Updated July 2014

Please note that this is the most up to date version of the re-submission for Rutland. Further work will continue to take place between 9th September and the date of the Health and Wellbeing Board (17th September) to ensure that the version ready for submission on 19th September sufficiently meets guidance.

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Rutland County Council (RCC)**
Clinical Commissioning Groups	**East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) ELRCCG covers two Local Authority (LA) areas and therefore feeds into 2 BCF Plans. We have worked with both LAs to ensure that there is alignment across plans. Rutland work closely with partners in Leicester, Leicestershire and Rutland (LLR) and therefore some of the strategies referenced within the document relate to joint work within this partnership**
Boundary Differences	**It is calculated that up to 70% of the Rutland adult population in need of an acute bed would use acute hospital services in Peterborough City Hospital, therefore engagement and agreement of plans with Peterborough NHS Trust has**

	been sought.
Date agreed at Health and Well-Being Board:	**Health and Wellbeing Board Extraordinary meeting – signed off on 17th September 2014**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF pooled budget: 2014/15	**£788k**
2015/16	**£2.226m**
Total agreed value of pooled budget: 2014/15	
2015/16	

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	East Leicestershire and Rutland Clinical Commissioning Group
By	Dr David Briggs
Position	Managing Director
Date	<date>
Signed on behalf of the Council	Rutland County Council
By	Helen Briggs
Position	Chief Executive
Date	<date>
Signed on behalf of the Health and Wellbeing Board	Rutland Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Christine Emmett
Date	<date>

c) Related documentation

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

Document or information title	Synopsis and links
Leicester, Leicestershire and Rutland 5 year plan "Better Care Together".	**A joint strategy between all NHS and Local Authority services from 2014- 2018. http://www.bettercareleicester.nhs.uk/information-library/better-care-together-plan-2014/**
Rutland Joint	**http://www.rutland.gov.uk/rutland_together/health__wellbeing_boa**

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Strategic Needs Assessment (2012)	**rd/jsna_2012.aspx** **The JSNA is due to be revised in 2015**
Rutland Joint Health and Wellbeing Strategy (2013)	**http://www.rutland.gov.uk/rutland_together/health__wellbeing_board/health_and_wellbeing_strategy.aspx**
Public Health Outcomes framework	
Adult Social Care Outcomes Framework	**https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015**
People First review	**A full scale review of Rutland County Council's People Directorate, looking at alternative mechanisms of delivery as well as restructuring to ensure the People Directorate structure can accommodate health and social care integration moving forward. The report went to Joint Scrutiny Panel on 28th August, available here: http://www.rutland.gov.uk/council_meetings/people_adults__health_scrut/28_august_2014_joint.aspx**
East Leicestershire and Rutland CCG Operating Plan (2014/15 – 2015/16)	
Better Care Together LLR 5 Year Strategy (June 2014)	
Integration Executive TORs (2014)	
Better Care Together LLR IM&T Programme Plan	

2) VISION FOR HEALTH AND CARE SERVICES

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

Our local vision for integration is based on 4 core strategic drivers, three of which are local and one of which is national.

Local strategic drivers:

Strategic Driver 1. The Leicester, Leicestershire and Rutland (LLR) Better Care Together 5 year strategy states the following agreed vision

"…to maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving the health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings." LLR Better Care Together 5 Year Strategy page 6

The LLR Five Year Strategy describes:	**The 5 year strategy is based on:**	**The 5 year strategy sets out:**
The overall direction for the models of health, care and support services that will need to apply in five years' time across the whole health and care system operating in LLR The steps needed to realise that vision; and A roadmap to better outcomes for our citizens	**A comprehensive analysis of the system challenges we face,** due to our: • Population profile • Configuration of services • Utilisation of services • Models of care delivery • Settings of care delivery • Costs of care delivery • Feedback from public/patients about the priorities for improvement from their perspective	**8 overarching service models -** each reflecting the current situation and desired outcomes in five years' time, identifying how change will be made. These are: • Urgent care • Frail and older people • Long term conditions • Planned care • Maternity and new born services • Children's services • Mental health • Learning disabilities.

The 5 year strategy will fundamentally change models of care in 8 key service areas by:

- Profiling the service pathways and models across settings of care
- Shifting a proportion activity away from acute hospital settings into community settings
- Intervening earlier in care pathways to prevent higher levels of dependency and cost in the health and care system in the medium term.

The Rutland BCF is a crucial enabler to the delivery of the LLR vision. It will drive a number of targeted changes with effect from 2014/15, thus providing some quick wins in the early stages of the Better Care Together Programme.

The authorities have consulted widely with the public, staff and stakeholders, and this strategy incorporates discussions that have taken place at consultation events throughout the LLR region. A further series of consultation events are in progress relating to the implementation of this strategy. A list of these consultation events can be found at http://www.bettercareleicester.nhs.uk/

Strategic Driver 2. Rutland Joint Health and Wellbeing Strategy

The key findings of the 2012 Joint Strategic Needs Assessment (JSNA) were a key contributor to the development of the JHWS, findings are summarised as follows:

Rutland is the smallest English county and the most rural unitary authority with a population of 38,800 (2011) expected to rise to 44,300 by 2026 and to 46,400 by 2033. There are above average proportions of the population in the 16-19, 35-69 and 80+ age bands and the number of people aged 65+ is expected to double between 2010 and 2026.

The County is a relatively affluent area, ranked 305 out of 326 nationally where 1 is the most deprived (IMD2010) There are low levels of unemployment (4.4% April 2010 to March 2011) and higher than average household incomes. However, there are pockets of deprivation and housing affordability problems.

Although life expectancy exceeds the national average, there are persistent inequalities between males and females and between the most and least affluent citizens.

Tackling inequalities in health and wellbeing outcomes continues to be a challenge and a driver for change. Additionally,
Rutland's geographic nature presents problems associated with rural isolation, Our chosen strategies thus target the accessibility of services for our rural population, and look at redressing inequalities in both gender, and pockets of deprivation

Joint Health and Wellbeing Strategy Vision:

To continuously improve the health and wellbeing of the people of Rutland, and ensure Rutland remains the healthiest place to live in the UK

Our vision is underpinned by a number of principles which will translate into tangible actions in our plan for integration:

Empowerment based on:

- A shared responsibility
- Communities looking after themselves
- Encouraging people to make informed healthy choices
- Communication – sharing success and learning

Provision based on:

- Prioritising the most vulnerable
- Doing more for less
- Listening to service users and the public, and acting on what they tell us
- Taking advantage of Rutland's small size to utilize our resources and assets so we can target
  those most in need

To deliver Rutland's Joint Health and Wellbeing Strategy the following four themes and associated priorities have been identified:

Themes	**Priorities**
1. Giving children & young people the best possible start	• Vulnerable families • Vulnerable teenagers • Emotional Health and Wellbeing
2. Enable people to take responsibility for their own health	• Obesity • Smoking • Alcohol
3. Help people to live the longest healthiest life they can	• Frail elderly population • Dementia • Cancer • Depression and anxiety • Wider determinants of health
4. Making health and social care services more accessible	• Living independently • Hospital discharges

The development of the Rutland BCF has been led by Rutland's Health and Wellbeing Board in the context of the LLR-Wide strategy and the Joint Health and Wellbeing Strategy for Rutland, both of which have been based on Rutland's Joint Strategic Needs Assessment.

The successful delivery of our Joint Health and Wellbeing Strategy and the LLR five year strategy are dependent upon the ability of partners in Rutland to focus on:

- Shifting a proportion of activity from acute to community settings
- Translating the LLR strategy and road map into the most effective practical changes that will transform the way care is delivered outside hospital
- Achieving greater integration of care for local citizens
- Leading the health and care economy driving change on the ground towards shared outcomes

Further details on how each scheme will contribute to the areas in need of change are included within the Annex 1 schemes.

Strategic Driver 3: People First – A Review of Rutland County Council's People Directorate

Between January 2014 and August 2014 Rutland County Council launched a full scale review of its People Directorate. This provided both a key challenge and opportunity to consult widely with stakeholders on a review of existing services in the light of changing

policy and the financial context. The Local Authority was able to use this opportunity to consult partners, employees and members of the public on the health and social care integration agenda, particularly in terms of the ethos and key themes in Rutland's BCF submission.

Through the People First review the concept of health and social care integration has been considered in detail and remains the ambition for the Local Authority, health and voluntary sector partners.
Key messages from extensive consultation with stakeholders include:

- Citizens have high expectations about the services they receive
- It is difficult to navigate through the range of services available due to a lack of coordination regarding what is available
- Rutland is unique. There is an opportunity to capitalise on Rutland's size and drive innovative local solutions
- Recognition that there is scope to make efficiencies, generate additional income or deliver services in a more joined up way with health/Voluntary, Community & Faith Sector
- Recognition that there isn't an open cheque book and therefore the most vulnerable need to be targeted

People First has set the future direction of services for People in Rutland. The Vision for the Directorate moving forward will be:

"The reason we are here is to serve our children, families, vulnerable adults and communities to the best of our ability. The culture that we will develop is one where we will regularly ask ourselves "Would this be good enough for my child, my parent or me?"

This vision is supported by key stakeholders including partners from the public and voluntary, community & faith sectors.

The Directorate is being restructured to support this vision and to better respond to the integration agenda for health and social care. A project plan exists which integrates three key strands within the directorates change programme:- the people First reorganisation agenda: preparation for the Care Act, and the preparation of the Better Care Fund Plan, and establishment of associated work streams.
Our focus will be on:

- Integration of services including multidisciplinary teams, integrated information and advice and co-location of services
- Supporting independent living
- Ageing well
- Early intervention and prevention and the contribution of Public Health
- Joint commissioning as a means of providing integrated service

Strategic Driver 4: King's Fund: Integrated, Person Centred Care

http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund

The work of The King's Fund has informed our vision for integration and the development of the BCF Plan in two key ways:

- The core elements of integrated care
- The evidence base for integrated care interventions

The Core Elements of Integrated Care

In line with The King's Fund recent report "*Making our health and care systems fit for an ageing population,"* partners in Leicestershire and Rutland have a clear view of the core elements of integrated care that should be in place to provide the optimum system of health and care - as illustrated in this diagram, taken from The King's Fund Report.

Leicestershire and Rutland partners agree that if care and support is designed and structured more effectively to meet the needs of the ageing population, it will also be planned and delivered more effectively for many other parts of the population, such as those under 65 who need support following surgery or illness, those who have a long term condition, or are at risk of developing a long term condition in later life.

Evidence Base for Integrated Care

The BCF evidence summary provided by The King's Fund has been used to consider the anticipated impact of the interventions and care pathway changes proposed in the Rutland BCF and to test our ability to improve our performance against the six metrics in the BCF plan.

The King's Fund evidence base has formed part of an overall evidence review, which has taken into account:

- Updated national BCF evidence support materials issued in early August 2014
- The BCF evidence workshops offered regionally in late August/early September 2014
- The expertise of the Leicestershire and Rutland Public Health team who performed a further confirm and challenge on the Rutland BCF evidence base in September 2014
- Results from the adult social care user and carer survey 2014

Based on the 4 strategic drivers described above, our vision for integrated health and care in Rutland through the Better Care Fund Plan is s:

"By 2018, there will be an integrated social and health care service that has significantly reduced the demand for hospital services and puts prevention at its heart"

The four aims of the Rutland BCF plan compliment that of Leicestershire's plan, and fit well with the overall approach of the 5 year Strategic Plan, Better Care Together.

The Rutland BCF plan will deliver important improvements to the way we collectively offer care and support to local citizens so that avoidable pressure on hospital care is reduced, and community options and support are increased.

Our BCF Plan shows the 4 main themes that form our operational plans to achieve this change:-

Unified Prevention Offer	Long Term Conditions
Bring together prevention services in Rutland communities into one consistent offer, including housing expertise and support to carers Provide better coordination in communities of this offer so that local people have easy access to information, help and advice.	Scale up the support already offered by primary and community care services for patients with long term conditions/the frail older – including through: • A review of care pathways • Changes to how records and data are shared between agencies and with patients so that ongoing care is planned more effectively and changes in needs/care plans can be anticipated and addressed earlier.

Integrated Urgent Response	Hospital Discharge and Reablement
Introduce an integrated two hour community services response, to avoid unnecessary hospital admissions for those who need urgent assistance Move towards appropriate access to primary care on a seven day a week basis which integrates effectively with community based health and care services, both in and out of hours Design and implement an integrated service for frail older people including support information and appropriate responses to falls	Make significant improvements in the timeliness and effectiveness of discharge pathways from hospital, especially for frail older people by creating new coordinated discharge facilitaties Consolidate, integrate and extend a number of Rutland's existing community based services into one 24/7 service operating across health and social care, with a single point of access - to focus on maintaining independence in the community for as long as possible

Each of the themes contains a number of schemes- the schemes are all summarised

These themes have been selected for their ability to effect operational and strategic change, and to bring about the differences to patient outcomes we are seeking.
Our governance will enable us to evaluate the success of our schemes, our themes, and our plan in delivering better services and better care for patients, using an integrated matrix of performance indicators, and a modelling tool which evaluates costs, benefits and performance of the schemes we have established.

We are clear that without the existence of the Better Care Fund, resources to deliver the universal preventative services would not have been delivered, and our plans for 7 day integrated services would have developed considerably more slowly.

Over the next two years we will work towards achieving an integrated health and care system through:

- Providing focused leadership to integration across organisational boundaries.
- Building on existing priorities and current work, where we can see measurable impact.
- Aligning our plans across the system of health and care.
- Streamlining and focusing our efforts on tackling a smaller number of areas.
- Identifying those citizens at greatest risk and supporting them to maintain or regain their independence which will reduce their reliance on more costly interventions.
- Adopting a whole system approach to pathway re-design (patient journey) ensuring integration of planning, commissioning and delivery is considered where appropriate.
- Improving the customer experience through driving up quality and performance.
- Delivering efficiencies through developing more effective and streamlined practices and processes.
- Integrating care records and using more integrated technology to support joint care plans
- Building community capacity by creating a network of community agents to reduce social isolation and increase access to support in the community from the community
  .

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

The Better Care Fund will provide a better experience of care to patients and service users and by so doing reduce the pressure on residential care and acute hospitals.

The 3 local strategic drivers outlined in the previous section will put service users at the centre of what we do.

We have decided on a metric to measure patient and service user experience, this will be taken from the Adult Social Care Survey which is an annual survey that is distributed to all adult social care users in Rutland. The metric will be in relation to Q2b of the survey "Do care and support services help you to have a better quality of life?" This will allow us to understand patient and service users perceptions on available support care and support in the community to ensure patient satisfaction.

<u>How will BCF schemes contribute to improved outcomes for the service user?</u>
Community healthcare and social care teams will work together in an increasingly integrated way moving towards **single assessments** for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.

Integrated teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to **remain healthy, independent and well**. We will invest in empowering local people through effective care navigation, peer support, mentoring and self-management to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

We will invest in integrated community services that will provide a **rapid response to support individuals** in crisis and help them to remain at home. Reablement services will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies. Where these are to be employed, we will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding in order to extend the quality and duration of reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria at the point of access to reablement, the service will be able to:

- Improve the management of demand within both the health and care systems, through earlier and better engagement and intervention and prevention
- Encourage communities to develop and sustain services which will enable people to maintain their independence at home for longer periods
- Work sustainably within current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals.

Systems will enable and not hinder the provision of integrated care. Providers will assume **joint accountability for achieving a person's outcomes** and goals and will be required to show how this delivers efficiencies across the system.

In doing so, our ambition is to go far beyond using BCF funding to protect existing social care budgets. Instead, working jointly to **reduce long-term dependency** across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

The volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision, will result in the minimisation of delays in transfers of care, reduce pressures in acute admissions and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible

The table below specifically outlines the impact each BCF theme will have on patient user experience:

Theme	**Impact on the service user**

Unified Prevention	• People will feel supported to live independently at home, key performance indicators include supporting people to leave residential care and hospital through signposting to services available and putting in place support within the community to aid transition • Reduced need for an invasive and costly care package. Equipment will provide peace of mind for users. • Patients are enabled to manage their own care. • Service users are clear what services are available in the community due to accessible information and advice.
Integrated Urgent Response	• Reassurance for the service user and their family that there is support closer to home reducing likelihood of being admitted to hospital
Hospital Discharge and reablement	• Patients will be in a community setting (at home or closer to home) rather than in hospital • Positive service user feedback regularly received about the way the Reach team have supported individuals to feel more confident and independent
Long term conditions	• Service users feel in control of their care • Service users feel supported
Enablers	• Health and social care systems will be aligned/joined up with a common dataset so that patients only have to tell their story once

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

People rarely need support from a single service as they age, or if they are vulnerable through ill health, disability, injury or social exclusion/isolation. They have told us that they find it difficult to navigate between services and feel that there are many barriers in the way as they move between health, social care and other statutory services. Community Agents will be at the forefront of signposting those in need to services available in the community, including the integrated information service which will encourage information prescriptions.

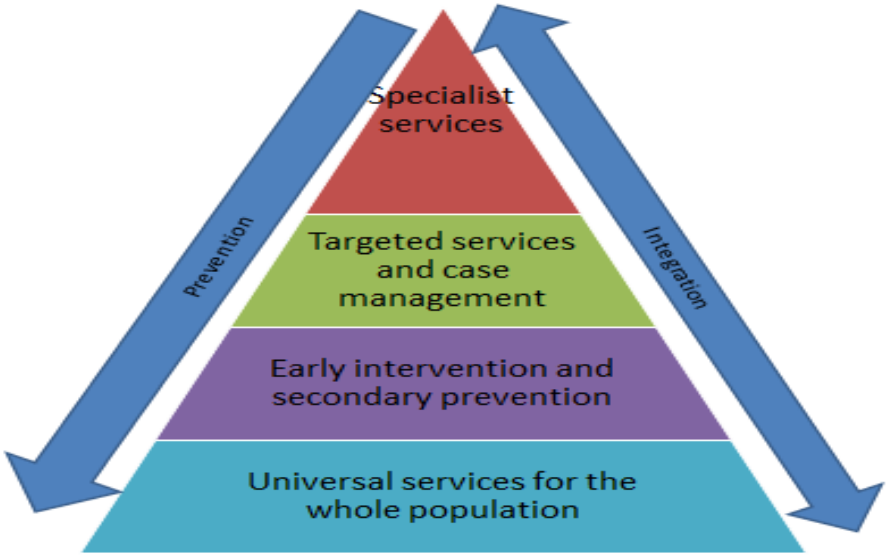
These barriers are simply not understandable or acceptable to the population we serve. A key feature of this plan is to address this, and support people and communities much more effectively so that when people are in need of information and support, or services to maintain or improve their health and wellbeing, local partners will:

- Deliver this support in a co-ordinated way across agencies
- Provide this support as early as possible, anticipating future needs, as well as dealing with immediate needs in the most appropriate setting.

Ultimately our BCF plan aims to provide a very clear articulation of the menu of services, information and support available to the public, and make this menu more understandable and accessible, particularly in community settings.

The Rutland BCF plan is based on improving how citizens access information, support and services and how these are designed across the stepped pyramid of care illustrated in this diagram.

There will be clear integrated service offer at each layer of a pyramid of health and social care needs which operate across organisational boundaries, with a view to coordinating care for individuals, carers and families. At the base of the pyramid is prevention and early intervention with specialist and hospital services at the top. (See diagram below).



We will design service offers that maintain people at the lowest possible level of the pyramid according to their needs, so that progression up the pyramid is avoided/delayed wherever possible and admission to specialist services is only undertaken when absolutely necessary.

The schemes funded by the Better Care Fund are described within the annexe documents, they are delivered by a mixture of providers from both the statutory and voluntary and independent sector – the Better Care Fund enables a mixed economy of provision to meet the needs of the young and older community of Rutland.

We will use the intelligence gathered by Public Health to determine where to target resources appropriately, this will be highlighted within regular reports to the Health and Wellbeing Boards concerning the public health outcomes framework. We will base the schemes around the following:

- peer support, including improving access to advice and information and working in partnership with voluntary, community and long-term conditions groups as part of the Better Care Together five year strategy.
- Invest in developing personalised health and social care budgets working with patients and service users and frontline professionals to empower people to make informed decisions around their care.
- Invest in reablement, reducing hospital admissions, nursing and residential care admissions and care costs.

- Reduce delayed discharges and work towards 7 day social care provision in hospitals.
- Integrate NHS and social care systems around the NHS Number to ensure that frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need and tell their story only once.

WHAT WILL OUR HEALTH AND CARE SYSTEM LOOK LIKE AS A RESULT OF THE CHANGES BROUGHT ABOUT BY THE RUTLAND'S BETTER CARE FUND?

- Integrated health and care services will be available in Rutland, combining the expertise of adult social care services from Rutland County Council and the community nursing and therapy teams of Leicestershire Partnership Trust, working hand in hand with a cluster of GP practices.
- Shared care records and care plans will be in place using the NHS Number to help the integrated team manage care more effectively across organisational boundaries
- 20 people with long term conditions per month will have their risks assessed and care needs coordinated by the integrated health and social care team in their locality, working hand in hand with their GP practice.
- 7 day services will be available in primary care, coordinated by GPs across Rutland, targeted to frail and vulnerable people from 2015.
- xx emergency admissions and yy associated bed days will be avoided - by the ambulance service working hand in hand with the integrated health and care teams in each locality.
- Due to this, Xxx people will receive care at home, instead of going into hospital, after a fall.
- Xxx fewer people will be permanently admitted to residential or nursing care, due to improvements to the care and support they can receive at home
- 25 carers will have benefit from enhanced information and health and wellbeing support, including via assessments being introduced by the Care Act
- 38,000 people will benefit from our universal advice and information service, operated and delivered by a newly commissioned Community Agents Scheme.300 people will access this new service operating in communities, to find out what's on offer on their doorstep and to tap into resources on a county regional and national level.
- Xx less bed days will be spent in hospital due to delays in discharge arrangements
- Due to the improvements in delayed discharges, the reduction in emergency admissions, and the enhanced locality services, we can confidently reduce the overall number of inpatient beds, in favour of investing in community care.
- People will be supported to live independently through the expanded use of Technology and adaptations. The service will offer practical expertise and support for people needing aids, equipment, adaptations, handy person services and

advice on energy efficiency/affordable warmth.

- Rutland people can see significant changes that have been made in how care is planned and delivered, feel confident in community based services, and report improvements in their overall experience of integrated care and support.

To put this into context, the BCF schemes will actively ensure that…

Theme	By 2018…
Unified Prevention	We aim to have a comprehensive offer for prevention services for the citizens of Rutland which is funded by bringing together the resources available to Rutland County Council and ELRCCG. This will mean citizens have access to a range of support early enough to enable them to feel more in control and to live healthier and independent lives and stay within their own communities for longer. We will measure our success in delivering this through seeing a reduction in the number of people accessing statutory services in crisis or inappropriately. We will measure where they have needed a health or care intervention that they can quickly return to their optimum independence within a supportive community. The Better Care Fund will provide the means for commissioners to review existing services, and commission an integrated offer that provides coverage to the whole community through schemes that support independent living such as community agents, assistive technology and adaptations. Joint commissioning of a prevention offer will ensure a consistent, integrated approach which is easy to understand from the service user perspective whilst seeking value for money through eradicating duplication due to alignment of our commissioning plans.
Integrated Urgent Response	A whole system response is required to ensure a fully coordinated and integrated service offer is developed, to truly prevent adults and older people from experiencing unnecessarily protracted admissions and for them to have the greatest opportunity for recovery so as to be able to return to their own homes. By bringing our resources together to have an integrated pathway which supports people more effectively within their own homes – we will measure the reduction in avoidable admissions and that people are not delayed in hospital. Services will be available seven days a week to enable urgent response to crisis. This will include the night nursing service provided by Leicestershire Partnership NHS Trust.
Hospital Discharge and reablement	Seven day working will be available to enable timely discharge. This will include an enhanced Reablement service, social work and district nurse capacity to support hospital discharge as well as shared posts to support joint assessments.
Long term conditions	Whilst the majority of those with long term conditions are older people there are other sections of our community who are affected by long term conditions that would benefit from a more co-ordinated approach to their care and support such as those with learning disabilities, dementia and mental health problems. For our citizens

	and their families it will mean they have access to a consistent co-ordinated support system that is responsive to their changing needs, and that they and their carers receive timely and appropriate advice and support.
Enablers	Statutory requirements as a result of the Care Act will be embedded in health and social care services. The Better Care Fund provides support to enable a cap on people's care costs and the ability to defer payments.

3) CASE FOR CHANGE

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

Everyone Counts: Planning for Patients 2014/15 t0 2018/19[1] sets the overall medium term planning framework for the NHS setting out what the NHS must deliver to patients nationally.

The NHS 'Call to Action[2]' asks all NHS providers and commissioners to respond to the significant challenges facing the NHS in delivering health and care policy into the future, including:

- An ageing society
- The rise of long-term conditions
- Rising expectations
- Increasing costs of providing care
- Limited productivity
- Pressure of constrained public resources that the NHS face
- Variation in quality of care across the health system.

Population of Rutland

Rutland's Joint Strategic Needs Assessment (JSNA) was published in 2012. Since the publication of the JSNA, additional reports have been published alongside the JSNA to further enrich the evidence base for the health and wellbeing of the population. These include the Director of Public Health's Annual Reports for 2011, 2012 and 2013 which focussed on health through the life cycle with reports on children, older people and working age adults.

Population estimates

- In 2012, the population of Rutland was 37,015 people.
- 7,115 people were aged 65-84 years (19.2%) and 1,129 people were aged 85 years and over (3.1%)

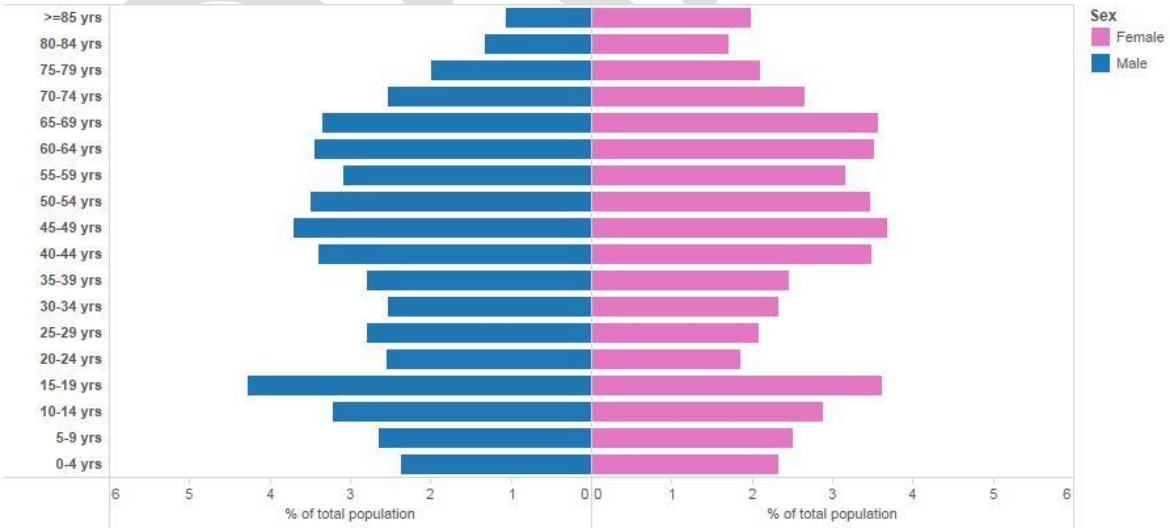
Table 1: 2012 Population Estimates for Rutland

1

2

	Female		Male	
	Mid-2012 Population Estimates	Mid-2012 Population Estimates - percentage of total	Mid-2012 Population Estimates	Mid-2012 Population Estimates - percentage of total
0-4 yrs	863.00	2.33	873.00	2.36
5-9 yrs	932.00	2.52	978.00	2.64
10-14 yrs	1,068.00	2.89	1,190.00	3.21
15-19 yrs	1,342.00	3.63	1,583.00	4.28
20-24 yrs	689.00	1.86	939.00	2.54
25-29 yrs	773.00	2.09	1,035.00	2.80
30-34 yrs	863.00	2.33	936.00	2.53
35-39 yrs	913.00	2.47	1,032.00	2.79
40-44 yrs	1,294.00	3.50	1,258.00	3.40
45-49 yrs	1,366.00	3.69	1,372.00	3.71
50-54 yrs	1,284.00	3.47	1,292.00	3.49
55-59 yrs	1,172.00	3.17	1,143.00	3.09
60-64 yrs	1,306.00	3.53	1,275.00	3.44
65-69 yrs	1,320.00	3.57	1,238.00	3.34
70-74 yrs	986.00	2.66	934.00	2.52
75-79 yrs	777.00	2.10	737.00	1.99
80-84 yrs	633.00	1.71	490.00	1.32
>=85 yrs	737.00	1.99	392.00	1.06
Grand Total	18,318.00	49.49	18,697.00	50.51

Figure 1: 2012 Population Pyramid



1.2 Deprivation

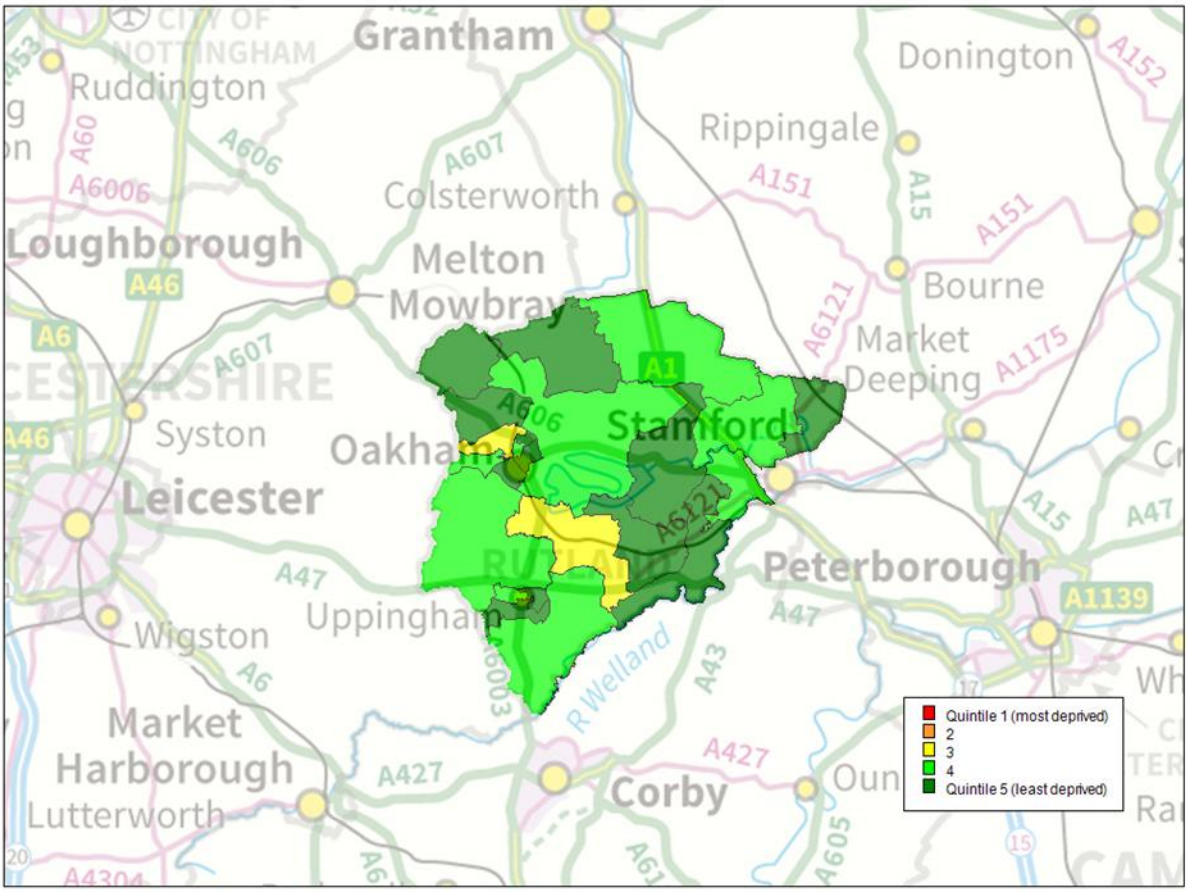
The English Indices of Deprivation 2010[1] provide a comparative measure of deprivation at both a national and a local level. It is a measure that calculates relative deprivation

across multiple aspects of deprivation at a small area across England and is the official measure of deprivation in England.[2] The indices of deprivation are based on the principle that deprivation refers to a general lack of resources and opportunities. The Indices of Deprivation 2010 is the collective name for a group of indices that all measure different aspects of deprivation. These are then combined into a composite indicator called the Index of Multiple Deprivation (IMD).

Error! Reference source not found. and **Error! Reference source not found.** illustrate the spread of the population of Rutland by deprivation quintile. These demonstrate that:

- On a national scale, the population of Rutland is less affected by material deprivation than the average for England.
- The whole population of Rutland falls within the least deprived 60% of areas in the country.
- 57% of the Rutland population live in the least deprived quintile of deprivation, accounting for over 21,000 people

Figure 2: English Indices of Multiple Deprivation 2010 by national quintile1



Source: Department for Communities and Local Government

Ethnicity

- The 2011 Census reported that 35,241 people in Rutland were White British, representing 94.3% of the total population. This is lower than the proportion in England of 79.8%.
- 2.3% of the population classed themselves as White Other and 0.6% as White

Irish.

Life Expectancy

- Between 2010 and 2012, life expectancy for males in Rutland is 81.0 years and for females is 84.7 years.[3] This is significantly better than the England average for both males and females.
- Healthy life expectancy for 2010-12 for males is 65.8 years for males and 70.3 years for females.[3] This is significantly better than the England average for females but not for males.

Lifestyles

- The role of public health in helping people to make the right choices for a healthier, longer life was set out in "Healthy Lives, Healthy People".[4] Many of the lifestyle factors within this report can be addressed in part through pharmacy – improving maternal health, supporting children's health and development and changing adults behaviour to reduce premature death, and illness, particularly with respect to cancers and vascular diseases.
- The lifestyle statistics presented below relate to the population of Rutland and they are taken from the Public Health Outcomes Framework:[3]
- In 2012, 13% of adults smoked. This is significantly lower than England average.
- In 2012/13, the alcohol related hospital admission rates was 485.8per 100,000 (182 admissions). This is significantly lower than England average.
- In 2012, 65.6% of adults were overweight or obese. This is similar to England average.
- In 2012/13, 23% of children aged 4-5 years were overweight or obese. This is similar to England average.
- In 2012/13, 24.1% of children aged 10-11 years were overweight or obese. This is significantly lower than England average.
- In 2013, 22.3% of adults were physically inactive. This is significantly lower than England average.
- In 2012/13, 25.4% of people reported a high anxiety score for self-reported wellbeing. This is similar to England average.

Burden of disease in the population

The 2012-13 Quality and Outcomes Framework Data collected by GPs gives a good indication of the numbers of patients that GPs are seeing with long term conditions. In Rutland there were:

- 5,839 people on GP hypertension registers, 16.5% of the total population. This is significantly higher than the England prevalence of 13.7%.
- 2,111 people on GP asthma registers, 5.95% of the total population. This is similar to the England prevalence of 6.0%.
- 1,917 people on GP diabetes registers, 6.7% of the population aged 17 years and over. This is significantly higher than the England prevalence of 6.0%.
- 1,331 people on GP depression registers, 4.7% of the population aged 18 years and over. This is significantly lower than the England prevalence of 5.8%.
- 1,321 people on GP coronary heart disease registers, 3.7% of the total population. This is significantly higher than the England prevalence of 3.34%.
- 1,264 people on GP hypothyroidism registers, 3.6% of the total population. This is significantly higher than the England prevalence of 3.2%.

- 979 people on GP cancer registers, 2.8% of the total population. This is significantly higher than the England prevalence of 1.9%.
- 712 people on GP stroke or transient ischaemic attacks registers, 2.0% of the total population. This is significantly higher than the England prevalence of 1.7%.
- 584 people on GP COPD registers, 1.65% of the total population. This is similar to the England prevalence of 1.7%.

Table 5: GP Recorded Disease Prevalence by Local Authority District

Disease prevalence

Quality and Outcomes Framework (QOF) for April 2012 - March 2013

Data Source: http://www.qof.hscic.gov.uk/index.asp (Accessed 04/11/2013)

	Significantly lower than England average
	Not significantly different from England average
	Significantly higher than England average

Area		England	Rutland
Number of practices		8,020	4
List sizes		56,012,096	35,501
Estimated list size population aged 16+		45,662,970	29,223
Estimated list size population aged 17+		44,950,726	28,801
Estimated list size population aged 18+		44,238,483	28,378
Estimated number 50+		19,509,029	15,404
Numbers on QOF disease registers and raw prevalence rates - all ages			
Coronary Heart Disease	Register counts	1,870,395	1,321
	Raw prevalence	3.34%	3.72%
Stroke or Transient Ischaemic Attacks (TIA)	**Register counts**	**951,469**	**712**
	Raw prevalence	**1.70%**	**2.01%**
Hypertension	Register counts	7,660,010	5,839
	Raw prevalence	13.68%	16.45%
Chronic Obstructive Pulmonary Disease	**Register counts**	**974,999**	**584**
	Raw prevalence	**1.74%**	**1.65%**
Hypothyroidism	Register counts	1,788,790	1,264
	Raw prevalence	3.19%	3.56%
Cancer	**Register counts**	**1,082,039**	**979**
	Raw prevalence	**1.93%**	**2.76%**
Mental Health	Register counts	470,971	248
	Raw prevalence	0.84%	0.70%
Asthma	**Register counts**	**3,359,368**	**2,111**
	Raw prevalence	**6.00%**	**5.95%**
Heart Failure	Register counts	397,548	384
	Raw prevalence	0.71%	1.08%
Heart Failure Due to LVD	**Register counts**	**213,828**	**259**
	Raw prevalence	**0.38%**	**0.73%**
Palliative Care	Register counts	130,233	168
	Raw prevalence	0.23%	0.47%
Dementia	**Register counts**	**318,669**	**239**
	Raw prevalence	**0.57%**	**0.67%**
Atrial Fibrillation	Register counts	849,407	808
	Raw prevalence	1.52%	2.28%
Peripheral Arterial Disease(PAD)	Register counts	365,408	226
	Raw prevalence	0.65%	0.64%
Numbers on QOF disease registers and raw prevalence rates - age specific			
Diabetes Mellitus (Diabetes) (ages 17+)	Register counts	2,703,044	1,917
	Raw prevalence	6.01%	6.66%
Epilepsy (ages 18+)	**Register counts**	**345,140**	**175**
	Raw prevalence	**0.78%**	**0.62%**
Depression (ages 18+)	Register counts	2,582,233	1,331
	Raw prevalence	5.84%	4.69%
Chronic Kidney Disease (ages 18+)	**Register counts**	**33,421**	**17**
	Raw prevalence	**0.08%**	**0.06%**
Obesity (ages 16+)	Register counts	90,220	47
	Raw prevalence	0.20%	0.16%
Learning Disabilities (ages 18+)	**Register counts**	**206,132**	**122**
	Raw prevalence	**0.47%**	**0.43%**
Osteoporosis (ages 50+)	Register counts	48,242	31
	Raw prevalence	0.25%	0.20%

Projected Future Needs

To be completed

Population Projections

- The population of Rutland is growing and by 2037 the total population is predicted

to reach 40,800 people, a total population growth of 10.3%.

- However, the population is not growing uniformly across the different age bands.
- In the next 25 years, the population is predicted to grow as follows:
    - A 3.8% decrease in children and young people age 0-24 years (10,400 people to 10,000)
    - A reduction in the working age population age 25-64 of 10.4% (from 18,300 people to 16,400)
    - A 49.3% increase in people aged 65-84 year olds (from 7,100 people to 10,600)
    - A 227.3% increase in the oldest population group of people aged 85 years and over (from 1,100 people to 3,600)

Table 16: Rutland population projections, in 1,000s - 2012 to 2037

	2012	2013	2014	2015	2020	2025	2030	2035	2037
0-24	10.4	10.2	10.0	9.8	9.7	10.1	10.3	10.1	10.0
25-64	18.3	18.2	18.2	18.1	17.9	17.7	16.9	16.7	16.4
65-84	7.1	7.4	7.7	7.8	8.6	9.3	10.1	10.4	10.6
85+	1.1	1.1	1.2	1.3	1.6	2.1	2.7	3.4	3.6
All Ages	36.9	36.9	37.1	37.0	37.8	39.2	40.0	40.6	40.6

By 2037, the population of Rutland is projected to grow to 40,600 people. To ensure that the number of dispensing contractors (pharmacies, internet pharmacies and GP dispensers) remains at the national average level of 2.02 per 10,000 population, Rutland would need 8 dispensing contractors. Rutland currently has 10 dispensing contractors and it is anticipated that this level of service will adequately meet the needs of the future population.

Long term conditions

This unprecedented increase in the older population will lead to increases in the number of people living with long-term conditions. The Projecting Older People Population Information System (POPPI) provides estimates and projections of the number of people that are likely to be affected by long term conditions both now and in the future in Rutland.[7] **Error! Reference source not found.** shows the number of people in Rutland predicted to be living with various long-term conditions.

Table 2: Projections of older people, age 65 ears and over, with long term conditions, 2015-2030 from POPPI

	2015	2020	2025	2030	% Change 2015-2030
Older adults with a limiting long-term illness	3,735	4,329	4,962	5,627	50.7%
Older adults who are obese or morbidly obese	2,386	2,568	2,816	3,135	31.4%
Older adults predicted to have Type 1 or Type 2 diabetes	1,147	1,260	1,401	1,603	39.8%
Older adults predicted to have depression	789	862	967	1,097	39.0%

Older adults predicted to have dementia	646	758	935	1,164	80.2%
Older adults predicted to have a longstanding health condition caused by a heart attack	449	501	566	642	43.0%
Older adults predicted to have a longstanding health condition caused by a stroke	214	241	273	311	45.3%
Older adults predicted to have a longstanding health condition caused by bronchitis and emphysema	156	173	193	219	40.4%

Future Housing

Rutland's Local Development Framework Core Strategy Development Plan, adopted in July 2011, describes the plans for future development until 2026.[8] The planned increases in households are indicated in **Error! Reference source not found.**.

Table 3: Planned development in Rutland

Area	Planned development per annum – number of dwellings	Total planned dwellings 2011 - 2026
Oakham	69	1,035
Uppingham	16	240
Local service centres	24	360
Smaller service centres	Limited	Limited
Restraint villages	0	0
Countryside	0	0
Total	109	1,635

LLR Context
In June 2014, the LLR wide programme "Better Care Together" published an overarching strategic case for change to respond to these challenges, which has been co-produced across the health and social care system, including via public engagement, illustrated below:

Modelling which supports the LLR Case For Change
Across Leicester, Leicestershire and Rutland (LLR), an integrated Long Term System Model has been constructed for the Better Care Together Programme which describes and measures how the system challenges will be addressed. This models the impact of actions/ interventions to improve the quality of services provided to patients and/or improve the financial value of services without quality being compromised.

The model has been constructed as an integrated tool based on a shared set of planning assumptions, which are mirrored in the individual plans of constituent organisations. It

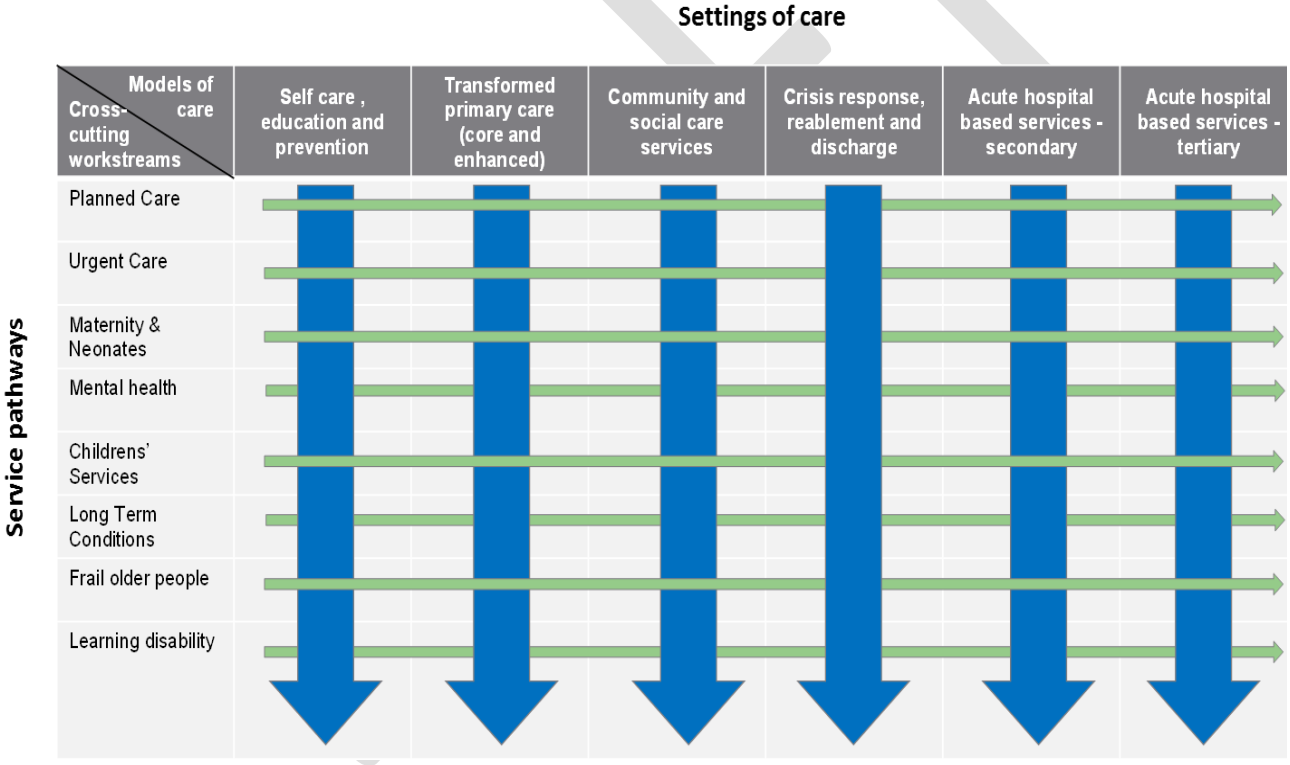
factors in the financial assumptions of all partners across health and social care economy and illustrates the impact of proposed changes on activity and costs across the system including the impact of:

- Implementing new models of care
- Shifting care between settings
- Planned efficiency programmes
- Planned investments across health and social care including those linked to the Better Care Fund.

The work to develop the Better Care Together 5 year strategy has involved analysing and prioritising the case for change in 8 main service areas, setting out:

- The main changes that are needed to these service models
- How care will need to shift across settings in the future.

The matrix below shows the 8 service pathways and 6 settings of care being addressed by the LLR 5 year strategy.



The Rutland BCF plan is constructed under 5 themes, in support of the BCT 5 year plan analysis. The table below show how each theme within the BCF maps to the BCT matrix:

BCF Theme	BCT Matrix
1: Unified Prevention Offer	Self-Care, Education and Prevention
2: Integrated Urgent Response	Urgent Care

	Crisis Response Community and Social Care services Frail Older People
3: Hospital Discharge and Reablement	Reablement and Discharge Community and Social Care Services
4: Long Term Conditions	Long Term Conditions Community and Social Care services
5: Enablers	Enabling strategies

The Rutland BCF plan will deliver specific changes in 3 of the BCT settings of care	**The Rutland BCF plan will deliver specific changes in 3 of the BCT models of care**
• Self-care, education and prevention • Community and social care services • Crisis response, reablement and discharge	• Frail Older People • Urgent Care • Long Term Conditions

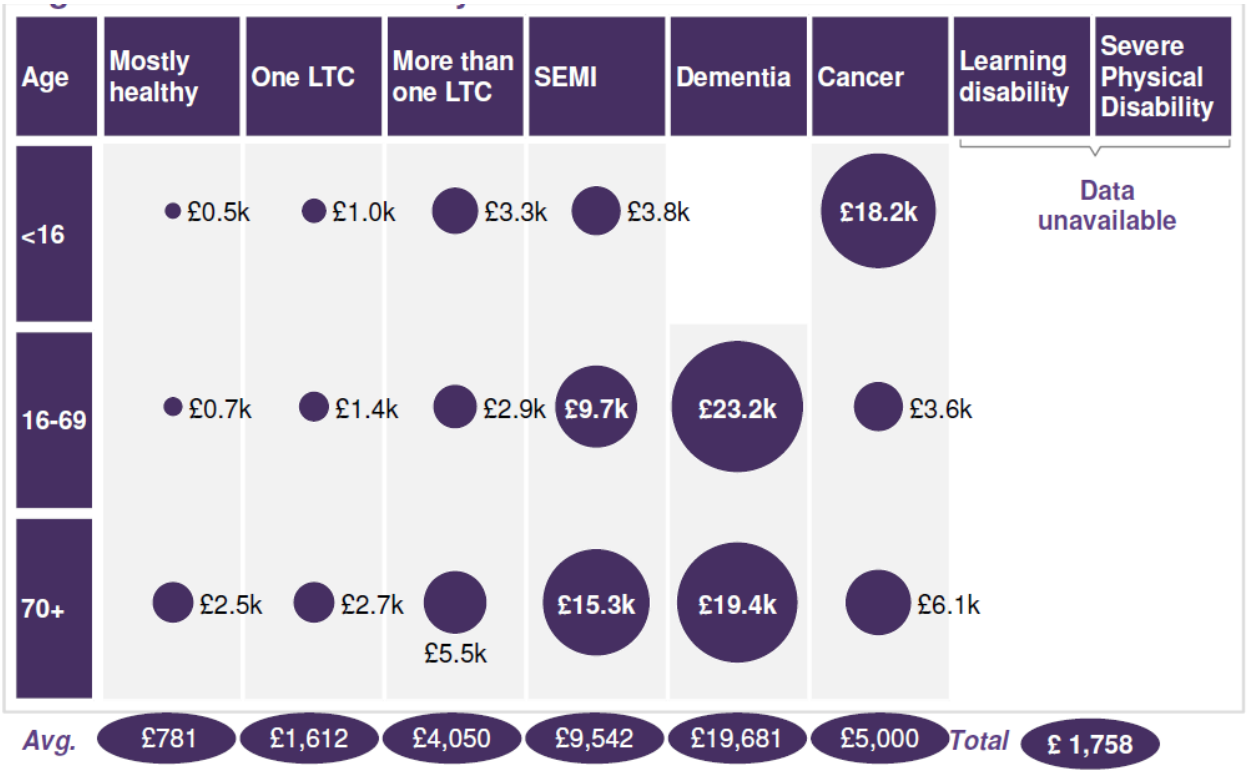
Risk Stratification and Population Segmentation

In line with the BCF guidance and webinars provided to support BCF resubmissions we have undertaken some initial population segmentation analysis with the support of the Greater East Midlands Commissioning Unit[3]. This serves as a precursor to the more systematic development of this approach which is reliant on changes to local information sharing agreements.

This initial analysis has been developed in the format recommended by the BCF guidance and webinar materials. to show segmentation by age and condition, and has been developed in particular in support of the case for change and evidence base for the BCF interventions associated with those with multiple long term conditions and/or the frail elderly, where the majority of our BCF plan is targeted..

(the slide shown below is illustrative of how this analysis will be presented segmenting the population by age and conditions - the local data is currently processed by GEM CSU for each BCF plan in LLR)

[3] Further details on the local approach to risks stratification can be found on p.xx



Insert key findings (2-3 bullets) from the Leicestershire population segmentation diagram

Locally we are using the Adjusted Clinical Groups (ACG) system to assign every patient in GP practice a probability of:

- Being in the top 5% highest cost group next year
- Being hospitalised in the next 12 months

The prediction is not based on past activity or thresholds. The model uses patterns of co-morbidities to predict future outcomes especially pertinent for older people with complex problems.

The tool has been rolled out to all the practices in Rutland and is in use to identify patients who would benefit from a multi-disciplinary team approach to co-ordinated case management which supports patients to optimise self-management including supporting independence.

Current information sharing agreements within the Leicester, Leicestershire and Rutland Unit of Planning do not permit the use of aggregated practice data at population level for secondary purposes, and this presents a barrier in being able to progress the risk stratification and population segmentation analysis recommended in the latest BCF guidance.

For the purposes of the BCF resubmission, we have undertaken some initial population segmentation analysis with the support of the Greater East Midlands Commissioning Unit. This has been developed in the format recommended by the BCF guidance and webinar materials, e.g. to show segmentation by age and condition, and has been

developed in support of the case for change and evidence base for the BCF interventions with respect to frail older people and those with long term conditions. This analysis is shown on xxxxx

The LLR Information Management and Technology programme board, which is part of the governance system for the LLR 5 year plan is taking the lead with respect to the developments needed locally to improve the data sharing, information management and technological platform for the local health and care system. The status of the current information sharing agreements has already been identified as a key issue to resolve.

An action plan is being developed to address this and will be designed to enable the approach recommended in the BCF guidance to become a routine part of system wide analysis for the health and care economy in the medium term.

The action plan will include:

- A proactive GP practice engagement plan across the primary care sector to promote the need for the changes to the agreements and to work in a coordinated way to achieve this across the whole unit of planning, supported by all 3 CCGs and the local Area Team.
- A project plan with clear milestones and responsibilities to authorise new agreements and implement the practical tools and reports needed to enable this data to be generated and applied effectively in LLR, with governance via the LLR IM&T workstream
- Briefings for all 3 health and wellbeing boards about the rationale and scope of the work to deliver an enhanced approach to risk stratification and population segmentation, showing how this supports not only the BCF related activities but also JSNA refresh activities and the Joint Health and Wellbeing Strategy priority outcomes and work plans.
- The action plan will also be informed by:
    - Examples of work and products in areas who have made early progress in this work such as the work in progress in South Central Region Commissioning Support Unit (Examples of the analysis we are seeking to develop in LLR are given in the slides at Appendix xx)
    - Imminent national regulatory changes affecting section 251 agreements and related information governance matters.
    - Related work in progress on business intelligence transformation within the County Council including how public health intelligence is developing in conjunction with other departments in areas such as unified prevention
    - The engagement and advice of partner agencies and IG experts across LLR.

Triangulation of needs assessment and non-elective admissions to be included in here to provide the evidence for case for change

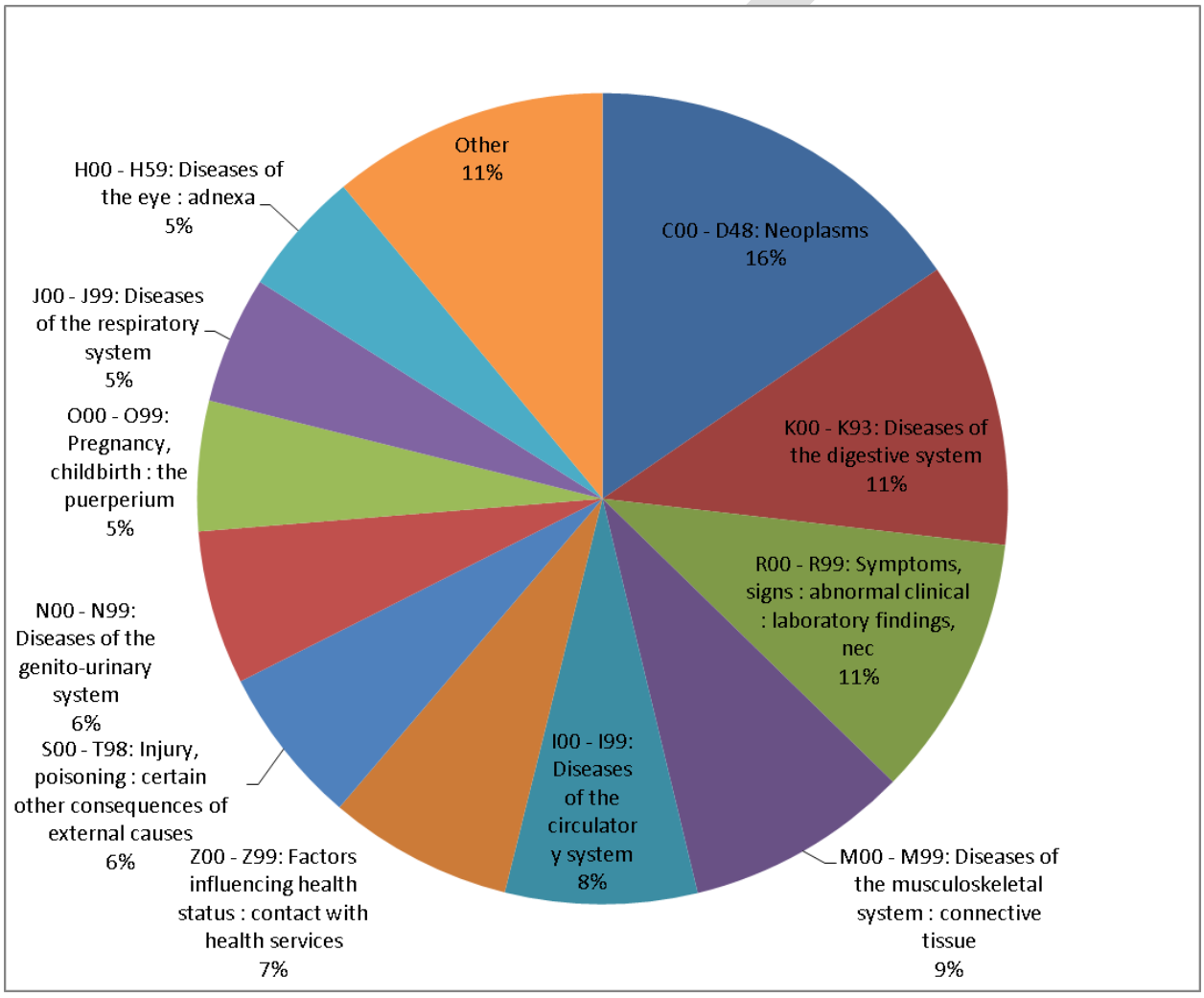
In 2013/14, there were:

- 6,752 hospital admissions
- 30,160 outpatient attendances
- 4,977 emergency department attendances
- The main provider for hospital inpatient activity was UHL with 40% of the activity, followed by Peterborough and Stamford with 37% of activity

- For outpatient clinics, Peterborough and Stamford is the largest provider with 36% of the activity, UHL has 28% of activity and Derbyshire Hospitals has 18% of the activity (this will be Leicestershire based community hospitals at Rutland and Melton).
- For emergency department attendances, 56% of activity went to Peterborough and Stamford, 16% to UHL and 11% to Kettering General Hospital.

Inpatient activity by ICD 10 Groups

The main reason for hospital admission in Rutland in 2013/14 was cancer with 1,043 admissions (16%), diseases of the digestive system with 768 (11%), symptoms and signs with 707 (11%), disease of the musculoskeletal system with 603 (9%) and diseases of the circulatory system with 517 admissions (8%).



Of the inpatient activity (6,752 total), 3,894 admissions were elective (58%), of which 3,163 were day cases.

42% of the inpatient activity was non-elective, and 33% was emergency activity.

Analysis of non-elective admissions trend by age has shown that the biggest area of growth in admissions and costs over the last 3 years has been in non-elective admissions in over 75s.

Table to insert here illustrating spend by age and provider (to come later in the week)

Rutland's financial context

RCCs Medium Term Financial Plan (MTFP) and the recent People First review of the social care services provided by the People Directorate within RCC also indicate the need for change and review of existing provision. The Local Authority is facing an uncertain financial future with funding reductions of 10% this year and a further 11% next year. Beyond that we expect funding to continue to reduce. However, it's important to remember this is not a problem unique to Rutland. Balancing the MTFP when such a significant proportion of RCC's expenditure is related to Services to People is an imperative. The MTFP currently projects expenditure exceeding income for some time into the future. The levels of balances have been increased to support this in the short term but in the medium to long term it is essential that there are devised and implemented plans to deliver significant savings from within the People Directorate Budget. RCC cannot rely on the current or future governments funding the Council at a level that will support the current imbalance of funding and expenditure. Service review and transformation must deliver savings in the required timescales whilst balancing projected increases in demand for some services.

The BCF will be imperative for both health and social care in order to drive efficiencies and support viable budgets across our organisations, for example integration will need to support reduced duplication in commissioned activity, streamline administrative and operational processes, promote multidisciplinary teams which work to one common agenda and share resources including facilities/estates where possible.

The following sections show a summary for each theme of the Rutland BCF covering:

- The case for change
- The desired outcomes
- The target population
- The interventions in the plan
- How the impact will be measured
- The evidence based used/referenced

Further details on each scheme can be found in Annex 1.

UNIFIED PREVENTION OFFER
THE CASE FOR CHANGE AND THE BCF RESPONSE

The case for change

Intervening early can have a major impact on the health and wellbeing of individuals, and can prevent or reduce the need for more costly care later on.

The LLR 5 year strategy places self-care and prevention at the heart of the care system with models of care designed to:

- Support people to live well and cope well
- Promote health wellbeing, and independence
- Reduce the need for traditional health and care services where possible.

In Leicestershire, prevention is a central strand of our Joint Health and Wellbeing Strategy, and form the base of our local delivery model per the care pyramid on p xx.

It is also an area where we believe collaboration is essential to achieving successful outcomes and a greater quality of life for the citizens in Leicestershire and to achieve the best value for money for the Leicestershire pound across agencies.

Historically commissioning for prevention is fragmented across the health and care system in Leicestershire and self-care interventions are not systematically embedded in commissioning specifications and models of care. The offer to the public in terms of how to access this kind of support, whether from statutory and non-statutory agencies, can also be unclear and inconsistent across Leicestershire's communities.

We have considered evidence from other areas of the country where prevention is more targeted, consolidated and cost effective and we can see many opportunities to achieve these benefits in Leicestershire.

By investing in the bottom tier of the care pyramid as a priority we will also provide the necessary infrastructure for other elements of the BCF plan and LLR 5 year plan to function effectively in the medium term, so our priorities in this part of the BCF plan are absolutely crucial to achieving our overall vision of health and care integration.

Local Evidence	**National Evidence**
Evidence on impact of the wider determinants of health **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data **Rutland JSNA**, Chapter on health inequalities **Rutland Health & Wellbeing Strategy** **Rutland DPH Annual Report** (2014) details the importance of tackling the wider determinants of health.	**Evidence on impact of the wider determinants of health** Significant, high quality evidence on the impact of the wider determinants of health and LA role's. Buck D, Gregory S (2013). Improving the public's health: a resource for local authorities. London: The King's Fund. World Health Organization, Commission on the Social Determinants of Health (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. [Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf] [Accessed on 21/08/2014]. Marmot M. Fair Society, Healthy Lives: A Strategic Review of Inequalities in England. London: University College London, 2010. [Available online at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review] [Accessed on 21/08/2014]. **Work and Wellbeing:** Good jobs enhance health and well-being and can promote recovery from mental illness *(DH 2010, Rickey et al 2012, Waddel and Burton 2006)* In both the short- and longer-term, being in work

	reduces the need for health services *(Bush et al 2009, Dewe and Kompier 2008, Gill and Sharpe 1999, NMHDU 2010, Naylor and Bell, 2010)* Employment can enhance access to wider social and economic determinants of healthy life expectancy such as a living income, secure housing, social networks, and increased agency *(Collingwood 2011, Marmot 2010, TUC 2012)* Many people living with mental illness see work as an important part of their recovery and value its place in enabling them to contribute to society, be part of social networks, build identity, and find hope or meaning *(MIND 2011, Perkins et al 2009, Rinaldi et at 2010, Shaw Trust2010)*. Despite many wanting to work, people living with mental illness are significantly disadvantaged in their attempts to gain or stay in employment *(CIPD 2011, NIC 2011, Paul and Moser 2009, Perkins et al 2009, Sayce 2011, Shaw Trust 2010)* Employment rates for people living with mental illness are between just 16% and 35% *(McDaid et al 2008, Perkins et al 2009)* and tend to be much lower than rates for people without a health condition (77%) or those with long-term physical health problems (59%) *(Black and Frost 2011, ONS 2011)* Depression and anxiety are 4 to 10 times more prevalent among people who have been unemployed for more than 12 weeks *(Rinaldi et al 2010)* The risk for mental health problems continuously rises through the first nine months of unemployment and only recedes partially afterwards *(Paul and Moser 2009)* Foresight Report, Five Ways to Wellbeing, 2008: http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqg5.pdf. Better health, lower crime a briefing for the NHS and partner agencies, McManus,1999, http://www.nacro.org.uk/data/files/nacro-2004120264-425.pdf. Buck D (2011) *How healthy are we? A high-level guide.* King's Fund. http://www.google.co.uk/url?url=http://www.kingsfund.org.uk/sites/files/kf/field/field_document/how-healthy-are-we-david-buck-dec11.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ei=Kqr9U9uZJZCXav3GgaAD&ved=0CBQQFjAA&sig2=GkdQX3wxoROSuHEE63xh5g&usg=AFQjCNHKOyJphwyVRV3dMmFyP3rQDilwcA.
Self-Care **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013	**Self-Care** Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.** http://www.kingsfund.org.uk/sites/files/kf/field/field_

• EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data **Rutland JSNA**, Various chapters on staying healthy, carers, various lifestyle behaviours and long term conditions. [Available online at http://www.rutland.gov.uk/rutland_together/health__wellbeing_board/jsna_2012.aspx) **Specific evidence on community based prevention & support** Rutland Community Agents draft service specification Other Local Area Coordination Evaluations; • Leicestershire LAC business case • Derby Local Area Coordination, Evaluation Report, Jo Hutchinson 2013 • Peter Fletcher Associates (2011) Evaluation of Local Area Coordination in Middlesbrough • Prevention Matters, Delivering a prevention-focused model for adult services in Buckinghamshire County Council, 2012	publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on primary prevention, self care, care coordination, care management, mental and physical health needs. Naylor C et al. (2012) Long term conditions and mental health – the cost of co-morbidities. King's Fund and Centre for Mental Health. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf] [Accessed on 22/08/2014]. • 30% of people with a long-term condition have a mental health problem (approximately 4.6 million people) (page 5) • 46% of people with a mental health problem have a long-term condition (approximately 4.6 million people) (page 5) De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation. [Available online at http://personcentredcare.health.org.uk/sites/default/files/resources/helping_people_help_themselves_0.pdf] Accessed on 22/08/2014] Evidence on the continuum of self-care techniques and the need to use varying approaches for different clinical conditions. A NICE Local Practice example is available at: Self-care support for long-term conditions The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' Making our health and care systems fit for an aging population. **The Kings Fund 2014**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population The King's Fund: Naylor et al, 2013. Transforming our health care system. Ten priorities for commissioners. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf]. Depression in adults with a chronic physical health problem: NICE Guideline 91: http://www.nice.org.uk/guidance/cg91. No health without mental health: a cross-government mental health outcomes strategy for people of all ages: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf.

	Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with- dementia-a-national-dementia-strategy NICE Draft Guidance - Excess winter deaths and morbidity and the health risks associated with cold homes. http://www.nice.org.uk/Guidance/InDevelopment/GID-PHG70 **Specialist Support to People with Dementia & Carers:** Alzheimers Society. 2011. Support.Stay.Save. 'every £1 spent (on community support) saves an estimated £1.20 in the cost of bed day' (Page 27). The Whole System Demonstrator (WSD) programme - largest randomised control trial of telehealth and telecare in the world, involving 6191 patients and 238 GP practices across three sites, Newham, Kent and Cornwall. http://3millionlives.co.uk/about-telehealth-and-telecare

2. INTEGRATED URGENT RESPONSE: SUPPORTING EVIDENCE BASE THE CASE FOR CHANGE AND THE BCF RESPONSE

Case for change

Our rationale for changing the way urgent care is delivered across LLR over the 5 year period is based on the following challenges:

Urgent Care Generally

- We are experiencing difficulty achieving national standards and ambitions, e.g. maintaining the four hour A&E target and achieving overall reductions in acute sector activity
- Existing urgent care settings are crowded and uncomfortable
- Navigating the urgent care system is complex and difficult and the varied alternatives to A&E are confusing
- Urgent care services are not well connected to wider community health services/pathways – for example the ambulance service not always aware of elderly frail patients already being case managed by community staff

Frail Older People Specifically

- The number of elderly people is forecast to rise in city and county

- Locally too many older people end up in hospital for too long – we need care to be delivered in or close to home
- Too many people end up in services such as residential care instead of going back home with the right changes made to that home to make it a safe environment – we need to support people to be independent
- Not enough services that are joined up to support physical and mental health and wellbeing needs – we need to deliver integrated pathways
- We accept the international and national evidence that integrated care pathways are needed to better support people with complex and multiple needs

Desired outcomes: The outcomes we are seeking to achieve across LLR over the 5 year period are as follows:

Urgent Care System Generally

- National 4 hour target consistently met
- More people being treated in the right place – e.g. shift of 25% of A&E attendances (minors) being seen in an urgent care setting rather than an A&E setting by 2018/19
- Improved patient experience e.g. through redevelopment of the A&E department, feedback on satisfaction with alternative community based services
- Simpler urgent care system (for professionals as well as the general public)
- A 25% reduction in emergency department (ED) admissions for chronic diseases through specific interventions for Frail Older People and those with Long Term Conditions
- Less time spent in hospital – 10% reduction in non-elective length of stay for those who still need to be admitted

Frail Older People Specifically

- Improved independence and wellbeing amongst the frail and the elderly as measured by fewer care home admissions
- More older people with agreed and managed care plans
- Fewer older people going into hospital – 15% reduction in admissions
- Reduced delayed discharged and length of stay
- A reduction in readmission rates
- Increased dignity as evidenced through patient surveys
- An increase in the number of people who die in a place of their own choosing
- More older people with agreed and managed care plans

Local Evidence	National Evidence
Scale of opportunity to avoid emergency admissions: **LLR 5 year Strategy June 2014**	**Scale of opportunity to avoid emergency admissions:** Quality Watch, The Health Foundation, Nuffield

Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data These collectively demonstrated the opportunity to avoid 13 of 100 emergency department admissions per day and achieve a 25% reduction in converted admissions from emergency department. Evaluation report of the acute visiting service (6 Month pilot), 2010. Commissioned by the North and South Charnwood Commissioning Group. LLR Admission Avoidance Detailed Report - Emergency Department.	Trust: Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' **Blunt 2013**, QualityWatch, The Health Foundation, Nuffield Trust Making our health and care systems fit for an aging population. **The Kings Fund 2014**. The King's Fund: Naylor et al, 2013. Transforming our health care system. Ten priorities for commissioners. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf]. Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.** http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on primary prevention, managing ambulatory care-sensitive conditions (which account for 15.9% of England's emergency admission in 2009/10) , falls, intermediate care, re-ablement and rehabilitation, managing emergency activity, discharge planning and post-discharge support, mental and physical health needs and delivering integrated care. Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
Interventions for Falls and Frailty **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data **Admissions Analysis by HRG, 2013/14 -** analysis focused on admissions due to falls, carer breakdown, housing issues, and other social care factors to identify where BCF interventions could have maximum effect **Frail Older People's Outline Business Case, June 2014** including the **EMAHSN Sparkler 2014** - academic review of evidence base to examine the impact of assessing and treating FOP outside of acute setting on emergency admissions http://www.nottingham.ac.uk/emahsn/documents/sparkler-2-v4--sp2v1-final-noisbn-21-7-14.pdf **The Director of Public Health Annual Report** (NHS Leicestershire County and Rutland,	**Interventions for Falls and Frailty** Campbell et al (2013) Northamptonshire Crisis response service, Source LGA: 'Integrated care evidence review, November 2013' Falls: the assessment and prevention of falls in older people. **NICE CG161**. http://www.nice.org.uk/Guidance/CG21 **Economic case for investing in falls prevention**: Fracture prevention services: an economic evaluation' (Department of Health, 2009) A study by **Tian et al (2013),** 'Exploring the system - wide costs of falls in older people in Torbay', used patient-level linked datasets to explore the health and social care costs for patients in the year before and after a fall. It showed that in the 12 months after a fall, community care costs increased by 160%, social care costs by 37% and acute hospital costs by 35%. Intermediate care for frail older people: **NHS Benchmarking (2013)** http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php

Leicestershire County Council and Rutland County Council, 2012). Indicates that frailty rather than age is an important indicator for poorer outcomes in older people. http://www.leics.gov.uk/dphannualreport.pdf **EMAS Analysis** mapping the opportunity of the Northamptonshire Falls/Crisis response for Leicestershire's population, July 2014 **Rutland JSNA** chapter on older persons, including frail older people 2012 **Rutland Health & Wellbeing Strategy** [Available online at http://www.rutland.gov.uk/rutland_together/health__wellbeing_board/health_and_wellbeing_strategy.aspx **Falls Service Review – Paper 2 – March 2013. Brian Joplin.** Includes outline business case and recommendations on various service options. **Project Brief: Addressing falls that result in attendance at A&E and/or admission to hospital, as part of the frail elderly pathway** Includes national and local background to falls in the background section.	
Integrated Crisis Response Service Crisis response Service (ASC only) Activity Summary 2 Sept 2013 - 31 July 2014. David Stanton. Includes referral rates / Referral Sources / referral outcomes	Based on other studies Salford PCT Investment £600k = savings £1m to £3m http://www.wales.nhs.uk/sitesplus/documents/829/Salford%20rapid%20reponse%20ppoint%20presentation.pdf Bristol. Investment £2.8m. Benefits £4.3m (£3.6 health, £0.7 social care) http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=11&cad=rja&ved=0CDkQFjAAOAo&url=http%3A%2F%2Farms.evidence.nhs.uk%2Fresources%2Fqipp%2F29511%2Fattachment&ei=53_rUvOIDeSS7Qb0roHgBg&usg=AFQjCNFcpHbdEzTKT7g9ogY0csqt5tQuoA Making our health and care systems fit for an aging population. **The Kings Fund 2014**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population Includes a section on rapid support close to home in times of crises.

3. HOSPITAL DISCHARGE AND REABLEMENT
THE CASE FOR CHANGE AND THE BCF RESPONSE

Case for Change

Better Care/Better Value national benchmarks show that University Hospitals of Leicester

(UHL) is currently ranked 73 in terms of performance on length of stay and there is a £3.8m opportunity to the health economy if this moved into the top quartile of performance nationally.
Awaiting similar information for Peterborough

Length of stay (LOS) has continued to rise in LLR with an increase of 19% in the last financial year for patients staying 11 days or more, with the majority of these patients aged over 65.

A LOS of 11 days or more is detrimental to frail older people in terms of

- Increasing their levels of dependency while in hospital
- Reducing their potential to return to their usual place of residence
- Reducing their potential to maintain their previous baseline of functioning [4].

During 2014/15 University Hospitals of Leicester commissioned Dr Ian Sturgess to review the overall performance of the urgent care system including the barriers to discharge both within and outside of the acute trust. He has presented evidence from other health and care economies nationally and internationally which have reduced LOS for frail and elderly patients and reduced the consequential longer term demand on health and care system as a result[5].

The LLR system is seeking to mirror the results achieved in other health and care economies though the reconfiguration of services and activity shifts associated with the LLR 5 year plan.

Dr Sturgess' findings and recommendations have been incorporated into the LLR 5 year plan workstreams for Urgent Care and Frail Older People, as well as into UHL's internal transformation programme where changes to clinical culture and practice are taking place to focus clinical care on preventing admissions and reducing LOS.

The local health and care economy's performance on delayed bed days and delayed transfers of care has also been a significant barrier to reducing LOS and performance in Q1 2014/15 has deteriorated. Reducing delayed bed days is one of the national metrics for the BCF and our BCF local plan is therefore responding to this challenge.

UHL have also identified (per overall planning assumptions aligned to the LLR Better Care Together Programme) that up to 450 beds could be reduced in the acute sector over a 5 year period if the health and care economy's performance on rates of admissions, discharge processes and LOS is improved. This will involve a number of changes spanning both elective and non-elective care across the 8 workstreams of the LLR 5 year plan. A proportion of this change requires a shift of a targeted proportion of this activity into community based settings, including patients' own homes.

Local Evidence	National Evidence
LLR 5 year Strategy June 2014 Based on • LLR Mckinsey Report 2013	Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.** http://www.kingsfund.org.uk/sites/files/kf/fiel

[4] Refer to Ian Sturgess evidence base
[5] Refer to Ian Sturgess evidence base

• EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data **Rutland JSNA** chapter on older persons, 2012 LLR Admission Avoidance Detailed Report - Emergency Department.	d/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on intermediate care, re-ablement and rehabilitation, managing emergency activity, discharge planning and post-discharge support, mental and physical health needs and delivering integrated care. Making our health and care systems fit for an aging population. **The Kings Fund 2014**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population Includes a sections discharge planning, post discharge support and reablement. Intermediate care for frail older people: **NHS Benchmarking (2013)** http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php A Department of Health funded review showed that home care reablement is almost certainly cost-effective because of improved outcomes for users. http://www.york.ac.uk/inst/spru/pubs/rworks/2011-01Jan.pdf **Social Care Institute for Excellence 2011:** Reablement: a cost-effective route to better outcomes http://www.scie.org.uk/publications/briefings/briefing36/ And maximising the benefits of reablement: **Social Care Institute for Excellence 2013:** http://www.scie.org.uk/publications/guides/guide49/ Berkshire example of Early discharge and intensive community rehabilitation for stroke patients Naylor C et al. (2012) Long term conditions and mental health – the cost of co-morbidities. King's Fund and Centre for Mental Health. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf] [Accessed on 22/08/2014].

Integrated Residential Reablement	Based on other studies: West Sussex CC. £361k investment = £600k saving. http://www2.westsussex.gov.uk/ds/mis/290212as16.pdf

4.LONG TERM CONDITIONS
THE CASE FOR CHANGE AND THE BCF RESPONSE

Case for change

Our rationale for changing the way care is delivered across LLR over the five year period for people with long term conditions is based on the following challenges:

- There will be an increasing number of people with LTCs /multiple LTCs over the next 10 years.
- There is a high level of health inequality between different areas of LLR leading to different outcomes for people with long term conditions.
- We need to work to increase screening and prevention for LTCs in response to current low detection rate for LTCs and some cancers.
- Too many people are being admitted for conditions that could be treated outside of hospital – we need to improve ambulatory care in support of these conditions and focus proactive care at this group of people.

Local Evidence	National Evidence
Scale of opportunity to avoid emergency admissions: **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data These collectively demonstrated the opportunity to avoid 13 of 100 emergency department admissions per day and achieve a 25% reduction in converted admissions from emergency department. **The Director of Public Health Annual Report** (NHS Leicestershire County and Rutland, Leicestershire County Council and Rutland County Council, 2012). States that the increase in the ageing population will drive an increase in the number of people living with long term conditions. http://www.leics.gov.uk/dphannualreport.pdf	**Scale of opportunity to avoid emergency admissions:** Quality Watch, The Health Foundation, Nuffield Trust: Blunt, I (2013) 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' Making our health and care systems fit for an aging population. **The Kings Fund (2014)**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population Includes a section on living with simple or stable long term conditions and co-morbidities. The role of GPs in personalised care of older people is set out in the Government policy **Transforming Primary Care**: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf

Rutlland's JSNA chapter on long term conditions 2012 **Rutland Health & Wellbeing Strategy**	**Care co-ordination report by The Kings Fund (2013)**: 'South Devon & Torbay: Proactive case management using the community virtual ward and the Devon predictive model' **Case management report by The Kings Fund (2011)**: 'Case management: what it is and how it can be best implemented' Depression in adults with a chronic physical health problem: NICE Guideline 91: http://www.nice.org.uk/guidance/cg91 *No health without mental health: a cross-government mental health outcomes strategy for people of all ages: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.** http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on primary prevention, managing ambulatory care-sensitive conditions (which account for 15.9% of England's emergency admission in 2009/10) , risk stratification, care coordination, care management, intermediate care, re-ablement and rehabilitation, managing emergency activity, discharge planning and post-discharge support, mental and physical health needs and delivering integrated care.
	Integrated, Proactive Care (Risk Stratification & Care Management) The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' Naylor C et al. (2012) Long term conditions and mental health – the cost of co-morbidities. King's Fund and Centre for Mental Health. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf] [Accessed on 22/08/2014]. • 30% of people with a long-term condition

	have a mental health problem (approximately 4.6 million people) (page 5) • 46% of people with a mental health problem have a long-term condition (approximately 4.6 million people) (page 5) • Including a psychological component in a breathlessness clinic for COPD in Hillingdon Hospital led to 1.17 fewer A&E presentations and 1.93 fewer hospital bed days per person in the six months after intervention (Howard et al 2010). This translated into savings of £837 per person – around four times the upfront cost.(Page 14) • In the year following a CBT-based disease management programme for angina, patients needed 33 per cent fewer hospital admissions – saving £1,337 per person (Moore et al 2007). (Page 14) De Silva D (2011) Helping people help themselves: a review of the evidence considering whether it is worthwhile to support self-management. London: The Health Foundation. [Available online at http://personcentredcare.health.org.uk/sites/default/files/resources/helping_people_help_themselves_0.pdf] Accessed on 22/08/2014] A NICE Local Practice example is available at: Self-care support for long-term conditions The King's Fund: Naylor et al, 2013. Transforming our health care system. Ten priorities for commissioners. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf].

THEME 1: UNIFIED PREVENTION OFFER

Intervening early can have a major impact on the health and wellbeing of individuals, and can prevent or reduce the need for more costly care later on.

The LLR 5 year strategy places self-care and prevention at the heart of the care system with models of care designed to:

- Support people to live well and cope well
- Promote health wellbeing, and independence
- Reduce the need for traditional health and care services where possible.

In Rutland, prevention is a central strand of our Joint Health and Wellbeing Strategy, and form the base of our local delivery model per the care pyramid on p xx.

It is also an area where we believe collaboration is essential to achieving successful outcomes and a greater quality of life for the citizens in Rutland and to achieve the best value for money for the Rutland pound across agencies.

Historically commissioning for prevention is fragmented across the health and care system in Rutland and self-care interventions are not systematically embedded in commissioning specifications and models of care. The offer to the public in terms of how to access this kind of support, whether from statutory and non-statutory agencies, can also be unclear and inconsistent across Rutland communities.

We have considered evidence from other areas of the country where prevention is more targeted, consolidated and cost effective and we can see many opportunities to achieve these benefits in Rutland.

By investing in the bottom tier of the care pyramid as a priority we will also provide the necessary infrastructure for other elements of the BCF plan and LLR 5 year plan to function effectively in the medium term, so our priorities in this part of the BCF plan are absolutely crucial to achieving our overall vision of health and care integration.

Desired outcomes:

We want people and communities to:

- Be able to access a range of support early, through social and community networks
- Be empowered to take control of their health and wellbeing
- Live healthier and independent lives
- Maintain their independence within their community for longer.
- Place less reliance on statutory support.

Awaiting information on:
BCT primary care records sharing project

metrics

Long Term Conditions deliverables by CCG:

The 2014/16 GP Support and Investment Framework focuses on end of life care, care homes, COPD and atrial fibrillation.

During 14/15 palliative care registers will increase by up to 1% and have a care plan in place.

95% care home patients to have a care plan in place.

2% of patients identified as at risk of admission (which would include EoL and Care home

patients) to have a care plan and be case managed in line with the NHS England admission avoidance des.

Over all care plans are expected to rise to over 4839

Increase in COPD prevalence rates by 1.5% to expected prevalence of 3.1%

Increase patients who are anticoagulated and avoid strokes. Plan is for minimum of 2 patients per practice to be anticoagulated effectively.

Insert highlight from adult social care business plans

4) PLAN OF ACTION

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

Theme	Scheme description	Task	Interdependency	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	2015/16
Unified Prevention Offer	UP1. Community Agents Service and Integrated Information Service	**Phase 1**											
		1.Develop service specification											
		2.Develop tender document											
		3.Invite to tenders											
		4.Evaluate tenders											
		5.Award contract	1-5										
		6.Service starts	E1										
		Phase 2											
		7.Set up information and advice workstream											
		8.Develop service specification											
		9.Recruit information development officer											
		10.Commission data store facility											
		11.Develop system	9										
		12.Online facility is up to date and live	9& 10										
	Independent Living through Technology and	13.Develop service specification for Telecare											
		14.Explore Telehealth options											

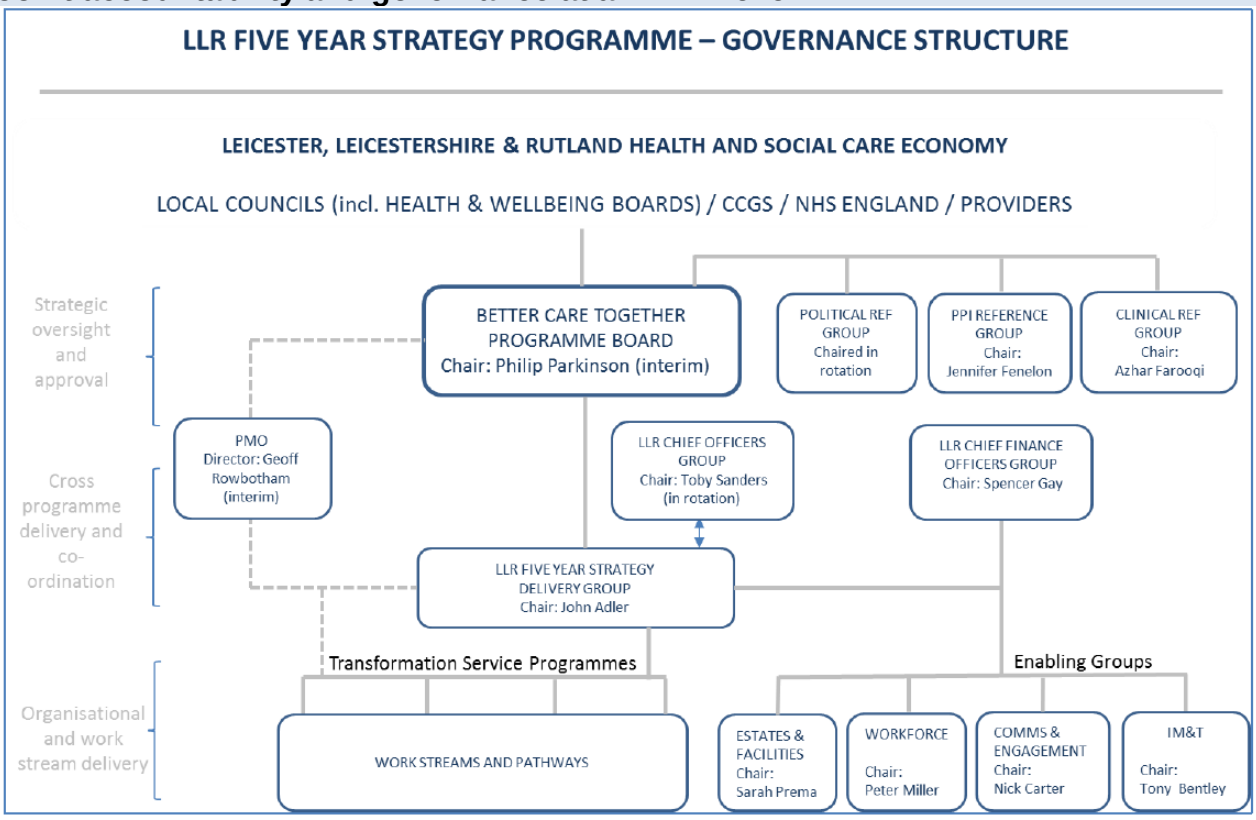
		15.Procure Telecare Service												
		16.Set up Telecare equipment store												
		17.Develop a "smart house"												
		18.Telecare offer in place	13-17											
		19.Telehealth offer in place												
	UP3. Disabled Facilities Grant	20.Disabled Facilities Grant (BCF) incorporated into Better Care Fund activity												
	UP4. Integrated Care Model	21.Evaluation of the model												
		22.Report findings from evaluation to the Health and Wellbeing Board												
		23.Implement recommendations from evaluation	21, 22											
Integrated Urgent Response	IUR1. Integrated Crisis Response	24.Engagement event with HSC staff "Rutland Hub Meet and Greet" to Launch pilot												
		25.Implement Crisis Response pilot based on an enhanced Reablement Service linked to night nursing												
		26.Ongoing evaluation and performance monitoring	25											
		27.Fully cost new service	25, 26											
		28.Full implementation of service	25-27											
	IUR2. Integrated Hub	29.Identify current pathways into and out of services	43											
		30.Review effectiveness of existing services specifically those linked to community health services												
		31.Scope potential and requirements for co-located, joint hub for local health and social care services												2015 onward
		32.Fully integrated and co-ordinated service offer is in place												2016
Hospital Discharge and Reablement	HDR1. Hospital Discharge	33.Evaluate effectiveness of the shared nurse and social care posts linked to the REACH team												
		34.Develop tracker to track those people who have left hospital to see what patients outcomes are												

		35.Implement tracker and monitor outcomes												
		36.Make posts substantive within new multidisciplinary team	33											
		37. Link to UHL pathways work to align services with the models established for Leicester and Leicestershire.												
	HDR2. Reablement	38.Social Care Protection: Improvements to reablement service are linked to Crisis Response Pilot												
Long Term Conditions	LTC1. Learning Disability	39.out of county link worker proposal agreed	29											
		40.Job description and person specification agreed	29											
		41.Recruitment process takes place	39, 40											
		42.New post commences	41											
	LTC2.Integrated Dementia Hub	43.Dementia mapping event with key stakeholders												
		44.Appoint dedicated social worker to develop specification												
		45.Develop Service Specification	44											
		46.Jointly Commission Service	45											
		47.Dementia service in place	45, 46											
Enablers	E1. IT and data sharing	48.Understand whether our existing case management system (RAISE) will meet the requirements of the Care Act and integration with health												
		49.Develop data sharing agreement with health												
		50.Appoint data inputter to correct errors and put in missing information into the case management system												
		51.Procurement of new service if required	48											
		52.50% of social care records will have NHS numbers recorded	50											
	E2. Care Act Carers Assessment and	53.Review how we assess carers												
		54.Develop light touch assessments	53											
		55.Review Carers Offer												

	eligibility	56.Revised offer of support available to Carers	8-11, 54											
S75	Pooled Budget arrangement in place	57. Develop draft pool budget mechanism and arrangement												
		58.Robust arrangement in place for early Jan: report to Integration Exec												
		59.Health and wellbeing board – to sign off (24.2.15) mechanism for pooled budget arrangement												
		60.S75 in place by 1 April 2015	57-59											

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

Joint accountability and governance at an LLR Level:



Rutland is heavily engaged in the LLR 5 year strategy, providing representation at each level in the governance structure:

Board	Rutland representation
Programme Board	Helen Briggs, Chief Executive Rutland County Council (RCC) + 1 elected member (Cllr Begy or Cllr Emmett)
Chief Officers Group	Helen Briggs, Chief Executive RCC
Political Reference Group	Cllr Roger Begy, Leader of RCC
PPI Reference Group	Jennifer Fenelon, Chair of Healthwatch Rutland
Clinical Reference Group	Dr Andy Ker, Rutland Locality Lead

Chief Finance Officers Group	Sav Della Rocca, Assistant Director Resources, RCC
Strategy Delivery Group	Lynda Bowen, Head of Service Better Care Fund, RCC
Urgent Care	Mark Naylor, Assistant Director for People, RCC
Long Term Conditions	John Morley, Head of Service Vulnerable People, RCC
Frail Older People	Julia Eames, Project Manager Health and Social Care Integration, RCC
Mental Health	Vicky Todd, Head of Service Inclusion, RCC
Planned Care	John Morley, Head of Service Vulnerable People, RCC
Learning Disability	Kim Sorsky, Team Manager Special Educational Needs and Disabilities, RCC
Maternity and Neonates	Jackie Difolco, Head of Service Families Support, RCC
Children's Services	Wendy Poynton, Assistant Director for People, RCC
Comms and engagement	Chris Jones, Strategic Communications Advisor, RCC
Information Management and Technology (IM&T)	Diane Baker, Head of Governance, RCC
Workforce	Wendy Poynton, Assistant Director for People, RCC
Estates and Facilities	Paul Phillipson, Director for Places, RCC

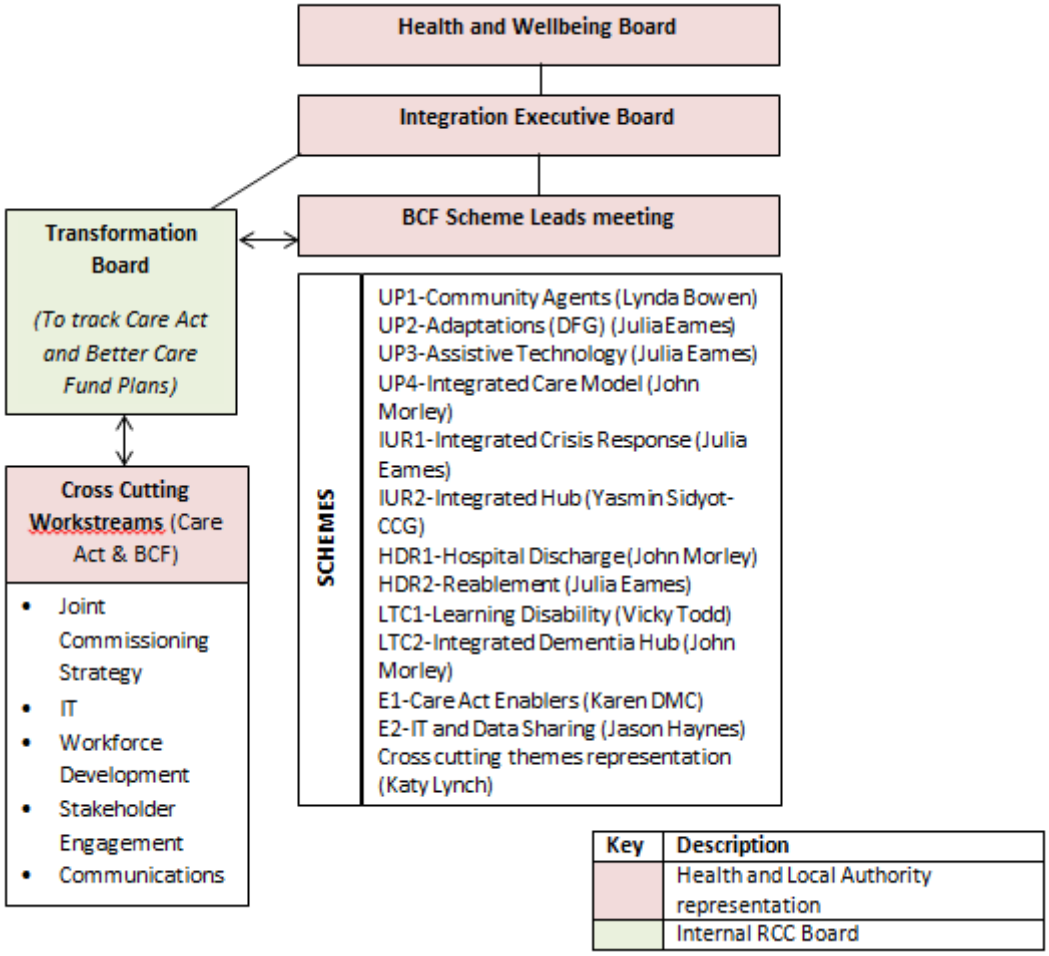
Joint accountability and governance at a Rutland Level:

Representation at the LLR 5 year strategy level is translated locally through two-way communication between the BCT Programme Lead and key members of Rutland Health and Wellbeing Board including the Chair (Cllr Emmett), the Leader of RCC (Cllr Begy), Chief Executive of RCC (Helen Briggs), the Director for Public Health (Mike Sandys) and the Chief Operating Officer of ELRCCG (Tim Sacks). The Board receives regular updated from the BCT Programme Lead, and RCC Senior Managers linked to the BCT workstreams report back to both the Transformation Board and Senior Management Team following meetings.

Patient user engagement is inherent in our plans with Healthwatch Representation at both the Health and Wellbeing Board and Integration Executive level. Furthermore, the Healthwatch Rutland Chair is the chair of the Better Care Together patient involvement reference group, giving Rutland strong representation in terms of user engagement across LLR which will be fed down to a local level through the Healthwatch Steering Group.

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

The Health and Wellbeing Board (HWB) has oversight of the BCF plan, assisted by the Integration Executive of the HWB. The HWB includes a member of NHS England.



The diagram above demonstrates at a local level how the Rutland BCF plan is monitored and reported. The plan is ultimately accountable to the HWB, which is where strategic decision making between local authority, health and the voluntary sector takes place. Quarterly reports against the BCF will be reported by exception.

The integration executive meets monthly and provides a sounding board and framework for informal reporting and planning in between HWB meetings at an executive level.

Lead officers for each theme are seamlessly linked in to the structure through the BCF scheme leads meeting which is where benefits and performance monitoring will take place regularly, reporting up to the Integration Executive. Operational issues will be dealt with through both the Transformation Board and BCF Scheme leads meeting; issues will be escalated up to the Integration Executive where decisions are required outside of agreed plans.

The Local Authority and Clinical Commissioning Group have jointly resourced a Head of Service Better Care Fund, who is ultimately accountable to both organisations and responsible for the operational management of the programme. This post is supported by a small Transformation Team that straddles projects across both the Better Care Fund and Care Act.

A Transformation Board (consisting of Transformation Team members) is chaired by the Deputy Director for People at RCC. The Board meets fortnightly and reports action plans,

risks and issues. This Board discusses where items should be raised/reported, this is dependent on whether items are internal focussed or have joint consequences for health and social care, the latter results in items being fed up to the Integration Executive for discussion.

Rutland County Council Cabinet and the Senior Leadership Group of ELRCCG receive at least quarterly updates on progress against targets.

The BCF plans are also supported by the regional team for the BCF and Rutland works closely with NHS and social care colleagues concerned with implementing the BCF plans within LLR. This includes regional conference calls, workshops and support regarding the plans for the BCF, sharing ideas, resources and support where possible.

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

Theme	Reference	Scheme Name
Unified Prevention	UP1	Community Agents
	UP2	Adaptations (DFG)
	UP3	Assistive Technology
	UP4	Integrated Care Model
Integrated Urgent Response	IUR1	Integrated Crisis Response
	IUR2	Integrated Hub: Assessment for Intermediate Care
Hospital Discharge and Reablement	HDR1	Hospital Discharge
	HDR2	Reablement
Long Term Conditions	LTC1	Learning Disability
	LTC2	Integrated Dementia Hub
Enablers	E1	Care Act Enablers
	E2	IT and Data Sharing
	E3	Programme Support

5) RISKS AND CONTINGENCY

a) Risk log
Section still to be finalised

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

There is a risk that:	**Likelihood** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Lead**	**Mitigating Actions**
The level of contribution to the pooled or aligned budget does not match the level of expenditure.	3	4	12	Sav Della Rocca (RCC)	The contributions to the BCF have been agreed as part of the revised submission and matched to expenditure levels. These will be agreed annually through the HWB.
Partners are unable to agree on how to deal with overspends.	1	2	3	Lynda Bowen (RCC)	For each project there will be a lead partner although some may be joint-led. The lead party shall use all reasonable endeavours to ensure that projects are carried out within the assigned budget in each financial year. For projects where funding is a contribution to the overall project cost i.e. a project is estimated at £400k of which £100k is a BCF contribution then project overspends will be met by the lead partner. For projects which are fully BCF funded, the lead partner will either meet all overspends unless agreed by the H&WB (subject to their being other funding available) or make project modifications to work within the overall allocation. For joint projects, parties shall meet the overspend in the proportions as set out in the finance section of each project.
Partners do not spend allocated funds	2	1	3	Yasmin Sidyot (CCG) and Lynda Bowen (RCC)	Any unspent monies shall roll over into the budget for the next financial year or be divided assuming that projects are not completed subject to the approval of the H&WB. Any unspent monies on completed projects will be

					retained in a contingency reserve to be allocated by the H&WB.
Partners cannot meet their contributions due to income reductions within their separate organisations.	3	3	9	Sav Della Rocca (RCC) and Donna Enoux (CCG)	Partners contributions must as a minimum be in line with national BCF allocations
Partners don't deliver agreed projects and improvements and it impacts on others are not met.	2	4	8	Yasmin Sidyot (CCG), Lynda Bowen (RCC) and Rachel Dewar (Leicestershire Partnership NHS Trust)	Whilst acknowledging that failure to deliver projects may result in savings not being achieved by partners, it is also recognised that: • Some projects are enablers and do not contribute in themselves to national metrics; • Intended benefits for other projects are provisional/estimated; • Some projects relate to protecting existing services or meeting new Care Act requirements; • Linking all projects to performance metrics or to a funding risk will stifle innovation and encourage 'safety first' behaviour. On this basis, it is not proposed to withhold fund or performance link funding at this stage. However, partners responsible for delivering projects must demonstrate their value to the H&WB which shall retain the right to stop/modify projects which are not delivering as intended.
Change of partners' objectives and responsibilities during the pooled or aligned budget period	1	3	3	Lynda Bowen (RCC)	Partners agree to be committed to BCF objectives for the period of the plan Any changes will be reported through t
Partners make changes outside the BCF which have a direct impact on partners or attainment of national metrics	2	4	8	Lynda Bowen (RCC)	Partners agree to consult with each other in respect of projects/service changes etc which may have a direct impact on other partners e.g. reduction in reablement service offering which could have a knock on impact on terms of admission etc
Potential financial exposures from	2	2	4	Sav Della	Where projects are funded from the BCF, there may be financial

delivering projects				Rocca (RCC) and Donna Enoux (CCG)	obligations e.g. contractual obligations arising beyond the timeframe of the pooled budget (should arrangements end early) or ongoing obligations that would still need to be met irrespective of whether the H&WB agree such projects should continue to be BCF funded e.g. a £200k sum is allocated to Community Agents for which the Council has a 5 year contract. If the H&WB wish to reduce funding or reallocate it then the Council could be left to fund it. Partners need to be clear about potential financial exposures and use reasonable endeavours to minimise them through contractual clause, use of fixed term arrangements etc
Currently we have no access to aggregated risk stratification data due to no information sharing agreement in place with each GP to get the information.	2	2	4	Yasmin Sidyot (RCC)	Plans are in place to contact each GP surgery in Rutland and Leicestershire asking them to sign up to a risk sharing agreement. This is a high priority and will be resolved by October 2014
Secure data sharing is not suitably in place to allowing sharing of records between health and social care	2	5	10	Diane Baker (RCC)	Robust protocol will be developed at an LLR level with local input in terms of approving at a local level

b) Contingency plan and risk sharing

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

In 2015/16 the Better Care Fund (BCF) will be put into pooled budgets under Section 75 joint governance arrangements between the CCG and the Council. A condition of accessing the money in the Fund is that CCG and Council must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.
Under the new pooled budget arrangements, there will be a number of risks that will need to be shared across partners and others that will affect individual partners. There needs to be formal agreement of how these risks will be shared between partners. The Health and Wellbeing Board has been consulted on the BCF spending plans and has agreed risk sharing arrangements as follows which will ultimately be enshrined in the s75

agreement:
The following principles/understanding underpin what is proposed:

- The BCF guidance recognises that the wider context of considerable reductions in Local Government funding mean that some element of expenditure is for **social care protection**;
- Some of the funding for some elements of the impact of the **Care Bill** in the BCF has the potential to put additional financial pressure on the pooled finances if the allocations for these impacts are not sufficient to meet the requirements. Partners will need to keep these issues under review, and agree mitigating actions as appropriate.
- There will be **on-going detailed performance management and finance monitoring** to enable decisions to be taken at the earliest opportunity to enable actions to be put in place quickly which will either reduce the financial impact of any under-delivery of planned improvements or enable a re-prioritisation of available resource into those areas which are having the most significant impact on performance.
- Wherever possible, **a contingency reserve** will be built up after year 1 from underspends to be utilised as agreed by the H&WB to meet any overspends on existing projects or mitigate other risks that may emerge etc.

Pay for performance element
The BCF funding allocation includes a performance related element. Per the national funding allocations the performance related element is £591k. The guidance is clear that part of the performance related element is conditional on achieving a reduction of c3.5% in non-elective admissions. Using the national template provided, the performance linked funding is estimated at £154k (this equates to a 3.5% reduction in admissions i.e. 103 multiplied by the 'unit saving' of £1490). This is a minimum amount but the H&WB have agreed that this minimum target is acceptable.
Under the agreed arrangements, the CCG will retain the performance link funding element and release it if performance is achieved. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services namely pressures on the acute sector of the failure to reduce admissions.
The H&WB have agreed that there is no contingency fund to start off with in the BCF allocation given the overall size of the fund. This means that the loss of funding will be shared 50:50 between the Council and CCG. In simple terms, if the Council was due to spend £1m via the BCF, it will receive a reduced level of funding if the admissions target is not achieved. Each organisation has built this into its financial plans. Both parties also accept that whilst BCF schemes may deliver some reductions or indeed all intended reductions, there may be other factors that mean the 3.5% performance reduction is not achieved. The CCG has built provisions into its agreements with providers setting out action it will take to share the loss with providers.
The payment arrangements will follow the national guidance but given the size of the pay for performance element, payment may be made annually depending on progress.
In order to minimise the likelihood that 3.5% performance will not be achieved, the following action has been/will be taken:

- The target reduction across all BCF schemes is X. This target is in excess of the minimum target of 103.
- Performance will be monitored monthly through X, Y and Z and corrective action taken; and
- Resources may be diverted from other schemes if possible to address specific

issues.

6) ALIGNMENT

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

The BCF aligns to plans within LLR BCT five year strategy and links with schemes within the council and ELRCCG. Considerable work has been undertaken in linking public health, the voluntary sector and Healthwatch into developing the community agent scheme. The Council has been involved by way of the HWB in the work undertaken by ELRCCG on community services and within the urgent care consultation. There continue to be strong links as part of the BCT and ELRCCG senior leadership group and with the commissioning team for ELRCCG and the transformation team within Rutland County Council.

The diagram in section 4b outlines the interrelatedness between the Better Care Fund and other transformational programmes i.e. the Care Act. The Transformation Team coordinates the broad range of workstreams in place to deliver the Local Vision programme, the common threads (crosscutting workstreams) are linked and reported through the Transformation Board. The Head of Service Care Act and Head of Service Better Care Fund are supported by a small project team which allows for ongoing communication between the related initiatives. Key interdependencies between the Better Care Fund and Care Act implementation where joint plans are required include:

- IT systems
- Workforce Development
- Communication and engagement
- Support for carers
- Information and advice

The Housing strategy lead has been engaged in developing a number of key schemes that link to housing, namely Assistive Technology, DFG and community agents to ensure that housing issues are aligned to plans particularly in relation to unified prevention.

Further information required to explicitly state all care act work streams

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

Alignment with Rutland County Council's Transformation Programme and MTFP

In 2014/15 Rutland County Council embarked on programme of work (People First) to release £1.5m by 2017/18 with drivers and sources of savings illustrated in the diagram below:

Business As Usual Activity[6]	**Review demand for services: Day Services**	**Create Learning & Skills Team**	**Family Support Model** a)review Structure b)thresholds c)pathways	**Health and Wellbeing Model** a)review structure b)thresholds c)pathways	**Youth Provision: a)Explore Charging b)Develop community capacity to support youth work**	**Children Centres: a)closure of Casterton b)explore charging**
Timescale	September 2014	November 2014	Phase 1: November 2014	Phase 1: November 2014	December 2014	December 2014
Business As Usual Activity	**Review demand for services: Meals on Wheels**	**Review demand for services: floating support**	**Review Charges for Adult Learning Classes and Community Learning Offer**	**Aligning political structure to new structure**	**Developing the provider market**	**Encourage the development of Social Enterprises**
Timescale	December 2014	December 2014	March 2015	April 2015	December 2015	April 2015
Business As Usual Activity[7]	**Review Aiming High Offer**	**Review Existing Contracts with the Voluntary & Community Sector**	**Public Health: a)review all spend b)integrate public health into one council**	**Full scale review of transport**	**Review support to Foster Carers**	
Timescale	December 2014	April 2016	December 2014	May 2016	December 2014	
Transformation programme – Explicitly linked to Rutland BCF	**Developing a Citizens Charter**	**Explore opportunities at Rutland Memorial Hospital**	**Community Agents**	**Integration with health:** a)shared posts b)co-located services c)multidisciplinary teams	**Joint Commissioning Strategy for Prevention**	**Increase support for those with Long Term Conditions**
Timescale	April 2015	April 2015	April 2015	December 2015	December 2015	April 2016
Transformation programme – Explicitly linked to Rutland BCF	**Review overall package for carers**	**Review community care packages**	**Rutland Information Service**			
Timescale	April 2016	April 2016	Phase 1: April 2015			

[6] See final report for detailed action
[7] See final report for detailed action

			Phase 2: tbc			

Within the council's transformation programme all green shaded items are aligned directly to the BCF (illustrated in the table above). The project plans and finance assumptions are taken directly from the BCF plan and enacted via the governance arrangements outlined in the previous section. People First makes the below assumptions of areas where efficiencies may be made:

Area	**Indicative £**
Staffing	£400 - £500k
Making better use of Public Health funding	£200 - £300k
Sustaining services through the Better Care Fund	£300 - £500k
Transport review	£100 - £300k
Service redesign, review and reconfiguration	£300 - £500k
Total	£1.3m - £2.1m

Alignment with Better Care Together LLR 5 Year Plan

Please see information provided previously on pages 5, 16-18

Alignment with CCG Operating Plans

The BCF interventions, metrics and associated financial contributions have been factored into the CCG operating plans with effect from 2014/15.

There have been further iterations of CC plans during June 2014 with refreshed data uploaded onto Unify.

The impact of the activity shifts and associated financial assumptions over the 2 financial years have been reflected in CCG capacity plans and in the contracted activated levels with providers e.g. for non-elective activity these levels reflect the reductions in total emergency admissions for 2014/15 and 2015/16.

These reductions are informed by the trajectories within the LLR 5 year plan. For example a 5% reduction in emergency admissions per year is indicated in the LLR 5 year plan. This will be achieved by interventions within the 3 local BCF plans in LLR and a range of other actions being taken by commissioners and providers, which sit outside of the BCF.

The contribution of the BCF related interventions have been mapped into the QIPP assumptions of NHS providers.

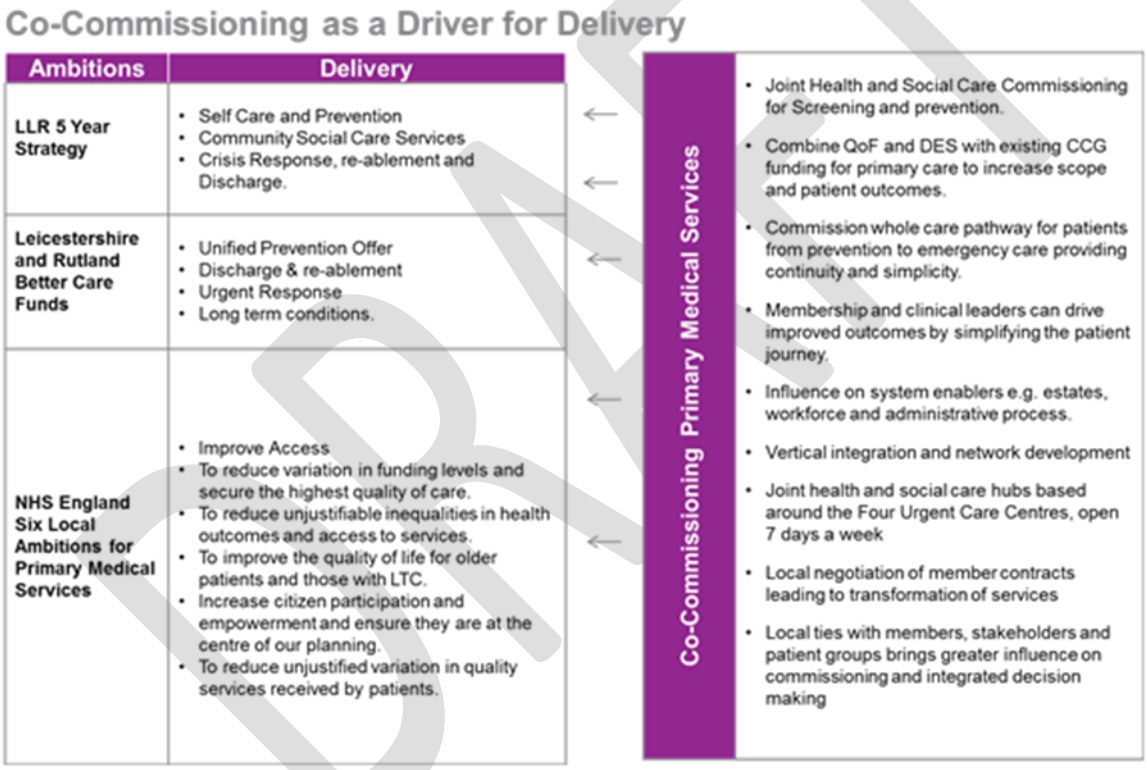
The CCG 2 year plans are set in the context of the LLR 5 year plan. These will be subject

to refreshed in conjunction with the production of the strategic outline case in the autumn of 2014/15
and in line with the 2015/16 planning round requirements.

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

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

Below is our co-commissioning plan and illustration of how this links back to the BCF



7) NATIONAL CONDITIONS

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

a) Protecting social care services –

Better Care Fund resubmission of plan_v2_Health and Wellbeing Board 9th September 2014

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

It is suggested that in the context of the Better Care Fund protection for social care means:

- Ensuring the ability to respond to demography/increasing social care needs of younger adults with disabilities and older people

JSNA data has indicated that there will be demographic pressures in adult social care over the next three years. In the indicative cost model produced by the LGA, demographic growth in over 65's was approx 3-4% per annum. The Council has an indicative demographic model which indicates that this type of growth equates to c£150k-£200k per year. Equally, the Council has recently updated its eligibility criteria to critical and substantial and at this stage believes that the impact of not attending to those formerly classed as moderate will assist but not cover the impact of population changes as it is likely that those who do present for support will be more costly care packages as the numbers of people with substantial needs grow due to increasing frailty.

The Council's MTFP does not quantify the impact of demographic changes however, as the Council's spending from 2015/16 exceeds available resources it is fair to say that any demographic growth cannot be funded from existing resources. At the same time there are cost base pressures e.g. re rates for residential care, contracts, cost of care packages which are partly reflected in the MTFP.

- Maintaining essential social care services that have a positive contribution to health outcomes in light of overall reductions in funding.

The Council has agreed to find savings of £1.5 - £2m out of the People directorate (this represents 11-12% of People directorate budget) following reductions in overall funding. This is essential to restore the Council's financial position to one where it can afford its spending. To maintain all services that are highly valued by health partners as essential to meeting need which is jointly addressed by health and social care would require some contribution to core funding whilst at the same time investment in service redesign/transformation.

Rutland County Council has embarked on a major review (People First Review) of its largest Directorate - The People Directorate. The Directorate accounts for 47% of the Council's expenditure and covers a range of Social care activity supporting individuals and families within the local community. Many of the services are provided to the target groups covered by the BCF submission including the frail elderly, those suffering from dementia and those who regularly access acute health services. The BCF investment will go some way to protecting services and also allow for investment to enable better outcomes to be achieved.

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

Local schemes and spending plans will support the commitment to protecting social services and achieving BCF outcomes by:

- Facilitating new investment in social care services such as 'community agents' and 'assistive technology' with the aim of reducing demand for more costly health and social care services;
- Excluding key services such as 'reablement' which has been very successful from service cuts;
- Supporting integration of Health and Social Care Teams to assist in the delivery of 24/7 care services;
- Build resilience in the form a crisis intervention team; and
- Giving the Council time to implement a new commissioning strategy for the People Directorate and re-engineer service delivery across a number of services.

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

In light of the above challenges to social care outlined it has been agreed that the financial value for the level of protection will be **£679,000** (this amount includes the allocation for DFG's for which there is no alternative use due to the terms and conditions associated with the funding). The breakdown of what this protection will comprise of is as follows:

- DFGs - £104k
- Integrated Care Model - £39k
- Reablement - £536k

The amount allocated to the Care Act duties is £110k.

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

The Care Act will be implemented in stages between 2014 and 2016. Amongst the key changes are:

- national eligibility criteria
- new responsibilities for Information and Advice
- increased rights and access to services for carers
- Adult Social Care funding reforms.

Some aspects of what is required for the Care Act have already been put in place. For example, the Council already has a Safeguarding Board and has recently set its minimum eligibility criteria at substantial. The Council has set up a series of Transformation work stream to address all aspects of the Care Act. These work streams include:

- **Charging** – which relates to paying for care and charging for care. It includes the development of an effective Charging Framework & ensuring our financial advice is in line with requirements. We also need to ensure our deferred payments scheme meets requirements and we effectively introduce the care cap locally plus

set up care accounts and respond to additional levels of assessment etc. We also need to develop our ICT infrastructure and develop our systems, processes, staff to meet the requirements of the Act.

- **Safeguarding** – This work stream will be responsible for ensuring that in partnership we meet the requirements of the Act in respect of safeguarding and accept our additional duties e.g. Safeguarding enquiries, serious case reviews, the supply of information, advocacy, protection of property etc. Our Safeguarding policies and procedures will need to be updated in light of the new legislation. Staff development will be key both internally and across organisations and this work stream will be responsible for developing effective systems and processes building on the Safeguarding Board arrangements already in place.

- **Assessment and Eligibility** – This work stream will focus on the development of effective systems, processes and staff development to ensure that the "welfare" principle and the concept of "preventing or delaying the need for care and support" are embedded in assessment and care management processes and that staff understand and implement the national eligibility criteria in a fair and transparent way. Local policies and procedures will need to be revised in light of the new legislation.

- **Carers** – This work stream will be responsible for reviewing the Carers Strategy to ensure that carers receive an assessment in line with requirements and that they have access to a range of good quality support and services locally. A new Carers Policy will have to be drafted to reflect changing requirements and staff will need to be developed to respond to carers needs appropriately.

- **Prisoners –** This work stream will be responsible for setting up structures, systems and processes to ensure that prisoners right to an assessment under the Care Act are met (within a prison or bail hostel environment) and ensure prisoners can access a range of good quality & appropriate services. It will involve developing plans across the region to meet this new requirement.

- **Transition -** This work stream will be responsible for ensuring that we assess a child, young carer or an adult caring for a child in line with requirements and we offer them appropriate support during the process. This will involve the drafting of a new Transitions Policy and ensuring that our services are joined up internally and externally so there is a seamless pathway for people in transition. Good quality information and advice is essential with a focus on delaying or reducing the need for care and support. Our systems, processes and staff will have to be developed to meet these new requirements.

Since the draft BCF was submitted, local Authorities have received confirmation of their specific allocation from a national investment of £135m for the implementation of the Care Bill. This forms one of the elements of the overall BCF financial envelope for each Authority and its partners. The RCC allocation is £81k.

There will be further allocations of resources directly to Local Authorities in 2015/16 to pay for implementation of the non-financial reform elements of the Bill and in 2016/17 to

fund the financial reforms. There is a risk that these allocations will not fully fund the actual costs.

Further analysis is needed to assess specific implications against the requirements of the Bill, and to assist with this a national modelling tool has been developed. This tool is being piloted in a number of Local Authorities and over time will be used to assess the potential impact of the Care Bill with respect to their population.

The development and application of the tool is iterative, and at the time of this submission further refinements to the modelling tool are anticipated. There is also a national consultation in progress about eligibility criteria. Risks in relation to the introduction of the Care Bill have been reflected in the risk register, and all assumptions and risks will be updated as further analysis becomes available, with regular updates to the Integration Executive.

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

The Care Act allocation in the BCF fund for carers is aimed to cover two elements:

- Put cares on a par with users for assessment; and
- Introduce a new duty to provide support for carers.

The notional allocations for the two duties above total £41k. The Council is using a national modelling tool to identify the additional costs of delivering these duties. Whilst this exercise is a work in progress, it is likely that the cost of delivering these duties will be in excess of the funding allocated. Part of the Council's response to this is to review

a) the way in which assessments are undertaken
b) the level of support offered to carers which at present is way in excess of the offer made by other local authorities.

The level of funding dedicated to carer-specific support will therefore be kept under review and in future years additional resource may be sought through the BCF should there be a shortfall.

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

The impact on the LA budget of the pay for performance element is not significant for the following reasons:

- The budget included some degree of protection for social care – whilst spending plans have been revised, the level of protection is not dissimilar to that originally envisaged;
- The original BCF spending plans already included significant investment in those areas which fall under 'NHS commissioned services' so spending plans have not been revised to meet the 'performance element';

- The total financial risk arising from pay for performance in relation to non-elective admission is £1xxk of which the Council may have to bear 50% - this is a maximum total of £75k. The Council has sufficient reserves to cover any shortfall in the short term;
- The risk sharing principles agreed across all partners do not expose the Council to any additional risks that it would not ordinarily have to manage.

At this stage it is too early to make a full assessment about the scale of the impact on the Council's budget of the level of funding allocated through the BCF for the Care Act as explained above.

b) 7 day services to support discharge
Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The LLR 5 year plan and ELCCG Primary Care strategy provides the strategic direction for 7 day services to ensure timely discharges at the weekends and to prevent unnecessary admissions to hospital 7/7.

Components of the Better Care Fund schemes will directly support the delivery of 7 day working, in particular;

- The Integrated Crisis Response Service, which will provide a combined health and social care service over the 24 hour period, 7 days per week, to provide an urgent health and/or social care response to avoid admission to hospital or residential care.
- Improved links for hospital discharge planning through additional Social Work capacity and Integrated Discharge Planning Teams. The development of clearer pathways for discharge and the development of joint or aligned step down facilities will help to ensure timely and appropriate discharges can be made at the weekends, including the more complex transfers where the individual would not be safe to return straight home and will include self-funders. The development of a shared Minimum Data Set between agencies will assist with ensuring discharges are safe and individual's independence can be maximised.
- Community Agents will be able to support people being discharged over the weekends and help to prevent avoidable admissions over the weekends.

Other schemes include the increased use of assistive technology, the 7 day Reablement service and joined up engagement with Independent Care providers will support the potential to undertake 7 day working.

Standard operating procedures have been developed for the ICRS to ensure clinical standards will be met and task groups are being formed to develop the pathways for the step down services. Clinical governance will be the responsibility of the Health and Wellbeing Board for the various BCF schemes.

The schemes are being evaluated to inform their future development. Year one milestones will be about developing the future integrated models by making use of

existing services and building on them as evidence becomes clear as to what elements of the service will make the most impact. It is anticipated that some of the additional resources in year two will focus on extending what is shown to be working well to cover 7 day working.

The risks to 7 day working locally will relate to low volumes, due to the size of the population, meaning that it would not be viable for all services to operate over 7 days. Creative design of the services, such as the plan to combine the social care crisis response service with the Reablement service will help to ensure a good range of options for discharge and to avoid admissions are still available.

The risk of sufficient Independent Provider services will need to be managed but the better alignment of contracts between health and social care will help to assist with this difficulty.

7 day working will have a positive impact on both reducing admissions at the weekends and supporting discharges.

c)Data sharing

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

Rutland's initial target is to have 50% of social care records containing the NHS identifier by 31st March 2015.

Progress made to date in relation to the primary identifier:

The NHS locally already uses the NHS number as a primary identifier.

Rutland has a significant challenge ahead to deliver both the requirements of the Care Act and health and social care integration more broadly. This is due to the capabilities of the existing system that the Local Authority uses.

Scoping work has taken place to fully understand the options and requirements necessary to match the NHS identifier to social care records. It is possible to migrate data into RAISE (RCC's current case management system) however there is a difficulty around validating that a specific NHS number matches to each individual social care record.

Priority actions for 2014/15:

a) The Local Authority is in the process of recruiting a "data inputter" to improve data quality associated with each social care record.
b) Data sharing agreement to be agreed between commissioners and providers.

These tasks are essential before any data matching can take place. The intention is that the new post will enter NHS records manually; this task is possible within outlined timescales due to Rutland's small population size.

Further actions required:

It is likely that the Local Authority will need to procure a new system due to the limited potential to upgrade with the existing provider. Alternative systems and providers are therefore being explored. Any new system that is purchased will have the capability to

batch-match records due to improved functionality and reporting tools.

Key risks associated with this plan include:

i. Procurement timescales for a new system
ii. Manual data entry is not a long term solution and is therefore reliant of the procurement of a system that has supporting functionality

An annexe 1 for IT and data sharing has been completed providing further detail and timescales.

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

We are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK).

Both the new Adult Social Care and home care rostering products being introduced by Leicestershire County Council have a range of open API's and XML schemas to utilise web services and re-use of interfacing code.

NHS systems used locally such as HISS (PAS); ICE, EMIS, Maracis/RiO are supportive of Open APIs and Open Standards. The main exception is the nationally contracted TPP SystmOne product.

Rutland County council are committed to provisioning GCSx secure email as part of the governments PSN secure network.

Rutland County Council are and will ensure all future systems meet the necessary application architecture for integration and data sharing protocols between all necessary providers.

At present Rutland County Councils RAISE solution for Adult and Children services does not natively support open APIs or standards, the Council are actively looking to replace this system at present.

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

We are committed to ensuring that the appropriate Information Governance (IG) Controls will be in place.

Local organisations are committed to PSN connectivity. Public Health is hosted by Leicestershire County Council which covers Leicestershire and Rutland.

NHS partners are committed to the IG Toolkit and N3 connections are covered by code of connectivity.

The majority of NHS systems are covered by the national NHS Registration Authority Chip and Pin access system which provides position based access control.

Rutland County Council is committed to and certified to the government PSN connectivity programme and on an annual basis is subject to stringent PSN IT Healthchecks to ensure conformance.

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

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

East Leicestershire and Rutland CCG utilises the Adjusted Clinical Groups (ACG) risk stratification tool to identify patients at risk of future avoidable hospital admissions at practice level.

The Integrated Care service uses this risk stratification tool with GP Practices to identify patients at risk, coordinate identified health and care interventions to reduce / manage this risk and allocate a lead professional through the MDT processes now established across the 4 Rutland practices. The health and social care coordinator role is critical to supporting this process and providing care coordination.

The Caseload per HSCC with each practice is 20 new caseloads per month per coordinator. This equates to case management register of minimum of 1% of registered list size of >18s.

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

Patients receive joint assessment, interventions and care plans per their assessed needs. Dedicated Health & Social Care Coordinator (HSCC) will arrange MDT and all preparatory work.

The MDT comprises of GP lead, HSCC, community health services and pharmacy input at risk stratification stage. The diagram attached provides an overview of the process.

In addition to the HSCC ELRCCG has invested in community health services for clinical case managers to strengthen the integrated model. the role of the clinical case managers is to work with the HSCC to identify and take on lead professional responsibilities for those patient identified that sit in the higher amber/bottom red of the Risk Stratification triangle.

Criteria used to identify patients through risk stratification:
Amber section of risk strat
>60 yrs

3 or > LTCs
5 or > repeat meds
Not on active CA treatment

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

Currently as at month 3 ELRCCG have 1063 joint care plans in place. (awaiting for confirmation proportion of those that relate to Rutland)

8) ENGAGEMENT

a) Patient, service user and public engagement

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

During 2013 Rutland Health and Wellbeing board held a significant number of development sessions in order to agree a joint health and wellbeing strategy which was based on need.

The National Voices principles and definitions for integration are used as a guiding principle for the Rutland Health and Wellbeing Board.

Patient, service user and public engagement in the development of the 5 year Better care Together strategy and the Rutland BCF Plan has involved a number of channels and there has been close, ongoing involvement of Healthwatch Rutland in shaping and influencing these developments throughout.

Summary of engagement to date in support of the LLR five year plan and BCF Plan for Rutland:

- NHS Call to Action events
- The Council's consultation with the public and partners on People First; focus group sessions took place for specific users groups such as older people as well as more general engagement over a 7 week period. Feedback from consultation has been articulated in the final People First report, demonstrating a tangible link from feedback and how this has been translated into recommendations for the Directorate including health and social care integration.
- In order to engage further on the specific BCF plan proposals we also held a stakeholder event with attendance from Healthwatch on 30th April. The purpose was to seek feedback on the progress to date with the Joint Health and Wellbeing Strategy and the emerging proposals in our BCF plan.
- Public engagement events for the LLR five year strategy during 2014 have included launch events in May/June and open public meetings in August as part of the review phase for the draft strategy.
- Healthwatch Rutland AGM was held in July 2014 – this was open to the public and provided an opportunity to let people know about its plans as well as the health and social care context.
- Healthwatch Rutland hosted a Better Care Together Engagement event on 5th August 2014, open to the public, this included a slot regarding Rutland's plans locally
- East Leicestershire and Rutland CCG AGM took place on 2nd September providing the chance to find out how ELR CCG is meeting the challenges facing the NHS, how it has been performing in its first year and what plans it has for the future. There will also be the opportunity for members of the public to ask questions.

Ongoing engagement plans

- The Transformation Team is in the process of developing a communications and engagement plan which identifies a range of channels and mechanisms for engaging on the specific changes affecting health and care services in the county of Rutland.
- Ongoing communication and joint working is taking place to deliver schemes within the BCF, for example Project Manager for Reablement, Crisis Response and Assistive Technology is working closely with Leicestershire Partnership Trust to ensure plans are aligned and developed jointly.
- The Project Manager has been engaging with Peterborough Hospital to ensure operationally there is an awareness regarding Rutland's BCF and how the two areas can work more closely.
- The LLR Better care Together Programme has an established PPI working group with an ongoing communications and engagement plan
- The Rutland Health and Wellbeing Board complies with the Public Sector Equality Duty and will ensure it gives 'due regard' in its decision making to the outcomes from public consultations and associated Equalities and Human Rights Impact Assessment.
- The Local Authority is holding a joint event with Healthwatch Rutland on 10th September, this event will have a specific focus on Dementia issues in the community – this will inform the development of a new jointly commissioned dementia service from 2015.
- A webpage outline Rutland's BCF is live; there are plans in place to extend this to include the broader Transformation Programme.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

The main providers engaged in the developed of the plan are:

- Peterborough Hospital – patient shift is from Peterborough
- University Hospital Leicester (UHL) – acute provider that is commissioned by ELRCCG
- Leicestershire Partnership Trust (LPT)

Provider engagement regarding the original submission in Spring 2014 and the final draft resubmission document has taken place via the Integration Executive on 4th September, providers in attendance included Peterborough Hospital (acute), Leicestershire Partnership Trust (Community Health Services), Healthwatch Rutland and Voluntary and community sector representation.

ii) primary care providers

There are 4 primary care providers in Rutland:

- Uppingham Practice
- Oakham and Market Overton
- Empingham Practice
- Ketton Practice

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

There is a Health and Social Care Forum that is administered by Voluntary Action Rutland; all health and social care related voluntary sector organisations are invited to join this forum. Both the Local Authority and health providers regularly use this forum as a vehicle for engaging the sector on key health and social care related issues. This Forum has a seat on both the Health and Wellbeing Board and Integration Executive.

There have been a number of key opportunities to engage the sector more substantially over the past 9 months, for example:

During People First consultation over 40 organisations attended a stakeholder workshop hosted by RCC. The majority of organisations in attendance were from the Voluntary, Community and Faith Sector.

An engagement event between the CCG, Local Authority and the sector took place on 18th July to discuss the role of the sector in delivering the prevention and intervention agenda .Organisations in attendance included:

- Voluntary Action Rutland
- Citizens Advice Bureau
- Spire Homes
- Healthwatch Rutland
- Age UK
- Alzheimer's Society
- Macmillan
- the Red Cross

There is willingness from the sector to be engaged and transform the way in which they work with communities in Rutland to meet changing need.

Rutland Domiciliary Care Providers are invited to a forum on a bi monthly basis, at its last meeting on 16th July 2014 providers were engaged on People First with specific discussion around the move to integration including the launch of the health and social care protocol, including an invitation to be involved in the 3 year training programme/rollout.

A "Strengthening Partnerships" event hosted by Rutland Community Spirit (the Rural Community Council) on 8th August. This was an opportunity for health, public sector, the Local Authority and Voluntary and Community Sector professionals to better understand what services were available in the community. The event was successful, it is anticipated that similar events are run frequently.

It will be important to continue to engage with all partners regarding what services are available now and in the future, so that citizens can easily navigate there way through the system. An information and advice workstream is in the process of being set up which will be aligned to the community agents scheme and Care Act agenda, partnership representation will be crucial in ensuring there is a joint, integrated response to information provision in the future.

A Launch event for the "Rutland Hub" (Crisis Response service) took place on 19th August, engaging and advising operational managers across health and social care on the operating procedures associated with the new service.

c) Implications for acute providers

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

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

This section is still to be completed - Text being populated based on the 1911 emergency admissions figure for the county for sign off with CCGs and UHL.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

confirm and challenge
Better Care Together info on workforce
Parity of esteem for mental health

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.

Scheme name

What is the strategic objective of this scheme?

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

What are the key success factors for implementation of this scheme?

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Information is currently being collated for the template, this template will need to be completed 3 times (once for each provider i.e. Leicestershire Partnership Trust, Peterborough Hospital and University Hospital Leicester

Name of Health & Wellbeing Board	Rutland Health and Wellbeing Board
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	