Nottinghamshire County Council

Report to the Health and Wellbeing Board

7 March 2018

Agenda Item: 8

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 Q3 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.

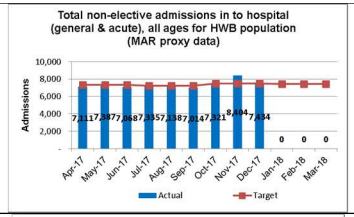
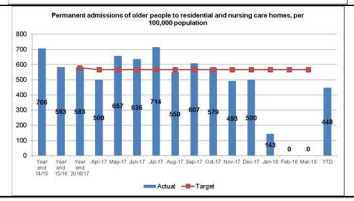
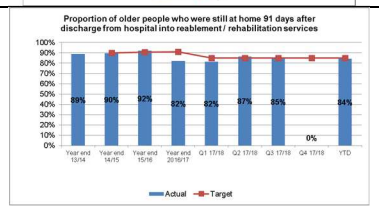
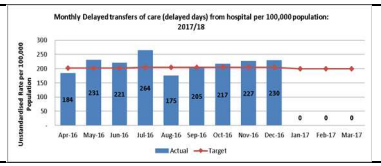
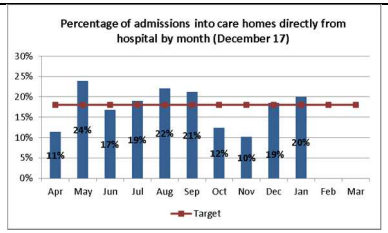
3. The performance update includes delivery against the six key performance indicators, the financial expenditure and savings, scheme delivery and risks to delivery for Q3 2017/18.

4. This update also includes the Q3 2017/18 national quarterly performance template submitted to the NHS England Better Care Support Team for approval by the Board.

5. Q3 2017/18 performance metrics are shown in Table 1 below.

   5.1. Three indicators are on track
   5.2. Three indicators are off track and actions are in place

Table 1: Performance against BCF performance metrics

REF	Indicator	2017/18 Target	2017/18 (to date)	RAG and trend	Trend	Summary of mitigating actions
BCF1	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	22,407 Q3	23,160 Q3	R ⇩		A&E Improvement Plans are in place in the three planning units. These plans form part of Winter Plans.
BCF2	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	565.6	500 Dec 2017	G ⇔		
BCF3	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85%	85.05% Q3	G ⇔		
BCF4	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	613.7 Q3	230 Dec 2017	R ⇩		NHS DTOCs performing above target. Social care and jointly attributable DTOCs performing below target.
BCF5	Percentage of users satisfied that the adaptations met their identified needs	100%	99% Q2	A ⇔	⇔	
BCF6	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	18%	18% YTD	G ⇔		

6. Reconciliation of Q3 2017/18 spend is complete. Expenditure is broadly on target with some in year slippage.

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 19 January 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 anticipated to be 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 Q3 2017/18 national quarterly performance report.

David Pearson
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Constitutional Comments (LMC 07.02.2018)

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

Financial Comments (XXX)

17.

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
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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	On track to meet target		Emergency Activity continues to be discussed at both the joint A&E Delivery Boards and the local Systems Resilience Groups.	
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target			
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	On track to meet target	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 FWi. This has increased the number of people that are included in this indicator as being	Since quarter one outcomes have improved and this indicator is currently on target. It is expected that this trend will continue and this indicator will be on target at year end.	

			discharged from hospital into reablement services however the percentage still at home after 91 days has reduced. The START service are maintaining performance at 91.4% (as measured in 2015/16), however the new step down discharge services are performing at 71%, which has reduced the overall figure to 82%. This indicator is currently off target.		
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Not on track to meet target	South Growth at NUH relates to an increase in health DTOCs and occurred as NUH switched from a paper based system to using Nerve Centre as the method of coding with social care colleagues in July. An action plan is in place to address this.	South Electronic monitoring system now in place at NUH 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 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	Q1 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		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	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		Timescales to deliver. Securing funding and licenses.	South NerveCentre being developed to incorporate system capacity to enable community bed stock to be visible Dashboard metrics also in development	Any further challenges will be noted and acted upon via the Provider to Provider meetings in place weekly.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Established			South Electronic Transfer of Care (eTOC) developed and agreed across all system partners	Further changes may be required to support the Truster Assessor role /

								implementation
Chg 4	**Home first/discharge to assess**	Established	Established	Established	Established	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	Any key challenges will be noted and acted upon via the Provider to Provider meetings in place weekly.
Chg 5	**Seven-day service**	Plans in place	Plans in place	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.	
Chg 6	**Trusted assessors**	Plans in place	Plans in place	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	The plan is to implement the model from April and any challenges arising will be actioned via the Greater Nottingham Trusted Assessor Steering Group.
Chg 7	**Focus on choice**	Plans in place	Plans in place	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		South Integrated teams established with key leads (community matrons and district nurses) in place aligned to each Care Home.	

	Hospital Transfer Protocol (or the Red Bag Scheme) Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.							
		Q2 17/18 (Current)	**Q3 17/18 (Planned)**	**Q4 17/18 (Planned)**	**If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.**	**Challenges**	**Achievements / Impact**	**Support needs**
UEC	**Red Bag scheme**	Established	Established	Established		Nervousness around the loss of the red bag has led to the development of a SOP to be signed off within the task and finish group and circulated to the care homes.	Red bag scheme rolled out across Greater Nottingham care homes on 02.10.2017.	Care homes will receive continued support from their respective CCG leads.

5. 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 Q3, 2 performance metrics are on plan, and 2 off plan (reablement, and delayed transfers of care – we additionally measure satisfaction with Disabled Facilities Grants and Friends and Family test data which are on 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

Social Services Interoperability Link – still preventing hospital admissions –case study

Background:

In Dec 2016 an innovative integration between a Social Services information system and Healthcare information Systems was piloted in the Emergency Assessment Unit at Kings Mill Hospital. As well as being technically ground breaking, information concerning whether an EAU (Emergency Assessment Unit) attender had a Social Care Package in place became directly available to Clinical Staff. The implications of this were profound, giving healthcare staff direct access to Social Care information without the need to always go through a third party. Access is available 24/7 irrespective of working patterns. Clinical staff reported then that it saved them time and enabled earlier discharge of patients often avoiding an overnight stay. This had obvious clinical benefits for frail elderly patients.

A year later, reviewing the system and what was classed then as a “proof of concept” it is exciting that the system is still making a return on the initial investment by facilitating earlier discharge and avoiding overnight bed stays: Read the case study that follows of an elderly lady who recently fell at an extremely busy time for the Hospital:-

A Patients’ Story:

18:00 Early Monday evening in December an elderly lady in her eighties had fallen in a local supermarket and was admitted to the Emergency Department at Kings Mill Hospital. The patient had some cognitive impairment and was not engaging with the staff either nursing, medical or therapy.

She passed her therapy assessments and was clinically safe to go home but when she was asked if she knew who her care provider was she either did not know or was unwilling to tell - it was it was difficult to assess her behaviour at the time. SystmOne (a healthcare computer system) was used to contact her next of kin, her elderly sister, who also was unable to say if there was a care provider in place or who they were.

At this point EDASS (a discharge facilitation service) asked one of the Discharge Nurses to access the interoperability link to see whether there was a package of care in place for the lady. The link was accessed and it was confirmed that a package was indeed in place. The Care Providers were contacted who did say that at times the patient did not always let them in but they always have to make sure she at least responds to them through the letter box! On their call that evening when she had not responded, they were worried and were going to invoke their escalation plan which may have involved forcing entry into the home.

All ended well. The care providers knew where the patient was and were happy to do subsequent calls as planned. The patient was discharged and did not need to have an overnight stay which benefited both the patient as it was in her best interest to go home. An unfamiliar environment would be disruptive to her routine and at least one night overnight hospital stay was avoided.

Positive Outcomes:

- An overnight stay in the hospital was avoided saving valuable resources.
- A bed would be freed up for more clinically appropriate patients.
- The elderly lady was able to recuperate from her fall in the familiar surroundings of her own home.
- The Care Providers were able to be kept informed giving reassurance that their client was safe and care for. The Care Package would not be suspended or stopped and valuable resources would not have to be diverted to establish whether the client was in danger i.e. potential forced entry to the living accommodation
- Health & Social Care are working together in a cohesive and unified way proactively supporting patient care.