Shropshire Council

Date: Thursday, 10 September 2020

Time: 9.45 am

Venue: THIS IS A VIRTUAL MEETING - PLEASE USE THE LINK ON THE AGENDA TO LISTEN TO THE MEETING

Contact: Michelle Dulson, Committee Officer
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HEALTH AND WELLBEING BOARD

TO FOLLOW REPORT (S)

5 System update (Pages 1 - 8)

Regular update reports to the Health and Wellbeing Board are attached:

STP Update

A presentation will be given.
Contact: STP Representative, Shropshire CCG

Shropshire Care Closer to Home

A presentation will be given.
Contact: Lisa Cliffe, Deputy Director of Performance & Delivery, Shropshire CCG

Better Care Fund

Report to follow.
Contact: Penny Bason, STP Programme Manager / Covid Community Response Lead

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Health and Wellbeing Board
10th September, 2020

HWBB Joint Commissioning Report - Better Care Fund Performance Update

Responsible Officer
Email: Penny.bason@shropshire.gov.uk Tel: Fax:

1. Summary

1.1 This report provides an update on the performance of the Better Care Fund (BCF) for Quarter 4 19/20 (Appendix A) an update for 20/21 progress, including an amendment to the BCF Section 75 Agreement (schedule attached in Appendix B), adjustments made to support people through the Covid 19 pandemic, the financial proposal for 20/21, and provides a brief summary of the national BCF support offer.

2. Recommendations

2.1 The HWBB endorse Appendix A, the BCF performance template and metrics.
2.2 The HWBB endorse Appendix B, Schedule 1 addendum to the Section 75 Partnership Agreement

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities. Covid 19 has shone a light on inequalities and requires all of our services to further risk assess individual risk and to support the population who are at increased risk of ill health due to Covid 19.

3.3. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research.

3.4. Continued reliance on grant funding (iBCF and Winter Pressures), to support system flow, admissions avoidance and transfers of care schemes, holds significant financial risk should the grant funding stop.

4. Financial Implications
Better Care Fund Allocations

	2020/21	2019/20
Pooled Fund		
Shropshire CCG Minimum Contribution	7,475,229	7,098,207
Shropshire CCG Additional Contribution	304,073	681,095
Total	**7,779,302**	**7,779,302**
Non-Pooled Fund		
Shropshire CCG Minimum Contribution	14,607,995	13,839,000
Original iBCF Grant	8,153,519	8,153,519
Additional iBCF Grant	1,967,260	1,967,260
Winter Pressures Grant	1,393,823	1,393,823
Disabled Facilities Grant	3,209,291	3,209,291
Additional Shropshire Council Contribution	1,831,023	4,632,133
Total	**31,162,911**	**33,195,026**
Total Better Care Fund	**38,942,213**	**40,974,328**

5. Background

5.1. The BCF in 20/21 continues to provide a mechanism for personalised, integrated approaches to health and care to support people to remain independent at home or return to independence after an episode in hospital. The Better Care Fund performance reporting includes the monitoring of additional grant funding known as IBCF (Improved Better Care Fund) and Winter Pressures funding. The performance reporting requirement has been reduced due to Covid 19, however the return prepared is similar to previous performance reports.

5.2. As a reminder, the priorities of the BCF (including improved Better Care Fund monies and Winter Pressures funding) continue to be:

5.2.1. **Prevention** – keeping people well and self-sufficient in the first place; Healthy Lives, including community referral (Let's Talk Local and Social Prescribing), Dementia Companions, Voluntary and Community Sector, Population Health Management, carers, mental health)

5.2.2. **Admission Avoidance** – when people are not so well, how can we support people in the community; out of hospital focus (Care Closer to Home, Integrated Community Services, new admission avoidance scheme), carers and mental health

5.2.3. **Delayed Transfers and system flow** - using the 8 High Impact Model; Equipment contract, Assistive technology, Integrated Community Service, Red Bag

5.3. The Quarter 4 performance report (**Appendix A**) highlights Care Closer to Home as our 'Integration Success Story'; The report also highlights that Shropshire is on track to achieve the Residential Admissions, Reablement, and Delayed Transfers of Care (DTOC) targets. For Q4 the CCGs were 4.6% below plan for Non-Elective Admissions. This was largely due to a significant underachievement against plan in last 2 weeks March due to

Covid 19. This was 16% below expectations, whereas Feb was almost exactly on plan, and Jan 3.2 % above plan. The majority of the Q4 template has been completed, however, due to the pandemic the reporting requirement was reduced for Q4 for a minimum return of the following parts:

5.3.1. Tab3: National Conditions
5.3.2. Tab6: Integration Highlights
5.3.3. Tab8: Income and Expenditure
5.3.4. Tab9: Year End Feedback, Part 1

5.4. Shropshire has been working at a STP system level to develop the 8 High Impact model designed to support local system partners to improve health and wellbeing, minimise unnecessary hospital stays and encourage them to consider new interventions. The performance report for Q4 19/20 highlights that as a system we are self-assessed as working to a mature level for monitoring patient flow, multi-agency discharge teams, home first/ discharge to assess and Trusted Assessors; we have established schemes for Early Discharge Planning, Seven Day Services, Enhancing Health in Care Homes and Red Bag scheme.

5.5. For 20/21 the High Impact Change model has been updated to reflect the changes brought about by COVID-19; details can be found here https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high/about

5.6. Additionally, the BCF planning for 20/21 has taken account of the new requirements and Covid 19 guidance; BCF planning and delivery continue to work through our key priority areas, as set out above, and are delivered through the funding detailed in the financial section 4 above.

5.7. To respond to COVID – 19 the system rapidly put in place key working and governance groups to adapt to what was needed. For hospital discharge and admission avoidance this took the following form:

Covid 19 Discharge Process Operational Group

Care Pathways: Hospital discharge

Local Health Resilience Partnership (LHRP)

5.8. The Covid 19 Discharge Process Operational Group managed the regular Care Act processes and the 4 discharge pathways, to deliver the discharge to assess pathways as set out in the COVID 19 guidance. Pooled funding associated with the discharge and admission avoidance during the Covid Pandemic is set in Schedule 1, Section 75 (**Appendix B)**.

5.9. Additional adjustments for BCF funded programmes were made as a result of the Covid 19 pandemic. A high level summary includes:

5.9.1. Let's Talk Local and Social Prescribing – phone and electronic based assessments and one to one support; Social Prescribing expanded to the whole of the county during lockdown, through a range of referral mechanisms including Shropshire Council Customer Services and the Community Reassurance Teams

5.9.2. Voluntary and community sector – commissioned services moved to phone based and online services; the sector provided home shopping schemes, befriending, medicine collection, and online mental health support

5.9.3. Mental Health – services were adjusted to ensure Covid 19 guidance compliancy; and staffing was adjusted to respond to the pandemic.

5.9.4. Care Closer to Home – the programme paused to allow a review of the data and development of next phases; this has been delayed due to Covid 19, however is moving forward as part of transformation, the STP Community and Place Based work and winter planning.

5.9.5. Integrated Community Services – This service remained in place but responded to Covid 19 Discharge to Assess processes. Key aspects in response to Covid 19 was to move people out of hospital very quickly and to stop people from coming into to hospital, whilst ensuring all processes were Covid secure (including all work with other hospital and social care providers).

- On the 19th March 2020, as a response to the national Covid-19 pandemic, Social Care along with health partners were required to implement changes to the complex discharge pathway to support rapid step down to community services in line with a discharge to assess model.

- In July 2020, the government released further requirements stating that following the success of the changes made to complex discharge pathways nationally all local systems now need to stabilise their improvements to secure ongoing delivery as we enter Winter 20/21

- Locally, system partners worked together to support the operational development of an integrated discharge team, providing an 8-8pm 7 days a week service. The integrated discharge team comprised of health and social care staff from across all organisations providing an enhanced skill mix and holistic approach to discharge planning.

- The results of the integrated hub model have been really successful, resulting in a length of stay reduction of 2.5 days, 7% increase in the number of patients discharging home with support and a 50% reduction in requests for pathway 3 nursing care home provisions.

- At the start of this process there was an average of 12.2 complex discharges per week day. This has increased to 25 at its highest, and weekend complex discharges have increased from 6.25 to 8.5.

- The ratio of complex discharges VS simple has increased by 10% during this period. From March- June 22% of all discharges within Shrewsbury and Telford Hospitals (SaTH) are complex compared to 12% prior to Covid 19, indicating that if demand continues in this trend then investing in complex discharge and streamlining the model is a key focus for the system

5.10. The system continues to work collaboratively to deliver the iBCF and Winter Pressures funding; both supporting winter planning and delivery. Currently there has not been confirmation that iBCF and Winter Pressures grant funding will continue in 21/22. This continues to be highlighted as a risk for our health and care economy.

5.11. The national Better Care Fund team continues to provide support to local areas to improve integration, and more recently to navigate changes associated with Covid-19. As

such the Team has provided a support offer to all local areas. The support includes 4 key areas:

5.11.1. Enable ongoing implementation of integration and Better Care Fund policy and programmes

5.11.2. Identify and share impact of, and learning from implementing and embedding integration ambitions

5.11.3. Support local systems to overcome challenges through tailored packages of expertise and sharing national learning

5.11.4. Inform and influence national policy and practice developments

5.12 The Joint Commissioning Group will monitor need for additional support in the system.

5.13 The Better Care Fund progress is reported at every Health and Wellbeing Board through the Joint Commissioning Report to the HWBB and can be found on the Shropshire Council website.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **For the final BCF plan please see HWBB paper here**
Cabinet Member (Portfolio Holder) Cllr Dean Carroll, Adult Social Services and Climate Change
Local Member n/a
Appendices **Appendix A BCF Q4 Template** **Appendix B Schedule 1, Section 75 Partnership Agreement**

Appendix A – BCF Q 4 return submitted as a separate document

Appendix B – Schedule 1 Section 75 Partnership Agreement
The Partners have agreed the following new Individual Schemes:

Covid-19 Hospital Discharge Scheme ("Scheme").

1. On 19 March 2020 the Government issue the COVID-19 Hospital Discharge Service Requirements ("the guidance") setting out the basis on which individuals meeting the criteria set out in the guidance would be funded (from the date the guidance was issued). The key principle of the guidance is that unless required to be in hospital, patients must not remain in an NHS bed.

2. Paragraph 1.6 of the guidance provides

> "The Government has agreed the NHS will fully fund the cost of new or extended out of-hospital health and social care support packages, referred to in this guidance. This applies for people being discharged from hospital or who would otherwise be admitted into it"

In addition, paragraph 10.4 provides:

> "This NHSE&I funding support will commence from Thursday 19th March 2020 and will reimburse, via CCGs, the costs of out-of-hospital care and support that arise as a result of the approach outlined in this document (both new packages and enhancements to existing packages), where it is provided to patients on or later than this date. Any patients already receiving out of hospital care and support that started before this date will be expected to be funded through usual pre-existing mechanisms and sources of funding". The guidance makes it clear that there will be a suspension of usual patient funding eligibility criteria while this process in in place. NHSE&I will ensure there is sufficient funding to support CCGs and their local authority partners to commission the enhanced discharge support outlined in this Scheme.

3. The guidance provides reference to four discharge pathways. A Covid 19 Discharge Process Operational Group has been set up to manage the suspension of regular Care Act processes and the 4 discharge pathways, and to deliver the discharge to assess pathways as set out in the guidance.

4. The parties have agreed that for the duration of this Scheme, the LA will identify which individuals qualify for inclusion in the Scheme ("Qualifying Individuals") and in doing so will be providing a spreadsheet listing the following;

- Care Home
- Other care accommodation
- Domiciliary care
- Reablement/intermediate care
- Day Care
- Respite care
- Transport
- Other (typically, equipment and adaptations)
- Those individuals who would "otherwise be admitted" to hospital

5. In terms of those who would “otherwise be admitted, the funding provided under this scheme will pay for all admission avoidance (from the 19th March to the restart of the Admission Avoidance Service (date to be determined), where a package of care has been provided or a person has been placed in a residential or care home and tracked by the Integrated Community Services and Sensory Support team. The local authority will calculate the cost of such qualifying individuals back dated to 19th March and include in the monthly invoice as the calculations are complete.

   Further, where a person has been admitted to secondary care and had previously been in receipt of a funded care package (either in a care-home or in their own home) the funding provided under this scheme is intended to support the restart of such a package (i.e. restarted care following discharge will be counted as covered by this funding)

6. Qualifying Individuals will be identified by the Integrated Community Services and Sensory Support Team, who will keep a record of each discharge or admission avoided.

   If there is a dispute as to whether someone meets the criteria for inclusion in the Scheme or not the decision will be escalated through the governance process until the dispute has been resolved. The governance is as follows:

   Covid 19 Discharge Process Operational Group

   Care Pathways: Hospital discharge

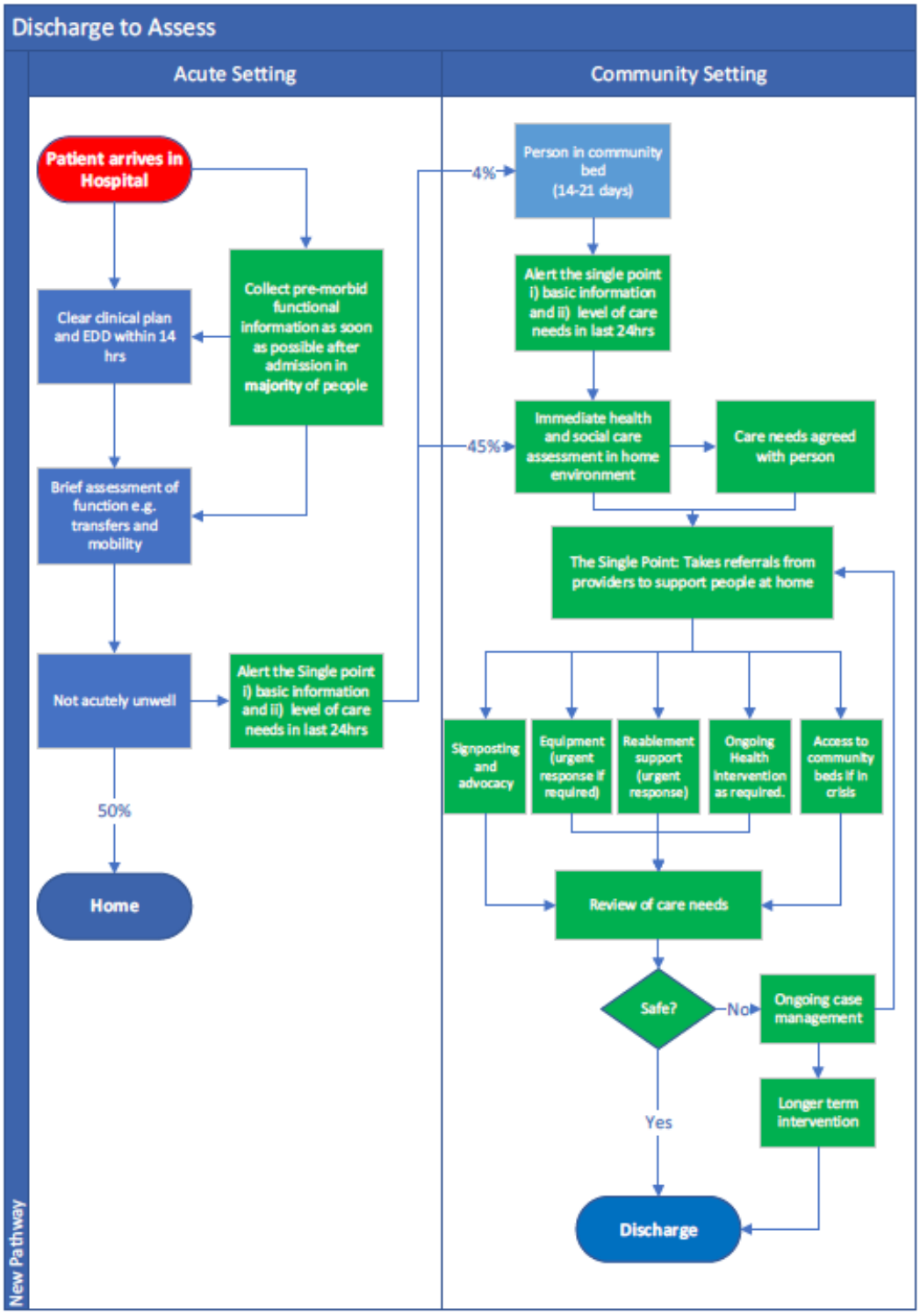
   

   Local Health Resilience Partnership (LHRP)

7. At the end of each calendar month, the LA will submit a claim to the CCG for the costs incurred for Qualifying Individuals for the previous month, or in the case with Admission Avoidance, the LA will calculate the cost and will include those costs within a claim as soon as possible. The CCG will either agree the claim or raise a challenge to it within 10 working days. If the CCG challenges the claim, the LA will have 10 working days to dispute the challenge or submit an amended claim. If the claim remains disputed it will be escalated following the procedure set out in paragraph 6 above. Following agreement to the claim, the LA will raise an invoice to the CCG within 10 working days, which must be paid by the CCG within 30 days.

8. Qualifying Individuals will be tracked and followed up by the Integrated Community Services and Sensory Support team and Adult Social Care to ensure that at the end of the period of this Scheme their long-term needs will be assessed.

9. The Discharge to Assess Pathway follows the guidance and has been agreed as described below:



10. Procurement and contracting rules continue to apply. Local commissioners should agree the most appropriate route to deliver the enhanced discharge support in their area. Enhanced discharge support is agreed through the governance structure described above.