REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **13 September 2017**
AGENDA ITEM:	**13**
SUBJECT:	**Better Care Fund (BCF) and Integration and Better Care Fund (iBCF)**
BOARD SPONSOR:	**Andrew Eyres, Chief Operating Officer, Croydon Clinical Commissioning Group** **Barbara Peacock, Executive Director - People**
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 administered through a Section 75 Agreement 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 revised final plan for 2016-17 was submitted.	
FINANCIAL IMPACT: *N/A*	

1. RECOMMENDATIONS

1.1 This report recommends that the Health and Wellbeing Board note the performance against BCF metrics for 2017/18 to date.

1.2 The HWBB consider the high level breakdown of the BCF and the iBCF schedule, which will be reviewed and finalised by the BCF Executive Group.

2. EXECUTIVE SUMMARY

2.1 This report summarises the latest performance position against the BCF metrics for 2017/18 to date. There has been improvement in permanent admissions for older people and non-elective admissions against target, whilst there is underperformance on the proportion of older people at home 91 days after discharge, and underperformance on delayed transfers of care from hospital.

2.2 The report also summarises the BCF finance breakdown for months 1-4, and the proposed iBCF spend plan for meeting adult social care needs, supporting hospital discharge, other hospital discharge projects, and stabilising the social care provider market.

3. BCF performance for 2017/18

3.1 The table below sets out the performance against the BCF metrics for 2017/18 to date (to month 3)

Performance trend	Indicator	2017/18 YTD Target	2017/18 YTD Actual	Baseline 2016/17 YTD actual)	RAG rating and trend
BCF1 	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population ***NB: Figures are as at Jun 2017***	6,625	6,234	6,273	**G**
BCF2 	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population ***based on Month 3 (2017/18)**	95	60.8	117.6	**G**
BCF3 	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (SNAPSHOT) ***NB: Figures are as at March 2017***	92%	91.8%	93.4%	**R**
BCF4 	Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) ***NB: Figures are as at May 2017***	252.9	303.9	273.7	**R**
BCF5 	*Local Performance Metric: '% of discharges over the weekend for Croydon Healthcare Service'.* ***(no longer part of the metrics in 17/19)***	*20%*	*21.72%*	*21.37%*	***G***
BCF6	Patient/Service User Experience Metric. Social Care related quality of life (ASCOF 1A) ***N.B. figures are annual and show 2016/17 achievement***	19	18.9	18.4	**A**

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

3.2 Performance against these metrics in Q1 (2017/18) shows the following:

- Improved performance on Permanent admissions of older people (aged 65 and over) to residential and nursing care homes and percentage of weekend discharges in Croydon Health Services
- Marginal performance for Non-Elective admissions against target
- Under performance on proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services and delayed transfers of care from hospital

3.3 Mitigating actions put in place for this underperforming target in 2016/17and carried forward to 17/18 includes:

- On-going weekly meetings and dialogue with Health colleagues to review and agree actions for the patients affected in the dataset
- Deep Dive analysis by the Performance and Intelligence Team is currently underway to understand current issues and target accordingly by the OBC Alliance.
- Sourcing appropriate places for people with complex needs and faster and more efficient process (for example, review the assessment tools and going forward development of a joint assessment tool)
- Additional post of 'Discharge Coordinator' to be recruited.
- Creation of a Working Group in partnership with HR to implement a 'Hospital Discharge Team'
- Looking at a sustainability and resilience plan e.g. changing locum roles into permanent roles and improving staff more.
- Looking at new models for 'Discharge to Access and in process of considering an internal review of teams
- Agree monthly returns at CHS with Local Authority for DTOC

4 BCF and iBCF

4.1 The BCF finance summary for months 1-4 is given below:

COST CENTRE NAME	Memo Better Care Fund £000s	Budget £000s	Total Commitment £000s	Var £000s	Revised 2017/18 Annual Budget £000s	Forecast Outturn £000s	Var £000s
Edgecome Unit	1,055	352	352	-	1,055	1,055	-
GP Roving Service (part of CUCA)	459	153	153	-	459	459	-
Croydon Community SLA - TACS (BCF)	2,491	830	830	-	2,491	2,491	-
Croydon Community SLA - TACS Nusing Homes (BCF)	207	69	69	-	207	207	-
Croydon Community SLA - COPD (BCF)	528	176	176	-	528	528	-
Croydon Community SLA - Falls (BCF)	223	74	74	-	223	223	-
Bladder Scanner	5	2	2	-	5	5	-
Croydon Community SLA - Enhanced Care Management	159	53	53	-	159	159	-
Intermediate Care - Beds (BCF)	470	157	160	4	470	470	-
End of Life Care GSF (ST CHRISTOPHER'S HOSPICE) (BCF)	133	44	85	40	133	133	-
St Christophers (EoLC QIPP Scheme) (BCF)	114	38	38	-	114	114	-
Marie Curie (BCF)	65	22	22	-	65	65	-
Marie Curie (EoLC QIPP Scheme) (BCF)	145	48	61	13	145	145	-
End of Life Care Training (BCF)	27	9	(9)	(18)	27	27	-
Integrated Stroke Service (BCF)	64	21	21	-	64	64	-
Age Uk -Integrated Falls Service (BCF)	30	10	10	-	30	30	-
Age Uk - Care Co-ordinators	160	53	38	(15)	160	160	-
Medicines Management (From Falls - BCF)	10	3	-	(3)	10	10	-
ST CHRISTOPHER'S HOSPICE - Palliative Care (BCF)	1,354	451	446	(5)	1,354	1,354	-
CROSSROADS - Palliative Care (BCF)	135	45	57	12	135	135	-
Medicines Optimisation - Community (BCF)	100	33	33	-	100	100	-
Diabetes Locally Commissioned Services	87	29	30	1	87	87	-
GP LIS to support nursing care homes - enhancement	48	16	16	0	48	48	-
Basket Locally Commissioned Services	405	135	133	(2)	405	405	-
PDDS excluding Prescribing Incentive Scheme (BCF)	2,020	673	622	(51)	2,020	2,020	-
Diabetes Service (BCF)	1,000	333	333	0	1,000	1,000	-
SLaM BCF Community Funding (BCF)	1,586	529	529	0	1,586	1,586	-
SLaM MHOA BCF Funding (BCF)	312	104	104	(0)	312	312	-
MHOA Dementia - Altzheimers (BCF)	150	50	50	(0)	150	150	-
Care UK - Amberley Lodge (BCF)	303	101	68	(33)	303	303	-
	13,845	**4,615**	**4,558**	**(57)**	**13,845**	**13,845**	**-**
Step Down & Convalescence Beds	510	170	170	-	510	510	-
TACS - Social Work Input	459	153	153	-	459	459	-
Mental Health - Reablement	204	68	68	-	204	204	-
Mental Health - Packages of Care	306	102	102	-	306	306	-
A&E Triage	179	60	60	-	179	179	-
Hospital Discharge	179	60	60	-	179	179	-
IAPT - Long Term Conditions Pilot	179	60	60	-	179	179	-
Early Intervention & Reablement	1,033	344	344	-	1,033	1,033	-
Prevent return to acute / care home	485	162	162	-	485	485	-
Extended Staying Put	122	41	41	-	122	122	-
Care Support Team nurses	128	43	43	-	128	128	-
Alcohol Diversion	61	20	20	-	61	61	-
Spealist Equipment eg Telehealth / Telecare	189	63	63	-	189	189	-
Demographic pressures - package of care	2,064	688	688	-	2,064	2,064	-
Care Act	606	202	202	-	606	606	-
Social Care Pressures	1,122	374	374	-	1,122	1,122	-
Social Care (Careline)	223	74	74	-	223	223	-
Sub-Total	**8,047**	**2,683**	**2,683**	**-**	**8,048**	**8,048**	**-**
Assisted Housing (MH OBD LoS)	40	13	13	-	40	40	-
STP Investment	655	218	218	-	655	655	-
Available for Investment	268	89	89	-	268	268	-
Sub-Total	**963**	**321**	**321**	**-**	**963**	**963**	**-**
Grand Total	**22,856**	**7,619**	**7,561**	**(57)**	**22,856**	**22,856**	**-**

4.2 The iBCF funding has been allocated to Croydon in two tranches. Tranche 1 total funding of £9.4m, of which £3.1m in 2018/19 and £6.3m in 2019/20 was allocated at spending review 2015 and formed part of adult social care core funding to mitigate the reduction in core grant funding. This allocation was built in to base budgets and enabled protection from cuts. Tranche 2 total funding of £11.5m, of which £5.5m in 2017/18, £4m in 2018/19 and £2m in 2019/20 was allocated in the Spring 2017 budget and due to timing Croydon has not built this additional funding into the Council's 2017/18 budget.

4.3 Proposed spend plan for the iBCF for 2017/18 and 2018/19 is set out below:

National Conditions for iBCF	Outcomes	2017/18	2018/19
		£'000	£'000
1. Meeting Adult Social Care Needs	Increase in complex packages	2,750	2,750
	Mental Health	500	500
	Autism Support (NAS)	100	100
	Dementia Social Inclusion	85	85
	Total Meeting Adult Social Care Needs	**3,435**	**3,435**
2. Supporting Hospital Discharge	Detail below (Croydon Out of Hospital Model)	1,232	2,000
	Total Supporting Hospital Discharge	**1,232**	**2,000**
2A. Other Hospital Discharge projects	Psychiatric Liaison Service	66	66
	Galvanising Communities (CVA)	75	-
	Telecare (inc. dementia bracelets)	100	25
	Total Other Hospital Discharge Projects	**241**	**91**
3. Stabilising the Social Care Provider Market	**Total Stabilising the Social Care Provider Market**	**592**	**1,574**
	TOTALS	**5,500**	**7,100**

4.4 Further work on the iBCF is being carried out for agreement by the BCF Executive Group.

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