**HEALTH AND WELLBEING BOARD**
**13 SEPTEMBER 2018**

**ITEM NO.**

# BETTER CARE FUND 2017 - 2019

## Purpose of the Report

1. To update the Health and Wellbeing Board on delivery of the 2017-2019 Better Care Fund submission and associated plans.

2. To provide the Board with a Year End position on the Fund at the end of 2017/2018 and an overview of the changes to the expenditure plan for 2018/2019.

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

## Background

4. As reported to this Board in September 2017 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.

5. The two-year plan remains in place and this report provides a mid-term update.

## Recommendation

6. HWBB is asked to:

   (a) Note the progress to date on delivering 2017-19 Better Care fund Objectives.
   (b) Note the delivery of the Better Care Fund within the financial envelope in 2017/18 and the plans to continue delivery with minimal alteration in 2018/19.
   (c) Note the position in respect of the national metrics and the actions taken.

## Reasons

7. The recommendations are supported by the following reasons :

   (a) The two-year plan remains in place with delivery progressing well; new guidance issued in June has not required any amendment or addition. Scheme reviews during the year have led to small changes in the expenditure plan for 2018/19 but not at a material level.

   (b) There is an expectation that a further plan will be required for 2019/20 but no guidance has yet been received.

   (c) This report summarises the current position.

**Suzanne Joyner**
**Director of Children and Adults**

**Background Papers**
The Better Care Fund narrative plan 2017 - 2019

Pat Simpson : Extension 6082

| | |
|---|---|
| S17 Crime and Disorder | Not applicable |
| Health and Well Being | The Better Care Fund is owned by the HWBB |
| Carbon Impact | None |
| Diversity | None |
| 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 efficiencies |
| Implications on Looked After Children and Care Leavers | none |

## Healthcare services to Care Homes

8. 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.

9. 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

10. A social prescribing testbed, 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 co-ordination 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.

11. 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

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

13. 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.

14. A deep dive into the mechanism of collecting the ASCOF 2B data is currently under way to ensure the data is robust and reliable and able to be used to inform service improvement.

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

## Transfers of Care: High Impact Change Model

16. Patient flow and discharge planning is pivotal, and work to implement the high Impact Changes will continue. 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 discharge planning and delivery for a number of years and the BCF Transfers of Care delivery group is focusing on patient flow.

17. 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 Change model, and has developed a system-wide action plan.

## New Models of Care

18. 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

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

## Dementia

20. 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 Core Service during transformation

21. 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 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.

22. The new grant funding (£2.1m in 2017/18 and £1,4m in 2018/19) 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 Adult Social Care (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.

23. In 2017/18 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.

24. In 2018/19 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 service**

25. In 2017/18 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.

26. 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 2017/18 Q4 (year-end) national monitoring report**

27. All monitoring requirements in 2017/18 were met on time, and endorsed by Suzanne Joyner and Ali Wilson on behalf of the Health and Wellbeing Board. The final quarter monitoring report was submitted in April.

28. 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.

29. It also required an update on the four BCF metrics:

| Metric | Definition | Assessment of progress against the planned target for the quarter | Challenges | Achievements |
|---|---|---|---|---|
| NEA | Reduction in non-elective admissions | On track to meet target | At the time of reporting we have data for just one month of Q4. Q1 was not achieved | Q2 and Q3 achieved |
| Res Admissions | Rate of permanent admissions to residential care per 100,000 population (65+) | On track to meet target | At the time of reporting we have data for just one month of Q4 | 12 month rolling figure to January 2018 shows on track to deliver target. Rate of 600.7 against a target of 785.2 |
| Reablement | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Not on track to meet target | Some local difficulty with getting data flows from all stakeholders. Q3 performance shows 77.73% against a target of 80% | Local work to improve reablement pathway progressing well |
| Delayed Transfers of Care* | Delayed Transfers of Care (delayed days) | Not on track to meet target | At the time of reporting we have data for just one month of Q4. Performance deteriorated in Q3 with issues identified within local Mental Health Providers and Out of Area Providers. | Achieved Q1 and Q2 |

30. An update on the High Impact Change Model implementation was also required. The national submission for Q1 is given here:

| | | Maturity assessment | | | | | Narrative | |
|---|---|---|---|---|---|---|---|---|
| | | Q2 17/18 | Q3 17/18 | Q4 17/18 (Current) | Q1 18/19 (Planned) | Q2 18/19 (Planned) | Challenges | Milestones met during the quarter / Observed impact |
| Chg 1 | Early discharge planning | Plans in place | Plans in place | Established | Established | Established | Develop more robust pre-assessment in some specialisms.<br>Review the current robustness of the pre-assessment to ensure it fully captures any potential discharge need.<br>Identify any gaps. | Whole-system self-assessment against HICM and actions defined |
| Chg 2 | Systems to monitor patient flow | Not yet established | Not yet established | Plans in place | Plans in place | Established | Improve surge management, particularly capacity matching – out of hospital at times of surge.<br>Track down waits in the system.<br>Complete work in the intermediate care area to better plan and commission step down and step up provision to speed patient flow out of hospital.<br>An action plan for Opel 4 so less reactive and more predictive. | Whole-system self-assessment against HICM and actions defined |
| Chg 3 | Multi-disciplinary/multi-agency discharge teams | Mature | Mature | Established | Established | Established | A whole-system self-assessment of HICM has led to a lower assessment than previously. Now we need to map current service capacity in relation to discharge, to identify any gaps<br>Explore the opportunities to develop an integrated team of dedicated staff to support people back home across Darlington.<br>Explore opportunities for voluntary sector support. | Whole-system self-assessment against HICM and actions defined |

| | | Maturity assessment | | | | | Narrative | |
|---|---|---|---|---|---|---|---|---|
| | | Q2 17/18 | Q3 17/18 | Q4 17/18 (Current) | Q1 18/19 (Planned) | Q2 18/19 (Planned) | Challenges | Milestones met during the quarter / Observed impact |
| Chg 4 | Home first/discharge to assess | Plans in place | Plans in place | Plans in place | Plans in place | Established | Improve the re-admission of residents back to their care-home after discharge.<br>Build trust in the community matron to keep an eye on the person in the care home.<br>Especially re medication. Ensure care homes know they had someone who could sort medication.<br>Solve the discharge medicines issue Red Bag scheme<br>Identify clear pathways out of hospital: home, home with reablement, step-down intermediate care, long term care. | Whole-system self-assessment against HICM and actions defined |
| Chg 5 | Seven-day service | Plans in place | Plans in place | Plans in place | Plans in place | Established | Develop an action plan to plug gaps. Darlington is ranked 117 of 150 on the NHS-social Care Interface Dashboard for weekend discharge of people 65+ who had an emergency admission. | Whole-system self-assessment against HICM and actions defined |
| Chg 6 | Trusted assessors | Not yet established | Not yet established | Plans in place | Plans in place | Established | Investigation of the Scarborough system of a District-nurse led two stage assessment.<br>Identify if community matrons could do this for Darlington, with the appropriate training.<br>Plan to identify how we can develop this with existing resources, perhaps drawing on the previously successful DDES model. | Whole-system self-assessment against HICM and actions defined |
| Chg 7 | Focus on choice | Established | Established | Plans in place | Plans in place | Established | A whole-system self-assessment of HICM has led to a lower assessment than previously. We need to agree and adopt one choice policy | Whole-system self-assessment against HICM and actions defined |
| Chg 8 | Enhancing health in care homes | Mature | Mature | Established | Established | Established | Identify where there appear to be repeat issues in individual homes. | Whole-system self-assessment against HICM and actions defined |

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 (known as “Project Margaret”) 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.

**Local delivery monitoring**

32. 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.

33. A number of schemes have been reviewed, resulting in specification changes, contract changes or scheme cessation. These changes are reflected in an updated expenditure plan for 2018/19 (attached at **ANNEX A**).

**The Operational Guidance published in July 2018: Metrics**

34. The current BCF plan is agreed over two years, but additional guidance was released in July which gives us the opportunity to amend or update our targets for the four metrics and reflect any changes to the expenditure plan arising from scheme reviews and contract changes.

35. In Darlington we do not plan to make any changes to the non-elective admissions target as it is embedded in the CCG Operational Plan for this year. Our residential admissions and ASCOF2B targets are part of the Council’s performance framework so will be changed in line with the refreshed performance framework.

36. Delayed Transfer of Care 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 five 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. As part of this work a formal 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."

**The Operational Guidance published in July 2018: Narrative and expenditure plan 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. However, one has been prepared for local monitoring and is attached at ANNEX A (combined with 2017/18 outturn).

**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.