READING HEALTH AND WELLBEING BOARD

DATE OF MEETING:	**13 JULY 2018**	**AGENDA ITEM:**	**18**
REPORT TITLE:	**INTEGRATION PROGRAMME UPDATE**		
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update on the Integration Programme – notably, progress made within the Programme itself, as well as the overall performance against target against the national BCF targets for the financial year 2017/2018.

1.2 Of the 4 national BCF targets:

- Performance against two (limiting the number of new residential placements & increasing the effectiveness of reablement services) is strong, with key targets met.
- We have not reduced the number of delayed transfers of care (DTOCs) in line with our targets, but DTOC rates since October have shown a strong downwards trajectory which represents very positive progress.
- We have not met our target for reducing the number of non-elective admissions (NELs), but work against this goal remains a focus for the Berkshire West wide BCF schemes.

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board are asked to note the general progress to date.

3. POLICY CONTEXT

3.1 The Better Care Fund (BCF) is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups (CCG) and Local Authorities to pool budgets and to agree an integrated spending plan for how they will use their BCF allocation to promote / deliver on integration ambitions.

3.2 As in previous years, the BCF has a particular focus on initiatives aimed at reducing the level of avoidable hospital stays and delayed transfers of care (DTOCs) as well a number of national conditions that partners must adhere to (including reducing the number of

non-elective admissions to hospital; reducing admissions to residential accommodation; and increasing the volume of individuals remaining at home 91 days after receiving reablement services).

4. BCF PERFORMANCE UPDATE

4.1 Please note the following in relation to performance against our national BCF targets:

DTOC

4.2 Under our 3.5% trajectory, we have aspired to no more than 240 bed days lost per month from September 2017 through to the end of March 2018.

4.3 We have not been able to meet our DTOC targets per month.

4.4 However, it is worth notice that since October there has been a decline in DTOCs per month, with 710 days lost in October, 661 in November, 493 in December, 435 in January, 413 in February and 374 in March (with a slight increase to 421 in April).

4.5 The figures of 493, 435 and 413 (a trajectory of 6.3%, 5.7% and 5.5% respectively) also represent the lowest number of DTOCs recorded in the financial year to date, and are the lowest reported number of DTOCs since April 2016 (in which 393 were reported). March's performance of 374 is lower even than that.

4.6 In terms of our local schemes' impact on the DTOC rates:

- *Community Reablement Team (CRT)* - the service appears to have engaged with 86 clients referred by acute hospital settings across the financial year. Consequently it would appear that the service may have prevented and/or reduced the impact of 86 delayed transfers of care. Given that the average length of stay in the service is 3.06 weeks (or 21.42 days), it would appear that this equates to 1842.12 delayed days avoided. Assuming a cost of £400 per NHS bed/day, this would equate to cost avoidance of £736,848.

- *Discharge to Assess (D2A)* - the service has engaged with 78 clients referred by acute hospital settings. Consequently it would appear that the service may have prevented and/or reduced the impact of 78 delayed transfers of care. Given that the average length of stay in the service is 4.5 weeks (or 31.5 days), it would appear that this equates to 2457 delayed days avoided. Assuming a cost of £400 per NHS bed/day, this would equate to cost avoidance of £982,800.

4.7 We believe that a number of factors have impacted on the DTOC performance, such as - severe winter pressures; reductions in the volume of available home care; and sometimes-limited capacity in reablement services (which is linked to the difficulties in sourcing home care for people who are ready to leave reablement services, thereby creating capacity issues for new referrals from hospitals).

4.8 We continue to proactively address DTOC performance through our the High Impact Model (HIM). We recently partook in a Local Government Association-led Peer Review of our HIM and based on the feedback, have begun collaborating with neighbouring authorities to ensure we are maximising opportunities for integration and sharing best practice in the course of implementing the High Impact Model.

Residential Admissions

4.9 Our target is to have no more than 116 new residential admissions for older people.

4.10 Based on our performance in the year to date we have had 112 new residential admissions in the financial year.

4.11 In terms of our local schemes' impact on the rate of residential admissions:

- *D2A* - 21 clients were living at home prior to entering the service, and of these 13 did not go on to a residential or nursing placement after leaving the service. The service therefore appears to have prevented 13 entrances into residential care.

4.12 This target has therefore been met (based on year-end data available at the current time).

Reablement

4.13 Our target is to maintain an average of 88% of people remaining at home 91 days after discharge from hospital into reablement / rehabilitation services; and to see 1195 people engaging with reablement (representing a 30% increase in the number of people accessing the service, compared to figures from 2016/17, during which 919 used the service).

4.14 Based on our performance to date, we have achieved an average of 93% of service users remaining at home 91 days after discharge from hospitals into our Community Reablement Service. We have also engaged with 1122 clients within our Community Reablement Service to date.

4.15 This target has therefore been met (based on year-end data available at the current time).

Non-Elective Admissions (NELs)

4.16 Our BCF target is to achieve a 0.97% reduction (expressed as 142 fewer admissions) against the number of NEL admissions seen in 2016/2017. This equates to a target of no more than 14,483 NELs in 2017-2018.

4.17 Based on our most recent performance data, we have seen 15,339 NELs across 2017-2018. This equates to an increase of 714, or 4.9%.

4.18 This target has therefore not been met.

4.19 However, in terms of the local versus national position on NELs the 4 Berkshire West CCGs are in the top 10 out of 211 CCGs for lowest numbers of NELs.

4.20 In terms of our local schemes' impact on the rate of NELs:

- *CRT* - by engaging with 126 "rapid referrals" (clients who are seen prior to hospital admission, hopefully negating the need for a non-elective admission), the service has potentially prevented up to 126 NELs[1].

- *D2A* - by engaging with 17 "rapid referrals" (14 of which did not progress onwards to hospital following discharge from the service), the service appears to have prevented 14 NELs.

[1] *Please note that further analysis is required to determine how many of these clients were subsequently admitted to hospital, in order to calculate the exact impact the service has had on NELs.*

4.21 Further actions to improve NEL performance are being progressed by the Berkshire West 10 Integration schemes that are designed to reduce NELs.

Additional local performance updates.

4.22 Please note the following successful areas of performance within CRT:

- The service aimed to support 48 "rapid referrals" across the financial year. Instead, the service has supported 126 "rapid referrals".
- The service aimed to ensure that 90% of service users found the service to be "satisfactory" or "very satisfactory". The service delivered a 99% satisfaction rate.
- The service aimed to ensure that no clients exceeded a 6 week stay with the service. On average, clients stayed with the service for 3.06 weeks.
- Please see 4.6 above for additional information re. the service's impact on DTOC rates; and 4.20 above for additional information re. the service's impact on NEL rates.

4.23 Please note the following successful areas of performance within D2A:

- The service aimed to support 88 clients across the year. Instead, the service supported 108 clients.
- The service aimed to ensure that 58% of clients remained at home 91 days after leaving the service. Based on year-end data, 75% of clients remain at home 91 days after departing the service.
- The service aimed to support 12 "rapid referrals" across the financial year; and instead supported 17.
- The service aimed to ensure that no clients exceeded a 6 week stay with the service. On average, clients stayed with the service for 4.5 weeks.
- The service aimed to have no more than 60 clients per annum readmitted to hospital following departure from the service; only 29 clients were readmitted.
- The service aimed to ensure that 90% of service users found the service to be "satisfactory" or "very satisfactory". The service delivered a 93% satisfaction rate.
- The service aimed for a 75% return rate when issuing service user feedback forms; and instead generated a 78% return rate.
- Please see 4.6 above for additional information re. the service's impact on DTOC rates; and 4.20 above for additional information re. the service's impact on NEL rates.

5. PROGRAMME UPDATE

5.2 Since March, the following items have been progressed:

- Following recruitment, 1x FTE **Performance & Data Analyst** is now in post.
- **Value for Money reports** continue to be submitted to Reading Integration Board in respect of key BCF-funded schemes. These outline the extent to which the funded

services have delivered against their remits. As part of this work, we have revised several targets for the BCF-funded CRT and D2A services, and have set more challenging goals to reflect and build upon their achievements outlined in 4.22 and 4.23 above.

- **Joint working between Adult Social Care (ASC) and North/West and South Reading GP Alliances** – an initial scoping document has been produced which outlines the standard operating procedures for a 6 month pilot, alongside a set of performance targets. Under the pilot, a multi-discipline team will be assembled comprised of representatives from Adult Social Care, Community Nursing, GPs, Primary Care, the Community Mental Health Team, Public Health and the Voluntary Sector. Monthly multi-disciplinary team (MDT) meetings will jointly review clients/patients who are referred to the MDT – with a focus on clients who are or have experienced:

    - A decline in functional Activities of Daily Living (ADL's)
    - Falls or who are at risk of falls
    - Social isolation or recent dependence on crisis social support/re-ablement or any long term social support in the last 6 months
    - Dementia or severe and enduring Mental Health illness where it is not their primary issue
    - Severe and enduring Long term conditions
    - Patients on multiple medications
    - Two or more unplanned admissions to acute hospital or intermediate care facility in previous 6 month
    - Patients who make frequent appointments with GP that could be resolved through other professionals
    - Frequent call outs to SCAS which do not need action or conveyance

    The pilot will commence in August 2018 and aims to bring key professionals together to assist in communication and prevent duplication of work, by providing a forum for multi-disciplinary discussion, risk assessment and comprehensive care planning. This will ensure that all members are valued as equal partners, while reducing the likelihood of peoples' care needs being missed. The pilot aims to produce the following outcomes:

    - Jointly support 84 clients/patients
    - Reduce the number of non-elective admissions for those clients/patients who are supported by the MDT process (based on a comparison of the number of NELs generated pre-engagement compared with post-engagement).
    - Reduce clients/patients' need to engage with primary care services (based on a comparison of the volume of primary care engagement generated pre-MDT compared with post-MDT).
    - Reduce the number of safeguarding referrals for clients/patients who are supported by the MDT process (based on a comparison of the number of safeguarding referrals generated pre-MDT compared with post-MDT).

- Conversations with stakeholders are ongoing regarding new methods of **delivering reablement** within Reading.

- Completing the year-end NHS England and iBCF/DCLG data returns for the BCF.

- Conversations with NHS England to understand national expectations regarding "**Integration by 2020**".

- Analysis of Jeremy Hunt's first speech as Health & Social Care Secretary, to understand the "**7 Key Principals**" that are likely to underpin the forthcoming Green Paper.

- Conversations with stakeholders to begin generating ideas for meeting the NHS England expectations & delivering against Jeremy Hunt's 7 Key Principals.

6. NEXT STEPS

6.1 The planned next steps for the Summer include:

- Overseeing the redesign of the BCF dashboard to provide additional clarity on the impact made by the BCF-funded schemes.
- Supporting further Berkshire West-wide discussions and working groups concerning the Berkshire West-wide implementation of the High Impact Model.
- Piloting the joint working arrangements between Adult Social Care and the North/West and South GP Alliances.
- Continuing to explore and pursue new ways of delivering reablement services.
- Developing a draft set of high-level proposals for what "wider integration" could look like (in line with Jeremy Hunt's and NHS England's expectations).

Future BCF targets for 2018/2019

6.2 NHS England have recently provided details of the proposed DTOC targets for 2018/2019. Based on a revised methodology for calculating DTOC trajectories, Reading's proposed target is to have no more than 419.75 bed days lost per month from September 2018 onwards; and to be actively working toward achieving this target between now and September 2018. Based on our recent performance, we have been frequently meeting this target.

6.3 Please note that at the current time this target is still at the "proposal" stage and has not yet been finalised. The 2018/2019 target will be confirmed in the publication of the BCF Operating Guidance for 2018/2019; which will also explain how Localities can propose changes to the additional (non-DTOC) BCF metrics (should they wish to do so).We understand that the Operating Guidance is due to be published in July 2018.

7. CONTRIBUTION TO STRATEGIC AIMS

7.1 While the BCF does not in itself and in its entirety directly relate to the HWB's strategic aims, Operating Guidance for the BCF published by NHS England states that: *The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners* […] *HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with*.

8. COMMUNITY & STAKEHOLDER ENGAGEMENT

8.1 Section 138 of the Local Government and Public Involvement in Health Act 2007 places a duty on local authorities to involve local representatives when carrying out "any of its functions" by providing information, consulting or "involving in another way".

8.2 In accordance with this duty, the Project Manager has met with Healthwatch to review and refine the existing service user engagement metrics set against the CRT, Discharge to Assess and High Impact Model schemes services, to ensure that they reflect best practice.

Meetings are ongoing to identify potential ways of improving service user feedback mechanisms.

8.3 Additionally, the Programme Manager will be meeting with Healthwatch in early May to discuss potential ways of satisfying NHSE's and Jeremey Hunt's additional expectations regarding service user engagement in the future.

9. EQUALITY IMPACT ASSESSMENT

9.1 N/A – no new proposals or decisions recommended / requested

10. LEGAL IMPLICATIONS

10.1 N/A – no new proposals or decisions recommended / requested.

11. FINANCIAL IMPLICATIONS

11.1 There was a slight underspend on BCF overall of £57,292 which represents less than 0.5% of the funding. This was made up of an overspend on the CCG components of BCF of £64k and an underspend on the LA components of BCF of £121k. The overspend on CCG components will be covered by the CCG and the underspend on LA items will, subject to agreement with the CCG, be carried forward to 2018-19 in line with provisions of the s75 agreement, for use on Better Care Fund priorities.

12. BACKGROUND PAPERS

12.1 N/A