Item 10a

Health and Wellbeing Board

18 September 2018

Better Together Programme – Progress Update

Recommendation(s)

1. To note the progress of the Better Together Programme in 2018/19 to improve performance against the four national Better Care Fund (BCF) areas of focus.

2. To note progress against the High Impact Change Model.

3. To note the additional national ambitions relating to the Red Bag Scheme and acute length of stay.

1.0 Better Together Programme Progress Update – 2018/19 Performance

1.1 Locally our plan for 2017/19 focusses our activities to improve our performance in the four key areas which are measured against the National Performance Metrics, these being:

a. Reducing Delayed Transfers of Care (DToC)
b. Reducing Non-Elective Admissions (General and Acute)
c. Reducing admissions to residential and care homes; and
d. Increasing effectiveness of reablement

a. <u>Reducing Delayed Transfers of Care</u>

The 2018/19 target for this metric has now been amended by NHS England and is now 43.2 average daily beds delayed (compared to 40 in 2017/18).

The downward trend in the number of delays has continued in quarter 1. At the end of quarter 1 2017/18 (June 2017) the average daily beds delayed was 85 and one year later at the end of June 2018 this has reduced to 32, which represents a 62% improvement in performance. Over the last 8 weeks this good performance has been sustained, with delays below or close to the target.

This improved performance has been achieved whilst seeing increasing numbers of admissions and acuity of patients. Despite this health and social care colleagues across all nine acute and community sites, along with domiciliary

(home care) and residential and nursing home providers, have and continue to work tirelessly to discharge patients safely.

The most significant improvements have been at the three main acute sites, Warwick, George Eliot and University Hospital Coventry and Warwickshire, where we have been working hard to educate our teams and patients about the deterioration which can take place if a frail elderly person spends too long in hospital and our focus has been to support people to return to their usual place of residence as soon as they are ready to do so.

The challenge now is to maintain this improvement whilst continuing to reduce the number of days patients are delayed elsewhere in the system. This includes delays of Warwickshire residents at out of county providers, which accounted for 16% of delays over the last 6 months.

Note: There is a 6 week delay in confirming actual delays data.

DToC performance is measured as the average number of daily beds occupied by a delayed Warwickshire resident.

Month	**Average daily beds occupied by a delayed resident**	**Target** (lower is better)
June 17	85	87
July 17	83	77
August 17	64	68
September 17	64	58
October 17	53	49
November 17	57	40
December 17	58	40
January 18	55	40
February 18	59	40
March 18	49	40
April 18	51	43
May 18	41	43
June 18	32	43

b. <u>Reducing Non-Elective Admissions (General and Acute)</u>

Non-elective admissions increased by 5.1% in 2017/18 compared to 2016/17 and this increased trend has continued into quarter 1 2018/19 with non-elective admissions 6.1% higher than the same period last year.

The main reason for the continued growth in volumes of non-elective admissions in quarter 1 was:

- a 7% increase in non-elective admissions of those aged 65+
- a 5.6% increase in A&E attendances of all ages and a 6.8% growth of those aged 65+

Non-Elective Admissions performance:

Quarter	Actual	Target	% over target
Q1 2017/18	13,309	13,138	1.3%
Q2 2017/18	13,281	13,280	0.0%
Q3 2017/18	13,818	13,289	4.0%
Q4 2017/18	13,388	13,003	3.0%
Q1 2018/19	14,138	13,065	8.2%

The main driver for growth in non-elective admissions is an increase in A&E attendances when compared to the same period in the previous year.

Non-elective admissions from North Warwickshire CCG patients have seen the greatest growth compared with the same quarter last year (7.0%), while growth at Rugby and SWCCG was 3.8% and 6.3% respectively.

NHS	65+ A&E Attendances	All Age A&E Attendances
SWCCG	+2.3%	+6.3%
WNCCG	+10.7%	+7.0%
Rugby	+15.2%	+3.8%
Total	**+7.0%**	**+6.1%**

The growth in non-elective admissions of Rugby patients and WNCGG patients was significantly higher in the 65+ group than those aged 0-64. This is manifested by a higher growth in A&E attendances of those aged 65+ at University Hospital Coventry and Warwickshire and George Eliot Hospital.

c. <u>Reducing long term admissions to residential and nursing care 65+</u>

In Quarter 1 2018/19, the rate of permanent admissions was 2.3% higher than the same period the previous year and 26% above target. This increased trend continues on from 2017/18 where admissions grew by 23.9% compared with 2016/17 and were 23.4% over target.

Underpinning the increases are the increasingly complex needs of customers and increased demand for 24 hour care, population growth of 2.9% each year, and a lack of other alternatives such as Extra Care Housing, as due to its popularity all

schemes are now at full occupancy, aside from any re-let units at schemes already in operation.

The current target for 2018/19 is 470 admissions per 100k population which equates to a quarterly target of 118. Under the recently published BCF Operating Guidance for 2017-18 local areas have an opportunity to review and amend locally agreed targets. The Better Together Programme Board has requested a change to the admissions target to 606 per 100k population.

Quarter	**Actual (rate per 100k pop)**	**Target** (lower is better)	**% Over target**
Q1 17/18	142	118	20.5%
Q2 17/18	156	118	32.9%
Q3 17/18	164	118	38.9%
Q4 17/18	170	118	44.0%
Q1 18/19	163	152 to be confirmed	7.0%

d. Increasing the effectiveness of reablement

This target measures the percentage of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement or rehabilitative services. This target is an annual measure and performance for 2017/18 was 93%.

Year	**Actual**	**Target** (higher is better)	**% Over target**
2016/17	87.9%	86.8%	1.1%
2017/18	93.0%	89%	4%
2018/19	Data available in June 19	89%	n/a

2.0 Better Together Programme Progress Update – High Impact Change Model (HICM)

2.1 The Integration and Better Care Fund Operating Guidance for 2017-19 updated and re-issued in July 2018 confirms the requirement for implementation of the HICM with particular focus in relation to length of stay and systems to monitor patient flow, seven day services and trusted assessors (changes 2, 5 and 6) in 2018/19. Areas that make insufficient progress in reducing long stays in 2018/19 may be subject to additional requirements in 2019/20.

2.2 The most recent self-assessment of progress against the model is detailed below:

		Status as at Q1 18/19
Change 1	**Early discharge planning**	Established
Change 2	**Systems to monitor patient flow**	Established
Change 3	**Multi-disciplinary/multi-agency discharge teams**	Established

Change 4	**Home first/discharge to assess**	Established
Change 5	**Seven-day service**	Established
Change 6	**Trusted assessors**	Plans in place
Change 7	**Focus on choice**	Established
Change 8	**Enhancing health in care homes**	Plans in place

Based on currently progress, to achieve 'Mature' status (the nationally and local Better Health, Better Care, Better Value target) against all 8 changes in the model, across all sites by March 2019, will be challenging.

3.0 Red Bag Scheme

National Context

3.1 Implementation of the Red Bag Scheme is now a formal requirement as part of the Better Care Fund to support a reduction in Delayed Transfers of Care. A national target that 90% of Health and Wellbeing Boards will have achieved 'established' status in this scheme by March 2019 has also been set.

3.2 Warwickshire's current status is Not Yet Established.

Local Context

3.3 Progress is being made to develop and improve arrangements for Hospital Transfer Pathways across the country and the Red Bag scheme is aimed at supporting health and social care to continue to enhance communication and information sharing when care homes residents move between care homes and hospital.

3.4 When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated Red Bag that contains standardised information about the resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern. The bag would also contain resident's personal belongings such as change of clothes, glasses or dentures. This means that ambulance and hospital staff can determine the treatment a resident needs more effectively.

3.5 The bag would stay with the resident in the hospital until they return to their care home. Upon discharge, a copy of the discharge summary would be placed in the bag so that care home staff have access to this information when their resident arrives back home.

3.6 The aim is to implement the scheme, using the national best practice guidance and which is consistent with that already implemented in Coventry.

4.0 Timescales associated with progress reporting

4.1 The Better Care Policy Framework requires quarterly reporting and monitoring against the four national performance metrics, high impact change model, red bag scheme and finances.

4.2 Please follow the link below to access the Better Together website.

https://www.bettertogetherwarwickshire.org/

Background Papers

1. None

	Name	**Contact Information**
Report Author	Rachel Briden	rachelbriden@warwickshire.gov.uk Tel: 01926 74 6978
Director of Public Health	John Linnane	johnlinnane@warwickshire.gov.uk Tel: 01926 41 3705
Strategic Director	Nigel Minns	nigelminns@warwickshire.gov.uk Tel: 01926 74 2655
Portfolio Holder	Cllr Les Caborn	cllrcaborn@warwickshire.gov.uk

The report was circulated to the following members prior to publication:

Local WCC Member(s): N/a
Other WCC members: Councillors Caborn, Morgan, Redford, Golby, Parsons and Rolfe.