Agenda Item 7

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 24 JANUARY 2019

REPORT OF DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND QUARTERLY UPDATE

Purpose of 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 27th September 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 19th October 2018.

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 (DFG)	-	-	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**	**10,469**	**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 Q3 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. The full year forecast, at the end of December, is for 872 admissions (or 611.4 per 100,000 population) against a target of 890 and therefore this target is currently on track to be achieved.

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 July and September 2018, shows that 90.2% 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 December is 90.3% which means we are currently on track to achieve this target.

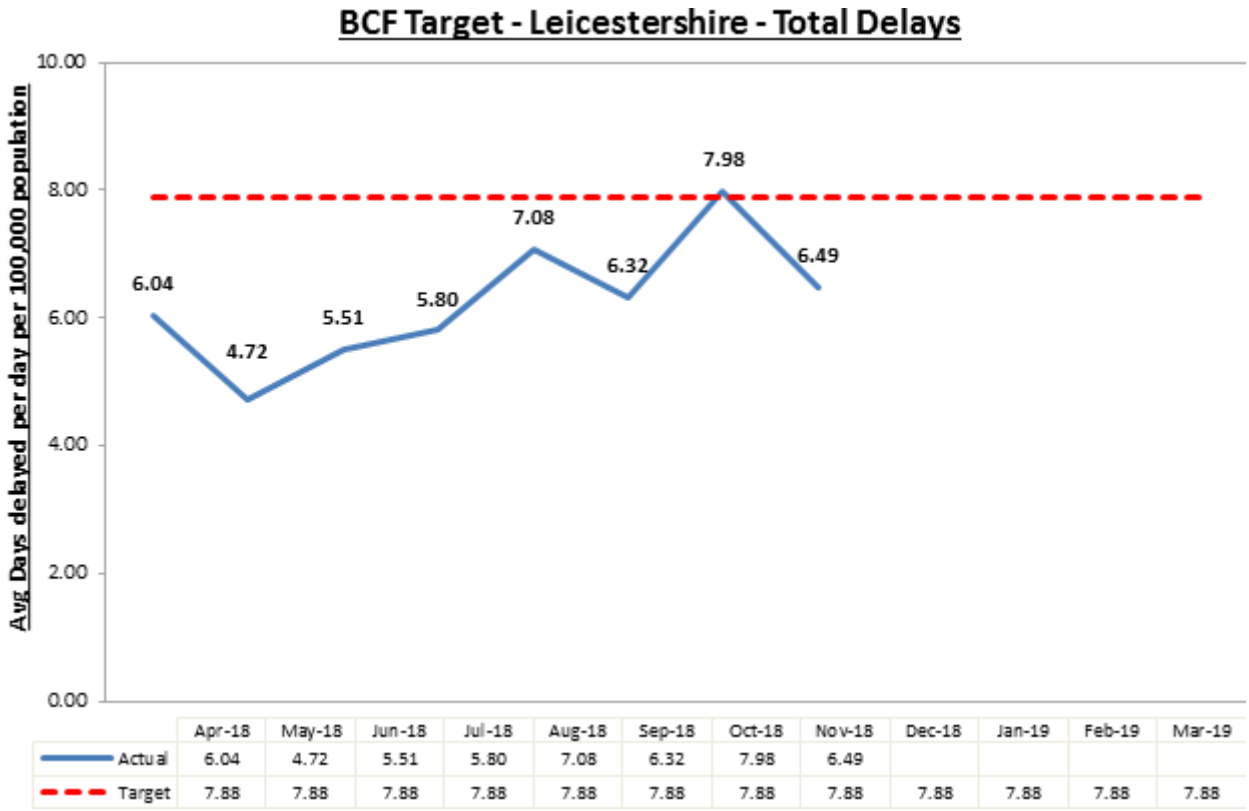
13. The BCF target for total **non-elective admissions into hospital (general and acute)** has been set for up to 70,569 (or 850.34 per 100,000 population) for 2018/19. For April to November 2018, there have been 44,956 non-elective admissions, against a target of 46,665, which is a variance of 1,709 admissions less than the target. The 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 68,860 admissions, against a target of 70,569.

14. **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.

15. By September 2018, Leicestershire was 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. In November 2018, Leicestershire achieved 6.49 average days delayed per day per 100,000 population.

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



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	6.04	4.72	5.51	5.80	7.08	6.32	7.98	6.49				
Target	7.88	7.88	7.88	7.88	7.88	7.88	7.88	7.88	7.88	7.88	7.88	7.88

Progress update of the Leicestershire BCF Plan 2018/19

17. 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 provided in Appendix B which provides an overview of the BCF themes.

Unified Prevention Offer

18. During the last 12 months the Unified Prevention Board (UPB) has focused on developing the asset-based offer in localities around tier zero (universal) and tier one (primary) prevention. This has included a Social Prescribing offer which includes First Contact Plus (a one-stop show for a multitude of prevention services) and Local Area Coordination.

19. One of the key programmes of work for the UPB is developing the wrap-around prevention offer to support Integrated Locality Teams (ILTs). ILT's are a multidisciplinary approach to delivering health care to patients who are in one of three cohorts (further information below). The UPB will help support patients by ensuring that prevention services are available and aligned to their care needs so that they are able to stay in their own homes and prevent further acute care.

20. Another key area of work for the UPB includes a workplace health programme, which is targeting the health and wellbeing of organisations involved in delivering the care. The campaign aimed to target 100 businesses and so far, there have been 1,066 responses from 24 organisations with an average response rate of 40%. A number of key priorities/issues have been identified and the programme will now aim to address these with organisations to achieve better outcomes for the Leicestershire workforce moving forwards.

21. Joined up communications across partners has also been a priority for the UPB since 2017, with partners joining together to integrate campaigns with a focus on prevention. Of particular focus was the development of the self-care campaign whose ongoing messages have so far focused on three key areas; healthy living, self-care options and long-term conditions. The winter campaign has been raising awareness on topics such as diabetes, healthy eating and high blood pressure.

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.” The project is working with a number of GP surgeries to develop better insights into the reason for these types of attendances, how the local prevention offer can be improved and how best to support patients and GPs with easy access to the most suitable support for the non-medical needs, via GP or self-referral into First Contact Plus, or via other agencies and the community itself.

Falls Programme

24. It is estimated that each year in Leicestershire falls cost the NHS approximately £23million with one in three people aged over 65 falling every year.

25. The aim of the Leicester, Leicestershire and Rutland (LLR) falls programme is to improve the treatment pathway for those identified as being at risk of suffering a fall or who have experienced a fall. The programme provides the tools to ensure the appropriate course of action is taken to help each individual maintain their independence and avoid falls related admissions to hospital.

26. Tools include specialist therapy triage and assessment for all referrals into consultant falls clinics and specialist therapy and falls prevention training for care home staff. The work also includes the development of the local falls management exercise programme ‘Steady Steps’ and extending access to an electronic Falls Risk Assessment Tool smart phone application.

27. The triage approach in the new falls pathway has evidenced that a significant proportion of the referrals for a consultant can be successfully seen and treated by therapy interventions. In 2017, the service saw 502 patients avoiding the need for them to go into a clinic. This has resulted in £133,000 being saved on consultant appointments. Waiting times to see a clinician and commence therapeutic interventions reduced from 25 plus weeks to 13 weeks.

28. Access has been improved to community and home-based exercise programmes, Steady Steps, which is designed to increase confidence in balance, postural stability and independence. A total of 48 courses, for over 300 participants, will have been completed by the end of March 2019 and 30 Postural Stability Instructors have been trained. Evidence from The King's Fund shows that £2.32 is saved within the health and care system for every £1 spent on Steady Steps. Reduced social isolation and social peer support is gained from patients regular attendance of the Steady Steps programme. With continued investment, the programme can roll out a further 78 courses to 1,100 residents in the county during 2019/20.

Integrated Housing Support

Disabled Facilities Grants

29. A national Disabled Facilities Grant (DFG) review, commissioned by the Department of Health and Social Care, was published in December. The review set out a number of practical ways to improve the delivery of home adaptions and ensure that they are tailored to the individual.

30. A report will be received by the Integration Executive at its meeting on 5th February to consider the implications of the recommendations in the review and the proposed next steps locally.

Lightbulb

31. 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 access 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.

32. Lightbulb has successfully managed to deliver the expected improvements during the first year of delivery, including:

    a. A reduction in transfers for customers between organisations/services/key workers from eight occasions to three for assessment and installation of stairlifts which has reduced costs by 11%.
    b. Reduced stages from 27 to 13 for level access showers and reduced costs by 4%.
    c. Managing a significant increase in demand across all areas of work.
    d. Transferred lower threshold work from high Occupational Therapists (OT's) to Housing Support Coordinators, allowing OT's to focus on complex cases resulting in increased capacity for that team, enabling them to deal with an additional 37% case work increase.
    e. Improved Disabled Facilities Grant delivery times in all but one district and achieved the stretch target of 20 weeks in two districts.
    f. Trained Housing Support Coordinators to become Trusted Assessors – this will further speed up delivery times going forward.

g. Customer centred outcomes have shown significant improvements in all areas from pre to post Housing “MOTs” with 96% of customers answering yes to ‘has the service achieved everything you wanted’.

33. A business case for Lightbulb, a refresh for 2019/20, has been developed which sets out the outputs achieved in year one of the service and the recurrent funding requirements for each local authority partner. Decisions are expected shortly on this.

Housing Enablement Team (HET)

34. 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.

35. 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.

36. The HET team provides up to 28 different types of interventions across a number of hospital settings. These range from cleaning and clearing properties and providing furniture, to reducing rent arrears and accessing more suitable accommodation.

37. Since April 2015, HET have helped over 1,700 patients, with demand increasing between April 2016 and March 2018 by 27% in University Hospital Leicester (UHL) and by 5% in the Bradgate Unit.

38. Referral to resolution times within UHL are typically six days, despite the increased demand. This is the length of time it takes to resolve housing issues and is a measure of the time between referral to the HET service and solution being put into place.

39. The outcomes of a cohort of 357 UHL patients were analysed and showed that their reduction in emergency admissions, after intervention from the HET service, saved the health and care economy around £220,000. Overall, NHS costs for the cohort could be reduced by approximately £550,000 annually 12 months post intervention.

40. Prior to the service, housing related DTOCs, during 2014/15, for mental health patients comprised on average 26% of all delayed bed days which translates to around 700 delayed days. Since the introduction of the HET service in 2016, this has reduced to an average of 15% of all days delayed or 400 days housing related delays per month.

41. A business case for the hospital housing enablement service, seeking approval for recurrent funding with effect from April 2019, is being considered by CCG commissioners, with decisions expected shortly.

Assistive Technology

42. New technology is transforming the care technology sector. Currently in Leicestershire a telecare service is provided based on pendant alarm systems. Nearly 6,000 alarms are in place in homes across the county. There are now many newer products available that can support people to live independent lives and deliver a more preventative response, which is more effective at delaying and reducing needs.

43. The BCF assistive technology project is looking at how the service offer in Leicestershire can be enhanced by maximising opportunities offered by new technology.

44. An initial market appraisal exercise was completed during 2018, which looked at experience elsewhere and is aiming to establish a standardised approach across the county to assistive technology. Testing some of the newer technology will take place in 2019.

Home First

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

46. The integrated approach will be offered to adults when they have a change in need, requiring additional or new interventions that if not met, will result in admission to hospital/care home or the person having to remain in hospital when they are medically fit for discharge.

47. Partners have developed a blueprint for integrated intermediate care services. Work to design and implement the integrated health and care reablement offer including referral and access points, skill mix, triage and service delivery was undertaken during 2018. The service commenced during October, ahead of winter pressures. Work on the performance measures is currently being finalised and progress will be reported to the Integrated Communities Board at the end of March.

Integrated Locality Teams (ILT)

48. Twelve ILTs have been established across LLR to provide more coordinated and comprehensive support in the community. These teams are comprised of GPs, community nurses, social care staff and partners from a number of organisations including the voluntary sector.

49. The 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 – frail, five or more long-term conditions and/or high care costs);
    c. Care coordination (based on the nine key features of care coordination developed as part of service design in LLR);

d. Prevention (setting the core prevention offer for each community, for the benefit of locality teams, and the wider population in each locality.

50. While ILTs are operating in all parts of LLR there are three locations that have been selected as early implementers of the full model For Leicestershire, the early implementer site is in Hinckley and Bosworth.

51. A flowchart is in place setting out how cases will flow into the pilot, how the frailty checklist will be utilised, how the prevention offer will be targeted and the role of the Care Coordinator in supporting the multidisciplinary team and patients so that care planning is effective and coordinated, and the impact of this new approach is measured, both in terms of the outcomes for patients and the professionals involved in their care.

52. Visits are currently taking place to acute ("out of county") hospital sites on the borders of LLR to ensure that patients registered with Leicestershire CCGs who attend these sites for their care have clear pathways back into Leicestershire's integrated community services when they return home, including the ILT and Home First models of care. We are working with these hospitals to ensure the arrangements well understood and any operational matters addressed.

Integrated Commissioning

53. 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

54. In December 2018, approval was received from NHS Digital to join and link health and care data to assist in the planning, transformation, design and evaluation of health and care services across LLR. The plan is to develop and implement an integrated data warehousing tool for this purpose during 2019.

55. The LLR business intelligence (BI) strategy, developed by a multiagency working group during Q1 and Q2 2018, has been approved and cascaded via the management teams of partner organisations and other key groups within LLR during Q3.

56. The initial focus for implementation will be on the data warehousing and population profiling workstreams during Q4. The next stage will be to consolidate the workforce, analytics and tools workstream into one programme of work with a view to commencing work on these areas from April 2019.

BCF Planning for 2019/20

57. Work to review the BCF Plan for 2019/20 in line with annual financial planning arrangements for CCGs and Leicestershire County Council was undertaken between September and December 2018.

58. The local programme of work to refresh the BCF Plan was completed in advance of the BCF Policy Framework and Operational Guidance for 2019/20 being published,

which is expected during January, to ensure that decisions could feed into commissioning intentions.

59. An initial multiagency workshop took place on 20th September, which considered the strategic context of the plan, evaluated the current BCF plan components and future requirements, and considered the commissioning intentions for 2019/20 that are linked to the integration programme. Engagement took place with Partners during October to December to review the proposals.

60. A further workshop was held on 22nd November to follow-up on actions and adjust/iterate the plan and the initial output was discussed at the Integration Executive at its meeting on 4th December.

61. 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

62. The Health and Wellbeing Board is asked to note the contents of the report, the good current performance across all four BCF metrics, and the positive progress made in transforming health and care pathways in 2018/19.

Circulation under the Local Issues Alert Procedure

None.

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Appendices

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

Relevant Impact Assessments

Equality and Human Rights Implications

63. 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.

64. 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.

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

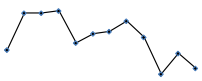
Partnership Working and associated issues

66. 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.

67. 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.

68. 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 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 November 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	40.67	611.4	G		Dood performance is represented by a fall in the figures	⇔	The RAD-rated data shows the 5ecember forecast for 2018/19, based on /tLLs. The ./C target for 18/19 is a maximum of 890 admissions. The current full year forecast is 872 admissions (or 611.4 per 100,000 population). terformance is RAD-rated green 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	90.2%	G		Dood performance is represented by a rise in the figures	⇔	Cor hospital discharges between Jul and Sep '18, 90.2% of people discharged from hospital into reablement / rehabilitation services were still at home after 91 days. This is above the 18/19 target of 87%. terformance is RAD-rated green and is statistically significantly better than the target.
METRIC 3: Delayed transfers of care from hospital per 100,000 population	236.49	n/a	194.63	G		Dood performance is represented by a fall in the figures	⇔	Ln bovember there were 1,058 days delayed, a rate of 194.63 per 100,000 population against a target of 236.49. This is RAD-rated as green and is statistically significantly better than the target. Cor the different attributable organisations (bIS, social care, and jointly attributable), 84.7% of these delays were attributable to the bIS, 4.6% attributable to Social /are and 10.7% Jointly attributable.
METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month	854.94	829.74	843.26	G		Dood performance is represented by a fall in the figures	⇔	Cor the period Apr-18 to bov-18 there have been 44,956 non-elective admissions, against a target of 46,665 – a variance of -1,709. This is RAD-rated as green. Curthermore, the forecast for the end of the 2018/19 financial year is that there could be 68,860 admissions, against a target of 70,569. This would be RAD-rated as green. Cor the month of bovember there has been 5,821 non elective admissions, against a target of 5,902 - a variance of -81. The monthly rate is 843.26 against a monthly target of 854.94 and this is RAD-rated green. The RAD methodology is green if non-elective admissions/rate is less than or equal to the monthly target, amber if non-elective admissions/rate is between the monthly target and monthly minimum, and red if non-elective admissions/rate is greater than the monthly minimum.

Appendix B - Better Care Fund Plan on a Page

Better Care Fund 2017/19 – Integrating health and care

www.healthandcareinleicestershire.co.uk

The Leicestershire BCF plan, developed by the county's Health and Wellbeing Board and Integration Executive, has a total pooled budget of £56 million provided by the council and NHS bodies. This is spent on developing and implementing plans for integrated health and care services, and to improve the quality and accessibility of services for people in local communities. The BCF plan includes specific funding allocated to councils to meet the increased pressures on Adult Social Care tackle delayed transfers of care and stabilise the local social care provider market.

Unified Prevention Offer

Prevention services for people and communities which support health, wellbeing and independence (accessed via First Contact Plus).

Home First

24/7 community care reducing delays in hospital discharge, preventing readmission and providing reablement.

Integrated Housing Support

Lightbulb

One integrated housing service for Leicestershire, which supports safety, independence and wellbeing at home.

Integrated Domiciliary Care

Help to Live at Home

Leicestershire's domiciliary care service providing help with day-to-day activities at home.

Integrated Locality Teams

GP services, community nursing and social care working hand-in-hand in each community to provide joint care and support.

Integrated Urgent Care

Clear, easy to access alternatives to A&E, with improved clinical triage and navigation.

Assistive Technology

Utilising opportunities presented by new technology to support people to live more independently.

Data Integration

Care Planning and Care Delivery supported by an integrated electronic summary care record, which can be accessed by different health and care professionals.

Integrated Commissioning

Improving joint infrastructure (between Local Authority and Clinical Commissioning Groups) in priorities such as integrated personal budgets, learning disabilities and domiciliary care.

Falls Prevention

Leading the implementation of the new falls prevention and treatment service across Leicester, Leicestershire and Rutland.

What improvements will we see?

- Reduce the number of permanent admissions to residential and nursing homes (to no more than 890 admissions) supporting people to stay in their homes for longer.
- Increase the number of service users still at home 91 days after reablement (to a minimum of 87%).
- Reduce the number of delayed bed days in hospital (no more than 7.88 delayed bed days per day per 100,000 population) by September 2018.
- Reduce the number of emergency admissions (no more than 850.34 admissions per 100,000 population).

Better care **together**

Leicester, Leicestershire and Rutland health & social care

Supporting Leicester, Leicestershire and Rutland's five year strategy to transform health and care.

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