Report of the
Chief Officer North Lincolnshire CCG and
Director of People North Lincolnshire Council

Agenda Item No: 12
Meeting: 22 March 2016

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

BETTER CARE FUND: 2015-16 PLAN UPDATE AND 2016-17 PLAN REQUIREMENTS

1. OBJECT AND KEY POINTS IN THIS REPORT

1.1 To inform the Health and Wellbeing Board of the key deliverables and implementation against the Better Care Fund plan.

1.2 To provide an update on the requirements for Better Care Fund planning and delivery 2016-17.

1.3 To seek approval for delegation to the chair to approve the final BCF plan for 2016-17 for submission to NHS England on 25th April 2016.

2. BACKGROUND INFORMATION

2.1 North Lincolnshire Council's Better Care Fund (BCF) plan and its submission were supported by the Health and Wellbeing Board (HWBB) at their meeting on the 9th December 2014 and the final plans were submitted in line with National Health Service England (NHSE) on 9th January 2015. The plans were subsequently approved.

2.2 The Joint Board for Health and Social Care was established with the responsibility for overseeing the implementation of the plan. The Joint Board includes membership from North Lincolnshire Council, North Lincolnshire Clinical Commissioning Group, Northern Lincolnshire and Goole NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust.

2.3 The plan set out updated performance metrics and targets. The key deliverables are:

- Reduced non-elective admissions
- Reduced length of stay (in hospital)
- A reduction in permanent admission to residential and nursing care homes
- An increase in the effectiveness of Reablement and rehabilitation
- A reduction in delayed transfer of care from hospital

- Improved service user experience

2.4 The Better Care Fund expenditure plans include funding for existing health and social care integrated services such as Intermediate Care and Re-ablement and Disabled Facilities Grants. In addition, several new schemes and services were funded in order to meet the outcomes that we are aiming to achieve, summarized in the following statements:

- I will be supported to maintain my independence for as long as possible
- I will feel confident to remain living at home for longer
- I will be in control of long term conditions and helped to manage it appropriately
- I will feel safe
- I will have my health and care needs met closer to home
- I will feel part of the community and are less isolated
- My Carer will feel able to continue in their caring role
- I will be supported back into the community following a medical intervention

2.5 The new schemes implemented under BCF include:

- Hospital based Social Work Team – the local authority established a new team of social worker based at the hospital, providing support to discharge planning for people 7 days a week. This service has been in place for over a year and the joint approach contributes to managing and supporting the safe discharge of people from hospital back into the community.
- Community Wellbeing Hubs – the plan identified that there would be 5 hubs established providing a focal point for a network of preventative activities across localities to support people remaining healthy, well and independent for longer. The community wellbeing hubs have been operating for over a year and the local authority has recently extended the provision to include an additional 2 satellite hubs.
- Frail Elderly Assessment Team – Northern Lincolnshire and Goole Foundation Trust have been commissioned to provide a comprehensive chair based geriatric assessment service at the hospital. Care plans aim to return individuals back home within 72 hours. The team has been in place since October 2015.
- Rapid Assessment Time Limited Service - Northern Lincolnshire and Goole Foundation Trust have been commissioned to provide and alternative provision of care in the home for people who may have otherwise had an attendance or admission to hospital. The service works closely with GP Practices and has been in place since October 2015, with an overnight service from November 2015.
- Locality Teams – investment has enabled the enhancement of existing community services, with new locality coordinator roles recruited, 7 day working for therapies, community equipment, social work assessment and additional Macmillan Nurses.

2.6 NHS England monitor BCF plans quarterly which includes information about budget arrangements, including pay for performance, the national conditions and performance on BCF metrics. As part of the national learning from Better Care Fund Implementation colleagues from NHS England came to North Lincolnshire as part of their 'Insight' visits to review the impact of delivery of the BCF. They attended the Joint Board and visited the Scunthorpe Wellbeing Hub and the FEAST team at Scunthorpe Hospital. They were particularly impressed by the tangible partnership working and strong leadership. They noted that we were focusing our attention on the right things, namely outcomes for citizens as well as the national metrics. The visit to the Wellbeing hub was particularly useful for the team to understand the focus on independence and proactive care. They were commended the passion of the workforce they met in the hub and in FEAST.

2.7 On the 8th January 2016 NHS England published new BCF guidance for 16/17. The detailed technical guidance was published on 23 February 2016. The guidance required an initial submission to NHS England outlining the indicative metrics and budgets for 2016-17 on 2 March 2016. A further iteration of North Lincolnshire Council's Better Care Fund (BCF) plans and narrative must be submitted on 25th April 2016.

3. OPTIONS FOR CONSIDERATION

3.1 To note the progress against the plan and note the implementation to date, including key deliverables (Appendix 1).

3.2 To consider the latest planning guidance, note the plans for submission and the indicative metrics (Appendix 2). The date of the submission of the 2016-17 BCF Plan is 25th April 2016, therefore, it is proposed that the Health and Wellbeing Board approve delegation to the Chair for sign off.

4. ANALYSIS OF OPTIONS

4.1 The report provides the quarterly monitoring information to the HWBB as required. Key points from the quarter 2 and 3 returns to NHSE are:

- A section 75 agreement is in place to set out the arrangements for the pooled budget.
- The national conditions are met or in progress to be met by the end of the financial year.
- On track to exceed the target set for reducing the length of stay in hospital for over 65 year olds.
- On track to exceed the target for the effectiveness of reablement
- Some of the NHS schemes were not fully implemented in quarter 2 as agreed by the joint board; therefore there was no improvement in the performance metric of non-elective admissions to hospital in quarter 2.
- All schemes were fully implemented in quarter 3 (from 1 October 2015).

4.2 Quarter 3 reporting to NHSE was submitted on 26th February 2016 and is also contained in this report for information.

4.3 The 16 /17 Better Care Planning Requirements are detailed in Appendix 2, with new conditions to note as follows:

- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital (the current arrangements and schemes include out of hospital services commissioned by the CCG).
- Agreement on a local action plan to reduce delayed transfer of care (DTOC) - North Lincolnshire performs relatively well compared to national benchmarks, therefore, these plans will focus patient flows and those areas that we know we can have a further impact on; choice, care package availability

4.4 The NHS England approval process for BCF plans is illustrated in Appendix 3.

5. RESOURCE IMPLICATIONS (FINANCIAL, STAFFING, PROPERTY, IT)

5.1 The BCF allocation is a ring fenced allocation to the CCG and the Council for the creation of a pooled budget of £12.37m for 2015/16 and £12.693m for 2016/17.

5.2 As part of the new planning guidance for 2016/17 there is an identified amount of £3.106m for CCG commissioning of out of hospital care services and risk share.

5.3 The Better Care Plans commit additional protection of social care services of £5m over the 3 year period 2015-2018.

6. OUTCOMES OF INTEGRATED IMPACT ASSESSMENT (IF APPLICABLE)

6.1 Consideration will be given to diversity issues as part of the development of service specifications and associated commissioning activity and impact assessments undertaken as necessary to ensure that service users are treated fairly.

7. OUTCOMES OF CONSULTATION AND CONFLICTS OF INTERESTS DECLARED

7.1 None

8. RECOMMENDATIONS

8.1 Health and Wellbeing Board are asked to note the progress against the BCF

Plan and its implementation arrangements and key deliverables.

8.2 Health and Wellbeing Board approve the proposed submission plans and delegate final approval of the BCF Plan to the chair.

CHIEF OFFICER NLCCG AND DIRECTOR OF PEOPLE NLC
Civic Centre, Ashby Road, Scunthorpe DN16 1AB

Author: Helen Childs/Becky McIntyre

Date: March 2016

Background Papers used in the preparation of this report:

Reports to Health and Wellbeing Board –December 2014, March 2015 and November 2015

Appendix 1 – BCF plan key deliverables and implementation against plan.

1.0 – National Conditions

1.1 Protecting Social Care Services.

- People who require social care support will receive support in line with their assessed need, at the right time and in the right place.
- The eligibility criteria remains the same and is in line with the Care Act 2014.
- The level of investment for Social Care Services from BCF equates to £6.224m and includes new investment in the hospital social work team, funding for Care Act implementation and an increase in the investment for Carer's support.

1.2 7 days services to support discharge.

- Roles have been successfully recruited to ensure delivery of all the new 7 day services supported within the BCF plans including the hospital social work team, community social workers supporting assessments, community Macmillan nurses, interim community equipment services, occupational therapy and physiotherapy.

1.3 Data Sharing: Use of the NHS number as the primary identifier.

- The plan to move to the NHS Number as primary identifier and implement an integrated care record consists of four phases. Progress against the Phase 1-3 Project Milestones is making good progress.
- The NHS Number is recorded in the social care record at initial contact, where NHS Services are involved in supporting the individual with a project being implemented to review the capture, validation and use of the NHS Number as a key identifier for integrated services/systems. This also links to the data sharing agreement.
- The 'first contact form' is currently being amended to capture the NHS Number at the first point of contact with Adult Services.
- In respect of network capability, connections are already in place for key council buildings to have secure access to the NHS Spine (N3 network). There are also integrated wireless connections available for NLAG devices and an on-going project to provide the same access to the Commissioning Support Unit device.
- The Social Care Case system supplier is reviewing a solution to provide a validation of the NHS Number service via the NHS National Spine. Initially this will be a batch process but their roadmap for 2015 has software developments which will enable a validated NHS number to be allocated at first contact.
- Phase 3 the development of an integrated Digital care record is currently awaiting approval from HSCIC to test the open source interface. We expect a solution to be in place during March 2016.

- An Information Sharing Charter has been agreed across Humber which sets down the principles for sharing records, and is based on a consent model. Charter 1, the principle in agreement to support data sharing agreement has been signed by all relevant organisations across the Humber footprint. Charter 2, is a service/function level agreement, which is currently being reviewed for collective sign off.

1.4 Joint Assessment and accountable lead professional for high risk population.

- The Locality Teams have devised a joint assessment which can be utilised within the newly emerging GP led ‘Care Networks’.
- IT leads from each statutory organisation are exploring options to enable ‘paper light’ solutions to assessment templates.
- New out of hospital models of care are being prototyped to agree an approach to ensure all those seen as ‘high risk’ have an accountable lead professional – ‘care coordinator’. This approach builds on the Elderly Care Fund plans developed within primary care and the role of the locality teams and the new BCF locality coordinator roles.

2.0 - Metrics

Quarter 2 reported position

Metric	Q2 Plan	Q2 Actual	Full Year Performance RAG
Non Elective Admissions to Hospital (per 100,000 population)	4251	4878	Unlikely to meet target.
Permanent Admissions to Residential and Nursing Care (Over 65 year olds per 100,000 population)	264	362.6	On track for improved performance but not on track to meet full target. Permanent Admissions in quarter 1 71 people were admitted, in quarter 2 this has reduced to 50 people. Current monthly average is 20 people per month. To meet the overall target admission (524.5) the month average needs to be approximately 15 people per month.
Delayed Transfer of Care from Hospital (per 100,000 population)	747	1037	The rate per 100,000 at Quarter 2 is 767.0 above target (552.5).
Effectiveness of Reablement (% of people still at home after discharge from hospital to reablement)	90.6	91.1	On track to meet target.
Patient survey (GP Patient Survey Q39 – does your GP or health professional review your care plan with you regularly) %	65%	56.14%	Survey captured in July and January. Q2 actual is the January 2016 result, therefore , target not achieved
Average length of stay in hospital for over 65 year olds (days)	7.1	8.5	October (7.1) and November (7.5) positions suggest on track for improved performance but not to meet full target.

Quarter 3 reported position

Metric	Q3 Plan	Q3 Actual	Full Year Performance RAG
Non Elective Admissions to Hospital (per 100,000 population)	4258	5404	Unlikely to meet target.
Permanent Admissions to Residential and Nursing Care (Over 65 year olds per 100,000 population)	395.6	485.5	On track for improved performance but not on track to meet full target. Permanent Admissions in quarter 1 71 people were admitted, in quarter 2 this has reduced to 50 people and in quarter 3 reduced again to 41 people. The current monthly average is 18 people this is a reduction from quarter 2 which were 20 people per month. To meet the overall target admission (524.5) the month average needs to be approximately 15 people per month. A number of people admitted to care are waiting for Continuing Health Care decision and therefore may not be LA placements.
Delayed Transfer of Care from Hospital (per 100,000 population)	723	876	The rate per 100,000 at Quarter 3 is 647.9 above target (534.8). Unlikely to meet target.
Effectiveness of Reablement (% of people still at home after discharge from hospital to reablement)	90.6%	92.9%	On track to meet target
Patient survey (GP Patient Survey Q39 – does your GP or health professional review your care plan with you regularly) %	65%	56.14%	Survey captured in July and January. Q3 actual is the January 2016 result. Target not achieved.
Average length of stay in hospital for over 65 year olds (days)	7.1	7.1	October (7.1), November (7.5) and December (6.7) positions suggest on track for improved performance and potentially meet full target.

3.0 - BCF Local Schemes

The Better Care funding has been used to create, and further enhance the following services:

3.1 Seven Day Hospital Social Workers – (North Lincolnshire Council)

- The hospital team, based at Scunthorpe General Hospital (SGH), have been in operation since November 2014 and fully operational working 8am to 8pm since December 2014.
- The team have already developed good working relationships with the discharge liaison team within the hospital. This new joint approach helps to manage and support the safe discharge of people from hospital back into the community.
- Hospital 'board rounds' are now attended by the team, each day supporting safe hospital discharge.

3.2 Frail Elderly Assessment Service Team (FEAST) – (Northern Lincolnshire and Goole Foundation Trust)

- This new team was developed to support individuals assessed as being frail and elderly. These patients benefit from a comprehensive geriatric assessment and plan of ongoing care by the newly funded specialist team.
- The patient may then spend time being assessed in a new 'chair based' unit with a plan to discharge on the same day or be admitted within a designated bed base with an aim to return home within 72 hours.
- The new team consists of a consultant geriatrician, therapists, advanced nurse practitioners, health care support workers.
- The new team, working with existing wards teams including 7 day social workers and older people mental health services also works closely with community services and GPs to ensure appropriate care and support when they go home.
- All key posts have been appointed to and the newly refurbished chair based area is also in use. The service commenced on 9th September and was fully launched, as planned, on October 1st.

3.3 Locality Teams – (Northern Lincolnshire and Goole Foundation Trust/North Lincolnshire Council)

- This BCF project enhances existing community services and is part of the out of hospital programme within the BCF and aligns to the wellbeing offer.
- The aim of the scheme is to manage and support patients closer to their home, by a workforce that know their local area better and are able to provide treatment, advice and signposting locally.
- The new locality co-ordinator posts have been recruited to, and have recently commenced in post.

- The scheme also supported 7 day working for therapies, which started at the end of July 2015.
- To support better end of life care closer to home new Macmillan nurses have been funded through the BCF and they are also now in post. They commenced 7 day working at the beginning of October.
- The community equipment service has also been extended on an interim basis to 6 day working with 1 day on call from the end of July.

3.4 Older Peoples Mental Health Services (OPMH) – (Rotherham, Doncaster and South Humber Foundation Trust)

- The OPMH service, initially a pilot last winter, aims to rapidly assess older people admitted to hospital who have been perceived to have a mental health problem such as dementia or depression.
- The service will also provide ongoing support, education and advise to those with mental health problems and their carer's.
- Due to the success of the pilot recruitment has been progressed during the first two quarters of 15/16. The nurse consultant, therapists and support workers are now in post in SGH and working across 5 days. Recruitment to the Band 6 nursing posts has proved challenging. Third round of interviews has just been completed in October and potentially all 3 roles have been recruited to. If successful the service will be operating against agreed plan by January 2016.

3.5 Community Wellbeing Hubs – (North Lincolnshire Council)

- The 5 wellbeing hubs outlined in the BCF plan are all fully operational in Scunthorpe, Brigg, Epworth, Barton and Winterton. In addition further satellite hubs in Broughton and Crowle have been developed by the council.
- The hubs that have been refurbished are dementia friendly environments and changing places type toilets (2 are fully compliant).
- In order to target individuals requiring additional support, the hubs operate a registration scheme. The Hub teams are currently providing targeted interventions on a 1:1 basis and working with 116 individuals. These numbers are steadily rising month on month as the population and other agencies become more aware of the services offered.
- There have been 5,500 newsletters distributed across the community outlining the support and activity available at the hubs.
- The wellbeing offer and hubs is being promoted to GP practices so that people can be referred and sign posted to early help support.

- Identification of the most vulnerable communities and people within those communities is done through the use of profiling data and partnership working.
- The hubs are actively working with the hospital team to create support links for service users admitted to hospital to help at discharge, and are also looking at ways to work differently with the intermediate care service at Sir John Mason House.
- The service is piloting the Healthy and Active passport, which will give citizens access to services and schemes aimed at improving health and wellbeing.
- Wellbeing hubs are also being designated as Spaces of Safety (SOS).

3.6 Rapid Assessment Time Limited service (RATL) – (Northern Lincolnshire and Goole Foundation Trust)

- The RATL service aims to provide an alternative provision of care in the home setting for people who may have otherwise had an attendance or admission to hospital.
- The service can respond to requests from GPs for assessment of need within an hour based on criteria agreed with GP commissioners within a new specification.
- The service is fully recruited to, with a number of the team in development posts. A comprehensive training plan has been formulated for all the practitioners.
- RATL service was implemented from the 1st October initially available from 7:15am until midnight 7 days a week. Overnight services commenced from 2nd November.

3.7 Disabilities Funding Grant (DFG) – (North Lincolnshire Council)

- The capital element of the BCF includes expenditure on DFGs. The council's Home Assistance team process all recommendations made by the OT service/social services for adaptations to a home.
- A recommendation is made when it is identified that an adaptation would support in keeping a vulnerable elderly or disabled adult or child safe at home.
- The council as a Housing Authority has a statutory duty to provide mandatory Disabled facilities Grants under the Housing Grants, Construction and Regeneration Act 1996. Service performance is currently monitored using end to end times.
- There are national guidelines on the time taken from the OT visit to the completion of the work which the service is monitored against. A multi-agency working group is reviewing the process involved to identify how timescales can be further improved.

BCF related developments

3.8 Falls Pathway

- The fire service is leading a multi partner approach developing a new offer to support individuals at risk of falls or who have fallen. This encompasses the newly commissioned primary care falls clinic for the over 75s.
- A business case is being developed which will seek support for funding from the CCG systems resilience fund to run a prototype in the 2nd quarter of 16/17 involving the fire service offering a different prevention and ‘pick up’ service.

3.9 Discharge to Assess

- The CCG systems resilience funding was used to invest in extra non acute beds from December 2014 to support discharge from hospital. The learning from this pilot will inform further development of the ’30 day beds’ provision, linking with BCF schemes and investment.

3.10 Care networks

- The GP Council of Members have supported a move to develop an out of hospital services model across 3 new care networks within the area.
- The care networks will include health and social care working in an integrated way based on the needs of the community.
- A care network summit was held on the 14th October to review the needs of the citizens within each network and identify ‘evidence based’ approaches to prototype in each network based on their need.
- ‘Ambassadors’ are being sought from all organisations providing care within the networks to help shape and lead the new approach.
- One aim of the care networks models will be to reduce unnecessary hospital utilisation and admission to long term care. These schemes enhance the existing BCF schemes by implementing new approaches to long term condition management. This moves North Lincolnshire into a period of large scale transformation and change.

Appendix 2

4.0 - BCF Planning Guidance 16/17

In 2016-17, the Better Care Fund will be increased to a mandated minimum of £3.9 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. From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund. 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

There was strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Better Care Fund has been taken on board, and they have streamlined and simplified the planning and assurance of the Better Care Fund in 2016-17, including removing the £1 billion payment for performance framework. In place of the performance fund 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 Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, and then implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements.

4.1 Statutory and Financial Basis of the Better Care Fund

Under the mandate to NHS England for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to Clinical Commissioning Groups to establish the Better Care Fund. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

Within the £3.519 billion Better Care Fund allocation to Clinical Commissioning Groups, £2.519 billion of that allocation will be available upfront to Health and Wellbeing Boards to be spent in accordance with the local Better Care Fund plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to a new national condition.

4.2 Conditions of Access to the Better Care Fund

The conditions are:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG (more detail in the section below on Assurance and Approval)
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital

5.0 – 8 National Conditions

NHS England will also require that the BCF plans demonstrate how our area will meet the following 8 conditions. The key elements of each condition are detailed below:

5.1 Plans to be jointly agreed

- Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. This should include an assessment of future capacity and workforce requirements across the system The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund.

5.2 Maintain provision of social care services

- We must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16

5.3 Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

- Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;

- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

- By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8.

5.4 Better data sharing between health and social care, based on the NHS number

It is vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. We should be able to ensure we can:

- confirm we are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that we are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary
- ensure we have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when we plan for it to be in place.
- confirm people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

5.5 Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

- We should be able to identify which proportion of our population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help following the principles of person centred care planning. Dementia services will be an important priority.

5.6 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

- The impact of local plans need to be agreed with all relevant Health and Social Care providers with assurance sought on public and patient and service user engagement in this planning

5.7 Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

- Local areas should agree how they will use their share of the £1billion that had been used to create the payment for performance fund
- Local areas can choose to put and appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency.

5.8 Agreement on a local action plan to reduce delayed transfers of care (DTOC)

It is expected the plans will:

- Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
- Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care
- Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance
- Demonstrate how local authorities, CCGs are working collaboratively to support sustainable local provider markets
- Demonstrate engagement with independent and voluntary sector

5.9 Assurance and Approval of Better Care Fund Plans

- Local Better Care Fund plans will be developed in line with the agreed guidance, templates and support materials issued by NHS England and the Local Government Association. For 2016-17, they have set out a more streamlined process that is better integrated into the business-as-usual planning processes for Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities. (Appendix 3)

6.0 National Performance Metrics

- They will remain the same

7.0 Indicative Metric Targets and Budget 2016-17

HWB Funding Sources	
	Gross Contribution
Total Local Authority Contribution	£1,763,000
Total Minimum CCG Contribution	£10,929,532
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	**£12,692,532**

7.1 Summary of BCF Expenditure

	Expenditure
Acute	£1,966,632
Mental Health	£283,000
Community Health	£1,086,900
Continuing Care	£0
Primary Care	£80,000
Social Care	£5,407,000
Other*	£2,106,000
Total	**£10,929,532**

*includes schemes that are a combination of the above categories, including voluntary sector

The table below contains the indicative metrics that have been submitted to NHS England for the first submission of the planning template as required on the 2nd March 2015.

Metric	2016-17 Target	Commentary
Non Elective Admissions to Hospital (per 100,000 population)	TBC	Dependent on final CCG activity plan submissions being approved.
Permanent Admissions to Residential and Nursing Care (Over 65 year olds per 100,000 population)	512.2	Published data for 2014-15 was 560.4 for North Lincolnshire compared to 668.8 England average
Delayed Transfer of Care(delayed days) from Hospital (per 100,000 population)	622.3	The latest published benchmarking data shows the number of delays per 100,000 population in North Lincolnshire as 6.3 compared to 11.1 England average.
Effectiveness of Reablement (% of people still at home after discharge from hospital to reablement)	91.7%	Published data for 2014-15 was 90.3% for North Lincolnshire compared to 82.1% England average
Patient survey (GP Patient Survey Q39 – does your GP or health professional review your care plan with you regularly) %	65%	
Average length of stay in hospital for over 65 year olds (days)	7.0	

APPENDIX 3 – Approval Process for BCF 16/17