Agenda Item 11

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 30 MAY 2019

REPORT OF DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND Q4 2018/19 PERFORMANCE

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, including assurance on the national quarterly reporting requirements for the BCF.

Recommendation

2. The Health and Wellbeing Board is asked to note the contents of the report, that the BCF achieved its target for all four BCF outcome metrics, and the positive progress made in transforming health and care pathways in 2018/19.

Policy Framework and Previous Decisions

3. 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.

4. The Board received the last BCF progress report at its meeting on 24th January 2019. An update on progress to refresh the BCF Plan for 2019/20 was reported to the Board at its meeting on 14th March 2019.

5. 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.

6. 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 set out the requirements for quarterly reporting along with the draft templates and analytical tools that are required to be used for this purpose.

Background

7. 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.

8. 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 Outturn for 2018/19

9. The budget for the BCF Plan in 2018/19 totals £55.9million. 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**

10. The actual outturn position for 2018/19 was for £55.8m, with the £196,000 underspend released back to the county Clinical Commissioning Groups (CCG) by agreement to off-set other system/ financial pressures through substituting suitable schemes into the BCF Plan. The expenditure plan included a £2m contingency and cost improvement allocation.

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

11. 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.

12. 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. By the end of March 2019, there was a total of 877 permanent admissions (or 615.0 per 100,000 population) into residential and nursing homes.

13. The target for the **proportion of older people who were still at home 91 days after discharge** has been set at 87% for 2018/19. The latest data, which relates to discharges between October and December 2018, showed that 87.7% of people discharged from hospital into reablement/rehabilitation services were still at home after 91 days. The target was achieved for 11 of the 12 months during 2018/19, with April only falling slightly under target.

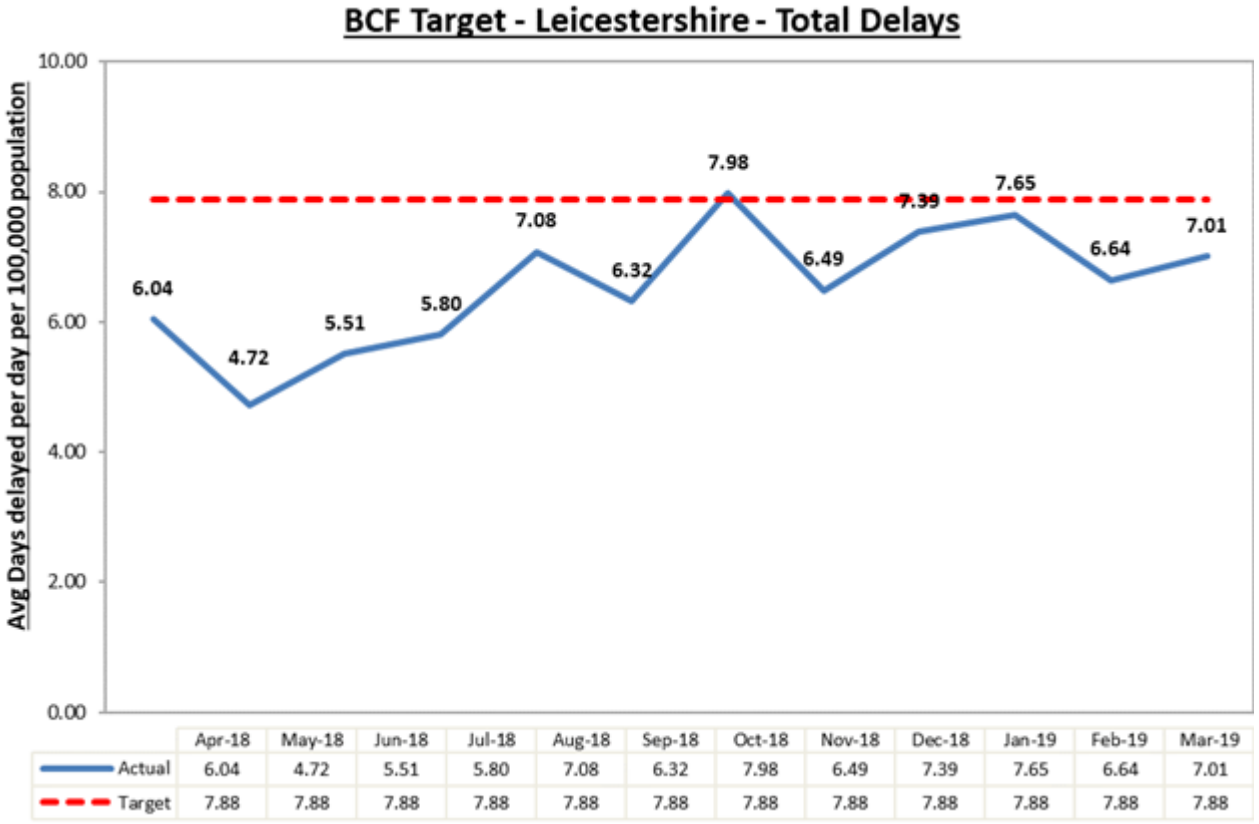
14. The BCF target for total **non-elective admissions into hospital (general and acute)** was set for up to 70,569 (or 850.34 per 100,000 population) for 2018/19. During 2018/19, there have been a total of 68,001 non-elective admissions, which is a variance of 2,568 admissions lower than the target.

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 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. Leicestershire achieved the monthly target for 11 of the 12 months, with October only being slightly over target.

17. The graph below highlights the performances 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	7.39	7.65	6.64	7.01
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

18. The following is a summary of current progress within the integration programme for Leicestershire.

Unified Prevention Offer

19. During 2018/19, 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 Leicestershire's social prescribing offer which includes First Contact Plus (a one-stop shop for a multitude of prevention services – via telephone and online) and face to face support via Local Area Coordinators.

20. One of the key programmes of work for the UPB is developing the wrap-around prevention offer to support Integrated Teams. This is a multi-disciplinary approach to delivering health care to patients who are in one of the three cohorts (frail, five or more long term conditions and high cost care needs – further information in para 23-26). The work of the UPB is helping 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.

Integrated Community Services Programme

21. The Integrated Community Services programme is developing the integrated health and social care offer across Leicester, Leicestershire and Rutland (LLR) by taking a home first approach.

Home First (Integrated Rehabilitation and Reablement)

22. Partners 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 commenced during 2018 and continues into 2019, aligned to the redesign of community nursing and therapy services. The integrated approach is 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.

23. Within Leicestershire, the pilot commenced in October 2018 and will run to the end of June 2019 before commencing roll-out through to February 2020. Work to evaluate the scheme is being undertaken during Q1 2019/20. Also, during Q1 2019/20, nursing and social care staff will be co-located into a decision unit to manage referrals and workload jointly into the team and through into its care pathways.

Integrated Teams

24. Twelve Integrated Teams were established across LLR to provide more coordinated and comprehensive multidisciplinary team 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.

25. The programme 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. 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 benefit of locality teams, and the wider population in each locality.

26. Currently three early implementer sites across LLR are setting up improved methods of multi-disciplinary working, so that care is planned, coordinated and delivered more effectively for patients, families, carers and the professionals supporting them.

27. For Leicestershire, the early implementer site is the Fosseway locality within Hinckley and Bosworth, who are setting up multi-disciplinary team working at a neighbourhood level, focusing on a practice population of 45,000 people. Care Coordinators were appointed by adapting the role of the existing Local Area

Coordinators; the pilot commenced in January. The evaluation of the three locality teams early implementer sites is underway and findings will be reported back during Q1 2019/20. Meanwhile, the redesign of community services will enable the commissioning health services in line with the building blocks of the LLR model.

Reducing Delayed Discharges

28. The LLR-wide Discharge Working Group has led on implementing the High Impact Change Model, which is a national self-assessment tool that tracks local achievement against eight categories of high impact changes which are evidenced on having the greatest impact on reducing delayed discharges. An action plan was developed for 2018/19 and progress monitored throughout the year.

29. Some of the key areas of progress and achievements for the current financial year are detailed below. These are the actions that have had the greatest impact either on collaborative working, system redesign or that have led to DTOC reductions.

30. Discharge to Assess (D2A) and Reablement: A comprehensive piece of work was undertaken to revise the D2A pathways, which included the consolidation of the previous D2A pathway. A multiagency workshop to define the new proposed two pathway model, taking in learning and best practice from other areas took place to help redefine pathways with partners.

31. A new bed based reablement service began on the 1st July 2018. Procurement of framework D2A beds began on 1st August with implementation in Q3 2018/19. A process is now in place to enable non-admission and base wards at Leicester Royal Infirmary to refer directly into Crisis Response Service/HART reablement services to support the Home First initiative. This has been reported as working well initially but further future evaluation will be required. It is hoped that this will reduce length of stay for patients as the process is now shorter.

32. The out of county D2A offer to be developed and implemented: connections with out of area providers have been established to improve flow of patients into D2A beds when coming from providers outside of LLR.

33. SAFER stranded patient review - a process to undertake the stranded patient review for those with a length of stay over six days, to resolve delays across University Hospitals Leicester (UHL) and Leicestershire Partnership trust (LPT). This is underway with Clinical Management Groups. UHL have implemented Long Stay Wednesdays and have made a real impact in reducing their stranded and super stranded patients. LPT have been looking at super-stranded and reducing these with appropriate care-planning. The action plan in place to reduce stranded and super-stranded saw a significant improvement in Q4 2018/19 against the trajectory.

34. Red2Green – Adult Mental Health: Red2Green has been rolled out onto two wards within the Bradgate Mental Health Unit. Fortnightly steering meetings develop the system with the ability to identify barriers and work to resolve them or escalate issues and roll-out to two further wards took place in March 2019.

35. Work is currently underway to finalise the Discharge Working Group action plan for 2019/20, which should be completed by the end of May 2019.

Falls Programme

36. The aim of the LLR falls programme, which has been led from the Leicestershire BCF, is to improve the treatment pathway for those identified as being at risk of falling or who have experienced a prior fall. The programme provides five core elements developed on the basis of NICE guidance and other evidence. These are: postural stability/falls prevention classes, therapy triage, non-conveyance to hospital/onward referral into community services for patients assessed on scene by East Midlands Ambulance Service (EMAS), falls prevention in care homes, and a range of new technology and equipment supporting assessment and treatment across the whole pathway including the EFRAT (electronic falls risk assessment tool) smart phone app/tool developed with EMAS. The technology aspects are being delivered in conjunction with East Midlands Academic Health Science Network with a view to evaluation and potential roll-out across the East Midlands.

37. The specialist therapy triage part of the pathway provides assessment for all referrals into consultant falls clinic and has proved highly successful in diverting consultant outpatient activity. During 2019/20, the final elements of the implementation/evaluation linked to CCG QIPP (savings) plans, upon which decisions will be made about transitioning to business as usual.

Integrated Housing Service - Lightbulb

38. Leicestershire's Lightbulb Service has both community-based and hospital-based components.

39. The hospital Housing Enablement Team, funded by the BCF plan, was created to work inside Leicester's acute hospitals and the Bradgate Mental Health Unit. Since April 2015, the service has helped in excess of 2,000 patients and, over time, demand for the service has risen. The team offers up to 28 different types of interventions to support patients in local hospitals, many of which relate not only to housing but also to other community support offers.

40. In the community-based Lightbulb Service there is also access to a full housing needs assessment with Lightbulb's housing support coordinators carrying out "housing MOTs" and acting as case managers to arrange solutions to the full range of housing support including aids and adaptions, tenancy and welfare advice, hoarding, house clearing and cleaning, furniture packs, affordable warmth, home safety and falls prevention. The Lightbulb service has won three accolades for innovation and partnership working.

41. The Lightbulb business case, a refresh for 2019/20, set out the outputs and outcomes achieved in year one of the service and the recurrent funding position for each partner. The business case has been approved for all eight Local Authority partners for a further three years, which commenced in April 2019. The recurrent funding for the hospital Housing Enablement Team element of the Lightbulb Service is subject to further decisions by CCGs during Q2 2019/20.

Assistive Technology (AT)

42. Currently in Leicestershire a telecare service is provided based on pendant alarms systems. Nearly 6,000 alarms are in place in homes across the county The BCF AT project is looking at how the service offer in Leicestershire can be enhanced by maximising opportunities offered by new technology. 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 AT.

43. The work has identified three priority areas – mental health, dementia and managing demand. A recent meeting of the pilot planning group mapped the current AT offer for people living with dementia and identified where there are opportunities for new technology to enhance this. The key objective for the pilot was agreed as helping people with dementia to stay at home for longer and three key priorities were identified:
    a. Being safe at home – including responding to falls for people who are not able to use a pendant alarm;
    b. Being safe outside the home – considering how GPS can be used for people who go missing;
    c. Increase participation in social or leisure activities – addressing loneliness and isolation.

Integrated Commissioning

44. Leicestershire County Council and the County CCGs put in place a workplan for joint commissioning during 2018/19 which included activities in support of priority areas such as domiciliary care, reablement, personal budgets and learning disabilities. The following provides a brief update on some of the areas of joint commissioning.

Domiciliary Care

45. Since November 2016, home care in the county has been delivered through the Help to Live at Home service. The service is commissioned jointly by the Council and two county CCGs with lead providers appointed to deliver home care services in each geographical area. The existing three-year framework contract expires in November 2019, with work undertaken during Q4 to extend this, using the initial plus one contract facility, through to November 2020. Work on how the future model of domiciliary care (post November 2020) will look in relation to current review work across health and social care partners currently underway.

Personal Health Budgets

46. The Leicestershire BCF proposed and led an LLR-wide workshop at the beginning of April 2019 to consider the future approach for personal health budgets and opportunities for integrated health budgets. The workshop reviewed the current position for all partners and considered joint working opportunities, including specific cohorts to work with, to optimise the integrated personal budgets offers. Outcomes of the workshop are being followed up during Q1 by a small working group who will scope and oversee delivery of the workplan.

Health and Social Care Protocol

47. Following a workshop in November 2018 to review the health and social care protocol and consider the strategic approach needed to the future content of the protocol and training model, further work has been undertaken to gauge market interest, skill and capacity for the training. One of the outputs of the work was to complete a more fundamental review of the protocol itself which will be undertaken in 2019 and align to the wider integrated community work.

Integrated Data

48. 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.

49. The LLR business intelligence (BI) strategy, developed by a multiagency group during 2018, was approved in Q3 and work on the delivery plan is now well underway. The strategy sets a framework for how organisations in LLR could work differently as BI partners in the health and care system and sets out the opportunity to join forces on a number of important priorities and investments, where it makes sense to do so.

50. The initial focus for implementation is developing and testing the new data integration warehousing tool with Midlands and Lancashire Commissioning Support Unit and progressing the population profiling workstream in conjunction with Public Health and the emerging Primary Care Networks. The next stage is to consolidate the workforce, analytics and tools workstream into one programme of work, which commenced during April 2019.

BCF Plan for 2019/20

51. The BCF Policy Framework for 2019/20 was published on 10th April 2019 but, at the time of writing this report, the BCF technical guidance and CCG minimum allocation into the BCF pooled budget is still awaited.

52. Work to review the BCF Plan for 2019/20 in line with annual financial planning arrangements for CCGs and Leicestershire County Council commenced in September 2018. A report that summarised progress to update the BCF plan was provided to the Health and Wellbeing Board at its meeting on 14th March. The BCF expenditure plan has been reviewed by Partners and agreed, subject to the technical guidance being published. Following the publication of the technical guidance, the work that has been completed to date will be reviewed and submitted back through the appropriate governance route for final approval.

Circulation under the Local Issues Alert Procedure

None.

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Appendix

Appendix – BCF Metrics as at March 2019

Relevant Impact Assessments

Equality and Human Rights Implications

53. 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.

54. 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.

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

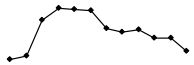
Partnership Working and associated issues

56. 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.

57. 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.

58. 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 – Better Care Fund Metrics as at March 2019

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	51.9	615.0	G		Good performance is represented by a fall in the figures	⇔	The RAG-rated data shows the year end actuals for 2018/19, based on CPLIs. The BCF target for 18/19 is a maximum of 890 admissions. The current actual position is 877 admissions (or 615 per 100,000 population), please note this position will increase with any late recordings. Performance is RAG-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	87.7%	G		Good performance is represented by a rise in the figures	⇔	For hospital discharges between Oct and Dec '18, 87.7% 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%. Performance is RAG-rated green and is statistically similar to the target.
METRIC 3: Delayed transfers of care from hospital per 100,000 population	244.38	n/a	217.44	G		Good performance is represented by a fall in the figures	⇔	In March there were 1,182 days delayed, a rate of 217.44 per 100,000 population against a target of 244.38. This is RAG-rated as green and is statistically better than the target. For the different attributable organisations (NHS, social care, and jointly attributable), 78% of these delays were attributable to the NHS, 17% attributable to Social Care and 5% Jointly attributable.
METRIC 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month	868.67	819.4	856.49	G		Good performance is represented by a fall in the figures	⇔	For the period Apr-18 to Mar-19 there have been 68,001 non-elective admissions, against a target of 70,569 – a variance of -2,568. This is RAG-rated as green. For the month of March there has been 5,956 non elective admissions, against a target of 6,041 - a variance of -85. The monthly rate is 856.49 against a monthly target of 868.67 and this is RAG-rated green. The RAG 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.