APPENDIX 2

Integration and Better Care Fund

Refresh 2018-19

August 2018

Version 10 FINAL SUBMITTED

Overview

Partners throughout the Health and Social Care system in Herefordshire continue to be committed to working together to deliver a local system *"where strong communities encourage individual citizens to live healthy lives and offer support when this is required for them to maintain their independence, with sustainable, aligned health and care services for local people".*

The purpose of this document is to provide an overview and rationale of the agreed changes to the Integration and Better Care Fund (BCF) plan for Herefordshire 2018-19. A reviewed planning template has been submitted which reflects the changes detailed below.

Achieving the ambitions set in relation to Delayed Transfers of Care (DToC) continue to pose a significant challenge to partners across the system. Whilst partners have agreed to align DToC targets to the national ambitions it is recognised that achieving this will require substantial performance improvements. To support the necessary improvements, partners have agreed to invest core BCF and iBCF funds in a number of additional areas throughout 2018-19, including the following:

- Urgent care investment
- Trusted Assessor
- D2A investment
- Community capacity
- Improving Quality of Care in Care homes

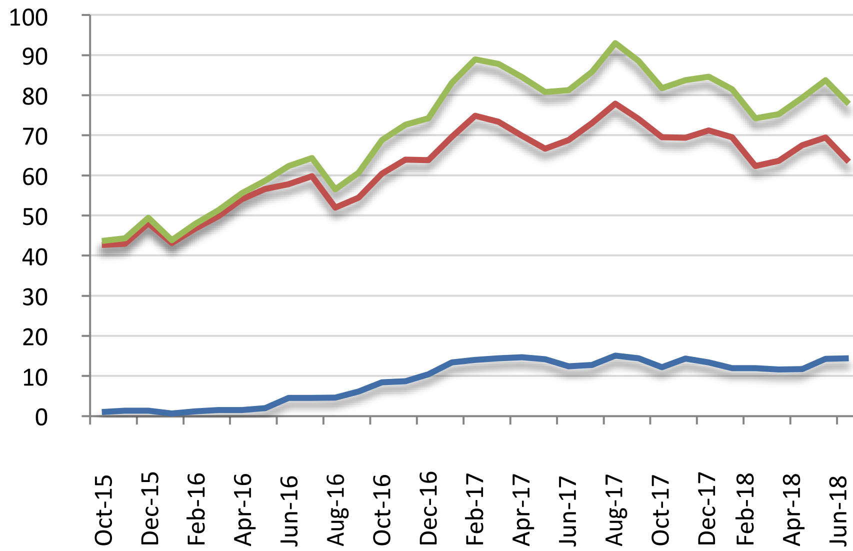
Further information regarding these areas of investment are detailed below.

Herefordshire Current Performance

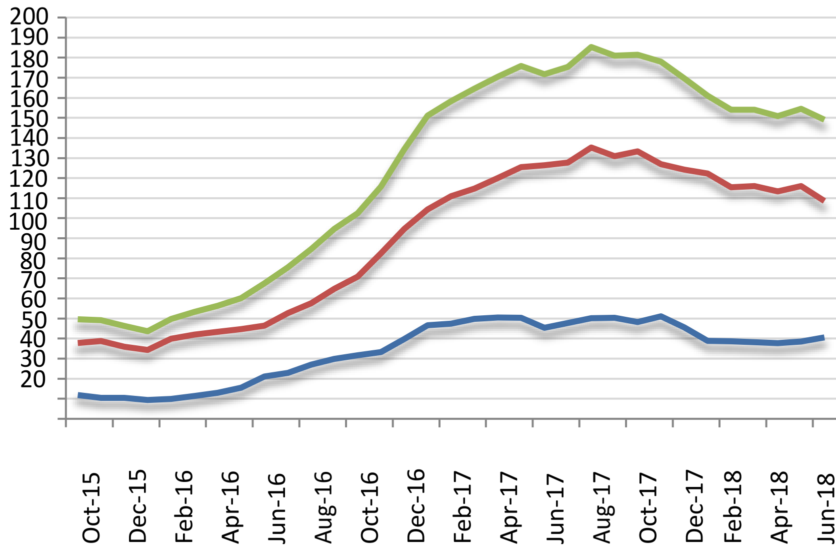
The tables below show the key areas in Herefordshire for delayed transfers of care. The graphs show that awaiting for a nursing or residential placement remains a pressure within the Herefordshire system and although in nursing care this reduced at the end of 2017 this has stabilised again resulting in patients awaiting assessments from care homes and subsequent placements.

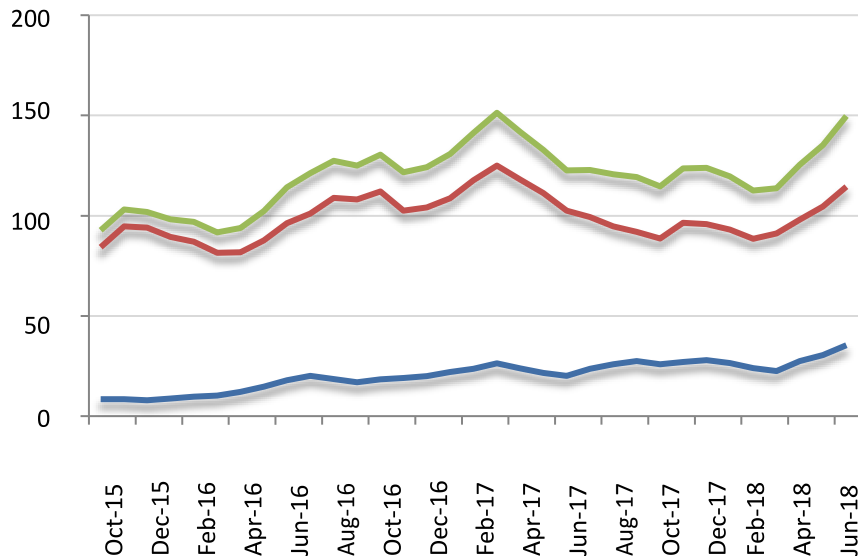
Another area of pressure is awaiting packages of care in their own home also showing that the number of individuals awaiting either a package of care or Homefirst is increasing. Within the Herefordshire BCF and Integration plan it demonstrates the plans for the Homefirst service and investment from BCF and iBCF for the expansion and improvements. The service is an amalgamation of an external reablement and internal rapid response team, the service has been through a period of cultural and management of change process to deliver the capacity required in the market, this has resulted in reduced capacity however the local authority are projecting the capacity to improve as a result of these changes.

Awaiting residential home placement or availability



Awaiting nursing home placement or availability





The integration developments outlined below evidence the work being undertaken to improve the transfer of care position for the system through investments from the iBCF.

Integration developments 2018-19

- **Integrated Urgent Care Model**

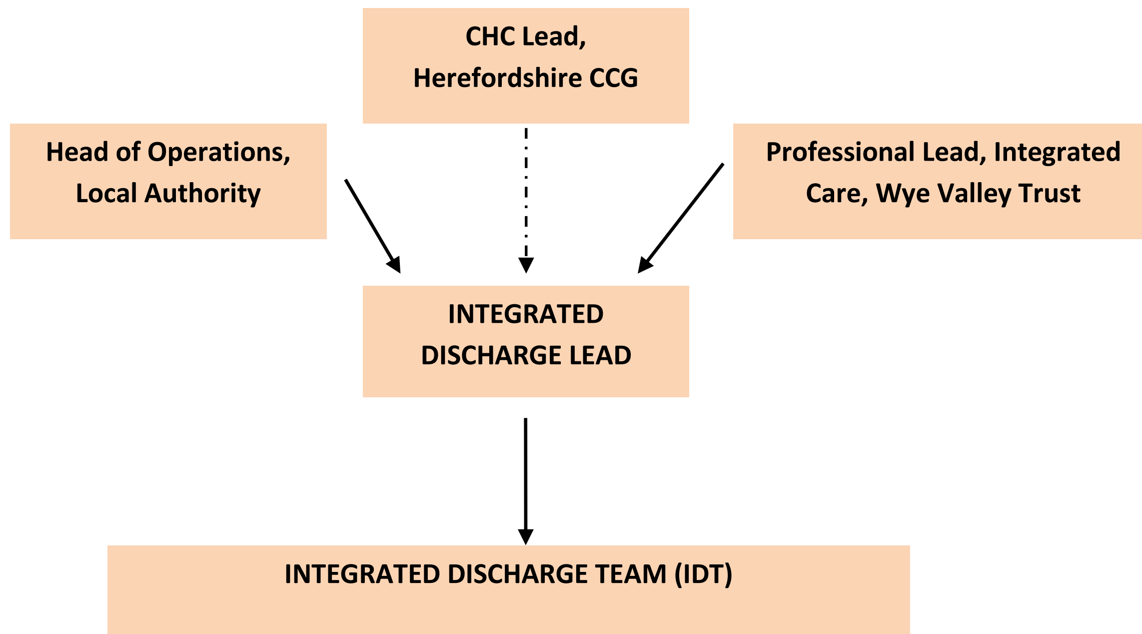
Throughout 2017-18 partners have recognised the need to further develop integrated practice in order to assist in addressing delays in transfers of care and developing services to assist in improving system outcomes. During 2018-19 an **Integrated Urgent Care Model** will be implemented across health and social care in Herefordshire.

Currently the local authority hospital discharge team and the Wye Valley Trust Complex discharge team are co-located and work together to support hospital discharge. However, there are vast improvements to be achieved through implementing a single, **integrated discharge team (IDT) function**. This will consist of a group of professionals, from both social care and health, who are co-located at the acute hospital and collaboratively work together to ensure the safe and timely discharge of patients. The main aims of the integrated discharge team will be:

1. To ensure that discharge planning begins at the point of admission to the hospital;
2. To ensure that outline assessments of complex patients' needs prior to discharge are undertaken;
3. To provide ward staff with support, education and training regarding discharge planning of both simple and complex patient discharges;
4. To work collaboratively with community agencies such as Continuing Health Care, Therapists, Social Services and Community Matrons to ensure that patient needs have been correctly assessed and are appropriately met on discharge;
5. To ensure the development of existing discharge services and transfer of care into community settings by developing key relationships with community services; and

6. To develop and produce discharge information and literature for our patients regarding the discharge process to assist them and prevent delays in their discharge.

The team will consist of the complex discharge team and hospital liaison team with both teams managed by the **Integrated Discharge Lead** (a jointly post funded through Herefordshire's core BCF and Wye Valley Trust)**.**



- **Integrated Community Capacity (ICC) Function**

An additional key element of the Integrated Urgent Care model is the development of an **Integrated Community Capacity (ICC) Function.** The integrated/aligned teams will provide daily community capacity information to inform the MDT and IDT of the availability of health and social care services in the community. The aligning (and ideally co-location) of the teams who inform the capacity and information will comprise of:

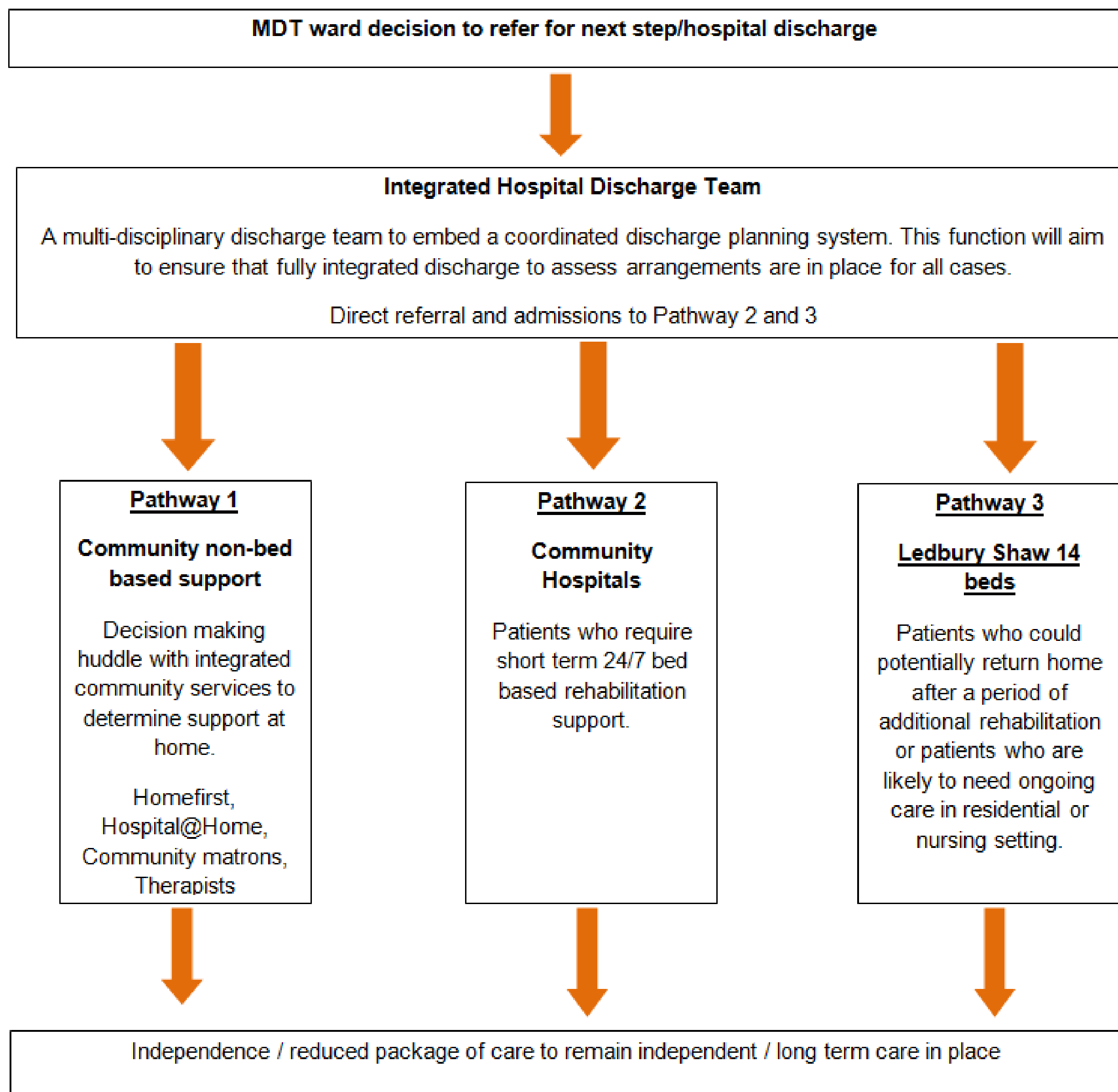
- Home First
- Hospital at Home
- AWB brokers
- Community Matrons
- Community occupational therapists and physiotherapists
- Community hospitals

The aim of the ICC will be to:

- Provide timely community capacity information to the Huddle and IDT to ensure the appropriate decision is made for discharges;
- Support with avoiding admissions to hospital;
- Support with timely discharges from hospital; and
- Support with improving the length of stay.

- **Discharge to Assess (D2A) model**

During 2017-18 partners approved Herefordshire's D2A pathway, as illustrated below. The implementation of the Integrated discharge team will facilitate the delivery of this model and assist in ensuring that D2A pathways meet the needs of all people leaving acute hospital care and that assessments for long term needs are completed at the right time and in the right setting for the individual.



- **Trusted Assessor**

The 'Trusted Approach' approach is an initiative driven by the NHS to reduce the number of delayed discharges. The underlying principle of the approach is to promote safe and timely discharges from NHS Trusts to adult social care services. The new approach allows adult social care providers to adopt and use assessments carried out while people are still in hospital, as long as the assessment was made under a suitable 'Trusted Assessor Agreement.'

A Trusted Assessor model will be implemented in Herefordshire during 2018-19, the desired outcomes of which will include:

- To reduce the number of assessments and re-assessments being carried out per person;
- To reduce the waiting time for assessments to be carried out;
- To support and facilitate timely and safe discharges from hospital to care homes, therefore reducing the number of delays in transfers of care; and
- To streamline the processes of transfer from hospital to care home.

- **Integrated Quality and Compliance function and Improving Quality in Care Homes**

  Herefordshire is experiencing a decline in the quality standards of the care homes in Hereford which adds pressure into the transfer of care system. There are currently a number of nursing homes that have compulsory or voluntary suspensions on placements due to the quality improvements required and the number of homes identified by the CQC as 'inadequate' or 'requires improvement' has increased.

  To support and improve the quality in care homes a number of strategic redesigns have been approved between the local authority, CCG and acute and community trust which will be funded by the iBCF, these include:

  - To develop a joint health and social care, care home quality team with an integrated joint team lead.
  - Investment in a robust training programme
  - To establish a rapid nurse-led intervention team that provides clinical, delivery support and guidance to homes
  - To develop a framework of providers to provide peer support and resilience
  - To develop and implement a 'nurse training programme' for senior carers to become nurses within the care home sector.

  These transformational redesigns have been approved for 18 months to support the market and the lives of the residents in Herefordshire.

Changes to national metric ambitions

As detailed in the resubmitted planning template, the following ambitions have been jointly agreed for 2018-19:

National metric	**Non-elective admissions**
Existing ambition 2018-19	16,520
Refreshed ambition 2018-19	19,596
Rationale	To align with CCG Operating Plan, as required

<table>
<tr><td>National metric</td><td>Delayed Transfers of Care (DToC)</td></tr>
<tr><td>Existing ambition 2018-19</td><td><table><tr><td colspan="4">2017/18 previously agreed plans</td></tr><tr><td colspan="4">Per day</td></tr><tr><td>NHS</td><td>ASC</td><td>Joint</td><td>Total</td></tr><tr><td>6.8</td><td>4.3</td><td>0.0</td><td>11.1</td></tr></table></td></tr>
<tr><td>Refreshed ambition 2018-19</td><td><table><tr><td colspan="4">2018/19 expectations</td></tr><tr><td colspan="4">Per day</td></tr><tr><td>NHS</td><td>ASC</td><td>Joint</td><td>Total</td></tr><tr><td>8.5</td><td>4.0</td><td>0.9</td><td>13.4</td></tr></table></td></tr>
<tr><td>Rationale</td><td>Partners across Herefordshire have agreed to align DToC ambitions to the national expectation, however it is recognised that achieving the required target will require substantial performance improvements.</td></tr>
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National metric	**Reablement**
Existing ambition 2018-19	85%
Refreshed ambition 2018-19	80%
Rationale	Expansion in client cohort due to change in ethos of service- service now open to all rather than focussed on targeted service users. 80% represents realistic stretch target based on performance since change in scheme ethos.

National metric	**Permanent admission to Residential care – no changes required**

Changes to schemes

As detailed in the resubmitted planning template, the following summary changes have been jointly agreed for 2018-19:

Herefordshire Better Care Fund Financial Summary			
Pool 1- Minimum Mandatory Fund	**Original 2018/19 Budget £**	**Revised 2018/19 Budget £**	**Change to Original Budget £**
Planned Social Care Expenditure	5,239,806	5,239,806	0
NHS Commissioned Out of Hospital Care	6,947,227	6,947,227	0
Total Minimum Mandatory Contribution from CCG	**12,187,033**	**12,187,033**	**0**
Disabled Facilities Grant (Capital)	1,852,932	1,852,932	0
Total Pool 1	**14,039,965**	**14,039,965**	**0**
Pool 2– Care Home Market Management	**Original 2018/19 Budget £'000**	**Revised 2018/19 Budget £'000**	**Change to Original Budget £**
Herefordshire CCG Contribution	8,757,286	9,564,000	806,714
Herefordshire Council Contribution	20,529,793	21,359,421	829,628
Total Pool 2	**29,287,079**	**30,923,421**	**1,636,342**
Pool 3- Improved Better Care Fund	**Original 2018/19 Budget £'000**	**Revised 2018/19 Budget £'000**	**Change to Original Budget**
IBCF Grant	4,721,971	4,721,971	0
Total Pool 3	**4,721,971**	**4,721,971**	**0**
Total Better Care Fund	**48,049,015**	**49,685,357**	**1,636,342**

The detail of changes at a scheme level are included with this annex as appendix one below

APPENDIX ONE- DETAIL OF CHANGES TO BCF BUDGET

Appendix One- D