Health and Wellbeing Board

Better Care Fund

Supplementary Information

Date: November 2014
Version: 0.4
Status: Draft

BACKGROUND

The second version of the Stockton Better Care Fund (BCF) plan was approved by the Health and Wellbeing Board at its meeting on 28/08/14. Since then the plan has been through a Nationally Consistent Assurance Review (NCAR) process and has been classified as 'Approved with Support'. This status is in line with the 60% of assessments across the Country only 6 plans were 'Approved'.

Through the NCAR process a number of areas of the Stockton BCF plan were identified as requiring either further information or clarification. The table below sets out the overall status of risk of the plan:

Risk Category	Number of risks in the category prior to Teleconference	Number of risks in the category following the Teleconference
Showstopper	2	1
Top Risks	11	7
Further Risks	11	6

The next steps in the process are:

1. Further information is to be provided to the Area Teams to mitigate all the outstanding risks to the plan. This additional information will need to be provided by the 21st November, following approval by the Health and Wellbeing Board.

2. The further information to be assessed by the NHS England Regional Lead (with Area Team input) to determine whether or not the information provided closes off the risks which were identified in the NCAR report.

3. Assuming the Regional Lead is satisfied with the information the National Taskforce will be recommended to move the plan to 'approved' status.

4. During w/c 8th December the Taskforce will then report the approvals to the BCF Programme Board and Cross-Ministerial Board. Following this, outcome letters will be issued.

ADDITIONAL INFORMATION – OUTSTANDING RISKS

Set out below is the additional information and clarification that is required in the NCAR action plan.

---

[2] National Condition has not been met: 7 day services

Set out in Annex 1, scheme 3 of the Stockton plan is the approach to be taken to meet the national condition. Additional evidence is needed to demonstrate how NHS providers will meet the milestones for inclusion of the Clinic Standards for 7 day services. There is also a need to provide evidence of assessment of the risks relating to the move to 7 day services.

Response

The 7 Day Working Group is established and last met on 16 October 2014. The purpose of this group that patients should experience the same high quality care regardless of the time of day / day of the week / time of year. As such the definitions of high quality care and the metrics used will be largely the same as are currently in use for emergency care but must include explicit reference to out of hours / weekends / winter to give assurance on the standards of care at those times.

There are a variety of documents and standards relevant to this, but almost all share a great deal of commonality. The report from Bruce Keogh pulls these together and tasks provider organisation with working towards the recommended standards over the next 1-2 years. In addition the commissioners are also looking actively at these standards, which link to the recent SEQIHS reports, and are likely to form part of the coming years CQUIN standards.

[4&5] A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions

[14&15] A7-Supporting Metrics: the level of ambition for a given metric is not consistent with the quantified impact of the schemes contributing to it

The Stockton plan shows an ambition of 4.3% reduction in emergency admissions it also sets out performance improvements across the remaining metrics. The plan doesn't set out specifically how each of the schemes will contribute to the improvements.

Response

The ambition of 4.3% reduction has been calculated based on the aggregated benefit of all the schemes in the BCF plus a number of other schemes that are being developed and implemented as part of the HaST CCG 2 year operational plans. Because they are complementary, it will be very difficult to identify the benefits associated with any individual scheme.

Set out at annex A is a matrix which shows how each of the schemes in both the BCF and the 2 year operational plan, will contribute to each of the performance metrics and savings outlined in Part 2 of the plan. The matrix supports the information already provided in Part 1 and Part 2 of the plan and brings together all the benefits into a single summary.

---

[6] F5-Full budgets are not identified to meet the additional costs resulting from the new Care Act duties

There is a discrepancy in the total expenditure figures provided in Part 2. An explanation of the discrepancy is needed in cell G18 of the spreadsheet.

Response

The explanation is set out below:

The amount in cell D18 is higher than the amount in F18 because there is to be new investment into social care beyond just protecting adult social care services.

---

[7] F4-BCF financial risks are not fully identified, inadequate contingencies, lack ownership

Further information is needed in the risk log about the financial risks to each of the partners.

Response

The risk table below supplements the risk table set out in the BCF Part 1 pages 17 – 20.

Likelihood: Scale 1 – 5 with 1 being very unlikely and 5 being very likely
Impact: Scale 1 - 5 with 1 being a relatively small impact and 5 being a major impact. And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)
Overall: Likelihood * Impact = Overall Score

There is a financial risk that:	Likelihood	Impact	Overall	Mitigating Actions
Expected growth in permanent admissions to residential care homes is not stemmed, leading to increased costs for the Local Authority	3	4	12	The Council will continue to fund preventative services which aim to keep people at home for as long as possible and will complement the Better Care Fund schemes. The Council will continue with the review and regular update to the Medium Term Financial Plan (MTFP) and assess the position as schemes develop.
The success of the Better Care Fund is impacted due to financial pressures faced by the Council as a result of reductions in funding and additional burdens introduced as a result of the Care Act	3	4	12	The Council has a strategy of regularly reviewing its overall budget position, this process will indicate at an early stage additional financial pressures as part of its overall MTFP strategy.

				The Council will also ensure that it holds a sufficient level of balances in order to mitigate risk.
The pooled budget is insufficient to cover committed costs as a result of the schemes failing to deliver on targets and the performance fund being withheld	2	4	8	Both the Council and CCG have agreed to operate the main schemes on a pilot basis thereby minimising risk and adding flexibility. Each individual scheme will be reviewed to identify whether they are adding value. Both the CCG and Local Authority have set aside contingencies within their financial plans which may be require should schemes not achieve agreed outcomes.
CCG financial risk – to be added				
NTHFT financial risk – to be added				

[8] F4-BCF financial risks are not fully identified, inadequate contingencies, lack ownership

[23] N8 – Insufficient documentation of the risks

Further information is needed to supplement Section 5b of template part 1 'contingency and risk sharing'. Further detail is needed on the implications of failing to meet the targets to reduce non-elective emergency admissions to hospital.

Response

The Council takes a sound and effective planned approach to the management of its services and finances. This will continue to be the case for the Better Care Fund. The position of the Better Care Fund will be continually monitored, managed and refined as necessary in line with the current Medium Term Financial Plan strategy, ensuring that reserves are sufficient to meet its plans.

The Council's sound approach is endorsed by the current auditor, Mazars in their assessment of financial reliance. The auditors said;
"The Council has systems and processes to manage financial risks and opportunities effectively, and to secure a stable financial position that enables it to continue to operate for the foreseeable future. There is an up-to-date Medium Term Financial Strategy which is aligned to priorities, and realistic assumptions underpin financial planning. Savings plans are expected to deliver forecast budget gaps, and progress is regularly reported to the Cabinet and Council. The financial position remains sound, with spending being contained within available resources, and General Fund balances maintained at the target level"

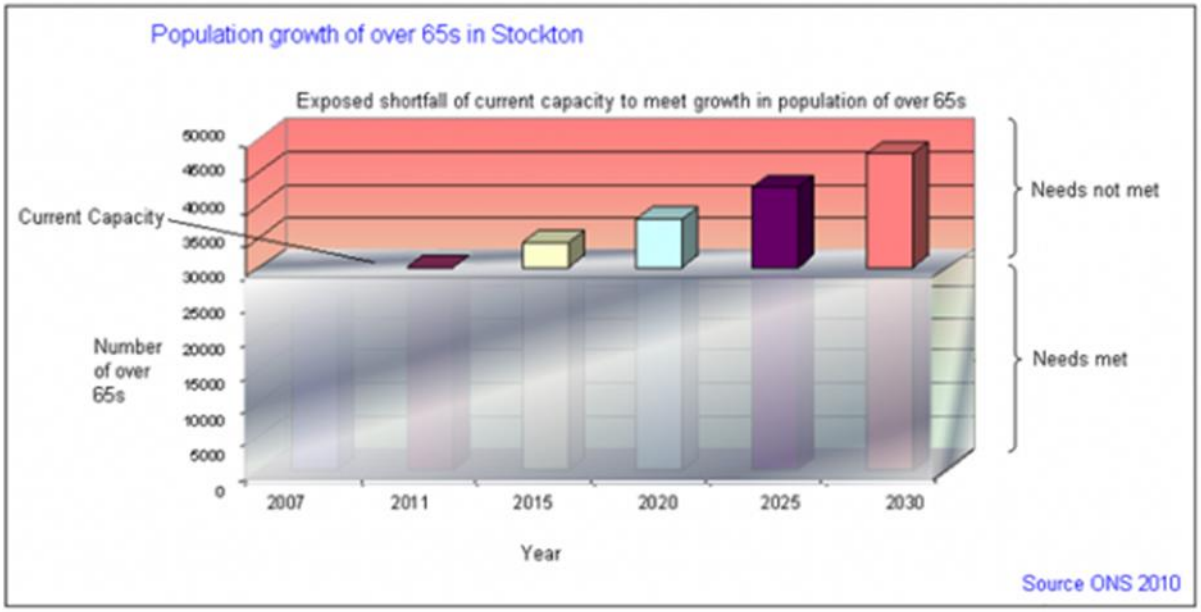
Risk sharing arrangements will be finalised and documented as part of the process for development of the Section 75 (National Health Service Act 2006) Agreement.

---

[9] N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area

Evidence is required of the data which supports the case for change, specifically, levels of unmet need to be quantified.

Response



When developing the original Better Care Fund plan for Stockton, several sources of information were used:

- JSNA data
- Adult Social Care data / trends / ASCOF
- Information about Health and emergency admissions
- Avoidable emergencies evidence CQC

This information was considered at several workshops and was the underpinning information in the development of the most appropriate solution to deal with unmet need across the Health and Social Care economy. It led to some key decisions:

- Population would be over 65 (originally thought to be over 75)
- Need a solution for both crisis response and also intervention and prevention
- There would be two schemes, a Multi-Disciplinary Service and also a scheme to build on the Dementia Collaborative – recognising the increase trend of early on-set dementia in Stockton.

The information considered is set out below:

JSNA

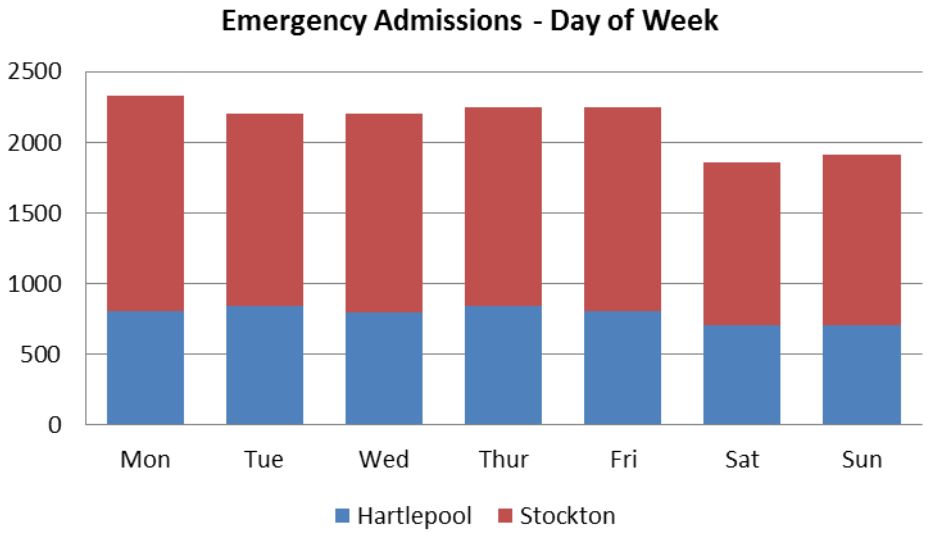
- Population of Stockton (2010) - 192,400
- Aged over 65 - 29,900 or 15.5%
- Projections (2010 – 2031):
  - Overall increase 12.08% = 215,641
  - Increase 65 – 74 is 35.34%
  - Increase 75+ is 44.66%
  - Projected 65+ - 41,761 or 19%
- SBC predicted to have 92% increase late onset Dementia between 2009 – 2030

ASCOF

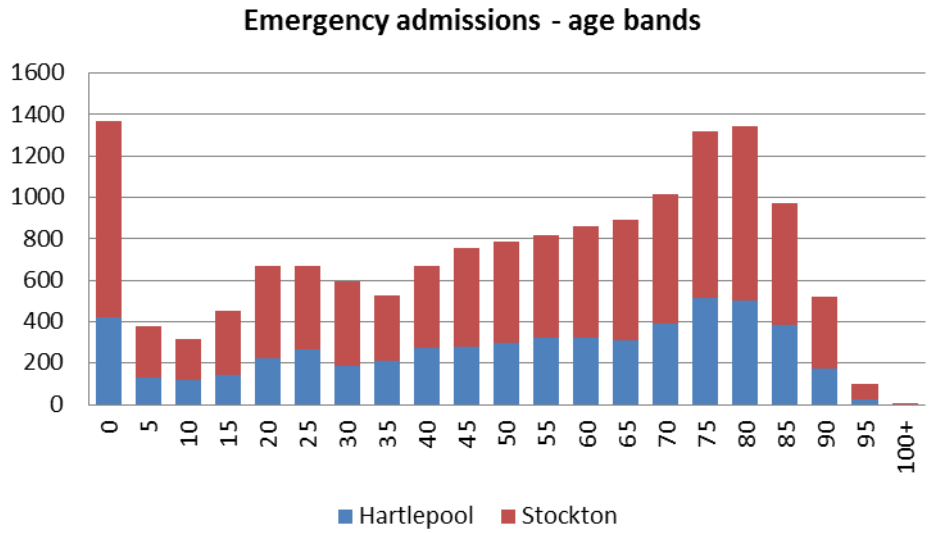
- % people at home 91d after reablement
  - SBC 79.1% (12/13); England 81.5%
- Permanent Admissions to Residential / Nursing 18 - 64
  - SBC 20.9 (per 100,000); England 14.9
- Permanent Admissions to Residential / Nursing 65+
  - SBC 891 (per 100,000); England 709
- Delayed Transfers attributable to ASC
  - SBC 0 (per 100,000); England 3.3

Health

- Monday is the busiest day for emergency admissions from Stockton, but Tuesday is the busiest for Hartlepool
- Saturday has the lowest level of emergency admissions in both localities

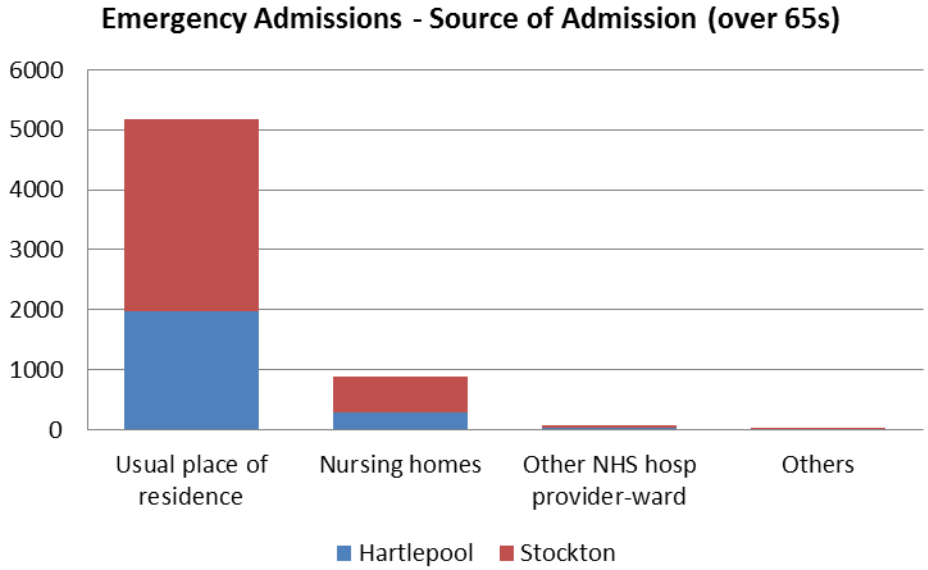


- Over 65s account for 41% of total emergency admissions



- 80% of emergency admissions of over 65s fall into 10 hrg sub-chapters
- Top 3 are:
  - DZ - Thoracic Procedures and Disorders (18.3% costs £3.3m)
  - EB - Cardiac Disorders (14.2% costs £1.6m)
  - FZ - Digestive System Procedures and Disorders (13.8% costs £2.4m)

- 84% of over 65s emergency admissions are from patients homes, and 14% from nursing homes



Stockton fares significantly worse than England as a whole for all premature deaths and mortality for cancer, heart disease and stroke and lung disease (faring slightly better on liver disease). Our rank for premature deaths is driven largely by premature mortality from cancer and from lung disease (largely COPD resulting from smoking and our industrial heritage).

Figure 3: Cause of death aged under 75 years in Stockton, 2009-2011 (Source: Longer Lives)

Cause of death, aged under 75 years, 2009-2011

Stockton-on-Tees	Number of deaths	Deaths per 100,000	National rank *(out of 150)*	Decile rank ● *(out of 15)*
All premature deaths	1,877	301	102nd worst	12th best
Cancer	797	125	127th worst	Highest
Heart disease and stroke	436	69	89th worst	8th best
Lung disease	179	27	95th worst	9th best
Liver disease	99	16	83rd worst	4th best

Each local authority is in a national decile group based on deprivation (see below). ●
Each group contains the 15 districts in alphabetical order.

England decile 5

Bournemouth
Bristol, City of
Calderdale
Derby
Dudley
Ealing
Kensington and Chelsea
Kirklees
Portsmouth
Sefton
Slough
Southampton
Stockton-on-Tees
Telford and Wrekin
Westminster

Avoidable Admissions Data – CQC

- They should be manageable, treatable or preventable within the community without the need to go into hospital:
  - Acute lower respiratory tract infections (such as acute bronchitis)
  - Chronic lower respiratory tract infections (such as emphysema and other chronic lung diseases)
  - Diabetes
  - Intestinal infections
  - Pneumonia
  - Urinary tract infections

- They can often be caused by poor care or neglect:
  - Food and drink issues(such as abnormal weight loss and poor intake of food and water due to self-neglect)
  - Food and liquid pneumonitis (inhaling food or drink)
  - Fracture and sprains
  - Pressure sores
  - In last six years admissions for pneumonia increased 64%, inhaling food or liquid (pneumonitis) increased 52% increase and urinary tract infections increased 45%.

[12] N5-The plan is not aligned

It is unclear in the plan how GPs have been involved in establishing the plans. Evidence should include minutes of meetings and forums where the BCF has been discussed with GPs, linked to transforming primary care.

Response

There have been several Better Care Fund development events which have been attended by different stakeholders. Set out below is a summary of some of these events.

Event / Date	Purpose	Stakeholder Groups attending
Better Care Fund development event (January & February 2014)	To engage all stakeholders in ideas of how the Better Care Fund will be taken forward in Stockton.	CCG SBC NTHFT TEWV GPs
Frail / Elderly summit (May 2014)	To engage all stakeholders on the ambition and aspiration for improved pathways of care for Frail / Elderly. Outcomes to feed into and inform the Better Care Fund planning.	CCG SBC HBC NTHFT TEWV GPs
Multi-Disciplinary Service event (June 2014)	Building on the initial Better Care Fund submission. The purpose of this event was to understand what is required to deliver a successful integrated service which would deliver both crisis and intervention and prevention services.	CCG SBC Voluntary Sector NTHFT TEWV GPs
Integrated Digital Care Fund (June 14)	One of the major barriers to successful joint working is access to effective ICT systems and information. The purpose of this event was to engage stakeholders on both the barriers to sharing information and also to understand what an 'ideal' solution might look like.	CCG SBC NTHFT TEWV GPs
House of Care Event (September 14)	This was a seminar organised by NECS to look at the House of Care. It was used by Stockton to help inform what needs to be put in place to deliver successful integration and to ensure the customer is placed at the centre of any solution.	CCG SBC NTHFT GPs
Multi-Disciplinary 3P service development workshop (A full week in October	Design the Multi-Disciplinary Service, including: - workforce	CCG SBC NTHFT

Event / Date	Purpose	Stakeholder Groups attending
2014)	- customer journey - pathways	GPs Voluntary Sector Healthwatch
Council of Members meetings: 11 Feb 2014 – Better Care Fund. 3 June 2014 – In-Committee GB	To set out the strategic vision of the CCG and to provide Governing Body the DRAFT 2 year operational plans required to be submitted by the 14th February to NHS England as described in the '**Everyone Counts: Planning for Patients 2014/15 to 2018/19.** The 2 year operational plans incorporate the Better Care Fund Plans for both Local Authority areas; in advance of the CCG submission on the 14th February the Better Care Fund Plans are required to be signed off by the respective Health and Wellbeing Boards.	CCG GP's CCG Lay Members
Clinical Reference Group: 6th November 2014	A market stall event was held to gain the views of member practices in relation to those services they feel would support them in maintaining individuals at home and avoiding unnecessary admissions to hospital.	CCG GP's
GP led work-streams: Frail / Elderly (October 2014)	Agreed that Frail / Elderly work-stream now be aligned to the Better Care Fund to reduce duplication of effort and attendance.	CCG SBC HBC NTHFT (clinical lead) GPs

[18/19/20] A10-Supporting Metrics: information provided on Patient Experience Metric is not valid

The Stockton BCF plan was based assumed that there would be a national Patient Experience Metric as set out in the original guidance. No metric has been developed nationally so it has been necessary for every locality to develop their own.

Response

Stockton and Hartlepool localities have agreed to jointly develop an indicator for Patient Experience – this is to ensure there is a consistent approach across the HaST CCG and NTHFT area.

An effective measure needed to understand the experience from the following three customer groups:

- The Patient experience measures the benefits from receiving a Health Service intervention
- The Carer experience measures the benefits carers can see from Patients / Service Users / or the carer themselves experiencing an intervention from either the Health Service, Carers services or Adult Social Care services
- The Service User experience measure the benefits from receiving an Adult Social Care intervention
- We also recognise that there could be any combination of interventions for any of our customers

The measure of success of the Better Care Fund can be summarised as follows:

'Did the Care and Support you received meet your individual needs?'

This question is designed to understand if the service was Person Centred – which sits at the heart of the Better Care Fund outcomes. It deliberately doesn't talk about 'joined-up' services or 'integration' which are about the delivery approach, because the customer doesn't care where the service is delivered or who delivers it – so long as it meets their needs.

To measure this a completely new Patient Experience performance metric could be created. But if this approach was taken it would be sometime before it would be possible to get an indication of the impact of the benefits of the Better Care Fund on the customer.

Also considered were various complexities of creating a new composite indicator – but it was agreed that the most pragmatic solution was to keep things as simple as possible, whilst being able to establish a baseline position from day one.

Therefore the metric is defined as follows:

A single question from existing surveys, which is similar to the question we want to ask our customers (see above)) will be used from the following:

- General Practice (GP) survey
- Carers Survey
- Adult Social Care survey

The specific measures to be used are:

- GP measure – Q45, *Overall experience of GP Surgery?*

- Carers measure - ASCOF 3B, *"Overall, how satisfied are you with the support or services you and the person you care for have received from Social Services in the last 12 months?"*
- ASC measure - Question 3a, *'Overall Satisfaction of people who use service with their care and support'*

These will simply be aggregated and divided by 3 to get an overall single indicator but behind the scenes we will have the detail so that it will be possible to analyse and put in place further developments depending on the direction of travel.

We will use or position of 68% overall satisfaction at 1 November 2014 as our current baseline position and propose that we aim for an overall improvement of 1%. Subsequently we will report this measure on 1st April every year, acknowledging that the surveys are undertaken at different points in the year. The improvement target is realistic based on the need to develop and implement the MDS to get full impact of improved satisfaction and also reflects the fact that not all of those people surveyed will receive the services developed as part of the Better Care Fund.

This will be the 'public facing' indicator used for the Better Care Fund. To supplement this we will undertake a Customer Experience survey so that we can get direct feedback to support our philosophy of continuous improvement for all the services we establish using Better Care Fund monies.

APPENDIX 2 – SUMMARY IMPACT MATRIX

Ref no.	Scheme
1	Multidisciplinary Integrated Service
2	Improving Pathways of Care for Dementia
3	Enabling Scheme 1: 7 Day Working
4	Enabling Scheme 2: Joint Assessments
5	Enabling Scheme 3: Digital Technologies
6	Enabling Scheme 4: Narrowing Health Inequalities
7	Enabling Scheme 5: ICT Systems and Data Sharing

Plan	Scheme	Enablers	How they contribute	PI's	Contributes to the overall Improvement / Savings target of:
BCF	Multi-Disciplinary Service	7 Day Working Joint Assessments	There are two key elements to the MDS: - response to crisis - intervention and prevention Crisis – by having a single joint assessment and information which is available to all professionals involved in the care of a person it will be possible to ensure the right support is provided including links to VCSE and other services which prevent a permanent admission. Intervention and Prevention – in the longer term these initiatives are going to have the greatest impact by keeping people fit and health and independent for longer.	Reduction in permanent residential admissions	£624k
BCF	Multi-	7 Day Working	There are two key elements to the MDS:	Reduction in non-elective	4.3%

Plan	Scheme	Enablers	How they contribute	PI's	Contributes to the overall Improvement / Savings target of:
	Disciplinary Service	Joint Assessments	- response to crisis - intervention and prevention Crisis – by having a single joint assessment and information which is available to all professionals involved in the care of a person it will be possible to ensure the right support is provided including links to VCSE and other services which would prevent an admission to hospital. Intervention and Prevention – in the longer term these initiatives are going to have the greatest impact by keeping people fit and health and independent for longer.	(general & acute only)	£2,265k
BCF	Multi-Disciplinary Service	7 Day Working Joint Assessments	A single joint assessment will cut down on the number of people who will need to see the customer – leading to a 'tell my story once' experience. Because the care plan will be available to all professional the person will have better outcomes which have been jointly agreed between themselves and the professionals. A care coordinator will provide support during the person's intervention from the MDS helping them to access all the services they need in a more joined up and supported environment.	Patient / Service User experience	
BCF	Multi-Disciplinary Service	7 Day Working Joint Assessments	The Reablement service is seen as a key part of the MDS and there will be closer links between health and social care ensuring that the	Reablement	No savings assumed – contributes to

Plan	Scheme	Enablers	How they contribute	PI's	Contributes to the overall Improvement / Savings target of:
			Reablement services are targeted and more effective.		main schemes
BCF	Multi-Disciplinary Service	7 Day Working Joint Assessments	There will be a decrease in the number of delayed discharges and lost bed days from acute settings for those patients medically fit for discharge as a result of improved pathways and 7 day working.	Delayed transfers of care	No savings assumed – contributes to main schemes
BCF	Improving Pathways of Care for Dementia	Joint Assessments	Benefits of the Dementia Scheme include: • Early identification of dementia • Ensuring the patient is fully involved in the decision making process – focused on outcomes • Improved information sharing • Better patient experience • More supportive impact on Carers • LiveWell Hub provides co-ordinated response to meeting patient information and advice needs • LiveWell Hub will provide a resource to support the professional development of the work force to equip them to meet the needs of people with dementia	Estimated diagnosis rate for people with dementia	No savings assumed – contributes to main schemes
BCF	Both	Digital Technologies	A full assessment will be made of the benefits of all digital technology interventions to measure the impact on a range of people using risk stratification tool. Deployment will be determined by a robust business case.	Reduction in permanent residential admissions	£624k

Plan	Scheme	Enablers	How they contribute	PI's	Contributes to the overall Improvement / Savings target of:
BCF	Both	Digital Technologies	A full assessment will be made of the benefits of all digital technology interventions to measure the impact on a range of people using risk stratification tool. Deployment will be determined by a robust business case.	Reduction in non-elective (general & acute only)	4.3% £2,265k
BCF	Both	Narrowing Health In-equalities	This is complementary to the MDS intervention and prevention services. Impact will be on reducing emergency hospital admissions / readmissions, maximising independence and reducing / delaying the need for long term care through addressing broader issues affecting health and wellbeing such as poverty, housing, loneliness/social isolation, adoption of healthy lifestyles	Reduction in permanent residential admissions	£624k
BCF	Both	Narrowing Health In-equalities	This is complementary to the MDS intervention and prevention services. Impact will be on reducing emergency hospital admissions / readmissions, maximising independence and reducing / delaying the need for long term care through addressing broader issues affecting health and wellbeing such as poverty, housing, loneliness/social isolation, adoption of healthy lifestyles	Reduction in non-elective (general & acute only)	4.3% £2,265k
BCF	Both	ICT Systems and	Sharing information will mean that better decisions	Reduction in non-elective	4.3%

Plan	Scheme	Enablers	How they contribute	PI's	Contributes to the overall Improvement / Savings target of:
		Data Sharing	are made by professionals, especially out of hours when decisions are made about admission to hospital because of a lack of information about the alternatives and the person's preferences.	(general & acute only)	£2,265k
BCF	Both	ICT Systems and Data Sharing	There will be a single care plan for everyone over age 65 and those with long term conditions. This will include joint assessments and ensuring that a person's information is available 24/7 for round the clock care. This means that decisions which are made will be better informed and specifically meet the needs of the person.	Patient / Service User experience	
CCG 2yr Operational Plan	 7.0 Enabling projects to deliver a reduction	Enabling projects to deliver a reduction in hospital admissions	The CCG enabling projects will support and enhance the delivery of BCF.		