Item 8

Gateshead Council

HEALTH AND WELLBEING BOARD
21 July 2017

TITLE OF REPORT: BCF Quarter 4 Return 2016/17 - Follow-up Report

---

Purpose of the Report

1. To update the Health & Wellbeing Board on action being taken to progress work linked to particular Better Care Fund (BCF) national conditions and metrics where the need for further progress has been highlighted within the quarter 4 return.

Background

2. The BCF Quarter 4 return for 2016/17 was on the agenda of the last Board meeting on 23rd June. However, there was insufficient time to consider the item due to time pressures linked to the Board's consideration of substantive items on its agenda.

3. At the request of VCS representatives, a follow-up report has been prepared focusing specifically on areas identified within the return where further progress is most required. In particular, the report focuses on BCF national conditions and key metrics.

BCF National Conditions

4. Work to progress each of the BCF national conditions was undertaken in 2016/17. Areas identified where further progress is most required as well as planned action is set out below:

   National Condition 4 ii) - Are you pursuing Open APIs (i.e. systems that speak to each other)? - *'No' (condition not fully met) entered in Q4 return.*

   Under progress commentary, the following was entered in the Q4 return:
   Following initial stakeholder events held in 2015, significant progress has been made to develop more robust plans for delivering information sharing between stakeholders, including across health and social care. The CCG has co-ordinated the development of the Newcastle Gateshead Local Digital Roadmap, which outlines the ambition across Newcastle Gateshead to deliver a paper free care system by 2021. Stakeholder organisations were involved in developing this joint plan which was completed in June 2016. The Newcastle Gateshead Local Digital Roadmap sets out ambition across several universal capabilities for shared information across care settings. The deployment of the Medical Interoperability Gateway (MIG) and Messaging Exchange for Social Care and Health (MESH) are key systems needed to achieve successful sharing of information between Gateshead Social Care and NHS partners.

   The local Gateshead Information Network (GIN) continues to meet regularly and covers a range of health, social care and third sector providers. Recently it has been agreed to hold joint meetings with Newcastle, to form the Newcastle

Gateshead Information Network, who will oversee the implementation of the Local Digital Roadmap. Progress has been made in provision of patient communications at a regional level, with posters, leaflets and a patient helpline for queries around information sharing going live in September 2016.

Implementation of projects to deliver this agenda continues:
Sharing of patient records from primary care to our local Mental Health provider has made progress, with engagement work currently being carried out with practices. This will involve sign up to an Information Sharing Gateway – a single portal to allow organisations to easily manage their information sharing agreements. This will provide a direct link between mental health care and GP records established at the point of direct care with the patient, using a solution called the Medical Interoperability Gateway (MIG). Information sharing is also being established for all local acute trust providers, who each have plans in place to begin accessing primary care records at the point of care (with urgent and emergency care settings being a high priority).

In addition, Gateshead and Newcastle Councils are working with Health Care Gateway (MIG supplier) and the Social Care system suppliers on an integration piece with the aim of presenting Social Care practitioners with GP record information via an agreed dataset and conversely, GPs with Social Care record information. Building on the work being undertaken across organisations to facilitate the use of the MIG into social care services, officers are considering options in terms of smaller scale pilots, which will be able to test the system; identify benefits and address any operational issues. There is a view that linking this with the existing Care Homes Vanguard work may be beneficial.

The GIN meetings bring together technical experts alongside frontline staff to discuss to map the systems currently in use across the health and social care. Through this network there will is regular discussion of how to move towards system integrations, including a working towards the Open API standards.

All NHS organisations use the NHS Number as the main identifier, all organisations have processes in place to identify and fill gaps relating to the NHS number. Usage of NHS number as the single identifier in Social Care is increasing with 90% of active social care clients in Gateshead having a matched NHS number. Work is ongoing within social care to increase this by mapping business processes and working with frontline staff to promote its use.

In the last six months, Newcastle Hospitals NHS Foundation Trust and Northumberland Tyne and Wear Mental Health Trust have both been identified as Global Digital Exemplar sites. This may present opportunities to further this area of work and this is being explored.

Planned Action:
The long term next steps are in the further development of the Great North Care Record, which is being developed at a regional level but with significant input from health and social care organisations from Newcastle and Gateshead. We will soon be able to make use of open APIs for Primary Care clinical systems as part of the national GP Connect Programme. This will provide opportunities to connect systems together in new ways.

Health & Social Care Network (formerly N3) connectivity is being explored and an initial fact finding meeting has taken place, led by the Council's ICT services. This

is as a result of the proposed co-location of the 0-19 public health nursing service and the Council Children's services. This will facilitate joint working between the Provider of the 0 to19 services and Council staff.

If HSNC is put in place, it will allow for further / easier information sharing between the Council and NHS, specifically in line with the Great North Care Record.

National Condition 4 iv) - Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights? - *'No' (condition not fully met) entered in Q4 return.*

Under progress commentary, the following was entered:
The local information networks are working with other CCGs and providers at a regional level to develop patient communications at a regional level. Posters, leaflets and a patient helpline for queries around information sharing went live in September 2016. Leaflets are available in all practices and soon in all foundation trusts.

Broad communication has happened through local media, such as the Evening Chronicle, Gateshead Council News.

Further work is scheduled to be undertaken around patient engagement and local communications to support implementation of the information sharing agenda.

Planned Action:
This is an ongoing piece of work which will need to be a regular feature of communications to the people of Newcastle Gateshead. We are currently seeking case studies to help us explain messages about data and technology in ways which are relevant to our population and professionals. These may include patient stories or views of frontline staff. Locally, we will make use of channels such as Council news, social media as well as through practices.

The next step is to develop a clearer plan in relation to communications which will happen at a local level to complement communications from the regional Great North Care Record level.

National Condition 6) - Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans. - 'No' (condition not fully met) entered.

Under progress commentary, the following was entered:
Newcastle Gateshead has well established governance arrangements supporting 'Better Care'. There is joint ownership across both Health and LA commissioners and providers to lead on the development and implementation of the plans.

Ongoing discussions around service redesign with a shift in 'closer to home' provision are transparent and as such implications for acute and non-acute providers both in Health and Care are understood. A shift in the 'national conditions' to explicit funding to support community health (including social care) underpins the ethos to Better Care, coupled with ring-fenced investment.

The current governance arrangements in 'Better Care' and wider system contractual and planning discussions (STP development) have enabled us to collectively understand the consequential impact on providers of our strategic plans

and sign off is undertaken in the Accountable Officers Forum; this being a meeting of all of the NHS and LA Chief Executives in the health and social care economy.

Planned Action:
As a Care Home Vanguard Programme, we are currently identifying what developments will be completed and what will be progressed further at the end of the Vanguard period. In particular, we are focusing on taking the learning from providing enhanced care to older people living with frailty in care homes to their own homes. This already involves much of our BCF initiatives and will continue to be improved upon whenever necessary.

National Condition 7) - Agreement to invest in NHS commissioned out-of-hospital services. - *'No' (condition not fully met) entered.*

Under progress commentary, the following was entered:
Through the STP process, there is a recognition that investment in Out of Hospital services is fundamental to sustainability of the whole system; therefore, modelling and redesign will prioritise what level of investment is required to deliver this shift. Following submission of the STP on 21st October, workshops took place to start to agree the Out of Hospital model for the STP footprint and representatives from health and social care have been involved in this key piece of work. Recognising the link to the 'Optimal use of the acute sector' workstream, the Mental Health and Upscaling Prevention, Health and Wellbeing workstreams, key personnel will represent their organisations across the workstreams to maintain continuity.

Planned Action:
As with the frailty developments identified above, this will involve many of our BCF initiatives and will continue to be improved upon whenever necessary. This includes a whole system integrated approach that ensures the voluntary care sector is also appropriately involved.

Supporting Metrics

5. The quarter 4 BCF return either reported 'no improvement in performance' or 'on track for improved performance, but not to meet full target' for the following metrics:

Estimated diagnosis rate for people with dementia – *'On track for improved performance, but not to meet full target' was entered.*

Under progress commentary, the following was entered:
Final end of year performance for 2016/17 was 69.9% which is marginally short of the trajectory of 70%. Last year's full year performance was 69.2% so there has been an improvement in year.

Planned Action:
It is understood, however, from a clinical audit completed as part of the Care Home Vanguard Programme that around 7% of care home residents are likely to have dementia but are not yet formally diagnosed. As a result a bespoke diagnosis pathway has been developed in order to address this.

Delayed Transfers of Care (DTOC) – '*No improvement in performance' entered.*

Under progress commentary, the following was entered:
Total delayed days for 2016/17 was 6,372 against a trajectory of 3,330. The plan for the year has therefore not been achieved. There appears to be a range of issues that are contributing to the lack of improvement in performance in delayed transfers, which we will be reviewing as a matter of urgency. This will include an analysis of the patient profile of this cohort.

Planned Action:
Work has been undertaken between the Council and the Trust to ensure that there is a coordinated and agreed approach to DTOC (as analysis identified that there had been some changes to recording, which had not been agreed across the system).

The CCG, LA and Trust worked together during the winter period to develop a different approach to facilitating home care packages from hospital. This was piloted as the "bridging service", and is in the process of being evaluated. The high level feedback, however, was positive and we are looking to develop a longer term model, through the improved Better Care Fund.

Patient/Service User Experience metric – *'On track for improved performance, but not to meet full target' was entered.*

The relevant patient/service user experience metric was 'Improve the percentage of patients who responded "Yes Definitely" to the following question from the GP patient survey:
"For respondents with a long-standing health condition: In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health"

Under progress commentary, the following was entered:
Aggregate results for the GP practice surveys conducted mid-year between July and September 2016 show that 43.8% of patients registered with a Gateshead practice answered 'Yes, Definitely' to the question in the last 6 months have you had enough support from local services or organisations to manage your long term condition. If this continues, the 2016/17 target of 48% will be missed but it is an improvement on the previous score at the end of 2015/16.

Planned Action:
In 2017, NG CCG in partnership with their key stakeholders have developed a Long Term Condition Strategy which seeks to improve care delivery and self-management of LTCs right across disease progression from diagnosis to end of life, including a specific focus on frailty.

Reablement – 'No improvement in performance' entered.

Under progress commentary, the following was entered:
The indicator value for quarter 4 of 2016/17 stands at 80.8% (147 out of 182) for all of those aged 65 and over that were discharged from hospital into reablement and still at home 91 days later, for the 3 month period January to March 2017. The value is lower than the same period last year, which was 85.6% (184 out of 215) and is also below the challenging target of 87.5%.

We are aware that performance has deteriorated, and are taking actions to address this. Examining the data we can see:

- 13% of people had died – this represented the fact that we had accepted people with limited life expectancy onto the service, in order to meet urgent need and facilitate appropriate discharge from hospital.
- There were a number of people who had experienced a significant health change, post discharge (such as CVA), and as such their health and social care needs were very different.
- Some people accessed the service as a means of preventing an admission to hospital; their needs then deteriorated and they were admitted, so there is a need to consider whether these were appropriate referrals in the first place.
- The age of the people accessing the service was considered, with 41% being over 85 years of age, 42% between 75 and 84 and 17% were aged 65 to 74. The mean age for someone accessing a reablement / rehab service is 82 years old for the 3 month reporting period.

Planned Action:

Going forward, where there is a requirement to provide urgent support (e.g. to support discharge from hospital or end of life care) and only the reablement service can provide this, we will look to make sure that such referrals are not recorded as reablement, as they are not truly reflective of the service and therefore should not be counted as such.

From the analysis of those people who were admitted to reablement in order to prevent a hospital admission but subsequently deteriorated and were then admitted to hospital, we will ensure that the lessons learned from the analysis are developed into an action plan.

Within any changes, we need to balance our approach in order to prevent a situation occurring whereby the system becomes risk averse and does not accept referrals from those people with higher level needs.

Proposal

6. It is proposed that the Board note the action being taken to progress areas of work linked to the BCF set out in this report. The BCF submission for 2017-19 will also set out plans to progress these areas of work which will be coming to the Board in September.

Recommendations

7. The Health and Wellbeing Board is asked to note the progress update set out in this report.

Contact: John Costello (0191) 4333065 and Hilary Bellwood (0191) 217 2960