

Better Care Fund 2019-2020 Summary Plan Report

London Borough of Richmond Upon Thames



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1.0 Introduction

In Richmond our vision is that we want all people to achieve their full potential, live their lives with confidence and resilience, and access quality services that promote independence and deliver value for money. We will deliver this by focusing on prevention and early intervention; supporting people to be involved in their own care; delivering integrated and accessible person-centred care; and supporting independence for as long as possible.

The Better Care Fund (BCF) programme in 2019-20 will continue to facilitate health and social care integration. The 2019-20 BCF Plan outlines the joint intentions of London Borough of Richmond upon Thames (LBRuT) and Richmond Clinical Commissioning Group (RCCG) for achieving the long term aim of health and social care integration and person-centred care.

The BCF Plan will be a continuation from the BCF Plan 2017-2019 and represents the joint plan for integration of health and social care locally. The BCF Plan will retain a focus on working in partnership across health and social care, with our local population, to start well, live well and age well, both physically and mentally. There will continue to be a focus on improving services provided outside of hospital and reducing the unnecessary delays that people have during their hospital admissions.

During 2018-2019, Richmond has been in consultation with local people and key stakeholders on what their priorities are for the local health and care system. Reflecting on evidence from the Joint Strategic Needs Assessment (JSNA) and informed by wide consultation with residents, staff and stakeholders the priorities of the Richmond Health and Care Plan have been developed. The Health and Care Plan has been developed across the whole life course of “Start Well, Live Well and Age Well” and the BCF will predominately support Age Well priorities.

Through the BCF schemes and delivery of the Health and Care Plan we want to join up health and social care services to provide a better service to residents. The priorities for “Age Well” are:

- i. Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation
- ii. Support people to live at home independently, for as long as possible including people with dementia
- iii. Support people to plan for their final years so they have a dignified death in a place of their choice

1.1 Summary of Funding Contributions

The BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from CCG allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures Grant.

The table below summaries the contributions made to the Richmond BCF by LBRuT and RCCG for 2019-2020:

Contributions	2019-2020 Income
CCG Minimum Contributions	£11,830,372
iBCF	£92,793
Winter Pressures Grant	£660,842
Disabled Facilities Grant	£1,697,204
Total BCF Pooled Budget	£14,281,211

1.2. Signatories and Wider Partners to the BCF Plan

The BCF Plan 2017-19 is jointly written and owned by LBRuT and RCCG, with authorised signatories for each organisation:

- I. Councillor Piers Allen, Chairman of the Richmond Health and Wellbeing Board
- II. Liz Bruce, Director of Adult Social Services, Richmond and Wandsworth Councils
- III. Tonia Michaelides, Managing Director Richmond and Kingston CCGs
- IV. Dr Graham Lewis, Chair Richmond CCG Governing Body
- V. Sarah Blow, Richmond Clinical Commissioning Group Accountable Officer
- VI. Paul Martin, Chief Executive, Richmond and Wandsworth Councils
- VII. Mark Maidment, Director of Resources, Richmond and Wandsworth Councils
- VIII. Sydney Hill, Head of Health and Care Strategy, Richmond and Wandsworth Councils
- IX. Sue Lear, Deputy Head of Commissioning, Richmond and Kingston CCGs

The Richmond BCF Plan has also been agreed by:

- I. Richmond Health and Care Integration Steering Group – 19 September 2019
- II. Health and Wellbeing Board- through urgent decision

2.0 The Better Care Fund

The BCF is a national policy programme between health and social care systems to promote joint working and sustainable integration. Jointly managed by CCGs and local authorities, organisations work in partnership to coordinate existing systems and develop more diverse services. Created with stakeholders from NHS England, the Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and the Local Government Association (LGA) the BCF places importance on the wider determinants of wellbeing within communities.

Services, supported by the BCF, aim to achieve integrated person-centred care by supporting all aspects of a person's wellbeing so that they can live independently in the community. The BCF predominantly supports vulnerable older people, many of whom live with frailty and multi-morbidity creating a greater demand for support from care services and acute hospitals. The success of BCF initiatives is monitored against a variety of performance indicators, including delayed transfers of care (DTocS); measuring any delays in discharging a patient home from hospital. NHS England sets out the focus of the BCF during the planning period through the policy framework and policy requirements.

2.1 National Context of the BCF in 2019-20

Nationally, the BCF in 2019-20 is designed to be a continuation of the local priorities set out in the 2017-19 planning process. The yearly reporting period provides the opportunity for continued monitoring and to survey the data and information on the impact of the BCF so far. NHS England have simplified the entire planning process, so that there is minimal duplication of information between the 2019-20 and 2017-19 plans.

For this reason, there is no requirement to submit a Narrative Plan, and the narrative has been incorporated into the Planning Template. The BCF Narrative Plan for 2017-2019 set out how Richmond would make progress towards integration by 2020, and this year plan will focus on updates to the 2017-2019 plan.

In Richmond, the BCF Plan 2017-19 outlines how the LBRuT and RCCG are committed to strategic joint commissioning, within the wider commissioning structure of the South West London vision for cross-borough integrated services. In 2017-19, LBRuT and RCCG named a key priority of developing a successful seven-day service, so that residents can access 'the right care at the right time'. The plan also outlines extensive schemes to promote integration, including focus on voluntary sector preventative services, Richmond Response and Rehabilitation Team and supporting carers.

By acknowledging the weight of future pressures, the BCF Plan 2017-19 establishes how joint working and services will continue to meet the growing complexity of need in Richmond. All schemes supported by the BCF are continually reviewed and appropriate adjustments made to ensure that LBRuT and RCCG achieving the best outcomes for residents.

Please find the published Richmond Upon Thames BCF Plan 2017-19 on the Richmond Health and Wellbeing Board Website:

<https://cabnet.richmond.gov.uk/documents/g4264/Public%20reports%20pack%20Wednesday%2015-Nov-2017%2019.00%20Health%20and%20Wellbeing%20Board.pdf?T=10> (page 19).

2.2 BCF Policy and Planning Requirements in 2019-2020

The BCF in 2019-2020 will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or return to independence after an episode in hospital.

The continuation of the national conditions and requirements of the BCF from 2017-2019 to 2019-2020 provides opportunities for health and care partners to build on their plans from 2017 to embed joint working and integrated care further.

The BCF Policy Framework for 2019-20 provides continuity from the previous round of the programme.

The four **national conditions** set by the government in the Policy Framework are:

1. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grand determinations, **must be signed off by the Health and Wellbeing Board (HWB) and by the constituent Local Authority and CCG**
2. A demonstration of 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 CCF minimum contribution

3. That a specific proportion of the area's allocation is invested in NHS-commissioned **out of hospital services**, which may include seven-day services and adult social care
4. A clear plan on **managing transfers of care**, including the implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all Health and Wellbeing Boards (HWB) must adopt the centrally-set expectations for reducing on maintaining rates of delayed transfers of care (DToC) during 2019-2020 into their BCF Plans.

The BCF Plan 2019-20 must also demonstrate how areas will improve performance against **four national metrics** of the fund:

1. Non-elective hospital admissions (specific acute)
2. Admissions to residential and care homes
3. Effectiveness of reablement; and
4. Delayed transfers of care (DToC)

2.3 The BCF from 2020 and the NHS Long Term Plan

In June 2018, the government announced a review of the "current functioning and structure of the Better Care Fund" to ensure it supports the integration of health and social care.

The NHS has set out its priorities for transformation and integration through the NHS Long Term Plan, published in January 2019. This includes plans for the investment in integrated community services and next steps to develop Integrated Care Systems. The government will set out further proposals for social care and health integration in the forthcoming Green Paper on adult social care.

The BCF Review is expected to be completed in 2019 and an update on the BCF beyond 2020 is expected from NHS England later this year. The Chancellor's 2019 Spending Review, announced on 4th September 2019, did confirm the continuation of BCF and iBCF funding for 2020-2021.

3.0 Progress since 2017

The ongoing approach to integration has brought to improvements in the delivery of health and social care services in Richmond. In 2017-19 the focus centred on but was not limited to:

- Avoiding unnecessary hospital admissions
- Improving hospital discharge process
- Improving the quality and availability of reablement care

By reviewing pathways and improving the quality of services, Richmond continues to have steadily improving performance of BCF supported schemes as it matures. This is reflected in improving the hospital discharge process, which remains a key priority of the borough.

A key indicator used by NHS England to monitor the success of the BCF programme is the number of DToCs. It provides an insight into the efficiency of health and social care services in working together to discharge a person from hospital in a safe and timely manner, with additional care and support at home. Between 2017-2019, Richmond has reduced DToCs by

34.7%. DToC performance has also improved quicker than the national average; please see graph below. Although improvements are gradual, this is to be expected given the complex nature of hospital pathways and the myriad of services. A greater level of maturity within the schemes brings a greater impact within the system as the changes harmonise into 'business as usual'.

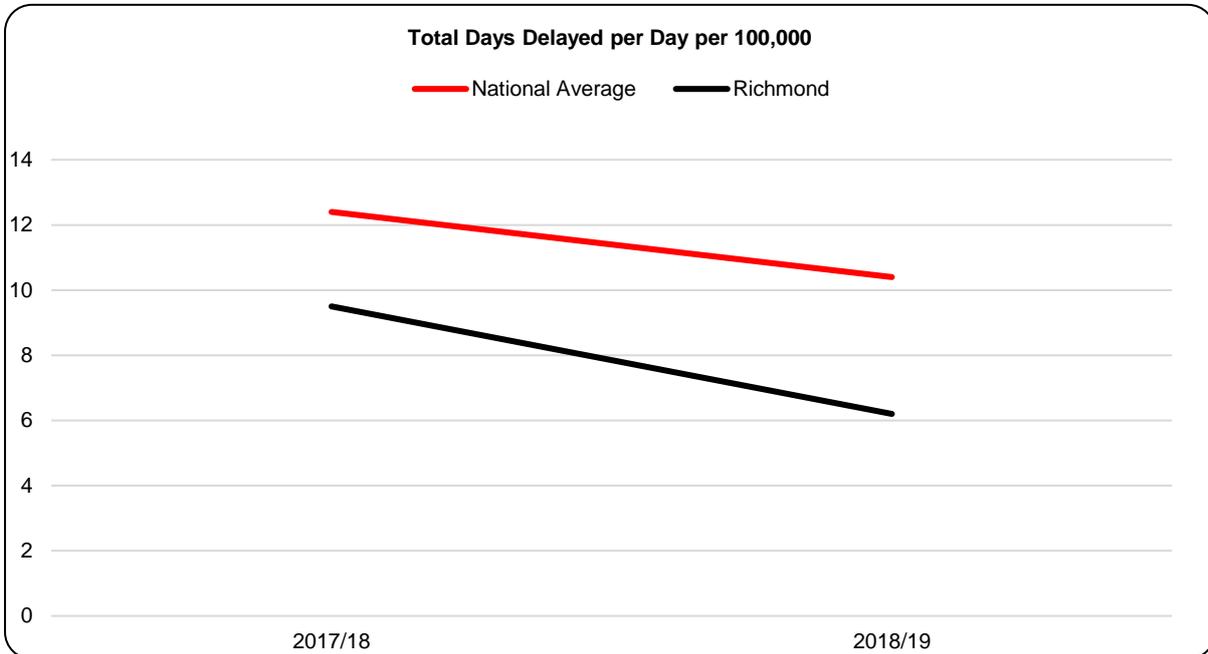


Figure 1: Graph above demonstrating the DToC average per day for 2017/18 to 2018/19

Another indicator used by NHS England is the non-elective admissions into hospital, which shows the non-planned admittances, such as emergency, hospital transfer or maternity admission. Please see graph below for data on 2017-2019.

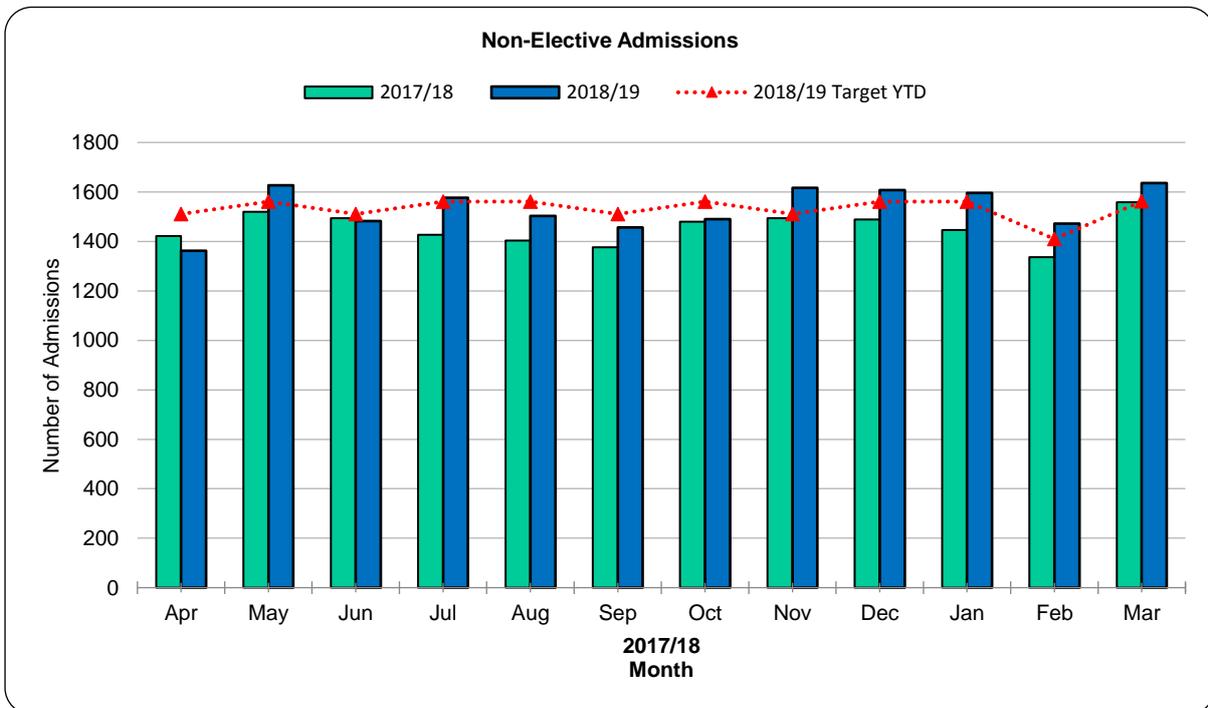


Figure 2: Graph demonstrating the NEA per month for 2017/18 to 2018/19

In Richmond, the average number of non-elective admissions per day was 47.8 in 2017-18 and 50.5 in 2018-19. This incremental rise can be linked to the increased demand on acute hospitals due population size increases year on year. Furthermore, increased admissions in the winter months demonstrates the impact of winter pressures in 2018-19 and the subsequent pressure on the system.

For 2019-20, it is aimed that schemes will continue to have a positive impact on system outcomes as schemes develop greater maturity and lessons can be learnt from previous years, such as measures to relieve winter pressures. The BCF schemes will continue to be closely monitored and adjusted accordingly to ensure that better outcomes are achieved for residents.

4.0 BCF Planning Template 2019-20

The BCF in 2019-20 is a continuation of the priorities set out in the 2017-19 plan. The main change in the BCF Planning Requirements from 2017-2019 is that the separate Narrative Plans have been replaced with a single Planning Template that will include short narrative sections covering local approach to integration; plans to achieve metrics and plans for ongoing implementation of the High Impact Change Model (HICM) for Managing Transfers of Care.

Please see the sub headings below for the strategic narrative on how the Local Authority and the CCG plan to focus the BCF programme in 2019-20 to meet the 2019-20 priorities set by NHS England.

4.1 System Level Alignment

Richmond has a long history of working together to deliver improved health and care to our local people. The CCG and the Local Authority work in partnership across health and social care, with our local population, to prevent ill health, reduce inequalities and support people to start well, live well and age well, both physically and mentally.

The BCF in 2019-20 will build on the existing 2017-19 Plan and reflect the “Age Well” priorities of the Richmond Health and Care Plan 2019-2020. It will continue to support and facilitate the strategic direction in Richmond to meet the requirements of the NHS Long Term Plan as set out in the vision of the SWL Health and Care Partnership to deliver integrated services, to give people the care they have told us they want.

The Richmond Health and Care Plan 2019-2020 has been developed alongside local health and care plans of the other boroughs in the South West London Health and Care Partnership. It describes the vision, priorities and actions to meet the health and care needs of local people in the borough, in themes of Start Well, Live Well and Age Well. The plan focuses on where health, social care and the voluntary sector can work together to have the biggest impact on what a single organisation cannot achieve alone.

In response to the South West London Sustainability and Transformation Plans (2016), there was a recognition that a local approach works best for planning and it was agreed that local health and care plans would be developed across the six boroughs in SWL Health and Care Partnership. Richmond’s Health and Care Plan has been developed in partnership with the Local Authority, CCG, NHS Providers, Healthwatch and representatives from the voluntary and community sector with consultation and engagement from local people in the borough.

Richmond Health and Care Plan is informed by the borough's Joint Strategic Needs Assessment (JSNA) outlining the key challenges and pressures across health and social care for the whole population of the borough. The plan reflects the whole life cycle and sets out priorities for **Start Well, Live Well** and **Age Well** acknowledging that there is transition between these stages. Richmond Health and Care Plan reflects the key priorities for improving health and wellbeing for the local population, and where we can have the biggest impact by working differently across health, social care and the voluntary sector.

The six borough plans will form an overall SWL Health and Care Partnerships Plan and will form part of the SWL response to NHS England in relation to achieving priorities set in the NHS Long Term Plan.

Richmond is part of a "complex system" with LBRuT and RCGG working across different geographies. Richmond Council has been part of a Shared Staffing Arrangement (SSA) with Wandsworth Council since 2016 and Richmond CCG have a shared Local Delivery Unit with Kingston CCG. NHS Community Services are largely provided by Hounslow and Richmond Community Healthcare, which also provide community services in Hounslow. Richmond has no acute hospitals in the borough, and most acute admissions are into Kingston Hospital and West Middlesex Hospital with a small flow to other hospitals. Working across CCG, Council and Provider boundaries offers benefits to how we engage with acute Trusts outside the borough. There is close working with Kingston Social Services and Kingston's Community Health Provider on developing aligned discharge pathways from Kingston Hospital, and we have established an integrated Joint Assessment and Discharge Team. There will be further opportunities through SWL on how we engage with acute hospitals across the system.

The BCF Plan and Health and Care Plan need to be set in the context of the wider strategic landscape for health and care integration for adults in the borough. This is supported by other joint plans, including:

- Carers Strategy
- Dementia Strategy
- Health and Wellbeing Strategy
- End of Life Care Strategy
- Richmond Mental Health OBC

4.2 Integrated Services at Borough Level

A core transformation programme is the establishment of Locality/Networks focused on 50k populations aligned to GP practices which facilitates multi-disciplinary working between primary, community, secondary care, social care and the voluntary sector to develop and deliver care plans to support people with complex care needs in managing their conditions, avoid crisis and reduce unplanned care needs. GP teams will use the SOLLIS risk stratification tool to identify those patients who are most vulnerable to admission.

The teams are configured from existing practitioners from primary, community, acute, mental health and voluntary sector working together to plan and manage the care for patients within their locality area. The multi-disciplinary teams will work with the Primary Care Networks (PCN's) to co-ordinate the care within a network population. Providing PCN's with population health profiles and information on health and care utilisation to support them in the planning of care for their populations. Developing a robust social prescribing model engaging with the voluntary sector to provide support to local communities.

There is an integrated Response and Rehabilitation Team within Richmond funded jointly by RCCG and LBRuT through the BCF. This team consists of therapists, nurses and social care staff working together to provide an urgent community response for people experiencing sudden deterioration in their condition. The aim is to maintain people in their usual place of residence by tailoring support to their individual needs. The service provides:

- A rapid response, urgent care assessment, observation and support in the community for people whose health needs may otherwise lead to an admission to hospital or an extended stay in hospital
- Improving the transition from acute hospital admissions to community services through facilitating safe and timely discharge from hospital
- A range of short-term interventions, which help people recover their skills and confidence after an episode of poor health, admission to hospital, or sudden deterioration of their functioning
- Providing short-term intensive support to people to regain independence and wellbeing
- A person-centred package of support to people in their own homes, in hospital or in a care home setting which is jointly delivered by health and social care professionals
- Ensuring an effective referral process to district nursing and/or other specialist teams as appropriate
- Maintaining effective communication with GPs and other referrers to the service
- Provide short term rehabilitation support to people in the community who are currently not as independent as possible. This is either from a community referral, routine or rapid response, or following a hospital discharge from either secondary care or from community hospitals.

The Multi-Disciplinary Teams/Locality Teams will impact on primary care consultations, A&E attendances and non-elective admissions with a focus on people with long term conditions. They will also facilitate early supportive discharge and end of life care for those people who require hospital-based care to enable them to return home as soon as their acute episode has ended.

Essential to the above is ensuring there is clear integration and alignment of the community mental health provision and the locality model. This will in part be achieved through a clear pathway for localities to access mental health services with confidence that referrals will be processed within time. There will also be potential opportunity for upskilling physical health practitioners to understand how to care for service users holistically.

Developments during 2019-20 include increasing the support for people in mental health crisis by investing in the development of the Crisis Support Team and the Core 24 Team in the emergency department along with a mental health assessment unit to ensure people with mental health needs are managed appropriately within the acute setting. During 2019-20, IAPT teams are starting to support the management of people with long term conditions bringing together mental and physical health problems.

Richmond has an active and established community and voluntary sector with offering a diverse range of services. Support for the voluntary sector is delivered through Richmond CVS. Richmond CVS is a champion of the local voluntary and community sector and they support the sector to raise their profile and provide opportunities for the voice of the sector to be heard. There is a strong theme of partnership working in Richmond with the voluntary sector. Richmond recognises the potential within the voluntary sector to play an active part in addressing the health and wellbeing challenges that we face and Richmond CVS represents the voluntary sector on the Health and Wellbeing Board

4.3 Integrated Care around the Person

The Richmond Health and Care Plan 2019-2021 sets out the key priorities for “Start Well, Live Well and Age Well” and the BCF will predominately support “Age Well” priorities. The Health and Care Plan describes key actions we plan to deliver across health and social care over the next two years. A key focus of the health and care plan is to integrate health and social care around the person, which has overarching focus on prevention.

Through the Health and Care Plan we have agreed a set of actions that will be taken that will have a positive impact for residents in the borough. Across the borough of Richmond we are committed to understanding and identifying where we have inequalities in health most notably we will focus on reducing health inequalities for people with a learning disability. We will increase the uptake of GP annual health checks, support the delivery of the Mencap Treat Me Well campaign and address the physical health needs of this cohort of people to minimise years lost to ill health.

Encourage active, resilient and inclusive communities that promote healthy ageing and reduce loneliness and isolation

We will explore and build opportunities for social connections / community hubs that bring people together in their community. We have made a commitment to promote wellbeing and healthy lifestyles for all older people, including through the rollout of the “Making Every Contact Count” initiative. We have plans to improve access to health and care information and advice for people and their unpaid carers; as well as to improve access for older people and their carers to outreach and community-based services, including through the delivery of Community Independent Living Services (CILS) and social prescribing. There will be investment in the training and provision of the voluntary sector throughout plans for social prescribing and development in IT connectivity. The underpinning philosophy is that ‘money follows activity’ to support what individuals need and to deliver positive outcomes for our residents.

Support people to live at home independently, for as long as possible including people with dementia

We will identify and proactively support older people with complex health and care needs by bringing health and care professionals together around the individual – through primary care networks, across the borough. We have plans to increase the number of shared care plans developed with older people who have complex needs and their unpaid carers. We have plans to redesign the pathways for integrated community based urgent care services and implementing a “home first” principle for people leaving hospital. This will be complimented by an increase in older people who receive reablement support and recover at home on discharge from hospital.

Support people to plan for their final years so they have a dignified death in a place of their choice

We will support people to plan for their old age and have sensitive conversations to include talking about death and dying. We will improve end of life care by progressing delivery of our End of Life Care Strategy to ensure that end of life issues are addressed. We will support people to take up health and social care personal budgets to enable them to receive personalised care to meet their needs, including for their end of life care by 2021. We have plans to improve care coordination and information sharing across health and social care at the end of life, including rolling out access to the integrated 'Coordinate My Care' system.

Supporting Carers

We have made a commitment to improve our practice in identifying and recognising carers of all ages, ensuring that they are linked into support options, enabling carers to reduce the emotional, social, financial and health impacts they face. We have made a commitment to implement the recommendations from the consultation on the Richmond Carers Strategy and work with Richmond Carers Hub to review how carers' needs are assessed and responded to in their own right to ensure they are 'not forgotten'. We have plans to improve the approach and practice in relation to carer assessments and support planning and improve the recognition of young carers and develop a range of support options.

4.4 Disabled Facilities Grant

Under the provisions of the Housing Grants, Construction and Regeneration Act 1996, the Council provides mandatory means tested Disabled Facilities Grants (DFG) to assist residents with the cost of providing adaptations to dwellings or common parts of buildings containing flats where the adaptation is considered 'necessary and appropriate' and 'reasonable and practical'. The Regulatory Reform Order (RRO) 2002 provides local authorities a broader freedom and opportunity to address living conditions in their area including to provide, directly or indirectly, assistance to adapt or improve living accommodation and repair living accommodation.

The RRO (2002) allows local authorities to create assistance schemes using the DFG funding which help people to meet their needs without going through the full DFG process. Additional funding under the BCF has expanded the scope of help available to include discretionary DFG schemes. This widening of funding enables more people to remain independent and prevents the need for care and support for longer.

The BCF has created new opportunities for the Local Authority to develop and fund joint commissioning plans with Clinical Commissioning Groups to meet the needs of residents across care groups. The Discretionary DFGs and Housing Assistance Policy supports the development of these plans by providing the policy context for how commissioning partners will use the funding available to develop a range of DFG funded services. The broad priorities of the policy are to improve outcomes for disabled and older people, reduce admissions or re-admissions through prevention, help people remain independent for as long as possible, reduce care costs where possible and help facilitate more efficient discharge from hospital.

More specifically, the funding for discretionary DFGs sits within the BCF and funding for services is prioritised and targeted at initiatives which:

- Reduce or eliminating hospital admissions;
- Allow speedier discharge from hospital;
- Consider the long-term needs of individuals and reductions in associated treatment and social care costs; and
- Provide for works, adaptations or provision of equipment that is not provided by any other service.

The Local Authority implemented a Discretionary DFG and Housing Assistance Policy in early 2019. The policy sets out how the discretionary funding can be used, and it includes the local agreed approach for funding in the following areas:

- Speeding up the delivery of adaptations: additional staff and/or training
- Funding adaptations over the maximum mandatory DFG limit
- Relocation funding
- Hospital Discharge Grants
- Fast Track non-means tested assistance
- Preventative outreach and independence assistance
- Telecare and Telehealth services
- Adaptation of temporary accommodation
- Provision of interim placements (for people awaiting adaptations)

Adaptations provided via Mandatory DFGs are managed by the Council's Home Improvement Agency while equipment and services provided via the Discretionary DFG Policy are delivered across a wider range of services including Social Services and Hospital Discharge teams.

The outcomes achieved by the Mandatory DFGs and the Discretionary DFGs initiatives are monitored by the CCG, Social Care and the Housing and Regeneration Department as the Local Housing Authority Spend and activity is reported to the BCF Board. The DFG Lead for the Council has been involved in BCF Planning and is a core member of the BCF Programme Board.

5.0 Metrics

BCF plans must include ambitions for each of the four metrics and plans for achieving these are a condition of access to the fund. Expectations for reducing or maintaining DTocCs will continue to be set centrally for each Health and Wellbeing Board area.

5.1 Non-Elective Admissions

A key focus of the BCF is to reduce non-elective admissions to hospital. In 2018-19 there were 18,447 non-elective admissions for RCCG patients against the 2018-19 Operating Plan expectation of 18,379 non-elective admissions. RCCG was 68 non-elective admissions above plan (0.37%) by March 2018.

RCCG is working collaboratively with partners across acute, community and primary care, and the LBRuT to adopt a co-ordinated and systematic approach to understanding the

cohort of people, who are at risk of admission, where this can be managed in the community and delivering a co-ordinated response.

We are doing this through the implementation of risk stratification searches that will enable general practice and community services to focus resource and expertise appropriately. Multi-disciplinary teams (MDTs) will also review their caseloads and highlight those complex patients who would benefit from a locality MDT review. The community matrons who form part of the locality MDT will provide a common link with the practice MDTs, thereby facilitating joint coordination of care and goal setting for patients. Locality social workers form an active part of the MDTs.

The jointly commissioned Richmond Response and Reablement Team provide a pro-active response to the management and support of people in the community requiring an urgent community response.

A target for the reduction of non-elective admissions has been set based on the cohort of people who are clinically considered suitable for management in the community. This is measured monthly by Primary Care Networks and discussed with them monthly and review any required actions to improve the position.

5.2 Delayed Transfers of Care (DToC)

Richmond has been set a DToC target for 2019-2020 of **12.2** delayed transfers of care per day (daily delays) from hospital. This includes people who are delayed for reasons attributable to the NHS, social care or both. Whilst a daily target has been set, performance will be monitored on a monthly basis. Richmond is part of a complex system with no acute hospitals in the borough, with the majority of residents being admitted to Kingston Hospital or West Middlesex Hospital.

One of the main aims of the 2017-2019 BCF Plan was to reduce the number of DToCs and the BCF has contributed to Richmond making significant improvements in managing delays both in acute and non-acute (including mental health) settings. Over the two-year period of the 2017-2019 BCF Plan, DToC's across health and social care improved by 48.4% (24.0% improvement health delays; 83.4% improvement in social care delays). There have been improvements for most reasons of delay, but of note are improvements in the following reason codes¹:

- Social Care Assessment - 94%
- Social Care Residential or Nursing Homes – 76.4%
- NHS Residential or Nursing Homes – 49.7%
- Social Care, Care Package – 77.2%
- NHS Care Packages – 28%
- Social Care and NHS “patient/family choice” – 40.2%
- NHS and Social Care Disputes – 69.4%

In 2018/2019, 86.2% delays were attributed to the NHS with 13.8% attributable to Social Care, this is in comparison to the national 61.9% attributable to NHS and 38.1% to Social Care. The main reasons for health and social care delays in 2018-2019 are listed below, with the percentage of total days delayed across the system:

NHS Delays:

- Further NHS Non-Acute Care – 56.6%
- Awaiting Assessment - 21.8%
- Patient or Family Choice – 21%

Social Care delays:

- Awaiting Residential or Nursing Home Placement -12.3%
- Awaiting Care Package in Own Home – 3.8%

This has been a key priority for Richmond's health and care system. Improvement in DToCs has been driven through the BCF Group and Kingston and Richmond A&E Delivery Board and has been achieved through a shared commitment to improve patient experience and reduce unnecessary delays in discharge from hospital settings. This has been supported by improved partnership working across CCG, Adult Social Care, Community Adult Health Services, voluntary sector and the Acute Hospital as well as learning from Multi-Agency Discharge Events (MADE) and implementation of the High Impact Change Model.

Most of the BCF schemes will have an impact on DToC performance, and the Richmond Response and Rehabilitation Team is a key service in maintaining progress in performance. RRRT is an integrated multidisciplinary team, with seven day working, and is a single point of contact for all community health and social care hospital referrals for Richmond residents.

Kingston Hospital reports on people who have long lengths of stay in hospital (over 7 days, and over 21 days), whereby performance is reported to the A&E Delivery Board monthly. A weekly meeting has been set up with executive leadership of partnership organisations to review individual delayed patients; to 'unblock' issues; identify common themes and develop strategic plans to resolve issues.

There is a Joint Assessment and Discharge (JAD) Team now in operation at Kingston Hospital, with multi-agency representation including Kingston Hospital and Richmond and Kingston Adult Social Services. For 2019-2020, we have plan to continue to build on this and to look at joint teams at the "front door" of A&E to prevent admissions as well as focusing on discharge.

We are also working with partners in Kingston to develop an integrated therapy offer to reduce the number of discharge assessments that are carried out in hospital, moving the resource into the community and operating an 'in-reach' model of assessments.

Winter Pressures Grant Funding

The Winter Pressures Grant funding will be used to maintain social care DToC performance. Plans for use of winter pressures funding take into consideration the main causes for Richmond social care delays, learnings from previous winters and findings from Multi-Agency Discharge Events (MADE) and known seasonal pressures.

Voluntary Sector Provision – The Nightingale service is provided by Richmond Age UK and funded through the BCF. The service has a team of staff and volunteers that provide practical support to enable people to be discharge from hospital and provide support to help people get (re)connected to their community after a stay in hospital. Winter pressures funding will increase this service over core months.

Home Care/Reablement – additional capacity in home care and reablement services will help to ensure that people are able to return to their homes in a timely way.

Residential and Nursing Care – additional provision will allow continued high performance for DTOC from hospital for people discharged to care home environments.

5.3 Care Home Admissions

Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care.

In 2018-2019 there were 107 new permanent admissions into care homes, which exceeded the target of 105. Richmond has set a higher target for 2019-20 (110 new placements compared to 105 last year), taking into consideration demographic pressures of the borough. Richmond has a high population of residents over the age of 80 with complex needs and presenting later in life for support. The BCF target has been aligned with the Council target, however, year to date performance (April – August) has been strong, and we hope to over achieve this.

		18/19 Plan	19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	341	352
	Numerator	105	110
	Denominator	30, 749	31, 272

Richmond Adult Social Services has a strong focus on 'Promoting Independence', which is supported by a shift to strength-based assessments and support planning with individuals. This practice sees a focus on the individual's assets, as well as family and personal networks and connection with the wider community. The overall priority is for residents to be independent, resilient, healthy, active and physically and mentally well.

When people become less independent or unwell, we want to ensure they can access care and support at the right time and in the right place. We will do this by supporting people at home, or in a home like setting, wherever possible and enabling them to access personal and community networks before introducing reliance on statutory services.

Richmond Response and Rehabilitation Team and reablement services have been successful in supporting people with complex needs to return home from hospital. It is recognised that making long term care decisions during an un-planned hospital admission, when people are often in crisis, should be avoided unless there is no other option. On occasion, people will access bed-based services including rehabilitation in non-acute settings to continue with their recovery and rehabilitation prior to making decisions about their long-term care needs.

Extra Care Housing provision in the borough has also been key in reducing residential care admissions. Extra care or supportive living offers people the opportunity to live in their own flat, with care staff on site, and for some people can be a viable alternative to moving into a care home setting.

Needs analysis and forecasts projecting demand to 2035 for accommodation with care and support ranging from independent living options, such as supported living and extra care to care home provision, have been undertaken. These provide an understanding and overview of existing provision and predicted need across all client groups including older persons, mental health, learning disability and physical disability and sensory needs in line with demographic growth and service use trends. They form part of a robust evidence base to ensure we plan, commission and develop the right accommodation options in a cost effective and sustainable manner working closely with Housing.

Our aim is to avoid care home admissions (although there will be a need for an increase in specialist residential and nursing care in response to increasing numbers with dementia) and to provide increased support in individuals' own homes and develop more extra care and supported living provision, encouraging people to live as independently as possible.

5.4 Reablement

There is evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their needs for ongoing support and dependence on public services.

This measure seeks to demonstrate the effectiveness of reablement services by determining whether an individual remains at home 91 days following their discharge from hospital. This measure is complimented by locally monitored performance on people who leave the service with a reduced need, or no needs for council provided services.

		18/19 Plan	19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.1%	91.7%
	Numerator	143	143
	Denominator	166	156

Richmond has over achieved the BCF targets set in 2017-2019 Plan, and a more stretching target of 91.7% has been set for 2019-2020. There has been a reduction in referrals to reablement, and this is something that is currently being reviewed to understand the causes. It is a priority for Richmond that people have access to the right services, in a timely way, to support their safe discharge from hospital as well as enable their recovery and maximising their independence once home. We are working with our community health provider to review pathways and criteria into the reablement service with the ambition to increase the number of people who access reablement from hospital.

6.0 High Impact Change Model

National condition four requires health and social care partners in all areas to work together to agree a clear plan for managing transfers of care and to continue to embed the High Impact Change Model (HICM). The HICM identifies eight system changes which will have the greatest impact on reducing delayed discharges.

In Richmond, we are “established” or “mature” across most areas of the HICM and have plans in place to develop in four of the areas:

- Home First, Discharge to Assess
- Seven-day services
- Trusted Assessors
- Focus on choice

High Impact Change Model			
System Change	2018-2019 (Achieved)	2019-2020 (Ambition)	How we will get there
Early discharge planning	Mature	Mature	In summer 2019, we established a weekly long length of stay meeting at the acute trust with executive level attendance from partners to review all long length of stays and identify strategic themes to enable us to develop new systems and processes. This has influenced reducing the long length of stays (over 21 days).
Systems to monitor patient flow	Mature	Mature	There is an established system within the acute trust, this is used to provide live information to identify the flow of patients and recognise when they are medically fit to enable early discharge planning.
Multi-disciplinary/Multi-agency discharge teams	Mature	Mature	There is an established joint assessment and discharge team working at the acute hospital that has input from all partners.
Home first / discharge to assess	Established	Mature	Work is in place to develop a system wide integrated service for the delivery of discharge

			assessments favouring a home first model. The principle behind this is that no discharge assessments are carried out in hospital. Quick wins will be implemented in time for winter. This work is engaging both local authority, and community provider along with the acute trust.
Seven-day service	Established	Mature	Services are in place seven days a week although further work is being done as a system to identify whether extending the opening hours of any community services will positively impact on the ability to facilitate earlier discharge or prevent an avoidable admission.
Trusted assessors	Plans in place	Established	Trusted assessors are being developed as part of the discharge to assess model as part of the integrated discharge service model.
Focus on choice	Established	Mature	There has been a significant reduction in “patient choice” delays. Voluntary sector provision is integrated in discharge teams through Nightingale service. Choice protocol is in place and well understood by staff and will be further embedded and used to challenge.
Enhancing health in care homes	Mature	Mature	A care home support team has been commissioned to provide a rapid response service for the deteriorating patient, along with a service that supports care home staff with advance care planning and skills training.

7.0 Programme Governance:

The BCF is a jointly developed and agreed approach and plan between the CCG and the Local Authority and the governance for the plan reflects this. As such governance for the plan is incorporated within existing joint structures. This allows oversight of delivery of the BCF plan in terms of ongoing delivery but also allows the consideration of the BCF's role in supporting and enabling the broader integration agenda for Richmond.

Richmond Health and Wellbeing Board have ownership of the BCF and is responsible for signing off BCF Plans.

Health and Social Care Leaders Group is a group of senior leaders across RCGG, NHS Providers and the Local Authority setting the strategic direction for health and social care integration in Richmond, including providing the leadership for the Health and Care Plan.

Health and Care Integration Group will oversee the delivery and progress of the BCF schemes. The Group will identify any emerging risks or difficulties with delivery and identify corrective actions for implementation. The group will report to HWB, providing highlight reporting on delivery and escalation of key risks and issues. It consists of commissioners and providers who focus on commissioning BCF services as well as monitoring and managing the contracts with providers

A&E Delivery Board - The Kingston, Richmond & Surrey Downs Local A&E Delivery Board is where executive partners across the health and social care system across Kingston, Richmond and Surrey undertake the regular planning of urgent care service delivery, planning for the capacity required to ensure delivery; overseeing the co-ordination and integration of services to support the delivery of effective, efficient, high quality accessible urgent and emergency services to the population and measuring performance and initiating and completing corrective action as necessary.

8.0 Approval of Agreed Plans

All BCF plans will be approved by NHS England following a joint NHS and local government assurance process at regional level. In addition to the national conditions to set the four-national metrics, NHS England is also placing the following requirements for approval of BCF Plans

- I. All funding agreed as part of the BCF Plan must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006
- II. That all plans are approved by NHS England in consultation with the Department of Health and Social Care (DHSC) and Ministry of Housing, Communities and Local Government (MHCLG)

NHS England will approve plans for spend from the CCG minimum in consultation with DHSC and MHCLG as part of overall approval of BCF Plans. The DFG, iBCF and Winter Pressures grants are subject to grant conditions set out in the grant determinations made under Section 31 of the Local Government Act 2003.

9.0 Appendix A

9.1 Draft Financial Plan 2019/20

Line ref	Scheme	Funding Source	Area of Spend	Provider	Lead Commissioners	BCF Funding 19/20 (£)
1	Outcome Based Commissioning - Falls Service	CCG contribution	Community Health	NHS Community Provider	CCG	299,421
1	Outcome Based Commissioning - Early Supported Discharge	CCG contribution	Community Health	NHS Community Provider	CCG	348,417
1	Outcome Based Commissioning - COPD Respiratory Team	CCG contribution	Community Health	NHS Community Provider	CCG	315,753
1	Outcome Based Commissioning - Community Geriatrician at Acute hospitals	CCG contribution	Community Health	NHS Community Provider	CCG	130,656
1	Community Services including Locality teams, Cardiac Rehab, Tissue Viability	CCG contribution	Community Health	NHS Community Provider	CCG	748,007
2	Carers Hub Service	CCG contribution	Social Care	Charity / Voluntary Sector	LA	404,869
3	HRCH	CCG contribution	Community Health	NHS Community Provider	LA	616,495
3.1	Homecare reablement	CCG contribution	Social Care	Local Authority	LA	731,620
3.1	RRRT (Integrated Care Teams) - RRRT Agency Social Workers	CCG contribution	Social Care	Local Authority	LA	50,950
4	RRRT (Weekend Working) - RRRT HRCH Team	CCG contribution	Community Health	NHS Community Provider	CCG	1,122,556
4	RRRT (Weekend Working) - RRRT Weekend Support	CCG contribution	Community Health	NHS Community Provider	CCG	272,201
5	GP & Multi-disciplinary Team - GP led Model (enhanced DES, community nursing)	CCG contribution	Community Health	NHS Community Provider	CCG	1,019,119
5	GP & Multi-disciplinary Team - Diabetes Locally Commissioned Service	CCG contribution	Primary Care	NHS Community Provider	CCG	76,216
5	GP & Multi-disciplinary Team - Community Matrons	CCG contribution	Community Health	NHS Community Provider	CCG	482,340

5	GP & Multi-disciplinary Team - Social Workers to participate in GP led model	CCG contribution	Other	Local Authority	LA	201,492
5	GP & Multi-disciplinary Team - Increased capacity of SW workforce to facilitate hospital discharge	CCG contribution	Other	Local Authority	LA	141,152
6	Improved Mental Health Out-of-Hospital Services - Contribution towards Psychiatric Liaison	CCG contribution	Mental Health	NHS Mental Health Provider	CCG	256,957
6	Improved Mental Health Out-of-Hospital Services - New funds for 16/17 only	CCG contribution	Mental Health	NHS Mental Health Provider	CCG	18,510
7	Equipment and assistive technologies - Joint Equipment Services (the £50k in the narrative last year for AT was not in the budget)	CCG contribution	Community Health	NHS Community Provider	CCG	653,282
8	Maintaining Adult Social Care Home care services	CCG contribution	Social Care	Local Authority	LA	1,400,185
8	Maintaining Adult Social - Residential/Nursing Care Homes	CCG contribution	Social Care	Local Authority	LA	1,292,478
9	DFG (Capital) - DFG & others	DFG	Social Care	Local Authority	LA	1,697,204
10	IBCF - RRRT support Services	iBCF	Social Care	Local Authority	LA	92,793
11	Additional responsibilities Care Act - Duties/Responsibilities	CCG contribution	Social Care	Local Authority	LA	579,048
12	Services commissioned from the voluntary sector	CCG contribution	Social Care	Local Authority	LA	464,849
12	Services commissioned from the voluntary sector	CCG contribution	Social Care	Local Authority	LA	0
12	Personalised Services and Care at Home - CILS	CCG contribution	Social Care	Local Authority	LA	203,800
13	Winter Pressures Grant	Winter Pressures	Social Care	Local Authority	LA	660,842
	Total					14,281,211