Health and Wellbeing Board

Item 9

Report title:	**Better Care Fund and Integration Plan**
Date of meeting:	**24 April 2019**
Sponsor (H&WB member):	**James Bullion**

Reason for the Report

The Health and Wellbeing Board (HWB) oversees the Better Care Fund programme and Norfolk's Better Care Fund (BCF) and Integration Plan for 2017-19, established according to national guidelines in 2017. This report explains progress for the second (and final) year of the plan, including information on how the Improved Better Care Fund (IBCF), Disabled Facilities Grants (DFGs) and the High Impact Change Model (HICM) have been applied to help meet our strategic objectives. A further one-year plan is in preparation and this report makes recommendations for the key components which the HWB will be required to support.

Report 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.

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.

Generally, Norfolk has been successful in achieving the objectives stated in its BCF and Integration Plan. Where it has been least successful has been in reducing a relatively high level of Delayed Transfers of Care (DToCs) to the NHSE target for the county. A significant volume of system-wide work has taken place to understand and rectify the position, with more planned.

In particular, a significant amount of iBCF funding has been invested into initiatives that contribute to addressing performance on DToC across the system. 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 Accommodation Based Reablement.

Social prescribing is an example of how we've used iBCF to pursue wider STP and BCF objectives. (See **Appendix 3**)

Recommendations:

The HWB is asked to:

- Review progress that has been made on Norfolk's 2017-2019 Better Care Fund and Integration Plan and DToC challenges.
- Review and comment on the proposals for developing a revised Better Care and Integration Plan for the transitional year 2019-20
- Delegate decision-making on the final version of the revised Better Care and Integration Plan 2019-20 to the HWB Chair and Vice-Chair's Group for submission nationally.

1. Background

1.1 The HWB is responsible for developing and implementing the strategic plan for the Norfolk Better Care Fund. A progress update for the first year was provided to the HWB on 2 May 2018. We are now at the end of the initial two-year planning phase.

1.2 In accordance with government guidance a further one-year interim plan is being developed for 19-20, based on the existing plan. During the year the government will undertake work on a more fundamental reshaping of the Better Care Fund, in part related to the planned national Comprehensive Spending review. Consequently, this report also contains proposals for the content of an interim plan for Norfolk.

2. Progress report on Norfolk's Better Care Fund (BCF) and Integration Plan 2017-19

2.1 Norfolk's Better Care Fund and Integration Plan 2017-19 is published on the HWB pages of the website.

Governance and Funding

2.2 The HWB oversees Norfolk's BCF programme, in line with its system-wide strategic oversight role and accountability for achieving an integrated, sustainable health and wellbeing system. Adult Social Care and CCG Chief Officers are responsible for ensuring the plan is delivered and reported appropriately to NHS England on a quarterly basis. They receive regular progress reports and review quarterly reports.

2.3 Funding for the plan is via a section 75 agreement and has totalled almost £70m for each of 2017-18 and 2018-19. This includes Disabled Faculties Grant capital funding of nearly £7m. An additional £20m IBCF (Improved Better Care Fund) for Norfolk was granted in the 2017 spring budget for 2017-18 and this rises to £34m for 2019-20, though this is non-recurring funding.

Progress against the five priorities

2.4 Norfolk's Better Care Fund and Integration Plan provides a delivery framework for five priority areas as follows:

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

2.5 Good progress has been made against all priorities, with milestones being met or updated to take account of new initiatives, including those funded by iBCF, or the impact of a new strategic decision on a previously planned activity.

2.6 A review of progress for 2018-19 against the plans for the five priority areas is provided in **Appendix 1**. Each quarterly return this year has required a narrative on a 'success' story. Those chosen for Norfolk have been: The Norwich Emergency Avoidance Team (NEAT), housing related supported based in the acutes and accommodation based reablement. A synopsis of these 'success' stories is contained in **Appendix 2** with Social Prescribing included as **Appendix 3** and Enhanced health in care homes in **Appendices 1 and 4.**

High Impact Change Model (HICM)

2.7 Implementation of the HICM was introduced as a mandatory national condition for the BCF during 2017. This comprises tried and tested ways to improve DToC. Each area is required to gauge progress quarterly against eight identified system changes:

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

2.8 The HICM supports system-wide integrated working and in Norfolk the use of iBCF funding has helped to accelerate progress on three of the eight changes. There is further work to be undertaken to progress work on the model across the Norfolk health and social care system, particularly to ensure that the eight changes link in an integrated way. This is being led by the STP Urgent and Emergency Care Board Transformation Programme.

2.9 There is a requirement that all areas must reach a (self-assessed) 'maturity' by April 2019, though it has been announced that this requirement is to be relaxed and shifted to April 2020. An outline of progress for Norfolk is contained in **Appendix 4.**

BCF Metrics

2.10 The four key metrics against which Better Care Fund performance is judged, show that targets for new admissions to care homes and non-emergency hospital admission (NEA) avoidance to hospital are on track, despite monthly variation against historical performance. The percentage of avoidable admissions for the Norfolk and Norwich University Hospitals NHS Trust, the county's largest hospital, is the lowest in the region.

2.11 Changes to local recording and reporting have impacted on the historically high rate of success in reablement. Furthermore, the reablement offer has been extended to more people, some of whom are less likely to benefit from the service and these reasons together account for Norfolk's performance dipping recently below target level. However, the percentage remains high when compared to other areas

2.12 Despite the considerable investment through iBCF and other health and social care funding, the target for DTOC will not be met. Over the course of the year under review, a number of improvements and investments targeting support for helping people home and preventing admission have been put in place – including additional investment in reablement, strengthened liaison with care providers, clearer processes for identifying care home vacancies, and earlier multi-disciplinary discussions on wards. Concerns about the reliability of data recording have resulted in detailed joint working to understand discrepancies and put in place mechanisms to ensure sign-off by both health and social care before national submission.

2.13 Critical to a step-change in improvement will be a whole-system commitment to a 'home first' ethos, and commitment to follow the revised NHS guidance (issued in November

2018) which ensures consistent ways of working between health and social care, and clarity about recording and attributing delays.

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3. BCF Plan 2019-20

3.1 It is clear that the Government wants to continue with the BCF, at least for the foreseeable future. The NHS 10 Year Plan calls for an enhanced focus on integration across health and social care with stronger links to housing and an expected stronger co-ordination with the work of Sustainability & Transformation Partnerships (STP) and successor Integrated Care Systems. It is expected that this will be replicated in BCF Guidance. However, it needs to be recognised that, for Norfolk, the geographic footprints and governance differ from those for the STP.

3.2 A new BCF and Integration Plan offers a useful opportunity to take forward new policy initiatives and to embed learning from the past two years. This includes:

- Publication of the NHS 10 Year Plan by NHSE e.g. the promotion of Integrated Care Systems and Primary Care Networks
- Implementation of key messages from the central Norfolk Multi-Agency Discharge Event (MADE) and LGA Peer Review
- Achieving 'maturity' of HICM elements and better co-ordination between them
- Mainstreaming successful pilots at pace and scale plus improved shared learning across localities
- Embedding the 'Living Well' approach to social care
- Dovetailing Plan with CCG Operational Plan intentions
- Greater emphasis on understanding person-centred experiences of the interface of health and social care services, in particular the importance of 'seamless' services and appropriate handovers
- Social care budget challenges and the impact of ending non-recurrent iBCF funding
- Use of transitional year to ensure less focus on specifics of BCF funding and more on integrated services systemwide
- Vision on what national 'full integration by 2020' means for Norfolk and Waveney testing against the Social Care Institute of Excellence (SCIE) Model
- Melding local integrated delivery with system-wide planning

3.3 Depending on the degree of change expected by national guidance, a new plan structure with four priorities is proposed as follows:

1. Prevention and Early Intervention (NEA, reablement and dementia metrics)
2. Integrated Community Care (care homes metric)
3. Admission Avoidance and Safe and Timely Discharges (NEA, DToC and reablement metrics and to HICM)
4. Improving the Home Environment (NEA and DToC metrics)

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BCF Narrative Summary – progress against plans

1. Good progress has been made across all five priority areas

Priority 1: Locality Integrated Care Programme Infrastructure

2. As the Primary and Community Care workstream of the Norfolk and Waveney STP progresses, five Local Delivery Boards (LDGs) have been established to enable further integration between primary, community, social care, the voluntary sector and district councils.

3. **Local Delivery Groups** The *YourNorwich* LDG is focussed on developing an integrated model of care for Norwich wrapped around GP practices/Primary Care Networks (PCNs). Plans are in place to establish Clinical Directors of the PCNs in Norwich and a review of One Norwich governance is underway to ensure that PCNs are fundamental to the transformation of primary care in Norwich.

4. North and South Norfolk CCGs are working to introduce the GEMIMA Risk Stratification Tool in all GP practices as part of the LDG focus. Identifying patients most at risk of hospital admission within 6 and 12 months, the tool allows specific searches to target patients for further intervention.

5. In South Norfolk, attendance at LDG meetings is now established and a workshop was held between the CCG and District Council to look at future collaboration which can be taken forwards through LDG. Discussion is ongoing between system partners in relation to the formation of PCNs

6. Great Yarmouth and Waveney are sending local system leaders to the 'Transformational Change through System Leadership' course, delivered through NHS Improvement. Priority areas of frailty and deprivation, and discussions around establishing measurable outcomes for these, remains a focus at LDG meetings.

7. West Norfolk LDG have now established key representatives required from Health & Social Care. Work around the use of population health data and how this can inform the future direction of development is currently underway. LDG workshops have taken place to feed into this agenda and discussions in relation to the formation of PCNs are in progress.

Priority 2: Care Homes

8. A draft STP Enhanced Health in Care Homes (EHCH) plan for 2019-20 has been submitted to NHS England. Following extensive engagement and feedback, a final version will be published during April 2019.

9. Work is ongoing around the data, but comparing the first 6 months of 2018/19 with the same period in 2017/18, there was an overall reduction of 23% in admissions from hospital to care homes. In the last year there was also an improvement in the number of homes in Norfolk and Waveney rated good or outstanding following CQC inspection.

10. From March 2018 to March 2019, the proportion of nursing and residential homes rated good/outstanding following CQC inspection increased by 4.6% to 78.4%. While this remains lower than the average for East of England (83.6%) and England (81.4%), the performance gap is decreasing.

Priority 3: The Home Environment

11. **Disabled Facility Grants** NCC is paying district councils the full MHCLG designated DFG funding for the current year. Work on the impact and outcomes of DFGs is reviewed at quarterly countywide meetings, with progress on DFG and related initiatives contained in Locality Plans monitored every six months. It has been agreed that district councils will top-slice some of their 19/20 DFG allocation to support people with dementia to live at home independently.

12. **District Direct** – See Appendix 2 Integration Examples
13. **Integrated Community Equipment Service (ICES**) Commissioned by NCC for NCC and the five Norfolk CCGs, this service provides a link between health and social care, providing equipment to help people stay safe, either in their own home or in a care home setting, keeping people out of hospital wherever possible. The partnership remains successful and contract performance is good.

14. The service was extended in October 2018 to include Waveney health and social care (with Suffolk County Council joining the delivery model). This means that the whole of the GY&W CCG area is now covered by a single equipment service and a consistent and more efficient service is provided.

15. ICES Equipment Review and Recalls Project is making significant savings through collecting equipment from Care Homes which is no longer being used. Success of the project in Norwich has led to expansion into South and North Norfolk.

Priority 4: Out of Hospital Schemes

16. **Reablement -** see Appendix 2 Integration Examples
17. **Social Prescribing** – Appendix 3

Priority 5: Crisis Response

18. **Single Point of Access** – see Appendix 2 Integration Examples
19. **Flexible dementia provision & EHSS (iBCF)** A systemwide review of dementia provision and pathways, coordinated by South Norfolk CCG, is continuing. Review work around community support and engagement, to feed into this STP review, is also underway.

20. **Enhanced Home Support Service**. Launched in February 2018, a Year 1 review highlighted the increased number of hours provided and number of people supported. This reflects both the increasing familiarity with the service by practitioners and the longer timescales for which people can be supported. The average number of days of EHSS support over the first 5 months was 14 days, over the year this increased to 26 days. As the length of time people can be supported increased, this impacted on flow through the service, highlighting increased demand. Additional winter monies are being used to increase capacity of the service. Improved utilisation of the service has resulted in better value for money.

21. **Services to Carers** - The Carers charter was successfully launched in December 2018. Development of a new Carers Strategy is underway. Phase 1 from January to June 2019 is focusing on engagement with carers about what they would want in the strategy.

22. Following the review and remodelling of short breaks for carers contract, plans are being developed to invest in increased respite options for carers. Meanwhile, Carers Matters Norfolk provide a good quality service, with work ongoing to ensure that target numbers of carers are being reached.

Appendix 2

Integration Success Stories

NEAT (Norwich Escalation Avoidance Team)

1. Norwich NEAT continues to operate on a seven-day basis, providing support for both admission avoidance and hospital discharge. Norwich NEAT recently presented at a Regional Admission Avoidance best practice workshop. Impact was demonstrated by highlighting that 82% of admission avoidance cases were still at home 7 days after referral to NEAT.
2. NEAT also supports Discharge to Assess pathways 1 and 2 from the NNUH, supporting people to be discharged to reablement provision, or home with additional temporary support. 90% of these supported discharge cases had not been re-admitted to hospital.
3. Norwich NEAT was shortlisted in the Health Service Journal Awards category for "Improved Partnerships Between Health and Local Government". Its success is also evidenced by the roll-out of similar models in the four other CCG areas in Norfolk and Waveney.
4. In South and North Norfolk, NEATs (Norfolk Escalation Avoidance Teams) were launched in Autumn 2018. North NEAT received 191 referrals in the first 12 week. South NEAT had received 94 referrals up to 8th February.
5. The Single Escalation Avoidance Team (SEAT) went live in the Great Yarmouth & Waveney locality early 2019. This service is being monitored through in partnership with the CCGs to ensure robust understanding of the impact across health and social care.
6. The West NEAT is continuing to develop in line with learning from the Norwich model.

Housing related support

7. Progress continues to be made on providing housing related support for people leaving acute care to assist in enhancing appropriate and timely discharge, with schemes covering the whole of Norfolk.

8. In the Great Yarmouth area two schemes operate. **Healthy Homes Assistance** which enables vulnerable people referred into the scheme, to have safety improvements made to their homes. The aim is to lower the risk of falls and other accidents at home, reducing avoidable hospital admissions/re-admissions. **I'm Going Home** is a short-term solution to enable hospital patients to be discharged as soon as they are medically fit, to recover fully at home. Families can be nervous about their vulnerable relative going home alone. I'm Going Home provides reassurance for families by loaning, for up to six weeks, a special pack including a 24/7 monitored community alarm and front door key safe. The projects were funded mostly by Great Yarmouth Borough Council, with additional funding secured through a partnership with GY&W CCG and NCC. Capital works are funded by the Disabled Facilities Grant through the BCF. In 2018 the schemes were submitted for an HSJ award.

9. **District Direct**, focuses on the NNUH catchment area, building on the pilot from the five central districts councils. Over 400 people have benefitted from the service and funding has been provided until July 2019. Work in underway to evidence the systemwide impact of District Direct to cover readmission rates, wellbeing, impact on excess bed days, DToCs and the impact of adaptations on the ability of someone to live independently, regional funding has been granted to support this work.

10. Similarly, **Home First** is a one-year pilot funded by Kings Lynn and West Norfolk BC, supporting flow from the acute setting. Going forward, there are plans to regularise these services (including names), so that there becomes a common offer across Norfolk.

Accommodation Based Reablement (ABR)

11. ABR is an iBCF funded scheme, supporting discharge from hospital. This is a new initiative to Norfolk, the aim is to maximise independence and reduce the number of people going into residential care. ABR works with people to ensure they regain their independence in a safe

environment, usually after an illness or injury. People return to their usual place of residence or an appropriate placement to meet their needs, having completed a reablement programme. The service is also offered to people who are at risk of going into hospital or long term residential care, have the potential to be reabled and would benefit from ABR.

12. There are various ABR schemes operating across the county. By the end of December 2018, 40 ABR beds were operational across seven locations in Norfolk. To the end of December, ABR has been used by 269 people, of which 247 were discharged and 22 remained within the service. An evaluation indicates that 74 % of people were re-abled to return home. (45% returned home with home based reablement, 18% needed no further service, 4% entered housing with care and 6% returned home with home care). Of the 26% of people who were not re-abled, 18% returned to hospital, 5% entered permanent residential care, 1% died and 1% entered short-term residential care.

13. An evaluation of the outcomes of ABR has been undertaken, looking at the outcomes and value for money of the different models in place across different schemes. A further review will be completed later in 2019 to inform decisions about the future of ABR schemes.

Enhanced Health in Care Homes

14. This is requirement of the High Impact Change Model which has achieved ‘Mature’ status. For further details please see Appendix 1 – Q4 BCF Narrative Summary (Priority 2: Care Homes) and Appendix 4 High Impact Change Model – HIC8.

Social Prescribing

15. For details on this integration success story, please see Appendix 3 – Social Prescribing.

Social Prescribing

1. In Norfolk, Social Prescribing services have been set up as a two-year pilot, beginning in July 2018, and funded by Adult Social Services iBCF monies and Public Health.

2. The vision for Social Prescribing in Norfolk is as a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to help them meet their needs. Social prescribing schemes 'connect' people with other organisations or activities that can help them to reduce or resolve their problems. It is also intended that Social Prescribing services will reduce avoidable demand on Social Care provision.

How does Social Prescribing work in Norfolk?

3. Thorough effective partnership working and a positive approach to integration Social Prescribing is now available across the whole of the county with referral pathways from GP Practices, from Norfolk County Council and in some areas, via Early Help Hubs. There are five locality models: North Norfolk; Great Yarmouth; Norwich & Broadland; West and Breckland; and South.

4. 'Connectors' are recruited and based within District Councils and Voluntary Sector Partners (this varies by locality) and receive referrals from the above routes. People referred are then triaged and the Connector will work with them to identify what type of support or advice they need. There is a focus on encouraging people to self-manage where possible and consider more creative solutions to their arising issues and take charge of their next steps.

5. The service is time limited and is focused on connecting people with other organisations and activities, rather than working with them for long periods of time. There is a recognition that sometimes people's needs may be too complex and additional support will be needed – in these cases Social Prescribing will not be suitable.

What's next for Social Prescribing?

6. The Social Prescribing models in Norfolk will be evaluated centrally and will have a Health and Social Care focus. Full evaluation will be completed following the pilot while an initial six-month evaluation is due to report shortly. So far Social Prescribing has received 2,175 referrals and some localities have exceeded the early indicators around demand for the service. Norfolk County Council have also been working with the Life Chances Fund to plan for social prescribing services beyond the pilot period using a Social Impact Bond.

7. The NHS Long-Term Plan (January 2019) committed to make personalised care, including Social Prescribing, business as usual across the health and care system. NHS England recommend that 'Social prescribing connector schemes are commissioned collaboratively, with primary care networks, local authorities, CCGs, other local agencies, the voluntary and community sector and people with lived experience all working together.' Norfolk's Social Prescribing offer places us in a strong position and it will be important to consider locally how best to integrate the new resources within the existing models of Social Prescribing avoiding the risk of a fragmented system.

8. There are initial discussions across the CCG's to advise further on the existing model and options for development in collaboration. In addition, Social Prescribing services will sit within the context of the wider review and recommissioning of Information, Advocacy and Guidance services which has been reported on in previous quarters.

High Impact Change Model

1. The High Impact Change Model (HICM) is a mandatory national condition in the Better Care Fund, delivering the requirements of the HICM requires co-operation and engagement across the health and social care system. The model identifies eight system changes which will have the greatest impact on reducing delayed discharge.

2. There had been a national requirement for all 8 elements to be at a 'mature' level by March 2019, but it's now accepted that this will not be achieved everywhere. The expected level of maturity has been revised to March 2020.There are five levels of status reporting.
    1. Not yet established
    2. Plans in place
    3. Established
    4. Mature
    5. Exemplary

3. Following Q3 reporting, progress on the HICM was discussed at the A & E Delivery Board, where there was agreement of the Urgent and Emergency Care (UEC) Transformation Programme priorities and governance, and the impact this should have on system wide delivery of the HICM. As part of UEC Transformation Delivery Plan, 3 HICs have been identified as key areas of prioritisation to support implementation of the whole model across the system.
    - **HIC 1 – Early Discharge Planning** Current status **Plans in Place**
    - **HIC 2 – Systems to monitor patient flow** Current status **Established**
    - **HIC 4 – Discharge to Assess/ Homefirst** Current status **Established**

4. A review of Discharge to Assess has already been completed, reviews of the other two will be undertaken as a matter of urgency.

HIC 3 – Multi-disciplinary Discharge Teams (MDT): Current status **Established**. At James Paget University Hospital (JPUH), the Integrated Discharge Hub (Team) are now co-located with social care staff, housing officer and British Red Cross. Norfolk and Norwich University Hospital (NNUH) MDT practice includes social workers attending daily board rounds so they can be involved earlier in discharge decisions. At Queen Elizabeth Hospital (QEH), informed by the NHS Emergency Care Intensive Support Team intervention, board rounds practice is continuing to be developed alongside the reintroduction of Red2Green.

HIC 5 – 7-day service: Current status **Established**. QEH continue to use UEC Transformation winter monies to fund staff at weekends to ensure that discharges and the discharge planning function is maintained 7 days a week. At JPUH social workers in the acute hospital project are on rotas for 7-day coverage. The NNUH Integrated Discharge Team has a 7-day service.

HIC 6 – Trusted Assessor: Current status **Established**. The Trusted Assessment Facilitators project is moving to Phase 2 which will focus on the development of the Trusted Assessment form to take forward Phase 1 work. Workshops will be held in April/May with care home providers to co-produce a generic provider assessment form.

HIC 7 – Focus on Choice: Current status **Established**. System-wide, the Direction of Choice policy is currently being reviewed to ensure it aligns to national guidance. It is intended that the procedures across the different NHS Trusts will be combined into one document, which will then be agreed by the STP.

HIC 8 – Enhanced Healthcare in Care Homes (EHCH): Current status **Mature**. A draft STP EHCH plan for 2019-20 has submitted to NHS England. Following extensive engagement and feedback, a final version will be published during April 2019. (Please see Appendix 1).