Better Care Fund 19/20

Tanya Miles, Assistant Director ASC

Penny Bason, STP Programme Manager

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Technical details summary

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- 19/20 Guidance published in July 2019, draft BCF due 27th September
- National conditions similar to previous years
  - Must be signed off by the HWBB and by the Local Authority and CCG;
  - Must demonstrate how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCGs minimum contribution;
  - Must allocate a specific proportion to out-of-hospital services;
  - Must provide a clear plan for managing transfers of care through the High Impact Change Model
- Other notable requirements of the 19/20 plan include:
  - The DFG, iBCF and Winter Pressures Grant monies are included within the BCF (although there has been no confirmation on the continuation of the iBCF and Winter Pressures – additional information in the Risk section below)
  - The narrative should reflect the joint plan for integration of health and social care locally as well as reflect jointly agreed approaches across the STP geography

Governance

- Governance – HWBB must approve/ endorse, Joint Commissioning Group recommends to HWBB, task and finish groups develop content (endorsement gained on 14th November, 2019)
- Funds managed through a Section 75 Partnership Agreement
- 19/20 Section 75 Partnership Agreement updated by way of a Variance to the Agreement (endorsed 14th November, 2019)
- Agreement will now be requested by Shropshire Council and Shropshire Clinical Commissioning Group

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Key Priorities and summary of schemes

- Prevention – keeping people well and self-sufficient in the first place; community referral including Let's Talk Local and Social prescribing, Dementia companions, Voluntary and community sector, population health management
- Admission Avoidance – when people are not so well, how can we improve their health in the community; out of hospital focus (Care Closer to Home, Integrated Community Services, new admission avoidance scheme), carers and mental health
- Delayed Transfers and system flow - using the 8 High Impact Model; Joint equipment contract, Assistive technology, Integrated Community Service, Red Bag

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High Impact Model – managing transfers of care between hospital and home (refreshed for 2019/20)

- Early discharge planning
- Monitoring and responding to system demand and capacity ✓
- Multi-disciplinary working ✓
- Home first ✓
- Flexible working patterns – including 7 days services
- Trusted assessment ✓
- Engagement and choice ✓
- Improved discharge to care homes ✓
- Housing and related services (new for this refresh)

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hange 1

rly discharge planning In elective care, nning for discharge should begin before mission. In emergency/unscheduled care, ust systems need to be in place to develop ns for management and discharge, and to allow expected date of discharge to be set within 48 urs.

hange 2

onitoring and responding to system demand d capacity Develop systems across health and cial care to provide real-time information about mand and capacity. All partners should work ether to match capacity and demand by sponding to emerging system needs, making ective strategic decisions, and planning rvices around the individual. Data should also used to identify and respond to system ckages.

hange 3

lti-disciplinary working Multi-disciplinary ms (MDTs), including the voluntary, community d social enterprise sector (VCSE), work ether to coordinate discharge around the rson. Effective discharge and positive tcomes for people are achieved through charge planning based on joint assessment ocesses and protocols, shared and agreed sponsibilities, and above all, good nversations with people and families.

Change 4

Home first Home first is as much a system mindset as a service. It means always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best.

Change 5

Flexible working patterns Where it will help to deliver the "right care, right time, right place", consider how seven-day working, weekend working and extended hours for services across health and social care can be utilised. This will help to deliver care throughout the week, reduce delays moving through the system and improve individuals' experiences.

Change 6

Trusted assessment Using trusted assessment to carry out a holistic strengths-based assessment avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7

Engagement and choice Early engagement with people who are using services, their families and carers is vital so they are empowered to make informed decisions about their future care and take ownership of their choice. The VCSE carers and advocates can be a real help with this. A robust choice protocol, underpinned by a fair and transparent escalation process, is essential so that when people have capacity they can understand and consider their options.

Change 8

Improved discharge to care homes The NHS Enhanced Health in Care Homes framework supports ways to join up and coordinate health and care services to support care home residents. In considering how to achieve timely and safe transfers of care, the initiatives in this high impact change focus on how to improve outcomes for care home residents by reducing unnecessary admissions to hospital and facilitating smoother hospital discharge into care homes.

Change 9

Housing and related services Effective referral processes and good services which maximise independence are in place to support people to go home. The need for housing and homelessness services, home adaptations and equipment are addressed early in discharge planning and readily available when needed.

Performance – Delayed Transfers of Care

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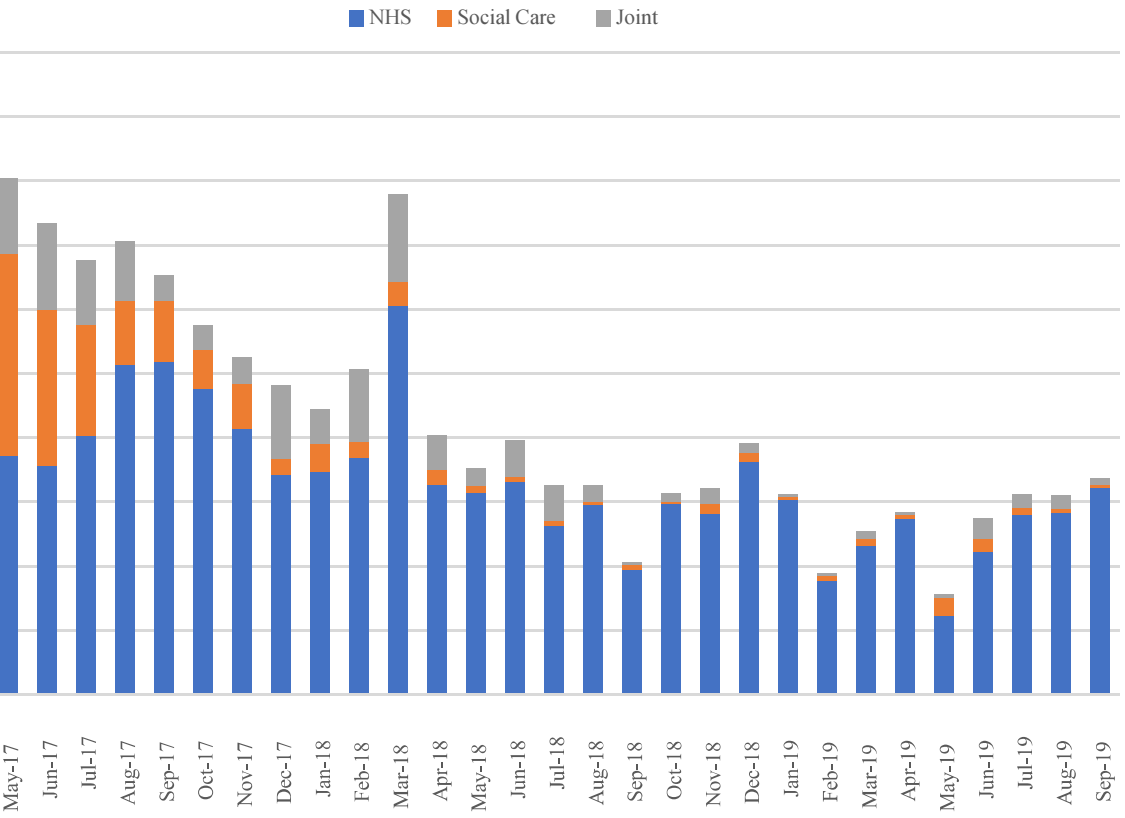
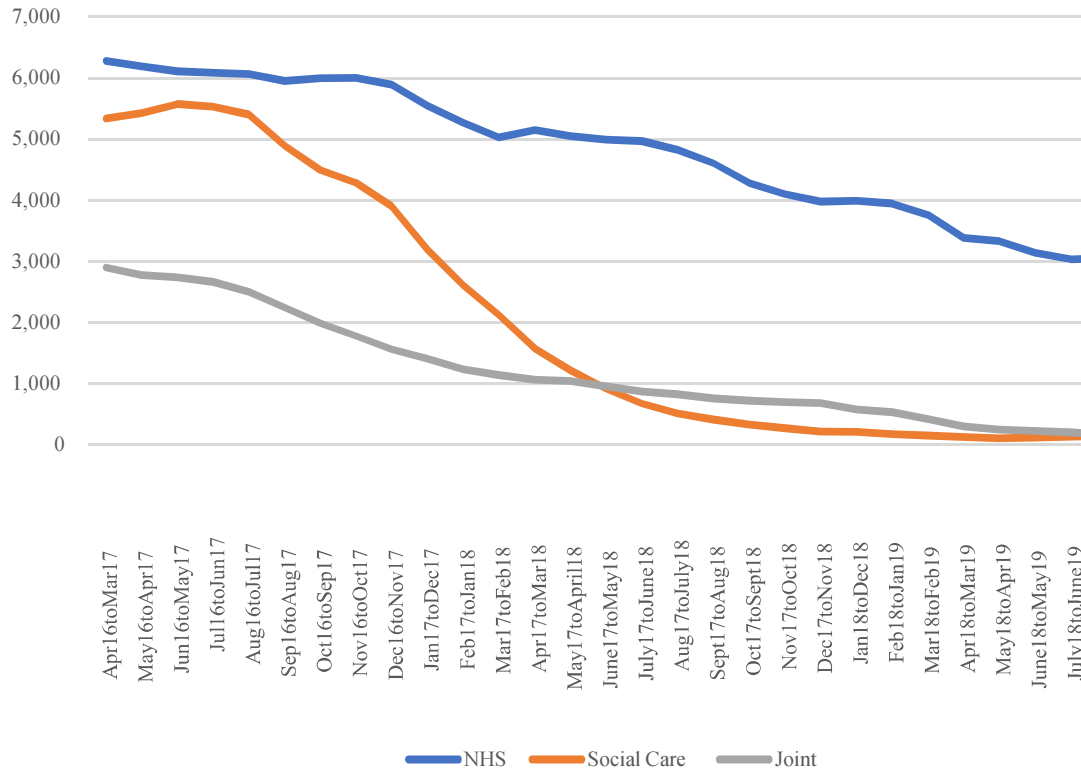
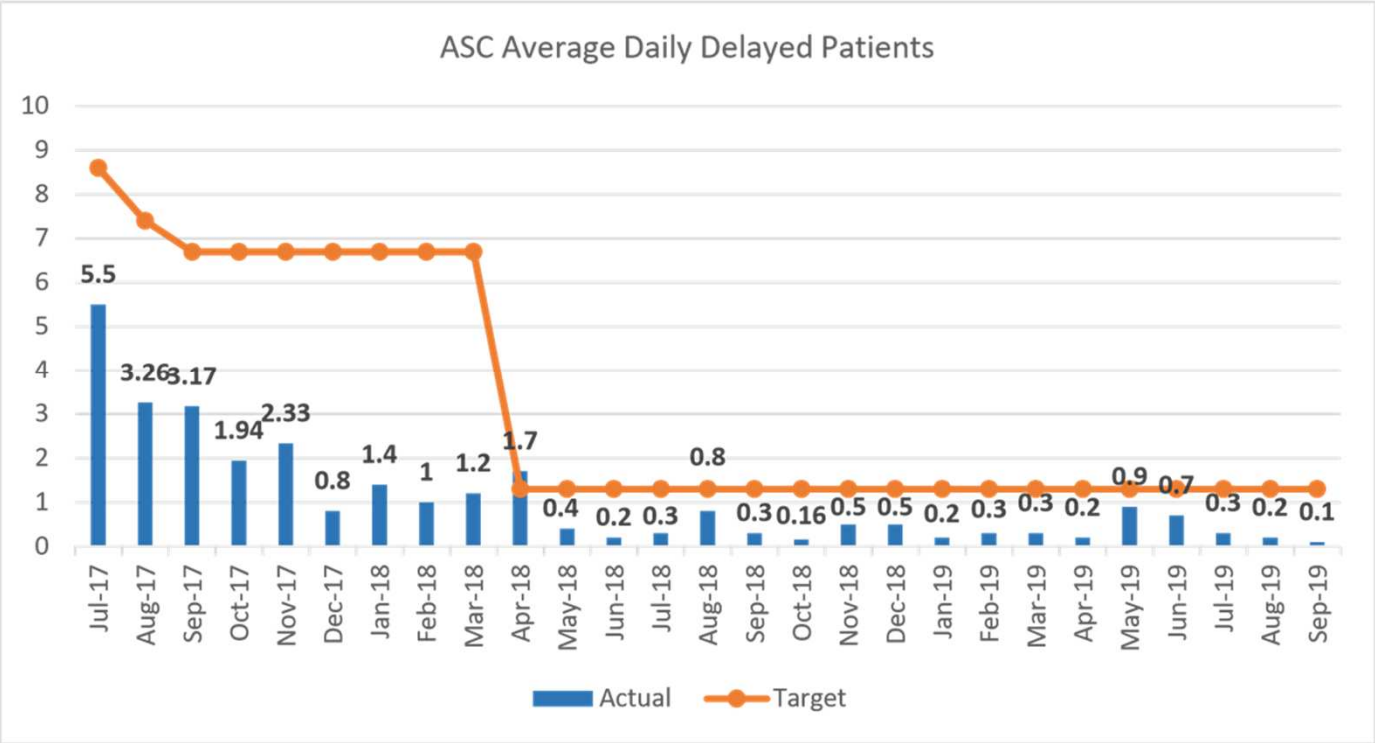
Delayed Transfer – consistently achieved





Delayed Transfers – attributable to ASC



Delayed Transfers – how do we compare?

England Rank

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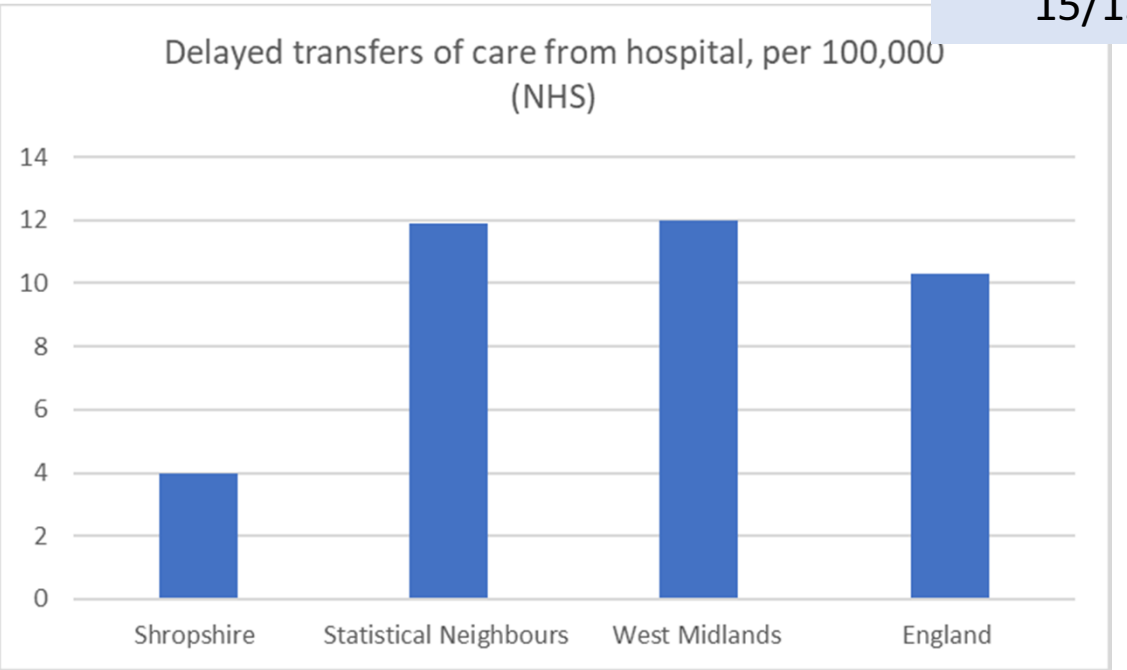
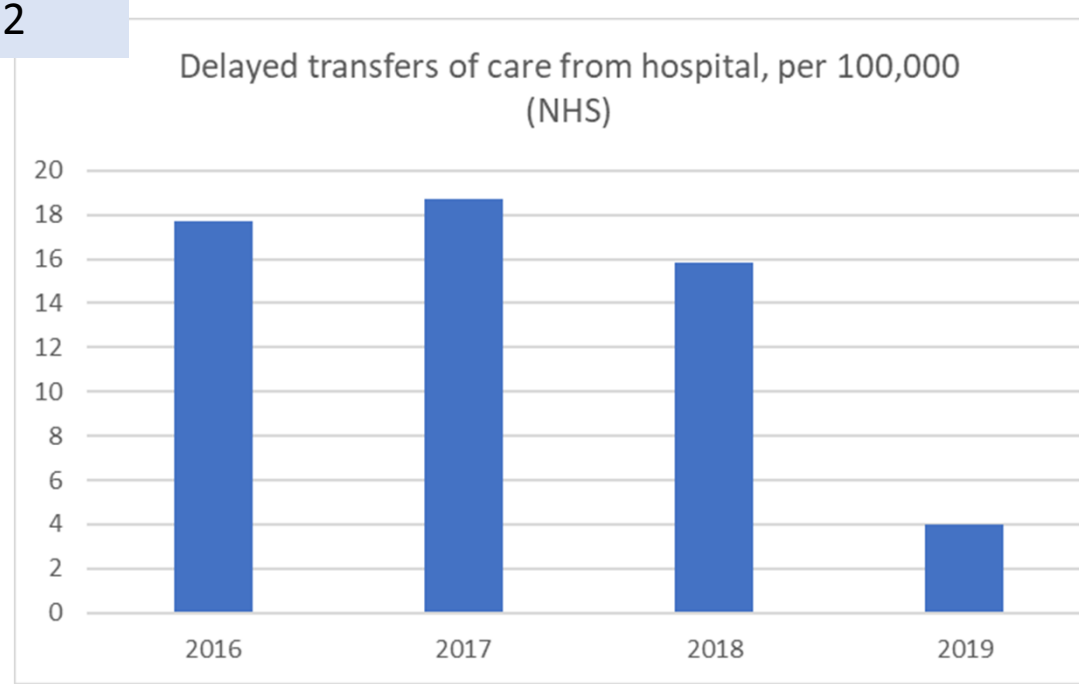




Performance – residential admissions, reablement and Non-elective admissions

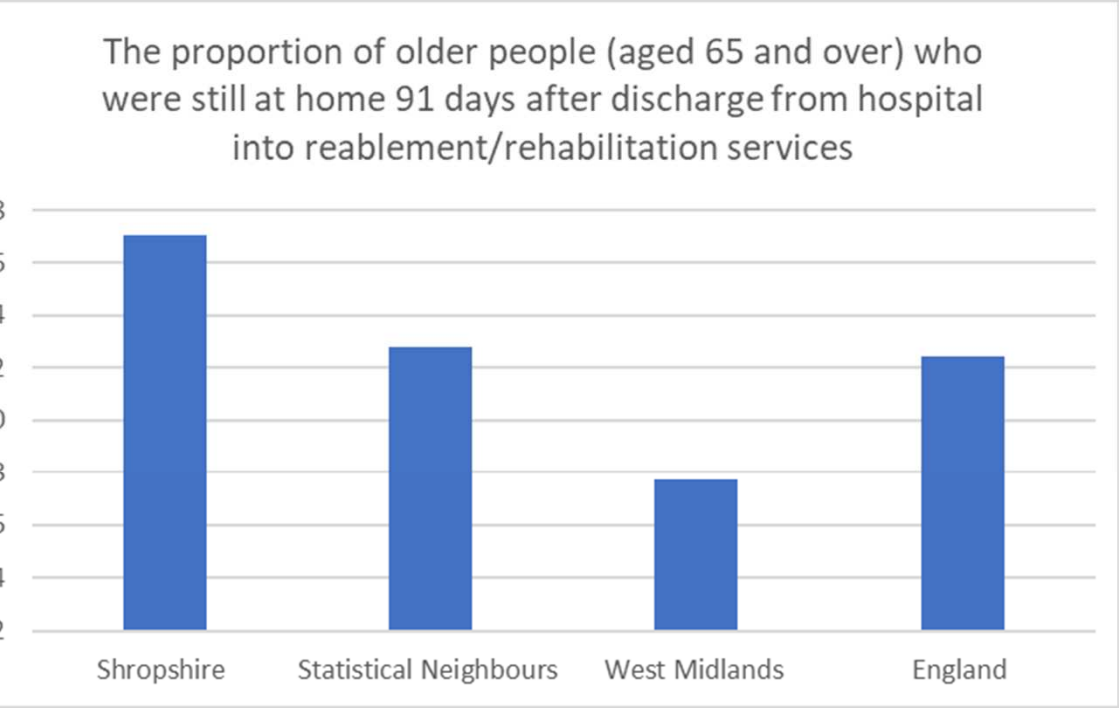
- Number of residential admissions is reducing

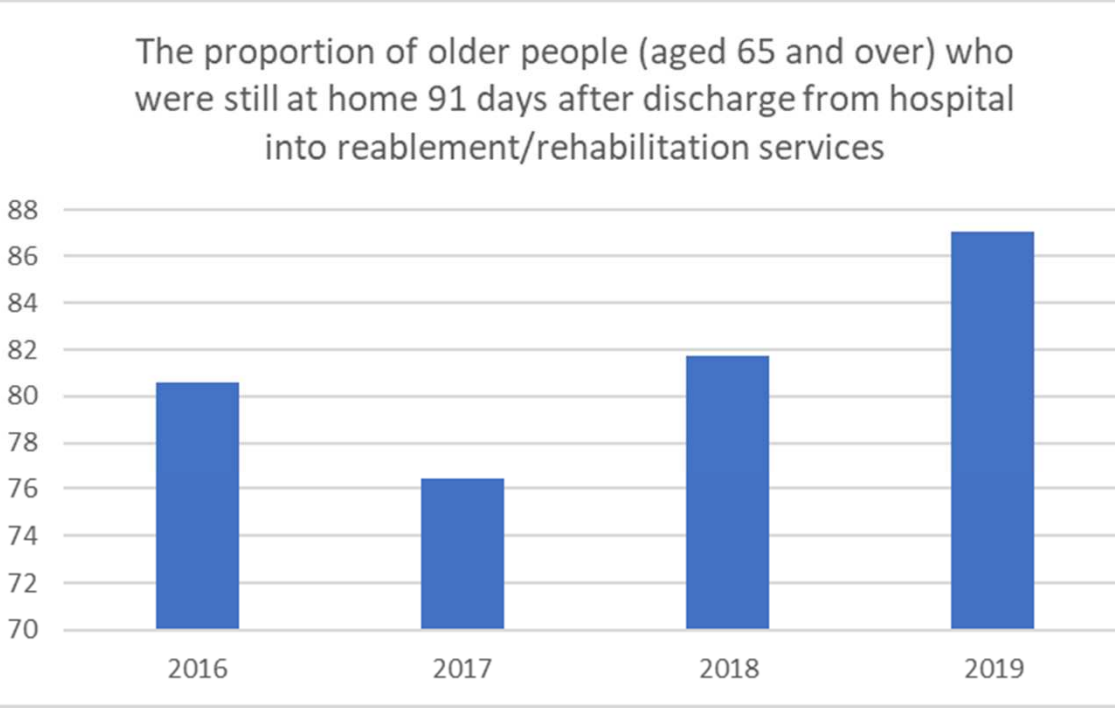
 - consistently achieve target (less than 600 per year per 100,000 population)

- Reablement – number home 91 days after discharge – consistency achieve 82% or better

- Non-elective admissions – did not meet in 2 quarters in 18/19
  - May not achieve target this year

Reablement – 91 day target





dmission to residential care – how do we ompare?