Better Care Fund
& Improved Better Care Fund

Health and Wellbeing Board
March 2019

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Strategic Development Unit

Background

Better Care Fund

- To drive transformation and integration of health and social care
- 5 national conditions, e.g. jointly agree BCF plans, to pool the BCF via a section 75 agreement, all of which have been met.
- Plan signed-off and monitored via the local Health and Wellbeing Board
- Targets set and performance monitored against a number of metrics
- Implement the 'High Impact Change Model – Managing transfers of care between hospital and home'

Improved Better Care Fund

- Paid as a direct grant to local government, with a condition that it is pooled into the local BCF plan.
- can be spent on:
  - Meeting adult social care needs
  - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
  - Ensuring that the local social care provider market is supported

Localities are required to provide quarterly BCF updates, signed off by the Health and Wellbeing Board (to meet national reporting timescales this is via Cllr Simpson's delegated powers)

BCF metrics

- Non-elective admissions - reduction in non-elective admissions
- Permanent admissions - rate of permanent admissions to residential care per 100,000 population (65+)
- Effectiveness of reablement - proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care (DToC) – reduction in delayed transfers of care (delayed days) from hospital

Non-elective admissions

Non-Elective Admissions (NEA)	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Actual activity level	5,930	5,339	5,874	-
Revised BCF NEA targets	5,479	5,359	5,662	5,602

Performance:
Q1 2018/19 – not on track
Q2 2018/19 – not on track
Q3 2018/19 – not on track

Lead – David Latham, Programme Manager, Bury CCG

Review – target revised to align to CCG operating plan

Rationale – as per BCF operating guidance

Actions:

- Structured approach to winter Planning
- Increased reablement via the LA Winter Pressures money
- Increase Community Bed stock via D2A.
- Urgent treatment Centre opened
- Improved pathways across IMC
- Enhance Green Car Model mobilised.
- Ambulance see and treat service expanded - reducing conveyances, reducing A&E attendances for relevant patients
- Integrated Virtual Clinical Hub (IVCH) mobilised

Permanent admissions

Performance:
Q1 2018/19 – on track
Q2 2018/19 – on track
Q3 2018/19 – on track

Lead – Deb Yates, Provider Relationship Manager, Bury CWB

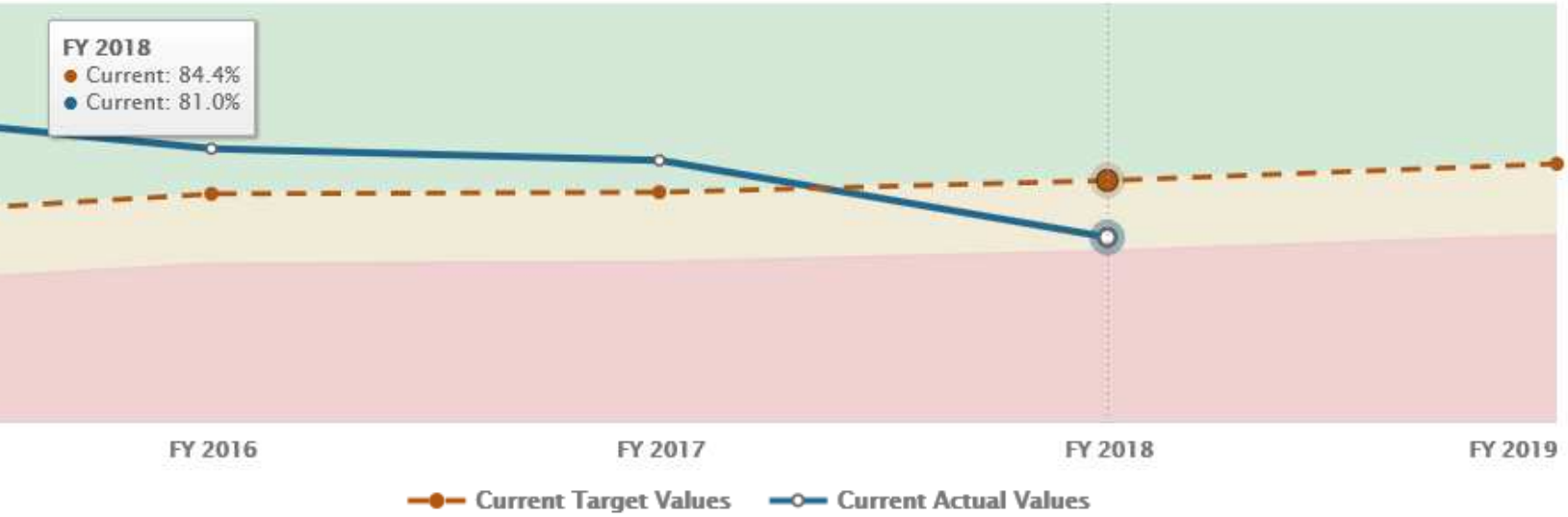
Review – retain level of ambition in 2017/19 plan submission

Rationale – it is anticipated that the target will be met during 2018/19 (20% reduction in rolling 12m admissions figure)

Actions:

- Positive impact of initiatives such as D2A beds and zonal homecare model continues to have an impact.
- Residential admissions target expected to be met during Q4 of 2018/19

Effectiveness of Reablement



Performance:
Q1 2018/19 – not on track
Q2 2018/19 – on track
Q3 2018/19 – on track

Lead – Dill Hawley, Business Manager, Bury Adult Operations

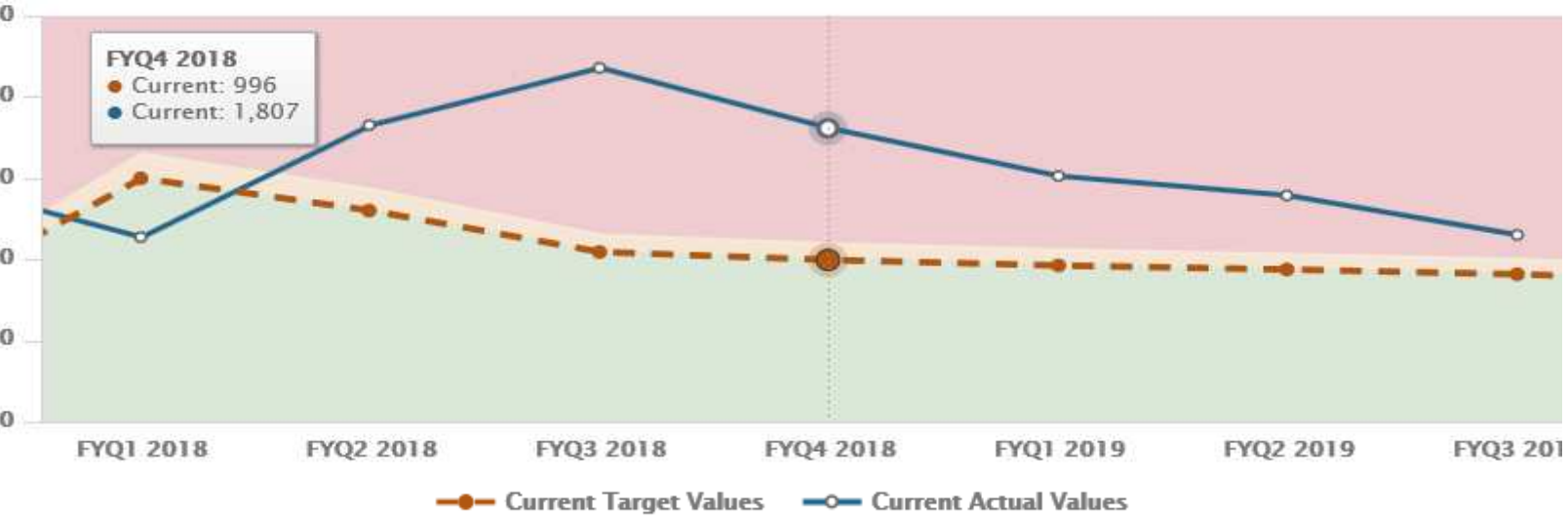
Review – retain level of ambition in 2017/19 plan submission

Rationale – Target has been met for this quarter

Actions:

- Review of Intermediate Tier as part of TPC&SC to develop a step up model
- Increased levels of activity / throughput
- Increased flexibility between home based and bed based services

Delayed transfers of care (DToC)



Performance:
Q1 2018/19 – not on track
Q2 2018/19 – not on track
Q3 2018/19 – Not on track

ad – Dee Colam, Interim Assistant Director, Adult Social Care Operations

view – revised to 12 delays per day

tionale – Bury's proportion of GM-wide DToC target

tions:

Improved data quality / recording, improving understanding of delays and targeting interventions

Strengthened performance management – DToC owned by integrated discharge team; daily discharge meetings; weekly review of 7+ days delays

Flexible deployment of resource – e.g. reablement into Home in a Day service

The work that was undertaken last year to reduce the number of DToC's within the Mental Health service has now been embedded in practice across CMHT and the Irwell Unit as a result of which they continue to remain low.

High Impact Change Model

- A successful **High Impact Change Model** (HICM) will assist in managing transfers of care
- Programme management approach introduced to delivery increasing levels of maturity to local arrangements
- Oversight provided by System Flow Group
- Status:

	Early discharge planning	Systems to monitor patient flow	Multi-disciplinary/multi-agency discharge teams	Home first/discharge to assess	Seven-day service	Trusted assessors	Focus on choice	Enhancing health in care homes	Red Bag schem
Q1 2018/19	Established	Established	Mature	Plans in place	Established	Established	Established	Established	Plans in place
Q2 2018/19	Established	Established	Mature	Plans in place	Established	Established	Established	Established	Plans in place
Q3 2018/19	Established	Established	Mature	Plans in place	Established	Established	Established	Established	Established

High Impact Change Model
Progress So Far

- Discharge planning starts in A & E
- Raised awareness of discharge options
- Integrated workforce with a joint approach to training and upskilling
- Additional resources to support seven day working for some services
- Process in place to review MOAT daily to help reduce DToC's
- Flexible discharge to assess beds to meet changing demand
- Trusted Assessor is some care homes
- Healthy Care Homes pilot in place in the north of the borough
- Market Development, locally and GM wide

iBCF Plan

There is no requirement to report iBCF to Better Care Fund this quarter, although information is still being collated through individual projects locally and regionally.

2018/19 additional allocation funded projects	Notes / narrative
Meeting adult social care needs, inc.: • Community care – care at home • Community care – residential • ASC staff capacity	 • Maintenance of previous levels of provision • Maintenance of previous levels of provision • Leadership, safeguarding / protection

Requirement to identify up to 5 key metrics to assess impact of iBCF spend
Local metrics, related to areas of spend:

- DToC for reason 'awaiting package of care’
- DToC for reason 'awaiting residential home’
- Time taken to grant DOLS application

Any Questions?