Report No: 42/2016
PUBLIC REPORT

SCRUTINY PANEL

18 February 2016

BETTER CARE FUND PROGRAMME 2015-16 AND 2016-17

Report of the Director for People

Strategic Aim:	Meeting the health and wellbeing needs of the community	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr Richard Clifton, Portfolio Holder for Health and Adult Social Care	
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DECISION RECOMMENDATIONS

That the Panel:

1. Notes the update and performance of the Better Care Fund 2015-16.
2. Notes the proposals for the Better Care Fund 2016-17 and makes recommendations for any improvements to the programme.
3. Notes the additional update provided on the Community Agents Scheme, as requested by Scrutiny.

1 PURPOSE OF THE REPORT

1.1 The 2015-16 Rutland Better Care Fund (BCF) plan is currently three quarters of the way through implementation, and planning is underway for the 2016-17 period. This report sets out the performance and impact thus far of the Rutland Better Care Fund Programme (BCF) and sets out the proposals for next year's BCF programme.

2 BETTER CARE FUND 2015-16

2.1 The Better Care Fund was established nationally to support transformation in integrated health and social care. It was designed to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care

and community services for the benefit of the people, communities and health and care systems.

2.2 The current programme in Rutland started in April 2015, with the aim to "deliver important improvements to the way we collectively offer care and support to local citizens so that avoidable pressure on hospital care is reduced, and community options and support are increased."

3 PROGRESS IN THE 2015-16 PROGRAMME

3.1 The BCF programme has proactive governance arrangements via the Integration Executive meeting and Section 75 Partnership Board, and reporting into the Health & Wellbeing Board. Plan progress is measured bottom up through qualitative reporting and tracking outputs and outcomes, and top down by monitoring change in five key national metrics and one locally defined one. A more detailed overview of current performance is provided in Appendix A.

3.2 There has been good progress on integrated, cross-sector working. Closer working between community health services and social care has impacted positively on reablement outcomes and to reduce delayed discharges. In addition, the 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. This approach to integration will continue to be built on into next year.

3.3 The highest priority 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.

3.4 New day and night crisis response approaches have been introduced and have avoided around 25 emergency admissions since September 2015. This has involved considering alternative urgent care options such as night nursing to manage the crisis instead of defaulting to hospital admission. This change in approach has been particularly valued in end of life cases. It is possible that there is more capacity to avoid admissions going forward, to ensure greater consistency of response day and night and also to intervene sooner to prevent people reaching crisis point.

3.5 The Integrated Discharge Team has deployed additional resources and developed pathways 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 and where we now have both dedicated nursing and social care personnel to facilitate discharge), with parallel changes to the delivery of reablement services helping people to remain at home through a reorganisation of Rutland County Council's adult social care services and closer working with community health colleagues.

3.6 Adult social care staff now work regularly from Rutland Memorial Hospital alongside their health colleagues and are an integral part of 'Ward and Board' rounds where patient plans are discussed. Through training, there is also now a greater crossover in terms of the skills of community health and social care colleagues thereby increasing efficiency as staff can take on a wider range of tasks for each other when they are in a service user's home.

3.7 Within the long-term conditions priority, the falls prevention and dementia schemes have both taken time to build momentum, but are now well placed to deliver tangible outcomes. A number of falls prevention projects are now underway, notably: enhanced falls training for professionals; a preventative exercise programme for people at risk; a communications campaign; and, a series of falls 'fetes' across the County to boost falls prevention awareness. For dementia, a range of services have been commissioned helping dementia sufferers and their carers and families, in parallel with developing dementia friendly communities through the 'Dementia Friends' scheme. A memory advisor is in place, driving forward work with Healthwatch and other partners to better coordinate dementia services locally and ensure they respond effectively to real needs.

3.8 The Assistive Technology scheme has provided people with technological solutions to help them to manage challenges they face due to age or ill health (e.g. through falls monitors, medication managers, GPS tracking devices and video calling technology). Home adaptations have also been delivered under the programme. Finally, the 'integrated care coordinator' approach has also provided a new bridge between primary and social care meaning that people who need more than health support are identified sooner and that local GPs are now more aware of the wide range of local non health services that can support their patients.

3.9 Underpinning the programme, has been work on enablers including: workforce development through staff training and reorganisation of Adult Social Care Teams to better respond to future needs; IT systems and the delivery of a new social care case management system; and information sharing. From April 2016, the Council will use NHS numbers as the primary patient/service user indicator to facilitate information sharing across social care and health.

3.10 There was also significant work undertaken as part of the programme to secure Care Act compliance. This work was successful and, again, opportunities to further develop aspects such as the Rutland Information Service for information and advice will continue to be built upon moving forward.

4 BETTER CARE FUND PLANNING 2016/17

4.1 To be able to meet the development timetable, provisional work on the 2016-17 Better Care Fund plan started in November 2015, although - at the time of writing - full national guidance on the new BCF programmes and confirmation of budgets is still awaited. Therefore the programme presented here is provisional and may be subject to change.

4.2 The new draft plan is presented as Appendix B. This was tabled at the Health and Wellbeing Board on 26th January for initial views, where the direction of travel was strongly supported. The Health and Wellbeing Board noted that the plan should be more ambitious in what Rutland wants to achieve through this work. The Plan has been revised accordingly.

4.3 The initial draft plan sets out how the new programme was developed and what factors have been taken into account in shaping it. Strong continuity is proposed with the current BCF programme, but with changes to build on the progress and learning secured during the current year.

4.4 The proposed aim of Rutland's 2016/17 programme is that: "By 2018 there will be

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

4.5 Four priorities are proposed, summarised below (set out in more detail in the Draft Plan):

- **Unified Prevention** - broadened across the work areas rather than scheme based, with opportunities for more coordinated responses through a new commissioning model;

- **Long Term Condition Management** – as a key opportunity to reduce health and social care demand, expanded beyond falls and dementia and strengthened through proposals for enhanced complex case management and community health and social care integration;

- **Crisis response, transfer and reablement** - consolidation of progress to date - including with key acute services outside LLR - is the focus to reduce non-elective admissions and delayed discharges; and

- **Enablers** - including IT; information sharing; and joint commissioning.

4.6 Rutland is expecting a similar level of funding to the current financial year, although this has yet to be confirmed.

5 NEXT STEPS

5.1 The current BCF Plan continues to be monitored for the remainder if this financial year.

5.2 It is anticipated that the final revised plan will be presented again to the Health and Wellbeing Board for their approval on 22nd March 2016, subject to the national timetable.

6 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

6.1 Performance data shows that the current BCF Programme is having an impact in Rutland, and although there are areas for improvement, we are cognisant of these and they will be built on into next financial year.

6.2 Planning for next year's programme is well underway and has been supported by a number of key stakeholders, including the Health and Wellbeing Board. The draft Programme is line with the national guidance.

7 BACKGROUND PAPERS

7.1 There are no additional background papers to the report.

8 APPENDICES

8.1 Appendix A – 2015/16 BCF Performance Report

8.2 Appendix B – Draft 2016/17 BCF Plan

8.3 Appendix C – Update on the Community Agents Scheme

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577. (18pt)

Appendix A – Current Performance

Attached

Appendix B – Draft 2016/17 Better Care Fund Plan

Attached

Appendix C – Update on the Community Agents Scheme

1 INTRODUCTION

1.1 The Community Agents Scheme was established to provide an initial point of access for people within their own communities to support them to help themselves and to signpost on to support services where needed.

1.2 The initial model involved Spire Homes and the Rural Community Council working as a single team to deliver this. During the year, it was agreed the 'split' the Scheme so that Spire concentrated on providing the individual Agents themselves, and the Rural Community Council – with separate funding they secured via Big Lottery – delivered community activities designed to reduce social isolation.

1.3 In addition, there were four smaller partners to the Scheme:

- Rutland Citizens Advice: providing dedicated face to face support on a range of issues within communities;
- The Bridge: providing specific training and employment support;
- Age UK: developing befriending within communities where this has been identified as an issue;
- Home Straight: delivering minor 'DIY' and repairs where individuals cannot afford to pay someone and it enables them to remain or return home.

1.4 During the course of the year, The Bridge had an internal restructure and so ended their specific involvement with the Scheme. They continue to provide education, training and employment support in Rutland and the Community Agents are able to signpost into that.

2 PERFORMANCE

2.1 Contract monitoring is undertaken with Spire as the lead provider on behalf of all the providers involved on a monthly basis.

2.2 The Scheme started slowly following recruitment issues, but has been fully staffed since August and has gradually been building up both contacts within communities and the numbers of people seen.

2.3 The latest performance report to end of December indicates 400 individuals seen since the Scheme started in April, with 112 individuals receiving longer-term support (more than three sessions). The Scheme is building month on month, with December alone seeing 32 self-referrals to the Agents, demonstrating the impact the scheme is now having. The majority of service users are over the age of 67 years, and there is a fairly even split between men and women. Referrals have been received from all wards.

2.4 For those individuals who need longer-term interventions, the Community Agents undertake an Outcome Star to identify individuals' needs and measure whether they have reduced following an intervention. The support needs identified most

frequently are: 'living environment' and 'looking after yourself'; and therefore further development next year both within this Scheme and the wider BCF will look at how support for people to help themselves can be improved for both of these.

2.5 There have been two aspects that weren't initially expected with the Scheme:

2.5.1 The Agents are spending longer with individuals than initially anticipated, which has had an impact on capacity. This suggests that people need more support to help themselves, including identifying how to access support services, and also much of this support is to assist people in co-ordinating the services they do, and could, receive.

2.5.2 There have been fewer volunteers than initially expected to support with areas such as home visits and access to social activities. This is partly due to the length of time the Scheme took to be fully staffed and therefore establish itself, and the providers have been requested to review how this can be improved going forward.

2.6 Given the current performance of the Scheme, it is anticipated that next year the Scheme will work with c650-700 people minimum across the county, building particularly in those areas where there are currently low proportionate referrals.

3 Funding

3.1 The funding for this year was £185,920, comprising:

£155,535	Spire Homes (including start-up costs)
£ 10,500	Rutland Citizens Advice
£ 11,185	The Bridge (contract ended in year)
£ 4,200	Age UK
£ 4,500	Home Straight

The forecast spend is lower due to the Bridge contract ending in year.

3.2 The allocation within the budget for Community Agents is currently indicative as the programme has not yet been agreed for next financial year, pending the national guidance. However, it is expected that the contract value will be reduced in next financial year to reflect the costs included this year for start-up of the scheme, and anticipated to be in the region of £148-150,000. The funding released from the reduced contract value will support other BCF work to develop prevention – as yet to be agreed by the Health and Wellbeing Board.

3.3 Using the data from April to the end of December, the average full year cost of the Scheme is c£335 per person supported. In terms of value for money, there are still further improvements to make. However within the context of reducing hospital or care home admissions and supporting return home, the cost per person supported by the Scheme equates to less than one week's cost of residential care or three day's delayed discharge from hospital. The expected increase in people supported next financial year will improve the 'cost per person' and the overall value of the Scheme.

4 Future Developments

4.1 Whilst the Scheme was initially designed to provide signposting only, it has become clear that the Agents themselves have spent longer supporting people to remain in their homes or return home after hospital than originally envisaged.

4.2 The Scheme is focussing on developing community capacity next year and building work with other organisations to create volunteer networks - as well as continuing individual support - so the service focuses on those who need it most, to enable the average length of time that they spend supporting individuals to be reduced and more individuals to be supported and signposted on. In addition, the continually improving links within communities will enable a greater focus on identifying those who are currently vulnerable but unknown to services. Next year's BCF programme, has taken this into consideration and the development of the unified prevention priority will see a broader focus on both the prevention itself, and on the communication of information and advice to enable people to support themselves and make it easier to navigate services with less overall support.