NHS
North Lincolnshire
Clinical Commissioning Group

Date:	11 August 2016
Meeting:	CCG Governing Body
Item Number:	7.2
Public/Private:	Public ☒ Private ☐

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Report Title:
Better Care Fund: 2015-16 Update and 2016-17 Plan Progress
Decisions to be made:
To note

Continue to improve the quality of services	☒	**Improve patient experience**	☒
Reduced unwarranted variations in services	☒	**Reduce the inequalities gap in North Lincolnshire**	☐
Deliver the best outcomes for every patient	☒	**Statutory/Regulatory**	☐

Executive Summary (Question, Options, Recommendations):
This paper, previously reported to the Health and Well-Being Board sets out the national deliverables for the Better Care Fund, the services invested in during 2015/16 and a range of proposals for implementation in 2016/17. New proposals will be subject to business case approval.

Equality Impact	Yes ☐ No ☒	
Sustainability	Yes ☐ No ☒	
Risk	Yes ☐ No ☒	
Legal	Yes ☐ No ☒	
Finance	Yes ☒ No ☐	All expenditure will be in line with BCF finance plan

Patient, Public, Clinical and Stakeholder Engagement to date									
	N/A	***Y***	***N***	***Date***		***N/A***	***Y***	***N***	***Date***
Patient:	☐	☒	☐	Engagement on elements through a range of opportunities and events e.g. Health Matters	**Clinical:**	☐	☒	☐	Staff engagement through a range of meetings and events
Public:	☐	☒	☐		**Other:**	☐	☒	☐	

Report of the
Chief Officer North Lincolnshire CCG and
Director of People North Lincolnshire Council

Agenda Item No: 10
Meeting: 1 July 2016

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

BETTER CARE FUND: 2015-16 UPDATE AND 2016-17 PLAN PROGRESS

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 To inform the Health and Wellbeing Board of the key deliverables and implementation against the Better Care Fund plan 2015-16.

1.2 To provide an update on the assurance of the Better Care Fund plan 2016-17.

1.3 To confirm the final BCF plan for 2016-17 that was submitted on 30th June 2016.

2. BACKGROUND INFORMATION

2.1 As part of the ongoing monitoring of local Better Care Fund plan, quarterly performance and progress returns have been made to NHSE. This report provides a summary of the final position for 2015-16 BCF plan and presents the revised plan which has been submitted for 2016-17 (Appendix 1).

2.2 Better Care Fund was intended to be a catalyst for transformation towards health and social care being better integrated to improve the quality, experience and outcomes of people. In North Lincolnshire, the BCF pooled budget of £12.37m has enabled the development of new services that are responsive to people's needs, aimed at maintaining and regaining independence for as long as possible. The Better Care Fund Schemes and performance measures are detailed in Appendix 2.

2.3 The North Lincolnshire Better Care Fund (BCF) 2016-17 plan and supporting data templates were submitted to National Health Service England (NHSE) on 29th April 2016, in accordance with the Health and Wellbeing Board (HWBB) report agreed at the meeting of the 22nd March 2016. This plan has been reviewed as part of the NHSE assurance process and was 'approved with support'.

2.4 Health and Wellbeing Board areas must submit revised plans by 30th June 2016. The North Lincolnshire Plan will be circulated for consideration by the board at the 1st July meeting.

2.5 The national deliverables required by NHSE remain the same as for 2015-16:

- Reduced non-elective admissions
- A reduction in permanent admission to residential and nursing care homes
- An increase in the effectiveness of Reablement and rehabilitation
- A reduction in delayed transfer of care from hospital
- Improved service user experience

North Lincolnshire's BCF plan sets out the local performance targets and includes a local metric of reduced length of stay (in hospital).

2.6 The National Conditions that BCF plans are required to meet remain broadly the same, with one new area for national focus, which is Delayed Transfers of Care. Whilst, this was one of the performance metrics in 2015-16, the revised National Conditions require local areas to have a clear action plan in respect of improving Delayed Transfers of Care.

2.7 The Better Care Fund expenditure plans include funding for existing health and social care integrated services such as Intermediate Care and Re-ablement and Disabled Facilities Grants. New schemes implemented as part of the development of our Better Care Fund from 2014-15 and 2015-16, continuing in 2016-17 BCF include:

- Hospital based Social Work Team – the local authority established a new team of social worker based at the hospital, providing support to discharge planning for people 7 days a week. This service has been in place for almost 2 years and the joint approach contributes to managing and supporting the safe discharge of people from hospital back into the community.
- Community Wellbeing Hubs – the plan identified that there would be 5 hubs established providing a focal point for a network of preventative activities across localities to support people remaining healthy, well and independent for longer. This model and focus on prevention was identified as good practice by a recent NHSE Insight team in building community capacity.
- Frail Elderly Assessment Team – Northern Lincolnshire and Goole Foundation Trust have been commissioned to provide a multidisciplinary specialist assessment, investigation and treatment service for frail older people. It is a chair based unit at the hospital and care plans aim to return individuals back home within 72 hours. The team has been in place since October 2015.
- Rapid Assessment Time Limited Service - Northern Lincolnshire and Goole Foundation Trust have been commissioned to provide and alternative provision of care in the home for people who may have otherwise had an attendance or admission to hospital. The service works closely with GP Practices and has provided an

overnight service since November 2015.

- Locality Teams – investment has enabled the enhancement of existing community services, with new locality coordinator roles recruited, 7 day working for therapies, community equipment, social work assessment and additional Macmillan Nurses. The Locality Team model will be further enhanced through the establishment of Care Networks, with G.P's involved in care co-ordination and care planning.

The 2016-17 plan describes new developments and proposals for implementing during 2016-17. These include:

- Discharge to Assess. In order to improve patient experience and further reduce length of stay in hospital plans to implement assessment of need being undertaken within the right community setting are included within the BCF plan.
- Care Home Support. Care homes transfer 4 residents a day to A&E for assessment. 50% are admitted. The new Care Networks will be seeking to improve advance care planning, end of life care and proactive health management of residents in care settings. This will be enhanced by the learning from the Care Home Vanguard sites in other areas.
- Falls service. Building on the learning and success of other areas, the fire service and ambulance service are developing a business case to improve the response times to non-urgent falls and also developing an education / prevention package for care homes and the well-being hubs to reduce the causes for falls

2.8 Better Care Fund plans for 2016-17 are an integral part of the whole system transformation as set out in the sustainability transformation plans and the NHSE Five Year Forward ambition for full integration by 2020. The provision of out of hospital care in North Lincolnshire will be delivered through a new Accountable Care Partnership which will enhance the integration of services across the local authority, RDASH, NLAG and Safecare (North Lincolnshire G.P. Federation) building on the Care Networks, incorporating Better Care Fund schemes and other services that will enhance people's needs being met earlier and closer to home.

3. OPTIONS FOR CONSIDERATION

3.1 To note the progress against the 2015-16 and implementation to date, including key deliverables.

3.2 To confirm the revised BCF plan 2016-17 and performance metrics.

4. ANALYSIS OF OPTIONS

4.1 The report provides the quarterly monitoring information to the HWBB as required. Key points from the 2015-16 quarter 4 return to NHSE are:

- The vast majority of the national conditions were met by the end of the financial year, with the requirement to have an accountable professional in place for the most vulnerable. Plans are being implemented to extend this further as part of the Care Networks
- On track to meet the target set for reducing the length of stay in hospital for over 65 year olds.
- On track to exceed the target for the effectiveness of reablement.
- There was no improvement in the performance metric of non-elective admissions to hospital in quarter 4.

4.2 Quarter 4 reporting to NHSE was submitted as required on the 27th May 2016 and is also contained in this report for information.

4.3 The 2016-17 BCF key deliverables are outlined in Appendix 1. The 2016-17 BCF new conditions to note as follows:

- The NHS require that a proportion of the BCF allocation will be subject to a new condition around NHS commissioned out of hospital (the current arrangements and schemes include out of hospital services commissioned by the CCG, which meets this requirement).
- Agreement on a local action plan to reduce delayed transfer of care (DTOC) - This is not a priority area for North Lincolnshire as we perform relatively well compared to national benchmarks, therefore, the local will focus how patients' needs can be met more efficiently during their treatment journey in hospital and those areas that we know we can have a further impact on, including choice and care package availability

4.4 Following the NHSE assurance outcome feedback, a further iteration of the plan had to be submitted to NHSE by June 30th 2016. NHSE identified the following areas requiring further detail in the plan narrative: an update on the contract position between the CCG and NLaG NHS FT and the mechanisms in place to manage any risk against key deliverables via the contract. They also expect to receive the Delayed Transfers of Care action plan which was not finalised prior to the last submission. It was also suggested that the format and layout of the plan be reviewed to assist in the ability to identify the NHSE assurance requirements.

5. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY, IT)

5.1 The BCF allocation is a ring fenced allocation to the CCG and the Council for the creation of a pooled budget of £12.37m for 2015/16 and £12.693m for 2016/17.

5.2 As part of the new planning guidance for 2016/17 there is an identified amount of £3.106m for CCG commissioning of out of hospital care services and risk share.

6. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

6.1 Consideration will be given to diversity issues as part of the development of service specifications and associated commissioning activity and impact assessments undertaken as necessary to ensure that service users are treated fairly.

7. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

7.1 None

8. RECOMMENDATIONS

8.1 Health and Wellbeing Board are asked to note the progress against the BCF Plan 2015-16 and its implementation arrangements and key deliverables.

8.2 Health and Wellbeing Board confirm the final BCF Plan 2016-17 has been submitted to NHSE.

CHIEF OFFICER NLCCG AND DIRECTOR OF PEOPLE NLC
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Date: June 2016

Background Papers used in the preparation of this report:

Reports to Health and Wellbeing Board –December 2014, March 2015, November 2015, March 2016

Appendix 1

Better Care Fund Plan and Template 2016/17 (To be circulated following final submission)

Appendix 2

1.0 - Metrics

Quarter 4 reported position – 2015-16 Outturn

Metric	Q4 Plan	Q4 Actual	Full Year Performance RAG
Non Elective Admissions to Hospital (per 100,000 population)	2375.2	3121.6	Length of stay has reduced since the full implementation of the BCF schemes, however further work is required to understand the increase in non-elective demand in certain specialties.
Permanent Admissions to Residential and Nursing Care (Over 65 year olds per 100,000 population)	524.5	587.4	The 2015-16 year-end the outturn was 587.4 which relates to 196 new admissions within the year. The service has experienced a 20% increase in activity from the hospital. Reducing the length of stay within hospital has increased the hospital capacity. The average age of people being admitted this year is 86 years and the primary reason for people being admitted to care is loss of physical functioning and needs associated with memory and cognition.
Delayed Transfer of Care from Hospital (delayed days per 100,000 population)All	514.2	650.3	The total number of delayed days during 2015/16 was 3469 which was 529 more than planned.
Effectiveness of Reablement (% of people still at home after discharge from hospital to reablement)	90.6	93.7	This indicator is above target and exceeds the latest known England, regional and comparator group outturns.
Patient survey (GP Patient Survey Q39 – does your GP or health professional review your care plan with you regularly) %	65%	56.14%	Survey captured in July and January. Q4 actual is the January 2016 result..
Average length of stay in hospital for over 65 year olds (days)	7.1	7.7	The 2015-16 outturn was 7.7 which is a reduction from 8.3 the previous year.

2016-17 Performance Targets

Metric	2016-17
Non Elective Admissions to Hospital (per 100,000 population)	10.93% reduction (1,969 less than 2015-16)
Permanent Admissions to Residential and Nursing Care (Over 65 year olds per 100,000 population)	512.2 (180 new admissions)
Delayed Transfer of Care from Hospital (delayed days per 100,000 population) All	2.5% reduction (87 people or 1.5 patients per week)
Effectiveness of Reablement (% of people still at home after discharge from hospital to reablement)	91.7%
Patient survey (GP Patient Survey Q39 – does your GP or health professional review your care plan with you regularly) %	65%
Average length of stay in hospital for over 65 year olds (days)	7 days

2.0 - BCF Local Schemes

The Better Care funding has been used to create, and further enhance the following services:

2.1 Seven Day Hospital Social Workers – (North Lincolnshire Council)

- The hospital team, based at Scunthorpe General Hospital (SGH), have been in operation since November 2014 operates 8am to 8pm , 7 days a week.
- The team have already developed good working relationships with the discharge liaison team within the hospital. This new joint approach helps to manage and support the safe discharge of people from hospital back into the community.
- Hospital 'board rounds' are now attended by the team, each day supporting safe hospital discharge.

2.2 Frail Elderly Assessment Service Team (FEAST) – (Northern Lincolnshire and Goole Foundation Trust)

- This new team was developed to support individuals assessed as being frail and elderly. These patients benefit from a comprehensive geriatric assessment and plan of ongoing care by the newly funded specialist team.
- The patient may then spend time being assessed in a new 'chair based' unit with a plan to discharge on the same day or be admitted within a designated bed base with an aim to return home within 72 hours.

- The new team consists of a consultant geriatrician, therapists, advanced nurse practitioners, health care support workers.
- The new team, working with existing wards teams including 7 day social workers and older people mental health services also works closely with community services and GPs to ensure appropriate care and support when they go home.
- All key posts have been appointed to and the newly refurbished chair based area is also in use. The service was fully launched, as planned, on October 1st.

2.3 Locality Teams – (Northern Lincolnshire and Goole Foundation Trust/North Lincolnshire Council)

- This BCF project enhances existing community services and is part of the out of hospital programme within the BCF and aligns to the wellbeing offer.
- The aim of the scheme is to manage and support patients closer to their home, by a workforce that know their local area better and are able to provide treatment, advice and signposting locally.
- The new locality co-ordinator posts have been recruited to, and have recently commenced in post.
- The scheme also supported 7 day working for therapies, which started at the end of July 2015.
- To support better end of life care closer to home additional Macmillan nurses have been funded through the BCF, working 7 days a week.
- The community equipment service has also been extended on an interim basis to 6 day working with 1 day on call since July 2015.

2.4 Older Peoples Mental Health Services (OPMH) – (Rotherham, Doncaster and South Humber Foundation Trust)

- The OPMH service, initially a pilot last winter, aims to rapidly assess older people admitted to hospital who have been perceived to have a mental health problem such as dementia or depression.
- The service will also provide ongoing support, education and advise to those with mental health problems and their carer's.
- The pilot was successful and a full team, including a nurse consultant, therapists and support workers And nurses working in Scunthorpe Hospital have been in place since January 2016.

2.5 Community Wellbeing Hubs – (North Lincolnshire Council)

- The 5 wellbeing hubs outlined in the BCF plan are all fully operational in Scunthorpe, Brigg, Epworth, Barton and Winterton. In addition further satellite hubs in Broughton and Crowle have been developed by the council.

- The hubs that have been refurbished are dementia friendly environments and changing places type toilets (2 are fully compliant).
- In order to target individuals requiring additional support, the hubs operate a registration scheme. The Hub teams are currently providing targeted interventions on a 1:1 basis G.P. practices are now signposting people to the wellbeing hub for advice, support, engagement in activity and access to a wellbeing conversation aimed at identifying an indiviual's wellbeing need. There have been 5,500 newsletters distributed across the community outlining the support and activity available at the hubs.
- Identification of the most vulnerable communities and people within those communities is done through the use of profiling data and partnership working.
- The hubs are actively working with the hospital team to create support links for service users admitted to hospital to help at discharge, and are also looking at ways to work differently with the intermediate care service at Sir John Mason House.
- The service is piloting the Healthy and Active passport, which will give citizens access to services and schemes aimed at improving health and wellbeing.
- Wellbeing hubs are also being designated as Spaces of Safety (SOS).

2.6 Rapid Assessment Time Limited service (RATL) – (Northern Lincolnshire and Goole Foundation Trust)

- The RATL service aims to provide an alternative provision of care in the home setting for people who may have otherwise had an attendance or admission to hospital.
- The service can respond to requests from GPs for assessment of need within an hour based on criteria agreed with GP commissioners within a new specification.
- The service is fully recruited to, with a number of the team in development posts. A comprehensive training plan has been formulated for all the practitioners.
- RATL service was implemented from the 1st October And operates 24/7.

2.7 Disabilities Funding Grant (DFG) – (North Lincolnshire Council)

- The capital element of the BCF includes expenditure on DFGs. The council's Home Assistance team process all recommendations made by the OT service/social services for adaptations to a home.
- A recommendation is made when it is identified that an adaptation would support in keeping a vulnerable elderly or disabled adult or child safe at home.
- The council as a Housing Authority has a statutory duty to provide mandatory Disabled facilities Grants under the Housing Grants, Construction and Regeneration Act 1996. Service performance is currently monitored using end to end times.

- There are national guidelines on the time taken from the OT visit to the completion of the work which the service is monitored against. A multi-agency working group is reviewing the process involved to identify how timescales can be further improved.

3. BCF related developments

3.1 Delayed Transfers of Care – Action Plan

The Delayed Transfers of Care Action Plan will be finalised at the Systems Resilience Group meeting on the 28th June with a focus on patient flow. The plan includes a range of actions including:

- Plans are underway to further integrate the hospital discharge team.
- The hospital social work team attends 'board rounds' to agree the fitness of people who may be discharged imminently
- Further investment has been agreed into the Council community support team to increase capacity for care at home.
- The recommissioning of all domiciliary care services in planned for December to improve sufficiency and diversification to enable more people to return straight home
- A 'why not home, why not now' mantra has been adopted
- The systems resilience group are working on the 'high impact change model' a research based model to understand what further work could support
    - Early discharge planning
    - Monitoring patient flow
    - Trusted assessor
    - Choice
- Enhancing health care in care homes is being looked into in the improvement plan for the 'perfect fortnight' to reduce hospital admissions out of hours.

3.2 Care networks

- The GP Council of Members (CoM) have supported a move to develop an out of hospital services model across 3 new care networks within the area.
- The care networks will include health and social care working in an integrated way based on the needs of the community.
- A care network summit was held on the 14th October to review the needs of the citizens within each network and identify 'evidence based' approaches to prototype in each network based on their need.
- 'Ambassadors' are being sought from all organisations providing care within

the networks to help shape and lead the new approach.

- One aim of the care networks models will be to reduce unnecessary hospital utilisation and admission to long term care. These schemes enhance the existing BCF schemes by implementing new approaches to long term condition management. This moves North Lincolnshire into a period of large scale transformation and change.
- The CoM now meet on a monthly basis with key partners, including care homes to explore by conversation and workshops in networks how services and their delivery could be changed to improve the citizens experience. The outputs from these meetings will be tested during the 'Perfect Fortnight' at the end of June 2016 including; working with 3 care homes with high conveyancy to A&E by supporting residents reviews and care planning, MDT meetings, SKYPE consultations and direct referral to RATL.

3.3 Accountable Care Partnership

- In line with NHSE Five Year Forward View, local areas are expected to consider new models of providing care to improve integration across health and care sectors. Accountable Care is a model being adopted in North Lincolnshire for delivering place based out of hospital care in community settings.
- As the main organisations involved in the Care Networks, Safecare (G.P. Federation), NLAG, RDASH and the local authority are taking forward Accountable Care in North Lincolnshire. The Accountable Care Partnership will formalize a collaborative approach to integrated working to deliver strategic outcomes for North Lincolnshire.