Report No. 39/2017

Report to Health and Wellbeing Board

Subject:	**Better Care Fund Programme Update**
Meeting Date:	**31 January 2017**
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Paper for:	**Noting**

1. Introduction

1.1 This report updates Health and Wellbeing Board (HWB) members on progress with the 2016-17 Better Care Fund plan and progress on planning for the 2017-18 to 2018-19 Rutland Better Care Fund (BCF) Programme.

2. Recommendation

2.1 The Board is requested to:

2.1.1 Note the content of the report.

3. Policy framework and context

3.1 The Better Care Fund is a joint health and social care integration programme managed operationally by the Rutland County Council People Directorate, in conjunction with the East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) and delivered under the oversight of the Rutland HWB.

3.2 The Rutland HWB approved Rutland's current 2016-17 plan in March 2016. This plan is currently being delivered in line with the NHS's current BCF operational guidance (https://www.england.nhs.uk/wp-content/uploads/2016/07/bcf-ops-guid-2016-17-jul16.pdf

3.3 Planning is now underway for the successor programme, to be delivered across two years to align with the two year CCG operating plans now required by NHS England.

3.4 At the time of writing, the Local Authority BCF allocations have not yet been confirmed (expected imminently), nor has the national BCF guidance yet been published.

3.5 However, the primary NHS planning guidance confirms the continuation of the BCF and the ongoing requirement for the implementation of integration by 2020.

3.6 It was anticipated that a draft BCF submission would be required to be submitted to NHS England by 26 January 2017, with a final submission date anticipated to be late February/early March 2017. However, this timetable has been subject to further slippage.

3.7 It has been confirmed that the assurance process will mirror last year's, with regional

then national assurance, anticipated to conclude by May 2017.

4. 2017-18 to 2018-19 programmes: Strategic and policy context

4.1 The strategic framework for the BCF re-planning process is set by: the BCF national policy requirements, BCF national conditions, BCF metrics, CCG commissioning intentions and Local Authority duties with respect to the Care Act.

4.2 Locally, the new Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Plan (STP) re-frames priorities and financial plans across the LLR health and care economy. The area's three Better Care Fund programmes will be required to align with, complement and support this strategy.

4.3 Although not all the detail of the policy context has yet been confirmed, a number of areas remain priorities within the integration agenda nationally and locally: keeping people out of statutory and acute provision wherever possible, including via prevention activities, sustaining adult social care within new models of care locally, ensuring there is a cohesive plan for data integration at population and care planning levels, implementing seven day services, improving hospital discharge, and developing an infrastructure for joint commissioning.

5. Renewing the Rutland BCF plan

5.1 An initial strategic and financial refresh of the plan is underway, including:

5.1.1 Confirming the minimum required levels of financial allocation to protected Adult Social Care and out of hospital services (including the uplift for inflation across the programme period).

5.1.2 Assessing the affordability of the plan and the opportunities to generate headroom, recognising the financial pressures affecting all partners.

5.1.3 Determining the potential contribution of the plan to key indicators so that realistic yet ambitious targets can be set.

5.1.4 Ensuring alignment with STP activity (including proposals for the Rutland Memorial Hospital), CCG operating plan assumptions, the Vanguard urgent care pathway and local GP plans to join the Primary Care Home approach to delivery of primary care.

5.1.5 Following through the implications of new models of service delivery including:

5.1.5.1 Integrated locality teams across LLR.

5.1.5.2 The 'home first' reablement model

5.1.5.3 The 'Primary Care Home' approach to primary care being adopted in Rutland.

5.1.6 Giving further consideration to the overall integration model which will be adopted as the end point for integration in Rutland and across LLR.

5.2 The refresh is also being informed by a BCF partnership engagement event which was

held on 5 January 2017 (see Appendix 1), which reviewed the performance of the programme during 2016-17 and looked ahead to potential future priorities.

5.3 Most of the BCF plan is committed to core NHS and Local Authority services, so, in large part, the challenge is one of evolution, further developing how services are configured and work together.

5.4 Any more significant changes would need to be incorporated into contracts or delivered through decommissioning/commissioning activities that are subject to the usual timescales, processes and governance.

5.5 No final BCF refresh timetable has yet been confirmed nationally and the BCF guidance, budgets and planning templates have not yet been published, although indicative information has been made available through a BCF webinar by the Better Care Fund Programme team.

5.6 In the interim, work is underway by RCC, working with ELRCCG, on a draft narrative for the new programme, which will be adjusted as required when the national materials are published.

5.7 It may be necessary to progress at speed when national guidance and templates are formally released, in a process which will require HWB sign off.

6. Financial implications

6.1 The financial framework for the Rutland BCF programme is set by the national CCG and Local Authority allocations, the financial model of the LLR STP, the council's Medium Term Financial Plan (MTFP) and the CCG's operating plan financial targets and control totals for 2017-18 to 2018-19.

6.2 The negotiation of the BCF programme will be taking place against considerable and increasing financial pressures for both RCC and ELRCCG.

6.3 The 2016-17 programme consisted of a minimum pooled fund between RCC and ELRCCG of £2.061m, supplemented by £317k of carry forward funding from 2015-16, £200k of which was allocated to one-off projects, with the remaining £117k providing a contingency fund. Alongside this, there was an RCC capital fund of £186k for Disabled Facilities Grants. Excluding the contingency fund, the value of the programme in 2016-17 was £2.447m.

6.4 The risk sharing fund of £101k that was agreed by the partnership, to be associated with emergency admission rates has so far not been required due to good admissions performance in the first three quarters.

6.5 While the exact value of the 2017-18 and 2018-19 programmes has not yet been confirmed, Rutland is anticipating a similar annual financial allocation to 2016-17, with a modest uplift for inflation. Rutland County Council has not been allocated any of the improved Better Care Fund resources for social care (the so-called iBCF), with this being targeted via a national formula towards areas of greater financial need.

6.6 The national recommendation is still that programmes retain a contingency budget, in case of the need to compensate other partners for the cost of poor performance, notably in terms of emergency admissions levels although a formal pay for performance scheme

is not anticipated this time.

7. Recommendations

7.1 That the HWB:

1. Note progress on implementing the Rutland 2016-17 Better Care Fund plan and on shaping the follow-on BCF programme for 2017-19.

8. Risk assessment

Time	M	Owning to national delays, the timetable for BCF plan development is likely to be compressed. However, groundwork is well underway that will accelerate the process of finalising a BCF plan when the relevant guidance and other structuring elements are released by Government.
Viability	L	The current and next BCF programme build on the positive partnership developed and progress made since 2014.
Finance	M	The future Rutland BCF minimum financial allocation is unlikely to increase, other than an adjustment for inflation, meaning that the challenge is one of further evolving the use of existing resources to further progress integrated health and care locally. Any underspend from the current programme can be ring-fenced for future use. In particular, the funding for a small number of delayed projects will be carried forward to allow these projects to be implemented in 2017-18.
Profile	L	The programme has a high profile at national, regional and local level and is well integrated as a complementary part of Leicester, Leicestershire and Rutland Better Care Together activity. The HWB will hold both RCC and ELRCCG to account for the delivery of the BCF.
Equality & Diversity	L	The BCF plan will have a positive impact on members of the Rutland community requiring health, care and wellbeing services and opportunities.

9. Timeline (including specific references to forward plan dates):

Task	Target Date	Responsibility

Appendix 1: Summary of 2016-17 Better Care Fund progress and 2017-19 proposals

A successful BCF planning event was held at Rutland County Council on 5 January to reflect with partners on progress with the 2016-17 Better Care Fund programme and to look ahead to priorities for the 2017-18 to 2018-19 programme. The event, which was well attended, involved around 40 staff and partners spanning a range of Council care services, commissioners from the Council and the CCG, commissioned providers, secondary care, and the community and voluntary sectors.

Attendees worked in three groups, aligned to the programme's current priorities of Unified Prevention, Long Term Condition Management and Crisis, Transfer and Reablement, exploring the successes, challenges and opportunities of this year's programme and pointing the way for future priorities.

There was consensus around sustaining the ambition of Rutland's current programme objective, aiming to achieve a well-integrated and well-understood health and care system by 2018. Financial allocations will not be increasing, so the challenge is one of evolving to progress to the next stage of integration within the current financial boundaries.

1: Unified Prevention

Progress to date

1.1 The strong focus on prevention, aiming to keep people well, active and engaged in their communities, has been a distinctive aspect of Rutland's BCF programme, recognised by the national NHS England Better Care Fund Programme.

1.2 Many Rutland residents have benefitted from the diverse BCF prevention measures (including assistive technology, falls prevention schemes and support from the Community Agents on life issues). New activities such as the Men in Sheds project at the museum and telephone befriending (also as a follow-on to Community Agent support), were also welcomed, including for their anticipated contribution to mental wellbeing and social connection.

1.3 Disabled Facilities Grants (DFGs) for home adaptations continue to be delivered to help people to remain living at home and support their independence and quality of life, with most projects involving the installation of adapted bathrooms, stair lifts and/or ceiling hoists.

1.4 At the same time, there is a need to ensure that services are modelled sustainably and are not over-fragmented, intervene earlier to be truly preventative and reach as many potential beneficiaries as possible.

New projects and approaches

1.5 A number of prevention activities are committed into 2017-19, and are also anticipated to continue to evolve in response to local needs. Assistive technology is now a well-established service, for example, while the Community Agent scheme will continue as part of a wider Community Prevention and Wellbeing contract. Falls prevention activities delivered well in 2016-17, as reflected in reduced falls injuries, but were somewhat fragmented.

A more strategic approach is being pursued, including opting into some LLR wide falls prevention services.

1.6 The discretionary scope of adaptations that can be funded under the DFG scheme is currently being more clearly defined via a DFG policy so that the funding can increase or sustain the independence of more individuals.

1.7 As physical activity is increasingly recognised as the lynchpin for continued good health, work has also been started with local partners to consider what interventions could increase activity levels among sedentary individuals. There was also a need to consider carefully the language used to promote prevention activities to more directly motivate and engage target audiences (e.g. by working directly with target users) and to remove perceived barriers to increasing activity levels, working on the 'nudge' principle – making it easy for people to make good choices.

1.8 Providers of prevention-related services suggested that they would like to work more closely to better support potential synergies – enabling communication, coordination and connection. The Rutland Information Service website improvement project, underway now, was felt to be important for capturing and communicating Rutland opportunities, either directly to target audiences or via community providers and navigators.

2: Long term condition (LTC) management

Progress to date

2.1 Work with patients/service users with ongoing health issues was felt to be going in the right direction, as reflected in key BCF indicators, including a 3% year on year reduction to emergency admission rates and the maintenance of low levels of permanent care home admissions. The core focus this year has been on the further integration of community health and long term social care teams, including through a leadership development programme and increased multi-disciplinary working. There is further potential to build on this by working more strongly with both primary care and voluntary and community services.

2.2 In addition, services have continued to be delivered to support households where an individual has dementia and funding support for carers. Dementia support is about to be strengthened through the recruitment of a specialist Admiral dementia nurse able to provide clinically robust advice and support.

2.3 The Integrated Care Coordinator at the GP surgeries has also continued to provide valued support to people identified by risk stratification as vulnerable and who may not be benefitting from all the services available to them. Recognising that a wider population could benefit from this general approach, including mental health support, new Wellbeing Advisors in GP surgeries have been funded for the next year through an ELR CCG BCF pilot project.

2.4 The connection with work under the prevention strand was also recognised, building on the capabilities of individuals and the assets in their communities for people to live the fullest life they can, in the way they want to, in spite of health challenges. The need for good quality information about local services and opportunities, including volunteering, was also highlighted, ensuring that more people are more easily 'in the know'.

New projects and approaches

2.5 At the heart of long term condition management is developing stronger ways of working between primary care, community health, social care and the community and voluntary sector to deliver more efficient, effective, coherent services that respond in a personalised way to the specific health needs of service users, helping them to manage their health to lead as full a life as possible.

2.6 Again, an aspect of future plans is continuity and evolution, continuing with the Care Coordinator approach, supplemented by the Wellness Advisors, with support for dementia sufferers and carers and with a core of multi-disciplinary integrated working.

2.7 Alongside this, two key local developments provide unique opportunities across the 2017-19 BCF programme to work together to re-imagine and reshape the delivery of primary, secondary and social care for patients in Rutland, particularly those with complex health needs:

2.7.1 Rutland GPs are going forward with the Primary Care Home model, introduced by the National Association of Primary Care, which aims to promote the redesign of primary care around the needs of defined communities, personalising care and further integrating the workforce across primary, secondary and social care.to improve outcomes.

2.7.2 Proposals under the LLR Sustainability and Transformation Plan to reshape the service offering at the Rutland Memorial Hospital are also a catalyst for change.

3: Crisis response, transfer of care and reablement

Progress to date

3.1 The focus of the Crisis Response, Transfer of Care and Reablement priority is on managing and reducing demand for hospital services.

3.2 Rutland progress on systems for hospital avoidance and prompt discharge were reviewed relative to a national hospital admission and discharge maturity model, demonstrating that significant progress has been made during this financial year to avoid unnecessary hospital admissions (e.g. local use of the ICRS night nursing service) and to ensure prompt onward transfers of care when patients are medically fit for discharge.

3.3 Rutland has taken a rapid cycle approach to solving discharge related issues, leading to a highly integrated and effective discharge process with clearer options and pathways, including the flexible call off of interim beds where people cannot return directly home but no longer need hospital care. In six months, this latter initiative has saved over £200k for the wider health and care system, relative to the higher cost of people remaining in acute beds beyond their fit for discharge date.

3.4 Mental health related discharge delays have been a significant issue this year, leading to 233 nights currently classed as discharge delays (the statistics are currently being reviewed). This relates to a number of factors: a lack of clarity across the system about when sectioned mental health patients are transfer

ready, a poor flow of information about these potential discharges and lack of capacity in suitable onward placements.

3.5 Data analysis has been strengthened as a means to track progress with discharge management and has successfully enabled layers of issues to be identified and prioritised for resolution to reduce future delays. A key success factor has been the maturing of relationships and understanding between different discharge professionals and the willingness to reshape actions flexibly in response to evidence, trying new ideas and embedding the ones that work. User engagement has also generated further helpful insights about the discharge experience.

3.6 The resulting incremental system improvement has helped to deliver a progressively stronger discharge response through e.g. introducing the flexible call-off of interim care home beds, establishing a complex case manager role to negotiate more difficult discharges, building stronger relationships with out of area hospitals regularly treating Rutland patients, improving information flows about mental health discharge needs, and identifying discharge options in an integrated way whether the resolution is health or social care related.

3.7 In spite of intensive work, the overall level of delayed transfers of care (DTOCs) has remained higher than target for most of the year, echoing continuing national patterns of high discharge delays. However, bucking wider national trends, we have seen a steep net improvement to DTOC levels in Q3, to a monthly level in November that was within target for the first time this year. While, cumulatively, the annual DTOC target is likely to be exceeded, the number of nights of delays to transfers of care would have been substantially higher without the creative and innovative transfer management work to date. The steep net decline in delays in Q3 also reflects the cumulative impact of system improvements to date which have increased the capability of the system to handle current and future transfers of care.

3.8 Alongside this, it should be noted that the number of patients needing discharge support appears to be increasing over time. This means that, even as approaches improve, the challenge continues to increase. Teams may be pedalling faster, but the road is also getting longer! Second, against the pattern of delayed discharges, most patients do get discharged on time, often as a result of proactive discharge support. The rate of successful activity is not made visible in the current national approach to monitoring patient flow.

3.9 Finally, following discharge, reablement has continued to deliver successfully, ensuring that around 90% of service users who receive post hospital reablement are still at home 3 months after discharge, against a target of 83.3%. The number of cases receiving reablement services has also been increasing quarter on quarter this year (25 in Q1, 36 in Q2, 47 in Q3).

<u>New projects and approaches</u>

3.10 The proposed approach for 2017-19 is twofold.

3.11 First, the DTOC Action Plan will be renewed as a reference point for partners, setting out the directions of travel for crisis management, transfer of care and reablement. Areas of opportunity or planned change include:

3.11.1 The reshaping of the crisis response night nursing service to focus more tightly on end of life needs, alongside coordinating with the wider LLR Vanguard work to improve the response to wider urgent care needs.

3.11.2 Pre-admission planning for the discharge of elective patients (particularly where e.g. adaptations or reablement will be needed to support the return home)

3.11.3 Improving the information patients receive about discharge so they feel more confident in the discharge process, including promoting the role of advocacy to help patients with limited family or informal carer support.

3.12 Second, partners will continue to work iteratively, informed by data, to identify and address issues and disjoints in transfer of care processes so that discharge delays, and their impact on the wider health care system, are reduced to a minimum.

4: Enablers

Achievements

4.1 A broad range of enabling activities have been actively progressed during 2016-17, addressing areas that partners have agreed were actual or potential barriers to progress on establishing an integrated, effective and well understood health and care system in Rutland.

4.2 There is a clear, prioritised work programme for IT and IG, firmly linked to the LLR IT roadmap. More of the underlying building blocks for integration are in place (e.g. at RCC, IG Toolkit accreditation obtained, interoperable social care system LiquidLogic in place, NHS numbers being obtained and becoming a more routine reference point in social care).

4.3 IT projects are being progressed to support integrated working, notably the joint laptop solution delivered in January 2017.

4.4 Data has been more central to shaping policy responses and we have increased our involvement in wider projects and toolsets able to support evidence based change, including the PI Care and HealthTrak system.

4.5 User engagement in shaping services has been strengthened, notably through the HealthWatch project listening to service user experiences of transfers of care.

4.6 There is an efficient solution to adapting to workforce challenges through proactive working with the social care training provider LSCDG.

4.7 The BCF programme and its activities and achievements have been more widely communicated.

New projects and approaches

4.8 Funding will be limited in 2017-19 for enablers activities, but it is anticipated that many of the above areas can be continued, to help to support integration, e.g. following through on the work to strengthen IG arrangements and IT

integration (activity which it may also be possible to fund eg via applications for national Digital Roadmap funding), and to make greater use of analytics platforms. Cost effective routes to increased user engagement are also a potential priority, helping to inform and target policy and service responses.