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Leeds Health & Wellbeing Board

Report of: **Dennis Holmes, Deputy Director Commissioning (ASC)**

& Matt Ward, Chief Operating Officer (LSE CCG)

Report to: **Leeds Health & Wellbeing Board**

Date: **22nd October 2014**

Subject: **Better Care Fund (BCF) Update**

Are there implications for equality and diversity and cohesion and integration?	X Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	X No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	X No

Summary of main issues

- National guidance for the BCF came out at the end of 2013. Central government intended the fund to radically speed up integration to provide better care. It is important to note that there is no new money attached to this ambition, and that the creation of the BCF requires over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive and community services.

- The last formal report regarding the BCF was brought to the Health and Wellbeing Board in March. The paper provided an update on the original draft BCF submission that had been prepared at the time and provided an update on the work that was being undertaken prior to the 'final' original submission on April 4th. Since the report in March, Leeds has submitted two further BCF submissions each building on the previous.

- This current report to the Health and Wellbeing Board, provides an update on the latest position with the BCF and what work will be undertaken prior to the official BCF 15/16 live year.

- Leeds has an excellent track record in integration of health and social care, both in terms of service delivery and commissioning. The city has been successful in becoming one of only 15 national Integrated Health and Social Care Pioneers, recognising Leeds' innovative practice in this area. Accordingly, Leeds has been in a strong position to develop a robust and effective Better Care Fund plan, and was identified as a potential national exemplar area in July 2014.

- The BCF proper is due to go live in 2015/16, and learning from the shadow year will be invaluable in moving this forward a pace. Furthermore, Leeds will continue to explore how partners across the city can use the opportunity presented by the BCF to derive maximum benefit from the Leeds £, in order to deliver the shared ambition of a high quality and sustainable health and social care system.

Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress on the BCF in Leeds to date:
    - That the most recent version of the BCF template was submitted on 19 September 2014.
    - That Leeds has established 2014/15 as a shadow year of the Better Care Fund through putting in place “pump-priming” arrangements ahead the first official BCF year in 2015/16.
    - That a number of schemes have been worked up to varying degrees of detail, as set out in the report.
- Note that work will continue throughout 2014/15:
    - To fully articulate the cost benefit of the individual schemes of the BCF with a view to their inclusion in 2015/16
    - To put in place robust management and governance processes through the Transformation Board programmes and a Section 75
- Note we are considering other joint commissioning arrangements through the Integrated Commissioning Executive as part of our wider ambition for a high quality and sustainable health and care system for the city.
- Note the increased financial risk associated with the revised payment-by-performance element of the fund which only relates to a reduction in all non-elective admissions. Whilst this provides greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction, it potentially adds additional risk and reduces the flexibility of the fund to develop community services if the reduction is not delivered.

1 Purpose of this report

1.1 This paper provides: an update to the paper presented to the Health and Wellbeing Report on 12 March 2014 of the progress made and an overview of the latest position with regards to the BCF.

2 Background information

'History' of the Better Care Fund

2.1 The Better Care Fund, a £3.8 billion pooled budget (originally named the Integration Transformation Fund), was announced as part of the Spending Round in June 2013. Central government said that: "the end goal is radical transformation to provide better care" with integrated care "the norm" by 2018. It is important to note that this did not represent new money, and that the creation of the BCF requires over £2bn in savings to be made on existing spending on acute care in order to invest more in preventive and community services.

2.2 The pooled budget will only be released to local areas from in 2015 with agreed plans for how it will be used which meet five "national conditions":

1. Protection for social care services (not spending)
2. 7 day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
3. Better data sharing between health and social care, based on the NHS number ensure a joint approach to assessments and care planning
4. Where there are integrated packages of care, an accountable lead professional
5. Agreement on the consequential impact of changes on the acute sector.

2.3 There are also five national measures to demonstrate progress towards better integrated health and social care services:

1. Admissions to residential and care homes;
2. Effectiveness of reablement;
3. Delayed transfers of care;
4. Total emergency admissions replaces the original metric of avoidable emergency admissions; and
5. Patient / service user experience.

And one locally determined measure:

1. Rate of diagnosis for people with dementia

Implementing the Better Care Fund

2.4 In order to manage the BCF locally, the total fund has been divided into schemes that represent existing and well-established commissioned services through recurrent funding, and schemes that provide further "invest to save" opportunities through use of non-recurrent funding. The schemes are framed via three key themes which articulate delivery of the outcomes of the Leeds Joint Health and Wellbeing Strategy, in particular the

commitment to “Increase the number of people supported to live safely in their own homes”:

- Reducing the need for people to go into hospital or residential care
- Helping people to leave hospital quickly
- Supporting people to stay out of hospital or residential care.

2.5 Additionally, the BCF schemes will support delivery of programmes as part of Health and Social Care Transformation, including Effective Admissions and Discharge and Urgent Care.

2.6 2014/15 is being used as a shadow year to “pump prime” the Better Care Fund proposals. As the BCF does not come into being until 2015/16, in 2014/15 the funding allocations for the recurrent schemes will not actually be transferred into the BCF until the following year.

2.7 Many of the “pump-priming” schemes have been allocated funding in 2014/15 to scope and develop robust business cases that will evidence, as far as possible, return on investment, anticipated shift in activity and impact on the acute sector. Locally, “pump-priming” funding was identified for 2014/15 through non-recurrent monies.

2.8 This approach effectively allows us to undertake a year-long planning exercise, enabling us to test out assumptions, develop robust and accurate evidence of benefits and provide an agile and flexible response to the key question of “is this individual scheme working for Leeds?”. This will also allow us to further develop schemes proposed for 2015/16 and take forward pilot schemes from 2013/14 which have evaluated successfully as well as test out governance and programme management arrangements.

2.9 Equally, it will be essential to establish whether schemes funded in 2014/15 will be able to demonstrate a return on investment before further funding is released for 2015/16 and this will be closely monitored. This is so we can accurately model and monitor once the BCF goes live in 2015/16 and ensure we are investing the full fund into the right schemes that will meet our objectives. If schemes cannot demonstrate a return on investment through the business case development phase, they will be withdrawn from the BCF.

2.10 Leeds has chosen to take this approach to make sure it is in the strongest position possible to benefit from the BCF in 2015/16 and answer the wider question *“is the BCF working for Leeds?”*.

2.11 The BCF in Leeds is made up of:

	Contribution (£000)	
	2014/15	**2015/16**
Leeds City Council (Pump priming, Disability Facilities Grant, Social Care Grant)	5,000	4,802
Total Local Authority Contribution	**5,000**	**4,802**
NHS Leeds North CCG		12,665
NHS Leeds South and East CCG		17,351
NHS Leeds West CCG		20,105
NHS England transfer	2,759	
Total CCG Contribution	**2,759**	**50,121**
Total Contribution	**7,759**	**54,923**

3 Main issues

Overview of the financial challenge facing Leeds

3.1 In Leeds, the recent financial modelling exercise (carried out as part of the development of the CCG five year strategy) estimated that there are budget pressures across the system of approximately £135 million in 15/16, rising to £633m over the next five years across the health and social care system, if no action is taken. It is estimated that all provider organisations in Leeds spend around £2.5bn a year on services. As the total local health economy budget is £1.7bn per annum then this deficit equates to approximately 7.3% of the overall budget.

3.2 With its size, ambition and health and wellbeing assets, Leeds has the ability to lead the way for healthcare delivery. Whilst doing so, the city faces a number of health challenges commensurate with its size, diversity, urban density and history. The concept of the Leeds £ helps to explain how making best use of our collective resource is the approach that is needed to address these challenges. In this context, the financial challenge will need to be met in a number of different ways. Individual organisations will continue to seek further efficiencies in the way that services are delivered; partners will also continue to deliver savings and efficiencies through the city's overall Transformation Programme arrangements, of which the BCF forms a part.

3.3 It is important to recognise that the BCF plans are only one part of the whole transformation of the health and social care system and as such the individual schemes contribute towards a much broader ambition in relation to savings. Whilst we have committed to the BCF process which amounts to £55m in Leeds, this represents only 3% of our total "Leeds £" revenue budget. As such, we will continue to look at further joint commissioning as part of our wider ambition for a high quality and sustainable health and care system.

National changes

3.4 Also on July 28th, a further set of templates and guidance were issued to all areas by NHS England. The templates were accompanied by a joint letter from the Department of Health and the Department of Communities and Local Government which set out the revised plans for the BCF nationally. This letter confirmed that:

> *"We remain convinced that the shift to integrated care is the right way to deliver a sustainable health and social care system that can provide better quality care and improve outcomes for individuals. That is the way we can preserve people's dignity by enabling them to stay in their own homes, and to receive care and support when and where they want and need it. That is why the Government remains fully committed to the Better Care Fund and are clear that pooled health and care budgets will be an enduring feature of future settlements".*

3.5 For fast track areas, this meant a third set of templates and guidance (each different to the previous) to complete. Leeds was asked whether it wished to continue to be part of the fast track process, which in effect meant that Leeds would have to resubmit its BCF plans by 29th August but could request some additional support to assist with addressing gaps. A decision was taken by accountable officers and in consultation with Members and the Deputy Chief Executive of Leeds City Council, that given the extremely tight deadlines and the fact that key resources were on leave over the period, Leeds would work to the national submission date of 19th September.

3.6 The national position on a 'pay for performance' element has changed several times over the course of the year from including it in the guidance, to then excluding it to, finally, reinstating it, but with a much narrower focus on the reduction of non-elective (emergency) admissions.

3.7 At the time of writing this report the latest guidance available stated that: "Health and Wellbeing Boards are invited to agree a target reduction in total emergency admissions. The funding corresponding to any reduction forms one element of the pay for performance fund. The outstanding balance will be spent by CCGs on 'NHS commissioned out-of-hospital services' as part of the BCF plan".

3.8 For the proportion of the £1bn funds linked to a reduction in total emergency admissions, money will be released from the CCG into the pooled budget on a quarterly basis, depending on performance. These payments start in May 2015 based on Quarter 4 performance in 2013/14. The remaining proportion of the £1bn will be released to the CCG upfront in Quarter 1 in 2015/16. If the locally set target is achieved then all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. If the target is not achieved, then the CCG will retain the money proportional to performance, to be spent by the CCG in consultation with the Health and Wellbeing Board. The expected minimum target reduction in total emergency admissions will be 3.5% for all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower. All areas can set more ambitious targets should they wish, and the amount of funding linked to performance will increase accordingly. The expected reduction in costs associated with the reduction in non-elective admissions is £3.5m for the calendar year 2015.

3.9 It is important to note that the local target and resulting funding linked to total emergency admissions will be based on the total figure for the whole Health and Wellbeing Board area, not just to the portion resulting from BCF schemes.

3.10 All plans will be expected to clarify the level of protection of social care from the £1.9bn NHS additional contribution to the BCF, including that at least the element related to the £135m has been identified nationally for implementation of the Care Act.

3.11 The Leeds Health and Social Care economy is committed to the protection of Adult Social Care Services. There is an understanding across health and social care partners of the critical contribution that social services make to reducing admissions and re-admissions, reduce delayed discharges and reduce length of stay in hospitals. There is also common understanding within the health and social care community of the very challenging financial context within which adult social care services is required to operate. Notwithstanding the increasing inflation, demand and demographic growth and other pressures being faced by Councils in maintaining Social Care Services, these continue to be experienced within the context of significant ongoing funding reductions for local government.

3.12 The approach to the use of the Better Care Fund in Leeds has been to free up resources for invest to save proposals to support the delivery of a high quality and sustainable health and social care system for the future. It has not been our approach to utilise this investment to meet current demand/demographic pressures and funding reductions experienced by Social Care. For full details on the city's approach to the protection of Adult Social Care services, please see page 36 of the final BCF submission.

Leeds' submissions to date

3.13 On April 4th, Leeds submitted its 'final' BCF plans in line with national guidelines. Since then, very little feedback was received until July 1st when Leeds was named as one of 15 health and wellbeing areas whose BCF submissions were identified as an 'exemplar'. This meant that Leeds' submission was considered to be one (with some refinement) that could be presented to the other areas as well on the way to meeting the national requirements for BCF plans. On July 9th, following an intense week, Leeds submitted a revised version of its BCF template.

3.14 EY (formerly known as Ernst and Young) was commissioned by NHS England to undertake a review of the Leeds' July submission. Official feedback received on July 28th indicated that out of the original 15 fast track areas identified, only 11 continued with the process - 4 having dropped out part way through. Leeds' submission was ranked as 7th out of the 11 plans which were resubmitted. The feedback specifically from EY gave a fair review of Leeds' submission and the progress Leeds has made to date on developing a robust BCF plan. A number of aspects were identified as 'good' along with recommendations for improving the submission.

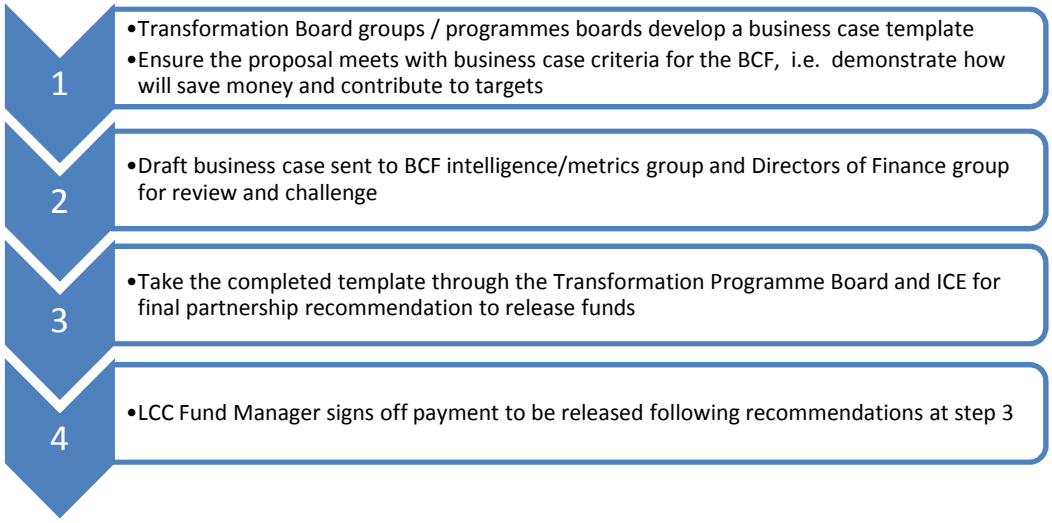
3.15 The Task and Finish group (resourced via ICE and the Directors of Finance forum) have used the EY review to inform the final re-submission on 19th September.

3.16 Leeds has received initial feedback from our 19th September from Deloitte who have been commissioned by NHSE to review Leeds' BCF plans with full feedback expected at the end of October. In this initial feedback described the Leeds bid as 'strong' and scored well against local and national peers. There was only one stand out deficit, regarding our data sharing arrangements, however, Leeds will be provided with what advice on how this can be rectified.

BCF schemes

3.17 The following section provides detail of the individual schemes that constitute the BCF in Leeds. Appendix A provides a complete list of currently identified BCF schemes, it is important to note that not all of these schemes have been given final approval with some currently working up detailed business cases.

3.18 In order for a scheme to be considered and funding to be released, scheme leaders need to submit a robust business case setting out anticipated outcomes for their scheme, following the process below:



3.19 The pump-priming schemes fall into three categories, as detailed below:

A. Taking forward programmes which began in 2013/14, costing and outcomes already known through previous evaluation

B. Further development and piloting of new proposals ahead of 2015/16 to ensure outcomes for both return on investment and improved quality of experience will be achieved

C. Scoping what a proposal for a particular pathway or area of work could look like and what outcomes can be achieved to allow a full business case to be developed and costed ready for implementation in 2015/16.

3.20 2014/15 schemes are at various stages in this process:

- It has been agreed via ICE and the Task and Finish Group that 4 schemes will be fully or partly funded immediately.
- Several B schemes have submitted a first draft of their business case, which has been reviewed by the Task and Finish Group and is with scheme leaders for further refinement.
- Other B schemes are still in the process of developing their initial business case for funding release in 2014/15.
- Category C schemes have already or are in the process of developing “light touch” business cases, reflecting that undertaking these schemes will inform full and detailed business cases for initiatives in 2015/16.

Scheme Type	Scheme title	Agreed 14/15 Spend (£000)	Proposed 15/16 Spend (£000)	Return on Investment (£000)
A	Expand community intermediate care beds a) CIC beds b) Bed bureau 7 days d) Homeless pathway	a) 600 b) 50 d) 240 **TOTAL 890**	a) 600 b) 50 d) 240 **TOTAL 890**	a) + b) 900 d) 253 **TOTAL 1,153**
A	Enhancing integrated neighbourhood teams a) Equipment service b) EDAT g) Int. geriatrician	a) 130 b) 300 g) 200 **TOTAL 630**	a) 130 b) 300 g) 200 **TOTAL 630**	a) 0 b) 1,200 g) 0 **TOTAL 1,200**
A	Information technology a) I.G. b) Improved B.I. c) Prog management d) Leeds Care Record	a) 60 b) 370 c) 85 d) 450 **TOTAL 965**	1,800	TBC
B	Eldercare Facilitator	188	565	500 (over 2 yrs)
C	Medication prompting – Dementia	50	320	TBC (following further scoping)
C	Falls	50	500 (TBC following scoping)	TBC (following scoping)
B	Expand community intermediate care beds c) EoL nurse beds	c) 0	c) 500	c) TBC
B	Enhancing integrated neighbourhood teams c) Discharge facilitator d) Home Care e) Comm matron f) Comm. Nursing – EoL	c) 86 d) TBC e) 450 f) 350 **TOTAL 886**	c) 260 d) TBC e) 1,500 f) 1,200 **TOTAL 2,960**	c) TBC d) TBC e) 3,000 f) 1,900 **TOTAL 4,900**
C	Urgent care services	50	TBC	TBC
C	Workforce planning & development	80	80	TBC
	TOTAL	3,789	8,245	

3.21 In essence, the combined effect of these schemes should be to shift activity from acute care to community and social care services. Following modelling work, it has been

estimated that the sum effect will be to reduce emergency hospital admissions by approximately 2300 in 2015/16 compared to 2014/15. If successful, this will free up the funds to enable the BCF to be funded recurrently and support the city to achieve it's target reduction of emergency admissions by 3.5%.

Next steps

3.22 Undertake a review of all scheme business cases to ensure that they are robust and undertake any necessary actions to ensure that they are robust and can be approved by the necessary boards.

3.23 Agree the S75 arrangements for fund

3.24 Build on the current work to further develop and refine the governance and monitoring framework and processes for the BCF so that it can be transferred from the BCF Task and Finish Group to being managed 'day-to-day' by the Transformation Board.

3.25 Ensure that each accountable officer understands their responsibilities as accountable officer for their schemes.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Following on from the submission of the first draft of the BCF, HealthWatch Leeds has led a rapid consultation with the public, using both face-to-face and social media approaches, to test out and support further development of proposals. The results of this consultation tell us that, overall, the proposals set out for Leeds' Better Care Fund were supported. A number of proposals particularly resonated, including Eldercare Facilitators, Enhancing Integrated Neighbourhood Teams and reducing emergency admissions through a case management approach to urgent care. Other findings on the proposed schemes will be used to inform development work going forwards.

4.1.2 A more in-depth consultation process with service users/patients on an individual scheme basis (where appropriate) is anticipated for later in 2014/early 2015. This will shape and develop the detail and delivery of the new schemes and will be aligned to transformation work. In particular, engaging with service users/patients is likely to play a key role in the scoping and development activity we will be funding through identified "pump-priming" monies in 2014/15 as per the "supplementary information".

4.1.3 In terms of the wider context of our plans for integrated care in the city within which the BCF sits, patients, service users and the public have played, and will continue to play, a key role in its development. Building on the National Voices consultation, local patient/service user voices of all ages have been used to frame the Leeds vision for person-centred care: "Support that is about me and my life, where services work closer together by sharing trusted information and focussing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect".

4.1.4 Finally, the NHS Call to Action and development of our 5 year CCG strategy has provided us with an additional platform to further strengthen our engagement with the public more broadly. The concept of investing in social care and integrated care to reduce demand on urgent and acute care is being promoted in the city and is actively discussed at patient and public forums.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 Through the BCF, it is vital that equity of access to services is maintained and that quality of experience of care is not comprised. Given that 'improving the health of the poorest, fastest' is an underpinning principle of the JHWBS, consideration has been given to how the schemes within the BCF will support the reduction of health inequalities.

4.3 Resources and value for money

4.3.1 The context in which this paper is written has indisputable implications for resources and value for money given the city is facing significant financial challenges in relation to the sustainability of the current model for the health & social care economy in Leeds. Whilst the BCF does not bring any new money into the system, it presents the opportunity to further strengthen integrated working and to focus on preventive services through reducing demand on the acute sector.

4.3.2 As such, the current local approach is to use the BCF is to derive maximum benefit to meet the financial challenge facing the whole health and social care system over the next five years, whilst recognising this represents only 3% of the total Leeds £ spend on health and social care.

4.3.3 It is imperative that the Leeds £55m is spent wisely in order to deliver as much value as possible to address the significant financial challenge set out earlier in the paper. There is a strong commitment from leaders in the city to work together through the Health and Wellbeing Board, the Transformation Board and ICE, to do so.

4.4 Legal Implications, Access to Information and Call In

4.4.1 This report is for information only.

4.5 Risk Management

4.5.1 Two key overarching risks present themselves, given the tight national timescales for the development of the jointly agreed plans and the size and complexity of Leeds:

- Potential unintended – and negative – consequences of any proposals as a result of the complex nature of the Health & Social Care system and its interdependencies.

- Ability to release expenditure from existing commitments without de-stabilising the system in the short term within the limited pump priming resource will be extremely challenging as well as the risk that the proposals do not deliver the savings required over the longer-term.

4.5.2 The effective management of these process risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the delivery of these plans to support the agreed future vision. The governance arrangements being put in place will also help to reduce the likelihood of any risk developing into an issue.

4.5.3 The implications of the recent announcement around the treatment of the performance element of the Better Care Fund are being worked through with full guidance still outstanding. This will provide greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction with this funding for acute to come from the performance element of the BCF. This does not change the approach of the Leeds BCF towards the wider system objectives (which always included admission avoidance as one of the key metrics) but potentially adds additional risk and

reduces the flexibility of the fund if the reduction is not delivered. This needs to be mitigated by ensuring delivery of the BCF schemes.

4.5.4 Risks associated with the BCF plan itself are being managed in line with recognised project methodology and a summary risk log has formed part of the submission.

5 Conclusions

5.1 This report has provided an overview of the current position with regards to the BCF. Leeds is in a strong position to deliver the BCF. In the time period before the 15/16 go-live is crucial in ensuring that the work currently underway to develop the governance framework and processes continues and is fully supported by the Health and Wellbeing Board, Transformation Board and ICE. It is crucial that all scheme business cases are robust and that each accountable officer is responsible for the successful delivery of their scheme.

6 Recommendations

The Health and Wellbeing Board is asked to:

- note the progress on the BCF in Leeds to date:
    - That the most recent version of the BCF template was submitted on 19 September 2014.
    - That Leeds has established 2014/15 as a shadow year of the Better Care Fund through putting in place “pump-priming” arrangements ahead the first official BCF year in 2015/16.
    - That a number of schemes have been worked up to varying degrees of detail, as set out in the report.
- Note that work will continue throughout 2014/15:
    - To fully articulate the cost benefit of the individual schemes of the BCF with a view to their inclusion in 2015/16
    - To put in place robust management and governance processes through the Transformation Board programmes and a Section 75
- Note we are considering other joint commissioning arrangements through the Integrated Commissioning Executive as part of our wider ambition for a high quality and sustainable health and care system for the city.
- Note the increased financial risk associated with the revised payment-by-performance element of the fund which only relates to a reduction in all non-elective admissions. Whilst this provides greater assurance to the acute setting around payment for non-elective activity if the BCF does not deliver the expected reduction, it potentially adds additional risk and reduces the flexibility of the fund to develop community services if the reduction is not delivered.