Peterborough & Cambridgeshire BCF Approach 2017-19

September 2017

PETERBOROUGH CITY COUNCIL

NHS

Cambridgeshire County Council

What is the Better Care Fund?

*"The Better Care Fund is a **single pooled budget** to support health and social care services to work more closely together in local areas…".*

NHS Planning Guidance, December 2013

BCF 2016/17 Overview

During the financial year of 2016/17, a Section 75 pooled budget was established in relation to the Better Care Fund (BCF) between Peterborough City Council (PCC) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). This was not new money in the system, but redistributed sums from health and social care.

View from Peterborough

The sum of £12,613k was invested into the pooled fund to deliver the outcomes of the BCF.

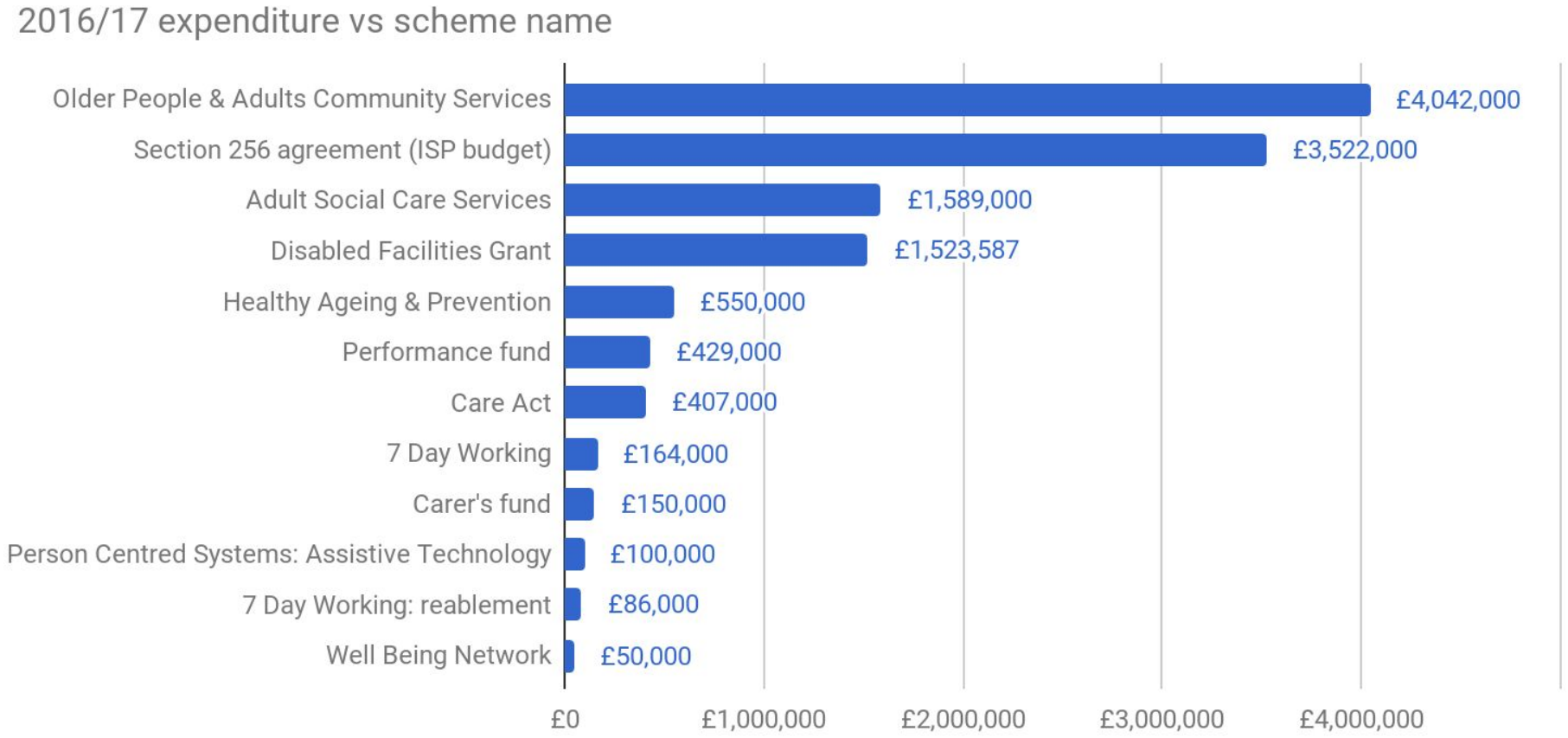
View from Cambridgeshire

The sum of £48,465k was invested into the pooled fund to deliver the outcomes of the BCF.

This financial contribution was redirected from existing Local Authorities and CCG budgets.

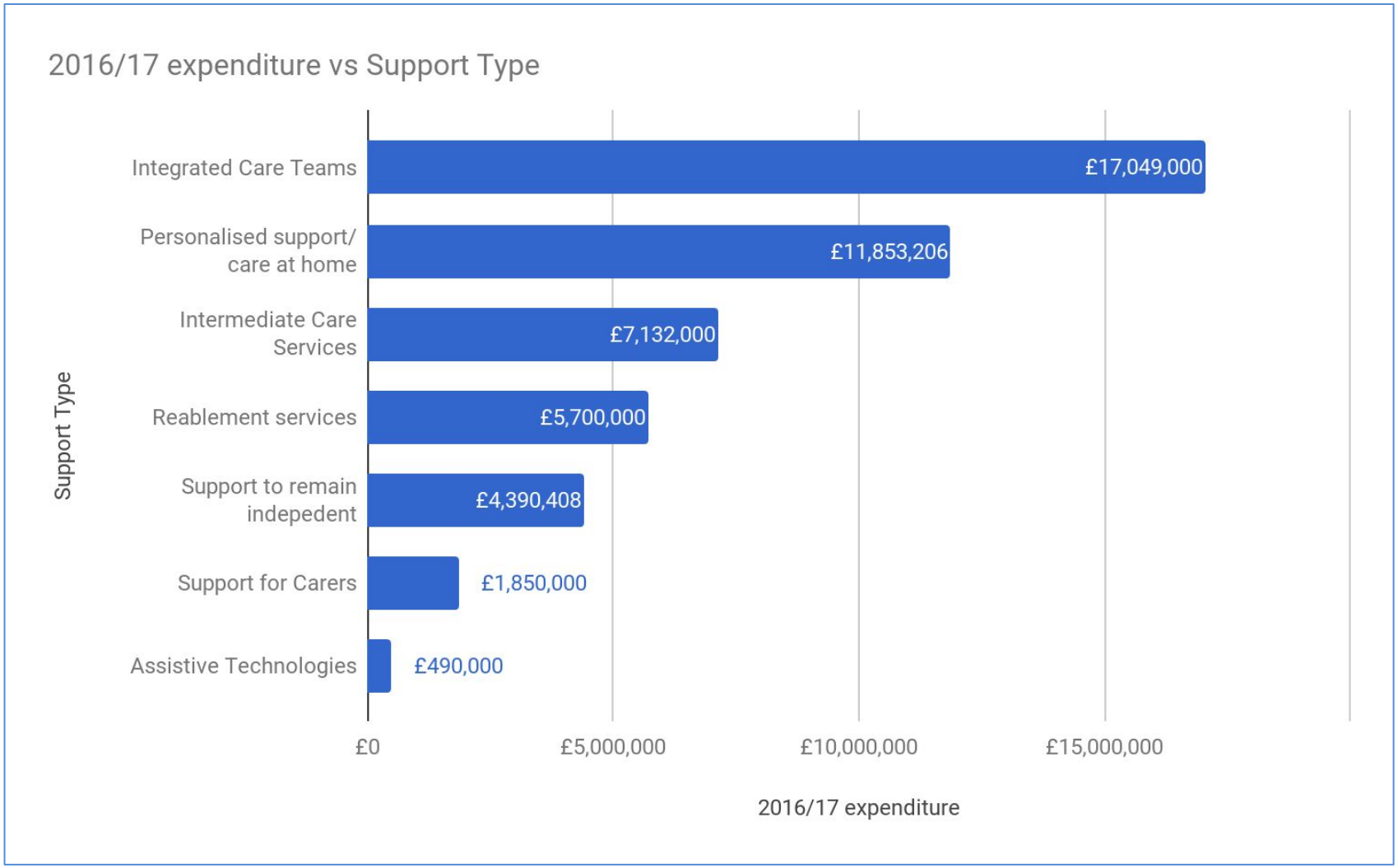
In 2017, Peterborough and Cambridgeshire will be required to submit new, jointly agreed BCF Plans, covering a two year period (April 2017 to March 2019).

BCF 2016-17 Local Spend: Peterborough



PETERBOROUGH CITY COUNCIL NHS Cambridgeshire County Council

BCF 2016-17 Local Spend: Cambs



BCF Progress 2016/17

A brief summary of the key progress to date of the five transformation work-streams:

Healthy Ageing & Prevention

-County wide falls pathway developed
-Falls pilot undertaken and evaluated
-County-wide Dementia Strategy in development
-Joint Wellbeing Commissioning Principles developed and agreed

Information, Comms & Advice

-System wide data standards developed
-Customer analysis research undertaken
-PCVS mapped and collated VCS and community services data
-Technical development of proof of concept search platform to feed data into MiDOS is in development

7 day services

-Improvements to the rapid community response service (JET)
-Investment in the reablement pathway to address increased demand
-SHREWD patient flow system implemented in PCH
-7DS mapping and gap analysis undertaken

Data sharing

-Local Digital Roadmap developed
-Information governance approach agreed
-proof of concept data sharing tool ro support case management was developed

Person centred systems

-Support for ongoing community health services across Peterborough,
-'Trailblazer' pilot sites established that have been refining the MDT proactive case management model. Wider roll out plans commenced.

BCF Progress against performance metrics - Peterborough

Metric	2016/17 Actual Performance	2016/17 Planned Threshold Target
Non-elective admissions to hospital	0.05% net reduction (19,229)	2.1% net reduction (18,834)
Delayed Transfers of Care (DTOCs) from hospital	7,174	3.5% occupied bed days (3,366)
Admissions to long-term residential and nursing homes	125	128
Effectiveness of re-ablement services	77%	82.8%
Injuries due to falls in 65+ year olds	563	515
Maintained patient satisfaction with NHS services (Friends and Family Test)	97%	93%

BCF Progress against performance metrics - Cambridgeshire

Metric	2016/17 Actual Performance	2016/17 Planned Threshold Target
Non-elective admissions to hospital	62,091	60,726
Delayed Transfers of Care (DTOCs) from hospital	35,732	10,886
Admissions to long term residential and nursing homes (per 100,000)	345	486.6
Effectiveness of reablement services	75.2%	81.20%
Maintained satisfaction with NHS Services (Friends and Family Test)	97%	93%
Proportion of adults receiving long term social care (per 100,000)	1,562	1600

DTOCs Performance 2017-19

- DTOCs were the worst performing target for 2016/17, with targets underperforming by 200% in Peterborough and 300% in Cambridgeshire.
- There is a big focus on DTOC planning in the BCF 2017-19 plan and there is a system commitment to deliver the 3.5% national target by September 2017.
- To deliver we need to:
  - Implement the High Impact Changes across the system in line with national conditions
  - Ensure a robustly agreed and costed DTOC plan to deliver the 3.5% trajectory
  - Focus on the understanding and addressing the key reasons for delays (e.g. assessment related delays)
  - Implement effective Discharge to Assess models
  - Re-design the Continuing HealthCare Pathway to support Discharge to Assess
  - Improve patient flow through the system and ensure appropriate community provision is in place
  - Plan effectively for winter
  - Utilise the Voluntary Sector more effectively for low level supported discharge
  - More effective MDT early discharge planning and organisational accountability for discharges across the system
  - Increased use of the Trusted Assessor model
  - Improved information and advice to patients regarding discharge processes and patient choice

High Impact Changes

The 8 High Impact Changes (HIC) are:

1) Early Discharge Planning -
    a) In elective care, planning should begin before admission.
    b) In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within
2) Systems to Monitor Patient Flow. Robust Patient flow models for health and social care
3) Multi-disciplinary/Multi-Agency Discharge Teams, including the Voluntary and Community Sector
4) Home First/Discharge to Assess. Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home
5) Seven-Day Service. Successful, joint 24/7 working
6) Trusted Assessor. Using trusted assessors to carry out a holistic assessment of need
7) Focus on Choice. Early engagement with patients, families and carers
8) Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services

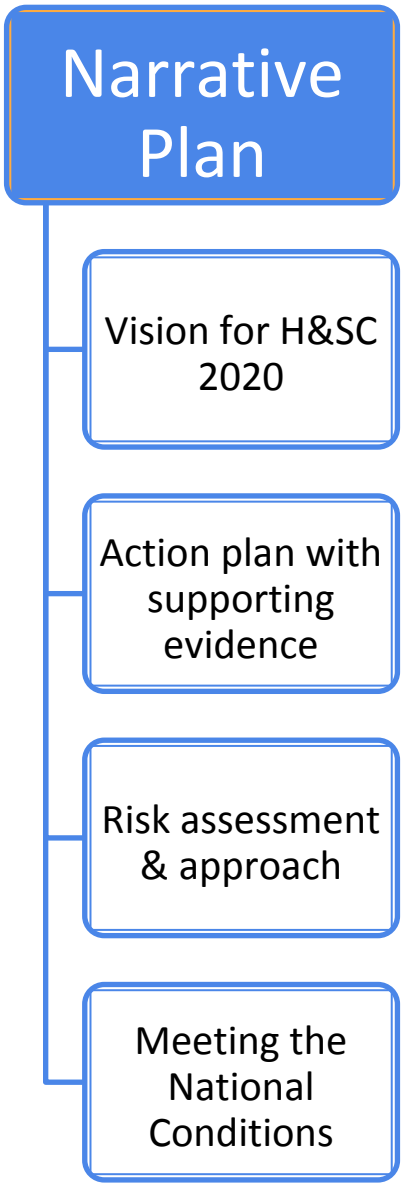
Cambridgeshire and Peterborough have developed costed plans to address the implementation of the 8 HIC. Following system wide self-assessments and workshops, the following 3 areas have been agreed as immediate short term system priorities:

- Discharge to Assess
- CHC Hospital Discharge Process
- Trusted Assessor

Better Care Fund Planning - 2017-19

2017-19 – Guidance:

- 2 year plan – how <u>we will achieve integration by 2020</u>
-
  - Local vision with patient focus
  - Alignment with STP & local plans
  - Compliance with national conditions
  - A plan of action
  - Use of the iBCF to support DTOCs
  - Engagement with a range of partners, including **housing**



Better Care Fund 2017-19

National Conditions

- Plans to be agreed jointly
- Maintain provision of social care
- Investment in NHS commissioned out-of-hospital services
- Managing transfers of care

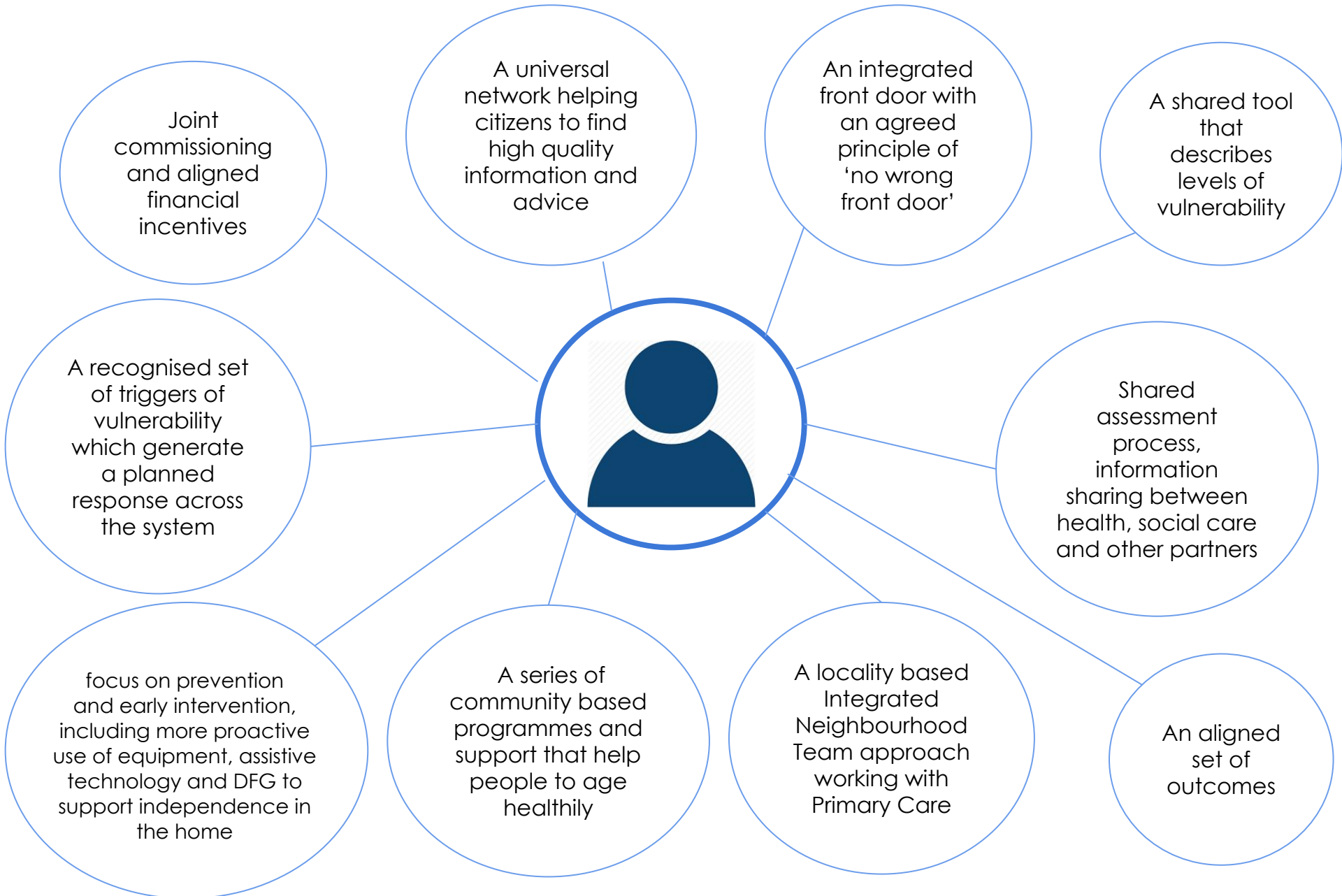
Performance Metrics

1. Reduce **non-elective admissions**
2. Reduce permanent **care home admissions**
3. Increased effectiveness of **reablement**
4. Reduced **delayed transfers of care**

Improved BCF (iBCF) quarterly reporting

The metrics apply to the BCF plan and the monies associated with its delivery. When we monitor against these metrics we need to consider how total BCF spend is helping to improve performance.

Integrated System Principles



The Local Vision

Before people have significant ongoing needs;

- Ageing well
- Eyes & Ears - Indicators of vulnerability
- Clear and joint sources of information
- A real or virtual 'single point of access' for advice and support
- Holistic identification of need with a coordinated response

Support for people with significant ongoing needs

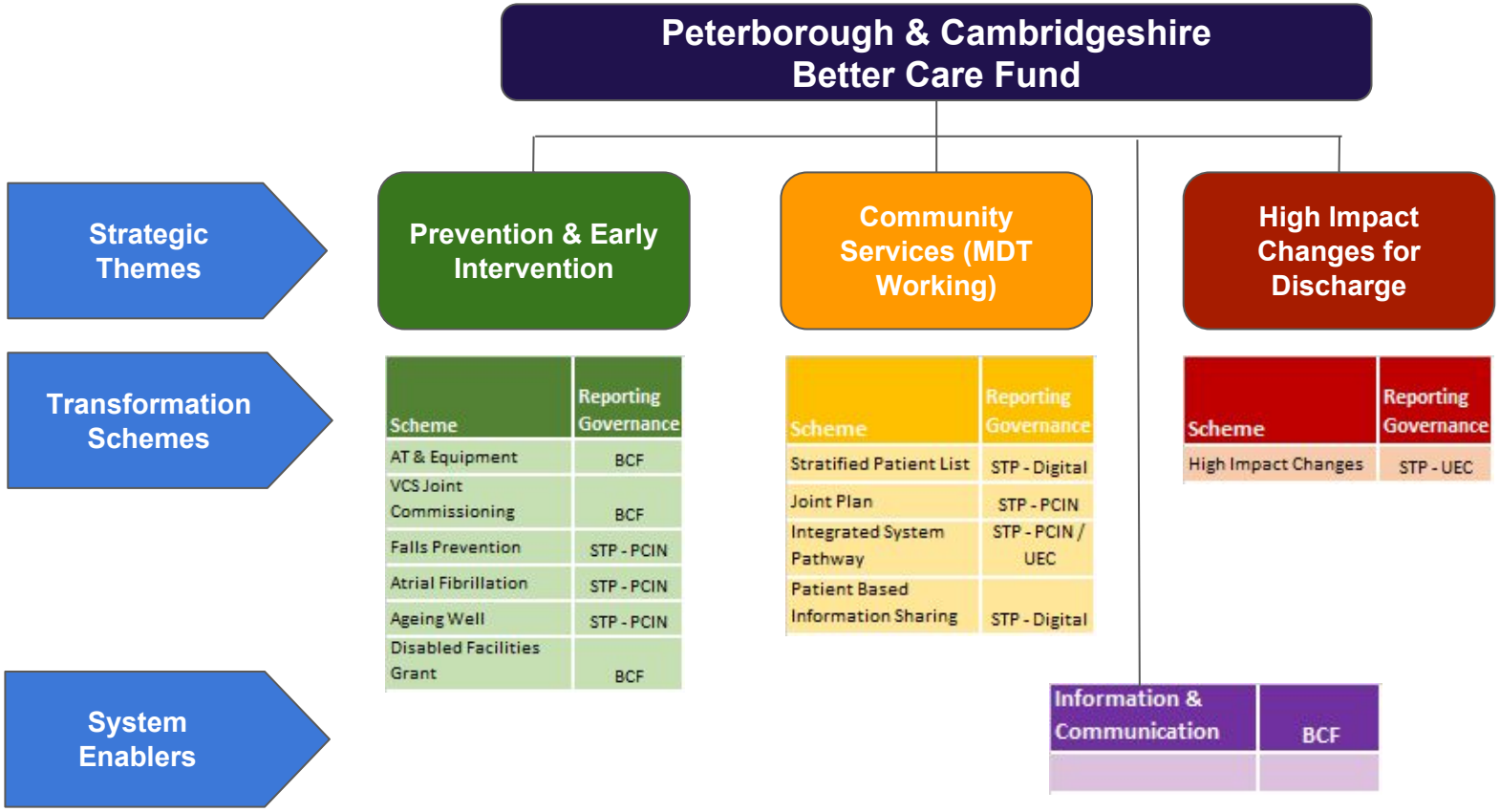
- Clear, coordinated pathways and handovers
- Neighbourhood teams and Multi-Disciplinary Team (MDT) working
- Case finding and case management
- Working with Care Homes
- Working with housing providers
- Enablers – support for delivery
- Joint outcomes
- Information and data sharing
- A common language
- Workforce development
- Property co-location
- Joint commissioning of the voluntary and community sector

BCF 2017-19: Alignment with Local Strategic Objectives

1. Cambridgeshire County Council: Transforming Lives, our approach to social work, emphasising the need to support people to stay fit & well
2. Peterborough City Council: Vision for Social Care - ensure that people in Peterborough can live in a strong and vibrant community that protects the vulnerable and most at risk
3. Fit for the Future - our STP, which emphasises three key messages:
    a. **'At Home is Best';**
    b. **'Safe and effective hospital care, when needed'**
    c. **'We're only sustainable together'**

There is a strong overlap between BCF priorities and those of the STP and one of the core principles of the 2017-19 plan is to align the approach to governance and implementation as much as practical across the BCF and STP programmes to ensure an integrated and coordinated response to maximise opportunities and reduce duplication across the system *(the BCF Plan for Delivery on Slide 14 highlights the overlap with the STP delivery groups and where STP has been agreed as the primary governance).*

BCF Plan for Delivery



BCF 2017-19: Managing Transfers of Care

'High Impact Change Model' – to support systems reduce DToC:

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

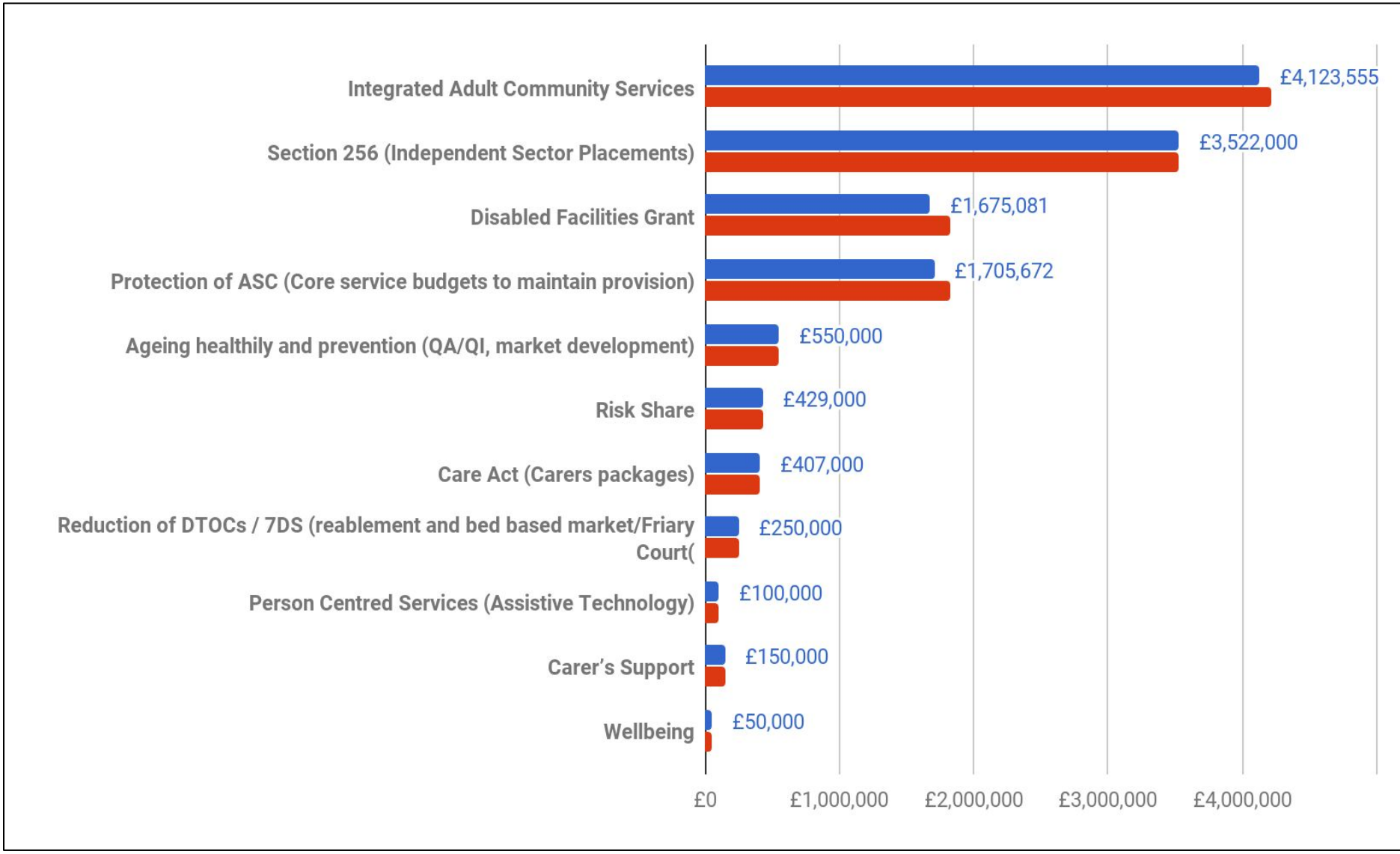
Improved BCF (iBCF)

- New non-recurrent social care grant allocation
- To be used for:
  - Stabilising the social care market
  - Meeting adult social care needs
  - Reducing pressures on NHS
  - Meeting High Impact Change model
- Must be pooled into BCF
- Working with CCGs and providers
- Quarterly reporting to the Department of Communities and Local Government (DCLG)

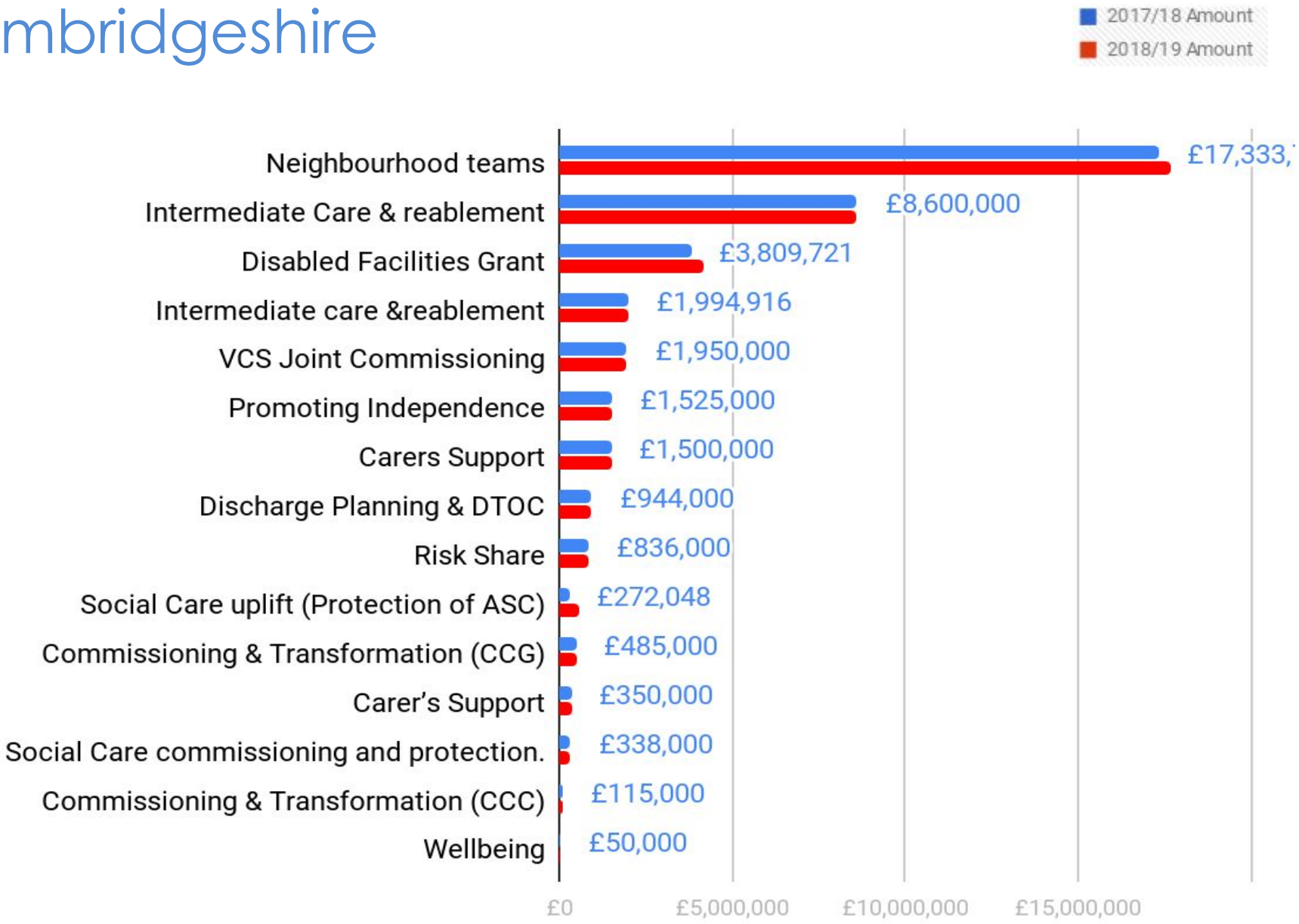
Quarterly Reports:

- Project/initiatives progress update
- HIC progress (LA perspective)
- Other metrics
- Impact on:
  - Number of care packages
  - Hours of homecare provided
  - Number of care home placements

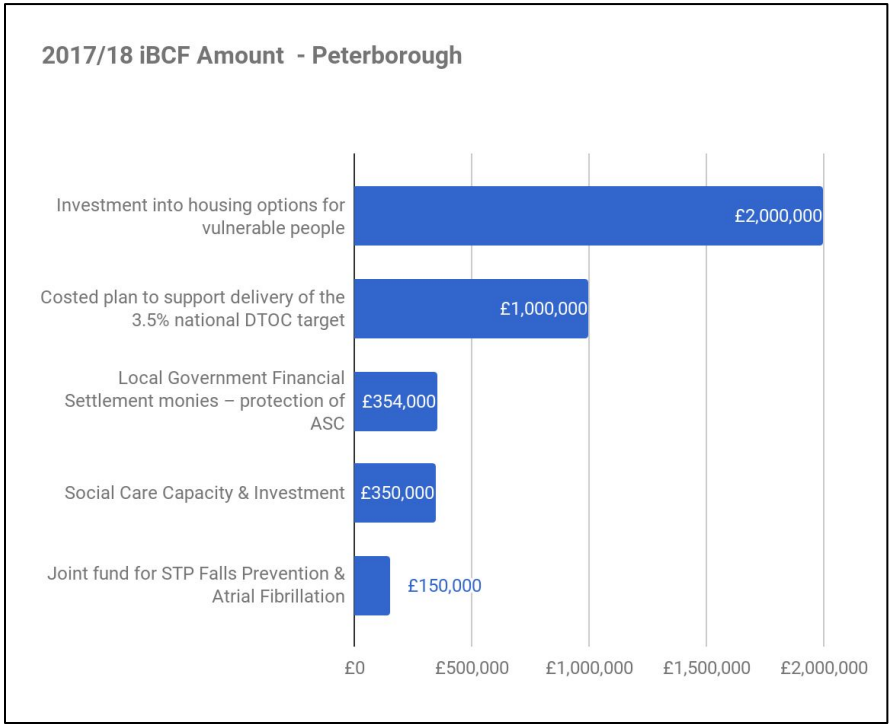
Local Better Care Fund Financials 2017-19 - Peterborough

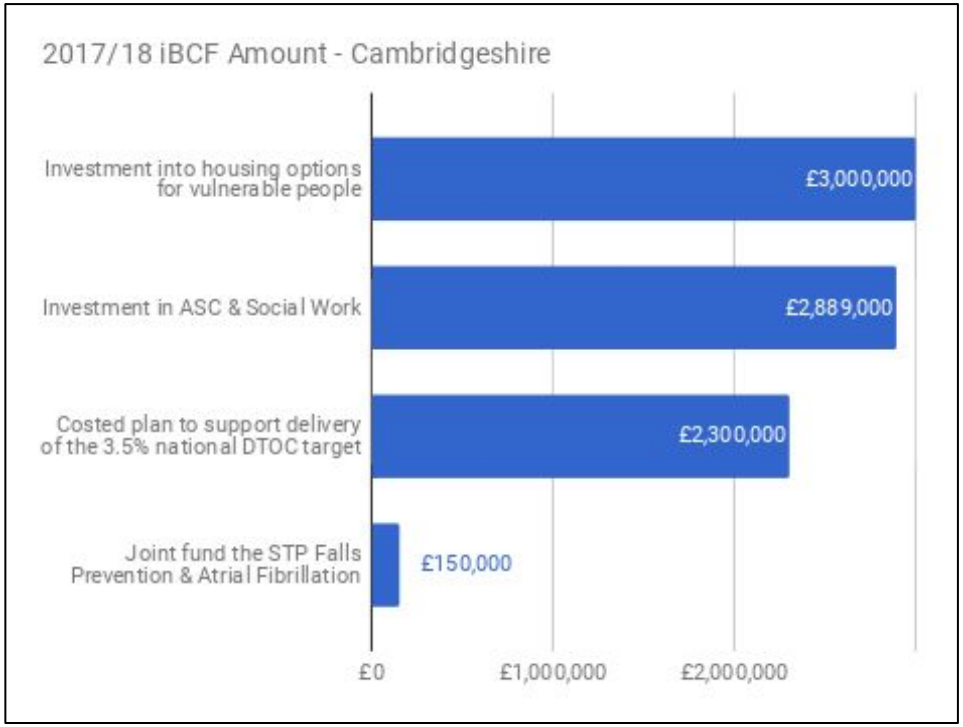


Local Better Care Fund Financials 2017-19 - Cambridgeshire

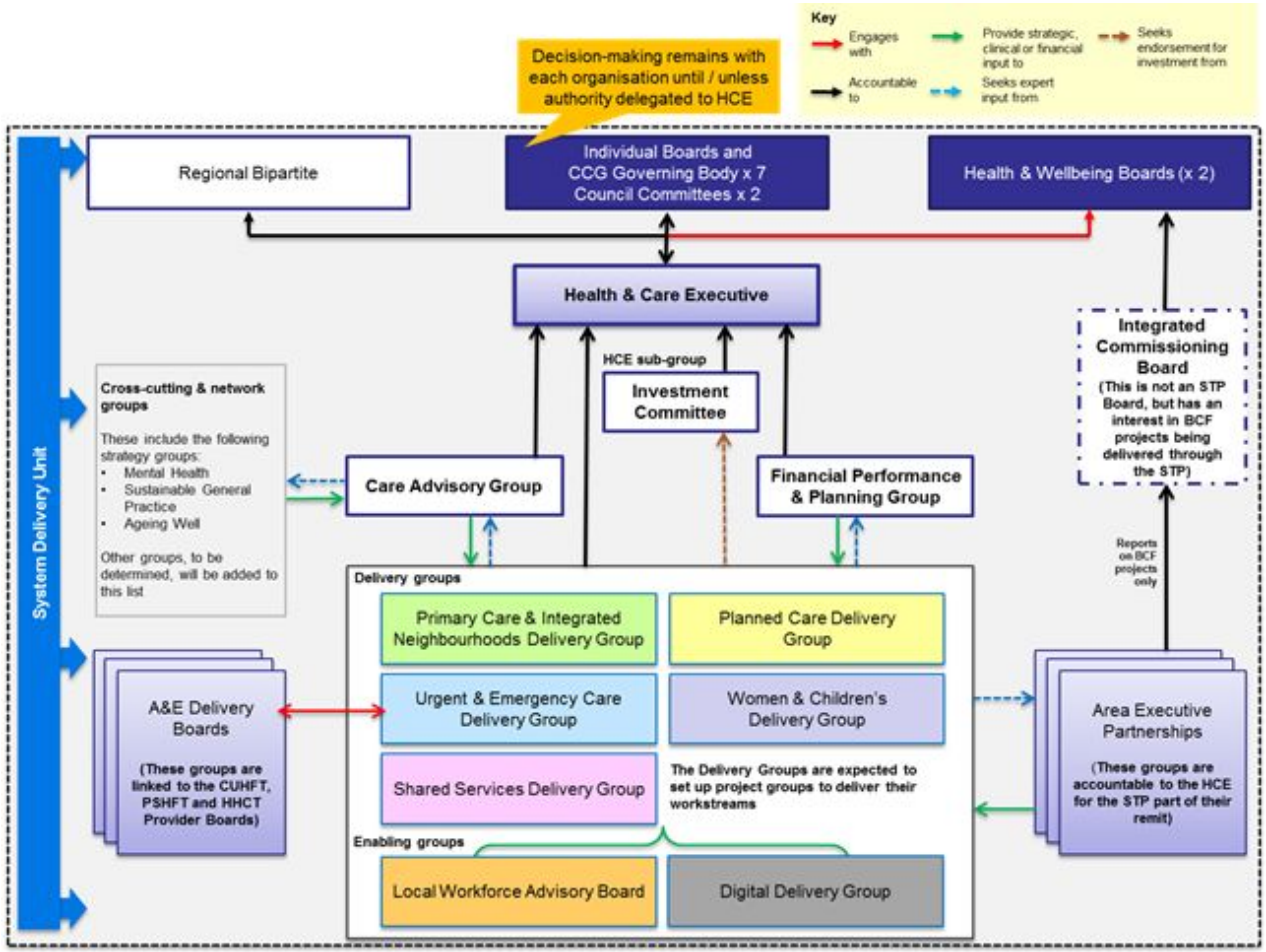


17/18 iBCF proposed funding split*





BCF Governance



The Health & Wellbeing Board is accountable for the BCF. They have delegated authority to the Integrated Commissioning Board (ICB). The ICB will oversee the BCF plan and delivery and review opportunities for joint investment opportunities. The ICB has been aligned with the STP governance structure, which is depicted below. We are merging the Local Health and Wellbeing Partnerships with Area Executive Partnerships to create Living Well Partnerships to join up the two tier LA system.

2017-19 BCF Approval Process