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The Rutland Better Care Fund

NHS
East Leicestershire and Rutland Clinical Commissioning Group

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Context of Better Care Fund

- Programme supporting transformation and integration of health and social care services to ensure local people receive better care

- Pooled budget of £2.2m last year for social care and community health services, plus £0.2m in a performance fund

  Not new money! Money to be spent differently

  National 'tasks' to achieve

- Locally, it's also helping to deliver the Leicester, Leicestershire and Rutland Better Care Together strategy

  Workstrands: Frail elderly people & dementia, urgent care

- Planning for the follow-on programme for 2016-17 – similar level of funding

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Better Care Fund Vision

"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."

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Why do we need to change?

- Changing health and social care landscape
  - Shrinking resources BUT growing needs
- Integration brings better outcomes
  - Local agencies working together to change
  - Health, social care, the community voluntary and faith sector, providers
- AND enabling people take an active role in their wellbeing

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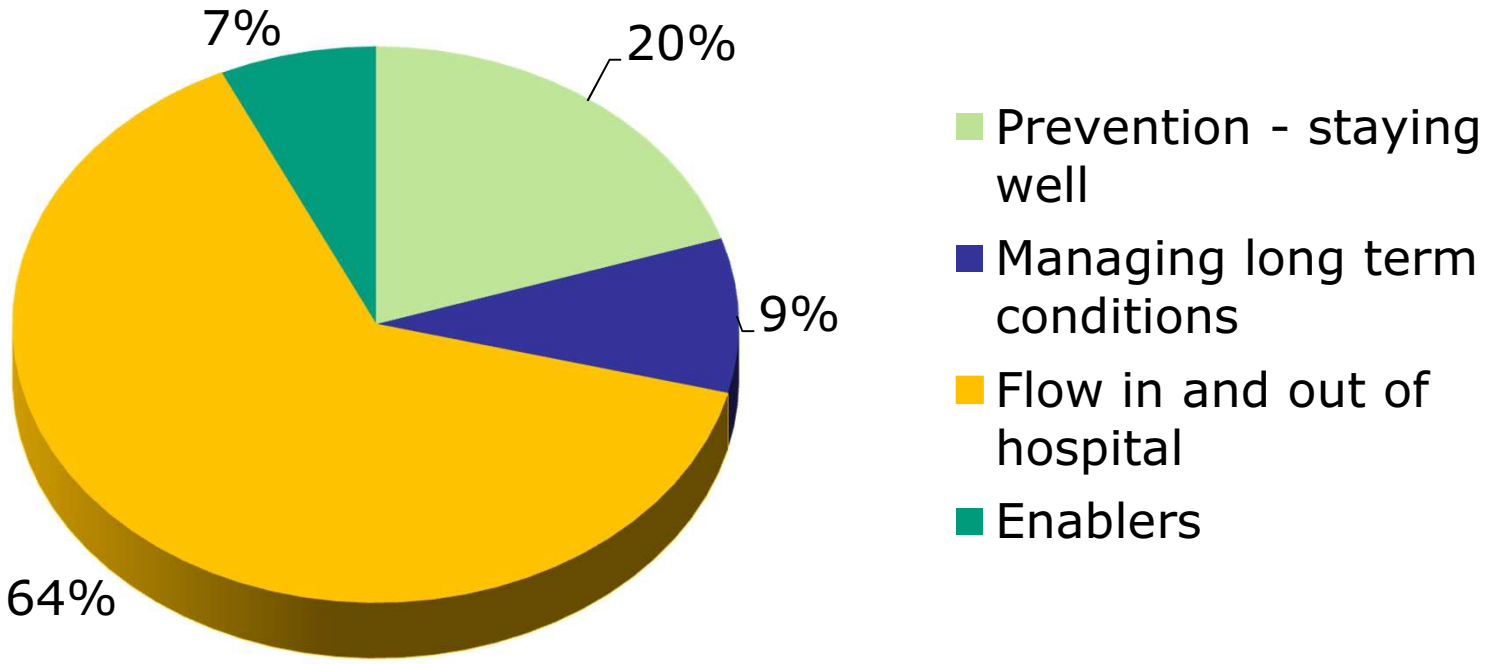
What's in the programme?



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The current plan focusses on four key areas

- Early intervention and prevention – 20%
  - Staying well. 'Whole person' responses, building on community assets
  - Early signposting and support – in the community and via the GP
  - Maintaining independence - accessible homes, assistive technology
- Long Term Conditions – 9%
  - Falls prevention
  - Coordinated dementia support
- The flow in and out of hospital – 64%
  - Crisis response - avoiding hospital admission where not the best answer
  - Where hospital is necessary, ensuring prompt discharge and supporting reablement so people recover as fully as possible
- 'Enablers' – 7%
  - Work in the background to make everything else work better
  - Training the workforce
  - Clear and usable information and advice for everyone
  - IT systems that can talk to each other and support coordinated care

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Measuring success – national indicators of improvement

- Fewer people going into residential care
- Fewer emergency admissions to hospital
- Reduced delays to 'transfers of care' out of hospital
- % of people discharged from hospital who are still at home 3 months later
- Reduced falls
- Satisfied service users

Staying well and independent

Living well with long term conditions

The right care at the right time in the right place

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Plus a wide range of other benefits

- Staying well and independent for longer
  - More 'self care' - People equipped to look after their own health & aware 'what's out there for them'
  - Increased community capacity
  - Reduced isolation, improved mental wellbeing – sense of connection

- And, when people do need more support…
  - Service users telling their story fewer times
  - Care that makes sense to people – more seamless services, professionals skilled to take on tasks whether from health or social care
  - More support choices, tailored to the individual
  - More care closer to home
  - Support for carers as well as the cared for

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Are we there yet?

- Not yet…but a lot of good work has been done

  Partnership, joint working, new approaches and services

  Many good impacts – for individuals, and on our targets

- More to do!

  ** More integrated prevention. Services in the community and via GP surgeries, helping people to find out what's available for them as their needs change

  ** Helping people manage more long term conditions – including through technology

  ** More integrated health and social care – tell your story once, receive a seamless service

  ** More robust approaches to hospital avoidance, discharge and reablement

  ** Working with service users to design effective services

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AN EXAMPLE OF OUR PROJECTS...ASSISTIVE TECHNOLOGY