Health and Wellbeing Board

7 December 2015

Better Care Fund – Quarter 2 Update 2015/16

1.0 Purpose

1.1 To report on the content of the second quarter assurance return required by NHS England on progress locally with implementation of our plans for the Better Care Fund. The deadline for this return submission is 27 November 2015.

2.0 Recommendation

2.1 To note the content of the second quarter assurance return for the Better Care Fund.

3.0 Report detail

3.1 An assurance report is required for each quarter, and the Health and Wellbeing Board received an update report for the first quarter in September 2015. The format for the second quarter is the same as for the first and an update is as follows:

3.2 National Conditions

There were 6 national conditions to be met by the original plan submissions for the Better Care Fund. The assurance return seeks to establish whether these have been met, and the response from Walsall is as listed below:

National Condition	Qtr 1 Response	Qtr 2 Response
Are the plans still jointly agreed?	Yes	Yes
Are Social Care Services (not spending) being protected?	Yes	Yes
Are the 7 day services to support patients being discharged and prevent unnecessary admissions at weekends in place and delivering?	No – In progress	No – In progress
In respect of data sharing, confirm that: i). Is the NHS number being used as the primary identifier for health and care services? ii). Are you pursuing open API's (Application Processing Interface i.e. systems that speak to each other)?	 No – In progress No – In progress	 Yes No – In progress

iii). Are the appropriate information governance controls in place for information sharing in line with Caldicott 2?	No – In progress	No – In progress
Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes
Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes

3.3 The main issues to be addressed are as follows:

- The measures set out in the plan for the Better Care Fund to reduce demand on adult social care services via the successful redesign and integration of community based health and social care services are critical to the requirement for the Social Care and Inclusion Directorate of Walsall Council to achieve proposed savings targets in 2016/17. There is a risk that additional funding for adult social care services within the Better Care Fund will be insufficient to meet increased demand during this period;

- There is a risk that implementation of 7 day services to support patients being discharged and prevent unnecessary hospital admissions remains unaffordable;

- Further work is needed to agree information sharing protocols and to identify and implement an information system that provides access to patient records for front line workers based upon the ability to interface with the various patient record systems across the health and social care economy;

- There is agreement on the consequential impact of these arrangements on the acute sector, in that it is recognised that a continued increase in emergency admissions to hospital will continue to require additional funding from the contingency. As stated above, this creates a strong likelihood that additional funding for adult social care services within the Better Care Fund will be insufficient to meet increased demand during this period.

3.4 **Performance Metrics**

There are 6 main metrics and progress for each is as follows:

Emergency Admissions to Hospital: Walsall's plan included a target reduction of 3.2% in the level of emergency admissions in the calendar year 2015 compared to the calendar year 2014. By February 2015 it was apparent that the level of emergency admissions was still increasing, and so this target was reduced to a reduction in the level of emergency admissions of 2%.

The actual level of emergency admissions during the first 9 months of the calendar year 2015 was 22,616, compared to the first 9 months of the calendar year 2014 of 21,835 – this is a 3.6% increase which is a decrease compared with the 4.6% increase on the first 6 months. The total increase by the end of the calendar year is likely to be near 4%, compared to the

target of a 2% reduction.

(NB: The national methodology of apportioning activity reported on CCG geographies to HWB geographies is reliant on the consistent submission of the Monthly Activity Return (MAR) by hospitals. Therefore these figures may be subject to further adjustment of between +/- 2%.)

Permanent Admissions to Residential Care: The baseline for this metric was set according to the number of permanent admissions to residential care funded by Walsall Council in the 2013/14 financial year which was reported as 234. The aim is to achieve a reduction of 10% over the four year period to 2018/2019. However, the total number of permanent admissions during 2014/15 was 274, and the level of admissions continues to rise.

There were 182 new placements in the period from April to end of October 2015, and this would mean a total of circa 312 placements in 2015/16 if the average per month to date is sustained (there is a normally a higher number of placements in the winter so this should probably be viewed as a minimum).

Number of People Living at Home 91 days after a period of reablement following hospital discharge: The target is to achieve 78% and this was not met consistently during the first quarter. The out-turn at the end of quarter 2 was 81.54%, and this suggests that the year-end target will be met. The reablement service provides a key element of Discharge Pathway 1 where the patient needs support to go home safely and it is important that as many older people as possible return to full independence after a period in hospital.

This is proving challenging, and further work is underway to examine more closely how many people continue receiving care at home, sometimes permanently, and how many end up as an admission to a care home, or as a readmission to hospital.

Delayed Transfers of Care: This metric is a measure of the number of days that patients who have been referred to social services are delayed in hospital. This is a sub set of the total number of patients being transferred from hospital. A majority of people leaving hospital do so without any on-going support, but where there is a need for on-going care and support there is sometimes delay caused by for example waiting for families to choose a care home; waiting for a decision on funding; waiting for completion of therapy assessments; waiting for prescriptions (especially week-ends); or waiting for availability of homecare or reablement services.

The focus of attention in The Manor hospital is upon all those patients who are clinically stable and thus medically fit for discharge, rather than the subset that have been referred to social services, and so the reporting of this metric shows a comparatively lower level of delays of patients referred to social services. Work is underway to ensure that the metric is reported more accurately in the future.

Number of people diagnosed with dementia: At the time of the submission of the plans for the Better Care Fund, a 67% of the prevalence target had been set at national level for people diagnosed with dementia. Walsall achieved 68%. New prevalence calculations were introduced by NHS England in April 2015, but there was no reporting between April and September 2015. The new calculation was supposed to lower the prevalence to show the effect of healthy lifestyle initiatives. However, Walsall's prevalence of dementia increased by 2.95%. Many of our neighbouring CCGs had their prevalence lowered, some by as much as 24.1% (556 people). A concern has been raised with the National Clinical Director for Dementia who has indicated this will be investigated. Based on the new prevalence rate, Walsall's dementia diagnosis rate had decreased to 66.4% (as at August 2015 for over 65s). However, one GP Practice had failed to submit data. Based on that GP Practice's last recorded dementia list, Walsall's rate should have been 68.83%, which shows a slight increase from March 2015 even with the new prevalence calculation. If Walsall's prevalence calculation had not changed, the dementia diagnosis rate would have been 70.44% by August 2015.
Satisfaction with integrated health and social care services received following a period of hospitalisation: This is measured by asking those people who were supported with reablement service to leave hospital of their level of satisfaction. This process is underway, with the aim of contacting a minimum of 1500 people and achieving a 90% satisfaction score. The survey covers Hollybank Residential Care Home, the Community Intermediate Care team and Discharge to Assessment team. An electronic recording spreadsheet has been set up which captures the names and address of service users and compiles six domains of satisfaction with their integrated services. From the completed responses so far received, the satisfaction level has been 90%.

3.5 **New Integration Metrics**

During September 2015, the Department of Health consulted upon a new set of metrics to measure how local areas are progressing at integrating social care and health. The purpose of these metrics is to identify and learn from best practice and provide support where things are going wrong. The following six metrics were issued for consultation:

1. Do all health and social care organisations have read/write access on care records?
2. Do you share data to drive the coordinated allocation of resources through risk stratification?
3. Total bed days for unplanned admissions of ambulatory care sensitive conditions per 100,000 population
4. Proportion of 65+ who were still at home 91 days after discharge from hospital into reablement and rehabilitation services
5. Proportion of people with both a personal health budget and social care personal budgets who have been able to link the two.

6. New survey question focused on experience of integrated care.

3.6 Information was required on three of these metrics as part of the quarter 2 assurance return as follows:

Integrated Digital Records: this repeats the questions in the national conditions in respect of data sharing;

Use of Risk Stratification: based on Walsall's GP population as at June 2015 there were 5,495 Patients (2% of 274,754) who are in the cohort of patients at risk of hospital admission. Across the five integrated localities in Walsall i.e. North, South, East, West and Trans, some 3,830 (70%) local residents have been identified as in need of preventative care. Out of these 3,830 residents, 81% have been offered a care plan. The aim is to increase this figure in 2016/17.

Personal Health Budgets: In Walsall 60 people have been identified as eligible to receive a personal health budget and they have all been offered this opportunity. A total of 29 people are currently in receipt of a personal health budget, which is one of the highest figures in the West Midlands. The CCG is in the early stages of considering whether to extend this to patients in receipt of planned care.

3.7 **Financial Position as at the end of Quarter 2**

The projected year-end overspend as at the end of Quarter 2 is £244,000 against the total pooled budget of circa £23,977,000. This is being shared as £93k against CCG expenditure and £151k against Council expenditure, and actions are underway in each agency to mitigate the projected overspend during the remainder of the financial year. This will be reported in more detail to the next Health and Well-being Board.

3.8 **Narrative Explanation of Progress to Date**

The final section of the assurance return is to provide a succinct account of progress to date. We have stated as follows:

We have established a Healthy Walsall Transformation Board where commissioners and providers across the health and social care system are meeting to oversee a strategic transformation toward care closer to home that will reduce hospital admissions and placements of older people in to care homes. The Board has met twice and has agreed three priority work-streams with the main elements for each as follows:

Staying Safe at Home: this includes integration of community services between community health, primary care, social care, mental health, and therapies – creating multidisciplinary teams with joint assessment and case management, risk stratification, and single point of access with rapid response to urgent situations;

Frail Elderly Service: this takes the previous Frail Elderly Pathway to a new scale with multi-disciplinary team assessment and care planning across primary, community and hospital settings (including social care and mental health) and a

common screening tool. This service will be the first to be supported with mobile working technology to support joint assessment and care management;

Getting Home Quickly and Safely: simplification of discharge pathways resulting in reduced delayed transfers; a single point of access to discharge pathways and trusted assessor role for discharge co-ordinators; a revised model for therapy services with greater emphasis upon prevention; improving the discharge process at ward level including at week-ends; reducing lengths of stay in step down and discharge to assess beds; increasing capacity in social care reablement at home service (in-house); negotiating more capacity availability at peak times from independent sector.

The overall aim is to focus more upon care closer to home and reducing hospital admissions and thus reduce the extent to which the whole system has become focused upon stepping patients down from hospital in order to provide capacity for the demand pressures at the front of the hospital. The service pathways available to support hospital discharge are the same service pathways that can support care closer to home, so the objective is to switch some of the capacity in the current range of service pathways from being used to support hospital discharge to community support.

This in turn will lead to a reduction in Delayed Transfers of Care (DToC) and an improvement in our overall A&E performance levels. Our overall plan for the BCF will be revised in accordance with this reshaping of the programme in Walsall.

There are also work-streams focused upon optimising use of assistive technology; support to carers; and working with the voluntary and community sector.

4.0 Implications for joint working arrangements

4.1 The Better Care Fund is a pooled fund arrangement between the Council and Walsall CCG. Its aim is to support further integration of commissioning of services for older people in a way that reduces admissions to hospital and placements to care homes.

4.2 There is a legal agreement over the pooled fund which is established under Section 75 of the National Health Service Act 2006.

5.0 Health and wellbeing priorities

5.1 The Better Care Fund supports the priority for independence of older people through the integration of the commissioning and delivery of health and social care services.

5.2 The number of older people aged 75 years or more in Walsall's population will increase between 2014 and 2020 by 14.8% compared to a growth for the whole of England of 16.2%. Within this, the growth of people aged over 85 years old will be 30% in Walsall compared to 22% in England.

5.3 In this context, together with the climate of financial austerity, it is extremely important that this programme of work is successful in maintaining the health and well-being of older people. It also important to ensure that a high quality of services is maintained in order that the outcomes experienced by those people who do use health and social care services are good, and in order to minimise safeguarding issues.

5.4 However, the latest metrics show a continuation of increasing levels of emergency admissions to hospital, and of the number of placements of older people in to residential care. This highlights the deep rooted nature of the challenge.

5.5 The Better Care Fund Insight Team will be visiting Walsall in the second week of January 2016 and this will provide an opportunity to test out our plans with a wider audience and to benchmark against good practice elsewhere.

Background papers

An update report on progress with the Better Care Fund is a standard item on each Health and Well-being Board.

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