Purpose

To update the Health and Wellbeing Board on Better Care Fund (BCF) and Improved Better Care Fund (iBCF) planning, performance and activity.

The refreshed BCF Plan was submitted to the BCF national team in line with requirements and an update was taken to the Health and Wellbeing Board on September 27th 2018 and informed the Board of the revisions to the plan.

The system received confirmation on October 1st 2018 from the Better Care Support Team, that 'the revised plan you provided has been reviewed against the BCF requirements. As it remains compliant, the revised plan has been noted and will form part of the BCF 2018-19 aggregation of plans'. We have also received a follow up email from our BCF manager lead for Bucks at NHS England (NHSE) indicating that no further clarification regarding the refresh of our plan is required.

The Quarter 2 return was submitted in line with the requirements by 19th October 2018. There has not been any feedback received.

The BCF allocation for 2019 / 2020 has still not been confirmed. This is anticipated in December.

Performance

Performance continues to be monitored through the Integrated Commissioning Executive Team ICET). Figures for September 2018 were published on Thursday 8th November.

1. Delayed Transfers of Care performance

The total number of bed days delayed for Buckinghamshire (social care, NHS and joint) in September was 1806 compared with 1245 days in August; and 1554 days in July. In June the total number of days delayed was 1593. Whilst for previous three months we have seen a month on month reduction of 309 days delayed per month between July and August, we have seen a significant increase in September of 561 days.

Month	No of days delayed per month	Direction of travel from previous month
April	1567	↑ + 73
May	1969	↑ + 402
June	1593	↓ - 376
July	1554	↓ - 39
August	1245	↓ - 309
September	1806	↑ + 561

The number of bed days delayed attributable to adult social care (ASC) decreased from June to July, but increased in August and September (328 in June, 247 in July, 282 in August and 345 in September). The number of NHS attributable delays has increased from June to July, decreased July to August but then increased significantly in September (1246 in June; 1307 in July; 957 in August; and 1459 in September).

The top five reasons recorded as reason for delay and delayed transfers of care (DToC) for September were:

- Care package in own home
- Further non - acute NHS care
- Patient choice – (this figure doubled from August to September)
- Nursing care home bed
- Residential care home bed

The system wide position for August was much improved against the July position but the number continued to be above the target level to achieve the Buckinghamshire contribution to the national ambition. In order to deliver in line with the national metrics adult social care should have no more than 6.8 delayed per day.

However the August level was 9.1 and September level was 11.5. If NHS DToC reductions are to be in line with national ambition, which is set to be delivered from September 2018 onwards, the number should be no more than 24.9 and the August performance was 30.9 and September 48.6 delayed per day.

	Target	**July 2018**	**August 2018**	**September 2018**
Health	24.9	42.16	30.9	48.6
Social Care	6.8	7.97	9.1	11.5
Joint	0.1	0	0.2	0.1
Total	31.8	50.1	40.2	60.2

Both NHS and adult social care performance need to improve to achieve the national ambition.

CIPFA comparator data shows:

- Buckinghamshire has just above the average number of DToC all bed days delayed year to date per 100,000 population (Buckinghamshire 12.9, group average 12.7, with performance of comparators ranging from 5.8 to 21.2).

- Buckinghamshire has below the average number of DToC adult social care and joint days delayed year to date per 100,000 population (Buckinghamshire

2.5, group average 5.2, with performance of comparators ranging from 0.6 to 11.9).

The High Impact Change work continues and we are planning to review the current activities and consider strengthening specific elements of work. The High Impact Change priorities form part of the Urgent and Emergency Care Transformation Programme which is monitored by the system through the A&E Delivery Board (A&EDB).

Actions in place to recover the position include:

- The establishment of a discharge to assess (D2A) programme of support including beds, domiciliary care and 24/7 care at home. This is supporting discharges from BHT and Wexham Park Hospital (WPH).
- BHT re-launch and roll out of 'get up, get dressed, get moving' at the Trust
- 'Fabulous fortnight' due to commence at Stoke Mandeville hospital on 19th November for two weeks – providing the opportunity to embed good practice with system wide support and input.
- The system multi-disciplinary team (MDT) action squad is being further developed to help support a reduction in long stay patients and DToCs.
- Red Cross team onsite to help support the process of patient re-settlement and repatriation to home.
- Additional on-site CHC clinical support.
- Daily 09:00 medically fit call with partners to discuss all patients on the medically fit list. Plans to incorporate other providers – particularly out of area.
- Local DToC (and stranded and long stay patient) escalation process being rolled out. This will be based on the Oxfordshire model.
- NHS Improvement (NHSI) report and recommendations to be shared. This is expected to be geared towards improving processes and improving pathways internally to maximise discharge options.
- BHT and social care are working together closely to continue the work to ensure the choice policy is robustly implemented.
- Weekly Escalation Call with senior system leaders – a review of the Top 20 longest stay patients across the Trust (acute and community beds).
- A system deep dive to better understand the delays for September across all providers, looking at what the key issues are and actions to support an improved position.
- Update the process of how medically fit for discharge (MFFD) and DToC patients are reported through the system to better understand current information and action to support and escalate where appropriate.
- Additional support to WPH through commissioning specific capacity for south Bucks.
- Further support to WPH includes additional therapy for Buckinghamshire discharges, a dedicated GP on-site to support discharges, some additional community GP support and project resource.

- Improved escalation processes to drive down delays in mental health beds within Oxford Health Foundation Trust (OHFT).

The Red Cross long lengths of stay project has been developed during September with input from BHT (Lead Nurse for Patient Flow) and Adult Social Care Commissioning and Operations (Specialist Commissioning Manager and Business Manager for Hospital Social Work Team). The first patient has been seen and is being worked with by the care navigator with a view to discharge, and work continues to finalise the criteria for selection onto the project. The approach will be to respond rapidly and will prototype the criteria and the activities to enable that. A provisional set of performance measurements have been agreed but will be subject to further refinement. The project team will continue to meet frequently for the time being to ensure that the maximum value is being derived from the project.

Target Areas

September data shows there were more year to date acute days delayed from Frimley Health NHS foundation (3294) than there were at Buckinghamshire Healthcare Trust (2840). This continues to need to be an area of focus.

The wait for a care package at home remains the most usual recorded reason for delays, accounting for 905 days delayed to date attributable to adult social care and 955 days delayed to date attributable to health. The most usual recorded reason for delays for health are attributed to waits for non-acute NHS (community hospitals): 2660 NHS delayed days to date and patient and family choice attributable for 1018 delayed days to date.

Figures for September 2018 for the remaining measures are not available for this report.

2. Reducing non-elective admissions (NEL)

Quarter 2 data is not yet available. However NEL continue to grow across several localities although a comprehensive programme of work is ongoing to address this. The programme amalgamates the following key elements:

1. Avoidable attendances to Emergency Department (ED) - ambulance conveyances, 0-4 hour NEL admissions, maximisation of ambulatory care sensitive conditions including children and attendances from care homes
2. Avoidable non-elective admissions - improved management of End of Life patients, delirium pathway, and respiratory pathways
3. Supported discharge - discharge to assess, reduction in excess bed days, CAREfully programme

As positive impact has been evidenced and the Airedale care home project for patients in care homes has been extended to more care homes in the county. There

is promotional activity to support increased access to alternatives to presentation in Accident and Emergency such as the Medical Day Service, Clinical Assessment and Treatment Service, minor injury and illness unit and out of hours service. Implementation of High Intensity User or Personalised Care Service (PCS) scheme is rolling out across several localities.

Quality Innovation Productivity and Prevention (QIPP) targets have been identified to try and drive improvements. Work also continues to establish the Buckinghamshire Integrated teams to support NEL reduction (admission avoidance) and also earlier discharge.

3. Reducing the rate of permanent admissions to residential care per 100,000 population

Performance remains strong and continues below maximum number of permanent admissions we were aiming to achieve. The target for the rate of permanent admissions to residential care per 100,000 population is no more than 260 and admissions in Q2 was 200.9. The national Adult Social Care Outcomes Framework (ASCOF) target has been revised and this strong performance remains within the revised ASCOF target.

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

This return is only available annually at year end.

Improved Better Care Fund (iBCF) update

The iBCF allocation is a three year allocation and for the third year, 2019/2020 the value is £2.3m which is £1.3m less than 18/19.

We submitted the iBCF update as part of the quarter one return for the BCF and established the anticipated level of activity in respect of the following:

- Number of home care packages 2100
- Hours of home care provided 683,793 Hours
- Number of care home placements 1,930

The areas of focus for the iBCF investment are:

- **Maintaining a stable care market** – the stabilisation which was achieved by uplifting payments to domiciliary care providers has been sustained into 18/19 and no provider exits to date from the market have been seen since the start of the financial year.

- **Support to self-funders –** at the moment our brokerage service is focussing on supporting people with direct payments to make the right care choices. We are now starting to work more closely with self-funders who with appropriate brokerage support would make appropriate care decisions, which could expedite their discharge from hospital and ensure that the care they purchase is appropriate and proportionate to their needs, preserving their assets for longer and enabling them to maintain their independence as long as possible.

  Broker coordinators will be based in hospital to ensure patients can access brokers in a timely way. There is an opportunity to look at how we might work with Frimley Park Hospitals Trust to provide brokerage support to Buckinghamshire residents being treated as inpatients in their hospitals, expediting discharge and contributing to reducing delayed transfers of care.

- **Protecting preventative services** – the level of grant funding into preventative services has remained consistent. Work is in progress to refocus the outcomes deliverable from our grants to support maximising and maintaining independence