S75/BCF: VFM review

Update to Health and Wellbeing Board

S75 Total Investment 2022-23: Overview

Borough	Barnet
ICB Min Contribution	29,344
Improved Better Care Fund (iBCF)	9,622
Disabled Facilities Grant (DFG)	2,885
BCF Discharge Fund	2,939
Total BCF	44,790
Section 75 (Non BCF)	11,399
Section 75 Grand Total (£'000)	56,189

S75 Total Investment by Borough 2022-23 by area of spend

There is again, **significant variation in approach, particularly in the non-BCF elements of the agreements**:

- Some boroughs include **core-NHS mental health contracts** (Haringey and Camden in particular), others do not;
- Some boroughs have many services sitting outside of a s.75 (Enfield as an example);
- The majority of the budgets are **"aligned" rather than pooled**;
- Some boroughs include **s.117 funding** (mental health aftercare) within the s.75 and others do not;
- Some budget lines included within the s.75 have **no investment from the partner organisation** i.e. they are either completely NHS or completely LA funded with no delegation of commissioning responsibility;
- Some boroughs include **LA-commissioned children's services** within the s.75 and others do not;
- Some boroughs have **shared commissioning teams** for the areas sitting under the s.75 and others do not; and
- With the exception of social care, there is **variation in approach in most areas of spend**.

	Barnet	Camden	Enfield	Haringey	Islington	Total
Area of spend	Budget	Budget	Budget	Budget	Budget	Budget
CAMHS	925	11,091	17	2,935		14,968
Children's	3,631	20,248	427	7,225		31,532
CIC	648	2,382	592	347	388	4,357
Community	13,837	8,203	13,730	13,762	9,450	58,982
End of Life care	1,499		167			1,667
Learning Disabilities	5,166	17,823	5,616	43,348	40,904	112,857
Mental Health	1,415	19,874	2,515	63,376	13,510	100,690
Primary Care		270		985	463	1,717
Safeguarding		315	0			315
Social Care	29,067	28,600	29,173	22,368	30,741	139,949
Grand Total	56,189	108,805	52,237	154,346	95,456	467,033

There is also significant variation in contributions made within s75 agreements between LA and ICB partners within different areas of spend, reflecting historical commissioning

Key opportunities within the review

1 STRENGTHENING INTEGRATION

Within **key areas of joint working at place** such as MH, LD, our UEC pathway, including with our VCS partners.

2 BETTER MEETING POST-PANDEMIC NEEDS OF POPULATION INCLUDING INEQUALITIES

We know our population needs have changed post-pandemic. There are **significant inequalities** in terms of outcomes. In terms of the UEC pathway, we are facing **rising complexity and need**. Borough partnerships have an opportunity through this review to **re-think the way place-based partners work together** to better improve population health outcomes.

3 SETTING THE SCOPE AND MANDATE FOR BOROUGH PARTNERSHIPS

In line with the 'NCL Place paper' (via the NCL Place Editorial Board) the review will act as **a pre-curser for potential delegation to place and an accountability framework.** This is key for supporting population health improvement work.

4 "OPEN BOOK" ACTIVITY AND FINANCE

We need to build a **better shared understanding** of what activity S75 agreements support, including their **productivity and effectiveness** at supporting population health outcome improvement. We can build on the baseline understanding for example, that national reporting for the BCF Additional Discharge Fund provided.

5 DRIVING VFM

The challenges both Local Authorities and the ICB are facing mean it is imperative to ensure together that **every influenceable pound within these agreements drives value**. ICB commissioned contracts and schemes within S75 agreements have not been through a contract review process to ensure VFM for some time.

6 BOOSTING ALIGNEMENT WITH NATIONAL OR LOCAL OBJECTIVES

S75 agreements should form the **basis for how we drive population health outcome improvement together**. In addition, all schemes within the **BCF** should support its aims, objectives and tangibly **drive at least one national metric (see slide 20).**

*See slides 21-22 for further information re. potential thematic opportunities within the BCF.

Principles and process 1/2

Following the publication of 2023/24 planning guidance, and the local government settlement, it is clear commissioning organisations will be operating in a **financially-constrained environment for at least the 2 two years.**

The following slides set out a **potential process,** for undertaking a shared, borough-based review of schemes and contracts to: (a) identify where potential opportunities may sit within local s.75 agreements, and (b) determine next steps.

Principles

It is proposed that joint (Council and NHS) reviews reflect the following principles:

- ✓ Taking shared Cabinet / corporate responsibility
- ✓ Appropriate time and senior input is committed
- ✓ Recommendations are scoped / agreed locally, and endorsed at system level
- ✓ An agreed route for escalation to support reviews commencing / continuing, and for resolving matters as required

Process

- Review to be co-led by Council and ICB lead
- Two stage process. Initial meeting to review / moderate / agree the schemes to focus on (*informed by matrix overleaf*). DCS, DASS, DPH and DOI to be involved
- Further meeting/s with co-leaders, and to be informed by joint commissioners to scope viable changes and efficiencies
- An ongoing T&F group to manage the delivery of specific projects, and to unblock potential issues
- A system-level fora should be identified where wicked issues can be fed back / addressed, and to provide space for considering schemes of pan-NCL value.

Principles and process 2/2

Identifying potential opportunities

- Joint review with schemes scored once by NHS and once by Council
- Scores to be shared and moderated through a joint meeting
- Opportunities can be agreed through:
  - 5 lowest-scoring schemes
  - Thresholds i.e. those under 10 points

Scoping action

- Once schemes are identified for more detailed review, joint commissioner input is key to quantify opportunities, and scope plans to implement
- Potential dispositions:
  - Terminate duplicative / overlapping schemes (commissioning efficiency)
  - Reprocure an individual scheme (contract efficiency)
  - Align and procure related schemes, at borough or NCL level (contract efficiency)
  - Vary an individual scheme – finance, scope/do-differently (operational efficiency)
  - Align and vary related schemes, at borough or NCL level (operational efficiency)

Potential **scoring framework** to identify opportunities

Scoring	**Strategic fit** *"Does the scheme deliver population health, borough partnership, and/or NCL system priorities?"*	**Economic value** *"Does the scheme meet local demand and need? And how efficiently is the scheme delivered assessed against comparators?"*	**Service effectiveness** *"Does the scheme demonstrate proven benefits for residents, clinicians, and the wider system?"*	**Ability to re-provide in an alternative way** *"Is the scheme provided in the most efficient and appropriate way, without alternative means to deliver?"*
5	Statutory services	Delivers over and above original baseline in terms of activity, complexity, or by addressing unmet need; and/or at exemplary unit cost	System-wide impact, robustly demonstrated, with a range of preventative outcomes	Setting of, or delivery model for, scheme is crucial to achieving outcomes; and/or cannot be rescoped due to geographic, economic or technological factors
4	Core services	Delivers original baseline in terms of activity, complexity, or by addressing local demand; and/or at a competitive unit cost	Service-level impact, robustly demonstrated, with a blend of preventative outcomes and operational outputs	Setting of, or delivery model for, scheme is important to achieving outcomes; and/or would be challenging to rescope due to geographic, economic or technological factors
3				
2	Discretionary services	Falls short of original baseline in terms of activity, complexity, or does not meet local need or demand; and/or at an uncompetitive unit cost	Narrow impact, and/or demonstrated in a limited way, with largely operational outputs	Setting of, or delivery model for, scheme is unrelated to achieving outcomes; and/or could be rescoped to better meet geographic, economic or technological needs
1				

Potential **scoring sheet** linked to the framework and review requirements

Provide tangible evidence of the impact against at least one population heath/national BCF metric (as appropriate) is being improved through the scheme including measurable impact such as bed days saved, admissions avoided, £ system savings etc.

How can the service be organised in a way that creates more value to the system e.g. in terms of the impact on metrics/pop health oucomes, activity, inequalities, changing the model or if not possible, decommissioned.

Scheme /Contract Name	(£)	Lead Org'n	Score from opportunity framework analysis (slide 15)	Which local or national metrics does the scheme drive and what contribution does it make?	Inequalities: contribution made by the service and/or how this could be enhanced?*	Cost per intervention analysis and benchmark	Explain how additional value could be enhanced from this service	Recommended outcome	What are the next steps to realise additional value from this service?
e.g. jointly comm P2 beds	*£480k*	*LA*	*5*	*N/A as unit does not meet P2 clinical criteria*	*The service is currently poorly utilised so the contribution is likely to be suboptimal and other social care interventions are likely to be more beneficial to tackling inequalities*	*£12k per episode vs £7k in units elsewhere which can meet clinical criteria*	*Significant options have been explored to assess whether clinical standards could be met – however this is not viable due to registration conditions* *Discussions are taking place including at DASS level on next steps with a view to potential consultation on the future of the service.*	*Consider termination*	*Discussion with DASS to agree approach (Jan 11th)* *Finalise governance approach in both LA and ICB (end January)* *Finalise suite of consultation documentation including QIA and EQIA (by mid February)*

For this section if you are unable to provide measurable impacts that justify the spend then you may need to consider whether this service should continue at all.

How much does each intervention cost (total contract size/activity). How does this compare with other similar services across NCL? Is the cost per episode and associated impact sufficient to justify the expenditure?

*Further work taking place on methodology for this element by ICB Communities team with suggested input from LA colleagues

High level timeline for joint review

Place based initial review of schemes

- Refine principles and process with LA colleagues
- Agree internal and external comms
- Place based review of schemes in line with potential scoring matrix and checklist for BCF schemes (slides 13 and 15)
- Identification of schemes for more detailed review

During February

Scoping action

- Once schemes are identified for more detailed review, joint commissioner input is key to quantify opportunities, and scope plans to implement

Potential dispositions:

- Terminate duplicative / overlapping schemes (commissioning efficiency)
- Reprocure an individual scheme (contract efficiency)
- Align and procure related schemes, at borough or NCL level (contract efficiency)
- Vary an individual scheme – finance, scope/do differently (operational efficiency)
- Align and vary related schemes, at borough or NCL level (operational efficiency)

March/April

Decision phase

- Confirm recommendations at relevant jt. governance including any next steps associated with relevant decision making forums in the ICB or LAs;
- Read across with relevant NCL governance – a report would be provided to the SDC on 21st June (for example); and
- Commence decision making process via appropriate governance where possible, e.g. for ICB commissioned contracts if a decision was made to terminate, duties around service change would need to be followed Quality Impact Assessment (QIA); Equalities Impact Assessment (EQIA)) would be required to inform relevant ICB/ICS decision making.

May/June

Implementation phase

- Implement optimised ways of working between organisations as part of partnership forums or within individual providers where this is about a change in service delivery
- Incorporate changes within joint planning for 2023/24* (with regard to notice periods for any services decommissioned/varied where applicable) via joint planning process:
- For BCF – set stretching joint metric ambitions for 2023/24 in line with changes agreed via joint planning process

July to Dec

*The committee should note any proposed changes to services commissioned through BCF or s.75 agreements must reflect the ICB's formal duties around both service change and contractual notice period. This means most proposed contractual changes will be subject to a lead in time to implement.

Appendix B: Themes for exploration within the BCF 1/2

A **Dementia Services (c. £1.86m)**	• Both ICB and LA's (dependent on borough) have contracts for dementia support • These services contribute to helping keep people at home and independent and admission avoidance • Are all optimised to add sufficient value to BCF metrics achievement given our UEC pressures? • Does unit cost analysis and comparison vs. the different models suggest value for money or an optimal approach?
B **P2 Beds in care homes (c. £2.6m)**	• Local Authorities and the ICB jointly commission P2 beds in care homes • The CSR P2 review has highlighted that care home based provision does not meet clinical criteria required for P2 at Mildmay, St Anne's and PWH (Islington/Haringey): opportunity to agree a joint approach re. the future of this provision and alternatives.
C **Staffing spend (c. £1.59m)**	• Is all of this funding (which is in both NHS and LA sides of BCF) recurrently spent? Are there any vacancies that have not been recruited to for a long time – are they still needed? • Do the staffing costs contribute sufficiently enough to BCF ambitions and metrics?
D **Discharge teams (c. £1.7m)**	• Initial analysis suggests that this is not duplicative with non-recurrent funding for Integrated Discharge Teams in 2022-23 • The areas that receive funding for this within the BCF seem to be very variable e.g. Barnet Hospital acute discharge team (£150k); Camden ASC (£300k); Haringey ASC SPA (£266k) etc. Are we confident this funding is having the impact on 7 day discharges that it needs to? • Are there areas of potential duplication with what we have committed to as part of the new ASC BCF funding?
E **Non-BCF services? (c. £2.1m)**	• The following services are all funded via the BCF and whilst the services may be required, they may not tie closely in with the BCF's aims, ambitions and metrics e.g. children's services in Camden (£776k); a Fracture Liaison service in Barnet (£109k); the Barnet CHS SPA (£350k) and IAPT in Enfield (£314k); Carer Bereavement Service (£84k) • Two possible scenarios: a) more appropriate substitution with areas of core contracts that tie in to BCF better or b) 'difficult decision' reviews

*Please note financial values are approximate based on desktop thematic analysis of Autumn 2022 planning returns

Appendix B: Themes for exploration within the BCF 2/2

F **Carers Support (c. £3.9m)**	• The role carers play is crucial to admission avoidance, discharge and the aims and objectives of the BCF • Commissioned by both ICB (some in Islington) and LA (others) in line with historic arrangements • Are we collectively confident between Local Authorities and the ICB that this invaluable support to the system is optimised? Do we understand which models work best across NCL and are we supporting partners to link into place based partnership improvement work sufficiently well?
G **Various others (c. £1.1m)**	• There are a range of contracts that may benefit from a value for money/impact review including unit cost analysis to assess whether they are adding maximum impact, or whether given the challenging financial situation for both the NHS and LA's other services should be prioritised for funding. • Note for some: sufficient detail not available in BCF submissions re. the service context and descriptors • For example: ASC in Primary Care in Camden (£671k); Family Group Conference in Camden (£64k) – LA ; PH Intervention F21M Islington £150k
H **Core Services across NHS Providers and ASC/LA (c. £164m)**	• Are we confident that we understand how this funding is spent in line with the aims and ambitions of the BCF or iBCF? • In terms of the NHS, are we substituting appropriate parts of provider contracts that most support admissions avoidance and discharge? If not, are there more appropriate things we can substitute in order to ensure alignment? • How mature is partnership work between partners at place to drive improvement in admission avoidance and discharge?

*Please note financial values are approximate based on desktop thematic analysis of Autumn 2022 planning returns

Appendix C: S75 Investment by Borough 2022-23 (showing LA and ICB contributions)

	Barnet			Camden			Enfield			Haringey			Islington			Total		
Area of spend	Budget	ICB	LA	Budget	ICB	LA	Budget	ICB	LA	Budget	ICB	LA	Budget	ICB	LA	Budget	ICB	LA
CAMHS	925	925	0	11,091	8,100	2,991	17	17	0	2,935	1,785	1,151				14,968	10,826	4,142
Learning Disabilities	5,166	3,193	1,973	17,823	6,737	11,086	5,616	2,386	3,230	43,348	12,452	30,896	40,904	5,580	35,324	112,857	30,349	82,509
Mental Health	1,415	475	940	19,874	9,650	10,224	2,515	1,634	882	63,376	46,781	16,596	13,510	6,548	6,962	100,690	65,087	35,603
CIC	648	324	324	2,382	2,382	0	592	592	0	347	347	0	388	388	0	4,357	4,033	324
Children's	3,631	2,983	648	20,248	10,349	9,899	427	302	125	7,225	297	6,928				31,532	13,931	17,601
Safeguarding				315	65	250	0	0	0							315	65	250
Community	13,837	13,837	0	8,203	8,203	0	13,730	12,687	1,043	13,762	13,741	21	9,450	8,592	858	58,982	57,061	1,921
Primary Care				270	270	0				985	985	0	463	463	0	1,717	1,717	0
Social Care	29,067	15,405	13,662	28,600	13,608	14,992	29,173	11,620	17,552	22,368	8,926	13,442	30,741	12,659	18,082	139,949	62,218	77,731
End of Life care	1,499	1,499	0				167	167	0							1,667	1,667	0
Grand Total	56,189	38,642	17,547	108,805	59,363	49,442	52,237	29,406	22,831	154,346	85,313	69,034	95,456	34,230	61,226	467,033	246,953	220,080

Exclusions

1. S256s
    - Tripartite (0 – 18)
    - S117 joint funding arrangements
    - Contribution to discharge brokerage

2. NHSE passthroughs:
    - SRS legal support and advocacy
    - Youth Justice Service
    - Mental Health Early Help
    - Mental Health Support Teams

3. Staffing funding for joint team currently under discussion as part of ICB restructure

Summary of scoring

Scoring	Investment lines evaluations
Excluded	8
0 – 5	2
6 – 10	1
11 – 15	3
16 - 20	29 (17[6], 18[8], 19[6], 20[9])

Recommendations - projects for greater review

Using a scoring threshold of ≤10:

- Frailty MDT - £76k
- Fracture Liaison Service - £109k
- Enhanced Health in Care Homes - £207k

Total - £392k

Further areas for consideration:

1. Use of the next round of planning for 23/24 BCF to identify opportunities for alignment with core offer implementation

2. Identification of key areas for greater investment in the event funding becomes available locally or through central allocations

3. Clearer articulation in BCF narrative of links with equalities and opportunity to diversify delivery models to third sector and through community led initiatives

4. Care Home LCS investment in context of equitable support and provision across NCL and a consistent primary care offer for residents of care homes.

5. Investment and sustainability of funding for Children's Integrated Therapies to meet current and future demand and deliver a full core offer of universal and statutory support