NHS
Wolverhampton
Clinical Commissioning Group

WOLVERHAMPTON CCG

Governing Body
12th February 2019

Agenda item 9

TITLE OF REPORT:	Quarterly Update Better Care Fund Programme
AUTHOR(s) OF REPORT:	Andrea Smith, Head of Integrated Commissioning
MANAGEMENT LEAD:	Andrea Smith
PURPOSE OF REPORT:	To provide an update on progress of the Better Care Fund Programme
ACTION REQUIRED:	☐ **Decision** ☒ **Assurance**
PUBLIC OR PRIVATE:	This Report is intended for the public domain
KEY POINTS:	• This report provides key highlights, risks and Issues across the programme • The national planning guidance for BCF post March 2019 has still not been published. Preparatory work is being undertaken to shape the programme for the future.
RECOMMENDATION:	To inform the Governing Body on the work being undertaken within the Better Care Fund Programme
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	
1. Improving the quality and safety of the services we commission	Within the BCF programme we continually aim to improve the quality and safety of the services we commission by reviewing current pathways and processes and developing integrated health and social care pathways where this will improve both the quality and the patient experience.
2. Reducing Health Inequalities in Wolverhampton	The BCF programme strives to ensure that health inequalities are reduced across the City. The plan is based on data and evidence which allows us to understand the health inequalities that we are aiming to address
3. System effectiveness delivered within our financial envelope	The Better Care fund programme is supported by a pooled budget with the City of Wolverhampton Council. The pooling of resources gives us the opportunity to use our resources more effectively together

1. BACKGROUND AND CURRENT SITUATION

1.1. The Better Care Fund Programme is a programme of work across multiple organisations across the City including WCCG, City of Wolverhampton Council (CWC), Royal Wolverhampton Trust (RWT), Black Country Partnership Foundation Trust (BCPFT), Wolverhampton Homes, Wolverhampton Voluntary Sector.

1.2. Organisations work together in an integrated way aiming to improve pathways and services to patients moving care closer to home where appropriate.

1.3. The programmes vision statement is "*'Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them to live longer, healthier and more independent lives no matter where they live in the city. Health & Social Care colleagues will work better together, alongside local community organisations to deliver support closer to where individuals and families live and in line with their needs'*

1.4. This is visualised below:-

Figure 1 BCF Vision

1.5 The Programme consists of 5 Workstreams; Adult Community Care, Mental Health, CAMHS, Dementia and Integration. Each workstream has a lead from WCCG and CWC and a Provider lead and members from all key stakeholders appropriate to the work being undertaken.

2. NATIONAL METRICS

2.1. **Delayed Transfers of Care**.

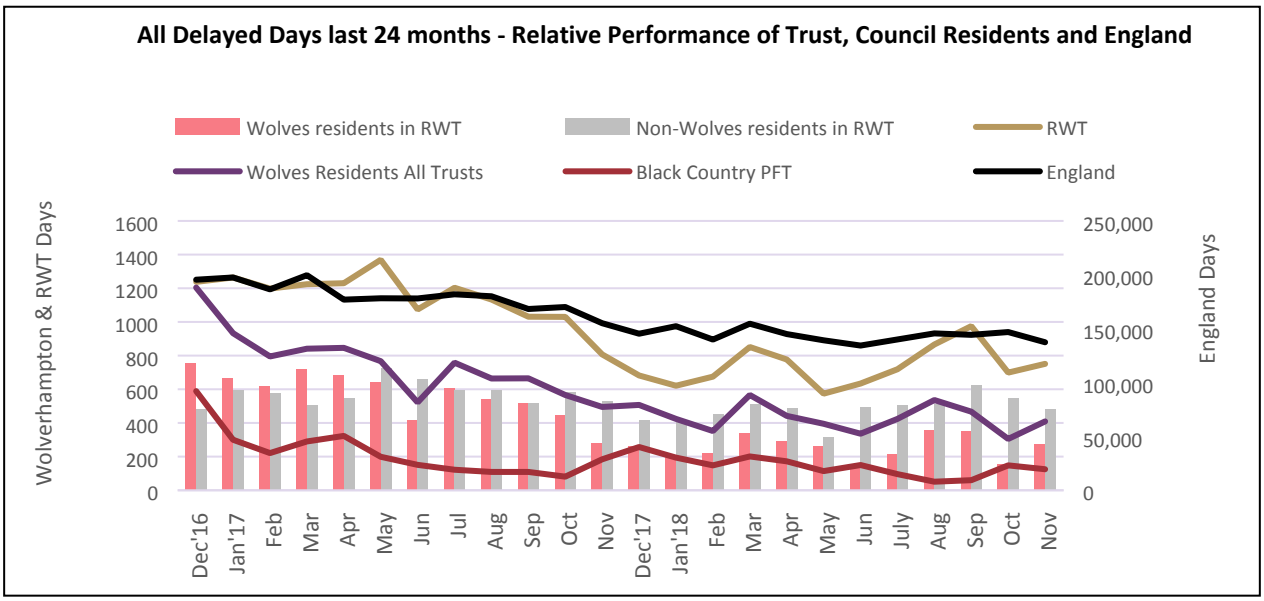

Figure 2 - Relative performance between December 2016 and November 2018 (Source: NHS Statistics)

2.2. The last 24 months data from December 2016 to November 2018, is set out in Figure 1 above. This shows a significant overall reduction in the levels of monthly delayed days over this period, however March, July and August saw reversals in this trend with increases in delays both locally and nationally. However, October saw the best DToC performance for Wolverhampton residents for many years and although November has since seen an increase in the number of delays it is still within target.

2.3. The relative performances of residents from the City of Wolverhampton Council (CWC) and patients treated in the Royal Wolverhampton Trust (RWT) and the Black Country Partnership Foundation Trust (BCPFT) are also included in the chart.

2.4. The latest daily delays rate per 100,000 population aged 18 and over for Wolverhampton residents when calculated over the eight months of the year to date is 6.8 against an NHS England 'ambition' of 7.4 and so remains below target. Additionally, the last ten months relative performances against comparators are shown below.

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
England	11.5	11.5	11.1	10.3	10.3	10.4	10.8	11.1	10.9	10.5
Wolverhampton	6.4	9.2	7.5	6.4	5.7	6.9	8.7	7.8	4.9	6.8
West Midlands	12.6	13.5	13.6	12.3	12	11.9	12.3	12.1	11.7	12.1
CIPFA Group	9.5	10	9.2	9.5	8.7	8.5	9.8	10.2	10.3	9.2

Figure 3 Daily Delays Rate per 100,000 18+

2.5. **Reduction of Non-Elective Admissions**.

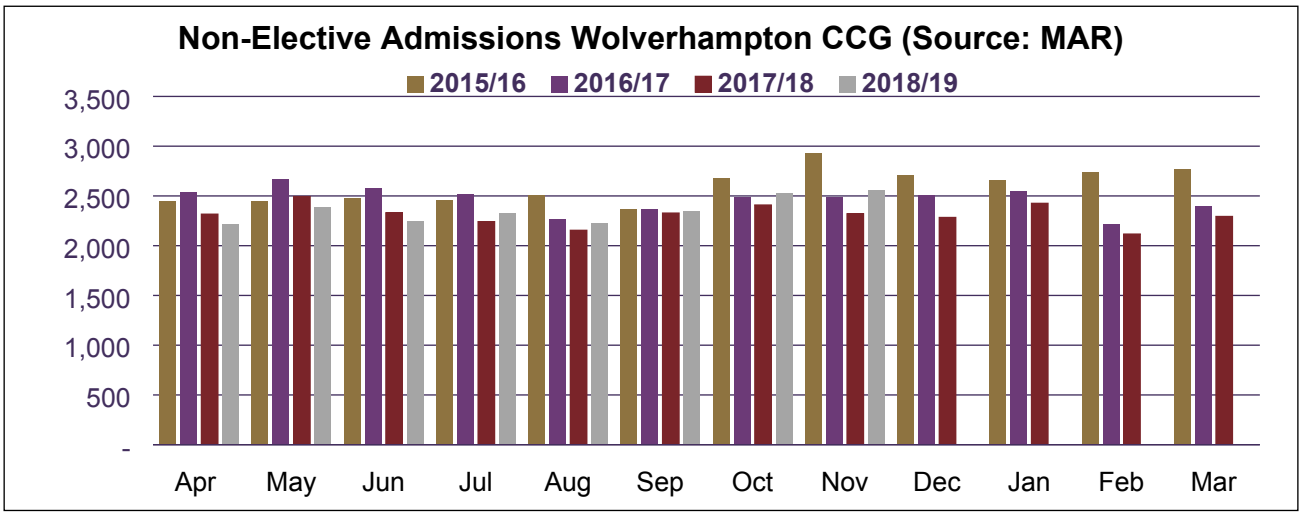

Figure 4 Non-elective admissions

2.6. The columns shown above in Figure 4 represent the Emergency Admission figures over the last 44 months contained within the NHS Monthly Activity Reports (MAR) for the Wolverhampton CCG and until recently these indicated an overall long-term trend of reduction since a peak in November 2015.

2.7. However, the five months since July have seen the first sustained monthly year on year increases in Emergency Admissions since June/July 2016. This can be compared with the growth in the equivalent rate at national level in Figure 5 below.

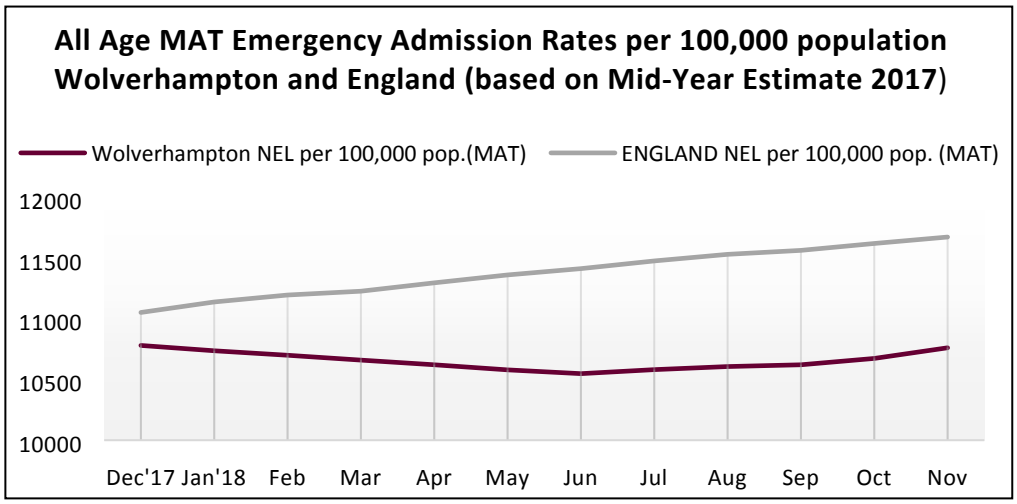

Figure 5 Admission rates

2.8. Permanent Admissions to Residential Homes.

2.9.1 The latest reported number of permanent admissions of people aged 65 and over to residential and nursing homes for the month of December (Figure 5) of 31 is higher than last year and continues the trend of increases since the start of the reporting year with the monthly target of just under 22 admissions (260 in the year) being met only twice in the year to date.

2.10 The year-end total for 2017-18 was 283 which although above the target figure of 260 was 102 admissions (26.5%) lower than the outturn in the previous year. The latest year-end estimate based on nine months performance is now 327 admissions and 26% above target.

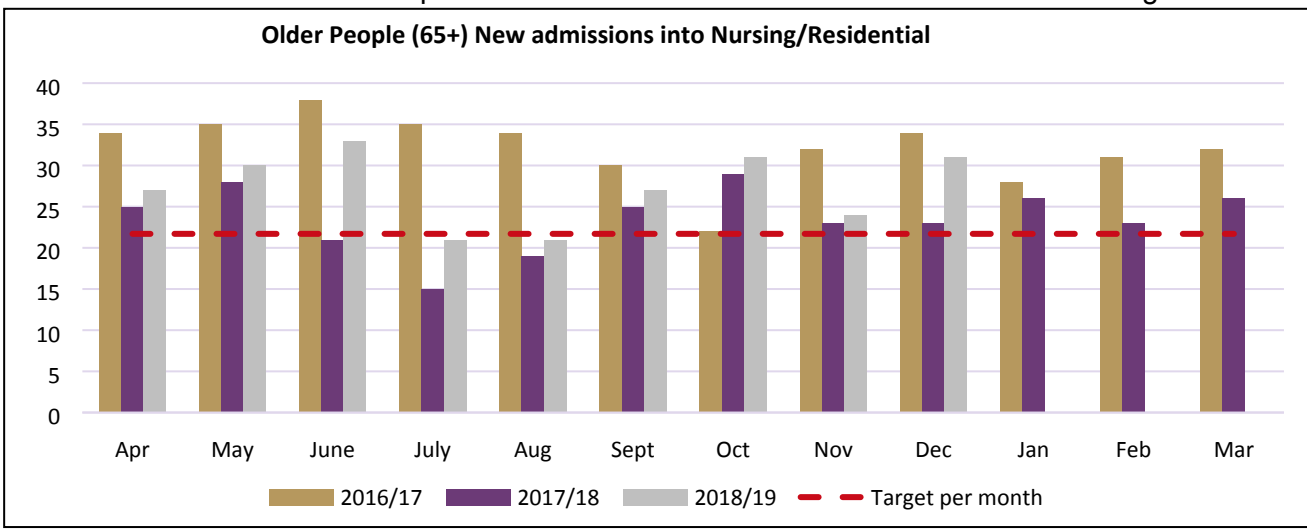

Figure 6 – Permanent Admissions of Older People to Care Homes over the last 33 months (Source: CareFirst)

2.11 Reablement – The proportion of older people (over 65) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services.

2.12 This figure is currently only calculated once a year and is made available each October as part of the SALT Return.

2.13 The provisional outturn for ASCOF 2B Part 1 (Effectiveness of reablement) based on the latest SALT Return for 2017-2018 is 80.7% which represents an improvement on the same figure for 2016-2017 of 74.5%.

3 HIGHLIGHTS

3.1 Co-Location of the NE Community Neighbourhood team

During the middle of December the first of the Community Neighbourhood teams was located at Wolverhampton Science Park. The core team consist of Community Matrons, District Nurses, and the Social Care team for the North Locality. In addition there are hot desks to allow additional staff such as Mental Health, Social Prescribing and Housing Colleagues to work with the team.

In a very short time there has already been positive feedback about the professions working together to manage patients and undertaking joint visits. This all supports our vision of care closer to home and more personalised care.

Work is ongoing with the team, now that they are settled to enhance the integrated working and to widen this further in line with the NHS long term plan in exploring how the team work in the future with Primary Care Networks.

Suitable premises will be sought for the South East and South West localities to enable this integrated model or working to be rolled out across Wolverhampton.

3.2 MDT working

Work continues to roll out MDTs across the City. There are three locality based MDT meetings which meet monthly and there are now a number of Primary Care based MDTs in place. Some are individual practice based and some are practices working together. Again, in line with the Long Term Plan we will be working to deliver MDTs wrapped around Primary Care Networks in the future where possible.

The current MDTs are proving positive and effective. The MDT held on 30th January with Parkfield Medical Practice and Duncan Street Surgery was extremely well attended with presence from GPs, Compton Care, Social Worker, CPN, Practice Nurse Practitioner, Social Prescribing Link Worker, Thrive to Work, Wolverhampton Homes and District Nursing. The MDT meetings are an opportunity to discuss patients with complex needs and to have support from a wide range of organisations and professions in the management of the patient.

Below is a case study from an MDT meeting

The Scenario…

- 82 year old male with a medical history of Hypertension, Type 2 Diabetes, Hypercholesterolemia and Chronic Kidney Disease 3.
- Over the last year (2018) patient has experienced 2 bouts of acute chronic renal failure. In August 2018 he refused to have further treatment following his bloods tests and refused to engage with health professionals.
- Attends dialysis appointments 3x a week
- Patient does not want any help or support from services
- Patient is the main carer for his wife who suffers with severe dementia who will be returning from a Respite Care Home. Patient is in discussion with Social Worker to arrange leaving current home and moving into 'Very Sheltered Housing

What we did…

Worked with Social Prescribing, Community Matrons, Clinical Pharmacist, Social Worker and Advance Nurse Practitioner

GP made referral via WUCTAS to Community Matron for patient to be seen, Social Prescribing Team met with patient once consent gained, they managed to meet with patient and his family and arranged;

- A Blister Pack to be arranged as patient was starting to get confused with his medication and had started to rely on others - **Social Prescriber arranged this with Pharmacist, patient receives Medication via Blister Pack**
- Patient informed their Social Worker he will look after his wife, however will need to attend his dialysis appointment 3x a week, this became a worry to his family, if there is no one to look after his wife during his appointment's he will not attend, also the appointments are based at different places each time (Wolverhampton, Cannock and Walsall) **ANP discussed patients appointments with Renal Lead at New Cross, Community Matron also followed up Dialysis to be at one setting**
- Social Services and patient are working on moving from current address to Very Sheltered accommodation – **Form Is in process Social Care Manager will monitor application progress**

The Outcome…

Patient's appointments are now 3x weekly at Walsall Hospital, sitting service has been arranged by the Social Workers, patients wife is not alone during his dialysis appointments, this has helped a lot due to ensure patient is now compliant with treatment.

Community Matron went out to see patient and mentioned he is doing very well, getting support from family and excellent support from the Social Prescribing Team.

3.3 Winter Pressures

In order to support winter pressures the BCF team worked together to put in place a number of short term solutions across the City. Social Care have led on the expansion of their Rapid Assessment service and additional reablement service so that this now has more capacity and operates City wide. The CCG, in collaboration with partners have commissioned a number of Step Up beds in a nursing home with the aim of supporting admission avoidance. These beds are for patients who are not unwell enough to be admitted to hospital but because of their presenting wellbeing and/or social situation require a period of additional support. The Step up beds are supported by social care and by a service run by the Red Cross that can transport patients to and from the Step up (and Step Down) beds and can resettle patients back home when required. The beds are accessible from RITs, ED, CDU and the Frailty Unit.

4 CLINICAL VIEW

4.11 Clinical view is taken upon each individual project that the programme delivers where necessary

5 PATIENT AND PUBLIC VIEW

5.11 Patient and public view is taken upon each individual project that the programme delivers where necessary

6 KEY RISKS AND MITIGATIONS

6.11 Outline the key risks associated with the report; this should include any reputational risks, litigation etc. You should also highlight any controls or actions in place to mitigate these risks.

6.12 Highlight whether the report either specifically relates to risks included on the risk register or if any risks need to be escalated.

7 IMPACT ASSESSMENT

Financial and Resource Implications

7.11 This report acts as a progress update and any financial implications are managed through the BCF Programme Board.

Quality and Safety Implications

7.12 This report acts as a progress update and any quality and safety implications are managed through the BCF Programme Board.

Equality Implications

7.13 Each individual project within the BCF Programme will undertake an equality impact assessment.

Legal and Policy Implications

7.14 Any legal and policy implications for individual projects will be managed by the BCF Programme Board.

Other Implications

7.15 N/A

Name: Andrea Smith
Title: Head of Integrated Commissioning
Date: 30.01.19

ATTACHED:

RELEVANT BACKGROUND PAPERS
Wolverhampton Integration and Better Care Fund Plan 2017-19

REPORT SIGN-OFF CHECKLIST

	Details/ Name	Date
Clinical View	**N/A**	**30.01.19**
Public/ Patient View	**N/A**	**30.01.19**
Finance Implications discussed with Finance Team	**N/A**	**30.01.19**
Quality Implications discussed with Quality and Risk Team	**N/A**	**30.01.19**
Equality Implications discussed with CSU Equality and Inclusion Service	**N/A**	**30.01.19**
Information Governance implications discussed with IG Support Officer	**N/A**	**30.01.19**

Legal/ Policy implications discussed with Corporate Operations Manager	**N/A**	**30.01.19**
Other Implications (Medicines management, estates, HR, IM&T etc.)	**N/A**	**30.01.19**
Any relevant data requirements discussed with CSU Business Intelligence	**N/A**	**30.01.19**
Signed off by Report Owner (Must be completed)	**Andrea Smith**	**30.01.19**

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BOARD ASSURANCE FRAMEWORK NOTES

(Please **DELETE** before submission)

Following a review of the BAF, it will now be based on the risks associated with the CCG achieving its strategic aims and objectives as follows:-

Strategic Aims	Strategic Objectives
1. Improving the quality and safety of the services we commission	a. Ensure on-going safety and performance in the system Continually check, monitor and encourage providers to improve the quality and safety of patient services ensuring that patients are always at the centre of all our commissioning decisions
2. Reducing health inequalities in Wolverhampton	a. Improve and develop primary care in Wolverhampton – Deliver our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this b. Deliver new models of care that support care closer to home and improve management of Long Term Conditions Supporting the development of Multi-Speciality Community Provider and Primary and Acute Care Systems to deliver more integrated services in Primary Care and Community settings
3. System effectiveness delivered within our financial envelope	a. Proactively drive our contribution to the Black Country STP Play a leading role in the development and delivery of the Black Country STP to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint. b. Greater integration of health and social care services across Wolverhampton Work with partners across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.' c. Continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework d. Deliver improvements in the infrastructure for health and care across Wolverhampton The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.