Health and Wellbeing Board
January 2020

BETTER CARE FUND PLAN Q3 REPORT

Report of the Associate Director of Commissioning, (Care and Health), Devon County Council and NHS Devon Clinical Commissioning Group.

Please note that the following recommendations are subject to consideration and determination by the Committee before taking effect.

Recommendation*:*
The Board note:

1. National approval of the Section 75 Framework Agreement and associated Service Specifications for 2019/20, underpinning the Better Care Fund arrangements between the Council and CCG.
2. That the Q3 BCF return will be submitted to NHS England on 24th January and delegate approval to the Chair given timeline constraints around the Health and Wellbeing Board meetings. This report provides a broad overview of the anticipated submission.

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1. Background/Introduction

1.1 The Better Care Fund is the only mandatory policy to facilitate integration, providing a framework for joint Health and Social Care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant and funding paid to local government for adult social care services. The Health and Wellbeing Board is required to complete a BCF plan each year for endorsement by NHS England alongside the Section 75 agreement which details the agreement for how the fund be utilised and operated between the Council and CCG.

1.2 **Summary of changes to the Section 75 Framework Agreement 2019/2020**

- A complete refresh to reflect changed organisational arrangements with the CCG.
- Update to the terms of reference agreed by the Joint Commissioning and Coordinating Group (JCCG) in March 2019
- The previous 2017 to 2019 Section 75 Framework Agreement covered two financial years. This new iteration is for the 2019-20 financial year only, so all budget references and totals are now representing a single financial year only.
- The Better Care Fund will have four pools in 2019/ 20, as opposed to the three that existed within the 2017 to 2019 agreement:

	2017-19	2019-20
Pool	Revenue Capital iBCF grant	Revenue Capital iBCF grant **Winter Pressures**
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The Winter Pressures fund was mandated by the Ministry of Housing Communities and Local Government to be managed within the overall BCF framework for 2019-20, accompanied by its own specific spending mandate. Relevant references to Winter Pressures have subsequently been required within many sections of the revised S.75 agreement.

- Risk sharing arrangements, as with 2017 to 2019 agreement all pools will have the same risk share percentage split, with that now moving to an equal 50:50 (DCC: CCG) split for 2019-20, from the 40:60 (DCC: CCG) share seen in the previous arrangement

NHS Devon CCG	50%
Devon CC	50%
Total	100%

2. Q3 Return
3. Compliance with national conditions

3.1 We will confirm that we have met each of the national conditions required of the submission:

NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**
	PR2	**A clear narrative for the integration of health and social care**
	PR3	**A strategic, joined up plan for DFG spending**
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**
	PR8	**Indication of outputs for specified scheme types**
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**

4. Strategic narrative – Integration of health and social care

We will provide narrative returns under 4 headings the responses which are summarised below:

A) Person-centred outcomes
Your approach to integrating care around the person

We will describe the importance of key areas in the delivery of person-centred outcomes, crucially comprehensive assessment and risk stratification to identify those who are frail or soon to be so – a single point of access to make it easier for GPs and others to obtain additional support when it is needed - and a comprehensive rapid response (care at home) service to help people to remain at home rather than be admitted to hospital or remain there beyond what is needed

We will detail the feedback we have received from the long-term plan engagement which highlights amongst other things the need for a focus on prevention and early detection of illness, the accessibility of care in a large rural county like Devon, the quality and affordability of local residential homes, that treatment should be a joint decision made in partnership with medical staff and that there is a desire to increase the use of technology whilst recognising it is not for everyone.

Lastly, we will describe how we are a demonstrator site for personalised care and that we have already far exceeded our targets for personalised / integrated budgets, embedding 'Making Every Conversation Count' (MECC) training, delivering HOPE (Help Overcoming Problems Effectively) programmes, and are increasing our social prescribing initiatives through the STP Social Prescribing Programme.

B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable)

We will describe the shared management structure which brings together commissioners and providers leading on more strategic work streams led by the STP Programme Delivery Executive Group (PDEG); and our ambitions within the Long-Term plan at system STP and the outcomes framework to which all organisations subscribe.

We will outline that there are joint commissioning arrangements in place for carers services; mental health; older people with mental health needs; learning disabilities; older people with physical disabilities - mostly supported by joint teams and strategies and co-located where possible. And that we have joint delivery arrangements between local authority and health providers with services focussed around community-based health and social care teams to support people when they are most vulnerable, working closely with primary care including the newly formed Primary Care Networks (PCNs), and the voluntary sector.

B) (ii) Your approach to integration with wider services (e.g. Housing) - This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)

We will describe how we have built upon the good working practices established over the past 3 years including reaching an agreement with the 8 district councils in Devon which prioritises the

delivery of major adaptations, supports the delivery of a range of local grants, secures the supply of modular ramps; and distributes the remaining DFG funding to district councils on an agreed local funding formula. We have also confirmed that the system continues to seek to improve its wider collaboration in this area.

C) System level alignment

We will describe how the BCF plan is owned by the H&WBB supported by the Commissioning Coordinating Group (JCCG) with monies distributed to scheme leads and local joint arrangements e.g. A&E boards for delivery. We have also restated our ambition to act as a mature Integrated Care System by April 2021 and explained that the working conditions and relationships built in part by the BCF are supporting that direction of travel, including beginning to share BCF outcomes across the County of Devon. Lastly, we will describe how the BCF investment aligns with the Long-Term Plan ambitions which has been developed jointly by Devon's NHS organisations and Devon County, Plymouth City and Torbay Councils in consultation with the people of Devon

4.0 High Impact Change Model

4.1 We are required to assess our progress against each of the metrics outlined in the High Impact Change Model – a set of best practice recommendations for tackling delayed transfers of care.

Having consulted with local systems leads our submission focuses on consolidating our position seeking to be a mature system in all but one of the areas and recognising that we are submitting the return six months into the year and are about to enter winter.

	Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020
Early discharge planning	Mature	Mature
Systems to monitor patient flow	Mature	Mature
Multi-disciplinary/Multi-agency discharge teams	Mature	Mature
Home first / discharge to assess	Established	Mature
Seven-day service	Established	Established
Trusted assessors	Established	Mature
Focus on choice	Mature	Mature
Enhancing health in care homes	Mature	Mature

5.0 Metrics

5.1 For the return are asked to outline our 19/20 target and plan around 4 key metrics. For each area a summation of performance and plans is included below:

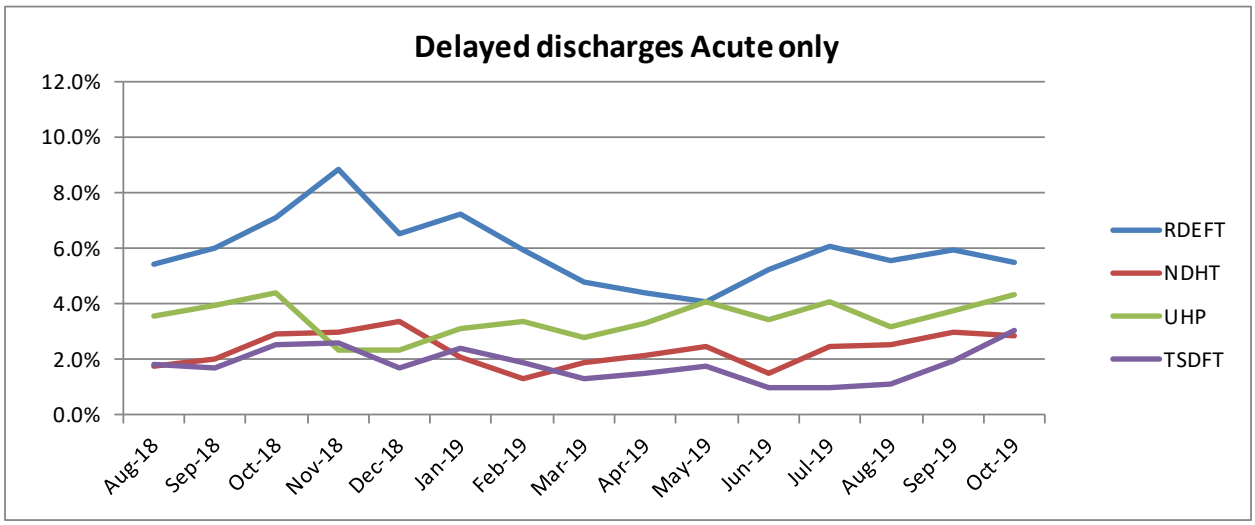
Total number of specific acute non-elective spells per 100,000 population

Performance is challenging in this area, but we remain around 5.53% below our 2019/20 plan with 36791 non-elective admissions against a system target of 38947. This will be difficult to maintain but our plan focusses on:

- Population Health Management capability to be embedded at neighbourhood and place which enables the delivery of proactive care.
- A 'One Team' model blurring organisational boundaries at place that is agile and adaptable to population need.
- Maturing Primary Care Networks delivering integrated care to meet population needs and working as part of that one team
- Continued investment in core approaches such as clinical triage at emergency departments, extending primary care and therapy support to Care Homes and developing voluntary sector capacity

Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)

DTOC performance continues to be a challenge across the system with focus on the Eastern area in particular. Delays are monitored daily across the all Devon's Acute trusts and local A&E Delivery Boards taking ownership locally.



The majority of acute delays in Devon are caused by one of three main issues:

1. Care Packages in own home
2. Patients waiting for further non-acute NHS care

3. Patients awaiting residential care home placements

The reasons for delay vary by organisation and also whether they are acute or non-acute delays. Non-acute delays generally have a wider spread of contributory factors focused around the patients' longer-term care needs, for instance higher levels of delays linked to housing, public funding or family choice

In response acute hospitals and the local authority are increasing capacity in the domiciliary and care home market, building intermediate care capacity and skills, extending community services and therapy and pharmacy hours are extending to provide capacity at key weekends and escalation times. This work ties together with broader recruitment and retention initiatives across Devon linked to the regional Proud to Care campaign and strong relationships with and investment in the 3rd sector and with carers.

A flow action plan has been developed in Eastern which specifically focuses on:

- Developing a discharge pathway to show the options available but focusing on the home first principle
- Reviewing community hospital bed criteria to ensure alignment with use of other beds
- Review of criteria and authorisation process for spot purchase beds
- Review of community hospital discharge team staffing and development
- Development of trusted assessor model
- Completion of Fasttrack assessments
- Review of Single Point of Access processes
- Review of Urgent Community Response Teams to ensure consistency
- A range of specific initiatives utilising winter pressure moneys including: Block purchase of beds within nursing home for winter, use of agency staffing, pilot GP's within Urgent Community Response Team.

These actions should provide assurance of how performance in this area will be recovered.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

There has been a sustained upward trend in admissions, with a profile of needs which is older, and both increasingly frail and with prevalence of dementia and behaviours that challenge which makes this a continued area of focus for us despite Devon County Council continuing to place fewer older people in residential/nursing care relative to population than comparator and national averages.

Our aim is to ensure we have sufficient and robust alternatives. This includes our integrated care model as detailed above but also a continuation of community based intermediate care solutions, such as Rapid Response, Social Care Reablement and regulated personal care to support people to remain in their own homes for as long as possible. Alongside this we are continuing to focus on developing a range of alternatives including Extra Care Housing and Supported Living.

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

The 2018-19 outturn for this indicator was 80.1% a decline on 2017-18 (82.6%). The target has been based on improving performance to 82.6% over the current year.

Previous arrangements screened people into the service rather than out and we now seeking to support those with the most potential to recover independence rather than those that need temporary support while they make a recovery. Extending the reach of services in this way may impact on current performance.

We also recognise that co-ordination of care and support will also be essential to ensuring people remain at home, and our ongoing development of a 'one team' self-organising ethos with multidisciplinary working that encourages blurring of professional boundaries and active management and ownership of people within a locality is core to this; again Primary Care Networks will be key; as will the vital role that carers play.

6.0 Winter Pressures

The Q3 return asks for brief narrative on the progress of the spend of the Social care winter funding. Our submission will state that the £3.5 million has been invested to strengthen acute admission prevention schemes, such as targeted care home management, early care home visiting for medical reviews, prescribing and medication reviews for patients who are 65+ (by either primary care, community pharmacists, and wider community services). Investment with this money means more people cared for at home with wrap around community services support that prevents escalation of care needs to an acute partner.

7.0 Next steps Q3 return

To compete the return and request endorsement for submission from the Chair of the Health and Wellbeing Board.

8.0 2019/20 BCF Monitoring

8.1 We currently expect to have to submit returns in quarters 3 and 4. It is likely that the format will change from previous years, but that detail is still emerging.

- Quarter 3: Friday 24 Jan 2020
- Quarter 4: Friday 1 May 2020

9.0 Future Years

9.1 Early indications are that Better Care Funding will continue in 2020/21 at similar levels although final details and conditions are yet to be confirmed, further updates will follow as they become available. At the JCCG January meeting the membership will consider proposals around the funding principles, allocation and governance of the fund.

Tim Golby
Associate Director of Commissioning, (Care and Health), DCC and NHS Devon CCG

Electoral Divisions: All

Cabinet Member for Adult Care and Health: Councillor Andrew Leadbetter

Chief Officer for Adult Care and Health: Jennie Stephens

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS
Contact for Enquiries:
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BACKGROUND PAPER	DATE	FILE REFERENCE
Nil		