Health and Wellbeing Board
16 July 2020

BETTER CARE FUND PLAN 2019/20 - QUARTER 4 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:

That the Quarter 4 BCF return will be submitted to NHS England in accordance with its timescales (yet to be confirmed); the Health and Wellbeing Board is asked to approve the Quarter 4 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.

2. Compliance with national conditions

2.1 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	**PR6**	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**
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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?**

3.0 High Impact Change Model

3.1 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.

3.2 We have reached maturity within all but one of the domains: seven-day services. Community based health and social care teams have been progressing towards 6 day working, and during the Covid-19 pandemic teams have been asked to cover 7 days a week to better support the national discharge guidance. This has provided teams with the opportunity to test the 7-day model and help understand how we might embed this further.

	Current position of maturity
Early discharge planning	Mature
Systems to monitor patient flow	Mature
Multi-disciplinary/Multi-agency discharge teams	Mature
Home first / discharge to assess	Mature
Seven-day service	Established
Trusted assessors	Mature
Focus on choice	Mature
Enhancing health in care homes	Mature

4.0 Metrics

4.1 We are required to outline our 19/20 target and plan around 4 key metrics. Below is a summary of performance and plans for each area:

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

4.2 Performance has been 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. We saw a significant drop in non-elective admissions in the last two weeks in March.

4.3 Our plan focused 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+)

4.4 Delayed transfers of care (DTOC) are monitored daily across each of Devon's acute trusts, with A&E Delivery Boards taking ownership locally. Prior to Covid-19 DTOC performance had continued to be a challenge, particularly within the Eastern locality. The reasons for delay vary by organisation, but in general delays were mostly around:

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

4.5 A Covid-19 Discharge Cell was established to support compliance with the national discharge guidance and has been monitoring acute and community hospital discharge daily. In the latter part of Q4 we have seen a significant reduction in DTOC, particularly within the Eastern system, which went from 50 (March) to 11 (April). We are capturing the learning as part of the restoration and recovery process in order to maintain this performance improvement.

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

4.6 Whilst we continue to place fewer older people in residential/nursing care relative to population than comparator and national averages, we have seen an upward trend in admission to long-term care. This is linked to our older population, with a prevalence of dementia and behaviours that challenge which makes this a continued area of focus for us.

4.7 Our aim is to ensure we have sufficient and robust alternatives to long term care, supporting people to remain living as independently as possible in their own homes. This includes our integrated care model and a continuation of community based intermediate care solutions, such as Rapid Response, Social Care Reablement and regulated personal care. Alongside this we are continuing to develop 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

4.8 This metric is designed to measure how well our reablement and rehabilitation services are working to help people recover after a spell in hospital. As we support more and more people with these services (i.e. increase the reach), we do expect the performance against this measure to reduce – as we are supporting people with very complex needs who may well need repeated hospital care, rather than simply those who only need a small amount of support.

4.9 Coordination of care and support and multi-disciplinary team working helps us to support more people to remain at home, and Primary Care Networks are key to the development of enhanced integrated health and social care teams. In quarter four we have seen the accelerated development of this 'One Team' approach in response to Covid-19 and in particular through joint working to support shielding patients and care homes.

5.0 Integration highlight

5.1 We are required to highlight one area which demonstrates our integrated working this quarter, and we chose to highlight our progress with the Enhanced Health in Care Homes Framework.

5.2 We have established weekly forums for care home providers via the Provider Engagement Network, as well as webinars to facilitate support to homes including testing, PPE, infection control, staffing and advanced care planning. This has facilitated the development of joined up care home support plans with local authority, community, acute and primary care colleagues and strengthened our engagement with the sector.

5.3 We have also established a bed bureau, through the Arranging Support Teams in each locality, as a means of managing and tracking care home vacancies across the county, using the national tracker, to have a more accurate and up to date picture of capacity and demand.

6.0 Winter Pressures

6.1 The Q4 return includes a brief narrative on how we have spent the £3.5 million social care winter funding. Investment of this money has meant more people cared for at home with wraparound support that helps prevent emergency admissions to hospital.

6.2 Our submission will state that the has indeed been invested to strengthen acute admission prevention schemes, including:

- targeted care home support
- early care home visiting for medical reviews
- prescribing and medication reviews for patients who are 65+

7.0 End of year report

The return confirms that we already have longstanding joint working arrangements, but the BCF funding has helped consolidate those through the joint development of workstreams to address shared challenges within the remit of the funding. The reflection of our key successes for integration this year have been strong system-wide governance and systems leadership, building on the joint working arrangements already in place.

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		