MUNICIPAL YEAR 2017/18		
MEETING TITLE AND DATE **Health and Wellbeing Board** **9th February 2018**	**Agenda – Part: 1**	**Item:**
	Subject: The Integration and Better Care Fund - Quarter 3 2017/2018 BCF Update	
	Wards: All	
REPORT OF: Bindi Nagra, Director, Health, Housing and Adult Social Care, LB Enfield, and Vince McCabe, Director of Strategy and Partnerships, Enfield CCG		
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1. EXECUTIVE SUMMARY

This report provides an update on:

- The assurance process and outcome of the Enfield BCF 2017-2019 Plan
- The metrics for 2017-2018 and our performance against these metrics
- The delivery of the 2017-2018 plan including the current performance against key indicators and service / scheme outcomes
- A summary of the financial position as at the end of Q3 2017-2018

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note:

- The Enfield BCF 2017-2019 Plan has been approved
- The current BCF performance against metrics and scheme outcomes
- The Q3 financial position, which is projecting a balanced position

3.0 POLICY AND PLAN APPROVAL

3.1 The Integration and Better Care Fund (BCF) is the only mandatory policy to facilitate integration. The policy framework has been set over a two-year period, 2017-2019, to align with NHS planning timetables and to enable greater strategic flexibility.

3.2 The Enfield BCF Plan 2017-2019 was submitted in September 2017 on behalf of the Enfield Health and Wellbeing Board. During the assurance process the plan was approved with conditions, with a requirement for the £528K over-commitment to be identified in advance of plan approval; this activity was completed, with the outcome of the regional assurance process being the reclassification of the Enfield BCF 2017-2019 Plan as approved in December 2017.

4. BCF PLAN 2017-2018 PERFORMANCE OUTCOMES

4.1 The following section is a summary of the BCF performance up to November 2017. Data on the metrics we monitor become available six weeks following the end of the period.

4.2 Metrics

4.2.1 **Diagnosis of dementia –**Currently surpassing the target of 66.70% set for dementia diagnosis at 71.28% for November 2017. Additional consultant capacity commissioned in 2016/17 and improvement in the diagnostic imaging pathway had a positive impact on waiting times. Though not a required metric for the BCF, the BCF Delivery Group continued to monitor this specific indicator as a measure of good practice. Early dementia diagnosis helps to ensure individuals and carers to get the information, advice and treatment that enables and supports them.

4.2.2 **Non-Elective Admissions (NEA) –** At the end of November 2017 the target for non-elective admission was not on target to be met. We had very positive results for NEAs generally from April and particularly in parts of Q2. Our data in October and November have indicated NEAs have increased due to increased systemic pressures. We are noting that this is not just a local issue, with NEAs for over 65s are up noticeably across NCL.

4.2.3 **Delayed Transfer of Care (DToC)-**

This metric is for delayed transfers of care from hospital per 100,000 population. The outcome sought is effective joint working of hospital services and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

For 2017/2018 the target of 7696 delayed transfers of care days has been set. This is in line with the Health London Partnership (HLP) and NHS England initiative to reduce delayed patients to an average of 20.4 per day by September 2017 and maintain this until March 2018. This target was met in Q2 and in both October and November 2017 are on track to again meet Q3 targets.

4.2.4 **Admissions to residential care –** this metric is measured in order to reduce inappropriate admissions of older people (65+) in to care. As at the end of November 2017 this target was on track to be met.

4.2.5 **Reablement –** This metric relates to the percentage of older people achieving independence through rehabilitation and/ or intermediate care. As at the end of November 2017 this target was on track to be met.

4.3 Outcomes achieved and the difference the BCF has made

4.3.1 The schemes which make up the BCF are reporting on the difference we have made to the health and wellbeing of individuals and our integrated approach. The Social Care Institute for Excellence (SCIE) in December 2017 published a report and model for integrated care which describes what good looks like, providing a visual depiction of how a fully integrated health and care system might be structured and function, and the outcomes and benefits it should deliver for those who use services and their carers. It describes:

- the enablers of integration
- the key components of integrated care
- the outcomes for people who use services, for the integrated services and for the wider health and care system
- the long-term impacts and benefits.

4.3.2 Our reporting on schemes has the difference we have made to individuals as a key focus. The SCIE report includes the 'Logic Model for Integrated Care', which can be found attached as appendix A.

4.3.3 Local providers and stakeholders in Enfield are working together to develop **Care Closer to Home Integrated Networks** (CHINs) and Quality Information Support Teams (QISTs). CHINs will offer an integrated approach to care for those patients with the most health and social care needs. This further embeds the focus on the outcomes for the individual, including their experience and the co-ordination of care around them. The QISTs aim to increase the quality of care and reduce unwarranted variation through identifying and developing best practice, that can enable the CHINs to enhance their integrated care of patients in each of Enfield's four localities. Enfield GPs have come together to form a GP Federation called Enfield Healthcare Co-operative Limited. This Federation is delivering out of hospital services to the entire patient population of Enfield and will be integral to offering patients a greater range of services.

4.3.4 One of our schemes contributing to the CHINs development, the **Integrated Locality Teams**, brought together health and social care services into a virtual team to case manage and support GP Practices. We have ambitious plans to extend the ILTs to cover Enfield over four quadrants, starting with adult social care (such as social worker, occupational therapists) and Enfield Health (such as district nurses and community matrons). These plans are being led by the Local Authority and will feed into the current CHINs Programme. For this financial year through to Q3 the ILTs have supported 729 patients through the existing virtual multi-disciplinary team model in place.

4.3.5 The **Care Home Assessment Team** has several indicators measured, with the following impact noted up to November 2017:

- Enabled individuals to choose to die in their preferred place (100% in both October and November 2017); individuals outcomes were supported around dignity and choice.
- The CHAT sees new residents within a target of two weeks in their care provision; for Oct they met this in 90% of cases, and 89% of cases in November.
- Work with care homes to reduce A&E attendance for falls continued; CHAT is measured on percentage of people who having falls go into A&E, which stood at 12% in October and 15% in November.

4.3.6 The CHAT are vital partners in reducing A&E attendance from care providers; they have a strong and collegiate relationship with care homes and are part of the Trusted Assessor implementation locally, creating a relationship where providers feel confident and safe to seek advice. A local target is set as 10% of A&E attendances per registered bed (CHAT coverage) and the performance was positive in both October and November at 7%; for individuals, this helps to support individuals to receive care where they live and outside of a hospital setting.

4.3.7 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 assess and treat patients in their own home. This includes facilitating and providing patient care out of hours, 7 days a week, 5pm - 2am, and reducing the need for unnecessary emergency hospital admissions. In December of 2017/18 the CCRT was funded to respond to in-hours (9am to 5pm) crisis calls on Saturdays. The service had a target of seeing patients within 2 hours of receipt of referral, and achieved this in 100% of cases in October, and 99% of cases in November. Importantly, the feedback from those who use the service is a vital indicator of their experience of care; 100% of patients surveyed reported a positive experience of care.

4.3.8 The **Older People Assessment Unit** (OPAU) provides unplanned care to patients who need rapid response for assessment and treatment, often to prevent hospital admission. We started to see in August through to October (November and December stats are not yet available) a

positive increase in the uptake of this service, which will assist in care outside of an acute in-patient setting. The service is well received by those experiencing care, with 100% of individuals surveyed during October reporting they felt dignity was always respected, and 100% would be extremely likely to use the service again or recommend to family and friends.

4.3.9 Several schemes funded through the BCF are with the Voluntary and Community Services (VCS) with a focus on preventing and delays the onset of needs. **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 other people to reduce isolation. So far up until November 2017, 295 individuals have been supported. Alongside this within the VCS is falls prevention, with 92% of individuals surveyed reporting they were satisfied with this service.

4.3.10 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
- Support to families and friends of individuals with mental health needs, so as to maintain their own health and wellbeing
- A home from hospital service to enable people to be safely managed at home and prevent re-admission to hospital
- Counselling, including intercultural psychotherapy

4.3.11 Some of the outcomes from schemes through our preventative model in Voluntary and Community Sector provision include:

- Home from hospital schemes, which can assist with earlier discharge through immediate implementation of the service; focuses on improving confidence over 5-6 weeks, with a total of 79 clients in Q3 assisted through this scheme.
- One scheme assisted 1250 clients with information, advice and advocacy, so that older people have the information and support to make informed decision and choices.
- Focus on improving the quality of life at end stage of life, by providing 1,560 hours of respite to support carers of terminally ill patients
- Through a scheme offering counselling, 72% of service users reported they felt significant difference after therapy, with a total of 440 clients who have been seen.

4.3.12 **Advocacy** is a key part of our integrated offer, providing the support to individuals to be involved in decisions about their life and improving the care and support around them. In Q3 2017-2018 a total of 348.20 hours of advocacy was provided. Feedback is received from some who use this service, which asks questions on a range of indicators including their involvement in decision, understanding of rights, through to ability to keep themselves safe in the future. For example:

- 14 out of 18 respondents felt their involvement in decisions about their life got better.
- 10 out of the 18 respondents felt their understanding of their rights and entitlements got better.

4.3.13 Our joint **wheelchair service** provides a vital provision to enable people to mobilise and actively participate in daily life. In Quarter 3 the Enfield Wheelchair Service, as part of Independence & Wellbeing Enfield, issued 159 wheelchairs (131 for adults and 28 for children). There were 102 new referrals within the quarter, with an additional 139 re-referrals. The service met 100% of its target of referrals seen within the 13 weeks' timeframe specified, and 98.5% prescribed equipment within the 18 weeks. In addition, the Enfield Wheelchair Service had 99% service user satisfaction reported.

4.3.14 The **Safeguarding Nurse Assessor** quality assures nursing care in local care provision to prevent abuse and neglect. Twelve nursing homes were visited in quarter 3, supporting significant improvements within these care providers. The Safeguarding Nurse Assessor also supports where homes are under the LBE Provider Concerns Process. For example, a nursing home with significant issues affecting safety and quality to residents was supported on issues including hydration, nutrition, hygiene and infection control. Through the support of the Safeguarding Nurse Assessor in Quarter 3, improvements in these areas have been met and a sustainability plans are in place by the provider so that they continue to provide quality care expected. In addition, 64 cases were supported for single reports of alleged abuse in which views from a clinical perspective were required.

4.3.15 The Better Care Fund is used to contribute towards **Safeguarding Adults Reviews** (SAR), with the intention that learning contributes towards the way in which health and social care work together to support individuals, with a focus on quality and safety. In Q3, two new SARs were commissioned. We are awaiting publication and learning events for the four existing SARs. Importantly, the Safeguarding Adults Boards that work across the North Central London area have agreed to do more collaborative work to share learning from these reviews. As they mature, these arrangements will mean that Enfield residents can benefit from improvements in services based on a much wider pool of SAR learning.

4.3.16 The **Quality Checkers** are volunteers who have either been or are service users of care and support, or unpaid carers. They provide additional eyes and ears out in the community and in people's home, providing their views on the services provided and how these can be improved. The manager of the quality assurance service reports that 'Quality Checkers pride themselves on recognizing that small changes made a big difference, and that these things enhance the quality of life and feelings of wellbeing.'

In quarter three the quality checkers completed the following activities, to improve the experience and outcomes for individuals in Enfield:

- Quality Checkers have interviewed 38 people with social care needs to find out what activities people consider important for wellbeing. The feedback was collated and submitted to inform the development of other Council led initiatives.

- Ten visits to Enfield Leisure Centres as part of a Dignity in Care Project on social care in leisure centres. Private leisure centres were visited to compare how facilities on offer differ with Council run centres. This project will be completed in January 2018 and recommendations and outcomes will be detailed in our Q4 monitoring.

- There were twenty mystery shopping calls were made to the Access Service to check the effectiveness of the customer pathway into adult services. This work will directly inform the development of the joint single point of entry for health and adult social care being taken forward, as part of the Integrated Locality Teams and wider Care Closer to Home Integrated Networks.

4.3.17 The Quality Checker program also extends to care home providers. In quarter three there were 28 visits to care provider across the borough, all of which have reports submitted to the provider to share the findings and support service improvement in line with feedback from residents and their families/friends. Some of the outcomes achieved by Quality Checker visits include:

- An outdoor open space was created for residents to use at their leisure. The area was previously used to store excess equipment.

- A full-time activities co-ordinator has been employed by a care home. This was a direct result of Quality Checker visits and the feedback given to us by residents which was passed onto the home's management team.

5. A summary of the BCF financial position as at end of Quarter 3

5.1 The Annual CCG BCF commissioning budget is £9.758m (exclusive of Section 75 pooled funds). As at the end of Q3 2017/2018 the CCG has spent £7.121, in line with the YTD plan less the required savings.

5.2 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 Q3 2017/2018 the Council has spent £9.819m.

5.3 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.

Appendix A: SCIE Logic Model