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TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

12 SEPTEMBER 2018

THE BETTER CARE FUND (BCF) ANNUAL UPDATE

REPORT OF – JONATHAN EATOUGH, ASSISTANT DIRECTOR: GOVERNANCE PROCUREMENT & COMMISSIONING; ANNA HAMMOND DEPUTY EXECUTIVE FOR COMMISSIONING & PLANNING (PRIMARY CARE)

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1. This report outlines the progress made over the last 12 months of the Better Care Fund programme

1.2. The principle aim of the BCF programme locally is to transform the health and social care system. This enables us to work towards a fully integrated intermediate care service, aiming to prevent admissions to an acute hospital, supports residents to live in the way they choose and reduce dependency on services

2. RECOMMENDATIONS

The Board is asked to note the progress made and the action plan for the coming year and how it will support the integrated delivery of the cross-cutting priorities of the Health and Wellbeing Strategy.

3. IMPACT OF ACTION

It is intended that this programmes of work will contribute to improve health & wellbeing outcomes within the borough.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	*Do these proposals contribute to a specific HWB Priority?*	
	Yes	The Intermediate care plan contributes to all of the Health and Wellbeing priorities.
	Will the proposals impact on specific groups of people?	

<table>
<tr><td></td><td>Yes</td><td>All borough residents who required a period of intermediate, reablement support predominantly the 75+ frail and elderly population</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">Yearly plan refreshed annually</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>The BCF Pooled Budget in 2017/18 was £18.18 million rising to £20.11m in 2018/19
<table>
<tr><th>Summary Statement</th><th>2017/18 Annual Budget £</th><th>2018/19 Annual Budget £</th></tr>
<tr><td>Intermediate Care</td><td>5,524,048</td><td>5,701,424</td></tr>
<tr><td>Community Resilience</td><td>1,056,220</td><td>1,107,414</td></tr>
<tr><td>Telford Neighbourhood Care</td><td>3,959,685</td><td>4,003,876</td></tr>
<tr><td>Other Care</td><td>7,640,489</td><td>9,292,066</td></tr>
<tr><td>Grand Total:</td><td>18,180,442</td><td>20,104,780</td></tr>
</table>
The increase is in relation to an annual inflation uplift and a growth in the value of the iBCF funding received by the Council

There is currently an identified financial risk of circa £300k in relation to the provision of Intermediate Care Beds; jointly funded by the CCG and the LA. An action plan, which is closely monitored for effectiveness, has been put in place to mitigate this risk.

The target number of beds and length of stay has been agreed on a quarterly basis. This is monitored on a weekly basis; costs are monitored on a monthly basis.

The financial position of the BCF pooled fund is reported to each organisation via their own financial management governance arrangements.</td></tr>
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LEGAL ISSUES	Yes	The Better Care Fund was established by the Government in June 2013 [in preparation for the Care Act 2014 coming into force] to provide funding to support the integration of health and social care to achieve National Conditions and Local Objectives. A requirement of the Better Care Fund is for pooled funds to be established for this purpose Section 75 of the National Health Services Act 2006 [as amended] enables local authorities and NHS Bodies to enter into partnership arrangements to provide more streamlined services and to pool funds, subject to meeting the requirements of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 [as amended] There has been a Section 75 Agreement in place between the Borough of Telford & Wrekin and NHS Telford & Wrekin Clinical Commissioning Group in respect of the Better Care Fund since 1st April 2015 [as updated and amended] The latest Better Care Fund plans Operating Guidance for 2017 – 19 was published on 18th July 2018 for Clinical Commissioning Groups, Local Authorities and Health and Wellbeing Boards and sets out the accountability arrangements and flow of funding. Health and Wellbeing Boards are expected to oversee the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners [Section 195 Health and Social Care Act 2012] KF 040918

EQUALITY & DIVERSITY	Yes	Joint Strategic Needs Assessment intelligence informs intentions to ensure resources are targeted appropriately to improve health and wellbeing and reduce inequalities.
IMPACT ON SPECIFIC WARDS	No	See above.
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	Engagement has taken place through the council's 'Making it Real' Board; Point Prevalence audits of people seeking feedback of their current care Over the next 3 months we will be working with Healthwatch Telford and Wrekin to develop a process to gather the views of the person's enablement and reablement experience through the hospital back to home.
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	Strong collaboration working with NHS commissioners in the CCG and NHS England is essential to delivering progress against the Health & Wellbeing strategy priorities. Opportunities and Risks are identified within the report

PART B) – ADDITIONAL INFORMATION

5 INFORMATION

5.1 BCF brings together a ring-fenced budget from CCG and Council allocations into a Section 75 Agreement (pooled budget). This enables the partners to:

- Build resilient local communities focussing on well-being and prevention
- Integrated preventative services delivered at a neighbourhood level
- Use a wide range of personalised approaches to support people to remain independent
- Reduced reliance on social care services
- Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day
- Reduced avoidable admissions

5.2 For 2017/18 the priorities for 20107/18 included:

- Improved function of Intermediate Care Team (ICT)
- Implementing the Frailty programme

- Having the Care Home MDT in place;
- Development of Community MDTs (Neighbourhood teams)
- Achieving the Delayed Transfer of Care (DToC) target
- Improving on the 8 High Impact Changes[1]
- Developing resilient community services and providers

Our performance against these priorities is provided at Appendix A

5.3 Key successes / achievements last year included:

- DToC performance was good in regional and national rankings last year. Month 1 (April this year) showed the Council as the best in the locality and 18th nationally
- Achieving the Quality Innovation, Productivity & Prevention (QIPP) admission reduction number .The lack of availability in the domiciliary market in July and August means that performance is likely to see a drop but should recover in September
- Permanent admissions ratio well below national levels
- Community MDT (Neighbourhoods) implementation
- Integrated working is showing reductions in Length of stay (LoS) in enablement care beds although some people are having to be placed in community beds due to lack of available domiciliary care
- Re-commissioned enablement beds to ensure enablement model implemented with a plan for continuing / re commissioning March 2019 subject to available BCF
- Care Home MDT is rolling out Patient Passports with WMAS, the Red Bag Scheme; preventive interventions and admission avoidance is identified care homes
- Integrated Discharge Team (developed from a Frailty programme priority to increase complex discharge numbers) is reducing DToC and LoS of Stranded Patients
- SATH fully engaged and seeking integrated working opportunities. This included community inclusion in Service Improvement Weeks and Events
- BCF Council funded posts to target improved performance including a Community Matron, additional therapists to support to stay at home beyond the enablement period.
- Visibility of Council performance though a performance dashboard
- Grants to organisations to support wellbeing and admission avoidance

5.4 Challenges last year included:

- Increased emergency admissions in the last quarter of 2017/18
- Domiciliary care capacity and resilience
- Pathway 2 and 3 as 'default' on some wards increasing enablement bed demand
- There is insufficient system visibility of the High Impact Changes targets
- There has been a lack of system wide visibility of related work programmes, outputs and that would support HIC achieving *MATURE* and support local key system targets

[1] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

5.5 BCF Programme priorities for 2018/19 are:

- Having the Frailty at Front Door at PRH in place from October-
- Embedding the integrated teams and functions (Frailty at the Front Door, Intermediate Care Team, Integrated Discharge and including SATH[2]
- Community MDT (Neighbourhood) programme across the localities
- Ensure independent sector community providers are robust and resilient to deliver services
- Achieve the four mandated BCF targets
- Manage enablement bed demand and capacity to ensure the potential financial pressure is mitigated and reduced by the implementation of the winter action plan. Progress regarding this plan is being managed at monthly BCF Operational Board meetings
- Actions to achieve *Mature* rating for the 8 High Impact Changes by Quarter 4 against assessment criteria. The Red Bag Scheme to be *Established.* Actions are set out in Appendix 2 below
- Close working with partners to develop alternative service provision to deliver statutory services in new ways.

ADDITIONAL INFORMATION

None

PREVIOUS MINUTES

None

APPENDICES:

Appendix A

[2] https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/

Metric	Performance at Month 12	RAG
Emergency admissions	Target: 18,908 Actual: 19,444 (+536/2.83%)	
DToC	Target: 9.60 average days per day 4.4 CCG:3.5 Council:1.7 Joint Actual: 7.16 average days per day 3.9 CCG; 1.0 Council: 2.2 Joint	
Local measure 70+ admissions by HRG	Target: 452 reduction of specific HRGs Actual: 472 reduction *Calculated on all ICT QIPPs*	
Permanent admissions to care homes	Target: 365/100,000 (105 people max) Actual: 339/100,000 (115 people) National: 600/ 100,000	
Home 91 days post Rehabilitation	Target: 80 % ASCOF Reporting period 61% Annual: Monthly average 72%	

Appendix B

HIC		Actions to achieve MATURE	Current RAG
1	Early discharge planning	EDD in place within 48 hours Embed flow processes eg SAFER, Criteria Led Discharge, End PJ Paralysis	
2	Systems to monitor patient flow	Demand and capacity modelling completed Capacity matches demand to support flow	
3	Multi-disciplinary/multi-agency discharge teams	Frailty Front Door in PRH in place ICT Operational Framework implemented	
4	Home First/Discharge to Assess	Consistent 60:30:10 discharge ratio	
5	Seven-day service	Weekend discharges at target levels Community MDT approach at weekends	
6	Trusted Assessors	Pathway decision 90%+ accurate first time Embed Trusted Assessor for care homes role	
7	Focus on choice	Fully implement agreed Choice policy Patient Information routinely provided	
8	Enhancing health in care homes	Care Home MDT in place Complete actions from ECHC self-assessment	
	Red Bag scheme (Established by Quarter 4)	Utilised effectively in pilot areas	

RAG rating key: Not yet established | Plans in place | Established | Mature | Exemplary

Report prepared by:

Sarah Bass	Service Delivery Manager, Commissioning, Procurement & Brokerage
Julie Smith	Service Delivery Manager Community Early Help
Michael Bennett	Head of Commissioning: Better Care Fund/ Care Closer to Home