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.

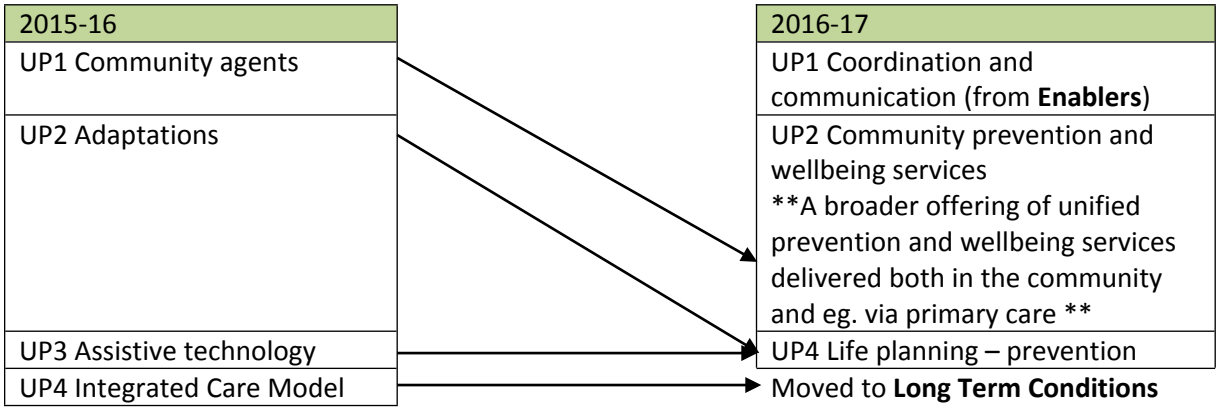
The priorities are described in more detail below. Each section summarises the rationale for the proposed changes, sets out how the 2016-17 proposals relate to 2015-16 schemes, and summarises each scheme and its potential to contribute to the programme's key metrics (assuming these remain the same as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

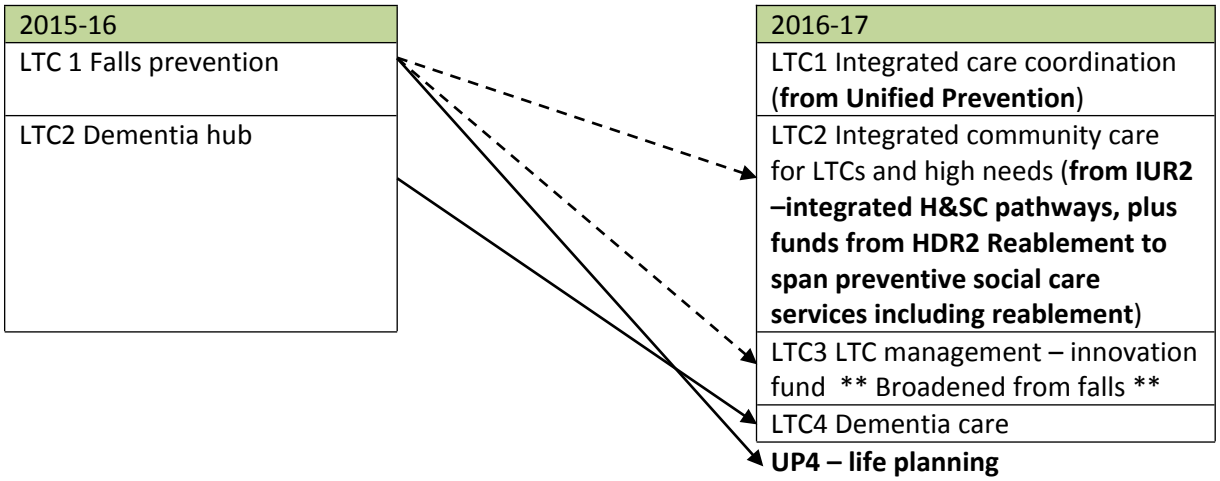
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		areas (cf. the Speakset pilot that allows video calling to/by service users). A number of other potential changes in approach were identified during the evaluation eg. new DFG purchasing choices where they offer 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

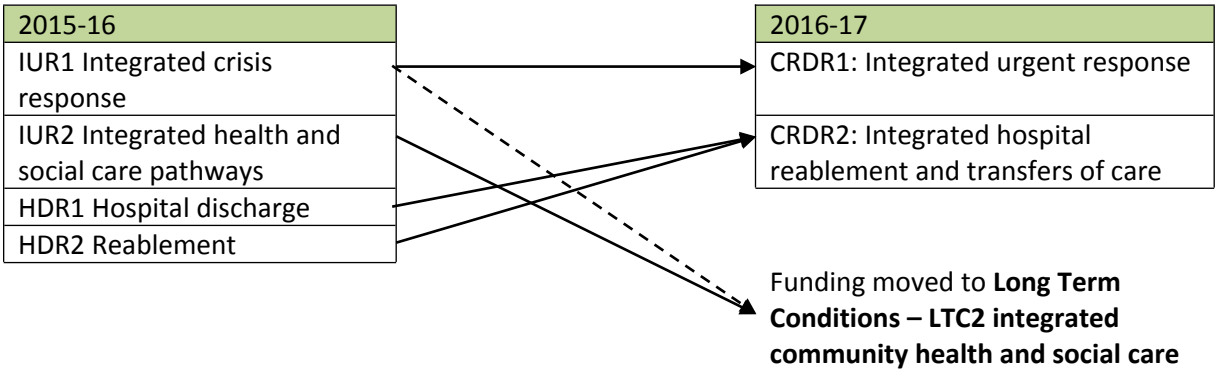
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
	management – innovation fund	conditions are managed, including through patient activation and self care. This would allow scope for the case managers anticipated in LTC1 to progress pilot projects trialling approaches 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**
1. Unified Prevention Services	19	429	
UP1 Coordination and communicating the offer	1	30	RCC
UP2 Community prevention and wellbeing services	8	190	RCC
UP3 Life planning – preventative services	5 5	104 105	DFG Capital RCC
2. Long Term Condition Management	35	795	
LTC1 Integrated case management for LTCs	2 4	40 100	RCC CCG
LTC2 Integrated community health and care services for LTCs and high needs	18 4	405 100	CCG RCC
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
CRDR2: Integrated hospital reablement and transfer of care	24 2 6	536 50 135	RCC RCC CCG
4. Enablers	4	90	
E1 Enablers	2	39	RCC
E2 Integrated commissioning			CCG
E3 Programme support and communications	2	50	RCC
Total	100%	2249	