Leicestershire County Council

HEALTH AND WELLBEING BOARD: 22 JUNE 2017

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND QUARTERLY PERFORMANCE REPORTING

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the Better Care Fund programme, including assurance on the national quarterly reporting requirements for the BCF.

Policy Framework and Previous Decisions

2. The Health and Wellbeing Board approved Leicestershire's current BCF plan in May 2016.
http://politics.leics.gov.uk/documents/s118710/Better%20Care%20Fund%20Plan%20Submission%20and%20Assurance.pdf

3. The day to day delivery of the BCF is overseen by the Leicestershire Integration Executive as agreed by the Health and Wellbeing Board in March 2014. (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=3981&Ver=4). The Integration Executive Terms of Reference have been refreshed, and were approved by the Health and Wellbeing Board in November 2015.

4. NHS England issued BCF implementation guidance in July 2016 https://www.england.nhs.uk/wp-content/uploads/2016/07/bcf-ops-guid-2016-17-jul16.pdf which set out the requirements for quarterly reporting along with the draft templates and analytical tools that are required to be used for this purpose.

Background

5. The BCF plan was initially submitted to NHS England in September 2014 and was implemented during 2014/15 and 2015/16.

6. In line with the national policy requirements, the BCF plan was refreshed for 2016/17 at the beginning of 2016. The final plan was submitted to NHS England on 3rd May. Confirmation was received in July that the plan was fully approved.

7. The purpose of the BCF is to transform and improve the integration of local health and care services, in particular to:

   - Reduce the dependency on hospital services, in favour of providing more integrated community based support, such as reablement, early intervention and prevention;
   - Promote seven day working across health and care services;
   - Promote care which is planned around the individual, with improved care planning and data sharing across agencies.

Financial Outturn for 2016/17

8. The BCF spending plan totals £39.4m in 2016/17. This comprises of minimum contributions from partners of £39.1m as notified by Government, and an additional locally agreed £0.3m allocation from the Health and Social Care Integration Earmarked Fund.

9. The actual outturn for 2016/17 was for £38.7m, with the £0.7m underspend released back to CCGs by agreement to off-set other system/financial pressures.

10. A risk pool of £1m was created within the BCF which would be accessed if the planned reduction of emergency admission was not achieved. The BCF plan also contains a general contingency of £1m. The risk pool and contingency were reviewed on a quarterly basis to ensure that they remain appropriate to the level of financial risks.

11. At the end of quarter two, it was agreed to release the full £1m set aside for under delivery against the emergency admissions risk pool. It should be noted that by the end of October, the BCF had delivered the level of avoided emergency admissions that was set for 2016/17. Therefore this was not due to an underperformance of the target, however due to the continued over performance in terms of emergency admissions activity affecting both Clinical Commissioning Groups (CCG), the risk pool was still need to off-set the cost of this additional activity.

12. It was also agreed that the general contingency (£570k) and uncommitted reserve funding (£769k) be released back to West Leicestershire CCG in recognition that these funds were not committed within the BCF during 2016/17.

13. It was acknowledged that releasing these reserves now would eliminate the opportunity for these to be included in the contingencies/reserves for the BCF budget in 2017/18. Therefore all partners would need to accept the risk this poses to headroom within the BCF for 2017/18 and have a shared plan for mitigations.

14. The Help to Live at Home (HTLAH) contingency pool includes £1m for potential non-achievement of QIPP savings in 2017/18 and a further £0.75m for non-achievement of MTFS savings. At a meeting between the Chief Finance Officers of Leicestershire County Council (LCC), East Leicestershire and Rutland Clinical Commissioning Group (CCG) and West Leicestershire CCG it was agreed that:

    - The CCG element of the contingency (£1m) will be released back to both CCGs in 2016/17.
    - Any issues arising from the HTLAH project that affect the CCG's finances in 2017/18 will be addressed through the use of CCG funds and will not affect the BCF.
    - The remaining £0.75m will continue to be used by LCC to offset the risk of achieving MTFS savings.

Performance against BCF Outcome Metrics at the end 2016/17

15. The BCF plan is measured against six outcome metrics. The following table explains the definition of each metric, the rate of improvement that is being aimed for, and progress at the end of 2016/17.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The target has been set at a rate of 606.4 per 100,000 per population aged 65+. This equates to 827 or fewer admissions in 2016/17. In 2015/16 there were 860 permanent admissions to residential care. Based on April – February data for 2016/17, the current forecast is for 874 admissions this year, a rate of 640.73 per 100,000 population. This will not meet the target. *No improvement in performance*.

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	The target for 2016/17 has been set at 84.2%. The latest data, based on admissions to reablement in October - December and followed up in January - March, shows a success rate of 87.0%. *Target achieved*

National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care (DTOC) from hospital per 100,000 population (average per	This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely	Reductions during 2015/16 in delays have focussed on interventions in the acute sector. Therefore the target was set based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The table below shows performance for

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<td>month)</td>
<td>and appropriate transfer from all hospitals for all adults.

The aim is therefore to reduce the rate of delayed bed days per 100,000 population.</td>
<td>each quarter:
<table>
<tr><th>2016/17</th><th>Target</th><th>Actual</th></tr>
<tr><td>Q1</td><td>236.66</td><td>287.04</td></tr>
<tr><td>Q2</td><td>231.91</td><td>357.19</td></tr>
<tr><td>Q3</td><td>214.66</td><td>382.17</td></tr>
<tr><td>Q4</td><td>312.19</td><td>377.10</td></tr>
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Targets for all four quarters of 2016/17 have been missed. The targets were based on good performance in 2015/16 but numbers have increased in 2016/17. However, benchmarking against our CIPFA statistical neighbours shows that we have been in the top quartile for performance for each quarter.

<u>No improvement in performance</u>

Further information on the key issues regarding the DTOC position and actions being taken is provided in para 21.</td>
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National Metric (4)	Definition	Trajectory of improvement
Non-Elective Admissions (General & Acute)	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	The target for 2016/17 is 724.37 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to a combined trajectory of 1,517 avoided admissions within the BCF schemes targeted at avoiding emergency admissions. Despite BCF admission avoidance schemes performing well and achieving 2,010 avoided admissions in 2016/17, the number of non-elective admissions continues to rise. System-wide plans are being delivered or developed as part of STP plans to stem the rise in non-elective admissions. The target for non-elective admissions in 2016/17 was 59,030 or 724.37 per 100,000 population per month. For the period April 16 to March 17 there have been 61,966 non-elective admissions, a variance of +2,936. <u>No improvement in performance</u>

National Metric (5)	Definition	Trajectory of improvement
Improved Patient Experience	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health."	This target was set at 62.2% for 2016/17. This is based on the 2015/16 target and a 2% increase in the number of positive replies. Current performance is 63.6% (as at July 2016). (Next data due July 2017). *Target achieved*

Local Metric (6)	Definition	Trajectory of Improvement
Injuries due to falls in people aged 65 and over	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	A realistic target was set for 2016/17 which holds the number of falls in the 65-79 age group at the 2015/16 level, while reducing those in the 80+ population by 5% allowing for population growth. The target for emergency admissions for injuries due to falls has been set at 2,287 or fewer admissions, or 1,677.07 per 100,000 population aged 65+. The year-end position is that there were 2,162 admissions during 2016/17 for injuries due to falls; a rate of 1,585.3 per 100,000 per population against the target of 1,677.1 *Target achieved*

Progress against BCF national conditions

16. The revised policy framework and technical guidance for 2016/17 indicated that BCF plans must demonstrate assurance regarding the following:
    - Delivery against five national BCF metrics and a locally selected metric (see para 15);
    - How a proportion of the fund will protect adult social care services;
    - How data sharing and data integration is being progressed using the NHS number;
    - How an accountable lead professional is designated for care planning/care coordination;

- Delivery of Care Act requirements;
- How a proportion of the fund will be used to commission care outside of hospital;
- How seven day services will be supported by the plan;
- That the impact on emergency admissions activity has been agreed with acute providers;
- That there is a locally agreed proactive plan to improve delayed transfer of care from hospital;
- That Disabled Facilities Grant allocations within the BCF will be used to support integrated housing solutions including the delivery of major adaptations in the home;
- Approval of the BCF plan by all partners being assured via the local Health and Wellbeing Board.

17. The Leicestershire BCF plan has been able to provide assurance that most of the national conditions of the plan have been met.

18. The exception to this is the question 'are support services, both in the hospital and in primary care, community and mental health settings available seven days a week to ensure next steps in the patient care pathway, as determined by the daily consultant-led, can be taken'.

19. It was agreed at this stage to state that this national condition was still in progress. This was due to the fact that work is still underway on the Leicester, Leicestershire and Rutland urgent care redesign. As the service was implemented in April 2017, it was reported that the national condition will be fully met by September 2017, to allow time for the changes to embed in.

Overall Performance of the Leicestershire BCF Plan 2016/17

Highlights and Successes

20. Implementation of the integration programme in Leicestershire continues at pace. The following is a summary of the highlights and successes to date:

a) The **emergency admissions reduction** target for the schemes within the Leicestershire BCF plan was to collectively avoid 1,517 admissions (in line with CCG operating plans). During 2016/17, the total number of avoided admissions across the different BCF schemes was 2,010 meaning that the BCF contribution to the target was achieved/exceeded.

b) However, it is acknowledged that the overall number of total non-elective admissions for county CCGs was 61,966 for 2016/17, against a commissioned level of 59,030, a variance of +2,936 (final figures are subject to validation by the new CSU).

c) The Leicestershire Integration Programme has led the work to develop the new **LLR falls pathway**. Each of the stages within the pathway has been developed into an agreed level of service that will form part of the LLR Falls Prevention and Treatment Strategy. The resulting LLR Falls Business Case has been

approved for a first 'proof of concept' year by both county CCGs with some areas of further financial and modelling validation work to be completed in Q2 2017.

d) Some components of the new falls model for LLR have already been tested/ implemented in Leicestershire during in 2016/17. This has included the development of the **Falls Risk Assessment Tool (eFRAT) App** during 2016/17 in conjunction with the De Montfort University Hackathon team and EMAS. The eFRAT is a key part of the admissions avoidance scheme for falls. This is now live on the smartphones of all Leicestershire EMAS paramedics, and is being very well received. This means that every falls patient that does not require conveying to hospital will be assessed for their risk of further falls with the opportunity to signpost and refer to other community based support.

e) A third phase of the app, which will enable other partner organisations to refer patients for assessment or prevention is being scoped, and it is intended that this will go live in September 2017. **The East Midlands Academic Health Sciences Network has selected the Leicestershire eFRAT tool as an innovation that should be adopted and rolled out East Midlands-wide.** Arrangements for this are at an early stage at the time of this report.

f) A new integrated and jointly commissioned domiciliary care service called **Help to Live at Home** was launched on 7th November in Leicestershire. This involved a new specification and contract which was co-produced between county CCGs and Leicestershire County Council. The service has been designed to support the revised discharge pathways which are now in place in LLR. It promotes reablement in the home and integrating domiciliary care providers more effectively with other health and care services, including primary care and prevention services in each locality. While this resulted in nine providers being appointed, during the launch of the service there were some significant operational problems in particular due to one provider exiting the process just before go live. Although the initial transition to the new service proved more difficult than anticipated the position has steadily improved since February 2017. An integrated back office for HTLAH is responsible for booking packages of care for both NHS and local authority partners, provider billing, and contract/performance management reporting.

g) A further phase of outcome based, integrated commissioning across Local Authority and NHS partners, focused on **residential and nursing home placements,** has recently commenced. An outline business case has been developed and the workplan is now underway.

h) During Q4 of 2016/17 BCF funding supported the implementation of the Integrated In-Reach Discharge Team which started on 30th January 2017. This team provides support to identify, transfer and then access suitable patients into a bed based reablement facility, based at **Peaker Park in Market Harborough**. Peaker Park will accept up to 14 patients for reablement.

i) **Further LLR wide work on Integrated Discharge** has led to the creation of Integrated Discharge Team (IDT) to work across a number of wards at the Leicester Royal Infirmary from July 2017 to provide expert discharge advice and assistance helping to get residents home as soon as they are well enough to be

discharged. The aim of the project is to create a single integrated discharge service within UHL. Leicestershire County Council and Leicester City Council hospital social workers, UHL Specialist Discharge Nurses, LPT Primary Care Co-ordinators, UHL therapists and the hospital housing discharge advisers will all be part of the new team. (The new model also draws on funding from the Leicestershire BCF.)

j) The Leicestershire Integration Programme has been leading work to scope opportunities to integrate the various **points of access for community based health and care services** across LLR. Given the integration of health and care teams in locality settings within the new models of care of LLR STP, this area of work looks at opportunities to integrate the multiple points of telephone/referral access for customers and professionals when arranging community based services - with a view to coordinating their care from one integrated point of access in the future. Existing Points of Access/customer call centres across the three councils, LPT and UHL (bed bureau) are fully involved in this work. Progress so far includes adopting a new standardised way of working in existing locations/services, ahead of a gateway review in August 2017, where potential solutions for co-location, integrated management and technology will be considered.

k) Leicestershire's prevention 'one-stop shop' **First Contract Plus** went live at the beginning of October 2016 with a new clinical referrals service, which has had positive feedback from GP's and other partners who utilise this approach to refer patients for advice, information and guidance. The new website developments http://www.firstcontactplus.org.uk/, include online self-referral, which went live on the 7th March 2017, with the ethos of "self-help". The **First Contact Plus** service offers signposting, information and targeted referrals to a broad range of preventative services from smoking cessation to fire safety. Two District Councils are currently working on specific **social prescribing pilots** with a view to creating a model of locality based prevention that will wrap around the new integrated locality teams.

l) The **Lightbulb Housing Offer** is a key part of prevention, offering a joined up support service across housing, health and social care to keep people safe, well, warm and independent at home for as long as possible. The business case for full roll-out was signed off by the Lightbulb Programme Board in September, and has since been approved by the Cabinets of each District and Borough Council and the County Council. Implementation of the new service started in Blaby on the 22nd May 2017, with full roll-out across all parts of Leicestershire in October 2017. This means all parts of Leicestershire will benefit from the same housing offer, with one central point of contact to access all housing support, including major and minor adaptations, home safety, and affordable warmth. **A new housing MOT** will ensure every opportunity is taken to assess and prevent housing problems which could impact on health and wellbeing. **The hospital housing discharge advisers at LRI and Bradgate Unit** were created as an integral part of this service.

m) There are currently 9,550 adult social care service users in Leicestershire County, of which 9,341 (98%) have a validated **NHS number** as a key enabler to data sharing across health and social care including through the **PI Care and Health Trak tool** and, in due course, the **summary care record (SCR2.1).**

n) **SIMTEGR8 evaluation** programme – the second phase of the Leicestershire Integration Programme evaluation approach was completed at the end of March 2017. This was delivered via a research partnership with Loughborough University, Healthwatch and SIMUL8 Corporation. Four integrated care pathways were analysed using simulation modelling, stakeholder workshops and patient experience focus groups.
    - Testing the business case assumptions for the Lightbulb Housing Service model
    - Impact of the Intensive Community Support (ICS) Step Up Service
    - Help to Live at Home capacity and resilience modelling
    - Glenfield CDU short stay/admissions avoidance pathway

Challenges

21. Having achieved good, sustained performance in 2015/16, the BCF DTOC metric is currently rated red and the DTOC target was not achieved in 2016/17. There are a number of system challenges that have affected this position, and a summary of the key issues and actions being taken is given below:

    - Volumes of attendances and admissions at UHL have continued to rise, which has created pressure on the health and care system overall, including the consequences of increased activity on hospital discharge across acute and non-acute sites.

    - Performance on delayed bed days has remained generally good on acute sector sites with the majority of the reason for target failure relating to non-acute sites.

    - Delays in CHC assessments and problems with the discharge to assess pathway have affected the ability to place NHS funded care packages out of hospital in a timely manner. A new CHC end to end process is being implemented via the new CSU with effect from July 2017.

    - The new domiciliary care service, Help to Live at Home, implemented in November 2016, had an impact on DTOC performance during Q3 due to the mobilisation issues, but a period of further intensive work and stabilisation has been undertaken, and the position has improved steadily since February 2017

    - Despite the overall system challenges, local authority delays remain in the top quartile of performance nationally.

    - A task and finish group has been established to work on system wide discharge data, as there are a number of concerns about data flows, data quality, and there is a need to provide one consolidated, integrated set of data/dashboards for the A&E Delivery Board.

    - The LLR self-assessment against the high impact changes for hospital discharge has recently been refreshed and will be considered by the A&E Delivery Board in June 2017.

    - The BCF plan continues to prioritise investment in hospital discharge support/reducing delays. For example the approach to integrated discharge

teams which has been developed for the acute sector is planned to be replicated on the non-acute sites, as part of the BCF plan/home first workstream during 2017/18.

Process to submit the BCF quarterly report to NHS England

22. The BCF Operationalisation Guidance required that a quarterly performance template was submitted to NHS England by 31st May 2017, summarising the final position for quarter four 2016/17.

23. The Integration Executive reviewed the completed template on 23rd May and submitted the required information to NHS England on 31st May on behalf of the Health and Wellbeing Board.

Recommendation

24. The Board is recommended to note the contents of the report and that the quarter four 2016/17 BCF return was approved by the Integration Executive on 23rd May, and submitted to NHS England on 31st May.

Officer to Contact

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Relevant Impact Assessments

Equality and Human Rights Implications

25. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

26. An equalities and human rights impact assessment has been undertaken which is provided at:
http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf

27. A review of the assessment was undertaken in March 2017.

Partnership Working and associated issues

28. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

29. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integration Executive's terms of reference which have been approved by the Health and Wellbeing Board.

30. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the five year plan to transform health and care in Leicestershire, known as Better Care Together http://www.bettercareleicester.nhs.uk

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