ACH/17/68
Health and Adult Care Scrutiny Committee
19 June 2017

THE BETTER CARE FUND: ALLOCATION OF ADDITIONAL SOCIAL CARE FUNDING

Report of the Head of Adult Commissioning and Health, DCC and the Director of Strategy, NEW Devon and South Devon and Torbay CCGs

Recommendations

Health and Adult Care Scrutiny

(1) Note the proposed approach to use of additional social care funding in Devon in 2017/18.

(2) Consider how it wishes to scrutinise the issues around 'Delayed Transfer of Care' and use of the new monies during 2017/18.

1. Introduction and Background

1.1 The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017.

1.2 There are specific conditions around how we use the money, and the metrics against which we will be measured, with a particular focus on reducing the numbers of delayed transfers of care. There are also conditions about how local authorities and clinical commissioning groups work together in agreeing proposals for how we use the money.

1.3 For Devon, the additional money amounts to:

2017/18	2018/19	2019/20
£15.15m	£10.15m	£5.04m

1.4 The specific conditions are as follows:

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care
- Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings)

1.5 Beyond this, we can agree locally how the fund is spent over health, care and housing schemes or services, but we need to agree how this spending will improve performance in the following four areas:

- Delayed transfers of care
- Non-elective admissions (General and Acute)
- Admissions to residential and care homes
- Effectiveness of reablement

1.6 The Care Quality Commission will hold targeted inspections informed by the use of an 'integration scorecard' built on the Better Care Fund metrics.

1.7 There are also conditions about how local authorities and clinical commissioning groups work together in establishing the fund:

- A requirement that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the local authority and Clinical Commissioning Groups.

1.8 This report recommends how this funding should be allocated, in line with national conditions, and targeting specific areas of local need. The proposals have been developed in consultation with health and social care staff and providers and are aligned to our local strategic transformation programmes of work.

2 Context

2.1 Integration

2.1.1 At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that to service users it feels like one service. People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and make more efficient use of available resources.

2.1.2 An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements. We are expected to set out how we expect to progress to further integration by 2020 in our 2017-19 Better Care Fund plan.

2.1.3 The Devon Sustainability and Transformation Plan (STP) submitted in 2016 sets out this context and case for change. All partners in the Devon health and care system share a single ambition and purpose to create a clinically, socially and financially sustainable health and care system that will improve the health, wellbeing and care of the populations we serve. Any allocation of funding needs to be supportive of this plan for a new model of care and help deliver these outcomes.

2.2 Population changes

2.2.1 People are living longer, with increasingly more complex care needs that require more support from health and social care services. In Devon, we are expected to experience the greatest population growth in the older age groups. 3.5% of the population in Devon is aged 85 and older, compared to 2.4% in England as a whole. An ageing population is hugely significant because older people are more likely to develop long term health needs such as diabetes, heart disease and breathing difficulties, and are more at risk of strokes, cancer and other health problems – which together means people tend to need more care and more treatment as they get older.

2.2.2 An ageing population also means increasing incidence of dementia. More than 2 out of 5 people over the age of 70 admitted in an emergency have dementia and over 45% of the hospital beds in Devon are occupied by someone with reported dementia who is medically fit to leave but has not been discharged.

2.2.3 While the average life expectancy of someone with learning disabilities is currently about 20 years less than the general population, the gap is narrowing with life expectancy of people with learning disabilities increasing by about 8 years for males and 5 years for females since the turn of the century. This presents the health and care system with the challenge of providing care

and support to this group for longer, and increasingly when parent-carers become too old to maintain such an active role in their children's lives, or pre-decease them.

2.3 Avoidable hospital admissions

2.3.1 Inappropriate admissions and unnecessarily long periods in hospital can be harmful, for older people in particular. The longer older people remain in hospital, the harder it is for them to regain their independence and return home, and the more likely they are to be re-admitted. NEW Devon CCG forecast that there will be 37,000 more emergency admissions to local hospitals over the next five years, an increase of more than 30% if we don't change the way we do things.

2.3.2 If we help people identify their strengths and what really matters to them and link them in with appropriate support when needed, there is potential to support people to remain independent, less reliant on care and less likely to have inappropriate admission to hospital or care homes or to need significant levels of care and support throughout their lifetime. This is the case for all people, including those with mental health conditions and learning disabilities, not just our older population. We also need to recognise that some of the support that people require can be delivered within their community and by the voluntary sector.

2.4 Winter Pressures

2.4.1 Starting in November each year, we begin to see the effect of winter pressures in the system. The term refers to how hospitals cope with increased demand but these pressures have an impact on the whole system, as increased demand at the front end affects the flow of people through the whole health and care system. However, whilst this is a seasonal spike, it now comes on top of already very high levels of activity.

2.4.2 Every urgent-care system experiences peaks of activity and 'acuity' which is often referred to as winter pressures, though these can and do occur throughout the year. These often consist of two key elements, a general increase in demand (e.g. the flu-season) often coupled with a rise in 'acuity'. Acuity is a broad term indicating the patients are more unwell and likely to take longer to get better. These two items combine to create a lack of flow through the hospital, which can cause immense pressures on delivery. It is managed within the hospital by opening extra escalation beds or cancelling planned work such as elective surgery.

2.4.3 Pressure in the system is measured using the Operational Pressures Escalation Levels (OPEL) framework which looks to collate a number of measures (e.g. A&E performance, bed availability, staff availability, discharges) to indicate a single status, OPEL 1 through to OPEL 4, to reflect the organisational situation. The measures of pressure in a complex system should not just be the acute hospitals and in Devon multiple organisations such as the ambulance service, Out-of-Hours GP service and combined Health and Social care teams are collated daily. OPEL 1 means the system is operating normally; OPEL 4 means organisations are unable to deliver comprehensive levels of care. There are specific actions, set nationally, which are required to be followed to manage the higher OPEL levels and to mitigate risk, led by the local A&E Delivery Boards.

2.4.4 Additional illnesses which are more common in winter (such as 'flu and norovirus) and colder weather can affect the most vulnerable groups in society. This results in reduced health and wellbeing in these groups, with a greater number of people dying in winter each year. These additional illnesses put further pressure on services that is not experienced during other seasons. Additionally, an increase in diarrhoea and vomiting / norovirus illnesses result in more wards being closed, reducing bed availability and the ability to move people through the system.

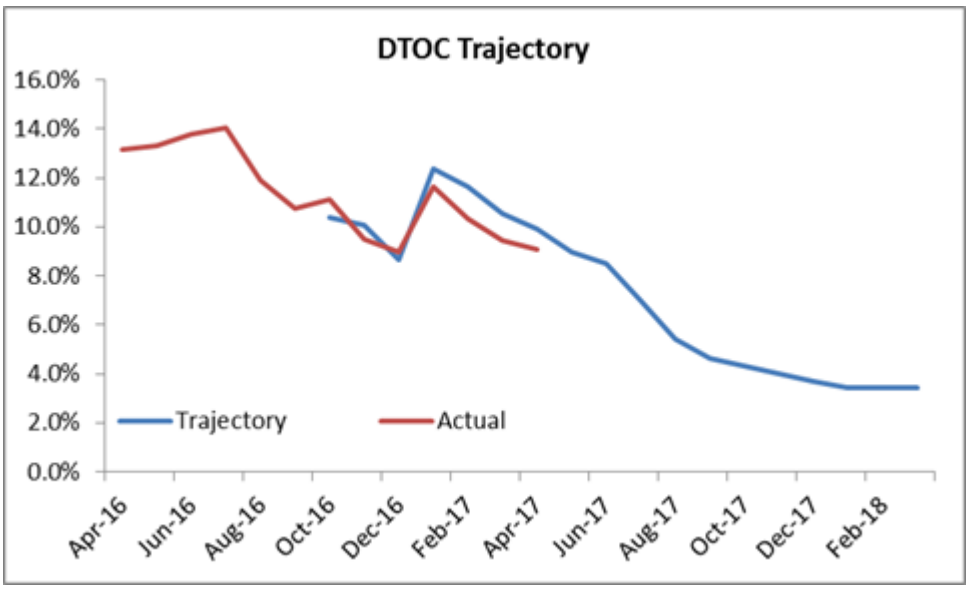
2.4.5 Many of those most affected tend to be our older and more vulnerable population who have increased care needs as much as a medical need. For example, for those over the age of 75 years there is a greater than 80% chance of needing admission from A&E, whereas for the under 30s, it is less than 20%. Once in A&E these patients will require a bed or trolley space until they are discharged from hospital. If the onward flow stops, new patients cannot be received.

2.5 Delayed Transfers of Care

2.5.1 Helping people to transfer smoothly and appropriately through the health and care system is one of the most complex tasks that the system faces. Frontline care and health staff have been dealing with this challenge for many years, but the pressure is increasing as our population ages and resources are stretched.

2.5.2 A 'delayed transfer of care' occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care, but is unable to do so. Sometimes referred to in the media as 'bed-blocking', delayed transfers of care are a problem for the NHS as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients. Delays can occur when patients are being discharged home or to a supported care facility such as a residential or nursing home, or require further, less intensive care and are awaiting transfer to a community hospital or hospice.

2.5.3 There are several national, regional and local initiatives related to reducing avoidable hospital admissions and delayed transfers of care (DTOC) out of hospital. The Better Care Fund has always had a focus on reducing delayed transfers of care, but for 2017/18, this goes further, with a requirement to reduce DTOC to 3.5% of total bed occupancy (the RDE rate is around 12%, see figure below). DTOC is measured in both acute and community settings.



2.6 Other Challenges

2.6.1 Mental health illness is relatively common in Devon and people with complex mental health needs experience poorer health outcomes than the general population. We need to support people with mental health conditions to be able to access the support they need and to support them to live as independently in their communities as possible.

2.6.2 Our providers have difficulties with recruiting and retaining staff: many NHS staff are due to retire in the next 10 years, and local organisations already have high levels of vacancies and staff turnover in many areas.

3. High-level Principles

3.1 We propose to take a zero-tolerance approach towards delayed transfers of care, with funding decisions informed by the following principles:

- Addresses local reasons for delayed transfers of care in each locality/ system by improving flow and/or reducing demand.
- All investments need to reduce emergency hospital admissions, readmissions, DTOC, length of stay.
- Manages demand through an improved short term services offer and developing individual and community resilience
- To implement STP priorities of:
    - Single assessment process
    - Single point of access
    - Rapid response
- Informed by the national 'high impact change' guidance for reducing delayed transfers
- Strategically designed and agreed in principle but locally delivered

3.2 We propose indicative allocations to:

- Strategic county wide investments – for areas where it makes sense to design change on a county wide basis

- Locality footprints and specialist systems
    - North, East, South and West localities
    - Mental health
    - Disabilities

3.3 The high impact changes recommendations focus on getting people out of hospital, but we would also aim to do this by reducing demand through prevention and increasing sufficiency and innovation in the personal care and care homes markets, plus developing community resilience through the voluntary and community sector.

3.4 We will agree funding allocations for 2017/18 now, and plan 2018/19 and 2019/20 as part of the standard local authority and NHS financial planning arrangements.

4. Allocation of funds

4.1 Based on the over 75 populations, the allocation per locality would be as follows:

North	20%
East	49%
West	11%
South	20%

Area of spend (locality / system)	Over 75 population
Mental Health	£2m

Disability	£2m
Specialist Sub Total	**£4m**
North	£1.2m
East	£3.0m
West	£0.7m
South	£1.2m
Locality Sub Total	**£6.1m**
Community Resilience/ Prevention	£1m
TOTAL	**£11.1m**

Area of spend (county wide)	17/18	Detail
Market sufficiency Care Homes – fee rates and innovations	£2m	Increased activity putting pressure on unit rates. New joint contracting model provides vehicle for individualised approach and innovations. Any investment is likely to be recurrent.
Market Sufficiency Personal care innovations	£1m	Unit rates not an issue, but innovations on new roles, better support for staff and better retention to improve supply. Opportunity for trusted provider model. May not be recurrent.
Assistive Technology	£0.5m	Under-developed model in Devon. Agree strategy and investment one off in delivery to support prevention and new model of care.
System development: - New model of care organisational development - New workforce roles	£0.5m	Facilitation/support for practitioners to implement new model of care and design of new roles and competence to implement.
Total	£4m	

5. Development of proposals

5.1 Outline proposals were sought from staff in health and social care, using the national high impact change guidance to inform decision making.

5.2 Proposals were grouped according to high impact change area and analysed at a multi-agency care and health leadership team away day.

5.3 The resulting agreed areas of spend were as follows:

Investment area	HIC	Detail

Market sufficiency **Care homes** – fee rates and innovations Increased activity and lack of visibility of market meaning increase in unit rates. Joint contracting model being developed – likely to require recurrent funding	8 9	Investment in new fee model Care services education support team to reduce avoidable hospital admissions and drive up quality. Upskill private sector staff, tackle key reasons for avoidable admissions to hospital Trusted provider model for reviews – ensuring care meets need, also creates h&sc staff capacity
Market sufficiency **Personal care** innovations May not need recurrent funding	4 6 10	Improved short term services offer – use LWAH providers for simpler reablement cases, freeing up SCR for complex cases Trusted provider model for reviews - creates h&sc staff capacity and ensures care meets need. Also release capacity back into the market Workforce development for private sector
Short term services Links to personal care innovations and STP priorities around SPOA and rapid response	3 4 7 10	Improved short term services offer – use LWAH providers for simpler reablement cases, freeing up SCR for complex cases Assistive technology – improve and extend offer with aim to reduce / delay care packages / admissions to care homes
System development: **NMOC** organisational development Facilitation / support for practitioners to implement NMoC, design new roles	2 4 7	External expertise for systemwide end to end reviews to ensure we have a simplified and streamlined access offer, single joined-up team solutions. A process enabler to complement the NMOC / STP priorities. Staff training to include the three phase conversation model, person-centred outcomes planning Include workforce development for private and voluntary / community sector
Prevention Focus on choice Community capacity building	4 7	Social investment into voluntary and community sector – with clearly defined outcomes and metrics Links to district councils and housing offer
Adults with Disabilities – In addition to all of the schemes above, additional funding will ensure appropriate resources in the community to ensure inequalities are tackled and people with disabilities have access to opportunities within their local communities to live as independently as possible.		Investment in care management staff with a focus on autism. Supporting people with disabilities into employment. A need for more radical thinking / transformation in how we approach support for people with disabilities to ensure they are able to be independent and access services as needed.
People with mental health needs – in addition to all of the schemes above, this additional funding will ensure appropriate resources in the community to ensure inequalities are tackled and people with mental health needs have access to opportunities within their local communities to live as independently as possible.		Provide support for people with mental health needs to navigate the system, with appropriate resources in the community. Recognition that we need to improve the accessibility for our other services to include people with mental health needs. Further strategic transformations as part of our Mental Health programme of change.

6. Next Steps (including governance)

6.1 The proposals need to be signed off locally, by DCC and the two CCGs. The resulting schemes will form part of our Better Care Fund (BCF) Plan. The BCF plan is required to be formally

endorsed by the Health and Wellbeing Board before being submitted to the NHS England Better Care Fund support team for formal approval.

6.2 The Programme Delivery Executive Group (PDEG) will receive a summary of investment proposals for mutual challenge and assurance. NHS England will also be monitoring improvement in performance. Scrutiny are invited to consider how they would wish to assure themselves of progress and impact in this area.

6.3 The approved outline proposals will be further developed into clear implementation plans, including metrics to evidence success, and timelines for delivery. This will be done using the same multi-agency approach used to develop the initial proposals.

6.4 We will establish a set of system metrics to monitor the impact of the schemes at system level, and in line with the Better Care Fund national measures. These will be monitored by the local A&E Delivery Boards, with mandatory quarterly reports to NHS England. The latter will also be reported to the Health and Wellbeing Board.

7. Considerations

7.1 There are no considerations.

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Electoral Divisions: All

Cabinet Member for Adult Social Care and Health Services: Councillor Andrew Leadbetter

Chief Officer for Adult Care and Health: Jennie Stephens

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS

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Background Paper	Date	File Reference

Nil