Better Care Fund 17-19

Rajni Cairns

Programme Manager for Integrated Care

NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

Buckinghamshire County Council

Better Care Fund

The Better Care Fund (BCF) creates a local, single pooled budget via a S75 to ensure a transformation in integrated health and social care.

Local allocations are based on a mix of:

- Existing CCG BCF allocations
- Social Care BCF allocations
- Disabled Facilities Grant
- Care Act funding allocation

BCF Value in 16/17 = £30.21m

BCF Value in 17/18 = £30.75m (minimum)

Local flexibility to pool more than the mandatory amount

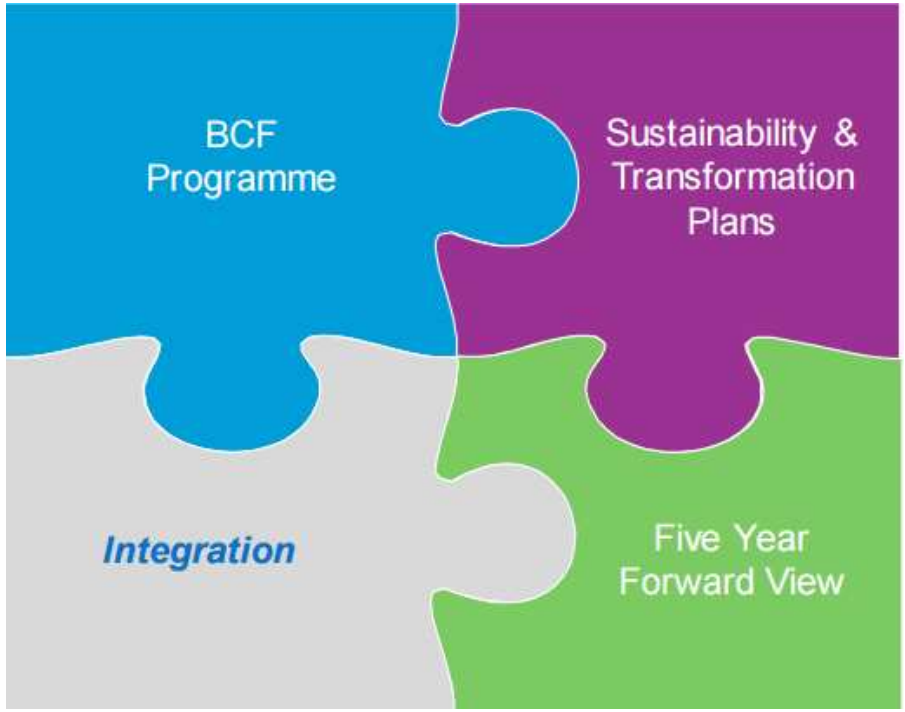
NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

BUCKINGHAMSHIRE COUNTY COUNCIL

Direction of travel for BCF 17-19

- Integration of health and social care by 2020
- Supported by STP
- Areas will 'graduate' from the BCF once they have demonstrated ambitious and transformative models of integration



NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

Buckinghamshire County Council

Buckinghamshire BCF plan for 17-19

Focus & scope of the plan for 17-19:

- Progress towards full integration of health and social care by 2020
- Continue to strengthen relationships and partnership working
- Move towards pooled budget
- Build on first two years of the Better Care Fund

Will be:

- Aligned to BOBW Sustainability and Transformation Plan
- Aligned to Buckinghamshire Health & Wellbeing strategy

NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

BUCKINGHAMSHIRE COUNTY COUNCIL

Vision statement - options

a. To fully integrate health and social care commissioning; improving outcomes for the population and delivering services efficiently

b. To further progress health and social care integration in Buckinghamshire ; improving and delivering best value services

c. To integrate health and social care commissioning ; improving outcomes for the population and delivering best value services

NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

BUCKINGHAMSHIRE COUNTY COUNCIL

Next steps

- Better Care Fund 17-19 allocations, planning guidance and template to be released 30th November
- Better Care Fund Planning Event with NHSE 9th December
- Vision statement and draft plan to CHASC Board on 5th Dec, Health & Wellbeing Board 15th Dec and CCG Execs meeting 22nd December
- First draft to be submitted to NHS England 12th January 2017
- Final plans to go through Cabinet Member approval process and CCG Executive approval process
- Final plan signed off by Health & Wellbeing Board 9th March 2017
- Final plan submitted to NHS England end of March 2017

NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

BUCKINGHAMSHIRE COUNTY COUNCIL

BCF Performance Dashboard
Quarter 2

NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

BUCKINGHAMSHIRE COUNTY COUNCIL

Buckinghamshire County Council

Better Care Fund Metric Dashboard

Date Published	04/11/2016

Current Year data period	Qtr2

1. Emergency Admissions

Source: NHS South, Central And West Commissioning Support Unit

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr2 2016/17	Qtr2 2016/17	
Total non elective admissions to hospital (general and acute) all ages			51003	52906	12545	11785	11969	Good to be low

Definition: Composite measure of:
- unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)
- unplanned hospitalisation for asthma, diabetes and epilepsy in children
- emergency admissions for acute conditions that should not usually require hospital admission (all ages)
- emergency admissions for children with lower respiratory tract infection.

Commentary: This is currently exceeding the target for 2016/17 - performance for quarter one was 2.8% lower than the target. **Q2 update: There was a significant increase in non-elective admissions in September and the monthly number was over plan for the first time this financial year. Performance for Q2 is -1.5% below plan**

2. Care Home Admissions

Source: BCC Adult Social Care AIS System

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr2 2016/17	Qtr2 2016/17	
Permanent admissions of Older People aged 65+ to residential & nursing care homes, per 100,000 population		687	581	486	697	185.2	275	Good to be low
Definition: This indicator reflects the number of admissions of older adults, aged 65 or over, to residential and nursing care homes relative to the population size of people in this age group. Numerator: Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers Denominator: Size of the older people population in area from the latest ONS mid-year estimate. Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency. The inclusion of this measure in the dashboard supports local health and social care services to work together to reduce avoidable admissions.								
Commentary: This is currently exceeding the target for 2016/17.								

3. Reablement

Source: BCC Adult Social Care AIS System & Buckinghamshire Healthcare NHS Trust

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr2 2016/17	Qtr2 2016/17	
Proportion of people over 65 still at home 91 days after discharge from hospital into reablement services		61%	71%	66%	75%	~	75%	Good to be high
Definition: This indicator measures the effectiveness of Reablement services. The figure reported represents the proportion of people discharged from hospital to reablement or rehabilitation services who are still at home 91 days after discharge. Denominator: The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. Numerator: The number of older people identified in the denominator and who are at home or in extra care housing or an adult placement scheme setting three months after discharge from hospital. This excludes those who are in hospital or in a registered care home those who have died within the three months. Improving the effectiveness of these services is a good measure of delaying dependency and will reduce avoidable admissions								
Commentary: Data collected between January and March and reported at year end only								

4a. Delayed Transfers of Care

Source: NHS England, https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr2 2016/17	Qtr2 2016/17	
Total delayed transfers of care from hospital (NHS, ASC, Joint)		6.7	7.6	9.8	10	10.1	10	Good to be low

Definition: This measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. A delayed transfer of care occurs when a patient is ready for ransfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
(a) a clinical decision has been made that the patient is ready for transfer AND
(b) a multi- disciplinary team decision has been made that the patient is ready for transfer AND
(c) the patient is safe to discharge/transfer.
This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services.
Denominator: Size of adult population in area (aged 18 and over)
Numerator: The average number of delayed transfers of care (for those aged 18 and over) on a particular day taken over the year. This is the average of the 12 monthly snapshots collected in the monthly Situation Report

Commentary: Performance is below target for Quarter One - however as the target is calculated as the average of a snapshot this does not imply that we will not meet the year end target. In 2015/16 our performance for Quarter One was slightly lower at 8.9 and within target at year end. Our current performance ranks as 3rd best in our comparator group

4b. Delayed Transfers of Care

Source: NHS England, https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	2016/17	2016/17	
Delayed transfers of care (delayed days) from hospital			1872	1076.8	468	748	690.6	Good to be low

Definition: As per 4a but measuring the number of days delayed rather than delay events
Numerator: The total number of delayed transfers of care (for those aged 18 and over) for each month
Denominator: ONS mid-year population estimate. The subsequent rate is divided by the number of months in the period and is per 100,000 population

Commentary: This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.The DTOC target was not met in Q1 with a rate of 862.3 next to a plan of 562.6. However, the DTOC has an increase of rates though 2016/16, and from April to June the number of delayed delays bed days decreased. In order for the yearly target to be met the monthly days delayed would need to drop to an average of 930 days of delayed discharge a month. **Q2: The number of delayed days has hugely increased from 3536 to 5607. However the figures for Oxford Univeristy Health Trust for July are exceptionally high. Figures have been queried and the Q2 figures have been reworked to exclude Oxford University Health Trust in July. Q2 has improved on Q1 however figures are still over target.**

5. Patient Experience (Social Care)
Source: BCC Adult Social Care Service-User Survey

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr2 2016/17	Qtr2 2016/17	
Overall satisfaction of people who use care and support with services		56%	58%	61%	60%	~	65%	Good to be high
Definition: This indicator is derived from the annual Adult Social Care Survey, Question 1: "Overall, how satisfied or dissatisfied are you with the care and support services you receive." This indicator is aligned to Domain Three of the Adult Social Care Outcomes Framework: Ensuring that people have a positive experience of care and support The survey is run annually between January and March with performance metrics available from April								
Commentary: Data collected between January and March and reported at year end only								

6. Patients aged 65+ discharged to the same address
Source: NHS South, Central And West Commissioning Support Unit

Indicator	RAG	Previous Years			Previous Target	Current Year (to date)	Current Target	Trend
		2013/14	2014/15	2015/16	2015/16	Qtr2 2016/17	Qtr2 2016/17	
Patients (65 and over) discharged to the same place from which they were admitted				92.0%	92.2%	92.6%	93.0%	 Good to be high
Definition: This is a local metric and the rate is expressed as a % of those admitted to hospital who are discharged to the same address from where they were admitted.								
Commentary: Q1 performance is slightly below the target of 93%, at 92.8%, but is moving in the correct direction								