ADULTS AND HOUSING SCRUTINY
13 FEBRUARY 2018

ITEM NO.4

BETTER CARE FUND 2017/18 & 2018/19

Purpose of the Report

1. To inform Adults and Housing Scrutiny committee of the 2017-19 Better Care Fund submission and associated plans.

2. The plan was submitted on time and received full assurance.

Better Care Fund Plan Content

3. 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.

4. The submission template captures the detail of the metrics, funding, expenditure plan, and national conditions.

5. The Better Care Fund for 2017/18 and 2018/19 has four National Conditions:

   (a) 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;
   (b) 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;
   (c) 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.
   (d) Implementation of the High Impact Change Model for Managing Transfers of Care

6. The plan is attached as **ANNEX 1**.

7. 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.

8. Reablement data indicates only a small improvement in effectiveness which will be addressed through an improvement plan.
9. The Local Authority and health partners are working together on discharge planning and delivery and have a robust relationship that facilitates productive patient flow.

10. 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

11. A social prescribing test-bed is implemented and runs until the end of April 2018. A specification for a full service will be developed from the learning and data accrued by the test-bed. .

12. Dementia has 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 (0.8%). 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.

13. There is also increased focus on how BCF contributes to the implementation of the New Model of Care proposed for Darlington.

BCF priorities 17/19

14. The plan has six broad workstreams to support the delivery of the BCF priorities in the areas of:

    (a) New models of Care and personalisation of services including through technology and domiciliary care.
    (b) Healthcare services to Care Homes; Equipping people to be resilient and self-reliant through.
    (c) Primary Prevention/Early intervention, and Care Navigation.
    (d) Intermediate Care and improvements to reablement and rehabilitation services.
    (e) Improving Transfers of Care through the implementation of the High Impact Change Model.
    (f) Supporting carers and delivering DFG adaptations.
    (g) Improving Dementia Diagnosis and post diagnosis support.

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. Commissioning outwith the BCF in support of improving the health of Care home residents include the availability of Medication Optimisation Pharmacists, and the infection control team.

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, got under way in May 2017, with Wellbeing navigators appointed from the voluntary and community sector, building on experience gained through the MDT approach at GP Practices, and will be monitored as part of BCF 2017/19. 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.

Dementia

18. New schemes to improve diagnosis of dementia in minority communities and to offer activities including singing for the brain, swimming from the brain and brain games will shortly be commissioned.

Intermediate Care

19. 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. We need to have a service that delivers and can evidence effective support, has clear connections with referrers and discharge destinations, and that can flex and accommodate a perpetually shifting landscape.

20. 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, currently being developed, 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 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

21. Patient flow and discharge planning is pivotal, and work to implement the high impact changes will continue. 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 (ref BCF Exchange Case Study on Darlington's community matrons). Social Care staff participate in twice daily on-ward huddles and have an escalation process in place to facilitate discharge where necessary. We have very well established relationships with patient flow teams at the hospital, robust communications, and social care staff participate in the weekly regional OPEL teleconferences. The hospital has in place "your ticket home" to ensure discharge is discussed as soon as possible after admission.

22. However, we are ranked poorly in the NHS-social care interface dashboard for weekend discharge, with just over 18% of discharges taking place at the weekend, compared with 22% for the best performers. This is a known issue to be resolved this year under the work of the Local Discharge Delivery Board.

23. We will jointly be carrying out a self-assessment against all eight changes and developing a 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. A specific Transfers of Care group for Darlington is in place, bringing together hospital, commissioning and provider representatives to further progress the work.

Additional iBCF Grant

24. Darlington Borough Council is ranked seventh best performing in the Country in respect of social-care related delays to transfer of care on the NHS-social care interface dashboard. When compared to similar councils, DBC has spent comparatively more on activity which has stemmed from NHS contacts. These two circumstances are linked.

25. The new grant funding will be used to offset expenditure on current pressures and demand to ensure sustainability while the service undergoes transformation, also funded through iBCF. This will reduce the immediate ASC budget pressure and achieve a more financially stable position for ASC in the medium term when a transformed service can operate sustainably within its resources.

26. The Council was required to submit a template plan in respect of iBCF to DCLG on July 21 and met this deadline.

DToC Plan

27. 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. The provisional metric will be adopted as the actual metric as part of the assurance process for BCF; the FT has been asked to verify the metric is in line with its expectations.

Future reporting and monitoring

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