Health & Wellbeing Board
Buckinghamshire

Title	Better Care Fund
Date	7th December 2017
Report of:	Jane Bowie Director of Commissioning
Lead contacts:	Jane Bowie, Director of Commissioning

Purpose of this report:

To update the Health and Wellbeing Board on progress in relation to the Better Care Fund (BCF) Plan for 17-19.

Summary of main issues:

Status of the Better Care Fund (BCF) Plan

The BCF Plan was submitted to NHS England on 11th September 2017. This plan complemented a Delayed Transfer of Care (DToC) plan submitted in July which set out a trajectory for the reduction in the number DToCs that the Bucks system would experience. Following a regional assurance process, our BCF plan has been classified as 'Approved'. This recognises that our plan has been agreed by all parties (local authority, Clinical Commissioning Group(s) (CCGs), and the Health and Wellbeing Board), and that the plan submitted meets all requirements.

The letter stated that amounts to be paid to the CCG in respect of the BCF are subject to the following conditions under section 223GA of the NHS Act 2006:

1. That the CCG will meet the performance objectives specified in its BCF plan; and
2. That the CCG will meet any additional performance objectives specified by NHS England from time to time.

In year funding is assured and this has been confirmed with the Bucks BCF regional lead. The Government's review of 2018/19 Improved Better Care Fund (iBCF) allocations will be based on September DToC data which were published on 9 November. The review will seek assurance that systems are deploying their iBCF against greatest local need.

CQC will also be publishing its interim report of the first areas to undergo a Local System Review and we expect a further eight areas for review will be announced in the near future. We are not expecting to be part of the next set of reviews.

The activities and work strands contained in our BCF plan are designed to improve performance against a set of national metrics detailed below:

- Reduction in non-elective admissions (data not finalised)
- Rate of permanent admissions to residential care per 100,000 population (65+) (reducing)
- Proportion of older people (65and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (increasing)
- Delayed transfers of care (reducing)

Progress against the national metrics is reported quarterly (from end of Quarter 2) to NHS England and the H&WB Board will continue to be updated.

A main strand of activity in the plan is a set out in a national model against which we have identified local delivery activities. The High Impact Change Model addresses key areas where improvements will have a significant positive impact on the effectiveness of the local health and social care economy. The key areas include: -

- 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
- Enhancing health in care homes

The oversight of activity to support the delivery of high impact changes is through a sub group of the A and E Delivery Board which meets monthly.

Progress update

Integration of health and social care

The Integrated Commissioning Executive Team (ICET) meets monthly, providing the senior leadership and oversight of all integrated commissioning arrangements and decisions. Membership includes senior officers from CCG and the County Council, including Children's and Adults services. Work is in train to develop options for greater integration in commissioning.

The development of a model for Bucks Integrated Teams bringing together health and social care is progressing and arrangements for working with a pilot site are in progress alongside developing plans for other sites.

Improving the effectiveness of reablement is a priority. Discussions are underway to explore an aligned model of reablement with CCG and Buckinghamshire Hospitals Trust (BHT).

Delayed Transfers of Care (DToCs) - Discharge to Assess and Trusted Assessor models are being developed through the high impact change approach with a view to

the development of an integrated discharge team at Stoke Mandeville Hospital. The system is committed to preventing DToCS so is therefore focussing on patients known as “medically fit for discharge” or “stranded patients”. This approach requires operational leads across the system to take a person-centred approach to addressing barriers to discharge and also includes escalation triggers to senior leaders if required.

A Single Joint Assessment form has also been rolled out to ensure a collaborative approach from all partners, so everyone is now using the same documentation for planning the patient’s discharge.

Performance

1. Reducing non-elective admissions (NEA)

Currently we are not appearing to be reaching our NEA target. This has been the trend since Q3 in 16/17. The current performance data is estimated and has been informed by local growth estimates, with actual data yet to be finalised following some data quality issues which came to light in respect of activity at the Frimley Health Foundation Trust hospital sites.

Q1 we missed the target (2286) by 61
Q2 we missed the target (2295) by 91

A number of strands of work are seeking to address this issue including Airedale telehealth system which is being rolled out across care homes to provide the right intervention and prevent hospital admission. The A/E Delivery Board will explore what more can be done to reverse this direction.

2. Rate of permanent admissions to residential care per 100,000 population

Performance is strong and exceeding the target significantly although there has been an increase in the rate.

Q1 target was 130 and actual was 63.5
Q2 target was 260 and actual was 143.6

There was an unusual increase in admissions in July, but the general picture remains positive, with admissions below target levels for year to date 17/18 and at a lower rate than for the same period last year.

3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services

Measures for this indicator are only available at the year end. Performance in 16/17 was below the England average although the combined health and social care reablement performance did achieve the 75% performance target. This is an area of opportunity and new models for effective integrated reablement are being explored.

4. Delayed transfers of care from hospital (days) per 100,000

Performance has deteriorated between Q1 and 2 and there has been considerable activity to reverse this.

Q1 target 9.8 with outturn of 10.6
Q2 target 9.3 with outturn of 12.7

This is a significant area of focus for the Bucks system and the activities within the High Impact Change Action Plan are based on national best practice to address the issues. Each of the workstreams has a group implementing the actions and delivering the required outcomes, which will contribute overall to DToC reduction. The progress is actively monitored by the A/E Delivery Board. Nationally this is presenting a challenge to health and social care systems, and our system performance is better than the England and our comparator performance.

Early indicators are that this targeted activity is delivering a reduction in DToCs.

The latest DToC monthly monitoring report for Buckinghamshire (April – Sept 2017) shows Buckinghamshire is 4th highest in comparator group for overall delays and top for Adult Social Care only.

The Buckinghamshire system missed the performance target for DToC in September. Actual delayed days have reduced from August, which had 1579 system delays, however in September:

Buckinghamshire had 1533 delayed days – target is 1157
Social care delays 298 – target is 306.7
NHS delays 1220 – target is 846
Joint delays 15 – target 2.3

Recommendation for the Health and Wellbeing Board:

- To note the update
- To support continuation of governance and sign-off arrangements in place