Nottinghamshire County Council

Report to the Health and Wellbeing Board

06 June 2018

Agenda Item: 10

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION, NOTTINGHAMSHIRE COUNTY COUNCIL

BETTER CARE FUND PERFORMANCE

Purpose of the Report

1. This report sets out progress to date against the Nottinghamshire Better Care Fund (BCF) plan and requests that the Health and Wellbeing Board:

   1.1. Approve the Q4 2017/18 national quarterly performance report.

Information and Advice

Performance Update and National Reporting

2. Performance against the BCF performance metrics and financial expenditure and savings continues to be monitored on a monthly basis through the BCF Finance, Planning and Performance sub-group and the BCF Steering Group.

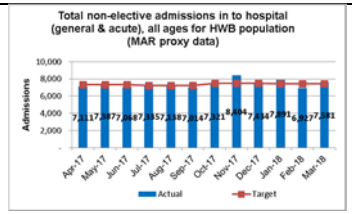
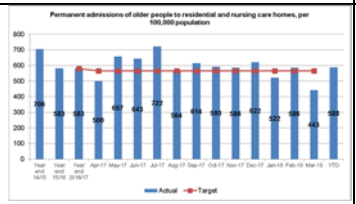
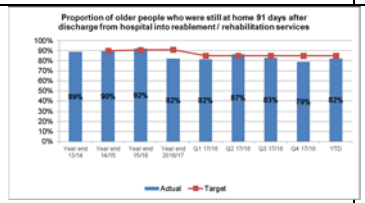
3. The performance update includes delivery against the six key performance indicators, the financial expenditure and savings, scheme delivery and risks to delivery for Q4 2017/18.

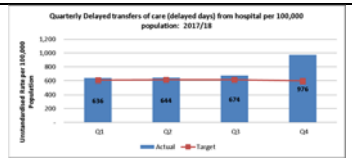
4. This update also includes the Q4 2017/18 national quarterly performance template submitted to the NHS England Better Care Support Team for approval by the Board.

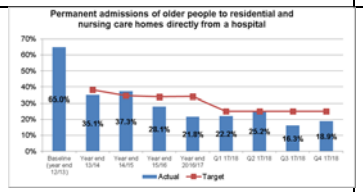
5. Q4 2017/18 performance metrics are shown in Table 1 below.

   5.1. One indicator is on track
   5.2. Five indicators are off track and actions are in place

Table 1: Performance against BCF performance metrics

REF	Indicator	2017/18 Target	2017/18	RAG and trend	Trend	Summary of mitigating actions
BCF 1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	22,388 Q4	22,399 Q4	R ⇧		South CCGs have seen growth in emergency admissions in 2017/18. Largely, the activity increase for the South CCGs has been seen within the short stay activity at NUH. Granular analysis has identified that the volume of recorded admissions has been impacted by the implementation of a pathway change within the emergency department. This has led to an increase in admissions for patients requiring further assessment or diagnostic tests. Discussions continue with the provider to review the impact of the change and agree an appropriate level of payment. Mid and North CCGs have seen a reduction in activity.
BCF 2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	565.6	588	R ⇩		Long term admissions to residential or nursing care have increased this year as the council faces increased demand from people with complexed needs. All placements are considered at panel and agreed where there is no viable alternative.
BCF 3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85%	82.19%	R ⇩		The percentage of people still at home after 91 days has reduced as reablement type services available upon discharge from hospital have expanded and are now offered to people with more critical needs. Also this period the indicator has been impacted by the increased number of deaths seen in January 2018 and potentially the indicator could have been closer to target. Provisional figures indicate 78% success rate for Q4 (down from 82% prior to January 2018).

REF	Indicator	2017/18 Target	2017/18	RAG and trend	Trend	Summary of mitigating actions
BCF 4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	597.0 Q4	976.19 Q4	R ⇩		**South** A regional DToC Plan has been produced and trajectories established. Regional actions to be taken to reduce DToCs include but are not limited to: encouraging active participation in the operational management of discharge, development of a discharge hub approach, effective implementation of a patient choice policy, Home First workbooks in Nottinghamshire and development of the Red Bag initiative. **Mid** • Commenced weekly meetings focussing on integrated discharge transformation scheme/programme • Commenced Better Together discharge initiative whereby Board Rounds are attended by Social Care and Community Services as well as the Discharge Team on the pilot wards. • Mobilised a D2A pathway into community teams/services in M&A **North** Using short term nursing care beds to ensure that DSTs aren't being done in hospital • Bassetlaw CCG is liaising and working with the Local Authority to facilitate discharges which are out of the CHC pathway • Delays are discussed at the Urgent Care Operations Group fortnightly to resolve local issues that are not covered by routine processes • Integrated Discharge Team at Bassetlaw Hospital works well with Local Authorities.

REF	Indicator	2017/18 Target	2017/18	RAG and trend	Trend	Summary of mitigating actions
BCF 5	Percentage of users satisfied that the adaptations met their identified needs	100%	99%	A ⇔	⇔	
BCF 6	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes	25%	20.8%	G ⇔		

6. Expenditure was on plan for 2017/18.

7. The BCF Finance, Planning and Performance subgroup monitors all risks to BCF delivery on a quarterly basis and highlights those scored as a high risk to the Steering Group. The Steering Group has agreed the risks on the exception report as being those to escalate to the HWB (Table 2).

Table 2: Risk Register

Risk id	Risk description	Residual score	Mitigating actions
BCF005	There is a risk that acute activity reductions do not materialise at required rate due to delays in scheme implementation, unanticipated cost pressures and impact from patients registered to other CCG's not within or part of Nottinghamshire's BCF plans.	12	Monthly monitoring of non-elective activity by BCF Finance, Planning and Performance subgroup and Steering Group (currently only for activity in Nottinghamshire CCGs). Oversight by A&E Delivery Boards.
BCF009	There is a risk of insufficient recruitment of qualified and skilled staff to meet demand of community service staffing and new services; where staff are recruited there is a risk that existing service provision is destabilised.	16	Monthly monitoring through A&E Delivery Boards and Transformation Boards. Workforce and organisational development identified as a Sustainability and Transformation Partnership (STP) priority.
BCF14	There is a risk that the DTOC target will not be met in 2017/18.	16	Advice to the system being given on counting to ensure accurate reporting. Actions being taken forward by A&E Delivery Boards.

8. As agreed at the meeting on 7 October 2015, the Q3 2017/18 national report was submitted to NHS England on 20 April pending HWB approval (Appendix 1). Due to the timing of the report, the content for Nottinghamshire County was prepared and agreed by the BCF Finance, Planning and Performance sub-group and approved by the BCF Steering Group. If the HWB requests amendments to the report, the quarterly report will be resubmitted to the NHS England Better Care Support Team.

9. Further national reporting is due on a quarterly interval with dates to be confirmed.

Other options

10. None.

Reasons for Recommendations

11. To ensure the HWB has oversight of progress with the BCF plan and can discharge its national obligations for reporting.

Statutory and Policy Implications

12. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

13. The £73.56m for 2017/2018 is fully spent.

Human Resources Implications

14. There are no Human Resources implications contained within the content of this report.

Legal Implications

15. The Care Act facilitates the establishment of the BCF by providing a mechanism to make the sharing of NHS funding with local authorities mandatory. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected.

RECOMMENDATIONS

That the Board:

1. Approve the Q4 2017/18 national quarterly performance report.

David Pearson
Corporate Director, Adult Social Care and Health, Nottinghamshire County Council

For any enquiries about this report please contact:
Joanna Cooper Better Care Fund Programme Manager
Joanna.Cooper@nottscc.gov.uk
0115 9773577

Constitutional Comments (LMC 24/05/2018)

16. The Health and Wellbeing Board is the appropriate body to consider the contents of the report

Financial Comments (OC 24/05/18)

17. The Financial are contained in paragraph 13 of the report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- "Better Care Fund: Guidance for the Operationalisation of the BCF in 2015-16". http://www.england.nhs.uk/wp-content/uploads/2015/03/bcf-operationalisation-guidance1516.pdf
- Better Care Fund – Final Plans 2 April 2014
- Better Care Fund – Revised Process 3 June 2014
- Better Care Fund Governance Structure and Pooled Budget 3 December 2014
- Better Care Fund Pooled Budget 4 March 2015
- Better Care Fund Performance and Update 3 June 2015
- BCF Performance and Finance exception report - Month 3 2015/16
- Better Care Fund Performance and Update 7 October 2015
- Letter to Health and Wellbeing Board Chairs 16 October 2015 from Department of Health and Department of Communities and Local Government "Better Care Fund 2016-17"
- Better Care Fund Performance and Update 2 December 2015
- 2016/17 Better Care Fund: Policy Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf
- Better Care Fund Performance and Update 2 March 2016
- Better Care Fund 2016/17 Plan 6 April 2016
- Better Care Fund Performance and Update 6 June 2016
- Better care fund Performance, 2016/17 plan and update 7 September 2016
- Better Care Fund Performance 7 December 2016
- Better Care Fund Performance March 2017

Electoral Divisions and Members Affected

- All.

Appendix 1

Better Care Fund Template Q3 2017/18

1. Cover

Health and Wellbeing Board:	Nottinghamshire
Completed by:	Joanna Cooper
E-mail:	joanna.cooper@nottscc.gov.uk
Contact number:	0115 9773577
Who signed off the report on behalf of the Health and Wellbeing Board:	TBC

2. National Conditions & s75 Pooled Budget

Confirmation of National Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

3. Metrics

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	Not on track to meet target	South CCGs have seen growth in emergency admissions in 2017/18. Largely, the activity increase for the South CCGs has been seen within the short stay activity at NUH. Granular analysis has identified that the volume of admissions has been impacted by the implementation of a pathway change within the emergency department. This has led to an increase in admissions for patients requiring further assessment or diagnostic tests. Discussions continue with the provider to review the impact of the change and agree an appropriate level of payment.	Emergency Activity continues to be discussed at both the joint A&E Delivery Boards and the local Systems Resilience Groups. North - Bassetlaw CCG has seen a decrease in A&E Attendances and Non Elective activity through a number of schemes which will continue into 2018 19 - Increased compliance with flu vaccinations for care homes, a relaunch of the head injury pathway within care homes, new care home with registered nursing support, training in care homes with regards to hydration and nutrition, increased social prescribing, rapid response teams in the community and Community Geriatrician support	A briefing paper has been produced to explain the increase of NEL admissions, which links to the introduction of the Luton Model of streaming in ED. This shows the correlation with the change of pathway, increase in NEL admissions particularly <24hrs LOS, Surgical assessment unit

			Mid and North CCGs have seen a reduction in activity.		and medical assessment unit.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Long term admissions to residential or nursing care have increased this year as the council faces increased demand from people with complexed needs.. All placements are considered at panel and agreed where there is no viable alternative.		
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	The percentage of people still at home after 91 days has reduced as reablement type services available upon discharge from hospital have expanded and are now offered to people with more critical needs. Also this period the indicator has been impacted by the increased number of deaths seen in January 2018 and potentially the indicator could have been closer to target. Provisional figures indicate 78% success rate (down from 82% prior to January 2018).	This year we are able to include step down services such as transfer to assess that are provided at the care and support centres as these are now recorded on Mosaic. This has increased the number of people that are included in this indicator as being discharged from hospital into reablement services.	
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	South Data analysis for Greater Nottingham highlighted that the most common reason for delay in transfers include a lack of capacity in further non-acute NHS care. Other less significant causes of delayed discharge were around completion of assessment and patient or family choice.	South A regional DToC Plan has been produced and trajectories established. Regional actions to be taken to reduce DToCs include but are not limited to:	

			Specific sub group of the A&E board, under the lead of County LA Director, with representatives from across the system is responsible for the further development of the discharge to assess/home first model across Greater Nottingham which was successfully launched in October 2017 and has demonstrated improved flow with increasing numbers of patients being managed through the D2A pathways however at times of peak demand waits have appeared. Learning from winter has clearly identified the system capacity constraints which have impacted on flow particularly over January and February when the number of referrals into the D2A pathways exceeded available capacity and resulted in an increase in DTOC over the last quarter despite additional investment in community health services. We have identified two key areas for improvement work and alternative models of delivery to address the capacity gaps and will be working with Newton Europe to further develop the action plan specifically tailored to reduce DTOC.	encouraging active participation in the operational management of discharge, development of a discharge hub approach, effective implementation of a patient choice policy, Home First workbooks in Nottinghamshire and development of the Red Bag initiative. Mid • Commenced weekly meetings focussing on our integrated discharge transformation scheme/programme, this has senior representation from all stakeholders • Commenced Better Together discharge initiative whereby Board Rounds are attended by Social Care and Community Services as well as the Discharge Team on the pilot wards. (now in week 2) • Mobilised a D2A	

				pathway into community teams/services in M&A North Using short term nursing care beds to ensure that DSTs aren't being done in hospital o Bassetlaw CCG is liaising and working with the Local Authority to facilitate discharges which are out of the CHC pathway o Delays are discussed at the Urgent Care Operations Group fortnightly to resolve local issues that are not covered by routine processes o Integrated Discharge Team at Bassetlaw Hospital works well with Local Authorities – daily dialogue.	

4. High Impact Change Model

		Maturity assessment					Narrative			
		Q2 17/18	Q3 17/18	Q4 17/18 (Current)	Q1 18/19 (Planned)	Q2 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Plans in place	Plans in place	Established	Established	Established		Key challenges were ensuring buy in / sign up from all system partners as well as trying to understand the concept	Integrated Discharge Functions now in place and managers appointed to oversee the function / team. Bassetlaw CCG IDT well established at Bassetlaw Hospital	Any further challenges will be noted and acted upon via the Provider to Provider meetings in place weekly.
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established	Established		Timescales to deliver. Securing funding and licenses.	South: NerveCentre being developed to incorporate	Any further challenges will be noted and acted upon via the Provider to Provider

									system capacity to enable community bed stock to be visible Dashboard metrics also in developme nt	meetings in place weekly.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Establishe d	Establishe d	Establishe d	Establishe d	Establishe d			South: Electronic Transfer of Care (eTOC) developed and agreed across all system partners	Further changes may be required to support the Trusted Assessor role / implementatio n
Chg 4	**Home first/discharge to assess**	Establishe d	Establishe d	Establishe d	Establishe d	Establishe d		South: Discharge to Assess / HomeFirst Pathway went live in September Additional 36 community beds secured across Greater Nottingham to support Pathway	Integrated Discharge Functions now in place and managers appointed to oversee the function / team. North: Bassetlaw - Discharge to assess well established No CHC	Any key challenges will be noted and acted upon via the Provider to Provider meetings in place weekly.

									assessments are completed in hospital.	
Chg 5	**Seven-day service**	Plans in place	Plans in place	Established	Established	Established		Workforce challenges in delivering this.	Refresh of mapping across the system to be completed in Q3 Primary Care at ED Reablement teams - 7 day limited Service Mental Health Assessment beds - 7 day full Service Crisis response - 7 day limited Service Social care reablement service (START) - 7 day limited Service Additional beds opened for winter	

									pressures in Q3. Bassetlaw - Some community services are 7 days and new social care contracts are for provision of a 7 day service.	
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Established	Established	Established		Challenge re competencies - plans now underway to develop a bespoke package in line with the principles of the holistic worker model.	Agreement to use the TOC as trusted assessment Dedicated lead for End of Life care now in post Need to identify leads from IDT. North: Trusted asssessor role in Bassetlaw is still being embedded across all the care	The plan is to implement the model from April and any challenges arising will be actioned via the Greater Nottingham Trusted Assessor Steering Group.

									home sector.	
Chg 7	**Focus on choice**	Plans in place	Plans in place	Established	Established	Established		Challenges in agreeing the funding/ and how providers were going to use it	South: Patient leaflet developed and signed off by all system partners Hospital patient letter also designed and signed off by system partners	On-going monitoring of usage
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Established	Established			South: Integrated teams established with key leads (community matrons and district nurses) in place aligned to each Care Home.	

	2017/18			
	Planned		Actual	
Disabled Facilities Grant	£ 5,958,425		£ 5,958,425	
Improved Better Care Fund	£ 16,060,542		£ 16,060,542	
CCG Minimum Fund	£ 51,536,899		£ 51,536,899	
Minimum Subtotal		£ 73,555,867		£ 73,555,867
CCG Additional Contribution			£ -	
LA Additional Contribution			£ -	
Additional Subtotal		£ -		£ -

	Planned 17/18	Actual 17/18
Total BCF Pooled Fund	£ 73,555,867	£ 73,555,867

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2017/18	

Expenditure

	2017/18
Plan	£ 73,555,866
Actual	£ 73,555,866

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2017/18	Reconciliation of the pooled fund complete. Scheme underspend identified in-year and re-allocated to other BCF priorities.

6. Year End Feedback

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Partners agreed this at our annual BCF evaluation event
2. Our BCF schemes were implemented as planned in 2017/18	Agree	Majority of programme delivered as planned, some rephasing of initiatives in year.
3. The delivery of our BCF plan in 2017/18 had a positive impact on the integration of health and social care in our locality	Agree	BCF programme evaluated positively.
4. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Non-Elective Admissions	Agree	Avoided admissions attributable to initiatives across the system including BCF schemes, however challenges remain.
5. The delivery of our BCF plan in 2017/18 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	Reductions in DTOCs seen over the year, however, targets not achieved. Reductions attributable to initiatives across the system including BCF schemes.
6. The delivery of our BCF plan in 2017/18 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	Funding has enabled performance levels to be maintained.
7. The delivery of our BCF plan in 2017/18 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	Reductions in care home admissions seen over the year. Reductions attributable to initiatives across the system including BCF schemes.

Part 2: Successes and Challenges
Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and three Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

8. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **successes**
Success 1	9. Joint commissioning of health and social care	Implementation of the Hospital to Home Prevention and Discharge Project and the partnership working between NHS and borough councils.
Success 2	9. Joint commissioning of health and social care	On-going work around mental health integration and in particular the work of the primary care psychological medicine project.

8. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2017/18.	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest **challenges**
Challenge 1	8. Pooled or aligned resources	Integration of occupational therapy teams across health and social care. The scope of this work needs to be much wider than OT for it to have a desired impact but this has to be addressed through the relevant governance committees for sign off which has taken longer than anticipated.
Challenge 2	8. Pooled or aligned resources	The integration of health and social care reablement teams has proved challenging due to internal work looking at efficiencies and how this fits with integration.

7. Narrative

Progress against local plan for integration of health and social care
In Nottinghamshire we have maintained our ambition for a strong BCF plan across our Health and Wellbeing Board footprint. Performance against all BCF metrics continues to be monitored monthly to ensure timely actions where plans are off-track. There continues to be a high level of commitment from partners to address performance issues e.g. daily discussions within hospitals to facilitate timely discharges, the development of transfer to assess models to reduce long term admissions to care homes, District Authority alignment with Integrated Discharge Teams to ensure housing needs of patients are addressed prior to discharge and avoid unnecessary delays. At Q4, all performance metrics are off plan. The 6 CCGs continue to work with local authority, District and Borough Councils, acute, mental health and community trusts and the community and voluntary sector in their 3 units of planning to ensure service transformation with a focus on reducing non-elective admissions and attendance, and care home admissions. Plans to accelerate improvement in trajectories are forecast to deliver further improvements as projects and programmes mature and transfer of investment and resources to primary and community setting manages demand more appropriately.

Integration success story highlight over the past quarter
Greater Nottingham approach to Integrated Discharge. Principles: - Embed 'Home First' mantra - Discharge planning will always include patient/carer input: 'No decision about me, without me' - A single point of access for health and social care to support 'discharge to assess'. Integrated discharge teams are linked to an integrated intermediate tier of local services - Collateral information; Therapy and social work teams work at the front of the acute care pathway, routinely collecting information on how people have been managing at home before becoming acutely unwell. - People are discharged to their usual place of residence, with additional support if required and assessment of their longer term needs undertaken there rather than in hospital. - A clear clinical care plan is set for all patients within 14 hours of [acute] admission and within maximum of 48 hours, which includes an expected date and time of discharge that are linked to functional and physiological criteria for discharge. - Continue strong focus on 'simple' discharges. The SAFER patient flow bundle and 'Red2Green days' tools are used routinely to ensure the most appropriate care for patients on all hospital wards. - Board rounds take place on all hospital wards each morning. The multidisciplinary team reviews the clinical plan (including the discharge elements) on the board rounds and any decisions communicated to the patient. - Duplication of assessment minimised using trusted assessors, building on the functional information collected on admission - Strong emphasis on maximising clinically designed technology to deliver high quality data to the system System Achievements – since Oct 17

- Working to an Integrated Discharge Team specification as well as one Community Bed specification
- 1 Transfer of Care form implemented
- Simplified development of pathways and consistent use of language
- Number of supported discharges per week has increased
- Early indications of IDT minimising variation on activity for pathway 1
- LoS of patients post 24 hours of MSFD is reducing for pathway 2
- Number of CHC assessments completed in an acute bed is decreasing