Item No.	Classification: Open	Date: 28th November 2017	Meeting Name: Healthy Communities Scrutiny sub-Committee
Report title:		Better Care planning 2017-19 and managing effective hospital discharge	
Ward(s) or groups affected:		All	
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SUMMARY OF THE REPORT

The BCF was first set up in 2014 with the purpose of driving the transformation of local health and social care services to ensure that people receive better and more integrated care and support in the community. The fund brought together a range of existing resources for community based health and social care into pooled budget arrangements.

Since that time, and following NHSE/Department of Health (DoH) guidance, the council and the CCG have annually submitted Better Care Fund (BCF) plans setting out how the pooled fund, which now stands at approximately £22m, will be used. This year, guidance set out a requirement for a two year plan detailing the expenditure and plans for 2017/18/19. This year a significant addition was made to the allocation to ensure stability of social care the Improved Better Care Fund (iBCF). Nationally this sum was approximately £2 billion, for Southwark this equates to £9.1m in 2017/18 rising to £12.5m in 2018/19. Plans for BCF and iBCF were submitted, with specific conditions attached to both funds.

The two year plan for Southwark was agreed by the Health and Well Being Board on the 11th September, and submitted to NHSE on the same day. Approval of the plans was received on 30th October – Southwark's plans were approved with no conditions, making Southwark one of the few boroughs nationally who have had each of its plans fully assured since the BCF was established in 2015/16

A key significant change in the targets for the BCF has put a primary focus on meeting Delayed Transfers of Care (DTOC) targets designed to ensure people are discharged from hospital in a timely and appropriate way. The report focusses on how the BCF and iBCF facilitate the meeting of the target and ensuring good quality community services are in place to enable safe and timely discharge and to enable residents to remain at home and retain their independence for as long as possible.

This report sets out the following:

- A summary of our BCF and iBCF plan:
- Governance and monitoring arrangements for BCF and iBCF
- Plans for improved our DTOC targets, performance against the key BCF metrics
- Winter planning arrangements for 2017/18

RECOMMENDATION(S)

That the Healthier Communities Scrutiny sub committee consider and endorse the contents of the report.

BACKGROUND INFORMATION

1. Councils and CCG have been required to submit BCF plans since 2015/16 the first financial year from when the fund was established. The fund brought together a range of existing resources for community based health and social care into pooled budget arrangements. Since that time BCF plans in Southwark have supported community services for adults to ensure effective reablement, discharge from hospital, 7 day working and home based services to support independence in the community.

2. Each year, guidance for the BCF is revised, guidance for 2017/18 and 2018/19 planning purposes was expected from NHSE/DoH in November 2016. Due to challenges across the national health and care system, final guidance was issued in July 2017 with a submission date for a final plan for 2017-2019 of 11th September 2017.

3. There were some significant changes to the BCF, including an additional allocation of the Improved Better Care Fund (iBCF). This was national recognition of the need to stabilise social care and had specific conditions attached, which were to minimise cost pressures in social care, stabilise the care market including home care and nursing care. The fund is £9.1m for 2017/18 and £12.5m in 2018/19. This is in addition to the current BCF allocation of approximately £22m.

4. There have been changes to some of the BCF targets with a much greater emphasis on ensuring people are discharged quickly and appropriately from hospital through improved integration of health and social care.

5. For 2017/18 it was proposed and agreed that plans for core BCF (£22.3m) were rolled forward from 2016/17 into 2017/18, providing stability for council and health services currently funded. During the remainder of 2017/18 this will be reviewed with a view to making some changes to plans for 2018/19 to align more closely with strategic priorities, such as the High Impact Changes Plan (HICP) and the budget process for the council and the CCG.

6. The plans for the iBCF grant of £9.1m in 2017/18 set out within the BCF plan will be applied in a way that reduces current budget pressures on homecare and expansion of nursing care, supporting current levels of activity. The plans for the iBCF are compliant with the grant conditions to spend all the funding on supporting social care services. The additional £3.4m iBCF grant allocation for 2018/19 will be applied to home care and nursing care.

7. Nationally there has been a level of uncertainty around the new iBCF monies. Both the planning guidance published by the DOH and the Secretary of State's address to the House on 3rd July 2017 linked the national iBCF increase of £2bn to delayed transfers of care (DTOC). Councils and CCGs have since received targets and metrics for monitoring and reporting DTOCs and whilst to date there has been no explicit threat of penalties for under-achievement, there have been challenges in other parts of the country where DTOC have not been performing against target. Southwark signed up to local targets in July which are considered to be achievable and to date Southwark have performed well against target.

8. The BCF was approved by NHSE on 30th October 2017 without any additional conditions or changes required. Southwark has to date had all of its BCF plans

signed off with no conditions since the BCF was first introduced in 2015/16. The existing Section 75 will be revised to take into account some of the changes to the BCF and IBCF plans, by end of November.

9. Oversight of the plan is with the Health and Well Being Board and is delegated to the Joint Commissioning and Strategy Committee (JCSC) for regular monitoring.

PERFORMANCE MANAGEMENT AND MONITORING OF THE PLANS

10. Quarterly returns are required on how we are managing the BCF and iBCF plans. Quarter 2 (Q2) returns have just been submitted (please see Appendix 1 for attached Q2 returns for NHSE and DoH).

11. In Southwark targets against DTOC to date have been met and exceeded. The key date against which DTOC targets will be compared against target will be November. The target for health and social care was agreed in July of this year and performance is measured on a combined social care and NHS target. The monthly target changes and is an average 454 days across both organisations.

12. Since that date Southwark has met and exceeded its targets. In September, the last date for which there are figures – there were 254 delays against a monthly target of 450 (appendix 2). Reasons for delays include lack of suitable and affordable nursing placements, patient choice and awaiting assessments. Winter will place additional pressure on the system and it is the predicted there will be pressure on nursing home capacity across South East London. Winter plans are in place and summarised later in this report.

13. The trajectory for Southwark is improving against target, and schemes and service in place for hospital discharge continue to keep the DTOC figures down.

14. The current Better Care Fund programme will be evaluated in December and this will help to inform any potential changes to plans for 2018/19.

PLANS TO SUPPORT SAFE AND EFFECTIVE HOSPITAL DISCHARGE

15. There are a number of schemes across health and social care which support safe and effective hospital discharge including BCF schemes, Discharge to Assess, intermediate step down and nursing care, the High Impact Changes plan and winter planning.

BCF PLANS

16. The BCF continues to fund seven days services including the weekend hospital discharge teams, funding for enhanced rapid response and 7 day primary care services. This complements the many services that already operate 7 days per week, including home care and residential and nursing care homes.

17. The 2 Hospital Discharge Teams, based at King's College and St. Thomas hospitals, offer a vital frontline service facilitating safe discharge for residents who are eligible for social care and are inpatients within a hospital ward. They provide multidisciplinary assessment screenings for adults requiring support on discharge from hospital including Supported Discharge Teams (SDTs), Reablement and Care home placements, Continuing Health Care (CHC) and advice and information regarding universal and voluntary sector services and undertake safeguarding alerts and investigations. As well as their assessment role they also manage the practical side of transferring vulnerable people out of an acute hospital setting.

18. As well as ensuring continued low rates of delayed discharge the service plays a key role in managing emergency re-admissions by supporting safe discharge processes, and managing the need for care home placements.

19. Success of the team is not to be underestimated, the hospital teams have achieved DTOC targets for a number of years for the same hospitals that Lambeth service, who have not achieved target.

DISCHARGE TO ASSESS (D2A)

20. The CCG is working in partnership with Lambeth CCG as well as social care, community health services and acute partners to transfer CHC assessment activity from acute settings to the community. The programme is overseen by the CHC D2A Board which reports to the Southwark and Lambeth A&E Delivery Board.

21. Since establishment of the programme in March 2017 the board has:

    - Developed agreed pathways for Discharge to Assess with all partners
    - Commissioned additional community assessment activity
    - Secured beds at Tower Bridge Care Centre for people requiring assessment who are not able to return home

22. CHC Discharge to Assess is a current assurance priority for NHS England. The CCG's plans for achieving the target of less than 15% of CHC assessment activity in acute settings by March 2018 were assured by NHS England in September 2017. As an area reporting more than 25% of assessments in acute in Q2 of 2017/18 the CCG has been asked to provide additional assurance of its plans to reduce this figure. The CCG met its trajectory for September and October. The CCG is currently focussing its efforts on reinforcing senior clinical engagement in the acute setting for the pathway in order to meet the increasingly challenging targets as the year progresses.

NURSING CARE, INTERMEDIATE CARE AND INTERIM CARE

23. The issue of limited nursing beds in Southwark is well known and we are working with the sector to look for opportunities to increase our nursing care beds and ensure that we have sufficient local provision for those people who could be discharged from hospital. For those that are ready to go home but require adaptation or some other adjustment, then the BCF is funding two beds in Lime Tree Court. Southwark does not currently have intermediate care or intensive bed based reablement, for those that need further intervention in a hospital bed but would benefit from support to regain motor skills for independent living.

HIGH IMPACT CHANGE PLAN (HICP)

24. A further change to the BCF planning for this year has been the inclusion of a HICP which has a specific focus on DTOC. The plan is monitored on a regular basis through the Lambeth and Southward A and E delivery board. (Appendix 3 for full plan). The plan includes assessment against 8 key themes to improve DTOC these include, BCF schemes, enhanced health care in care homes, D2A and Trusted assessors

25. The CCG have piloted enhanced health care in care homes and are looking to scale this up across the Borough, this provides enhanced GP access to residents in nursing and residential homes including, Multi Disciplinary Teams. This results in GP being able to respond more quickly to residents within the home, reducing the need to GP and hospital visits and unnecessary admissions.

WINTER PLANNING SUMMARY OF ARRANGEMENTS

26. Through the Lambeth and Southwark A&E Delivery Board for winter planning, allocations have been made to local providers to:

- Increase resilience within the urgent and emergency care system
- Fund additional capacity within the system to support patient flow and delivery of the 4 hour performance target, and
- Support the local system to deliver national 'must-do's' and embed best practice

27. Key schemes supported by winter monies for Southwark and Lambeth include:

Scheme	Description
Southwark & Lambeth Social Services	Provide additional support for social work assessment, advice and input to discharge planning 7 days a week across KCH and GSTT.
Southwark & Lambeth CHC Discharge to Assess	Provide increased investment to support the required shift from acute to community based assessment in line with national targets / local improvement. Also provides funding to support post-acute discharge out of hospital care costs.
SLaM	Expanding the Acute Referral Centre by operating an out of hour's crisis assessment service that responds to individuals in crisis whether at home, in the community, with the police or London Ambulance Service.
Redirection to GP practices from ED / Increase hub capacity	Provide additional primary care appointment slots for Waterloo Health Centre for GSTT and set up a similar scheme to a local GP practice for KCH to redirect. Also in Southwark, increase the number of EPCS sessions during peak times to alleviate pressure on general practice and ensure sufficient capacity to allow re-direction from ED.
SAIL / Warm and Well in Winter	Supporting SAIL to help older, vulnerable residents by providing social inclusion, handymen and wellbeing support. In addition, funding of the Warm and Well in Winter campaign in Southwark and Lambeth which includes ensuring that vulnerable patients receive advice and practical support during cold weather, including neighbour drop in support and advice on hydration and keeping warm.
Frequent A&E attenders service - Southwark	Funding a psychologist from SLaM to support an existing MDT team with frequent attenders of urgent and emergency care services at KCH and frequent callers to LAS with the objective of reducing unnecessary attendances and improving

	the experience of those who frequently attend by supporting them in accessing more appropriate care.
GSTT Community	Pharmacy support for ERR and SDT - Pharmacy support for out-of -hospital transition / admission avoidance to increase capacity for staff. Care home pathway for @home – Increase nursing support to help with new care home pathway for @home services. Community phlebotomy service - Community phlebotomy service to improve capacity of the district nursing team.
Communication campaigns	National campaign targeting the use of Integrated Urgent Care (formally 111). The Stay Well This Winter campaign will aim to ease seasonal pressure on NHS services. It is designed to reduce the number of people, who become so ill that they require admission to hospital.

SUMMARY

28. The BCF and the IBCF plans for Southwark have facilitated an integrated health and social care response to ensure that effective community services are in place which facilitate effective hospital discharge and that integration within hospital settings ensure fast and effective discharge processes. Other services across the system support and compliment those plans and have to date resulted in enabling Southwark to meet DTOC targets.

END REPORT