BETTER CARE FUND: PERFORMANCE REPORT (OCT - DEC 2019)

Relevant Board Member(s)	Councillor Jane Palmer Dr Ian Goodman
Organisation	London Borough of Hillingdon Hillingdon Clinical Commissioning Group
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Papers with report	None

HEADLINE INFORMATION

Summary	This report provides the Board with the second performance report on the delivery of the 2019/20 Better Care Fund plan.
Contribution to plans and strategies	The Better Care Fund is a key part of Hillingdon's Joint Health and Wellbeing Strategy and meets certain requirements of the Health and Social Care Act, 2012.
Financial Cost	This report sets out the budget monitoring position of the BCF pooled fund of £92,952k for 2019/20 as at month 9.
Ward(s) affected	All

RECOMMENDATIONS

That the Health and Wellbeing Board:
a) notes the progress in delivering the plan during the Q3 2019/20 review period; and
b) agrees the proposal for the development of the 2020/21 BCF plan.

INFORMATION

1. This is the second performance report to the HWBB on the delivery of Hillingdon's Better Care Fund (BCF) Plan for 2019/20 and the management of the pooled budget hosted by the Council. It updates the Board on the position to 31 January 2020 where possible. The plan and its financial arrangements are set out in an agreement established under section 75 of the National Health Service Act, 2006 agreed by both the Council's Cabinet and Hillingdon Clinical Commissioning Group's (HCCG) Governing Body in January 2020. This followed notification by NHSE on 23rd December 2019 that Hillingdon's plan had been approved.

2. The pooled budget is intended to address issues that can arise for people whose needs cut across health and social care boundaries. It does this by bringing together local authority and health funding into the equivalent of a joint bank account so that the focus is on addressing

need rather than who the funder is. The value of the pooled budget for 2019/20 is nearly £93m.

3. There are three types of measures used to determine the success of the plan:
- *National metrics*: There are four metrics against which every health and wellbeing board area in England is required to report progress to NHSE.
- *Local metrics*: These are local scheme specific measures where progress is reported to the Health and Wellbeing Board and CCG Governing Body only.
- *Delivery plan milestones*: Identify how performance against the agreed delivery plan is progressing.

4. All Health and Wellbeing Board areas in England are required to submit to NHS England a prescribed performance template to provide an update on the delivery of their BCF plans. It is a requirement that templates are signed off by Health and Wellbeing Board chairmen.

National Metrics

5. **Emergency admissions target (also known as non-elective admissions): *Slippage* -** During the period April to December 2019 there were 2,075 emergency admissions, which would suggest a forecast outturn of 2,766 admissions against a ceiling of 2,411. This would be approximately 181 admissions over the 2018/19 outturn.

6. It is not possible to compare Hillingdon's performance against this metric with the rest of London. This is because the national emergency admissions target relates to the 18 and over population and Hillingdon's target in 2019/20 is focussed on older people with conditions where early identification of support needs could help to prevent hospital admissions, e.g. diabetes, dementia, chronic obstructive pulmonary disease (COPD).

7. A key objective of the eight Neighbourhood Teams (please see below) established across the borough is to actively manage the 15% of the population at greatest risk of future hospital admission and developing long-term care needs. Although at different points of development across the borough, this work is having results and without it the numbers of emergency admissions would undoubtedly be higher.

Neighbourhood Teams Explained

The eight Neighbourhood Teams are multi-disciplinary teams consisting of staff within a range of GP practices, community health professionals, professionals concerned with the assessment, diagnosis and treatment of adults with urgent medical needs, a mental health professional and voluntary and community sector staff.

8. **Delayed transfers of care (DTOCS): *On track***.

DTOCs Defined

A DTOC occurs when a person is ready for transfer from a hospital bed, but is still occupying the bed. A person is ready for transfer when:

a) A clinical decision has been made that the patient is ready for transfer; AND
b) A multi-disciplinary team decision has been made that the patient is ready for transfer; AND
c) The patient is safe to discharge/transfer.

9. Table 1 below shows that there were 2,695 delayed days in the period April to December 2019. This would suggest an outturn for 2019/20 of 3,593 delayed days against a ceiling of 4,964 delayed days imposed on Hillingdon by NHSE for this year.

Table 1: DTOC Performance April - December 2019			
Delay Source	**Acute**	**Non-acute**	**TOTAL**
NHS	1,951	538	2,489
Social care	72	83	155
Both NHS & Social Care	3	48	51
TOTAL	**2,026**	**669**	**2,695**

10. Hillingdon's relative position compared with other London boroughs (and the City of London) for the review period is shown below. The aim is to have the lowest number possible.

- Total delays: 10th lowest
- NHS attributed delays: 18th highest
- Social Care attributed delays: 4th lowest
- Delays attributed to both NHS and Social Care: 18th highest

11. The main reasons for delayed days are:

- *Access to care homes (41% of delayed days)*: The main issue in respect of access to care homes for the NHS concerns people with more challenging behaviours. A solution being explored is to work in partnership with specific care homes to encourage them to accept more complex patients but with additional support. The implementation of the Enhanced support in care homes and extra care service (see below) presents opportunities to deliver this support. However, care homes will always be mindful of the number of residents they have with more complex needs and their impact on other residents;
- *Further non-acute NHS care* (*17% of delayed days*): This includes access to specialised mental health services such as secure rehabilitation facilities. There is a national shortage of this type of provision;
- *Patient/family choice (12% of delayed days)*: This is where a reasonable offer of care to meet assessed needs has been refused. Setting expectations at an early stage helps to address this issue and there is an action within the 2019/20 delivery plan focussed on patient information;
- *Housing (9% of delayed days)*: This reason applies to housing delays relating to people for whom the Council does not have a social care responsibility under the 2014 Care Act. This includes asylum seekers, people from overseas, single homeless people or those with no fixed abode who do not meet the national eligibility criteria for Social Care.

13. **Permanent admissions to care homes target: *On track*** - There were 126 permanent admissions to care homes during the period between April and December 2019, which suggests an outturn for 2019/20 of 168 permanent admissions. The ceiling for 2019/20 is 170 (or 408 admissions per 100,000 people aged 65 and over). 56% of permanent admissions were into

nursing homes and nearly 44% into residential dementia care homes.

14. The Board may wish to note that as part of the Adult Social Care quality assurance process the Assistant Director, Adult Social Work and Head of Service for the Hospital and Localities undertake periodic reviews of placements. The review that was undertaken for placements in Q3 showed that these were all appropriate to the needs of the individual residents concerned. The Board may also wish to note that placement data for 2018/19 showed that our numbers of older people per 100,000 living in permanent placements was the seventh lowest in the capital.

15. A review of this metric and several other ASCOF measures is being undertaken by the Association of Directors of Adult Social Services (ADASS) and may inform the requirements for the 2020/21 BCF plan.

16. **Percentage of people aged 65 and over still at home 91 days after discharge from hospital to Reablement: *Data not available*** - This metric looks at people who were discharged into Reablement in Q3 and were still living at home at the end of Q4. It will therefore not be possible to report on the 2019/20 performance until the Q4 report to the Board in June 2020. 2019/20 will be the final year of this metric.

Scheme Specific Metric Progress

Scheme 1: Early intervention and prevention

17. ***Falls-related Admissions: On track*** - This metric includes people aged 65 and over admitted to hospitals as an emergency as a result of a fall. Projections based on April to December 2019 admissions data suggest that there will be 902 admissions in 2019/20, which is broadly in line with the ceiling of 892 emergency admissions. This is an improvement on Q2 data and suggests that the falls management initiatives that are in place are having a positive effect.

Scheme 2: An integrated approach to supporting Carers

18. ***Carers' assessments: Slippage*** - 694 Carers' assessments took place during the period April to December 2019. On a straight line projection this would suggest an outturn for 2019/20 of 925 assessments against a target of 1,090 assessments. The Board may wish to note that there are services available through the Hillingdon Carers' Partnership that do not require a formal Carer's assessment under the Care Act to be undertaken. In addition, the Hillingdon Carers Partnership model has proved attractive to external funders and enabled additional resources to be obtained to support Carers in the borough. For example, £225k over three years has recently been secured to improve support to Carers of people with acute mental health conditions, as well as for providing support to Carers dealing with their own low-level mental health issues.

19. ***Carers in receipt of respite or other Carer services:*** During the review period 350 Carers were provided with respite or another Carer service at a cost of £1,340k. This compares to 290 Carers being supported at a cost of £1,190k during the same period in 2018/19.

Scheme 4: Integrated hospital discharge

20. ***Seven day working: Slippage*** - Table 2 below illustrates performance against the seven

day metric at Hillingdon Hospital. This shows that there has been a reduction in discharges taking place on weekends.

Table 2: Seven Day Discharge at Hillingdon Hospital October - December 2019				
Week Days	**Weekends**	**TOTAL**	**W/e as % of total discharges Oct - Dec 19**	**W/e as % of total discharges Apr - Sept 19**
6,373	1,294	**7,667**	16.8	18.7

21. Community partners, including the Council, have the resources in place to support discharges on weekends and the issue appears to be related to infrastructure being established by the Hospital, e.g. medical decision making, access to medication and access to transport. Additional funding has been made available for the period 16th November 2019 to 31st March 2020 and as a result performance during Q4 is expected to improve and this experience will inform investment decisions for 2020/21 and beyond.

Scheme 5: Improving care market management and development

22. ***Emergency admissions from care homes: Slippage***.- Activity for the April to December 2019 period suggests that an outturn for the year of 966 admissions. This would be similar to the outturn for 2018/19 of 968 but significantly above the ceiling for 2019/20 of 844 emergency admissions.

23. 78% of hospital admissions from care homes for older people go to Hillingdon Hospital. Information about the reasons for admission to the Hospital from care homes and also about length of stay once admitted is now available to partners. This is being used to target support and interventions to those care homes identified as having particular issues. Examples of interventions include allocating a matron or GP from the Enhanced Support in Care Homes and Extra Care Service as explained above. A deep dive into those patients with the highest cost episode of care will be undertaken by a consultant geriatrician in Q4 to identify both the appropriateness of the admission and whether there are any learning opportunities.

Key Milestone Delivery Progress

24. The following key milestones for Q3 in the agreed plan that were delivered were:

- *Implement Enhanced Support for Care Homes and Extra Care Service:* Four matrons started with the service in Q3 enabling the range of support that it provides to be extended to more care homes and also to extra care housing schemes. By the end of February a mental health nurse, speech and language therapist and dietician will all be in post, thus broadening the range of support that the service can provide;
- *Explore the feasibility of rapid access care provision to prevent admissions that are avoidable:* A pilot was established in December that enables District Nurses, Guided Care Matrons within the Neighbourhood Teams and the Community Palliative Care Team to deploy urgent day time homecare, sleeping night cover and night sitting cover on a short-term basis where this will prevent an emergency admission. This will be evaluated in March to determine the extent to which it has made a difference to residents

and the health and care system;
- *Develop a lead commissioning pilot for nursing care home provision by the Council on behalf of the CCG*: The Council commissioned six beds for people on behalf of the CCG who were non-weight bearing in order to facilitate timely hospital discharge. The benefits of the Council undertaking this function on behalf of the CCG is being evaluated and will be reported on in due course;
- *Regularise current operational case management arrangements for people with learning disabilities*: The Council provides a case management service to the CCG for people with learning disabilities whose care is funded by the NHS. Approval by both the Council and the CCG of the section 75 agreement clarifies the terms of these arrangements.

25. There is slippage on the following milestones:
- *Criteria-led discharge (CLD):* There are six wards where CLD has gone live and these are a mix of acute elderly, internal rehab, planned surgery, general surgery and respiratory wards. The internal rehab ward and planned surgery are currently the most successful with CLD, achieving approximately 50% of their monthly discharges and showing an increase in the number of patients discharged earlier in the day.
- *Develop training for care homes in how to manage people with challenging behaviours*: The delivery of this milestone is linked to the completion of the tender process for supported living schemes for people with learning disabilities in order to release staff capacity and this will not be completed until 2020/21. It is therefore proposed that this action roll forward to the 2020/21 BCF delivery plan.

Successes and Achievements

26. Key successes and achievements for Q3 can be summarised as follows:
- Agreement across Hillingdon Health and Care Partners to reconfigure services and streamline management to align common functions. This is critical progress in the journey towards integration as it helps to eliminate duplication and achieves improved efficiency.
- Agreement achieved on the appointment of a Joint Clinical Director (role split between a primary and secondary care clinician) and a joint senior manager to manage services supporting discharge. Both changes will contribute to appropriate staff being deployed according to professional competence and avoid duplication.
- 8 patient flow coordinators based within the Integrated Discharge Team at Hillingdon Hospital all took up their posts. Each post has responsibility for individual wards within the Hospital and liaising with relevant stakeholders to expedite the return home of people who no longer need to be in hospital.

Key Issues for the Board's Attention

<u>2020/21 BCF Plan</u>

27. The NHS Operational Planning Guidance for 2020/21 states that the policy framework and planning guidance for the next iteration of the BCF plan will be published in February. The expectation is that there will be a requirement for a three-year plan aligned to the Comprehensive Spending Review (CSR) that will run from April 2021. As it is understood that the CSR will not take place until October it is unlikely that any further guidance will be published before then. It is therefore proposed that the approach to the 2020/21 plan should be about consolidation and that the schemes within the 2019/20 plan be rolled over with the following

priorities:

- Preventing hospital admission.
- Managing hospital discharge.
- Development of integrated brokerage arrangements.
- Development of integrated homecare.
- Implementing the integrated therapies model for children and young people.
- Development of an integrated model for care and support for people with learning disabilities.

Financial Implications

28. The forecast financial position at the end of Quarter 3 2019/20 is summarised in Table 4 below.

Table 4: BCF Financial Summary 2019/20			
Key Components of BCF Pooled Funding (revenue unless classified as Capital)	**Approved Pooled Budget 2019/20**	**Forecast Quarter 3 2019**	**Variance as at Quarter 3 2019**
	£000's	£000's	£000's
Hillingdon CCG - Commissioned Services	39,418	39,008	(409)
LB Hillingdon - Commissioned Services	49,079	50,138	1,058
LB Hillingdon - Commissioned Capital Expenditure	4,455	4,455	0
Overall Totals	**92,952**	**93,601**	**649**

29. The Better Care Fund budget is projecting an overspend of £649k as at Quarter 3 (December 2019). This is due to an overspend of £1,058k on the LB Hillingdon Commissioned Services budgets, which relates to pressures on the Adult placements budgets across Scheme 4: *Improving Hospital Discharge* (£565k overspend); Scheme 5: *Improving Care Market Management and Development* (£1,125k overspend) offset by an underspend in Scheme 8: *Integrated Care & Support for LD*. The overall position assumes the receipt of monies owed of over £800k in relation to an Ordinary Residence case, awarded to Hillingdon following High Court judgement. This will continue to be monitored closely over the remainder of the year.

30. This is netted down by an underspend of £409k on the Hillingdon CCG Commissioned Services budgets, which predominantly relates to underspends across Scheme 5 (*Improving Care Market Management and Development*) and Scheme 8 (*Integrated Care & Support for LD*) of £745k, alongside an overspend of £336k in Scheme 4: *Improving Hospital Discharge*.

EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendations?

31. *Performance report* - The monitoring of the BCF ensures effective governance of delivery via the Health and Wellbeing Board.

32. *2020/21 BCF Plan proposals* - This will provide the Board with an opportunity to give

feedback on the proposal from officers on the content of the plan for 2020/21. The proposal is intended as a pragmatic response to current uncertainty about Government requirements, which will facilitate the submission of the next iteration of the BCF plan within the nationally set timescale. The expectation is that the latter is likely to be no longer than six weeks from the date of publication of the planning guidance.

Consultation Carried Out or Required

33. Hillingdon Hospital, CNWL and H4All have been consulted in the drafting of this report.

Policy Overview Committee Comments

34. None at this stage.

CORPORATE IMPLICATIONS

Corporate Finance Comments

35. Corporate Finance have reviewed this report and concur with the financial implications above, noting the overspend reported against the Better Care Fund. The financial position reflects that reported in Month 9 monitoring, with part of the pressure falling within the Council's Development and Risk Contingency budgets. Corporate Finance note that the pressure reported has been covered within the Council's Social Care position, which is reporting a net underspend of £383k across the service.

Hillingdon Council Legal Comments

36. As is indicated in the body of the report, the statutory framework for Hillingdon's Better Care Fund is Section 75 of the National Health Service Act, 2006. This allows for the Fund to be put into a pooled budget and for joint governance arrangements between the Governing Body of Hillingdon's HCCG and the Council. A condition of accessing the money in the Fund is that the HCCG and the Council must jointly agree a plan for how the money will be spent. This report provides the Board with progress in relation to the plan.

BACKGROUND PAPERS

NIL.