**Southend-on-Sea Borough Council**
**Legal & Democratic Services**
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17 September 2019

**HEALTH & WELLBEING BOARD - WEDNESDAY, 18TH SEPTEMBER, 2019**

Please find enclosed, for consideration at the next meeting of the Health & Wellbeing Board taking place on Wednesday, 18th September, 2019, the following report(s) that were unavailable when the agenda was printed.

**Agenda No Item**

5. **Primary Care Networks**

This item will now be a verbal update - a list of the PCNs and who the members are in each will be provided at the meeting

6. **BCF 2019/20 (Pages 1 - 40)**

Joint Report of Deputy Chief Executive (People), Southend Borough Council and the Accountable Officer, Southend and Castle Point and Rochford CCG

7. **Dementia Community Support Model (Pages 41 – 48)**

Joint Report of Deputy Chief Executive (People), Southend Borough Council and the Accountable Officer, Southend and Castle Point and Rochford CCG

Fiona Abbott
Principal Democratic Services Officer

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# Southend Health & Wellbeing Board

**Agenda Item No.**

6

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough Council;
Terry Huff, Accountable Officer, Southend and Castle Point and Rochford CCG

to

**Health & Wellbeing Board**

on

**18 Sep 2019**

Report prepared by:
Nick Faint, Head of Integration and Partnerships, Southend Borough Council

| For discussion | X | For information only | | Approval required | |
|---|---|---|---|---|---|

**Better Care Fund**

**2019/20**

Part 1 (Public Agenda Item)

## 1 Purpose of Report

The purpose of this report is as follows;

1.1 To update members of the Health and Wellbeing Board (HWB) regarding the Better Care Fund (BCF) for 2019/20;

1.2 To note that the BCF plan 2019/20 submission will be made on 28th September 2019 and that the submission will be made to NHS England; and

1.3 To agree delegated authority to the Deputy Chief Executive (People) (Southend-on-Sea Borough Council 'SBC') and the Accountable Officer (Southend Clinical Commissioning Group 'SCCG') in conjunction with the Chair and Vice Chair of HWB to agree the BCF 2019/20 plan in accordance with the Better Care Fund Planning Requirements (published June 2019), see appendix A.

## 2 Recommendations

HWB are asked to;

2.1 note the update for BCF 2019/20;

2.2 agree priorities for setting the BCF 2019/20 plan, including the need to abide by the national BCF conditions; and

2.3 agree delegated authority to the Deputy Chief Executive (People), SBC and the Accountable Officer SCCG in conjunction with the Chair and Vice Chair of HWB to sign off the BCF plan for 2019/20 on behalf of HWB.

## 3 Background & Context

3.1 The BCF for 2017/19 was established between SCCG and SBC from 1 April 2017. It is underpinned by a legal Section 75 Agreement between the two organisations that sets out the proposed schemes to be funded, the required flows of income into the pooled budget and the distribution back to the scheme / organisational leads.

3.2 Throughout the course of 2017/19 HWB has reported quarterly BCF activity to NHS England and the LGA. The most recent return made to NHS England (31 May 2019) continued the theme of reporting that the Southend system continues to operate in challenging financial and operational circumstances but that integrated mitigations and projects are beginning to have an impact, key issues being reported were;

3.2.1 Non-elective admissions are higher than the previous year but the trend is starting to decrease;

3.2.2 Admissions to residential care is stable and is being robustly managed within the context of a challenging adult social care environment;

3.2.3 Delayed Transfers of Care (DToC) performance is good but still presents a significant challenge to both health and social care; and

3.2.4 Reablement (those still at home 91 days after discharge) is undergoing a review and a trajectory of improvement has been identified.

## 4 Southend BCF 2019/20

National

4.1 The BCF Planning requirements was published in June 2019 (see Appendix A).

4.2 The summary points for the BCF Planning Requirements are;

4.2.1 The planning cycle will move from biennial (once every two years) to annual to reflect the current national position regarding funding for social care, the status of Sustainability and Transformation Partnerships and the NHS Long Term plan. A review of the BCF was announced in June 2018 and is due to be published later this year.

4.2.2 National conditions remain the same as in 2017/19; (1) plans to be jointly agreed; (2) NHS contribution to adult social care is maintained in line with inflation ; (3) commissioning of out of hospital services; and (4) Managing Transfers of Care;

4.2.3 The additional funding announced as a result of the 2015 Spending review and 2017 spring budget additional funding will continue; the improved Better Care Fund (iBCF) provides a focus on managing transfers of care and sustaining the social care market place. Additional it

is a requirement of the BCF that the allocated winter pressures grant be pooled into the BCF pool; and

4.2.4 Metrics to measure performance will continue to focus on non-elective admissions; admissions to residential care homes; reablement; and DToC;

Principles

4.3 Since March 2019 SCCG and SBC have agreed the following principles that will be followed whilst setting the BCF 2019/20 plan, these are;

4.3.1 BCF fund is largely committed to existing community health and integrated social care activity;

4.3.2 The existing section 75 agreement will be amended to accommodate 2019/20 BCF plan;

4.3.3 All national conditions will be met, consistent with previous planning round approaches; and

4.3.4 Both SCCG and SBC will contribute the mandated funds to the BCF pool. This will be the same as all previous planning rounds with an anticipated uplift set and agreed by both Central Government and NHS England.

Financial

4.4 Within the Planning Requirements there are mandated funding streams that are to be pooled via the BCF, these are;

| | | |
|---|---|---|
| 4.4.1 | CCG Minimum Contribution | £12,875,651 |
| 4.4.2 | DFG | £1,516,820 |
| 4.4.3 | iBCF | £6,744,235 |
| 4.4.4 | Winter Pressures | £824,000 |
| 4.5 | The total Southend BCF pool | £21,960,706 |

Planning

4.6 NHS England require that the Southend BCF plan is submitted on 28th Sep 2019 the Southend BCF plan for 2019/20 will be submitted to NHS England according to the planning guidance, (Appendix A).

4.7 The Southend plan summarises the vision that Southend has in terms of delivering an integrated health and social care model via the Locality approach, reviews the 2017/19 activity and presents a plan with supporting evidence that demonstrates how the locality approach will be implemented.

4.8 The plan confirms agreement to the 4 national conditions.

4.9 Further, the plan outlines the associated financial elements for Southend BCF 2019/20, which includes income and expenditure.

iBCF

4.10 The Planning guidance at Appendix A outlines the national conditions associated with BCF. One of these conditions is that local areas are responsible for managing transfers of care.

4.11 To enable local areas to manage transfers of care a grant for adult social care (iBCF) was announced in 2015 and will continue for 2019/20.

4.12 The iBCF will be paid direct to Local Authorities via a Section 31 grant from the Department for Communities and Local Government. Conditions attached to the grant are outlined below.

4.13 The grant conditions are;

4.13.1 Grant is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and stabilising the social care provider market.

4.14 A recipient local authority must:

4.14.1 pool the grant funding into the local Better Care Fund, unless the authority has written Ministerial exemption;

4.14.2 work with the relevant Clinical Commissioning Group(s) and providers to meet National Condition 4 (Managing Transfers of Care) in the Better Care Fund Planning Requirements 2019-20; and

4.14.3 provide quarterly reports as required by the Secretary of State.

4.15 To support the planning for the allocation of iBCF the Government has updated a High Impact Change model which supports the requirements for meeting the national condition re 'Managing Transfers of Care'. The High Impact Change model outlines a number of step changes that should be considered and planned against to ensure local areas are able to manage more efficiently transfers of care.

## 5 National Assurance of the BCF plan

5.1 NHS England have delegated responsibility for assuring plans to regional level whilst maintaining responsibility for moderation.

5.2 During the period 21st October – 22nd October 2019 plans will be assured by regional representatives from both local government and NHS England.

5.3 From 22nd October plans will be moderated at both regional and national level with letters confirming either plan status early November 2019.

## 6 Reasons for Recommendations

6.1 As part of its governance role, HWB has oversight of the Southend BCF 2019/20.

## 7 Financial / Resource Implications

7.1 None at this stage

## 8 Legal Implications

8.1 None at this stage

## 9 Equality & Diversity

9.1 The BCF plan should result in more efficient and effective provision for vulnerable people of all ages.

## 10 Appendices

| | |
|---|---|
| Appendix A – 2019 – 20 Better Care Fund Planning Requirements | |
| Appendix B – Southend Better Care Fund Plan 19/20 | To follow |


5

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Department of Health & Social Care

NHS

# Better Care Fund Planning Requirements for 2019-20

**Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and NHS England**

**CONTENTS**

# PART 1 – THE BETTER CARE FUND

## Section 1 - Introduction

1. The Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2019-20. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The Framework forms part of the NHS mandate for 2019-20. The framework sets an objective for NHS England to issue these further detailed requirements to local areas on developing and implementing BCF plans for 2019-20.

2. The BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

3. BCF planning and reporting will incorporate the separate processes for iBCF and Winter Pressures grants, removing duplication in collection and reducing the reporting burden overall. This will include:

    - Incorporation of narratives into a shorter single template.
    - Removal of the requirement to submit separate plans for Winter Pressures grant.
    - Removal of separate reporting on iBCF schemes and initiatives.
    - Single format for scheme level planning and reporting.

4. This document contains the BCF planning requirements which support the core NHS Operational Planning and Contracting Guidance for 2019-20. CCGs are therefore required to have regard to this guidance by Section 14Z11 of the NHS Act 2006. It is being published jointly with Departments to disseminate it directly to local government.

5. This document also incorporates the BCF Operating Guidance, which in the previous cycle was published in a separate document. All planning and operating guidance for the BCF in 2019-20 is therefore contained in this document.

6. The framework for the Fund derives from the government's mandate to the NHS for 2019-20, issued under Section 13A of the NHS Act 2006, which sets an objective for NHS England to ring fence £3.84 billion to form the NHS contribution to the BCF. These Planning Requirements set allocations for each CCG from this ring fence and apply conditions to their use. BCF plans and their delivery should comply with these conditions as part of the delivery of CCGs' duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

### The BCF from 2020 and the NHS Long Term Plan

7. In June 2018, the government announced a review of the 'current functioning and structure of the Better Care Fund' to ensure it supports the integration of health and social care. There will be an update later this year.

8. The NHS has set out its priorities for transformation and integration through the NHS Long Term Plan, published on 7 January this year, including plans for investment in integrated community services and next steps to develop Integrated Care Systems. This includes a commitment for a new NHS offer of emergency response and recovery support through expanded multidisciplinary teams in primary care networks. This work will roll out from 2019-20. It is not a requirement that BCF funds are spent on this work, but it is expected that local areas will be considering how provision across health, local government, social care providers and the voluntary sector can support the shared aims of providing better care at or close to people's home and a clear focus on prevention and population health management.

9. The BCF in 2019-20 will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital. The continuation of the national conditions and requirements of the BCF from 2017-19 to 2019-20 provides opportunities for health and care partners to build on their plans from 2017 to embed joint working and integrated care further. This includes how to work collaboratively to bring together funding streams to maximise the impact on outcomes for communities and sustaining vital community provision.

## Section 2 - BCF Policy and planning requirements in 2019-20

10. The Better Care Fund Policy Framework for 2019-20 provides continuity from the previous round of the programme.

11. The **four national conditions** set by the government in the Policy Framework are:

    i. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed off by the Health and Wellbeing Board (HWB), and by the constituent local authorities (LAs) and CCGs.

    ii. A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.

    iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, which may include seven day services and adult social care.

    iv. A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans.

12. The Policy Framework also sets out the **four national metrics** for the fund:

    i. Non-elective admissions (Specific acute);
    ii. Admissions to residential and care homes;
    iii. Effectiveness of reablement; and
    iv. Delayed transfers of care (DToC).

13. All BCF plans must include ambitions for each of the four metrics and plans for achieving these are a condition of access to the fund. Expectations for reducing DToC will continue to be set centrally for each HWB area. The national ambition for reducing DToC is for the average daily number of people who are ready to go home, but still awaiting discharge to be less than 4,000. Local expectations set in the BCF Operating Guidance for 2018-19 have been retained. Areas that have not already achieved their local expectation should plan to achieve this as early as possible in 2019-20.

14. The main change in the BCF Planning Requirements from 2017-19 is that separate narrative plans will be replaced with a single template that will include short narrative sections covering:

    - the local approach to integration;
    - plans to achieve metrics; and
    - plans for ongoing implementation of the High Impact Change Model for Managing Transfers of Care.

## Approval of agreed plans

15. BCF plans will be approved by NHS England following a joint NHS and local government assurance process at regional level. In addition to the national conditions and the condition to set the four national metrics, NHS England is also placing the following requirements for approval of BCF plans:

    - That all funding agreed as part of the BCF plan must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
    - That all plans are approved by NHS England in consultation with DHSC and MHCLG.

16. NHS England will approve plans for spend from the CCG minimum in consultation with DHSC and MHCLG as part of overall approval of BCF plans.

17. The DFG, iBCF and Winter Pressures grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.

## Maintaining progress on former national conditions

18. BCF plans in 2017-19 were required to describe how partners would continue to build on progress against former BCF national conditions to:

    - Develop delivery of seven-day services across health and social care;

- Improve data sharing between health and social care; and
- Ensure a joint approach to assessments and care planning.

19. In 2019-20, areas should continue to make progress towards these goals.

## Section 3 - Funding sources and expenditure plans

20. It will be a condition of the BCF that plans for spending all funding elements are jointly agreed by local authority and CCG partners. Plans will need to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these requirements.

21. Scheme level spending details will need to include, where appropriate, an indication of the metric or metrics that a scheme is intended to improve. Where a planned scheme is an enabler for integration (for instance a workforce or digital integration scheme), then areas will be asked to indicate this on the spending plan (linked to the enablers identified in the Logic Model for Integrated Care) and are not required to indicate corresponding outcome metrics. Areas should also include short descriptions of schemes commissioned in the scheme level expenditure plan.

22. Areas can agree to pool additional funds into their BCF plan and associated Section 75 agreement(s). These additional contributions are not subject to the conditions of the BCF but should be recorded in the Planning Template. The mandatory contributions are set out below:

### Table 1: BCF mandatory funding sources 2019-20

| | |
|---|---|
| Minimum NHS ring-fenced from CCG allocation | £3,840 million |
| Disabled Facilities Grant (DFG) | £505 million |
| Improved Better Care Fund (iBCF) | £1,837 million |
| Winter Pressures grant | £240 million |
| **Total** | **£6,422** million |

### CCG minimum contribution

23. The mandate to NHS England for 2019-20 sets out an objective to ring-fence £3.84 billion in 2019-20 within its overall allocation to CCGs to be pooled into the BCF and subject to the conditions set out in the Policy Framework and these Operating Requirements.

24. NHS England has published allocations from this national ringfence for each CCG for 2019-20, on its website. The allocations for all mandatory funding sources are pre-populated in the Planning Template at an HWB level.

25. The allocation for each CCG includes funding to support local authority delivery of reablement, Carers Breaks and implementation of duties to fund carer support under the Care Act 2014.

26. Expenditure details in Planning Templates should set out the level of resource that will be dedicated to delivery of these activities. Reablement and other support to help people remain at home or return home from hospital with support, remain important outcomes for integration and the BCF, and are also priorities in the NHS Long Term Plan.

27. National conditions two and three apply only to the minimum funding allocation from CCGs.

**National condition two: NHS contribution to social care is maintained**

28. National condition two requires that, in each HWB area, the contribution to social care spending is maintained in line with the percentage uplifts for the CCGs that contribute to the BCF in that HWB. The uplift applies only to the CCG minimum contribution to social care and will be applied to the minimum expectation from 2018-19 for the HWB, rather than the assured contribution in 2018-19 (if this was higher than the minimum expectation). The purpose of this condition is to ensure that support from the NHS for social care services with a health benefit is maintained in line with the overall growth in the CCG minimum contribution to the BCF.

29. As in 2017-19, the minimum expectations will be confirmed in the BCF Planning Template. Any schemes where the spend type is 'social care' and the funding source is the CCG minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. CCGs and councils can agree larger contributions, where this will deliver value to the system and is affordable.

**National condition three: Agreement to invest in NHS-commissioned out-of-hospital services**

30. A minimum of £1.091 billion of the CCG contribution to the BCF in 2019-20 is ring-fenced to deliver investment or equivalent savings to the NHS, while supporting local integration aims. Each CCG's share of this funding is set out in allocations and will need to be spent as set out in the national condition. This condition will be assured through the Planning Template, based on spend allocated to primary, community, social care or mental health care, that is commissioned by CCGs from the CCG allocation.

**Grant Funding to local government to be pooled into BCF plans**

31. The DFG, iBCF and Winter Pressures grant monies are paid directly to local authorities under Section 31 of the Local Government Act 2003, with specific grant conditions, including a requirement that the funding is pooled in the BCF. Allocations will be pre-populated in the Planning Template. The conditions for individual grants are set out below.

**Improved Better Care Fund**

32. The Grant Determination issued in April 2019 sets out that the purposes will replicate those from 2017-18 and 2018-19 – and therefore that the funding be used for:
    - meeting adult social care needs;
    - reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
    - ensuring that the local social care provider market is supported.
33. The grant conditions for the iBCF also require that the local authority pool the grant funding into the local BCF and report as required.

34. iBCF funding can be allocated across any or all of the three purposes of the grant in a way that local authorities, working with CCG(s) determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the three purposes. The funding does not need to be directed to funding the changes in the High Impact Change Model (HICM). This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

35. Since April 2018, reporting on the iBCF has been incorporated into the main BCF reports and this will continue for 2019-20.

**Winter Pressures Funding**

36. The Grant Determination for Winter Pressures funding was issued in April 2019. In 2019-20, the Grant Determination sets a condition that this funding must be pooled into BCF plans. The grant conditions also require that the grant is used to support the local health and care system to manage demand pressures on the NHS with particular reference to seasonal winter pressures. This includes interventions that support people to be discharged from hospital, who would otherwise be delayed, with the appropriate social care support in place, and which help promote people's independence. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

37. Each BCF plan should set out the agreed approach to use of the Winter Pressures grant, including how the funding will be utilised to ensure that capacity is available in Winter to support safe discharge and admissions avoidance. The BCF process will ensure that the use of this money has been agreed by plan signatories and the HWB, confirmed in the Planning Template.

38. Details of planned schemes and expenditure should be confirmed in the Planning Template. Reporting on the grant will be through the main BCF process.

**Disabled Facilities Grant**

39. The DFG continues to be allocated through the BCF. Areas should think strategically about the use of home adaptations, the use of technologies to support people to live independently in their own homes for longer, and to take a joined-up approach to improving outcomes across health, social care and housing. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans and strategic use of the DFG can support this.

40. Innovation in this area could include combining DFG and other funding sources to create fast-track delivery systems, alongside information and advice services about local housing options. Local housing authority representatives and DFG leads should have a clear role in developing and agreeing BCF plans, supporting closer integration of housing, social care and health services.

41. DFG will continue be paid to upper-tier authorities. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore, each area will need to ensure that sufficient funding is allocated from the DFG monies in the pooled budget to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

42. In two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government must be passed down to the relevant housing authorities (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans.

43. During these discussions, it will be important to continue to ensure that local needs for aids and adaptations are met, while also considering how adaptation delivery systems can help meet wider objectives around integration. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

    - The funding is included in one of the pooled funds as part of the BCF;
    - The funding supports a strategic approach to housing and adaptations that supports the aims of the BCF; and
    - The use of the funding in this way has been developed and agreed with relevant district housing authorities.

44. Since 2008-09, the scope for how DFG funding can be used includes to support any LA expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding for wider purposes.

45. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. For example, LAs could use an alternative means test, increase the maximum grant amount, or offer a service which rapidly deals with inaccessible housing and the need for quick discharge of people from hospital. The Care Act also requires LAs to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

46. The government commissioned an independent review of the DFG in February 2018. The review was published in December 2018 and makes 45 detailed recommendations. The government is carefully considering the review and will respond to its findings in due course.

## PART 2 – COMPLETING BCF PLANS

### Section 4 - The Planning Template

47. BCF plans must meet all four national conditions of the Fund, as set out in the Policy Framework and operationalised by the conditions and requirements contained in this document. Under national condition one**,** local government and CCGs are required to agree a plan for use of the pooled funding in the BCF for 2019-20. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans.

48. Local partners are required to develop a joint spending plan that meets the national conditions and planning requirements. In developing BCF plans for 2019-20, local partners will be required to develop, and agree, through the relevant HWB(s) a completed Planning Template, including:

- A narrative on the approach to integration of health and social care, highlighting key changes from 2017-19;
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
- A scheme-level spending plan demonstrating how the fund will be spent and compliance with national conditions two and three;
- A brief description of the overall approach to progressing the implementation of HICM along with the planned level of implementation for each of the changes; and
- Quarterly plan figures for the national metrics on effectiveness of reablement and admissions to residential care. Metrics for non-elective admissions will be mapped directly from CCG operational plans. Areas will be expected to achieve and maintain DToC expectations agreed between NHS England and Departments, pre-populated in individual Planning Templates. Brief narratives describing how elements of the overall HWB plan will impact these metrics are required to accompany the plan figures set out on the template.

### Completing the Planning Template

### Narratives

49. BCF narrative plans for 2017-19 set out how CCGs and local government were making progress towards integration by 2020, both through BCF funded schemes and more widely. The agreed BCF narrative will be collected through the Planning Template for 2019-20 and it is expected that they will be shorter and focussed on updates to 2017-19 plans.

50. As in 2017-19, BCF plans should represent the joint plan for integration of health and social care locally, with clear governance through the HWB. The narrative sections of the template should confirm these arrangements, particularly highlighting how these have developed since 2017-19. Where a single narrative is agreed across two or more HWB areas, for instance to reflect jointly agreed approaches across a wider geography (for example, Sustainability and

Transformation Partnership (STP)/Integrated Care System (ICS)), this narrative can be submitted in the template of one of the HWBs. Separate Planning Templates will still need to be submitted for all HWBs, with completed expenditure, metrics and confirmations tabs, to enable assurance of the national conditions on behalf of NHSE and Departments.

51. All confirmations of compliance with the requirements will be collected nationally through the Planning Template. Guidance on completing these are included in the Planning Template.

52. Narratives will need to describe:

- The approach to joining up care around the person.
- Approaches to joint commissioning and delivery of health and social care at HWB level.
- How the BCF plan and relevant elements of the STP/ICS plan align, including any jointly owned outcomes.

**Joining up care around the person**

53. Plans should set out the approach locally to person centred care. This may include single assessments, personal budgets, and Integrated Personalised Commissioning (IPC). There is no specific requirement to fund particular types of activity through the BCF, but the agreed local approach and links to these agendas should be set out in the narrative section. Further information on IPC is set out below.

**Integrated Personalised Commissioning**

Building on the learning from IPC, NHS England published their vision for personalised care in January 2019. This includes a comprehensive model for personalised care that brings together 6 key components. The components are:-

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets.

There are currently 21 demonstrator sites including three integration accelerator sites (Lincolnshire, Nottinghamshire and Gloucestershire) who are implementing this model and learning will be shared as soon as available on NHS England website.

Some examples from the programme include:

- In Lincolnshire, Nottinghamshire, and Gloucestershire, the council and the NHS are introducing joined-up assessment and personalised

care and support planning for people who have health and social care needs.

- Tower Hamlets are working across health and social care to provide people with integrated provision of wheelchairs and home equipment
- Gloucestershire and Hampshire, the NHS and local government are working together to train staff to deliver personalised care.

Other parts of the country are encouraged to consider this approach and how they can plan to support the roll out of this comprehensive model including joint working to expand the use of joint assessments and care and support planning, integrated personal budgets and expand social prescribing schemes in partnership with primary care networks.

**HWB level plans**

54. Plans should set out the high-level approach to integrated care in the area. This could include:

- Approaches to joint commissioning
- Delivery of integrated care, preventative services and population health management.
- Approaches to integration with housing and other local services, including work with the local voluntary sector.

**Links to system level plans**

55. Narrative plans should set out the alignment locally between the BCF plan and the STP or STPs it overlaps.

56. The NHS Long Term Plan sets out how STPs and ICSs should work with local government to plan and commission health and care services at 'place' level – usually HWB level, including shared decisions on the use of resources. This will include production of five-year plans by each ICS and STP in 2019. The expectation is that local systems will align these geographies in a way that makes sense in relation to local authority and health boundaries. The Long Term Plan sets an expectation that all ICSs will have a partnership board that includes representation from local government and that ICSs and HWBs will work closely together. One key consideration should be how data and information will be made accessible and shared across sectors.

**Continuing to address inequalities in BCF plans**

57. Local partners should continue to consider how the activities in their BCF plan will address health inequalities in the area in line with duties in the Health and Social Care Act 2012, and reduce inequalities for people with protected characteristics under the Public Sector Equality Duty in the Equality Act 2010, building on approaches agreed in 2017-19 plans. Local strategies for reducing inequalities across the constituent organisations can be referenced where appropriate, but the narrative plan must include a short overview of any priorities and investment to address inequalities.

## Implementation of the High Impact Change Model for Managing Transfers of Care

58. National condition four requires health and social care partners in all areas to work together to:

    - Agree a clear plan for managing transfers of care and improved integrated services at the interface of health and social care that reduces DToC, encompassing the HICM, and home based intermediate care (including reablement).
    - Continue to embed the HICM.

59. In the HICM section of the Planning Template, areas should set out the current state of implementation for each of the eight changes in the model and the planned level of implementation by March 2020. Areas should agree a narrative describing the priorities and actions for 2019-20 to embed the model, including:

    - Details of changes;
    - Anticipated improvements to care and discharge, minimising delays and ensuring that as many people as possible are discharged safely to their normal place of residence.

60. Areas were expected to implement the model during 2017-19 as part of the BCF planning and operational requirements, and should be able to confirm that each of the eight changes are at least established. If this is not the case for any of the changes, the plan should set out what is being done to ensure that the relevant change is implemented as soon as possible.

61. Where all parties in an area have implemented a variation on the model (for example if an existing, successful, approach would be duplicated by elements of the change model) the plan should briefly explain the rationale for this, that sets out how the aims of the specific change are met. All partners, including relevant A&E Delivery Boards, should be involved in agreeing the approach.

62. The LGA, Association of Directors of Adult Social Services (ADASS), NHS England and NHS Improvement and Government are reviewing the HICM and a new version will be published later in the year. For the purposes of the BCF in 2019-20, areas should set out their plans against the existing model.

## Developing approaches to managing transfers of care

63. In 2017-18, the Better Care Support programme commissioned Newton, to work with nine HWBs in 14 health and care systems experiencing persistent challenges with levels of DToC. In addition to the specific diagnostic, planning and improvement work done in these systems, the findings have been brought together into a report '[People First, manage what matters]'.

64. The report makes several recommendations for all areas to consider:

    - Ensure that those making decisions about people's discharge from acute settings have robust, timely and accurate information about the flow and capacity within the entire system (enabled by interoperability, data and information sharing between health and social care).

- Question the outcomes achieved for people once discharged.
- Put rigorous systems of outcome measuring and monitoring in place.
- Assess the effectiveness of system-wide leadership.
- Ensure that the mechanisms of governance in place are aligned with the outcomes the system is seeking to achieve.
- Align resource allocation with achieving the best outcomes for people, rather than with current patterns of discharge decision-making.

65. Local areas are encouraged to take these recommendations into account in developing their ongoing implementation of the HICM.

**Reablement and the NHS Long Term Plan**

66. The Long Term Plan outlines how the NHS, over the next five years, will be implementing the commitments to invest in reablement, crisis response and intermediate care services, to increase their responsiveness and reduce delays in people receiving the right care in the right place. The NHS has set itself a target for services to be in place to support people within two days for reablement and two hours for crisis response. These targets are not BCF conditions, and areas are not required to implement any specific schemes or allocate BCF funds to their implementation in 2019-20. Local health systems will need to continue to work with social care colleagues to deliver these commitments over the coming years and agree the approach to commissioning and co-ordination to ensure that these services are in place and deliver the best outcomes for individuals who need them.

**Further guidance**

67. There is an increasing range of material available to support local systems with the practical development of joint integration strategies and integrated services. The NHS England Integrating Better project recently produced a practical guide based on learning from 16 areas, which is available to health and care practitioners as part of the STP/ICS library of good practice. The LGA also provide a range of support, tools and case studies, such as through the recently published evidence review and case studies of integrated care or the support provided through its Care and Health Improvement Programme. Further guidance includes:

- BCF ‘How to’ guides are available on the BCF pages of the NHS England Website;
- Guidance supporting the High Impact Change Model, which can be found on the LGA website;
- A series of ‘Quick guides’ from NHS England to support health and social care systems;
- The Logic Model for Integrated Care, developed by the Social Care Institute for Excellence on behalf of government.

## Expenditure plans

68. The Planning Template will include the scheme-level spending plan for the use of the full value of the budgets pooled through the BCF. These plans will need to include:

    - area of spend;
    - scheme type;
    - commissioner type;
    - provider type;
    - funding source;
    - the metrics that the scheme is intended to influence;
    - total 2018-19 investment (if existing scheme);
    - total 2019-20 investment;
    - the anticipated number of beneficiaries (for certain schemes).

69. To understand and account for the impact of funding committed to the BCF, the Policy Framework makes a commitment that more information on the impact of the BCF will be collected, through the planning process. The BCF Planning Template for 2019-20 will collect this through:

    - Clear narratives on the four national metrics describing the activity that is being commissioned through the BCF to support achieving these ambitions, including preventative approaches.
    - Scheme level data to indicate the metric(s) or integration enablers that schemes are intended to impact on (where appropriate).
    - Planned outputs from certain scheme types (comprising significant spend areas that have easily definable outputs).

70. Detailed instructions on completing this are included in the guidance section of the Template.

71. Expenditure plans must include indicative outputs for the scheme types listed in Table 2.

**Table 2: Output measures for selected BCF scheme types.**

| Service | Unit |
|---|---|
| Domiciliary care | Packages/hours of care |
| Reablement/rehabilitation | Packages/hours of care |
| Bed-based intermediate care Step up/step down | Number of beds |
| Residential placements | Placements |
| Personalised care at home | Packages |

72. There will be an option to select the output unit that is relevant to the scheme – for instance for a domiciliary care scheme this might be total hours or number of packages planned. Plans will not need to show additional packages.

73. As the Planning Template is now collecting more information on the outputs expected from schemes, iBCF reporting will be significantly reduced. Local authority finance directors have still been asked to certify that the iBCF grant is being used exclusively on adult social care in 2019-20.

74. This information will not be used to make judgements on value for money or to make assurance decisions, but will be used to understand how the BCF is used and the levels of activity it supports. National partners recognise that further work is needed to improve measurements of the impact of integrated approaches through the BCF. They will work with local areas to develop models to inform future programmes.

75. CCGs should ensure that these returns mirror their operational planning returns for 2019-20, submitted through central UNIFY and finance return templates. This will include some of the same data, for example funding contributions and baseline Non-elective admission metrics agreed in the CCG operational plans. There will be a national reconciliation process to ensure the data provided matches in all cases.

**Section 5 - National metrics**

76. The BCF Policy Framework confirms that the existing four national metrics will continue as conditions for the fund. The metrics are:

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

77. Information on all four metrics will continue to be collected nationally. The table below sets out a summary of the information required and where this will be collected. The detailed definitions of all metrics are set out in Appendix 2.

**Table 3: National Metrics**

| Metric | Collection method | Data required |
|---|---|---|
| Non-elective admissions (Specific acute) | • Collected nationally through UNIFY at CCG level<br>• HWB level figures confirmed through BCF Planning Template | Quarterly HWB level activity plan figures for 2019-20. |
| Admissions to residential and care homes | • Collected through nationally developed high level Planning Template | Plans should confirm an annual metric for 2019-20 |
| Effectiveness of reablement | • Collected through nationally developed high level Planning Template | Plans should confirm an annual metric for 2019-20 |

| Metric | Collection method | Data required |
|---|---|---|
| Delayed transfers of care | • Collected nationally through UNIFY at CCG level<br>• HWB level figures confirmed through the Planning Template | Local expectations will be set at HWB level and prepopulated in the metrics tab of each HWB Template. |

**Metric plans**

78. BCF plans must include narratives that describe how the schemes and enabling activity for health and social care integration in the agreed BCF plan will support the delivery of each metric.

79. These narratives should include any significant changes from 2017-19 plans, including any schemes that have been decommissioned or planned new schemes.

**Non-elective admissions (NEAs)**

80. The detailed definition of the NEA metric is set out in the Planning Round Technical Definitions. Figures submitted in CCG operating plan returns have been pre-populated into the Template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for reducing NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

**Delayed transfers of care**

81. The BCF Policy Framework for 2019-20 retains the centrally set expectation for reducing DToC nationally to below 4,000 delays per day across England. The expectations set for HWBs for 2018-19 in the BCF Operating Guidance 2017-19 have been retained and are pre-populated in each area's Planning Template. Where an area has not met their expectation, they should ensure that there are plans in place to do so as soon as possible. Where areas have already met these expectations, they should continue to implement joint plans to manage discharge and flow to minimise delays.

82. Progress in reducing DToC will continue to be monitored regularly by national partners. Support for areas experiencing significant challenges (and areas keen to further improve and innovate) will continue to be provided through the Better Care Support offer based on performance over time, taking into account the overall rate of delays as well as the distance from BCF plan expectations. This will include a review of progress prior to Winter.

83. Narratives for implementing the HICM and reducing DToC must set out how CCGs, LAs, NHS providers of acute, community and mental health bed-based services and providers of social care will work together to achieve the DToC expectation. Local plans should focus on system wide approaches to ensuring that people are discharged in a safe and timely way to the most appropriate setting, taking account of guidance referenced in Section 4 of this document.

84. Expectations for reducing DToC in 2019-20 are articulated as a single HWB ambition and have not been split into separate NHS and social care expectations. This is intended to support joint working and accountability at system level and BCF plans should describe how these ambitions will be met locally through integrated, collaborative approaches.

## PART 3 - ASSURANCE, APPROVAL AND INTERVENTION

### Section 6 - Local plan development, sign off and assurance

85. Plans will be assured and moderated regionally, which will be a joint NHS and local government process. Recommendations for approval of BCF plans will be made following cross regional calibration of outcomes to ensure consistent application of the requirements nationally. From April 2019, the NHS has moved to a new regional structure with integrated NHS England and NHS Improvement regional offices. Moderation of HWB BCF plans will be carried out at the new NHS regional footprint, with full involvement of local government.

86. The main Planning Requirements included in this document (summarised on Appendix 1) and a set of underpinning key lines of enquiry (KLOE) have been produced to support a consistent assurance process. These will be available to local areas on the planning requirements confirmations sheet within the Planning Template.

87. The Better Care Support team (BCST) will provide a range of resources to help local areas develop their plans, including signposting to support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice. Better Care Managers (BCMs) will provide practical support and advice during the planning process.

88. The assurance of plans will be a single stage, with an assessment of whether a plan should be approved or not approved. Plans should be submitted by 27 September 2019, having been approved or scheduled to be approved by the relevant HWB(s).

89. Areas are asked to send their Planning Template to their BCM, copied to england.bettercaresupport@nhs.net. The BCST will collate data from the Planning Template to assist regional assurance. If an agreed plan is not submitted by the deadline, the BCSt will work with the local BCM to agree appropriate support for the area to agree a plan promptly. Areas will be expected to take up this support. If it appears that a plan is unlikely to be agreed locally within a reasonable timeframe, formal escalation will be considered.

90. The assurance process, including reconciling any data issues, will be a joint NHS England and local government process. Local government has been funded to carry out assurance via regional local government leads. BCMs and the BCST will work with these teams to ensure they are fully briefed on the requirements of the BCF for 2019-20 and have capacity in place to participate in the process. The confirmations sheet in the Planning Template sets out the main planning requirements for the BCF and associated KLOEs. NHS regional finance teams will be involved in assurance, particularly in assuring that larger increases to social care from the CCG minimum contribution are affordable and present value to the NHS.

### Calibration and plan approval

91. Following regional assurance and moderation, the BCST will co-ordinate a cross-regional calibration exercise with regional colleagues to provide assurance that plans have been assured in a consistent way across England. The BCST will

provide data on provisional assurance outcomes and facilitate the cross-regional discussion to agree a consistent approach to assurance outcomes across all regions. This may result in regions being asked to revisit recommendations from assurance panels where it is agreed that the requirements have not been applied consistently. Following this, recommendations and advice for approval will be provided to DHSC and MHCLG and then to NHS England for approval of spending plans from the CCG minimum contribution.

**Table 4: BCF assurance categories**

| Category | Description |
|---|---|
| Approved | • Plan agreed by HWB.<br>• Plan meets all national conditions.<br>• Agreement on use of local authority grants (DFG, iBCF and Winter Pressures).<br>• Metrics are set and plans agreed for delivery of these metrics.<br>• No or only limited work needed to gather additional information on plan – where there is no impact on national conditions or metrics. |
| Not approved | • One or more of the following apply:<br>  • Plan is not agreed.<br>  • One or more national conditions not met.<br>  • No local agreement on use of local authority grants (DFG, iBCF and Winter Pressures).<br>  • Plans not agreed for delivery of metrics. |

92. Formal approval of BCF plans and authorisation for CCGs to use the CCG minimum element of the BCF will be given by NHS England, following agreement with DHSC and MHCLG that all conditions are met. These decisions will be based on the advice of the assurance process set out above. Where plans are not initially approved, the BCST may implement a programme of support, with partners, to help areas to achieve approval as soon as possible or consider placing the area into formal escalation.

93. Following formal approval, CCG funding agreed within BCF plans must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.

**Section 7 - Intervention and escalation**

94. Escalation will be considered in the event that:
    - CCGs and local authority are not able to agree and submit a plan to their HWB; or
    - The HWB do not approve the final plan; or
    - Regional assurers rate a plan as ‘not approved’.

95. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. This will initially be a regional process. If regional escalation is not able to address the outstanding planning requirements, senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to a National Escalation Panel meeting to discuss concerns and identify a way forward.

96. If a plan is not approved, the area should not proceed with the signing of a Section 75 agreement in relation to NHS monies.

**Section 8 - Monitoring continued compliance with the conditions of the fund**

97. BCMs and the wider BCST will monitor continued compliance against the national conditions (including the metrics) through the BCF reporting process described below and their wider interactions with local areas.

98. If an area is not compliant with any of the conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan resulting in a risk to meeting the national conditions, or if performance against metrics is problematic, the BCST, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be appropriate to the risk or issue identified.

99. It is recognised that owing to various circumstances, places may wish to amend plans in-year to:

- Modify or decommission schemes
- Increase investment or include new schemes.

100. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the LA and the CCGs and continue to meet the conditions and requirements of the BCF. A jointly agreed and HWB approved resubmission of an updated BCF Planning Template with an accompanying rationale will be required. If the need arises to amend BCF plans in-year please contact the relevant BCM in the first instance.

101. The intervention and escalation process (outlined in subsequent sections) ultimately leads to NHS England exercising its powers of intervention provided by NHS Act 2006, in consultation with DHSC and MHCLG, as the last resort.

**Section 9 - Reporting in 2019-20**

102. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

103. To serve these purposes, areas are required to provide quarterly reporting for the BCF over 2019-20 in relation to the CCG minimum contribution and the Winter Pressures grant.

104. These reports are discussed and signed-off by HWBs (or with appropriate delegation) as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into s.75 agreements. Monitoring will include confirmation that s.75 agreement is in place.

105. The reporting template will be made available to the local systems with associated guidance and timetables via the Better Care Exchange, an online platform that all Better Care leads are able to access.

**Section 10 – Timetable for planning and assurance**

106. The submission and assurance process will follow the timetable below:

**Table 5: 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 |

## Appendix 1 - BCF planning requirements

| Condition/Requirement | Collection method | Assurance approach |
|---|---|---|
| Jointly agreed plan including;<br>• Confirmation of funding contributions<br>• National conditions<br>• Scheme level spending plan | Collected through single Planning Template, submitted to Better Care Managers and copied to england.bettercaresupport@nhs.net | Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level, supported by collation and analysis of data on national conditions and expenditure plans carried out nationally. |
| National Metrics | Submitted through UNIFY (NEA) and through the Planning Template (Effectiveness of Reablement and Residential admissions) | Collated and analysed nationally, with feedback provided to relevant NHS teams and local government assurers for regional moderation and assurance process.<br><br>Regional assurance will also confirm that the area has a coherent plan for achieving these metrics. |

## Appendix 2 - Specification of Better Care Fund metrics

### Metric One: Total Non-elective spells (specific acute) per 100,000 population

| | |
|---|---|
| **Outcome sought** | A reduction in the number of unplanned acute admissions to hospital. |
| **Rationale** | Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings. |
| **Definition** | **Description**: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population.<br><br>Numerator:<br>Number of specific acute non-elective spells in the period.<br><br>Data definition:<br>A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider.<br><br>Number of specific acute hospital provider spells for which:<br><br>• Der_Management_Type is 'EM' and 'NE'<br><br>**Where** 'EM' = Emergency and 'NE' = Non-Elective<br><br>Please refer the Joint Technical definitions for Performance and Activity (2019-20) and see Appendix A- SUS Methodology for details of derivations and Appendix B for full list of Treatment Function Code categorisation.<br><br>**Denominator:** ONS mid-year population estimate for all ages (mid-year projection for population |
| **Source** | Secondary Uses Service NCDR(SEM) – SUS+ NCDRis derived from SUS+ (SEM) and not the SUS+ PbR Mart. Adjustments are made to the data to correct for improbably high or low data points and ensure a consistent time series; this is in line with monthly activity reporting within NHS England.<br>For more details see Joint Technical definitions for Performance and Activity (2019-20).<br><br>Population statistics (ONS) |
| **Reporting schedule for data source** | Collection frequency: Numerator collected monthly (aggregated to quarters for monitoring).<br>Denominator is annual.<br><br>Timing of availability: data is available approximately 6 weeks after the period end. |
| **Historic** | From 2017-18, total number of specific acute non elective spells replaces non elective (general and acute) episodes metric |

**Metric Two: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population**

| | |
|---|---|
| **Outcome sought** | Overarching measure: Delaying and reducing the need for care and support. |
| **Rationale** | Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation. |
| **Definition** | **Description**: Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes.<br><br>**Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital<br><br>**Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection. |
| **Source** | Adult Social Care Outcomes Framework:<br>NHS Digital (SALT)<br><br>Population statistics (ONS) |
| **Reporting schedule for data source** | Collection frequency: Annual (collected Apr-March)<br><br>Timing of availability: data typically available 6 months after year end. |
| **Historic** | Data first collected 2014-15 following a change to the data source. |

**Metric Three: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**

| | |
|---|---|
| **Outcome sought** | Delaying and reducing the need for care and support<br>When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence. |
| **Rationale** | There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.<br><br>This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement. |
| **Definition** | The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.<br><br>**Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator.<br><br>The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator.<br>This data is taken from SALT collected by NHS Digital.<br><br>**Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).<br><br>The collection of the denominator will be between 1 October and 31 December.<br><br>This data is taken from SALT collected by NHS Digital<br><br>Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital. |
| **Source** | Adult Social Care Outcomes Framework |
| **Reporting schedule for data source** | Collection frequency: Annual (although based on 2x3 months data – see definition above)<br><br>Timing of availability: data typically available 6 months after year end. |
| **Historic** | Data first collected 2011-12 (currently five years data final available (2011-12, 2012-13, 2013-14, 2014-15 and 2015-16) |

**Metric Four: Delayed transfers of care from hospital per 100,000 population**

| | |
|---|---|
| Outcome sought | Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. |
| Rationale | This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care.<br><br>The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF. |
| Definition | Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)*<br><br>A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.<br><br>A patient is ready for transfer when:<br><br>(a) a clinical decision has been made that the patient is ready for transfer AND<br>(b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND<br>(c) the patient is safe to discharge/transfer.<br><br>**Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period*<br><br>**Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population)<br><br>*Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month. |
| Source | DToCs (NHS England)<br><br>Population statistics (ONS) |
| Reporting schedule for data source | Collection Frequency: Numerator collected monthly (aggregated to quarters for monitoring).<br>Denominator is annual.<br>Timing: data is published approximately 6 weeks after the period end. |
| Historic | Data first collected Aug 2010 |

## Appendix 3 - Support, escalation and intervention

Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCST and BCM will take steps to return the area to compliance. Broadly this will involve the following steps:

| | |
|---|---|
| 1. **Trigger** –<br>a. Concern during planning process that a compliant plan will not be agreed<br>b. BCF plan not submitted<br>c. BCF plan submitted does not meet one or more planning requirement | The BCM and regional partners in consultation with the BCST will consider whether to recommend specific support or if the area should be recommended for escalation.<br><br>Initially support may be appropriate or a defined timescale set for the issue to be rectified. |
| 2. Informal support | If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or local government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting. |
| 3. Formal Support | The BCM will work with the BCST to agree provision of support. |
| 4. Formal regional meeting | Areas will be invited to a formal meeting with regional NHS and local government representatives and the BCST to discuss the concerns, plans to address these and a timescale for addressing the issues identified. |
| 5. **Commencing Escalation** as part of non-compliance | If, following the regional meeting, a solution is not found or issues are not addressed in the timescale agreed, escalation to national partners will be considered.<br>If escalation is recommended, BCF national partners will be consulted on next steps.<br><br>To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-compliance and informing the parties of next steps, including date and time of the Escalation Panel. |

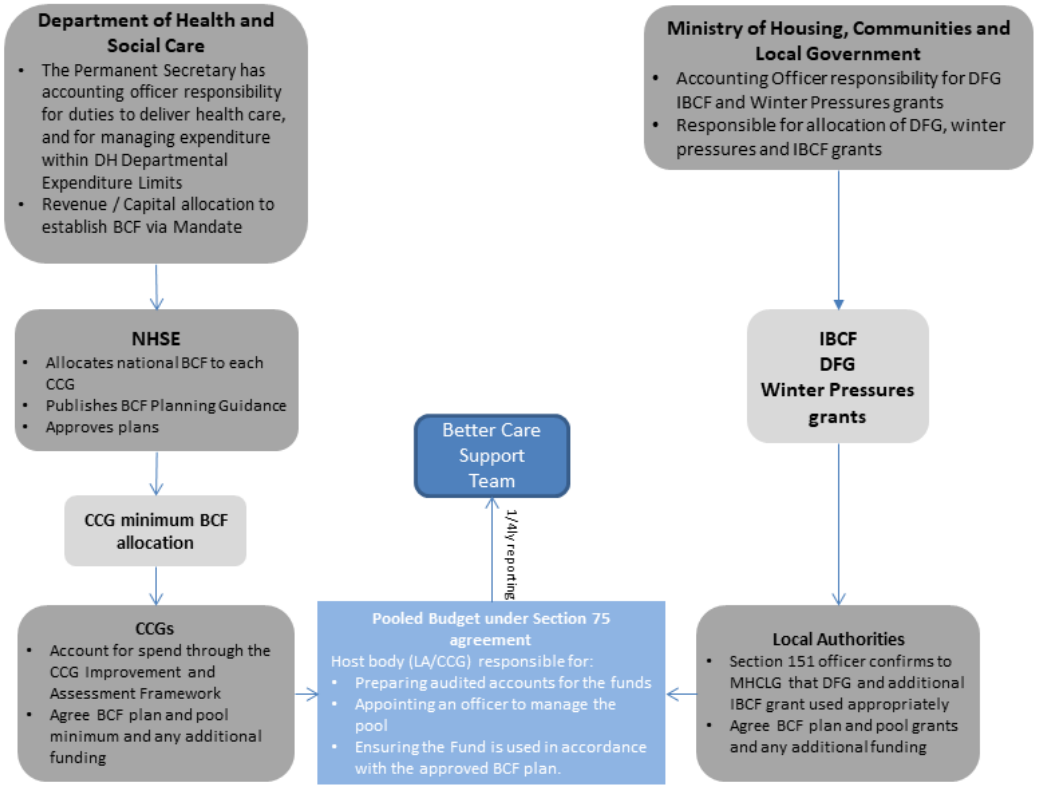
| | |
|---|---|
| 6. The **Escalation Panel** | The Escalation Panel will be jointly chaired by MHCLG and DHSC senior officials, supported by the BCST, with representation from:<br>• NHS England<br>• LGA<br><br>Representation from the local area needs to include the:<br>• Health and Wellbeing Board Chair<br>• Accountable Officers from the relevant CCG(s)<br>• Senior officer(s) from LA |
| 7. **Formal letter and clarification** of agreed actions | The local area representatives will be issued with a letter, summarising the Escalation Panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the Escalation Panel, an update on what support will be made available will be included. |
| 8. **Confirmation** of agreed actions | The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCST. |
| 9. Consideration of **further action** | If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include:<br>• Agreement that the Escalation Panel will work with the local parties to agree a plan.<br>• Appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan.<br>• Appointment of an advisor to develop a compliant plan, where the Escalation Panel does not have confidence that the area can deliver a compliant plan.<br>• Appointment of an advisor or support to address performance issues, including progress towards agreed DToC metrics.<br>• Withholding BCF payments that are due to be made. |

| | |
|---|---|
| | • Directing the CCG as to how the minimum BCF allocation should be spent.<br><br>The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off. |

NHS England has the ability to direct the use of the CCG funds where an area fails to meet one of the BCF conditions and NHS England considers that the CCG(s) in question is failing, has failed or is at significant risk of failing to discharge any of its functions. This includes the duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006. If a CCG fails to develop a plan that can be approved by NHS England or if a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DHSC and MHCLG ministers. The final decision will then be taken by NHS England. Once a decision has been taken any directions would be made under Section 14Z21 of the NHS Act 2006.

The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG, Winter Pressures or iBCF. This money is not subject to NHS England powers to direct. A BCF plan will not be approved, however, if there is not agreement between health and local government partners on the use of these grants (a requirement of national condition one). Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

## Appendix 4 – Funding flows and accountability



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# Southend Health & Wellbeing Board

Agend
Item No

7

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough Council;
Terry Huff, Accountable Officer, Southend and Castle Point and Rochford CCG

to

**Health & Wellbeing Board**

on

**18 Sep 2019**

Report prepared by:
Nick Faint, Head of Integration and Partnerships, Southend Borough Council

| For discussion | X | For information only | | Approval required | |
|---|---|---|---|---|---|

**Dementia Community Support Model**

**2019/20**

Part 1 (Public Agenda Item)

## 1 Purpose of Report

The purpose of this report is as follows;

1.1 To update members of the Health and Wellbeing Board (HWB) regarding potential plans for remodelling the Dementia Community Support Model (Appendix A) for 20/21;

1.2 Seek the views from HWB board members on the proposed dementia community support model.

1.3 To note that the model is still to be approved at Clinical Executive Committee and Governing Body for both Southend and Castle Point and Rochford CCGs.

## 2 Recommendations

HWB are asked to;

2.1 Note the update for Dementia Community Support model for 20/21;

2.2 Give their views on the proposed dementia community support model.

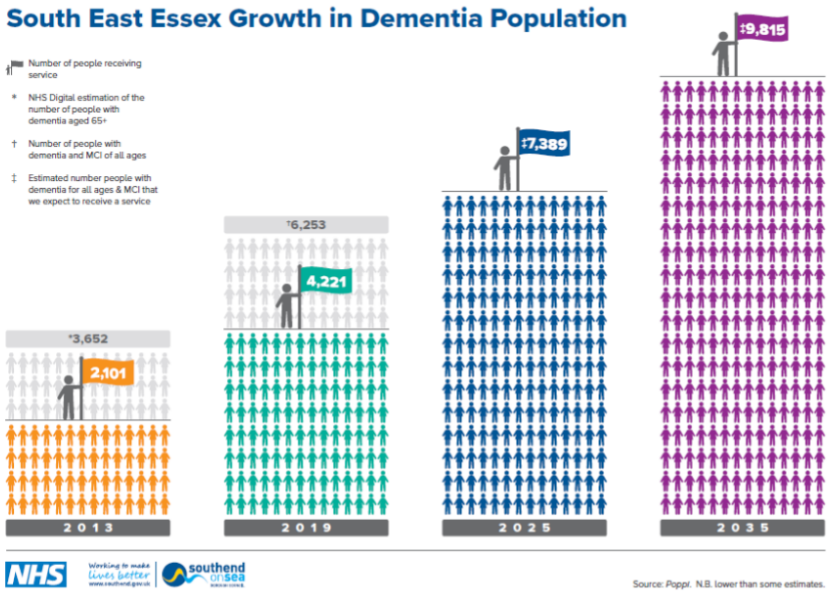
2.3 Agree to review the new model after it has been fully operational for a full year to review the outcomes and decide whether to take a joint commissioner approach/ ICS.

## 3 Background & Context

3.1 In late 2018, following a decision taken by People Scrutiny in both Southend on Sea Borough Council and Essex County Council to close Maple Ward (A 24 bedded organic assessment unit in Southend that was running at half occupancy), Dr Jose Garcia was asked to chair a clinical group to look at: the current dementia offer; identify the requirements of a new wraparound model to ensure robust community support to the person with dementia and their carer and to identify any gaps in knowledge and data.

3.2 As well as a commitment to develop a robust community model there was also a commitment to offer 10 beds (from the totality of 70 across Clifton and Rawreth) in Clifton and Rawreth (five in each) exclusively to the south east as step up/step down beds. The aim being to prevent as many people from the south east as possible being detained in Thurrock Meadowview ward. The beds have had a low occupancy rate overall since Maple Ward closed and one person has moved to Meadowview at the family's request because of their local connection to Thurrock.

3.3 The infographic below shows the rise in people with Dementia in South East Essex over the next 15 years. The person standing on top represents the current service. As shown, if the number of people with dementia rises as expected, the current service will not be able to safely manage and support the number of people with dementia. The growth numbers indicate that the number of people with dementia is likely to increase up to 4 times the current rate. The business case introduces a smarter model with a more diverse range of skilled staff which will enable the service to safely support the increase in demand for the service at a lower cost.




## 4 Proposed Dementia Community Support Model:

4.1 As a system we are driving through changes that put the person and their families at the centre of their care. The premise is wellbeing and living longer and more fulfilling lives in the community for as long as possible. We want to manage

rising risk, take a preventative approach and avoid crisis by deploying resources pro-actively. The desire includes the mobilisation of all the assets at our disposal (within Local Authorities, Health and 3rd Sector) which can be used to engage communities and empower a supportive functionality.

4.2 The new model is a culmination of work that has been taking place in the south east as well as the clinical group chaired by Dr Garcia. The south east has a good reputation for dementia services. This began with a series of public and stakeholder consultation engagement events; followed by system checks such as EQUIP, clinical tasking of diagnosis, running the Dementia Quality Toolkit (DQT) in practices; plus a number of test and learns of different scale and magnitude. Examples can be found on page 7 of the business case.

4.3 During the last nine months the Dementia Intensive Support Team (DIST) have developed a strong working relationship with Day Assessment Unit (DAU) and SWIFT (physical health community support team) to help support the admission avoidance process.

4.4 The new model comprises of;

4.4.1 **The Locality Teams** are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient, and all will be able to input into and update the dementia care plan. We aspire to work with PCN's as they develop to explore how they can complement the dementia locality offer. It is envisaged both will work closely together. On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

4.4.2 **Care Home Team** A Dementia Nurse Specialist leads in the care home team offering expert advice and supports the GP when diagnosing. Registered nurses can offer training and support to care home staff on site which will enable understanding of their clients; understand a response appropriately that can be challenging and identify rising risk. This will help reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They will help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases). The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer. Locality Dementia Navigators also support the home to achieve dementia friendly accreditation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for resident's families.

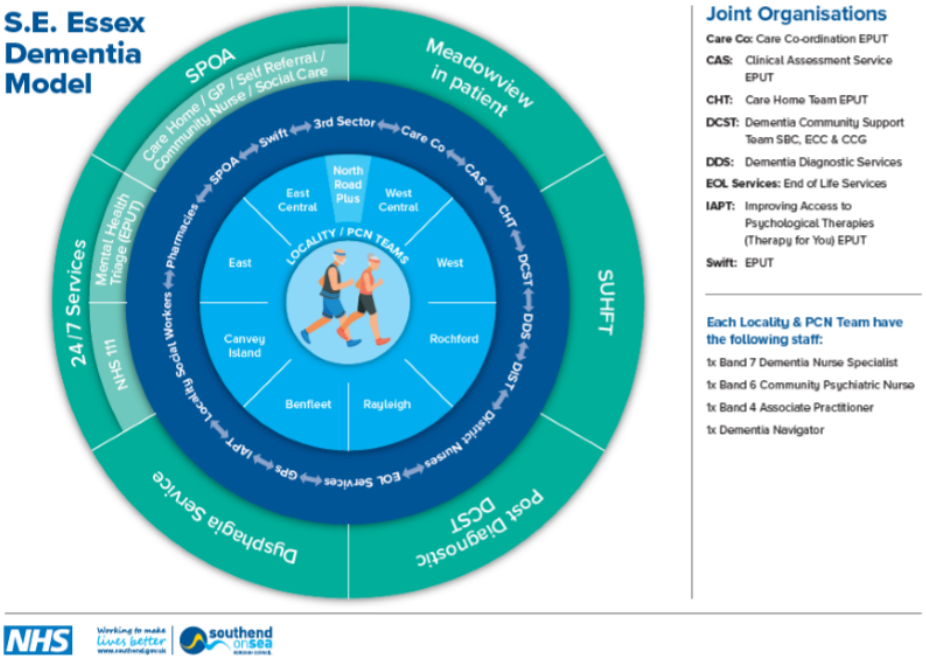
4.4.3 **Clinical Assessment Service** Offering a specialist assessment service for older adults not previously known to Mental Health services. It is an intermediate service that gives a greater level of clinical expertise in assessing a patient. This expertise ensures that individuals are referred efficiently and effectively into the most appropriate onward care pathway, including consultant lead secondary care services. The service consists of a Mental Health Nurse

Practitioner, Community Mental Health nurse and Community Support Workers to support comprehensive assessment and appropriate support in completing actions identified in assessment.

4.4.4 **SPOA (Single Point of Access)** Staffed with a Dementia (Mental Health) Nurse Specialist and an associate practitioner, this will provide a single access point to community Dementia and older adult mental health services, triaging and passing to the appropriate team/team member. They will also offer advice and support to other professionals in SPOA in providing appropriate MDT responses to referrals.

4.4.5 **The Dementia Intensive Support Team (DIST)** work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend General Hospitals A+E Department, DAU (Day Assessment Unit) and SPOA (Single Point of Access). The interventions offered by the Service are aimed at managing pre crisis and enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to Southend University Hospital the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

4.4.6 The visual below shows the narrative of the new model in an easy to understand diagram.



The principles of the model are:

4.5 Easy access, no wrong door approach to our service, pre, peri, post diagnosis through to end of life.

4.5.1 The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.

4.5.2 The service is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers.

4.5.3 The emphasis is on identifying rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.

4.5.4 Services are responsive, appropriate, integrated with whole locality systems and provide right care, right place and right time interventions and support.

4.5.5 Where inpatient care is required that it is planned, purposeful of optimal length and has clear value to the person admitted.

**Alignment to Southend 2050**

4.6 The proposed changes align with the Southend 2050 five themes; Pride and Joy, Safe and Well, Active and Involved, Opportunity and Prosperity and Connected and Smart.

The National Dementia Alliance describes the following outcomes for people with dementia and their carers. These outcomes will directly measure the success of the new community model.

'*We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.'*

*'We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.'*

*'We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.'*

*'We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.'*

*'We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.'*

The outcomes can be mapped across to the 2050 outcomes in the following themes:

4.6.1 Safe and Well

- We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
- Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.

4.6.2 Active and Involved

- The benefits of community connection are evident as more people come together to help, support and spend time with each other.
- A range of initiatives help communities come together to enhance their neighbourhood and environment.
- More people have active lifestyles and there are significantly fewer people who do not engage in physical activity.

4.6.3 Connected and Smart

- People have a wider choice of transport options.
- Southend is a leading digital city with world class infrastructure that enables the whole population.

4.6.4 Contribution to the Southend 2050 Road Map

The dementia offer is already responding to some of the milestones for 2019, such as, ***increased numbers of active people*** and ***community based social work practice embedded.*** We are aligned with localities and Primary Care Networks to help us meet the 2020 milestones ***Localities - integrated health and social care services provided locally*** and are working with colleagues to be integrated with the ***New social care home operational*** and ***More integrated transport provision*** and ***Campaign for a new hospital for Southend.***

4.7 The Primeministers Challenge 2020 sets out clear commitments that cover all aspects of dementia; risk, diagnosis, heath and care support, workforce training, social action and research. A report written for CCGs Governing Body outlining the local response to the PM challenge can be found in appendix F.

**Financial**

4.8 The funding will be taken to the CCG Governing Body for approval but as a system solution there may be future opportunities to explore pooled funding options.

## 5 Reasons for Recommendations

5.1 There are many reasons why an enhanced community model is paramount, which include:

- Being able to pro-actively review patients so people with rising risk are monitored and not just those with the highest need.
- Growth of number of people likely to have a dementia diagnosis in the SE over the next 15 years.
- Supporting the integrated care plan; Co-ordinator of care role and regular dementia reviews.
- Increased risk of crisis, hospital admission (both acute and mental health) increased CHC funding, increased care home and care package usage.
- Increased carer stress due to reduced support and understanding of their unique role.

## 6 Financial / Resource Implications

6.1 None at this stage

## 7 Legal Implications

7.1 None at this stage

## 8 Equality & Diversity

8.1 An Equality Impact and Quality Impact assessment have been carried out and are embedded in Appendix E.

## 9 Governance Route

| Date | Meeting | Time | Lead Presenter |
|---|---|---|---|
| 22/08/19 | EDMT (Executive Departmental Management Team SBC) | 11.30am | Jo Dickinson |
| 28/08/19 | CMT (CCGs) | CMT 11.30-1.30pm | Jo Dickinson supported by Spencer Dinnage (Dementia Lead Clinical Services and Jacqui Lansley) |
| 11/09/19 | CMT (CCGs) | 11.30am | Jo Dickinson, Jacqui Lansley, Dr Gupta and Dr Garcia |
| 18/09/19 | HWB (Southend) | PM | Jo Dickinson, Jacqui Lansley and Dr Garcia |
| 19/09/19 | Joint CEC (CCG) | PM | Dr Gupta and Dr Garcia supported by Spencer Dinnage and Jo Dickinson. |
| 26/09/19 | GB CPR CCG | PM | Jacqui Lansley supported by Jo Dickinson |
| 27/09/19 | GB Southend CCG | PM | Jacqui Lansley supported by Jo Dickinson |
| 08/10/19 | Southend People Scrutiny | PM | Cllr Harp and Dr Garcia |

# 10 Appendices

| | |
|---|---|
| Appendix A -  Dementia Services Transformation Mode | |
| Appendix B –  Embedded documents 1.docx | |
| Appendix C -  Embedded documents 2.docx | |
| Appendix D -  Embedded documents 3.docx | |
| Appendix E -  Embedded documents 4.docx | |
| Appendix F -  GB Dementia Report 13.02.19V3.docx | |