Report to Rutland Health and Wellbeing Board

Subject:	**2017-18 - 2018-19 Better Care Fund Programme**
Meeting Date:	**31 May 2017**
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Presented by:	**Mark Andrews**
Paper for:	**Noting and decision**

1. Introduction

1.1 This report updates Rutland Health and Wellbeing Board (HWB) members on the closure of the 2016-17 Rutland Better Care Fund programme and progress on planning the follow-on Programme for 2017-18 to 2018-19.

2. Recommendation

2.1 The Board is requested to:

2.1.1 Note the budget position, with increased funding available.

2.1.2 Note the position in relation to the new 2017-18 - 2018-19 BCF programme, where national delays have impacted.

2.1.3 Confirm interim approval for the actions in Appendix 1 to continue or proceed, pending national readiness.

2.1.4 Confirm support to review and approve the final BCF plan by correspondence if the eventual timetable does not coincide with a scheduled HWB meeting.

3. Policy framework and context

3.1 The Rutland Better Care Fund is a joint health and social care integration programme managed operationally by the Rutland County Council People Directorate, in conjunction with the East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) and delivered under the oversight of the Rutland HWB.

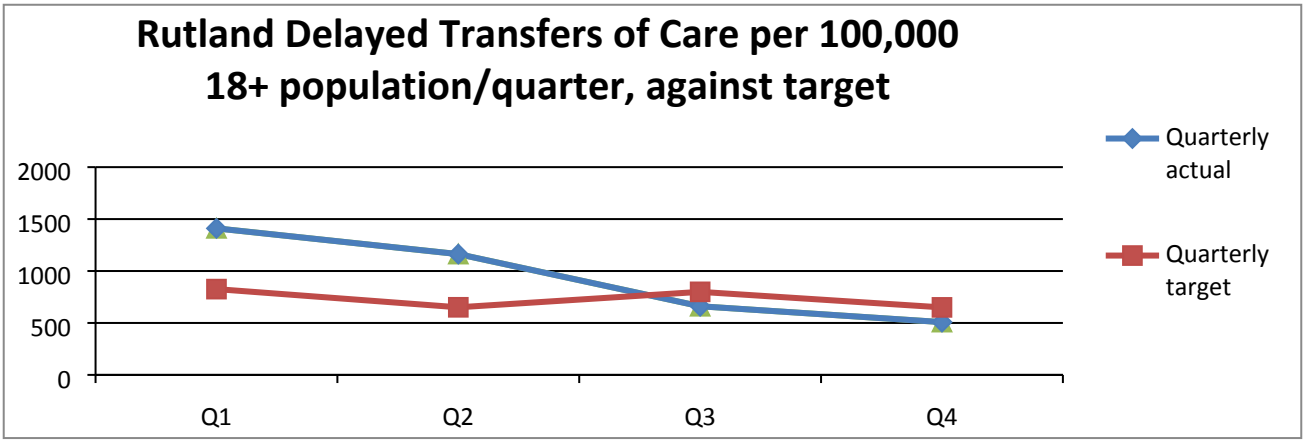
3.2 The 2016-17 Better Care Fund programming period has ended. The programme was delivered successfully, as reported to the HWB in January 2017, also performing well in terms of the national metrics, meeting most of its ambitious targets (see Appendix 2):

- The rate of people entering permanent council funded residential care was 118 per 100,000 65+ population, half last year's level and just a third of the annual target of 355.
- In Q4, 97% of people receiving reablement in Q3 were still at home 91 days after hospital discharge, against a target of 83.3%.
- Emergency admissions reduced by 2% relative to 2015-16 and met the annual target.

- Injuries due to falls fell by 9% relative to 2015-16 and met the annual target.

- Some 91.4% of service users confirmed that care and support services helped them have a better quality of life. This was an improvement over 2015-16's rate of 87%, but did not quite reach the very high target of 93.1%.

3.3 Delayed transfers of care (DTOC) was the most challenging indicator. After a difficult start to the year for hospital discharge delays, the level of delayed transfers of care was driven down quarter on quarter through a concerted focus on process and system improvement, until Q3 and Q4 levels were not only on target, but seeing levels of performance as good as the average rates in the two best performing regions of the country, London and the North East. Although the local annual target was not in the end met, the level of ambition of the target motivated rapid, robust improvements to discharge processes which we anticipate will be sustained into the next programming period, to the benefit of both patients and the wider health and care system.



3.4 Some actions in the programme took longer to be implemented than anticipated. The resulting carry forward (£277k on plans totalling £2.447m) will be reinvested in health and care improvement in the next programme, much of it targeting further reductions to non-elective admissions, which should also help to reduce the number of patients needing discharge support.

4. Funding available for 2017-18 to 2018-19

4.1 Overall funding available for Better Care activity in 2017-18 - 2018-19 is set out in the below table and now consists of five elements:

- **Better Care Fund.** Exact sums are still to be confirmed, but anticipated to equal last year's amount (£2.061m) plus an almost 2% increment each year for inflation. Set amounts of this budget (sums to be confirmed) must continue to be spent on social care and out of hospital services.
- **Disabled Facilities Grant.** Capital funding for home adaptations, confirmed as £203k for 2017-18, up from £186k in 2016-17.
- **Improved Better Care Fund (i-BCF**). This budget, with allocations across three years (£203k, £168k then £77k), was announced in the 2017 Spring Budget and is intended for social care, although channelled through the BCF mechanism. It must not substitute any of the social care minimum allocation required under the main

BCF budget.

- **Underspend from 2016-17 of £277k.** This sum will be focussed towards interventions with potential to reduce non elective admissions as this is anticipated to bring sustainable savings to the local health economy.
- **A voluntary additional contribution to the BCF by the Council of £136k.** This one-off social care grant payment from government will fund a pilot of a new model of homecare, providing additional capacity to the community based health and care system.

Better Care Fund funding components	Reference: 2016-17	2017-18	2018-19	Conditions on use of the funding
Core BCF	£2,061k	c£2,061k	c£2,061k	Complying with the BCF policy framework. Will largely be used to continue successful 2016-17 activity.
Disabled Facilities Grant	£186k	£203k	TBC	Capital grant. Use must comply with DFG legislation.
i-BCF (Spring budget 2017, social care relief)	-	£203k	£168k	Draft grant conditions state the funding is: "to quickly provide stability and extra capacity in local care systems." This includes reducing DTOCs.
Social care one-off grant	-	£136k		Must be spent on social care.
2016-17 BCF underspend, carried over	-	£277k		Local agreement, March Partnership Board (RCC/ ELRCCG): to be focussed towards investments aiming to reduce ELRCCG costs, notably associated with the number and duration of hospital admissions.

5. 2017-18 to 2018-19 programmes: Strategic and policy context

5.1 Publication of the BCF planning framework and budget for 2017-18 to 2018-19 remains significantly delayed, currently as a result of the national election. In the interim, BCF areas have been asked to proceed with planning their new programmes based on the policy framework and with reference to a number of draft planning documents released to BCF programmes on an informal basis in May 2017 by the LGA.

5.2 They have also been asked to proceed as soon as possible to spend the Improved Better Care Fund (i-BCF) allocations, which have already started to be distributed, particularly where this will ease pressure on capacity in acute health care.

5.3 To support early spend of the i-BCF, and in readiness for when the final guidance and planning templates are published, an updated strategy and spending plan have been drafted for the 2017-18 - 2018-19 period.

5.4 The outline spending plans have been reviewed and agreed in principle by the

following:

- the Portfolio holder for Health and Care and Leader of the Council,
- the Section 75 Partnership Board (consisting of the plan's funders, ELRCCG and RCC),
- the Rutland Integration Executive,
- the LLR AE Delivery Board, where the proposals were presented in April and "very well received", leading to confirmation on 27 April 2017 that "LLR AEDB is happy for the additional investment to be used as proposed"… and …"to see if some aspects could be replicated …if they are successful".

5.5 A positive assurance meeting has also been held with the NHS England East Midlands BCF lead, Wendy Hoult.

5.6 Approval in principle of the outline plans set out below is also sought from the Rutland Health and Wellbeing Board.

6. Renewing the Rutland BCF plan

6.1 The provisional BCF plan has been defined relative to a number of reference points:

- Formal guidance and requirements
  - The published BCF policy framework and draft planning documents released to Local Authorities by the LGA.
- The local strategic framework
  - The Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (LLR STP) and its relevant workstrands eg. around the Integrated Locality Team model, Prevention, Home First hospital at home and Vanguard approaches to management of urgent care demand.
  - The Rutland Health and Wellbeing Board strategy, the ELRCCG Operating Plan and the RCC Adult Social Care strategy.
- Local reference points
  - The evolving Rutland context, including up to date data about patterns of health and care need and use of available health and care services (notably analysis of hospital episode data).
  - Partnership-based in-house evaluation of the 2016-17 BCF programme, including its performance against key metrics.
  - Involvement of local partners in shaping proposals and in agreeing the approach.
  - Relevant local factors including the decision of Rutland GP practices to develop a 'Primary Care Home' model of care in Rutland, and proposals to develop integrated health and social care facilities under the One Public Estate banner.
- Good practice frameworks

- Wider studies reviewing best practice in health and social care improvement, both in the UK and wider, including the Nuffield Trust review of the effectiveness of different care initiatives (Shifting the Balance of Care – Great Expectations,(2017)).
- Better Care Fund technical assistance guidance and case studies.
- The High Impact Change Model for Managing Transfers of Care, which was already used to shape the 2016-17 Delayed Trandsfers of Care Action Plan.

6.2 There has been consensus across the Partnership around sustaining the ambition of Rutland's existing BCF programme objective, aiming to achieve a well-integrated and well-understood health and care system by 2018:

> "By 2018 there will be an integrated social and health care service in Rutland that is **well understood** by users and providers and **used appropriately**, has **reduced the demand for hospital services** and **puts prevention and self-management at its heart**, including by building on existing community assets.
>
> Beyond 2018, integrated working, iterative system improvement and personalised care will be the norm, in a more sustainable system that improves outcomes for patients and service users."

6.3 As reported to the HWB in January 2017, the 2016-17 programme evaluation, undertaken with BCF partners, confirmed the overall wisdom of sustaining the actions contained in the 2016-17 programme, with scope for adjustment or reorganisation where this was likely to improve potential outcomes (eg. transitioning some dementia care to a more specialist Admiral Nurse post, reallocating parts of measures to improve visibility or synergies). Therefore, the draft programme proposes strong continuity, remaining structured into four priorities as follows, shown with 2017-18 indicative budgets.

6.4 Meanwhile, the additional sums that have become available since the January 2017 HWB meeting offer the opportunity to support a number of new activities developing the next phase of health and care integration at pace, particularly around health and care services supporting the population who already have impaired health and are the most likely to call on health and care services.

Priority	**Indicative funding allocations, 2017-18 (For full 2017-18 - 2018-19 breakdown, see Appendix 3)**					
	Core BCF	**DFG**	**i-BCF**	**ASC one off**	**2016-17 carry-over**	**Total**
1. Unified prevention	£227k		£58k		£116k	**£401k**
2. Holistic health and wellbeing in the community (Long Term Condition management)	£808k	£203k	£76k	£136k	£43k	**£1,266k**
3. Hospital flows	£936k		£26k		£20k	**£982k**
4. Enablers	£73k		£43k		£22k	**£138k**

6.5 The measures to be supported under each of the four priorities are set out in Appendix 1.

6.6 The Health and Wellbeing Board are asked to confirm their support for the planned actions to proceed or continue, and for the new programme, when finalised, to be reviewed and approved by the most practical method at the time. The timing of this is dependent on progress nationally.

7. Financial implications

See above.

8. Recommendations

8.1 That the Health and Wellbeing Board:

1. Note the position in terms of renewing the 2017-18 - 2018-19 BCF programme, and note the proposed actions to be funded.
2. Confirm their support for the planned actions to proceed.
3. Confirm their support to approve the final plan by correspondence when this becomes possible, if the timing does not coincide with a scheduled HWB meeting.

9. Risk assessment

Time	M	Owing to national delays, a pragmatic approach is being taken nationally in which areas are continuing BCF actions from 2016-17, with additional actions being approved to proceed as soon as possible through local governance. The key priority here is to ensure the i-BCF can start to relieve budget pressure on Adult Social Care and acute services. Groundwork has been done such that it will be possible to finalise the BCF plan rapidly when the final guidance and planning framework are issued by government. Submissions will be due 5-6 weeks after guidance is issued.
Viability	L	The 2017-18 - 2018-19 BCF programme builds on the positive partnership and progress made in health and social care integration in Rutland since 2014. Most of the proposed measures continue 2016-17 activities, ensuring that the programme will sustain momentum in spite of the delayed renewal process resulting from national delays.

		Groundwork has been done for key new proposals, such as the holistic homecare service to help to ensure rapid start-up.
Finance	M	In the absence of an approved programme for 2017-18 - 2018-19, 2016-17 BCF funded activities have been continued into the new financial year, effectively relying on previous approval and local evaluation evidence that they are worthwhile to continue. We have been assured by national Better Care contacts that this approach is reasonable and acceptable in the face of national delays. In parallel, areas have been encouraged to confirm early agreement locally around planned actions, both for core BCF activity and, urgently, for i-BCF actions aiming to relieve pressure on social care and health services. The financial risk is considered low if the HWB is supportive of the proposals put forward. We anticipate that actions approved to progress will contribute to relieving local health and care budget pressures. Given this year's delays to BCF announcements, to avoid high underspends, any new funding has been programmed into the BCF plan with budgets only to cover the remaining 3 quarters of this year.
Profile	L	The programme has a high profile at national, regional and local level and is well integrated as a complementary part of Leicester, Leicestershire and Rutland Better Care Together activity. The HWB will hold both RCC and ELRCCG to account for the delivery of the BCF.
Equality & Diversity	L	The BCF plan will have a positive impact on members of the Rutland community requiring health, care and wellbeing services and opportunities.

Appendix 1: Summary of proposed Rutland BCF priorities 2017-18 - 2018-19

1. Priority 1: Unified Prevention

Progress to date

1.1 The strong focus on prevention, aiming to keep people well, active and engaged in their communities, has been a distinctive aspect of Rutland's BCF programme, recognised by the national NHS England Better Care Fund Programme.

1.2 Many Rutland residents have benefitted from the diverse BCF prevention measures (including assistive technology, falls prevention schemes and support from the Community Agents on life issues). New activities such as the Men in Sheds project at the museum and telephone befriending (also as a follow-on to Community Agent support), were also welcomed, including for their anticipated contribution to mental wellbeing and social connection.

1.3 Disabled Facilities Grants (DFGs) for home adaptations continue to be delivered to help people to remain living at home and support their independence and quality of life, with most projects involving the installation of adapted bathrooms, stairlifts, ramps and/or ceiling hoists.

1.4 At the same time, there is a need to ensure that services are modelled sustainably and are not over-fragmented, intervene earlier to be truly preventative and reach as many potential beneficiaries as possible.

1.5 It is proposed to sustain the relative prominence of prevention measures under Priority 1. This is in recognition of the importance of intervening earlier to help extend healthy life expectancy and thereby reduce demand on the health and care system in the longer term. Local commitment to this principle is reflected in the current Rutland Health and Wellbeing Board strategy.

- Providers of prevention-related services suggested that they would like to work more closely to better support potential synergies – enabling communication, coordination and connection. Therefore, improving coordination across and between available services and providers and proactively promoting services to the public remain key priorities.
- Also important is the provision of services supporting individuals to help themselves and to tackle issues early which could otherwise have a greater impact on their health and wellbeing (Community Prevention and Wellbeing Services and the pilot GP based Wellness Advisors).
- Alongside the more mainstream community outreach services supporting members of the public, i-BCF funding will be used to fund two specialist social care posts who will work with 'hard to reach' individuals considered to be at risk of harm. This is part of the Vulnerable Adult Risk Management (VARM) safeguarding response in Rutland and aims to enable social care to intervene much earlier to support people considered to be at risk but who do not yet have eligible social care needs. The aim is to prevent later deterioration and crisis which can be harmful to the individual, and is complex and resource intensive to manage.

- As physical activity and social connectedness are increasingly recognised as the lynchpins for continued good health, there will be scope to support more activities enabling more people to become more active and to connect socially, including addressing some of the barriers to activity and building on local community assets. This is anticipated to contribute to mental and physical wellbeing and to healthy life expectancy.
- Falls prevention activities delivered well in 2016-17, as reflected in reduced falls injuries, but were somewhat fragmented. A more strategic approach is being pursued, including opting into new LLR wide falls prevention services.

Priority 1: Summary of 2017-18 - 2018-19 Measures

Priority 1: Unified prevention		**Lead**	**2017-18**	**2018-19**
1.1 Communication and coordination Continuing and broadened	A. **Enhance the Rutland Information Service (RIS) online directory of local services** for consistent and reliable prevention signposting. B. **Establish a network of prevention-related organisations** to coordinate services and enhance prevention capabilities. C. **Developing community capacity**, including via the Community Wellness and Prevention contract, building on existing community assets.	RCC (carry over)	£26k	£0k
1.2 Prevention and Wellbeing Services Continuing and broadened	**Support for early prevention:** • **Community Wellness and Prevention Services** including the Community Agents. • **Wellbeing Advisors** at the GP surgery. • **Adult Social Care early prevention service** targeting hard to reach people at risk (in the Vulnerable Adults Risk Management framework).	RCC ELRCCG (carry over) RCC (i-BCF)	£147k £90k £77k	£147k TBC £77k
1.3 Active and connected	**Raising healthy life expectancy by increasing activity levels and social connectedness.** Targeting barriers to people	RCC	£80k	£80k

Refocussed. Assistive tech and DFGs moved to Priority 2.	becoming and staying active and involved, including: • Awareness and availability of suitable opportunities. • Motivation. • Physical and psychological access barriers. Falls prevention remains a focus, coordinating local activities with the wider LLR falls prevention strategy.			

2. Priority 2: Holistic health and wellbeing in the community

2.1 Work with people with ongoing health issues was felt to be going in the right direction in 2016-17, as reflected in key BCF indicators, including a year on year reduction to emergency admission rates and the maintenance of low levels of permanent care home admissions.

2.2 Building on this foundation, long term condition management is the main focus for innovation in 2017-18. Priority 2 will progress the next stage of reshaping health and care services in Rutland, prioritising holistic, person-centred care models that help to maintain wellbeing, independence and quality of life for those with significant health and care needs. This will bring about an increase in self care and bring about further integration across primary, community and social care.

2.3 Improved management of the health of complex patients could be the most powerful means to delay or minimise the impact of illness, reducing the number of non elective admissions and overall demand on the health and care system.

2.4 Numbers of people with one or more long term conditions are growing as the population ages and life expectancy increases, with growing numbers having complex and variable health and care needs. This has a significant impact on those individuals, who may experience disjoints between the many different elements of care they receive and who may not feel 'in the driving seat' in terms of their own care and wellbeing. It also places significant demands on local health and care systems.

2.5 The 2016-17 programme invested significantly in building up effective working relationships between teams supporting people in the community with long term conditions, including through collocation and leadership development. It also funded a number of new or ongoing schemes that form a toolkit of tailored support to people with ongoing health issues (dementia support, carers' support, and, under the Prevention heading, assistive technology and Disabled Facilities Grants). These activities will be sustained and further evolved. In particular, the discretionary scope of adaptations that can be funded under the DFG scheme has been more clearly defined via a DFG

policy so that the funding can increase or sustain the independence of more individuals.

2.6 Alongside this, additional one-off funding for 2017-18 – 2018-19 has allowed a number of further ambitious schemes to be developed that could deliver a step change in the care of people with complex needs. These aim to improve the coordination and coherence of care and to increase the involvement of patients in their own care, improving quality of life, avoiding crisis and reducing the need for hospital admissions.

2.7 Two projects are proposed responding to the call to increase self care promoted by National Voices and underlined in the 2017-19 BCF Policy Framework. They recognise the strong potential of self care for delivering tangible improvements in care, as reflected in the March 2017 Nuffield Trust review of the effectiveness of potential interventions 'Shifting the balance of care':

- A pilot project funded by carry-over funds will introduce a personalised care planning toolkit into primary care including self care tools for patients who want to take a greater role in tracking and maintaining their own health and wellbeing. It is anticipated that personalised 'whole person' care and improved self management will improve patient wellbeing and reduce GP demand, enabling GPs to manage their patients by exception. It will also improve the flow of information enabling other involved care providers to work together in a coherent way with the patient. This toolkit has wider potential if successful, eg. being used to support the monitoring of care home residents or to encourage people who could benefit from lifestyle changes.
- The rate of personal social care budgets will also be enhanced to encourage more people to shape their own personalised care packages, meeting needs in ways unique to them (via i-BCF).

2.8 For those with significant care needs who continue to live at home, a new holistic model of homecare will be piloted in which more highly skilled homecare assistants work in stable area-based teams, building relationships with their clients and undertaking a broader set of tasks, including some routine healthcare. This is anticipated to improve the user experience of care, to be more efficient and responsive to demand and to improve the ability to maintain wellbeing and prevent avoidable deterioration leading to emergency admissions. It also has the potential to support end of life care choices.

2.9 Alongside this, primary, community and social care services will continue to find new ways to work closer, aiming to streamline and consolidate care roles and services, reducing duplication while improving the coherence and effectiveness of care.

2.10 In parallel, there will be work to support the wellbeing of residential and nursing home residents, for example through pre-emptive therapies avoiding falls, also drawing on lessons learned from LLR Integrated Locality Team pilot projects.

Priority 2: Summary of Measures

Priority 2: Holistic health and care services		Lead and source	2017-18	2018-19
2.1 Integrated health and care services Merges 2 pre-existing measures (integrated community care, care coordinator) .	**Further integrate local community, social and primary care services,** particularly benefitting people with long term conditions, frailty and complex needs. Mechanisms to include: Integrated Care Coordinator, and multidisciplinary coordination of care.	RCC BCF ELRCCG BCF	£153k £405k	£153k £405k
2.2 Self care New	A. **Individuals empowered to play a greater role in maintaining their wellbeing** and to be at the centre of their care, through personalised care planning at the GP, supported by an online self care toolkit. B. **Encouraging take up of personal budgets for social care** through increased funding. Bringing forward a change already factored into the mainstream 2018-19 ASC budget.	BCF carry over RCC i-BCF	£43k £70k	£43k -
2.3 Holistic homecare New	**'Whole person' model of domiciliary care** which prioritises relationships and continuity and is responsive to the evolving wishes and needs of individuals. Funding for a pilot of the new approach and transition to 'business as usual' if successful.	RCC (ASC grant and i-BCF)	£142k	-
2.4 Health and wellbeing in care homes New	**Supporting care homes in the management of complex and frail residents**, including via pre-emptive therapy to prevent falls, assistive technology, etc.	£TBC	£TBC	

2.5 Support services sustaining wellbeing and independence Continuing schemes, reconfigured as a 'toolkit' or menu of support options	**Support helping individuals living with long term conditions and their carers to sustain wellbeing and independence**: • Dementia care • Carers support, including respite • Disabled Facilities Grants • Assistive Technology • Falls prevention interventions for people who have already fallen	 RCC RCC DFG RCC RCC	 £100k £85k £203k £65k £TBC	 £100k £85k £203k £65k £TBC

3. Priority 3: Hospital flows – crisis response, reablement and transfers of care

3.1 The focus of the Crisis Response, Transfer of Care and Reablement priority is on managing and reducing demand for hospital services.

3.2 Investment in 7 day crisis response services will continue in 2017-18 - 2018-19, with revised services currently being put in place across the LLR area, reflecting learning from the previous two years. There will also be further work to review the prevention and management of crisis, for example working with care homes.

3.3 The 2016-17 programme already allocated significant resources to reducing delayed transfers of care (DTOCs). The model developed then refined delivered progressive improvements across 2016-17, reflected in quarter on quarter reductions in DTOCs, until Rutland DTOC levels have come consistently within the very ambitious targets set. It is proposed that the approaches developed should be sustained into 2016-17, and further improvements progressed, eg. earlier engagement for people being admitted for planned care.

3.4 Partners will continue to work iteratively, informed by data, to identify and address issues and disjoints in transfer of care processes so that discharge delays, and their impact on patients and the wider health care system, are reduced to a minimum.

3.5 Proposed improvements are largely around working to accelerate the discharge of planned care patients by starting preparations for their discharge before they are admitted (anticipating their post-treatment needs, optimising their resilience through pre-operative therapies, arranging equipment, etc).

3.6 We also propose to review step up step down arrangements to explore whether the use of virtual wards could be increased. For example, through clinical agreement in defined circumstances, patients could be transferred

sooner from acute hospitals to the local virtual ward offer to continue their treatment, avoiding protracted hospital stays.

3.7 Reablement services have been successfully ensuring that patients discharged from hospital are not readmitted and this service will be continued and further evolved.

Priority 3: Hospital flows		**Lead and source**	**2017-18**	**2018-19**
3.1 Integrated urgent response Continuing and broadened	Continuing 7 day crisis response services. Broadened to consider whether there is further potential to reduce 'just in case' hospital admissions (eg. care home support, virtual ward step up)	RCC BCF ELRCCG BCF BCF carry over	£125k £115k £20k	£125k £115k £20k
3.2 Transfer of care and reablement Continuing, with ongoing rapid cycles of change	Continuing the effective arrangements already in place for reablement and transfers of care. Implementing a further DTOC Action Plan (Appendix 3) to further raise the maturity of the system. Addition of a technical instructor role to work with planned care patients pre-admission. (Would also support 2.4 care home pre-emptive reablement)	RCC BCF ELRCCG BCF RCC i-BCF	£561k £135k £26k	£561k £135k £35k

4. Priority 4: Enablers

4.1 A broad range of enabling activities provided inputs that enriched and improved the effectiveness of the 2016-17 programme.

4.2 There is now a clear, prioritised work programme for IT and IG, firmly linked to the LLR IT roadmap and more of the technical and governance related building blocks for integration are in place.

4.3 IT projects are being progressed to support integrated working, notably the joint laptop solution delivered in early 2017.

4.4 Data has been more central to shaping policy responses and we have increased our involvement in wider projects and toolsets able to support evidence based change, including the PI Care and Health Trak system.

4.5 User engagement in shaping services has been strengthened, notably through the HealthWatch project listening to service user experiences of transfers of care.

4.6 It is proposed that the funding for programme management and analytics should be continued, with support for an updated set of complementary enablers activities supporting the 2017-18 - 2018-19 proposals, including:

- Funding to improve the IT equipment and systems available to mobile social care and community health staff who work directly with service users, enabling them to collect information and transact in more efficient ways and to involve the individuals they are working with more effectively in defining their needs and shaping their care (enabled by i-BCF and 2016-17 carry over funding).
- Funding to build on the 'Transfers of care user engagement project' undertaken in 2016-17, for example to understand the experiences of people with complex care needs, so that services can be shaped in ways that are more customer focussed.

Priority 4: Enablers		**Lead and source**	**2017-18**	**2018-19**

4.1 Enablers
 	
Continuing.
 	
Activity tailored to current integration needs
	Programme management and analytics supporting evidence based change, plus a number of further areas of activity.
	• Improved IT hardware for mobile working
	• Integration between IT systems
	  ○ Single trusted assessment for community health and social care
	  ○ Access to the GP Summary Care Record for community health and social care
	• Information Governance assurance and data sharing arrangements supporting integrated working
	• Research into the user experience of new services and approaches
	• Provider engagement and workforce development supporting new models of care
		RCC BCF
		
		RCC i-BCF 2016-17 carry-over
		
		£10k
			£73k
			
			£33k
			£22k
			
			£14k
				£73k