Appendix 2 – Poole and Bournemouth Better Care Fund Quarter 4 (2017/18) submission

Better Care Fund Template Q4 2017/18

3. Metrics

Selected Health and Well Being Board: Bournemouth & Poole

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	Not currently on track to achieve the agreed plans for 2017/18 however demand remains broadly consistent with activity levels reported in 2016/17. Data available to 28th February 2018	Establishment of a Dorset System collaborative agreement in 2017/19. The system has proactively developed a real time report identifying long stay and stranded patients for 7+, 14+ and	N/A
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	Not on track to meet target	Poole UA have acheived this standard however Bournemouth UA have not, this has resulted in the HWB not achieving the standard. The HWB had been reporting a downward trend in the rate of placements on a month by month basis through the year however figures reported in quarter 4 have increased. Data is up to 31st March 2018	N/A	N/A
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Data not available to assess progress	The ability to report this standard remains an issue. Bournemouth UA do not currently collect this data on a monthly basis, the UA collect data during the statutory collection months	Although the audit results from the NHS rehabilitation service are not currently available, the Trust do report a monthly performance indicator on the percentage of people in their usual place	N/A
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	On track to meet target	The are a number of issues around reporting including 'Court of Protection'. B&P HWB will see a positive impact when agreement is given to remove COP delays.	Throughout 2017/18, the number of bed days lost reported was relatively static for the first half of the year with a general trend of month on month reductions in the second half of the	N/A

Narrative

Better Care Fund Template Q4 2017/18

7. Narrative

Selected Health and Wellbeing Board: Bournemouth & Poole

Remaining Characters: 9,209

Progress against local plan for integration of health and social care

Strong and Sustainable Care Markets

Bournemouth, Poole and Dorset CCG homecare framework of 17 providers has now been mobilised. The principle is to drive a more integrated approach to maintain people in their own homes. The framework sits within Proud to Care - a branded identity set up to engender partnership working amongst homecare providers.

We are also working to support and influence the Residential Care Market through developing a learning/training tool for new and existing managers. Through taking part in Action Learning Sets managers will build on their competencies, knowledge and experience to effectively lead the delivery of care within residential settings.

We are also continuing to engage with providers through a series of workshop, learning and recruitment events. Workshops focussing on areas such as delayed transfers of care, CQC quality standards and how we can use the Proud to Care initiative to promote the care industry . The local authorities are also working with providers to promote caring as a career choice for men. The development of a local campaign has already been adopted as a campaign by a national provider through out the country.

Work continues on the construction of a new 80 bed care home, Figbury Lodge, owned by Poole council, but operate by an independent sector provider will bring additional long-term capacity to the care market. Twenty of the beds are designated for intermediate care, jointly funded by the local authority and Dorset Clinical Commissioning Group, the remainder for dementia (with or without nursing) and challenging needs.

To further increase the dementia bed capacity within the area accreditation and self-assessment tools have been introduced along with an enhanced fee structure. Use of the tool is enabling homes to become sustainable as the local demand moves from frail elderly to dementia.

Advancing Locality Care

Locality multi disciplinary teams are providing good outcomes for people and we are seeing further development in consultant outreach from Poole hospital into care homes to prevent unplanned admissions. Increasingly locality care has a connected interface with acute hospitals in particular safe discharge into community settings, the establishment of the integrated hospital discharge hub in Poole has facilitated this. The Hub is beginning to link more closely with community hospitals in order to facilitate more timely discharge for patients after a period of rehabilitation. There has also been progress in moving forward on a similar configuration for Royal Bournemouth Hospital with proposals to have an integrated hub in place during 2018/19. It has, until recently, been challenging to co-ordinate multi agency services when staff have been dispersed across the hospital (and beyond) and without a single co-ordinator to provide leadership and improve communication.

The hub in Poole Hospital is helping to direct day to day resources more effectively at patients with the greatest need, reducing delayed discharges and developing new and more co-operative ways of working between the partnership. This service has been jointly funded and governed by the three Local Authorities, Dorset Healthcare and Poole Hospital. Dorset CCG have been key partners in the development of the model.

Maintaining Independence

The integrated care facility - Coastal Lodge - is still in its early stages of delivery but already through great team work the partnership is succeeding in enabling people to remain independent. The joint working between Dorset Health Care and Tricuro (a joint Local authority trading company) has seen positive results, supporting people in step-up or step down situations. Embedding this different way of working will take time, leading to further developments in practice.

The integrated equipment service goes from strength to strength. Joint working between health and social care practitioners is now embedded, and we are seeing a consistency across the partnership in supporting people to remain independent.

Work has begun to decommission My Life My Care on a PAN Dorset basis, with Bournemouth and Poole retaining the brand and much of the content to become a Bournemouth and Poole only brand by July 2018.

Carers Services

The Pan Dorset Carers steering group oversees the development of the joint vision 'Valuing Carers in Dorset'. With this comes the chance to discuss some of the practical challenges facing organisations following recent, and impending, personnel changes, and how this can be addressed. The membership of this group includes carers, naturally leading to services and solutions being coproduced. Carers get a real say in how resources are directed, and the level of support made available to support carers to maintain their caring role. After a review of carers services early in 2017, work is underway to ensure that a more targeted approach is taken to ensure that carers are receiving the services they need and use the most.

The CCG Carers lead role will be transferring to Dorset Healthcare to work with the community service carers lead and develop a more sustainable team to support primary and community services.

Early supported discharge

Work with acute hospitals is ongoing in planning for safe discharge into community settings. The integrated hospital discharge hub is now well established in Poole and is making a positive impact, introducing more efficient and co-operative ways of working by having all aspects of discharge co-ordination taking place within the hub. The hub is now linking closely with community hospitals to facilitate timely discharge.

Poole Hospital have introduced the red bag scheme in order to improve transition from hospital back into the community in particular when working with nursing homes. Ticket home and getting home leaflets are available and used in line with Discharge to Assess (in Poole) and Trusted Practitioner pathways.

Primary care streaming has started in Poole hospital since September 2017. This service is supporting GP's stream patients away from A&E and also reduce the number of admissions to hospital.

A stroke pathway has been implemented within Poole Hospital with a dedicated stoke practitioner appointed working on a multiagency basis to ensure discharge is timely.

In Poole, additional step-down bed capacity has been commissioned to facilitate timely discharge for further assessment and/or recuperation before a return home.

Bournemouth has increased hospital discharge social work team capacity, including specialist occupational therapy and assistive technology resource, to provide greater resilience and capacity for hospital discharge. In addition, an independent discharge service for self funders is also in place to facilitate timely discharge. Over the winter period of January to March 2018 an enhanced domiciliary service has been designed to increase capacity within the domiciliary care market, this is a particular area that is challenging the system in Bournemouth.

Staff at Band 3 level and above are trained in the use of the Trusted Practitioner model in conjunction with Dorset Healthcare Trust, this has been rolled out across the Dorset area. Project plans are in place to increase activity and improve consistency in the acute settings.

As a result delays have remained very low with Poole and Bournemouth local authorities exceeding their targets in regards to delays attributable to social care.

Reablement support has been retained and there has been an increase in activity levels and number of hours available to support adults maximise their independence on discharge from hospital using funding from the improved Better Care Fund.

Extra staff have been recruited in Poole to undertake DOLS assessments to ensure that care choices made for those who lack mental capacity are applied in their best interests. At the time of writing assessors have recently been appointed and are beginning to demonstrate improvement in this area . Money has been invested in this area as maintaining and investing in high dependency care placements for those with very complex care needs is a challenge, it has proved difficult to place these adults in a residential setting out of community hospitals.

Integrated health and social care teams

Teams are strengthening their focus on the most complex patients with an increased focus on frailty. Using the revised frailty specification the GP investment in over 75's is being reprofiled for 2018/19. Through Health Educations England, Wessex frailty programme we have developed a toolkit to support identification for people at greatest risk of frailty. Protected learning time within localities is focusing on frailty and utilising the toolkit. The localities that were early adopters of the population segmentation approach (all outside of Bournemouth and Poole) are seeing a reduction in emergency admissions, lengths of stay and readmissions. The Bournemouth and Poole localities are being supported by our frailty lead GP and Weymouth who have made greatest progress on integrating teams from community hubs. More recently we have seen greater changes within the Poole localities in reductions in lengths of stay and relative growth in emergency admissions. The CCg intends to invest in 2018/19 part of the ICS Transformation Funds to enable locality teams to be enhanced. This will be invested differentially to support those localities that are not making the gains we are seeing elsewhere.

As part of the Primary Care ICS programme Primary Care Home will be implemented across the County next year.

Learning disability moving on from hospital living- updated

The pooled budget arrangement continues to manage the costs of a defined group of complex people with significant health and social care needs which has been extended to meet the cohort of the next generation of people being discharged back to the community in line with the national Transforming Care Agenda. The projected overspend remains at approximately £103,000 for the Pooled budget as a whole this year and may still increase.

This is in part due to increased cost of current cohort of campus clients including NLW in respect to sleep in rates and, and also new costs associated with those named former inpatients that have transferred out of hospital in since April 2016.
Discussions continue at this time to agree whether to use underspend from 2016/17 to cover the projected overspend in 2017/18.

There is a commitment to continue the agreement for 2018/19.

Understanding Joint Expenditure
Prior to further aligning NHS and social care budgets, we are sharing financial information in order to better understand our joint expenditure and common areas of spend.

Integration success story highlight over the past quarter
Work with acute hospitals is ongoing in planning for safe discharge into community settings. The integrated hospital discharge hub is now well established in Poole and is making a positive impact, introducing more efficient and co-operative ways of working by having all aspects of discharge co-ordination taking place within the hub. The hub is now linking closely with community hospitals to facilitate timely discharge.