Agenda Item 14

HEALTH AND WELLBEING BOARD: 27 SEPTEMBER 2018

REPORT OF DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND QUARTERLY UPDATE

Purpose of the report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the Better Care Fund (BCF) programme.

Policy Framework and Previous Decisions

2. The BCF policy framework was introduced by the Government in 2014, with the first year of BCF plan delivery being 2015/16. The County Council's Cabinet in February 2014 authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.

3. The Board received the last BCF progress report at its meeting on 24th May 2018.

4. The BCF National Team published the Operational Guidance on 18th July 2018 to refresh the two year plan for 2018/19. The Board approved the BCF plan refresh for 2018/19 at its meeting on 12th July 2018.

5. NHS England issued BCF implementation guidance for 2017-19 in July 2018 https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/ which sets out the requirements for quarterly reporting along with the draft templates and analytical tools that are required to be used for this purpose.

Background

6. The Leicestershire BCF Plan for 2017-19 was submitted on 8th September 2017 to the BCF National Team. Confirmation was received on 20th December 2017 that the plan was fully approved.

7. In line with the national process and timetable for 2018/19, refreshed BCF metrics were submitted, along with confirmation that the plan was otherwise unchanged, to NHS England on 20th August 2018. Regional and national assurance processes for 2018/19 are still progress at the time of this report.

Financial Forecast Outturn for 2018/19

8. The budget for the BCF Plan in 2018/19 totals £55.9m. This comprises the following income streams:

BCF Approved Budget	WLCCG	ELRCCG	LCC/DC	Total
	£'000	£'000	£'000	£'000
CCG Minimum Contributions	21,240	16,139	-	**37,379**
CCG Additional Contribution	1,367	1,196	-	**2,563**
Disabled Facilities Grants	-	-	3,632	**3,632**
Improved BCF – Autumn 2015	-	-	5,582	**5,582**
Improved BCF – Spring 2017	-	-	6,837	**6,837**
Total Funding	**22,607**	**17,335**	**16,051**	**55,993**

9. The forecast outturn position for the financial year is for £55.4m. The expenditure plan includes a £2m contingency and cost improvement allocation.

Performance against BCF Outcome Metrics at the end Q1 2018/19

10. The BCF plan is measured against four outcome metrics. For Leicestershire, progress against the key targets is shown in Appendix A, and the following paragraphs summarise the position for each target.

11. The BCF target for the number of **permanent admissions of older people (aged 65 and over) into residential and nursing care homes** is for fewer than 890 admissions (or 624.1 per 100,000 population) during 2018/19. Between April and August there were 378 admissions to residential and nursing care homes, against a target of 379. The full year forecast is currently 927 against a target of 890 and therefore this target is currently rated amber.

12. The target for the **proportion of older people who were still at home 91 days after discharge** has been set at 87%. The latest data, which relates to discharges between February and April 2018, shows that 92.7% of people discharged from hospital into reablement / rehabilitation services were still at home after 91 days. The average figure for 2018/19 between April and August is 89% which means we are currently achieving this target

13. The BCF target for total **non-elective admissions into hospital (general and acute)** was initially set at 67,879 (or 817.92 per 100,000 population). Following recent updates to planned non-elective admissions metrics in Clinical Commissioning Group (CCG) operational plans, the BCF national team produced an updated dashboard showing the adjusted CCG non-elective admission planned figures and weightings. This was published on 30th August 2018. This adjusted the target for Leicestershire for 2018/19 to 70,569 non elective admission (or 850.34 per 100,000 population).

14. For the period April to July 2018 there have been 22,551 non-elective admissions, against a target of 23,152, which is 601 admissions less than the target. This target is currently on track to be achieved. The current forecast for the end of the 2018/19 financial year is that there could be 69,968 admissions, against a target of 70,569.

15. **Delayed Transfers of Care (DTOC)** – the Government's mandate to the NHS for 2018/19 set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018.The national target was apportioned across each Health and Wellbeing Board area and translated into a rate per 100,000 population for each local area.

16. By September 2018, Leicestershire is required to achieve a rate of no more than 7.88 average days delayed per day per 100,000 population and maintain this rate through to March 2019.

17. The table below highlights the performances so far during 2018/19 against the BCF target:

	NHS Delays	LA Delays	Joint	Total
Target for September 2018	**5.50**	**1.25**	**1.13**	**7.88**
Performance at April 2018	5.30	0.34	0.40	6.04
Performance at May 2018	4.31	0.24	0.17	4.72
Performance at June 2018	4.57	0.55	0.39	5.51
Performance at July 2018	5.13	0.50	0.17	5.80

Progress update of the Leicestershire BCF Plan 2018/19

18. The following is a summary of current progress within the integration programme for Leicestershire (ordered by theme of the BCF Plan). A copy of the BCF Plan on a Page is attached as Appendix B which provides an overview of the BCF themes.

Unified Prevention Offer

19. In June the (multi-agency) Unified Prevention Board worked with the Integrated Locality Teams programme to design the model of prevention for Integrated Locality Teams. This was subsequently approved by the Integrated Teams Programme Board in August.

20. The approach involves using the existing, well established, First Contact Plus service (Leicestershire's single point of access and coordination for prevention services), and Local Area Coordinators provide a specific and proactive set of interventions for those patients being cared for by the Integrated Locality Teams. This will wrap around patients they are working with that fall into the frailty category, those with long term conditions or having other high costs, complex needs. This approach will be tested initially in the Hinckley and Bosworth area in Q3 2018/19.

21. First Contact Plus can be accessed by professionals or the public, by telephone or online and provides a one stop shop for a multitude of prevention services including:

    a. **Lifestyle services** (such as physical activity, smoking cessation and weight management).

b. **Leicestershire's Lightbulb Integrated Housing Serv**ice (help with adaptations and equipment, home safety, warm homes and a wide range of other housing support).
c. **The Leicester, Leicestershire and Rutland (LLR) falls prevention service.**
d. **Leicestershire's Local Area Coordinators** (who support vulnerable people with information, support and advice to help them stay well and independent and avoid crisis).

Prevention at Scale

22. The Prevention at Scale project is a nationally funded initiative via the Local Government Association. Through this initiative Local Authorities are seeking to develop greater insights into the impact and value of preventative services.

23. The Leicestershire element of this work focuses on the estimated 30% of GP appointments that can be categorised as "patients who are in need of non-medical help/interventions."

24. The project is working with a selection of GP surgeries in Leicestershire to ascertain:

    a. The reasons for attending the GP for non-medical reasons, from a patient and practice perspective (e.g. whether the person feels vulnerable or isolated, other non- medical needs).
    b. Any barriers to accessing Leicestershire's existing preventative services.
    c. What types of support pathway would work best for patients and practices.

25. The findings from this work will provide valuable insight into:

    a. How we can release more GP capacity/appointments for those activities that only GPs can/should deliver.
    b. How prevention services in Leicestershire can best be configured and developed to support patients, practices and integrated locality teams across Leicestershire.
    c. How best to commission Leicestershire's prevention services in the future.

Integrated Housing Solutions

26. The county-wide roll-out of the Lightbulb integrated housing support service took place during 2017. The service is a pioneering programme which aims to make it easier to find and receive practical housing support to live at home. The overall ambition of the programme is to maximise the contribution that housing support can play in keeping vulnerable people independent in their own homes, helping to avoid unnecessary hospital admissions or GP visits and facilitating timely hospital discharge.

27. Part of the Lightbulb service is the Hospital Housing Enablement service which focuses on people being discharged from hospital. The service aims to enable patients to settle back into a safe home as quickly as possible when they are medically ready to be discharged.

28. The service places housing specialists within the acute and mental health hospital sites, to work with the patient and hospital staff to identify housing issues that are a barrier to discharge and to put things in place so patients can return home as soon

as possible. It also offers practical ongoing support once they are home, including help with further adaptations, furniture, tenancies and access to benefits. Opportunities to extend the model to community hospitals are being piloted, initially in Coalville.

29. A business case for the hospital housing enablement service is currently being developed to seek approval for recurrent funding with effect from April 2019, which will be considered by commissioners in Q3 2018.

Home First

30. The Home First programme is working on developing an integrated health and social care offer across LLR.

31. The plan for the county is for there to be a 'soft launch' during October 2018 to develop an Integrated Home First service. The expectation being that full service development will continue over the winter.

Integrated Outcomes for Phase One (October to December 2018)

32. To see improved joint working between members of Crisis Response Service, HART and Integrated Community Services on a case by case basis and increased use of trusted assessments.

33. Simplified single entry points for health and social care referrals are being developed to enable a decision, and if appropriate an appointment, to be given at the time of referral.

34. The Home First service will be offered to adults when they have a change in need, requiring additional or new interventions that if not met results in admission to hospital/care home or result in the person having to remain in hospital once medically optimised.

35. If the person already has support from health or social care this will continue and we will coordinate our response with theirs to meet the person's additional needs and only stay involved for as long as is necessary. Engagement has commenced with the Help to Live at Home providers.

36. The integrated team will provide a rapid response provision for up to 72 hours including support to individuals and their carers when they are unwell or following a discharge from hospital and short term interventions (up to six weeks) to help with recovery; optimise health; improve wellbeing and independence. The service will undertake exit planning to review the support required to keep the person safe, independent and well.

37. Overtime the teams will be co-located and achieve greater levels of integrated working to fully act as one service.

38. Developing the entry point is the key action and risk to be overcome ready for October.

Integrated Locality Teams (ILT)

39. The ILT programme has identified four building blocks that will underpin a consistent approach to integrated care in the community. These building blocks are:

    a. Population profiling (including risk stratification)
    b. ILT operating model / multi-disciplinary teams working (focusing initially on three cohorts of patients)
    c. Care coordination (setting a clear definition of what good looks like)
    d. Prevention (setting the core prevention offer for each community, for the benefit of locality teams, and the wider population in each locality (see paras 19-22 above).

40. Small groups of locality representatives were tasked to work on each building block and turn this into practical implementation. Three organisational development workshops have also been held to co-design the four building blocks. Outputs from the work were reported to the July Integrated Teams Programme Board. The Board has now concluded its design phase with the four building blocks in place.

41. A test of the model will take place across three localities starting in quarter 2018/19. Leicestershire's test site is within Hinckley and Bosworth.

Integrated Commissioning

42. Leicestershire County Council and the County CCGs have put in place a workplan for joint commissioning for Q3 and Q4 of 2018/19 which includes activities in support of priority areas such as domiciliary care, personal budgets and learning disabilities.

Integrated Data

43. Between January and June 2018, a draft LLR business intelligence (BI) strategy was developed by a multiagency working group led by the Director of Health and Care Integration.

44. This was presented to, and approved by the LLR Information Management and Technology Board and LLR Senior Leadership Team in June 2018.

45. The strategy contains a number of key themes covering; information governance, BI tools, developing the BI workforce, data management, data warehousing and data integration and population profiling.

46. A multiagency workshop took place on 24th August which focused on developing a detailed delivery plan for the first 6-12 months of the strategy under each of the priorities, as well as discussing the governance and engagement arrangements.

47. An LLR-wide delivery group has been tasked with delivering the strategy, commencing on 17th September.

BCF PLANNING FOR 2019/20

48. Work has commenced to review the BCF Plan for 2019/20 in line with annual financial planning arrangements for CCGs and Leicestershire County Council.

49. The local programme of work to refresh the BCF Plan is being undertaken in advance of the BCF Policy Framework and Operational Guidance for 2019/20 being published, as the timescale for this is not yet confirmed.

50. A multiagency workshop of the Leicestershire Integration Operational Group is scheduled to take place on 20th September. The workshop will consider the strategic context of the plan, evaluate the current BCF plan components and future requirements, and consider the commissioning intentions for 2019/20 that are linked to the integration programme. Outputs from the workshop will be discussed by the Integration Executive on 2nd October.

51. A further workshop for the Integration Operational Group is scheduled for 22nd November to follow-up on actions and adjust/iterate the plan as needed, for ongoing review by the Integration Executive. Engagement across all stakeholders will also take place during the period October to January.

52. The draft refreshed BCF plan will be cross checked following the publication of the national policy framework and guidance, and taken through formal governance processes including via the Health and Wellbeing Board, for final approval.

Recommendation

53. The Health and Wellbeing Board is asked to note the contents of the report, and the good current performance across all four BCF metrics.

Circulation under the Local Issues Alert Procedure

None.

Officer to Contact

Cheryl Davenport
Director of Health and Care Integration (Joint Appointment)
0116 305 4212
Cheryl.Davenport@leics.gov.uk

Appendices

- Appendix A – BCF Metrics as at August 2018
- Appendix B – BCF Plan on a Page

Relevant Impact Assessments

Equality and Human Rights Implications

54. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

55. An equalities and human rights impact assessment has been undertaken which is provided at http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf. This finds that the BCF will have a neutral impact on equalities and human rights.

56. A review of the assessment was undertaken in March 2017.

Partnership Working and associated issues

57. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

58. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.

59. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the five year plan to transform health and care in Leicestershire, known as the Sustainability and Transformation Partnerships http://www.bettercareleicester.nhs.uk/

Appendix A – Better Care Fund Metrics as at August 2018

Metric	Target	Latest Data	RAG-rated data	Data RAG	Trend	Aim / Polarity	DOT	Commentary
METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population, per year	624.1	56.1	650.1	A		Good performance is represented by a fall in the figures	⇩	The RAG-rated data shows the August forecast for 2018/19, based on CPLIs. The BCF target for 2018/19 is a maximum of 890 admissions. The current full year forecast is 927 admissions (or 650.1 per 100,000 population). Performance is RAG-rated amber and is statistically similar to the target.
METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	87.0%	n/a	93.2%	G		Good performance is represented by a rise in the figures	⇧	For hospital discharges between Mar and May 2018, 93.2% of people discharged from hospital into reablement / rehabilitation services were still at home after 91 days. This is above the 2018/19 target of 87%. Performance is RAG-rated green and is statistically significantly better than the target.
METRIC 3: Delayed transfers of care from hospital per 100,000 population	244.38	n/a	179.91	G		Good performance is represented by a fall in the figures	⇔	In July there were 978 days delayed, a rate of 179.9 per 100,000 population against a target of 244.4. This is RAG-rated as green and is statistically significantly better than the target.
METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month	832.57	843.1	818.63	G		Good performance is represented by a fall in the figures	⇔	For the period Apr-18 to Jul-18 there have been 22,551 non-elective admissions, against a target of 23,152 - a variance of -601. This is RAG-rated as green. Furthermore, the forecast for the end of the 2018/19 financial year is that there could be 69,968 admissions, against a target of 70,569. This would be RAG-rated as green. For the month of July there has been 5,651 non elective admissions, against a target of 5,747 - a variance of 96. The monthly rate is 818.63 against a monthly target of 832.57 and this is RAG-rated green.

This page is intentionally left blank