Agenda item 6

Health and Wellbeing Board

29 February 2016

Better Care Fund Plan 2016/17

1. Purpose

1.1 This report sets out the planning requirements as issued in draft form by the Department of Health at the end of January 2016 and seeks approval to the Walsall plan for the BCF in 2016/17.

1.2 A plan for the Better Care Fund in 2016/2017 was originally required to be submitted to the Department of Health (DH) by a deadline of 8 February 2016, followed by a process of assurance and any subsequent changes to be made for a final submission on 16 March 2016, and for final plan approval by 1 April 2016. Guidance from the DH has been delayed and so the initial submission has not been made at time of writing.

2. Recommendations

2.1 That the Health and Well-being Board approve in principle the action plan for the Better Care Fund 2016/17 as set out in paragraph 7.3;

2.2. That the Health and Well-being Board endorse the financial schedule as set out in Section 8 (subject to final decisions on budgets by the Walsall Council and Walsall CCG);

2.3 That the Health and Well-being Board approve the target metrics for the Better Care Fund as set out in paragraph 11.1;

2.4 That the Health and Well-being Board approves the plan for Better Care Fund as attached for submission to the Department of Health.

3.0 Background

3.1 On 8 January 2016, the Government issued the Better Care Fund Policy Framework which set out the policy framework for the implementation of the fund in 2016-17, as agreed across the Department of Health, Department for Communities and Local Government, Local Government Association, Association of Directors of Adult Social Services, and NHS England.

3.2 In 2016-17, the Better Care Fund will be increased nationally to a mandated minimum of £3.9 billion (from the current minimum of £3.8 billion) to be

deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. The local flexibility to pool more than the mandatory amount will remain. The actual amount available in Walsall is not increased (i.e. 0%). In looking ahead to 2016/17, it is important that Better Care Fund plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

3.3 In place of the performance fund, there are two new national conditions, requiring local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The national conditions are designed to tackle the high levels of DTOC across the health and care system, and to ensure continued investment in NHS commissioned out-of-hospital services, which may include a wide range of services including social care.

3.4 Whilst the policy framework remains broadly stable in 2016/17, local areas should be mindful in developing their plans about the linkages with NHS strategic and transformation plans which NHS partners will be required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-2020.

4.0 BCF Planning Requirements

4.1 Local partners are required to develop a joint investment plan that is approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. The process for developing plans has been aligned to the timetable for developing CCG operational and Council financial plans. In developing BCF plans for 2016-17, local partners are required to develop, and agree, through the relevant Health and Wellbeing Board:

- A short, jointly agreed narrative plan including details of how they are addressing the national conditions;
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
- A scheme level spending plan demonstrating how the fund will be spent;
- Quarterly plan figures for the national metrics.

4.2 Local partners are also required to submit a high level narrative plan that demonstrates collective agreement to the following:

- A local vision for health and social care services – showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards fully integrated health and social care services by 2020, and the role the Better Care Fund plan in 2016-17 plays in that context;
- An evidence base supporting the case for change;
- A coordinated and integrated plan of action for delivering that change;
- A clear articulation of how they plan to meet each national condition; and

- An agreed approach to financial risk sharing and contingency.

4.3 There will not be a need to restate information that is already satisfactorily provided in existing plans. This does not diminish the need for local areas to be developing plans together and taking steps to publish plans in line with the requirements of their respective organisations.

4.4 In addition to the national condition relating to improving data sharing (see below under national conditions), narrative plans are expected to describe how digital or information technology are being used to support the delivery of integration, in the form of local digital roadmaps. Where these are in place they should be referenced within BCF plans; where they are not it is expected that Better Care Fund plans will include a reference to their development.

5.0 Assurance process

5.1 Assurance will be conducted at regional level as a joint exercise between NHS England and the Association of Directors of Adult Social Care Services (ADASS). As part of this regional moderation process an assessment will be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Agency, Monitor (now called NHS Improvement), and local government.

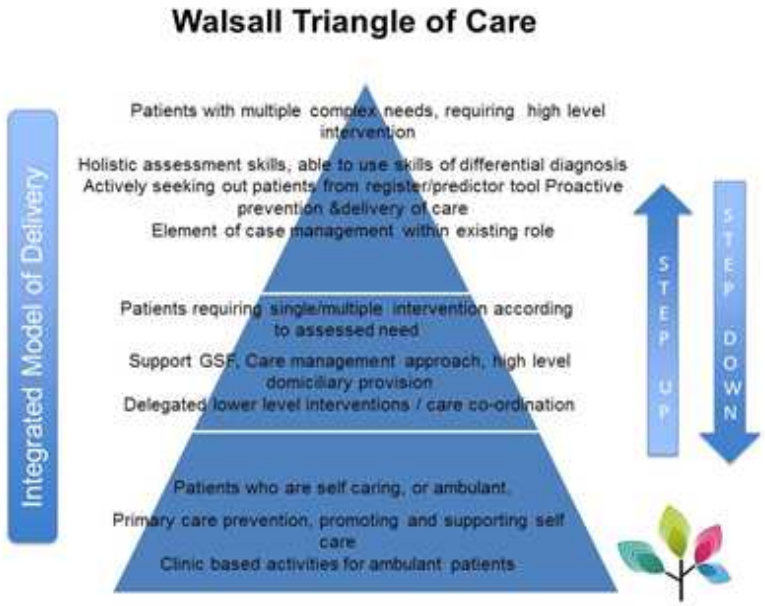
5.2 These judgements on 'plan quality' and 'risks to delivery' will contribute to the placing of plans into three categories by regions – 'Approved', 'Approved with support', 'Not approved'. The next steps for a HWB whose plan is placed within each category are set out below:

- Approved – proceed with implementation in line with plans;
- Approved with support – proceed with implementation with some ongoing support from regional teams to address specific issues relating to 'plan quality' and / or 'risks to delivery';
- Not Approved – do not proceed with implementation. Work with NHS England and LGA / ADASS representatives to put in place steps for achieving plan approval (and / or meet relevant conditions) ahead of April 2016.

6.0 Stocktake of progress so far

6.1 A stocktake was conducted by the Joint Commissioning Committee (JCC) from December 2015 to January 2016 with an 'insight visit' from the National Better Care Fund Support Team.

6.2 In the first part of the JCC stocktake the following vision for the future development of the health and social care system in Walsall was agreed:



6.3 This was followed by a detailed account of the current make-up of the BCF and progress to date in forming three priority work-streams under the Healthy Walsall Partnership Board i.e. staying well at home; rapid emergency assessment and treatment; and getting home from hospital quickly and safely.

6.4 There was recognition of the progress made in the programme. The BCF has supported the development of commissioning aspirations around a small number of work-streams based on these 3 key priority areas of work. However, the BCF was intended to enable overall service transformation and it is has not yet had that effect. Developments in community services have taken place separately from the BCF and different elements of services have continued to be commissioned separately according to legacy contracts, and with individual service specifications

6.5 There has been a necessary investment in hospital related services to secure improvements in performance in hospital, albeit with mixed outcomes both for hospital and care home admissions. It is now acknowledged that a greater focus needs to be on community based and preventative services.

6.6 The post discharge services have a capability to support more people before they go to hospital and thus avoid a hospital admission, and to provide intensive intermediate care or rehabilitation/reablement that means that a higher proportion could remain in their own homes. This would have the effect of reducing the length of time that older people are in institutional care (i.e. a combination of a hospital stay followed by bed based intermediate care) and thus reduce the extent to which older people are entering residential care homes.

6.7 In order to achieve this switch in the extent to which 'intermediate care' services are currently supporting people to step down from hospital and instead support people in their own homes, there is a need to:

- Establish integrated community locality multi-disciplinary teams using joint assessment and case management based upon an agreed model of risk stratification;

- Commission intermediate care services to become more integrated i.e. combines current/legacy specifications for social care reablement (bed and non-bed based); community health rapid response service; community health intermediate care service; CCG purchased intermediate care (i.e. spot purchased and Richmond Hall), with an explicit aim to utilise more of this capacity to support people at home – often in 'urgent' circumstances, and thus reduce hospital and care home admissions;

- Commission an IT solution (integrated Digital Care record via interoperable Application Programming Interfaces e.g. EMIS) to support real time access for front line workers in the multi-disciplinary teams to access the critical parts of patient held records in primary care, community health, hospital, social care and mental health that enables them to provide/arrange effective support.

6.8 These conclusions from the stocktake were used as the basis for developing a plan for the BCF in 2016/17.

7.0 Walsall Plan for the Better Care Fund 2016/17

7.1 The plan has been developed in the form of the same narrative template that was used for the original submission and a draft technical template which was issued by DH in January 2016, but is yet to be confirmed and so there may have to be further changes.

7.2 The narrative template is attached and the main features are as follows:

Section	Content
1 Plan Details	Overall level of funding, authorisation and sign off.
2 Vision for Health and Social Care	The vision has been revised to reflect the outcome of the stocktake, whereby it was recognised there is a need for greater emphasis upon care closer to home resulting in more effective prevention of hospital admission and care home placements.
3 Case for Change	The Walsall Health and Social Care System remains under considerable pressure from rising emergency admissions to hospital and rising care home placements. As a result, all agencies are working in partnership via the System Resilience Group to implement a Recovery Plan that will achieve the

	constitutional targets for emergency services e.g. 95% of patients are seen within 4 hours upon arrival in A&E. The Recovery Plan consists of 10 'high impact' changes that taken together will improve the whole system. There is then an account of progress made against the actions set out in the original submission to be achieved during 2014/15 and 2015/16. In particular, progress has been made on developments in community health services including risk stratification and case management; rapid response services; frail elderly services and support to nursing homes.
4 Plan of Action	These are the main actions in the plan for 2016/17. See below for further information on these.
5 Risks and Contingency	The BCF Risk Register has been updated.
6 Alignment	This section provides an assurance that the plan for the BCF aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents e.g. Walsall Council's Medium Term Financial Plan.
7 National Conditions	Provides an update with progress on the original 6 national conditions and the current situation with two new conditions. The Walsall plan meets the conditions for: • plan to be jointly agreed; • protecting social care services; • use of NHS number as primary identifier in all health and social care records; • joint approach to assessment and care management; and • agreement on consequential changes in the acute sector. Further progress is needed in the following areas: • Seven day services to support seven day discharge and prevent avoidable admissions at week-ends; • IT systems that provide co-ordinated patient level data from different systems to front line workers; • Information Governance Controls consistent with Caldicott 2 principles. Progress with two new conditions is as follows: • Walsall meets the condition for investment in NHS commissioned out of hospital services, which may include a wide range of services including social

	care; and • the focus of work on Delayed Transfers of Care (DToC's) in Walsall is upon the overall numbers on the Clinically Stable list, and this included as part of the SRG Recovery Plan.
8 Patient, service user and public engagement	In 2014 we set out a public engagement and communications plan to be led by Walsall Healthcare Trust and taking learning from the 'Hot-House' programme developed by Coventry and North Warwickshire CCG. We have made limited progress with implementing this plan to date, and will revisit our arrangements for patient, service user and public engagement during 2016/17.

7.3 The actions that have been set out in the plan for 2016/17 are as follows:

- **Implement the ten high impact actions set out in the SRG Recovery Plan:**

  - Increase ambulance diversion via direct access for paramedics to patient GP at point of incident and enhanced access to Rapid Response Service.

  - Support care homes to enable more 'end of life' patients to die in the home rather than be admitted to hospital to die.

  - Conduct therapy assessments in Emergency Department (ED) or within 24 hours of admission aligned with therapy support for discharge to assess at home.

  - Complete implementation of Frail Elderly Service (with social care and mental health input).

  - Improved senior clinical decision making in ED –improved ED pathways including between Urgent Care Centre and ED.

  - Complete Implementation of the 'SAFER' bundle consistently across all wards (Senior review, All patients have an expected date of discharge, Flow early from assessment units, Earlier discharge, Review long length of stay patients).

  - Enhance weekend focus on discharge, review senior rostering.

  - Implement individual case management of patients on Medically Fit For Discharge longer than 14 days.

  - Continue enhanced flow management in SWIFT Ward.

  - Halve the number of Discharge to Assess (DtA) beds in nursing homes (from 40 to 20) and transfer funding to additional social care reablement capacity to support home-based DtA mode and enhance specialist support.

7.4. The 2016/17 BCF priorities:

- Continue the development of multi-disciplinary teams at locality level comprising community health, primary care, social care, mental health and therapy workers based upon the locality structure of community health services; using a common approach to risk stratification and supporting frequent flyers and those most at risk of admission to hospital or care home with long term conditions;

- Implement a redesign of community mental health services for older people to provide crisis response and recovery services 7 days a week linked to the development of the community integrated teams (as above);

- Develop a combined specification for the current range of separate intermediate care services to become more integrated i.e. combines current/legacy specifications for social care reablement (bed and non-bed based); community health rapid response service; community health intermediate care service; CCG purchased intermediate care (i.e. spot purchased and Richmond Hall), with an explicit aim to utilise more of this capacity to support people at home – often in 'urgent' circumstances, and thus reduce hospital and care home admissions;

- Develop a combined specification for a single point of access/referral to the full range of intermediate care services bringing together current access points in WHT, DWMHT and Walsall Council (again drawing together existing separate specifications);

- Develop a 'Local Digital Roadmap' IT solution to support real time access for front line workers in the Multi-disciplinary Team (MDT) to access the critical parts of patient held records in primary care, community health, hospital, social care and mental health that enables them to provide/arrange effective support. This will also need to create an opportunity to track and monitor the movement of patients through the system and the outcomes in terms of the extent to which individuals are supported in their own homes, or are admitted, readmitted to hospital or to care home placements, etc.

- Work with Walsall Strategic Housing Partnership to mitigate the impact of rising demand for Disabled Facilities Grant's (DFG's) and ensure that the provision of DFG's is tailored to those most in need, this to be delivered in partnership with the Registered Social Landlords in the Borough;

- Continue to develop the plan for the Better Care Fund to ensure alignment with the SRG Recovery Plan, the CCG Operational Plan, and the emerging plans of the Healthy Walsall Partnership Board in the context of the Walsall Health and Well Being Strategy.

- Explore opportunity to add additional funding to the pooled fund from the Council or the CCG based upon identified benefits of a higher level of pooled funding leading to improved outcomes;

- Conduct work during 2016/17 to consolidate the 8 work-streams that comprised the original submission in 2014 to align with the priority work-streams identified by the Healthy Walsall Partnership Board, and bring forward recommendations to the Health and Well Being Board to transfer funding and services between work-streams to support this process as appropriate;

- Agree to a principle of performance related payment to be associated with specific initiatives which are funded to achieve a reduction in hospital admissions or care home placements.

7.5 The Health and Well-being Board is recommended to approve these actions in the plan for the BCF for 2016/17.

8.0 Financial Schedule 2016/17

8.1 The draft technical template submission sets out the funding and metric targets and compliance with the national conditions. The finance schedule has maintained the same structure of work-streams as the original submission, and so the sums carried forward from 2015/16 to 2016/17 remain in the same work-streams.

8.2 The total BCF funding for 2016-17 is £24,608,000 which can be reconciled as follows:

Funding	£000
CCG Minimum contribution 2016-17	19,327
CCG Additional contribution	2,206
CCG 2016-17 Inflation	208
Adjustment for Queslett Rd practice transfer	(28)
Total BCF Revenue 2016-17	21,713
Disabled Facilities Grant (DFG)	2,895
Total BCF 2016/17	24,608

8.3 In 2015/16 the funding for DFG's was £1,632,000 and there was an additional sum of £797,000 labelled as a social care capital grant. For 2016/17, these two sums have been combined as funding for DFG's and the combined sum has been increased to £2,895,000.

8.4 In 2015/16 there was a contingency reserve of £1,050,000 which was allocated as non-recurring funding to Walsall Healthcare Trust to meet the costs of increased acute activity arising from an increased level of emergency admissions. There is a similar contingency sum (£1,060,000) in the 2016/17 financial plan. However, there was a 4.4% increase in emergency admissions in the calendar year 2015, compared to 2014, which amounts to 1,297 extra admissions. The tariff price for these is £1,490 each, and so the total additional cost of these carried forward amounts to £1,932,530.

8.5 The BCF plan for 2016/17 sets a net target reduction of 2% in emergency admissions which, if successful, would reduce the financial impact of the increased level of emergency admissions to be funded by the BCF. This is calculated at an average cost of £1,490 each, as a total of £1,008,730. The achievement of this objective would enable the release of the contingency reserve held by the CCG to be committed to schemes agreed by the Health and Well Being Board in line with national and local priorities.

8.6 There is one significant change in the finance schedule for 2016/17 compared to 2015/16 which is a proposed high impact action in the SRG Recovery Plan. This is to transfer half of this resource to a model of discharge to assess at home by reducing the number of beds commissioned from nursing homes from 40 to 20 and increasing the capacity of domiciliary care by 700 hours per week. This will require a re-commissioning of the 40 discharge to assess beds in nursing homes to release half of the funding for a combination of increased social care reablement (300 hours); domiciliary care (400 hours) and increased capacity in the social care support team for social care reablement and the Frail Elderly Service.

8.7 The business case for this reinvestment is to reduce the lengths of stay in the remaining 20 discharge to assess beds from the current commissioned level of 6 weeks to 5 weeks resulting in an increased throughput of patients from 173 to 208 patients per year. The target for the additional social care reablement and domiciliary care hours will be to support 325 patients to leave hospital or avoid hospital admissions compared to the 173 patients who were supported through the beds in the nursing homes during 2015.

8.8 This results in an additional 187 patients supported in the new care pathway compared to the current pathway of 40 discharge to assess beds in nursing homes. Where this is to prevent a hospital admission it will reduce the number of emergency admissions, and where it is supporting hospital discharge it will reduce the number of patients on the clinically stable list and the length of their stay on that list.

8.9 Additional reductions of some areas of BCF investment will sought by agreement in 2016/17 to secure reinvestment in priorities such as in dementia related services, and align commissioning budgets outside the pooled BCF budget where possible to meet these objectives.

9.0 Finance Report for Quarter 3 2015/16

9.1 The projected out-turn position of the Better Care Fund, based on financial information of the third quarter of 2015/16 (April to December), is an over spend of £263k against the approved budget of £23.976m.

9.2 The risk share arrangements have been agreed as part of the Section 75 legal agreement and this identifies that the current £263k forecast over spend would be allocated as follows:

- £97k to the Clinical Commissioning Group
- £166k to the Local Authority

9.3 The main movements are due to:

- £24k increase for payments to GPs due to computer licence fees incurred to support delivery of service;
- (£15k) decrease in non-bed based reablement due to staffing costs;
- (£89k) decrease in Frail Elderly Pathway due to reduced costs of medical staff input;
- £29k increase in bed based reablement due to staffing costs;
- £76k increase in spot purchase of intermediate care beds due to increased utilisation.

10.0 Performance Metrics 2015/2016

10.1 There were six performance metrics for which targets were set in the original submission in 2014 and progress against each of these to date is as follows:

Non Elective/Emergency admissions all ages:
As explained above, there has been a 4.4% increase in emergency admissions in 2015 calendar year compared to 2014. This is set against the original target of a 2% reduction.

Permanent Residential Placements for Adults age 65 years and over:
Projected out-turn as at the end of December 2015 is for over 300 placements by the end of March 2016 compared to a target for the financial year of 232. Whilst there is a concerted effort to reduce permanent placements, the absence of suitable alternatives for those with dementia continues to place a pressure on this measure.

Reablement for Adults age 65 years and over:
This is the percentage of people still in their own home 91 days after leaving hospital and being supported by social care reablement. Around 60% of these cases are supported discharge from hospital. The target is for 80% to be at home, and this is currently projected to be on target.

Delayed Transfers of Care (DToC) :

There has been a change in reporting of this metric since new guidance was issued in July 2015. The level of DToC's being reported was well below the national average, and given the high levels of patients in hospital who are clinically stable/medically fit for discharge, this was giving a misleading impression. The level is now nearer the national average, but further work is needed to consolidate the new reporting system over a longer period of time.

Dementia:
At the end of March 2015, Walsall had achieved the national ambition for a diagnosis rate of 67% and achieved 68%. From April 1st 2015, NHS England introduced a new methodology for calculating prevalence that was supposed to take into account the positive effects of healthy lifestyle interventions. However, Walsall's prevalence of dementia actually increased by 3% when five of its neighbouring CCGs from the same Local Area Team have their prevalence reduced by between 12 and 24%. This was not reported by NHS England until mid-October 2015. The CCG challenged this data and despite several follow-up requests, has still not received a satisfactory explanation form NHS England.

Walsall's dementia diagnosis rate for December was 65.8%. This reduction was due to the increase in prevalence, deaths from the dementia registers and Memory Assessment Service performance. Since 1 April 2015, 130 people have been diagnosed with dementia and 106 have been removed from the registers due to death or moving out of area.

The Memory Assessment Service had a 25% reduction in staff which was not reported to the CCG and resulted in a waiting list of 152 people. The CCG issued a Contract Performance Notice and the Memory Assessment Service is due to be back on track by April 2016.

Commissioners have met with all four GP localities and encouraged them to use the tools provided to increase the diagnosis rate and specialist dementia support workers work with care homes to improve dementia care, end of life care with a view to reducing acute hospital admissions. Hospital dementia support workers continue to support care improvements in the acute hospital and the dementia cafés support carers to reduce the strain of caring which can often lead to acute admissions.

The national target for 2016/17 will remain at 67%, whereas the Better Care Fund target for 2015/16 was established at 70%. If the prevalence had not altered, a 70% diagnosis rate would have been achieved by August 2015.

Patient Satisfaction with integrated services:
The Better Care Fund Service User Satisfaction Survey for integrated services covers Hollybank Residential Care Home, the Community Intermediate Care team and Discharge to Assessment team. There is an electronic recording that captures the names and addresses of service users and compiles six domains of satisfaction with their integrated services. From the completed responses received so far, over 90% have been satisfactory which would meet the target set.

11.0 Performance Metric Targets 2016/17

11.1 Proposed targets for the performance metrics in 2016/17 are as follows:

Non Elective/Emergency admissions all ages:
The BCF draft financial plan presented here for 2016/17 sets a net target reduction of 2% in emergency admissions which, if successful, would reduce the current level of emergency admissions by 618. This local target may have to be adjusted to align with an NHS England directive.

Permanent Residential Placements for Adults age 65 years and over:
A target of 301 new permanent admissions has been set for the financial year 2016/17. This projects a similar level of placements in 2016/17 as were made in 2015/16.

Reablement for Adults age 65 years and over:
A target of 81% has been set for the financial year 2016/17, compared to 80% in 2015/16. The reporting of this metric now reflects the full reablement services of the local authority, and this is the reason for the increased number of cases.

Delayed Transfers of Care (DToC):
There has been a change in reporting of this metric since new guidance was issued in July 2015 and it is proposed to align with the nationally mandated target of 2.5%.

Dementia:
It is proposed that the national target for 2016/17 should remain at 67% (see above para 10.1)

Patient Satisfaction with integrated services:
A local target of 92% people expressing satisfaction with integrated services is proposed.

11.2 The Health and Well-being Board is asked to approve these targets for 2016/17.

12.0 Implications for Joint Working arrangements

12.1 Walsall CCG and Walsall Council have agreed the legal, financial and governance arrangements for the management of the Better Care Fund and this report provides an update of those arrangements.

13.0 Health and Wellbeing Priorities

13.1 The overall aim for the Better Care fund is to support older people in their own homes in a way which means there are fewer emergency admissions to hospital or permanent placements in to care homes, and which optimises their safety, independence, health and well-being.

Background papers

An update on the Better Care Fund is a standard agenda item for the Health and Well Being Board.

Author

Andy Rust – Strategy Lead for Unplanned Care
☎ 603052
✉ Andy.Rust@Walsall.nhs.uk