ADULT AND HOUSING SCRUTINY
NOVEMBER 3 2015

ITEM NO. ..6.....

BETTER CARE FUND

SUMMARY REPORT

Purpose of the Report

1. To provide an update on progress at the mid-way point of the Better Care Fund programme of work

Summary

2. Darlington is on track to deliver 3.5% non-elective admissions, as per the BCF plan. At the half-way point (the end of Q1 2015/16), NEL admissions were down 218 against a target of a reduction of 235, a 1.64% reduction against a target of 1.76%. Given the direction of travel on this indicator we are currently confident in meeting the 3.5% objective despite being very slightly off this quarter. We routinely get statistics about 6 weeks from the end of the period so will be able to verbally update at the meeting with numbers from August.

3. Overall the numbers are all heading in the right direction, with the exception of the number of people still at home 91 days after a programme of reablement. However, this measure is not telling the whole story as the number of people going through reablement has increased significantly beyond the number used to set the target, and a review of the entry criteria is to take place as a consequence.

4. Permanent admissions of older people to 24 hour care have increased from a low in April, having undergone a dramatic reduction in 2014/15, but are still broadly on track at this time.

5. Delays to transfer of care continue to reduce, with well under 200 days delay each month since April; lower than the national average. We need to recognise however that this target was set with slightly different criteria than that being used now to record DToC, but the direction of travel is consistent.

6. The proportion of social care service users who feel they have enough social contact is 47% (pending national validation). This exceeds both this year's and next year's target.

7. Work under way now and in the near future includes reviews of the discharge function, and of the domiciliary care framework, proposals around intermediate bed provision, a long-term conditions rapid improvement event, and the development of a new medical model for nursing homes building on the GP/Nursing home pilot which is nearing its completion.

8. The Health Call nutrition pilot in care homes is late in getting under way but due to start imminently, and the service user experience survey is behind in being implemented, but a pilot (from which the baseline can be established) will be in place in Q3.

Recommendation

9. It is recommended that:-

   (a) Scrutiny Committee note the progress being made, and the expectation that we meet the targets set in the expected timeframe.

   (b) Members ask any questions and request further information.

Murray Rose, Director of Commissioning

Background Papers

Summary update provided to NHS England in September 2015

Pat Simpson, BCF Project Manager: Extension 6082

S17 Crime and Disorder	n/a
Health and Well Being	The Better Care Fund is owned by the HWBB
Carbon Impact	None
Diversity	National EIA has been undertaken
Wards Affected	All
Groups Affected	Frail Elderly at risk of admission to hospital
Budget and Policy Framework	Budgets pooled through a s75 agreement between DBC and Darlington CCG
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Aligned
Efficiency	New ways of delivering care have the capacity to generate efficiency

MAIN REPORT

Information and Analysis

Overview

10. Our approach to delivering BCF outcomes is a whole system approach, comprising a basket of schemes and working arrangements that collectively attack unnecessary emergency admissions and readmissions as a way of ensuring patients are cared for in the most appropriate place and reducing the demand on acute capacity. This "end to end" approach provides:-

    a) Support in people's own homes (help with heating, disabled facilities grants, assistive technology etc.).

    b) In the community (through services such as Good Friends, a resilient voluntary sector).

    c) A market position statement for providers.

    d) Targeted, holistic support for people identified as at greatest risk of admission through a risk stratification process and the Multi-Disciplinary Teams.

11. The effect to date has been in reducing non-elective admissions, reducing admissions into 24 hour care, and reducing delays to discharge.

MDTs at the centre

12. At the heart of our BCF approach is the 'multi-disciplinary team' (MDT) in Darlington for Complex and Frail Elderly people over 60 who are most at risk of unplanned hospital admission.

What works?

13. 'Care Coordinators' coordinate the care planning and management for the cohort of patients across the MDT. The Care Coordinators – who may be Community Matrons in a care home setting, a GP, Practice Nurse or other professional - also ensure consistency in care planning documentation and processes working with the Darlington GP practices, towards meeting the requirements of the Primary Care 'Unplanned Admissions Direct Enhanced Service' (DES).

14. Community Matrons at the weekend manage the reactive needs of care home residents and housebound patients, and are now also working in Darlington Memorial Hospital (DMH) to prevent unnecessary admissions and to expedite discharges.

15. Service users highlighted that this way of working is particularly useful for liaising with relatives as this is the highest period of visits. During the weekend a high proportion of proactive work such as Emergency Health Care Planning (EHCP) and DNACPR planning is undertaken because of the relatives' availability.

16. Matrons assess around 25-30 patients over the course of the weekend. The matrons also offer expertise/advice/prescribing to the district nursing team, and contribute to the identification of patients suitable for discharge from medical assessment unit and acute wards at DMH – facilitating discharges; avoiding admission to acute services. This admission avoidance work has been enhanced by the opportunity for the matrons to closely collaborate with the GP's who have started to work as part of this model on a Sunday.

17. The impact of the Matrons at weekends is an average of four patients either prevented admission or discharged earlier due to matron involvement. Matrons have reported collaborative working relationships with consultants and doctors in the acute setting. The number of patients discharged on a weekend is dependent on the Consultant on Medical Assessment Unit's (MAU) confidence in Community Services' ability.

18. Interactions with GPs and supporting services such as RIACT (Rehabilitation and Reablement) and Allied Health Professionals remain positive and meaningful. Matrons attend GP surgeries for monthly MDT meetings to discuss high impact service users, twice-weekly RIACT MDT meetings, and are part of the discharge and admissions avoidance team on a weekend.

19. Darlington CCG has just commissioned County Durham and Darlington Foundation Trust (CDDFT) to provide an Acute Admission Prevention Service to its care homes as part of its overall model of care. The service builds on evidence based practice that dedicated nurses working within care homes can significantly reduce emergency conveyances into acute care.

Hospital to Home (Adults Transitions Care Team)

20. The Hospital to Home component was developed to avoid unnecessary admissions by working alongside the Emergency Department and Medical Assessment Unit to reduce the demand on acute capacity. The role was also to facilitate earlier discharge for patients who have already been admitted by working alongside the Discharge Management Team and the Palliative Care Discharge facilitator. Community Nurses backfill experienced full-time Community Nurses, working seven days, 9-5, linking with social care staff through an MDT approach.

What works

21. Initial response from the Emergency Department and Medical Assessment Unit in referring patients was low with both units continuing to refer to the Discharge Management Team. As the staff became more involved with patients on both units the uptake for the team increased.

22. The scoping process revealed the impact the community team would have in facilitating earlier discharge for patients who have already been admitted on the wards: the discharge process is now being reviewed as part of the wider integrated management function, to ensure resources are used to best effect.

23. Since 2012/13 the recorded average number of days tied up by people who are medically stable and fit to leave hospital but unable to do so, has fallen consistently and is now well below the national rate.

RIACT

24. RIACT provides time limited support to service users who have experienced sudden, short term deterioration in their health and or a change to their physical functioning. The service promotes rehabilitation and recovery enabling service users to attain their optimum level of independence. Following the success of the practice MDT's it was recognised that RIACT and those accessing the service could benefit from this way of working.

25. The RIACT MDT meetings have been held every Monday and Friday morning since January 2015 and make use of immediate access to patient and service user information via Care First and SystmOne.

26. Current attendance at the meetings includes RIACT Team Manager (Social Care), the Lead Nurse or Therapist for Health, a Community Matron and District Nurse and a representative from the voluntary sector. A member of staff aligned to the Practice MDT's from Social Care also attends as does a representative from the Ongoing Care Team, to ensure there is a link between RIACT and the other assessment teams.

27. The key focus of the MDT discussion is around those people who are already receiving a support through the RIACT service. Maintaining capacity within the service is key to ensuring the service can provide a rapid response to help prevent admissions to hospital or residential care and facilitate timely hospital discharges. The MDT's allow for clear monitoring of progress in relation to the persons identified outcomes and planning can take place for transition from the service.

What works

28. The meetings have led to more proactive management of service provision. The flow of people moving from brief interventions via RIACT to Ongoing Care, for those people who have long term care needs, is timelier and the length of stay within a bed has been reduced. Greater use of community services including the voluntary sector has increased; there is a better understanding from all professionals of what the voluntary sector can offer and a real opportunity to make greater use of their skill and expertise.

29. The development and enhancing of relationships between professionals is a real and positive outcome of the MDT meetings. Greater understanding of roles and responsibilities has been achieved and the sharing of information enhanced. Now that the relationships are established the meetings are efficient and focused, while still providing an opportunity for more in-depth case discussion, exchange of ideas, advice and support. This is vital in terms of being able to deliver positive outcomes for the person whilst managing increasing demand for resources and capacity across all organisations.

What's off-track?

30. The piloting of our patient experience survey is behind schedule as we seek a way of easily administering our questionnaire (which is agreed and designed) to patients who have received a service having been assessed by the MDT. We expect the pilot to be under way, via GP Practices, during Q3. We are also seeking clarity from the national team to ensure we avoid any duplication of effort and avoid patients being over-surveyed.

Better Care fund summary				
High level overview	**Leadership**	**Governance**	**The overall timeline and the key milestones**	**Delivery**
BCF brings together a number of schemes that collectively attack unnecessary emergency admissions and readmissions by frail elderly people, identified through a risk stratification process.	Delivery of the BCF is owned by the Health and Well Being Board, and delivered through a partnership comprising CDDFT, TEWVFT, Primary Healthcare Darlington, Darlington CCG and Darlington Borough Council	Individual Partners' executives ↑ Health and Wellbeing Board (Accountable owners) ↑ Joint Management Team (responsible officers) ↑ Unit of Planning – sounding board, coordination, ad hoc direction, and escalation of issues ↑ Project manager	Oct to Dec '14: • Multi-Disciplinary Teams (MDT) implemented, focused on GP Practices • "Good Friends" scheme launched as part of implementing a resilient Voluntary and Community sector • Single director of commissioning LA and CCG. Jan – Mar '15. • Advance Care Plans in place for the identified cohort • Geriatrician phone contact for clinicians in place • GP Frail Elderly Champion in place Apr – June '15 • MDT implemented for care homes • MDT implemented for rehabilitation and reablement • Frail elderly rapid assessment available in an ambulatory setting • Diagnostic samples collected at weekends July – Sept '15 • "Hospital to Home" operating 8 – 8 7/7 • Intermediate care review started • Domiciliary care review started • Digital health: "nutrition call" introduced in care homes Oct – Dec • New medical model for care homes • Reablement pathways reviewed • Intermediate care review completed • Long term conditions rapid improvement event • Domiciliary care review completed • 3.5% reduction in Non-elective admissions planned to be achieved	Implementation of a joint management team across the five partners. Single Director of commissioning. Identification of £9,522,00 from CCG and DBC budgets delivering reviewed, existing or new work against the BCF objectives. P4P Criteria in relation to Non-elective admission NELS.