TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

21st JANUARY 2015

BETTER CARE FUND UPDATE REPORT

REPORT OF: FRAN BECK EXECUTIVE LEAD FOR COMMISSIONING TELFORD AND WREKIN CCG AND CLIVE JONES ASSISTANT DIRECTOR FAMILY, COHESION & COMMISSIONING

LEAD CABINET MEMBER: CLLR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 The Better Care Fund (BCF) is a national programme, jointly led by Telford & Wrekin CCG and Telford and Wrekin Council. The aim of the BCF programme is to transform the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care by:

- Delivering the best possible health and social care outcomes for individuals in a personalised way.
- Promote and encourage self-help and self-care wherever and for as long as possible
- Enabling those at increased risk of hospital, nursing or residential care admission to have easy access to systems in place, to get appropriate help at an early stage.
- Ensuring financial efficiency and reducing duplication.

1.2 The initial focus is on the transformation of services for adults needing high levels of health and/or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission to hospital or care home
- Discharged from hospital with a need for rehabilitation and/or enablement

1.3 To deliver the BCF aims, two thematic areas and objectives have been developed which are:

1.4 Theme (Scheme) 1 - Building Community Capacity in Telford and Wrekin

- To review current spend by both organisations on the voluntary sector services to develop shared understanding of how to improve the effectiveness of the sector

- To support improvements in the infrastructure of the voluntary sector
- To jointly design and procure a range of support services that can be delivered by voluntary and community organisations
- To work through a robust engagement process with self-help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
- To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.
- Achieving efficiency and reducing duplication

1.5 Theme (Scheme) 2 – Enhanced community services for Telford and Wrekin as an alternative to hospital provision

- To maximise use of pooled resources to improve and enhance the quality, value for money, and outcomes of currently funded services.
- To model the number of people that can be supported in Out of Hospital care, the staff required (clinical and care) and the future costs.
- To establish an enhanced and expanded integrated and multi-disciplinary 'Out of Hospital Service'. This will provide a comprehensive continuum of services from admissions avoidance to end of life care.
- To utilise non-recurring Transformation monies in the CCG allocation for 14/15 to 'Invest to save' in staff and processes, evaluate Pilots and innovations to reduce admissions in readiness for 2015/16.
- To establish processes for referrals/access/assessment and support by the enhanced integrated service including the establishment of a Single Referral Point.

1.6 An update on progress is provided in Part B section 1

1.7 Six performance measures are being used to monitor progress through the BCF Programme Management Board:

- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Improved patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.
- Reducing emergency admissions in 65 years + age group.

An update on performance is provided in Part B section 1

2. RECOMMENDATIONS

2.1 The following recommendations are made

2.1.1 Note the formal approval of the Better Care Fund
2.1.2 Note the progress and developments of the work-streams
2.1.3 Ensure respective organisations support and facilitate approved BCF implementation within the identified timescales

3. IMPACT OF ACTION

There was significant focus on detailed work to ensure formal approval of the submission. With formal approval the focus is now fully on implementation. Key actions will be:

- Agreeing the Pooled Budget arrangements for 2015/16 including how financial risks will be shared
- Agreeing the investments within specific teams and services within the Pooled Budget to maximise likelihood of achieving targets and outcomes
- Reductions in admissions by at least 3.5% for Payment for Performance and 7% to achieve the local target.
- Achievement of key targets should improve quality and reduce costs to the economy

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Improve emotional health and wellbeing of Borough residents. Support people with specific health needs to live independently for as long as possible. Support people with dementia
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	Vulnerable adults and children
	Will the proposals impact on specific groups of people?	
	No	The BCF will impact on all groups.
TARGET COMPLETION/ DELIVERY DATE	The BCF will commence from April 2015. The Pooled Budget (section 75) will commence on that date.	

FINANCIAL/VALUE FOR MONEY IMPACT	Yes	In Telford, the net contribution to the Better Care Fund in 2015/16 will be to £12.068m. Significantly more detail showing how the fund will be spent and the expected value of benefits is now included in the plan. This plan is required to consider risk in more detail describing the process for developing a risk sharing model. The final risk sharing model will need to be approved by all parties as part of the finalisation of the Section 75 legal agreement with final approval by the HWBB. This work is still ongoing. Whilst all metrics included within the plan will be monitored, only the reduction in admissions target will have any impact on funding to the Pooled Budget. The required minimum 3.5% reduction is linked to £840k of performance pay which will be held back out of the Pooled Budget and only released as and when admission reductions are achieved. If they are not achieved then this money will flow to the acute sector to fund admission activity. This is currently the only quantifiable financial risk known. Potential areas of financial risk are being identified but further work will be needed to ensure the value of these risks can be identified.
LEGAL ISSUES	Yes	NHSE planning guidance set out the process and format for developing the BCF plan. There were specific requirements in relation to national requirements, which have been acknowledged as now being attained through being formally Approved. However, the Council and CCGs have their own requirements to have effective Governance, contract management and data protection processes in place. Where the BCF results in possible changes to existing service provision to people, consideration will be given through Quality and/ or Equalities Impact Assessment and consultation will be undertaken. New integrated provisions will bring significant changes to the commissioning of some Council and CCG commissioned services. Where changes affect the Council and CCG commissioning plans, separate reports through respective Governance structures will take place. Where identified, clarification with respective legal advice has been, and will continue to be, utilised.

		TWC Legal Comments:- NHSE appointed external lawyers have produced an overarching generic BCF s75 Agreement (entitled the "***Framework Partnership Agreement Relating to the Commissioning of Health and Social Care Services***") which will need to be reviewed by the Council, and by negotiation and cooperation between the parties, will become a final draft document to be used. Its commencement date should be no later than the 1st April 2015 (but may be earlier) so any such review and discussions, particularly over potentially complex issues such as risk sharing and overspends, governance arrangements and joint working should take account of such a timescale, how the partnership is to be structured and how the specific outcomes are to be delivered in order to ensure that the document properly reflects the aims and outcomes of the Better Care Fund plan. Under the BCF s75 Agreement the Partners will need to demonstrate that they have jointly carried out consultations with all those persons likely to be affected by the arrangements, as required by the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).
EQUALITY & DIVERSITY	Yes	The BCF is intended to reduce risks of admissions to groups at high risk of hospital admission as identified from local analysis. Further targeted engagement of hard-to-reach groups has been identified as an action.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	Yes	Engagement has taken place with: Carers Partnership Board Joint Scrutiny Committee Local Strategic Partnership Health Round Table Shropshire partners in Care Voluntary Sector Chief Officers Group A BCF launch event took place in June 2014. 69 stakeholders attended including users, carers and representative groups. Healthwatch are a member of the programme

		Management Board and all work-streams
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	A risk register was completed as part of the BCF submission. Risks identified include: • Lack of engagement of stakeholders and patient groups • Failure to reduce reliance on acute care • Lack of transformation of models of working • Lack of numbers of GPs locally • Insufficient capacity within the local community to support self-help/ self-care • Implications of under-or overspending on the BCF pooled budget • Lack of agreement of team base location Mitigating actions and risk scores are reviewed at each Programme Management Board.

PART B) – ADDITIONAL INFORMATION

1. **INFORMATION**

1.1.1 Update on Progress
A resubmission of the BCF plan was made to NHS England on 19th September 2014. Through a National Consistency Assurance Review (NCAR) the economy's submission was rated as 'Approved with Support'. 26 areas were identified as needing further actions and an Action Plan was developed and agreed with NHS England for completion by 28th November 2014 in line with national requirements.

1.1.2 All action plans and further evidence submitted were re-assessed and rated by NHS England. On 22nd December 2014 the economy was informed that the revised plan has been classified as **'Approved'**. The submission was described as 'clear and ambitious and we support your ambitions. This puts you in a strong position for delivering the change outlined above'.

1.1.3 The BCF Programme Board has adopted a Programme Management Office approach to delivery of the BCF programme. This includes the establishment of 5 work-streams to lead the key elements of the work. Each work-stream has an identified project lead and CCG Executive or Council Senior Officer sponsor. The work-streams are:

- Community Capacity
- Single Point of Access
- Single assessment and care planning
- Integrated Community Enablement Service
- Data Sharing

1.14 A process of regular monthly reporting to the Programme Management Board is in place and includes:

- Work-stream progress update reports against the Implementation Plan and Quality Impact Assessments from each work-stream lead
- Risk Register update
- BCF programme overall Performance report
- BCF Programme overall Finance Report

1.2 Summary of progress within each BCF theme:

1.2.1 Theme 1: Increasing Community Capacity/ Community Capacity Work-stream
A work-stream has been established and some of the overlapping work areas are being progressed as part of the Council's overall Prevention work programme to avoid duplication.

1.2.2 A Prevention strategy has been developed with the overall objective of supporting people to remain in the community and avoid moving into care – whether provided by social care or health services. The strategy describes four tiers of care and support. For each of the four tiers a summary is provided of what each tier involves by way of service provision; what each of the services aims to deliver and what the expected outcomes are.

1.2.3 Tier 1 - delivers local approaches to keeping people healthy and in control of their own wellbeing.
Tier 2 - delivers higher level services in the community that are preventative and not statutory
Tier 3 - delivers services that the council and CCG have a statutory obligation to provide, in the community
Tier 4 - delivers specialist services (acute and complex) still aiming to avoid admission into long term services

1.2.4 Improved links have been forged with the voluntary sector through the Voluntary Sector Chief Officer Group (COG) meetings. Each member organisation has completed a template of the contribution they can make to all BCF work areas (which align to the four tiers above):

- Preventative activity
- Team around the GP
- Rapid Response and community- based enablement.

1.2.5 A 'working together' event has been held organised by the voluntary sector and a smaller number of voluntary sector organisations have formed a Network group to assist in progressing BCF.

1.2.6 Following a Network meeting on 22nd October 2014, a proposal was supported by the BCF Programme Management Board for Transformation funding to support a Voluntary Sector Coordinator post to be co-located with Rapid Response to support admission avoidance. This role will co-ordinate potential referrals to voluntary sector services for low level support; support admission avoidance and gather the data and evidence required to demonstrate cost benefit analysis of voluntary services.

1.2.7 Work is progressing through Public Health to engage with self-help organisations and establish ways to strengthen them and improve signposting. Further work is required between the voluntary sector and data and performance teams to establish robust ways of collecting outcomes.

1.2.8 CCGs are implementing a Grant Making Framework. This enables the CCG to support voluntary sector organisations who contribute directly to CCG priorities. It also allows a more robust transparent means of scrutinising proposals and monitoring outcomes than has previously been deployed.

1.2.9 Consultation workshops took place in October 2014 and the overall response was very positive. A number of questions were raised during the workshops about the new grants process which we have responded to. Grant applications can now be submitted. Implementation of new services will commence from April 2015.

1.2.10 The Council Commissioning team is undertaking a detailed needs analysis of the provider sector which will be linked with the work on increasing community capacity.

1.3 Theme 2: Integrated Enhanced Community Services

This theme has a number of component work-streams:

- Single Point of Access
- Single assessment and care planning
- Integrated Community Enablement Service
- Data Sharing

1.4 Single point of access and single assessment and care plan work-streams

1.4.1 These two work-streams are being managed together and form an integral part of the development of the integrated community enablement service. The key principles and requirements of a single point of access were developed as part of the joint workshop on 18th December 2014.

1.4.2 It is recognised that there are different opinions and options about the development of a single, Single Point of Access to services from the existing provisions – Shropdoc, Council's Access, Shropshire Community Trusts' SPoA, 111 and the mental health Trusts access points (CMHTs and Psychological therapies). Discussions and analysis continues to take place about the development. This work-stream is behind Implementation Plan timescales.

1.5 Integrated Community Enablement Service work-stream

1.5.1 This work-stream is focussed on the phased development of a fully integrated health and social care team. Extensive mapping of existing services across primary care, community services, acute hospital, voluntary sector, third sector and social care to establish an overview of

all services currently provided, their key role, numbers of staff and current activity/capacity.

1.5.2 A key part of the service model is to co-locate the existing service elements within a single central location, bringing together elements from social care, community care, acute care and the voluntary sector to work in a more integrated way. To facilitate this, a detailed option appraisal has been undertaken of all potentially suitable locations across the Telford area. Additional discussion is taking place to agree the location for the team.

1.5.3 To further support the development of phase 2 (integrating via co-location of Rapid Response with the Enablement team), a multi-disciplinary workshop involving all main stakeholders was held on the 18th December to establish the key principles of the service model and specification for an integrated enhanced community enablement service. A detailed service specification is now being developed which will set out the anticipated activity, workforce, finance and management/governance requirements for the new service.

1.5.4 The Accelerated Admission Avoidance Pilot commenced on 7th July 2014, to test out the implementation of improved pathways to reduce admissions. The pilot enhanced the existing Rapid Response Team to enable delivery of intensive Rapid Response interventions with the aim of reducing admissions by up to 5 per day. Referrals were encouraged from GPs, WMAS, care homes, 111 and SaTH of patients from the target population identified on page 1 of this report.

1.5.5 After 3 months the pilot had received 183 referrals and an admission to hospital was successfully avoided for 112 of these (61%). Further 3 months data identifies a similar level of referrals.

1.5.6 Further innovations are in place. Shropshire Community Trusts Nurse Consultant attends SaTH on a daily basis. This is avoiding admissions of people conveyed by ambulance on a daily basis.

1.5.7 Rapid Response Nurses are travelling with WMAS crews to illustrate the patients they could maintain at home. This would support the current pathway as agreed within the 111 Directory of Services.

1.5.8 Rapid Response Nurses are arranging to pilot home visits with GPs to identify those who they could be maintained at home with appropriate health and social care support.

1.5.9 A care home helpline was developed by Shropdoc. Since July 2014 this has been in place, initially piloted with a small number of care homes. Full roll out took place in October. 49 admissions have been avoided through utilisation of this approach to the end of December 2014.

1.6 Rehabilitation sub-group

1.6.1 This sub-group is focussing on the transition of rehabilitation services from within an acute hospital setting into a community setting is a key

part of the development of the integrated enablement service. The CCG has formally de-commissioned enhanced rehabilitation from June 2015 from SaTH and an alternative model and approach is being developed with acute and community stake-holders.

1.6.2 To facilitate development:

- the existing service provision within the community has been mapped
- acute rehabilitation activity has been analysed
- an audit has been carried out by SaTH, Shropshire Community Trust and Enablement therapists to identify rehabilitation needs and activities
- a new service specification for community rehabilitation has been developed; informed by the above
- a further prospective review and audit of all patients fit to be discharged is being carried out during January 2015 by SaTH therapists in order to analyse their rehabilitation as part of acute care and community rehabilitation needs

1.6.3 There is strong engagement from the SaTH therapists to co-create the model; have closer integration with enhanced enablement services and work within the community.

1.6.4 The developing model has been shared with SaTH Executives to demonstrate progress the alternative rehabilitation model. The further analysis is intended to clarify the need for hospital based rehabilitation outside the existing tariff costs.

1.7 Data sharing work-stream

1.7.1 This work-stream is an enabling work-stream focusing on the development of data sharing principles to ensure:

- effective data sharing is in place to meet current and immediate future needs for more integrated working
- plan for and develop an integrated record across the local economy in line with the national requirement
- ensuring effective Information Governance is in place to support current and future development of data sharing arrangements across the participant health and social care organisations involved in the BCF programme.

1.7.2 An additional local development is to bring together health and social care activity and financial information to model trends and develop approaches to deliver services more cost effectively across the economy. The economy is part of a Pilot programme with Midlands and East Commissioning Support Unit (CSU) and a private company (Pi Healthtrak).

1.7.3 The Information Governance issues have now been resolved sufficiently to enable health and social care data can be analysed anonymously. The Project Team from the CSU will be working with local economies to agree the local implementation timescales to be able to utilise available data.

1.7.4 A work-stream group is currently being established with cross-organisational representation from senior IT and Information Governance leads. This group will identify further task and finish sub-groups to lead on individual elements of programme work-stream. The group will also review the timescales set out within the Implementation Plan. It is recognised that the development of a single shared record for health and social care will likely require interim solutions as part of a phased implementation plan over the next 1 to 2 years.

1.7.5 A key requirement of the BCF programme to the success of this work-stream is that all organisations use the NHS number as the primary identifier. This is in place within all healthcare providers but has yet to be fully implemented across social care.

1.8 BCF Performance for October '14 (as reported to December programme board).

BCF Indicator	Period	Target	Actual	FOT	RAG	Trend
Total non-elective admissions in to hospital (general & acute) all-age, per 100,000 population	Qly	Q2 2271 FY 9424	Q2 2393	9892	A	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population	Annual	14/15 550 15/16 498	14/15 No Data	546	G	
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Annual	14/15 65 15/16 66	14/15 No Data	Proxy Data	A	
Delayed Transfer of Care (delayed days) from hospital per 100,000 population (aged 18+)	Monthly	Q3 497 FY 3072	Q2 1317	4320	R	
Question 32 of GP survey - proportion of patients feeling supported to manage their condition	Annual	14/15 64.4 15/16 65.6	*Published Aug 2015*	No Data	ND	
Total PbR emergency admissions into SaTH NHS Trust, aged 65+, per 100,000 population	Monthly	Q2 4048 FY 16191	Q2 4976	19833	R	
Quality Premium Indicator Reduction in avoidable emergency admissions	Qly	Q1 556 FY 2132	Q1 578 *CSU Proxy Indicator*	2184	A	

Key:

R	Off track - High risk of non-achievement
A	Off track - Moderate risk of non-achievement
G	On track to deliver
ND	No data provided/available

1.8.1 In summary:

- The overall rate of non-elective admissions has been above target for the previous 2 quarters, however this appears on a downwards trajectory and has been demonstrating month on month reductions.

- Contract monitoring information shows that overall admissions to SaTH for frail and complex patients during August and September reduced by 178 admissions compared to the same period last year.

- Performance against the measure 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per

100,000 population' is monitored using proxy data but currently appears on track to deliver by the year end.

- Actual 2014/15 performance for the indicator 'Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services will be taken from October, November and December 2014, with the 91 day follow-up falling in January, February and March 2015. Therefore actual performance data is not yet available.

  The data provided represents indicative values only and a system for regular and more frequent monitoring and reporting of the actual metric is required. Current data is for the number of people starting and ending enablement and does not actually demonstrate the number still at home 91 days later. This represents a risk to the BCF programme.

- Compared to the same period in 2013/14, the rate of PbR emergency admissions per 100,000 population was lower for five out of the 7 months so far this year - only July and September were higher. However the rate has still been above the BCF target for all 7 months, suggesting a forecast outturn admission rate per 100,000 population of 19833 against a target of 16191.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

2.1 No further details to include at this time

3. PREVIOUS MINUTES

3.1 The BCF submissions have been presented to the Health and Well-Being Board at the February, April and September meetings for Approval.

4. BACKGROUND PAPERS

4.1 A number of reports are available:

- NCAR Action Plan submitted 14th November 2014
- BCF Re-submission Planning template 28th November 2014
- BCF Re-submission Performance and Finance template 28th November 2014
- CCG Governance Board report: Accelerated Pilot Evaluation report
- Pooled Budget agreements for 2014/15 (two section 256 agreements; one section 75 agreement) – previously presented to HWB Board
- Draft Integrated Community Enablement Team Service Specification
- Draft Rehabilitation Service Specification

Report prepared by Michael Bennett Head of Commissioning for Integrated Care Telford and Wrekin CCG 01952 380457