AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

21 December 2016

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STOCKTON BETTER CARE FUND UPDATE AND QUARTERLY PERFORMANCE

SUMMARY

The purpose of this paper is to update the Health and Wellbeing Board on the progress of the implementation of the Better Care Fund and to provide the Board with a copy of the quarter 2 2016/17 Better Care Fund quarterly performance submission.

RECOMMENDATIONS

It is recommended that Health and Wellbeing Board:

1. Note the progress of the implementation of the Better Care Fund
2. Note the Better Care Fund Q2 2016/17 performance submission

BACKGROUND

1. The Better Care Fund (BCF) plan for 2016/17 was approved by the Health and Well-being Board and approved by NHS England. The purpose of this report is to provide the Board with an update on the progress and achievements during the year.

MAIN REPORT

Quarter 2 2016/17 Performance Report

2. Set out at appendix 1 is a copy of the Quarter 2 2016/17 performance report. Most of the performance is on target with the exception of the following:

Non-Elective Admissions

There has been a continuous increase in the Non-Elective admissions.

When comparing to the same period last financial year the increase in activity in Non-Electives has been across all age bands (0-19) 2.6%, (20-64) 9.8% and (65+) 12.6%. The cost of the increase is £2.3m, of which £1.4m relates to over 65's.

In the over 65s the main increases are in Thoracic, Ambulatory Care and Renal.

Pneumonia is the biggest increase in Thoracic and accounts for £255k of the £287k year on year increase. UTIs are the reason for the increase in Renal

accounting for £369k of the £523k increase. Ambulatory Care activity has increased by 26.3% but this only equates to £53k increase.

Delayed Transfers of Care

During Q2 2016/17 in Stockton LA there were 675 delayed days (all transfers of care, not specifically related to care homes).

Over the quarter, 346 delayed days were reported as being the responsibility of the NHS, 244 days were reported as the responsibility of social care and 85 days were the responsibility of both NHS and social care.

The main reasons for delays were completion of assessment, waiting further NHS non-acute care, awaiting residential or nursing home placement/availability, and patient/family choice.

The number of delayed days increased in each month of the quarter across most of these reasons, so it is not possible to identify a single cause for the increase in delayed days.

It should be noted that Stockton Council are in negotiation with NHSE and North Tees and Hartlepool NHS Foundation Trust regarding the revised categorisation of the delayed transfers of care and an agreement is still to be achieved.

3. The return was approved by the Chair of the Health and Well-being Board before being submitted to NHS England and is being presented to the Board to be noted. This is in line with the agreed approach because it is not possible to seek Board approval due to the constraints of the timescales for submission.

Better Care Fund Plan 2017 – 19

4. The guidance for the next version of the Better Care Fund plan is due out shortly. The next plan will be a two-year plan taking the planning period up to the end of March 2019. This will be a transitional plan leading up to Better Care Fund being part of the Sustainability and Transformation Plans in the longer term. The plan will come to the Health and Well-being Board for approval before it is submitted to NHS England.

Stockton Better Care Fund Plan

5. The Stockton Better Care Fund plan is broken down into two main schemes and five enablers:

Main Schemes	Enablers
Multi-Disciplinary Service	7 day working
Dementia Pathways	Joint Assessments
	Digital Health
	Narrowing Health Inequalities
	ICT Systems and Data Sharing

Multi-Disciplinary Service (MDS)

6. The Multi-Disciplinary Service currently consists of an MDS Manager and a team of six Well-being Facilitators who undertake holistic well-being assessments and develop holistic care plans. The Housing Occupational Therapy team and the Falls Early Intervention team are also part of the MDS and report to the MDS Manager. Also co-located with the team are the Stockton Welfare Advice Network, a service provided by the Stockton District Information and Advice Service (SDAIS) and a newly commissioned Proactive Intensive Community Liaison Service (ICLS) which is provided by Tees Esk and Wear Valleys FT (TEWV).

7. Some service highlights:

- 1040 referrals have been received by the MDS team since the service launched in October 2015, of these only 22 have gone on to be referred to social work teams for a Care Act assessment.
- Increase financial benefits for 517 referrals of £727,594 through support from SWAN
- Health referrals have started to increase with 64 clients to the MDS to date
- Housing OT joined MDS on 1st February 2016 and has received 347 referrals, including 124 referrals for over 65's
- Falls Early Intervention services went live 2nd May 2016 and received 602 referrals
- MDS won "Best health and well-being initiative" in this year's Association of Public Service Excellence Awards (APSE).

Dementia Pathways

8. The Dementia Strand is developing several projects to support people with dementia and their carers through the journey of the condition and promote a greater understanding of the causes and consequences of dementia.

9. The Dementia Strand is focussed on:

- Providing timely advice and information to people with and without a diagnosis of Dementia
- Creating awareness through training and the development of video materials which can be accessed widely including the Stockton Information Directory
- Providing one-to-one and group support to people with a diagnosis of dementia and in doing so, provide support and respite to carers
- Support people to establish their own groups which become self-sustaining

10. Early indications are that these interventions are providing benefits to people and their carers.

11. The Dementia Strand has been working with TEWV to develop a new Pro-active ICLS service. This new service is co-located with the MDS and provides support to GPs, providing early intervention and support to people with a diagnosis of dementia. The new service went live in July 2016.

7 Day Working and Joint Assessments

12. 7 day working and joint assessments were two of the national conditions specified as part of the BCF requirements.

13. There are a number of services which are already delivered 7 days a week and the new Well-being Facilitators will work 7 days a week commencing early in the New Year. A piece of work is underway to look at the value and benefits of the current 7 day services and identify any gaps which will support the following main objectives:

- prevent admission to hospital
- prevent permanent admission to nursing or care homes
- facilitate discharge from hospital

Digital Health

14. There are two digital health pilots underway:

- Falls prevention in Care Homes

- Pilot of offering people with early diagnosis of dementia telecare and recommendations of home environment based on the dementia friendly design principles – to support people with dementia and their families and carers

15. It is too early to determine how successful these projects have been. There were some initial problems engaging with Care Homes to utilise the equipment and provide the evidence and information needed by the Commissioners. This has now been resolved.

Narrowing Health Inequalities

16. There are two projects under this strand:

- Falls Early intervention team which is now managed by the MDS Manager
- Warm Homes Healthy People

ICT Systems and Data Sharing

17. All partners have worked together to produce a Local Digital Roadmap which sets out how we will all be paper-free at point of delivery by 2020. This roadmap also sets out the local ambition for integrating ICT systems across Health and Social Care.

18. In the last few months, across Stockton and Hartlepool, all but one of the GP practices have signed Information Sharing Agreements which allows the sharing of Primary Care information across all Health settings.

19. In September, Stockton and Hartlepool went live with the Medical Interoperability Gateway (MIG) which is a system that GPs, including Out of Hours GP's to access primary care records for all patients that provide consent.

20. The next phase is to roll out the MIG into TEWV and North Tees and Hartlepool FT (NTHFT). This should be completed by April 2017. The final phase is to make some of this information (appropriate to support the care planning process) available to social care.

21. In addition to what is happening locally across Stockton and Hartlepool, there is an ambition for wider systems integration across the Sustainability Transformation Plan (STP) footprint. The Better Health Programme (BHP) is currently the governance for this project. This would see the sharing of Health and Social care data across all appropriate settings.

Other Developments Currently Underway

22. There are three major developments currently underway. Business cases will be put forward to the Pooled Budget Partnership Board before any funding decisions are made, all of these developments are set out in the current Better Care Fund plan:

- Delayed Transfers of Care
- Person-Centred Pathways to Care
- Telecare Business Case
- Joint Health and Social Care Single Point of Access (jointly with Hartlepool Borough Council).

FINANCIAL AND LEGAL IMPLICATIONS

23. Financial risks have been assessed and contingency arrangements have been developed to mitigate the risk of not delivering the performance targets set out in the BCF plan.

RISK ASSESSMENT

24. The BCF requires partners to develop a shared risk register and have an agreed approach to managing and sharing risk. The BCF Plan also identifies proposed contingency arrangements in the event that the expected reductions in emergency admissions are not achieved.

COMMUNITY STRATEGY IMPLICATIONS

25. The BCF plan supports the delivery of the Stockton-on-Tees Community Strategy and Joint Health and Wellbeing Strategy. Making a significant contribution to a number of the key themes including; healthier communities

and adults; helping people to remain independent; improved access to integrated health and social care services and promoting healthy living. The BCF plan also focuses on older adults, one of the key supporting themes in the community strategy.

CONSULTATION

26. The BCF plan has been jointly developed and agreed with key stakeholders from the LA, CCG, primary care and community, acute and mental health service providers. The plan has been informed by a range of engagement activities, involving service users, carers, families and the public, that were already underway focusing on a range of local health and social care services.

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