ADULTS AND HOUSING SCRUTINY
31 October 2017

ITEM NO. .....**5.**.....

BETTER CARE FUND UPDATE

Purpose of the report

1. To provide an update of the progress in respect of Better Care Fund submission for 2017-19 and delivery thus far; plans for the iBCF (the additional social care grant announced in the Spring Budget) and of the Reablement review and follow-up work.

Summary

2. The 2017/19 Better Care Fund plan was approved at Health and Wellbeing Board in September and was submitted on deadline. At the time of reporting assurance feedback is expected week commencing October 6. A verbal update can be given at the Scrutiny Committee. The plan is attached as **Annex 1**.

3. First quarter performance data indicate that, of the mandated BCF metrics, delay to transfer of care and admissions to 24 hour residential care are well within target, but non Elective Admissions (NEA) are not on target. There are issues with availability of data from Health in respect of the proportion of people still at home 91 days after a period of reablement. The Quarter One performance report is attached as **Annex 2.**

4. The plan for use of the additional social care grant, announced in the Spring Budget (iBCF), has been jointly approved in principle by Health and Wellbeing Board in September and work is under way now to add detail to that plan. The first monitoring report was submitted on time and the second quarter report is due October 20. A verbal update can be given at the Scrutiny Committee. The plan, with the internal Highlight Report for September, is attached as **Annex 3.**

5. A summary report of the findings of the review of Intermediate Care/RIACT is attached as **Annex 4**. Work is under way now on a pathway improvement project, focussing on the Local Authority reablement service, and on reviewing the use and eligibility criteria for step down beds, being delivered by CCG. Both pieces of work will come together through the Local Discharge Delivery Group work which feeds into BCF delivery and governance via the Pooled Budget Partnership Board.

Recommendation

6. It is recommended that:

   a. Scrutiny Committee note the content of the 2017-19 BCF plan and impact to date and the requirements in respect of the next, two year, BCF plan.

b. Scrutiny Committee note the plans for use of the additional social care grant announced in the Spring Budget (iBCF).

c. Scrutiny Committee note the content of the Intermediate Care and RIACT review report, and the subsequent action in place.

d. Members ask any questions and request further information.

Suzanne Joyner
Director of Children and Adults

Background Papers

None

S17 Crime and Disorder	n/a
Health and Well Being	The Better Care Fund is owned by the HWBB
Carbon Impact	None
Diversity	If significant changes are proposed an EIA will be undertaken
Wards Affected	All
Groups Affected	Frail Elderly at risk of admission/re-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
Impact on Looked After Children and Care Leavers	This report has no impact on Looked After Children or Care Leavers

MAIN REPORT

Better Care Fund Delivery Overview

Better Care Fund Plan Content

1. The technical guidance for the plan was released on Friday July 7th and the submission template on August 4th, along with the detail of the assurance process and the KLOEs by which the plan will be assessed.

2. The narrative plan comprises context setting in the form of a statement of the vision and approach to health and social care integration, evidence base and priorities, risk, and detail on the meeting of national conditions, metrics, governance and funding, and Delayed Transfers of Care – a key focus of this plan.

3. The submission template captures the detail of the metrics, funding, expenditure plan, and national conditions. It is attached as **Annex 1**.

4. The Better Care Fund for 2017/18 and 2018/19 has four National Conditions:
    1. That a BCF Plan, including the minimum of the pooled fund specified in the Better Care Fund allocations, should be signed off by the HWB itself, and by the constituent local authorities and CCGs, and with involvement of local partners;
    2. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in 2017/18 and 2018/19, in line with inflation;
    3. That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement.
    4. Implementation of the High Impact Change Model for Managing Transfers of Care

5. The Better Care Fund Plan 2017/18 seeks to build on foundations laid in 2015/16 and 2016/17 in the areas of admissions avoidance in 65+, a joint approach to discharge management, reablement and intermediate care services, improving health in care homes, and building a robust community and universal services offer in support of managing demand into the future.

6. Reablement data indicates only a small improvement in effectiveness which will be addressed through an improvement plan.

7. The Local Authority and health partners have been working together on discharge planning and delivery for a number of years and have a robust relationship that facilitates productive patient flow.

8. A rapid response service implemented over winter proved very effective and allowed discharge to assess to function well, along with seven day working.

Changes from previous BCF plans

9. MDT teams involving navigators from VCSE have been discontinued in the absence of evidence of value, and the social prescribing test-bed will pick up the objectives of identifying and supporting access to universal services, across a wider cohort.

10. Dementia will have an increased focus in Darlington's BCF Plan for the next two years, given the evidence: the prevalence of registered patients diagnosed with dementia in Darlington is higher at 1% of the population in Darlington compared to both the North East region (0.9%) and England (o.8%). There has been a steady upward trend in Darlington from 0.7% in 2011/12 to 1.0% in 2015/16. This has been similar to the trend regional and nationally. A report from Darlington UA's Adult and Housing Scrutiny Committee called "Living Well with Dementia" provides the basis for developing services for Darlington as part of our BCF plans.

11. There will also be increased focus on how BCF contributes to the implementation of the New Model of Care proposed for Darlington.

BCF priorities 17/19

12. The plan has six broad workstreams to support the delivery of the BCF priorities in the areas of:
    - New models of Care and personalisation of services including through technology and domiciliary care;
    - Healthcare services to Care Homes;
    - Equipping people to be resilient and self-reliant through primary prevention/early intervention, and care navigation;
    - Intermediate Care and improvements to reablement and rehabilitation services;
    - Further improving transfers of care through the implementation of the High Impact Change Model;
    - Supporting carers and delivering DFG adaptations;
    - Maintaining the good level of Dementia Diagnosis and post diagnosis support.

13. All workstreams are interlinked.

14. The Quarter 1 performance report prepared for the Pooled Budget Partnership Board is attached as **Annex 2**.

New Models of Care

15. A key programme currently in development will build on the outcomes of the Discharge to Assess model piloted in 16/17 and further implement the High Impact Change Model. This has the capacity to impact on intermediate care and the use of social care "short stays". Also under this umbrella are elements of domiciliary care, personalisation of services use of telehealth and technology, and the pathways for people to "step up" social care and reablement and avoid admission into care homes or hospital.

Healthcare services to Care Homes

16. A range of health-focused activities to ensure residents have consistent healthcare and avoid unnecessary admissions to hospital. This links with discharge planning and the “step-down” pathway. A Care Home Commissioning Group has been established, to aid closer working of health and social care commissioners to support the residential care sector.

Primary prevention and care navigation: equipping people to be resilient and self-reliant

17. A social prescribing test bed, trialling a primary prevention approach, and supporting care navigation specifically targeting those who are not able to find or access community based services without help, got under way in May 2017. Wellbeing navigators were appointed from the voluntary and community sector, building on experience gained through the MDT approach at GP Practices. Measures of success include client outcome monitoring, breadth of services referred to (resilience of the VCSE sector), quantification of the service need and appropriate entry criteria. Allied to this is the development and provision of a comprehensive directory of Service for Darlington, a searchable service containing information about major providers through to very small community groups, allowing people to find their own provision, and for first points of contact, care navigators and other advocacy services to find suitable options for people below the eligibility or treatment threshold. An assessment of the effectiveness and impact of this test bed will be carried out at the end of October.

Intermediate Care

18. The RIACT and intermediate care service is central to helping keep people out of hospital, and for speeding their journey home if they have had to be in hospital, aiming to provide therapy, nursing care, or domiciliary support in the community to help a person regain optimum independence. At the same time, the health and social care landscape within which the service operates is changing quite rapidly in Darlington as more and more multi-disciplinary teams come together at different stages in the patient pathway, driven by different partner priorities.

19. An external review commissioned in Q3 16/17 has begun to identify what might need to change in terms of the operating model, and the way the parts of intermediate care work together, to make the most effective contribution to Darlington people’s health and care support. This improvement plan will be delivered as a key pillar of BCF 2017 – 19 and is intended to address, among other objectives, the relatively poor performance of Darlington on the effectiveness of Reablement metric. The plan is to see performance move from under eighty per cent to the realm of the top performers, in the nineties, over the next two years.

Transfers of Care: High Impact Change Model

20. Patient flow and discharge planning is pivotal, and work to implement the high impact changes will continue (the model is attached as **Annex 5**). The Local Authority and health partners have been working together on discharge planning and delivery for a number of years and are probably at the "mature" stage in terms of change 3 (Multi-disciplinary discharge teams) and Change 8, (enhancing health

in care homes). Social Care staff participate in twice daily on-ward huddles and have an escalation process in place to facilitate discharge where necessary and there are very well established relationships with patient flow teams at the hospital.

21. However, Darlington is ranked poorly on the NHS-social care interface dashboard for weekend discharge, with just over 18 per cent of discharges taking place at the weekend, compared with 22 per cent for the best performers. This is a known issue to be resolved this year under the work of the Local Discharge Delivery Group.

22. A self-assessment against all eight changes is planned by the Local Discharge Delivery Group, to be followed by an action plan, with the intention of maintaining our current good DToC performance, delivering the targets set out in the DToC metric and preserving our existing good relationships.

Dementia

23. A report into dementia commissioned by the Adult and Housing Scrutiny Committee provides the basis for planning new or different dementia services as part of BCF 2017/19. BCF plans for 2017-19 include the introduction of a project to increase diagnosis among BME and LGBT communities, and the introduction of activities such as games for the brain, swimming for the brain and singing for the brain.

Additional social care grant (iBCF)

24. The Local Government settlement announced in 2015 included an amount for Improved BCF and subsequently, in the 2017 Budget, an additional Improved BCF Grant was announced:

	17/18	18/19	19/20
iBCF	£160,683	£1,731,000	£3,147,000
Additional Grant	£2,192,117	£1,425,577	£707,667

25. The purpose of the grant is to provide support to local authorities in England towards expenditure lawfully incurred or to be incurred. The grant is subject to conditions: the grant may only be used for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

26. Part of the funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems.

27. The grant must be pooled into the Better Care Fund and the Council and CCG must work together to meet BCF National Condition 4 - a joint plan for managing transfers of care (reducing delays) and implementing the high impact change model for managing transfers of care.

28. DCLG has also required Authorities to certify via the s151 officer that the spending of the additional money announced at the 2017 budget will be additional to previous plans for adult social care spending.

Accessing the grant and reporting its use

29. The Council can begin spending the grant as soon as locally agreed plans for its use, jointly agreed between the Council and the CCG, is in place. The Pooled Budget Partnership Board received and agreed an outline plan in August, and this was further agreed at the September Health and Wellbeing Board at its meeting on September 7.

30. The Council was required to submit a report in respect of iBCF to DCLG on July 21 and met this deadline. The first quarter's report covered the impact of the money on budget-saving decisions, the initiatives being deployed, and engagement with care providers. It also required declaration of last year's and this year's average unit costs for home care per contact hour and care home provision 65+, per client, per week. Other quantitative data requested were number of home care packages, hours of home care provided, and number of care home placements. It also included a narrative on progress deploying the high impact change model. That plan, and the internal transformation programme highlight report in respect of iBCF as at September 2017, is attached as **Annex 3**.

31. Another monitoring report is required on October 20 – a verbal update can be provided at the Scrutiny Committee.

Principles and components for Darlington's iBCF

32. The intention is to allocate the grant as follows: 50 percent to offset expenditure on current pressures and demands and 50 per cent to support transformational activity to enable system changes to take place. The intention is to achieve a model of care and support that can manage demand, in a sustainable way, by year three, beyond which there is no guarantee of any additional funding.

33. The rationale for this approach is that Darlington Borough Council is performs very well in respect of delays to social care related transfer of care. The Council is also a high spending authority by comparator group in terms of per-head of population expenditure on social care. These two circumstances are linked, and investing in the ongoing delivery of the core Adult Social Care offer, while transformational changes take place, will benefit the health and social care system as a whole.

Investing in Adult Social Care to manage current system pressures

34. The new grant funding will be used to offset expenditure on current demand. This will reduce the immediate ASC budget pressure and achieve a more financially stable position for ASC in the medium term.

35. This approach will support the continued delivery of the core ASC offer, while the ASC transformation programme is delivered and embedded. The funding will be used to support financial expenditure on activity relating to strength based assessment and support planning functions across all client groups. It will support

the provision of direct payments, domiciliary care, residential and nursing care, short break stays, carers support, day care and extra care housing.

36. The expenditure of ASC in these areas, together with a whole system focus, contributes significantly to the very positive delayed transfers of care (DToC) performance achieved by DBC. DBC is currently the 5th best Local Authority for DToC nationally and the aspiration is to maintain this performance.

37. DBC has maintained relatively high levels of spend per head of population on ASC compared to similar Local Authorities. This level of expenditure is not sustainable in the long term and a transformational shift has to take place in order to manage demand, maximise independence, deliver personalised outcomes and promote a cost effective and stable market.

38. This approach will benefit the health and social care system as a whole. It will continue to reduce pressure on the local NHS system and support effective and efficient patient flows. It will meet condition 4 of the BCF, in that, it will be spent on social care needs, relieve pressure on the NHS and ensure a continued focus on hospital discharge.

39. Retaining the current focus on transfers of care will support the continuation of positive DToC performance, and help mitigate any impact that might arise from changes elsewhere in the system. In particular, targeting “upstream” activity to reduce the likelihood of admissions is proposed as a key plank of the strategy.

40. Embedding strength-based assessment/support planning, by increasing capacity in the review team, is an area that will improve an individual’s independence, ability to self-care and reduce the potential for future service need.

41. Short stay bed usage avoids admission to hospital (step-up) and facilitates transfers of care (step-down), but it represents a budget risk which the grant can mitigate. This usage also supports the wider BCF condition 2 (being additional to the NHS contribution to adult social care, maintained in line with inflation) and condition 3, agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care.

42. Domiciliary care packages support admission avoidance to hospital and facilitate transfers of care. As with short stay beds, this is a significant area of activity that represents a budget pressure that is unsustainable without additional investment.

43. Allocating grant funding in these key areas will provide more stability for ASC and the system as a whole. It will create the conditions needed to continue to develop and embed the transformational changes that will move the system towards achieving a sustainable model of care and support.

Supporting the transformation of Care and Support

44. Darlington Borough Council is amidst its transformation programme. This is designed to deliver an efficient and effective model of Adult Social Care that is able to manage the projected increases in demand resulting from demographic pressure and complexity of needs.

45. The programme is underpinned by a strength based approach that will help people to achieve their full potential for self -care and independence and maintain it for as long as possible.

46. Developing such a model is essential to the health and social care system and will divert pressure from local NHS services. Allocating grant funding will add capacity and speed of delivery in key areas.

Key areas of transformation that will benefit from investment

47. Reablement is fundamental to an effective health and social care system and is central to achieving priority outcomes. Reablement helps people to achieve their optimal level of independence and capacity for self- care. It prevents, reduces and delays the need for formal services including hospital admissions. Investment to improve the reablement pathway will contribute to reducing NEA and maintenance of good DToC performance. The expansion of reablement provision will introduce more 'step up' capability". It will also strengthen the social care contribution to partnership working in the areas of hospital discharge.

48. The New Models of Care currently being proposed by the CCG present the opportunity to align staff around real or virtual hubs. A mobile and agile workforce is needed to enable Adult Social Care to work efficiently and flexibly with partners. Investment in agile technology will support social care staff to maximise their capacity and contact time in the community, and will facilitate working from different locations. This will support effective multi-disciplinary working and the delivery of integrated care around the person.

49. There is also scope to invest in telecare equipment, and its deployment, particularly in respect of falls prevention. A fall is often a trigger event for reduced independence and often results in unnecessary permanent care home admissions. Grant funding will enable the use of assistive technology to become a default offer that will maximise self-care and independence.

50. The implementation of online systems to provide people with tailored information, advice and guidance and effective sign posting to community and voluntary sector services is also part of this transformation. A new, comprehensive directory of services in Darlington is in development, linked to online needs assessment and screening tools, and including as wide a range of voluntary and charitable services as possible, as well as health and social care services, the Local Offer and Families Information Service. The directory will be maintained by the team currently supporting the Families Information Service with additional resource procured from within the Voluntary sector in Darlington, and funded by iBCF, to ensure those small organisations have full, rich and well-maintained information.

51. Finally, transformation objectives include the aspiration to develop service capability across the week in specific areas of the social care pathway. Darlington does not perform well in respect of the proportion of discharges from hospital which happen at the weekend, so work to ensure social care reasons do not aggravate DToC at the weekend is necessary. This will support discharge to assess initiatives and the implementation of trusted assessor approaches.

52. Some specific, targeted and defined capacity to support transformation as a whole: policies and systems to support new ways of working, support to get the most from the social care pathway, support with diagnostics and additional capacity for the Review Team, as mentioned above.

Governance

53. The grant is subject to a s75 and must be pooled with BCF monies.

54. As a pooled budget, subject to a jointly agreed plan, its use will be overseen by the Pooled Budget Partnership Board, comprising Darlington Borough Council Director of Children and Adult services, the CCG Accountable Officer, commissioning leads for both organisations, and the pooled budget managers.

55. At its last meeting the Pooled Budget Governance Group established the Intermediate Care Joint Delivery Group, to oversee the development and delivery of the Intermediate Care (RIACT and reablement) improvement plan.

56. The newly set up Integration Board will also provide a sounding board and information sharing function for BCF delivery.

DToC Plan

57. The CCG and Council were required to submit a provisional plan in respect of DToC to Better Care Fund on July 21 and met this deadline. That provisional metric was then included in the BCF Plan on submission for adoption as the actual metric.

Assurance Process

58. Assurance of plans in 2017 will take place in one stage, after which plans deemed to meet the requirements set out in the Policy Framework and Planning Requirements will be put forward for approval. Plans rated 'approved with conditions' will be given permission to enter into s75 agreements on condition that any outstanding requirements are met by the date specified in the notification.

59. Final decisions on plan approval will be agreed by NHS England and the Integration Partnership Board (IPB). These decisions will be based on the moderated recommendation of the regional assurance panel.

60. The IPB is a joint board that oversees government activity to deliver integrated health and social care. It is jointly chaired by the Department for Health and The Department for Communities and Local Government, with senior officials from HM Treasury, the Cabinet Office, the Local Government Association, ADASS, NHS England and NHS Improvement.

61. Regional assurance will be co-ordinated by BCF Regional Leads and Better Care Managers, working with Directors of Commissioning Operations (DCO) teams, in partnership with local government assurance teams. NHS regional staff (including finance staff) and BCMs will be responsible for ensuring that regional assurers have access to appropriate information and guidance to assure plans and that

arrangements are in place for joint agreement by NHS and local government of assurance outcomes and feedback to local areas.

Future reporting and monitoring

62. Quarterly reporting is required for both BCF and iBCF. Dates have been published for iBCF but at the time of reporting not yet for BCF. There is no expectation currently that separate monitoring reports will be required for the DToC metric.

RIACT and Reablement review

63. In summary, the main issues identified through the review (report attached as **annex 4**) were that
    - Criteria for service access are unclear
    - There is potential duplication of the service offering across acute and community teams, but the current arrangements make it difficult to ascertain
    - Effectiveness of the service in its current format is unclear
    - Efficiency of the service in its current form is unclear
    - Current ability to evaluate both effectiveness and efficiency is limited

64. An improvement plan for the local authority reablement pathway has been developed, and in tandem, the CCG is reviewing the specification and access to "step down" beds. At the same time the work of the Local Discharge Delivery Group, which includes CDDFT representation, alongside Adult Social Care and the CCG, is looking at the discharge process in the round, in the context of the High Impact Change Model. This is intended to result in an improved reablement pathway and step-down provision which are available to be offered to the right people at the right time for the right reasons.

65. Improved data collection is part of the improvement plan, bringing into place data that can be used to inform service development on an ongoing basis.