Rutland Better Care Fund Programme 2022-23

Programme of the Rutland Health and Wellbeing Board

Contents

BCF narrative plan template: There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

1 Context and Governance

This document, combined with the Excel workbook 'BCF 2022-23 Planning Template Rutland' sets out the Rutland Better Care Fund (BCF) Programme for 2022-23.

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. Rutland falls within the wider health and care footprint of the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS).

1.1 Governance

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),
- NHS Leicester, Leicestershire and Rutland (LLR) – the LLR Integrated Care Board (ICB),
- the Rutland Primary Care Network (PCN) on behalf of its constituent practices,
- Leicestershire Partnership Trust (LPT),
- Healthwatch Rutland,
- Citizens Advice Rutland, on behalf of the wider Voluntary and Community Sector (VCS) community,
- NHS England,
- Longhurst Housing Association, on behalf of the social housing sector,
- Leicestershire Constabulary,
- plus such other persons as are appropriate to the Board's agenda.

Operationally, the programme is managed by the Integrated Delivery Group (IDG) which is a formal sub-group of the HWB chaired by the Integrated Care Board, with the Director of Adult Social Services (DASS) being the vice chair. The IDG meet monthly to monitor and progress two inter-related strategies running in parallel, the BCF programme and the newly agreed Joint Health and Wellbeing Strategy 2022-27 (JHWS).

The full BCF programme as set out here will be approved through the delegated authority of the chair of the HWB and presented to the ICB Executive Management Team alongside the Leicester and Leicestershire BCF programmes. The next HWB meeting will be held on October

1.2 Engagement

Programme development has been led by the Integrated Delivery Group (IDG), involving all its members (RCC, LLR ICB, LPT, the Rutland PCN and Healthwatch Rutland). VCS partners have also been involved as providers of services which are integral to the current BCF programme.

While there has been limited time to engage broadly on this year's BCF programme (also with programme development taking place across the peak of the summer period), the

Council undertook wide local engagement across 2021-22 with both partner agencies and the public to prepare its new Joint Health and Wellbeing Strategy (JHWS) 2022-27. We see the JHWS and BCF programme as closely inter-related programmes. The BCF programme submitted is therefore well aligned with key messages and priorities from this engagement process (with the exception that the JHWS has a broader scope, e.g. also covering interventions for children, young people and families, and with a greater emphasis on mental health and end of life care).

2 Programme overview

Priorities for 2022-23, key changes since previous BCF plan, including commissioning changes

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 2022-23 programme has strong continuity with that delivered in 2021-22.

The programme remains structured into four high-level priorities. Actions at the next level down have evolved or been reshaped in response to national policy guidelines and local opportunities and needs, as set out in **Section 3** below.

1. **Unified prevention:** improving individual health and wellbeing, and the vitality of communities.
2. **Holistic health management in the community:** services for those people living with ill health, particularly those whose needs are complex, providing a range of 'home first' coordinated support tailored to the care needs of individuals, helping them to live well and, wherever possible, to sustain their independence.
3. **Hospital flows:** reducing avoidable hospital admissions and ensuring prompt, safe and sustainable discharge.
4. **Enablers:** support to the programme itself, alongside analytics, technology and communications and engagement.

The programme is set out in more detail in section 3, where this demonstrates the *local approach to meeting condition 4:*

(i) enabling people to stay well, safe and independent at home for longer (Priorities 1 and 2); and
(ii) providing the right care in the right place at the right time (Priorities 2 and 3).

Among the key changes in the programme this time are the following:

- The contract for the integrated Community Wellbeing Service (Priority 1) ended in March 2022 and it has been replaced by the direct commissioning of an adjusted blend of wellbeing services meeting local priorities and complementing the Council's RISE social prescribing service.
- We have increased resources for public and partner engagement (Priority 1), opening up the scope for more co-design and co-production of solutions in line with national guidance around the delivery of Joint Health and Wellbeing Strategies.

- In prevention and community intervention, an Integrated Neighbourhood Team approach is enriching collaboration and coordination across local partners, also supported by the new social prescribing management and referral platform. As part of this, cohort-based population health management analysis is helping to inform the targeting of preventative services.
- The commissioned dementia support service (Priority 2) has been recommissioned with a greater emphasis on pre/peri diagnostic support and integrated working with the Council's Admiral Dementia Nurses.
- Hospital discharge services have evolved in line with national Discharge to Assess changes (Priority 3, see section 4).

3 Meeting the BCF policy objectives

Approach to embedding integrated, person centred health, social care and housing services. National condition four requires an overarching approach to meeting the BCF policy objectives to: (i) enable people to stay well, safe and independent at home for longer; and (ii) provide the right care in the right place at the right time

Outline, for each objective set out the approach to integrating care, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.

Plans for supporting people to remain independent at home for longer should reference: steps to personalise care and deliver asset-based approaches; implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches; and multidisciplinary teams at place or neighbourhood level.

3.1 LLR's strategic context for prevention and integrated care closer to home

National condition four requires areas to agree an overarching approach to meeting the inter-related BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

In LLR at a system level, a key enabler to the achievement of the BCF objectives is the principle of '**Home First'**. Home First services support people to remain in their homes when they are having a health or social care crisis rather than needing to go into hospital or a care home. Home First services also help people get home from hospital quickly and provide them with rehabilitation and reablement to help restore their health, wellbeing and independence.

'Home First' is an overarching principle of the whole Integrated Care System, which requires all teams and individuals involved in health and care to ask "why is this person not at home?" or "how best can we keep this person at home?". It also supports the concept that not every patient's progression is linear.

There are **10 key aspects to the Home First** programme, as set out below, elements of which are funded by LLR's BCF programmes.

Elements 2, 3, 8 and 9 below have particular relevance to the national BCF prevention priority (enabling people to stay safe, well, and independent at home for longer), while **all of these priorities contribute to the national BCF aim of providing the right care in the right place at the right time**.

1 Transforming and building community services capacity through growing the LLR virtual ward model

A virtual ward is a team of professionals working to manage a group of patients in the community. It allows patients to get the care they need at home, safely and conveniently, rather than being in hospital. Using a combination of remote monitoring by healthcare professionals and home visits, virtual wards can help prevent hospital admissions or allow for an earlier, supported discharge. It has been shown that people make a better recovery in their own surroundings and that staying in hospital longer than necessary can have a detrimental effect on their condition and their independence.

By Winter it is hoped that 275 patients across LLR will be able to be looked after simultaneously across nine virtual wards including frailty, cardiology, acute respiratory and diabetes. The number of beds will increase to more than 440 by December 2023. (Rutland represents 4% of the LLR population and would be using these services in a broadly proportionate way.)

The virtual ward service has been arranged by NHS LLR and will be provided by a collaborative of local organisations, including University Hospitals of Leicester NHS Trust, Leicestershire Partnership NHS Trust, Local Authorities and the local hospice, LOROS.

Among the priorities will be: to increase utilisation of existing virtual ward beds, ensuring appropriate use to avoid admission/ facilitate earlier discharge; and to enhance step up and step-down access to virtual ward beds through growing the LLR unscheduled care hub.

2 Transforming and building community services through Home First Urgent Crisis Response and reablement

The aim of this priority is to deliver an urgent community response within two hours for more patients than in 2021-22 and achieve this target at least 80% of the time for the system.

Urgent crisis response referrals will be increased through: Emergency Department front door diversion; enhancing pendant alarm referral routes; alignment to other local offers; expansion of the falls crisis response offer; and maintaining delivery of rehabilitation and reablement within 2 days at least 80% of the time across LLR.

3 Embedding integrated neighbourhood working and delivering anticipatory care

- Embedding operational MDTs and an anticipatory care/population health management (PHM) approach to jointly manage frail, complex and high-risk patients, ensuring that all neighbourhood teams have well-functioning MDTs in place by October 2022;

- Ensuring consistent use of care co-ordinators, care navigators and social prescribers to maximise use of the Voluntary and Community Sector and other wellbeing offers;
- Developing high-performing Integrated neighbourhood leadership teams consistently across LLR with full engagement, clear governance and shared purpose, underpinned by a local PHM plan by March 2023.
- Increasing the identification of carers enabling support to be offered;
- Developing an Integrated Neighbourhood Team maturity matrix;
- Increasing care planning to 55% of vulnerable patients;
- Recruiting additional care co-ordinators and finalising an MDT draft framework; and
- Recruiting MDT Facilitator roles through LAs (underway).

4 Reducing community services waiting lists

- Developing a system understanding of community services waiting lists; and
- Developing clear plans to reduce and address these waiting lists through prioritisation, efficiencies and investments where required.

5 Improving awareness, identification, and management of frailty

- Increasing the use of effective care planning (including ReSPECT forms to capture care wishes), ensuring that all vulnerable patients (end of life, frailty and care home) have quality care plans in place;
- Addressing the care planning backlog to ensure that 95% of vulnerable patients have an agreed care plan in place by October 2022;
- Ensuring care planning underpins effective decision making through availability and use by all partners;
- Increasing frailty identification and assessment by 25% by October 2022 through: the development and delivery of frailty training across primary care, community services, care homes and acute; and, planning and delivering a public awareness campaign.

6 Strengthening the community palliative and end of life care response

LLR partners will support more people to die in their place of choice through:

- Increased identification of people in their last year of life via increased use of ReSPECT planning;
- Improved access to end of life care provision through the design and mobilisation of a 24/7 advice line for patients, carers and professionals;
- Enhancing the end of life discharge pathway by testing an integrated end of life social care bridging and co-ordination offer and undertaking quality and co-production reviews of patient and carer experiences at the end of life.
- Ensuring end of life remains everyone's business through appropriate training and support
- Refreshing place-level JSNAs and the LLR all-age end of life strategy. The JNSA development will be undertaken on a rolling basis from 2022 to 2026.

7 Implementing the enhanced health in care homes (EHCH) model

- Ensuring full and consistent delivery of all parts of the EHCH PCN DES, including allocating named GPs for all care homes and residents;
- Piloting the use of a care home virtual ward with remote monitoring for patients with a frailty score of seven or above or a higher risk of admission, and developing a plan for further roll out by September 2022;
- Embedding comprehensive geriatric assessments and effective MDTs across all care homes by August 2022;
- Determining the ongoing model of care for bed based reablement care;
- Implementing the National Early Warning Score (NEWS) which is a tool for identifying and responding to acute illness. When used in care homes, staff measure residents' vital signs and record them on a tablet computer, which calculates a NEWS to share with health partners; and

Complementing this by piloting WHZAN and Spirit digital technologies in care homes to support the identification of deterioration using NEWS2. The Whzan Blue Box is an all-in-one telehealth case. It measures vital signs, records photos, and performs multiple assessments and questionnaires including NEWS2. Signs of deterioration or illness are identified earlier, for a clinical response or carer support. This is being implemented from 1st oct to end of Dec 2022 and a full evaluation will be published after then – (Jan 2023)- results of the pilot will inform whether further investment is supported and whether these digital observation tools are continued.

8 Implementing equitable falls prevention and management across LLR

- Evaluating and developing longer term plans for the falls crisis response model to maintain an equitable response across LLR by August 2022;
- Developing a plan for early identification and support for people at risk of falls by October 2022; and
- Embedding a consistent falls management offer across LLR.

9 Implementing an integrated therapy model that maximises shared resources

The Integrated Therapies Vision is to best utilise LLR therapy resources across LLR where services provided are similar or across patient pathways where there are key therapy interfaces. This will support seamless and effective patient care, efficiencies, flow, admission avoidance, and a single model of care within certain pathways with agreed standards and ways of working. This needs to be underpinned by a robust LLR Therapy workforce plan. Among the changes are:

- Maximising the use of LLR's integrated therapy workforce across ICS shared roles, a single leadership model, a single clinical model and shared waiting lists across each pathway;
- Development of a single clinical model and pathway for stroke therapy;
- Introducing an extended seven day therapy offer at Rutland County Council by March 2023; and

- Development of an integrated therapy model for community health and social care.

10 Growing community capacity through the workforce

- Engaging with independent providers of care home and domiciliary care, through provider forums, to support system resilience and the integration agenda;
- Co-design of a responsive system-wide Home First career pathway encouraging more effective integration and sharing of future workforce capacity by collectively developing a pipeline by championing of new roles and shared training and development; and
- Further exploration of Multi-Professional Teams/ co-location/ collaborative working to ensure consistent working practices and to promote better integration of the LLR workforce as well as care pathway delivery improvements.

3.2 How the programme supports national policy aims

Priorities 1 to 4:

Priority 1 and, to a lesser extent, priority 2 are prevention focussed, maximising wellbeing and independence, while Priorities 2 and 3 are focussed on ensuring the right care in the right place at the right time.

Priority 1: Unified Prevention, is targeted towards improving individual health and wellbeing, and the vitality of communities. While maintaining health and independence is an increased priority nationally in 2022-23, it has been a long-standing focus of the Rutland BCF programme as part of a wider health and care demand management strategy aiming to keep people as well and independent as possible for as long as possible. Actions are centred around the following:

- **The Council's RISE service**. This is a close collaboration between RCC and the four GP practices of the Rutland PCN, providing social prescribing assistance and more specialist wellbeing services for those living with multiple comorbidities and/or low level mental health challenges. The service takes a personalised, asset based approach, helping people to engage with what motivates them in their lives, and to use this to drive changes that improve their health and wellbeing.

  The team is also now leading on **multi-disciplinary neighbourhood facilitation and coordination**, acting as a central point of information on health, social care and voluntary sector services and as a hub for coordinated collaborative working between associated partners. As part of this, they have made two key changes: putting in place a BCF funded social prescribing referral system which supports secure and efficient referrals and monitoring of impacts; and, introducing a population health management approach to case finding, using algorithms to interrogate GP data to identify cohorts sharing characteristics that mean they are likely to benefit from the prevention and wellbeing services provided by the social prescriber link workers, PCN pharmacists, case coordinators, health coaches, etc.
- **Online self-service information** is a key enabler in prevention, so the Rutland Information Service (RIS) online directory is also included under this priority to ensure it can play its full part in the wider collaborative prevention network and in reaching the public with high quality wellbeing-related information. The system helps communities to make the best of local assets. It promotes tailored public health campaigns and makes it

easier for people to find opportunities to live healthily, including by engaging with a wide range of groups and activities, connecting socially in their communities and increasing their activity levels.

- **Wellbeing services delivered by a number of local VCS organisations**, including: the Citizen's Advice Rutland Information and Advice service supporting people with welfare advice and support, referrals to the Foodbank, and referrals on for wider health and wellbeing support; and a sensory impairment service supporting people with sensory impairments discharged from hospital and in the community, enabling them to remain independent and at home for longer, and to maintain other aspects of their health. Activity this year also includes a one-off piece of work to develop the VCS Strategy for Rutland, which will identify how the VCS can best develop to support our wider communities, including around reducing inequalities.
- **There is a rapid response social work service** for those needing urgent social work support to avert or address a crisis. This service, which works closely with the above-mentioned services, supports the preventive approach at the statutory social work front door. The work centres on responding quickly to a crisis to prevent further deterioration in the home situation. This can include commissioning services within the home or short respite, with a return home if safe to do so. An important aspect of this service is professional input to assess risk and to keep people safe in their own homes, if possible.
- Finally, in a boost to **co-design/co-production**, resource has been provisioned to reinforce personalisation in shaping individual service responses and to increase opportunities for service users/patients to use their lived experience to help to inform and shape future services.

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**, where recruitment challenges were overcome last year to ensure a full strength team. The Therapy Team Manager has driven forward the integration agenda and has forged close ties with the local LPT Therapy Team Manager. They meet regularly and referrals are moved between the two services to ensure the most efficient allocation of resources. As such, waiting lists are kept to a minimum whilst allowing the therapists to have greater input into safeguarding cases and falls prevention work.
- 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. Relevant service users benefit from some of the actions set out in Priority 1, plus the Housing MOT, Assistive Technology, support for care-givers (see also Section 5), and dementia support.
- The **Admiral Nurse service is a key part of dementia support** in Rutland and has continued to grow and develop over the last year. An extended service continues to work closely with primary and secondary care to support people to live well with dementia and, where appropriate, to delay accessing a care home or hospital admission. **Advanced Care Planning** (ACP) remains a priority across LLR, further embedding use of genuine ACP and RESPECT forms. Alongside this, the commissioned Age UK Leicestershire and Rutland dementia contract was renewed in April 2022 for 3 years to cover a new **pre/peri diagnosis support**. This targets support for those on waiting lists for memory services which are now longer following services being halted during the pandemic. The contract change also has the Age UK worker working more closely with the Admiral Nurses, using

the same case recording and picking up step-up and step-down cases from the Admiral Nurses.

- 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. See Section 6 for more detail.
- A dedicated role supports local **care homes** to participate in **multi-disciplinary working** with health and social care partners, including improved care planning, anticipatory care and prevention of unwarranted deterioration using the Whzan Blue Box monitoring system (see below). A further role supports the domiciliary care market with sustainability and expansion of provision available in Rutland along with providing a brokerage service.

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. Following changes to working practices in the teams last year around Discharge to Assess, there is broad continuity in the roles being funded this year.

- RCC currently has a **seven-day therapy offer** funded until March 2023. Having the ability to visit patients over the weekend following discharge from hospital gives working families more opportunity to be involved in their relatives' care planning. Weekend working also allows Discharge to Assess cases to be progressed more promptly, helping to move cases on in a safe and timely fashion to free up care capacity for new discharges. RCC has also just recruited to a social work post covering weekends – again, only funded until March 2023, which should make the Discharge to Assess process even more efficient.
- The Council's in-house care provider and reablement team, in turn, provides **care and support enabling safe and timely discharges**, including through a home first approach to ensure that people can be discharged to their usual place of residence wherever possible with appropriate short-term support. In this role, they also help to inform 'right sized' care decisions for the longer term.
- **Reablement**, starting within 2 days of referral, is also primarily delivered by Micare, which follows the NICE guidance on intermediate care as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care". The Micare integrated health and social care offer is delivered by community-based nursing, therapy and Micare carers to support people and their carers when there is a change in need. They also provide a **step up crisis response service** offering short-term care and support following a referral via health or social care emergency routes to reduce the risk of unwarranted hospital admission e.g due to a health crisis, a temporary inability to transfer, risks following a fall or a carer crisis.
- Complementing the above, we are increasing **anticipatory and proactive care** helping to prevent hospital admission and enable step down. Coordination through Micare and Rise will support proactive care management of long-term conditions and reduce the risk of unwarranted deterioration, while the Whzan Blue Box patient monitoring system in both cohorts, combined with the National Early Warning Score (NEWS2), will enable early identification of deterioration. Whzan allows vital signs to be taken and then remotely

accessed by clinicians including in primary care, so that timely clinical decisions and escalations can be made which can help to avoid escalation through inappropriate pathways.

For further details on the approach to hospital discharge, see Section 4.

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

4 Supporting hospital discharge

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to: (i) support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support. (ii) Carry out collaborative commissioning of discharge services to support this. Include confirmation of self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Alongside the Home First programme set out above, we continue to work at system and place level on supporting safe and timely hospital discharge.

Working closely with the LLR Discharge Hub, Rutland has had an integrated Hospital Discharge Team for several years, consisting of social workers, care managers, therapists and nurses. This responds to a local pattern whereby many Rutland patients are hospitalised in Trusts outside the ICS. The two nurses and the physiotherapist and technical instructor in the team are employed by the local community health provider (Leicestershire Partnership Trust - LPT) but embedded within a joint Hospital Discharge/Reablement service. Having nurses working within the team makes transfer of care considerably smoother as they manage patients who may need Decision Support Tools completing, non-weightbearing patients and those who require nursing care.

All members of the team bring their own professional areas of expertise and support each other as required. It is particularly useful having a multidisciplinary team when triaging Home First forms because they are better able to identify where further clarification is required. This enables the team to place patients more accurately onto the correct Pathway for discharge and allows for more successful outcomes. The team continue to learn from each other and to gain a better understanding of their colleagues' respective disciplines.

High Impact Change Model – self-assessment
Teams continue to keep their practice under review, including relative to the High Impact Change Model.
Rutland has undertaken a self-assessment against the high impact change model of care for 22/23. Attached is the summary of the assessment conducted and the work to progress through the levels of maturity.

RCC HICM Review - 2022-23.docx

Dr Ian Sturgess recently reviewed Urgent and Emergency Care in LLR, making a number of recommendations. Currently, all three Local Authorities run a 'selective' model of reablement on discharge – determining on a case by case basis which patients will benefit most from a period of reablement. However, Dr Sturgess recommended an 'inclusive' model where the majority of discharges – whether Pathway 1 or 2 – should receive some form or reablement, rehabilitation or recovery. To enable this to happen for Pathway 1 cases, there will be a need to expand the capacity of RCC's in-house care team (MiCare) and potentially to recruit an additional therapist and care manager. The Discharge Team is currently reviewing historical data to determine what the increased staffing numbers would need to be and their cost.

The Team currently spot purchases Pathway 2 Discharge to Assess beds in Rutland. While this is flexible and local, it is not the most efficient use of resources, and also presents the disadvantage that therapy cover is not uniformly developed across the homes, and that care home staff are primarily trained to 'do for' residents rather than to reable them. Options are being explored across the ICS, potentially leading to a joint tendering exercise for Pathway 2 Therapy beds. While this may bring improvements, it is not the optimum solution for Rutland residents as the beds are likely to be located in either Leicester City or Leicestershire. Rutland residents would like a Rutland-specific resource so that they can be closer to their families. Other options for local dedicated provision are being considered, including establishing a council-run facility. In this case, the Therapy Team would have an on-site presence with equipment and facilities on-hand for more intensive reablement – ideally leading to more patients ultimately returning home. Owning a residential facility would have the added benefit of helping the Council to limit the increasing cost to the Council of residential care – something which will be even more needed with the introduction of the funding reforms in October 2023.

RCC HICM Review - 2022-23.docx

5 Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Care Act 2014 places a duty on Local Authorities to promote wellbeing and support carers to achieve outcomes that matter to them. Priorities include preventing, reducing and delaying the need for services.

According to the Act, Carers' assessments must seek to establish not only the carer's needs for support, but also the sustainability of the caring role itself, which includes both the practical and emotional support the carer provides to the adult. Factored into this must be a consideration of whether the carer is, and will continue to be, able and willing to care for the adult needing care. This will allow local authorities to make a realistic evaluation of the carer's present and future needs for support and whether the caring relationship is sustainable…The carer's assessment must also consider the outcomes that the carer wants to achieve in their daily life, their activities beyond their caring responsibilities, and the impact of caring upon those activities.

The BCF programme reflects a long-standing commitment to supporting unpaid carers, both through payments under the Care Act for interventions for carers, including respite care, and through the work of the Council's Carers Team and other involved officers.

A Senior Practitioner provides leadership on carers support, working with internal and external partners, prioritising and coordinating activities. They contribute to the local delivery plan for the LLR Carers Strategy and promote community engagement that helps to identify more carers, enabling the priorities in the strategy to- achieved.

The Carers' Team in turn comprises two officers – a significant commitment in a small ASC team. One of their priorities is to identify more carers, and earlier in their caring journey, both to provide support and advice to those individuals to improve their day to day lives, and to understand wider carer needs across Rutland to inform effective services. 'Carers passports' have been established and give carers a sense of recognition thereby promoting their wellbeing. They will be an integral part of how we go forward to develop carer friendly communities. For shops, businesses and services, they aim to encourage them to ensure they are accessible to carers.

Information and advice is given to carers which enables them to put systems into place which make their role more manageable and sustainable and avoid deterioration into crisis. An important aspect of this is encouraging and enabling carers to look after their own wellbeing so as to be in a better position to care for their loved one. A crisis may lead to avoidable admissions to residential care or hospital for the cared for person and/or the carer. Contingency planning is carried out as part of this work.

Timely, person-centred and empathetic support from the carers team, working in collaboration with other colleagues in health, social care and the voluntary sector, promotes carers' psychological wellbeing and enables them to maintain their caring role and the independence of their household, while reducing the need for more costly care and support. Practical work includes advocating for carers to support them to access sources of funding and benefits.

Community engagement and information sharing events are an opportunity to engage with both the public and professionals around carers' needs, and these are being extended to reach less well connected individuals and communities.

One area of challenge which was highlighted by Carers UK has been carers' experience of hospital discharge. In response, the carers team are collaborating with hospital discharge teams and main acute hospitals (UHL, PCH) to support identification of carers and instances where carers may need additional help (eg. coping with changed care needs on discharge).

Wider staff have reported that this is beneficial to their practice and understanding of the needs of carers.

There is an ongoing risk of crisis for carers so, alongside the above, RCC's Rapid Response Service provides same-day responses to prevent crisis, including where there is a risk of carer breakdown or avoidable hospital admission.

The needs of carers also vary depending on the situation of the person who is being cared for. Complementing the Carers Team, Rutland has also made a commitment to Admiral Dementia Nurses as part of its BCF programme. They support the carer as much as the cared for person through their stages of their journey with this progressive condition.

£k has been allocated for carers Direct Payments, providing carers with respite or support with practical tasks. The above work to support carers in making their lives more manageable has enabled the Council to reduce their spend on these Direct Payments.

6 Disabled Facilities Grants (DFG) and wider services

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

Rutland County Council is a unitary authority and therefore does not draw up formal agreements with districts around the use of the DFG. Instead, there is close working between relevant in-house services and with commissioned providers as set out below. Housing services are also 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. Resettlement is a service within this team, supporting people in Rutland to remain well and support community cohesion.

The Disabled Facilities Grant (DFG) is used to fund both standard DFG projects and smaller, swifter Health and Prevention (HaP) Grants, typically for adaptations such as home access improvements, stair lifts and level access showers. The DFG continues to be managed in-house, delivering a preventative and creative service which places the individual at the centre of the process. The Council's continued commitment to delivering adaptations without delay, including through the pandemic, has ensured it delivers on presenting need. There are no lengthy wait times for any level of adaptation, offering preventative solutions, optimising wellbeing and reducing carer burden. The Trusted Assessor approach with the Council's commissioned 'Housing MOT' Service (a broader home check leading to a range of referrals and other advice) has now been embedded into practice, reducing duplication and delays.

The Council's Therapy Team Manager and Principal Occupational Therapists continually review service demands and delivery to ensure that the service remains accessible, responsive and is delivered to a high standard. Understanding the importance of technology in increasing independence, health and wellbeing and in reducing care needs has led to the development of a DFG Assistive Technology Occupational Therapist post. Developed in line with the newly published DFG guidance and in consultation with Foundations, the national

body for the Home Improvement Agency, this new role offers specialist advice on how Assistive Technology can be incorporated into a scheme of works to maximise the benefits of home adaptations.

The Council is in the process of writing a standalone Regulatory Reform policy whose purpose is to maximise the benefits and increase understanding of the ways DFG funding can be used creatively. An example of this last year was providing grant funding for an accessible community space that delivered greater benefits to a wider community rather than to a single household through as would be the case through an individual grant award.

As the Housing MOT has proved a successful model for assessment, intervention and signposting for a healthy home, we have replicated this model to launch a Digital MOT for Rutland. The Digital MOT provides an assessment of need, establishing the extent to which a person is or could be digitally enabled, and any barriers to this. Replicating the MOT model a suite of offers have been considered to meet a diverse range of needs. Age UK are partnering with the local Housing Improvement Agency to provide a multiple option offer to upskill people, and a technology loan service. The Council is collecting initial data to demonstrate outcomes and, if successful, hopes to fund this ongoing in the future to combat digital exclusion.

7 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 BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

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

In 2021-22, a health inequalities plan was developed by LLR ICS partners to consolidate LLR's approach 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 wider range of other disadvantages, including the wider determinants of health (low incomes, rural isolation, lifestyle choices, etc). The plan is helping to support the response to health inequalities both in Rutland and the wider LLR health and care system.

Building on this strengthened LLR framework, a Rutland Health Inequalities Needs Assessment is currently in progress as a key part of Rutland's Joint Strategic Needs Assessment. This assessment, which has involved engagement with a wide range of Rutland partners, aims to develop a greater understanding of inequalities across Rutland.

Inequalities can often be masked by whole population dashboards in rural areas, requiring closer analysis in order to surface patterns and issues with greater confidence.

The assessment is covering the four overlapping dimensions of health inequality:

- socioeconomic groups and deprivation;
- inclusion health and vulnerable groups;
- protected characteristics in the Equality Duty; and
- geography.

Recommendations will identify opportunities to apply a proportionate universalism approach, providing universal services with an element of targeting residents and communities most in need, ultimately reducing inequality.

BCF delivery this year and BCF planning and delivery going forward will be aligned to the findings and recommendations of the needs assessment, ensuring allocations are supporting those experiencing the poorest health outcomes, or with worse access to services.

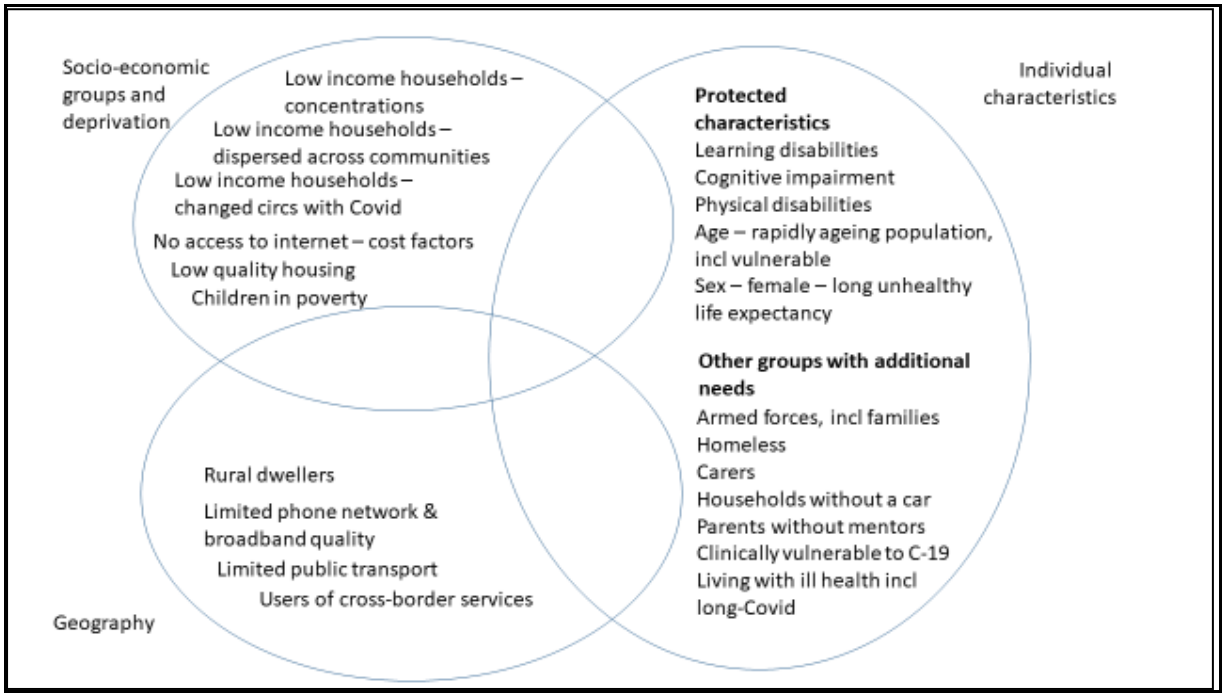
In parallel, health inequalities have become a strategic focus of the Integrated Delivery Group, the subgroup of the Health and Wellbeing Board which operationally drives the BCF programme. This will help ensure partners to work collaboratively on reducing the inequalities presented in the needs assessment, including through the delivery of BCF actions.

A more considered and governed approach to addressing health inequalities will enable more structured mechanisms to monitor progress on reducing inequalities, allowing BCF projects to align and demonstrate their impact in a more coherent way.

Core20Plus5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at national and system (LLR) level. Rutland is a relatively affluent area so does not have populations among the 20% most deprived nationally according to the Index of Multiple Deprivation. The ‘Plus’ element, however, allows local places to determine priority disadvantaged groups sitting outside of the core 20% most deprived. The Rutland Health and Wellbeing Board are currently confirming their local ‘plus’ groups based on local intelligence. Once identified, these groups will also be considered in respect of BCF implementation and future planning.

We also recognise that disadvantage is often multi-faceted (see Figure below). Considering equality factors in this way helps to see circumstances in the round to ensure appropriate responses. 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 within this holistic framework.

Figure 1: Rutland: overlapping inequalities



The following examples illustrate how Rutland's 2022-23 BCF programme has the capacity to enhance equity, promoting equity of access and outcomes as a cross-cutting aspect of health and care delivery under the programme.

Under Priority 1: Unified Prevention

- Strengthening social prescribing capacity through RISE and the Community Wellbeing Service to ensure that a holistic, personalised response is provided to any individual whose mental or physical health, or ability to live with ill health, could be improved through actions complementing clinical interventions, 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 wellbeing interventions including 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, lifts and other access adaptations) 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

ICB Integrated Care 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

UHL University Hospitals of Leicester