer crisis
- D2A—support out of hospital whilst long term needs are assessed. The Micare integrated health and social care offer is delivered by community-based nursing, therapy and Micare carers to support people and their carers when there is a change in need.
- Complex Care—people who may require a gradual/flexible introduction to support, who may benefit from longer term support from Micare before a long term package can be considered..
- End of life—people who may require support to support them to stay/return home inline with their advance care plan / end of life wishes.

Following the CQC inspectors visit on 12th January 2023,

Micare has been awarded a rating of outstanding overall, with good being awarded in the key lines of enquiry of safe, effective and caring service and outstanding awarded in the areas of responsive and well led.

In the summary - the inspector highlighted that People's experience of using this service and what we found was that People were at the heart of the service and received exceptionally responsive, person-centred care which enabled them to live a life of their choosing. In light of this, the service is planned to continue for 2023-24.

In line with this approach and promoting this further, there is work planned on analysing the 'Wider Determinants of Health' from a Health Inequalities perspective. This is linked with the JHWS Prevention priority. Staying healthy and independent, as per the mission of MiCare, further work is planned for 2023-24 to prevent and reduce health inequalities.

The Rutland JSNA identified work was needed regarding End of Life care. This work is supported by MiCare and joint working with community nursing to enable people to remain at home or receive treatment in the first choice of location. This continues to be a priority in Rutland and will be delivered by this collaborative approach.

In addition, a new project is planned based on learning from the JSNA and Health Inequalities. A specific area within Rutland has been identified as a priority area based on socio-economic deprivation and rurality and access to the community. The project will involve active working with small communities to identify and build on the strengths of assets withing villages and surrounding areas, with the purpose of improving access to health and wellbeing resources.

National Condition 3 (continued)

Estimates of demand and capacity for intermediate care to support discharge from hospital.

Estimates of demand and capacity have largely been made based on last year's usage. There was no unmet demand where people had to be offered support in a less beneficial service, due to there being sufficient capacity. There is ample capacity to provide support for people in their own homes on discharge from hospital meaning there is no over utilisation of bedded provision. Assumptions have been made that this will continue as there has been no reduction in provision of services such as MiCare and therapy led reablement. The Home First model continues to be further embedded which will serve to promote the efficient utilisation of support in people's own homes. We are confident in the use of 2022-23 data due to the above.

National Condition 3 (continued)

High Impact Change Model

LLR HICM
Assessment June 202.

Teams and services continue to keep their practice under review, including relative to the High Impact Change Model (HICM). LLR has undertaken a self-assessment against the HICM of care for 2023/24. Attached is the summary of the assessment conducted and the work to progress through the levels of maturity. This interweaves with this content of this narrative.

National Condition 3 (continued)

Duties under the Care Act

Care Act 2014 duties include promoting wellbeing, preventing need for care and support, promoting integration, promoting diversity and quality in provision of services.

Commissioning and carers support are covered elsewhere in the plan.

BCF funding supports functions such as a reviewing officer, required to ensure that an adult's needs are being met in line with choice and using and asset- based approach. A Rapid Response worker is also funded whose remit is to react to potential crises, to prevent deterioration and the need for admission to hospital or residential care. Social care, therapists and nurses are funded from BCF who work together to facilitate safe, timely and effective discharges following the D2A pathway and utilising an integrated approach.

Supporting unpaid carers

It is recognised that informal carers have a vital role, often without recognition of the commitments they make, and the substantial impact that their commitment to providing care can have on their own wellbeing. The RCC Carers Team provides support to informal carers to prevent carer breakdown and enable the cared for to remain in their own home, reducing the need for admission to residential and nursing care and the impact on health services.

The aims of the team are below:

- Ensure carers have access to support that promotes their physical and emotional well being
- Early identification of carers to ensure that the right support is accessible in the right places and at the right time for all carers
- Promote supporting carers and the cared for the live at home for as long as possible
- To provide support to carers and the cared for to prevent hospital admission
- To provide carers with a holistic support service

The team remit includes the identification of resources, planning events and undertaking networking activities to communicate relevant and helpful information to carers to help meet their needs. It is an integrated service to which therapists and health professionals are able to refer for carers' assessments.

There is an ASC Rapid Response function, the roles for this also being funded through BCF. This, in the case of carer breakdown, enables prevention of admission to hospital by visiting the carer and cared for quickly, and co-ordinating any necessary response or actions to keep the person safe, well and sustain levels of independence in their own home setting.

The LLR Joint Carers Strategy 2018–2021 'Recognising, Valuing and Supporting Carers' sets out eight key strategic priorities relating to unpaid carers of all ages, and was developed jointly by the LLR local authorities and the (then) CCGs. It is currently being refreshed.

The strategy aims to ensure that carers have access to support that promotes their physical and emotional wellbeing. An important element is identifying carers early and ensuring that the right support is accessible in the right places and at the right time. The priorities were built upon feedback from carers. There is a LLR Carers Delivery Group in place to ensure the outcomes of the strategy are actioned.

The BCF contributes to the funding of the RCC Admiral Nurse Service and Age UK Leicestershire and Rutland dementia contract.

The Admiral Nurse service is a key part of dementia support in Rutland and continues to grow and develop. Referrals have increased by 36% over the last two years. The nurses support the carers of those living with dementia and work with health colleagues on programmes such as refining the dementia assessment pathway to promote people being diagnosed in a timely manner. They work to improve access to the Dementia Support Service which through its interventions helps to delay admissions to residential care or hospital.

There is a three-year contract in place for a support worker to cover pre and peri diagnosis support. This offers practical and emotional support to people living with dementia and their carers through activities and home visits. Information and advice and help to access group events which support for those on waiting lists for memory services.

Disabled Facilities Grant (DFG) and wider services

The strategic approach centres on prevention, enabling people to stay at home for as long as possible using creative and innovative approaches.

Housing services are managed in Rutland as part of Adult Social Care through the Housing Options Team, with Private Sector Housing, Environmental and Enforcement being commissioned out to Peterborough City Council. The team is part of the Prevention and Assurance Service within adult social care, working to prevent and relieve homelessness in line with duties set out in the Homelessness and Reduction Act 2017. This extended entitlements to help, placed a renewed focus on the prevention of homelessness and local joint working. The Team working alongside local housing providers in line with these duties, only occasionally having to support people in emergency temporary accommodation. Rutland is a non- stock holding authority.

RCC is a unitary authority and therefore does not have formal agreements with districts around the use of the DFG, so RCC staff work with providers to facilitate adaptations and provision of equipment.

As in previous years, the DFG continues to be used to fund standard DFG projects and smaller Health and Prevention Grants for a range of adaptations including home access improvements, stair lifts and level access showers. There are no delays in provision of adaptations, again supporting the prevention agenda, enabling people to remain at home for longer, optimising the wellbeing of service users and their carers.

The Housing MOT scheme, funded by BCF, continues to be a successful service providing holistic assessments of the home environment, including elements such as falls prevention, equipment, adaptations and general housing conditions. This is a home check service providing information, advice and support to promote people's independence and living safely in their own homes. The Digital MOT continues to assess the extent a person can be digitally enabled. Age UK partner with the local Housing Improvement Agency to provide options to upskill people, and a technology loan service.

The AT service has successfully been recommissioned, the new contract focussing on new technologies and smart home technologies. The AT OT will continue to work closely with the AT Development and Quality Manager to research this and look at how these can be incorporated into DFG schemes of work where appropriate.

Additional information

Regulatory Reform

Further to the traditional DFG process delivery RCC fully utilised the wider purpose of Regulatory Reform Order to deliver all adaptation creatively and effectively without delay. The latest data showed RCC are completing adaptation from initial inspection/ assessment to full completion of work within an average of 56 working days.

RCC plans to use this element of the Grant flexibly and according to the needs of the demographic. This will flow between DFG, RRO and HaP. This is in line with the Government's narrative regarding flexible use of the Grant in line with need. The DFG is individual to Rutland at place level, having distinct needs and demand. The tight boundaries of the DFG do not align with the needs of many Rutland residents. Therefore, the therapy service utilises the RRO to cover situations, for example, supporting a house move, where adaptions would be extremely costly and take time to complete.

Equality and health inequalities

Reducing health inequalities and disparities for the local population

In 2021-22, a health inequalities plan was developed by LLR ICS partners to consolidate LLR's approach to reducing health inequality. To develop a Place level understanding of health inequalities, Public Health developed a Rutland Health Inequalities Needs Assessment in 2022-23. The assessment, developed with partners, has been well received by the Health and Wellbeing Board and subgroups.

The assessment covered the four overlapping dimensions of health inequality:

- socioeconomic groups and deprivation;
- inclusion health and vulnerable groups;
- protected characteristics in the Equality Duty; and
- geography.

Recommendations from the assessment included the need for a Health and Wellbeing Board development session on health inequalities to identify actions and an approach to take forward. The session was delivered in January 2023. From the session, additional engagement was identified as a need to supplement the quantitative understanding we gained from the assessment.

The assessment identified variation in economic and health indicators across small areas of Rutland. Partners are therefore progressing developments on an asset-based approach, working with small areas of Rutland showing additional need. Pilots will commence throughout 2023-24 and learning taken forward for sharing across the wider county.

BCF delivery this year and BCF planning and delivery going forward will be aligned to the findings and recommendations of the needs assessment, ensuring allocations are supporting those experiencing the poorest health outcomes, or with worse access to services.

Strategically, at Place level reducing health inequalities remains a cross cutting priority within the Rutland Health and Wellbeing Strategy. The priority has its own workplan, with oversight from a Health and Wellbeing Board subgroup – Staying Healthy Partnership. As it is a cross cutting priority, reducing health inequalities is also engrained within other priorities and workplans. In parallel, health inequalities have become a strategic focus of the Integrated Delivery Group, the subgroup of the Health and Wellbeing Board which operationally drives the BCF programme. This will help ensure partners work collaboratively on reducing the inequalities presented in the needs assessment, including through the delivery of BCF actions.

A more considered and governed approach to addressing health inequalities will enable more structured mechanisms to monitor progress on reducing inequalities, allowing BCF projects to align and demonstrate their impact in a more coherent way.

Core20Plus5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at national and system (LLR) level. Rutland is a relatively affluent area so does not have populations among the 20% most deprived nationally according to the Index of Multiple Deprivation. The ‘Plus’ element, however, allows local places to determine priority disadvantaged groups sitting outside of the core 20% most deprived. The Rutland Health and Wellbeing Board are currently confirming their local ‘plus’ groups based on local intelligence. Once identified, these groups will also be considered in respect of BCF implementation and future planning.

We also recognise that disadvantage is often multi-faceted. Considering equality factors in this way helps to see circumstances in the round to ensure appropriate responses. This underlines the need to tailor services to individuals and their circumstances in order to bring

about positive change and reduce avoidable need for health services, also building on available strengths. The County's social prescribing, health and care services all aim to work within this holistic framework.