Adult Social Care Committee

Item No:

Report title:	**Norfolk's Better Care Fund and Integration Plan 2017-19: Progress Report for 2017-18**
Date of meeting:	**14 May 2018**
Responsible Chief Officer:	**James Bullion, Executive Director of Adult Social Services**

Strategic impact

Norfolk Health and Wellbeing Board (HWB) oversees Norfolk's work on integration that has been undertaken in accordance with Norfolk's Better Care Fund (BCF) and Integration Plan 2017-19. This report provides the Committee with information that was presented to the HWB on 2 May 2018. This report reviews progress during 21017-18, including information on how the Improved Better Care Funding (iBCF) and Disabled Facilities Grants (DFGs) have been used to support our integration work.

Executive summary

Norfolk has made good progress with its BCF and Integration Plan and the initiatives funded through BCF have made an important contribution to STP priorities.

A significant amount of iBCF funding has been invested into initiatives that contribute to addressing performance on Delayed Transfers of Care (DTOC) across the system, as this has been the only mandatory metric most at risk of not being delivered to target. The iBCF funding has been focused on areas in the recently developed High Impact Change Model (HICM) that social care can influence effectively, such as Trusted Assessors, Enhanced Home Support Services and Active Assessment Units (bed based reablement).

The complexity of the health and social care system in Norfolk means there is further work to do in order to achieve the priorities identified for system-wide change, which will be the ongoing focus of the BCF and Integration Plan.

Recommendations:

Committee is invited to review and agree the report, noting progress that has been made with integration in Norfolk.

1. Introduction

1.1 The Better Care Fund (BCF) initiative was established by Government to encourage closer working at local level between health, housing and adult social care through creation of a pooled fund.

1.2 Previously national guidance had been for these plans to be prepared for one year only, but for 2017 it was decided that they should be for two years to ensure longer planning timescales and should incorporate integration plans. Other key changes have been the in-year funding announcement of supplementary non-recurrent Improved Better Care Funding (iBCF) which has enabled quicker implementation of some initiatives and imposition of a national High Impact Change Model (HICM) designed to improve hospital discharge arrangements.

1.3 The local requirement for the Health and Wellbeing board to oversee the programme remains in place, as does quarterly reporting against four key targets for emergency

hospital admissions; delayed discharges from hospital; long-term admissions to care homes and success of reablement.

1.4 As a consequence of changes to the financial framework (the improved iBCF), final national guidance was delayed significantly, meaning that Norfolk's Better Care Fund and Integration Plan 2017-19 was not agreed by the Health and Wellbeing Board until September 2017 and not formally signed off by NHS England until December 2017. Please click here to see a copy of the Plan

1.5 The Plan sets the context for BCF and integration in Norfolk, so the detail of that will not be repeated here. However, it should be reiterated that the Plan is aligned closely with the Norfolk and Waveney Sustainability and Transformation Plan and reflects its guiding principles. It dovetails with Norfolk County Council's (NCC's) Promoting Independence Strategy and Clinical Commissioning Group (CCG) commissioning intentions for 2017-19. Also, it incorporates district council Prevention and Promoting Independence initiatives

2. Delivery of the Plan

2.1 Progress against the Plan for 2017-18

This report reviews progress that has been made during 2017 -18 in delivering the key elements identified in the 2017-19 Plan. These include:

a) Norfolk's five identified priorities
b) High Impact Change Model (HICM)
c) iBCF Initiatives
d) Performance against metrics

2.2 Norfolk's Five Priorities

Norfolk identified five priority areas to focus its BCF activity:

Priority 1: Locality Integrated Care Programme Infrastructure
Priority 2: Care Homes
Priority 3: The Home Environment
Priority 4: Out of Hospital Schemes
Priority 5: Crisis Response

2.2.1 **Priority 1**: Locality Integrated Care Programme Infrastructure

The Primary and Community Care workstream of the Norfolk and Waveney STP is progressing at pace with five Local Delivery Boards set up (one for each CCG footprint) with a focus on the development of New Models of Care. This will enable further integration between primary, community, social care, the voluntary sector and district councils. Areas of activity include:

a) Integrated social work and community health staff, based around GP surgeries
b) Engagement with Early Help Hubs
c) Risk stratification of patients
d) A well-developed multi-disciplinary team (MDT) approach is delivered through Integrated Care Teams
e) The Supported Care Service for North and South CCGs

All activities in this priority have been progressed as planned for this year. Next year will see more targeted work on risk stratification to embed a countywide approach.

Successes include a countywide approach to the role of Integrated Care Coordinators supporting multi-disciplinary teams and the introduction of the Supported Care Service. This latter service aims to enable adult patients, including frail older people and those with long-term conditions, to stay safe and well at home with over 80% of referrals to the service avoiding a hospital admission

2.2.2 **Priority 2**: Care Homes

The Norfolk system is engaged with the Enhanced Health Care in Care Homes framework as a basis for reducing admissions from care homes to hospital and is collaborating to support improvement in the quality of care offered. This is also a HICM priority.

This work has progressed well and all milestones have been achieved. Further investment has been agreed for the coming year to ensure the pace and impact of this work can be maintained.

Norfolk has developed the care homes dashboard to show admissions to hospital, use of 111 and quality ratings by care homes. It has been adopted by NHS England and is being presented and promoted as a model of good practice. It highlights a reduction in avoidable hospital admissions to hospital from care homes for 2017/18 compared to 2016/17 (based on data from the first half of each year).

- North Norfolk: 8.3%
- Norwich: 35.3%
- South Norfolk: 14.6%
- West: 15.8%

From 1 April 2018 the CCGs will be purchasing their business intelligence services from the Arden GEM Commissioning Support Unit (CSU) which should enable inclusion of GY&W data in the existing Norfolk dashboard, so providing data consistency across the STP area.

2.2.3 **Priority 3**: The Home Environment

This area of work covers interventions in the home that focus on housing as an enabler to improve health and wellbeing and, in particular, the use of Disabled Facilities Grant (DFG) funding.

The expenditure of nearly £7m for 2017-18 was overseen and distributed by seven district councils and spent primarily on statutory DFGs. However, work is ongoing with the districts to expand and diversify services provided to better support vulnerable people to return to their homes after a health incident.

A comprehensive report on progress and initiatives in localities is contained in **Appendix 1**.

2.2.4 **Priority 4**: Out of Hospital Schemes

Activities to support out of hospital schemes include:

a) Review of Information and Advice Services
b) Intermediate Care Strategy Planning
c) Delivery of the High Impact Change Model (HICM)
d) Social Prescribing

Use of the iBCF funding has enabled significant progress to be made on this priority, with the introduction of; active assessment units, enhanced home support services, and trusted assessment facilitators and the recruitment of six additional Discharge to Assess social workers to support hospital discharge. These schemes are expected to impact on the Delayed Transfer of Care (DToC) metric and contribute to an improvement in performance, as well as continuing to help maintain our rate of non-emergency admissions.

To progress work on social prescribing, Norfolk County Council is investing £1.9m from Adult Social Care and Public Health over the next 2 years to ensure that social prescribing is available across Norfolk. CCGs, district councils and voluntary sector 'umbrella' providers have been involved in developing the models which are being designed to reflect the local make up of services, needs, priorities and assets.

2.2.5 **Priority 5**: Crisis Response

Initiatives include:

a) Services for Carers
b) Early Intervention Vehicles (EIVs)
c) The Enhanced Home Support Service
d) Norwich Escalation Avoidance Team (NEAT):
e) West Norfolk Rapid Assessment Team

All milestones for this priority have been met. Further work will be undertaken in year two of the plan to analyse the impact of initiatives.

An example of effective work in this priority area is the new carer's support service 'Carers Matter Norfolk', which was launched in October 2017 and continues to support unpaid carers in Norfolk. Through the BCF part of a shared commitment it offers a 'carer-led' support service and telephone support, information and guidance to carers. Milestones for the service including the commencement date were all met.

2.3 **High Impact Change Model** (HICM)

2.3.1 The HICM aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters when pressures are greatest.

2.3.2 It offers a practical approach to supporting local health and care systems to manage patient flow and discharge. It can be used to self-assess how local care and health systems are working currently, and to reflect on, and plan for, action that can be taken to reduce delays throughout the year.

2.3.3 The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

1. Early discharge planning
2. Systems to monitor patient flow
3. Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
4. Home first/discharge to assess
5. Seven-day services
6. Trusted assessors
7. Focus on choice
8. Enhancing health in care homes

2.3.4 As part of the BCF plan 2017 -19 Norfolk submitted a HICM plan (see **Appendix 2**) showing progress against the eight areas of the plan. Each has been rated as either green or amber. with all actions having been completed, though there was some slippage in timescales. Whilst plans are in place for all eight changes in the model, some are more established than others.

2.3.5 Most progress has been made on the areas of change where iBCF monies have been invested, such as Home First Discharge to Assess and Trusted assessors. With key iBCF initiatives now in place, impact is expected to accelerate and be demonstrated through improvements in transfers of care.

2.3 The main challenge to delivering the HICM has proved to be ensuring consistency across the three acute systems. Further work is planned to review the model and update the plans to maximise impact.

2.4 **iBCF Initiatives**

2.4.1 The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Norfolk received £18.561m in 17/18, followed by £11.901m in 2018/19 and £5.903m in 2019/20. The funding is paid as a direct grant to councils by the DCLG and as a condition of the grant, councils were required to pool the funding into their BCF.

2.4.2 The guidance received by DCLG requires that the funding is used by local authorities to provide stability and extra capacity in the local care system. Specifically, the grant conditions require that the funding is used for the purposes of:

a) Meeting social care needs
b) Reducing pressure on the NHS supporting people to be discharged from hospital when they are ready
c) Ensuring that the local social care provider market is stabilised

2.4.3 Plans for the use of the funding were reported to Adult Social Care Committee in July and were subsequently agreed with Norfolk's Clinical Commissioning Groups.

2.4.4 The plans included £9.1m earmarked to help support the local care provider market, rising to £10.8m in 2018-19. This was additional to budget plans already agreed for 2017-18, so in-year was targeted on managing the impact of new legislation on providers, managing the impact of market failures and amending pre-banded contracts for working age adults. The funding assigned for this purpose was not used in full and is part of the iBCF funding carried forward within reserves to ensure that it remains earmarked as planned. The iBCF will support the market through funding the 2018-19 impact of the residential and nursing care cost of care review, implementing the additional cost of the new home support framework, managing the impact of the national living wage on sleep in care provision and purchasing packages of care. By 2019-20 it is expected that £33m of the £34m iBCF funding will be spent on either sustaining the market through prices increases or protection of social care, which will mean buying an increased volume of care with the care provider market

2.9.4 The Adult Social Care Committee receives an update on the iBCF within the Adult Social Care Finance Monitoring Report. The latest published information for period 10 (Jan) 2017-18 is attached at **Appendix 3**

2.9.5 Funding has enabled us to:

a) Strengthen our Social Work capacity - By mid-February 40 appointments had been made to new roles in the service

b) Invest with Public Health in a countywide approach to social prescribing, enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services. This is being taken forward on CCG boundaries, working with Districts Council, CCGs & the voluntary sector. Locality plans have been developed with services commencing between January and June 2018
c) Appoint five Trusted Assessment Facilitators across the three acute hospitals. This role has been developed with care providers. The service commenced in January 2018 in the Norfolk & Norwich University Hospital, all three hospitals had this service in place by early March
d) Open new Active Assessment Units. This is an occupational therapy led service, designed to maximise people's independence and reduce permanent admissions to residential care, reduce hospital admissions and support safe and timely hospital discharge.
   A unit at Benjamin Court in Cromer has 18 beds available with services which commenced in February 2018. The East Norfolk scheme, provided by Burgh House, currently has four beds. The unit opened early January and by the end of February had already provided services to seven people. A West Norfolk unit will open later this year
e) Commission three independent flats within a 24-hour housing with care setting at Dell Rose Court in Norwich, supporting people who have been assessed as being medically fit for discharge from hospital, but unable to return to their home safely. Flats are fully contained and have been equipped to replicate a home from home environment. Referrals to the service commenced early February 2018
f) Establish the Enhanced Home Support Service, a small, flexible and enabling service which provides targeted home support to reduce delayed discharges from the three acute hospitals and unnecessary admissions from the community.
   This is a three-year pilot service, free to the service user for visits over a period of up to 72 hours and delivered in partnership by three Home Support providers: Carewatch, Allied Health Care and The Carers Trust.
   The service can offer support around meal preparation, personal care, shopping, welfare checks, medication monitoring and facilitation of the access to and the use of community resources and assistive technology solutions. It is suited to individuals with a low level of short term need. The service launched early February 2018 and by the end of the month had provided services to 30 individuals.
g) Open an additional six beds/flats commissioned as "step down" and admission avoidance from mental health hospitals jointly funded with NSFT with social care support to provide suitable discharge destinations. The service commenced in October 2017.

2.9.6 Where investment in social care is evidenced to provide wider system benefits the expectation is that financial support will be sought from across health and social care to enable new ways of working to continue beyond the project timescales. Where benefits cannot be evidenced or wider financial support from the health sector is not available, it is expected that the interventions will need to be stopped at the end of the projects.

2.10 **Metrics**

2.10.1 A BCF data dashboard is produced and monitored on a quarterly basis and a summary dashboard is included - **Appendix 4**.

The four main metrics that BCF activity is monitored against are:

- Reduction in non-elective admissions
- Rate of permanent admissions to residential care per 100,000 population (65+)
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed Transfers of Care (delayed days)

For the 2017/18 Norfolk has been on track to meet target for three of the four metrics.

2.10.2 **Reduction in non-elective admissions**

- On track to meet target

The total figure for 2017/18 at January 2018 is approximately 77,838 (a rate of 10,7129 per 100,00 population); below the target for this period of approximately 78,934 (10,863 per 100,000).

Enhanced Care in Care Homes work is having a countywide impact on the reduction of non-elective admissions from Care Homes, along with a range of community initiatives such as the creation of the Norwich Emergency Avoidance Team (NEAT).

2.10.3 **Rate of permanent admissions to residential care per 100,000 population (65+)**

- On track to meet target

There is a continued reduction in permanent admissions based on improved practices and a focus on strength based social work practice, underpinned by good performance in reablement.

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

a) On track to meet target

Performance in reablement services continues to have a positive impact on this metric. Up to January 2018 96% of older people (65 and over) were still at home 91 days after discharge from hospital into reablement / rehabilitation services. This is above the target of 90%.

It should be noted that due to the introduction of Liquid Logic the new social care system January's figures are unconfirmed. This is in line with reporting prior to the introduction of Liquid Logic.

2.10.5 **Delayed Transfers of Care (delayed days)**

Not on track to meet target.

Performance has not been on target and peaked in October 2017, performance improved during November and December but declined slightly in January. February's performance has seen an improvement there were 2242 total delayed days in February 2018, of which 890 were attributable to Social Care. This is a 17% decrease from January 2018, where there were 1078 Social Care delays.

3. Financial Implications

3.1 Funding for the plan is by a section 75 agreement and totals almost £70m for each of 2017-18 and 2018-19. This includes Disabled Faculties Grant capital funding of nearly £7m

3.2 Following the announcement of the one-off iBCF grants for 2017-18, 2018-19 and 2019-20, the use of the grant was agreed by NCC and health partners at the end of July 2017. A three-year plan was agreed that also took account of recurrent iBCF funding. The plan was focused on protection of social care, help to support the care market and initiatives to improve discharge from hospital.

3.3 Due to the timing of the grant announcement and finalisation of plans, it was not expected to be able to spend all the 2017-18 grant in year and carry forward has been agreed, both as part of the original plan and within monthly monitoring of progress. This has enabled initiatives to be planned in a structured way, with a clear commitment for pilot schemes to run for an agreed period to enable proper evaluation of benefits and assessment of the cost benefits for future funding. For example these include, social prescribing, enhanced home support and accommodation based reablement, which have mainly been implemented in Quarter 4 of 2017-18. The County Council has set the budget for 2018-19 to ensure that the funding is carried forward for the purposes agreed. At Period 10, the planned carry forward of iBCF funding to future years was £10.971m from a total grant of £18.561m.

4. Governance

4.1 The Health and Wellbeing Board oversees Norfolk's BCF programme, in line with its strategic oversight of the wider system and pursuit of an integrated, sustainable health and wellbeing system. Adult Social Care and CCG Chief Officers are responsible for ensuring the plan is delivered and appropriately reported to NHS England on a quarterly basis.

4.2 Feedback to NHS England on year one identified that two key successes observed in Norfolk toward driving integration in 2017/18 were:

a) Strong, system-wide governance and systems leadership, through the Health and Wellbeing Board partnership, including buy-in from elected representatives and health organisation leaders, plus regular meetings of senior CCG and NCC leaders
b) Empowering users to have choice and control through an asset based approach, shared decision making and co-production especially via Implementation of the three conversation model which promotes an asset-based approach to social care in innovation sites

4.3 Feedback to NHS England on year one identified that two key challenges observed in Norfolk toward driving integration in 2017/18 were:

a) Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors) particularly with the ageing population and providing services in rural areas resulting in unprecedented pressures on the local health and social care system
b) Integrated electronic records and sharing across the system with service users. The implementation of Liquid Logic has impacted on the availability of social care data between September 2017 and January 2018. The complexity of five CCGs (one half in county), three acute trusts and two community providers complicates joint planning and record sharing

4.4 The BCF risk register is monitored and reviewed regularly with the most significant risks being:

a) Inability to adequately reduce Delayed Transfers of Care across the system.

Mitigating actions include introduction of iBCF initiatives, appointment of a capacity manager, weekly monitoring of DTOC, and a system wide review

b) Workforce capacity and/or skill set insufficient to deliver quality services in some sectors

4.5 Mitigating actions include a STP workforce workstream, a Sector Skills plan and development of a European Social Fund bid to address capacity and skills issues

5. Conclusion and next steps

5.1 Norfolk's Better Care Fund and Integration Plan 2017-19 has made good progress in year one.

5.2 The five priority areas have delivered against the identified milestones. Priorities for year two include countywide development of risk stratification and analysis of the impact of a number of new initiatives that have been developed to support integration and keep people at home. These assist in continuing to prevent emergency admissions and are impacting on a reduction in delayed transfers of care

5.3 The iBCF has been used to support the BCF priorities and has enabled delivery of key elements of the HICM. System-wide delivery of HICM remains a challenge and this will be a focus for the next year

5.4 Initiatives continue to deliver performance that ensures most targets are met. Performance against DTOC is an area of concern, but with an increased focus on HICM, the implementation of iBCF initiatives, a planned review of health & social care DTOC and ongoing joint working, performance is expected to improve.

5.5 The Better Care Fund and Integration Plan 2017-19, has evidenced effective and innovative working through the delivery of, Supported Care, the Enhanced Care in Care Homes Initiative, Supported Care Programme, Social Prescribing, IEVs and use of the iBCF. Work is underway to address identified challenges and risks are being managed.

5.6 The progress review for 17/18 will be used to refresh and update the plan to ensure year two is targeted on the correct priorities and on supporting the delivery of the desired outcomes and impacts.

6. Recommendations

6.1 **Committee is invited to review and agree the report, noting progress that has been made with integration in Norfolk**

Officer Contact

If you have any questions about matters contained in this paper or want to see copies of any assessments, eg equality impact assessment, please get in touch with:

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