Derby City Council

HEALTH & WELLBEING BOARD
21st January 2016

ITEM 8b

Joint Report of the Strategic Director of Adults Health and Housing & the Chief Operating Officer of Southern Derbyshire CCG

Better Care Fund Update

SUMMARY

1.1 In March 2015, Board Members approved the Better Care Fund Plan for Derby and the governance arrangements to deliver the plan. This was a requirement set out by NHS England.

1.2 Throughout 2015, quarterly reporting templates have been submitted to NHS England focusing on progress against key performance measures.

1.3 This report provides a summary of performance to date and highlights the arrangements for 2016 and beyond.

RECOMMENDATION

2.1 To note the performance of the Better Care Fund in Derby to date and the arrangements for the programme from 2016 onwards.

REASONS FOR RECOMMENDATION

3.1 The Health & Wellbeing Board need to have oversight of the Better Care Fund to ensure the agreed governance arrangements are appropriate in the delivery of the required outcomes from the BCF plan.

SUPPORTING INFORMATION

4.1 Better Care Fund (BCF) plans were submitted to NHS England in January 2015 and were approved in February 2015. This was followed by the requirement to provide quarterly submissions to NHS England – these follow a standard national template and are used to report on key performance measures and achievements. The autumn 2015 Comprehensive Spending Review detailed six national conditions that central government expected all BCF's to adhere to and work towards. Progress on Derby's performance against these are as follows:

4.2 National Conditions -
1) Plans to be jointly agreed – the BCF plan should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. All providers likely to be affected by the use of the fund should be involved and have a shared view of the future shape of services, including future capacity and workforce requirements across the system.

Derby update – this action is complete. The BCF plan is set out in a formal s75 Agreement between the Council and Southern Derbyshire Clinical Commissioning Group (SDCCG) – with delegated authority provided by the Council Cabinet and SDCCG Board. The Adult Commissioning Board (which is a multi- agency board with senior officer representation from both the Council and Southern Derbyshire Clinical Commissioning Group) has received updates on the plan. The system transformation and integration elements of the BCF are largely being driven by the wider Derby and Southern Derbyshire Joined Up Care programme which has relevant key providers represented, and has enabling workstreams looking at workforce, infrastructure and communication requirements.

4.3 **2) Protection for social care services -** Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally.

Derby update – This action is complete. £4.287m was earmarked within the overall BCF fund (£17.403m) to be provided to protect social care services and this has been used to ensure essential assessment and care management services remain available to the wider health and social care system.

4.4 **3) 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends –** There is no nationally defined level of 7-day services to be provided, rather this will be for local determination and agreement.

Derby update – a 7 day working workshop was held in Derby on the 17th July 2015 with all key health and social care partners invited. From this some key objectives and work streams were agreed to move towards an appropriate level of 7 day cover. Progress has been good, with the Urgent Care Board (under the Joined Up Care programme) receiving regular updates on the numbers of weekend hospital discharges. In addition, developments such as the "virtual" ward and "rapid response" services, components of which are funded by the BCF, are also facilitating unnecessary admissions and early discharges for people deemed to be medically fit.

Winter resilience plans have also been developed and delivered across the system, with weekly operational resilience meetings taking place with all key agencies represented.

4.5 **4) Better data sharing between health and social care, based on the NHS number –** safely and securely sharing data about people who use care and support is considered essential to the provision of safe, seamless care with the use of the . The use of the NHS number as a primary identifier is an important element of this.

Derby Update – all social care records now gather and hold the NHS number and there are appropriate Information Governance controls in place between key agencies.

To progress this issue within the rapidly changing IG and Cauldicott principles there has been the creation of a Derbyshire-wide Informatics and Delivery Board which includes all IG and IT leads. The Summary Care Record Extension is now accessible via Smartcard, with appropriate access level & permissions, to view essential patient level information. This is currently being rolled out and Derbyshire is ahead of most counties in being able to add in extra information and finding a route for Social Care staff to access this information.

4.6 **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 -** Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

Derby Update - This composite measure has been the subject of a lot of work and progress it is reported as “in development”. Joint City / County / CCG / IT lead / Provider workstreams have been established to help achieve this measure. The evidence-based Comprehensive Geriatric Assessment principles- (which delivers a multi-agency, holistic H&SC care and support plan) are being examined for adoption. The Summary Care Record Extension information template was jointly created to allow for cross-provider familiarity with initial assessment format and content.

Every GP practice now has a care co-ordinator and aligned social care staff who participate in Multi-Disciplinary Meetings for those patients identified as high risk or complex by members of the MDT. In these cases the GP is accountable for patient care unless another professional is better placed. In this respect the BCF measure is met.

Not funded by the BCF but also relevant to this mandate, there is also a national Primary Care initiative to identify the top 2% patients (on a GP case list) at higher risk of avoidable admission- usually these people are elderly and often have multiple long-term conditions including Dementia. This target has been achieved- but not all

patients have proven to require case management or MDT approach. However the GP is named and accountable.

SDCCG and partners agree that if person centred planning processes are utilised then it not possible too simplistic to state “a proportion of the population” who should receive case –management and a proportion who “self-manage”. However those at higher risk are identifiable and all jointly funded packages of care have a named professional.

Dementia services have also been significantly developed in year via the BCF. The national focus for this year has been to achieve the 67% appropriate levels of identification and diagnosis against population as a proportion of the number expected. This is part of gaining a better understanding the level of need facing H&SC. The Memory Assessment Services have been created to work alongside GPs to better identify dementia cases. This previously unmet target has now been exceeded.

4.7 **6) Agreement on the consequential impact of changes in the acute sector -** Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Derby Update - This action is complete. Affected providers were signatories to the BCF plans and the BCF was subject to appropriate consultation levels.

Significant progress (largely outside of the current BCF framework) has also been made in developing the community health workforce in Derby City. This includes a shift of significant staff numbers out of the Acute Trust and into a Community-based provider to help with the staff culture change required as well as aligning named social care staff to link to practices. Due to activity levels the impact of the BCF “payment for performance” aspect on the Acute Trusts has not been nearly as significant over the last year as the efforts made to promote changed working practices, corporate expectation and changing culture into supporting and enabling the safe transition to shifting activity in accordance with the Derby Wedge.

Joint H&SC workstreams one of which is for social and personal empowerment including the joint development of personal health budgets for long term conditions have third sector and lay members as part of their structure and co-production. This is planned to be increased further.

There has been no negative in-year impact of the BCF on Parity of Esteem for mental health services to date.

4.8 **Performance Metrics –** There are a number of national and locally defined performance measures in the BCF. All measures are on track to achieve the planned performance. The table below demonstrates this as at Quarter 2 (July – September 2015):

Area	Q2 Plan	Q2 Actual
Residential Admissions per 100,000 population 65+	273	272
reablement – still at home 91 days after discharge	91%	93%
Delayed Transfers of Care (DTOC) per 100,000 population 18+	539.6	549.3
Non Elective Admissions to hospital – payment for performance	6,536	6,835
Improvement in Citizen Health and Social Care outcomes	No data currently available, GP survey	

4.9 **New Integration metrics**

During 2015, DH have asked CCGs and Councils to start monitoring some new metrics that will be developed further to measure the degree to which a health and social care economy is making progress towards delivering integrated, coordinated and person-centred care.

This set of metrics was only captured in the latest monitoring submission to trial a small number of new measurements. These metrics are listed below with Derby's update included:

1. The development and use of integrated care records – DH have acknowledged that this is a long-term ambition that will take several years to realise therefore they are seeking to measure progress towards this goal. The metric asks which settings integrated digital records are being used in?

Derby Update – In the recent monitoring return, we reported that in all settings (GP / Hospital / Social Care / Community / Mental health / Specialised palliative), the NHS number is being used as the primary identifier, information is being shared and the appropriate Information Governance controls are in place.

2. Risk stratification - The second new measurement concerns the use of risk stratification tools to inform both strategic commissioning across health and social care, and case finding of those individuals who would most benefit from preventative care. Given this is generally in early development stages, DH are looking to understand how many CCGs are using risk stratification tools, and how they are being used.

Derby Update – It was reported that SDCCG are not currently using risk stratification tools due to a number of information governance issues. However as much available data as possible is being used to target interventions, such as working across primary and acute settings to identify and support "frequent flyers" i.e. individuals with repeat admissions to A&E.

3. Personal Health Budgets - DH expect that in the long-term individuals who hold personal budgets in both health and social care will benefit from combining these into an integrated personal budget. At this stage, CCGs are being asked about progress in expanding the use of personal health budgets beyond people in receipt of continuing health care.

Derby Update - A scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial has taken place and currently 13 people are using PHBs. Of these 85% are in receipt of CHC.

4.10 **BCF in 2016/ 17 -** The Comprehensive Spending Review in November 2015 confirmed that the BCF will continue into 2016-17 – with a mandated minimum of £3.9 billion nationally to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. The process for the development and approval of BCF plans will be more streamlined for 2016/17 and it is expected to be better integrated into the "business-as-usual" planning processes for Health and Wellbeing Boards, CCG's and Councils.

Planning guidance will be issued in February 2016, although timescales are expected to be tight given the need to have sufficient certainty on funding to support Councils' budget setting processes. Locally, liaison with the regional BCF advisor is ongoing to make sure all timescales are met as far as possible.

OTHER OPTIONS CONSIDERED

5.1 The Better Care Fund is a national requirement and all areas need to submit a plan should they wish to make use of the funding flexibilities between Council and CCGs. In addition, the integration agenda between health and social care remains a key priority for the current government and the BCF is seen as an integral lever for change and system transformation.

This report has been approved by the following officers:

Legal officer	Olu Idowu, head of Legal
Financial officer	Pete Shillcock, Group Accountant
Human Resources officer	n/a
Estates/Property officer	n/a
Service Director(s)	Kirsty Everson, Acting Service Director – Integration & Direct Services
Other(s)	Mick Burrows, Assistant Director – Joint Commissioning, SDCCG

For more information contact:	Kirsty Everson 01332 642743 kirsty.everson@derby.gov.uk
Background papers:	None
List of appendices:	Appendix 1 – Implications

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 The Derby City BCF amounts to £17.403m in total for 2015/16. A certain proportion of the fund has to be spent on NHS commissioned out of hospital services, £3.110m. In addition, £1.475m has to be held by Southern Derbyshire CCG to cover the risk of the 3.5% emergency admissions reduction target. £12.817m of the fund shall transfer to the Council. This is fully reflected in the overall Council budget for 2015/16 and does not represent additional funding.

The Council receives quarterly payments of the fund form the CCG and this is currently up to date.

Legal

2.1 The Council must enter into a section 75 agreement with Southern Derbyshire Clinical Commissioning Group to transfer the BCF funding to the Council, under section 75 of the NHS Act 2006.

Personnel

3.1 Council Care staff already work collaboratively with NHS staff, further movement in this direction shall be required as a result of the BCF plan. This will require scoping by both the Council and its NHS partners to understand the options and implications for employers and employees, as further collaborative work is carried out. Any future significant personnel implications as a result of the scoping shall be subject to a further report. Assignment of a lead professional to more complex cases is a requirement of the BCF plan. This shall be undertaken through the Community Support Teams.

IT

4.1 In order to facilitate information sharing at a patient level, the NHS number shall be captured in all source systems to support professionals working with individuals in order to better plan and co-ordinate care with NHS colleagues.

Equalities Impact

5.1 Better care for older people and disabled people is a key aim of the BCF plan. The plan shall have a positive impact on treating and supporting older people in the community, as well as disabled people.

Health and Safety

6.1 None arising directly from this report.

Environmental Sustainability

7.1 None arising directly from this report.

Property and Asset Management

8.1 None arising directly from this report.

Risk Management

9.1 The Better Care Fund supports the Councils overall budget as an income stream to allow delivery of key care services to support the overall health and care system in Derby. The loss of this fund would present a significant financial risk to the Council. The current fund is currently only agreed for 2015/16. Governance arrangements are in place as detailed in paragraphs 4.8.to 4.12 of the report.

In order to share data with the NHS the Council needs to achieve and retain NHS IG Toolkit compliance.

Corporate objectives and priorities for change

10.1 The vision and guiding principles set out in the BCF plan are compliant with the Council's corporate objectives and those of the Derby and SDCCG Plan to achieve good health for all.