ANNEX 1

Better Care Fund Annual Report to Health and Wellbeing Board

September 2019

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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.

2. Although we are now into a single planning year for 2019 -2020, the previous Policy Framework for the Better Care Fund (BCF) covered two financial years (2017-19) to align with NHS planning timetables and to give areas the opportunity to plan more strategically. The Framework included significant amounts of local authority social care grant funding. Some of this was announced at the 2015 Spending Review, with an additional £2 billion over three years announced at Spring Budget 2017, with grant conditions on this new money to ensure it had the expected impact at the care front line.

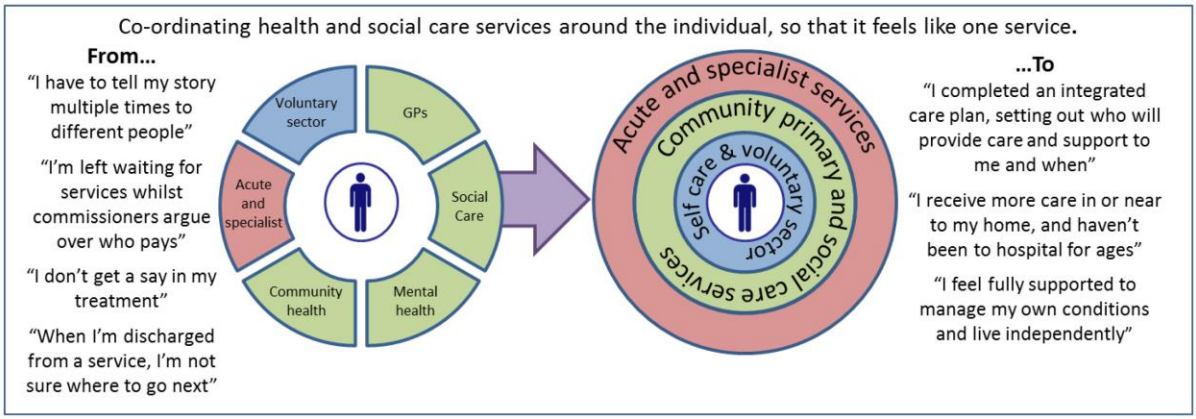
3. The national conditions that areas were required to meet in their plans for 2017-18 and 2018-19 were:

    - plans to be jointly agreed;
    - NHS contribution to adult social care is maintained in line with inflation;
    - agreement to invest in NHS commissioned out of hospital services; and
    - managing transfers of care.

[Adapted from Integration and Better Care Fund Policy Framework 2017-19, DH and DCLG, 2017]

4. The aim of the BCF is to improve outcomes for people who need care and support:

People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.



[Integration and Better Care Fund Policy Framework 2017-19, DH and DCLG, 2017]

5. The value of the York BCF in 2018-19 was £17,427,000. 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.

6. The term 'Section 75 Agreement' refers to the NHS Act, 2006, as explained below:

Under Section 75 of the NHS Act 2006 (as amended), the Secretary of State can make provision for local authorities and National Health Service (NHS) bodies to enter into partnership arrangements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised. The specific provision for these arrangements is set out in the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. The regulations:

- *Set out the NHS bodies and local authorities that may participate in partnership arrangements;*
- *Set out the functions of those bodies that may be the subject of partnership arrangements;*
- *Enable partners to enter into arrangements for or in connection with the establishment of a pooled fund;*
- *Enable partners to enter into arrangements for an NHS body to exercise the prescribed health-related functions of local authorities; and*
- *Enable partners to enter into arrangements for a local authority to exercise prescribed NHS functions.*

[NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015 Public Consultation, DH, 2015]

York BCF Plan 2017-19

7. The Integration and BCF Narrative Plan 2017-19 was submitted on 11th September 2017, in line with the prescribed timetable. We received written confirmation that the York Plan was approved on 20th December 2017, following amendments agreed through the national assurance process. It was published as part of the papers for the HWBB meeting on 24th January 2018, and can be accessed here:

   https://democracy.york.gov.uk/mgChooseDocPack.aspx?ID=10242

8. The narrative plan cited the Joint Health and Wellbeing Strategy vision and took account of the Joint Strategic Needs Assessment to shape our commissioning priorities. It includes a description of each of the schemes, all of which are intended to join up care around individuals, shift from acute towards intermediate care or community support and focus on prevention.

9. During the life of the two year plan we have held partnership events and evaluation sessions to refine our vision for integration, summed up in the phrase:

   Integration: Collaboration; Innovation; Prevention.

National monitoring arrangements

10. CCGs were required to report each quarter 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.

11. Councils were also required to report quarterly to DCLG on their expenditure from the Improved Better Care Fund (iBCF).

12. In 2018-19 these quarterly reports were combined as a single return on behalf of the system. The templates for returns requires 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.

Annual evaluation of schemes

13. In May 2018 and May 2019 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.

14. 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.

15. Presentation materials from the 2019 session are available on request.

Planning and policy guidance for 2019-20

16. The BCF Policy Framework 2019-20 was published in April 2019, and the Planning Requirements in June 2019. The four national

conditions (see section 1 of this report) are unchanged. However, there is no requirement to publish a separate narrative plan. Instead, the planning template incorporates the requirement to update our vision and strategy for integration, describing the progress we have made across the system over the past two years.

17. The deadline for submission of the York BCF Plan 2019-20 is 27th September 2019. The assurance timetable is set out below.

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

19. The BCF Performance and Delivery Group has been developing the financial plan and commissioning intentions for 2019-20 in anticipation of the policy framework and planning requirements, incollaboration with our partners and providers.

BCF Planning and assurance timetable

BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercaresupport@nhs.net	By 27 September
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	By 30 October
Regionally moderated assurance outcomes sent to BCST	By 30 October
Cross regional calibration	By 5 November
Assurance recommendations considered by Departments and NHSE	5-15 November
Approval letters issued giving formal permission to spend (CCG minimum)	Week commencing 18 November
All Section 75 agreements to be signed and in place	By 15 December

Performance summary 2018-19

Performance against national metrics

20. 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.

21. 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.

22. 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

23. During 2018/19 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)	22,977	24,628

Delayed Transfers of Care: Raw number of bed days	7,559	10,969
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	93%	83%
Number of permanent admissions to residential & nursing care homes for older people (65+)	222	252

24. **Non-elective** admissions **–** Most areas of the country have found non-elective admission targets very challenging to meet with only 22% across the north of England (50 H&WBB's) being 'on track'. This reflects the increasing demands from an aging population and increasingly complex acuity. Although York has seen increases in the numbers of non-elective admissions (and the CCG continues to investigate the reasons behind this growth in demand) the successful growth in same day emergency care (for medical and surgical specialties as well as front door frailty assessment) means that more of these patients do not require an overnight stay in hospital (reducing their risk of deconditioning and of subsequently being delayed in hospital). The CCG and the main acute provider are now one year into the Aligned Incentives contract and are having collaborative discussions around improving emergency pathways for patients as well as ensuring that patients are receiving quality care at the right place at the right time. Although NEA activity levels are above plan, this new model of care appears to have mitigated some of the impact on the urgent care system during winter, with the Main Hospital provider maintaining a higher ECS standard this year over last year. The Main provider has also seen an overall decrease in occupied bed days throughout the year despite an increase in NEAs. The impact of ward closures due to winter illnesses has also been lessened due to patients being assessed, treated and discharged quicker.

25. **Delayed transfers of care –** The national picture is slightly better with 51% of areas in the north of England being on-track to meet their targets. Continuing pressures exist in ensuring that those discharged are placed in appropriate settings. Due to limited provider capacity to deliver suitable home care packages and appropriate residential and nursing care placements. Seven day working and the

One Team have had positive impacts in will continue to do so in 2019/20.

26. **Effectiveness of reablement –** Two thirds of areas in the north of England were on course to meet their target, however York saw a decline in performance from the previous year. Around the country there is great variation in the make-up and arrangements for reablement services, making direct comparison unreliable.

27. The **indicator** represents a snapshot of the over 65s population who were discharged from hospital into reablement services during quarter 3 each year, following them up after three months to find out if they are still at home, or have returned to hospital or been admitted to care, for example. York's service is delivered by HSG (Human Support Group) as part of the One Team and accepts referrals of people who have high levels of complexity in their care and support needs when compared to other similar services. A strong focus of their work is to enable people requiring care to leave hospital and return home. This inevitably results in fewer individuals being able to remain independently living at home, as a proportion of all referrals. Changes to the pathway over the past year have included all cases being triaged by the Community Response Team; people with greater reablement potential access therapy through our NHS teams which are not counted in the indicator.

28. One of the startling messages from the Venn Capacity and Demand model is that one third of people they looked at who were receiving reablement did not need that type of service at the time, and about one quarter of people who were receiving reablement were waiting for long term packages of care at home. This results in people who need reablement waiting for it in other places, such as short term beds. This will be a key focus of our work in 2019-20.

29. Admissions **to care homes –** The national picture is similar to above with just under two thirds of areas in the north on track to reach their targets. Although activity in York was slightly above plan, activity in the second half of the year showed a reduction in admissions when compared to the same period in the previous year. There has also been a progressive increase in the number of people supported to live independently via preventive services and a consequent decrease in numbers receiving a funded support package

Impact of BCF Funded Schemes.

30. 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:

31. 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. During 2018/19 the team has avoided around 1200 hospital admissions through identification of need in local population and delivery of tailored support. The majority of people who have received short–term support have subsequently been discharged without any need for ongoing care.

    "The knowledge that someone will be paying a visit to see if help is needed with an everyday task like washing, dressing, preparation of a meal, help with medication and a chat alone makes this day seem brighter, particularly if you live alone and do not get out due to a variety of reasons (age being one reason, mobility etc)"

32. **Arc Light – Changing Lives** - This scheme provides support for homeless clients who present at ED in the form of a link worker, and also takes referrals from inpatient wards to assist with discharge arrangements. 150 referrals were received, 87 from inpatient wards and 63 from the ED. There was an increase in bed nights (824) with positive outcomes in around 88% of cases. Increased support for those attending out-patient appointments has been an important development.

33. **Fulford Nursing Home Beds** - Four nursing care beds plus OT 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. During 2018/19 over 80% of people admitted to these beds were successfully returned to their home with no need for ongoing care and support.

34. **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. During 2018/19 the team has seen around 3500 patients with the vast majority of those being sent directly home or referred to other services without the need for admission to a hospital bed.

35. **Carers Support** – 2018/19 saw an additional 621 new carer registrations with York Carers Centre, 986 referrals into the Carers Support Service and 112 referrals for a Carers Needs Assessment, plus 39 young carers impact assessments/statutory young carers assessments.

36. 522 1:1 carers advice sessions were delivered and 44 carers received 1:1 counselling. 200 carer referrals were made into the Financial Support Service, 48 youth club sessions took place and a further 116 new registrations were made for the Carers Emergency Card.

37. 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.

38. 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. In 2018/19 the One Team dealt with an average of 225 referrals per month; 54% of these were for step-down (speeding hospital discharge) which is a slight increase on the previous year. The majority of people receiving short term support do not are discharged from these services without on-going care needs.

39. **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. In 2018/19 67 patients were able to leave hospital quicker through the use of step-down beds and a further 36 avoided an admission to hospital through the use of step-up beds.

40. **Local Area Coordination** – 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.

41. In an 18 month period, one Local Area Coordinator had the following impact in one area of York:
    - 3 people moved into paid work
    - 56 people provided with welfare benefits advice
    - 32 people given housing advice/support to prevent homelessness
    - 46 people given additional physical/mental health advice
    - 10 people now volunteer regularly
    - 10 people supported in court through legal proceedings including support to report incidents to the police.

    "You have been a rock and brilliant at helping me sort everything out. If it wasn't for your help I don't think I would be here now – I did think about joining him in that first week after his death."

    "I feel hopeful about the future for the first time in years."

42. **Telecare** and **Community Equipment (Be Independent) –** Avoided nearly 200 admissions to hospital and enabled the speedy discharge of over 30 patients. Over 60 admissions to care homes avoided or delayed as well as enabling reduction in the size of ongoing care packages and family/informal carer support for a further 250 residents.

43. **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 2018/19 274 major adaptations were funded via Disabled Facilities Grants. 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.

44. **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 Future Focus work. As a result waiting time for assessment has been reduced from 47.5 days to 8.6 days at the end of March 2019.

45. **Social Prescribing** - Improvements have been achieved across all mental well-being scale outcome measures with over 50 % of people referred reporting they felt more able to make up their own mind and again over 50% feeling they had people they could ask for help after working with Ways to Wellbeing. 70 % of those referred reported feeling more confident than before they accessed support, 60% reported thinking more clearly, 53% reported feeling more relaxed, and 56% reported feeling more optimistic. The total decrease in GP appointments after accessing the service is 29.6 %.

46. **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 (23 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 22 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.

47. **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 almost 600 community activities and 96 community groups promoting volunteering opportunities. Plus and events calendar with 40-80 events posted every month. Already over 1,600 people (citizens and practitioners) are using the website every month.

48. **Alcohol Prevention** - Training has been delivered to a range of primary care staff including GP's, Nurses, HCA's, Health Visitors and non-clinical staff in the identification of problems associated with alcohol misuse in older drinkers and how behaviour can be modified. The aim is to lower alcohol intake and therefore prevent problems escalating. 150 staff received training in total across 9 courses.

49. **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

Financial Summary 2018-19 – see Annex 2