Report to: Overview and Scrutiny Committee

Report Title: The Better Care Fund	**Date: 27th April 2017**
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1. EXECUTIVE SUMMARY

This report provides an update on:

- the 2016/17 year-end financial position
- the delivery of the 16/17 BCF plan and the current performance against key indicators.
- the NHS England policy framework and planning process
- the status of the activity associated with integration and future planning.

2. RECOMMENDATIONS

The Overview and Scrutiny Committee is asked to receive the report and note:

- At the end of March 2017 the BCF pooled fund was on budget for the year
- The update on the current performance against the nationally defined metrics (as at the end of Q3 - December 2016) and the key points from the recent analysis of the Delayed Transfer of Care (DTOCs) metric.
- The Residential Admissions summary report content (Appendix 1)
- The additional funding available for social care in from the Improved BCF (iBCF) for the next two years and the draft grant conditions
- That the BCF policy framework for 2017/19 has now been published and the key themes and changes are outlined in section 4.3.
- A future Health and Wellbeing Board development session will focus on the further development of Health and social Care integration in Enfield

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 **Delayed transfer of care (DTOCs)**

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.

Key points from an analysis of data provided by the LBE Performance Analysis Team that covers the period from April 2012 to December 2016:

- There has been a clear rise in delayed transfers of care in recent years, from 3,914 bed days delayed in 2012-13 to 5,527 days delayed for Apr-Dec 2016 (so this will increase further for the full year).
- This trend is not unique to Enfield. National Data (ADASS) shows that DTOC have risen nationally by 42% in four years (to 2015-16)
- As you would expect, DTOC in Enfield is dominated by local providers, with 85% of DTOC within the first nine months of this year occurring within three trusts, the Royal Free London NHS Foundation Trust (20.5%), North Middlesex University Hospital NHS Trust (25.3%) and Barnet, Enfield and Haringey Mental Health NHS Trust (BEHMHT) (39.8%).
- In 2016-17 to date, BEHMHT alone is responsible for almost the same amount of DTOC (2,200 days) as the two local hospitals combined (2,500 days).
- Delays with the two hospital trusts are mainly related to 'Further non acute NHS care', 'patient or family choice' and then 'care package in own home'. In contrast, most of the days delayed for BEHMHT are related to 'Awaiting residential care home placement', 'completion of assessment' and 'public funding'

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.

It is also noted that the 2017/19 policy framework supports DTOCS:

- one of the BCF national conditions for 2017/19 is **Managing Transfers of Care** and all local areas must implement the high impact change model which identifies a number of changes that can support local health and care systems to reduce delayed transfers of care
- the draft conditions for use of the iBCF state that it can only be used for:
    - meeting adult social care needs
    - reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
    - ensuring that the local social care provider market is supported

3.2.3 **Admissions to residential care**

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 shorter placement lengths.

N.B. Please see appendix 1for more detail on this performance metric.

3.2.4 **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 the BCF (Integrated Care programme) schemes on admission avoidance of affected (50+ yrs.) cohort.

Underutilisation of Ambulatory Emergency Care (AEC) pathways, particularly during high demand periods over winter, 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. The 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.

3.2.5 **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.

3.2.6 **Re-ablement**

The target for 2016/17 is 88.2% and 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.

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:

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

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 and subject to a formal sign off process by the Health and Wellbeing board (HWB).

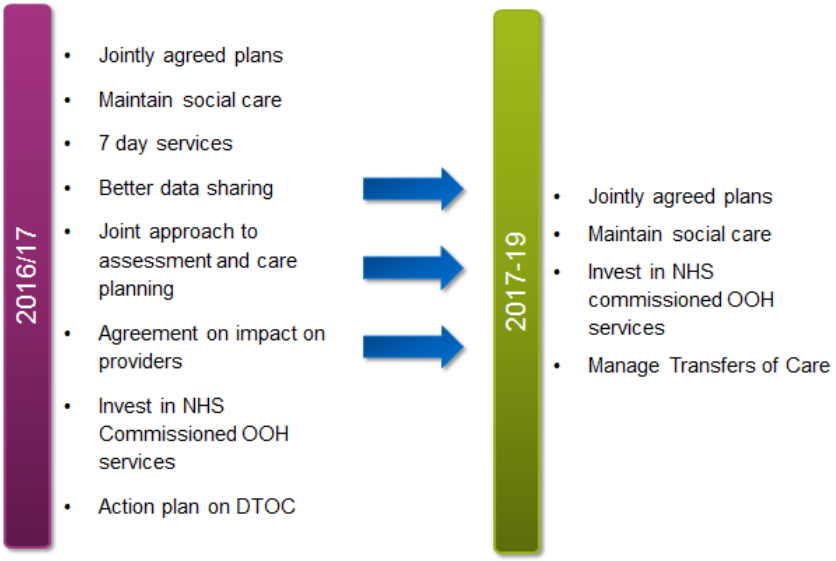
4.3 Proposed Better Care Fund requirements 2017-19

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

The detailed policy and framework was published on March 31st 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 has final clearance.

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

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



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.

4.3.3 **Measuring progress on integration:**

To help areas understand whether they are meeting their integration ambition, NHSE/DCLG is 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

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 BCF 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.
The current draft includes:

- Our priorities
- The Context for change – National Guidance and Policy Context
- Local Guidance
- How the plan 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, so it has been suggested that this is presented ("where we are now") to be followed by future planning.

The session will be delivered by an external facilitator and planned with senior officers from the Council and CCG with support from volunteers from the HWB.

The session is likely to include: an overview of where we are now, highlighting current successes and achievements, how integration supports the North Central London (NCL) Sustainability and Transformation Plan and future activities.

6.0 APPENDIX 1

Residential & Nursing Homes Admissions: Summary of Analysis

Produced by LBE Performance Analysis Team

This is based on data that covers the period from April 2013 to February 2017 (the latest available data). It should also be noted that the Data and Management Information Team have confirmed that data collection methods have not changed since HHASC produced these figures and they follow the same guidance. This means that are change in numbers is not due to changes in data collection. Decants from Honeysuckle House are also not reflected in these figures.

Those aged 65+

There is a clear rise in admissions in recent years, which can be seen below with there being 138 admissions in 2013-14 to over 200 in 2016-17 (up to February).

	Apr-Feb 2016-17	2015-16	2014-15	2013-14	Total
Total People Count	204	162	167	138	671
Total Agreements Ended in year	75	52	47	50	224
% Agreements Ended	36.8%	32.1%	28.1%	36.2%	33.4%
Average Age Clients	84	85.4	84.5	84.8	

This is being caused by three main issues. An increasing number of people aged 65 or above, changes brought about by the Care Act 2014 leading to an increase in '12 week disregard' cases and the increasing complex needs of people going into care, which leads to both a higher demand for nursing care but shorter placement lengths as there are increasingly more palliative care cases entering care homes.

You will see from the table above that the average age of clients has remained stable over this period (around 84-85 years old). Notably however, the proportion of agreements that have ended during the year has increased since 2014-15. Further analysis of placement length has also shown that this is reducing. This is tied into the increasingly complex needs of care home clients who, because they are supported to remain at home as long as possible, often come to care home with more complex needs and requirements such as palliative care.

This is further evidenced when we look at the breakdown between residential and nursing care. There has been a rise in the proportion of admissions needing nursing care when comparing 2016-17 (approx. 40% nursing care) to 2013-14 and 2014-15 (approx. 35% nursing care).

	Apr-Feb 2016-17	2015-16	2014-15	2013-14	Total
Residential	124	93	109	90	416
Nursing	80	70	59	50	259
% Residential	60.8%	57.1%	64.9%	64.3%	61.6%
% Nursing	39.2%	42.9%	35.1%	35.7%	38.4%

The number of clients who have used the council to broker care home arrangements but who pay for their own care has also impacted on admission numbers. '12 week disregards' are clients who have a delay to any care bill whilst they sell property or raise funding to pay for their care home (or are seeing if care home admission is a suitable prospect). This has doubled according to analysis of recent years.

We have also looked at where the admissions referrals are coming from in order to understand if there are any trends here. As you would expect the Care Management Service (CMS) and the hospitals dominate this, being responsible for over 90% of admissions at any one point. This remains relatively stable, so is not impacting on the increase due to a specific area or team.

Those aged 18-64

This is based on data that covers the period from April 2013 to February 2017 (the latest available data). It should be noted that these are relatively small numbers making any trends and assumptions somewhat less reliable.

The Data and Management Information Team have confirmed that data collection methods have not changed since HHASC produced these figures and they follow the same guidance. This means that are change in numbers is not due to changes in data collection.

Looking at the numbers of admissions, these have risen from 4 in 2013-14 to 16 in this year to date. We have also seen an increase in the number of agreements ended and people being admitted on more than one occasion (although they only count once in the admissions figures).

	Apr-Feb 2016-17	2015-16	2014-15	2013-14	Total
Total People Count	16	6	9	4	35
Total Agreements Ended	6	1	0	1	8
% Agreements Ended	37.5%	16.7%	0.0%	25.0%	22.9%
Average Age Clients	49.5	54.2	50.4	57.5	

Looking at the primary client type (box below), small numbers make trend analysis difficult. However, if we look at 2016-17 alone, you can see that mental health and personal care needs are listed 20 times, which represents approximately 87% of all the highlighted needs. It should also be noted that clients can have more than one type of need (hence why 16 admissions in 2016-17 have 23 recorded needs).

	Apr-Feb 2016-17	2015-16	2014-15	2013-14	Total
Learning Disability (Support)	2	1	0	1	4
Mental Health (Support)	9	0	1	2	12
Personal Care Support	11	0	0		11
Physical and sensory disability/frailty	1	5	6	1	13
Other Vulnerable People	0	0	2		2
Total (Clients can have multiple categories)	23	6	9	4	42

End of Report.