Meeting:	Adult Social Care, Health and Wellbeing Sub-Committee
Date:	9 March 2017
Title:	Better Care Fund update

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Service:	Adult Social Care	
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Wards affected:	All	

1 Background

- The Better Care Fund is now in its' second year of operation.
- The Health and Wellbeing Board approved the plan for 2016/17 on 28th April 2016.
- The Governing Body of NHS North Tyneside CCG agreed the plan on 24th May 2016.
- The Cabinet of North Tyneside Council agreed the plan on 13th June 2016.
- The plan has been fully approved by NHS England.
- A previous report to the Adult Social Care, Health and Wellbeing Sub-committee, on 2nd June 2016, outlined the content of the plan.

This paper will be accompanied by two presentations to the Sub-Committee:

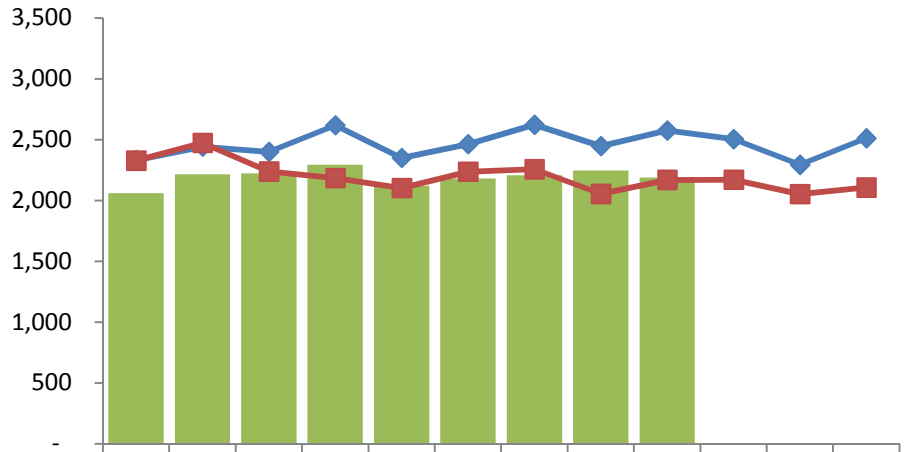
- Actions to reduce delayed transfers of care, by Eleanor Binks (adult social care) and Maureen Grieveson (NHS North Tyneside CCG)
- Actions to reduce permanent admissions to residential care, by Alison Tombs (adult social care)

2 Progress from April to December 2016

Emergency admissions

2.1 Figure 1 below shows performance against the BCF trajectory for emergency admissions.

Figure 1: Non-elective emergency admissions - BCF measure



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17 actual	2,060	2,214	2,224	2,294	2,120	2,182	2,207	2,247	2,188			
2014/15 actual	2,332	2,442	2,400	2,618	2,350	2,463	2,622	2,447	2,575	2,504	2,293	2,511
2015/16 actual	2,328	2,473	2,238	2,184	2,102	2,237	2,257	2,054	2,169	2,171	2,053	2,106

2.2 The BCF plan called for a reduction of 376 (or 1.8%) in emergency admissions,in Apr-Dec 2016 compared to the same period in 2015. The actual reduction was 306 (or 1.5%); hence the target was partially achieved but not totally achieved.

It should be noted that this metric, chosen nationally for BCF reporting purposes, does not reflect the total experience of activity growth in the urgent healthcare domain.

Other forms of healthcare intervention, such as ambulatory care attendances, accident and emergency attendances, and walk-in centre attendances, also contribute to both the workload pressures and cost pressures of the healthcare system, but are not included within the definition of the BCF metrics.

When ambulatory care attendances are added to emergency admissions, the aggregate number of attendances increased by 4.6% in April-November 2016, compared to the same period in 2015.

There are no direct financial consequences for the BCF, or the Council, arising from this situation. Unlike in 2015/16, there is no “pay-for-performance” element of the BCF; the level of contributions to the BCF does not vary in line with the level of emergency admissions.

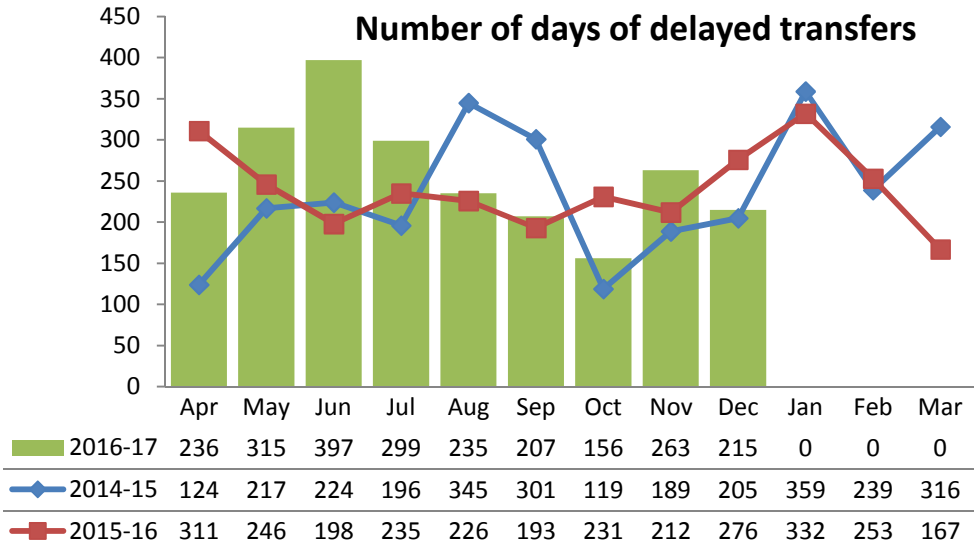
<u>Delayed transfers of care (DTOC)</u>

2.3 Whilst North Tyneside had a DTOC rate in the lowest 10% of English HWBs in 2015/16, the volume of delays in April-December 2016 were 9.2% higher than the same period in 2015.

All of the data in this section refers to the number of days of delay, NOT the number of patients. For example, a delay of 200 days could relate to 200 patients waiting one day, or 20 patients waiting 10 days, etc.

There are no direct financial consequences for the BCF, or the Council, arising from this situation

Figure 2



2.5 Table 1 below shows the distribution of the delays between NHS providers, and between the responsible agencies, for April-December 2016.

Table 1 – number of days of delayed transfers, grouped by NHS provider and responsible agencies.

Provider	NHS responsible	Social Care Responsible	Both responsible	Total delays
GATESHEAD HEALTH NHS FOUNDATION TRUST	0	10	0	10
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	61	61	0	122
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	18	2	0	20
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	1879	292	0	2171
Grand Total	**1958**	**365**	**0**	**2323**

- 93% of delays relate to North Tyneside patients admitted to Newcastle Hospitals[1]
- 84% of delays are classed as "NHS responsible"

[1] To some extent the difference between reported delays at Newcastle Hospitals and Northumbria Healthcare is a structural issue caused by the data definitions. A transfer between the RVI and NTGH can potentially lead to a delay, but a transfer between NSECH and NTGH cannot lead to a delay because transfers between hospitals managed by the same NHS provider are never reported as delays.

2.6 Table 2 below shows the reasons for delay. The most common cause of delay is "waiting for further non-acute NHS care".

Table 2

Reason	NHS responsible	Social Care Responsible	Both responsible	Total delays
Further non-acute NHS care	772	0	0	772
Care package in own home	438	172	0	610
Patient or family choice	432	33	0	465
Completion of assessment	165	27	0	192
Nursing home	59	61	0	120
Disputes	12	61	0	73
Community equipment or adaptations	50	11	0	61
Awaiting public funding	21	0	0	21
Residential home	7	0	0	7
Housing	2	0	0	2
Grand Total	**1958**	**365**	**0**	**2323**

The redesign of intermediate care services is expected to reduce the number of delays related to "waiting for further non-acute NHS care". The new model began operation in December 2016.

- All patients discharged from hospital requiring an intermediate care assessment will be referred to Carepoint, which acts as a single point of access to the new Intermediate Care facility at Princes Court. Akari, the providers of this facility, will provide 24/7 nursing support. GP cover will be provided by Collingwood Medical Group.

- A new Community Rehabilitation Team works closely with the Princes Court team to ensure appropriate packages of care are in place prior to discharge and will provide relevant rehabilitation and therapy input working with and alongside Occupational Therapists and Physiotherapists.

To accompany this report, Maureen Grieveson of NHS North Tyneside CCG, and Eleanor Binks of North Tyneside Council will give a presentation on measures being taken to reduce delayed transfers of care.

Effectiveness of reablement

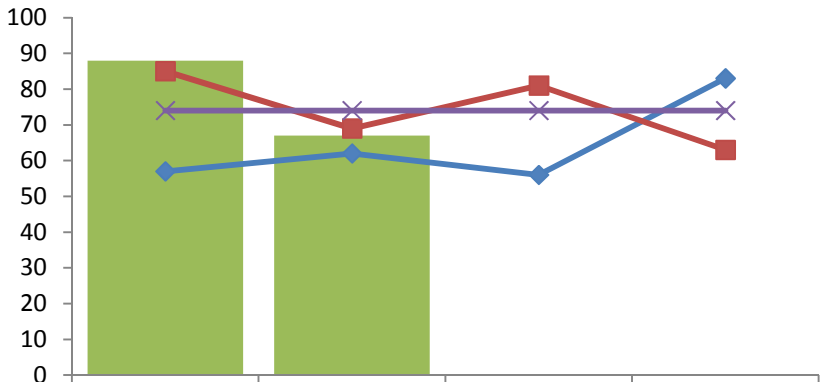
2.7 The target for the number of patients at home 91 days after discharge from hospital to reablement was 93.1%. The outturn for April-December was slightly below, at 91.9%. In 2015/16 the England average was 82%.

There are no direct financial consequences for the BCF, or the Council, arising from this situation

Permanent admissions to residential care

2.8 Our BCF trajectory is for a rate of permanent admissions to residential care, per 100,000 persons aged 65+, of 741, which would equate to 296 admissions. In April-Sept 2016 there were 155 admissions, 7 more than the half-year target

Figure 3



	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar
2016/17	88	67		
2014/15	57	62	56	83
2015/16	85	69	81	63
BCF trajectory	74	74	74	74

Data for December 2016 is not yet available to complete the Oct-Dec data; for October-November there were 51 admissions. This suggests that there is a good possibility that the Oct-Dec quarter will end within the BCF trajectory (assuming 74 admissions per quarter).

There are no direct financial consequences for the BCF, or the Council, arising from this situation.

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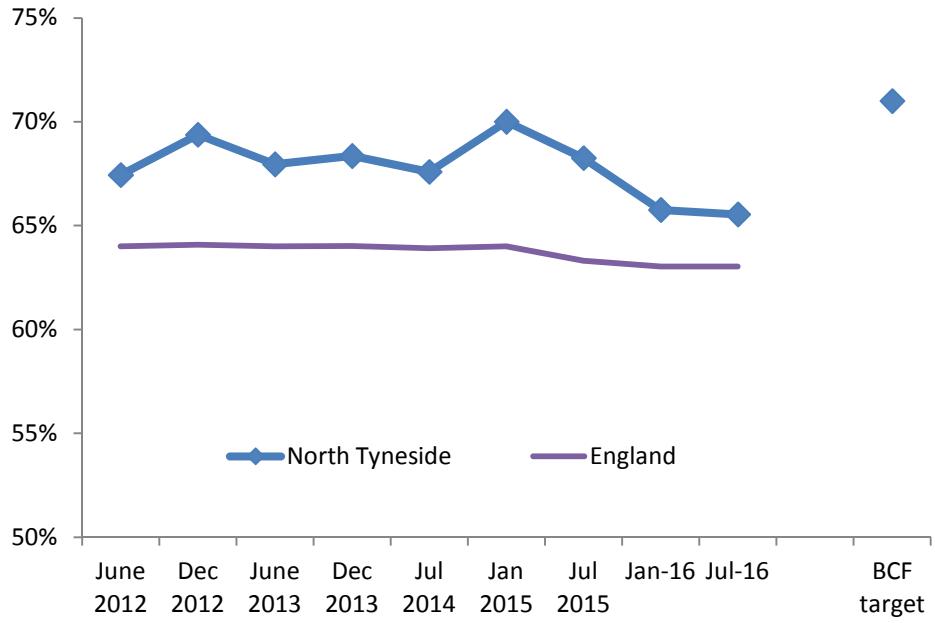
User experience measure

2.9 In the absence of a nationally-agreed measure of the user experience of integrated care, Health and Wellbeing Boards were invited to select their own metric for this purpose. The North Tyneside measure was drawn from the GP-Patient Survey – the % of patients who answered "Yes, definitely" or "Yes, to some extent" to "In last 6 months, have you had enough support from local services to help manage long-term health condition(s)".

2.10 Our target is to achieve a score of 71% but the latest data, released in July 2016, shows a score of 65.5%; the score has reduced in each of the last three reporting periods.

2.11 Figure 5 below shows the trends for this metric since 2012.

Figure 4: Percentage of patients who report having received enough support for long term conditions

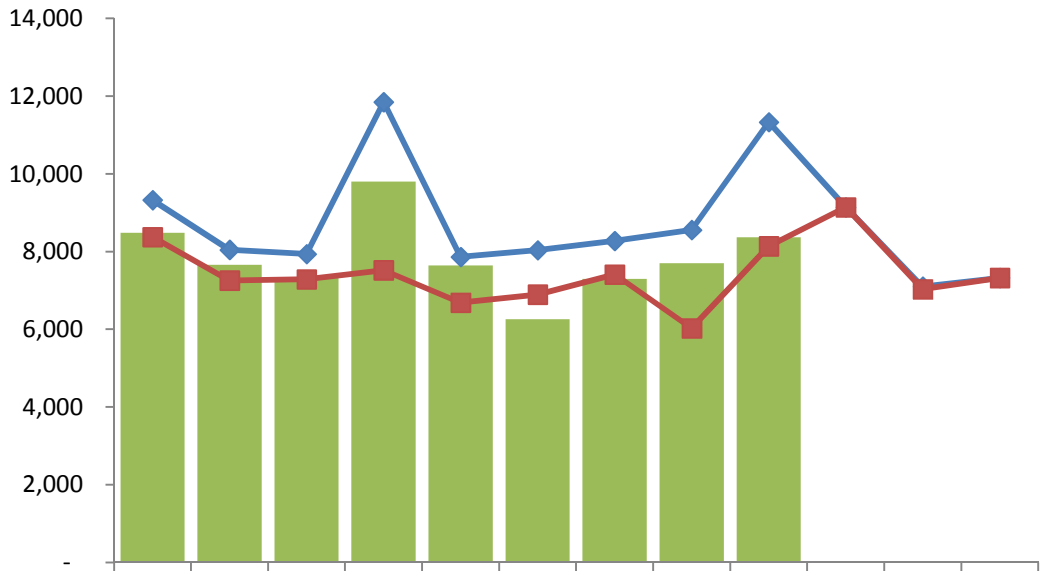


There are no direct financial consequences for the BCF, or the Council, arising from this situation.

<u>Locally selected metric – Hospital bed days arising from emergency admissions of patients aged 75+</u>

2.12 Figure 5 below shows performance against this metric. In April-December 2015 there were 65,591 emergency bed days for patients aged 75+. This increased to 70.453, in April-Dec 2016, a rise of 7.5%.

Figure 5



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	8,480	7,662	7,335	9,799	7,644	6,260	7,296	7,703	8,364			
2014/15	9,327	8,046	7,937	11,849	7,863	8,036	8,274	8,556	11,332	9,140	7,102	7,325
2015/16	8,374	7,255	7,285	7,523	6,686	6,895	7,410	6,024	8,139	9,140	7,029	7,324

There are no direct financial consequences for the BCF, or the Council, arising from this situation.

3 Planning for 2017/18 and 2018/19

Government have announced that the next round of BCF planning will cover two years, i.e 2017/18 and 2018/19. At the time of writing, the national BCF planning guidance has not been published, which means that it is not yet possible to produce a draft plan.