Public Document Pack

# Agenda
Supplement

Dorset County Council

| | |
|---|---|
| Meeting: | Dorset Health and Wellbeing Board |
| Time: | 2.00 pm |
| Date: | 13 March 2019 |
| Venue: | Committee Room 1, County Hall, Colliton Park, Dorchester, DT1 1XJ |

**Mike Harries**
Chief Executive

Contact: Helen Whitby, Senior Democratic Services Officer
County Hall, Dorchester, DT1 1XJ
01305 224187 - h.m.whitby@dorsetcc.gov.uk

5. **Quarter 3: Better Care Fund Performance and Update** 3 - 12

To consider an updated Appendix 1 to the report.

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# Better Care Fund Template Q3 2018/19

## 1. Cover

**Version 1.01**

*Please Note:*
*- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. **Narrative sections of the reports will not be published.** However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
*- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.*
*- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.*



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|---|---|
| **Health and Wellbeing Board:** | Dorset |
| **Completed by:** | Johnny Pigott |
| **E-mail:** | jonathan.pigott@dorsetcc.gov.uk |
| **Contact number:** | (01305) 224227 |
| **Who signed off the report on behalf of the Health and Wellbeing Board:** | Helen Coombes |

**Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'**

**Complete**

| | Pending Fields |
|---|---|
| 1. Cover | 0 |
| 2. National Conditions & s75 Pooled Budget | 0 |
| 3. National Metrics | 0 |
| 4. High Impact Change Model | 0 |
| 5. Narrative | 0 |

<< Link to Guidance tab



**1. Cover**

| | Cell Reference | Checker |
|---|---|---|
| Health & Wellbeing Board | C8 | Yes |
| Completed by: | C10 | Yes |
| E-mail: | C12 | Yes |
| Contact number: | C14 | Yes |
| Who signed off the report on behalf of the Health and Wellbeing Board: | C16 | Yes |

| Sheet Complete: | | Yes |
|---|---|---|

**2. National Conditions & s75 Pooled Budget**

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| | Cell Reference | Checker |
|---|---|---|
| 1) Plans to be jointly agreed? | C8 | Yes |
| 2) Social care from CCG minimum contribution agreed in line with Planning Requirements? | C9 | Yes |
| 3) Agreement to invest in NHS commissioned out of hospital services? | C10 | Yes |
| 4) Managing transfers of care? | C11 | Yes |
| 1) Plans to be jointly agreed? If no please detail | D8 | Yes |
| 2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail | D9 | Yes |

| | | |
|---|---|---|
| 3) Agreement to invest in NHS commissioned out of hospital services? If no please detail | D10 | Yes |
| 4) Managing transfers of care? If no please detail | D11 | Yes |
| Have the funds been pooled via a s.75 pooled budget? | C15 | Yes |
| Have the funds been pooled via a s.75 pooled budget? If no, please detail | D15 | Yes |
| Have the funds been pooled via a s.75 pooled budget? If no, please indicate when | E15 | Yes |

| | |
|---|---|
| Sheet Complete: | Yes |

**3. Metrics**

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| | Cell Reference | Checker |
|---|---|---|
| NEA Target performance | D11 | Yes |
| Res Admissions Target performance | D12 | Yes |
| Reablement Target performance | D13 | Yes |
| DToC Target performance | D14 | Yes |
| NEA Challenges | E11 | Yes |
| Res Admissions Challenges | E12 | Yes |
| Reablement Challenges | E13 | Yes |
| DToC Challenges | E14 | Yes |
| NEA Achievements | F11 | Yes |
| Res Admissions Achievements | F12 | Yes |
| Reablement Achievements | F13 | Yes |
| DToC Achievements | F14 | Yes |
| NEA Support Needs | G11 | Yes |
| Res Admissions Support Needs | G12 | Yes |
| Reablement Support Needs | G13 | Yes |
| DToC Support Needs | G14 | Yes |

| | |
|---|---|
| Sheet Complete: | Yes |

**4. High Impact Change Model**

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| | Cell Reference | Checker |
|---|---|---|
| Chg 1 - Early discharge planning Q3 18/19 | F12 | Yes |
| Chg 2 - Systems to monitor patient flow Q3 18/19 | F13 | Yes |

| Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19 | F14 | Yes |
|---|---|---|
| Chg 4 - Home first/discharge to assess Q3 18/19 | F15 | Yes |
| Chg 5 - Seven-day service Q3 18/19 | F16 | Yes |
| Chg 6 - Trusted assessors Q3 18/19 | F17 | Yes |
| Chg 7 - Focus on choice Q3 18/19 | F18 | Yes |
| Chg 8 - Enhancing health in care homes Q3 18/19 | F19 | Yes |
| UEC - Red Bag scheme Q3 18/19 | F23 | Yes |
| Chg 1 - Early discharge planning Q4 18/19 Plan | G12 | Yes |
| Chg 2 - Systems to monitor patient flow Q4 18/19 Plan | G13 | Yes |
| Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan | G14 | Yes |
| Chg 4 - Home first/discharge to assess Q4 18/19 Plan | G15 | Yes |
| Chg 5 - Seven-day service Q4 18/19 Plan | G16 | Yes |
| Chg 6 - Trusted assessors Q4 18/19 Plan | G17 | Yes |
| Chg 7 - Focus on choice Q4 18/19 Plan | G18 | Yes |
| Chg 8 - Enhancing health in care homes Q4 18/19 Plan | G19 | Yes |
| UEC - Red Bag scheme Q4 18/19 Plan | G23 | Yes |
| Chg 1 - Early discharge planning, if Mature or Exemplary please explain | H12 | Yes |
| Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain | H13 | Yes |
| Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain | H14 | Yes |
| Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain | H15 | Yes |
| Chg 5 - Seven-day service, if Mature or Exemplary please explain | H16 | Yes |
| Chg 6 - Trusted assessors, if Mature or Exemplary please explain | H16 | Yes |
| Chg 7 - Focus on choice, if Mature or Exemplary please explain | H17 | Yes |
| Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain | H18 | Yes |
| UEC - Red Bag scheme, if Mature or Exemplary please explain | H23 | Yes |
| Chg 1 - Early discharge planning Challenges | I12 | Yes |
| Chg 2 - Systems to monitor patient flow Challenges | I13 | Yes |
| Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges | I14 | Yes |
| Chg 4 - Home first/discharge to assess Challenges | I15 | Yes |
| Chg 5 - Seven-day service Challenges | I16 | Yes |
| Chg 6 - Trusted assessors Challenges | I17 | Yes |
| Chg 7 - Focus on choice Challenges | I18 | Yes |
| Chg 8 - Enhancing health in care homes Challenges | I19 | Yes |

| | | |
|---|---|---|
| UEC - Red Bag Scheme Challenges | I23 | Yes |
| Chg 1 - Early discharge planning Additional achievements | J12 | Yes |
| Chg 2 - Systems to monitor patient flow Additional achievements | J13 | Yes |
| Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements | J14 | Yes |
| Chg 4 - Home first/discharge to assess Additional achievements | J15 | Yes |
| Chg 5 - Seven-day service Additional achievements | J16 | Yes |
| Chg 6 - Trusted assessors Additional achievements | J17 | Yes |
| Chg 7 - Focus on choice Additional achievements | J18 | Yes |
| Chg 8 - Enhancing health in care homes Additional achievements | J19 | Yes |
| UEC - Red Bag Scheme Additional achievements | J23 | Yes |
| Chg 1 - Early discharge planning Support needs | K12 | Yes |
| Chg 2 - Systems to monitor patient flow Support needs | K13 | Yes |
| Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs | K14 | Yes |
| Chg 4 - Home first/discharge to assess Support needs | K15 | Yes |
| Chg 5 - Seven-day service Support needs | K16 | Yes |
| Chg 6 - Trusted assessors Support needs | K17 | Yes |
| Chg 7 - Focus on choice Support needs | K18 | Yes |
| Chg 8 - Enhancing health in care homes Support needs | K19 | Yes |
| UEC - Red Bag Scheme Support needs | K23 | Yes |

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|---|---|
| Sheet Complete: | Yes |

**5. Narrative**

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| | Cell Reference | Checker |
|---|---|---|
| Progress against local plan for integration of health and social care | B8 | Yes |
| Integration success story highlight over the past quarter | B12 | Yes |

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| Sheet Complete: | Yes |

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## Better Care Fund Template Q3 2018/19

### 2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Dorset

**Confirmation of Nation Conditions**

| National Condition | Confirmation | If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed: |
|---|---|---|
| **1) Plans to be jointly agreed?** (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas) | Yes | |
| **2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?** | Yes | |
| **3) Agreement to invest in NHS commissioned out of hospital services?** | Yes | |
| **4) Managing transfers of care?** | Yes | |

**Confirmation of s75 Pooled Budget**

| Statement | Response | If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed: | If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY) |
|---|---|---|---|
| **Have the funds been pooled via a s.75 pooled budget?** | Yes | | |

## Better Care Fund Template Q3 2018/19

**Metrics**

Selected Health and Wellbeing Board: Dorset

**Challenges** Please describe any challenges faced in meeting the planned target
**Achievements** Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
**Support Needs** Please highlight any support that may facilitate or ease the achievements of metric plans

| Metric | Definition | Assessment of progress against the planned target for the quarter | Challenges | Achievements | Support Needs |
|---|---|---|---|---|---|
| NEA | Reduction in non-elective admissions | Not on track to meet target | Non Elective activity continues to increase, when compared to the previous year, this together with increased levels of frailty and acuity is challenging for all health and social care providers. | Initiatives are being commissioned and developed within NHS111 and CAS to manage emergency admissions.<br>Development of same day emergency care services and 7 day services are supporting a reduction in the need for acute admission, but demand continues to outweigh capacity. | NA |
| Res Admissions | Rate of permanent admissions to residential care per 100,000 population (65+) | On track to meet target | Dorset County Council is currently looking like it is not quite on track to meet target. Whilst our monthly BCF submission appears to paint a positive picture (a full-year rate projection of around 475 against a target of 513.7), we continue to experience issues with data lag. Once this is resolved, we expect the true full year picture to be slightly over target. We are implementing a number of approaches to tackle these issues which should allow for a more accurate picture each month and a better flow of data. | The current arrangements for localites to manage their block bed provision is has now been centralised and managed through brokerage to ensure that there is a consistent 'offer' to all Dorset residents and that delays are kept to a minimum. | There continues to be a shortfall in the market place for high quality and cost effective Older Person's Mental Health care home provision. |
| Reablement | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | On track to meet target | The challenge continues to be ensuring reablement services for Dorset are effective at supporting people to reable and reduce their long term support needs. A significant challenge is to ensure interim placements are kept to a minimum when domiciliary care/reablement is not available to ensure we do not create dependency, and that people are supported to return home. | The Health and Wellbeing Area is currently only 1.7% points below target between April 2018 and December 2018. The year to date actuals for this indicator are currently underreported due to a delay in data entry. The figures will be refreshed throughout the year. Whilst Dorset's year to date figure is 2.9% below target (77.1% against 80%), the more recent months are affected by an element of data lag. Once this has 'caught up', we expect our performance to just about meet target. | A dedicated commissioning colleague has been put in place to address and resolve issues with reablement, and to ensure the service maximises every opportunity for the person to get home as soon as possible. |
| Delayed Transfers of Care | Delayed Transfers of Care (delayed days) | Not on track to meet target | The most significant callenge to delay continues to be the market place for domiciliary care | Although the Health and Wellbeing area is not on track to meet the target, the number of delayed days year to date in 2018/19 is almost 3,000 fewer than the same period in 2017/18. The Dorset system continue to work jointly to reduce delayed days. Real time data reports identifying long stay and stranded patients within the Dorset acute Trusts are accessible across the Dorset system. Dorset County Council is on track to meet its target for the number of Social Care-attributable delays. Against a target of 9 delays per day, in Quarter 3 there | The daily calls and meetings need to continue to ensure there is a good 'flow' in the system. Commissioning colleagues are now focused on addressing any issues with reablement opportunities and efficiencies in the system. |

**Better Care Fund Template Q3 2018/19**

**4. High Impact Change Model**

Selected Health and Wellbeing Board: Dorset

| | |
|---|---|
| **Challenges** | Please describe the key challenges faced by your system in the implementation of this change |
| **Milestones met during the quarter / Observed Impact** | Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change |
| **Support Needs** | Please indicate any support that may better facilitate or accelerate the implementation of this change |

| | | | | | | Narrative | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **Q1 18/19** | **Q2 18/19** | **Q3 18/19 (Current)** | **Q4 18/19 (Planned)** | **If 'Mature' or 'Exemplary', please provide further rationale to support this assessment** | **Challenges** | **Milestones met during the quarter / Observed impact** | **Support needs** |
| Chg 1 | **Early discharge planning** | Established | Established | Established | Established | | Continued high levels of NEL demands and acuity of patients continues to provide challenges. This is compounded with workforce vacancies across health and social care organisations in Dorset. It is recognised that all staff should be trained in good discharge process. | There is a pan Dorset ICS programme of work which has been established and work has begun on improving the process for supporting stranded patients. There is planned regular meetings and calls in place focussing on this area. There is an identified pathway of highlighting which patients need to be picked up under this pathway and regular review and learning workshops. U&EC transformation funding of £257k supporting this strand of work plus the some of the LA winter money. | N/A |
| Chg 2 | **Systems to monitor patient flow** | Established | Established | Established | Established | | Pressures continue within the system and demand for health and social care remains high. Care capacity in private providers, domicilliary care and reablement services can cause bottlenecks. This continues to prove problematic in regards to recrutiment and retention of staff. | There are regular forums now established that have good attendance at a senior level where patient flow is discussed, monitored and where needed issues addressed and changes made to improve patient flow. There is a dedicated focus around front of house which is linking in with the ICPCS plans which is beginning to see positive outcomes. | N/A |
| Chg 3 | **Multi-disciplinary/multi-agency discharge teams** | Established | Established | Established | Established | | Workforce capacity in the voluntary / community sector can be an issue when attendance is required at MDTs or other specific meetings, and due to winter pressures. | Continuation of the Integrated discharge hubs in the acute hospitals. The discharge bureaus are working as one which involves doing cross cutting work across LAs which is a real positive and is reducing duplication and creating more time for patient assessments. The greater focus and dedicated staff being applied to front of house encompasses a whole system approach to discharge and is showing really positive signs within the acutes and at the same time bringing benefits to patients being able to return home promptly. | N/A |
| Chg 4 | **Home first/discharge to assess** | Established | Established | Established | Established | | Challenges with capacity in the care market impact on the successful implementation of a D2A model.<br>Ongoing pressures continue to cause high demand for all services.<br>The observed improved impact of the Dorset Care Framework mobilisation is being monitored and areas of capacity are raised and potential difficulties are discussed. Systems are also in place to monitor off-system referrals. | Home first and D2A is embedded in daily practice and the use of the winter money has enabled homefirst/D2A to have a good responsiveness. The LA's have in place services that are accessed for discharge in line with the principles of homefirst and these are now up and running and these once again are linked to the LA's winter plans. | N/A |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Chg 5 | **Seven-day service** | Plans in place | Plans in place | Plans in place | Plans in place | | The challenge continues to be that planned discharges take place at weekends, but a lack of certain services at weekend continue to mean that an increase in discharges cannot be achieved consistently. | The LA winter money has enabled there to be an extension to working hours running into the evening and has enabled weekend cover to be in place for longer periods of time. This also covers being able to access Brokerage and other operational teams. These | N/A |
| Chg 6 | **Trusted assessors** | Established | Established | Established | Established | | Consistent uptake across all providers Information sharing across health and social care | TA is embedded with the hospital discharge process and is done collectively with LA's and hospital staff. | N/A |
| Chg 7 | **Focus on choice** | Established | Established | Established | Established | | Community options can limit the effectiveness, the implementation and compliance of the Choice Policy. | The LA's have been involved and continue to be involved in difficult conversations and have escalation processes in place and we would suggest that a review of the hospital discharge standards and the discharge policy and choice elements within that are reviewed and changes made where necessary. | N/A |
| Chg 8 | **Enhancing health in care homes** | Established | Established | Established | Established | | Scale of the change required for full implementation. | 1. Enhanced primary care support plans being implemented within enhanced frailty services; 2. 2 out of 5 localities have Care Home Forums established; 3. Care Home conveyancing task and finish group established. 4. Locality care home mapping completed and available; 5. Care home conveyance dashboard developed by CCG Business Intelligence. | Support from NHSE particularly with implementation of the DSP toolkit. Continuued leadership from system partners. Continued development of data and intelligence to inform planning and improvement. |

**Hospital Transfer Protocol (or the Red Bag scheme)**

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

| | | Q1 18/19 | Q2 18/19 | Q3 18/19 (Current) | Q4 18/19 (Planned) | If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents. | Challenges | Achievements / Impact | Support needs |
|---|---|---|---|---|---|---|---|---|---|
| UEC | **Red Bag scheme** | Established | Established | Established | Established | | Further work is underway as part of the Urgent and Emergency care place based evaluation and with Wessex AHSN to evaluate the programme. | A combined task and finish group with representation from the CCG, Community Services, Acute trusts, Ambulance Service and Care Homes is driving forward a relaunch of the red bag scheme across the county. The programme and pathway have been reviewed and a complehensive implementation plan developed to ensure that the programme is fully and consistently embedded accross Dorset. | NA |

# Better Care Fund Template Q3 2018/19

**5. Narrative**

Selected Health and Wellbeing Board: Dorset

| Remaining Characters: | 19,199 |
|---|---|

**Progress against local plan for integration of health and social care**

The Dorset Better Care Fund has continued to evolve throughout quarter three, particular highlights include the Dorset Care Framework being reopening in January 2019. The Dorset Care Framework is a key element to achieving the BCF metrics as it offers the opportunity to gain some structure and control over a marketplace where the vast majority are self-funding, current joint spend on framework has now acheived 89% for domicillary care. The Home First Project has now been approved and various elements have been expedited to support winter pressures. A cohesive system of both increased social work capacity within acutes, increased capacity within the domicillary care market, and the incorporation of voluntary sector resources are in place to manage increase demand through the winter period.

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

| Remaining Characters: | 16,539 |
|---|---|

**Integration success story highlight over the past quarter**

Maintaining Independence - Over the last quarter the scope of the promoting independence project has been defined and the 'as is' discovery phase started; this has included mapping the customer journey and seeking customer insight through a survey and focus groups. This as is working will support the 'to be' design of the new pathway and how the commissioning services and workforce will support this in the future.

The technology enabled care team has continued to support a culture shift towards technology and collated a number of customer stories and how assistive technology solutions have supported their independence, as well as delivered savings in care packages and hospital admissions. This includes the story of a dementia patients who has been able to continue his daily walks unaided with a GPS and falls detector that his wife can monitor with peace of mind.

Carers Narrative (integration success story) - the council and CCG have jointly agreed future approach for development of carers offer and delivery is now being planned for a go live date around May/ June 2019. Two specific initiatives being progressed this quarter relate to:

1.GP PRACTICE CARERS SUPPORT ACCREDITATION SCHEME which sets out best practice in providing appropriate support for carers and the person they are caring for, enabling GP practices to develop a culture of proactively recognising and responding to carers' issues and needs. It will be piloted in the North Dorset locality in 2019 with NHS Dorset CCG commitment to roll-out across the County in 2020. This scheme is a Preventative At Scale locality project – the majority of carers are not registered and are therefore not receiving proactive information, guidance or support. Key Outcomes/Successes to date are that all North Dorset GP Practices are committed in principle to participate in this accreditation scheme. NHS Dorset CCG, Dorset Community healthcare Trust, GP practices and Dorset County Council are jointly investing in funds and staffing resource to deliver this accreditation scheme and have committed to find a way to roll this out to the rest of the county in 2020.

(The key benefits of this scheme are:

- Development of a 'Caring for Carers' culture in all GP practices.
- Consistent, coordinated whole-team approach to providing proactive support for carers.
- Increased levels of registration of carers with their GP practice and Local Authority.
- More personalised service for the carer, i.e. flexibility when booking healthcare appointments, annual health check, signposting to appropriate services.
- Better integration with other statutory and VCS services providing carers with personalised information, advice and support.
- Prevention of avoidable crises for carers and better coordination in response to unavoidable crises.
- Increased opportunity for peer-to-peer support between carers and other user-led initiatives, supported by GP practice Carers Leads.)

2.CARERS TRAINING – a joint plan is being agreed for commissioning carers training to benefit people caring for people with mental health problems, and all other carers of all ages, with a variety of delivery modes including

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.