# Rutland Better Care Fund Programme 2021-22

Programme of the Rutland Health and Wellbeing Board

## Contents

# 1. Context and Governance

This document, combined with the Excel workbook 'BCF 2021-22 Planning Template Rutland' sets out the Rutland Better Care Fund (BCF) Programme for 2021-22.

The area covered coincides with the unitary Local Authority boundary of Rutland County Council, which is a 'place' as defined in the NHS Long Term Plan, and falls within the wider health and care footprint of the emerging Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS).

## 1.1 Governance

| |
|---|
| Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)<br><br>How have you gone about involving these stakeholders? |

The BCF programme is governed by, and has been developed under the leadership of, the Rutland Health and Wellbeing Board (HWB) which meets on a quarterly basis and brings together the following:

- Rutland County Council (RCC) (members and officers, including for People services and Public Health),
- the Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs),
- the Rutland Primary Care Network (PCN),
- Leicestershire Partnership Trust (LPT),
- Healthwatch Rutland,
- VCF representation,
- NHS England,
- Longhurst (social landlord),
- Leicestershire Constabulary,
- plus such other persons as are appropriate to the Board's agenda.

The programme has been developed and is progressed operationally by the County's Integrated Delivery Group (IDG), a sub-committee of the HWB, which consists of operational members representing RCC, LLR CCGs, LPT, the Rutland PCN and Healthwatch Rutland.

Some VCF partners have been involved as providers of services which are integral to the current BCF programme. In a context of stretched resources across the voluntary, community and faith sectors post Covid, the Council has undertaken wider engagement with the VCF sector, using VCF forums to share and elicit feedback on/input to Rutland health and care plans. In the background to this, a significant Local Authority recommissioning exercise is underway for a range of services provided by the local VCF sector, including some currently in the scope of the BCF programme.

Rutland is one of three Local Authority areas in the health and care footprint of LLR. As such, we have also aligned our approaches with the strategic direction of the LLR ICS, tailoring this to the profile and needs of the local population (see below).

HWB and IDG members, including as agencies delivering BCF actions, have fed into the design of the current programme. In light of this year's delayed BCF timetable, and pending the current more detailed programming process, an outline budget for the 2021-22 programme, mirroring that set out in the parallel Excel workbook, was discussed at IDG in May 2021, then ratified by HWB on 22 June 2021.

The full programme as set out here will be approved through the delegated authority of the chair of the HWB, then presented to the CCG Executive Management Team alongside the Leicester and Leicestershire BCF programmes on 8 November 2021. Approval by the HWB will then be confirmed retrospectively at the next HWB meeting on 11 January 2022.

### 1.2 Wider engagement on the programme

In light of this year's delayed publication of the Better Care Fund Policy Framework (August 2021, updated October 2021) and the BCF Planning Requirements (September 2021), and resulting uncertainties, a dedicated round of public engagement was not undertaken in adjusting the Rutland BCF programme for 2021-22. Instead, the outcomes of closely related parallel public engagements have been used to validate the approaches taken. This has notably drawn on the following two exercises:

- **What matters to you?** An engagement study commissioned by Rutland County Council from Healthwatch Rutland about what local people want from Rutland's health and care services, which was undertaken from March to July 2021 and is informing the development of the County's Health and Wellbeing Strategy and Place Led Plan for 2022-25.
- **The Future Rutland Conversation.** This is an open-ended public engagement exercise by RCC, taking place throughout 2021-22, which aims to find out what people value about living in Rutland and what they would like to change, including in the area of health and wellbeing.

The current proposed BCF programme is well aligned with many of the key themes coming back from this engagement, for example:

- **Supported by Priority 1 – unified prevention**
  - People and families want to be at the centre of decision making about their health and wellbeing.
  - An appropriate balance of digital and non-digital services.
  - Communication that empowers people to take a full role in their care journey and their wellbeing, with increasing provision of self-help and prevention support.
  - Increased promotion of local services and support options so people can find the right support for them.
  - Reaching out to those whose health is affected by isolation.
  - Mental health services need to be easy to access, and also consider the needs of wider family.
- **Supported by Priority 2 – complex care**
  - Seamless journeys and coordinated care are a high priority.
  - High quality care from appropriate well trained staff working well together.
  - Need for everyone to be able to access the services they require including in rural areas.
  - Support with health literacy and self-help.
  - Concerns around pressure on carers and the wellbeing of people living with dementia.
  - A need for high quality social care options when required.
- **Supported by Priority 3 – step up and step down care**
  - Care at home is preferred wherever possible, including at end of life.

## 2. Programme summary

| |
|---|
| This should include priorities for 2021-22. |

Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

BCF programmes have been being delivered in Rutland since late 2014, through a succession of one or two year plans, as directed by national government. Their scope and approach has evolved over time in response to changing policy directions and local needs. The 2021-22 programme has strong continuity with that delivered in 2020-21, with some interventions reorganised to reflect changes, as set out below.

**Priority 1: Unified Prevention**, is targeted towards improving health and wellbeing, and the vitality of communities, and is centred around increased funding for the Community Wellbeing Service delivered by the Rutland Access Partnership (Citizens Advice Rutland, Longhurst Group, the Bridge), and for the Council's RISE social prescribing service which is a stronger focus of the plan this time. The latter is a collaboration between RCC and the Rutland PCN, providing general social prescribing assistance and more specialist wellbeing services for those living with multiple comorbidities and/or mental health challenges. Both services help people to engage with what motivates them in their lives, and to use this to drive changes that improve their health and wellbeing. Online information is a key enabler in Prevention, and the Rutland Information Service online directory has now been included under this priority to ensure it can play its full part within the wider collaborative prevention network. We will also commission an online platform for social prescribing case management and referral to enable local partners to work together more efficiently for the benefit of service users, an action deferred from 2020-21 owing to the pandemic.

**Priority 2: Holistic Health Management in the Community** is focused on services for those people living with ill health, particularly those whose needs are complex, providing a range of coordinated support tailored to the care needs of individuals and helping them to live well and, wherever possible, to sustain their independence. This includes community health services, therapy and social care working together in integrated ways. There is ongoing commitment to collaborative working in physiotherapy in particular, where recruitment challenges have recently been overcome to ensure a full strength team. Core services are complemented by a range of additional, often preventative, support which is called on as required as part of a personalised approach to care. These services include the Housing MOT, Assistive Technology, support for care-givers (which has been increased in this programme), the County's admiral dementia nurses and other commissioned dementia-related services. As last year, complementing these preventative interventions, the bulk of Disabled Facilities Grants are being delivered as non means tested Health and Prevention Grants, sustaining independence, preventing falls and reducing carer breakdown through routine small adaptations such as level access showers and stairlifts. It is important that people have equal access to appropriate services wherever they live and whatever their circumstances. We are also working closely with our care homes to help to progress the Enhanced Health in Care Homes agenda, including increasing advance care planning, and minimising unwarranted deterioration and hospitalisation, with a further role supporting a robust homecare sector.

**Priority 3: Hospital Flows** addresses crisis response and hospital discharge, including: avoiding unwarranted deterioration; swift and safe transfers of care after a spell in hospital; and support for post-hospital recovery, including through reablement. The integrated discharge team, and the Micare person-centred care and reablement team are key elements of this. There is continuity in the roles being funded this year, with changes to the working practices of teams. Team capacity is also being increased

through the addition of Ageing Well resources. For further details on the activities funded by this priority, see section 3.

Finally, **Priority 4: Enablers** includes provision for programme delivery and other actions assisting the successful delivery of the programme and achievement of its aims, notably around analytics and technology.

# 3. The approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.

How are BCF funded services supporting your approach to integration?

## 3.1 The local strategic context for integrated health and care

This year, the wider strategic and operational context for health and care has been changing, with the coming together of LLR's three CCGs and a transition from LLR's Sustainability and Transformation Partnership towards the new Integrated System of Care. The role of the ICS is to coordinate all of the resources available (workforce, buildings, volunteers, local knowledge, technology and innovation, funding, and so on) to further join up primary care, community services and hospitals, physical and mental healthcare, social care, public health and other partners, to give the people of LLR seamless, appropriate and effective care that is tailored to the needs of local populations.

The ICS is currently further developing key heath and care improvement workstrands into a comprehensive joint change programme for LLR, also working with Rutland partners. The direction of these plans is well aligned with the priorities of the Rutland BCF programme, and will form the backdrop for future developments.

The following summaries of the workstrands most relevant to BCF objectives and scope set out key aspects of the LLR approach to integration. The Rutland BCF programme is well aligned to support these programmes and proposals.

- **Caring for patients with frailty and/or complexity.** The LLR Frailty Collaborative brings together clinical and managerial leadership across the system and aims to deliver optimal outcomes for complex/frailty patients through the design and delivery of an integrated system of complex care for LLR. Over the years, many great services have been developed to support people at home and keep them at home, but we are now looking to opportunities to ensure the offer fits together without gaps in provision for all frail and complex patient groups. The framework for delivery of this integrated complex care model includes:

    1. Proactive anticipatory care through integrated neighbourhood teams using population health management approaches and multi-agency MDTs to ensure robust care plans for our most vulnerable patients.

2. A consistent sub-2 hour health and care response in the community, in and out of hours, through the 'Home First' offer.
3. Equitable and responsive falls management and falls crisis response provision.
4. Integrated end of life care provision with a focus on supporting people to die at home if this is their wish.
5. A trained workforce with sufficient capacity and IT infrastructure to integrate care.

**Home First Urgent Crisis Response (UCR) and Reablement.** The integrated 'Home First' pathway first launched in December 2019, delivered by nursing, therapy and social care services, will continue to provide a crisis response service to avoid hospital admissions and facilitate early supported discharge. The Home First offer provides 2 hour crisis response to support patients who would otherwise be admitted to hospital, mobilising a health and social care response in the patients' own home and supporting their needs until the patient can be stepped down to other services. Home First also provides integrated rehabilitation and reablement within 2 days of referral, with a focus on increasing people's functioning to regain independence. The Home First offer is available 7 days 7am-10pm, with continued crisis response provision out of hours. Home First approaches are a particular priority in Rutland, both to enhance outcomes and the care experience, and cognisant of the County's relative remoteness from many care services and the associated travel challenges, particularly for those with the greatest care needs.

LLR continues to invest in this delivery model growing the community workforce to ensure increasing numbers of patients can receive these care responses as quickly as possible to support more delivery of care closer to home. Recent investment has also enabled LLR to ensure full coverage of the 7 day period, grow the falls crisis response offer, test enhanced night time social care support and increase evening capacity. All these developments will strengthen the resilience to support discharge to assess and help maintain people living at home. This growth in workforce will enable LLR to achieve its target of 80% achievement of 2 hour crisis response and 2 day reablement targets by October 2021, ahead of the rest of the county in LLR's capacity as an Ageing Well accelerator site.

- **Same Day Emergency Care (SDEC).** This avoids ED/CDU attendances and emergency ward admissions through improved triage and treatment of specific conditions. This avoids unnecessary emergency admissions (both in CDU and emergency wards). Cardiology and Respiratory emergency lengths of stay have fallen from 4.52 days pre-SDEC to 3.75 in 2019/20 (pre-COVID). In Cardiology, lengths of stay have fallen from 4.34 to 3.28 over the same period, and Respiratory lengths of stay have fallen from 4.73 to 4.27 days.

  This scheme looks to transact that benefit, recognising that scaling up the service will improve effectiveness, and to source the necessary funds to cover the cost of permanently recruiting workforce into the SDEC service. This scheme also seeks to make a recurrent saving in the process and to use the model to open/extend other SDEC services across the trust.

  This will enable SDEC to change clinical pathways to enable the service to accept direct referrals from primary care, and accept direct ambulance transfers (bypassing the Leicester Royal Infirmary

and diverting straight to the Glenfield General Hospital) (further improving the effectiveness of the service and improving the patient experience).

- **Palliative and end of life care.** This programme seeks to adopt a whole system approach to improvement in end of life care pathways.
  - The Integrated Specialist Palliative Care offer now provides robust provision for patients with specialist end of life needs to keep them at home and support their care post discharge.
  - There remain gaps in generalist end of life capacity for hospice at home to support effective discharge at end of life. LLR is piloting approaches to increase social care capacity to support end of life discharge and create greater alignment to the urgent community response home first offers.
  - Advanced Care Planning remains a priority across LLR, further embedding use of genuine ACP, and RESPECT forms. In Rutland, this is also supported under the BCF by the Admiral Dementia Nurses.

## 3.2 Integration in Rutland

Across the lifetime of the BCF, Rutland has taken innovative approaches to integration across health and care services for the benefit of Rutland residents, and this year's programme, set out in the context of the LLR programme presented above, continues to embody this. Rutland's scale (39,000 people) has facilitated the strong working relationships and mutual understanding which enable services and the interfaces between them to be reshaped and iteratively improved to enhance outcomes. The routes to this are various and include coordinated (re)commissioning and change management applied to pre-existing services and roles. We have formed integrated multi-disciplinary teams, including jointly funded roles, ensure coordinated case management, and make extensive use of trusted assessment to expedite decision-making. We also work together across key agencies to support people in a personalised way to live well with multi-morbidities, helping to slow or prevent the progression of disease and maintain independence, to the benefit of individuals and their families and to the heath and care system. When healthcare escalation is needed, the home first model informs approaches.

In terms of its policy approach, Rutland's partners have also been distinctive in consistently promoting the prevention of ill health through BCF programmes, via interventions delivered by a range of different partners including the Local Authority (including via Public Health and, latterly, the RISE social prescribing team) and through local commissioning of the VCF sector and other providers. Evidence consistently shows that it is the wider conditions of people's lives – their homes, financial resources, opportunities for education and employment, access to public services, and the environments in which they live that exert the greatest impact on health and wellbeing. These 'wider determinants of health' require partners to work together to consider how they all combine to affect wellbeing and health. The partnerships embodied in the BCF programme and its governance ensure that the NHS focus on diagnosis and treatment of illness is complemented by other partners' expertise in promoting wellbeing and preventing ill health by addressing address the social, economic, and environmental determinants of health.

Our tailoring of measures to our local population includes:

- An expansion in the support offered by the Council to informal carers, who can often be critical in prolonging the ability of households to continue living safely and independently at home.

- Support to households with someone living with dementia through the Council's commissioning of Admiral Dementia Nurses and complementary lower level dementia support.
- The provision of assistive technology at low/no cost to service users or households to support them in maintaining their independence at home and preventing or postponing the need for care services or a move to a residential care setting.
- Support to care homes to participate in multi-disciplinary working with health partners to implement the aims of the Enhanced Health in Care Homes (EHCH) Framework, including improved care planning, anticipatory care and prevention of unwarranted deterioration.
- Extending the ability of the Council's in-house care and reablement service and of other related partners to provide step up or step down support reducing the need for time in hospital (including participation in a rapid faller response project).

We also work hard to streamline services to ensure people can benefit rapidly from cost-effective interventions, for example:

- Continued commissioning by the Local Authority of interim care home beds (step up or down) on behalf of both health and social care, achieving lower average fees and leveraging local insights to accelerate commissioning.
- Offering non means tested small home adaptations under the Disabled Facilities Grant to prolong independent living at home.

For those who require social care, the Rutland BCF programme includes only a modest Improved BCF sum supplementing the Local Authority homecare and domiciliary care budgets. These services, where the Council is funding them, are predominantly met from parallel core Adult Social Care Council budget. The BCF focusses, in turn, on preventative interventions, including those helping to reduce or delay social care need by enhancing the ability to continue living independently.

# 4. Supporting hospital discharge (national condition 4) and improving patient outcomes

| |
|---|
| What is the approach in your area to improving outcomes for people being discharged from hospital?<br><br>How is BCF funded activity supporting safe, timely and effective discharge? |

## 4.1 The LLR approach to hospital discharge

The LLR health and care system has invested significantly in effective and efficient hospital discharge arrangements, with system-wide infrastructure and approaches complemented by local discharge resources and processes operating in each of the Local Authority areas. As part of this, local teams are tailored to local circumstances. In Rutland, the Discharge team is configured to work effectively with both University Hospitals of Leicester (UHL) and the North West Anglia Federation Trust (NWAFT) which receives more than half of Rutland's non-elective admissions. This long-standing pattern of admissions is not considered a fragility or risk of the system, simply a fact of life, with permanent teams structured and resourced to support discharge from the hospitals of these two main acute trusts (and PCH's associated community hospitals).

The LLR discharge system has three main pathways: Pathway 1 is going home with support; Pathway 2 is going to a bedded facility for short term support or assessment; and Pathway 3 is permanent placement. LLR is currently challenged with high numbers of inpatients who are medically optimised for discharge. The percentage of inpatients over the age of 65 being discharged into residential settings is also currently higher than the national ambition, with widespread staffing challenges across homecare exacerbating this pattern, making it more difficult for some patients to return home where support is required (effectively escalating Pathway 1 to Pathway 2).

LLR's approaches to hospital discharge have evolved considerably in response to the above challenges and the pressures of the pandemic, with some changes coming into place which are likely to be lasting, for example in terms of a more fully embedded Discharge to Assess approach and improvements to information systems enabling enhanced discharge management and patient flow. PCH has experienced similar trajectories of change.

In 2020-21, LLR established an Integrated Discharge Hub to streamline, coordinate and facilitate discharges for patients requiring support post-discharge on pathways 1 to 3, with the Rutland Discharge Team working closely with the Hub. More recently, an electronic LLR Discharge Tracker was introduced for the Hub to support patient flow, thereby also improving patient outcomes. This also provides system-wide assurance across the single bed-base of acute and community hospital inpatient beds on key quality and performance metrics aligned to the national discharge guidance. This system was recently extended to track all LLR patients, whether in hospital in LLR or elsewhere, which has been particularly valuable for Rutland patients, as more than half of Rutland non-elective admissions are to hospitals outside LLR owing to the location of the County on LLR's eastern boundary. LLR stakeholders have also recently established a System Flow Partnership including Rutland and are developing a dashboard of quality and performance indicators. As part of this, there has been dialogue between the Rutland team and main acute hospitals around the BCF discharge targets.

Rutland teams work constantly and collaboratively with relevant teams at both the UHL hospitals, and Peterborough City Hospital, on coordinated and prompt discharge. Information on patients requiring support is now channelled for all Rutland patients via the UHL Tracker, which gives a single picture of demand, making this more efficient. Supplementing this, these acute hospitals have implemented national priorities into local discharge acceleration eg. using 'red to green' monitoring to ensure that each day in hospital entails purposeful progress, and running MDTs to prevent avoidable extensions to stays. At the 14 day point in PCH, patients are discussed with the ward manager or nominated deputy with regard to criteria to reside, red to green code and stranded patient code. The purpose is to provide assurance that required interventions and treatment are happening in a timely manner whilst also providing a forum for escalation and highlighting potential complexities with regard to the patient journey and discharge arrangements. Similar approaches exist in UHL. This acute activity is augmented by associated local actions to expedite transfers of those who are medically fit for discharge (MFFD) (see below). We have been applying a particular focus locally on early intervention and 7 days a week responses to avoid extending stays beyond the necessary.

## 4.2 Hospital discharge support in Rutland

Within the context of the wider LLR system, Rutland has incrementally shaped its approach to prompt, safe and sustainable hospital discharge for Rutland residents, with an integrated Hospital Discharge Team at the heart of this, working with a wider network of health, care and provider colleagues both in

and out of area. The aim of the team is to keep hospital stays to a minimum, to avoid delayed transfers of care of those who are medically fit for discharge, and to ensure safe and sustainable discharges where people are provided with the best opportunity for recovery in the community.

The multi-disciplinary Hospital Discharge Team consists of Social Workers, InReach Nurses and Therapists. Two of the team's Therapy posts (Physiotherapist and Technical Instructor) are filled by the local community health services provider, Leicestershire Partnership Trust. One or both of these posts have been vacant for large periods over the last year. However, both posts have now been successfully recruited to and we are already seeing benefits of having a fully functioning team again in terms of reablement outcomes.

Workforce, particularly in adult social care, remains a significant area of challenge across LLR with regards to discharge. The Better Care Fund has been, and continues to be, instrumental in supporting the development of roles and services, across health, social care, VCSE and Housing sectors to support discharge in line with LLR's Home First ambitions.

Also instrumental in successful hospital discharge is the Council's in-house care provider and reablement team, MiCare, which has been particularly important in enabling the full Discharge to Assess model by ensuring that those needing homecare on discharge can be provided with this at a safe level from the outset. Under the direction of our therapists, our reablement workers continue to achieve excellent reablement outcomes for discharged patients, optimising function and independence.

The vitality and capability of the commercial care sector is another important pillar in both hospital discharge and admissions avoidance. Via the BCF, RCC has put in place two officers who support the care sector in Rutland, providing a wide range of advice and support and also facilitating effective MDT working.

We are continually evolving discharge processes and follow-on care, as set out in the below local Hospital Discharge Action Plan, which includes both recent and proposed system wide developments and changes within Rutland. This plan does not include the already well-established actions and approaches. Each action is anticipated to improve discharge processes and/or to improve patient outcomes, as set out in the Detail column. The table also indicates which actions are anticipated to contribute to the discharge-related BCF metrics ((ii) reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions, (iii) reducing lengths of stay, and (iii) increasing the proportion of patients discharged to their usual place of residence, (iv) successful reablement. A subset of the actions below will also contribute to reducing hospital admissions, another important aspect of driving down the pressure on acute facilities, whilst improving patient outcomes.

*Table 1: Hospital Discharge Action Plan*

| Detail, including rationale/benefits | Scope | Progress/ timescale |
|---|---|---|
| **1. Rutland adaptations implementing the LLR Discharge to Assess model**<br>Rutland patients discharged on Pathway 1 (discharge requiring support) supported on initial discharge by Rutland's in-house domiciliary care team, MiCare, to ensure safety.<br>Seen by a social worker, occupational therapist and a MiCare coordinator within 72 hours of arriving home, enabling a joint decision on whether the | LLR, Rutland | In place from January 2021 |

| Detail, including rationale/benefits | Scope | Progress/ timescale |
|---|---|---|
| service user will benefit from reablement or an ongoing package of care. Progressed accordingly.<br><br>**Benefits**:<br>• Reduced length of stay: Discharge to Assess model enables discharge as soon as medically fit.<br>• Increased discharge home: Initial bridging care can be dialled up or down as required.<br>• Swift, confident decisions about care needs sustain discharge and optimise recovery. | | |
| **2. Introduction of UHL Discharge Tracker, with capability to also track patients hospitalised out of area**<br>Patient Tracker introduced for residents of Leicester, Leicestershire and Rutland, for patients discharged from University Hospitals Leicester (UHL), and for discharges of LLR patients from other Trusts.<br><br>**Benefits**:<br>• Reduced length of stay: Improved information supporting discharges, including for patients hospitalised out of area, increasing efficiency.<br>• The addition of referrals from other Trusts is particularly valuable to Rutland, as over half of patients from the County are admitted to Peterborough City Hospital, which is part of North West Anglia Foundation (NWAFT).<br>• The Tracker is an excellent source of data when analysing where improvements can be made in the discharge process. | LLR, Rutland | In place. |
| **3. Supporting 7 days a week discharge decision-making capability in Rutland**<br>Extension to working hours to support increased 7 day working. Recruitment of 1.6 fte occupational therapists (OTs) and additional social care capacity for weekend working. Previously, key decisions were taken in the working week, then acted on 7 days per week for any day discharge.<br><br>**Benefits**:<br>• Reduced length of stay: Enables safe discharge when medically fit.<br>• Successful reablement: The therapists in particular have enabled quicker assessment on discharge, therefore faster commencement of reablement where appropriate. Early commencement of reablement gives service users the best chance of still being in their own homes 91 days after discharge. | Rutland | In progress – complete for OTs, underway for social care. |
| 5. **Minimising patient stays over 14 or 21 days.**<br>Prior to Discharge to Assess, the Discharge Team visited wards to plan discharges prior to receiving discharge referrals. With referrals now being routed through the Discharge Hub and information being recorded on the Patient Tracker, we will be proactively contacting the Discharge Hub for updates on patients with relatively high length of stay metrics and, where appropriate, commencing pre-discharge planning. | Rutland | Underway |

| Detail, including rationale/benefits | Scope | Progress/ timescale |
|---|---|---|
| We will also be making continued use of daily patient reports from UHL and NWAFT (Peterborough) hospitals to track and support prompt discharge.<br>The approach includes close liaison between the Discharge Team and MiCare to provision care in a timely way enabling Discharge to Assess.<br>NB: A caveat to this action is that reducing hospital stay lengths is also dependent on the improvement actions of acute hospitals. We are liaising with relevant hospitals to understand how local services can support this.<br><br>**Benefits**<br>• Shorter stays: Freeing up hospital capacity, improving throughput.<br>• Reducing the deconditioning and loss of independence which can result from long hospital stays. | | |
| 6. **Complex care pilot supporting enhanced care in the community**<br>Currently, two InReach Nurses within the Hospital Discharge Team are largely responsible for discharges involving Pathway 2 (short-term stay in a bedded facility, eg. where service users may require further assessment for Continuing Healthcare, are non-weight bearing or require nursing placements).<br>We aim to recruit a third Nurse and give all three more of a community-facing role. In addition to their current discharge work, they will have a greater role in liaising with Community Nurses where patients have ongoing health needs and will offer support to the MiCare Team if they have concerns about the health of discharged patients they are working with.<br><br>**Benefits**<br>• Among the aims are confident handover into the community where patients have complex needs.<br>• Reduced readmissions, and potential to avoid some admissions. | Rutland | In progress |
| 7. **Safe discharge home for those with cognitive impairment**<br>Currently, patients being discharged with delirium or other cognitive impairments often go into placements to be assessed as this is felt to be the best way to ensure their safety. We will pilot an approach offering enhanced levels of support in the service user's own home.<br><br>**Benefits**<br>• Offering patients the best opportunity of remaining in the community in the long term, as even a short term placement can create dependency.<br>• Improved understanding of patients' situation and potential, which can more accurately be assessed in an environment they are familiar with to get the best picture of their levels of functioning.<br>• Avoided admissions, reduced lengths of stay.<br>• Increased proportion discharged to usual place of residence. | Rutland | Oct 2021 - Mar 2022 |
| 8. **Care sector support** | Rutland | Underway |

| Detail, including rationale/benefits | Scope | Progress/ timescale |
|---|---|---|
| Advice and support to the homecare and care homes sector, including supporting multi-disciplinary team working for care home residents progressing the Enhanced Health in Care Homes agenda.<br><br>**Benefits**<br>• A more commercially viable care sector able to offer the required care to people discharged from hospital.<br>• Shorter lengths of stay.<br>• Avoided admissions: Increased capability in care homes around managing deterioration to avoid unwarranted hospital admissions, particularly out of hours. | | |
| 9. **Pilot of a falls response service to reduce hospital conveyance of fallers**<br>Previously in LLR, the East Midlands Ambulance Service (EMAS) was predominantly relied on to assist people who had fallen and potentially injured themselves. A new service has been commissioned to respond more rapidly to fallers and, wherever possible, to support them without recourse to hospital.<br><br>**Benefits**<br>• Improved patient outcomes with fewer long lies by fallers, shorter stays if hospital is needed.<br>• Reduced avoidable admissions. | LLR, Rutland | Underway |

## 5. Disabled Facilities Grants (DFG) and wider services

| What is your approach to bringing together health, care and housing services to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people? |
|---|

Disabled Facilities Grants (DFG) are fully managed by Rutland County Council (RCC), where the process in place deliver a consistent, responsive and streamlined service well attuned to the needs and resources of the local population.

RCC is committed to enabling more people to benefit from DFG funding. The discretionary Health and Prevention Grant (HaPG), which removes restrictive means testing for home adaptation projects costing £5K or less, has been a successful step towards this. This 'no-bar to provision' approach is inclusive of all property ownership across the county and our dedicated Grants Facilitator works closely with a range of stakeholders to ensure that as many as possible access this service. The benefits of this approach have been far-reaching in supporting individuals to remain safe and independent in their own homes, preventing falls and hospital admissions, and reducing carer strain and breakdown.

The introduction of a Trusted Assessor approach for some adaptations, such as a level access showers, is currently being piloted with our commissioned Housing MOT Service, and is an area for further development. If an adaptation need is identified, rather than referring on to Therapy Services, workers who are trained to do so will recommend and support individuals to complete a HaPG application.

Oversight and support is offered by our Grants Facilitator and, if required, our Therapy Service. If successful, there is scope to expand this approach to some of our Social Care colleagues and Health Partners. In addition to supporting our commitment to integration, this offers opportunities to improve individual experience by not having to wait to be referred on to the Therapy Service before adaptations can be progressed or needing to repeat their story.

Alongside the highly successful and streamlined HaPGs, funding is reserved as required to meet demand for small numbers of statutory DFGs enabling higher cost adaptations where these are required by service users of all ages to support them to access their homes and live independently.

Housing services are managed in Rutland as part of Adult Social Care, which supports good working relationships and a shared ethos of preventative working and achieving the best outcome for individuals requiring our services. Increasing awareness and understanding of how Regulatory Reform Orders (RRO) can be used to support re-housing or adaptions is a key objective. Foundations, The National Body for Home Improvement Agencies will shortly be presenting to staff at a Leicester, Leicestershire and Rutland event outlining opportunities for creative use of DFG, with a focus on RRO's.

As impacts of the pandemic continue to be felt, proactive and creative thinking is at the forefront of all that we do. Our Principal Occupational Therapists continually review the demands on the service and issues which affect its delivery. Solutions such as investments in modular ramping kits will be considered as a means to mitigate the risk of continued supply disruption and further cost increases.

## 6. Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Health inequalities are avoidable and unfair differences in health between different groups of people. Health inequalities concern not only people's health outcomes, but also the differences in care they receive and the opportunities they have to lead healthy lives.

This year, a health inequalities plan has been developed by LLR ICS partners to consolidate LLR's approaches to reducing health inequality. This spans both equality for people with protected characteristics under the Equality Act 2010, and inequality in access to services or in outcomes that people may experience due to a range of other disadvantages, including the wider determinants of health (low incomes, rural isolation, etc). The plan's key actions are set out in Table 2 below. This plan is now being operationalised and progressed at pace, and will help to support the response to health inequalities both in Rutland and the wider LLR health and care system going forward. Some key actions have been achieved or are underway, but are still presented as within the scope of 2021-22 programmes.

*Table 2: Key actions in the LLR ICS Health Inequalities Plan*

| Action | Detail |
|---|---|
| **1 Places to apply the principles in this framework** to their populations to meet local needs. | To embrace the various factors that affect people's health.<br>The framework has been introduced to Rutland partners who are reviewing their activities relative to it. |
| 2 The ICS will make **investment decisions** for people across LLR that reflect the needs of different communities | Actions can be universal, but adjusted and made proportionate to the level of disadvantage. Reducing health inequalities will be a high priority. Specifically, we will develop a new strategic long-term model of primary care (GP practice) funding, distribution and investment. This will 'level up' funding based on population need rather than historical allocation.<br>Rutland is a county with some hidden disadvantage eg. dispersed low income households in more affluent areas, micro communities eg. travellers, etc and local partners will be active in ensuring that allocation mechanisms recognise these less visible needs. |
| 3 Establishment of a defined **resource to review health inequalities** at the strategic level. | This will be a virtual partnership between the NHS, Local Authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will gather and share best practice in effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level. Specifically, a proposal for the establishment of an LLR health inequality resource will be presented to the system executive by the end of September 2021. Pending this resource coming onstream, Rutland has undertaken a refresh of its Joint Strategic Needs Assessment to support its planning for 2021-25 interventions. |
| 4 **Decision-makers in the ICS** will have expertise, skills, insight and understanding of health inequity and how to reduce it. | Health inequity and inequality training will be mandatory for all executive decision-makers in each organisation by the end of November 2021. We will work with local and regional partners to develop appropriate and robust training packages relevant to roles. Rutland's governance and management teams will be included in this process. |
| 5 Partner organisations will **work together to understand the impact of Covid-19** on health inequalities across LLR to allow effective and equitable recovery. | Across LLR's communities, including in Rutland, we will be looking to:<br>• Identify groups and communities, across all ages and protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages.<br>• Undertake proportionate additional work to ensure vaccine uptake is equitable.<br>• Include consideration of the role of the wider determinants of health, such as education, employment, housing and poverty.<br>• Promote equal support for mental and physical health to groups worst affected by the pandemic and lockdown consequences. |
| 6 Partners will work to improve the **completeness and** | This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner |

| | |
|---|---|
| **consistency of their data** to enable a better understanding of health equity. | organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records by the end of July 2021. In addition, we will make better use of data sets to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams.<br>As Rutland's Integrated Neighbourhood Team comes fully into place, it will be using Population Health Management, including equalities data, to support targeting of local interventions. |
| 7 At the ICS level, we will obtain and **use data to better understand** where more can be done to reduce health inequity. | Specifically, by the end of autumn 2021, each organisation will have adopted a standard health equity audit tool and put training plans in place to use this tool, so that each place can compare their performance against other areas. |
| 8 We will undertake **health equity audits** to identify health inequalities between different population groups. | These will be carried out at the planning stage when we commission, redesign or evaluate services. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010). Rutland planning and commissioning activities will embrace this audit approach as and when it becomes available. |
| 9 ICS NHS and public sector partner organisations, including Rutland partners, will **work together** to reduce health inequalities. | This includes in the areas of work opportunities, use of buildings and purchasing. |

In relation to the Equality Act 2010, health and care services and recruitment to them in Rutland are subject to equalities regulation, routine equalities monitoring and follow up as appropriate, and staff are routinely trained in equalities awareness, including in unconscious bias. Care practice is personalised to the individual, including appropriate consideration of protected characteristics such as religious beliefs, sexual orientation and ethnicity.

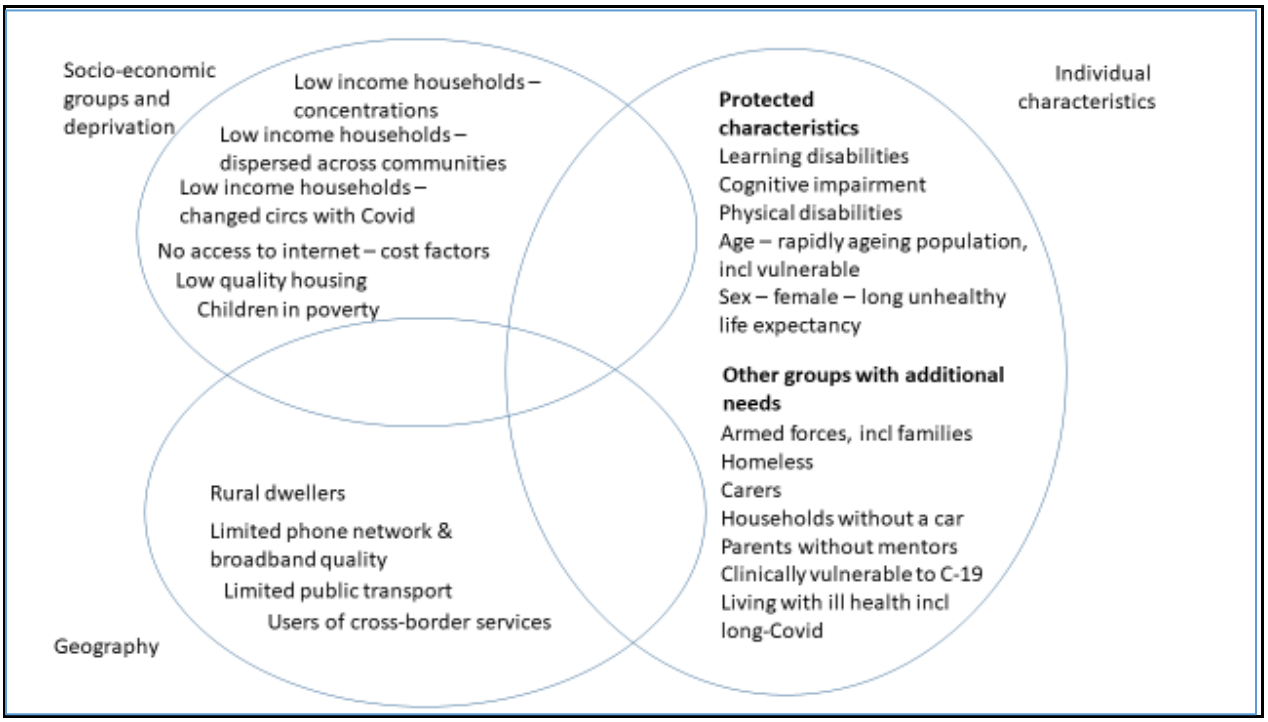
The dataset provided nationally as part of the BCF planning process for lengths of hospital stay and discharge destinations per Upper Tier Local Authority (April 2019 to the present), breaks down the dataset by both ethnicity and age. The small population of Rutland (39,000) and its limited ethnic diversity means that it is difficult to gain reliable insight from this dataset. Nevertheless, discharge destination data, for example, broadly reflects the proportions in the population. The ethnic make-up of Rutland's resident population is predominantly white British (estimated in 2016 at 97.4%) and other white (2.6%), with other ethnicities representing less than 0.1% of the population. Of those discharged to their usual place of residence whose ethnicity was known, 94.5% were white British and 5.5% of other ethnicities. There is some wider variation across other categories of destination between white British and other ethnic groups, but numbers with destinations other than usual place of residence are so small, it is difficult to conclude reliably whether any variations in destination outcomes may be unwarranted.

From March 2021, emerging from the pandemic, Rutland has been engaged in renewing its Health and Wellbeing Strategy and in developing a Place Led Plan for 2022-25 to progress this. As part of this work, the data contained in the County's Joint Strategic Needs Assessment has been refreshed, including

reviewing equality-related data. In Rutland, against a backdrop of overall good population health, there are particular populations whose prospects and outcomes are less positive. To give a flavour of distinctive populations, Figure 1, below, sets out a range of circumstances that have been highlighted through analysis as affecting access to health services and health outcomes for parts of the Rutland population, grouped into three aspects of life – socio-economic groups and deprivation, individual characteristics and geographical circumstances.

Disadvantage is often multi-faceted and setting out equality factors in this way helps to see circumstances in the round to ensure appropriate responses. For example, an 85 year old female carer, living in rural Rutland on a low income, with impaired physical mobility, unable to drive and without access to the internet will face a range of compounding risks and constraints. As a result, she might not take up health screening or inoculation services, may have limited opportunities to look after her own health in other ways, and may be facing factors such as social isolation which can also impact on mental wellbeing. This underlines the need to tailor services to individuals and their circumstances in order to bring about positive change and reduce avoidable need for health services, also building on available strengths. The County's social prescribing, health and care services all aim to work in this holistic way.

*Figure 1: Inequalities in Rutland*




The following examples illustrate how Rutland's 2021-22 BCF programme aims to enhance equity. We have not introduced additional dedicated measures at this stage addressing inequity, rather promoting equity of access and outcomes is a horizontal aspect of health and care delivery under the programme. This approach may evolve further in next year's interventions.

- **Under Priority 1: Unified Prevention**

- Strengthening social prescribing capacity through RISE and the Community Wellbeing Service to ensure that a holistic, personalised response can be provided to any individual whose mental or physical health, or ability to live with ill health, could be improved through actions complementing clinical intervention, wherever they live in Rutland and whatever their characteristics and circumstances. Social Prescribing teams actively work to reach different populations who may not come forward via GP practices, for example undertaking outreach into Rutland villages, offering wellbeing support as part of inclusive social events such as the Rural Coffee Connect, and attending wellbeing events at the military base.
- Supporting an integrated wellbeing contract which includes funding for Vista, which targets people facing challenges due to sensory impairment, and Citizens Advice Rutland, which works to support people facing financial difficulties or other discrimination.

- **Under Priority 2: Holistic Health Management in the Community**
  - The Disabled Facilities Grant provides non means tested access to small adaptations within the home (notably level access showers and access adaptations including lifts) to enable prompt adjustments that allow people living with disabilities to maintain their independence at home for longer.
  - Sustaining the focus on supporting people living with dementia and other cognitive impairment to live well with their condition and to access the wider set of health and care services which they may need, including through the County's Admiral Dementia Nurses.
  - Interventions helping carers, 6 out of 10 of whom report feeling isolated as a result of their role.

## Appendix 1: Abbreviations

| | |
|---|---|
| BCF | Better Care Fund |
| CCG | Clinical Commissioning Group |
| DFG | Disabled Facilities Grant |
| ED | Emergency Department |
| EHCH | Enhanced Health in Care Homes |
| HaPG | Health and Prevention Grant |
| HWB | Health and Wellbeing Board |
| ICS | Integrated Care System |
| IDG | Integrated Delivery Group |
| LLR | Leicester, Leicestershire and Rutland |
| LPT | Leicestershire Partnership Trust |
| NWAFT | North West Anglia Foundation Trust |
| OT | Occupational Therapist |
| PCH | Peterborough City Hospital |
| PCN | Primary Care Network |
| RCC | Rutland County Council |
| RRO | Regulatory Reform Order |
| SDEC | Same Day Emergency Care |
| UCR | Urgent Crisis Response |
| UHL | University Hospitals of Leicester |