Meeting: Adult Social Care, Health and Wellbeing Sub-Committee of the Overview and Scrutiny Committee

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Title: Better Care Fund update

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Service: *Health, Education, Care & Safeguarding*

Wards affected: *ALL*

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1. Background / introduction /context

This report informs the sub-committe on the delivery of the Better Care Fund (BCF) Plan covering the period 2078/18 and 2018/19, the progress towards metrics; the policy background concerning the BCF in 2020/21 and beyond; and the implementation of a review of the North Tyneside BCF.

2. Introduction

A report to the sub-committee in January 2019 summarised the findings of a North Tyneside BCF Review and outlined progress towards metrics. At that stage the publication of the national BCF Policy Framework was awaited. That framework was published in April 2019; this report outlines the content of the Policy Framework.

3. Key points

3.1 The Policy Framework for 2019-20

The BCF Policy Framework for 2019-20[1] was published on 10th April 2019 by the Department of Health and Social Care and the Ministry of Housing, Communities, and Local Government.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/795314/Better_Care_Fund_2019-20_Policy_Framework.pdf

The Framework notes:

> "The Government is committed to the aim of person-centred integrated care, with health, social care, housing and other public services working seamlessly together to provide better care. This type of integrated care is the key to strong, sustainable local health and care systems which prevent ill-health (where possible) and the need for care, and avoid unnecessary hospital admissions. It also ensures that people receive high-quality care and support in the community. For people who need both health and social care services, this means only having to tell their story once and getting a clear and comprehensive assessment of all their needs with plans put in place to support them. This means they get the right care, in the right place, at the right time." (para 1.1)

> The NHS Long Term Plan outlines objectives for joined-up care across the system with commitments to increased investment in primary medical and community health services to support new service models including an urgent response standard for urgent community support; integrated multi-disciplinary teams; NHS support to people living in care homes; the NHS Personalised Care model; an integration index; reducing Delayed Transfers of Care; and supporting local approaches to blend health and social care budgets, amongst other initiatives (para 1.6)

> The forthcoming Adult Social Care Green Paper will also build on the approach to joined-up, person-centred integrated care (para 1.7)

2019-20, the report states, is to be a year of minimal change for the BCF.

- The national conditions for the fund are unchanged
- BCF plans should be signed off by Health and Wellbeing Boards
- CCGs will continue to be required to pool a mandated minimum amount of funding
- Local Authorities will be required to pool grant funding from the Improved Better Care Fund and the Disabled Facilities Grant.
- The Improved Better Care Fund, as in previous years, can be used only to meet adult social care needs; reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and to ensure that the local social care provider market is supported.
- Local Authorities will be required to pool Winter Pressures funding in the BCF in 2019/20.
- Winter Pressures funding will be paid to local authorities, with an attached set of conditions, requiring the funding to be used to alleviate pressures on the NHS over winter, and to ensure it is pooled into the BCF. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

Ministers are holding a review of the BCF. Any major changes arising from that review will take place from 2020 onwards.

Further information on the timetable practical arrangements for plan submission and monitoring are expected to be set out in BCF Planning Requirements, the publication of which are awaited.

National Conditions

The four national conditions will continue to be:

i. Plans to be jointly agreed
ii. NHS contribution to adult social care to be maintained in line with the uplift to the CGG minimum contribution
iii. Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care.
iv. Managing transfers of care: A clear plan for improved integrated services at the interface between health and social care that reduces DTOCs, encompassing the High Impact Change Model[2]. All Health and Wellbeing Boards are expected to adopt the centrally-set expectations for reducing or maintaining rates of DTOC.

National Metrics

The four national metrics will continue to be:

i. Delayed transfers of care
ii. Non-elective admissions (general and acute)
iii. Admissions to residential and care homes
iv. Effectiveness of reablement

3.2 Progress against national metrics

3.2.1 Delayed transfers of care

The national ambition for DTOCs, for 2018-19, was to achieve a rate no higher than 7.6 beds per day per 100,000 population aged 65+ to be occupied by delayed patients.

The rate achieved in North Tyneside was 5.9, therefore the national ambition was achieved.

The rate achieved in England was 10.6, well above the North Tyneside rate.

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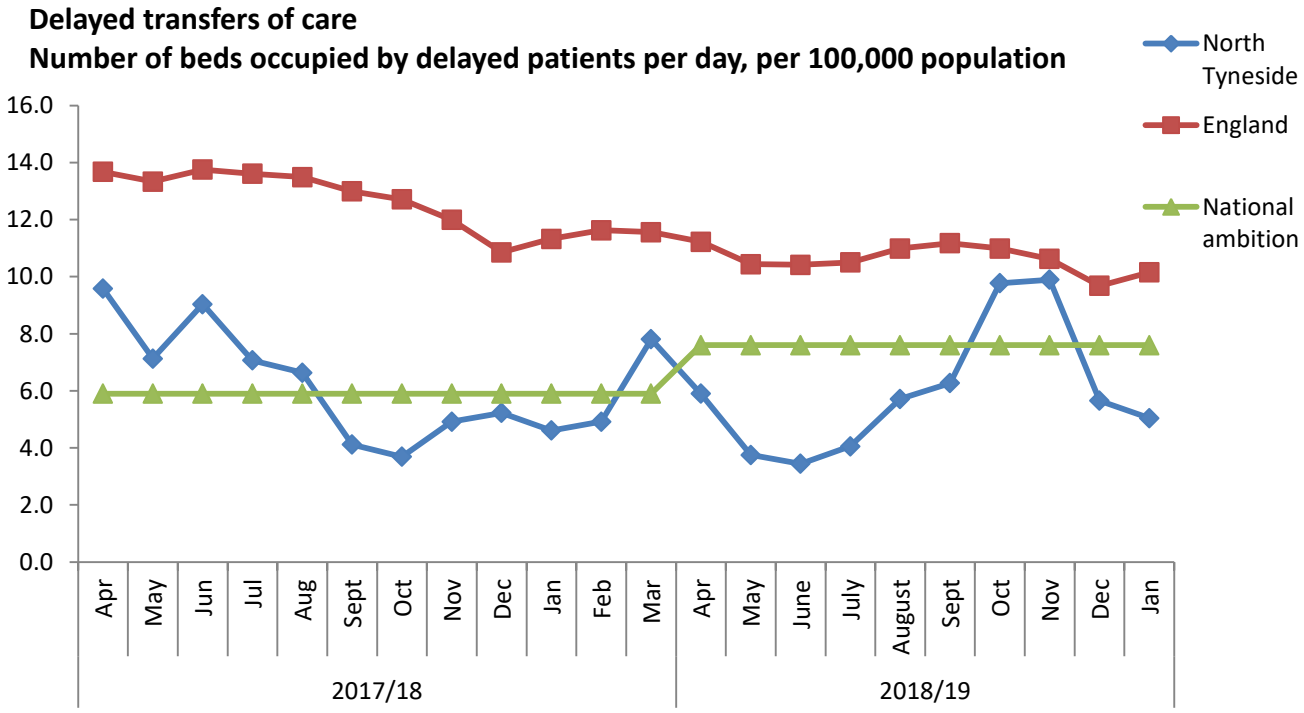

Figure 1

Figure 1 above shows that:

- The rate of delays in North Tyneside has been well below the England rate throughout 2017/18 and most of 2018/19.
- Since September 2018, the North Tyneside rate of delays has been below the national ambition on 14 out of 17 months, the exceptions being March, October, and November 2018.
- The England rate started at a higher level than North Tyneside, and has fallen faster than North Tyneside.

3.2.2 Non-elective admissions

The volume of non-elective admissions has been above the BCF trajectory, by 2.2%, from April 2-18-February 2019.

It is worth noting that the national metric does not include ambulatory care attendances, and therefore does not reflect the total volume, or cost, of demand.

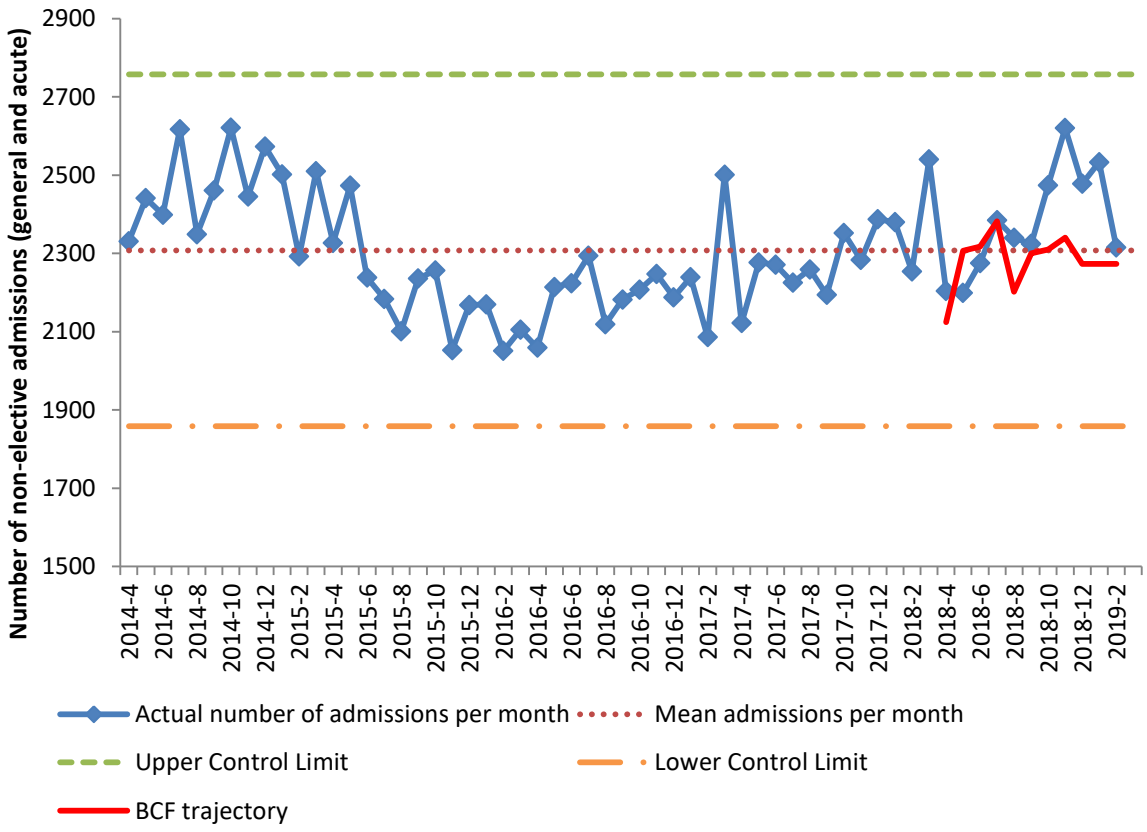

Figure 2

3.2.3 Admissions to residential and care homes

The number of permanent admissions to residential care was within the target for 2018/19 and considerably lower than the previous year:

2017/18 - 362 against a target of 300

2018/19 - 274 against a target of 300

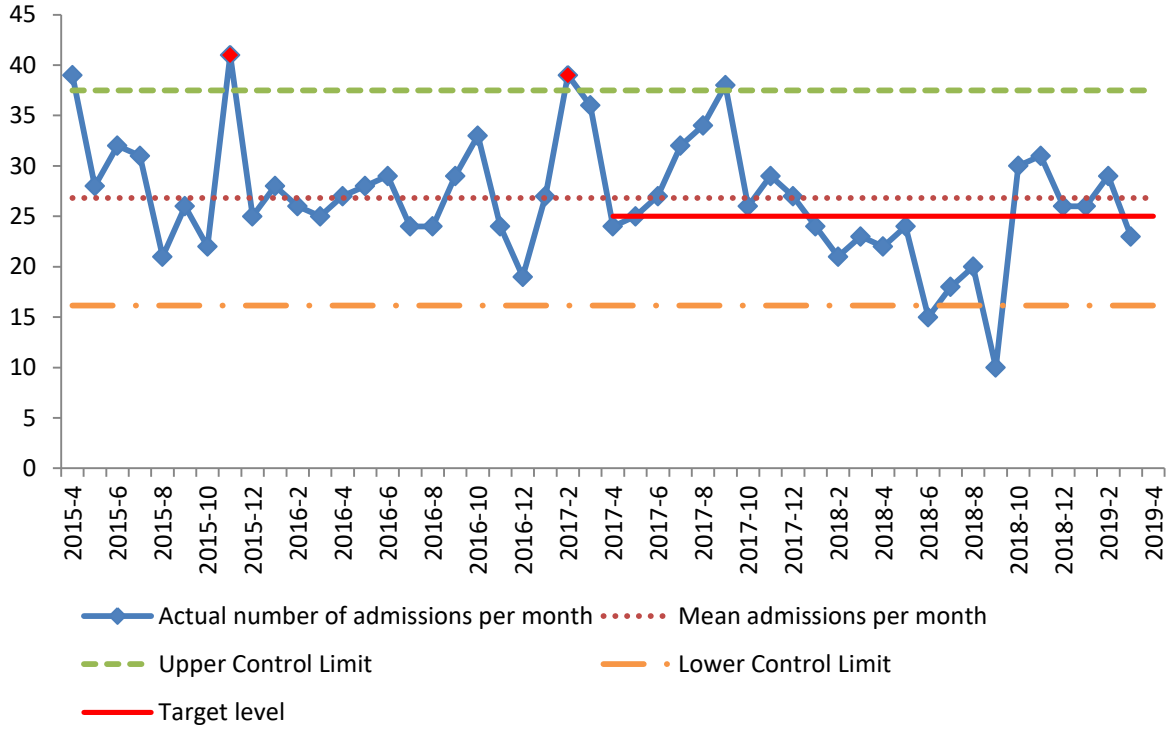

Figure 3

3.2.4 Effectiveness of reablement

The measure of the effectiveness of reablement is the proportion of people aged 65+ who were still at home 91 days after discharge from hospital into reablement or rehabilitation services.

The target for the number of patients at home 91 days after discharge from hospital to reablement is 93.1%.

From April-December 2018 the level of achievement was 94.5%, in excess of target. The latest date for England is for 2017-18 and showed a national achievement of 82%.

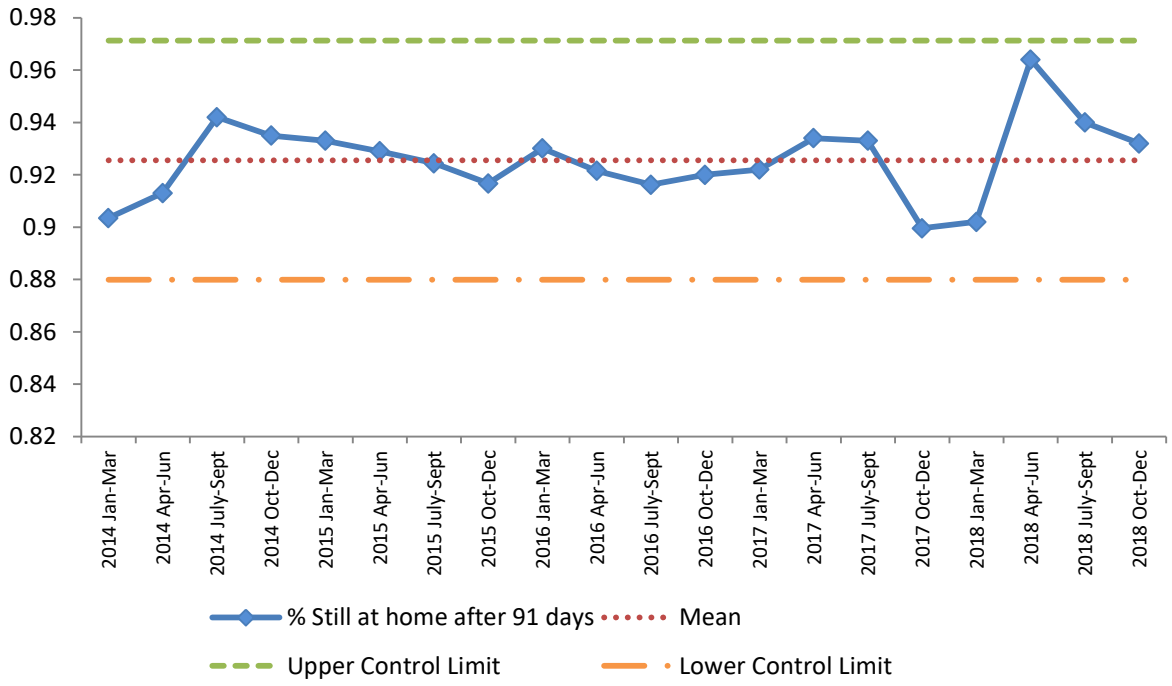

Figure 4

3.3 Review of BCF services

A report to the sub-committee on 10th January 2019 noted that "the North Tyneside BCF plan identified that the CCG and the Authority will work in collaboration to review and rebase existing schemes within the BCF document, ensuring value for money and positive quality outcomes, identifying opportunities to include (where appropriate) system and service changes, working within the current financial envelope. Any changes to services provided will take effect from April 2018 for 2018/19, or later as agreed between the two organisations. Any changes must ensure that the North Tyneside BCF plan continues to comply with the BCF national requirements. Both organisations will work together to ensure that the residents of North Tyneside get the best return for investment in the BCF.

Accordingly, a review of BCF schemes was carried out and considered by the BCF Partnership Board. For each scheme, the BCF Partnership Board considered:

i. Does the scheme improve or maintain health or social care outcomes?
ii. Does the scheme contribute to sustainability of the health and/or social care systems longer term (e.g. QIPP)?
iii. Does it significantly improve people's outcomes and experience?
iv. Is there evidence to support delivery of the intended activity
v. Is the proposal aligned with CCG/ Council Strategic or Local Objectives and can it be delivered within timescales?
vi. Is the scheme still viable?

Some findings are specific to one scheme but there are some general points which apply to the BCF as a whole.

Some, but not all, schemes had robust methods for reporting service user experience. For example the reablement service reports outcomes using EQ5D, a well validated tool which is widely used internationally and can be used in many different settings. It is possible that some schemes are collecting some form of service user experience data but do not report that data through BCF routes.

It was recommended that all schemes funded through the BCF should, where possible, implement and report a service user experience measure which is relevant to their service.

*C*urrently our understanding of the ways in which service users move between services is often limited by the available information. Episodes of acute hospital care are recorded at the level of individual episodes including NHS number, so that it is possible for commissioners to obtain pseudonymised[2] views of all the acute episodes for a person. However community health services data is either not recorded in the same way, or even if it is recorded is not made available to commissioners. Social care data is recorded in detail; within the last 12 months a new case management system has been implemented and most records include NHS number.

Technically, we now have the capability to link records between social care and health data; however progress in this regard has been hampered in recent years by national regulations regarding data linkage.

It was recommended that the BCF Partnership Board, should pursue linkages between health and social care data, as far as possible within legal constraints, to gain a better understanding of how BCF services can be further optimised.

Following the review, work is underway to consider how the work of services related to the frail elderly population work together most effectively. This particularly relates to Carepoint, CarePlus, and Intermediate Care and is being progressed via the community frailty work ongoing with partners.

There were also recommendations relating to individual schemes, and work is ongoing on those schemes via the relevant lead organisation with input from partners as appropriate.

One area to note is the scheme review which was entitled Care Act implementation. The review demonstrated that there were activities in place which are in keeping with the requirements of the Care Act, for example in relation to support for carers and the provision of advice and information. These activities were also referenced in other BCF schemes and it is not possible to quantify the exact health or social care benefits delivered by this scheme, over and above other schemes.

However the BCF Planning Framework for 2017-19 stipulates the amount that must be included in the BCF for this purpose. If future national guidance for the BCF in 2019/20 and beyond continues to include a mandated contribution, then the BCF Partnership Board should consider allocating the investment in a way which makes a clear and unique contribution not already covered by other schemes.

Another recommendation was that a feasibility study be undertaken for the implementation of a pooled budget for clients with a learning disability. The study would help organisations to understand if this would lower the transactions costs associated with current methods of commissioning services for this client group.

4. Implementation plan/next steps

5.1 Implementation of the BCF review

Following further consideration within the CCG and North Tyneside Council, implementation of the review is under way. The implementation work is, for some strands, managed by bodies other than the BCF Partnership Board, e.g. the Future Care Programme Board.

Recommendation	Progress
Reporting service user experience	The BCF Partnership Board will prepare a paper explaining the use of EQ5D in the reablement service, and considering the relevance of similar approaches to other BCF services.
Understanding user journeys across health services and between health and social care.	North Tyneside Council has begun to establish a process for extracting data on the use of social care services, which has the potential to be matched to healthcare data, subject to information governance approval, to establish patterns of service use across boundaries. Discussions are also under way with Northumbria Healthcare with a view to echanging information on social care service users who are admitted to hospital.
Care Plus	See the actions under “Care Point” below
Enhanced Healthcare in Care Homes	Three of the four localities have implemented new services for enhanced healthcare in care homes; the fourth is currently recruiting the staff required to allow service commencement.
Care Act implementation	The NTC Stategic Commissioning Manger will bring forward proposals to the BCF Partnership Board for the refocusing of BCF funds associated with Care Act implementation.
Intermediate Care	The CCG have commissioned new intermediate care beds from Northumbria Healthcare. The beds would be provided at Howdon Care Centre under a sub-contract arrangement and were expected to be coming on stream at the end of May.
Independent Supported Living (ISL) for people with Learning Disabilities	NTC and CCG commissioning managers are meeting to explore the potential scope of a pooled budget. They will contact South Tyneside and Northumberland, who already have such pooled budgets, to learn from their experience.

Care Point	This recommendation is being taken forward through the Integrated Neighbourhood Care Clinical Pathways for Frailty workstream, reporting to the Future Care Programme Board.
	
	It is based upon a strategy which aims to :
	
	• Create a single point of access to coordinate the delivery of care for frail elderly patients
	• Ensure that patients receive this care in their homes or in the community wherever possible
	• Create an integrated service that makes the best use of the resources available.
	
	The initial work areas have been identified as follows.
	
	Single Point of Access
	
	• Care Point becomes a genuine single point of access for all referrals into community frailty services.
	• It has the capability and authority to assess patient needs and deploy the resources of the community-based frailty teams accordingly, managing capacity and demand across the system. It also has the capacity to step patients up or down to intermediate care beds as required.
	• It also interacts with hospital-based teams to coordinate the deployment of community-based frailty teams to support discharge for North Tyneside residents from Newcastle and Northumbria on an equitable basis.
	
	Integrated Community Frailty Service
	
	• The resources which currently sit within the following teams can be deployed by Care Point in order to prevent deterioration / admission and facilitate discharge:
	  • Care Point 'Front of House' teams
	  • Care Plus
	  • Jubilee Day Hospital
	  • Community Falls Clinic (eventually)
	• The team will be responsible for providing MDT-based assessment, diagnosis and management of frail elderly patients with the aim of enabling self-management, preventing further deterioration, avoiding admission and facilitating discharge.
	• The Integrated Community Frailty Team will be aligned to Primary Care Home North Tyneside, ensuring that practices / community nursing teams have a consistent point of contact for help and advice.

	Single assessment and care planning process across North Tyneside • Patients will receive a single geriatric assessment and care plan and will be assigned a named coordinator who will be responsible for coordinating their care and facilitating admission / handover / discharge. Intermediate Care • Creation of step-up community bed capacity to support the admissions avoidance and discharge to assess functions of the SPA. • Strengthening the role of the peripatetic service. • Consideration of how the functions currently provided by Ward 23 at North Tyneside General Hospital could be provided in a community setting.

5.2 Preparing a BCF Plan for 2019/20

5.2.1 It is not yet possible to prepare a BCF Plan for consideration by the Health and Wellbeing Board, because the Government departments have not yet published the detailed planning requirements, which in previous years have set out the format of the submission, and the process and timescale for submitting plans and receiving approval of those plans.

5.2.2 In the absence of the detailed BCF Planning Requirements, and taking into account the statements of minimal change contained in the BCF Policy Framework, the BCF Partnership Board agreed to roll forward the BCF services funded in 2018-19, whilst continuing the implementation of the BCF Service Review.

6. Recommendations

7.

The Board is asked to note:

6.1 The good performance in 2018-19 against the national BCF metrics for Delayed Transfers of Care, Admissions to Residential care, and Effectiveness of Reablement.

6.3 That completion of a BCF Plan for 2019-20 cannot yet be carried out, ending publication of national guidance

Appendices and further information

8. Appendices

None

9. Further information relevant to the report

2019-20 Better Care Fund: Policy Framework - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/795314/Better_Care_Fund_2019-20_Policy_Framework.pdf

The High Impact Change Model for reducing delayed transfers - https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model