Better Care Fund – Provisional proposal for the 2016-17 programme v1.0

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Contents

Introduction

This paper sets out proposals for a new Rutland Better Care Fund programme for 2016-17. These proposals have been developed in advance of national BCF guidance, which is due out in early January. Therefore, the proposals must be seen as provisional.

The proposals have been informed by:

- The **interim evaluation of the 2015-16 Rutland Better Care Fund programme** and the inputs of the Rutland Better Care Fund partnership to this exercise, including through the peer review discussion held at the 3 December Integration Executive.
- **Programme monitoring up to December 2015**, including performance against metrics and regular highlight reports.
- **New project workshops** held on 23 November (Oakham) and 1 December (Uppingham).
- **Relevant Rutland strategies**, including the Health and Wellbeing strategy and Adult Social Care strategy.
- **National BCF announcements** to date, including confirmation that the minimum mandated budget will be similar to 2015-16.
- **National NHS planning guidance** 'Delivering the Forward View', released in December 2015.
- New and revisited **health and social care research** relevant to the programme and the circumstances of Rutland.

Interim Evaluation of the 2015-16 programme

An interim evaluation exercise was undertaken in November/December 2015, with a core methodology adapted from a framework issued nationally by the national Better Care Support Team. The evaluation involved three main elements:

- reviewing top-down achievements as captured in the programme's key indicators,
- scheme level evaluations, which were then discussed at a special Integration Executive meeting to establish a 'moderated' view of performance across the programme and to agree key directions to progress further in the next programming round, and
- undertaking two new projects workshops, which partners were invited to attend and which provided a space to discuss new or additional directions of work.

Progress against indicators

There is a lag time in key indicator updates, but most indicators have been going in the right direction overall up to the end of quarter 2 (September 2015), notably reablement (the proportion of people who remain at home 91 days after discharge from hospital), avoided admissions to residential care and delayed transfers of care (but with some volatility in the latter case).

Days of non elective admissions were also sufficiently below the target threshold in the first two quarters of 2015-16 for the pay for performance payments to be made. However, ELR CCG has indicated that this latter indicator is unlikely to be on target in the third quarter as the wider trend for non elective admissions is rising. Analysis has been commissioned to better understand these patterns and to identify any opportunities to impact on this trend (eg. considering whether admissions of longer duration are arising from to exacerbation of existing conditions that could be stabilised through pre-emptive care at home).

It is more difficult to comment on performance in relation to the local indicator, falls, as up to date comparable data is limited, with a lag time in the issuing of Public Health England falls statistics (the 2014-15 figure is not as yet available). Even with falls prevention projects taking time to come on stream, falls prevention is believed to have been a tangible outcome of many parts of the programme, however, evidenced through scheme highlight reports and the evaluations detailed below (eg. reablement, assistive technology, DFGs, care coordination, dementia care). However, local health data indicates that it is likely that the number of falls remains high relative to targets. Levels of falls would, however, probably have been higher still without the BCF interventions.

Finally, the customer satisfaction survey is undertaken annually in the spring, so it is not possible to gauge performance directly against this. More could potentially be done to capture user satisfaction ongoing, using unified tools, to feed back into informing the programme.

Scheme level evaluations

For this stage of the evaluation, scheme leads worked with their stakeholders to complete a questionnaire which captured:

- the scheme rationale, achievements to date and outstanding plans for 2015-16,
- a score based assessment of performance in a set of key areas (eg. the extent to which the scheme is addressing an important issue, delivering as planned, building integration capacity, progressing early help or self help and supporting end users),
- an assessment of the extent to which the scheme had progressed the 'six domains of integrated care' (see below), presented via a SWOT analysis (identifying strengths, weaknesses, opportunities and threats),
- the lessons learned to date and recommendations for the scheme's future development, and

The six domains of integrated care (proposed by the Better Care Exchange)

1. **Leadership/**management of a successful Better Care implementation
2. Delivery of **excellent on the ground care, centred around the individual**
3. Developing underpinning, integrated **datasets and information systems**
4. **Aligning systems** and **sharing benefits and risks**
5. **Measuring success** (metrics, feedback, evaluation)
6. **Workforce and culture** - developing organisations to enable collaborative health and social care working relationships

The scheme level evaluations are summarised in **Appendix 1**. Overall, this stage of the evaluation demonstrated that the programme has been progressing well in the main with clear connections being drawn between most of the schemes and desired outcomes as measured by the programme's metrics.

The programme has positive and proactive governance and there has been good progress on integrated, cross-sectoral working, preparing the way to take integration further in the next programme (eg. closer working between community health services and social care has impacted positively on reablement outcomes and reduced delayed discharges, while closer ties between GP surgeries and social care through the care coordination role have ensured that patients with growing needs are offered a wider range of services than purely health). Some schemes took time to get off the ground due to procurement or recruitment processes, and scheme performance has also been

affected in some cases by staff turnover or competing demands. The resilience and consistency of systems is something to work on going forward.

The highest priority aspect of the current programme has been to reduce the burden on acute care, by avoiding emergency admissions wherever possible, ensuring prompt hospital discharge and avoiding readmission through reablement. New day and night crisis response approaches have been introduced and have reduced emergency admissions. It is possible that these could be used more extensively and could be more joined up. Additional resources have been deployed and pathways further developed to facilitate prompt discharge from hospitals in and out of the area (with a particular emphasis on Peterborough Hospital which currently handles over half of Rutland's non elective admissions), with parallel changes to the delivery of reablement services helping people to remain at home (including through a reorganisation of Rutland County Council's adult social care services and closer working with relevant community health colleagues).

Turning to long term conditions, the falls prevention and dementia schemes have both taken time to build momentum for a variety of reasons (eg. procurement or recruitment time), but are now well placed to deliver tangible outcomes contributing to programme metrics. To further evolve the local health and care system, the programme's focus on long term conditions could usefully be broadened out from dementia and falls, building on the care coordination work, as many more conditions are challenging for people to manage and impact on both their quality of life and demand for health and social care services. There is also scope to increase the person-centredness of approaches, addressing the whole person and in ways tailored to them (mental and physical, health issues and issues impacting on health, the individual and the circle of support around them), also responding in a coherent way around life events (retirement, significant diagnosis, bereavement, downsizing) and making it easier for people to take a greater role in shaping and maintaining their own wellbeing. An important aspect of the changes is to facilitate closer working by community health care and social care. Other aspects that there is scope to build up include support for carers. Users could also be more involved in helping to shape services and in feeding back on whether new approaches are working in practice for them.

Looking at the broader prevention landscape, there have been positive opportunities to increase the role played by VCF organisations, for example through the Community Agents scheme, dementia work and falls prevention projects. This builds up individual and community capacity. The introduction of new services such as assistive technology and falls prevention training and awareness raising alongside well established interventions such as Disabled Facilities Grants has broadened out the options helping people to stay independent for longer.

Underpinning the above changes, work has been done on enablers including workforce development (eg. training enabling staff to work to the health and social care protocol, reorganisation of Rutland social care into team structures better responding to future needs, new job descriptions), IT systems (procurement and delivery of a new social care case management system, ability for workers to access their own information resources directly across all the main health and social care buildings), information sharing (the council has obtained NHS numbers which will be used from April 2016 as the primary patient/service user indicator). There was significant work done under the programme to secure Care Act compliance. This work was successful but some systems require ongoing development (eg. further developing the Rutland Information Service for information and advice) and this needs to be factored in. There is also work to do on other enablers,

particularly around the care records which underpin the work around patients and the ability to coordinate effectively.

New projects workshops

The two BCF new projects workshops, held on 23 November and 1 December were an opportunity for a wider range of stakeholders to work together to generate new ideas for projects or areas of work that could be progressed under the 2016-17 Rutland BCF programme, either as identified new schemes or through competitive calls for bids once the programme was underway. A summary of the outcomes is provided through a set of slides in **Appendix 2**.

In practice, the workshops tended to generate ideas to further develop or evolve existing areas of activity, rather than proposing whole new areas of work that had not yet featured locally. This is in a way encouraging – there was agreement that the programme was already doing broadly the right things but that there was scope to enrich this.

Key areas where ideas were generated were:

- **Communication.** It was agreed that more work could be done on communications locally, building on existing communications channels, so that the plethora of support available was communicated coherently and was easy to understand and stay up to date with, both for professionals and end users. This is addressed in the unified prevention priority of the new programme.
- **Further developing established services.** A range of ideas came forward to further evolve some existing schemes, notably assistive technology and home adaptations, which also have the potential to be coordinated together. In terms of technology, ever more older people have access to smart phones and are increasingly confident with technology – does this mean there is more potential to supplement or enrich care using these tools?
- **Partnership building.** There was further potential to further build the partnership, both between health and social care and eg. working differently with providers. It is anticipated that the Council's new 'innovation partnership' approach to commissioning will have an impact here. There was also scope to engage and involve end users more in shaping services – we are currently low down on the 'engagement ladder', doing things to and for end users, not yet with them.
- **Enhancing prevention services, making it easier to keep well.** GP surgeries were recognised as key trusted focal points in the community. More services could wrap around these, making it easier for patients to access a wider range of 'whole person' support and freeing up GP capacity in the process to focus on more complex health cases.
- **Long term conditions.** The existing interventions were welcomed, but there was scope to broaden out. Half of GP appointments are long term condition related. Mental health is also a part of this picture, including for younger people. We could join up local insights about long term conditions to bring more benefits.
- **Enablers.** IT was also recognised as a blocker.

Revisiting the original Rutland BCF aim and priorities

The Rutland 2015-16 BCF plan sets out its overall medium term aim as follows:

> "By 2018 there will be an integrated social and health care service that has significantly reduced the demand for hospital services and puts prevention at its heart."

This high level aim summarises the main direction of travel nationally for health and social care and remains key in Rutland. Given good progress to date, we propose that the aim to achieve the objective by 2018 offers a good balance of challenge and realism. To emphasise the critical role of individuals in managing their own health journey, the importance of appropriate healthcare choices and the contribution of communities to health, it is proposed that the following underlined changes would be worthwhile additions to the main programme objective.

> "By 2018 there will be an integrated social and health care service that is <u>well understood by users, providers and communities</u> and <u>used appropriately</u>, has significantly reduced the demand for hospital services and puts prevention <u>and self management</u> at its heart<u>, including by building on community assets</u>."

The 2015-16 Rutland BCF plan anticipated working towards this objective via operational plans in four thematic areas, supported by a fifth 'enabling' workstrand:

1. Unified prevention services
2. Integrated urgent response
3. Hospital discharge and reablement
4. Long term conditions
5. Enablers (notably IT, Information Governance, information and programme management)

These high level priorities remain relevant to Rutland's needs. They are also consistent with the main proposed areas of activity of neighbouring authorities for 2016-17, which is helpful when working in a health economy in which many organisations cover a wider area than Rutland.

There is scope for the programme to evolve, however, within the detail of these priorities to progress Rutland to the next stage of its health and social care transformation. It is proposed that urgent response and hospital discharge and reablement should be consolidated into a single priority and that the priorities should then be reordered as follows:

1. **Unified prevention services**
2. **Long term condition management**
3. **Crisis response, transfer and reablement**
4. **Enablers**

This sets out a logical hierarchy of universal and more targeted prevention services, complex management of long term conditions, then, at the apex of the pyramid, services around acute care. Activiities span the classic pyramid of preventative measures, the lower levels having universal scope, and the higher levels a smaller target population but with greater needs:

- Help people to remain well whenever possible through primary prevention activities, removing risk factors before they have done the harm (eg. quitting smoking, losing weight, having flu jabs so they do not become ill at all).

- Use secondary prevention to diagnose disease early and delay its progress (eg. reducing high blood pressure or cholesterol or delaying the development of Alzheimer's symptoms).
- Where people do have symptomatic health issues, to undertake tertiary prevention, mimimising the symptoms or reducing their impact so people stay as well as they can for as long as they can, including through reablement to maintain mobility, for example.
- Then, wherever possible, for patients suffering greater ill health, avoiding the health crises that can lead to hospitalisation and, if people do need to be taken into hospital, ensuring a transfer of care back home or to local providers as soon as possible to avoid deconditioning and secondary infections, etc, as well as reducing demand for acute services.

2016-17 themes	Proposal	Impact on service users
Unified prevention services	Make it easier to find out what services are on offer locally to support health and wellbeing, by further developing the Rutland Information Service as a joint platform for the public, professionals and advocates. Bring prevention services in Rutland communities into a more coherent, consistent offer, including housing expertise and support to carers, including by using a new commissioning model. Provide better coordination and communication of this offer in communities and via trusted primary care settings so that local people have easy access to information, help and advice. Build community capacity so that communities are more self sufficient.	• People keep themselves well and know where to go to get information and advice if needed about what is available in their communities. • People feel supported to live independently at home. • Delaying the need for invasive and costly care packages. • Equipment provides peace of mind for users. • Patients can manage their own care. • More self sufficient, self sustaining communities, tackling social isolation.
Long term conditions	This priority addresses the support offered by primary and community health and social care for patients with long term conditions and the frail elderly, including through: • Enhanced approaches to care management and support planning (building on the care coordinator approach), including anticipating and reducing needs. • A review of care pathways. • An integrated system spanning primary care and community based health and care services in and out of hours. • Consolidating, integrating and extending a number of Rutland's community health based services into one 24/7 service operating across health and social care – to focus on maintaining independence in the community for as long as possible.	• Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness. • Service users feel in control of their care. • Service users feel supported and that their needs are understood. • Service users are better able to manage their condition(s). • Service users are able to stay as well as possible for as long as possible.

Crisis response, transfer and reablement	• Rapid response services avoid unnecessary hospital admissions and residential care for those needing urgent assistance. • Significant improvements in the timeliness and effectiveness of discharge pathways from hospital, especially for frail older people by consolidating new coordinated approaches to transfers of care. • Optimised independence and recovery when returning home.	• Reassurance for the service user and their family that there is effective support closer to home reducing likelihood of being admitted to hospital. • If they do have to be hospitalised, patients return sooner to a community setting, rather than deconditioning in hospital. • People can more easily resume their normal lives on their return home, maintaining independence. • Choice for end of life patients who may want to remain at home. • Acute beds are freed up for acute needs.
Enablers	IT and Information Governance facilitate integrated care rather than being a barrier to it. Integrated commissioning is progressed as an important transformational enabler.	• Health and social care systems will be aligned/joined up with a common dataset so patients are asked less often to tell their story and can receive improved service. • Joint commissioning drives integration and reduces duplication, reducing overall costs of care.

The BCF priorities and schemes

The proposed actions to be supported under each of these four priorities are described in more detail below. The overall thrust is one of continuity, but with some reshaping that builds on progress to date and aims to progress more concerted integration.

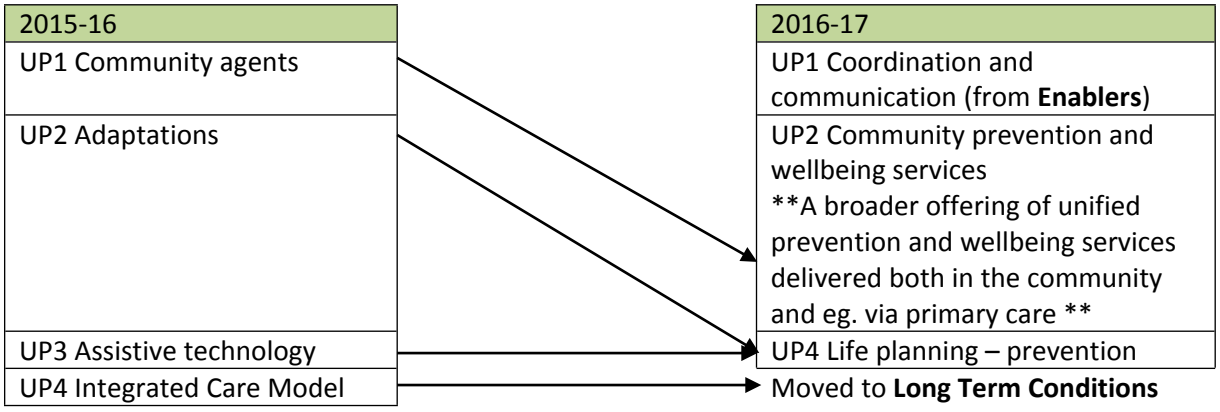
The priorities are described in more detail below. Each section summarises the rationale for the proposed changes, sets out how the 2016-17 proposals relate to 2015-16 schemes, and summarises each scheme and its potential to contribute to the programme's key metrics (assuming these remain the same as in 2015-16):

Programme metrics
1. Avoided admissions to residential care
2. Reablement (people still at home 91 days after discharge from hospital)
3. Delayed transfers of care reduced
4. Reduction in non elective/emergency admissions to hospital
5. Patient satisfaction (agreement that services have improved quality of life)
6. Reduction in admissions due to falls

1. Unified prevention

Main prevention activities have been positive but potentially too scheme focussed and largely divorced from prevention activities taking place in parallel outside the BCF programme (eg. as led by Public Health). While there have been clear benefits, it is difficult to say, therefore, that we have reached the point where there is a 'unified' prevention offer. A key aim needs to be to consolidate the valuable services developed and offered in 2015-16 (within the programme and in parallel with it), and at the same time to reach more people more easily with prevention messages.

Mapping – Unified prevention schemes – 2015-16 to 2016-17



Unified prevention - schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
UP1	Coordinating and communicating the offer	Further developing the Rutland Information Service as a common/collective online information platform that partners and users believe is an effective, easily navigable, up to date view of what activities and services are available in local communities. Partners will be working together to streamline and improve information, making life easier for providers, advice givers and advocates and making self help easier to achieve. This will also help involved organisations to position their offer relative to the wider picture.	Y			Y	Y	Y
UP2	Community prevention and wellbeing services	As part of the prevention strategy, there is a continuing need to work with 'harder to reach' people and those who are below the threshold for social care directly in their communities, and to increase community capacity, including by building on existing community assets. Therefore, community based advice and community capacity building would continue, largely via the Community Agents scheme and their associated services and networks. In parallel, to increase the reach and take-up of prevention services, supporting people to help themselves, the proposal is for a wider range of tangible services including some offered by the Voluntary Community and Faith sector and public health (so not just information and advice) to be accessible via GP surgeries. This gives a 'whole person' response via a service that people trust,	Y	Y	Y	Y	Y	Y Y

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		helping individuals to tackle life issues and behavioural risk factors more easily. This complements the CCG's proposed healthcare GP wraparound, boosts prevention, keeping people well for longer, and increases GP resources for more complex case management (research indicates that around 20% of GP time is spent on health issues whose cause or solution lies outside medicine (eg. money problems, social isolation, stress, housing (Citizens Advice , 2015)). This could include offering access to Public Health and VCF prevention services via or from GP surgeries (eg. around smoking, debt, housing, stress). During 2016-17, RCC is developing a commissioning model in which a partnership will be established via a procurement who then work together to co-design and develop models of delivery. The activities under this scheme would be in scope. There is also potential to coordinate the CCG's VCF commissioning into this picture.						
UP3	Life planning – preventative services	This brings together a range of schemes offering tangible support to help people stay independent for longer. Some of these services map to the social care 'front door'. From the current programme, they would include the Disabled Facilities Grants, assistive technology, falls prevention projects such as the FaME exercise programme and the next stage of the 'lifelong design' scheme for accessible homes. The possible benefits of the latter to the health service were underlined in a recent study for Public Health England which found that, nationally, simple improvements to the homes of older people could save the NHS £600m per year (BRE Group, 2015). This is also an opportunity to draw together a broader range of services and support addressing different types of prevention activity helping people to retain their independence, so that these are easier to access. The priority's name highlights that it is about getting people to plan ahead, not just delivering for urgent need. The scheme could include a small projects fund. It is important that delivery here continues to explore new	Y Y Y	Y Y Y			Y	Y Y Y

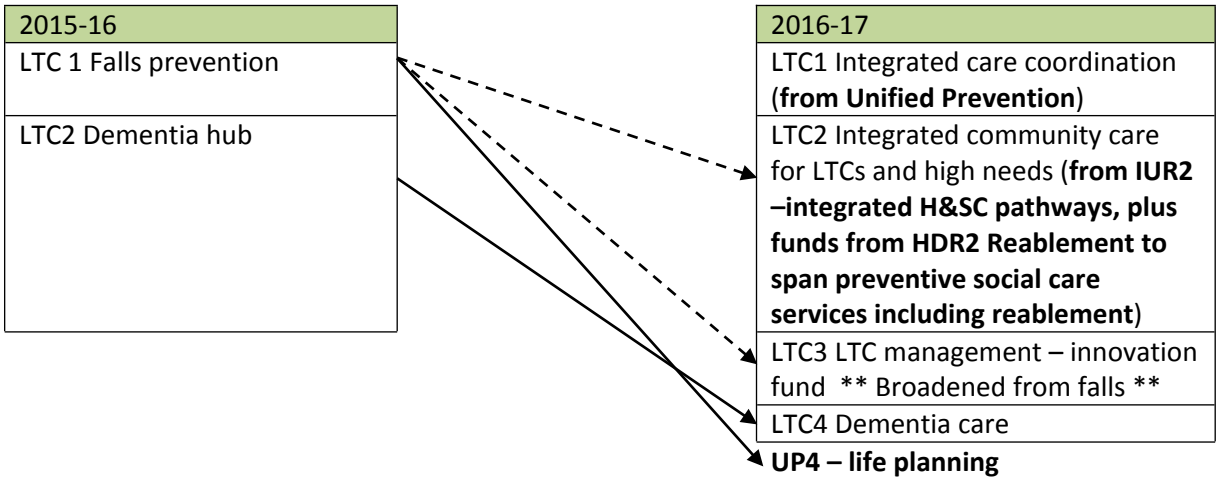
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		areas (cf. the Speakset pilot that allows video calling to/by service users). A number of other potential changes in approach were identified during the evaluation eg. new DFG purchasing choices where they offer benefits to users and reduce overall costs. (The capital budget for DFGs would need to be ringfenced, and may therefore need to be managed and reported on as a separate scheme.)						

2. Long term condition management

In the 2015-16 Rutland BCF programme the focus of the long term conditions priority was on two specific issues: dementia management and falls prevention. While these remain important issues in the County, this focus left little room to address one of the biggest causes of demand on health services locally and nationally: the difficulties posed in managing the health of individuals with multiple long term conditions. The proposal here is therefore to strengthen the Long Term Condition management priority to respond to this, as this broader aim has further potential to reduce non elective admissions in particular and to help people remain living at home. A core part of this priority is to build up an integrated community health and social care service that is well coordinated and tailored to local needs.

Dementia is a growing issue given Rutland's ageing population, so it is proposed that the Rutland dementia scheme should continue. Falls prevention will no longer be a stand-alone scheme but, as illustrated in the table below, will continue to be progressed under a number of other headings and tracked via the local falls indicator if this is retained. The current falls projects would be progressed, if still ongoing, under the 'Unified Prevention' priority. Given people's reluctance to seek an early diagnosis for dementia, the dual focus of this scheme should continue: developing dementia friendly communities on the one hand (at the same time ensuring more people are more informed about the condition) and helping sufferers of the condition and their carers on the other.

Mapping – Long term condition management – 2015-16 to 2016-17



Long term condition - schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
LTC1	Integrated case management for LTCs	The Integrated Care Coordinator previously worked under the prevention priority, reviewing whether people with complex health needs (as identified by GPs using risk models) have other unmet needs (eg. in social care), that, if addressed, could help keep them well. To further enrich the local approach to helping people manage their long term conditions, it is proposed that the care coordinator role be moved to the LTC priority and that, to further strengthen the LTC management response in Rutland, the focus shifts towards 'integrated case management'. Additional specialist medically trained case manager capacity would be created that could lead on specialist support planning and prevention, creating a small team that can take this activity to the next level. These specialist prevention services would draw on the integrated community health and care services covered under LTC 2 below. This shift would also help to drive forward support planning and the use of Personal Health Budgets and would support Continuing Health Care assessment and management. This scheme would focus on those with chronic health problems (so, those with multiple long term conditions (including mental health) and/or frailty and who are having	Y	Y		Y Y Y	Y	Y Y Y

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		difficulty managing their situation). It could also address mental health and end of life planning. There remains a need for good coordination and linkage with other prevention schemes, notably UP2 Integrated prevention and wellbeing (especially as some of this activity would be tightly associated with primary care). The shift in emphasis also helps to articulate a clearer distinction between community prevention services and integrated case management.						
LTC2	Integrated community health and care services for LTC and high needs	**Community health services** (including ICS and district nursing) and **social care teams** (particularly the long term and reablement teams) already work closely to support people in the community who have health and/or social care needs. This scheme aims to further integrate and enrich this approach. The scheme, effectively another aspect of the GP patient 'wraparound', would provide follow through on coordinated person-centred support planning, reduce duplication in overlapping areas `of care and offer scope for the effective deployment of prevention services to people at risk eg. making more use of reablement therapies to sustain health. There is also likely to be increased scope to intervene before developing issues become urgent care needs. A further aspect is coherent support for the planned care journey. This scheme would support any developments which were needed to drive forward integrated working, for example coordinating job descriptions and terms and conditions, developing shared posts and processes, joint commissioning of services. The health and social care protocol which allows trained social care professionals to undertake health-related tasks is an enabler to this integration. This scheme would be further supported through a proposal to collocate health and social care teams at the Rutland Memorial Hospital and to establish integrated leadership.			Y	Y		Y Y
LTC3	LTC	This scheme offers scope to innovate locally in how long term	Y	Y	Y	Y	Y	Y

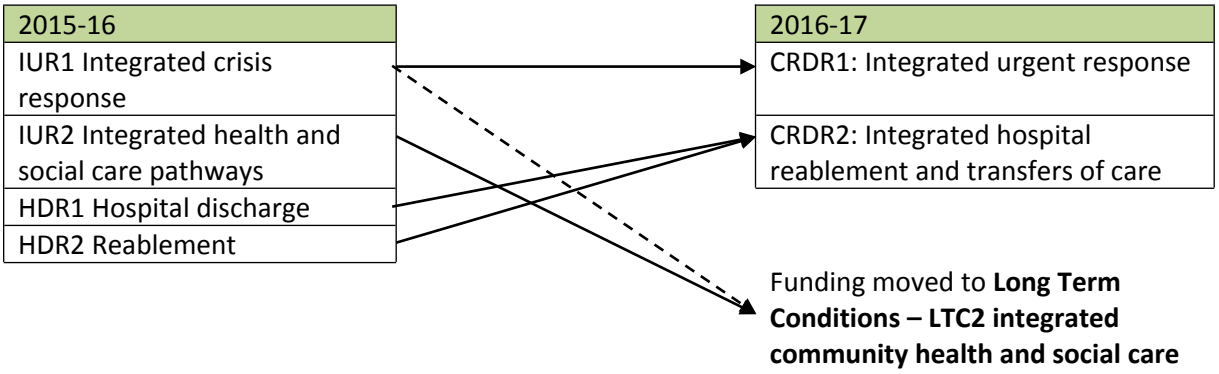
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
	management – innovation fund	conditions are managed, including through patient activation and self care. This would allow scope for the case managers anticipated in LTC1 to progress pilot projects trialling approaches that are new in Rutland. Successful interventions could offer scope to reduce health and social care demand while improving individual quality of life. There is potential to work more closely with patients to co-design approaches to improved condition management which could include eg. telehealth pilots for self-monitoring and enhanced responses to the mental health impacts of living with illness. It would also be helpful to understand what factors help patients to take a proactive role in managing their own health and how to encourage these.						
LTC4	Dementia care	The dual focus of this scheme should continue: i. developing dementia friendly communities, and ii. services to help sufferers of the condition and their carers. Healthwatch work confirms that the wider awareness work remains important to reduce the stigma around dementia and to give people the confidence to take early action should this condition affect their lives directly. Continuing with a scheme focussed on a specific condition provides a test bed in which lessons can be learned about shaping services across multiple sectors that can then be applied to other contexts where there is a need for coordinated working across all sectors around a specific health challenge.	Y		Y Y Y	Y	Y	Y

3. Crisis response, discharge and reablement.

This priority needs to be continued as it is at the 'sharp end' of the immediate need to reduce the burden on health's acute services. However, it is proposed that the priority's funding should be rebalanced to more accurately reflect the proportion of local activity that relates to directly avoiding hospital admission and managing hospital discharge and reablement. Activity that is instead longer term community based care for patients/service users and has a preventative aspect will be reflected under the LTC heading.

This priority will continue to work to avoid people in crisis being hospitalised and, if they do need to be taken to hospital, getting them home again as soon as possible and enabled. New approaches here will be continued and consolidated, with further integration. A key challenge is to build up resilience and consistency, both of which are challenging in small systems reliant on small numbers of staff, particularly where staff turnover affects continuity. This includes 24/7 consistency.

Mapping – Crisis response, transfer of care and reablement – 2015-16 to 2016-17



Crisis response, transfer of care and reablement schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
CRDR1	Integrated urgent response	2015-16 established 24:7 services to ensure that people in a health crisis are offered assistance other than hospitalisation, if hospitalisation is not the best option for them. 2016-17 will be focussed on consolidating these services. Night and day services operate differently: • Night: Single Point of Access and night nurses. Participation in the wider Leicestershire night nursing scheme (the most cost effective approach given low volumes of demand locally). • Day: Ensuring that integrated ICS and Reach activity is able to respond to crisis, preventing hospitalisation wherever this would not be the best course of action. Service Level Agreements would help to ensure activity and performance was captured regularly and consistently, helping to better understand patterns of use and impact and the scale of demand/need. Currently, numbers of avoided admissions feel low relative to the overall patterns of emergency admissions - as a ratio, they represent less than 5%				Y Y	Y	Y

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		of all emergency admissions locally.						
CRDR2	Integrated hospital reablement and transfer of care	This addresses hospital discharge pathways 1, 2, 3 (1 = straight home with existing support, 2 = home with some new or additional support, 3 = complex transfers of care where the individual is unable to go straight home and needs an interim stage of care). There is potential for Rutland to progress further along the 'maturity scale' for discharge planning and management, including by boosting resources for transfers of care. More than 50% of admissions are now out of LLR, so the distribution of resources to support the return home needs to continue to map to this pattern and be able to respond if the pattern changes. This scheme involves the In-reach team, ICS and Reach. The In-reach team could be further embedded. There is also scope for further change eg. co-commissioning of the independent sector, person centred planning of the pace of reablement, readmission risk management. Residential reablement needs to address discharge to assess and continuing healthcare issues.		Y Y Y	Y Y Y		Y	Y Y Y

4. Enablers.

A main focus of the 2015-16 programme Enablers priority was Care Act 2014 compliance. As compliance has been achieved, this priority no longer needs to figure in the programme. There is a continuing need for programme management. In addition, there is further work to do on 'enablers' for change. This is reflected in the proposed structure of this priority (below).

Mapping – Crisis response, discharge and reablement – 2015-16 to 2016-17

2015-16	2016-17
E1 Care Act enablers	E1 Enablers
E2 IT and data sharing	E2 Programme support and comms
E3 Programme management	

Enablers schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
E1	Enablers – revenue	Comprises actions relating to: • facilitating secure and appropriate information sharing through sharing agreements and training, and securing use of the NHS number as primary identifier, • IT systems supporting integrated care, • whole system leadership, culture and workforce development, also development of the provider workforce, and developing new ways to work with the community, voluntary and faith sector, • customer profiling and targeting, • user engagement and increasing the person centredness of delivery, and • analytics and evidence-based decision-making (including further development and exploitation of the LLR-wide Health and CareTrak system). There is a key need to meet mandatory requirements around use of the NHS number and ability to share case information. Alongside this, some of the other enablers merit attention as they will help to unlock progress on integration. These would benefit from more oxygen & visibility eg. leadership development and increasing the role of service users in informing service and system design. If there is capital spend for the enablers, this may need to be managed as a separate line.						
E2	Integrated commiss-ioning	This scheme addresses joint commissioning across health and social care in Rutland to help to drive change in the other three priorities. A planning stage is needed that confirms the potential scope of this activity. Candidates include commissioning of care homes, domiciliary care and residential reablement. This scheme will benefit from lessons learned from the CCG's joint commissioning activities with Leicestershire County Council during the current financial year. It offers opportunities to tailor services directly to Rutland. Defining a separate commissioning workstrand will help to ensure clear leadership of commissioning versus operational change and bring greater visibility to commissioning as a						

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		transformational activity. There is no dedicated budget here for this activity – budgets being committed are reflected, where relevant, elsewhere in the programme. If joint commissioning is undertaken for budgets not yet included within the BCF section 75 agreement, the option is available to establish stand-alone section 75 agreements for risk and benefit sharing. This avoids bundling jointly commissioned spend into the BCF agreement where this may not fit well in terms of timescales and governance.						
E3	Programme support and comms	Although programme support is presented as a separate line in the budget for transparency, this capacity not only supports the administration and governance of the programme but is also engaged in working with the partnership to shape the programme and progress the enabling workstrands.						

Draft budget allocations

The budget below is indicative and will be subject to change following confirmation of budget allocations and full technical guidelines. In this indicative allocation, around 20% of the BCF budget is allocated to unified prevention, a third to long term condition management and 40% to crisis response, transfer of care and reablement, with the remainder of the funding allocated to enablers. In the long term conditions, crisis response and discharge areas, this redistribution of funding shown here aims to reflect more meaningfully the actual distribution of resources and effort across the programme's priorities, rather than signalling a review and reorganisation of associated posts.

At a next stage, as well as adjusting to actual amounts available, a further round of checks will be done to align budgets so that they can be managed efficiently (eg. so that whole posts and contracts are managed under single cost centres).

Priorities and schemes	%	In BCF programme (£k)	From/Lead	Comment
1. Unified Prevention Services	19%	429		
UP1 Coordination and communicating the offer	1%	30	RCC	
UP2 Community prevention and wellbeing services	8%	190	RCC	Alongside parallel public health spend and some existing VCF contracts.
UP3 Life planning – preventative services	5% 5%	104 105	DFG Capital RCC	DFGs will be higher. Sum not known. Alongside relevant existing VCF spend and eg. subset of Active Rutland budget.
2. Long Term Condition Management	35%	795		
LTC1 Integrated case management for LTCs	2% 4%	40 100	RCC CCG	Care coordinator CCG 2015-16 underspend for case managers – accelerating change
LTC2 Integrated community health and care services for LTCs and high needs	18% 4%	405 100*	CCG RCC	Is community nursing, end of life, ICS. Alongside RCC long term team spend. Creates a shared integration priority.
LTC3 LTC management – innovation fund	2%	50	RCC	
LTC4 Dementia care	4%	100	RCC	
3. Crisis response, transfer of care and reablement	42%	936		
CRDR1: Integrated urgent response	4% 5%	100* 115**	RCC CCG	Used to be £450k - 20% of the programme – too much relative to level of need.
CRDR2: Integrated hospital reablement and transfer of care	24% 2% 6%	536 50* 135**	RCC RCC CCG	* Former £250k for RCC crisis & discharge, redistributed. **Former £250k CCG crisis & discharge redistributed
4. Enablers	4%	90		
E1 Enablers	2%	39	RCC	
E2 Integrated commissioning				No funding allocated.
E3 Programme support and communications	2%	50	RCC	
Total	100%	2249		This consists of: £104k DFG capital

				£2045k BCF revenue (of which £655k CCG) £100k CCG 2015-16 underspend from crisis response

Appendix 1: Internal interim evaluation of the 2015-16 BCF programme – summary of priority and scheme level evaluations

Overall, there have been many positive changes delivered as part of Rutland's BCF programme to date. The Rutland health and social care economy would now benefit from a stage of consolidation in which progress to date is more fully embedded to avoid eg. those situations where progress is lost simply through staff turnover. This need for consolidation is a strong argument to sustain the overall aim of the programme and its main priorities, whilst being open to adjusting and retuning them to build on the progress made to date.

Priority 1: Unified prevention services – learning from the 2015-16 evaluation

Under the 2015-16 programme, four prevention schemes have been supported:

- two signposting and enrichment schemes - the **Rutland Community Agents** and the GP-based **Integrated Care Coordinator**, both of which work to ensure that individuals in need can identify routes for assistance or involvement that will help them to better manage their health and wellbeing; and
- two schemes helping individuals to retain their independence and remain living in their homes through the supply of equipment and devices (the more traditional home **Adaptations/Disabled Facilities Grants** and **Assistive Technology**).

Highlight reports to date and the scheme level evaluations indicate that, following an early phase of design, recruitment and procurement (where relevant), the schemes have each been operating successfully relative to their initial objectives, gaining good buy-in and momentum. However, the dynamic so far has been very much one of separate schemes strands rather than a unified prevention offer.

- There is arguably scope to improve the reach, coordination, coherence, visibility and accessibility of Rutland's prevention activities.
- As part of this, it may be time to build on successes to date by reducing the fragmentation and overlap across services. It is possible that the support offer has become more complex for users rather than less, with more services operating in the same finite space.
- Anecdotal feedback also indicates that, without an advisor to navigate the services available, it remains difficult for people to identify what services and support might be right for them. A number of cataloguing initiatives have been undertaken (notably the online Rutland Information Service collects online service listings, and service catalogues by the Citizens Advice and the Rutland Community Agents). There appears to be potential to improve how services are presented online (for people searching online and for those advising or representing them).
- We should consider whether the balance is right between signposting activities and the provision of tangible hands-on services, and whether the reach of services is sufficient.

UP1 Community Agents

The Community Agents scheme needed to be restructured after its initial launch, with Lottery funded activities becoming a separate activity. This caused some early confusion. It took some time to recruit to short-term posts, but the scheme has been fully staffed since September, focussing first on delivering face to face services and online information, then moving on to work to develop community capacity. There are several aspects to the service:

- the assistance to individuals has good momentum and the Health Agent has been a positive addition. The duration of support per household has needed to be longer in many cases than anticipated (6-8 weeks rather than 2-3 weeks), with the agent taking a more active role on behalf of the user in many cases, brokering support. 227 individuals have received advice and everyone who has moved on from the service has demonstrated progression in their aims as a result of the support.
- Community capacity building activities building on local community assets were just getting going when the evaluation was done. The aim here is to encourage more community based activity with the potential for wellbeing outcomes (eg. social groups, good neighbour schemes). Nine new groups have been set up so far.
- The service is exploring how it can progress eg. by strengthening the relationship with GP surgeries and with health more generally (flagged as something needing work) and playing a greater role post-discharge from hospital. The scope for greater coordination and a more holistic approach to access has also been highlighted.
- The negative impact of short term procurement rounds on recruitment and stability of service was also highlighted.

Reviewing the self-evaluation the Integration Executive agreed that the Community Agents scheme was a valued part of the BCF programme that could evolve further – coordinating with Public Health and other universal services, progressing community development further and flagging observed gaps or issues back to the Integration Executive to inform BCF decision-making.

UP4 Integrated care coordination

The integrated care coordinator is a member of Rutland County Council staff who works at the 4 Rutland GP practices, following up on patients over 60 with long term conditions who may not be accessing all the support available to them – including social care. The aim is to keep people well and, in the process, to reduce health crises and admissions to care or hospital. The post has similarities with the community agents, but is more targeted. There was a delay in recruitment but, since then, the appointed person has made good progress. Activities have spanned both providing advice to individuals and raising awareness among GPs of the wide range of services that are available.

There is potential to further develop the mechanisms that are bringing key services from different disciplines together to support patients, broadening this scheme out from its focus on the coordinator post to a wider picture of integrated service provision. It will be important to continue work on enablers that help to support this – eg. datasets and information systems are developing but there are still challenges in terms of using health and social care platforms to coordinate care.

UP2 Adaptations/Disabled Facilities Grants

The delivery of DFGs is a statutory obligation on the Council that has been brought into the scope of the Better Care Fund Programme. Positive work has continued on this scheme, which is required by law to deliver only necessary adaptations at the point of need. Speed of processing of DFG requests was affected temporarily by a social care staffing reorganisation, but this ground has since been made up. Nine major adaptations have been completed (cost £38k), a further 11 approved (£56k) and 8 more recommended and subject to means testing and tendering (£57k). These projects are effective in helping individuals to stay in their own homes and avoid moving to residential care. A

recent review of DFG impacts in England confirms the benefits of DFGs more broadly, finding that they can postpone admissions to residential care by an average of four years.

The DFG scheme, which contributes directly to BCF programme aims (ability to remain at home, falls prevention, avoided admissions), is set to continue. It is recognised that there is also scope to evolve - for example:

- First, to provide different adaptations within the scheme where this offers an equivalent service but reduces overall costs. For example, switching to single rather than dual operator equipment in appropriate cases. This can have a higher up front costs but lower 'on costs', reducing the overall cost of operation. Such equipment can also be more compatible with the wishes of users and with the constraints of their home.
- Second, DFGs only address one extreme of housing adaptations – major adaptations at the point of urgent need. There is a much broader range of adaptations activity, with existing processes to deliver more minor and less urgent adaptations, including to people who are self-funding and, at the other extreme, scope for people who do not yet have health or social care needs to make more accessible choices when they invest in their homes. All of this has preventative potential. There may be scope for greater coherence and coordination in this space and to encourage more preventative investments at an earlier stage.
- There is also scope for closer working across health and social care OTs when delivering urgent adaptations for health care needs (often associated with life limiting illness).

UP3 Assistive Technology

Assistive Technology is a broad term for enabling technologies that help people to continue to manage their day to day activities and maintain their independence. Following procurement of a provider, Spire Homes, the scheme got off to a very good start, with strong demand for this type of support (at or above the target level of 15-17 referrals a month), that has been answered to the timescales set out in the contract.

- The Assistive Technology scheme merits being sustained and the contract could begin to be managed as part of 'business as usual' provision.
- It could be linked more closely with the Adaptations scheme – the schemes together offer a menu of options that can help people to maintain independence and quality of life.
- There is still a need to promote the service among professionals and raise awareness of the role AT has to play alongside more traditional measures. The action learning group has been a successful part of this process.
- Demand is anticipated to grow further for AT as community health, social care and other community advisors start to consistently call on this as part of their 'toolkit'. Some aspects of AT delivery have become routine. Where the devices are simple to set up and only have only a capital cost, delivery could be undertaken as part of social care or health to reserve specialist capacity for those cases needing more expert involvement. A further option is the active prioritisation of requests.
- There is further scope to innovate eg. in terms of remote interactions with service users supplementing face to face contact.

Priority 2: Integrated Crisis Response and Integrated pathways

IUR1 Integrated crisis response

The aim of this scheme is to reduce the number of avoidable admissions to acute hospitals and residential care by providing alternative forms of care to manage crisis where this is more appropriate eg. a nursing watch service. The plan and funding were initially for a night nursing service and developing a social care crisis response service. However, the scale of the scheme was found to not be well matched to the scale of demand in Rutland, so the management of this service and scheme was merged with the reablement and hospital discharge schemes under a 'Step up step down' banner. BCF has provided new posts in the Prevention, Discharge and Reablement model that may be responding to issues or deterioration before a crisis point is reached.

Since the scheme's launch in September 2014, there have been 25 cases that we are confident were prevented from being admitted to hospital or residential care as a result of the service. This has included helping patients at end of life to stay at home, an important outcome for them and their families. Overall, involved patients have seen tangible outcomes, but the overall volume of use feels low relative to an average local rate of over 100 non elective admissions per month.

It is proposed that work should continue on this scheme, also coordinating with the LLR Vanguard work on Urgent and Emergency Care, particularly the workstrand addressing integrated community urgent care. There is a need for more detailed work to ascertain whether there is potential (and capacity) for more admissions at crisis to be avoided. Are alternatives systematically considered? If so, and options are still underused, is this rooted eg. in workforce development or more fundamental issues that might benefit from changes to the service scope or design?

Night and day services are also operated differently, and while ICS and Reach are starting to feel more joined up in the day but less connected with the night service. There is a reliance on ICS to make the scheme work but they are pressured. The scheme could usefully evolve to address this eg. through improved use of trusted assessments to reduce the ICS load, secondment of reablement support workers to ICS. Not all posts in the health establishment have as yet been filled, giving an opportunity to revisit the resourcing model.

IUR2 Integrated health and social care pathways

This is a broad and varied scheme whose aim has been to develop a whole system response ensuring coordinated and integrated health and social care in Rutland. It is useful to differentiate between two aspects of change: first, shaping the strategic framework and commissioning as routes to change and, second, operational change and reshaping as part of ongoing delivery. This latter area includes use of risk stratification to support care planning; linking public health to health services more effectively; and, new pathways, integrated care plans and case management for key groups eg. patients over 75, with long term conditions, at end of life or with continuing health care needs.

From a strategy and commissioning perspective, an important goal has been progressing the wider ELR CCG Community Strategy which has recently been out for public engagement (October 2015 to January 2016). This sets out a model for three tiers of integrated local, community and sub-acute health services and will guide commissioning decisions and the overall configuration of local services going forward.

In terms of change work on the ground, some of this work is captured more fully in other workstrands reported on and evaluated here (eg. under care coordination, discharge and reablement). However, the broader work to evolve community health services and integrate them with social care services in more fundamental ways (changed pathways and care planning approaches, integrated teams, etc) does not feel as strongly connected as it could be into the Rutland BCF programme and its governance framework. For these aspects of the scheme to achieve their full potential, it is suggested that leadership for change, focussed at the Rutland scale, could usefully be allocated more clearly to relevant providers, so that there was direct proximity, ownership and accountability, linking back to the BCF programme. This could better enable progress to be driven proactively, working closely with local stakeholders, including social care, as part of the delivery of the Rutland BCF programme.

In the next programming period, it is proposed that the operational dimension of the scheme could be reshaped into a joint health and social care scheme, led locally, to deliver integrated community health and care services (particularly focussed around long term conditions, frail elderly, end of life). This could be positioned under the Long Term Conditions priority. The transition to leadership by providers for this work could usefully begin, however, during the current programme.

Priority 3: Hospital discharge and reablement

This is the heart of the Better Care programme. Good progress has been made in reducing delays to hospital discharges and to reabling people following discharge so that they are not readmitted to hospital or admitted to permanent residential care. There is further potential for improvement in both areas, as detailed below.

HDR 1 Hospital discharge

This scheme aims to reduce delayed bed days from acute hospitals, freeing up beds for those with a priority need and reducing the clinical risks for people of being in hospital, also reducing the overall cost of acute care and preventing reimbursement charges to the local authority. The scheme aims to make pathways between services simple, effective and consistent, and to ensure that home first options are considered wherever possible.

Particular attention has been given to out of area discharges. An in-reach nurse role has been created to provide a home first approach. This nurse and a designated social worker work with Peterborough Hospital to ensure smooth discharge.

Performance has fluctuated, mainly due to staffing changes or absences, but it is clear that, when consistent staff are in place, performance improves markedly. We also have a better understanding of the reasons for delayed discharges. We are now looking for more consistent DTOC patterns, including by identifying alternative mechanisms to ensure that there is always somewhere for patients to be discharged to who cannot return straight home.

This scheme needs to be continued and consolidated, developing use of the minimum dataset, becoming more resilient to staff change and absence (eg. by capturing, publishing and refining processes), embedding the trusted assessment processes, and developing shared outcome measures and evaluation tools to learn from the customer experience.

HDR2 Reablement

The aim of this scheme is to deliver successful reablement that reduce the need for health and social care services, reducing avoidable admissions, preventing readmissions and reducing delayed transfers of care. Activities have included: delivering more integrated working, streamlining pathways, reducing duplication and ensuring that services are timely, safe, effective and person centred.

There was already a reablement service at RCC, REACH, and this has evolved to work in more integrated ways. Some new approaches have been trialled: a 'stepping stone' flat was tried, evaluated and discontinued due to limited use; offering reablement via a care home setting prior to returning fully home has been more successful. These initiatives have also generated lessons for the programme where new approaches are being taken eg. in the building blocks to help with take-up. ICS have built up more of a relationship with the reablement team, with a member of the REACH team attending Board rounds and RMH ward rounds. Relationships are building well and the integration is broadening out beyond REACH to involve the whole Discharge and Reablement Team. There has been reduced duplication, improved use of the Health and Social Care Protocol and the skills of reablement workers have been extended. The changes are believed to be having a positive impact on patients. Over 60% of service users do not have ongoing eligible needs at the end of the reablement period and the readmission rate is low.

Building on the closer working that has been established, there is more scope for integration across health and social care in the next programme eg. with the alignment of outcome measures, job descriptions and recruitment processes and scope for joint generic and skilled posts. The required skills mix could also be reviewed. Seven day services are not in place currently and this is something that will need to be worked towards. Alongside post-hospital recovery, there is also potential for more reablement work targeting admissions avoidance, and to call more consistently on a wider range of interventions that can complement reablement to keep people at home eg. assistive technology. This set of work will need to continue to be proactively driven forward and would benefit from strong leadership to sustain the momentum and integrate related health and social care services more fully.

Priority 4: Long term conditions

Two schemes have been progressed to improve the management of long term conditions, one focussed on dementia and the other on falls prevention. Both schemes have had a slow start, but are now gaining momentum. The aim here is to keep individuals in the best health possible for as long as possible, and, as a result, both improve their quality of life and reduce the demands placed on health services and, in particular, the need for emergency admissions to hospital when conditions are exacerbated.

A key question for the next programme is whether the programme has the right balance of long term condition interventions. In particular, long term conditions are a significant cause of non elective hospital admissions. Most of the longest duration non elective hospital stays are by older people and, if these could be reduced in number or duration, including through improved management of LTCs, this would both be better for those patients and reduce the acute NHS burden. This is an active area of innovation and research. Alongside this possibility, there is also potential for closer integration between community health services and social care providing ongoing support to people with from long term and age-related conditions.

LTC1 Falls prevention

The Falls Prevention scheme was only approved in March 2015, replacing a Learning Disability scheme at an early stage of the programme (the rationale being that falls was a significant issue locally and that learning disability interventions would be more effective if mainstreamed across the other parts of the programme. A falls summit was held in June 2015 to better understand existing provision in this area and work with partners to identify gaps. The scheme then followed through to address a number of gaps via: a call for projects to raise awareness of falls prevention in the wider community; falls prevention training for practitioners including in care homes; a research based exercise referral project for people who have already fallen (FaME); and, a lifelong design project accrediting local suppliers able to help householders make their homes more accessible.

Although it took time, the falls summit is recognised to have been a strength in terms of stakeholder engagement and joint priority setting informed by the Rutland context and expert input. The resulting projects have a strong rationale and are developing well, but are all at too early a stage to have had tangible impacts. It is important that the projects have the opportunity to be seen through to completion (many will extend into the 2016-17 programming period) and that lessons are drawn from them that can help to inform future approaches and practice. This does not necessarily have to be done in the next programme via a stand-alone falls scheme.

In the interim, a number of other schemes across the programme have continued to help to prevent falls by working directly with individuals eg. via post discharge reablement, assistive technology, DFGs and other services, some accessed directly and others signposted via the community agents and care coordinator.

LTC2 Integrated dementia pathway

The aim of this scheme has been to improve the quality of life and experience of care and support for people living with dementia, their families and carers in Rutland. The scheme has included helping to map out and coordinate support, encouraging awareness and early diagnosis and providing tangible support services throughout the journey of an individual and their carer(s). In parallel, there has been continuing work to develop dementia friendly communities (including proposals involving the business community). These activities are being delivered through a dementia contract, RCC dementia specialist staff and active work with local stakeholders including Healthwatch. Some progress was delayed due to recruitment issues, so the scheme is at a fairly early stage in terms of some of its impacts. It is proposed that the scheme be continued as there is potential for more to be achieved building on recent foundations.

Priority 5: Enabling services

There were three schemes under the enablers heading: Care Act 2014 compliance; ICT and data sharing; and programme management/support.

Care Act compliance projects have largely been completed meaning that enabling element is no longer required. Programme support needs to continue to sustain momentum and serve the programme's governance, coordination and reporting requirements.

IT and data sharing is the core of the enabling services strand and has contributed the following, either directly, or via wider Better Care Together projects: a universal online information and advice platform was established, the **Rutland Information Service**; f**oundations were laid for information sharing** by obtaining verified NHS numbers for social care users and implementing the same social

care case management system used by Leicestershire and Leicester City; i**mproved insights into real patient pathways and local health and care trends were obtained via the Health and CareTrak system**, making it possible to shape and steer change projects with more confidence; and reciprocal network access at partner sites meant workers could access their own information systems and resources without using remote access. This went online in Rutland in October and is already facilitating side-by-side working between health and social care colleagues.

In future:

- **How we are working:** The connection could be strengthened between the enablers workstrands and the frontline workers/managers who are the intended beneficiaries for this work, whether in terms of IT systems, sharing agreements, analysis, etc. As a small authority that is part of a bigger health and care economy, Rutland also needs to remain an active participant in LLR-wide IT and IG initiatives. This includes the LLR Information Governance forum.
- **Information:** There is considerable scope to develop programme communications – to keep staff in the loop, to let the public know what is changing locally and to encourage feedback and input.
- **Information governance:** NHS numbers will start to be used as the common identifier between health and social care in the next programme. This may need some awareness raising/refresher training for staff so common standards are used to protect information across health and social care. There is also still a need to confirm what data sharing agreements need to be set up or revised to support new ways of working, including between community health services and social care. National work is progressing which will make this easier to achieve. As part of its compliance activities, RCC is working on securing NHS Information Governance Toolkit compliance as a common Information Governance benchmark or assurance mechanism.
- **ICT:** The BCT project to implement a data sharing system called the MIG is still ongoing. By participating, social workers should be able to gain direct access via LiquidLogic to summary health data, supporting their decision making. Adapting LiquidLogic collectively at the LLR level may reduce the cost to the three Councils. At a practical level, some staff are having to do more double and triple recording on IT systems as a result of closer working. There is a need to streamline this wherever possible. The MIG may help address this, but there is a need to understand the issues in more detail to be sure.

Appendix 2: Outcomes of the new projects workshops

Communications driving change

Issues/opportunities

- Multiple info systems and lots of mapping and pathways, but the 'offer' isn't fully captured or clear
  - duplication, missed opportunities,
  - organised to the logic of providers not users – not person centred
  - Even the providers can't keep track
- More/different comms needed
  - For staff and stakeholders
  - For the public
  - Joint comms
- How to reach the hard to reach – esp those who will only seek help when in crisis?
- Life changes trigger the need for new info/support eg. retirement, bereavement, having a fall.
  - How well do we respond to this?
  - Opportunity to be person centred

Ideas

- Understanding the links between different info systems and offerings – reduce duplication, drive up clarity
- Further development of the Rutland Info Service community content – positive offer
- Consider how to present the offer in a more person-centric and less fragmented way
- BCF comms plan. Possible newsletter
- Front line staff are the direct route to understanding user needs and views – encourage this conversation
- Reach the hard to reach…via the easier to reach
  - friends, neighbours, practitioners who want to change and will tell/influence others

Innovation for established services

Issues

- **Disabled facilities grants (DFGs)** – statutory = 'business as usual' – missing out on innovation?
- **Assistive Technology (AT)** –Good uptake and parts becoming business as usual. Can we go further, mindful of local conditions eg. rural?

Ideas

- DFGs – continue and build in change, eg.
  - to deliver adaptations faster or
  - that have lower on-costs (for a higher initial cost).
  - DFGs as a form of support to carers.
  - Independent advice to self funders on most useful purchases?
- AT – alongside 'Speakset' video calling pilot, explore scope for:
  - video calling to augment advice giving/follow up care during change/ crisis (proven in prisons and for mental health)
    - With care homes – eg. established for mental health backup in some LLR areas
    - For individuals/families at home with access challenges
    - A way to deliver some Integrated Care Coordinator & Community Agent support?
    - 'Buddying' contact from volunteers
  - Evidence from contact with service users that some are confident online with tablets, smartphones etc – we could improve their services using this - often at no extra cost to them.
  - Telehealth – eg. condition monitoring undertaken at home – logged via technology? Useful to avoid admissions? Appetite for this & viable here?

Rutland County Council — Continue building partnership

Issues/opportunities

- Relationship with users is unequal – little scope to shape services. Could offer more…
  - Listening
  - Focussed involvement of end users rather than consultation/awareness – coproduction
  - Low on the 'ladder of involvement' – doing to and for, not yet 'doing with'
- Joint commissioning with health underdeveloped
- Co-design
- Relationship with providers can be unequal
- What does the wider business community have to offer?

Ideas

- Engaging users
  - Regular multi-agency listening
  - Front line staff hear views on the ground – encourage the conversation & structure to capture and learn from it
  - Small grants for bottom up ideas, community capacity? Local ownership
- Joint commissioning, RCC and health
  - map the overlaps and gaps
  - identify and progress concrete opportunities
- Providers – look at ways to engage with them more positively
  - Build on market shaping
  - Joint look at workforce issues?
- Business community
  - Continue to look for scope to involve them

Rutland County Council — Making it easier to keep well

Issues/opportunities

- People's 'health' needs are broad as so many things have an impact eg. health plus housing, money, relationships, stress, lifestyle, work
  - Hard work now for an individual to deal with their own 'whole person' set of issues
  - Dispersed and disjointed agencies & services
  - Coherent front door?
- GPs don't have time to deal with everything discussed with them. 19% of time on non health issues. Less time for health.
- Social prescribing is growing – can we take this further?

Ideas

- Potential to pilot a more rounded set of wellbeing support closer to primary care?
  - Successful precedents elsewhere – various designs and mixes
  - More than signposting – substantive support, often there and then
    - Public health prevention eg. stop smoking, weight management
    - Management of non health matters – debt, relationships, housing…
  - Potential for side by side presence – allowing GP+ appointments there and then?
  - Integrated Care Coordinator would still focus on the subset with greatest need for condition management

Admissions avoidance – Long Term Conditions

Issues/Opportunities

- Is our LTC view broad enough – just falls & dementia?
  - Need to do more to avoid admissions
  - Half of GP appointments are for long term conditions.
  - Admissions stats reflect heart & respiratory issues, cancer, what else?
  - Mental health is the main LTC for 30-50s.
  - Also the impact of combinations of conditions.
- Care coordinator is valued BUT does the toolkit need to be enriched?

Ideas

- Enrich risk stratification
- Understand local patterns of admission and adjust to respond
  - analytics followed through into response design
- Identify condition management opportunities Join up local insights and wider innovation.
  - eg. telehealth monitoring
  - UTI detection
  - …?

Other issues

Issues/Opportunities

- Short term projects = workforce instability
- Right balance of signposting vs substantive services?
- IT remains a barrier – different systems, lack of a shared view onto patient data.
  - Must respect patient data and rights, but standing in the way of better service

Ideas

- Short-termism – no easy answers, but needs consideration in planning and commissioning
- IT
  - Engage more with the BCT IM&T technology workstream.
  - Build understanding of the real front line issues locally to ensure the right solutions.
  - Look at the scope to change who has access to what system instead of changing the systems.
- Need to better understand and broaden out the LTC work locally
  - Continue to support via Integrated Care Coordinator & risk stratification – but don't stop innovating
  - Analysis to understand patterns
  - Scope for targeted condition management projects like the falls projects to contribute to hospital avoidance?