MUNICIPAL YEAR 2017/18

MEETING TITLE AND DATE Health and Wellbeing Board 10th October 2017	Agenda – Part: 1	Item:
	Subject: The Integration and Better Care Fund	
	Wards: All	
REPORT OF: Bindi Nagra, Asst. Director, Health, Housing and Adult Social Care, LB Enfield, and Vince McCabe, Interim Director of Commissioning, Enfield CCG	Cabinet Member consulted: Cllr. Doug Taylor, Leader of the Council	
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1. EXECUTIVE SUMMARY

This report provides:

- A summary of the governance process undertaken for the Integration and Better Care Fund prior to NHS England submission on September 11th
- A summary of the assurance process in progress for the Integration and Better Care Fund 2017-2019
- A summary of the BCF plan Q1 2017/2018 including performance, indicators and outcomes
- Finance update
- Information in relation to BCF audit, including the schedule, timescale and summary of scope

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- **Note** the submission made to NHS England on 11th of September, following circulation to HWB members for comments
- **Note** the assurance process and submission timescale set out in the final guidance
- **Note** performance against metrics and the significant work being undertaken around mental health delayed transfer of care
- **Note** progress in relation to existing schemes
- **Note** the BCF audit being held in Nov/Dec 2017

3. BCF Plan Submission and Assurance

3.1 BCF Plan Submission

3.1.1 On 9th August 2017 a report on the Integration and Better Care Fund Plan (BCF) for 2017-2019 was circulated to Health & Wellbeing Board members for review and comment, in advance of formal sign-off of the plan to meet the September submission deadline. Comments were received from Cllr Doug Taylor, with a response supplied; these have been attached as Appendix A.

3.1.2 In addition to the feedback from Health and Wellbeing Board members, we strengthened our position prior to submission through close liaison with the regional BCF Team and met with representatives on August 23rd. They found the Enfield BCF Plan was in a good state and we

were given the opportunity to consider this against key lines of enquiry set out in planning requirements and areas we could elaborate further in our narrative.

3.1.3 The Enfield submission of the Better Care Fund plan, which includes both the narrative, planning template and appendices, was signed off on behalf of the Health & Wellbeing Board with representatives from both the Local Authority and Clinical Commissioning Group. The submission deadline of September 11th was met.

3.2 Assurance

3.2.1 Assurance of the BCF Plans for 2017-2019 are taking place over one round for 2017-2019, with an assessment of whether a plan should be approved, not approved, or approved with conditions. All plans will be subject to regional assurance and moderation. The spending of the iBCF is not contingent on this assurance process, and this funding was available as soon as there was agreement between the Local Authority and Clinical Commissioning Group.

3.2.2 Following the BCF regional team visit and the good feedback, we are positive about the assurance process. This assurance process is following the timescale below:

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCP Planning Requirements; Planning Return template, BCF Allocations published	4 July 2017
First Quarterly monitoring returns on use of iBCF funding from Local Authorities	21 July 2017
Areas to confirm draft DToC metrics with Better Care Support Team	21 July 2017
BCF planning submissions from local Health and Wellbeing Board areas (agreed by CCGs and local authorities)	11 September 2017
Scrutiny of BCF plans by regional assurers	12-25 September 2017
Regional moderation	w/c 25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend	From 6 October 2017
Escalation panels for plans rated as not approved	w/c 10 October 2017
All section 75 agreements to be signed and in place	30 November 2017

4. Quarter 1 2017-2018 BCF Metrics

4.1 The following section is a summary of the BCF metrics for Q1 2017/2018, in line with national planning requirements

4.2 **Non-Elective Admissions (NEA)-** this metric relates to the outcome sought of reducing the number of unplanned acute admissions to hospital. For 2017/2018 the target as submitted to NHS England in the recent CCG operating plan is 28,771. Performance in April 2017 was within target, while admissions were above target in May and June 2017.

4.3 **Delayed Transfer of Care (DToC) –** NHS England has set the HWB trajectory for areas, in which the Enfield Health and Wellbeing Area (which is larger than the Enfield CCG area as it includes a small portion relating North Middlesex Hospital) has set a target of no more than 20.6 DToC per day. At the end of Q1 we have been able to stay within our target for each month, but our awareness of seasonality pressures means we are keeping vigilant to this trajectory and

driving forward additional activities to continue moving individuals swiftly and safely from hospital.

Significant actions are being taken to address DToC, including implementation of the High Impact Change Model, which is national condition four of the BCF policy. This model sets out eight broad changes that will help local systems to improve patient flow and processes for discharge and so help to reduce delayed transfers. There is also work in partnership around the capacity of nursing placements, so that service provision will be flexible and able to meet the future needs of Enfield residents.

Activities are taking place to reduce **mental health delayed transfer of care** which remain a significant portion of the overall delays in Enfield and comparatively high against those from the Acute Trusts. There is currently a priority review by the Council and the CCG of the mental health delayed transfer of care and in response, partners have collectively agreed:

- A working group approach that aims to identify from data the root causes of delays and implementation of targeted actions to mitigate these. For example, issues relating to public funding, which can include no recourse to public funds, can be addressed through local agreements with the Home Office. There is evidence of this model in other London boroughs we can learn from and replicate.
- Additional investment through the Improved Better Care Fund (iBCF) into a scheme which aim to help navigate mental health service users out of hospital safely and with the appropriate support in place
- Delayed transfers of care need to also be seen in the context of preventing individuals in the first place from going into hospital. New funding for enhanced support of mental health services users by placing link workers with primary care will contribute to this objective.
- Current MH DToC action plan for BEH MHT exists as submitted to NHSE by Enfield CCG as lead commissioner on behalf of Barnet, Enfield and Haringey CCGs. This identifies several recovery actions across the Trust, CCG and Local Authority to contribute towards a reduction in delays.

4.4 **Admission to residential care -** an annual target of 514 new admissions to residential and nursing care per 100,000 population over 65 was set. At the end of Q1 we were amber, with a higher number of placements in May 2017. The latest figures for August show that this metric is back within target.

4.5 **Reablement –** an annual target of 85% has been set for achieving independence for older people through Reablement. At the end of Q1 we are currently within target and have achieved 90.72% as the number of clients living independently 3 months after service provision.

5. Indicators and outcomes achieved

5.1 The following section is in relation to schemes which continued from 2016/2017. Due to the delay in national policy, planning guidance and the submission/ assurance process timeframe, new schemes did not commence in April 2017 but awaited Health and Wellbeing Board approval in August 2017. We are in the process of updating all the business cases for the existing schemes and as part of this are collating Q1 and Q2 outcomes concurrently. Emerging highlights from this work and the information we have on schemes for quarter 1 2017/2018 are set out below.

5.2 **Older People Assessment Unit (OPAU)** provides unplanned care to patients who need rapid response for assessment and treatment, often to prevent hospital admission. The service in the first three quarters saw a total of 417 patients with capacity to 540, which if utilised would further assist in care outside of an acute in-patient setting. The service is well received by those experiencing care, with 100% of individuals surveyed reporting they felt dignity was always respected, and 93% would be extremely likely to use the service again or recommend to family and friends.

5.3 The **Care Home Assessment Team** has several indicators measured, with the following impact noted to date in this first quarter:

- Enabled the majority to choose to die in their preferred place
- Consistently seen above 90% of new residents within two weeks
- Work with care homes to reduce A&E attendance for falls continued; CHAT are measured on percentage of people who having falls go into A&E, which stood at 13%, 8% and 12% for the three months consecutively in Quarter 1

Indicators which are not measurable but impact on the overall system of health and social care integration is the relationship between CHAT and Care Providers in Enfield; the enabling and supportive partnership approach means that there is increased communication and flexibility in a care system where providers feel more confident to support service users when they know they have the additional support in the community from this service. This latter point is part of what is facilitating the Trusted Assessor model, part of the High Impact Change Model for delayed transfer of care, to be implemented locally.

5.4 To prevent avoidable admission and provide a response to individuals in the community in crisis, the **Community Crisis Response Team (CCRT)** is funded by the BCF to deliver several core functions. During quarter 1 the service had a target of seeing patients within 2 hours of receipt of referral, and achieved this in 98% of cases in April, 100% of cases in May and 99% of cases in June. Overall, 129 individuals in the community received this service.

5.5 A number of schemes funded through the BCF are with the Voluntary and Community Services (VCS) with a focus on preventing and delays the onset of needs and access to statutory services. **Community Navigation** delivered through Age UK is a service which helps to connect individual to their community, for example through linking to services, activities or connecting with people to reduce isolation. So far, 126 individuals have been supported. Alongside this within the VCS is falls prevention, with 95% of individuals surveyed reporting they were satisfied with this service.

5.6 The VCS, through several providers, are also leading on supporting the community to access:

- Advice and support around issues such as caring roles, benefit maximisation and managing health and wellbeing
- Supporting their families and friends with mental health needs while maintaining their own health and wellbeing
- Culturally specific services, for example with Asian women
- Home from hospital service to enable people to be safely managed at home and prevent re-admission to hospital
- Counselling, including intercultural psychotherapy

5.7 The outcome from some of the VCS schemes include:

- The **Carers Centre** registered 258 new carers and their respite programme allowed 420 carers to have a break from their caring role

- The young carers project is working well, with a successful bid for sustainability and an additional 19 young carers identified; identification of young carers is important to provide the opportunity to support these individuals to remain healthy and well.
- 101 carers attended training, with a further 40 receiving one to one counselling
- As a Trusted Assessor, the Carers Centre completed 83 stand-alone carers assessments and 211 carers reviews
- **Crossroads Lea Valley** provided 2441.50 respite care hours' flexibility to meet the needs of individual families, with an additional 495 hours of overnight service and 295.5 hours of sitting service.

The indicators for these services are primarily based on individuals supported and feedback on experience; these are being further developed in this year to provide a narrative on their role within integrated health and social care system.

5.8 **Safeguarding Schemes** integrate the work of health and social care professionals to manage quality issues within provider services and single safeguarding concerns related to risk of or experience of abuse and neglect. The **Nurse Assessor Project** provides quality assurance of the care provided for residents of care homes and services in the community to protect people from abuse and neglect. The Nurse Assessor in Q1 undertook several activities, most notably risk assessment in nursing homes to support providers in meeting acceptable standards of care where concerns exist. Last year the Nurse Assessor Project developed a Dehydration Policy, which is being implemented currently and the impact of this will be reported on later in the year

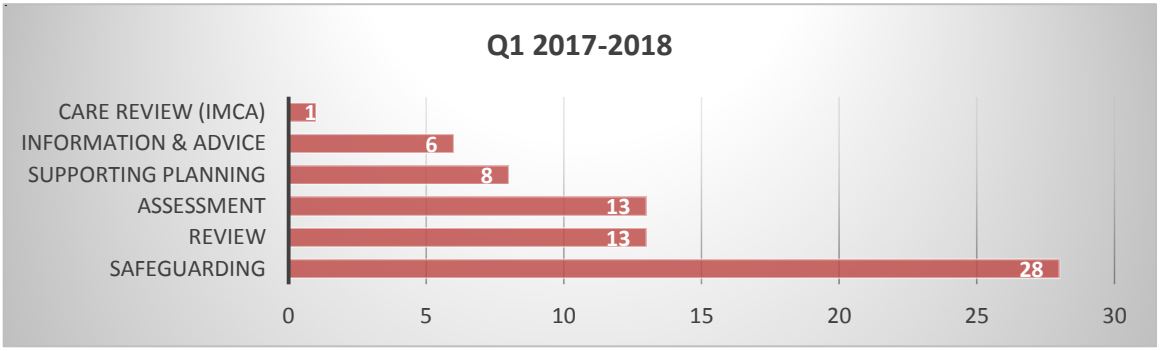
5.9 The **Quality Checker Project** assures the quality of care provided to people in residential settings and of services in the community. Some of the activities undertaken in Q1 by the Quality Checkers include:

- 32 care home visited with subsequent reports produced for service improvements based on feedback from residents, family and friends. These have been shared with service providers. The manager of the quality assurance service reports that 'Quality Checkers pride themselves on recognizing that small changes made big difference, and that these things enhance the quality of life and feelings of wellbeing.' Changes were as simple as residents having drinks served in a cup and saucer rather than a mug.
- 36 mystery shopping calls were made to the Local Authority Access Team, with suggested improvements that would improve the experience for service users in accessing the right service at the right time.

5.10 **Disabled Facilities Grant** are paid to people without sufficient income or capital to fund adaptations and in Q1 a total of 59 enquiries were made to the service, with 33 grant approvals and 35 completed adaptations in the period. An audit was undertaken by the service of 19 adaptations during Q1 2016-2017, to assess one year on whether these adaptations contributed to the person being able to remain living in the community. The audit found one person had passed away, while of the remaining 18 all continued to live in their home. Of this number, 11 were able to remain living at home without a package of care, some of which had not required any additional contact with the Local Authority. There was evidence that informal carers were involved with many individuals, further highlighting the important of supporting carers to continue within their role while maintaining their own health and wellbeing.

5.11 Similarly, **Enfield Wheelchair Service** supports personal mobility, helping people to manage their long-term conditions, remain independent, achieve personal goals and participate more fully in society. In Q1 the service provided wheelchairs and associated equipment to 179 adults with mobility needs, all of whom were seen within the target time of 13 weeks.

5.12 Being in control of day-to-day life (including over care and support provided and the way it is provided) helps people remain independent and retain their personal dignity. The voluntary sector **Advocacy Scheme** provides an advocacy service to people in the statutory care assessment and review process. This helps people to understand the health and social care process and make decisions in relation to their care planning and related issues. In Q1 69 received advocacy support in the following areas:



6. A summary of the BCF financial position as at end of Quarter 1

6.1 The Annual CCG BCF commissioning budget is £9.758m (exclusive of Section 75 pooled funds). As at the end of Q1 2017/2018 the CCG has spent £2.373m, in line with the YTD plan less the required savings.

6.2 Of the fund, the Annual LBE BCF commissioning budget is £13.095m (£2.796m capital and £10.299m revenue and exclusive of the iBCF and additional Section 75 pooled funds). As at the end of Q1 2017/2018 the Council has spent £3.273m. Work is on-going throughout 2017/2018 to achieve the required savings of £0.528m in partnership with the CCG for this financial year through existing governance arrangements.

7. Audit of the BCF Performance and Financial Monitoring

7.1 As part of the Council's internal audit programme for 2017/2018, which has been approved by the Council's Audit Committee, a review will be undertaken of the Better Care Fund. The review will consist of high level consideration of scheme performance management and mechanisms to seek assurance around how funds are spent.

7.2 The audit is expected during November 2017, with a draft report in December 2017 outlining the findings, recommendations and an action plan. It is the responsibility of the named officers to ensure that the recommendations are implemented in accordance with the agreed action plan. The audit owner is Bindi Nagra, Assistant Director Health, Housing and Adult Social Care.

7.3 The HWB will be updated on the outcome of this audit once complete, alongside progress with any actions arising.

Appendix A: BCF HWB report August 2017 – Briefing note for questions raised

Q1. Point 4.3 – Can you explain a little bit how this cost control will work.

This question relates to the potential scheme overspend of £528k which will be split between the Council and the CCG and it has been agreed that the savings will be found from proposed new schemes that will be not be operating for the full year and existing schemes savings.

This will be managed via the existing BCF governance routes:

- At the monthly BCF Delivery Group meetings – 3 key responsibilities of the group relate to the monitoring of schemes and spending:
  - Ensuring that business cases are in place for all schemes and that there is evidence to support the expenditure and the outcomes. (Scheme leads are required to produce a business case each year and to provide a written quarterly review of the expenditure and outcomes achieved).
  - Receiving financial reports on the BCF spending plan and assess expenditure against the agreed plan and scheme allocations. This is facilitated by the Finance leads at LBE and CCG who are responsible for the preparation of monthly finance reports.
  - Review, agree and document any changes to business cases, spending plan allocations and outcomes.
- BCF Executive Group meetings - finance is monitored quarterly and this group is the escalation point for any issues / risks that the BCF Delivery Group require a decision on or further discussion. Ad-hoc meetings of this group are also scheduled as required.
- Quarterly BCF data returns that are submitted to NHS England – the finance section includes a report of scheme spend and projected budget outturn for the year. These returns are reviewed by the BCF Executive Group and approved by Bindi Nagra and Graham MacDougall (Director of Commissioning Enfield CCG)

Q2. Point 5.2.4 – What is the impact of the 12 week disregard?

Where a service user owns their own property and is entering residential care, there is a legal entitlement to request the 12 week disregard, where the value of their property is not taken into account as part of the financial assessment for the first 12 weeks of their placement. The number of people requesting this has doubled over the last three years. Following the 12 week period the person can then opt to either make their own private arrangement with the care home (where they pay the full cost of the residential bed to the home directly if they have sufficient weekly income or savings to do this) or they can opt for a deferred payment where the Council continues to pay and places a legal charge on the person's property. The impact of increased 12 week disregard cases is not of significance in financial terms but does increase the number of admissions attributable to the Council. The Council does encourage people thinking about entering care of this type to do so through the Council route as it does ensure appropriate assessments and reviews are done to ensure quality of care. It also enables the Council to negotiate a better price for the bed and to reduce instances of people who self-fund entering very expensive placements, having their savings deplete very quickly and subsequently approaching the Council to request funding at rates in excess of what the Council would normally expect to pay.

It is noted that take up of the Deferred Payment option has increased since the Care Act came into force. Pre 2014 - there were10 clients and post 2014 - 36 clients (15 setup and 21 in progress). See separate spreadsheet attached for further details

Q3. Point 5.3.1 – What is the evidence that the BCF is improving health and wellbeing? The evidence given is that people stay longer at home but no evidence of improved outcomes other than that.

During the 1st quarter of 2017 all the BCF schemes leads were asked to complete a review in line with the approved business cases and to report on the following:

- What the allocated funding had been spent on
- What difference this scheme has made to service users, carers or patients in terms of:
    - The activity that has been undertaken taken
    - What outcomes have been achieved

Detailed below are some of the key outcomes from the review that have supported peoples' health and wellbeing and enabled them to stay at home or in their preferred residence for longer and avoid hospital admission:

The Integrated Care Programme

- A 6% reduction in A&E attendances by people over 65 years. For those people aged 50-64, there was a 4% reduction. This means that for those people who remained outside of hospital their health and wellbeing can be managed in the community and within their existing environment.
- A 17% reduction in hospital related activity for all fractures compared to 2015/16. The programme has several activities around falls prevention, which benefits individuals to remain independent in the location of their choice
- 99% of Care Home residents with an Advance Care Plan (ACP) in place who died, did so in their preferred place of death (PPD) - this supports the choice and control individuals can have over their care.
- A 7% reduction in London Ambulance Services call outs to Care Homes, with additionally a 4% reduction in the number of patients conveyed. More care home residents have been treated in their residence, resulting in a reduction in unnecessary disruption the person's routine and environment.

The Integrated Locality Teams (ILT) - bringing together health and social care services into a virtual team to case manage and support GP Practices.

- 18% reduction in the number of individuals attending A&E and 13% reduction in hospital admissions, which is helping people to remain in the community and have their health and wellbeing addressed through an integrated team.
- Of 100 patients reviewed, 58% had reduced (or no) A&E attendance and 62% saw reduced stays post ILT intervention.

The Care Home Assessment Team (CHAT) Team helped those living in care homes to achieve a better quality of life within the home.

- Reduced medication for 42% of residents
- Enabling 147 residents to have a specialist mental health review, so that this aspect of their wellbeing receives the same emphasis as their physical needs
- A 15% reduction in A&E attendance and a 7% reduction in emergency admissions, so residents can have care which is planned and coordinated to address their health needs and in community based services where possible.

The Enfield Wheelchair Service helped more people to remain independent and manage their long-term condition. There were 1,002 new and re-referrals received, of which 602 new wheelchairs issued. The service has a 93% satisfaction rate.

Carers support runs through several schemes:

- Supporting carers whose cared for having mental health needs, with 325 carers supported each quarter to not only support the person they care for, but to make sure they keep themselves well
- Enabling carers to have a break through respite, to maintain their own wellbeing
- Ensuing carers also have an assessment within their own right, so that the right information and advice is provided which enables them to provide the level of care they would like to
- Providing advocacy support and benefits advice, so carers can manage to continue in their role within financial difficulty

Q4. Point 5.3.9 – What is the average time taken from first contact to completed adaption?

It should be noted that the Disabled Facilities Grant (DFG) can only be accessed for major adaptations i.e. those that are in excess of £1,000. All adaptations below £1,000 (termed minor) are provided by social care at no cost for example: commodes, stair hand rails, bathing aids and walking frames. In terms of activity levels, a total of 204 grant applications were approved last year (2016/17) and 194 adaptations were completed.

It takes on average 9 months from a referral received from an Occupational Therapist to completion of a major adaptation, although the timeframe varies depending of the requirements and the examples below give more detail:

- Straight Stair-lifts – 2 to 4 months
- Curved Stair-lifts – 3 to 6 months
- Step lifts – 3 to 6 months
- Ceiling hoists – 2 to 4 months
- Ramps – 3-6 months
- Level access showers – 3 to 6 months
- Extensive work for ground floor living – 9 – 18 months
- Off sets schemes 9 – 24 months. This is where the service user wishes to pursue their own scheme. We pay what the cost would be for the Council recommended scheme and the service user / their family fund the difference. Their scheme is approved by an Occupational Therapist and payment is made after works are completed and signed off.

These are average calculations as there are a number of external dependencies for example: the service user providing information, manufacture led time, planning department processes, Housing Association providing information, service user/family health issues and contractor availability/work load.

Q5. Point 6.1.6 – What were the alternatives to this that could have been used?

This refers to the use of the £1.5m risk share / contingency fund to support NHS commissioned out of hospital services for 2017/18.

During 2115/16, in line with the BCF policy and planning guidance, a risk sharing approach was agreed and the proportion of the fund allocated was £1.5m. This was calculated per cost of non-elective admission (NEAs) at £2039 per admissions and a target reduction in NEAs of 736 was set. This reduction is in addition to the CCG Operating plan metrics. However this target was not achieved and the year outturn was an over-performance of 8.2% (target was 26,112

admissions against an actual of 28,266) so no monies were released from the contingency fund and were used at the year end to fund the additional demand.

The 2017/19 BCF policy and guidance states that areas are expected to consider holding funds in a contingency if they agree additional targets for NEAs above those in the CCG operational plan. Given the performance at year end, Enfield chose not to take this option but to recommend using the funds in activities where district nursing services are provided which will support the reduction in demand in acute services