Meeting:	Adult Social Care, Health and Wellbeing Sub-committee
Date:	10th March 2016
Title:	Better Care Fund update

Author:	Kevin Allan	**Tel:** 07958 055 897
Service:	Adult Social Care	
Directorate:	Deputy Chief Executive	
Wards affected:	All	

1 Purpose of the report

This report provides members with a summary of the outcomes of the Better Care Fund for 2015/16.

2 Choice of metrics

A number of metrics were set nationally for use by all Better Care Funds in England. These were:

- Number of emergency hospital admissions
- Number of permanent admissions to residential care
- Number of delayed transfers of care
- Effectiveness of reablement

In addition each Health and Wellbeing Board was required to choose one local metric and identify a metric related to service integration. The local metric chosen was:

- Hospital admissions due to falls

Our definition of a metric related to service integration was drawn from the national GP-Patient Survey, specifically the following question:

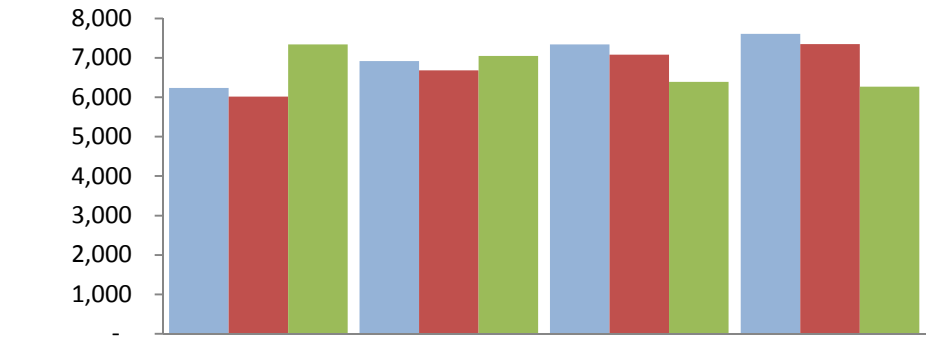
- % of patients who answered "Yes, definitely" or "Yes, to some extent" to "In last 6 months, had enough support from local services to help manage long-term health condition(s)"

In addition to the above high-level metrics, a number of measures specific to each service funded through the BCF were defined and have been regularly monitored by the BCF Partnership Board. These are shown in Appendix 1

3 Achievement against the metrics

<u>Emergency hospital admissions</u>
The BCF target was for a 3.5% reduction in emergency hospital admissions.

Figure 1: Non-elective emergency admissions - BCF measure



	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
2014 actual	6,234	6,920	7,339	7,608
2015 target	6,015	6,678	7,082	7,343
2015 actual	7,335	7,050	6,392	6,268

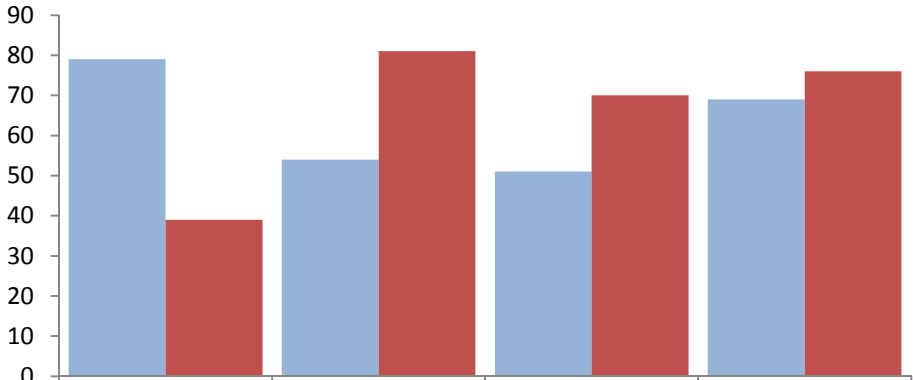
The actual number of admissions was above the BCF target in Jan-Mar, and Apr-Jun. However, due to lower volumes of emergency admissions in from July-December, the BCF target reduction has now been met:

Total non-elective admissions Jan-Dec 2014	28,101
Total non-elective admissions Jan-Dec 2015	27,045
Difference from 2014 to 2015	1,056
% difference	3.8%

Permanent admissions to residential care

In 2014 there were 253 permanent admissions to residential care; this rose to 266 in 2015, hence the BCF target reduction was not met.

Figure 2



	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
2014	79	54	51	69
2015	39	81	70	76

The national definition of permanent admissions to residential care has now changed. The measure in Figure 2 includes only “council-supported” admissions, therefore it excludes self-funders and people who receive NHS Continuing Health Care. The new measure, which will be adopted for BCF monitoring in 2016/17, includes those

categories, and therefore data from previous years will not be comparable to the new definition.

Delayed transfers of care

The BCF target called for the numbers of days of delayed transfers to be no more than 3,201 days. The actual level of delays was lower than the target, (i.e. better performance) at 3,042.

However the target for 2015/6 was set before all of the data for the preceding year, 2014/15, was available. The number of delays in 2014/15 turned out to be 2,834, hence the target was not as stretching as it might have been.

To give a national context, the North Tyneside position is within the best-performing 20% of HWBs.

Table 1 overleaf shows that the majority of delays for North Tyneside patients relate to Newcastle Hospitals and increased between 2014 and 2015. The number of delays relating to Northumbria Healthcare were very small and reduced between 2014 and 2015.

Table 1

	Provider = Northumbria Healthcare			
	NHS responsible	Social Care responsible	Both responsible	Total delays
2014	47	7	2	56
2015	4	0	0	4

	Provider = Newcastle Hospitals			
	NHS responsible	Social Care responsible	Both responsible	Total delays
2014	1527	308	52	1887
2015	2057	218	75	2350

A comprehensive action plan for reduction of delayed transfers will be developed as part of the 2016/17 BCF.

Effectiveness of reablement

This metric measures the percentage of people who were discharged from hospital to reablement, who remain out of hospital 91 days after discharge.

The baseline measure in 2013/14 was 91.3%, compared to an England average of 82.1%. North Tyneside has the best performance in Northern Region. The BCF plan aimed to improve performance further to 94.0%. However the actual level achieved in 2015 was 92.6% so the target was not achieved.

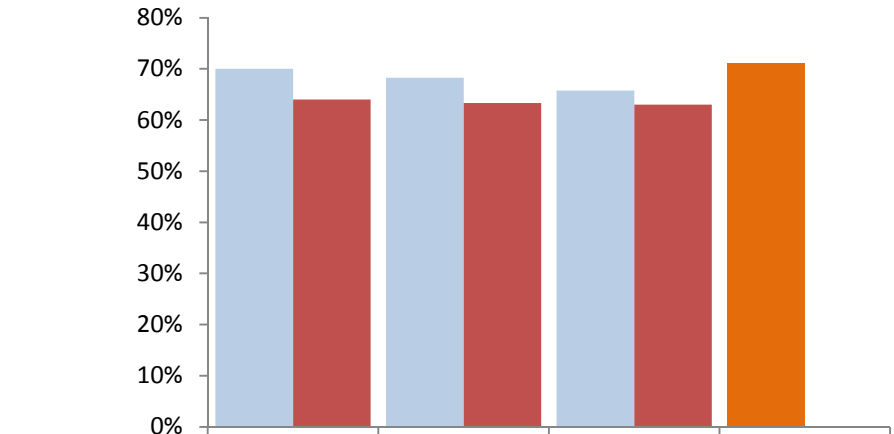
Hospital admissions due to falls

In January-November 2014 there were 1,359 hospital admissions due to falls. The BCF target was for a 10% reduction; the actual reduction was 4.8%

Support for management of long-term conditions

This metric is drawn from responses to the national GP-Patient Survey; results are reported twice a year. In the latest results (reported in January 2015), the relevant question attracted 1,740 responses from North Tyneside patients.

Figure 3: % of patients who answered "Yes, definitely" or "Yes, to some extent" to "In last 6 months, had enough support from local services to help manage long-term health condition(s)"



	Jan 2015	Jul 2015	Jan-16	BCF target
North Tyneside	70%	68.3%	66%	71%
England	64%	63.3%	63%	

Figure 3 above shows that the percentage of positive responses declined in the last two survey rounds and hence the BCF target of a 71% positive response was not met.

5 Planning for 2016/17

The Chancellor's Autumn Statement confirmed that the BCF would continue in 2016/17, as a transitional step towards full integration of health and social care by 2020.

The BCF Policy Framework was published in January 2016, The key points are:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG (as set out in section 3 below)
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.
- NHS England will also require that Better Care Fund plans demonstrate how the area will meet the following national conditions:
    - Plans to be jointly agreed;
    - Maintain provision of social care services;
    - Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
    - Better data sharing between health and social care, based on the NHS number;

- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

The Council is working with NHS North Tyneside CCG to agree the content of the BCF plan for 2016/17. The national timetable calls for Health and Wellbeing Boards to agree a plan by 25th April 2016.

4 Appendices

Appendix 1 – Outcomes report

Appendix 1 – BCF outcomes

Service Name	Outcomes	Measures	Higher is good/ lower is good	Baseline	Latest	% Change	Direction of travel
Providing proactive care and avoiding unplanned admissions	A reduction in avoidable hospital admissions of patients aged 75+	· Total number of emergency admissions	Lower is good	28,101	27,045	-3.8%	
		· Number of emergency bed days	Lower is good	171,724	154,681	-9.9%	
		· Number of avoidable admissions	Lower is good	5,957	5,551	-6.8%	
End of Life Care	To reduce the number of hospital admissions of patients on the palliative care register; and to increase the number of people able to die in the place of their choice	· Proportion of people on the palliative care register dying in the place of their choice	Higher is good	29.3%	34.2%	16.6%	
		· Number of non-elective hospital admissions	Lower is good	28,101	27,045	-3.8%	
		· Number of Accident and Emergency attendances	Lower is good	49,136	54,963	11.9%	
		· Number of emergency hospital bed days in the last 100 days of life	Lower is good		Not available due to information governance issues		
Falls Pathway	To reduce the number of hospital admissions related to falls.	· Numbers and cost of falls-related admissions	Lower is good	1,503	1,448	-3.7%	
Seven-day social work	To provide an enhanced social work service in the evenings and weekends with the objective of reducing hospital admissions and facilitating earlier discharge.	· Number of emergency admissions for patients aged 75+	Lower is good	8,742	8,667	-0.9%	
		· Number of referrals stratified by outcome, per social work team	Not applicable	Not available as service commenced in Feb 2015	Arranged discharge - 46		
					Ongoing monitoring - 513		
					Other - 26		
		· Average length of stay of emergency hospital admissions (in days), of patients aged 75+	Lower is good	10.5	9.2	-11.6%	

Service Name	Outcomes	Measures	Higher is good/ lower is good	Baseline	Latest	% Change	Direction of travel
Immediate response and overnight home care	To prevent unnecessary admissions to hospital and long term care.	· Proportion of service users who are supported to live independently at home (ASC 14)	Higher is good	75.0%	74.5%	-0.7%	
	Effective and responsive emergency support to carers in times of crisis will allow them to continue in their caring role, which is important in terms of preventing carer breakdown and avoiding increased costs to the health and social care system.	· Number of permanent admissions into residential care per 100,000 of the population (ASCOF 2A)	Lower is good				
		· Number of new service users this period	Higher is good	Not available as service commenced in Nov 2014	214		
		· Number of visits to service users this period	Higher is good		9632		
		· Number of hospital admissions of service users this period	Lower is good		34		
Increased use of telecare	To reduce the number of A&E attendances by people aged 75+	· A&E attendances for people aged 75+	Lower is good	10,142	10,784	6.3%	
		· The proportion of calls to the Care Call crisis response service resulting in A&E attendance	Lower is good	0.5%	0.5%	0.0%	
		· Number of calls to the crisis response dervice (ASC77)	Higher is good	136,341	151,761	11.3%	
Intermediate Care – “The Cedars”	· prevent unnecessary admission and readmission to hospital;	· Number of individuals admitted to intermediate care	Not applicable	254	243	-4.3%	
	· reduce number of attendances at A & E;	· Number of admissions to facilitate discharge from hospital	Not applicable	62	243	291.9%	
	· provide care closer to home to ensure active recovery and rehabilitation to prevent unnecessary loss of independence;· reduce the average	· Number of admissions to prevent admission to hospital	Not applicable	22	0	-100.0%	
		· Length of stay	Lower is good	30.2	27.7	-8.3%	
		· Average bed occupancy	Not applicable	85%	83%	-2.9%	

Service Name	Outcomes	Measures	Higher is good/ lower is good	Baseline	Latest	% Change	Direction of travel
	length of stay for older people in hospital; · prevent unnecessary admissions to long term care; · promote independence and reduce dependence upon long term home care packages;	· % of Discharges to home address	Higher is good	79%	76%	-3.2%	
		· % of Discharges to residential care	Lower is good	3%	1%	-66.7%	
		· % of Discharges to Extra Care	Not applicable	0%	0%		
		· % of Discharges with home care packages	Not applicable	28%	42%	50.5%	
		· % of Discharges with reableme nt/ongoing therapy	Not applicable	27%	20%	-24.5%	
		· Admissions into hospital from Intermediate Care	Lower is good	46	49	6.5%	
"Halfway home" beds	To reduce the number of admissions to permanent residential care direct from hospital.	· The number of admissions to permanent residential care direct from hospital	Lower is good		Data currently being recalculated due to change in indicator		
		· Average length of hospital stay for patients aged 75+	Lower is good	10.5	9.2	-11.6%	
		· Delayed transfers of care, in days	Lower is good	2838	3042	7.2%	
Improved homecare service	The provision of a high quality, responsive, outcomes focussed and person centred domiciliary care service is a critical component in supporting older people and people with complex disabilities to	· Average length of hospital stay for patients aged 75+	Lower is good	10.5	9.2	-11.6%	
		· Reduced re-admissions within 30 days following discharge, patients aged 75+	Lower is good	2608	1897	-27.3%	
		· Mean average change in EQ-5D VAS score for clients of the reablement service	Higher is good	17.30%	18.10%	4.6%	

Service Name	Outcomes	Measures	Higher is good/ lower is good	Baseline	Latest	% Change	Direction of travel
	live independently in their own homes, rather than in a residential setting. It also helps to facilitate and improve hospital discharge and can act to prevent avoidable hospital admissions.	· The number of admissions to permanent residential care direct from hospital	Lower is good		Data currently being recalculated, linked to change in definition of the indicator		
NHS support to social care	Improve services in the community	· Proportion of service users who are in permanent residential care (ASC15)	Lower is good	25.6%	25.5%	-0.3%	
	Support carers	· Carers receiving a needs assessment or review and a specific carers service or advice and information (ASC28)	Higher is good	67.1%	82.9%	23.5%	
	Support people with learning disability	· Proportion of adults with learning disability in paid employment (ASCOF 1E)	Higher is good	6.2%	6.5%		
		· Proportion of adults with learning disability who live in their own home or with their family	Higher is good	87.9%	88.4%		
	Prevention/self help/ early intervention	· Number of users of the crisis response service (ASC76)	Higher is good	4,437	4,242	-4.4%	
		· Number of calls to the crisis response dervice (ASC77)	Higher is good	136,341	151,761	11.3%	
		· The proportion of calls to the crisis response service resulting in A&E attendance (ASC78)	Lower is good	0.5%	0.5%	10.8%	
		· The proportion of calls to the crisis response service resulting in a healthcare response other than A&E attendance (ASC79)	Lower is good	0.3%	0.4%	38.7%	

Service Name	Outcomes	Measures	Higher is good/ lower is good	Baseline	Latest	% Change	Direction of travel
	Increase access to Telecare & telehealth	· Percentage of items of equipment or minor adaptations delivered within 7 working days	Higher is good	91.2%	93.1%	2.1%	
		· Median waiting time for delivery of equipment or minor adaptations (days)	Lower is good	3	3	0.0%	
Reablement	· Reduction in admissions to permanent residential care	· Proportion of Older People (65+) who are still at home 91 days following discharge from hospital into reablement/rehabilitation services (ASCOF 2B pt1)	Higher is good	93.3%	91.8%	-1.6%	
	· Reduction in emergency hospital admissions	· The proportion of older people aged 65 and over offered reablement services following discharge from hospital (ASCOF 2B part 2)	Higher is good		Awaiting data		
		· Emergency hospital admissions of people aged 75+	Lower is good	8,742	8,667	-0.9%	
		· Mean average change in EQ-5D VAS score for clients of the reablement service	Higher is good	17.3%	18.1%	4.6%