Appendix C: Summary of proposed Rutland BCF priorities 2019-20

The programme set out below is still indicative pending further local stakeholder engagement and final confirmation of the BCF guidance, budget and templates.

1. Priority 1: Unified Prevention, including social prescribing and wellbeing services

1.1 It is proposed to sustain the prominence of prevention measures in the programme, also aligning with the increased emphasis on prevention contained in the NHS Long Term Plan, but with a clearer divide between earlier prevention activity under Priority 1 and secondary and tertiary prevention under Priority 2.

Priority 1: Potential 2019-20 Measures

Priority 1: Unified prevention		Indicative source	Budget
1.1 Healthy Rutland Consolidated 1.1 and 1.3 to a single measure. Refocused to support NHS Plan, building on local assets	**A. Multi-sectoral collaborative social prescribing model for Rutland** • **Collectively, deliver a visible, accessible and effective signposting and prevention service**, networking Rutland's social prescribers including in primary care to refer citizens at the right time to Rutland's prevention and wellbeing services. Using online resources to best effect directly and via advisors. Shared tools including a secure, efficient referral mechanism. Making every contact count for healthy lifestyles. • **Front line wellbeing signposters and service providers network** to share intelligence ongoing, enhancing prevention. • **Promote Rutland's wellbeing offer to the public** in ways that support self help and self care. **B. Raising healthy life expectancy by increasing healthy lifestyles, linking to GP prevention** • **Develop community capacity**, building on community assets, including via the Community Wellbeing contract. • **Encourage community-led approaches to supporting healthy lifestyles**, also to tackle health inequalities, considering approaches such as Healthy Rutland grants and skills exchange. • **Falls prevention** in the community **Parallel activity:** NHS Long Term Plan prevention focus, including PCN social prescribing.	RCC BCF & RCC (carry over)	£63k

1.2 Prevention and Wellbeing Services Ongoing and new elements. Dementia actions now grouped in P2.	**Enhanced prevention support:** A. **Community Wellbeing Service, Rutland Access Partnership** B. **Adult Social Care rapid response,** targeting hard to reach people at risk and urgent needs, with a prevention focus. **Parallel activity:** GP priorities of reducing inequality, prevention, early diagnosis.	RCC BCF RCC (i-BCF)	£147k £77k

2. Priority 2: Coordinated care for health and wellbeing

2.1 The focus of the locality pilots has been on primary, community and social care and the voluntary and community sector working effectively together in a defined area to support the health of people living with multiple long term conditions – including encouraging and enabling self-care. This priority aims to sustain and enable that innovation, to embed holistic, person-centred care models that help to maintain wellbeing, independence and quality of life for those with significant health and care needs.

Priority 2: Potential 2019-20 Measures

Priority 2: Coordinated care for health and wellbeing		Indicative source	Budget
2.1 Support services sustaining wellbeing and independence in the community Ongoing, grouped for more holistic response.	**Support helping individuals and their carers to live well with ill health, sustaining wellbeing and independence**: • **Living well with ill health:** Dementia care support (Admiral Nurses and dementia services), carers support • **Mental health outreach worker** linking to the GP surgery, and addressing challenges associated with life change and ill health. • **Falls prevention** interventions for people who have already fallen • **Sustainable homes**: Assistive Technology • **Develop self care models to support people to better manage the impact of health challenges**, taking forward the learning from the Vitrucare and diabetes management pilots, and drawing on evolving NHS approved self care tools. **Synergies:** Closely linked to Priority 1, but with a focus on tertiary prevention (living well with ill health).	RCC BCF RCC BCF carry ELRCCG BCF RCC BCF carry RCC BCF	£104k £79k £35k £65k

	Parallel PCN aims: GP pharmacy support – medication optimisation, personalised care, cardiovascular disease prevention		
2.2 Funding for care	**Funding for care:** • Carers packages including respite • Support for domiciliary care		£87k £26k
2.3 Housing adaptations	**Disabled Facilities Grants and Housing and Prevention Grants** sustaining independence	DFG ASC winter funds	£238k £54k
2.4 Integrated health and care services delivering 'home first' care Continuation, with ongoing learning	**Further integrate local community, social and primary care services,** particularly benefitting people living with long term conditions, frailty and complex needs. Including services for those at end of life. Consideration of how to serve different groups better, improving equality of care. Funds personnel. Mechanisms to include: • Integrated care coordinator acting as a bridge between primary and social care. • Multidisciplinary coordinated care, including innovations such as improved care planning and nursing coordination emerging from the Better Care Together programme, locality pilot and the Community Services Review. • MICARE nurse – supporting delegation of health tasks in care. **Parallel PCN aims:** GP pharmacy support – medication optimisation, personalised care	RCC BCF ELRCCG BCF	£169k £424k
2.5 Health and wellbeing of those in care homes Broadened	**Support care providers in the management of complex and frail service users** • QA support to care providers. • Tailored support: falls prevention, assistive technology, care planning, enhanced GP relationship, medication management. • Improving access to health information by domiciliary and residential care providers, including video calling and access to NHS mail (topping up wider work). **Potential to support PCN priorities:** GP enhanced health in care homes, reducing inequality.	RCC BCF RCC BCF carry	£27k £10k

3. Priority 3: Home first model for hospital step up and step down

3.1 Reducing avoidable hospital admissions and ensuring prompt transfers of care remain significant priorities, as do reabling patients post-hospital and supporting their ongoing independence.

Priority 3: Hospital flows		Indicative source	Budget
3.1 Integrated urgent response Continuing and evolving	Urgent response staffing. Evolving management of health crisis. Consideration of potential to reduce 'just in case' hospital admission (eg. care home support, virtual ward step up) or shorten hospital stays using local step down care.	RCC BCF ELRCCG BCF BCF carry over	£129k £145k
3.2 Transfer of care and reablement Continuing, with rapid cycles of change	Transfer of care and reablement staffing. Continuing the effective arrangements already in place for transfers of care and reablement. Implementing the next DTOC Action Plan to further raise the maturity of the system. To consider local clinical input to the discharge process to reduce readmission, and improve hospital flows for those residing in care homes. Sustaining a further social worker supporting transfers of care, and nomination of lead coordinators to support smooth transfers.	RCC BCF ELRCCG BCF i-BCF carry RCC winter funds	£592.5k £142.5k £35k £55k

4. Priority 4: Enablers

4.1 It is proposed that the funding for programme management and analytics should be continued, with support for complementary enablers activities supporting the 2019-20 proposals, including work to evolve case management tools so that they support local care pathways, sometimes spanning both health and care platforms.

Priority 4: Enablers		**Lead and source**	

4.1 Enablers
 	
Continuing.
 	
Activity tailored to current integration needs
	Programme management and analytics supporting evidence based change, plus a number of further areas of activity.
	• Integration between IT systems
	  ○ Single assessment for community health and social care
	  ○ Sustaining access to the GP Summary Care Record for social care
	• Information Governance assurance and data sharing arrangements supporting integrated working
	• Research capability to capture user experience of new services and approaches
	• Provider engagement and workforce development supporting new models of care
	
	Parallel PCN activity: GP TeamNet investment for improved sharing of policies and other information across the Primary Care Network and wider.
		RCC BCF
		
		2016-17 carry-over
			£77k
			
			TBC
			
			£30k