HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Claire Jackson, Interim Director of Commissioning (Operations), BwD CCG Sayyed Osman, Director of Adult Services, Neighbourhoods and Community Protection, BwD LA
DATE:	12th December 2017

SUBJECT: Better Care Fund Quarter 2 Report

1. PURPOSE

The purpose of this report is to:

- Provide Health and Wellbeing Board (HWBB) members with an overview of Better Care Fund (BCF) performance reporting for quarter 2 (July – September 2017), including progress in relation to delivery of the plan since the previous report to Board Members on 26th September 2017.
- Provide HWBB members with an update in relation to Better Care Fund finance position at month 6.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- Note the BCF quarter 2 submission and progress made against delivering the BCF plan, including performance metrics.
- Note the month six finance position

3. BACKGROUND

As outlined in previous reports, the Health and Wellbeing Board is accountable for the delivery of the Better Care Fund plan. The management of the plan is undertaken through Blackburn with Darwen joint commissioning arrangements.

The Blackburn with Darwen BCF plan for 2017/19 was submitted on 11th September 2017, with a resubmission on the 25th of September 2017. The plan was approved on the 30th of October with an expectation that planned performance metrics are achieved.

There was no requirement to submit a quarter 1 report for April 2017 – June 2017 due to the delay in the release of the national guidance.

4. RATIONALE

Better Care Fund

As outlined within previous reports to the HWBB, the case for integrated care as an approach is well evidenced. Rising demand for services, coupled with the need to reduce public expenditure, provides a

compelling argument for greater collaboration across health, care and the voluntary sector.

The Spending Review set out an ambitious plan so that by 2020 health and social care is integrated across the country. Every part of the country must have a plan in place for 2017-19. This is also reflected in the NHS Planning Guidance 2016/17-2020/21 Delivering the Forward View. The Better Care Fund remains a key policy driver to support integration of health and care services at a local level.

5. KEY ISSUES

5.1 BCF Quarter 2 Submission

The BCF Quarter 2 submission was made on 23th November 2017 following sign off on behalf of the HWBB. There was no requirement to report on Quarter 1 given the BCF planning exercise had not been completed at that time.

There are a number of changes to reporting requirements for the BCF in 2017/18:

- Expenditure against the planned budget will be reported annually rather than quarterly
- A more detailed narrative of progress against delivery of BCF schemes is required
- Assessment and narrative on the implementation of the High Impact Change Model (HICM) for Transfers of Care is required
- There is a reduction in national conditions

5.2 BCF quarter 2 Performance

Reduction in non-elective admissions – currently on track to deliver

There continues to be a reduction in NEL hospital admissions. The impact is particularly positive in relation to the 50+ age group, which is in line with local investment decisions aimed at deflecting frail elderly and people with long term conditions from admission.

Integrated working at a neighbourhood level across health, care and the voluntary sector continues to support people to avoid hospital admission and remain independent.

Rate of permanent admissions to residential care – currently on track to deliver

The reported number of placements over this period reflects a positive picture and our approach to reducing the number of people entering long term care. It is important to note that in the vast majority of cases, service users go into short term care first and a proportion will be appropriate for a long term placement which may reflect in the figures in future periods.

The 2017/18 planned figure was set at 175 admissions (817.1 per 100,000 population). As at the end of September there were 73 admissions for people aged 65+, 345.9 per 100.000 population.

Blackburn with Darwen continues to provide in reach reablement, dedicated social worker support and access to therapy services to maximise the opportunity for service users to return home following a period of short term care.

Reablement – currently on track to deliver

The reablement target relates to the proportion of people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. The 2017/18 target was set as 91.4%. In quarter 1 there were 110 people still at home after 91 days, out of 122 admissions (90.2%). In quarter 2 there were 64 people still at home, out of 68 admissions (94.1%)

The last two quarters show an average of 92.1% which is above the planned target for the service.

The reablement service continues to be on track to achieve agreed 2017/18 target. Service delivery supports mainstream reablement, crisis, in-reach and Home First services.

Delayed Transfers of Care (delayed days)- currently not on track to deliver

Several schemes have been agreed to support the reduction in DToC and are progressing as planned:

- Active recruitment is underway to the Home First service in BwD, with plans for a fully mobilised service to be in place by December 2017
- An integrated discharge pathways leadership post is being recruited to. This post will lead the current Integrated Discharge function across health and care within Pennine Lancashire
- The Home of Choice policy has been agreed across Pennine Lancashire

There is significant work at hospital level to clearly identify and apportion DToC in line with current guidance. This will also provide consistency across Lancashire and South Cumbria.

A system diagnostic of discharge pathways commenced in in early November, as part of the Pennine Lancashire transformation programme, which will inform the future redesign of discharge pathways.

5.3 High Impact Changes

At quarter 2, BwD reported the following position in relation to the 8 High Impact Changes for Transfers of Care.

	High Impact Change	**Self assessment**	**Evidence**
1	Systems to monitor patient flow	Plans in place	All referrals coming into the discharge service are triaged to ensure patient flow through the correct pathway for a safe discharge with social care, health or community services.
2	Home first/discharge to assess	Plans in place	The simple Home First pathway supports an early discharge into home based reablement and residential rehab beds via the Trusted Assessment. This pathway is well established and performing well. The Enhanced Home First offer will be operational by December 2017.
3	Focus on choice	Plans in place	Patient groups have been involved in policy development which has been approved across Pennine Lancashire.
4	Enhancing health in care homes	Plans in place	Red bag scheme is being piloted in 6 homes and telehealth in 8 homes. INTs and reablement provide support to people in care homes.
5	Multi-disciplinary/multi-agency discharge teams	Established	An integrated discharge service is established and co-located, supporting patients to access the most appropriate discharge pathway.
6	Seven day service	Established	Weekend social worker offer in place to support assessment and discharge across 7 days.
7	Trusted assessors	Established	Trusted assessment is well established within the integrated discharge pathways. Trusted Assessment will also facilitate the Home First pathway.
8	Early discharge planning	Mature	Complex case and patient flow teams have been integrated to ensure patient flow through the correct pathway for safe discharge.

5.4 Scheme Updates

An update detailing the progress made locally to the area's vision and plan for integration set out in the BCF narrative plan for 2017-19 can be found in appendix 1. This includes milestones met, agreed variations to the plan and challenges faced.

5.5 Case Study
A case study highlighting the impact that integrated neighbourhood working has had on a patients experience and outcomes of care has been included within the quarter 2 report (appendix 2)

5.6 2017/18 BCF Finance Month 6 Update

The CCG minimum pooled budget requirement for 2017/18 was £11,169,000. This was an increase of £197,000 from 2016/17 requirement.

The total BCF budget for 2017/18 is £12,769,145 and is allocated as follows;

Spend on Social Care	- £5,812,187	(46%)
Spend on Health Care	- £4,191,560	(33%)
Spend on Integrated Care	- £2,165,033	(17%)
Contingency	- £600,365	(5%) (allocated 50/50 to BwD BC and CCG)

The BCF budget currently has a forecast underspend of £57,807. This is as a result of an under spend on the community equipment services and a delays filling a locality post.

Additional funding for Disabled Facilities Grant in 2017/18
As part of the Autumn Budget announcement on 22 November, the Government announced that an additional £42 million of funding will be provided nationally for the Disabled Facilities Grant (DFG) in 2017/18. This will increase the total national DFG budget for this year to £473 million.

This is additional and complementary to the DFG funding already included within the BCF. Given that BCF plans have already been agreed and that additional funding comes later in the financial year, the Government has decided that the quickest way to make it available to those qualifying for grants is for it to be paid directly to lower-tier LAs by the Department for Communities and Local Government. This additional funding will replicate the purpose and flexibilities of the existing DFG. Currently, LAs are able to spend DFG money on wider social care capital projects, and we will maintain this flexibility and encourage local areas to use the funding innovatively by working with others across health and social care. We are awaiting confirmation of an allocation for BwD and will update HWBB in due course.

5.7 Improved Better Care Fund (iBCF)
The total iBCF budget for 2017/18 is £4,306,752. A separate return has been made to update on delivery of the Improved Better Care fund schemes. Quarter 2 progress against plans is outlined below;

Supporting Pressures within the NHS:
The Enhanced Home First offer will support service users with more complex needs to be discharged home from hospital much sooner than would otherwise be the case. This will optimise outcomes for the individual and reduce the risk of a protracted hospital admission and/or admission into a care home setting. Recruitment is progressing well and Pathways have been documented. The Enhanced Home First pathway is currently being tested with small number of service users.
Pathways and processes for Continuing Health Care (CHC) are being reviewed. This will include a realignment of assessment capacity from the hospital into the community. There is a clear commitment across the Partnership to achieve a significantly lower percentage of CHC assessments being completed in hospital.

Social Care Pressures:
The iBCF has also been utilised to support significantly increasing costs and demand for services. Demand management strategies are in place, including strength based approaches, to ensure effective pathways into Integrated Neighbourhood Teams and a clear focus around community engagement and universal services. Additional social work capacity has been put in place to undertake Deprivation of Liberty

assessments (DoLS).

Stabilisation of the social care market:
Fees increases to stabilise the social care market have been agreed and implemented for 2017/18. This includes addressing the pressures associated with the increase in the National Living Wage. The cost of the fee increases for 17/18 is in excess of £1.6m.

5.8 Section 75 Agreement:
Following the allocations of the new Section 31 grant for Improved Better Care Fund (iBCF) to Local Authorities in 2017/18 it has been agreed that an in depth review of the Section 75 agreement would be undertaken to include changes to the BCF and iBCF funding. This is currently being progressed.

6. POLICY IMPLICATIONS

The key policy drivers are outlined within the main body of this report and within previous BCF papers presented to HWBB members. Local areas are expected to fulfil these requirements. Any further impact due to changes in National Policy or planning guidance will be reported as they arise.

7. FINANCIAL IMPLICATIONS

No further financial implications have been identified for quarter 2. This report outlines the budget position at month 6.

8. LEGAL IMPLICATIONS

Legal implications associated with the Better Care Fund governance and delivery has been presented to Health and Wellbeing Board members in previous reports. A Section 75 agreement is in place between the Local Authority and CCG which outlines risk sharing arrangements associated with the Better Care Fund and other funding streams aligned to integrated delivery locally.

9. RESOURCE IMPLICATIONS

Resource implications relating to the Better Care Fund plan have been considered and reported to Health and Wellbeing Board members as part of the initial plan submission.

10. EQUALITY AND HEALTH IMPLICATIONS

Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.

Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care schemes, including new business cases, and are integral to service transformation plans.

11. CONSULTATIONS

The details of engagement and consultation with service providers, patients, service users and the public have been reported to Health and Wellbeing Board members throughout development of the local BCF plan. Learning from the Pennine Lancashire 'Together a Healthier Future' engagement has informed the development of the 2017-18 BCF plan. Consultation and engagement has formed part of business case development for any new or redesigned BCF schemes.

CONTACT OFFICER:	Claire Jackson Sayyed Osman
DATE:	28th November 2017
BACKGROUND PAPER:	Previous BCF reports to HWBB members

Appendix One

Better Care Fund Scheme Updates- Quarter 2

Scheme one: Voluntary Sector

i. Information Advice and Guidance

- A comprehensive review process has been completed to guide commissioning intentions beyond March 2018 when the 3 years funding ends. The service specification for Phase 1 set out its purpose for a consortium based commissioning approach to deliver services for information, advice and guidance within the Borough of Blackburn with Darwen including a single point of contact. The contract will now be extended to March 2019 to enable learning from best practice.

ii. **Phase 2 Integrated Carer Services**

- The aim of the service is to deliver information, advice and guidance to all age carers who live in Blackburn with Darwen, or (by arrangement) who care for someone who does. Over the past quarter they have provided a more in depth service to those Carers with more complex needs, and those who face barriers to full participation in the assessment process.

- Over the past 3 months there has been integrated sharing of resources and attendance at staff meetings which are now fully integrated and cross service location is in place. Fund raising has increased significantly due to recent new fundraising role and the Carers Champions are increasing in number and identification. Through partnership working with Shelter the numbers of carers in receipt of relevant benefits is increasing.

iii. **Phase 3 Keeping Well and Healthy Homes**

The delivery of the Keeping Well project began in June 2017.

Keeping Well:

- Phase three aligns the Age UK 'Here to Help', MIND 'Achieving Self Care' and Care Networks 'care navigator' to support community capacity and resilience, improve wellbeing through self-care and offer targeted approach to reduce demand on health and social care.

- The service aims to improved Wellbeing, health perception, decreased loneliness, improve access to volunteering opportunities, reduce GP consultations and contact for non-medical needs and reduce prescription rates.

Stakeholder feedback:

"I really love the programme, the patients really benefit from it and it has reduced GP appointments for our practice" (GP)

*"I'm really happy with the service and really appreciate the care you give to patient's needs. It improves patient wellbeing and I look forward to continuing to work with you." (*GP)

Healthy Homes:

- The Healthy Homes service was commissioned in 2017 for one year, following objective setting this has now been extended to two years to align with the wider voluntary sector offer. The launch of the service is set for November 2017 and staff have now been employed into post to provide awareness raising, advice and signposting to reduce health harms relating to housing in Blackburn with Darwen (BwD)

Co-ordination of Dementia services

- A review/standardisation of the service to be completed by Pennine Lancs CCG's and LCFT MAS Service to address the issues and the development of the service and pathways is currently being undertaken for the MAS service.

Scheme Two: Integrated Neighbourhood Teams

- Four locality Integrated Neighbourhood Teams (INTs) continue to be developed across Blackburn with Darwen. The weekly meetings include regular attendance by all relevant stakeholders including social workers, community nursing teams, hospice specialist nurses, mental health teams, therapists, and reablement teams, voluntary sector organisations and Lancashire Fire and Rescue Service.

- The Darwen INT fully co-located within Darwen Health Centre during the first quarter of 2017. This move has further aligned ways of working across the teams and has had a positive impact on patient and service user

care. Workforce development and engagement strategies are ongoing to support staff to operate as a single team.

- Plans are currently underway to relocate the West INT to Barbara Castle Way Health Centre by February 2017. Timescales, costs and issues are being worked through.

- Engagement with individual GP practices is ongoing and integral to the success of the INTs. A wide range of patient stories have been developed to highlight the benefits of integration between health, social care and voluntary sector organisations. The patient stories are being used to engage GP's and key stakeholders. The case studies will also be used to evidence cost effectiveness and improved patient outcomes as a result of the INTs.

- Across Pennine Lancashire 'hospital markers' have been agreed for the INTs, the Intensive Home Support Service (IHSS) and District Nursing Teams. The purpose of the hospital marker is to inform the community team when an individual has been admitted to the acute trust. This will support early discharge planning and enable a review of support needs.

- The Integrated Neighbourhood Co-ordinators have been involved in an extensive piece of work to identify the top 4 over 85 year old patients from each GP practice with high acute admission costs, using the risk stratification tool. The exercise demonstrated a high number of patients who were already known to the INTs, distinguished those who had multiple acute conditions that needed to be in hospital and identified those whose needs could have been met in the community. Those patients not already known to the INTs were referred for support, once consent had been gained. Plans are in place to repeat this piece of work.

- Partnership working between the four INTs and Transforming Lives continues to develop and strengthen. This has improved access to the whole spectrum of support available across the system.

Scheme Three: Intermediate Care

- The development at Albion Mill is progressing as planned and represents an innovative approach towards bed based intermediate care. The build is due to start in November 2017 with completion by May 2019. The project is well supported with a representative steering group that will drive progress, monitor risks and report through the appropriate governance processes. A procurement timescale has been developed for the nursing and therapy element of the model and a local vision has been developed that will be used to launch a soft market test with potential providers. This model includes principles that are detailed within the Pennine Lancashire Out of Hospital Business Case and will readdress the balance of step up and step down support, focusing on supporting patients to regain their independence and return home with additional wrap around care if required.

- The local model includes a 'community hub' that will be used by all members of the community, residents of the intermediate care facility and their family members. This will include an offer of advice and guidance, the opportunity to build personal resilience and the opportunity to increase confidence in the range of support services and equipment available to promote independence and self-care.

Scheme Four: Integrated discharge service & Home first

- The Enhanced Home First offer will support service users with more complex needs to be discharged home from hospital much sooner than would otherwise be the case with wrap around access to crisis, reablement, therapy and social care. This will optimise outcomes for the individual and reduce the risk of a protracted hospital admission and/or admission into a care home setting. Recruitment is progressing well and Pathways have been agreed and documented. The Enhanced Home First pathway is currently being tested with small number of service users.

- The simple Home First pathway supports an early discharge into home based reablement and residential rehab beds via the Trusted Assessment. This pathway is well established and is performing well. Discharge from hospital is achieved either same day or the following day, once a Trusted Assessment has been received and validated.

- Weekend social workers: Additional investment has been added to remodel the weekend offer into 4 day rather than 2 day offer as a means to improve patient experience and avoid hand over delays. Staff consultation and recruitment is underway.

Scheme Five: Intensive Home Support Service

- Work is ongoing to align the IHSS offer with neighbourhood and Home First provision to support step up and down from hospital.

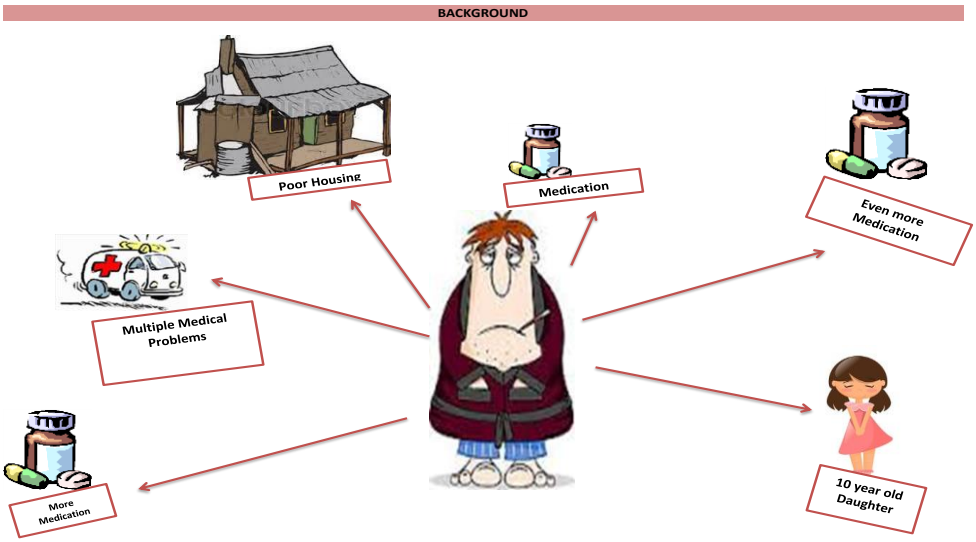
- The Chronic Obstructive Pulmonary Disease (COPD) team is working with the Acute Respiratory assessment Unit to support patients with both COPD and asthma. The team will carry out community reviews and promote self-care strategies.

Scheme Six: Directory of Service / Navigation Hub

- CCGs are working across Pennine Lancashire to develop an Integrated Urgent Care model based on the National requirements. The current navigation hub will be incorporated into the integrated urgent care model to support increased clinical advice to professionals 24/7.

Appendix Two:

Blackburn with Darwen Integrated Neighbourhood Teams case study



Background:

- David (not his real name) was referred to the Complex Case Manager (CCM) following a GP Multi-Disciplinary meeting. At this meeting the CCM was concerned about his health conditions, the home environment and the wellbeing of his young daughter.

- The CCM agreed to visit him at home for an assessment and he was subsequently brought to the weekly INT meeting for further discussion.

Summary of Medical, Physical and Social Conditions:

- David was 55 years old and diagnosed with multiple medical problems including severe Chronic Obstructive Pulmonary Disease (COPD), Epilepsy, Asthma and fluctuating blood pressure. It was identified that he was also suffering from poor mobility, substance misuse and high levels of pain which affected his activities of daily living and ability to care for his daughter.

- David's daughter provided support with meals, washing and cleaning. Various services had raised concerns about her welfare and general wellbeing and contingency plans were in place to ensure her safety should David be admitted to hospital or his health deteriorate further.

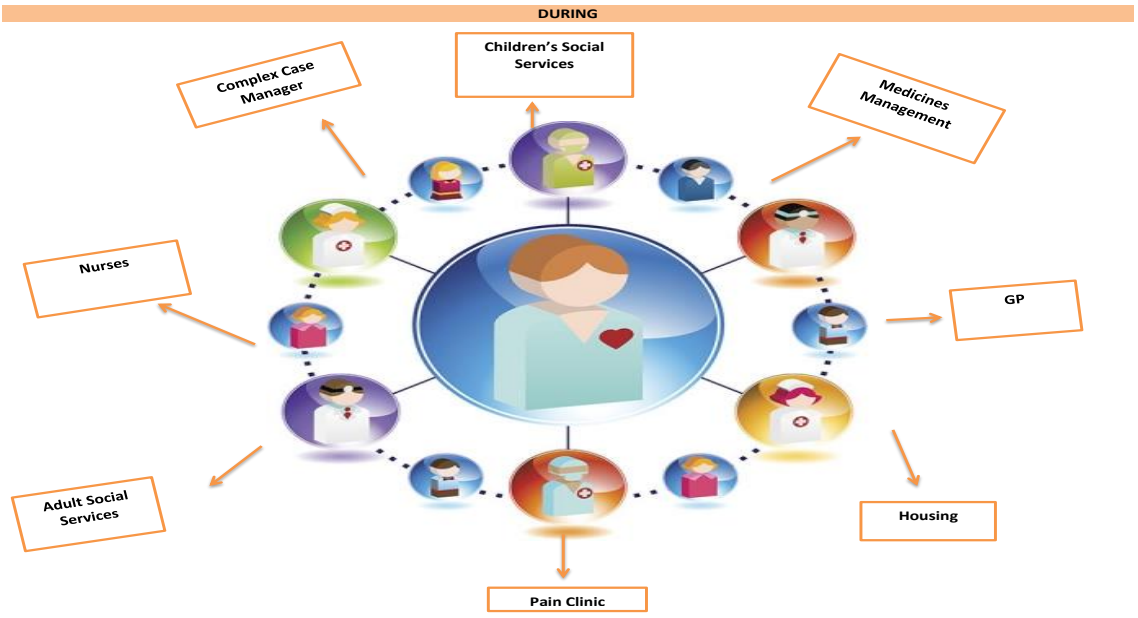
- The home environment was initially a concern due to excessive damp. David was initially reluctant to accept any help or support as he feared he would be assessed as being unable to care for his daughter. These concerns were addressed and assurance given that this would be considered only as a last option.

Discussion at the GP MDT Meeting:

- David was initially referred to the CCMs for uncontrollable asthma however the risk stratification tool identified David as a high risk patient. There was also a referral into Blackburn with Darwen Transforming Lives team due to concerns regarding social circumstances and his daughter's wellbeing.

- David was taking a number of high dosage medications for his heart, chest, stomach, blood pressure, pain, bladder and diabetes. This resulted in him taking daily medication in excess of 49 medications, causing him to be drowsy and explained why he was spending excessive time in bed and struggling to look after his daughter.

- It was agreed for Complex Case Manager and Medicine Management to work together to identify which medications could be potentially reduced taking into account all his co-morbidities.



INT Weekly Meeting:

The CCM brought this David for discussion at the weekly INT meeting and the following professionals became involved in his care:

- The **Complex Case Manager** took on the role as case manager for David to ensure that all services had one point of contact and care was joined up and co-ordinated. The complex case manager worked closely with David to ensure that trust was gained and that he stayed at the centre of the plans. It was identified that David would benefit from other services and he gave consent for these referrals to be made.
- **Medicines management** and the complex case manager worked closely together to review David's medication and formulate a plan to reduce it further. They started to reduce the medications over many weeks and David was closely monitored to observe any side effects. There was close liaison with the GP to ensure there was no miscommunication.
- **Housing Officers** reviewed David and deemed it appropriate that he and his daughter were rehoused. Suitable accommodation was identified and David and his daughter were supported with this move.
- **Transforming Lives** Key Worker developed a positive relationship with David over time and supported him to develop a more positive routine.
- The **Social Worker** assessed David and arranged a care package to assist with his personal care, showering and washing which significantly improved his wellbeing and self-esteem. The social worker also identified that David's daughter is a young carer and she was linked to appropriate support for herself.
- The **Pain Clinic** tried to engage David and an appointment was offered – ultimately he did not accept this service.
- **Medicines Management** Team have successfully reviewed and have been able to reduce David's medication to 15 per day, resulting in him being less drowsy and being able to more effectively care for himself and his daughter. When the multidisciplinary team visited the David they have reported that he appears alert and is engaging much more fully in activities of daily living.
- David's **son and daughter in law** are now more connected with the family and are providing informal support to himself and his daughter.

An Integrated Neighbourhood Team Approach:

- The INT worked with David to manage and improve his health conditions, personal care, social circumstances and parental responsibilities.
- All agencies worked together and planned support as an integrated team to support both father and daughter staying at home with a better quality of life.
- Regular integrated care meetings and Children & Families meetings enabled joined up care planning and enabled a clear understanding of progress and ongoing needs.
- The multidisciplinary team worked very closely with other services including mental health, young carers and daughter's school to help support daughter. The team worked with daughter to recognise the signs when David is unwell and she now feels confident to access support for herself and summon support for her father as necessary.
- The multi-disciplinary team built up trust and rapport with David and his daughter in order to support them as a family unit.
- David continues to receive support from Complex Case Manager, Social Work, General Practice, Medicines Management, and Children's Social Care.