Leeds Health & Wellbeing Board

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Report of: Chief Officer Resources and Strategy – Adult Social Care & Chief Operating Officer - Leeds South and East CCG

Report to: The Leeds Health and Wellbeing Board

Date: 20 January 2016

Subject: Better Care Fund Update

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

Summary of main issues

The Leeds Better Care Fund schemes are now live. A robust structure of reporting and oversight has been embedded, with effective participation from stakeholders across the city. The Governance arrangements are defined within a 'Partnership Agreement', with Health and Wellbeing Board responsible for Strategic Oversight of the BCF.

Health and Wellbeing Boards are required to provide a report to NHS England on the performance of their Better Care Fund on a quarterly basis. The Quarter 2 2015/16 submission is provided at **appendix 1** of this report.

Non-elective hospital admissions are the only BCF metric with a direct associated payment for performance mechanism. Non-elective admissions have not attained the Q2 BCF target. Cumulatively to date a slight reduction against the baseline has been achieved since Q4 14/15 and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year.

BCF Partnership Board have approved spend on seven schemes not included in the original approved 15/16 BCF Plan. These schemes will be resourced from forecast underspend/slippage. At the time of this report, a net financial underspend/slippage of circa £881,792 is forecast against the approved £54,923k BCF plan.

Planning for BCF in 16/17 is under way. It is likely that an increase of circa £5.5million in the contingency fund (prompted in a change in the contract tariff rate) will necessitate corresponding reductions in the size of the fund made available to support 'non-recurrent' schemes next year.

Following receipt of national guidance, a detailed BCF Plan for 16/17 will be finalised and presented to Health and Wellbeing Board for approval.

Recommendations

The Health and Wellbeing Board is asked to note the contents of this report

1 Purpose of this report

1.1 The schemes delivered though the BCF in Leeds are aligned with the outcomes of the Leeds Joint Health and Wellbeing Strategy. This report provides a concise overview on the current implementation of the programme and also provides visibility of the Quarter 2 BCF reporting submission which has been made on behalf of the Health and Wellbeing Board.

1.2 This report also summarises current guidance relating to BCF in 2016/17 and beyond.

2 Background information

2.3 The Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to deliver transformation in integrated health and social care. It creates a local pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

2.4 Leeds' BCF plans were given final approval by NHS England on 31st December 2014. As of 1st April 2015 the Leeds BCF schemes for 2015/16 are live.

2.5 A background paper providing a concise introduction to the Better Care Fund, including measures and objectives was provided at appendix 2 of the BCF report presented to Health and Wellbeing Board in September 2015.

2.6 The Leeds BCF Plan includes a targeted 3.5% reduction in the number of non-elective hospital admissions. A payment for performance mechanism is in place which (in 15/16) will release up to £2million into the Better Care Fund (for re-investment) or to the acute hospital trust depending on the extent to which this 3.5% reduction target has been met.

2.7 Leeds Better Care Fund comprises two distinct pooled funds (supported by non-pooled, nominal funds), with one fund hosted by Leeds Council and one by the CCGs – all under an overarching partnership governance structure which is led by the 'BCF Partnership Board' which is a sub-group of the Integrated Commissioning Executive (ICE).

2.8 The Leeds Better Care Fund in 15/16 is delivering existing commissioned services through recurrent funding, and schemes that provide further "invest to save" opportunities through use of non-recurrent funding. The Better Care Fund does not represent new money.

2.9 The governance structure which oversees the delivery of Leeds BCF plans is set out within a Partnership Agreement – based upon a national template. The arrangements have been designed to accommodate existing structures as far as possible.

2.10 In accordance with national legislation and guidance, the Leeds Health and Wellbeing Board are responsible for strategic oversight of the Better Care Fund.

3 Main issues

Performance

3.11 Health and Wellbeing Boards are required to return a BCF data collection template to NHS England on a quarterly basis. The Quarter 2 BCF submission was returned in accordance with the 27th November deadline, and was circulated to HWB members prior to submission. The Quarter 2 template includes:

- confirmation that national conditions are being met;
- planned, forecast and actual income and expenditure figures;
- reporting on non-elective admissions (and resultant implications for the payment for performance mechanism);
- reporting on other defined BCF measures (admissions to residential care, reablement, dementia diagnosis and patient experience);
- preparations for BCF 16-17;
- reporting of 3 new integration metrics (integrated digital records, risk stratification, personal health budgets); and
- narrative on overall progress in delivering the Better Care Fund plan.

3.12 The national reporting template has been designed to fulfil local and national BCF reporting obligations against the key requirements and conditions of the Fund. The template is however structured as a data collection tool so is not conducive to printing or reviewing on screen.

3.13 The Leeds response is therefore replicated in 'word' format, and is provided at **Appendix 1** for information. The narrative response contained on page 1 of the Appendix presents a broad overview of the current status of the delivery of the Leeds BCF Plan, and is replicated below:

> A robust structure of reporting and oversight has been embedded, with effective participation from stakeholders across the city.
>
> In recent months, a number of priority schemes have been approved for delivery this year, to be resourced from slippage arising from a number of the planned BCF schemes (as reported in Q1). These additional schemes are listed below. All of which have been through a robust governance and approvals process to ensure they fulfil BCF criteria:
>
> - High Volume Service Users
> - Additional Community Beds
> - Falls Response Service
> - Discharge to Assess
> - Assisted Living Leeds Innovation 'pop-up'
> - Informatics – map of medicine
> - Informatics – digital literacy
>
> Work is under way to assess the impact of BCF schemes this year, to inform planning for the BCF in 16/17. Challenges exist in relation to identification, and realisation of financial savings arising from 'invest to save' schemes. In the absence of clear justification, non-recurrently funded schemes which are not able to evidence impact on BCF metrics will not be continued in 16/17.

At this point there is no specific requirement for additional support in developing our BCF Plan for next year, although it is hoped that guidance on requirements and funding will be made available shortly.

Non-elective admissions have not attained the Q2 BCF target. There were 87, more admissions in in Q2 2015 than Q2 2014. Cumulatively to date a slight reduction against the baseline has been achieved since Q4 14/15 and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year. The rate of non-elective admissions in Leeds remains below the national figure.

The cost of admissions from (April to August) has increased by £1.5m compared with the same period last year. The increase in cost is due to an increase in average price of spell compared to last year. An independent audit is to be carried out to determine the reasons for this increase (which may be due to: more complicated patients, improved coding or incorrect coding).

Performance against other BCF metrics within this submission is largely positive (admissions to residential care, reablement, dementia diagnosis). As reported, work is underway to fully embed processes to monitor the 'patient experience' metric. It is intended that performance against this measure will be reported next quarter.

Leeds Teaching Hospitals are experiencing ongoing pressures on beds. As a result the Systems Resilience Group (SRG) are sponsoring a project led by the Trust Development Authority (TDA) with engagement from all partners. To date the TDA have undertaken two workshops followed up by a Rapid Improvement Event which involved senior managers from across Health and Social Care working together to review current processes and identify key initiatives to reduce overall system dependence on acute medical beds. Although the work was initiated to address perceived issues with DTOCs the project scope has subsequently increased to focus on improving all processes that support reducing bed occupancy, primarily on medical wards.

3.14 As noted within the submission, the Q2 BCF targets for non-elective admissions were not met. Fig 1. below, illustrates that the number of Q2 non-elective admissions (dark red) were above 2014 baseline (dashed red) and BCF target (light red). The graph also illustrates that the number of non-elective admissions in England (dark blue) are above target (light blue), based on Q1 data.

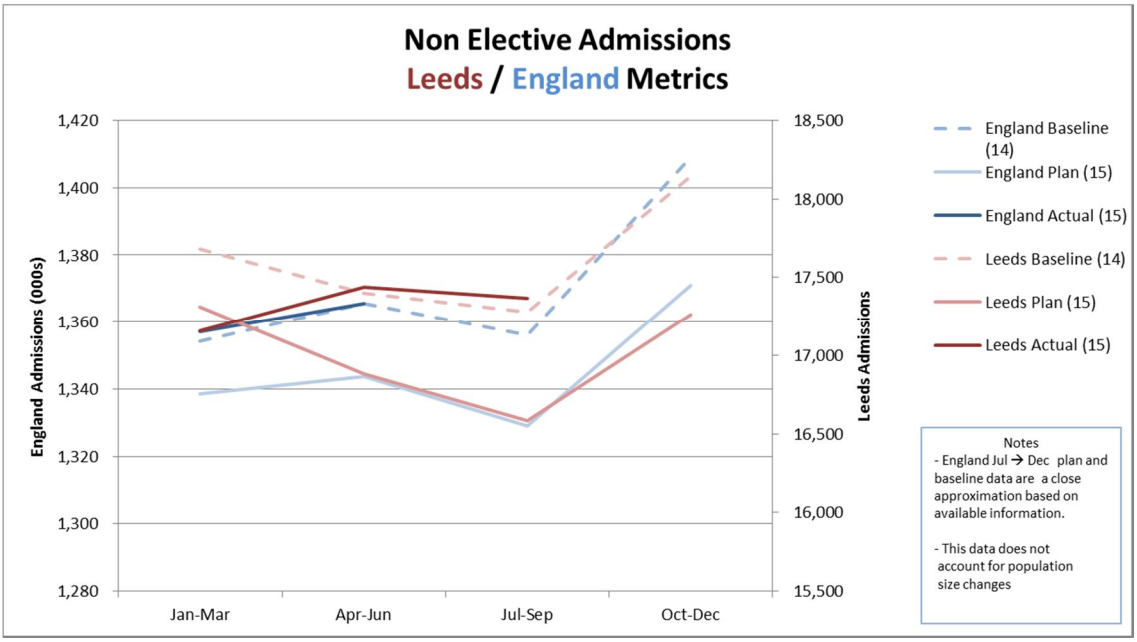

Fig 1

3.15 Please note that the graph above shows the 'number' of admissions for Leeds and England, not the 'rate', and as such it is not appropriate to use the above information to directly compare Leeds' performance with England figures.

3.16 The rate of non-elective admissions in Leeds in Q2 was 15% lower than the England average, although it is thought that coding may account for this difference.

3.17 The reporting process did not encompass the rate of Delayed Transfers of Care (DTOC). This metric is nevertheless a BCF indicator and in Q2 was more than double the target rate. As indicated in our narrative response at 3.13, the Systems Resilience Group is sponsoring a project led by the Trust Development Authority to address this issue. Recent daily and weekly figures show signs of improvement at the time of writing this report.

3.18 The submission includes a high level summary of Better Care Fund income and expenditure at the end of Quarter 2. A more detailed financial summary of 'invest to save' scheme planned and forecast spend is provided at **appendix 2**. This appendix identifies forecast spend on seven schemes approved by BCF Partnership Board subsequent to the approved BCF Plan (listed within 3.13 narrative). The figures presented remain subject to further refinement over the coming months but (at the time of this report) indicate forecast net financial underspend/slippage of circa £881,792 against the approved £54,923k BCF plan.

3.19 The identified slippage has been caused in part by a lack of workforce capacity in respect of some specialisms (most notably community nurses). This challenge is being considered as part of the scope of the 'Workforce' BCF scheme. Slippage has also arisen from the 15/16 requirement for capital from the Informatics scheme being lower than in the original BCF Plan.

Financial and planning assumptions for BCF 16/17

3.20 The Spending Review and Autumn Statement 2015 announced the creation of a social care precept, and states that from 2017 the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund. The statement identifies that every part of the country must have a plan for integrated health and social care by 2017, to be implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management arrangements once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution. Further details are provided at **Appendix 3**.

3.21 At the time of writing this report detailed national planning guidance for BCF in 16/17 has not been released. It is anticipated that this guidance will be provided during January**.**

3.22 A review of the impact of non-recurrently funded BCF Invest to Save Schemes has been undertaken. In general, schemes are struggling to evidence a financial impact. The reasons are varied, but can be broadly categorised as follows:

- Difficulty quantifying and attributing savings
- Lack of ownership of the figures in the original plan
- Schemes which have only commenced recently and have yet to deliver full impact
- Schemes which have been in place 12+ months so can't deliver a significant saving above that delivered last year
- Schemes which were not designed to deliver immediate cashable savings (eg Quality schemes, Enabling schemes and Pilot schemes)
- Where schemes do identify a saving the stated saving may not be cashable.

3.23 Many of the schemes are delivering benefits, including quality benefits – 'better care'.

3.24 Leeds specific guidance has been developed and issued to facilitate the robust evaluation of these schemes. Nevertheless, there is a need for commissioners to consider these 'non-recurrent' schemes in the context of available funding, now, in order to frame the development of the 16/17 plan, and to ensure proposals are affordable.

3.25 The Invest to Save component of BCF was designed as a non-recurrent pump prime fund, with recurrent funding for schemes to be generated from the savings delivered.

3.26 It is likely that the national move from a 30% to a 70% contract tariff rate will necessitate a larger contingency in 16/17 to provide for the payment for performance mechanism (in the event targets are not hit). This will need to be met from either (or all of): additional funding into the BCF, a smaller invest to save component, or efficiencies elsewhere in the BCF funding pot. It is currently assumed that £7.5m contingency be budgeted for the 16/17 BCF (a £5.5million increase on the £2m contingency in 15/16). Failure to deliver reductions in non-elective admissions will result in this funding being paid to the acute trust, rather than being invested in the BCF.

3.27 Pressures may also arise from both contract inflationary price changes to recurrent and non-recurrent BCF schemes, and the apparent rise in the cost of admissions. There is also a need to consider the 'full year effect' cost of delivering the programme of non-recurrently funded BCF schemes. Many schemes in 15/16 commenced mid-year.

3.28 As such it has been proposed that Leeds BCF Plans for 16/17 focus on recurrently funded core services, and opportunities to deliver economies and efficiencies through integrated delivery. Due to the pressures outlined above, the 'non-recurrent' BCF pot will be correspondingly smaller next year, on the assumption that the total value of the BCF will remain unchanged.

3.29 This approach would represent a significant reduction in the funds available to deliver 'non-recurrent' schemes. Correspondingly, if BCF targets in 16/17 are met, a larger sum would be made available to be invested in the BCF.

3.30 Consideration of these issues will take place at BCF Partnership Board in December. It will not however be possible to finalise plans for BCF 16/17 until full national guidance has been released (see 3.21). Specifically, any changes to the BCF Payment for Performance Mechanism may have significant implications for planning the 16/17 BCF.

3.31 Following receipt of national guidance, a detailed BCF Plan for 16/17 will be finalised and presented to Health and Wellbeing Board for approval.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Significant consultation and engagement activity was undertaken throughout the development of the approved Leeds BCF plan. This included a Healthy Lives Leeds hosted event for the 3rd Sector with BCF leads, public engagement through HealthWatch Leeds and a special session of LCC cabinet with CCG BCF leads and the Chief Executives of NHS Provider organisations.

4.1.2 Routine monitoring of the delivery of the BCF is undertaken by a 'BCF Delivery Group' with representation from commissioners across the city. This group reports in to the BCF Partnership Board, which is the main decision making forum relating to the Better Care Fund in Leeds.

4.2 Equality and Diversity / Cohesion and Integration

4.2.3 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 BCF plan will support the reduction of health inequalities.

4.3 Resources and value for money

4.3.4 Whilst the BCF does not bring any new money into the system, it has presented Leeds with the opportunity to further strengthen integrated working and to focus on preventive services through reducing demand on the acute sector. As such, the agreed approach locally to date has been to use the BCF in such a way as to derive maximum benefit to meet the financial challenge facing the whole health and social care system over the next five years.

4.3.5 The current financial position of the Better Care Fund is summarised at 3.18, and within **appendix 2**. High level planned, forecast and actual income and expenditure figures are also provided within the BCF submission provided at **appendix 1**.

4.3.6 As referred to in paragraph 2.6, a Payment for Performance mechanism exists within BCF which means that in Leeds up to £2million could be released into the fund in 15/16, subject to the realisation of a 3.5% reduction in the number of non-elective admissions.

4.4 Legal Implications, Access to Information and Call In

4.4.7 There are no access to information and call-in implications arising from this report.

4.5 Risk Management

4.5.1 The following risks have been identified in relation to the BCF:

- Failure to effect whole systems change as set out in the BCF plans.
- Failure to meet national performance targets, which may lead to NHS England intervention and money set aside for the BCF schemes being reallocated to LTHT.
- Reduced quality of service for people of Leeds.
- Implications for successful partnership working and lost opportunities which may arise from the need to decommission (or find alternative funding sources for) some services funded non-recurrently through BCF in 15/16.

4.5.2 As outlined in 3.19, the lack of workforce capacity in respect of some specialisms (most notably community nursing) presents a challenge for partners across the city, with implications for the successful delivery of some BCF schemes. This is being considered as part of the scope of the 'Workforce' BCF scheme.

5 Conclusions

5.1 This report has presented an overview of the implementation of the Better Care Fund in Leeds.

5.2 Non-elective hospital admissions are the only BCF metric with a direct associated payment for performance mechanism. Non-elective admissions have not attained the Q2 BCF target. Cumulatively to date a slight reduction against the baseline has been achieved since Q4 14/15 and as such a proportion of the P4P payment can be released into the Leeds Better Care Fund, subject to continued reductions being realised through the year.

5.3 Planning for BCF in 16/17 is under way. It is likely that an increase of circa £5.5million in the contingency fund (prompted by a change in the contract tariff rate) will necessitate a smaller fund made available to support 'non-recurrent' schemes next year.

5.4 Following receipt of national guidance, a detailed BCF Plan for 16/17 will be finalised and presented to Health and Wellbeing Board for approval.

5.5 The BCF forms a component of Leeds' ambition for a sustainable and high quality health and social care system, through the achievement of the outcomes of the Joint Health and Wellbeing Strategy. The continued support and commitment of key leaders in the city is critical to the delivery of BCF objectives.

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the contents of this report

7 Appendices

Appendix 1 – Quarter 2 2015/16 BCF submission
Appendix 2 – Invest to save scheme financial summary
Appendix 3 – Spending Review and Autumn Statement 2015 extracts