CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Better Care Fund Plan 2019 – 2020
Date of meeting:	28/01/2020
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Health & Wellbeing Board Lead:	Cllr. Laura Jeuda (Adults Social Care and Health)

Executive Summary

Is this report for:	Information ☐	Discussion ☐	Decision x
Why is the report being brought to the board?	This report provides an overview of the Better Care Fund plan 2019-20. The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group allocations, the Disabled Facilities Grant and the Improved Better Care Fund (iBCF). The aim of the BCF is to bring about greater integration between health and social care. The plan includes the Improved Better Care Fund, Better Care Fund and winter pressures, in total there are 21 schemes in operation across the fund.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Starting and Developing Well ☐ Living and Working Well ☐ Ageing Well x All of the above ☐		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above x		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	The Health and Wellbeing Board (HWB) is asked to agree the Better Care Fund plan for 2019-20.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	The following report has separately been distributed to the Better Care Fund Governance Group.		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 This report details the Cheshire East Better Care Fund for 2019-20. The aim of the BCF is to bring about greater integration between health and social care. The plan includes the Improved Better Care Fund, Better Care Fund and winter pressures, in total there are 21 schemes in operation across the fund. In total schemes cover some £35m of expenditure.

2 Recommendations

2.1 The Board is asked to agree the Better Care Fund plan for 2019-20.

3 Reasons for Recommendations

3.1 There is a requirement for the Better Care Fund plan to be signed off by the Health and Wellbeing Board. There was a national delay to the release of planning guidance for the Better Care Fund which in turn has delayed the local planning process, following the submission of the BCF plan on 27/09/2019 this report has been produced to provide an overview of the BCF plan.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This report supports the Health and Wellbeing Priority of Ageing Well.

5 Background and Options

5.1 The following report includes what's in the BCF, the current schemes for 2019/20 an overview of funding and finally expected performance during 2019/20.

5.2 **<u>What is in the BCF</u>**

5.3 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group allocations, the Disabled Facilities Grant and the iBCF.

5.4 Local BCF plans are subject to national conditions and guidance. Local plans are monitored through NHS England and there are strict timelines regarding submission of plans for both regional and national assurance of plans to take place.

5.5 National Conditions for 2017-19: In 2017-19, NHS England required that BCF demonstrated how the area will meet the following national conditions:

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care.
- Managing Transfers of Care (Delayed Transfers of Care)

5.6 The key objectives for the effective utilisation of the BCF resource include:

- Carers are valued and supported Staff work together, with the person at the centre, to proactively manage long term physical and mental health conditions. The four Cheshire CCGs are committed members of the Cheshire West and Chester and Cheshire East Health and Well Being Boards.
- Those who receive care and the staff providing them have a positive experience of care
- Care is person centred and effectively coordinated
- People spend the appropriate time in hospital with prompt and planned discharge into well organised community care when needed and there are effective alternatives to hospital admission

5.7 The Cheshire East Health and Wellbeing Board (NHS Eastern Cheshire, NHS South Cheshire CCGs with Cheshire East Local Authority) approve plans to manage pooled budgets, the 'Better Care Fund' (BCF), pooled budgets between health and social care to deliver against four key metrics;

- Reduce non-elective admissions
- Effective rehabilitation
- Reduce long term admissions to residential and nursing care homes
- Reduce delayed transfers of care (DTOC)

5.8 **Current schemes**

The following table summarises the schemes which comprise the iBCF, BCF and winter pressures.

Number	Scheme	Description
1	iBCF - Increased weekend capacity for social workers	To maintain Social Work assessments and advice services over 7-days per week. Based within the hospitals at Macclesfield and Leighton.
2	iBCF - Care Sourcing team model	The funding supports and expands the work of the Care sourcing team. The team undertakes all aspects of the

		Brokerage cycle: enquiry, contact assessment, support planning, creation of support plan, brokering, putting the plan into action as well as monitor and review of the support. The service operates 8am until 2pm / 2pm until 8pm, Monday to Sunday.
3	iBCF - Live well	'Live Well Cheshire East' is an online resource. It is designed to give people greater choice and control by providing easily accessible information and advice about care and support services in the region and beyond. This digital channel provides information and advice and a directory of local services in one place covering Adult, Children, Community and Public Health services.
4	iBCF - Funding for additional social care staff to support Discharge to Assess initiatives	Funding for additional Social Care staff (Locality Manager and Practice Manager) for each hospital team to implement and maintain 'Assessment Outside of Hospital' (previously known as 'Discharge to Assess) in a range of locations across Cheshire East. This includes bed-based services and within a person's own home to prevent admissions to hospital and facilitate timely discharge.
5	iBCF - Winter funding	Additional capacity to support the local health and social care system to manage increased demand over the winter period.
6	iBCF - Sustain the capacity, capability and quality within the social care market place	This funding supports and stabilizes the local social care market by offering fee uplifts for both 'Care at Home' (domiciliary care) and Accommodation with Care (Care Homes). The funding relates to the following: • Residential/nursing care – 1360 bed weeks which is 26 placements over the course of the year. • Domiciliary care – 380 new people until the end of the year.
7	iBCF - Electronic Call Monitoring (ECM)	The monitoring providers to ensure that individual level care calls meet planned activity as set out in care plans. The electronic call monitoring system (ECM) will support the delivery of the recommissioned Care at Home service. ECM offers an automated solution to monitor care visits undertaken by the provider's staff, which will help to improve performance monitoring and safeguarding and improve the safety of staff. The ECM solution will also offer the potential to move towards the monitoring of outcomes for service users.

8	BCF Assistive Technology (AT)	Assistive technologies are considered as part of the assessment for all adults who are eligible for social care under the Care Act where it provides greater independence, choice and control and is cost-effective for individuals. The provision of assistive technology is personalized to each individual and is integrated within the overall support plan. This will entail: • Increasing the independence of people living with long term conditions and complex care. • Supporting Carers to maintain their caring role. • Improving access to the right service at the right time. The scheme supports the existing assistive technology service users. But will also involve piloting assistive technology support for adults with a learning disability (both living in supported tenancies and living in their own homes).
9	BCF Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator also forming part of this scheme is the commission of the British Red Cross service.	Early discharge service – ECT is commissioned to provide an Early Discharge Co-ordinator, as part of this scheme there is also a commissioned element which supports the British Red Cross service: Cheshire East 'Support At Home' Service is a 2-week intensive support service with up to 6 Interventions delivered within a 2-week period for each individual. The aim is to support people who are assessed as 'vulnerable' or 'isolated' and who are at risk of admission to hospital or becoming a delay in hospital. Service users have been identified as requiring additional support that will enable them to remain independent at home, or to return home more rapidly following a hospital admission. The interventions may include: A 'safe and well' phone call. A 'follow-up visit' within 1 working day. Help with shopping. Signposting and referring to other agencies for specialist support. The main focus of the service is on supporting people to remain at home (preventing unnecessary hospital admissions by increasing intensive support at home).
10	BCF Combined Reablement Service	The current service has three specialist elements delivered across two teams (North and South): 1. Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve

		maximum independence, or to complete an assessment of ongoing needs. 2. Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their Carers. The service is focused on prevention and early intervention following a diagnosis of dementia. 3. Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.
11	BCF Statutory Social Care activities resulting from the Care Act including Safeguarding	The Care Act 2014 introduced and revised the statutory responsibilities of local authorities. The Partnership will ensure sustainable appropriate embedded solutions are in place to meet these responsibilities. The Partnership encompasses the duties of the Safeguarding Adults Board. This safeguarding scheme also includes the responsibilities which come from the Care Act which includes the following sub-schemes: Provider Quality Reports (BCF Social Care Act Allocation), Maintaining minimum care eligibility thresholds - Contribution towards maintaining care eligibility thresholds at critical and substantial, Continuity of care for people moving into areas - Additional social worker capacity, Assessment of Social Care in prisons - Additional social worker capacity, Disregard for armed forces Guaranteed Minimum Income - Allocated to care packages, Training social care staff in Social Care Act - Delivery of Care Act training to staff, Less reduction for savings from staff time and reduced complaints
12	BCF Disabled Facilities Grant (DFG)	The Disabled Facilities Grant provides financial contributions, either in full or in part, to enable disabled people to make modifications to their home in order to eliminate disabling environments and continue living independently and/or receive care in the home of their choice. Disabled Facilities Grants are mandatory grants under the Housing Grants, Construction and Regeneration Act 1996 (as amended). The scheme will be administered by Cheshire East Council and will be delivered across the whole of Cheshire East.

13	BCF Carers hub	The Cheshire East Carers Hub is an information and support service designed to help Carers of all ages fulfil their caring responsibilities and still enjoy a healthy life outside of their caring role. The Hub will support Carers who live in Cheshire East, along with those who live outside the area but care for a Cheshire East resident.
14	BCF Programme Management and Infrastructure	Overall responsibility for delivery of the principles and targets of the BCF and identifying barriers, risks and mitigation to ensure they are achieved. Staff employed and infrastructure required to support the management and governance arrangements for the BCF.
15	BCF Winter Schemes ECCCG	Evidence-based interventions designed to keep people at home (or in their usual place of residence) following an escalation in their needs and/or to support people to return home as quickly as possible with support following an admission to a hospital bed.
16	BCF Homefirst ECCCG	'Home First' is the 'umbrella' term used to describe a collection of services commissioned by NHS Eastern Cheshire CCG and predominately delivered by East Cheshire NHS Trust
17	BCF Homefirst SCCCG	Home First is an ethos, to support patients to remain in their own homes. This scheme is delivered through a number of community health services predominately delivered by Central Cheshire Integrated Care Partnership.
18	Winter - rapid response	The Rapid Response Service facilitates the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.
19	Winter - additional beds	We have 60 short stay beds per week to support step down and step up per bed. Existing Commissioning resource will be used to procure these beds.

20	BCF - Mental health social workers	This scheme supports individuals with mental health who are requiring assessment.
21	Trusted assessor service	The overall aim of this service is to develop and establish a trusted assessor service in Cheshire East; this service will provide a trusted assessment function through Independent Transfer of Care Coordinators. This service will initially work with existing care home residents who have been admitted to hospital and require assessment prior to transferring back to the care home. This service will in part help reduce patient length of stay as well as contributing to a reduction in Delayed Transfers of Care.

5.9 **Overview of funding**

5.10 The following table is a summary of the BCF running balances:

Running Balances	Income	Expenditure	**Balance**
DFG	£2,064,279	£2,064,279	£0
Minimum CCG Contribution	£24,577,102	£24,901,102	-£324,000
iBCF	£6,999,291	£6,999,291	£0
Winter Pressures Grant	£1,450,638	£1,450,638	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£324,000	£0	£324,000
Total	£35,415,310	£35,415,310	**£0**

5.11 Note: The BCF national template (which has been approved for Cheshire East) categories groups types of income and expenditure together, hence the positon that while the overall income and expenditure fully reconciles there are variances on a couple of individual lines.

5.12 **Expected planned performance**

5.13 Definitions of key metrics are shown in Appendix one, The following tables provide an overview of the expected annual performance of the Better Care Fund in relation to the key metrics, these metrics cover the following areas:

- Delayed transfers of care
- Residential admissions
- Reablement
- Non-elective admissions

8.1 Delayed Transfers of Care

	19/20 Plan
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	24.4

This target uses the average daily DTOC beds. DTOC performance (June) was 37.7, which would require a 35% reduction to hit this target. This target equates to 756 monthly bed days in a 31 day month and 732 in a 30 day month.

Significant progress has been made to reduce DTOC in the two years since the last review (June 2017 to 2019) with monthly DTOC's reducing from approximately 2,000 days per month to approximately 1,000 days per month. However further effort and focus is required to reduce this further. Operational meetings between assessment and care management as well as care sourcing have been held to reduce waiting lists and delays experienced by people awaiting a care package in their own home. In addition a number of winter funding schemes are being deployed which have the aim of reducing Delayed Transfers of Care. We have also held a number of strategic meetings to further reduce delays, these have identified that we need to establish processes for hospitals outside of Cheshire to sign-off on DTOC data which relates to the Cheshire East HWB footprint.

As part of our plan we have 19 schemes which cover a number of funding streams (winter, bcf, ibcf) of these 19 schemes, 14 of them will have an impact on Delayed Transfer of Care. We have a number of schemes which have varying levels of support to ensure service users/patients are supported to return home, this ranges from low level support such as the British Red Cross up to more intensive Reablement and intermediate care solutions. The schemes also recognise that a number of solutions support effective DTOC reduction which includes appropriate levels of assessment and care management as well as weekend working and ensuring that the home has the appropriate level of adaptions.

One of the main winter schemes is rapid response. The Rapid Response Service will facilitate the safe and effective discharge of service users from hospital who have been declared as medically fit for discharge but who may have still have care needs that can be met in the service users own home. The service will seek to prevent readmission to hospital by ensuring wrap around services are in place in the first 48 hours following hospital discharge. The Service will also provide support to Service Users with complex health needs and end of life support at a level. Through the provision of 7 day working, the service will ensure a timely response to hospital discharge to reduce delayed transfers of care and create capacity and throughput for non-elective admissions.

Of all of the DTOC attributable to social care, the largest single source of delays is Awaiting care package in own home – total number of delayed days 2013, % of all delays 53.54, average number of delayed days per month 167.75.

As part of the Cheshire East efforts to reduce DTOC a rapid response service is due to be in place from 1/10/2019, this will provide packages for between 600-969 people, if each of these packages conservatively reduces the delays associated with awaiting a care package in own home by at least one day, then the total number of delays associated with this reason would reduce from 2013 to between 1044-1413.

This would reduce the monthly delay from the average of 167.75 to 87-118. It should be noted that this is the planned performance and the actual performance will be tracked.

In addition to this Cheshire East are implementing a number of other schemes focused on reducing these delays further, these schemes include: Stockport social worker (Stepping Hill), Rapid response, Homecare coverage, Social worker for Station House, Rapid response social worker, Block book beds. These schemes will have the impact of reducing DTOC delays in the following areas: assessment completion, awaiting care package in own home, awaiting community equipment and adaptions and awaiting nursing home placement or availability

8.2 Residential Admissions

		18/19 Plan	19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	711	601
	Numerator	616	530
	Denominator	86,688	88,205

In 2018/19 Cheshire East saw reducing rates of admission to residential and nursing homes for people over the age of 65. More recently the homecare service has been re-commissioned we also have a number of homefirst schemes as well as extracare provision. The target set locally is based on a number of admissions in the year rather than a rate. 18/19 actual performance was considerably lower than the plan figure.

8.3 Reablement

		18/19 Plan	19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement / rehabilitation services	Annual (%)	89.8%	83.3%
	Numerator	193	320
	Denominator	215	384

This suggested target, whilst quite a bit lower than the previous plan, would still represent a challenge given our 18/19 performance (75.6%) and is reasonable given the 17/18 national performance of 82.9%, regional performance of 84.6% and comparator average of 83.4%, and that we have a higher proportion of 85+. Recent analysis of Reablement performance information (01/04/19-31/07/19 discharge direct to Reablement and Macc IC only) shows the following:

- % of service users who are deceased prior to 91 day marker: 7.0%
- % of service users who go into residential care prior to 91 day marker: 14.0%
- % of service users who are readmitted to hospital prior to 91 day marker: 1.2%

- % of service users who go into residential care or readmitted to hospital prior to 91 day marker: 15.1% (this does not add up to the two figures above due to rounding)

Here is the age group summary for 2019/20 data:

1. Intermediate Care age range vs % of service users: 65-74 - 8.5%, 75-84-36.6%, 85+- 54.9%
2. Reablement age range vs % of service users: 65-74 -16.7%, 75-84 -36.7%, 85+ - 46.7%
3. Reablement / Intermediate Care combined age range vs % of service users: 65-74 -9.9%, 75-84 -36.6%, 85+ - 53.5%

In order to meet the Reablement performance metric two activities are going to be undertaken: 1.The Reablement service will be re-focused to increase the number of referrals accepted from hospital discharge and 2. The eligibility criteria will be reviewed to re-target the service as those best placed to benefit from a spell of Reablement.

8.4 Non-Elective Admissions

	19/20 Plan
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.

The planned Non Elective Admissions information 46,733 as noted in the Non Elective Admission 2019/20 dashboard for CCG mapping.

In reference to Non Elective Admissions information collection the following has been noted: The way these have been calculated involves applying a percentage of each CCG's plan to each HWB area i.e. there will be a number of CCGs for CE HWB not just South Cheshire and Eastern Cheshire CCGs. Just under 5% of the target is made up from CCGs outside of Cheshire East (for residents outside Cheshire East admitted to Cheshire East hospitals. This is different to how we currently monitor this metric as we use the two CCGs totals (whether hospital is in or outside Cheshire East).

As part of our plan we have 19 schemes which cover a number of funding streams (winter, bcf, ibcf) of these 19 schemes 14 of them will have an impact on Non Elective Admission data. A number of the schemes seek to ensure that where possible individuals are helped to remain as independent as possible and in their own homes. In addition to this a number of the schemes can be characterised as assisting with market management and ensuring that demand for services can be dealt with in as efficient manner as possible. We have a number of services such as combined Reablement and British Red Cross which seeks to provide ‘step up’ and ‘step down’ support to individuals in the community and from hospital discharge. We also have a number of projects which we are piloting in care homes these include:

trial of an app in care homes to reduce falls, information and advice for care homes, the use and adoption of a nursing and residential triage tool.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

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Appendix one – definitions of key metrics

Delayed transfers of care

- Description: Delayed transfers of care from hospital per 100,000 population
- Data definition: Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
    - a clinical decision has been made that the patient is ready for transfer AND
    - a multi-disciplinary team decision has been made that the patient is ready for transfer AND
    - the patient is safe to discharge/transfer.
- Rationale: This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
- Outcome sought: Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

Residential admissions

- Description: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population
- Data definition: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.
- Rationale: Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
- Outcome sought: Reducing inappropriate admissions of older people (65+) in to residential care

Reablement

- Description: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement / rehabilitation services
- Data definition: The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
- Rationale: Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.

- Outcome sought: Increase in effectiveness of these services whilst ensuring that those offered service does not decrease.

Non-elective admissions

- Description: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population.
- Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.
- Rationale: Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.
- Outcome sought: A reduction in the number of unplanned acute admissions to hospital.