ANNEX 1

Better Care Fund Annual Report 2019-20

October 2020

Contents:

Introduction and background to Better Care Fund

1. Announced in June 2013, the **Better Care Fund (BCF)** brings together health and social care budgets to support more person-centred, coordinated care. Last year's annual report to the HWBB included a detailed account of the background to the BCF, including the meaning of the term 'Section 75 Agreement'. That report can be accessed here:

   https://democracy.york.gov.uk/documents/g11336/Public%20reports%20pack%20Wednesday%2011-Sep-2019%2016.30%20Health%20and%20Wellbeing%20Board.pdf?T=10

2. The value of the York BCF in 2019-20 was £18,629,000. A breakdown of how this money was spent is set out in the financial summary, in section 7 of this report. The BCF is pooled through a Section 75 Agreement between NHS Vale of York CCG and City of York Council.

York BCF Plan 2019-20

3. The Integration and BCF Plan 2019-20 was submitted on 27th September 2019, in line with the prescribed timetable. We received written confirmation that the York Plan was approved on 8th January 2020.

4. The plan was required to be produced in an EXCEL Template (available from the author on request). It included a brief strategic narrative, which was published in a 'word' format with the HWBB papers in December 2019, and can be accessed here:

   https://democracy.york.gov.uk/documents/g11337/Public%20reports%20pack%20Wednesday%2004-Dec-2019%2016.30%20Health%20and%20Wellbeing%20Board.pdf?T=10

National monitoring arrangements

5. CCGs were required to report to NHS England on the performance and delivery of BCF. We are measured against the following 4 key metrics:

a. Non-elective admissions (General and Acute);
b. Admissions to residential and care homes;
c. Effectiveness of reablement; and
d. Delayed transfers of care.

6. Councils were also required to report to MHCLG on their expenditure from the Improved Better Care Fund (iBCF).

7. These reports are combined as a single return on behalf of the system. The template for returns required us to report against the national conditions and metrics, the implementation of the High Impact Change Model and Red Bag Scheme, and also provide an opportunity to share examples of good practice and progress towards integration. Quarterly returns are signed off by the chief officers and the chair on behalf of the HWBB. The returns are available (for information) on request from the Assistant Director – Joint Commissioning.

8. In 2020-21 the frequency of reports and the detail of detail have been scaled back by NHSE and MHCLG as other demands have taken precedence over these processes.

Annual evaluation of schemes

9. Since 2018 the BCF Performance and Delivery Group has hosted annual evaluation sessions to share learning across the system and review the performance of the schemes. This has proved to be a positive opportunity for partners to learn from each other and to spread awareness of the range of commissioned services covered by BCF.

10. The wealth of community activity and social impact volunteering has been a vital and growing part of this story, enabling more people to remain resilient and independent in their homes, supported by good preventative services and care when needed.

11. The 2020 sessions' presentation materials are available on request from the author of this report.

Planning and policy guidance for 2020-21

12. The BCF Policy Framework 2020-21 has not yet been published. It is anticipated during the autumn. The reporting against the four national conditions (see section 1 of this report) has been eased. During the pandemic, the Hospital Discharge Service Policy Requirements resulted in the recording of delayed transfers of care (DTOC) being suspended. The government has indicated that the DTOC targets will no longer be included in the BCF performance framework.

13. The deadline for submission of the York BCF Plan 2020-21 and the related assurance timetable is not known.

14. The plan must be approved by the HWBB prior to submission, and responsibility for this may therefore need to be delegated to the Chair and Vice Chair of the HWBB, due to the meeting schedule.

Performance summary 2019-20

Performance against national metrics

15. Performance and delivery of the Better Care Fund is judged against four national metrics:

    a. Non-elective admissions (General and Acute);
    b. Admissions to residential and nursing care homes;
    c. Effectiveness of reablement; and
    d. Delayed transfers of care.

16. These metrics present a somewhat narrow window of evaluation of performance across a vast and complex system of service delivery and a very broad spectrum of client need. It is also worth noting that BCF funding is a very small proportion of the totality of funding across health and social care and yet these measures are high level, 'whole system' metrics.

17. Of particular importance in York is the constructive use of Better Care Funding to support primary prevention activity aimed at building community capacity and increasing personal resilience. This is longer-term thinking with the intention of managing down future demand over years rather than months and therefore short-term impact on the four national metrics is likely to be limited. Nevertheless there is a growing body of evidence of the positive impact that this activity is having on people's lives in York

18. During 2019/20 York, as with all systems nationally, measured performance against the national metrics in relation to specific targets. For non-elective admissions, the local target was consistent with that set by the CCG in its operating plan; for Delayed Transfers of Care targets the target was determined by central government in line with national ambitions: the targets for admissions to care homes and effectiveness of reablement were set locally. Performance in relation to the national metric targets was as follows:

National Metric	Plan/Target	Actual Outturn
Reduction in non-elective admissions (General & Acute)	25,035	25,254
Delayed Transfers of Care: Raw number of bed days	6,919	8,966

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	84%	81%
Number of permanent admissions to residential & nursing care homes for older people (65+)	227	201

19. **Non-elective admissions –** Non-Elective spells were 0.9% higher than plan over the full financial year 2019/20, which represents 219 admissions out of a total of 25,254 admissions. At York Hospitals NHS Foundation Trust, The number of adult non-elective admissions and A&E Attendances has increased by 7% in 2019/20 compared to 2018/19. Activity was slightly above plan each month from October 19 to February 20, which is most likely an effect of improvements in Same Day Emergency Care (SDEC) which although means a greater number of Non-Elective Admissions being recorded, these are all mainly 0-1 days length of stay with a reduction in patients being admitted for 3+ days and a reduction in longer hospital lengths of stay. There was a sharp decrease in March 20 against plan, due to COVID-19.

    A lot of improvement activity has been carried out by York Teaching Hospitals NHS Foundation Trust over the year. This includes improvements to pathways for Same Day Emergency Care (SDEC). The Service expanded to a full 7 day SDEC service, on both York and Scarborough hospital sites. Workforce models were tested and implemented for 12 hour opening on the York hospital site, for Medical SDEC and Surgical Assessment units at weekends. These improvements continue to have a positive impact on patient flow through the Emergency Care system as well as maintaining and improving patient safety and experience. Bed occupancy for medical specialities for over 65s has reduced significantly during 2019-20. The York Hospital site have tested and implemented a new Medical SDEC patient selection method during March 2020, to try to further reduce admissions to inpatient wards, which has had a positive impact on reducing lengths of stay for patients in Hospital, reducing Delayed Transfers of Care and the numbers of stranded patients each month.

20. **Delayed transfers of care –** The figures shown reflect a revised target and outturn up to the end of February, when DToC counting was stopped due to the pandemic. The target reflects the extremely challenging target set centrally by NHS England. Nonetheless, the actual outturn represents significant progress compared to 2018-19, with an 11% reduction in bed days caused by DToC from April 2019 to February 2020 compared with the April 2018-February 2019 period. The main reason for the reduction was that delays due to waiting for places in nursing homes halved.

21. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services** – the outturn for this year, although slightly below our target (to improve marginally on 2018-19 performance), is consistent with the level seen in recent years and is likely to be around national/regional averages for this indicator when those figures are published in December. A relatively small number of people – those

supported by our service provider Human Support Group (HSG) - are eligible to be included in the denominator. The rate was higher for women (85%) than for men (75%).

22. **Number of permanent admissions to residential & nursing care homes for older people (65+)** – we set ourselves a target to reduce admissions by 10% compared with 2018-19 and actually achieved a 20% reduction in admissions. During 2019-20 a policy decision not to send people following a hospital discharge directly into care homes had an impact on the numbers admitted, and this has continued into 2020-21. It also reflects well on the efforts of CYC's preventative teams to ensure that as few people as possible entered residential/nursing care during the year.

Impact of BCF Funded Schemes.

23. As referenced above, the impact and success of BCF funded activity in York cannot solely be judged by performance in relation to national metrics and targets. There have been many notable successes resulting from the BCF programme and there is much to celebrate. Highlights include:

24. **York Integrated Care Team** – The BCF funds a multi-disciplinary team comprised of a range of health and care professionals, working from a single location, with the aims of reducing avoidable hospital admissions, expediting safe discharge from hospital and enabling patients to remain independent longer through person centred care in the right place at the right time. The holistic assessment and continuous review of complex and vulnerable patients has included the following activity:
    - Over 3,000 people on the register
    - Average 800 care plans reviewed per month
    - 300-600 cases discussed at Multi-disciplinary Team meetings (MDTs)
    - Average 28 people per month provided with short-term interim care
    - More than 200 calls to the Hub telephone number as the single point of access

    During the year the team received the well-recognised 'Making a Difference' Award from Healthwatch York. The award was in recognition of the team's excellence in health and social care service.

25. **Changing Lives 'A Bed Ahead'** - This scheme provides support for homeless clients who present at the Emergency Department (ED) in the form of two homelessness liaison workers and two dedicated step-down beds at Union Terrace hostel. Referrals are taken from inpatient wards to assist with discharge arrangements. During 2019/20 there were 129 referrals, 73 from inpatient wards and 56 from the ED. Positive outcomes and intervention is achieved in around 83% of cases. This year saw an increase in emergency bed nights - 969 compared to 824 in 2018/19. Providing support for those attending out-patient appointments has been an important development and helped 33 individuals to 67 outpatient and 76 primary/community appointments.

26. **Fulford Nursing Home Beds** - Four nursing care beds plus Occupational Therapy support at Fulford Nursing Home (with flexibility to increase to six to meet peaks in demand) are utilised with a focus on avoiding admissions to hospital for people who present at A&E. This is now a well-established pathway to prevent admissions to York Hospital. During 2019/20, there were 67 admissions with 82% of people admitted to these beds successfully returned to their home with no need for ongoing care and support. The team has managed to continue to provide a high turnaround of admission to discharge with an average of 13 days. The scheme has helped facilitate a culture change and different way of working which promotes a focus on movement and rehabilitation, preventing deconditioning now runs through the home and benefiting all residents, not just the rehabilitation residents.

27. **Rapid Assessment and Therapy Service (RATS), YTH (Extended Hours)** - The aim of the RATs team in York ED is to provide timely and appropriate multidisciplinary assessment and interventions for individuals who present with diverse/complex physical, functional, psychological and social problems, thus avoiding any unnecessary admissions. The service runs 8am-8pm 7 days a week. Better Care Funding allows the service to operate Monday – Friday 4.30pm – 8pm and at weekends and bank holidays. During 2019/20 the team has seen around 4000 patients with the vast majority (74%) of those being sent directly home or referred to other services without the need for admission to a hospital bed.

28. **Carers Support** – 2019/20 saw an additional 630 new carer registrations with York Carers Centre, 1160 referrals into the Carers Support Service and 111 referrals for a Carers Needs Assessment, plus 72 young carers impact assessments/statutory young carers assessments.

    564 one to one carers' advice sessions were delivered, and 42 carers received one to one counselling. 186 carer referrals were made into the Financial Support Service and 33 youth club sessions took place.

    A series of hubs and 'pop up' hubs were delivered on a monthly basis, as well as specialist support groups for carers of customers with mental health and substance misuse issues. The hubs and specialist support groups have acted as a lifeline to marginalised and isolated carers within communities who would not have had the ability to travel to a city centre location, but have benefitted greatly from engaging with an outreach service in their local neighbourhood.

29. **Reablement (One Team)** – this is a collaborative approach across a number of partner services – York Integrated Care Team, Community Reablement Team (YTH), Intensive Support Service (CYC) and Human Support Group (commissioned by CYC). These partners provide short-term support at home to support safe, early discharge from hospital, avoid unnecessary admissions and to help people regain skills and confidence that help them live independently. The majority of people receiving short term support are discharged from these services without on-going care needs. In 2019/20 the service achieved 55% of people requiring no or reduced care following episode of reablement.

30. **Step-up/Step-down beds** - Funding from the Better Care Fund was agreed for ten step up/step down beds at Haxby Hall, a CYC Residential care home, and two further beds to be spot purchased in the private sector. Step down beds offer an effective means of enabling patients to move out of an acute hospital as soon as they are medically fit. Step up beds are used to avoid unnecessary admissions to hospital. Having access to a physiotherapist has led to increased successful home discharges and a reduction in hospital readmission rates via the recognition and prevention of unsafe discharges. 86% of discharges are successful at 3 month follow up, crediting the detailed assessment and discharge planning undertaken by the therapist and wider Multi-Disciplinary Team (MDT) whilst patients are in Step-Down. Readmission rates remain low, though incidence of patients moving into 24 hour care increases at 6 months.

31. **Local Area Coordination (LAC)** – The ethos is to develop person centred relationships focused on a 'good life' and building on the assets and contribution of people and the community in which they live. The LAC team in CYC has grown from 3 to 8 coordinators since May 2017 and coverage has increased to 8 of 21 ward areas.The total number of people the team has worked with to date is 1915 and currently 572 are active (including reactivated cases). In the period 06/03/20 – 17/04/20 the team has been in contact with a total of 772 people related to COVID 19 support, information and advice, 136 of these were not previously known to the service.

32. **Telecare** and **Community Equipment (Be Independent) –** During 2019-20, Be Independent supported:
    - 2500 customers (individual customers)
    - In addition we have 30 business customers ie care homes/supported living/shared housing which equates to an additional 400 customers
    - 400 active customers are from hospital discharges each month (who are already BI customers)
    - Deliveries and collections totals 18,000 (12,000 deliveries, 6000 collections)
    - We are undertaking pilots for younger adults customers with learning disabilities and mental health support needs, trialling 'Brain in Hand' technology, and a smart watch pilot with Independent Living Communities

33. **Home Adaptations** – Funding has been used to support people to remain in their home through provision of e.g. level access showers, stair lifts, ramped access. In 2019/20, 299 major adaptations were funded via Disabled Facilities Grants, compared with 274 in the previous year. This continues a trend of steady increase over the past four years. A non means-tested approach has been introduced to speed up delivery of low value work. In total 1561 referrals received and completed for minor adaptations.

34. **Self-support Champions** - BCF funds additional capacity in the Intensive Support Service and First Contact Team which is designed to enable more consistent early engagement by reducing/avoiding waiting times, ultimately resulting in better outcomes for customers and reduced spend on long term support. The funding has also enabled staff to be available to support the

Talking Point community access sessions as part of the adult social care improvement programme.

35. **Social Prescribing** - 296 customers accessed the scheme in 2019/20, for an average of 6 to 12 weeks. Improvements have been achieved across all mental well-being scale outcome measures with 80 % of people referred reporting an increase in their overall wellbeing score after working with Ways to Wellbeing; 58% of people reported an increased sense of optimism; 42% of people reported feeling more useful; 50% reported feeling and increased sense of relaxedness; 62% reported feeling more confident; 60% reported being able to think more clearly; 60% reported feeling closer to other people; 50% reported an improvement in relation to their ability to make decisions and be decisive.

36. **Handyperson Service –** Enhanced provision of 'small tasks at home' through expansion of community volunteering. Blueberry Academy are providing opportunities for people with learning disabilities to gain experience by volunteering to support people who are frail or have physical disabilities to maintain their garden (35 residents supported). Goodgym York providing one off tasks in the home and garden by utilising volunteers that run to their "mission" in pairs, a run with purpose and commitment, and carry out the requested task. Goodgym have completed 59 missions including a home from hospital initiatives that prevents DTOC e.g. moving a bed downstairs. Community Bees have recently been commissioned to walk alongside vulnerable people to develop independence skills at home. Community Bees has worked with 134 service users.

37. **Live Well York** – 2018/19 saw the official launch of the Live Well York website which provides a searchable health and wellbeing information and advice resource for York citizens. The site includes information on a wide variety of community activities and community groups, as well as promoting volunteering opportunities. During 2019/20 there has been a steady increase in the number of new users accessing the site (3,400 new users across the year) and the activities section has received the most engagement from visitors. Twitter followers have also increased to 665 by the end of the year.

38. **Alcohol Prevention** - Training has been delivered to a range of primary care staff including GPs, Nurses, Health Care Assistants, Health Visitors and non-clinical staff in the identification of problems associated with alcohol misuse in older drinkers and how behaviour can be modified. It has also been delivered to CYC staff such as social workers, housing officers, health trainers and customer centre staff. The aim is to lower alcohol intake and therefore prevent problems escalating. In 2019/20 training was delivered to 95 members of staff in total, across 6 courses.

39. **Seven Day Working** – Having a social work presence at the hospital at weekends and on bank holidays has enabled some patients to be discharged at weekends and speeded up the discharge of others by smoothing out peaks in assessment workloads. It has also facilitated better communication with patients' families and staff, at a time with fewer competing priorities than may be the case on weekdays.

Financial Summary 2019-20 see Annex 3