Report to Rutland Health and Wellbeing Board

Subject:	**Better Care Fund Programme update: Q3 2017-18**
Meeting Date:	**6 March 2018**
Report Author:	**Sandra Taylor**
Presented by:	**Mark Andrews**
Paper for:	**Note**

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. Rutland BCF programme progress

2.1 Implementation of the Rutland BCF programme is progressing well overall, as set out below, with the main focus of new approaches being under Priority 2 (Holistic long term condition management).

2.2 During BCF implementation, well established partnership working is helping to provide continuity and bridging resilience as other system changes take place, for example the reorganisation of LPT community nursing. Meanwhile, the Integrated Locality Team for Rutland is keenly anticipated next year as a central partnership forum to progress to the next stage of integrated services.

2.3 Alongside many successful activities, there have been some challenges in the programme:

- The range of activity that the programme was able to support increased at a late stage as a result of additional funding announcements (IBCF, social care grant, additional DFG funding), including via the spring budget, and implementation capacity had to be spread across these projects. This means that, while most new activity is well underway and showing promising results, a small number of actions are being implemented somewhat behind the anticipated schedule. These are now gaining momentum and will be delivered across the overall programme lifetime.
- Not all projects have developed as initially anticipated. For example, it has been challenging to secure the nursing input in the holistic homecare project that is needed to delegate community nursing tasks to care workers. It is anticipated that this will be resolvable in the coming quarter.
- In addition, a signposting scheme was discontinued by the Integration Executive as alternative solutions had come on line that showed greater potential.
- We have seen a winter peak of hospital admissions due to falls injuries. New falls prevention measures have been added and we are reviewing further possible interventions.

2.4 PRIORITY 1 UNIFIED PREVENTION

2.5 Two new, more integrated early prevention services have bedded in:

- the integrated Community Wellbeing Service from the Rutland Access Partnership, which includes the former Community Agents, community dementia support, sensory impairment services and more; and
- a new social care preventative outreach service under the Vulnerable Adults Risk Management (VARM) framework, focussed on people who may be hard to reach and are likely to face later risk.

2.6 The discontinued service was a pilot wellbeing advice service at the GP surgery which was found to be less effective than anticipated and would be superseded by a new national scheme to develop GP receptionists as 'navigators'.

2.7 The online directory of prevention and support services, the Rutland Information Service (http://ris.rutland.gov.uk), has been further improved. Building on a 'no wrong front door' principle, a network is also being established of front line advisors and signposters to share intelligence about changing services in a more tangible way, building prevention capacity.

2.8 Falls prevention activity is evolving. The successful FaME falls prevention class, renamed 'Steady Steps', has been expanded, and we are identifying ways to increase falls prevention efforts to reach more people in the wider public or at confirmed risk.

2.9 An 'Active and Connected' grant fund is being developed to bring forward more asset based community projects from across the whole of Rutland to increase physical activity and reduce social isolation. It is taking time to establish the scheme, which will run to at least the end of the 2017-19 BCF programme; the design stage is key to ensuring the fund brings forward effective and sustainable projects.

2.10 PRIORITY 2 - HOLISTIC LONG TERM CONDITION MANAGEMENT

2.11 Alongside ongoing integrated working, a number of key projects have progressed in Q3, enabling new learning about supporting wellbeing among those with ongoing health challenges. Given the ageing population, as DToCs come under better control, this population will become a more central focus of Better Care effort.

2.12 The 'holistic homecare' pilot is fully staffed and running at capacity. This new more personalised approach to shaping and delivering homecare has been showing positive early impacts, including cases where individuals' independence has been improved through confidence building, reablement and other support, enabling a reduction in the hours of support required, or where personalised care has enabled service users to engage with support services that they might previously have refused.

2.13 Two developments are helping reduce the potential impact of housing on health:

- The Housing MOT is now fully up to speed and providing a new way to offer timely preventative support. In the first 2 months, 36 households were supported, leading to 100 instances of service delivery or referral (an average of 2.8 services each) addressing a range of challenges.
- There has also been strong demand for the new streamlined Disabled Facilities Grant for adaptations costing under £10k, the Housing and Prevention Grant (HaP). This means more people with disabilities are benefitting from simple preventative adaptations more quickly across Rutland, which we anticipate will help to reduce or delay future demand for health and care services, including by preventing falls injuries and reducing carer strain.

2.14 The Admiral Nurse is in post and reshaping dementia support services, including plans to make further use of technology.

2.15 Given their critical role, we are also looking at how to reach more carers, including through services in the community and peer support, and to ensure holistic support is available, considering the carer and the cared for in tandem.

2.16 The introduction of a self care toolkit for Rutland patients via their GP practice has been agreed and platform procurement is underway. The initial focus is anticipated to be on patients with diabetes or COPD and on video consultation in care homes.

2.17 With the focus on care homes, a partner workshop in December identified areas of collaboration, building on national Care Home Vanguard experience, with some ideas now being implemented:

- a red bag hospital process for improved continuity of care on hospital admission;
- providing care homes with access to a physiotherapist to build up falls prevention knowledge and capability; and
- improving training in end of life planning and care, also to reduce inappropriate hospital admission.

2.18 An aim of much of the above activity is to achieve more person centred care. To establish how the experience of care is changing for individuals, HealthWatch Rutland has been commissioned to undertake a listening exercise under the BCF 'Enablers' priority to understand the recent care experiences of people living with long term conditions. It will report back to a panel of stakeholders in early March, which will highlight potential avenues for further improvement in 2018-19.

2.19 PRIORITY 3 - HOSPITAL FLOWS

2.20 Complementing established crisis response services, local work is looking at how we can reduce numbers of EMAS ambulance callouts, including for mental health related escalation where there may be more effective alternatives and for falls without serious injury, which have long wait times associated that can impact on prognosis.

2.21 In parallel, very proactive work continues to minimise delayed transfers of care (DToCs). This enabled the very challenging DToC expectation target to be met in November, with a rate of just 2.6 DToCs per 100,000 adults per day.

2.22 In recognition of the success of local approaches to discharge management, Rutland was recently invited to share its practice at London and Manchester NHS Improvement learning events as part of the Emergency Care Improvement Programme (ECIP).

2.23 The established integrated discharge team continues to operate a pull model in which Rutland patients in surrounding hospitals are identified early and supported to move on from hospital as soon as medically fit for discharge, with follow-on services in place. We continue to take a lean approach, addressing the root causes of delays to minimise or prevent recurrence:

- The growth of DToCs in Kettering General Hospital in June-July has been fully resolved by strengthening working relationships.
- A new discharge pathway in Lincolnshire now means that having a Lincolnshire GP does not mean a Rutland resident will wait longer for discharge.
- Capacity in the discharge team was increased pre-emptively in anticipation of winter pressures.
- We are currently seeing an increase in delays with a mental health dimension which would benefit from further reflection.

2.24 Supporting integrated discharge, the planned integrated assessment form has now been built under the Enablers priority to support efficient single assessment of patients in preparation for discharge.

3. Programme performance

3.1 The BCF programme remained on track in Q3 against the four national mandatory BCF metrics for health and social care (see Appendix 1). However, the local falls target is being exceeded.

- Quarter 3 performance for **reablement success** is **93.3%, relative to a target of 89%**.

- **The rate of permanent admissions to residential care is on track**. We are projecting to have 196 admissions per 100,000 over 65s, well within this year's target of 322, but higher than last year's low of 118.
- **Rates of non elective admissions (NEAs)** are on target, with a cumulative 5,518 days of admissions per 100,000 population, relative to the target ceiling of 6,624. 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)** have been under continued scrutiny nationally. A risk was highlighted to the Health and Wellbeing Board in 2017 relating to the level of ambition of DToC targets being asked of the local BCF programme. Through concerted effort, however, the extremely challenging 'national expectation' target for Delayed Transfers of Care was successfully met for November 2017. While the overall trend in DToCs is downward, DToC rates continue to vary considerably month on month as new issues arise, with a significant increase seen again in December. The December peak is under investigation now, and appears related to delays with a mental health dimension where it can be difficult to find patients a suitable onward destination.
- **Rates of falls injuries are running at 109% of target**, with a cumulative total of 1329 injuries per 100,000 people aged 65 and over by the end of Quarter 3, relative to a target of 1224.

3.2 There continue to be discrepancies between locally signed off DToC numbers and those reported nationally, with higher than actual numbers reported for November and December. While local negotiation continues to ensure that numbers reported nationally are aligned with those agreed locally, the issue is being addressed from February onwards through a new national approach to local sign off across health and social care which is supported by the Local Government Association.

4. Financial implications:

4.1 The programme is on track overall in terms of implementation and therefore also spend, although some measures are running behind the planned schedule. These are often new activities which awaited formal 2017-19 programme approval or were being implemented alongside other new measures.

4.2 A smooth transition into the 2018-19 phase of the current programme will help to sustain delivery momentum, and associated funding for delayed actions will be rolled forward. There will be an opportunity to review the distribution of funding across measures as we move into the next programming period (see section 5).

4.3 There is currently no risk of loss of elements of next year's funding due to performance.

5. BCF 2018-19

5.1 The current BCF programme spans the two year period 2017-19. Guidance is currently awaited from NHS England to support a light touch review of the programme's targets and measures going into year 2.

Recommendations:

That the board:

1. Note the contents of this report.

Strategic Lead:	Mark Andrews

Risk assessment:

Time	L	
Viability	L	
Finance	L	
Profile	L	

Equality & Diversity	L	