Appendix A: BCF Programme Progress and Performance 2018-19

1 PROGRAMME PROGRESS 2018-19

PRIORITY 1: UNIFIED PREVENTION

1.1 The focus of the Unified Prevention priority has been on ensuring people can access relevant advice and support early to sustain their health and wellbeing and delay the onset or progression of health conditions and social care needs. Actions under both Priorities 1 and 2 of the programme have sustained Rutland's long-standing focus on prevention (spanning primary prevention - preventing disease, secondary - early intervention, and tertiary - reducing the impact of living with disease). The prevention focus is essential to managing demand for health and care services well into the future, a priority which is strongly evident in the NHS Long Term Plan (2019). The approach taken in Rutland coincides with recent Public Health England guidance (Health matters: Prevention - A life course approach, 2019) which underlines the need to respond holistically at each life stage or transition, rather than addressing individual issues or conditions in isolation.

a) Building on previous work to enhance the Rutland Information Service online directory (https://ris.rutland.gov.uk), the communication of available support was enhanced last year through two issues of a new care and wellbeing brochure 'Living well in Rutland' distributed via GP surgeries, libraries and front line advisors. This publication has been praised by the NHS Clinical Lead for Health and Social Care Integration as a practical and positive self help resource (**measure 1.1**). In parallel, Rutland Healthcare's new 'hub and spoke' website (https://rutlandhealth.co.uk/), which aggregates local and national health and self care information, is now live in all Rutland practices, again praised by NHS England as an innovative model.

b) In its second full year, the integrated Community Wellbeing Service (CWS) delivered by the Rutland Access Partnership has strengthened its public profile and matured its approach to offering a menu of support to individuals via a single front door (including healthy lifestyles, emotional and financial wellbeing, housing issues and ageing well) (**measure 1.2**). In parallel, RCC's rapid response social workers have enabled a consistently fast turnaround where people come forward in circumstances entailing urgent social care need or risk (**measure 1.2**). Further substantive services supporting prevention are set out in **Priority 2**.

c) The above services are elements of a much broader information, advice and support network across Rutland. Public Health in Rutland is leading a participative project to enhance and coordinate 'social prescribing', promoting a 'no wrong front door' approach. This involves key public sector funded front-line advisory services establishing a joint cooperative model, making the routes to support more visible and support more consistent, wherever it is requested. This harnesses the combined

expertise of over a dozen existing advisors plus the forthcoming Primary Care Network social prescribing role which will be provisioned locally under the NHS Long Term Plan.

d) The Healthy Rutland Grant scheme, part-funded by the BCF, is fostering sustainable ideas from groups or communities across Rutland, offering them modest kick start funding. This has included funding for equipment for Junior Parkrun, and a gardening and food project 'Plot to Pot' (measure 1.3). Across two funding rounds, the number and quality of applications has increased as has the range of applicant organisations. The process of bidding is in itself growing community capacity, building up essential skills in understanding needs, planning interventions and considering sustainability and the cost-benefit equation.

2 PRIORITY 2: LONG TERM CONDITION MANAGEMENT

2.1 In common with Priority 3, a significant amount of the funding under Priority 2 is allocated to roles in mainstream health and social care teams whose integrated working is now very much business as usual, and who are continuing to evolve how they work together to better serve local needs.

a) Strong demand continued for the Housing MOT scheme and Housing and Prevention (HaP) grants (**measure 2.5**). 57 HaP projects and 5 larger DFG projects were delivered in 2018-19. The total cost was £353k, offering a significant preventative impact for 62 Rutland households. The additional spend beyond the 2018-19 DFG budget of £220k and the £29k DFG uplift was met by the winter pressures social care grant and a contribution from RCC reserves. The DFG allocation for 2019-20 has been confirmed as £238k, an uplift of £18k from last year's basic allocation. Demand will be monitored closely in 2019-20 and prioritisation approaches considered.

b) Five members of the expanded Admiral Nurse led carer support team are in place (carer support, Integrated Care Coordination and dementia support (measure 1.2, 2.1, 2.5). A first review of early progress against the dementia and carers strategy delivery plans has been conducted to take stock and adjust where required. A key finding is how well embedded the team has become into the wider health and care network over the last 6-9 months, ensuring timely inputs improving the care and wellbeing of some of our most vulnerable citizens.

c) Allied with this, ELRCCG has confirmed its go-ahead to introduce a preventative Mental Health role for Rutland, including to better support those whose mental health is affected by living with complex health challenges. This role will be recruited for 2019-20 and will work closely with the GP practices for case finding.

d) The Vitrucare GP self care pilot ran for most of 2018-19, gathering around 100 participants living with diabetes or hypertension. However, owing to extended technical issues outwith the control of the supplier, momentum

was lost and Rutland GPs opted to end the pilot (measure 2.2). In parallel, success was achieved in working with pre-diabetic and diabetic patients using education and proactive follow up. There is an opportunity to build on this experience in the next programme, and also to capitalise on new self care options, for example, the national NHS App which has been launched locally, and an NHS 'app store' in place with clinically approved self care tools.

e) Extending the MICARE complex care service to a second part of Rutland was delayed due to recruitment issues, but is now being progressed in the East of the county, where it is also being used to build effective collaboration with Stamford health colleagues over the border with Lincolnshire (measure 2.3).

f) A local digital falls prevention trial has been agreed, where the same electronic devices will be used for falls risk assessment across Council reablement and therapy teams and LPT's falls programme. Implementation has been awaiting completion of an integration between the QTUG devices and SystmOne, the GP case management system, as this offers wider benefits than stand-alone assessments. Further falls prevention interventions are at the planning stage, with collaboration with the Fire service also being considered for falls prevention and response. Meanwhile, the care homes personalised falls prevention trial is complete and being written up, with some promising learning which will be rolled out to other homes, addressing residents as individuals rather than developing approaches at the level of the home.

g) Also targeting the most complex patients, we have enhanced the use of digital tools by care providers to access health information via a wider project. Four homes have completed NHS Information Governance accreditation and can now access NHSmail. Two homes plus MICARE and RCC Supported Living are also looking to become users of the SystmOne Electronic Patient Record care homes module, conditional on agreement to this by relevant Rutland GP practices. Information Sharing Agreements are being brokered by L-HIS (measure 2.4).

3 PRIORITY 3, HOSPITAL STEP UP AND STEP DOWN

3.1 Priority 3 is largely focussed on staffing and services associated with hospital discharge and reablement, with effective teams now very much business as usual.

a) After a challenging start to the year, to ensure prompt discharges, social care winter pressures funding was used to increase assessment capacity. Changes were also considered to improve the resilience of discharge pathways by ensuring there is a nominated 'lead coordinator' supporting each stage of a patient's transfer of care, with a clear process of 'passing the baton' at the appropriate time to the next lead professional.

b) Local data validation is improving steadily, but still with regular disparities between locally agreed and nationally reported data (the 'Sitreps') - see Section 3 below.

c) Reablement, enriched by wider signposting and referral activity to related schemes supporting different aspects of independence, delivered excellent results this year in terms of avoiding hospital readmission.

4 PRIORITY 4. ENABLERS

4.1 Priority 4 is for enablers – or interventions helping to underpin programme-led change - including funding for programme support, which also enables the programme to participate in LLR-wide strategic work around the enablers, analytics, support for Information Governance assurance and IT change. A key project this year has been an NHS Digital pilot project to allow Adult Social Care access to the GP Summary Care Record, accelerating social care assessment.

5 PROGRAMME PERFORMANCE IN 2018-19

5.1 Whole year BCF performance data is set out in **Appendix B: Performance report**. Five metrics were tracked across the year to capture BCF performance at a high level.

5.2 Performance was positive for the prevention-related indicators in 2018-19, but with some challenges.

a) **Sustaining independent living:** Rutland has been able to sustain its low numbers of people entering Council funded residential care, instead working to enable people to remain living at home where this is their wish. Numbers of people entering permanent council funded residential care were on track overall, with the ceiling target exceeded by just one admission, or 4% (29 relative to a target of 28). Relative to last year, this was the same number of admissions, against a rising population of over 85s. Care home admissions remain low compared with most other areas, with 0.3% of the over 65 population permanently entering residential care this year. This was 293 per 100,000 over 65 population.

b) **Avoiding hospital admission:** In 2018-19, the number of hospital admissions was 20% lower than the ceiling target set by the CCG based on the local population. While this is very positive, numbers of non elective admissions are growing, and faster than previously, with growth of 10% this year relative to last, in spite of a range of interventions that we would anticipate having a positive impact on admission numbers. As part of the Locality Pilot, stakeholders have been identifying actions across primary, social and community care to reduce numbers of (particularly) frail and complex individuals needing to be admitted, including during end of life care.

c) **Avoiding falls injuries.** Falls injuries in the over 65s ended the year 9% above the ceiling target overall, but had been improving steadily across 2018-19. They were at or below the ceiling target from December to March. Work under the Locality Pilot therapy workstrand is broadening and strengthening the falls prevention response (see above).

5.3 In the step down from hospital, timeliness of hospital discharges has returned to target levels after a difficult start to the year, while reablement performance was excellent.

a) **Avoiding delays to hospital discharge.** It has been a mixed year for the timeliness of transfers of care from hospital. On paper, the aggregate target for the year was exceeded by some 27%. However, this overstates the actual situation: some delays misallocated to Rutland could not be rectified after the event due to technical constraints at one of the trusts. Positively, while the early part of the year saw higher than usual DToCs, performance improved steadily over the latter part of the year, bringing DToC levels back well within the challenging NHS ceiling target by the end of the year (March's DToCs were 33% under the monthly target). DToC issues continue to evolve month on month and to be followed up proactively as they arise.

b) **Reablement**: in Quarter 4, 97% of those who received post-hospital reablement services were still at home 91 days later, against a target of 90%. Reablement enables people to learn new ways to accomplish daily tasks that have become more difficult as a result of health challenges. Reablement success is an important measure of the ability to optimise people's independence following a hospital admission. Increasingly, reablement is combined with other relevant interventions such as a Housing MOT or connection to the Community Wellbeing Service or similar where there are other challenges such as the impact of social isolation on psychological wellbeing. This also contributes to positive post-hospital outcomes.