NHS
Bedfordshire
Clinical Commissioning Group

Central Bedfordshire

Social Care Health and Housing Overview and Scrutiny Committee
18 September 2017

Better Care Fund Plan 2017-19

Julie Ogley
Director of Social Care, Health and Housing
Central Bedfordshire Council

What is the Better Care Fund?

- "The Better Care Fund is a single pooled budget to support health and social care services to work more closely together in local areas…".

  NHS Planning Guidance, December 2013

- Subsequent requirement for local areas to develop an Integration and BCF Plan – setting out the plans for integration of services by 2020.

Achievements of 2016-17 BCF plan

- Place based MDT (community, mental health, social care) approach in Ivel Valley progressing. Roll out planned for other localities.
- Caring Together – risk stratification across several practices in Chiltern Vale
- Partnership working with EPUT - joint Associate Director post; progress made in joint approach to access and assessment (specifically closer alignment of IMC and reablement, new arrangement at the Luton and Dunstable relating to discharge planning)
- Work with Ambulance service leading to reduction in the number of conveyances to hospitals for EOL patients with more calls to the PEPS Service (Partnership for Excellence in Palliative Support)
- Reduction in admissions due to injury from falls - falls prevention training in care homes and UHFRS support to care homes
- Stroke ESD service live from March 2017; M1: 19 referrals for CBC residents with all referrals being seen within 24 hours
- Successful funding bids from ETTF and OPE to support the development of business cases for integrated health and care hubs

Challenges during 2016-17 BCF plan

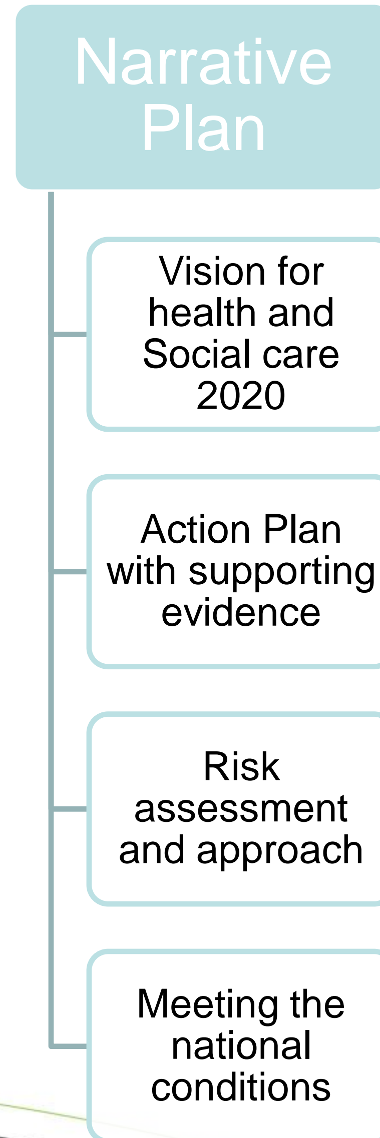
- Recruiting and retaining sufficient care workers; particularly in the domiciliary care sector.
- Information and shared records to facilitate timely transfers of care and joint care planning.
- Increasing complexity of need, multiple morbidities due to ageing population
- Delivering timely care in a predominantly rural area
- The broad patient flows and footprint for Central Bedfordshire residents - working with several acute trusts, particularly in relation to DTOC and engagement in A&E delivery Boards where Central Bedfordshire residents are in minority.

2017-19 Integration and Better Care Fund Plan

2017-19 guidance

2 year plan how we will achieve integration by 2020

- Local vision with patient focus
- Alignment with STP and local plans
- Compliance with national conditions
- A plan of action
- Use of the iBCF
- Engagement with partners including housing



National Conditions and Performance Metrics for 2017-19

Better Care Fund 2017 - 19

National Conditions

- Plans to be jointly agreed
- Maintain provision of social care
- Investment in NHS Commissioned out of hospital services
- Managing transfers of care

Enablers

- Agreed delivery of 7 day services
- Better data sharing
- Joint approach to assessment and care planning
- Agreed impact on providers

Performance Metrics

1. Reduce non-elective admissions
2. Reduce permanent care home admissions
3. Increased effectiveness of reablement
4. Reduced delayed transfers of care

- Increased service user experience
- Increased dementia diagnosis rate

Improved BCF (IBCF) quarterly reporting

The metrics apply to the BCF Plan and the IBCF. Quarterly monitoring will need to reflect how the total BCF Pool is helping to improve performance

Better Care Fund Plan 2017/19

- Builds on 2016/17 plan , continues progress towards integration
- Shared principles
    - Care coordinated around the individual;
    - Decisions made with, and as close to, the individual as possible
    - Care provided in the most appropriate setting; and
    - Funding flowing to where it is needed.
- Small increase on total pooled funds, in line with inflation
- Meets required alignment with NHS FYFV and delivery of IBCF
- Alignment with STP triple aim of better health, transformed quality of care delivery and sustainable finances mapped across Luton, Bedfordshire and Milton Keynes footprint.
- Area specific focus for Primary Care and Out of Hospital Services to reflect Central Bedfordshire's patient flows and wider footprint

BCF Pooled Budget

	2017/18	2018/19
CCG	15.545m	15.844m
CBC (including DFG)	5.535m	6.511m
IBCF	1.810m	1.956m
Total Pooled Budget	22.895m	24.312m

- Significant proportion of the pool is tied to the current community health services contract
- Total spend on Out of Hospital Services £10.7m and £10.9m respectively.

Improved BCF (iBCF)

- ✓ New non-recurrent social care grant allocation (£1,810,048 in 17/18 and £1,956,290 in 18/19)
- ✓ To be used for:
  - Stabilising the social care market
  - Meeting adult social care needs
  - Reducing pressures on NHS
  - Meeting High Impact Change Model
- ✓ Must be pooled into BCF
- ✓ Working with CCGs and providers
- ✓ Quarterly reporting to the government

Quarterly Reports:
- Project/initiatives progress update
- HICM progress (LA perspective)
- Other metrics
- Impact on:
  - Number of care packages
  - Hours of homecare provided
  - Number of care home placements

New National Condition: Managing Transfers of Care - high impact changes that can support local health and care systems reduce delayed transfers of care…

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Focus of 2017/19 Plans: Five Schemes

1. **Prevention and early intervention**

2. **Delivering integrated and improved outcomes through Out of Hospital Services**

3. **Integrated Health and Care Hubs**

4. **Enhanced Care in Care Homes**

5. **High Impact Change Model**

Schemes 1&2

1. Prevention and early intervention

- Expansion of telehealth/telecare
- Implementation of Social Prescribing, support from community and voluntary services through an enhanced network of Village Care Schemes
- Wellbeing in Care Homes - OOMPH physical activity programme
- Falls and fracture prevention – strength and balance classes, Fracture Liaison Service, Falls Prevention training for Extra Care Homes

2. Delivering integrated and improved outcomes through out of hospital services

- Transformation of community health and care services
- Multidisciplinary approach, place based care, co-location teams
- Primary Care Home – risk strat, CGA, trusted assessor, shared records
- Community Bed Redesign
- Integration rehabilitation & reablement
- Develop integrated care pathways , including End of Life and Stroke

Schemes 3&4

3. Integrated Health and Care Hubs

- Commission scoping and Strategic Outline Case documents for the remaining 3 Hubs
- Commission Outline Business Cases (OBCs) and thereafter Full Business Cases (FBCs) for each of the Hubs.
- Procurement and construction of Hubs.
- Development of interim “Hub” virtual/estates solutions to enable multi-disciplinary working within each locality, including co-location of MDT where possible.
- Review plans in line with Central Beds Council Local Plan development.

4. Enhanced Care in Care Homes

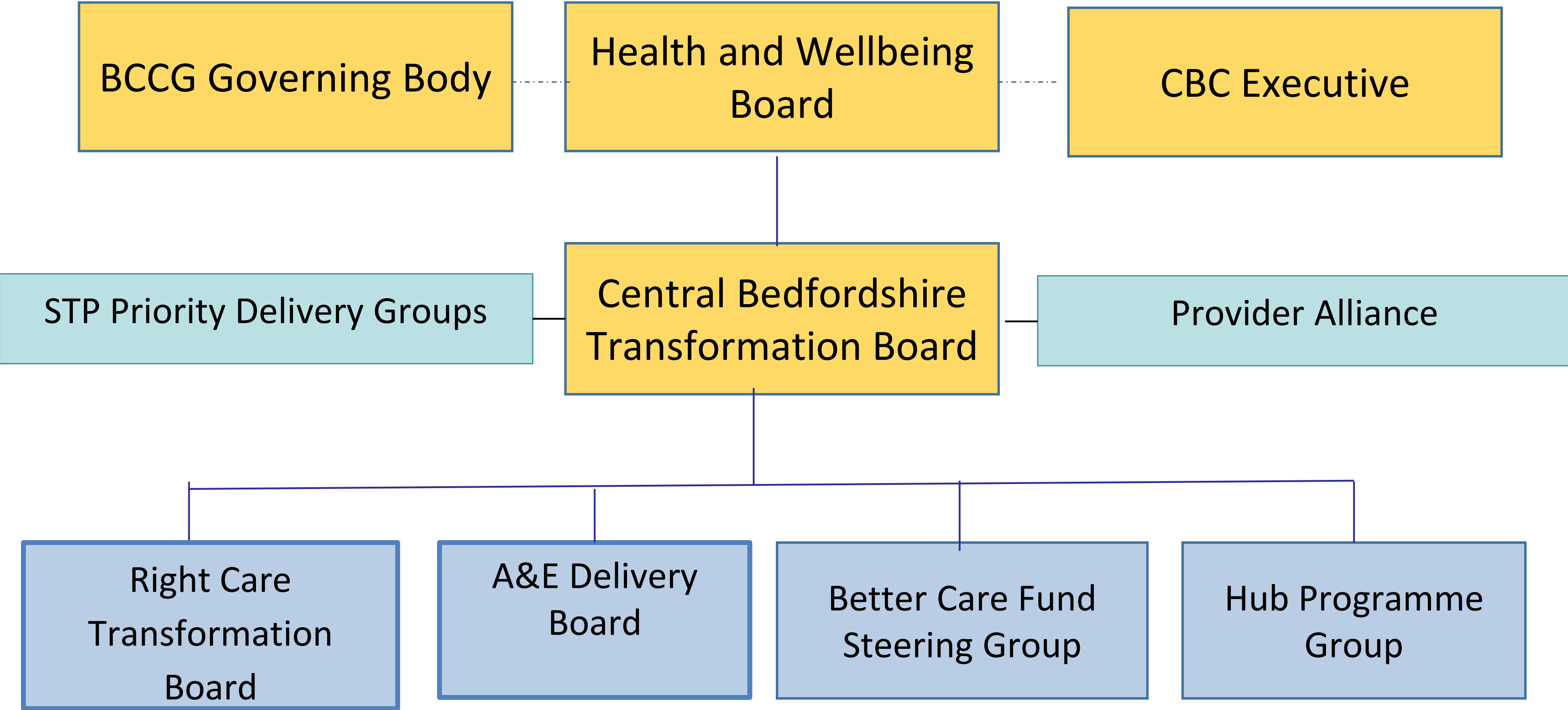
- Trusted Assessor model in place to advise and support care homes in the admission and discharge of patients to/from acute care settings
- Red bag scheme in place to ensure safe transfer of client information, medication
- Undertake medication reviews to reduce inappropriate polypharmacy
- Complex care support (such as geriatricians) available to care homes to reduce ambulance call out , conveyance and hospital admission
- Continuation and expansion of training programme to care home staff
- Digitisation progressed in care home sector (infrastructure, wifi, SystmOne etc)
- Airedale model scoped, including single point of contact (SPOC)

Scheme 5

5. High Impact Change Model

- Early discharge planning – additional social workers in post
- Systems to monitor patient flow – implementation of local tracking system
- Multi-disciplinary/multi agency discharge teams, including the voluntary and community sector – Integrated health and social care discharge service established providing a single assessment process. Rehabilitation and reablement teams provide an offer of integrated intermediate care
- Home First/Discharge to Assess – agree model, commission community
- Seven Day service – trusted assessor model agreed health and social care
- Trusted Assessor –establish for care homes and intermediate care
- Focus on Choice –action plan to address key issues
- Enhancing health in care homes – previous slide

Governance Structure 2017-19



Key challenges for delivery

- Non elective admissions
- DTOC targets against NHSE Expectations
- Definition of DTOC
- Community Health Services Procurement
- Information sharing and alignment of systems
- Workforce
- Finance

Final Assurance Time Lines

Assurance	
First submission	11 September
Plan scrutiny and assurance panels	21 & 22 September
Sign off by BCF Leads Panel	25 September
Regional Moderation	26 September
Cross Regional Calibration	w/c 2 October
Approval letter issued	From 6 October
Escalation/escalation panels	Tbc
Plans approved with conditions: Resubmission of plans for programmes approved with conditions	31 October
Section 75 agreements in place	30 November