Item 6

Meeting:	OSC Adult Social Care, Health and Wellbeing Sub-committee
Date:	October 5th 2017
Title:	Better Care Fund update

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Service:	Adult Social Care	
Directorate:	Deputy Chief Executive	
Wards affected:	All	

1 Background

The Better Care Fund is now in its third year of operation. The current planning cycle covers two years, i.e. 2017/18 and 2018/19.

The national planning requirements for the BCF were published by the Department of Health, Department of Communities and Local Government, and NHS England on 4th July 2017.

The planning requirements set out the following national conditions:

1. That plans be jointly agreed by the Council and CCG, and signed off by the Health and Wellbeing Board
2. The NHS contribution to social care must be maintained in line with inflation
3. Agreement to invest in NHS-commissioned out-of-hospital services
4. Implementation of the High Impact Change Model for reducing delayed transfers of care

2 Current status of the BCF plan

The deadline for submission of plans to the national bodies was September 11th 2017; however the CCG and the Authority were unable to agree a plan. The CCG submitted a plan which had not been agreed by the Authority.

Because the plan had not been agreed, it cannot be approved, and will be considered by a national escalation panel in October 2017.

2 Reasons for not agreeing the BCF plan

As noted above, it is a national requirement that the NHS contribution to social care must be maintained in line with inflation. A planning template issued by the national bodies is prepopulated with the required amount of social care expenditure from the CCG minimum contribution.

Table 1 below shows the required amounts of social care expenditure, together with the proposal made by the CCG. The amount proposed by the CCG is over £2m less than the required amount.

Table 1

	2016/17	2017/18 (includes an inflationary uplift of 1.79%)	2018/19 (includes an inflationary uplift of 1.90%)
Baseline expenditure on social care from the CCG minimum	£9,723,750		
Minimum mandated Expenditure on Social Care from the CCG minimum		£9,897,805	£10,085,863
CCG Proposal		£7,456,000	Not stated
Difference between the national requirement and the CCG proposal		£2,021,666	Not known

3 Next steps

As noted above, the national bodies will convene an escalation panel to consider the progress of the North Tyneside BCF. The terms of reference and working methods of the escalation panel are set out in Appendix 1.

Prior to escalation, the BCF national support team have appointed an independent facilitator to work with both parties to attempt to seek agreement on the content of the plan. The facilitator is an experienced manager who has recent experience in assisting the parties in another Health and Wellbeing Board area to reach agreement on their BCF plan. He is currently carrying out discussions with officers of both North Tyneside Council and North Tyneside CCG.

4 Effect on current services

In the interim, the CCG have continued to make payments to the Authority at the levels agreed in the previous year, and those services continue to operate as normal. The services which were funded by the BCF in 2016/17 are summarised in Appendix 2.

5 BCF metrics

Four national BCF metrics have been retained from the previous year:

- Emergency hospital admissions
- Permanent admissions to residential care
- Delayed transfers of care
- Effectiveness of reablement

The following metrics are no longer being collected nationally through the BCF:

- User experience measure
- Locally selected metric – Hospital bed days arising from emergency admissions of patients aged 75+

Appendix 3 summarises the target levels for the national BCF metrics and current performance against those metrics

Appendix 1 – extract from " Integration and Better Care Fund planning requirements for 2017-19"

Escalation and use of Direction Powers

98. In the event that:

- Signatories to a plan are not able to agree and submit a draft plan or:
- The Health and Well-being Board do not approve the final plan; or
- Regional assurers rate a plan as 'not approved'.

The Better Care Support Team, in collaboration with the relevant Better Care Manager, will commence an escalation process to oversee the prompt agreement of a compliant plan.

99. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. Senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to an Escalation Panel meeting to discuss concerns and identify a way forward.

100. The escalation process will involve the following steps.

1. Trigger - following failure to submit a plan, or a decision not to approve a plan during assurance	The Better Care Support Team in consultation with the BCM will consider whether a plan should be escalated. If escalation commences, a formal letter will be sent, setting out the reasons for escalation, consequences of not agreeing a plan and informing the parties of next steps, including date and time of the Escalation Panel
2. Escalation Panel	The Escalation Panel will be jointly chaired by DCLG and DH senior officials with representation from: - NHS England - LGA/ADASS - Better Care Support Team Representation from the local area needs to include the: - Health and Wellbeing Board Chair - Accountable Officers from the relevant CCG(s) - Senior officer/s from LA The Escalation Panel meeting is the opportunity to use national and local insight to consider the planned approach being put forward by the parties to the BCF plan to deliver a compliant plan and agree actions and next steps, including whether support is required. It is expected that in line with the principle of 'no surprises', issues will have been raised through ongoing relationships with Better Care Managers, NHS England regional offices and local government regional peers.
Formal letter and clarification of agreed actions	The local area representatives will be issued with a letter, summarising the Panel meeting and clarifying the next steps and timescales for submitting a compliant plan. If support was requested by local partners or recommended by the Panel, an update on what support will be made available will be included.

4. Confirmation of agreed actions	The Better Care Manager will track progress against the actions agreed and ensure that a locally agreed plan is submitted within the agreed timescale for regional assurance. Any changes to the timescale must be formally agreed with the Better Care Support Team.
5. Consideration of intervention options	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: Agreement that the panel will work with the local parties to agree a compliant plan Appointment of an independent expert to make recommendations on specific issues and support the development of an agreed plan – this might be used if the local parties cannot reach an agreement on certain issues. Appointment of an advisor to develop a compliant plan, where the panel does not have confidence that the area can deliver a compliant plan The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

101. The Escalation Panel members will consider all relevant information, including financial and performance issues. This could include:

- Wider financial context, such as whether the LA has taken sufficient action to protect its funding for social care – including, but not limited to, making use of precepting powers, the balance of financial risk between parties and appropriate use of reserves;
- Whether all financial commitments mandated in the BCF have been met, including passporting of Care Act funding, funding for social care managed reablement and carers' breaks;
- Whether the agreed transfer to social care from CCG minimum contributions represents a real terms maintenance of allocations. This will also include consideration of transfers prior to the establishment of the BCF

102. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DH and DCLG ministers, (as required under the 2017-18 NHS Mandate), with the final decision then taken by NHS England. In accordance with the legal framework set out in section 223GA of the NHS Act 2006 (as amended by the Care Act 2014), NHS England powers are only applicable to the minimum contribution from CCG budgets set out in the policy framework.

The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG or IBCF. This money is not subject to NHS England powers to direct. A BCF plan will not be approved, however, if the IBCF or DFG grant conditions are not met. Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

Appendix 2 – services funded through the BCF in 2016/17

Service	Responsible Commissioner	
	CCG	Authority
Providing proactive care and avoiding unplanned admissions	723	
End of Life Care	314	
Community-based support, including Carepoint; reablement; immediate response and overnight care; adaptations and loan equipment service		7,013
Seven day social work		63
Liaison Psychiatry	212	
Carers Support		560
Intermediate Care Beds	4,493	
Intermediate Care - community services[1]		58
The Cedars		1041
Independent Supported Living for people with learning disabilities		600
Improving access to advice and information		50
Care Act implementation		597
Total of pooled fund	**5,742**	**9,982**
Non Pooled -Disabled Facilities Grant		1,307
TOTAL	**5,742**	**11,289**

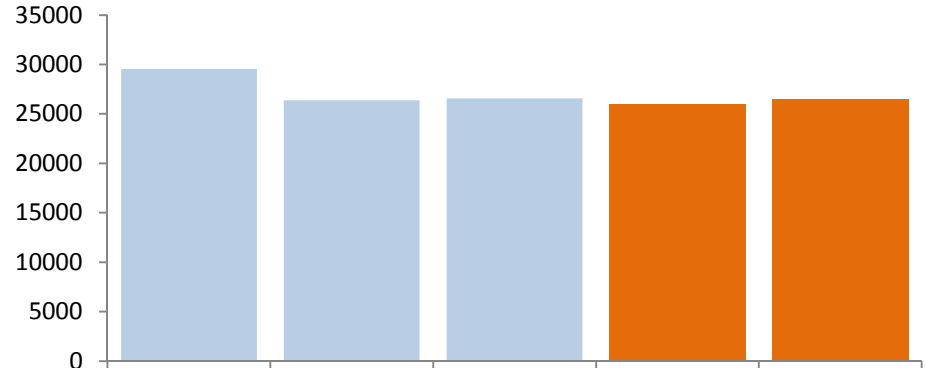
[1] In addition to this figure, there will be a non-recurrent payment of £45,000 in 2017/18 to reflect a deferred element of the total service cost, and a recurrent full year cost of £414k

Appendix 3 – BCF metrics

A Emergency hospital admissions

Figure 1 below shows the year-on-year trend in emergency hospital admissions and the planned trajectory for 2017/18 and 2018/19.

Figure 1

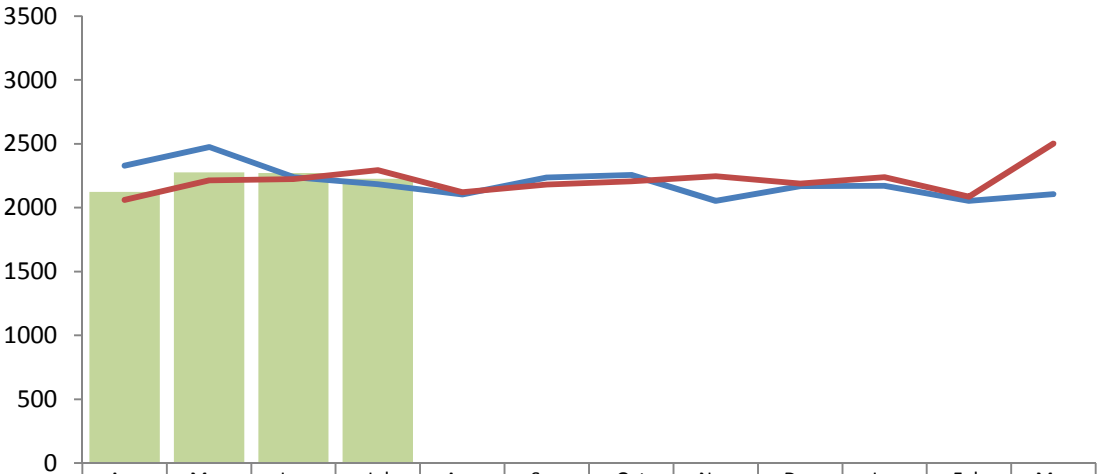


	2014/15	2015/16	2016/17	2017/18 plan	2018/19 plan
Non-elective emergency admissions	29557	26372	26562	25949	26526

- There were 26,562 emergency admissions in 2016/17. This was 190 more than the previous year, an increase of 0.7%.
- The BCF plan called for a reduction in emergency admissions to 26,172; hence the outcome was 1.5% above the plan.
- Across England, there was a 2.3% increase in emergency admissions over the same time period.
- The plan for 2017/18 calls for a reduction of 2.3% compared to the 2016/17 outturn

The latest monthly data is shown in Figure 2 below.

Figure 2



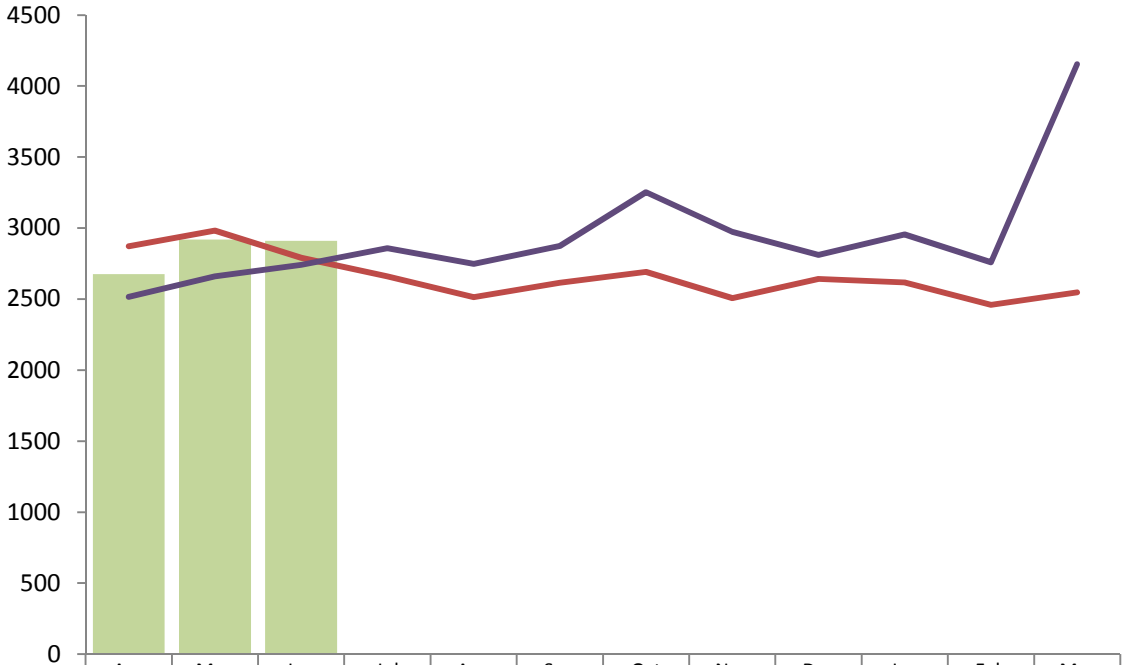
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18 actual	2123	2277	2271	2225								
2015/16 actual	2328	2473	2238	2184	2102	2237	2257	2054	2169	2171	2053	2106
2016/17 actual	2060	2214	2224	2294	2120	2182	2207	2247	2188	2239	2086	2501

- In April 2016-July 2017 there were 8,792 emergency hospital admissions
- This increased to 8,896 in April 2017-July 2017, an increase of 1.2%

The official BCF measure of emergency hospital admissions does not include all elements of urgent activity which impact on hospital workload or NHS costs; for example it does not include ambulatory care.

Figure 3 below does include ambulatory care; using this definition it is apparent that the increase in emergency hospital activity is greater than that shown by the BCF data alone.

Figure 3



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	2675	2919	2910									
2015/16	2872	2982	2791	2659	2514	2615	2692	2507	2642	2617	2460	2547
2016/17	2516	2659	2741	2859	2748	2875	3253	2973	2812	2955	2760	4153

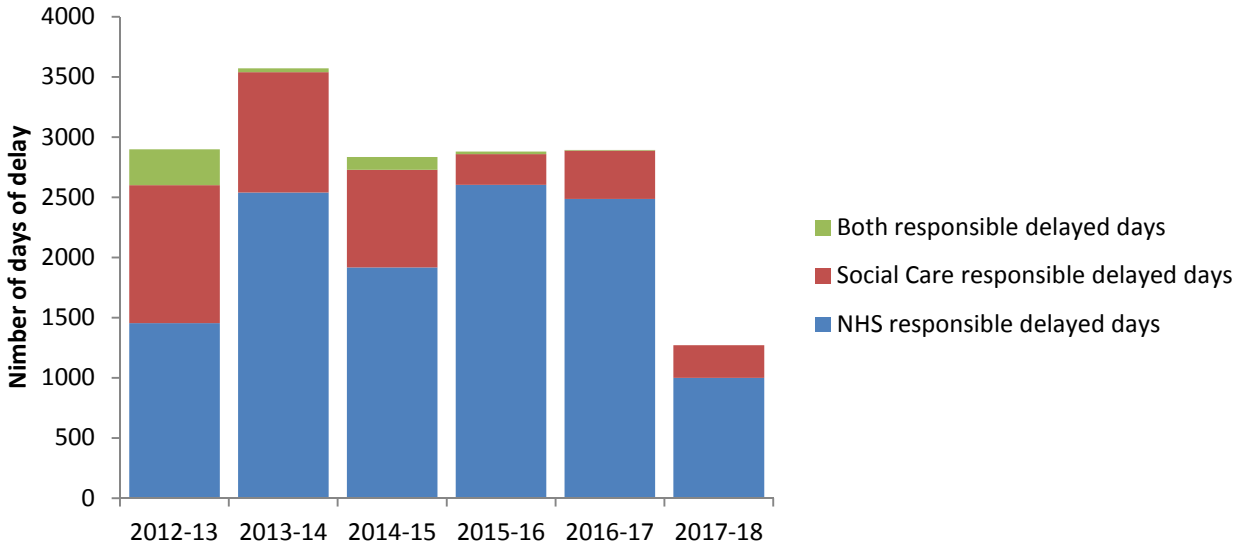
- In April 2016-June 2017 there were 7,916 emergency admissions including ambulatory care.
- This increased to 8,504 in April 2017-Jun 2017, an increase of 7.4%

B Delayed transfers of care (DTOC)

Figure 4 overleaf shows the year-on-year trend of the number of days of delay, which fell in 2014-15 and have stayed approximately level since then, despite a national increase of around 23% in 2016/17.

Note that the numbers are the total days of delay, not the number of delayed patients. 2017/18 is of course a part-year measure.

Figure 4



The level of delays in North Tyneside is in the best 10% of HWB areas in England.

The Department of Health have set very challenging targets for reductions in the levels of delay. These targets are expressed in delayed days per 100,000 patients:

Total delayed days per day. Per 100,000 population aged 18+)	Baseline Feb-April 2017	Target November 17-March 2018
NHS responsible	3.5	3.4
Social care responsible	0.4	0.2
Both responsible	0	0
Total	4.0	3.5

These ambitions are reflected in our BCF plan and we will aim to achieve them, whilst noting the following risks to delivery:

a) North Tyneside has a very low starting point – the ninth lowest rate in England – which reflects the adoption of best practice over many years, leaving less opportunity available for further reductions.
b) Only 16% of our delays are social care responsible and yet the national ambition proposes that 50% of the desired improvement comes from social care.
c) Despite a generally low level, there have been an increased number of delays from April-June 2017, which reflects the growing level of acute hoospital activity, and the fragile state of the social care provider market.

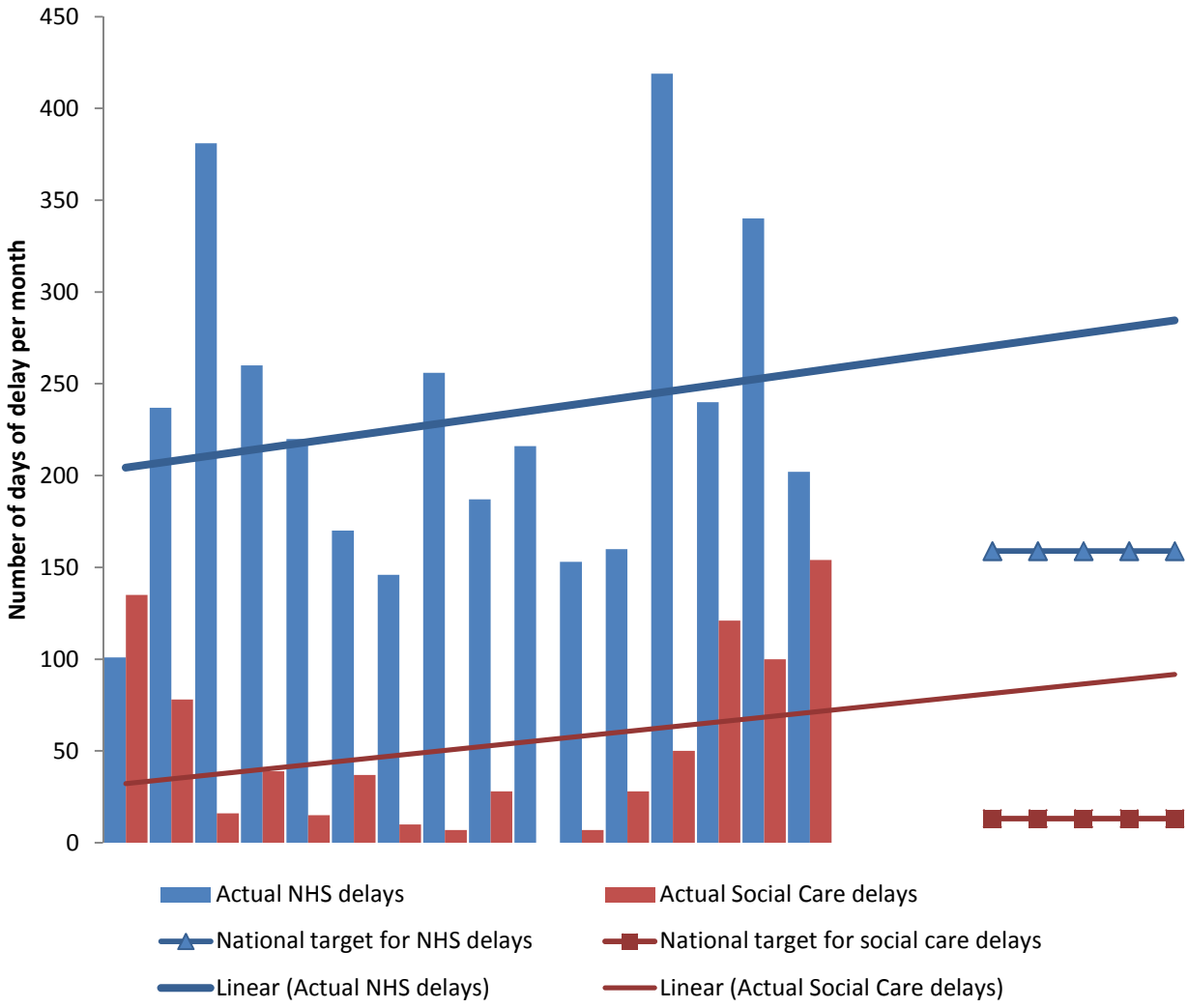
Whilst the level of delays in North Tyneside are relatively low, we are committed to maintaining them at that low level and to seek further reductions

Figure 5 shows North Tyneside performance since April 2016 and the national target for the period November 2017-March 2018.

Study of the graph suggests:

- The trend for both NHS-responsible delays, and social-care delays, is moving up rather than down.
- In particular there has been a rising trend for social-care delays from April-July 2017.
- In order to meet the national targets between November 2017-March 2018, it would be necessary to consistently match the best monthly levels of performance that were achieved in 2016/17.

Figure 5



C Effectiveness of reablement

The target for the number of patients at home 91 days after discharge from hospital to reablement remains at 93.1%. Current performance is marginally below at 92%. In 2015/16 the England average was 82%.

D Permanent admissions to residential care

Our BCF trajectory is for a rate of permanent admissions to residential care, per 100,000 persons aged 65+, of 739, which would equate to 300 admissions per annum. In Q1 there were 75 admissions, which is on target for 300 per year.