Report to Rutland Health and Wellbeing Board

Subject:	**Better Care Fund: Learning Disability Proposal to reallocate scheme funds**
Meeting Date:	**27th January 2015**
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Presented by:	**Vicky Todd/ Katy Lynch**
Paper for:	**Approval**

1. Introduction:

The purpose of this report is to present the Health and Wellbeing Board with a revised plan for the Better Care Fund Learning Disabilities (LD) Scheme as supported by the Integration Executive.

This proposal sets out the rationale for why a new proposal is required to supersede the existing LD draft business case, and identifies other opportunities for spend within the BCF in order to maximise the impact of the BCF on the health and social care system.

The key message within our approved BCF plan relating to LD is around better coordination of care for people with Long Term Conditions which includes those people with LD; this revised proposal continues to support this objective.

The current allocation for LD as approved by the Health and Wellbeing Board and outlined in the BCF plan is £84k for 2015/16.

The BCF plan was approved by the Health and Wellbeing Board in 2014 although Business Cases for individual schemes within the plan still needed working up and presenting to the Board; it was agreed that any amendments to the plan including re-allocation of scheme funds and developed Business Cases must be approved by the Board.

2. Recommendations:

That the Health and Wellbeing Board:

1. Approves the plan to discard the existing Learning Disability Scheme stated in the approved Better Care Fund Plan which includes an “Out of County Link Worker”.

2. Supports the plan to incorporate support for those with LD into a number of planned schemes as follows:

a) Assistive technology (Business Case being presented to Health and Wellbeing Board 27th January 2015)

b) Community Agents

c) Integrated Dementia Pathway (Business Case being presented to Health and Wellbeing Board 27th January 2015)

3. Agrees to reserve a small proportion (£10k) to support developments within Better Care Together linked to LD.

4. Agrees to redirect the remaining allocation of £74k to new scheme(s) that will have a greater impact on the health and social care system.

5. Agrees to receive a progress update at the next Health and Wellbeing Board meeting on 24th March 2015.

3. Reasons for Recommendations:

The aim of the original LD scheme was focussed around employing an Out of County Link Worker, to work with service users who are placed out of county (Rutland) as well as to work with those service users who are placed in Rutland by another local authority, this was to ensure improved co-ordination amongst services both within the host authority and placing authority. Following further consideration with health and social care colleagues this scheme has not identified a moderate or high impact on any of the BCF metrics[1] other than improved patient user experience.

Joint working with Health

Feedback from the Integration Executive in November 2014 highlighted the need to further develop the scheme to strengthen work regarding personal budgets, integrated commissioning and personalisation. The number of individuals with LD in Rutland, in receipt of full or joint packages of care with health are low; the breakdown of individuals with LD supported with packages (as understood by RCC) is as follows:

Local Authority supported	Fully Health funded	Joint packages
57	6	7

It must be noted that all joint funded packages of care are managed by the Local Authority, and Rutland is not part of any pooled budget arrangement for LD commissioned services with health or any other organisation.

Rutland has no one on the Winterbourne register however Rutland is fully engaged in the Leicestershire, Leicester City and Rutland (LLR) Winterbourne Group.

[1] BCF metrics include: Permanent admissions of older people to residential care, proportion of people still at home following a reablement service, delayed transfers of care from hospital, hospital admissions for injuries due to falls and improved patient experience

Fortnightly Multi-Disciplinary Team meetings take place between the community learning disability team (Leicestershire Partnership Trust) and Adults LD social care team (RCC), to discuss any Rutland cases which require joint working; this is beneficial to both organisations.

Better Care Together
There is limited specialist support available locally for people with complex needs which results in placements being commissioned out of the county. Additionally, due to the relatively low numbers of commissioned placements, the council has limited 'leverage' in negotiating down costs. Residential placement costs vary widely depending on individual need. For example, we have 2 placements in excess of £2000 per week and others which are in the region of £400 per week. A very rough calculation based on the number of people in residential care (20) divided by the total cost of placements results in a cost per user of approx. £48,000 per annum.

Rutland is represented on the Better Care Together LD work stream. There are plans within this work stream to fund:

- An LLR project officer to support market development including an analysis of funding
- The development of a comprehensive market position statement to be undertaken by Oxford Brookes University

It is anticipated that this will be funded from BCT however there may be a short fall in the interim, leads have been asked to explore whether Local Authorities across LLR would be willing to fund this work if funding does not materialise.

The presence of LD initiative's across other BCF plans
LD is not a common theme being picked up across other BCF plans, exemplar plans have focussed on:

	Scheme	**Description**
1	Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
2	Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
3	Intermediate	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions

	Scheme	Description
	care services	avoidance, early discharge.
4	Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
5	Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non-essential healthcare skills. Admission avoidance, re-admission avoidance.
6	Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7	7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
8	Assistive Technologies	Supportive technologies for self-management and telehealth. Admission avoidance and improves quality of care

Comparative work has been undertaken to understand what neighbouring Local Authorities have put in their BCF plans linked to LD:

Nottinghamshire	Community based care services for younger adults with complex health care Needs. These aim to meet increasing demand for large complex packages of care to support people with LD to remain living at home. The services also enable carers to maintain their employment and to have a break from their caring duties.
Leicestershire	In September 2014, an Integrated Personal Commissioning (IPC) prospectus was published which is in the process of being reviewed and discussed by the Leicestershire Integration Executive. The IPC will build on work already commenced to extend personal budgets for health and social care for four defined groups: 1. Children and young people with complex needs. 2. People with LD. 3. Mental health service users. 4. People with long-term conditions – in particular frail, elderly people.

Alternative options
The recommendation to the Health and Wellbeing Board is to consider all options below as the approach to supporting those with LD through the Rutland BCF:

a) Identify other schemes that would contribute to the BCF metrics not currently outlined in our plans

There are a number of potential ideas for how this BCF allocation could be spent which would have greater impact on the BCF metrics, particularly in terms of keeping people out of hospital. For example work with care providers on the issue of falls; the Integration Executive has invited a more detailed proposal on this matter for the Board to consider in February 2015. If this proposal is accepted then funding from the BCF would need to be identified; it is recommended that £74k of the £84k is reallocated to other projects.

b) Incorporate support for those with LD into the Community Agent model

Given the local picture and support provided to people with LD, it is recognised that there could be better coordination of support for individuals. The planned Community Agent service will be able to work with people who have mental health problems, learning difficulties or disabilities and autism but have a low level of need. Community agents will support the preventative agenda by supporting these people as a potential alternative to services commissioned by Adult Social Care.

Community agents will be able to work with disabled people, older people and transition cases that fall below the adult social care eligibility thresholds but may have a low level of need due to a mental health problem or LD. The support provided will promote peoples independence reducing the need for specialist health and Social Care services. Those people whose needs increase can then be referred to Social Care by the Community Agents if necessary.

It is anticipated that there will be no additional cost associated with this plan.

c) Expand the Assistive Technology service to cater for those with LD living in the community

The personalisation agenda, Valuing People and Winterbourne Concordat are all drivers for supporting people with LD to develop and maintain their independence and continue living in their own homes. The Assistive Technology service supports this aim.

Assistive technology can reduce the need for commissioned support for those with LD representing increased value for money whilst maximising the independence of the individual concerned.

There is a gap in terms of awareness raising and uptake of Assistive Technology therefore this scheme would aim to publicise the benefits.

It is anticipated that there will be no additional cost associated with this.

d) Ensure that people with LD are supported pre and post diagnosis of having dementia

The prevalence of early onset dementia is higher in people with LD. The planned integrated dementia pathways scheme will support those with LD who have been identified as having dementia, and provide that much needed support to individuals and carers to develop coping strategies, and make sure those working with LD are equipped with the right information and advice to allow individuals to live independently.

It is anticipated that there will be no additional cost associated with this.

e) Support LD activity within the BCT programme

As outlined in this report, Rutland does suffer from an under developed market of LD providers and the work being undertaken around this as part of BCT will be of benefit to Rutland health and social care services.

The Health and Wellbeing Board is recommended to reserve £10k from the £84k allocation to support market development.

4. Next Steps

If the Health and Wellbeing Board supports this proposal, an alternative plan for spending the remaining £74k will be reported to the Board at its meeting on 24th March 2015.