Adult Social Care Scrutiny Commission

Better Care Fund Update

2017/19

Date:5th September 2017

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Leicester City
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Leicester
City Council

1. Leicester City Better Care Fund 2017 – 2019

1.1 This update report sets out the new requirements of the Better Care Fund (BCF) for 2017 – 2019. The principles and use of the fund are essentially the same as the two previous years; however there are some new elements to the fund, notably the Improved Better Care Fund (iBCF) aspect, and with this some additional expectations. The plan is now required to cover a two year period, to 2019.

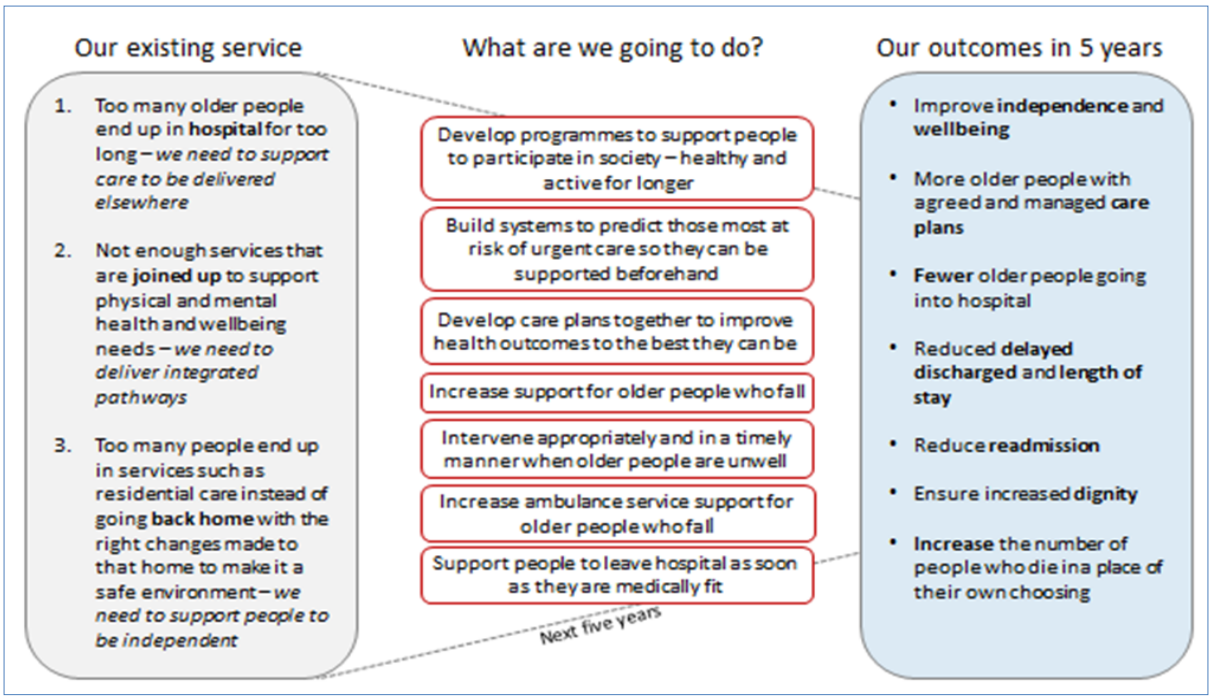
1.2 The planning guidance for the BCF was delayed at a national level; the plan is due for submission by 11th September 2017. A short submission was required in July 2017, setting out the trajectory towards meeting the national Delayed Transfer of Care (DTOC) target together with a grant return to Department for Communities and Local Government (DCLG), explaining the Council's use of the iBCF.

2. The BCF Plan – What we aim to achieve

2.1 The main report that was presented to Adult Social Care Scrutiny Commission in December 2016, with an update on Q2 of 2016 / 17 is attached for background reference (appendix 1).

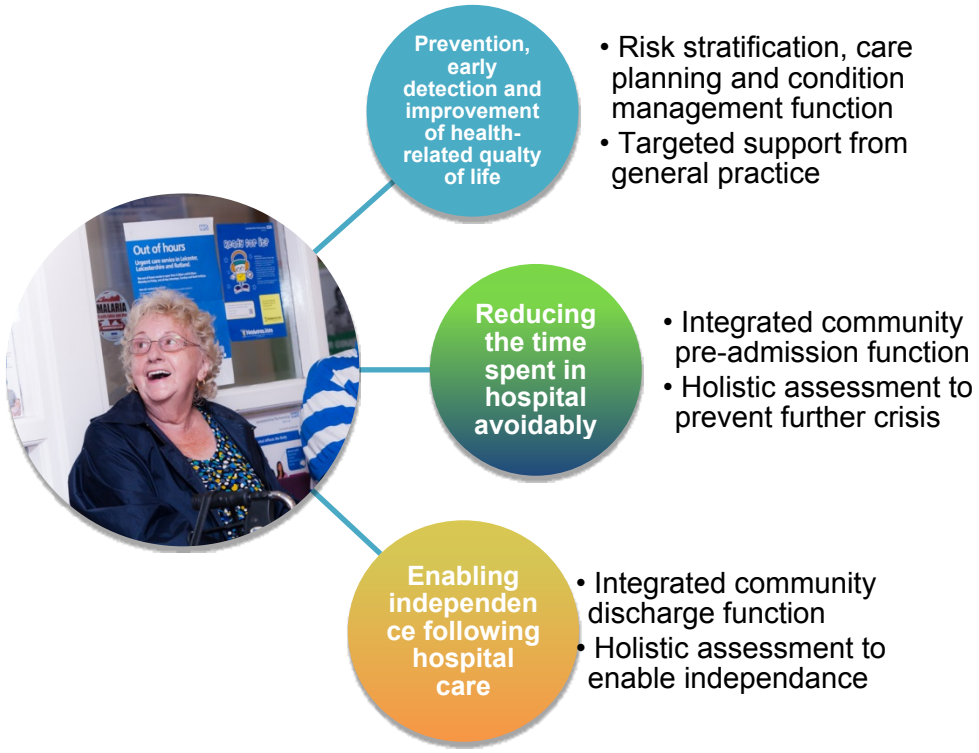
2.2 Within Leicester City we have agreed jointly to use the opportunities presented by the Better Care Fund to drive a clinically-led, patient-centred transformative change programme. This harnesses the collective views, innovations and ideas of many experienced health and social care professionals as well as the views of our patients and carers.

2.3 The programme is purposefully aligned with longer-term strategic planned change in our acute sector, including the plans of Leicester, Leicestershire and Rutland *Better Care Together* programme. The figure below depicts our plans at a strategic level:



3. The BCF Plan 2017-19

For this population, we propose to continue to invest in specific services in the following areas:



The Leicester City pre- and post-hospital pathway

3.1 Given the improved outcomes noted in both pre- and post-hospital systems of care since inception of the BCF, the 2017-19 BCF plan simply increases capacity in the services that require growth.

3.2 A summary of these is outlined below; schemes highlighted in yellow are delivered wholly or in partnership with staff in Adult Social Care (ASC).

3.3 Priority 1: Prevention, early detection and improvement of health-related quality of life

We will achieve this by implementing:

Services for complex patients:

- Increasing the number of people identified as 'at risk' and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health
- The Leicester City Lifestyle hub (enhanced self-care): Commissioned by Public Health
- Delivering 'great' experience and improving the quality of life of patients with long term conditions by expanding our use of available technology, patient education programmes and GP-led care planning, reducing avoidable hospital stays.

3.4 Priority 2: Reducing the avoidable time spent in hospital

We will achieve this by implementing:

The Clinical Response team (integrated into a 24/7 home visiting service):

- Providing an Emergency Care Practitioner-led 2 hour response to patients at risk of hospital admission from GP's, care homes, 999 and 111.
- Providing a proactive care home service to ensure our care home population receive high quality care in their usual place of residence

Our joint Integrated Locality Teams:

- Four integrated physical and mental health teams, ranging from health and social care to housing and financial services, which respond in a coordinated way to ensure care is delivered in the community and around the individual, geographically aligning services from our ASC, GP practices and Community services for the first time.

Interoperable IT systems & governance:

- Enabling the use of the NHS number as a primary identifier for all patients, linked to high-quality care plans for our frail elderly patients or those with complex health needs.

Our Intensive Community Support Service:

- Increasing community nursing capacity to look after people in their own homes rather than in a hospital bed.

3.5 Priority 3: Enabling independence following hospital care

We will achieve this by implementing:

Our nationally commended Integrated Crisis Response Service (ICRS):

- Ensuring timely hospital discharge via the provision of in-reach (pull) teams to swiftly repatriate people to community-based services and maintain independence across physical and mental health services. This service also has an admission avoidance function through partnership working with our GP's. Access to assistive technologies is also provided through ICRS.

Our Hospital based Health Transfers Team:

- Ensuring optimal discharge pathways for our patients requiring Adult social care – this team is based on-site at the acute trust preventing delays to discharge. The BCF is newly investing in staffing capacity and extended hours of service in 2017/18.

Our holistic enablement & reablement services:

- Increasing the number of patients able to live independently following a hospital stay by helping them back to independence

Our Joint community mental health teams:

- Mobilising community-based capacity specifically targeting the discharge of patients in mental health care settings.

3.6 A funding schedule for schemes is attached at appendix 2. It should be noted that a significant proportion of the overall BCF is attached to protecting mainstream ASC service and supporting previous funding streams that were in place prior to, but then incorporated in to the BCF pooled budget (for example, funding for carers' services).

3.7 The services supported by the BCF are very practical and well regarded by citizens and professionals alike. Case studies are collected to illustrate the benefit to people who may otherwise have needed to go into hospital, and highlight the holistic, coordinated nature of services.

Mrs P

94 years old, Mrs P calls the ambulance after a fall at home on Sunday evening. The Clinical Response Service attends rather than an ambulance and establishes that Mrs P is shaken and requires some practical support at home if she is not to go into hospital. ICRS visit within an hour and establish a care plan for 72 hours. During this time Mrs P has a full assessment; it is noted that she has not been eating well as she finds shopping difficult. Equipment is put in place to reduce the risks of further falls and a friend of Mrs P's is engaged to help her with shopping once a week. Mrs P requires no further statutory care. In other circumstances Mrs P would have been taken to hospital due to the time of the incident and her age. She is very likely to have been admitted. Once physically stable she is likely to have been sent home.

The underlying issues at home would have been unaddressed and there is every likelihood that Mrs P would quickly be in the same situation again.

3.8 The drafted plan meets all national conditions & metrics required except achievement of a DTOC rate of 3.5% of all occupied beds by September 2017. A realistic assessment of issues has led the LLR health and social care economy to present a trajectory which allows the target to be met by March 2018. This has been agreed at the LLR A&E Delivery Board.

3.9 The delivery of the plan will be monitored by the City Joint Integrated Commissioning Board, with quarterly updates received by the Health and Wellbeing Board.

3.10 The 2017-19 Better Care Fund approval process requires each area to submit a 2 part plan on September 11th 2017 – the first requirement is a planning template detailing activity, finance & metrics and the second is a narrative plan providing a detailed description of plans for 2017-19.

3.11 Plan assurance will include moderation at NHS regional level, led by Better Care Fund leads for each region, with appropriate representation from regional NHS and local governance. The regional lead for the East Midlands has seen the Leicester City draft and has complimented it as one of the better plans across the region.

4. New Elements to the BCF

4.1 Additional funding was announced by the Chancellor in March 2017, called the Improved Better Care Fund (iBCF). This extra money, £8.954m in 2017/18, is specifically for ASC and comes to the Council via DCLG. The funding must be used to support adult social care, help councils to support local health systems and to stabilise the social care market.

4.2 The BCF planning guidance linked the delivery of DTOC targets to the iBCF funding; this was not supported by the Local Government Association (LGA) or Association of Directors of Adult Social Services (ADASS). However, this does now form an element of the planning requirements. As noted above, the overall delivery of DTOC targets will be challenging; however adult social care delays are well below the 3.5%.

4.3 A return to DCLG was submitted on 21st July explaining how Leicester will use this funding and is attached at appendix 3.

4.4 Due to the delayed planning guidance, and therefore later submission date, a final plan and performance schedule will be available after 11th September, against which delivery can then be monitored.

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