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

Agenda Item No: 8
Meeting: 10 November 2015

NORTH LINCOLNSHIRE COUNCIL

HEALTH AND WELLBEING BOARD

BETTER CARE FUND: PLAN UPDATE

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.

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, with delegation to the CCG Chief Officer, Council Chief Executive and the Chair of the HWBB to agree the final submission by Friday 9th January 2015.

2.2 Building on the Nationally Consistent Assurance Review (NCAR) feedback and using information from further modelling work, the BCF schemes and supporting information was updated to meet the required conditions. The plan was subject to further NCAR assessment, with the outcome that the plan was approved.

2.4 The Joint Board for Health and Social Care is responsible 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.

2.5 The revised 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

2.6 The outcomes that we are aiming to achieve through the Better Care Plan are that people say:

- 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

2.7 NHS England monitor BCF plans quarterly which includes information about budget arrangements, including pay for performance, the national conditions and performance on BCF metrics. Appendix 1 includes quarter 1 monitoring information and updates on the progress being made on the implementation of the plan, including an overview of the scheme developments.

. OPTIONS FOR CONSIDERATION

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

4. ANALYSIS OF OPTIONS

4.1 The report provides the quarterly monitoring information to the HWBB as required. Key points from the quarter 1 return 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.
- Some of the NHS schemes were not fully implemented in quarter 1 as agreed by the joint board; therefore there was no improvement in the performance metric of non-elective admissions to hospital in quarter 1. All schemes are expected to be fully implemented in quarter 3 (from 1 October 2015).

4.2 Quarter 2 reporting to NHSE is due on 27th November 2015, and will be reported to the next HWBB

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.

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.

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Background Papers used in the preparation of this report:

Reports to Health and Wellbeing Board –December 2014 and March 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 remain the same and are 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

Metric	Q1 Plan	Q1 Actual	Full Year Performance RAG
Non Elective Admissions to Hospital (per 100,000 population)	4491	4965	On track for improved performance but not to meet full target
Permanent Admissions to Residential and Nursing Care (Over 65 year olds per 100,000 population)	132	191	On track for improved performance but not to meet full target
Delayed Transfer of Care from Hospital (per 100,000 population)	771	672	On track to meet target
Effectiveness of Reablement (% of people still at home after discharge from hospital to reablement)	90.6	91.5	On track
Patient survey (GP Patient Survey Q39 – does your GP or health professional review your care plan with you regularly) %	65	n/a	Survey captured in July and January
Average length of stay in hospital for over 65 year olds (days)	8.3	8.7	On track for improved performance but not to 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 7 Day Hospital Social Workers - 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 as soon as possible.

3.2 Frail Elderly Assessment Service Team (FEAST) – 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 worker and older people mental health services. The team 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 – 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. 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) – 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 – 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 are being 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 re-ablement beds 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) – 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 planned to commence from 2nd November.

3.7 Disabilities Funding Grant (DFG) – 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 EMAS Falls Pathway – The fire service are 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 funding to run a prototype over the last quarter of 15/16 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 and move North Lincolnshire into a period of large scale transformation and change.