Report No.
CS18165

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**BETTER CARE FUND 2017/18 - Q4 PERFORMANCE UPDATE**
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Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director of Education, Health and Care Services, London Borough of Bromley Angela Bhan, Manager Director, NHS Bromley Clinical Commissioning Group
Ward:	Borough-wide

1. Summary

1.1 This report provides an overview of the performance of the Better Care Fund 2017/18 on activity and expenditure for the final quarter (January - end of March 2018).

2. Reason for Report going to Health and Wellbeing Board

2.1 This is the final performance report on the Better Care Fund for the year 2017/18 to keep the Board informed on the position of the pooled fund and progress of the locally agreed Better Care Fund schemes.

3. **SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS**

3.1 That the Health and Wellbeing Board notes the performance and progress of the Better Care Fund schemes and the financial position to end of March 2018.

Health & Wellbeing Strategy

1. Related priority:

   General overarching regard to local health and care priorities.

Financial

1. Cost of proposal: £22,125,000
2. Ongoing costs:: £22,125,000
3. Total savings: Not Applicable
4. Budget host organisation: Local Authority
5. Source of funding: Top slicing of existing budgets (primarily BCCG budgets) to create the BCF in 2015/16
6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

Yes

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4. **COMMENTARY**

4.1 Bromley's Better Care Fund 2017-19 local plan was formally agreed and endorsed by the Health and Wellbeing Board at its meeting on 7th September 2017. The plan was subsequently submitted to NHS England for approval on 11th September 2017 and formal approval was received on 27th October 2017.

4.2 The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Bromley Clinical Commissioning Group (BCCG) and the local authority. For 2017/18 the Better Care Fund grant allocation was £22,125k.

4.3 In order to ensure that local areas are meeting the standard conditions of the Fund it is a requirement to report back to NHS England on a quarterly basis progress against the agreed plan including expenditure.

4.4 The purpose of this report is to provide the Health and Wellbeing Board with an overview of the final quarter performance for the Better Care Fund for 17/18. A report on Q1- Q3 performance was presented to the Board at its meeting on 8th February 2018.

Performance Metrics

4.5 Bromley is responding to the national metrics with the BCF. Under the BCF Policy Framework 2017-19 the national metrics continue as they were set out for 2016-17. In summary the metrics are:

a. Reduction in non-elective admissions
b. Rate of permanent admissions to residential care per 100,000 population
c. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
d. Delayed transfers of care (DTOCS) (delayed days)

a. Non-elective admissions (emergency admissions)

4.6 There were 25,722 emergency admissions up to the end of March 2018.

	NE Admissions	Actual Performance#	Quarterly Plan	Variance
Apr-17	2,158			
May-17	2,201			
Jun-17	2,228	6,587	6,486	**101**
Jul-17	2,162			
Aug-17	2,126			
Sep-17	2,107	6,395	6,640	**-245**
Oct-17	2,246			
Nov-17	2,226			
Dec-17	2,142	6,614	6,929	**-315**
Jan-18	2,160			
Feb-18	1,914			
Mar-18	2052	6126	6780	**-654**

#Actual performance is derived from SUS activity.

4.7 There are a number of challenges facing us in the delivery of the reduction of non-elective admissions. Large and increasing elderly and frail population, with high numbers of self-funders which impacts on early engagement with statutory services before crisis, are all factors that are being addressed cross agency.

4.8 In terms of achievements however, the pro-active care pathway is now up and running with delivery and outcomes built into contracts across all key community providers underpinned by a robust Alliance Agreement. Social care are now also signed up to the MOU and all key agencies are now represented. Initial analysis is showing positive impact on reduced A&E attendances and closer working with LAS to reduce conveyance to hospital wherever possible, is ongoing.

b. Delayed Transfers of Care (DTOCS)

4.9 In compliance with the national 2017-19 BCF plan condition, a DTOC joint action plan has been developed which sets out Bromley's agreement to reduce delayed transfers of care.

		17-18 plans			
		Q1 (Apr 17 – Jun 17)	**Q2 (Jul 17 - Sep 17)**	**Q3 (Oct 17 - Dec 17)**	**Q4 (Jan 18 - Mar 18)**
Delayed Transfers of Care (delayed days)	**Number**	No target set as 2017/18 plans submitted after Q1	1321	991	928

		17-18 actuals			
		Q1 (Apr 17 – Jun 17)	**Q2 (Jul 17 - Sep 17)**	**Q3 (Oct 17 - Dec 17)**	**Q4 (Jan 18 – Mar 18)**
Delayed Transfers of Care (delayed days)	**Number**	1484	1446	1594	1475

Actual performance derived from NHS England Delayed Transfers of Care Data 2017/18
https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

4.10 An update report on Delayed Transfer of Care performance (report CS 18142) was presented to Members at its meeting on 7th June 2018. Please refer to the separate Delayed Transfer of Care (DToC) performance report which provides a more detailed update on published and local performance to date.

c. Admissions to residential care

4.11 During the final quarter there were 298.2 admissions into residential care and for the year 2017/18 there were a total of 387.1 admissions. Bromley has therefore exceeded its planned target of 425 admissions.

		Planned 17/18	**Qtr 1 Actual**	**Qtr 2 Actual**	**Qtr 3 Actual**	**YTD Performance**
Long term support of older people (aged 65 and over) met by admission to residential and nursing homes per 100,000 population	**Number**	425	95.9	195.3	298.2	387.1

4.12 Bromley's achievement in exceeding its target is due to some seasonal variation, often seeing an increase in placements during the winter period.

4.13 The increasing elderly population along with a high number of care homes and a high number of self-funders continues to pose a challenge for Bromley.

d. Reablement

4.14 Based on local data the percentage of people still at home 91days after discharge is 93.5% (392/419) as of end of March 2018. Bromley has exceeded its planned target of 90%.

		Planned 17/18	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Actual	YTD Performance
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	90.1%	92.6%	93.0%	92.1%	93.5%
	Number	446/495	(88/95)	(172/185)	(269/292)	(392/419)

4.15 The use of Bridging (where a domiciliary care agency is used as a temporary measure to manage the needs of a person whilst they await the opportunity for the reablement service to work with them) has been adopted to facilitate timely discharges from hospital and the reablement service as a holding prior to reablement starting and after it has finished. It has proven successful in moving secondary users (SUS) through pathways of care.

Update on BCF Scheme Delivery

4.16 The BCF programme for 2017-19 continues to be aligned with the model of providing services with funding to underpin the wider objectives to move care from an acute setting into the community. Progress against the local projects are detailed below.

i) Reablement - Additional capacity

4.17 Increasing the capacity of reablement should enable more people to become independent on discharge from hospital, and in some cases reduce hospital admission. The effect of this should be a reduction in the number of residents requiring ongoing packages of care and enabled to live as independent as possible in the community.

4.18 The success of providing additional capacity is dependent on the recruitment to additional posts including occupational therapists, care management and reablement facilitators.

4.19 Further to the Q1-Q3 report to members (CSD18038), the two therapy posts and also the two additional care management assistants have now been recruited and are in post.

ii) Dementia Universal Support Service

4.20 The Dementia Universal Support Service (Dementia Hub) was commissioned to establish a clear pathway for people and their carers immediately following diagnosis. The service provides a 'one stop shop' in terms of information, advice, support and planning for people with dementia and their carers immediately following diagnosis.

4.21 Approval was given back in February to extend the current contract for a further year in order to demonstrate the longer term effects of the service. It has been agreed that a full review of the service will be undertaken by the latter end of 2018 including the options for future commissioning.

4.22 During the last quarter the service has continued to meet the target of triaging people within 3 working days and continues to capture an increase number of people who are re-referred to the service.

4.23 The Dementia Hub aims to continue to have a positive presence in the community. The evidence has been shown in the increase of self-referrals that the hub has received during the

last quarter. The hub team continues to receive a number of referrals from GPs and in the last quarter the hub has made positive links with Bromley Well and has started receiving referrals from the service.

4.24 The case study below provides just one example of how the service has been able to support Bromley residents.

Case Study – Dementia Advisor Service

Background

Mrs W has mixed type Dementia, Alzheimer's and Vascular. She was diagnosed in Feb 2016 and is being supported by her granddaughter who lives in Whitstable. Mrs. W. is very anxious and often her granddaughter, who has her own family needs to stay the night and rush out to help her grandmother manage her anxiety. As a result, the carer is very stressed. Also her grandmother is refusing to go out and socialise and this is causing her anxiety to get worse.

Information and support given

- Information on carers workshops
- Information on Day Centres
- Advice around understanding dementia and anxiety
- Support for carer around self-care strategies

Actions

- Referred to Bertha James Day Centre
- Signposted Driving Miss Daisy for personal transport
- Support session with carer around emotions of being a carer

Outcomes

- Mrs W. is now attending Bertha James weekly. She is enjoying social stimulation and has developed a relationship with staff and driver.
- Carer is able to manage her grandmother's anxiety and no longer rushes from Whitstable to care for her when she rings in an anxious state.
- Carer says she feels less stressed as she understands her behaviour and how to communicate. She also feels less alone as Bertha James are also involved in her care.

She says that the Hub's service has been 'fantastic' and has made such a difference to her and her grandmother's life. She feels supported and less stressed as she has a Dementia Advisor who she can call for support or queries. She says she particularly values the fact that the Hub have specialist knowledge of Dementia, which she feels other agencies do not have.
She has arranged for her Mum and Stepfather to have the hub Coaching service.

iii) Health Support in to Care Homes and Extra Care Housing

4.25 A new Care Homes Programme Board (which reports to the Integrated Commissioning Board) was established in November 2017 and covers the following three broad areas;

- Joint commissioning strategy between London Borough of Bromley and NHS Bromley CCG
- The health and care offer to residents of care homes
- Joint quality framework between London Borough of Bromley and NHS Bromley CCG

4.26 Since the programme started a number of milestones have been achieved including:

- A workshop held to look at the NHS England Care Homes Vanguard recommendations as set out in their report and toolkit 'Enhanced Health in Care Homes'. Further workshops are planned for July and August.
- The Hospital Transfer Pathway (Red Bag' scheme) has been delivered to 39 out of 43 elderly care homes and 2 learning/disability homes. Further 1-2-1 engagement is being undertaken with all care homes to support the flow of consistent documentation. Engagement is also taking place with the PRU as the Hospital Discharge letter is not currently being completed by them.
- A pilot has started to use a shared inspection form between Continuing Health Care (CHC) and LBB.
- A pilot has been agreed to share placement and review workload between CHC and LBB at Mission Care homes.
- The programme team has engaged with care home providers at two Care Homes Forums hosted by LBB.

4.27 BCF investments in care homes settings are currently committed within the 2017/18 programme. In future, available BCF funds in this area will be directly aligned with the priorities and initiatives led by the Care Homes Programme Board.

iv) Self-Management and Early Intervention

4.28 The Bromley Well service (launched in October 2017) provides a single point of access for local people to prevent them from falling into a crisis and improve their health, wellbeing and independence. Their services include support for:

- Older people
- Young carers
- Adult carers
- Mental health carers
- Mutual carers
- Learning difficulties
- Physical disabilities
- Mental wellbeing
- Long term health conditions
- Volunteering, training and paid employment
- Support to the sector

4.29 The first quarter monitoring meeting was held on 15th January 2018. Since the launch of the service a total of 4,596 people have been through the single point of access. Table 1. below provides an indication of the numbers referred to the various services during this period.

Table 1.

Support Service	Number of referrals
Long Term Health Conditions	190
Elderly Frail pathway	93
Employment and Education	77
Learning Disabilities	29
Physical Disabilities	47
Carers pathway	29
Mental Health pathway	173

4.30 The case study below provides just one example of how the service has been able to support Bromley residents to stay both emotionally and physically well, avoid or delay the use of health and social care services and remain independent.

Case Study – Learning Disability Pathway

Name of Service:
Learning Disability Pathway

What was your situation on first coming to the Bromley Well service?
When I contacted the Single Point of Access in January, I had been granted one week of temporary housing before I was to be street-homeless. I was living in a room with a bed and a cupboard with shared toilets and shared kitchen. I had failed a PIP assessment and my income was very low. I was very anxious, isolated and felt that no one was listening to me.

Describe the support you received and the difference it made
I received a call from X, who came to meet me at my temporary housing. He looked through my paperwork and read doctor's notes to see if I could prove to the housing office that I should be viewed as a priority and should be able to stay at the temporary housing until I could make other arrangements. He then spoke to the Council and wrote a description of my learning disability, assisted me to contact private landlords to view properties and assisted me to apply for housing with Clarion, detailing the support which Bromley Well can offer me, so that I could be considered for a tenancy. X put me in touch with the Cotmandene Community Resource Centre at an outreach session and I used their computers to track my housing application. This week X helped me to move to a Clarion house and is looking into my paperwork for energy bills, housing benefit and PIP.

Explain how your life and situation is different now
I am now in a new, spacious flat with local shops and a great view. I am very excited to start decorating and to feel like it is a place of my own and gain some independence, knowing that I still have support. Without this service I would be homeless, on the streets. I will continue to use the Bromley Well outreach sessions and now I feel that I have support in most aspects of my life which has greatly improved my wellbeing.

4.31 The service is still in its early stages and going forward solutions are required for measuring outcomes and the full impact of the service. A system for tracking the NHS numbers of the users also needs to be set up.

Update on progress for Integration of Health and Social Care

4.32 In line with the 2015 Spending Review which set out the Government's intention that, by 2020, health and social care will be more fully integrated across England, it was a requirement for BCF plans for 2017-19 to set out the joint vision and approach for integration and how CCGs and local authorities are working towards better co-ordinated care, both within the BCF and in wider services. During 2017/18 the following progress has been made:

- As part of our joint commitment towards integration and since the 2017-19 BCF plan submission, the joint Director of Transformation and Integration was appointed in September 2017. Priority areas for joint working have been identified, aligned with the BCF plan, and an integrated work programme has been developed on a collaborative basis between BCCG and the Council.
- The governance of joint working arrangements have been reviewed and a new Integrated Commissioning Board (ICB) has been established (formerly the Joint Integrated Commissioning Executive (JICE)) to lead and direct the transformation and integration programme.

- Implementation of the work programme, overseen and directed by the ICB, with accountability to the Health and Wellbeing Board was formally endorsed by the Health and Wellbeing Board at its meeting on 8th February 2018.
- During the final quarter of 17/18 proposals were put forward to the Integrated Commissioning Board (ICB) for the further development and strengthening of joint working arrangements particularly operational arrangements in order to make quicker progress on our local journey towards integration.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 All services are designed to avoid people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission.

6. FINANCIAL IMPLICATIONS

6.1 The budget and expenditure for the Better Care Fund up to the end of March 2018 is detailed in the table below.

BCF 2017/18 - QUARTER 4

Resp.	Description	2017/18 budget	Forecast Apr to Jun	Forecast Jul to Sep	Forecast Oct to Dec	Forecast Jan to March	Forecast Outturn	Difference bud/act
		£'000	£'000	£'000	£'000	£'000	£'000	£'000
LBB	Reablement capacity	853	213	213	213	134	774	-79
CCG	Winter Pressures Discharge (CCG)	646	162	162	162	162	646	0
LBB	Winter Pressures Discharge (LBB)	1,027	257	257	257	212	982	-45
CCG	Integrated care record	433	108	108	108	108	432	0
CCG	Intermediate care cost pressures	625	156	156	156	156	625	0
LBB	Community Equipment cost pressures	422	106	106	106	106	422	0
LBB	Dementia universal support service	520	130	130	130	88	478	-42
CCG	Dementia diagnosis	620	155	155	155	155	620	0
LBB	Extra Care Housing cost pressures	418	105	105	105	105	418	0
CCG	Health support into care homes/ECH	314	12	13	0	0	25	-289
CCG	Self management and early intervention (inc Vol sector)	1,047	0	0	0	1,047	1,047	0
CCG	Carers support - new strategy	633	0	0	0	510	510	-123
CCG	Risk against acute performance	1,347	0	449	449	449	1,347	0
CCG	Transfer of Care Bureau	611	153	153	153	153	611	0
LBB	Protecting Social Care	8,977	2,244	2,244	2,244	2,244	8,977	0
LBB	Disabled Facilities Grants - CAPITAL	1,838	226	304	274	543	1,347	-491
CCG	Carers Funding	527	132	132	132	132	527	0
CCG	Reablement Funds	952	238	238	238	238	952	0
LBB	Reablement Funds	315	79	79	79	79	315	0
LBB	Continuation of agreed joint schemes	0	0	0	0	550	550	550
	Total Recurrent Budget	**22,125**	**4,474**	**5,002**	**4,959**	**7,170**	**21,606**	**-519**

6.2 The underspend of £519k in year is split between £491k of capital funding and £28k of revenue funding. The total underspend will be carried forward into the new 2018/19 financial year to be used against BCF projects.

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers.

7.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. For 2017-19 NHS England set the following conditions to access the CCG element of the funding:

- The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
- The requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).

7.3 Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except for those amounts paid directly to local government.

7.4 In 2017-19, NHS England will require that BCF plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- NHS contribution to adult social care is maintained in line with inflation;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and
- Managing Transfers of Care