

## MUNICIPAL YEAR 2017/18

<b>MEETING TITLE AND DATE</b>  <b>Health and Wellbeing Board</b> <b>19<sup>th</sup> April 2017</b>	<b>Agenda – Part: 1</b>	<b>Item:</b>
	<b>Subject: The Better Care Fund and Integration</b>  - Outcome of the 2016-17 Better Care Fund plan - Planning for the 2017-19 BCF plan and Integration	
	<b>Wards: All</b>	
<b>REPORT OF:</b> Bindi Nagra, Asst. Director, Health, Housing and Adult Social Care, LB Enfield, and Graham MacDougall, Director of Strategy and Partnerships, Enfield CCG	<b>Cabinet Member consulted:</b>  Cllr. Doug Taylor, Leader of the Council	
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### 1. EXECUTIVE SUMMARY

This report provides an update on:

- the year-end financial position
- the delivery of the 16/17 BCF plan including the current performance against key indicators and service/scheme outcomes
- the status of the Shared Care Record development
- the proposed NHS England policy framework and planning process
- a status on the activity associated with integration and future planning.

### 2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- **Note** the year-end financial position
- **Note and receive** the current BCF performance and performance dashboard including outcomes
- **Note** the current status with the development of the shared care record
- **Update Note** that the BCF policy framework has now been published and key themes outlined in section 4.
- **Action** - Identify HWB volunteers to take part in the planning of the future Board development session that will be focused on Health and Social Care Integration.

### **3.0 OUTCOME OF THE 2016-17 BCF PLAN**

#### **3.1 Year-end financial position**

For information: the expenditure plan 2016/17 was £777k over the total pooled budget. It was agreed that this potential overspend would be funded by: the £194k performance payment (for non-elective admissions) that related to Q4 2014/15, a £265k under spend from 2015/16, both of which have been carried forward to 2016/17 and scheme savings of £318k which is split between the CCG & Council (£159k each).

Financial monitoring has been ongoing throughout 2016/17 and it is confirmed that both the CCG and Council have achieved the required savings and are on budget for the year.

#### **3.2 Current performance against key performance indicators and scheme outcomes**

3.2.1 The following section is a summary of BCF performance as at the end of Q3 and as reported to NHS England. It is important to note that whilst we must continue to seek ways to improve performance where required, this needs to be considered within the wider context of the pressures on A&E's more generally, the population growth, growing demand and the funding position for adult social care.

##### **3.2.2 Diagnosis of dementia -**

Performance in Q3 has been above the target 66.7% and as at the end of December was 69.8%. Additional consultant capacity commissioned in 2016/17 and improvement in the diagnostic imaging pathway are having a positive impact on waiting times.

3.2.3 **Non-elective admissions (NEAs)** - this continues to be a significant area of challenge as admissions continue to be above the BCF and CCG Operational Plan targets. Activity in progress to improve performance includes:

Work is underway to assess the effectiveness of BCF (Integrated Care) schemes on admission avoidance of affected (50+ yrs.) cohort.

Underutilisation of Ambulatory Emergency Care pathways, particularly during high demand periods over winter, (AEC) is one of the key drivers of the over performance. The AEC pathway activity has been below plan, treating 619 fewer patients than planned at month 9 and thereby increasing the NEA by the same number. An increase in paediatric admissions at North Middlesex university Hospital, although outside the scope of the BCF Integrated Care programme has also contributed to the overall performance.

North Middlesex has recruited paediatric consultants in A&E to support a change in pathway which will result in fewer paediatric NEAs. CCG is also in the process of setting up Local Ambulance Service (LAS) Frequent Callers forums with the view to reducing inappropriate calls, conveyances and admissions. This will be in place before the end of the financial year.

##### **3.2.4 Delayed transfer of care (DTOCs) and admissions to residential care**

The target in the Better Care Fund is a maximum of 5838 days lost to DTOCs between April 2016 to March 2017 and this continues to be very challenging. Based on current activity, the projection indicates that performance will be 7369 days.

National Data (ADASS) shows that DTOC have risen nationally by 42% in four years (individual days from 119,736 to 169,928) In 2015/16 nationally 32% of DTOC were due to social care delays, however Enfield performed much better than the national position at 27%. There are two out of hospital groups (one for North Middlesex and one for Chase Farm) attended by health, social care and commissioners from each local authority (Barnet, Enfield and Haringey). The groups meet regularly to review delays and the reasons behind them and to agree actions required to mitigate.

Likewise the admissions to residential care continue to show a rise, reflecting the increasing demand of an ageing population and trends also suggest that those going into care have greater needs but have spent as long as possible in their own homes. The annual target has been set at 419 and at the end of quarter 3 the actual is 449.

Actions undertaken to improve the above performance indicators includes new activity (funded by the BCF) which commenced in December. This involves step down for further assessment and rehabilitation either in temporary residential setting or the persons own home. It is anticipated that this will contribute to a reduction in the number of delayed discharges and also admissions into permanent residential care. It will also contribute to establishing a clearer understanding of the factors contributing to delays where we could and should do something differently e.g. addressing the lack of nursing home spaces.

The Council and CCG performance and data management teams are also in the process of undertaking a detailed analysis of both DTOCs and residential admissions. A summary of this, with key messages will be available shortly for the HWB and Overview and Scrutiny Committee for a meeting later in April.

### **3.2.5 Re-ablement**

The target for 2016/17 is 88.2% & current performance is 83.4% (as at December). Percentage of clients living independently at the same point last year was 81.5%, so we are on track for improved performance, but not to meet the target.

## **3.3 Commissioned schemes and examples of Q3 outcomes achieved (as at end of December)**

### **3.3.1 Integrated Care Programme**

It is noted that this programme is currently being reviewed to assess the impact of the investment and to inform the 2017/19 plan. The results will be available for the next WHB meeting.

However there are some clear benefits and outcomes currently being produced, including:

#### **Care Home Assessment Team (CHAT)**

Evidence from the December service evaluation indicated improved quality of care and a reduction of 9% in hospital admissions in CHAT covered homes between 2014-25 and 2015-16.

There has been a significant improvement in outcomes in 2015-16 with high levels of service satisfaction from residents, families, GPs and care homes; 25% of residents had reduced medications post-CHAT review

Use of assisted technology – number of patients with long term conditions including COPD, and Heart Failure who are being monitored using Telehealth equipment.

Evidence from the December scheme evaluation show up to 60% reduction in hospitalisation with appropriate targeting of patients; all patients are satisfied with the service; 88% felt better informed about their condition and 66% felt they could manage their condition.

### **Integrated locality teams**

Phase I of the Programme brought together a number of services in a “virtual team” to case manage and support GPs in their practices without any organisational changes. This approach was successful in managing more complex cases of older people at risk of hospitalisation.

A review of the ILT following this found:

- 31% reduction in A&E attendances
- 28% reduction in emergency admissions
- 57% of people had reduced A&E attendances or no attendance at all
- 70% of people had reduced emergency admissions or no emergency admissions post ILT intervention
- 96% of patients were ‘very satisfied’ or ‘satisfied’ with the range of services they received from the ILT.
- 80% of patients who were discharged 2 months prior to ILT involvement remain at home 91 days after ILT involvement. 18% were initially at risk of being placed in a residential home prior to the ILT involvement

### **Palliative care rapid response**

- Of the people who used the service – 92 % passed away in their preferred place (generally at home)

### **OPAU unit patient feedback**

- 98% of people would recommend the unit to
- 83% of people felt care was well co-ordinated

## **3.3.2 Safeguarding and Quality checker programme**

### **Outcomes achieved include:**

- Call Centre Staff trained to escalate safeguarding concerns to MASH. Follow up calls demonstrate staff are following this procedure, which enables early identification of abuse and escalation to ensure any safeguarding risk is appropriately managed in a timely manner.

- fewer low level complaints escalated to the Provider Concerns process following the implementation of improvements to safeguarding practices identified by the Quality Checker programme.
- cards containing key hydration information distributed to care providers - providers identified as having poor hydration methods at the start of the project have shown a measurable improvement in hydration practices
- LGBT project has had a positive impact, with a number of providers requesting further LGBT training and service development support and one provider welcoming a same sex couple into their accommodation
- The production of a Making Safeguarding Personal DVD, to ensure that service users, carer and communities in Enfield can recognise what abuse is and how to report it. A safeguarding film provides an accessible medium for displaying what abuse is and though a visual narrative can connect with people's experiences. The film is delivered with audio description and British Sign Language options, so that more adults at risk can access information. By raising awareness and providing contact details to report abuse, adults experiencing abuse or neglect will be able to access services through the Multi Agency Safeguarding Hub which focus on their wellbeing, recovery and resilience.

As a result of the 4 Safeguarding Adult Reviews that were signed off by the Safeguarding Adults Board (SAB) in December the following service improvements have been implemented:

- New discharge checklist for patients at Enfield based hospitals to ensure adequate stock of medication dispensed
- A comprehensive transfer summary to accompany residents from care home to hospital with a particular provider

3.3.3 **Advocacy** – the key objective of this scheme is supporting independent advocacy for adults who would otherwise have difficulty accessing and/or using the care and support provision

**Outcomes achieved include:**

Advocacy was provided to 144 individuals during needs assessments, reviews, support planning and safeguarding investigations.

Customer feedback shows that the scheme has a positive impact on residents accessing the service provided and is making a difference:

- 45% said “I can speak up for myself more now I have had advocacy support”
- 45% said “I live more independently now I have had advocacy support”
- 91% of respondents felt “more involved in decisions about my life now I have had advocacy support”

3.3.4 **Disabled Facilities Grant (DFG)** – the key objective of grant is to provide appropriate aids and adaptations in a person's home to support the following the outcomes:

- To reduce the risk of hospitalisation due to falls or other injury
- To facilitate hospital discharge
- To prevent or delay the need for residential or nursing care

These outcomes have been achieved via:

- 158 grant applications approved in Q1 to Q3
- 116 grants adaptations completed in Q1 to Q3

**3.3.5 Wheelchair service** – the key outcome of this service is to provide wheelchairs that are appropriate to a user's needs to enable them to remain independent and in their own homes for as long as possible.

A survey user experience survey is given to all customers to complete and at the end of Q3 overall satisfaction level was 93%.

Activity to December includes:

- 777 new and re-referrals received from (657 adults/120 for children)
- 507 total wheelchairs issued across range of equipment. Of these, 452 wheelchairs were for adults and 55 for children.

#### **Childrens Services - Strengthening the Support Around You (STAY)**

This scheme is working on supporting Children and Young People with Learning Disabilities/ Autism to remain in schools and with their families thus avoiding family breakdown and disrupted education as well as costly out of borough placements.

Achievements to date:

- Young People in crisis who have deliberately self-harmed are seen within 1 working days following referral
- Young people in crisis are seen within 2 weeks following referral
- Achieved measurable improvement in mental health outcomes
- Ensured effective coordination of statutory and voluntary services to the young person and improved outcomes for education and employment.
- Feedback has shown high satisfaction ratings with the service

#### **3.3.6 Mental Health Liaison services**

Improvement in the reduction of lengths of stay in acute settings and as at the end of December performance was:

% of assessments begun within 1 hour of A&E – 85 %

% of assessments begun within 24 hours on wards – 88%

#### **3.3.7 Carers services**

Enfield Carers Centre support family carers to maintain their own health and wellbeing, to have a break from caring and to enable them to remain in their caring role for as long as possible.

The support of carers contributes to the prevention of hospital admission, speeds up discharge from hospitals, prevents admission to care homes and reduces the demand for home care support.

**Key activities that support the above:**

- Carers Register has increased by 804 since Dec 2016 and now stands at 5156
- Benefit advice and general advocacy services have been provided to 484 carers
- Training for 527 carers and counselling services for 83 carers have been provided
- 45 young adult carers (age 16 -25) have been identified and supported by the scheme
- 806 new carers have been registered and encouraged to have a Carers Assessment
- The number of carers receiving a Carers Assessment and/or review has increased by 436
- Respite care, ranging from meals out to weekends abroad, has been provided to 808 carers

#### **Carers Trust Lea Valley, Crossroads Care Service activities:**

Crossroads provides services to children, adults and older people with care needs to enable their carer to have a break and help carers maintain their own health and well-being.

- Over the three quarters of 2016/7 Crossroads has provided support to 152 carers and 152 people needing care.
- They have provided 5994.75 hours of respite care and an additional 1717 overnight care.

### **3.4 Shared Care Record update**

Enfield Council and CCG are in the process of working with partners to finalise the options appraisal to determine which solution to adopt. A demonstration and evaluation session was held on March 30<sup>th</sup> with the two potential providers. This session found that in terms of functionality both systems are appointable. Financial information is to be supplied by the end of April, after which a further evaluation meeting will be held to make a recommendation on the preferred solution. Following this a paper will be presented to the May CCG Finance and Performance Committee so that a decision on the way forward can be made.

Estates and Technology Transformation Fund (ETTF) – there is agreement in principle that Enfield will be allocated money for the SCR solution.

## **4.0 BCF PLANNING 2017/19**

### **4.1 Funding**

It is expected that the current BCF fund will continue (with a small inflationary increase) in line with the 2016/2017 funding

For information, the Enfield funding for 2016/2017 can be summarised as follows:

- Revenue funding from CCG - £19,185,445
- Local Authority contribution (Disabled Facilities Grant) - £2,540,000
- Total - £21,725,445

And the allocation includes the following:

- Protection of Adult Social Care Services - £6,055,000
- Care Act monies (priorities are for advocacy and carers) - £734,000
- Funding held as a contingency as part of a local risk sharing agreement - £1,500,000

In addition to the above, the Improved BCF (iBCF) allocations for Enfield are summarised below:

The local government settlement by DCLG

2017/18	2018/19	2019/20
£443,000	£4,549,000	£8,249,000

#### **Additional funding for adult social care announced in Budget 2017**

A new grant, worth £2bn over the next three years, will be paid to local authorities (LAs) with social care responsibilities. This funding will be additional to the existing Improved Better Care Fund (iBCF) allocations to LAs. The grant conditions for the iBCF will require councils to include this money in the local BCF Plan, and is intended to enable areas to take immediate action to fund care packages for more people, support social care providers, and relieve pressure on the NHS locally by implementing best practice set out in the [High Impact Change Model for managing transfers of care](#).

2017/18	2018/19	2019/20
£5,694,016	£3,694,655	£1,833,840

## **4.2. Approach to the 2017/19 plan**

### **Scheme review**

It has been agreed by the BCF Executive Group that the Integrated Care (IC) programme as a whole will be reviewed and evaluated (this includes 24 separate schemes with a funding allocation of £7.8m). An approach has been proposed which uses the NHS England logic model – the evaluation will look at the impact each service has made on outcomes for Enfield residents, their successes, cost effectiveness of changes made and barriers faced.

The intention is to continue with the current IC programme from April until the review has been completed. The results and recommendations will inform how the programme will be developed during the latter part of 2017/18 and for the second year plan for 2018/19.

For all other schemes, lead officers have been asked undertake a review and have provided a one page summary that covers the following:

- What the money has been spent on and how much
- What difference this scheme has made to service users, carers or patients in terms of:
  - The activity that has been undertaken taken i.e. the outputs
  - What outcomes have been achieved



The summaries have been evaluated by BCF Delivery Group members and recommendation made. This will be subject to review by the BCF Executive Group early April.

#### 4.3 Proposed Integration and Better Care Fund requirements 2017-19

**N.B.** The Better Care Fund has now been renamed 'Integration and Better Care Fund' to emphasis the broader remit and importance of wider Health and Social Care integration agenda.

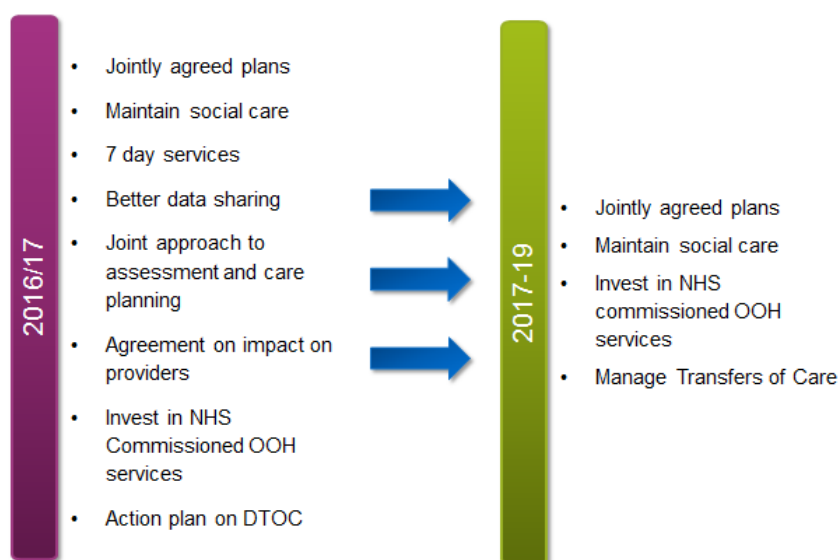
The detailed policy and framework was published on March 31<sup>st</sup> but the submission timeframe is not yet available. The detailed planning requirements document and allocations that underpin the framework will be published once NHSE/DCLG have final clearance

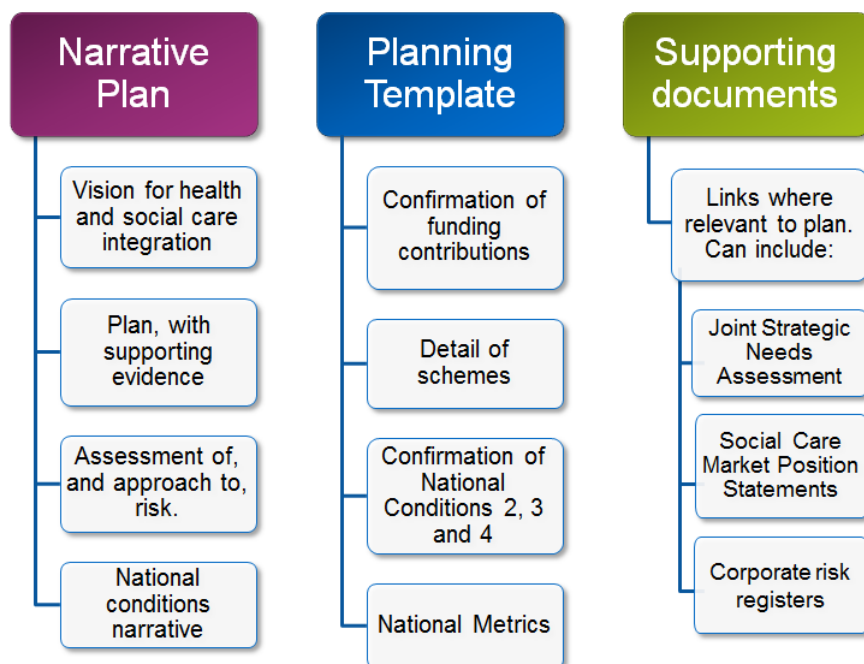
For information an overview of the proposed changes and conditions follows:

For 2017-19, there are four national conditions, rather than the previous eight:

1. Plans to be jointly agreed
2. NHS contribution to adult social care is maintained in line with inflation
3. Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care
4. Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and effectiveness of reablement.





### Measuring progress on integration:

To help areas understand whether they are meeting our integration ambition, NHSE/DCLG are seeking to rapidly develop integration metrics for assessing progress, particularly at the interface where health and social care interact. These will combine outcome metrics, user experience and process measures. Following the development of the metrics and an assessment of local areas, NHSE/DCLG will ask the Care Quality Commission to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care

**Local metrics currently in place** – noted that there is no longer a requirement for the national collection of a locally proposed metric.

1. Diagnosis of dementia – plan will be aligned to the national ambition reported diagnosis rate (currently 66.7%)
2. Survey data. Satisfaction measures for patients and service users (Carers survey, ASC users survey, GP patient survey and OPAU patient feedback survey). Target is an improvement in 3 of the 4 surveys (based on showing an improvement from the previous survey data)

## 4.4 Proposed BCF plan assurance process

### Key points

- Two rounds of assurance.
- Shared process across local government and NHS.
- Plan ratings simplified – no longer a separate rating on risk.

### First stage process

- First submissions are assured by regional panels.
- All areas to confirm that agreed spending plans for market capacity and stabilisation from new IBCF element are in place.
- If a local area believes that the baseline for the social care contribution (National Condition 2) is wrong, there will be an opportunity to query the amount at this stage.
- Moderation will take place at NHS regional level after first stage.
- Cross-regional calibration.
- Plans are rated 'compliant' 'on track' or 'off track'.

### Second stage process

- All second submissions to be approved by Health & Wellbeing Board.
- Assured by regional panels.
- Moderation will take place at NHS regional level after first stage.
- Cross-regional calibration.
- Plans rated 'approved' or 'not approved'.
- If no agreed plan then escalation will commence immediately in order to address issues quickly.

## 4.5 BCF graduation

### Key points

- Places will be able to 'graduate' from the BCF if they have moved beyond its planning requirements
- There will be a first wave to trial the process

### Key Criteria

- Have in place a sufficiently mature system for health and social care
- Provide evidence of improvement and / or approach to improving performance on BCF national performance metrics
- Set out plans to pool an agreed amount greater than the minimum levels of the BCF

## 5. HEALTH AND SOCIAL CARE INTEGRATION

### 5.1 Current status

Although the production of a separate strategic plan is not a BCF planning requirement, it is noted that the narrative will need to describe our vision and what integration will look like in Enfield and the progress made so far. So work has continued on the development of a joint Integration discussion document, as previously reported to the HWB.

The current draft includes:

- Our priorities

- The Context for change – National Guidance and Policy Context
- Local Guidance
- How this strategy was developed
- About Enfield
- Where are we now and our successes?
- Gap Analysis and Design of Future Provision
- Implementation and monitoring arrangements

## **5.2 Next steps**

As discussed with the Chair of the HWB, it has been agreed that the next HWB development session is focussed on a discussion and workshop on integration. We already have a number of schemes and activities in place that are integrated and are demonstrating positive outcomes and it suggested that this is presented (“where we are now”) to be followed by future planning.

The session will be delivered by an external facilitator from the Regional BCF Support Team (LGA and NHS England) and planned with senior officers from the Council and CCG with support from volunteers from the HWB. This would involve agreeing the agenda and outcomes for the session.

It is proposed that the session includes: an overview of where we are now, highlighting current successes and achievements, how integration supports the Sustainability and Transformation Plan and future activities.

**End of Report.**