ENCLOSURE: P

Agenda Item: 150/15

NHS Bexley Clinical Commissioning Group

Governing Body meeting (held in public)

DATE: 24 September 2015

Title	**Better Care Fund Update**
This paper is for **Discussion**	
Recommended action for the Governing Body	That the Governing Body: **Note**
Potential areas for Conflicts of interest	None.
Executive summary	The Better Care Fund (BCF) was announced as part of the June 2013 spending round. The first cut of the BCF was submitted in February 2014 and the final BCF plan submission was on 19 September 2014. Bexley's submission as agreed by the Governing Body and Health & Well-being Board was as follows: • That the target reduction in non-elective admissions for Bexley would be 1% with any achievement up to 2% being honoured and the funds paid over to the s75 joint pooled fund. This reflected the realistic expectation at the time but also safeguarded any over-achievement (i.e. funds would only be paid across in line with achievement of the target). • That £5.476m of the £13.708m BCF would be transferred to the council, for existing spend, and that the balance of the BCF would remain within Bexley CCG, to use for existing spend on NHS commissioned healthcare (in line with guidance). For the avoidance of doubt this included the balance of the ringfenced fund. • That the funding for the 2% target reduction would be ringfenced by Bexley CCG, and paid over to the s75 joint pooled fund on achievement, and that any balance (from non-achievement) would be retained by the CCG to spend on unplanned acute over-performance (as in the guidance). • That the first calls on any funds paid into the pooled fund would be: o Should the reductions not be seen then this would be used to fund

	the costs to the CCG and o New investment carried out to make any non-elective reduction/ savings. • That spend against any balance in the S75 joint pooled fund, after new investment, would be jointly agreed between the CCG and Council. This could include protecting existing services The attached report provides an update on the current position with regard to the non-elective admission target and the impact on the pooled fund, as well as the national and local metrics.

How does this paper support the CCGs objectives?	**Patients:**	Improve the health and wellbeing of people in Bexley in partnership with our key stakeholders.
	People:	Empower our staff to make NHS Bexley CCG the most successful CCG in (south) London.
	Pounds:	Delivering on all of our statutory duties and become an effective, efficient and economical organisation.
	Process:	Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience.

What are the Organisational implications	Key risks	• That acuity of patients continues to rise • That acute trusts will continue to admit people so commissioners will "pay twice" • That reducing budgets will undermine partnerships • That Primary Care does not have the capacity to deal with increased demand • Managing patient/carer expectations
	Equality	The Better care Fund is intended to improve care and treatment of the most vulnerable people.
	Financial	The Better care Fund is intended to secure seamless services for patients and to eliminate the risk of falling between the services of health and social care.
	Data	Minimum required value of ITF pooled budget: 2014/15 - **£774,000** 2015/16 - **£13,708,000** Total agreed value of pooled budget: 2014/15: **£774,000** 2015/16: **£15,301,000**
	Legal issues	The Better Care Fund is covered by a Section 75 Agreement.
	NHS constitution	The proposal is in line with the principles of the NHS Constitution in particular principle 5, by working across organisational boundaries.

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Engagement	Our Better Care Fund Plans are set out in our commissioning intentions and form part of our engagement in this respect. Engagement around the improvements to End of Life Care has included Dying Matters Week which involved patients and the public in discussions around advance care planning and also the establishment of the End of Life multi-disciplinary steering group has involved clinicians and partners, including the voluntary sector in shaping, monitoring and evaluating the delivery of care to end of life and palliative patients.	
Audit trail	The draft plan was considered by the Bexley Health and Wellbeing Board at their meeting in January 2014 and the final plan was subsequently circulated to the Health and Wellbeing Board for approval, prior to submission. All subsequent assurances and performance submissions are approved by the Governing Body and Health and Well Being Board.	
Comms plan	All communications are co-ordinated by the End of Life Steering Group.	
Author: Alison Rogers AD of Bexley Integrated Commissioning	Clinical lead: Dr Nikki Kanani	Executive sponsor: Sarah Valentine Director of Commissioning
Date	11 September 2015	

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Better Care Fund

Background

The Better Care Fund was announced as part of the June 2013 spending round.

The first cut of the Better Care Plan was submitted in February 2014 and following feedback from NHS England further work was undertaken to finalise the plan by 4 April 2014. The draft plan was considered by the Bexley Health and Wellbeing Board at their meeting in January 2014 and the final plan was subsequently circulated to the Health and Wellbeing Board for approval, prior to submission.

In line with National Planning Guidance, a review of all BCF plans was carried out by NHS England (London Region) with local authority input provided by the London Social Care Partnership and London Councils.

In carrying out their review, NHS England recognised that BCF plans were beginning to set out a shared vision for transformational improvement; delivering sustainable services, driving closer integration and improving outcomes for patients and service users.

There was also recognition that changing services and spending patterns to deliver this change would undoubtedly take time and the plan for 2015/16 would need to be subject to on-going refinement to ensure alignment with the ambitions detailed in longer-term five year strategic plans for health, and care and provider plans.

Subsequently therefore, following this initial agreement of key themes, considerable further work ensued over the spring and summer of 2014 to finalise the respective financial position for each BCF area, the national and local performance metrics and risk share arrangements. This culminated in the final Better Care Fund Submission on 19 September 2014.

Bexley's submission as agreed by the Health & Well-being Board was as follows:

- That the target reduction in non-elective admissions for Bexley would be 1% with any achievement up to 2% being honoured and the funds paid over to the s75 joint pooled fund. This reflected the realistic expectation at the time but also safeguarded any over-achievement (i.e. funds would only be paid across in line with achievement of the target).
- That £5.476m of the £13.708m BCF would be transferred to the council, for existing spend, and that the balance of the BCF would remain within Bexley CCG, to use for existing spend on NHS commissioned healthcare (in line with guidance). For the avoidance of doubt this included the balance of the ringfenced fund.
- That the funding for the 2% target reduction would be ringfenced by Bexley CCG, and paid over to the s75 joint pooled fund on achievement, and that any balance (from non-achievement) would be retained by the CCG to spend on unplanned acute over-performance (as in the guidance).
- That the first calls on any funds paid into the pooled fund would be:
  - Should the reductions not be seen then this would be used to fund the costs to the CCG and
  - New investment carried out to make any non elective reduction / savings.

- That spend against any balance in the S75 joint pooled fund, after new investment, would be jointly agreed between the CCG and Council. This could include protecting existing services

This approach was agreed following detailed analysis of the national Better Care Fund ambition of a 3.5% reduction in 2015/16 against a baseline of Q4 13/14 to Q3 14/15.

Benchmarking and analysis was undertaken to better understand Bexley's position in relation to its peer groups, and also in relation to information provided in the Non Elective GA Unify Data. Analysis showed that in 2013/14 we reduced Non Elective activity by 3% on the previous year – or by 8% in the previous 3 year period. In addition the benchmarking revealed that we were already in the Top 25% of performers nationally (using weighted population to admissions per 100,000) and that we would be heading into the Top Decile (benchmarking since has shown that Top Decile performance was achieved in 2014/15). See also next section.

The reductions in 2013/14 were in the main through the establishment of the joint service initiative between the CCG and the LBB established in 2013 to put in place the 7 day a week integrated care service (social and health care) to avoid unnecessary admissions, and to improve discharge. In 2014/15 the health economy expected to see the full benefit of this initiative, which contributed to the forecast operating plan reduction of -4% in non-elective admissions (and was part of the CCG's QIPP plans).

In addition to extending the 7 day offer, the LBB with the CCG planned to extend this service for End of Life Care and further Ambulatory Conditions, these were designed to deliver the target reduction of 1% (199 admissions) for the Better Care Fund in 2015/16 (with a stretch target of 2%) . These schemes were already accounted for within the CCG's QIPP plans.

Better Care Better Value – NHS Productivity (Benchmarking) Findings

We completed two peer CCG group comparisons using the Better Care Better Value NHS website (the peer group used within the Right Care analysis, and then our ONS cluster peer group of comparable new town CCGs) which both cases demonstrated that this health economy already had low rates of non-elective admissions compared to its peers - already achieving 25th percentile (Top Quartile), and that through the ambitions in End of Life Care we would move into the 10th percentile (Top Decile).

This detailed analysis was undertaken at both the population basis (admissions per 100,000 weighted for our population) and then at a more detailed specialty level to look at potential focus areas (many of these were not within our control i.e. Specialised Services commissioned by NHS England or were of extremely low value).

Population and Opportunities

Bexley has an aging population. We saw a rise (7.8%) in the number of people aged 65+ between the 2001 and 2011 Census (from 34,506 to 37,200 people). This represents 16% of all residents. This figure is in line with the national average (16.4%) but is the third highest rate amongst London boroughs with only Bromley (16.8%) and Havering (17.8%) having a greater percentage of the overall

population aged 65+.

The largest increase has been the numbers of people aged over the age of 90 (1,700 in 2011 compared to 1,243 in 2001). In 2011 one in every 136 people in Bexley were aged 90+.

It is estimated that these increases will continue over the next decade and by 2021 there will be 5,329 more people aged 65 and over in Bexley (a 15% increase). The largest proportional increases will be in the older age band, especially the very elderly, which is predicted to rise by over 46% (Source: ONS mid 2011 interim population projections). Therefore, the needs of our future population suggests we will have diminishing scope for further reductions in admissions, although we will be using our Integrated Care Service for Older People to maintain reductions where appropriate.

Given the achievements of our Integrated Care Services further reductions would be challenging. Therefore the targets were set for the Better Care Fund at 1% only using our End of Life Care scheme. This was reviewed in detail by NHS England and found to be robust, our detailed analysis of the situation was praised, and lead to the End of Life Care Business Case.

Disaggregated Spend and Provider Engagement in Reductions

Bexley residents attend 3 main providers of acute A&E services, and are therefore admitted to 3 separate acute hospitals. The distribution of our main acute total local spend is approximately:

Provider	Main Sites (Hot acute) (bold shows the key sites)	% of activity (note excludes prime contractor contracts)
Dartford & Gravesham	**Darent Valley**	23%
Lewisham & Greenwich	**Queen Elizabeth** & Lewisham	38%
Kings College	**Princess Royal** and Denmark Hill	16%

In addition to the above Guys and St Thomas' account for 12% and the remaining 12% is divided across other providers of services. These percentages are based on the M3 spend with acute providers.

The above results in:

- Our admission avoidance (and rapid discharge) services having to focus on 3 main provider sites (this leads to complexity and additional staffing).

- Our number and percentage of admissions with any one provider being low when compared to their major (lead) commissioner – see estimated of activity below per day.

In the following chart we analysed the results of the Better Care Better Value productivity improvements available to us, in the potential for admissions avoided per annum (where feasible) and then correlated those to our activity with each Trust shown above. This provided an estimate of the

likely number of avoided admissions per Trust per calendar day and week for the movement to the 10th percentile.

Description	Dartford & Gravesham	Lewisham & Greenwich	King's College
% of Non Elective Activity	25%	56%	19%
Forecast reduction admissions **per annum** 14/15 plan to 15/16 plan	49.75	111.44	37.81
Forecast reduction admissions **per week** 14/15 plan to 15/16 plan	0.95	2.14	0.73
Forecast financial reduction **per annum** 14/15 plan to 15/16 plan for activity reductions above	£74,250	£166,320	£56,430

As part of the Better Care Fund submission processes the providers were asked to review the submissions and the analysis, and provide signatures to those.

Current Financial Position

Planning guidance was issued on 27 July 2014 covering Better Care Fund revenue funding for Bexley of £13,708,000.

The Council previously received from the NHS £4,937,000 in funding to support social care and re-ablement services. From 2015-16 the CCG continues to pay this money at the previous level from the Better Care Fund. This funding is already committed to current social care services.

The Better Care Fund also includes funding of £539,000 intended to cover the cost of some elements of Care Act implementation in 2015-16. The CCG is paying this money to the Council in 2015/16 It is fully committed to funding new burdens under the Care Act.

£3,962,000 of Bexley's funding is ring-fenced with an element linked to performance and the balance is retained by the CCG for spending on NHS-commissioned out of hospital care.

As above we set a target of a further reduction 1% in non-elective admissions, with any achievement up to 2% being paid into the pooled fund. If 1% is achieved this will generate a performance fund of £296,000 and 2% would generate a maximum of £592,000.

Therefore £5,476,000 of the £13,708,000 has been transferred to the Council for existing spend and the balance of the BCF remains with Bexley CCG to use for existing spend on NHS commissioned health care (in line with the guidance). This includes the balance of the ring-fenced fund.

The funding for the 2% target reduction is ring-fenced by Bexley CCG, and paid over to the s75 joint pooled fund on achievement, and any balance (from non-achievement) will be retained by the CCG to spend on unplanned acute over-performance (as in the guidance).

The first call on any funds paid into the pooled fund (if the reductions are achieved see above) is the new investment in End of Life Care to deliver on the BCF further reductions in non elective admissions.

Spend against any balance in the pooled fund, after new investment, will be jointly agreed between the CCG and council.

The position at the end of Quarter 1 with regard to non-elective admissions as reported to NHSE was as shown below.

Baseline				Plan				Actual			
Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
4,814	5,076	5,525	5,683	4,766	5,026	5,470	5,637	4,766	5,002		

However we are concerned that at the time of this submission SUS was unfrozen and non-elective (emergency activity) is usually the most complex to code. Therefore, we advised NHSE in the submission that it was too early to state that we will make a performance payment.

Performance and Metrics

Performance against the nationally mandated Better Care Fund Metrics is shown at Annex 1.

However the Bexley BCF has focused on improving the system of end of life care to prevent unnecessary admissions to hospital for people at this time (1% reduction – 199 spells). We have taken a whole systems approach to this with an emphasis on advance care planning and full use of Co-ordinate My Care (CMC). Since December 2014, we have seen growth in the number of people on CMC from 249 to over 850 people. This is mostly people in the last year of life stating where they wish to be treated and have a care plan. We are monitoring the trend in death in place of choice using data direct from general practice and early indications show an increase from 48% deaths in normal residence in Q1 2014/15 to 56% in the same quarter this year. However, this upward trend in deaths outside hospital is not reflected in the non-elective admission data.

Better Care Fund Submissions History:

The original submissions to set the targets and provide the background data were approved by the Health and Well Being Board and the Governing Body in April and May 2014 respectively.

The Governing Body has also been provided with regular verbal updates by the Director of Commissioning.

In May 2015 the CCG with the HWBB needed to provide an updated submission for the 'Better Care Fund: New Quarterly Reporting Template' in line with statutory requirements

This was approved by Chairman's action for the CCG on 22 May 2015 and reported to the public Governing Body meeting on 30 July 2015.

In July 2015 our teams also received a request from NHS England asking if the Better Care Fund baselines should be changed in light of:

a) Any key issues that had emerged during the Operating Plan rounds with NHS England and

b) The opportunity to change the data used for calculating the baseline from MAR to SUS data sources.

After consultation between London Borough of Bexley and the CCG we submitted a request to:

i) Change the baseline for performance from Q4 of 2014/15 (so the number to be achieved) to reflect that in 2014/15 (and through our Operating Plan submissions) the CCG had agreed to fund a Clinical Decision Unit (CDU) at Queen Elizabeth Hospital to assist with both the A&E achievement and admissions. Our planning for 2015/16 showed that this would be equal to an increase in emergency (NEL) admissions of +1297 per annum. These needed to be taken into the account within the baseline before calculations for the End of Life Care / Better Care Fund schemes were calculated.

ii) Change the data source for the calculations and returns from MAR data (a source of data that is not used by the CCGs, reconciled or reported on) to SUS data (which is used extensively in our reporting).

The request was made in late July, but no notification of approval for the request was received by the CCG (or the HWBB).

In early August we then received a request to provide data on the activity for Q1 2015/16 and within that request they had changed the baseline data to i) above. We also received a request to formalise the re-setting of the baselines and the forecasts of performance and achievement – after discussion with LBB this was submitted on 17th August 2015.

A further request for performance data was received by the HWBB and the CCG (submission at end of August 2015) in respect of Quarter 1 performance 2015/16. This submission has been made (after Chairman's approval for both the CCG and HWBB on 28 August 2015) – the details of this submission are given below.

In making this submission the CCG team (with the LBB team) have been clear that in respect of emergencies and non elective admissions the data is incomplete (it is not frozen data/ final reconciliation point) and will change until the final reconciliation point in line with the NHS's data and coding systems (procedures) – therefore this cannot be taken as a final performance figure, and that position would not be available until October 2015.

The 28 August submission is attached at Annex 2

ANNEX ONE

Performance and Metrics

As above the payment for performance element of the Fund is linked to our performance in reducing non-elective admissions in line with the trajectory agreed in our BCF plan.

In addition to the KPI on Non-Elective Admissions, there are a number of supplementary metrics against which the CCG and Local Authority are measured. Performance against these measures is shown below:

Total non-elective admissions into hospital (general & acute), all-age, per 100,000 population

Table 1: Non-Elective Admissions:

Baseline				Plan				Actual			
Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
4,814	5,076	5,525	5,683	4,766	5,026	5,470	5,637	4,766	5,002		

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

Table 2 shows a gradual downward trend in the number and rate of new residential admissions between 2010/11 and 2013/14. In 2015/16, we wish to see a further reduction to 197 new admissions, equivalent to a rate of 490.2 admissions per 100,000 population.

Table 2 – New Residential Care Admissions (65+), Baseline and Target:

Year	Number of new admissions	Care Home Admissions (rate per 100,000 pop)	65+ population
2010/11	254	693.9	36603
2011/12	254	677.2	37505
2012/13	211	547.8	38520
2013/14	214	545.9	39200
2014/15 Target	195	490.5	39752
2015/16 Target	197	490.2	40185
Annual change in admissions 2014-15	-20	-9%	
Annual change in admissions 2015-16	+2	+1%	

Chart 1, which is based on provisional results for 2014/15, shows that there were 197 new residential care admissions during the year. This is equivalent to a rate of 494.7 admissions per 100,000 population. This represents a reduction in the rate from 2013/14 but is slightly above the BCF target of 490.5. Final results will be published by the Health and Social Care Information Centre later in the year.

Chart 1 – New Residential Care Admissions (65+), 2014/15

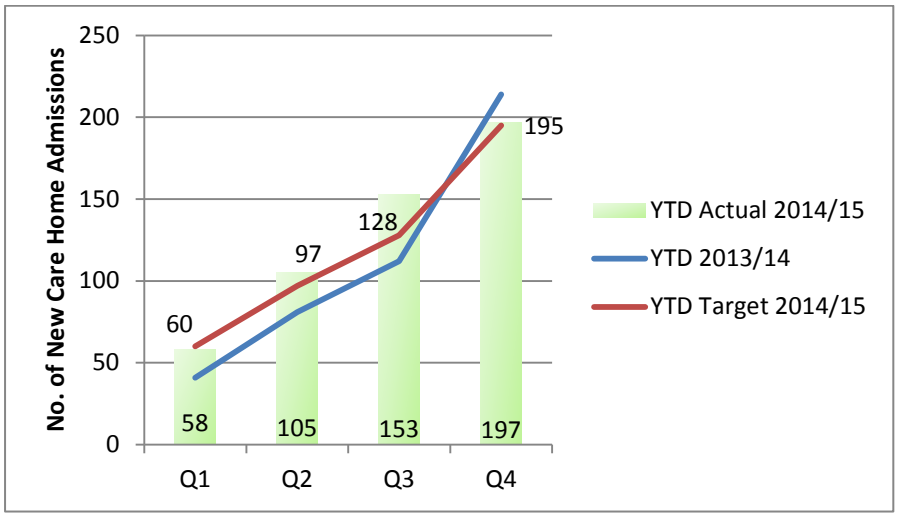
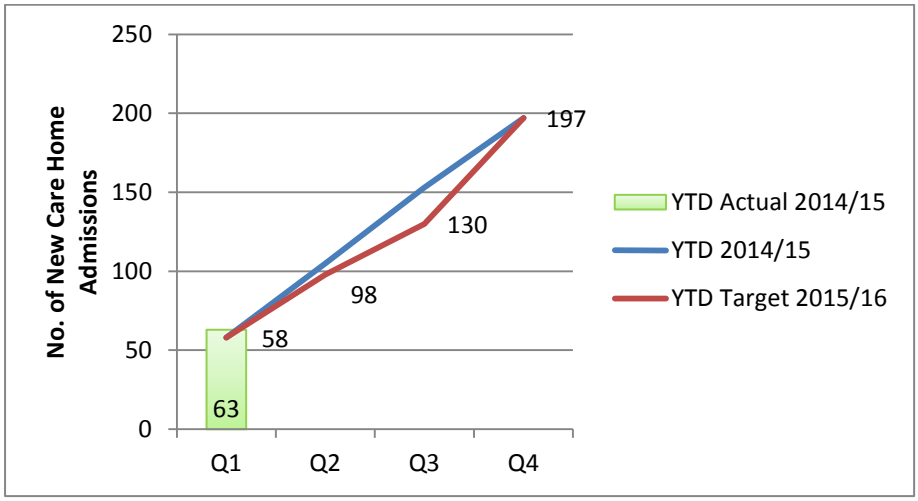


Chart 2 shows that there were 63 new residential care admissions during Q1 2015/16. This is equivalent to a rate of 158.2 admissions per 100,000 population. This compares to a Q1 target of 58 admissions.

Chart 2 – New Residential Care Admissions (65+), 2015/16

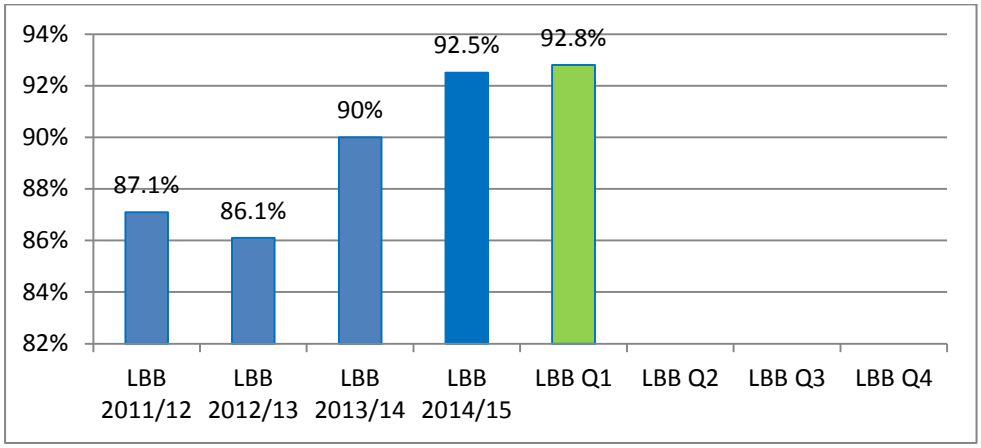


Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

The 2014/15 outturn for this indicator was 92.5%, above the 90% BCF target. Performance in Q1 continues to show above target performance. 103 out of 111 older people (92.8%) who were discharged from hospital into reablement or rehabilitation services were still at home 91 days later. As

the focus of this indicator is on older people with a 'route of access' of discharge from hospital into reablement, this is a smaller sub-set of the overall reablement cohort. The BCF target of 90% is based on a baseline from 2013/14.

Chart 3 – Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services



Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)

Data from NHS England on delayed transfers of care (delayed days) from hospital shows that delayed days increased from 424 days in March 2015 to a peak of 692 days in April. In Q1, we have seen a reduction since then to 528 days in June 2015.

Chart 4 – Delayed Transfers of Care (No. of delayed days per month)

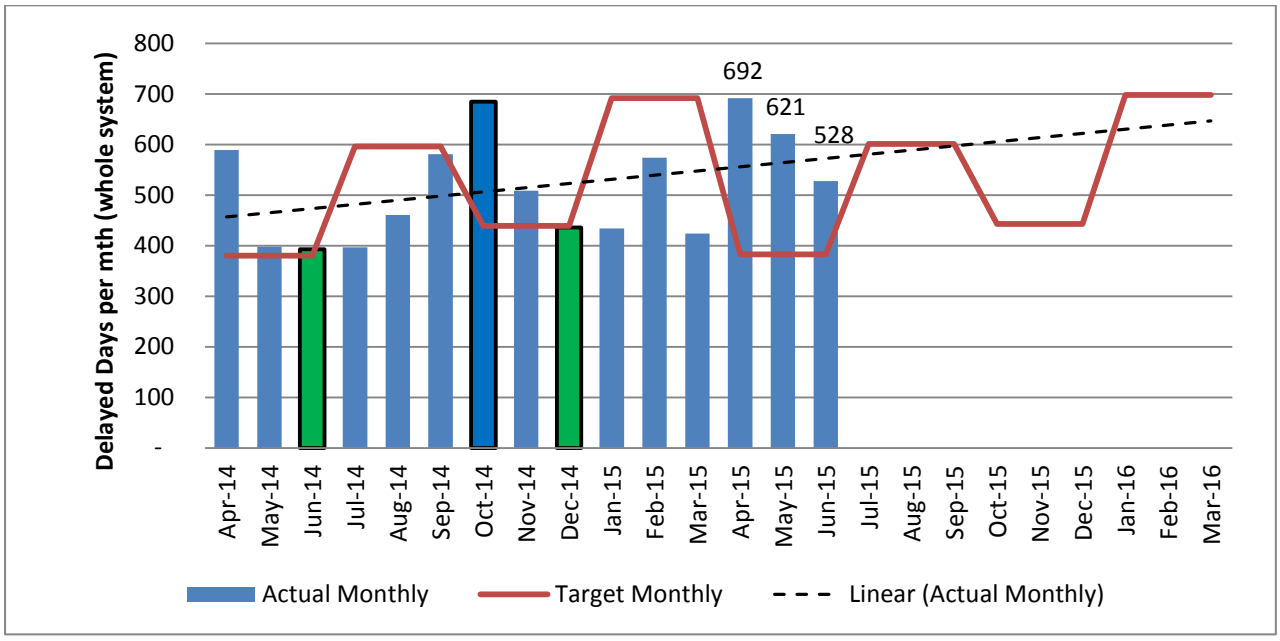


Table 3 (below) compares the quarterly rate of delayed transfers of care per 100,000 population (aged 18+) to our BCF target and BCF projected quarterly rates. The rate of delayed transfers of care

in Q4 2014/15 was below our BCF target rate. However, we have seen an increase in the quarterly rate in Q1 2015/16 to 998.9, which takes us above the BCF target of 622.9.

Table 3 - Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)

	2014-15				2015-16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Actual quarterly rate	**754.9**	**787.2**	**891.6**	**777**	**998.9**			
Numerator	1,380	1,439	1,630	1,432	1841			
Denominator	182,811	182,811	182,811	184,297	184,297	184,297	184,297	185,887
BCF target quarterly rate	**623.0**	**978.6**	**721.0**	**1126.4**	**622.9**	**978.3**	**720.6**	**1126.0**
Numerator	1,139	1,789	1,318	2,076	1,148	1,803	1,328	2,093
Denominator	182,811	182,811	182,811	184,297	184,297	184,297	184,297	185,887
BCF projected quarterly rate	**862.8**	**892.9**	**923.0**	**945.4**	**975.3**	**1,005.1**	**1,035.0**	**1,055.7**
Numerator	1,577	1,632	1,687	1,742	1,797	1,852	1,907	1,962
Denominator	182,811	182,811	182,811	184,297	184,297	184,297	184,297	185,887

Injuries due to falls in people aged 65 and over (per 10,000 older population)

The latest available figures from PHOF show that there was a decrease in the number of injuries due to falls from 753 in 2012-13 to 736 in 2013/14. When expressed as a rate per 10,000 population, this shows a reduction from 195 injuries due to falls per 10,000 population in 2012/13 to 188 in 2013/14. 2014/15 data from Public Health England is not yet available. Our BCF target is a rate of 192 in 2014/15 and 189 in 2015/16.

There is a considerable time-lag with the publication of PHOF data, which makes it difficult to track progress during the year. Therefore, we are currently using CCG-sourced data on the number of first finished consultant episodes (FCEs) from patients (aged 65+) admitted due to falls. This shows 518 FCEs in 2014/15 among patients aged 65+, compared to 376 in 2013/14. The figures for Q1 2015/16 show 127 FCEs compared to 116 FCEs in the same period the year before. This indicates an upward trend in the number of injuries as a result of falls.

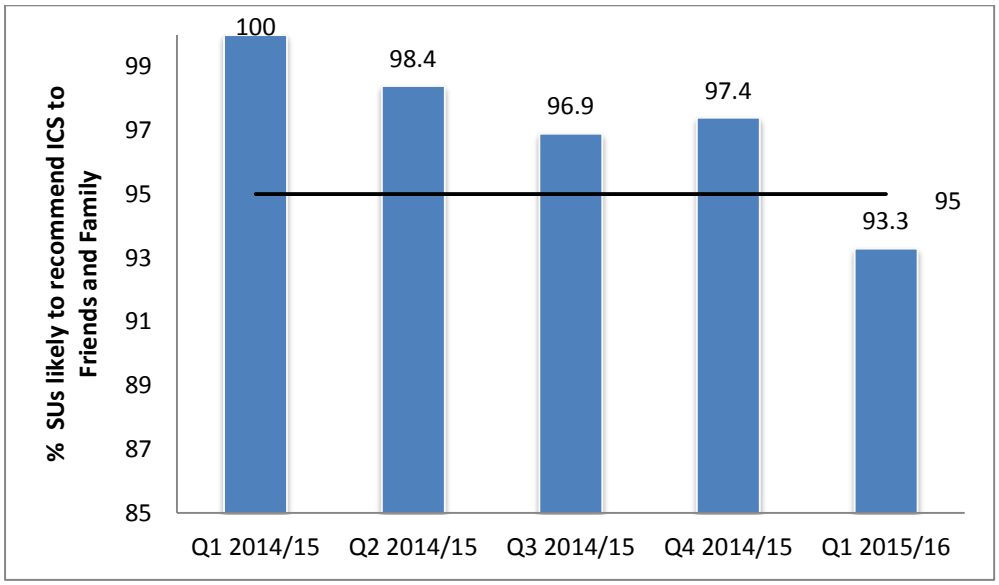
We continue to offer preventative interventions, such as equipment provision and referral to the Council's Staying Put Service. We are working through the Integrated Care Service, with GPs and the Community Geriatrician to identify those at highest risk so we can ensure appropriate timely interventions. We will continue to monitor the impact of interventions and this includes consideration of alternative approaches that can be used to help us reduce admissions as a result of falls.

Table 5 – No. of first finished consultant episodes from patients (aged 65+) admitted due to falls

Financial Year	Age Band	FCEs (first episodes) Q1	Q2	Q3	Q4	Total
2012/2013	65-79	33	40	59	44	176
	80 and over	68	82	81	68	299
2012/2013 Total		101	122	140	112	475
2013/2014	65-79	35	44	33	31	143
	80 and over	48	55	48	82	233
2013/2014 Total		83	99	81	113	376
2014/2015	65-79	34	43	63	39	179
	80 and over	82	75	81	101	339
2014/2015 Total		116	118	144	140	518
2015/2016	65-79	41				
	80 and over	86				
2015/2016 Total		127				

Percentage of service users likely to recommend the Integrated Care Service to friends and family if they needed similar care or treatment.

Chart 5 - Patient / Service User Experience Metric



This indicator is based on responses to a patient/service user survey. Our BCF target is 95%. The results for 2014/15 are based on 152 survey responses. Of these, 148 respondents (97.4%) would be likely to recommend the Integrated Care Service to friends and family. In Q1 2015/16, 75 survey responses were received. Of these, 70 respondents (93.3%) would be likely to recommend the Integrated Care Service to friends and family.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 28th August 2015

This Excel data collection template for Q1 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on local metrics. It also presents an opportunity for Health and Wellbeing Boards to register interest in support. Details on future data collection requirements and mechanisms will be announced ahead of the Q2 2015/16 data collection.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Local metrics - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) Narrative - this allows space for the description of overall progress on plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the 2014-15 Q4 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously you can selection 'Not Applicable' this time.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4. Three figures are required and one question needs to be answered:

Input actual Q1 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell L12
Input actual value of P4P payment agreed locally - Cell D23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Input actual value of unreleased funds agreed locally

This section also requires indication of the area of spend that unreleased funds have been spent on for Q4 and Q1 using a drop-down list. If no funds were left unreleased then 'Not Applicable' should be selected.

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets 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 Q1
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 Q1

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Local metrics

This tab tracks performance against the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In both cases the metric is set out as defined in the approved plan for the HWB and **the following information is required for each metric:**
Confirmation that this is the same metric that you wish to continue tracking locally

Confirmation of planned performance for each quarter of 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Confirmation of actual performance for Q1 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Commentary on progress against the metric and details of any changes to the metric including reference to reasons for changing

7) Understanding Support Needs

This asks what the key barrier to integration is locally and what support might be required in delivering the six key aspects of integration set out previously. This section builds upon the information collected through the BCF Readiness Survey in March 2015. HWBs are asked to:
Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) 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?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Comments	Any unreleased funds were used for: Q4 14/15	Any unreleased funds were used for: Q1 15/16
Yes	Yes	Yes	Yes	Yes

I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the total yearly plan and the pooled fund
Income to	Plan	Yes	Yes	Yes	Yes	Yes
	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
Expenditure From	Plan	Yes	Yes	Yes	Yes	Yes
Expenditure From	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
	Commentary	Yes				

Local Metrics

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local performance metric plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local patient experience plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Understanding Support Needs

Area of integration greatest challenge
Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

Narrative

Brief Narrative
Yes

Cover and Basic Details
Q1 2015/16

Health and Well Being Board	Bexley
completed by:	Alison Rogers, Assistant Director, Integrated Commissioning
E-Mail:	alison.rogers2@nhs.net
Contact Number:	0208 298 6025
Who has signed off the report on behalf of the Health and Well Being Board:	Will Tuckley, Chief Executive, London Borough of Bexley

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	21
6. Local metrics	18
7. Understanding Support Needs	13
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Bexley

Data Submission Period:

Q1 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q4 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board:

Bexley

Data Submission Period:

Q1 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Comment
1) Are the plans still jointly agreed?	Yes		
2) Are Social Care Services (not spending) being protected?	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes		
4) In respect of data sharing - confirm that:			
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress	31/03/2016	At present about 15% of 2014/15 service users on the new ASC case management system have the NHS number recorded. In particular the NHS numbers of clients referred from acute trusts are recorded following receipt of Assessment and Discharge Notices. This allows our integrated teams to use the NHS number as the primary identifier. As part of
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	No - In Progress	31/03/2016	We have in place existing information governance controls for information sharing between some existing organisations, i.e., covering our existing integrated care service (social and health care) and we will continue to build on these arrangements as we move to a single access platform. Therefore, the timescales for developing these arrangements are
5) 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?	No - In Progress	31/03/2016	There is now a joint approach to assessment in integrated rapid response based on comprehensive geriatric assessment. However, work towards ensuring an accountable GP in all cases is still in progress.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes		

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) 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
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) 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

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Bexley

	Baseline				Plan				Actual							Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment						
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed
D. REVALIDATED: HWB version of plans to be used for future monitoring.	4,814	5,076	5,525	5,683	4,766	5,026	5,470	5,637	4,768	5,002			0.9%	199	£295,944	48	98	153	199	£71,013	£74,887	£81,503	£68,540	48	74			£71,013	£110,647			£295,944	£3,962,000	£0

Which data source are you using in section D? (MAR, SUS, Other)	SUS
Cost per non-elective activity	£1,490

If other please specify

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Quarterly payment taken from above	£71,013	£110,647		
Actual payment locally agreed	£0	£0		

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	We are concerned that SUS is unfrozen and non elective (emergency activity) is usually the most complex to code, therefore, to state that we will make a performance payment is too early

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggest amount of unreleased funds	£0	-£35,760		
Actual amount of locally agreed unreleased funds	£71,013	£74,887		

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	acute care	acute care		

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 19th August 2015.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Bexley

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£8,443,000	£2,967,000	£2,967,000	£2,958,000	£17,335,000	£17,521,000
	Forecast	£8,443,000	£2,818,750	£2,892,875	£2,883,875		
	Actual*	£8,294,750					

Please comment if there is a difference between the total yearly plan and the pooled fund	There have been minor changes in the values of projects within the Better Care Fund giving a £186k difference between planning and actuals for 2015/16. However, the value is still in excess of the required value of the Better Care Fund. The Q4 14/15 reduction in activity was not achieved and therefore no payments for this were made in Q1 15/16. In Q1 15/16, the reduction in activity is uncertain and therefore no payment will be made until this is finalised. For Q3 & Q4 15/16 1% reduction is forecast.

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£4,336,000	£4,336,000	£4,336,000	£4,327,000	£17,335,000	£17,521,000
	Forecast	£4,336,000	£4,187,750	£4,261,875	£4,252,875		
	Actual*	£4,187,750					

Please comment if there is a difference between the total yearly plan and the pooled fund	There have been minor changes in the values of projects within the Better Care Fund giving a £176k difference between planning and actuals for 2015/16. However, the value is still in excess of the required value of the Better Care Fund. The Q4 14/15 reduction in activity was not achieved and therefore no payments for this were made in Q1 15/16. In Q1 15/16, the reduction in activity is uncertain and therefore no payment will be made until this is finalised. For Q3 & Q4 15/16 1% reduction is forecast.

Commentary on progress against financial plan:	The End of Life Care scheme is up & running but in Q4 2014/15 no reductions in NEL activity were seen. In Q1 2015/16, the reduction in activity is uncertain and therefore no payment will be made until this is finalised.

Footnote:

Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q4 collection previously filled in by the HWB.

Local performance metric and local defined patient experience metric

Selected Health and Well Being Board:	Bexley
Local performance metric as described in your approved BCF plan	Injuries due to falls in people aged 65 and over (per 10,000 older population)
Is this still the local performance metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	192	0	0	0	0	0		

Please provide commentary on progress / changes:	Please note this is an annual measure. Falls are a significant cause of emergency hospital admissions for older people and have an impact on long term outcomes, e.g. being a major cause of people moving from their own home to long term nursing or residential care. By including this as a local indicator in our BCF Plan, we can measure the success of services in preventing falls and work together to tackle issues locally. There is a timelag in the publication of this data, which forms part of the Public Health Outcomes Framework. The BCF Plan reflected a

Local defined patient experience metric as described in your approved BCF plan	% of service users likely to recommend the Integrated Care Service to friends and family if they needed similar care or treatment.
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	95	95	95	95	97	93		

Please provide commentary on progress / changes:	This indicator is based on responses to a patient/service user survey. Our BCF target is 95%. The results for 2014/15 are based on 152 survey responses. Of these, 148 respondents (97.4%) would be likely to recommend the Integrated Care Service to friends and family. In Q1 2015/16, 75 survey responses were received. Of these, 70 respondents (93.3%) would be likely to recommend the Integrated Care Service to friends and family.

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board:	Bexley

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	3.Developing underpinning integrated datasets and information systems

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Case studies or examples of good practice	
2. Delivering excellent on the ground care centred around the individual	Yes	Case studies or examples of good practice	
3. Developing underpinning integrated datasets and information systems	Yes	Case studies or examples of good practice	
4. Aligning systems and sharing benefits and risks	Yes	Central guidance or tools	
5. Measuring success	Yes	Central guidance or tools	
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Central guidance or tools	

Narrative

Selected Health and Well Being Board:

Bexley

Data Submission Period:

Q1 2015/16

Narrative	Remaining Characters	31,955

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time with reference to the information provided within this return where appropriate.
The Bexley BCF has focused on improving the system of end of life care to prevent unnecessary admissions to hospital for people at this time. We have taken a whole systems approach to this with an emphasis on advance care planning and full use of Co-ordinate My Care (CMC). Since December 2014, we have seen growth in the number of people on CMC from 249 to over 850 people. This is mostly people in the last year of life stating where they wish to be treated and have a care plan. We are monitoring the trend in death in place of choice using data direct from general practice and early indications show an increase from 48% deaths in normal residence in Q1 2014/15 to 56% in the same quarter this year. However, this upward trend in deaths outside hospital is not reflected in the non-elective admission data.