REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **11 April 2016**
AGENDA ITEM:	**9**
SUBJECT:	**Better Care Fund and TACS**
BOARD SPONSOR:	**Paula Swann, Chief Officer Croydon CCG & Paul Greenhalgh, Executive Director, People, Croydon Council**

BOARD PRIORITY/POLICY CONTEXT:

Croydon Council and Croydon Clinical Commissioning Group (Croydon CCG) are required to produce and implement a joint plan for the delivery of an integrated approach in transforming health and social care services to be delivered in the community (the Better Care Fund – or BCF- Plan) using pooled funds (the BCF) transferred from Croydon CCG's revenue allocation and the Council's capital allocation. The initial joint plan gained approval from NHS England (NHSE) in January 2015, and a refresh for 2016/17 is now due.
The report acts as an up-date to the Health and Wellbeing Board on key issues and the performance in regards the implementation of the plan, key metrics and planning for 2016/17.

FINANCIAL IMPACT:

BCF funds of £24.5m for 2016/17 are to be managed via a pooled budget.

1. RECOMMENDATIONS

This report recommends that the health and wellbeing board:

1.1 **Give delegated authority to the Health & Wellbeing Executive to approve Croydon's 2016/17 BCF plan.**

1.2 **Note the status of BCF delivery.**

1.3 **Note the progress of TACS implementations**

2. EXECUTIVE SUMMARY

2.1 The Better Care Fund (BCF) is a national initiative which aims to promote better integration between health and social care to provide a whole system approach to improving patient outcomes through investing in community based services and by doing so reduce demand on acute services.

2.2 A previous report on the Croydon Council and Croydon CCG Better Care Fund Plan 2014-16 was presented to the Health and Wellbeing Board on 21st October 2015.

2.3 The BCF plan comprises a wide range of schemes across health and social care which are delivering against 6 key metrics. Though there are individual scheme successes, mitigation actions are ongoing to bring delivery on track to achieve the metric targets, where these are not being met.

2.4 The transforming adult community services programme has successfully supported the delivery of integrated care in Croydon over the past year, with patients being cared for outside of a hospital environment. This has enabled people to be seen in the best place for their care, reducing the need for inappropriate high-cost hospital care for those patients.

2.5 BCF continues in 2016/17, and each Health and Wellbeing Board is required to approve its local BCF plan for 2016/17 by 25th April 2016.

3. BCF 2014-16

3.1 BCF changes for 2015/16 were planned to deliver benefits through

3.1.1 Improved self-management by providing individuals the support they need to stay at home

3.1.2 Improved primary and secondary prevention through better co-ordination of care for people with long term conditions through MDTs and access to a single point of assessment

3.1.3 Better management for people with ambulatory care sensitive conditions with rapid response services available

3.1.4 Increased integration and care co-ordination through both the single point of assessment and MDT meetings

3.1.5 Reducing emergency activity by better management of care and directing patients to the best available services

3.2 The 6 nationally reported indicators for Croydon's BCF are:

- Non-elective admissions
- Permanent admissions of older people to residential and nursing care homes
- Proportion of older people still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Delayed transfers of care from hospital
- Discharges over the weekend for Croydon Healthcare Service (Croydon local metric).
- Social care-related quality of life

3.3 During 2015/16 a payment for the performance element of funding is linked to non-elective admissions.

3.4 In summary, Croydon's BCF performance is on an upward trajectory towards its ambitious performance targets, but performance is not yet meeting the required targets in all areas. A range of mitigating actions is in hand to bring performance to the required level.

3.5 In addition to performance against the BCF indicators (see following table), Croydon's BCF plan has enabled positive service delivery to accomplish the following:

3.5.1 TACS – The transforming adult community services programme has successfully supported the delivery of integrated care in Croydon over the past year, with patients being cared for outside of a hospital environment. This includes a dedicated social work team as part of an MDT approach, which has enabled people to be seen in the best place for their care, reducing the need for inappropriate high-cost hospital care for those patients.

3.5.2 ASC reablement service – primarily a “step-down” facility of 6 reablement beds and 2 reablement flats. 82% of service users have reduced or no further care needs.

3.5.3 IAPT (Improving access to psychological therapies) – improved access and capacity to support people with long-term conditions, enabling further delivery against Croydon’s IAPT access target.

3.5.4 Pilot of a mental health reablement service offering interventions that aim to restore life skills and build resilience in meeting non-medical issues such as accommodation, income, service navigation, social inclusion and symptom management. Of those who completed the programme, 90% were discharged to their GP.

3.6 A summary of performance against the BCF metrics is given in the following table:

TABLE: Performance summary by BCF indicator

The table below sets out the performance against the BCF metrics for the reporting period up to 31st January 2016.

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
BCF1 	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	36,914	38,067 M8 YTD	R	To mitigate this performance the BCF Exec have put in place a set of service enhancements which collectively have started to demonstrate impact to reduce non-elective admissions from Nov/Dec 2015. ▪ Development of a Rapid Assessment Medical Unit (RAMU) to reduce admissions through clearer assessment of 'at risk' patients referred by A&E, Urgent Care Centre, GPs and London Ambulance Service (in place from late 2015) ▪ Enhancement, (from late 2015) of the Roving GP service for patients urgently at risk of being admitted to acute hospital. Immediate access to a GP medical opinion will allow the patient to remain at home or be place into a community bed (Step Up Beds). • Extension of rapid response service with nursing and specialist therapy support to care and nursing homes – in place from Sept 2015

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
BCF2 	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	317.0 (end Jan 16)	302.6 (end Jan 16)	G	Current performance is better than target. However, provisions data is often retrospectively uploaded, and there have been significant retrospective changes since the last report. Therefore it is likely that outturns could understate the true number of admissions being made.
BCF3 	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	88%	88.1%	G	Performance is fluctuating slightly around the target level but this appears to be due to random variations rather than any underlying issue for mitigation, and Croydon are on track to meet the target over the year.
BCF4 	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	145.7 (Dec 15)	214.6 (Dec 15)	R	The high volume of delays being seen for 2015-16 in part are attributable to a high number of delays from the mental health commissioned service provider. Mitigation actions in place include: • Weekly meeting in the Trust to review any barriers to discharge. • Closer scrutiny of recording to ensure DTOCs correctly captured. • Greater direct liaison between the Trust and Council Housing Needs team to arrange temporary emergency accommodation. • Transfer of the mental health supporting people facility to more suitable accommodation in Dec 2015, thereby ending a temporary reduction in capacity in the lead up to transfer. Planning for greater use of the “look ahead” contract to support service users in their own homes.

REF	Indicator	2015/16 YTD Target	2015/16 (to date)	RAG rating and trend	Comments and mitigations
BCF5 	Local Performance Metric: '% of discharges over the weekend for Croydon Healthcare Service'.	20%	18% M9 YTD (year end forecast = 18.5%)	**A**	The indicator is under-performing and is behind target predominantly due to a reduction in elective discharges over the weekend which has outweighed the increase in non-elective discharges. Mitigation plan in place with action on perfect wards, golden patients and ward rounds. Discharge improvement trend reflects current improvement plans created for the System Resilience Group (SRG) and the 95% Recovery Plan.
BCF6 	Patient/Service User Experience Metric Social Care related quality of life (ASCOF 1A)	19	18.4 (Mar 15)	**R**	This measure is an average quality of life score based on responses to the Adult Social Care Survey covering control, dignity, personal care, food and nutrition, safety, occupation, social participation and accommodation. The survey is run annually and next results will be available in June 2016. The survey is based on a sample (sent to approx. 28%) of service users that received services in the financial year, across all adult (18+) age groups.

Key:

Rating	Thresholds	Trend	Meaning
G	Improvement on baseline and target met		Performance from the last two data points indicates a positive direction of travel
A	Improvement on baseline yet below target		Performance from the last two data points indicates no change
R	Deterioration on baseline		Performance from the last two data points indicates a negative direction of travel

4. BCF PLAN FOR 2016/17

4.1 The Comprehensive Spending Review (25 November 2015), confirmed that the Better Care Fund will continue into 2016-17 – with a mandated minimum of £3.9 billion (nationally) to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups.

4.2 The BCF 2016-17 policy framework was published on Fri 8th Jan and can be found here: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

4.3 Key points from the document are:

- Mandated minimum funding has increased from £3.8 to £3.9 billion
- The requirement for a pay for performance element of funding linked to non-elective admissions has been removed.
- There is a new requirement to fund NHS-commissioned out-of-hospital services. This is introduced as a new national condition.
- There is a new requirement to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The existing DTOC BCF metric remains in place, and the requirement for a local action plan is introduced as a new national condition.
- By 2017, plans are to be in place for health & social care integration for 2020 and beyond.
- A lighter touch is anticipated for 2016/17 plans, compared with the 2014 plans. “Brief narrative plans” are to be submitted via “short high level template” with a “reduced amount of finance and activity information”.
- Assurance of plans is to be carried out on a regional rather than national level.

4.4 The timescales for submitting Better Care Fund local plans will follow the timeline set out here:

Date (2016)	**Event**	**National/local deadline**
21/03	Submit first draft narrative plan and updated planning template to NHSE	National
11/04	Deadline for NHSE to respond to Croydon with assurance feedback on 21st March plan submission	National
13/04	Health and wellbeing board meeting – paper seeking delegated approval of BCF plan by Health & wellbeing Executive	Local
14/04	Deadline for papers to H&WB exec – this needs to be final version of BCF plan plus covering paper	Local
19/04	H&WB exec meeting – approval of 2016/17 plan	Local
25/04	Deadline for submission of H&WB-approved plans to NHSE	National
30/06	Deadline for s75 agreements to be signed	National

4.5 The timing of the nationally-set deadlines does not allow for presentation of the final version of the Croydon 2016/17 BCF plan for approval at the April meeting of the Health and wellbeing board.

4.6 **Therefore the health and wellbeing board are asked to delegate authority to the health and wellbeing executive for approval of Croydon's 2016/17 BCF plan.**

4.7 The BCF planning submission for 2016/17 is in 2 parts:

- A numerical planning template return
- A "brief narrative plan"

4.8 The draft narrative plan as submitted to NHSE on 21st March 2016 is attached as a supporting document, (Appendix A). The content of this plan is focussed on new requirements for 2016/17 and incremental change since Dec 2014. As such, extensive references are made to previous (Dec 2014) BCF plan and other supporting documents, but content from these other documents is not reproduced here.

4.9 The plan has been produced taking into account :

- The need to ensure stability in the local social and health care system
- Delivery against the BCF performance metrics, as well as individual BCF scheme delivery
- Alignment with other plans and strategic initiatives in particular Croydon's Outcomes Based Commissioning Contract (OBC) for over 65s which is expected to come into effect during 2016/17.
- Revisions to national requirements for 2016/17

4.10 Our 2016/17 BCF portfolio builds strongly on our 2015/16 delivery, but based on our review of 2015/16 activity, some adjustment to schemes and funding has taken place to increase investment in:

- GP roving services – extending to weekends and care and nursing homes
- End of life care – sitting service in care homes and at service user's homes
- Enhanced care co-ordination for frail and vulnerable patients – greater support to MDTs and improved sharing of care plans

5. TRANSFORMING ADULT COMMUNITY SERVICES (TACS)

5.1 Croydon CCG and Croydon Council's Model of Integrated Care in Croydon for over patients over 65 years is based on all partners (statutory, voluntary and community) coming together to provide high quality, safe, efficient, coordinated, seamless care to the people of Croydon (see Appendix B: A Proposed Model of Integrated Care in Croydon Over 65s).

5.2 The Transforming Adult Community Services (TACS) programme was implemented to support delivery of the Model of Integrated Care by:

5.2.1 Ensuring patients received the most appropriate care at the times they needed it through the development of a 24 hour, 7 days a week Integrated Single Point of Assessment.

5.2.2 Supporting the avoidance of unnecessary admissions by establishing a 24 hour, 7 days a week Rapid Response service to provide health and therapy support to patients in their own homes or in care homes.

5.2.3 Enhancing case management through the introduction of GP led primary and community care multidisciplinary team meetings that would increase the number of patients who would be supported through dedicated case management.

5.2.4 Increasing the capacity to provide intermediate care beds allowing patients to be supported away from hospital avoiding unnecessary admission and allowing swifter discharge from an acute setting.

5.3 The Programme has now been fully implemented with the following key achievements in 2015/16 (ytd performance at month 10) for the 4 targeted areas:

5.3.1 Single Point of Assessment – 25,368 referrals made to the 24/7 service have been triaged to the most appropriate service for the patient. In addition the service provides GPs and other healthcare professionals with the ability to speak to experienced community nurses to ensure that patients are seen by the most appropriate health team.

5.3.2 Rapid Response - 1,480 referrals made from GPs, London Ambulance Service, NHS 111, Accident & Emergency, and Social Services to the service to support patients to be cared for within the community rather than having an unnecessary visit to and possible admission in hospital. 94% of patients were seen within the target time of 2hrs, with an average of 20% subsequently appropriately admitted to hospital.

5.3.3 Intermediate Care Bed - 239 patients cared for in the service enabling:

- 149 patients who weren't yet fully capable of returning home after being in hospital to be cared for in a community environment rather than still being in a hospital ward, and;
- 90 patients who were too ill to be treated at home to still be cared for in a community environment rather than having to be in a hospital.

5.3.4 Enhanced case management - 1,256 patients supported through dedicated case management through the joint GP-led Primary, Community, Social Care and Mental Health multi-disciplinary team meetings (MDT).

- 67% of referrals were to Health Visitors for Older People service for frail/vulnerable people with lower level social care needs (e.g. social isolation support, carer assessments etc)
- The remaining 33% of referrals were to the Community Matron service for people with more complex health support needs

5.3.5 Social Care input to MDTs – Referrals have also been made to the social care workers supporting the MDTs. These have resulted in various outcomes following initial fact finding e.g. liaising with other agencies like Staying Put (service offered by Croydon housing in order to keep people in their own homes whilst essential blitz cleans and repairs are undertaken), Older People Floating Support (service funded by Croydon adult services and housing, delivered by One Support to provide housing related support to maintain independence), Careline Plus, Welfare Advice etc. to support people to still live at home under their terms, thereby improving their social care related quality of life.

5.4 Further service developments have also been taken forward in 2015/16 to improve care provision, including:

5.4.1 Elderly Care Consultants participating in more GP Practice MDT's to ensure that GPs can access specialist advice for supporting patients.

5.4.2 GPs having greater access to Older Adults Mental Health Consultant Psychiatrists advice for patients needing multidisciplinary input.

5.4.3 Proactive involvement in care homes by the Consultants in Elderly Care including ward rounds with GPs of patients in Nursing and Care Homes, and the development of a Purple Guide Care Home guide by the Consultants to support all care homes in understanding how to manage common problems in homes.

5.4.4 Investment in additional nursing and speech and language therapy capacity in the Rapid Response service from September 2015, to work proactively to improve care management and planning in nursing care homes, as well as working with the Care Support team to identify, support or deliver training for care homes.

5.4.5 Greater integration between the A&E Liaison and rapid Response services with both now working as one service to support unnecessary admissions within the community and at the Croydon University Hospital (CUH) Emergency Department (ED).

5.4.6 The Care Support team has also continued to provide support, education, specialist advice, observation and training to all provider services including residential, nursing home and domiciliary care providers, to raise standards so that servicer users receive a better quality of care, and incidents of harm and unnecessary hospital admissions are reduced.

5.4.7 In addition the service has widened its interventions to include clinical and direct observation, responding to requests from managers who have identified gaps in staff knowledge and skills. The multidisciplinary nature of the Care Support team enables them to draw on their shared knowledge to raise awareness about outcomes from current research and best practice e.g. National Institute for Health and Care Excellence guidelines, and Department of Health and Regulatory Frameworks.

5.4.8 Piloting of a mobile Roving GP service (initially 5 days a week between 08:30–17:00 from June 2015, and then 7 days/wk Mon-Fri 08:30:17:00 and Sat-Sun 13:00-01:00 from December 2015). The service which enables patients to seen and treated quickly (within 1hr) in their place of residence has successfully supported 221 people to be cared for at home, with the GP linking into other appropriate services like Rapid Response, Community Matrons or Social Services if needed for ongoing support.

5.4.9 The establishment of a Rapid Access Medical Unit (RAMU) in November 2015 operating 7 days/wk 09:00-21:00, providing a one-stop acute medical day care service for patients with urgent medical needs who have been either referred by their GP, or have attended CUH ED. Activity figures are currently being validated but performance at month 10 ytd indicates that around 2,000 patients have been appropriately cared for without the need for a hospital admission.

5.4.10 Co-location of the RAMU with the CUH Ambulatory Emergency Care Unit (a one stop medical day care unit for urgent medical intervention including same day diagnostics), the Acute Care of the Elderly service (a rapid assessment clinic for older people providing specialist treatment avoid unnecessary admissions), and the HOT Clinic provided by the respiratory team for patients with Chronic Obstructive Pulmonary Disease. This has enabled better care for patients with the ability to be seen quickly by the most appropriate clinician and/or multi-disciplinary team. The impact of these initiatives will be further evaluated so that the envisaged benefits can be fully assessed.

5.5 Some examples of the impact of the Transforming Adult Community Services programme at a patient level are provided in Appendix C: Health and Wellbeing Board TACS patient outcomes and experience.

6. CONSULTATION

6.1 Both Croydon Council and Croydon CCG are committed to ensuring that there is regular communication and engagement with our population, the wider health and social care community and our local stakeholders to maintain public trust and confidence in services for which we are responsible.

6.2 BCF draws on a range of existing services and work programmes, and receives inputs from consultation and engagement from those services/programmes. Service user and patient participation groups at GP network level and wider public forums, and service user feedback from Friends and Family Test surveys carried out by primary care, community, hospital and mental health services, will help to ensure we continually capture views and suggestions about services and service development. Examples of public engagement during 2015 on OBC include:

- Have held a public discussion and feedback event in Fairfield Halls 24th June with 50 people attending
- Attended and gained feedback from the CCG's PPI Reference Group 25th June
- Attended and distributed leaflets at Croydon's Ambition Festival 25th July
- Met with community leaders/ groups including PPG Groups, Cultural Groups, Carer Groups, Lunch Clubs and Community Panels, Day Centres, and the general public
- Public event, held on 19th October at Fairfield Halls
- OBC survey designed and online (both websites): closed 16th October (56 responses as at 12th October)
- https://www.surveymonkey.com/r/Croydon_Survey
- Continuing to update web pages to show what engagement has taken place and how it's informed the development of the future model:
- http://www.croydonccg.nhs.uk/get-involved/Pages/Outcomes-based-commissioning.aspx
- https://www.croydon.gov.uk/healthsocial/adult-care/outcome-based-commissioning
- Creation of the OBC Service User Engagement Specialist group that will inform the OBC Programme Board.

7. SERVICE INTEGRATION

7.1 Croydon Council, Croydon CCG, and Croydon Health Services have a history of close partnership working since 2011, and have worked together on a number of joint initiatives through the Council's Reablement and Discharge Programme and the CCG's Strategic Transformation Programme to jointly deliver innovative community-based patient/client-focused services. The BCF provides the momentum to continue this development, enable on-going joint service innovation, and facilitate the cultural change that will ensure that integration is sustained and continues to deliver the best outcomes for patients.

8. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

8.1 BCF funding allocations by Health & Wellbeing Board area were published on 10/02/16. The minimum mandated allocations for Croydon are shown in the table below, and compared with the 2015-16 allocations.

Description	2016-17 £000	2015-16 £000	Difference
Mandated CCG contribution to BCF	22,454	21,498	956
Disabled Facilities Grant	2,046	1110	936
Adults social care capital grant		780	-780
Total - minimum mandated	24,500	23,388	1,112
Additional contribution s256 carry forward	-	754	-754
Total Croydon BCF fund	**24,500**	**24,142**	**358**

8.2 Croydon anticipate making a substantial commitment to integration of health and social care via OBC contracts of approximately £212m during 2016/17. Therefore, only the mandated minimum is planned for investment via BCF.

8.3 In 2016/17, the requirement for a pay-for-performance element of funding has been removed. All other arrangements for risk share and management of under- and over-spends will be set out in the section 75 partnership agreement governing the BCF pooled fund, as per the 2015/16 agreement.

9. EQUALITIES IMPACT

9.1 Any new initiatives that are commissioned through BCF are subjected to an Equalities Impact assessment where it has been assessed as being required.

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BACKGROUND DOCUMENTS
Appendix A: 2016/17 Draft BCF plan as submitted to NHSE on 21st March 2016
Appendix B:Model of care
Appendix C:TACS example outcomes