North Tyneside
Health & Wellbeing Board Report
Date: 12th September 2019

ITEM 9

Title: Better Care Fund Plan for 2019/20

Report from : North Tyneside Council & North Tyneside CCG

Report Author: Kevin Allan, Programme Manager, Integrated Care for Older People (Tel: 0191 643 6078)

1. Purpose:

This report presents a proposed plan for the Better Care Fund covering the financial year 2019/20.

2. Recommendation(s):

The Board is recommended to

a) endorse the general principles of the use of the Better Care Fund, set out in the report; and

b) authorise the Chair of the Health and Wellbeing Board to sign off any further revisions to the submission on behalf of the Board, before the deadline for submission to NHS England on 27th September 2019.

3. Policy Framework

This item relates to the following objectives of the Joint Health and Wellbeing Strategy 2013-23:

- To continually seek and develop new ways to improve the health and wellbeing of the population
- To shift investment to focus on evidence based prevention and early intervention where possible
- To reduce the difference in life expectancy and healthy life expectancy between the most affluent and most deprived areas of the borough;
- To shift investment to focus on evidence based prevention and early intervention;
- To build resilience in local communities through focussed interventions and ownership of local initiatives to improve health and wellbeing; and
- To integrate services where there is an opportunity for better outcomes for the public and better use of public money

4. Information:

The BCF Policy Framework for 2019-20[1] was published on 10th April 2019 by the Department of Health and Social Care and the Ministry of Housing, Communities, and Local Government.

The Framework notes:

> "The Government is committed to the aim of person-centred integrated care, with health, social care, housing and other public services working seamlessly together to provide better care. This type of integrated care is the key to strong, sustainable local health and care systems which prevent ill-health (where possible) and the need for care, and avoid unnecessary hospital admissions. It also ensures that people receive high-quality care and support in the community. For people who need both health and social care services, this means only having to tell their story once and getting a clear and comprehensive assessment of all their needs with plans put in place to support them. This means they get the right care, in the right place, at the right time." (para 1.1)

2019-20, the report states, is to be a year of minimal change for the BCF:

- The national conditions for the fund are unchanged
- BCF plans should be signed off by Health and Wellbeing Boards
- CCGs will continue to be required to pool a mandated minimum amount of funding
- Local Authorities will be required to pool grant funding from the Improved Better Care Fund and the Disabled Facilities Grant.
- The Improved Better Care Fund, as in previous years, can be used only to meet adult social care needs; reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and to ensure that the local social care provider market is supported.
- Local Authorities will be required to pool Winter Pressures funding in the BCF in 2019/20.
- Winter Pressures funding will be paid to local authorities, with an attached set of conditions, requiring the funding to be used to alleviate pressures on the NHS over winter, and to ensure it is pooled into the BCF. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

This year, there is no requirement to submit a detailed narrative plan to the BCF national team; the central reporting requirements are met through a spreadsheet, which is available on request from the author of this report.

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/795314/Better_Care_Fund_2019-20_Policy_Framework.pdf

Governance arrangements
The detailed operations of the Better Care Fund in North Tyneside are set out in a Section 75 Agreement between North Tyneside Council and NHS North Tyneside Clinical Commissioning Group (CCG). That agreement establishes a BCF Partnership Board with representatives from each party.

As previously requested by the Health and Wellbeing Board, regular reports on the operation and performance of the BCF have been provided to the Adult Social Care, Health and Wellbeing Sub-Committee of the Overview and Scrutiny Committee.

The BCF Policy Framework requires that BCF plans are agreed by Health and Wellbeing Boards. As in previous years, the Cabinet and the Governing Body of the CCG will also be asked to agree the BCF Plan.

The value of the Better Care Fund

The minimum value of the North Tyneside Better Care Fund is set nationally.

Table 1

Income Component	2018/19	2019/20	% difference	£ difference
Disabled Facilities Grant	1,526,533	1,647,220	7.9%	120,687
Minimum CCG Contribution	15,833,838	16,603,777	4.9%	769,939
Improved Better Care Fund	6,772,688	8,265,809	22.0%	1,493,121
Winter Pressures Grant		1,031,077		1,031,077
TOTAL	24,133,058	27,547,883	14.1%	3,414,825

The national framework also stipulates minimum contributions to be paid by the CCG to adult social care, and on NHS-commissioned out of hospital services

Table 2

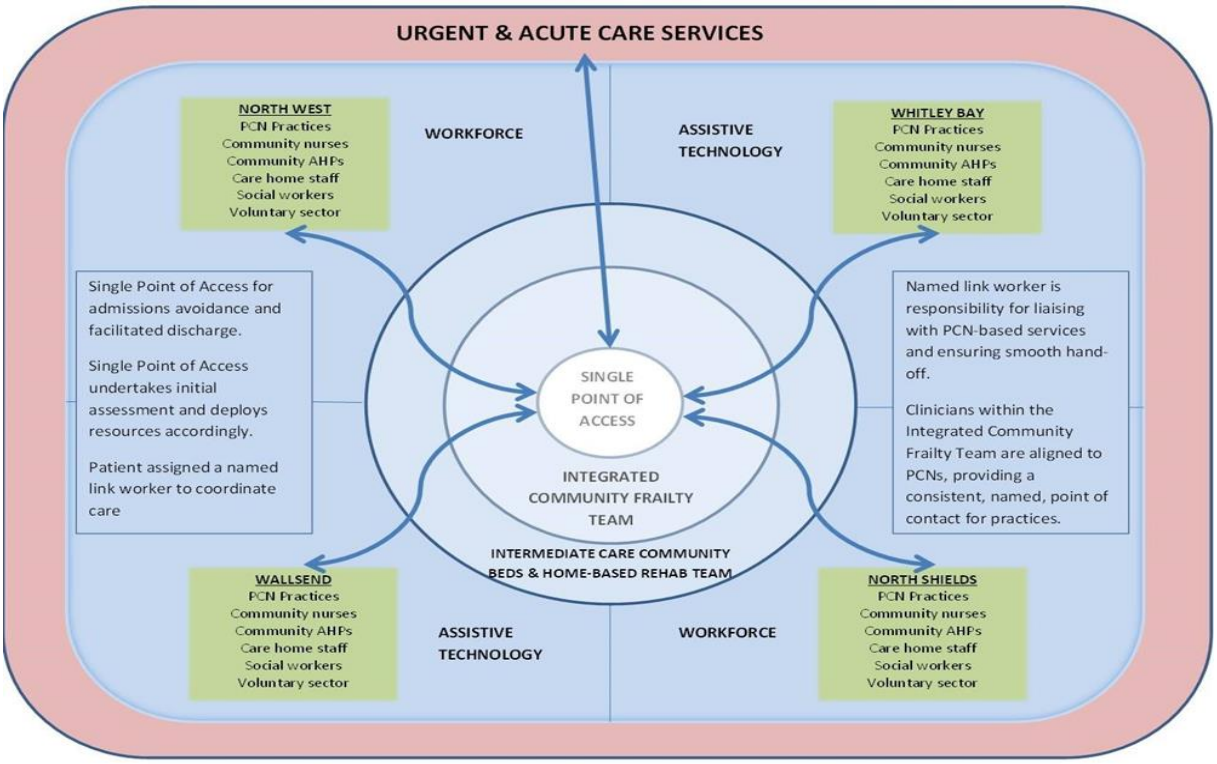
	2018/19	2019/20	% difference	£ difference
CCG minimum contribution to adult social care	10,085,863	10,576,301	4.9%	490,438
NHS commissioned out-of-hospital spend	4,449,528	4,718,332	6.0%	268,804

Key features of the BCF plan

The plan represents a natural progression from the 2017/18/19 plan, with some changes to take into account progress that has been made. Within the Future Care Programme, action is under way to further develop services for older people, which will lead to reconfiguration of some services included in the BCF, within the overall financial envelope set out in the BCF Plan.

An Integrated Community Frailty Service for North Tyneside will be created through the reconfiguration of Care Point, Care Plus, Jubilee Day Hospital and the intermediate care beds at Howden and Royal Quays.

- The development of an integrated frailty service within exiting NHS and Local Authority services contracts.
- The development of a new community bed based intermediate care facility that will also house an integrated community frailty / aging well service, which would bring together Care Point, Care Plus and Jubilee Day Hospital and community bed based care under a shared management structure to provide a 'one-stop-shop' for frailty elderly patients.



The key components of the planned model are:

- A single point of access and assessment, capable of understanding demand and deploying resources to avoid admission and facilitate rapid discharge.
- A single integrated community frailty team providing proactive and reactive, multidisciplinary assessment, interventions, rehabilitation, reablement and care planning for frail elderly patients in North Tyneside.
- All North Tyneside residents have rapid and equitable access to step-up and step-down beds, regardless of which local hospital they are accessing that care from.
- Coordination of care and closer alignment with community nursing teams, including mental health and Primary Care Networks.

This service will consist of:

- Single point of access
- Integrated Community Frailty Team
- Integrated Care community beds and reablement
- Integration with primary care networks and community services

Single point of access

The single point of access will:

- Act as a true single access to the Integrated Community Frailty Service. This will end the current system whereby referrals can be made via Care Point or directly into individual services themselves.
- Assess the patient's needs and deploy the resources of the Integrated Community Frailty Team accordingly. This will include the assignment of a clinical link-worker who will take responsibility for coordinating the patient's care.
- Assess patients requiring access to community step-up and step-down beds.
- Replicate the 'back of house functions' of the existing Care Point service and the admissions avoidance and discharge planning resource funded under the BCF.
- Coordinate the alignment of the clinical and social care workforce within the integrated community frailty team to the localities, ensuring that there is a consistent, named, point of contact for practices and community nursing teams seeking guidance and support.
- Use technology to manage system wide community capacity and demand in real-time

Integrated community frailty team

The integrated community frailty team will bring together the teams currently delivering the following services:

- Jubilee Day Hospital
- Care Plus
- Care Point 'front of house functions and teams'
- Falls First Responder
- Community Falls Clinic (once existing contracts expire)

To provide:

- Single MDT-based assessment, diagnosis and management of frail elderly patients with the aim of enabling self-management, preventing further deterioration, avoiding admission and facilitating discharge.
- A person centred single assessment and care plan based upon CGA process
- Patients will also be assigned a clinical link worker to act as their main point of contact to ensure person centred care coordinated care delivery.
- Care will be delivered in the patient's place of residence or a community-based setting wherever possible, particularly for patients with more severe levels of frailty.
- The service will be accessed on an equitable basis which reflects the fact that c.40% of North Tyneside residents' access acute care in Newcastle.

Intermediate care community beds and reablement

Intermediate care services in North Tyneside will continue to be provided in line with the 2017/18/19 BCF Plan.

Phase two of the agreed plan commenced in 2019. More care will be delivered in a community setting, with additional investment in community services and social care provision being used to support this transition. This will include:

- Creation of a new community-based facility capable of housing the Single Point of Access and the Integrated Community Frailty Team alongside the intermediate care beds.
- Creation of step-up community bed pathways to support admission avoidance and functions of the SPA.

- Strengthening the role of the peripatetic service.
- Enhancing the role of Personal Independence Coordinator workers and volunteers.

Integration with Primary Care Networks and community services

Patients and clinicians have both identified the need for a single named person to coordinate care and manage transition into and out of specialist frailty services. This ensures that patients will only have to "tell their story once" during a specific episode of care and that healthcare is delivered more efficiently by removing unnecessary duplication of assessment.

The Community Matrons that are currently deployed within Care Plus will normally act as the named link-worker for the majority of patients referred into the Integrated Community Frailty Service. They will also act as the primary point of contact between the specialist frailty teams and the wider healthcare system, including practices, district nursing teams and hospital-based services.

In order to foster strong working relationships between the Community Matrons, GP practices and community services, the Community Matron workforce will be aligned to an existing locality of North Tyneside.

5. Winter Pressures

The Winter Pressures element of the BCF is not new money. The same amount was paid directly to North Tyneside Council in 2018/19. In that year the money was used to support short-term admissions to residential care (79% of the funds) and additional hours of home care support (21% of the funds). Both of these measures relieve pressure on the NHS by supporting discharge from hospital or avoiding admission to hospital.

The timetable for submitting a BCF plan is in advance of the timetable for agreeing a winter plan. Discussions with NHS and social care stakeholders have been organised by the Local Area Delivery Board (LADB) in mid-September, to progress a Winter Plan for 2019/20.

The BCF Partnership Board will take soundings from the LADB, to determine the most appropriate use of winter pressures funding to support the 2019/20 Winter Plan, as it is developed further.

6. Decision options:

The Board may either:-

a) Endorse the general principles of the use of the Better Care Fund, set out in the report and authorise the Chair of the Health and Wellbeing Board to authorise any further revisions to the submission, before the deadline for submission to NHS England on 27th September 2019, or
b) Request relevant officers, in consultation with the Chair and Deputy of the Board, to undertake further work to make changes to the submission taking into account the comments and suggestions made by the Board at the meeting.

7. Reasons for recommended option:

The Board are recommended to agree option a). The continuation of the Better Care Fund presents a major opportunity to take forward the principles of the Health and Wellbeing Strategy. Delay in agreeing a plan for use of the Fund may lead to delay in the release of funds by NHS England.

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

8. Financial Implications

The financial implications for the Council and the Clinical Commissioning Group will be considered separately by each organisation as part of their approval processes.

9. Legal Implications

The NHS Act 2006, as amended, gives NHS England the powers to attach conditions to the payment of the Better Care Fund Plan. In 2016/17 NHS England have set a requirement that Health and Wellbeing Boards jointly agree plans on how the money will be spent and plans must be signed off by the relevant local authority and clinical commissioning group.

10. Equalities and diversity

There are no equality and diversity implications arising directly from this report.

11. Risk management

A risk assessment has been undertaken and included in Appendix A

12. Crime and disorder

There are no crime and disorder implications directly arising from this report.

SIGN OFF

Chair/Deputy Chair of the Board	X
Director of Public Health	X
Director of Children's and Adult Services	X
Director of Healthwatch North Tyneside	X
CCG Chief Officer	X
Chief Finance Officer	X
Head of Law & Governance	X

Appendix 1

List of Better Care Fund Schemes

(with comparative scheme values for two previous years)

Funding source, scheme type, and scheme name	2017/18 £	2018/19 £	2019/20 £
Disabled Facilities Grant	**1,416,617**	**1,526,533**	**1,647,220**
Social Care	**1,416,617**	**1,526,533**	**1,647,220**
Disabled Facilities Grant	1,416,617	1,526,533	1,647,220
Improved Better Care Fund	**5,043,226**	**6,772,688**	**8,265,809**
Social Care	**5,043,226**	**6,772,688**	**8,265,809**
Impact on other increased fees (ISL, day care, direct payments, etc) of national living wage	1,244,000	1,609,000	3,483,827
Impact on care home fees of national living wage	2,145,226	2,775,688	2,345,847
Effect of demographic growth and change in severity of need	1,270,000	1,892,000	1,689,666
Impact on domicilliary care fees of national living wage	384,000	496,000	746,469
Winter Pressures Grant			**1,031,077**
Social Care			**1,031,077**
Measures to respond to winter pressures			1,031,077
Minimum CCG Contribution	**15,538,604**	**15,833,838**	**16,603,777**
Community Health	**5,225,197**	**4,881,835**	**4,376,591**
Intermediate Care Beds	3,653,432	3,722,847	2,709,097
Admission avoidance and discharge planning services	724,177	737,936	762,586
CarePlus	620,208	189,351	677,528
End of Life Care - RAPID	227,380	231,700	227,380
Mental Health	**749,991**	**764,241**	**713,817**
Liaison Psychiatry	749,991	764,241	713,817
Primary Care	**100,000**	**101,900**	**937,068**
Enhanced Primary Care in Care Homes	100,000	101,900	937,068
Social Care	**9,463,416**	**10,085,863**	**10,576,301**
Community--based support	7,138,533	7,274,165	7,627,881
Intermediate Care - Community Services	421,411	747,059	783,386
Care Act implementation	607,686	619,232	670,914
Independent support for people with learning disabilities	610,740	622,344	652,606
Carers Support	570,024	580,854	609,099
Community Falls First Responder Service	0	125,000	131,078
Seven Day Social Work	64,128	65,346	68,524
Improving access to advice and information	50,895	51,862	32,813
Grand Total	**21,998,447**	**24,133,059**	**27,547,883**