ADULTS AND HOUSING SCRUTINY
11 SEPTEMBER 2018

ITEM NO. .....

BETTER CARE FUND

SUMMARY REPORT

Purpose of the Report

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

2. To update the committee on updated guidance received in July 2018 in respect of the second year of the plan.

3. To provide a short glossary of terms used across health and adult social care, attached as **Appendix 1**.

Summary

4. Delivery of the two-year Better Care fund plan is ongoing. A range of schemes have been reviewed resulting in some small schemes stopping or having reviewed specifications, and some larger pieces of work in the Intermediate Care sphere. Operational Guidance was published during July updating the previous guidance and opening the opportunity to refresh metrics and plans, if necessary.

Recommendation

5. It is recommended that:

   (a) Scrutiny Committee notes the content of the report and raises questions.

   (b) Scrutiny Committee reviews the Glossary of BCF terms and reflects on additional helpful content.

Suzanne Joyner
Director of Children and Adult Services

Background Papers

Better Care fund Plan submitted September 2018

Patricia Simpson : Extension 6082

S17 Crime and Disorder	No impact
Health and Well Being	Contributes to the delivery of the Health and Wellbeing Strategy and Plan
Carbon Impact	No impact
Diversity	Particular scheme to improve Dementia diagnosis in BAME communities
Wards Affected	All
Groups Affected	65+
Budget and Policy Framework	Better Care Fund
Key Decision	No
Urgent Decision	No
One Darlington: Perfectly Placed	Contributes to the livery of the Health and Wellbeing Strategy
Efficiency	Contribution to reduced demand for Adult Social Care
Impact on Looked After Children and Care Leavers	None

MAIN REPORT

Information and Analysis

6. As reported to this committee in February 2018 the BCF plan 2017-2019 has seven broad workstreams to support the delivery of the BCF priorities in the areas of:

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

Healthcare Services to Care Homes

7. A BCF Darlington Care Home Commissioning Delivery Group has been established, to aid closer working of health and social care commissioners to support the residential care sector.

8. The GP alignment scheme has been reviewed as not all practices were taking part leading to inequitable access by homes. The new approach is delivered through the Federation and takes the shape of a monthly “ward huddle”. This is in the form of an intensive MDT (led by GP, with CPN, community matron, and therapist) at every home every month to review residents who have had an unplanned admission, three unplanned community matron visits, had a fall, or had an adverse medications management event. Recommendations are then made to the person's own GP.

Primary Prevention and Care Navigation Equipping people to be Resilient and Self-Reliant

9. A social prescribing test bed, trialling a primary prevention approach, ran as planned to April 2018, with Wellbeing navigators appointed from the voluntary and community sector, building on experience gained through the MDT approach at GP Practices. Lessons learned from the testbed have informed the development of a care coordination scheme to be delivered through the Federation. Implementing the new approach is currently on hold while the detail of the new community health contract are worked through, to ensure close and effective working.

10. Allied to this is the development and provision of a comprehensive directory of resources and community assets for Darlington. Livingwell.Darlington is up and running and efforts to ensure it is kept fully and effectively populated, and able to give easy access to information about community assets and resources.

Intermediate Care

11. An improved reablement pathway is currently being prepared for implementation at the Council.

12. In parallel the CCG has reviewed its step down provision through Community Hospitals and nursing homes (Ventress and Eastbourne). It will be changing its offer to ensure equitable provision and through the integrated care group started to look at whether something jointly can be commissioned in terms of an intermediate care bed base for Darlington. Work is underway to identify at the Council its current usage of beds for step-up provision and identify what is possible and desirable.

13. A deep dive into the mechanism of collecting the ASCOF 2B data (the proportion of people still at home 91 days after a discharge from hospital into a period of reablement) is currently under way to ensure the data is robust and reliable and able to be used to inform service improvement.

14. A BCF Darlington Intermediate Care Delivery group is being established to ensure system-wide co-ordination.

Transfers of Care: High Impact Change Model

15. Monitoring delivery of the High Impact change model is now part of the quarterly monitoring required nationally. The Local Authority and health partners have been working together on patient flow and discharge planning for a number of years.

16. The BCF Darlington Transfers of Care group is in place, bringing together hospital, commissioning and provider representatives to further progress the work. This group has "ownership" of the High Impact of Change model, and has developed a system-wide action plan.

New Models of Care

17. This workstream is the link between the New Models of Care programme in Primary Care (the development of care hubs) with BCF delivery. Consequently the key deliverables are included in the Transfers of Care and Intermediate Care.

Supporting Carers and Delivering DFG Adaptations

18. While part of the BCF pooled budget, the work to deliver support to carers and the DFG are led outside of BCF.

Dementia

19. 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 have been commissioned. Impact will become measureable from mid-year.

Additional iBCF Grant Plan

Maintaining the Adult Social Care Core Service During Transformation

20. Darlington Borough Council was ranked seventh in respect of social-care related delays to transfer of care on the NHS-social care interface dashboard (last updated December 2017). The Council was a high spending authority by comparator group in terms of per-head of population expenditure on social care. Maintaining spend on Adult Social care support good DTOC performance.

21. The new grant funding (£2.1m in 17/18 and £1,4m in 18/19) is being used to offset expenditure on current pressures and demand to ensure sustainability (50%) while the service undergoes transformation (50%). 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.

22. In 17/18 key areas where the grant was used include the Rapid Response Service, which expedites the discharge of people from hospital, the engagement of external consultant support to identify where change will result in improved service and increased efficiency, and the supernumerary review team examining every package of care and identifying where change would benefit the person.

23. In 18/19 we anticipate these main uses to continue, albeit with a taper, and to include implementing changes identified by our external consultancy support, including a programme of workforce development.

Transforming the Adult Social Care Service

24. In 17/18 the main uses to which the iBCF additional grant was put included the extensive review of our reablement service, the implementation of agile working through equipping staff with appropriate tools including laptops and table computers, support for new community asset and resource directory Livingwell.Darlington.

25. This year the focus will be on moving those deliverables forward. The implementation of the new reablement pathway will be a significant piece of work supported by iBCF grant. First point of contact is also undergoing improvement supported by the grant, and a portion of grant is reserved for delivering any local authority changes required through the delivery of external, whole system programmes such as New Models of Care and High Impact change model implementation.

Performance and Monitoring

Summary of the 2018/19 Q1 National Monitoring Report Content

26. The first quarter monitoring report was submitted within the permitted timeframe in July, endorsed by Suzanne Joyner and Ali Wilson on behalf of the Health and Wellbeing Board.

27. The monitoring report required confirmation that Darlington complies with the national conditions attached to BCF:

    (a) Plans are jointly agreed
    (b) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements
    (c) Agreement to invest in NHS commissioned out of hospital services
    (d) Managing transfers of care
    (e) Funds Pooled through a s75 agreement

28. It also requires an update on the four BCF metrics:

Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
Reduction in non-elective admissions	On track to meet target	It is difficult to influence the whole of this indicator through BCF related schemes due to it covering all age ranges. Only Apr-18 data is available.	Achieved target in Q2&Q3 in 17-18. Anticipating to achieve Q1 but only April and May data available at time of reporting.
Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Rolling 12 month rate to May -18 reports well below target.	Position was achieved throughout 2017/18.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Data not available to assess progress	No data yet available for 2018/19. Target just missed in 2017/18 and higher target in 18/19 will be challenging.	Difficulties gathering data from local Acute Trust throughout 2018 look to be resolved. Task and Finish group has been set up to review and improve data collection and robustness.
Delayed Transfers of Care (delayed days)	On track to meet target	We saw a big increase in delayed days throughout Q4. Only Apr and May-18 data available at this stage but is on track to meet the new target from October 2018.	The position improved significantly in Apr-18.

29. While BCF retains just four mandated metrics, over the course of the current two-year plan, the monitoring report has been expanded to include an update on the High Impact Change model, the hospital transfer protocol ("red bag" scheme), and most recently, length of stay.

30. The High Impact Change Model is a set of eight changes developed by the Local Government Association (LGA), directors of Adult Social Services (ADASS), NHS England, Department of Health, the Emergency Care Improvement Team, Monitor and NHSi in 2015. The changes are designed to improve transfers of care across

the whole health and care system. The eight areas for change are early discharge planning, systems to monitor patient flow, multi-disciplinary/multi-agency discharge teams, home-first/discharge to assess, seven day service, trusted assessors, focus on choice, and enhancing care in care homes. Darlington's self-assessment, carried out by the Transfers of Care delivery team, which has representatives from across the system, was submitted as part of quarter 1 monitoring:

	Maturity Assessment				
	Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)
Early discharge planning	Established	Established	Established	Established	Established
Systems to monitor patient flow	Plans in place	Established	Established	Established	Established
Multi-disciplinary/multi-agency discharge teams	Established	Mature	Mature	Mature	Mature
Home first/discharge to assess	Plans in place	Plans in place	Plans in place	Established	Established
Seven-day service	Plans in place	Established	Established	Established	Established
Trusted assessors	Plans in place	Plans in place	Plans in place	Plans in place	Established
Focus on choice	Plans in place	Plans in place	Established	Established	Established
Enhancing health in care homes	Established	Established	Established	Mature	Mature

31. In terms of current activity implementing the HICM, key actions are being delivered by all parts of the BCF plan, and other programmes in the health and social care system. For example, blockages to early discharge planning, and trusted assessors are being addressed through an "Action on A&E" project involving the whole health and social care system, and improvements to multi agency discharge team include the use of iBCF funding to support rapid response social care.

32. The Hospital Transfer Protocol is an NHS scheme by which care homes use a specially designated red bag for a resident's personal effects, medication details and other relevant information when a resident is admitted to hospital, to ensure everything necessary is readily available to hospital staff. Rollout in Darlington is

being led by CCG with liaison through the Care Homes Forum.

Local Delivery Monitoring

33. Locally, BCF delivery is managed through the BCF Darlington Delivery Group, which meets monthly, with input from performance and finance colleagues who also attend quarterly, in line with the national reporting schedule.

34. A number of schemes have been reviewed, resulting in specification changes, contract changes or scheme cessation.

The Operational Guidance Published in July 2018

Metrics

35. The year end position is as give at 28 above.

36. Delayed Transfer of Care (DToC) targets are being refreshed nationally. The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018.

37. All areas will be expected to agree a DTOC metric for 2018-19 that meets the nationally set HWB level expectations for 2018-19. Areas should plan based on the assumption that the expectation will be met by the end of September 2018 and that this level will be maintained or exceeded thereafter.

38. The new target for Delays to Transfers of Care in Darlington is set at 5 people delayed per day (five beds unnecessarily occupied each day). The new target is slightly more generous than previously, but system changes including the introduction of electronic assessment, discharge and withdrawal notices, and the associated agreement of how delay categories are interpreted in each locality is resulting in a short term increase in numbers of delays, while in fact the patient experience is unchanged, and in Darlington patient transitions out of hospital remain very smooth and timely. The BCF Darlington Transfers of Care Group is ensuring that all partners to discharge are working closely during this system change to ensure a common understanding and practice in terms of recordable delays, and any delays reported in error are corrected.

39. A process of ensuring the delays recorded as attributable to Social Care by Acute and Non-Acute Trusts is being finalised: such a process is already in place with Tees, Esk and Wear Valleys Foundation Trust.

40. It is important to remember that delays can be recorded not just from our “local” hospital trust CDDFT but from anywhere. There has been an increase in delays recorded by South Tees Hospital Trust for patients from Darlington in the past six months, for example: (delays attributed almost exclusively to NHS rather than Social Care). Consequently, once the new system is embedded with CDDFT, work will start with other Trusts to ensure data accurately reflects what happens “on the ground.”

Delivery Plans

41. The refreshed guidance advises that as Better Care Fund plans were agreed for two years (2017-18 and 2018-19), places are not required to revise their plans for 2018-19 other than in relation to metrics for DTOC as set out above. Places can, if they wish, amend plans to:

    (a) Modify or decommission schemes
    (b) Increase investment, including new schemes.

42. There have been a number of scheme reviews in Darlington but with no impact on the BCF financial envelope as a whole, so we do not need to submit a refreshed expenditure plan.

Length of Stay

43. NHS England and NHS Improvement have recently set out their ambition for reducing long stays in hospital by 25% to reduce patient harm and bed occupancy.

44. The refreshed BCF guidance advises that while this ambition is not part of BCF, they expect BCF plans to support delivery of this reduction through the continuing focus on delivery of the local DToC expectations and through the implementation of the High Impact Change model in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven). National partners will give consideration to applying additional requirements for 2019/20, including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19.

Graduation

45. There is passing reference to graduation from BCF, which was first mention in 16/17. However, as the criteria for graduation are yet to be established the guidance simply sets out that a first wave of shortlisted areas eligible for graduation from the Better Care Fund will be confirmed in 2018-19. National partners would then work with shortlisted areas to test readiness for full graduation and co-produce what a meaningful graduation model would look like.