Manchester Health and Wellbeing Board
Report for Information

Report to: Manchester Health and Wellbeing Board – 13 January 2016

Subject: Better Care Fund Performance Quarter 2 2015/16

Report of: Deputy City Treasurer (Manchester City Council) and Chief Financial Officer (North, South and Central Clinical Commissioning Groups)

Summary

The Better Care Fund (BCF) has been established by Government to provide funds to local areas to support the integration of health and social care. Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions.

The Guidance for the Operationalisation of the BCF in 2015/16 was published on the 20th March 2015. CCGs and Local Authorities have been requested to use the quarterly reporting template, distributed as part of the guidance, to be submitted NHS England at five points in the year. Due to the submission dates not being aligned to the Health and Wellbeing Boards, delegated approval to submit returns was granted to the Strategic Director for Families, Health and Wellbeing on the 8th July 2015.

The purpose of this report is to provide the Health and Wellbeing Board with an overview of the template submitted for Better Care Fund Quarter 2 2015/16 performance.

This report sets out:

The response to the six sections of the performance template:

- Budget arrangements;
- National conditions;
- Non elective and payment for performance;
- Income and expenditure;
- National / local metrics;
- Information to support the development of new metrics and;
- Feedback on preparations for the BCF in 2016/17.

Recommendations

The Board is asked to note the report.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	
Educating, informing and involving the community in improving their own health and wellbeing	
Moving more health provision into the community	The Better Care Fund supports the integration of health and social care.
Providing the best treatment we can to people in the right place at the right time	Funding for the testing of service delivery models to improve outcomes for the five priority cohort groups for Manchester's Living Longer Living Better Programme is provided through the Better Care Fund. The priority cohorts are: • Frail elderly and dementia • Adults with long term conditions • Children with long term conditions • Complex needs • End of life
Turning round the lives of troubled families	
Improving people's mental health and wellbeing	
Bringing people into employment and leading productive lives	
Enabling older people to keep well and live independently in their community	

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

- Better Care Fund Performance Quarter 1 2015/16 – Report to Health and Wellbeing Board, 11th November 2015.
- Better Care Fund Monitoring 2015/16 – Report to Health and Wellbeing Board, 8th July 2015.
- Better Care Fund: Guidance for the Operationalisation of the BCF in 2015/16 - NHS England Publications Gateway Reference 03001

- Living Longer Living Better update – Report to Health and Wellbeing Board, 5th November 2014
- Better Care Fund – Report to Health and Wellbeing Board, 10th September 2014

1. Introduction and Background

1.1. One of the city's community strategy priority outcomes is for more residents to be living healthier, longer and fulfilling lives. The key principle is to provide effective safeguarding and protect the most vulnerable by supporting effective integration of health and social care and integrated commissioning at neighbourhood level. The Living Longer, Living Better (LLLB) programme will reform health and social care services in Manchester to co-ordinate them in a way that delivers better outcomes and efficiency savings.

1.2. The Better Care Fund (BCF) has been established by Government to provide identified funds to local areas to support the integration of health and social care. Section 75 of the National Health Service 2006 Act gives powers to local authorities and health bodies to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed National Health Service (NHS) functions.

1.3. The Guidance for the Operationalisation of the BCF in 2015/16, published on the 20 March 2015, sets out in detail the:

- reporting and monitoring requirements for the BCF;
- how progress against conditions of the fund will be managed;
- advice around the alignment of BCF targets for reducing non-elective admissions.

1.4 CCGs and Local Authorities have been requested to use the quarterly reporting template distributed as part of the guidance. The template return requires sign off by the Health and Wellbeing Board. The Health and Wellbeing Board will need to submit a written narrative with the quarterly report to explain any changes to plan and any material variances against plan. The reports are due for submission at 5 points in the year:

- 29 May 2015 – for the period January to March 2015
- 28 August 2015 – for the period April to June 2015
- 27 November 2015 – for the period July to September 2015
- 26 February 2016 – for the period October – December 2015
- 27 May 2016 – for the period January – March 2016

1.5 The submission dates do not coincide in a timely way with the Health and Wellbeing Board meetings. The information required to complete the template would not be available in such a short timeframe, from the end of the reporting period to populate the template. The Health and Wellbeing Board has delegated approval to submit returns from the Strategic Director for Families, Health and Wellbeing, in consultation with City Wide Leadership Group.

1.6 The purpose of this report is to provide the Health and Wellbeing Board with an overview of the template submitted for BCF Quarter 2 2015/16 performance.

1.7 The data collection template for Quarter 2 2015/16 focused on:

- **Budget Arrangements** - this tracks whether Section 75 agreements are in place for pooling funds;
- **National Conditions** - checklist against the national conditions as set out in the Spending Review;
- **Non Elective and Payment for Performance** - this tracks performance against non elective ambitions and associated payment for performance payments;
- **Income and Expenditure** - this tracks income into, and expenditure from, pooled budgets over the course of the year;
- **Local Metrics** - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans;
- **Information to support the development of new metrics** - These relate to Jeremy Hunt's announcement at the Local Government Association Conference in July that a new set of metrics is needed to measure the degree to which a health and social care economy is making progress towards delivering integrated, coordinated and person-centred care and;
- **Feedback on preparations for the BCF in 2016/17** – this included the option to register an interest in planning support.

2. Budget Arrangements

2.1. This section plays back the response to the question regarding Section 75 agreements from the 2014/15 Quarter 4 submission. The question is "Have the funds been pooled via a s.75 pooled budget?" of which the answer was Yes in 2014/15 Quarter 4 submission and thus stays the same.

3. National Conditions

3.1. This section required confirmation on whether the six national conditions detailed in the BCF Planning Guidance are still on track to be met through the delivery of the plan.

3.2. The template sets out the six conditions and required to confirm 'Yes', 'No' and 'No - In Progress' that these conditions are on track. If 'No' or 'No - In Progress' was selected then a target date when the condition is expected to be met was inserted. Further detail was provided in the comments box on any key issues and the actions that are being taken to meet the condition.

3.3. Four of the National Conditions, detailed in the BCF planning guidance, are on track to be met through the delivery of the plan. These conditions are:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number

3.4. Two of the National Conditions are 'in progress', with a completion date of 31st March 2016 and the following comments:

- **Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?**

  A Practitioner Design Team (PDT) was formed at the beginning of August this year, in order to ensure that the newly integrated teams are implemented by April 2016. A brief outline of the workstreams are:

  - Integration of reablement and intermediate care services -The aim of this workstream is to design an integrated service model between Health and Social Care that provides step up and step down intermediate care and reablement services in Manchester as one provider, building on the early implementer work undertaken by Pennine Acute Hospital Trust and Manchester City Council in the North of the city. The project will design services across the city which have a common set of principles, so that citizens will be able to access quality and consistent service provision across the whole of Manchester based on the main principals from the North Manchester early implementer work.

  - Integration of care management and neighbourhood teams - This workstream will set out the 'gold standard' for the neighbourhood team for an enhanced model of joint assessment and place based care delivery. The design will determine which multi-disciplinary roles will be part of the place based care teams and how they will utilise other specialist and non specialist community services to support people to stay at home for longer, ensuring closer integration with community mental health services and primary care. The reach of the workstream is wide, in that it will impact upon the way services are configured and accessed by both residents and professionals across the whole system. The depth of change related to day-to-day operations is also likely to be significant, particularly as services are currently managed, delivered and held to account very differently and will require cultural, behavioural and structural change. The geographical reach of the project covers the city.

  - Development of single point of access/integrated access - As services across the health and social care system begin to integrate further, the service access points that people use will need to change to reflect the new configuration of services. This workstream is about ensuring the people who deliver and use services can access these services and connect and share relevant information in a safe, timely and efficient way.

- **Is an agreement on the consequential impact of changes in the acute sector in place?**

  The services in scope for a pooled budget, risk sharing arrangements and governance are being considered and developed as part of the One Team Contract.

4. Non Elective and Payment for Performance

4.1. This section tracks performance against non elective ambitions and associated payment for performance payments. The latest figures for planned activity and costs were provided along with a calculation of the payment for performance payment that should have been made for Quarter 2, 2015/16.

4.2. For the period 1 January 2015 to 30 September 2015, the Manchester non elective reduction target has not been achieved, with a 3.5% cumulative over-performance (or 1,619 admissions) above targeted levels.

4.3. More positively, the CCGs' nine month performance to 30 September 2015 reported in the data for BCF purposes is better than expected, as non elective admissions growth appears to be relatively flat compared to the same period in 2014.

4.4. Non elective admissions relating to patients registered with 'non-Manchester Clinical Commissioning Groups' contribute to the performance of the Manchester Health and Wellbeing Board. Such activity has increased by 1.7% over the nine month period (37 admissions).

4.5. Based upon the performance against target in the first three quarters of 2015, it is unlikely that the remaining quarter will secure sufficient admission reductions in order to deliver the full year target of 3.5% (2,180 admissions) by 31 December 2015, and the winter months will also impact on the next reporting period.

4.6. £2.4m of the NEL risk reserve (£3.2m in total) has been released to date and therefore unavailable for investment in new integration schemes at this stage. Payment of activity over and above the 3.5% risk reserve will be met by the CCGs.

4.7. The Council's risk reserve, held within the BCF pooled budget, has been released to support residential and nursing admissions and home care packages.

4.8. An evaluation of those approved schemes / delivery models which contribute to the reduction in non elective activity is underway. The evaluation will be completed by the end of February 2016.

5. Income and Expenditure

5.1. This section tracks income into and expenditure from the pooled budget over the course of the year. This requires provision of the following information:

- Planned and forecast income into the pooled fund for each quarter of the 2015/16 financial year
- Confirmation of actual income into the pooled fund in Quarter 2
- Planned and forecast expenditure from the pooled fund for each quarter of the 2015/16 financial year
- Confirmation of actual expenditure into the pooled fund in Quarter 2

5.2. The response can be seen in the table below:

Income	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total
Plan	£10,965,250	£10,965,250	£10,965,250	£10,965,250	£43,861,000
Forecast	£10,965,250	£10,965,250	£10,965,250	£10,965,250	£43,861,000
Actual	£10,965,250	£10,965,250			
Variance	£0	£0			

Expenditure	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total
Plan	£10,784,453	£10,896,104	£10,923,288	£11,257,245	£43,861,090
Forecast	£10,192,329	£10,773,675	£11,148,360	£11,746,726	£43,861,090
Actual	£10,192,329	£10,773,675			
Variance	-£592,124	-£122,429			

5.3. The slippage in Quarter 2 expenditure against planned spend is due to Disabled Facilities Grants for major adaptations (£49k) and approved schemes / new delivery models in North Manchester (£73k). The year end forecast is breakeven.

6. National / Local Metrics

6.1. This section tracks performance against the two national metrics, the locally set metric and locally defined patient experience metric submitted in the approved BCF plan. In all cases the metrics are set out as defined in the approved plan and the following information is required for each metric:

- An update on indicative progress against the four metrics for Q2 2015/16
- Commentary on progress against the metric

6.2. The first national metric described in the approved BCF plan is the percentage change in rate of permanent admissions to residential care per 100,000. The response to the information requirements for this metric were:

- On track for improved performance, but not to meet full target.
- The original target was based on the Adult Social Care Outcomes Framework (ASCOF) reporting for 2014/15 which has since changed to Short- and Long-Term (SALT) return. Bearing this in mind, it had been

raised that the measure being used may not be fully in line with the original baseline. On the basis of SALT reporting, quarter 2 cumulative admissions totalled 122 which exceeded the target of 108 to date.

6.3. The second national metric described in the approved BCF plan is the change in the annual percentage of people still at home after 91 days following discharge which relates to reablement. The response to the information requirements for this metric were:

- On track to meet target.
- The current position shows that we exceeding the target on a monthly basis for 2015/16 except for August where there was a marginal underachievement. .

6.4. The local performance metric described in the approved BCF plan is the estimated diagnosis rate for people with dementia. The reporting frequency for this metric is annual. The response to the information requirements for this metric were:

- On track for improved performance, but not to meet full target.
- Information has been taken from Health and Social Care Information Centre (HSCIC) - Quality and Outcomes Framework (QOF) Recorded Dementia Diagnoses - April 2014 to March 2015. The 2014 actual was 2,688 against a target of 2,957.

6.5. The locally defined patient experience metric described in the approved BCF plan is the 'proportion of people reporting that they have a written care plan'. Surveys are completed twice annually in January and July.

- On track for improved performance, but not to meet full target.
- Information from the GP Patient experience survey publications as at January and July 2015 show that this target is not being met by a margin of 0.11%. Out of 5590 responses, 218 reported 'Yes' to having an agreed written care plan which equates to 3.89% against the target of 4%.

7. Information to support the development of new metrics

7.1. This section requests information as part of the development of a new set of metrics to measure the degree to which a health and social care economy is making progress towards delivering integrated, coordinated and person-centred care.

7.2. These metrics are currently in the development stages, and the Better Care Support Team (BCST) are taking the opportunity, through the quarter 2 reporting process, to trial a small number of new measurements. There are three metrics for which we are collecting data.

7.3. The data collected on these subjects will be used as part of a wider suite of metrics that will be published in beta form in the New Year, with a view to launching an official set of integration metrics in the first quarter of the next

financial year. This set of metrics will be used in a similar fashion to the current BCF reporting process, allowing best practice to be collected and shared, and support to be targeted towards those areas that would most benefit from it.

7.4. **Proposed Metric 1 - The development and use of integrated care records.** There is widespread consensus that having digital care records that are available across health and care settings will facilitate the delivery of more coordinated, person-centred care. However, it is equally clear that this is a long-term ambition that will take several years to realise. In the first instance, therefore, BCST will be seeking to measure early progress towards this goal by asking slightly modified versions of the pre-existing reporting questions on use of the NHS number and open application program interfaces (i.e. systems that 'speak to' each other).

7.5. **Proposed Metric 2 - Risk stratification**. The second new measure concerns the use of risk stratification tools to inform both strategic commissioning across health and social care, and case finding of those individuals who would most benefit from preventative care. While this practice is recognised as an effective way to deliver more appropriate, targeted and responsive services, it is also in the relatively early stages of development. In the short term BCST are looking to understand how many CCGs are using risk stratification tools, and how they are being used to inform strategic commissioning decisions on the one hand and the use of care plans on the other.

7.6. **Proposed Metric 3 - Personal Health Budgets.** Personal budgets in both health and social care are likely to play an important role in the evolution of the health and social care system towards a greater degree of personalisation. In the long-term the BCST expect individuals who hold personal budgets in both health and social care to benefit from combining these into an integrated personal budget. However, at this stage the BCST are interested to learn what progress areas are making in expanding the use of personal health budgets beyond people in receipt of continuing health care.

7.7. Appendix 1 provides a breakdown of questions and corresponding responses for the proposed integrated metrics.

8. Feedback on preparations for the BCF in 2016/17

8.1. Following the announcement that the BCF will continue in 2016/17, this section assessed the level of preparation so far. The following questions required a response:

- Following the announcement that the BCF will continue in 2016/17 have you begun planning for next year? Answer: Yes
- How confident do you feel about developing your BCF plan for 2016/17? Answer: Moderate confidence
- At this stage do you expect to pool more, less, or the same amount of funding compared to that pooled in 2015/16, if the mandatory requirements do not change? Answer: More funding

8.2 There was also an opportunity to ask for support advice in line with preparation of the BCF plan and in what format. The response for additional support was 'Yes' with the preferred support medium of case studies or examples of good practice in the area's of:

- Evidence based planning (to be able to conduct full options appraisal and evidence-based assessments of schemes / approaches)
- Financial planning (to be able to develop sufficiently robust financial plans that correctly describe the impact of activity changes, and the investments required)
- Benefits management (to effectively map the benefits of their BCF strategy to ensure a coherent programme the delivers at the scheme level and in aggregate)

9. Local Integration Fund Bid

9.1. In October, the BCST invited local areas to bid for a share of £500k (limited to 10% per area) to support the implementation of integrated care.

9.2. Manchester submitted a bid for £50k and a brief summary of the proposed support requirements to improve capacity, capability and confidence to implement integrated care submitted is outlined below:-

- The support requirements for the Practitioner Design Team (PDT) Project Managers and Practitioners which are:
    - Support the three citywide Project Manager's to be at a consistent stage of development and understanding of project methodology and how to flex and adapt to respond to the programme needs for a complex system change which involves multiple organisations.
    - Support the Practitioners and Integrated Commissioners in working in this environment, and whilst some of them already come from a transformation background, others are new and work is needed to enable them all to be working with a consistent level of knowledge and understanding of basic project methodologies so that they feel confident to respond to the needs of a complex system.

- Aligned to the above, to focus upon setting up a rolling programme on a train the trainer basis that would support the development of generic skills for staff. Taking the example of the trusted assessor model to put in place a citywide system that would ensure health and social care staff are developed to adapt to more generic roles and also for other referral services to have a clearer understanding of what it means for them and their services.

9.3. The outcome from the bid was Accepted up to £50k with clarification. Manchester has worked closely with the Better Care Manager and provided the clarification required. Notification was received on the 30th November 2015 confirming that the bid is now fully approved.

10. Commissioning Support Unit (CSU) Offer

10.1. Manchester has also responded to a free of charge support offer via the CSU, as part of the North of England / Midlands and Lancashire Commissioning Unit regional offer. The focus of support would be targeted to process and pathway mapping to support the work of the PDT integration workstreams.

10.2. Manchester has asked for 10 days of support due to the complexity of Manchester and the extensive integration transformation programme. A setup meeting took place on the 9th December 2015 to discuss the support requirements and the CSU are aiming to present a proposal by the end of December 2015.

11. Summary

11.1. The BCF Quarter 2 performance template was submitted to NHS England within the deadline and was fully populated.

11.2. Two of the National Conditions are ‘in progress’ with a completion date of 31st March 2016 which are:

- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.
- Agreement on the consequential impact of changes in the acute sector.

11.3. For the period 1 January 2015 to 30 September 2015, the Manchester non elective reduction target has not been achieved, with a 3.5% cumulative over-performance (or 1,619 admissions) above targeted levels.

11.4. The completed income and expenditure statement showed slippage of £122k as at Quarter 2 2015/16 mainly due to spend to date against the Disabled Facilities Grant and slippage against approved schemes and new delivery models in North Manchester.

11.5. Manchester have been successful in the Local Integration Fund Bid to the tune of £50k which is to support:

- Support the 3 citywide Project Manager's to be at a consistent stage of development and understanding of project methodology;
- Support the Practitioners and Integrated Commissioners in working in this complex environment and;
- Focus upon setting up a rolling programme on a train the trainer basis that would support the development of generic skills for our staff.

Appendix 1 – Proposed Metric Responses

1. Proposed Metric: Integrated Digital Records

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
In which of the following settings is the NHS number being used as the primary identifier?	Yes	Yes	Yes	Yes	Yes	Yes
other', i.e. share information through the use of open APIs?	Yes	Yes	Yes	Yes	Yes	Yes

Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes

Comments:	Partner organisations from the care settings listed above share information as part of the Manchester Care Record. At present 6,000 patients across Manchester have am Integrated Care Record consisting of a Care Plan and their associated health and social care record is available to clinicians responsible for their care. The health record contains data flows from GPs, hospitals, social care and a Mental Health feed will follow shortly. The next phase of the project involves the implementation of an Electronic Palliative Care Plan.

2. Proposed Metric: Use of Risk Stratification

Is the local CCG(s) using an NHS England approved risk stratification tool to analyse local population needs?	Yes
If 'Yes', please provide details of how risk stratification modelling is being used to allocate resources	GP Practices have used the Combined Predictive Model to select patients for intervention by Multi Disciplinary Care Teams. Anonymised outputs from the RST has also been used for commissioning intelligence purposes.

Based on your latest risk stratification exercise what proportion of your local residents have been identified as in need of preventative care? (%)	1.50%
in need of preventative care have been offered a care plan? (%)	1.4%

Comments:	Approx 1.5% of patients are at very high or high risk of emergency admission to hospital, these patients have been targeted to have a Care Plan. At present approximately 8000 patients have a Care Plan, 6000 of which have an Integrated Care Record on Graphnet

3. Proposed Metric: Personal Health Budgets

Have you undertaken a scoping exercise in partnership with local stakeholders to understand where personal health budgets would be most beneficial for your local population?	In the planning stages
How many local residents have been identified as eligible for PHBs during the quarter?	148
Rate per 100,000 population	28
How many local residents have been offered a PHB during the quarter?	24
Rate per 100,000 population	5
How many local residents are currently using a PHB during the quarter?	102
Rate per 100,000 population	20
What proportion of local residents currently using PHBs are in receipt of NHS Continuing Healthcare during the quarter? (%)	70.6%
Population (Mid 2015)	522,148