MUNICIPAL YEAR 2018/19		
MEETING TITLE AND DATE **Health and Wellbeing Board**	**Agenda – Part: 1**	**Item:**
	Subject: Integration and Better Care Fund	
	Wards: All	
REPORT OF: Bindi Nagra, Director, Adult Social Care, LB Enfield, and Graham MacDougall, Director of Strategy and Partnerships, Enfield CCG	**Cabinet Member consulted:**	
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1. EXECUTIVE SUMMARY

This report provides an update on:

- Year-end financial position for the BCF
- The delivery of the 17/18 BCF plan against the key performance indicators
- The service / scheme outcomes for 17/18 and the difference they are making to integrated care
- Audit of the BCF undertaken by the LBE Internal Audit Team
- The review of schemes to inform the 2018/19 plan and the outcome of this review

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- **Note** the year-end financial position
- **Note** and **receive** the current BCF performance and outcomes
- **Note** the 2018/19 plan with the noted changes

1. OUTCOME OF THE 2017-2018 BCF PLAN

1.1 Year-end financial position

For information: the expenditure plan for 2017/18 was £512K over the total pooled budget, because of commitment to schemes. Our submitted plan to NHS England for 2017-2019 provided a balanced budget though an equitable reduction off individual schemes across the fund. The over-commitment has been identified during 2017/18 by slippage in schemes, contract monitoring and savings from those schemes commencing mid-year.

Financial monitoring has been ongoing throughout 2017/18 and it is confirmed that both the CCG and Council have achieved the required savings to provide a balance position at end of year.

1.2 Performance against metrics

1.2.1 The following section is a summary of BCF performance as at the end of Q4 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.

1.2.2 Delayed Transfers of Care (DToC)

Significant actions were taken by partners throughout the year to manage DToC and as a system we have been able to achieve and meet our target for this metric.

The Enfield Health and Care System, alongside partners in Barnet and Haringey, have prioritised reducing DTOC in mental health services for 2017/18 and 2018/19. This applies equally to working age adult and older people Mental Health services, as part of the Parity of Esteem Agenda. Commissioners from health and care have worked with the Barnet, Enfield and Haringey Mental Health Trust to identify the causes of DTOC in inpatient services and describe a range of interventions that collectively we can implement. The top three causes for delay are described as access to housing, access to accommodation-based services, and people with no recourse to public funding.

DTOC levels have been reducing overall in Enfield and this is due to a range of interventions introduced to work in partnership to manage DTOCs effectively:

- A weekly partnership escalation call that includes CCG Commissioners, Local Authority representatives and BEHMHT operational teams
- BEHMHT hold daily bed management escalation calls internally where DTOC is prioritised
- Tracking of DTOC performance at monthly Contract meetings
- Held a Mental Health DTOC workshop with executive membership in September, followed by another in November 2017 to review position and performance

1.2.3 Non- elective admissions (NEAs)

Further to an improving position reported in quarter 2, the number of NEAs from quarter 3 increased due to systemic winter pressures because of demand and as a result the target for this financial year was not met. We are noting that this is a wider issue across North Central London (NCL) and other areas; as a result, further work is underway to review both remedial actions and the wider lessons learnt through the NCL system resilience groups.

Enfield Paediatric admissions have continued to reduce. Our Integrated Care Programme continues to have a focus on reducing NEAs through co-ordinated support in the community. We will continue to support this model and its expansion with the Care Closer to Home Integrated Networks (CHINs) to reduce NEAs consistently going forward.

1.2.4 Reablement

Reablement refers to the proportion of older people who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. Our target has been met for this year and is an important indicator for us, in terms of indicating the extent to which we are enabling and supporting people to achieve independence.

1.2.5 Admissions to residential care

For residential admissions, as a system in Enfield we are working with individuals so they are both supported to be assessed at home and to take positive risks. Although outside of our target this year, the gap between actual admissions and target has reduced every month since October 2017 through to February 2018. Final figure of 228 admissions to residential care (against a target of 225), which is a reduction from last year which had 263 admissions, despite an increased population during this time.

2. Commissioned schemes and outcome achieved

As at the end of Quarter 4 2017/18, progress against local plans for the integration of health and social care are advancing well, and have been set out below against our five priority areas.

2.1 Integrated Care Models

Our two-year intention was to develop integrated care models to deliver services in the community where possible, including a single point of access to services, and to embed prevention in all planning and commissioning activities to support the self-management of long term conditions. The following outlines the progress made and our current position:

Our **Integrated Care Programme,** consisting of 25 schemes in total, is aimed at those who are 50+ who are frail and pre-fail. This is strongly linked with our Care Closer to Home Integrated Networks (CHINs) as part of the North London Sustainability and Transformation Plans. Schemes work together to improve the experience and pathway for patients and their carers.

The **Enfield Care Home Assessment Team (CHAT)** has consistently supported above 95% of deaths in preferred places; most recent performance for Q4 17/18 was at 100% and is particularly important to us as it shows the importance of supporting individuals and their carers at end of life to maintain this choice and control. The CHAT aims to reduce admission to A&E and have a target of less than 10% of falls going to A&E, which was met at last performance measure in January 2018 at 7%, though increased above this in February and March. Attendances to A&E per registered bed (CHAT coverage) was also positive and within their target of less than 10%. Overall this is a key service for Enfield and is extending its reach to support the trusted assessor model.

Community Navigation delivered through Age UK is a service which helps to connect individuals to their community, for example through linking to services, activities or connecting with people to reduce isolation. For the 17/18 financial year there were 418 individuals who have been supported. A number of these individuals access the service for falls prevention, of which there is a 98% satisfaction rate with the service.

To prevent avoidable admissions 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. The service had a target of seeing patients within 2 hours of receipt of referral and achieved this in more than 92% of cases over the quarter, with February seeing the target met 99% of the time.

Supporting Adolescents and Families in Enfield (SAFE) outreach team is a specialist community multidisciplinary team working with Adolescents and Families in crisis with acute mental health problems or concerns. The team also provides an early intervention in psychosis service for young people to support and stabilise them. BCF is used to fund part of the service. Response times are within one working day to a young person in an acute setting and two working days for other urgent referrals. The funding covers 2.5 senior clinicians. Performance is monitored monthly as part of the CCG's Technical and Contract Review governance structures. Strategic direction is provided through the Children and Young People's Mental Health Partnership, which includes CCG and Council representation. In month 11, there were a total of 431 attended appointments to the SAFE Team. Of these appointments, 17 attendances were initial face to face appointments, 323 were follow-up face to face appointments, 91 were telephone contacts.

Also related to children and families is the **Strengthening the Team Around You** (STAY Project). STAY is the positive behaviour support team for young people which aims to keep children and young people in the Transforming Care cohort out of hospital (and residential placements/school). The original business case was developed by a joint working group which has since July 2017 turned into a monthly At Risk Meeting to discuss cases – children and adults – who form part of the Transforming Care cohort. It is at these meetings that packages/actions are agreed and the Council and CCG maintain a single at risk register. With an increasing number of children and young people in this cohort who we are concerned about, the Integrated Learning Disability Service took the project over, and successfully recruited staff in quarter four to support this area.

2.2 System Resilience

We aimed to increase system resilience and seven-day working with additional investment in clinicians to facilitate the safe discharge of patients without unnecessary delay, a market facilitation plan to create sustainable and diverse care and support provision, and a joint integrated workforce strategy to equip staff with the skills and knowledge needed to deliver patient centre care closer to home.

For mental health our system resilience plan has been progressing well, and we have set up a system resilience structure for mental health that has parity of esteem with physical health e.g. requires engagement at a senior executive level across partnerships and is part of the current wider system resilience processes. We have developed a new post called the Mental Health System resilience Programme Manager that is funded by the iBCF from contributions in Barnet, Enfield and Haringey areas, and is responsible for:

- Developing enhanced systems to identify and manage DTOC and reduce avoidable admissions
- Developing criteria with clinicians for clinically optimised patients
- Working alongside wider system resilience resources
- Working with key partners and stakeholders to identify key pressures and unblock barriers
- Working as part of the Transformation team to develop a sustainable Mental Health system going forward
- We intend to explore the Red and Green Day system and how this can be used effectively for Mental Health Services. Camden & Islington FT and BEHMHT are working closely on this

We have maintained investment in our seven-day services through the BCF and a continued commitment to work with partners to provide this. We have for example

introduced a pilot for Discharge to Assess over seven days and are working with our care providers to build relationships of trust that enable safe discharges on weekends.

The BCF continues to fund **adult social care capacity** at weekend, supporting the ability to respond to adults needing to be discharged back into the community swiftly and safely. This allows staff to be on cover at hospital sites, attendance at MDT meetings, facilitating the discharge and undertaking assessment and care planning.

Our integrated workforce planning is set for development over the next year as part of our plans for the implementation of the Integrated Locality Teams.

2.3 Prevention

We aimed to provide information and advice in a range of formats and at different locations, to promote prevention, limit the escalation of health conditions and help people manage their own care and health. Our aim remains for service users and carers to be fully involved in decisions about health and social care support and we will provide independent advocates to support their involvement when necessary.

Our advocacy services commissioned jointly across Barnet, Enfield and Haringey areas continues to progress well. In total over Q4 there were 78 active cases, with 32 new and a total of 397 hours of advocacy provided. Advocacy is important to us as a system, as it supports people to contribute to their care and support and have their voice heard at times when they are often most vulnerable. The advocacy service also receives feedback from those who use services, and in this quarter found:

- 94% felt they got better at being more involved in decisions about their life since they had advocacy support
- 28% felt they understand their rights and entitlements more, though for 72% there was no change
- 94% felt they got better at being more involved in decisions about their life since they had advocacy support

Our safeguarding services while partly in response to concerns of abuse, are very much focused on prevention and building resilience to help contribute to the safety of individuals and communities. Our **Safeguarding Nurse Assessor** works with nursing homes to identify issues proactively and support the providers to address these. During this quarter 13 homes were supported with quality assurance activities to help prevent abuse and neglect, with support provided around issues such as nutrition, dehydration and pressure care. There is also support provided during the Provider Concerns Process, which is instigated when there are significant concerns about the ability of a provider to deliver safe care, and the local authority alongside partners work with providers to improve care and support. Eleven providers were supported during this quarter.

Our **Quality Checkers** are volunteer service user and carers, who provide additional eyes and ears to review services. During Q4 the Quality Checkers conducted 25 mystery shopping telephone calls to the Council's Access Team. This was to follow up and check progress of the recommendations made during our initial project in 2017. Quality Checkers made recommendations regarding extra staff training to be given in areas of Mental Health and Safeguarding – this was due to the differing responses received by staff to Quality Checkers during the project. During the 2nd part of our project, the advice given by staff was correct and consistent, and we concluded that our original recommendations were implemented and successful.

There were also 36 Quality Checker visits made to care providers across the borough. Some of the outcomes achieved by Quality Checker visits are detailed below.

- Residents communal area was re-decorated and residents helped to decide on colours. This followed feedback collected from residents by Quality Checkers.
- Garden area of residential home has been improved for residents. Grass cut/ new plants planted and general tidy up. Quality Checkers supported the provider by providing them with details of volunteer schemes specialising in assisting care providers with such projects – which provider was previously unaware of.
- Mobile library service now visiting a residential home, who were previously unaware of the service. This was following feedback given to Quality Checkers by residents requesting a service.

Finally, in relation to safeguarding, the funding towards **Safeguarding Adults Reviews** has contributed to six reviews in 2017/18, which aims to share learning and where possible prevent abuse and harm of a similar nature in the future. There has been considerable work done because of this around fire safety, and a partnership approach between the London Fire Brigade and Enfield Safeguarding Adults Board towards fire prevention and safety.

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 and access to statutory services. 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

The Mind in Enfield contract as part of the above, has now become IAPT compliant and will be moving forward to form part of the IAPT offer commissioned by the CCG. This is a positive step forward in building up the offer locally in Enfield.

For 17/18, Enfield's Improved Access to Psychological Therapies Service (IAPT) Access and Recovery Standard was delivered by our Provider: Barnet, Enfield & Haringey Mental Health Trust (BEH MHT). The Access and Recovery Standards form part of the CCG Operating Plan. Where delivery does not match the plan, escalation procedures are enacted to look at the reasons for non-delivery and implement recovery plans accordingly.

In addition to this, the IAPT service delivery is overseen on a monthly basis at the following groups:

- IAPT Network Meeting;
- BEH MHT Contract Review Group;
- Submission of Minimum dataset to NHS Digital to record delivery against protected characteristics and vulnerable populations;
- Monthly performance reporting to NHSE through CCG.

The recovery rate achieved across Quarter 4 was 50.9%; while the access rate 1487 which fell below the 4.2% access target by 10 patients.

2.4 Place Based Commissioning

We aimed to deliver collaborative models of care that meet outcomes while also being financially sustainable. Services are effectively commissioned through an understanding of the needs of local people, future demand and cost of services.

The BCF has provided a platform where the Local Authority and Clinical Commissioning Group work collaboratively to arrange service which are outcome focused and deliver for the community. The Joint Health and Social Care Commissioning Board continues to meet monthly and provide a steer and commitment towards partnership working and collaboration around our commissioning intentions.

Additional pooled funds were added to the BCF for 2017-2018, marking an ongoing commitment from both the Local Authority and Clinical Commissioning Group to partnership collaboration on commissioned services. This pooled funds also includes a joint commissioning team, with the ability to develop services that are financially sustainable through greater integration of care and a focus on improving population health and wellbeing. Over the last quarter a number of contracts were awarded and work is moving forward with the new VCS providers to commence service delivery.

2.5 Infrastructure and Estates

We aimed to integrated information sharing and technology, so that services can work together in the most effective and efficient way, including ensuring that our physical assets (such as land or buildings) are put to the best use for patients and service users

The programme for a shared care record has been restarted across North Central London STP. It is now a collaboration between 5 CCGs, 5 LA's, 12 providers, 220 GPs and around 500 active social care sites. They are at the point of appointing a preferred supplier as a solution and setting up the necessary governance to commence delivery.

3.0 BCF Audit by the LBE Audit Team

A review was undertaken as part of the 2017/18 Internal Audit programme that was agreed by the Council's Audit & Risk Management Committee, to provide assurance on the key controls in place to deliver a successful Better Care Fund (BCF). To avoid duplication and to enhance partnership working, the CCG and Council together agreed to the scope of the audit with the Council's Audit & Risk Team.

Five schemes were selected for review and these included District Nursing, Improving Access to Therapies (IAPT), STAY Scheme enhanced behaviour support, Disabled Facilities Grant and preventative services under the Voluntary and Community Sector Provision.

The review identified:

- one high risk finding related to performance monitoring at a scheme level, particularly for CCG commissioned services and schemes under the Improving Access to Psychological Therapies (IAPT) fund. As a result, there is insufficient assurance that these schemes are delivering planned outcomes to an acceptable level or providing value for money; and

- one medium risk finding, relating to the absence of an approved business case for all project schemes included in the plan.
- The LBE Audit Team concluded that there is 'Reasonable' assurance' for the areas covered by the review. LBE and CCG partners have agreed the actions need to increase assurance and meet the areas identified in the audit report by 1 October 2018. The Audit Team will follow up progress made in implementing the agreed actions, to ensure that they are implemented in accordance with the target dates set out in the action plan.

4. BCF Plan 2018-2019

4.1 Funding

4.1.1 The current BCF funds have continued with an inflationary increase. The Enfield funding for 2018/2019 can be summarised as follows:

Year	**2018/2019**
Revenue funding from CCG	£19,899,913
Local Authority contribution (Disabled Facilities Grant)	£3,051,322
Improved Better Care Fund (iBCF)	£8,243,487
BCF total	**£31,194,722**
Additional pooled funds from the Enfield Council and Enfield CCG 75 Agreement for managing jointly commissioned services	£10,464,157
Pooled fund total	**£41,658,879**

4.1.2 The Better Care Fund allocation towards schemes was agreed as part of a two-year plan 2017-2019. This was ratified by the Health and Wellbeing Board in August 2017 and submitted to NHS England, with the plan agreed formally in October 2017.

4.1.3 The Improved Better Care Funding (iBCF) allocation for 2018-2019 has been allocated to meet the following grant conditions:
- 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

4.1.3 As noted in the funding summary, there is additional pooling of the **Section 75 Agreement** into the Better Care Fund. Enfield Council and Enfield Clinical Commissioning Group have continued in their commitment towards a joined-up approach to support the transformation and integration of health, adult social care and children's services.

4.2 Monitor and Returns

4.2.1 Both the Better Care Funds and additional monies through the iBCF require regular monitoring and returns to NHS England. Following requests from local areas to combine quarterly reporting templates for the Better Care Fund (BCF) and Improved Better Care Fund, the Ministry of Housing, Communities and Local Government and the BCF's national partners are working together to merge them into one template, with one set of deadlines per quarter. Provisional deadlines for submitting combined templates in 2018-19 have been set.

4.2.2 We are awaiting the formal publication of the BCF Operating Guidance for 2018-2019. Provisional ambitions for Delayed Transfers of Care have been shared and Enfield HWB area is being asked to maintain the level set in Q3 17/18 of 15.3 per delayed transfer of care per day, which was the lowest within the North Central London area.

4.3 Scheme Plan Changes 2018-2019

4.3.1 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; this means we will be able to identify and respond to any changes that take place, both locally and nationally, and if required, change our commitment of resources to new activities.

4.3.2 A review of schemes was undertaken in March 2018 as an opportunity to provide assurance that schemes were delivering as agreed, continued to contribute to the required areas and where providing value for the funding allocated. As a result of this review, the following points should be noted as proposed in the 2018-2019 plan:

1) Integrated Care Programme to continue as is from 2017/18 based on outcomes achieved. This programme is a key delivery mechanism for the Care Closer to Home Integrated Networks (CHINS), which are part of the North Central London Sustainability and Transformation Plans. In addition, schemes will be flexible to respond and adapt to activities needed to implement the High Impact Change Model.

2) Mind in Enfield achieved successful accreditation in Improving Access to Psychological Therapies (IAPT). The funding for Mind is agreed as being moved within the BCF from Third Sector Schemes to sit within Mental Health Schemes.

3) A contract with IG Spectrum that contributed to data analysis has been decommissioned and is being delivered through an alternative route in an existing scheme. This has contributed to savings within the BCF Plan.

4.3.3 Appendix A sets out a summary of the Better Care Fund Scheme Plan for 2018-2019, alongside funding changes. The Health and wellbeing Board are asked to note the changes to the scheme plan which sits within 2017-19 plan previously agreed.

5. Assessment of Risk and Risk Management

5.1 Risks related to the BCF as a programme has been reviewed and considered at the BCF Executive and Delivery Group over 2017-2018. These are separate from individual risk registers for schemes or projects, which rest with the lead commissioner, but will be escalated to the BCF Delivery Group as required.

5.2 Three overall programme level risks have been identified, with plans for risk mitigation and are set out in brief below:

1. Strategic risk identified that BCF may be unable to meet metrics because of the system not being flexible enough to refocus activity when necessary to meet targets. A plan is in place to measure monthly targets and identify any emerging areas where additional activity is required.
2. Strategic risk identified that with increasing demand the system will be unable to sustain services. In response, changes have been agreed more widely to focus on prevention, with the outcomes in individual projects to be reviewed so that we can identify the ability to manage demand more effectively.

3. Strategic risk identified around managing transfers of care, with the risk of blockages in the system which prevent patients being discharged to the community. Joint work has been undertaken to assess the implementation of the High Impact Change Model and these changes are being prioritized for implementation.

5.3 The Health and Wellbeing Board are being asked to note the above risks and the plans set out to mitigate these.

Appendix A: BCF Scheme Plan 2018-2019

Scheme / project		Total Budget 2018/19	Investment/ Disinvestment from 2017/18 to 2018/19
1	Integrated Care Schemes	9,359,428	No change
2	Mental Health Schemes	1,323,308	+ 128,000
3	Safeguarding Schemes	449,000	No change
4	Long Term Condition Schemes	756,000	No change
5	Childrens Schemes	385,000	No change
6	Carers Schemes	489,000	No change
7	Third Sector Schemes	282,000	- 128,000
8	Infrastructure Schemes	100,000	-16,000
9	Care Act Schemes	734,000	No change
10	Protection of Social Care	6,280,000	+ 117,000
	Total scheme spend	20,157,000	Noted that the 257k savings required will be found from existing scheme savings
	Revenue funding received	19,899,913	
	Potential overspend	257,823	
12	iBCF	8,243,487	+ 2,106,594
13	Capital total	3,051,322	+254,545
14	Additional S75 Commissioned Services	10,464,157	+290,147