Report to Rutland Health and Wellbeing Board

Subject:	**Better Care Fund programme 2017-19**
Meeting Date:	**5 December 2017**
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Presented by:	**Mark Andrews**
Paper for:	**Noting**

1. Introduction

1.1 The purpose of this report is to update the Health and Wellbeing Board on progress with the 2017-19 Better Care Fund programme.

2. Better Care Fund 2017-19 Programme approval process and timetable

2.1 Following approval by the Rutland Health and Wellbeing Board, the 2017-19 Better Care Fund programme was submitted for national moderation on the national deadline of 11 September 2017. Possible outcomes were: approved, approved with conditions, or placed in escalation.

2.2 The assurance process checks that plans meet all key lines of enquiry:

- Meeting the national conditions.
- Setting out the required metrics including the delayed transfers of care trajectory.
- Having agreed a spending plan for the Improved Better Care Fund grant.
- Setting out a vision and progress towards fuller integration of health and social care by 2020.
- Having in place a robust approach to managing risk to plan delivery.

2.3 As reported to the HWB in September 2017, Rutland's BCF programme was initially at risk of being 'approved with conditions' because its proposed Delayed Transfer of Care (DToC) targets, agreed by the local partnership and HWB, diverged from the Department of Health expectation targets.

2.4 The divergence was proposed to ensure that local targets were realistic and not solely benchmarked against February DToC levels which were anomalously low for Rutland.

2.5 The Council was subsequently notified that all programmes not agreeing to their expectation targets would be placed in escalation by the national moderation process. As this could have affected the flow of funding this year to the £2.1m programme, much of which now supports 'business as usual' activity, a counter proposal was made in October which set out a downward trajectory of DToCs from the July level down to the expectation level in the key monitoring month of November.

2.7 The Council has been notified verbally by the Better Care Support Team that the programme has been approved on this basis. Formal written confirmation is anticipated.

2.8 The programme's risk management framework has been updated to reflect the potential risk to future Improved BCF funding (£168k in 2018-19) of not achieving the BCF DToC targets.

2.9 The key challenge with meeting the DToC targets is that, once DToC levels have been significantly reduced, as in Rutland, even small numbers of significantly delayed patients, which can occur at any time for a wide range of reasons, would have a significant impact on performance. Improvement to DToC levels is also unlikely to be delivered as a linear month on month reduction in delays, and this is incompatible with an approach to measuring progress which gauges performance at a single point in time.

3. Rutland BCF programme progress

3.1 The plan approval timetable notwithstanding, we are now well into quarter three of implementing the first year of the 2017-19 BCF programme. The programme has a similar structure and aim to previous years, sustaining a successful model focussed on:

- Priority 1: Unified prevention
- Priority 2: Holistic long term condition management
- Priority 3: Hospital flows (crisis response, transfer of care and reablement)
- Priority 4: Enablers

3.2 The programme has a more complex budgetary make-up than previously, with the following funding elements across two years.

Total programme size	**£2,840,542**	**£2,604,656**
Of which:		
Minimum required value of BCF pooled budget (CCG minimum)	£2,098,189	£2,138,054
Disabled Facilities Grant	£203,261	£220,732
Improved BCF – Local Authority allocation	£203,092	£167,870
Other additional contributions Of which:	£336,000	£78,000
2016-17 BCF carry-over funds	RCC £84,000 ELRCCG £110,000	RCC £55,000 ELRCCG £29,000
RCC social care grant	£136,000	

3.3 As an increasing proportion of the programme is now part of the business as usual approach to health and social care, the scope to innovate is constrained, even if learning and adjustment continues under those headings. The additional sums in the programme in 2017-19 are important in sustaining the momentum of continued innovation.

Programme context

3.4 The aim of the BCF programme is to achieve a fully integrated health and care system in Rutland by 2018. After more than two and a half years of Better Care Fund collaboration, Rutland is well advanced on its integration journey, with effective joint working on the ground across health and care teams and a fully integrated Hospital Team in place with joint leadership.

3.5 There is further to go to achieve the level of integration demonstrated by the Hospital Team in other areas, though, with scope for primary care, community nursing and the Council's long term team, for example, to connect more fully to create a more responsive, agile, seamless health and care system which is able to reconfigure and adapt dynamically in response to needs and performance feedback.

3.6 Under the STP, the wider Leicester, Leicestershire and Rutland (LLR) area is being structured into 'localities' to further progress health and care integration on the ground. A recent decision by ELRCCG that the Rutland Local Authority area will be one of six health localities within the ELRCCG area offers coterminous boundaries across health and care for the first time and is a significant step laying the foundations for moving to the next stage in the local integration journey. Other significant changes feeding into the next phase of integration maturity are the One Public Estate proposal for an integrated services hub in Oakham and for the redevelopment of St George's Barracks, and the local GP commitment to a programme of change under the 'Primary Care Home' banner.

Programme implementation

3.7 Given the delayed BCF programme development and approval timetable, a pragmatic approach has been taken so far in 2017-18, endorsed by the national BCF Support Team, continuing established BCF measures and developing and progressing new measures by mutual agreement through programme governance. This means that the programme has been able to sustain good momentum in its first half year. National instructions to spend the Improved Better Care Fund (IBCF) social care relief allocations from in the Spring Budget promptly have also been followed.

3.8 We have just submitted the Quarter 2 national monitoring return summarising programme performance over the first half year. The programme remains on track for the four mandatory national BCF metrics for health and social care (see Appendix 1), and for the local falls prevention metric.

- Mean performance across the first two quarters for **reablement success** is **91%, relative to a target of 89%,** so on target overall.
- **The rate of permanent admissions to residential care is on track**, remaining exceptionally low relative to many other areas. We are projecting to have 181 admissions per 100,000 over 65s, well within the 2017-18 target of 322, but higher than last year's low of 118.
- **Rates of non elective admissions (NEAs)** are on target at Q2, with a cumulative 3,684 days of admissions per 100,000 population, relative to the target ceiling of 4,484. Rates are projected to be similar to last year, with no net reduction, but against underlying trends of increasing admissions.
- **Rates of Delayed Transfers of Care (DToCs)** are under close scrutiny nationally, given ongoing pressures in acute care. Although Rutland is performing well against its challenging targets (on track overall, and for NHS and joint delays, but running slightly over the very low social care target), there is some volatility in DToC rates month on month which could still mean that the target in the key monitoring month of November could be exceeded. The target is just over one delay per day. The Hospital Team is working intensively to keep all delays to an absolute minimum, with parallel

work to tackle identified root causes of delays and prevent recurrence (see below).

- **The rate of injuries due to falls** was slightly over target in Q1, but is **now back on target**, with a cumulative Q2 rate of 728 per 100,000 65+ population, relative to a target of 816. Continued prevention activity is needed over the winter. Among the innovations that supporting this are growth of the FaME exercise programme and the new Housing MOT service (see below).

3.9 The following are highlights from programme implementation across the first half of 2017-18.

Priority 1 Unified Prevention

3.10 As part re the strategic approach to managing demand for health and social care services, a central tenet of the Rutland BCF programme remains to support people to maintain their health and independence for as long as possible. Under the BCF prevention priority, prevention and wellbeing services have been further developed and improved, and their promotion enhanced so that it is easier for members of the public to identify and access the right prevention services for them.

Improving prevention services – navigation and advice

3.11 Mirroring the more integrated working across health and social care, a number of community services were brought together into a single integrated Community Wellbeing Service contract in April 2017. This service, which incorporates the former Community Agents and community dementia support services as well as smoking cessation and sensory services, is delivered by the Rural Access Partnership consisting of Citizens Advice Rutland, Spire Homes and the Bridge and subcontracting partners AgeUK.

3.12 The service has been operating for seven months, embedding a new single access route into a range of prevention support that can be combined flexibly in response to the specific needs of individuals. After an initial bedding in phase, the service is progressively maturing. There were 973 new referrals in Q1, increasing to 1043 in Q2, with growth also in the proportion of self referrals. Building on the initial experience, a new website is also in development providing a direct gateway into the services.

3.13 With one-off funding, ELRCCG has also supported the development of an element of social prescribing through the 'Wellbeing Advisor Service' in Rutland GP practices. Although anticipated for all practices, and aiming to trial a number of different models of support, the service was only then put in place in a single surgery, Uppingham, where it has very much mirrored the core Citizens Advice offering (providing tangible financial and other support). Most recently, the GP practices requested a review of needs, to ensure best use of available funds for wellbeing support helping to relieve primary care demand. An options paper has been prepared for the November Integration Executive.

3.14 Alongside this newly reshaped set of services, Improved BCF (IBCF) funding has been used to establish two more specialist outreach social care posts at the County Council as part of the LLR Vulnerable Adult Risk Management framework. These posts target people who may be harder to reach but would

benefit from early preventative intervention. The posts have been successfully recruited to.

3.15 In parallel with these developments, the Council's social care front desk continues to respond positively to people who report that they need help but are pre-eligible for social care, referring them on to appropriate support, and to adapt to trends in the advice being requested (for example recently increasing the capacity to provide pre-emptive Occupational Therapist and physiotherapy support).

Promoting preventative services

3.16 To improve information flows and the profile of local support services, the local online directory of prevention and support services, the Rutland Information Service (http://ris.rutland.gov.uk), was renewed and relaunched in 2017, making the site more visual and intuitive. Since implementation in July, monthly activity on the site has increased by more than 40%. The project has also increased mutual awareness across a number of key local stakeholders of each others' prevention offering, supporting referral.

3.17 The reach of the RIS has also been increased through a 'search widget' which enables the RIS search to be embedded as an element of partner websites.

3.18 In parallel, a printed Rutland care brochure has been co-produced with service users, setting out the support options both in the community and from health and social care for people with different levels of need.

Other prevention activities – broadening the reach and sustainability

3.19 Rutland is part of the LLR falls prevention strategy which includes:

- A new accelerated pathway for falls clinical advice, which has removed the requirement for most patients to see a consultant before they can be referred to the LPT falls programme or other intervention.
- Extended use of assistive technology in care homes.
- Further development of the FaME falls exercise programme, an extended 6 month exercise programme including a social element, which improves strength, balance, coordination, confidence, bone density and muscle mass reducing the risk of falls.

3.20 Local falls prevention activity is progressing alongside this, including increasing the capacity of the popular FaME falls prevention programme by training additional instructors.

3.21 The programme had a slow start last year as it was part of a wider research exercise and required ethical clearance and accreditation of staff, followed by close monitoring of initial classes. There were early doubts whether participants would stay the course, but the physical benefits of the course and its sociable approach appear to sustained commitment and attracted new participants, with more than 50 people participating so far and potential to increase throughput.

3.22 An advanced FaME class has also been introduced for people with further potential to improve but who are not yet ready to join mainstream exercise programmes (31 participants), while seven 'graduates' of the programme have

gone on to a variety of mainstream activities including joining the gym.

3.23 AgeUK's 'Men in Sheds' is another ongoing project, offering older men in Oakham a hub for practical activities. The project has been run at Rutland Museum but is now looking for larger premises where it can expand, including by operating on more days of the week. The focus to date has been woodwork, with potential to extend to gardening. The project has connected with other community schemes, including Oakham in Bloom.

3.24 To broaden the benefit of preventative projects and increase their sustainability, a new approach is being taken to implementing the wider 'Active and connected' measure. A grant fund is being established, funded by Public Health funds and BCF to bring forward community projects from across Rutland that build on local assets to increase physical activity and reduce social isolation, while helping to tackle rural deprivation in access to services. This scheme, whose governance and terms and conditions are currently being confirmed, will run a number of calls for projects (likely to be small bids up to £1k and medium bids of up to £10k), developing a project pipeline across 2017-19.

Priority 2: Holistic Long Term Condition Management

3.25 Priority 2 is the main area of innovation in this year's programme, focussed on coordinating and evolving health and care services for people with significant health and care needs, aiming to sustain independence and wellbeing, in the process reducing non elective admissions, permanent care home admissions and falls injuries.

3.26 Alongside ongoing integrated working between health and care in the community, where the new locality definition will bring further opportunities, and continuing to deliver and refine a number of targeted services including assistive technology, dementia support (with its newly recruited admiral nurse) and a carers programme (anticipated to evolve in line with a developing LLR carers strategy), we are using additional funding this year to run a number of innovative projects.

3.27 The first project is piloting and refining a new model of personalised, holistic homecare, informed by successful innovations in Monmouthshire and Buurtzorg in the Netherlands. While the holistic homecare pilot had a delayed start due to backfilling staff, it has been live since October and is now at capacity, supporting 10 clients in a defined locality with around 70 hours a week of personalised care. The scheme is taking on complex long term clients that the market tends to struggle to provide for, and is able to step in for urgent unmet support needs. It is taking a highly personalised approach, responding to the preferences and goals of individuals, and proactively enhancing their independence and wellbeing rather than simply delivering 'time and task' care. A number of service users have already seen their care needs reduce as a result of progress made.

3.28 It is intended that care workers will also take on routine health tasks alongside their care-related activities, reducing the number of visits to individuals' homes and relieving pressure on community nursing, opening capacity for that service to evolve. Further evaluation will be taking place of this scheme before

deciding whether to roll the pilot out to further service users.

3.29 Personalisation is also a key theme in the self care measure.:2016-17 underspend is enabling a self care pilot in primary care in which practice staff will identify the personal goals of patients and offer an online toolkit enabling them to self care. This toolkit, which has proved effective in other contexts, will help to support the Rutland GPs' own Primary Care Home change strategy and will be rolled out to patients in defined circumstances to build their confidence in managing their condition(s) and/or addressing lifestyle risk factors.

3.30 Based on experience elsewhere, the project is anticipated to reduce pressure on GP services, avoid unnecessary outpatient clinic appointments, and avert non elective admissions by avoiding or taking prompt action to de-escalate health crisis.

3.31 Partners are also defining a set of joint projects around the health and wellbeing of care home residents, building on Care Home Vanguard experiences elsewhere,. These will be aligned with the wider STP Enhanced Care in Care Homes workstream.

3.32 The approach to Disabled Facilities Grants has also been rethought to increase the number of people benefitting from adaptations and the speed with which those adaptations can be delivered. A Housing MOT service delivered by Spire Homes was introduced on 1 October enabling housing issues affecting wellbeing to be reviewed more efficiently (home safety, energy, accessibility, etc), helping to sustain people living independently and safely in their own homes for longer. For eligible people, small adaptations are offered free of charge, while a new light touch non means tested Housing and Prevention grant has been introduced for adaptations under £10k. The full Disabled Facilities Grant process still applies for larger adaptations.

3.33 There is early evidence that the new approach is accelerating DFG spend. Over the first two quarters of 2017-18,£29.7k was spent on DFG funded adaptations, a sum almost equalled by spend from the DFG budget in the first two months of Q3 (£28.2k). The most frequent investments in Q3 are level access showers and hoists.

3.34 Other recent innovations include creating a therapist role who will be working with care homes to accelerate the step down of people in interim beds after a hospital stay and to increase preventative work with permanent care home residents, building up physical activity levels, improving wellbeing and reducing the need for step up services. We are also participating actively in the process to develop carer and dementia strategies to apply across the LLR area.

Priority 3: Hospital Flows

3.35 Under this priority, a new crisis response service is bedding in across the wider LLR area, aimed at identifying and providing the appropriate response in a health crisis. This service, provided by Derbyshire Health United, includes telephone triage and rapid response vehicles.

3.36 Capitalising on the changing crisis response arrangements, a workshop has

been run locally involving EMAS, RCC, ELRCCG, LPT and the community and voluntary sector to review the handling of emergency callouts and to identify ways that some types of call could be handled differently, potentially increasing the use of DHU services to free up EMAS capacity to respond to EMAS-only calls. This new approach could also reduce admissions.

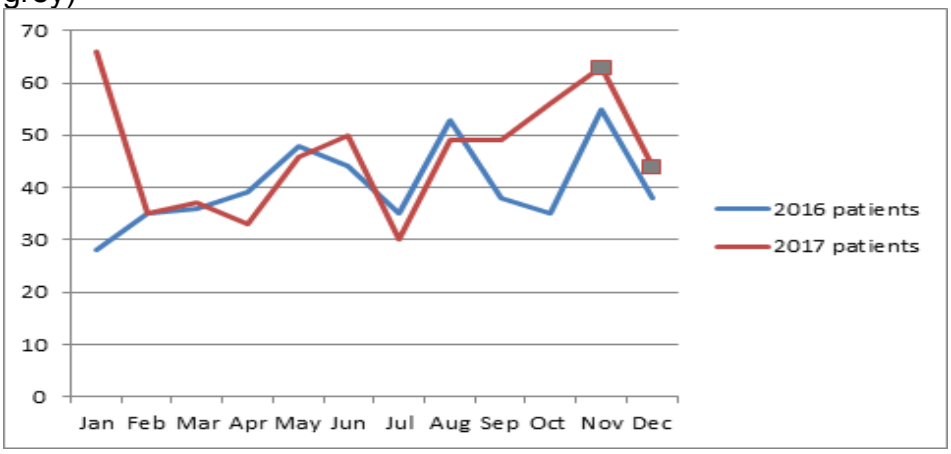
3.37 Alongside this, very proactive work continues to keep delayed transfers of care (DToCs) to an absolute minimum. Change plans are structured into a DToC action plan informed by the national high impact model for DToC reduction. The integrated health and care team is fully staffed and well embedded. It continues its pull model in which Rutland hospital patients are identified as early as possible, with the cooperation of relevant hospitals, and supported to move on from hospital on schedule.

3.38 We continue to take a lean-informed approach in which performance is closely monitored and the root causes of delays are identified and addressed systematically to minimise or prevent recurrence. Over time, this approach is building an increasingly resilient system based on close collaborative working with a wide network of stakeholders. A recent issue identified and tackled was a sudden growth in DToCs in Kettering General Hospital. By strengthening working relationships with Kettering, fuller information is now flowing sooner, enabling the Rutland team to intervene as needed to prevent delays. This is now reflected in DToC numbers.

3.39 Levels of DToCs are currently on track to meet Rutland's key national DToC target for November, but there is no room for complacency as even small additional delays have a disproportionate impact on performance in a small system.

3.40 The number of cases needing discharge support is also increasing, 15% up on last year (see chart), with this increase concentrated in autumn and winter. The grey points are forecast demand at 115% of last year's demand, but these figures could well be higher based on last January's level. Funding has been vired within the programme to support a winter pressures social worker to avoid volumes undermining discharge performance.

Chart: Rutland patients needing social care related discharge support (forecast in grey)

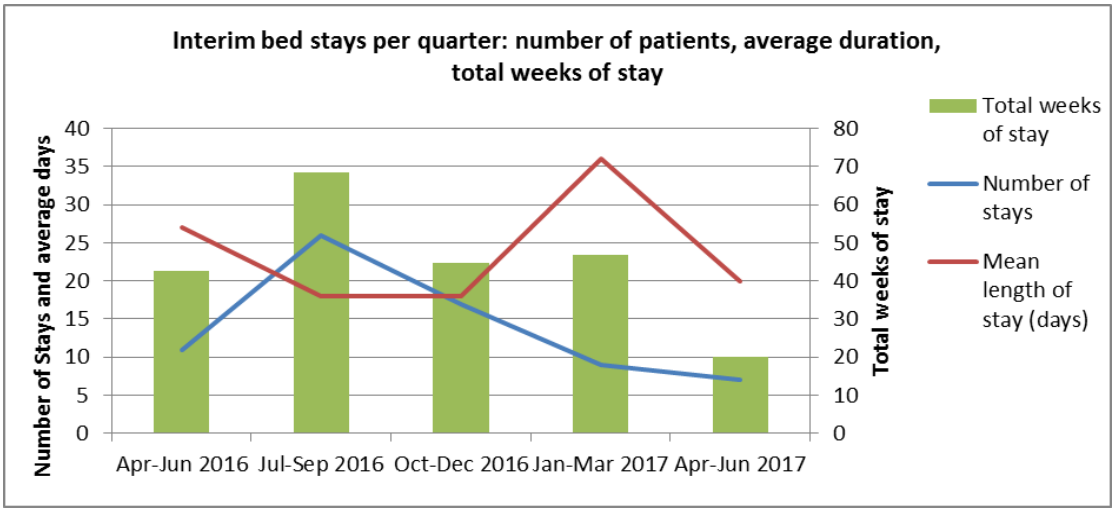


3.41 We also regularly review the success and fit of discharge pathways. A recent

piece of work reviewed progress with complex discharges, including the introduction of a complex case manager and the interim bed option, an alternative destination for those who are not yet fit to go home but do not require a sub-acute bed.

3.42 This demonstrated that interim beds offered more than £271k of net savings to the health and care system in their first 14 months of use, relative to the cost of patients remaining in acute beds (April 2016 to June 2017).

3.43 Interim beds were initially used fairly frequently, with up to 8 beds in use on any given day at the peak, but, as practice has matured, more patients are being enabled to go directly home, with interim beds only deployed for patients whose needs cannot be met in this way (non weight bearing and/or with night needs). Even though this has meant that the average length of interim bed stays has increased slightly, the shift to going directly home is potentially offering even greater savings to the health and care system, and demonstrates the value of retaining flexibility in sourcing solutions while new approaches are trialled.



3.44 As part of the step down from hospital, reablement also continues to be delivered successfully.

Enablers activity

3.45 Alongside continued programme development, management and monitoring activities, among the highlights in the enablers area have been the following:

- IBCF investment in improved IT equipment supporting mobile working by social care staff. Staff have been issued with hybrid tablet/laptop devices, changing how care managers are able to work with their clients. There is more immediate recording of assessments and increased participation by service users in those assessments. Efficiencies are also available as the devices can convert handwriting into typed text. The ability to take and annotate photographs is also helping with the quality of communication eg. where OT's are specifying equipment.

- Finally, a further user engagement study has been commissioned from Healthwatch Rutland, this time exploring the experiences of care of people

living with one or more long term conditions. This should help to inform further improvements to health and care services delivered directly in the community.

4. Conclusion and Questions

4.1 On balance, the programme is progressing well overall, with some well established care models complemented by new areas of activity, and a number of areas where, following groundwork, momentum will build over Q3-4 and into next year through specific innovative projects.

4.2 Integration is furthest advanced between core elements of community health and social care, particularly as relates to hospital step up and step down services, but with further to go in many other areas where a more traditional approach to joint working still applies. This is focussed on cooperation and coordination between stakeholders, dialogue and mutual adjustment, and a project driven programme of work. The pace and impact of future progress may depend on the ability to unblock the way now for a more profound rethinking and reshaping of services and models of collaboration.

4.2 The Health and Wellbeing Board is invited to reflect on the following questions:

- Integration has progressed at different speeds. There is potential for partners including primary care, community nursing, long term social care and the community and voluntary sector, to go further in working together in new ways, challenging assumptions about the design and delivery of services and evolving new operating models which would be simply unachievable acting alone or simply in tandem. Innovative projects alone are not the answer. What are the barriers preventing this reshaping from 'taking off'? Is there the appetite to progress more profound changes? And what can be done to invigorate this?

- How can Rutland best capitalise on becoming a single health and care 'locality' to drive forward further health and care integration? What are the next opportunities for health and social care integration?

5. Financial implications

4.1 We understand that the Rutland BCF programme is now approved, The programme is progressing well currently, largely to its financial profile.

4.2 As set out above, there is some risk that the flow of Improved BCF funding next year could be interrupted in the event of DToC targets not being met. Teams are working hard to achieve the expectation levels of DToCs.

Appendix

Appendix 1: Q2 BCF Performance Report

Recommendations:

That the board note the report setting out progress against the Rutland Better Care Fund programme 2017-19.

Strategic Lead:	Mark Andrews

Risk assessment:

Time	M	BCF approvals have taken place halfway through the first year of a two year programme, creating a risk on building programme momentum and committing and spending funds. This has been mitigated as follows: • Many programme spend lines have been continued from 2016-17, sustaining momentum. • We have acted on the national directive to agree Improved BCF plans locally as soon as possible and begin spending. There remains a risk for new actions which have not yet been committed. Groundwork has been undertaken on relevant measures to prepare to commit and get underway once the programme is approved.
Viability	L	The programme has good local buy-in across its partnership, and many activities are already in place and known to be effective. There are some dependencies out to wider programmes, eg. the LLR falls prevention programme and STP activities. Partners are also facing their respective financial pressures.
Finance	M	There is a risk that, if the stretching DTOC targets are not met, this could affect our 2018-19 Improved BCF allocation. The Department of Health have not yet confirmed the detail around how they will determine this. DTOC performance is better than most areas of the country, but sustaining the stretch targets will be challenging as there is still variation in performance month on month due to factors outwith our direct control.
Profile	M	Late approval of the new programme is likely to have reduced its profile outside directly involved stakeholders – eg. the current programme is not yet published online, pending final approval.
Equality & Diversity	L	The programme is shaped to improve health and wellbeing services and outcomes for some of the most vulnerable groups in Rutland.