REPORT NO: 30-2015

PEOPLE (ADULTS AND HEALTH) SCRUTINY PANEL

Date 5th February 2015

UPDATE FROM THE HEALTH AND WELLBEING BOARD INCLUDING BETTER CARE FUND DELIVERY

Report of the Director of People

STRATEGIC AIM:	**Meeting the Health and Wellbeing Needs of the Community**

1. PURPOSE OF THE REPORT

1.1 To update Scrutiny on the work of the Rutland Health and Wellbeing Board.

1.2 To update Scrutiny on specific progress relating to the delivery of the Rutland Better Care Fund plan.

2. RECOMMENDATIONS

2.1 That Scrutiny notes the contents of this report.

2.2 That Scrutiny next receives an update on Health and Wellbeing Board activity including progress against the Better Care Fund metrics in 6 months' time.

3. HEALTH AND WELLBEING BOARD HIGHLIGHTS

3.1 Health and Wellbeing Board last met on 2nd December 2014, key items discussed included:

a) Better Care Fund: each scheme within the plan is in the process of working up detailed Business Cases, the Board will have seen a Business Case for each scheme before 1st April 2015
b) Care Act Implementation Update
c) Better Care Together: Strategy Outline Case presented
d) Leicestershire and Rutland Safeguarding Children's and Adults Annual Report was received
e) Update provided on the Primary Care Operating Framework and Co-commissioning Timescales and Process

3.2 The Rutland Better Care Fund Plan was formally approved at the end of 2014 with full go ahead to continue with implementation. The plan can be accessed from the Rutland County Council website at: http://www.rutland.gov.uk/health_and_social_care/better_care_fund.aspx

3.3 The Board held an Informal Development Session in November 2014; the purpose of this session was to understand the Board's commitment and aspirations for "integration" and to develop a shared understanding of what the vision will look like. It is recognised that the Better Care Together 5 year strategy and Better Care Fund plan will be the key delivery mechanisms for delivering integration. Many ideas were shared at the session and this has provided the confidence that our plans are taking the right direction of travel.

3.4 In order to monitor delivery of the Better Care Fund Health and Wellbeing Board meetings have been scheduled every 2-3 months rather than quarterly to ensure the programme receives the leadership necessary to make the plan a reality.

4. BETTER CARE FUND DELIVERY

4.1 Key Messages:

a) "Single Pooled budget between Health and Social Care" from 1st April 2015
b) £2.2m for 2015/16 – this is not new money.
c) Government wants this money to be used differently between health and social care.
d) Aimed at promoting closer joint working between health and social care.
e) There is no funding guaranteed beyond 2015/16 at present.

4.2 Key aims of the Better Care Fund:

a) Keep people out of hospital
b) If people are admitted to hospital, we need to get people out of hospital quicker
c) Enable people to live independent lives
d) Provide care for the frail and elderly at or closer to home
e) 7 day health and care services so people can access care when they need it

4.3 What projects do we have to support delivery of the Better Care Fund?

Project Title	Funding for 2015/16	New or existing project
Community Agents	£200k	New
Assistive Technology	£98k	New
Adaptations and Disabled Facilities Grant	£104k	Existing
Integrated Care Coordinator in GP surgeries	£39k	Existing
Integrated Dementia Pathways	£100k	Existing but being developed/improved
Learning Disability Pathways	£84K	New

Project Title	Funding for 2015/16	New or existing project
Step Up Step Down: • Reablement • Hospital Discharge • Integrated Crisis Response Service	£536k £50k £450k Total: £1,036,000	50% New money 50% existing
Integrated Health and Social Care Pathways	£405K	Existing but being developed
Project Support	£50k	New
Supporting Care Act Delivery including IT requirements	£110k	New

4.4 Individual project updates:

Project	Information
Community Agents	Service due to commence 1st April 2015. This is an expansion of the existing good neighbour schemes and Rutland First Contact. Local coordination and a single point of contact for providing information and signposting to other types of local support including services, peer support and community resources. A network of community agents will be working flexibly and providing consistent county wide cover so that they are accessible to those in need. The service will aim to reduce social isolation and increase social contact for all age groups and disabilities but particularly for older people.
Assistive Technology	A service provider (Olympus) is in place to respond in a timely way to referrals for people who may benefit from assistive technologies (6 month pilot starting December 2014). As at January 2015 5/6 referrals have gone to Olympus indicating positive outcomes. Tools to monitor have been developed and will be audited. Plans to raise profile underway, article in GP newsletter, Action learning groups and team meetings. The Service undertakes the assessment, provision of equipment and follow-up. Assistive technologies support independent living.
Adaptations and Disabled Facilities Grant	Disabled Facilities Grants (DFG's) are means tested and the funding is now part of the Better Care Fund. The service is already in place and is a statutory requirement of RCC. Adaptations facilitate access to essential facilities for the disabled person in their own home and includes adaptations such as stairlifts, ground floor toilets, wheelchair adapted kitchens, walk in showers, safety features for a disabled child. Appropriate adaptations can help people to remain independent, safe and healthy.

Project	Information	
Integrated Care Coordinator in GP surgeries	This post supports all 4 GP practices in Rutland, providing advice and information on wellbeing and maintaining good health for people to a carefully selected cohort of people aged 60 plus with long term conditions. The Service commenced in 2014 however the post is currently vacant and going through the recruitment process.	
Integrated Dementia Pathways	Individuals and their families and/or carers will be better supported through their journey pre and post Dementia diagnosis. The health and social care system will be integrated through joined up working and coordination between the different services working to support those suffering with Dementia and their carers. A memory advisor will be appointed by 1st April 2015 to support this process.	
Step Up Step Down	Reablement	The Reablement Service helps people to gain or regain the skills necessary for daily living which have been lost through deterioration in health. Reablement ideally takes place in the person's own home but if the person is unable to be at home safely then a bed based facility may be required for part of the programme.
	Hospital Discharge	We currently have a social worker and community health nurse specifically appointed to prevent delayed discharges from hospital, this is working well at Peterborough Hospital but we want to develop the scheme to ensure there is coverage to support discharge of all Rutland Residents out of hospital. "Stepping Stones" facility at Gainsborough Court commenced on 12th January 2015 for a 3 month trial period. Spire Homes are working in partnership with Rutland County Council and the East Leicestershire and Rutland Clinical Commissioning Group to provide temporary accommodation and reablement for Rutland residents. This service is for people who are unable to return straight home from hospital, because their own home is unsuitable for them, or to provide a safer or more suitable environment for reablement to take place.
	Integrated Crisis Response Service	A range of health and social care services that work in an integrated way to prevent people's level of care requiring an admission to hospital or residential care. The Service can be for up to 72 hours and includes a night nursing pilot, Intensive unscheduled nursing and therapy interventions and urgent social care support through the REACH Service. Of 8 referrals since the service commenced in September 2015, 5 prevented hospital admission and 2 prevented short stay

Project	Information	
		residential care admission. Numbers of referrals still appear low despite promotion but service still in early phase of development and formal evaluation will help to inform if receiving all referrals it could be responding to.
Integrated Health and Social Care Pathways	Individuals will be supported to live more independently in their own homes through the provision of joined up, co-ordinated health and social care services, designed to meet individual need and delivered at local level. This is a significant task which involves whole system change particularly in the way in which Community Health Services are configured. Engagement on the Community Services Strategy is currently taking place, this will inform the development of a strategic outline case due in February 2015 which will in turn result in operational detail being developed regarding how community services will be configured. This is a significant piece of work and potentially involves substantial change across a number of CCG contracts with its main provider.	
Project Support	A proportion of funding is allocated to support project delivery across health and social care. A small Transformation Team is in place with project management supporting implementation of the full Transformation Programme (People First, Better Fund and Care Act)	
Supporting Care Act Delivery including IT requirements	This scheme ensures that there are sufficient plans in place to meet the governments Care Act 2014 requirements.	
Learning Disability Pathways	We have a very small number of individuals with complex learning disabilities requiring support from Health. Therefore we are currently exploring other opportunities to best use the funding so that the health system is supported in the most effective way. Approval is being sought from the Health and Wellbeing Board on 27th January 2015 in order to develop new plans.	

4.5 Monitoring effectiveness of individual schemes:

a) A performance framework has been developed including a performance dashboard in order to track progress against each metric; the Health and Wellbeing Board will be discussing this at its meeting on 27th January 2015 with the intention of receiving quarterly performance reports from 1st April 2015.

b) The Board is responsible for determining the effectiveness of each scheme, the Board is supported by the Integration Executive which will make recommendations to the Board where changes to the Better Care Fund plan and its scheme allocations is required.

c) The effectiveness of each areas Better Care Fund plan is based on delivering against the following Metrics:

Metric	Outcome sought	Local Target for 2015/16
METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Reduce inappropriate admissions of older people (65+) into residential care	Baseline (13/14 actual activity): 45 Target: 33
METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Increase no. of older people still at home 91 days after hospital discharge into reablement (whilst ensuring we continue offering the service to those who will benefit)	Baseline (13/14 actual activity): 25 Target: 20
METRIC 3: Delayed transfers of care from hospital per 100,000 population (average per month) *Based on delayed bed days not people*	Reduce delayed transfers of care from hospital per 100,000 population	Baseline (13/14 actual activity): 1361 Target: 825
METRIC 4: Total emergency admissions into hospital, per 100,000 population *(general and acute)*	Reduce emergency admissions which can be influenced by effective collaboration across the health and care system - Pay for performance metric	Baseline (13/14 actual activity): 2954 Target: 2868
METRIC 5: Patient / service user experience *Annual Patient survey question: "Do care and support services help you to have a better quality of life?"*	Increase in positive patient responses to survey question	Baseline (13/14 actual activity): 91.1% Target: 93.1%
METRIC 6: Local Metric - Injuries due to falls in people aged 65 and over *Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population*	Reduce emergency admissions from injuries due to falls in over 65s	Baseline (13/14 actual activity): 171 Target: 151

5. HEALTH AND WELLBEING BOARD FORWARD PLANNING

5.1 Key responsibilities for the Health and Wellbeing Board through 2015 will include:

a) Approving a refreshed Joint Strategic Needs Assessment for Rutland (2015-2018)
b) Monitoring the impact of the Rutland Better Care Fund Plan
c) Rejuvenating the links with the Children's Trust to ensure that Children and Young People have a focus on the Boards agenda

6. RISK MANAGEMENT

RISK	IMPACT	COMMENTS
Time	**High**	Implementation is taking place or planned to start on 1st April 2015.
Viability	**Medium**	"Enabling resources" are in place to make the Better Care Fund Plan a reality.
Finance	**High**	Funding is only allocated for 2015/16; scheme leads will be responsible for planning adequate exit strategies in case funding was to cease beyond 2016.
Profile	**High**	The Better Care Fund is a national initiative receiving high levels of publicity. The Health and Wellbeing Board will receive quarterly updates on delivery; this information is publicly available.
Equality and Diversity	**Low**	Scheme leads will complete individual Equality Impact Assessments as part of the project planning process. The Better Care Fund aims to meet the needs of the most vulnerable particularly those with complex needs; schemes will enhance patient experience rather than have any adverse impact.

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(NB If Report contains Exempt Information, no reference should be made to Background Papers)

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