City of BRADFORD
METROPOLITAN DISTRICT COUNCIL

Appendix 2 - Briefing Note

Subject: Better Care Fund Quarter 2 Submission	**Confidential: No**

1. **Purpose**
   This briefing is to inform Health and Wellbeing Board members of the compliance with the quarter 2 submission requirements to NHS England and update on the current progress on the 2017-19 BCF Plan as outlined in the submission.

2. **Decision required**

   To note progress at Q2 and compliance with reporting arrangements as set out in BCF Guidance.

3. **Background**
   The Bradford Better Care Fund Plan 2017-19 was formally approved by NHS England on 27/10/2017 (see 2c below). Following this signoff process the Q2 submission was announced with a very tight timescale of 2 weeks for submission.

   The return for Q2 focused upon the following areas:

   - Compliance with the BCF National Conditions
   - Progress on achieving the mandated performance metrics for BCF
   - Progress on implementation of the High Impact Change Model (HICM)
   - Progress towards integration

4. **Progress at Q2**

   National Conditions
   The submission confirms compliance with the following National Conditions: Jointly agreed plans, including the use of the Disabled Facilities Grant; contribution to social care from the CCG minimum contribution is in line with the planning requirements; agreement to invest in NHS commissioned out of hospital service; process for managing delayed transfers of care.

   Metrics
   Targets are forecast to be met for 3 of the 4 metrics – Delayed Transfers of Care, Permanent Admissions to Care and Reablement (see 2a below), whilst the target for Q2 for Non Elective Admissions has narrowly been missed and as such it is likely that the target for 17/18 year end may not be met. Provisional data suggests we are currently 2% above plan YTD. Performance is viewed as part of a wider set of multiple system pressures regarding urgent care including a general increase in A&E attendances, increasing non-elective admissions and added complexity of patient needs, delayed transfers out of hospital and available bed capacity .

High Impact Change Model & Red Bag Scheme

The high impact change model offers a practical approach to manage transfers of care. It can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year.

The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

- early discharge planning
- systems to monitor patient flow
- multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- home first/discharge to assess
- seven-day services
- trusted assessors
- focus on choice
- enhancing health in care homes.

The **High Impact Change Model** includes an editable action plan and can be used to support collaborative conversations across local systems. It is recognised by the sector as a valuable resource / practical self-assessment tool to enable care and health systems to examine current practices and look at where and how improvements can be made to manage transfers of care. Plans are in place that all the 8 stages will be implemented in Bradford by the end of 17/18.

The **integrated Red Bag Pathway** is designed to support transition between care homes, ambulance services and the local hospital. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with the resident. It is still at the planning stage and is not anticipated to be implemented this year.

The progress on both the HICM and the Red Bag Scheme are shown in 2b below.

Progress towards local plan for integration
Bradford : A common diabetes outcomes framework has been agreed across partners applicable to and for inclusion in all relevant contracts. The initiatives for implementation during 2017/18 are now becoming embedded These are:

Medicines Support at Home (MESH)
Multi-Agency Integrated Discharge Team (MAIDT)
Home from Hospital (HFH)
Proactive Care Local Incentive Scheme (LIS)

The impacts of these initiatives are reviewed and overseen by the Bradford Out of Hospital Programme (BOHP) Board. The BOHP now has a third ‘long term conditions’ work stream including diabetes new models of care, cardiovascular (Bradford’s Healthy Hearts) and respiratory (Bradford Breathing Better). A revised operating model and

business case for the future provision of community beds is in development, with a view to implementation during 2018/19. Across Bradford, GP practices and other primary, secondary and community health service providers, along with social care and third sector partners are coming together to form ‘Primary Care Home’ communities to serve populations of around 30 – 60k people. These communities, with wrap around services at a larger locality hub level are expected to form the building blocks of our future accountable care system.

Airedale: At the October AWC programme board each of the 3 communities (Airedale, Wharfedale & Craven) presented a comprehensive update on progress being made towards developing the AWC model of care. The presentations demonstrated the great commitment and energy from the range of multi-agency clinicians and care professionals involved and each group expressed that solid foundations of trust and relationships were already forming. The ‘Primary & Community Transformation Group’ is bringing together the developments at each community level and considers the ‘1 system’ elements for AWC. Other areas of work include: An intermediate care review is underway and each community will identify representatives to contribute to this work. This will develop into a clinical modelling group involving broader stakeholders; Work has been undertaken to define the 3 AWC communities and align with local authority boundaries and practice population; A needs assessment profiles programme of work is ongoing; There is recognition that wider system wide workstreams e.g. mental health, maternity and children's, learning disability, medicines optimisations need to be connected into and aware of the AWC developments and priorities to ensure that each workstream is contributing to the developments and there is a common message around the agreed delivery model; and Work has been initiated to develop a common narrative around accountable care.

2a BCF Quarter 2 Metrics

Metric	Definition	Q2 Outturn
NEA	Reduction in non-elective admissions	Provisional data suggests we are currently 2% above plan YTD Performance is viewed as part of a wider set of multiple system pressures regarding urgent care including a general increase in A&E attendances, increasing non-elective admissions and added complexity of patient needs, delayed transfers out of hospital and available bed capacity .
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	As the new operating model for social care is embedded we are seeing a reduction of long term admissions to care. The ethos of no decision for long term care to be made in an acute setting is becoming embedded.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	The target of 90% of people who use the service being at home 91 days later is being achieved at Q2 at 94.2%, showing good outcomes for those who enter the service. As such we do not anticipate any challenges meeting the target if the current level of performance is sustained.
Delayed Transfers of Care*	Delayed Transfers of Care (delayed days)	Q1 data showed an improvement on the Q4 2016/17 position. Going into November the enhanced target set by NHS England is proving challenging due to increased pressure within the hospital system. The system was on high alert going into the weekend of 4/5th November due to ward closures due to D&V and Norovirus. The additional pressure in the system affecting flow is proving challenging. However, DToC is being effectively managed..

2b – High Impact Change Model & Red Bag Scheme

	Maturity assessment			
	Q2 17/18 (Current)	**Q3 17/18 (Planned)**	**Q4 17/18 (Planned)**	**Milestones met during the quarter / Observed impact**
Early discharge planning	Established	Established	Established	Bradford: SAFER in place (See endnote for explanation). Implementation of readmission flagging of complex patients at pre-assessment to the MAIDT (Multi-agency integrated discharge team) and Home from Hospital is in place. The Electronic Patient Record (EPR) will improve visibility of the discharge process. Airedale: SAFER in place. Plans need to expand to ensure community identification of complex cases before admission. Executive oversight now in place to improve metrics
Systems to monitor patient flow	Established	Established	Established	Bradford: Implemented EPR and the capacity management system in EPR will support oversight of patient flow in the hospital Airedale: In place
Multi-disciplinary/multi-agency discharge teams	Plans in place	Plans in place	Established	Bradford: the team should start operating 7 days a week when the discharge nurses commence working weekends in early November. Work is required to strengthen the operating model and move discharge to assess

				forward, including using the 5Q streaming tool to identify the most appropriate place for a person to be assessed. Airedale: Airedale are strengthening the multiagency team working and using the operating model agreed in Bradford as the basis for change. Staff in Airedale have been trained in the use of the 5Q streaming and this will be incorporated into the MAIDT operating model to implement discharge to assess
Home first/discharge to assess	Plans in place	Plans in place	Established	Bradford: There are some final issues to resolve in the process between Continuing Health Care (CCG) and the local authority this includes ensuring we have the right level of assessment staff in the right place so that assessments are undertaken in a timely manner.
Seven-day service	Established	Established	Established	Bradford: Multi-disciplinary team work across 7 days – work to ensure discharges remain across all 7 days needs completing. Assessment of gaps in place. Airedale: Elements in place Frail Elderly pathway (FEP), social services, 7day Acute Medical Unit ward rounds, community)- key work stream is criteria lead discharge over weekends.
Trusted assessors	Established	Established	Established	Currently in both hospitals we operate a trusted assessor for nurses on wards who are able to restart a domiciliary care package as long as it is not increased. Increased packages of care will go to the MAIDT. Nurses on wards are also able to agree the transfer plan for people returning to their care home as long as there is no change to the care package, increases in care packages will be arranged by the MAIDT. The MAIDT operating model in both hospitals will include joint training opportunities such as the 5Q training which will enable trusted assessor roles to develop. At the recent Care home provider forum the role of a trusted assessor was raised with Care Home owners, further discussion will take place in the Care Home provider

				development group
Focus on choice	Plans in place	Established	Established	Bradford: Policy in place this is being revised due to EPR. As part of the Commissioning for Quality and Innovation scheme (CQUIN) the three Trusts BTHFT, ANHSFT and BDCT are working collaboratively to develop integrated discharge policies. Anticipated completion Dec 17. Implementation of the multiagency (including LA and carers support). Airedale: Home of choice policy in place
Enhancing health in care homes	Established	Established	Established	Many different services in place including community integrated teams, telemedicine and goldline . A piece of work is underway to map areas of input

	Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	Achievements / Impact
Red Bag scheme (see end note)	Plans in place	Plans in place	Plans in place	Engagement with all stakeholders has taken place Workshop taking place 16/11/17 Commencing a test from Dec 1st across 6 homes to map out the process and check the effectiveness of the paperwork A pilot study to commence, with those care homes 'signed up' to the national CQUIN, from Jan 2018 Implementation across all care homes is likely to be from April 2018

Notes

SAFER patient flow bundle

The SAFER patient flow bundle blends five elements of best practice. It’s important to implement all five together for cumulative benefits. It works particularly well when used with the ‘Red2Green days’ approach.

The five elements of the **SAFER** patient flow bundle are:

S – Senior review, **A** – All patients have an expected discharge date and clinical criteria for discharge, **F** – Flow, **E** – Early discharge, **R** – Review

https://improvement.nhs.uk/uploads/documents/the-safer-patient-flow-bundle.pdf

Red Bag Scheme

The integrated Red Bag Pathway is designed to support transition between care homes, ambulance services and the local hospital. A red bag is used to transfer standardised paperwork, medication and personal belongings and stays with the resident throughout their hospital episode and is returned home with the resident.

https://www.nice.org.uk/sharedlearning/hospital-transfer-pathway-red-bag-pathway

2c Better Care Fund Plan 2017-2019 – NHS England Approval Letter. See following page