Meeting:	Adult Social Care, Health and Wellbeing Sub-committee
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Title:	Better Care Fund update

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Wards affected:	All	

1 Purpose of the report

This report updates members on the implementation of the Better Care Fund (BCF), in 2015/16, and summarises the content of the 2016/17 BCF plan.

2 Recommendations

The sub-committee is invited to note the briefing contained in this report

3 Details

In its June 2013 Spending Round, the Government announced a national £3.8billion pooled budget for health and social care services, subsequently known as the Better Care Fund (BCF) The BCF is intended to provide the opportunity to transform local services so that people are provided with better integrated care and support. It acts as an enabler to take forward the integration agenda, building upon the work of the North Tyneside Health and Social Care Integration Programme, of which the Authority is a partner

The BCF will benefit the people of North Tyneside by continuing to support:

- extended home care services, including overnight care, to provide a rapid response to a crisis;
- the provision of telecare, aids to independence, and adaptations;
- social work services seven days per week, focussed on facilitating discharge from hospital;
- services to support people at the end of life;
- services to support people admitted to acute hospitals, who have both mental and physical health conditions.

The BCF was first introduced in 2015/16, as a one-year arrangement. The continuation of the BCF was confirmed in the Chancellor's Spending Review and Autumn Statement 2015:

> "1.111 The Spending Review continues the government's commitment to join up health and care. The government will continue the Better Care Fund, maintaining the NHS's mandated contribution in real terms over the Parliament. From 2017 the

government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund.

1.112 The Better Care Fund has set the foundation, but the government wants to go further, faster to deliver joined up care. The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution."

In the main, the BCF funding is not new money to the health and social care system, but is comprised of a number of existing allocations including the current NHS social care allocations. In addition, the BCF includes some core Clinical Commissioning Group allocations and the Disabled Facilities Grant.

The national guidance sets out that the minimum value of the BCF in 2016/17 as £16.572m. Local partners can agree a larger fund if they wish. The planned value of the fund for 2016/17 is £16.773m; the £0.201m excess over the minimum amount being provided by the CCG.

Performance-related element

In 2015/16, there was a national requirement to link payments into the BCF by the CCG to reductions in emergency hospital admissions. The s75 Agreement stated that £1.485m would be dependent upon achieving a reduction of 3.5% in emergency hospital admissions. This reduction was achieved. However the funding of the agreed BCF services did not require the use of these funds, and therefore there was a resulting underspend in the BCF of £1.485m. The terms of the s75 Agreement was that underspends were returned to the party which provided the funding, in this case the CCG.

In 2016/17, there is no national requirement to include a performance-related element in the BCF, and there is no local proposal to do so. Hence, all of the BCF will be committed up-front to service provision, with no contingency held back.

Key features of the proposed plan

The plan represents a natural progression from the 2015/16 plan, with some changes to take into account progress that has been made. The plan includes:

- Implementation of the **CarePoint** service, which brings together a number of previously-separate services which aim to prevent admission to hospital and facilitate discharge from hospital. The predecessor services were:
    - North Tyneside Council's reablement service, including immediate response and overnight home care
    - North Tyneside Council's hospital-based social workers
    - Northumbria Healthcare FT's admission avoidance resource team
    - Northumbria Healthcare FT's "hospital to home service"

Implementation of the **CarePlus** service in the Whitley Bay locality. Our 2015/16 BCF plan outlined our intention to introduce such a model which is an example of "New

Models of Care". A team is now in place comprising GPs, geriatricians, nurses, social workers, and admin support, serving the Whitley Bay locality of North Tyneside. Arrangements are in place to share patient records with the patients' registered GP

The service has four key components:

- Coordination of Care – to ensure patients actually receive the care they need when they need it and to eliminate waste and duplication.
- Standardised Care - to drive consistency and high quality while leveraging systems that encourage clinicians to find the most cost effective solutions to meet patient needs.
- Matching patients need with an appropriate care delivery model – Patients with complex chronic diseases need a different kind of care than patients with injuries or simple episodic diseases and therefore the philosophy of directing patients into the right care model or delivery channel applies to clinicians as well.
- Facilitate the development of health literacy- which will ensure that patients are supported to develop the confidence and knowledge to manage their own conditions.

CarePlus will bring improved outcomes for both patients and the health economy through:

- Patient centred care: the system comes to them
- The patient tells their story once
- Better, quicker, more consistent care across the whole system
- Caring for patients at home and within the community
- Reducing avoidable admissions
- A more efficient productive health economy with less duplication and waste

CarePlus will look after patients with the greatest needs in a different way. Patients with multiple/ poly-chronic long term conditions will be offered proactive care planning from a core MDT, a rapid response service in line with escalation plans and a "pull service" to support early possible discharge when patients have needed hospital care.

A team is in place comprising GPs, geriatricians, nurses, social workers, and admin support, serving the Whitley Bay locality of North Tyneside. Arrangements are in place to share patient records with the patients' registered GP.

An additional element of the service provides support through personal independence coordinators, recruited and managed by Age UK North Tyneside. Their role is to:

- Build a strong supportive relationship with the patient
- Address social isolation through connecting with the community
- Be the point of contact for the patient and their family/ carer
- Responsible for self-management support (patient activation)
- Bridge the gap between the clinician and the patient
- Assist in navigation of the health and social care system
- Facilitate patient independence

The plan also includes a new focus on **intermediate care**. The Department of Health describes[1] intermediate care as

[1] DH 2001. Intermediate Care Health service/local authority circular HSC 2001/001 LAC (2001)1. DH 2009. Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities.

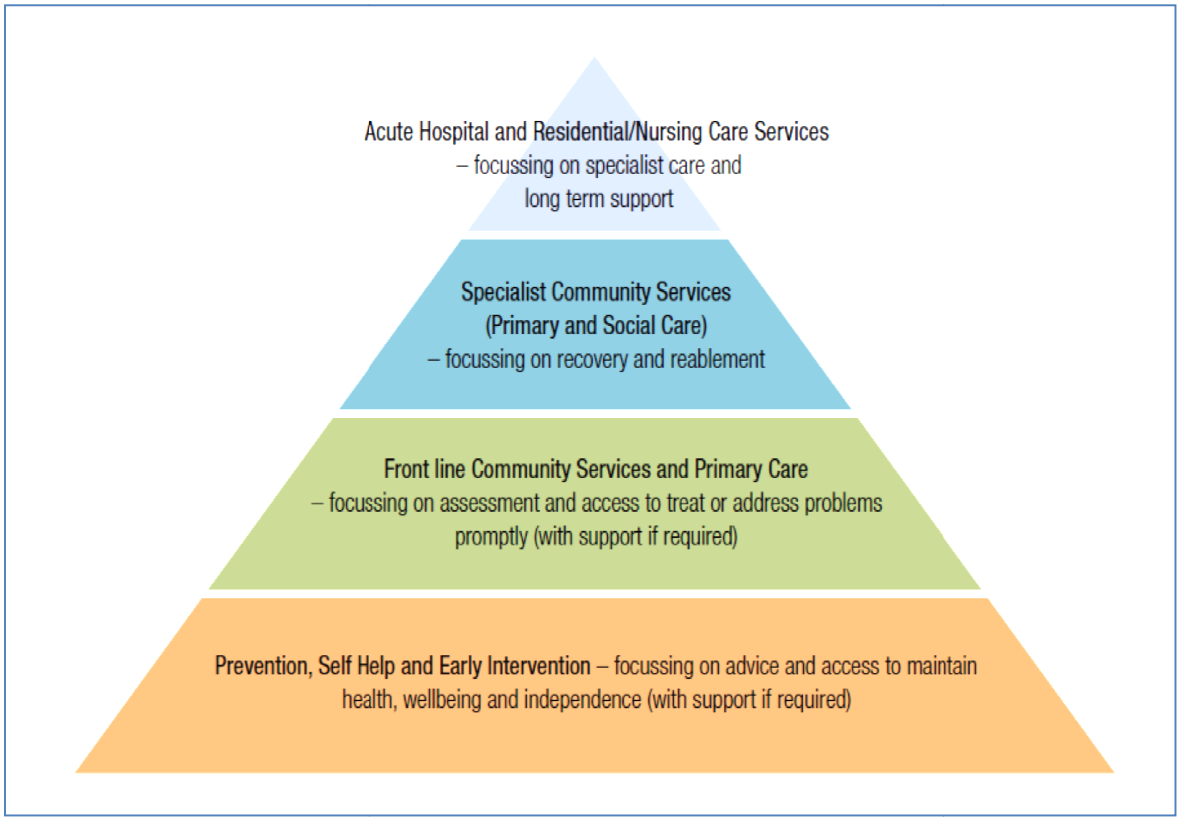
"a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living." .... "a function rather than a discrete service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It should support anyone with a health-related need through periods of transition, operating between other service units, so will need to adapt in response to any changes in the surrounding services. It is part of a continuum, spanning acute and long-term care, linking with social care reablement."

The Older Peoples Programme Board identified that a new model of intermediate care is required which:

- Provides an adequate number of "step-up" beds, for people in the community who are at risk of an inappropriate acute hospital admission.
- Provides "discharge to assess" beds, with appropriate therapy input, which would support the timely discharge of patients from an acute ward into an intermediate care facility, enabling a period of rehabilitation whilst CHC assessments are being carried out or decisions are being made about the appropriateness of permanent placements into residential or nursing homes, or designing the optimal package of community-based care which can support the person in their own home.
- Utilises high-quality accommodation
- Defines clinical responsibility for all intermediate care beds whether GP, nurse, or consultant led.

Relationship to the Health and Wellbeing Strategy

The Health and Wellbeing Strategy states that we will work within the four levels of service delivery, shown below, to achieve better service integration.



The table below shows how the BCF plan aligns to the layers referred to in the Health and Wellbeing Strategy:

	BCF services	Other relevant initiatives
Acute hospital and residential/nursing care services – focussing on specialist care and long term support	End of life care Liaison psychiatry	GP enhanced service for care homes
Specialist community services (primary and social care) – focussing on recovery and reablement	• Careplus (New Models of Care) • Proactive Care and Avoiding Admissions • Carepoint • CareCall / Telecare • Adaptations and Loan Equipment Service • Intermediate Care Beds	• Mental health community pathways

Front line community services and primary care – focussing on assessment and access to treat or address problems promptly (with support if required)	• Seven-day social work
	• Community-based services
	  • older people
	  • dementia
	  • mental health
	  • drug and alcohol
	  • homelessness	

Prevention, self-help and early intervention – focussing on advice and access to maintain health, wellbeing and independence (with support if required)	• Improving access to advice and information • Support for Carers	• NT Sign • Care and Connect

4 Monitoring Process

As in 2015/16, a number of national indicators have been specified to assess the outcomes of the BCF. These are:

- Emergency hospital admissions
- Delayed transfers of care
- Effectiveness of reablement
- Permanent admissions to residential care

Each Health and Wellbeing Board was requested to select their own indicator to reflect user experience of integrated care. Our chosen indicator is:

- % 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 the GP-Patient Survey

In addition, one local indicator is chosen to be reported nationally. Our local indicator is:

- The number of hospital bed days occupied by patients aged 75+ who were admitted as an emergency

Appendix 1 shows the previous level of achievement of these metrics and the BCF targets for 2016/17.

5 Appendices

Appendix 1 – National BCF metrics
Appendix 2 – BCF Narrative Plan

Appendix 1- National BCF Metrics

Emergency hospital admissions

	2014/15 actual	2015/16 plan	2015/16 actual	2016/17 plan
Number of non-elective emergency hospital admissions	29,202	27,116	25,976	26,172
HWB population (all ages)	203,669	204,882	204,882	206,125
Rate per 100,000 population	14,338	13,234	12,679	12,697
Percentage change in rate from previous year			-12%	0.1%

Delayed transfers of care

	2014/15 actual	2015/16 plan	2015/16 actual	2016/17 plan
Total number of hospital bed days attributed to delayed transfers	2,838	3,042	2,880	2,895
HWB population (aged 18+)	161,678	163,218	163,218	165,423
Rate per 100,000 population	1,755	1,863	1,765	1,750
Percentage change in rate from previous year			1%	-0.8%

Effectiveness of reablement

	2014/15 actual	2015/16 plan	2015/16 actual	2016/17 plan
% of patients at home 91 days after discharge from hospital into reablement	92.7%	94.0%	92.1%	93.1%

Permanent admissions to residential care

	2014/15 actual	2015/16 plan	2015/16 actual	2016/17 plan[2]
Number of admissions	239	253	298	309
HWB population (aged 65+)	38660	39423	39423	40144
Rate per 100,000 population	618	642	756	770
Percentage change in rate from previous year		3.8%	22%	

% 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 the GP-Patient Survey

	2014/15 actual	2015/16 plan	2015/16 actual	2016/17 plan
Number of admissions	70%	71%	66%	71%

[2] The national ASCOF definition of permanent admissions to residential care has now changed. The measure used in 2015/16 included 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.

Hospital emergency bed days - patients aged 75+

	2014/15 actual	2015/16 actual	2016/17 plan
Number of bed days	107,477	81,760	80,000
HWB population (aged 75+)	17,992	17,992	18,000
Rate per 1,000 population	5,974	4,544	4,444
Percentage change in rate from previous year		-24%	-26%