TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD - 10th JUNE 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

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 the Borough of Telford & Wrekin. 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.
- Promoting and encouraging 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

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

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:

- **Note the progress of the Better Care Fund programme**
- **Note the progress of the development of the section 75 pooled budgets agreement**
- **Ensure respective organisations support and facilitate approved BCF implementation within the identified timescales**

3. IMPACT OF ACTION

3.1 Key actions for the development of the Better Care programme are:

- Finalise and sign the s 75 agreement
- 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

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>Improve emotional health and wellbeing of Telford and Wrekin residents.

Support people with specific health needs to live independently for as long as possible.

Support people with dementia</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>Vulnerable adults and children</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>No</td><td>The BCF will impact on all groups.</td></tr>
<tr><td>TARGET COMPLETION/ DELIVERY DATE</td><td colspan="2">The BCF will commence from April 2015.

The Pooled Budget (section 75) will commence on that date.</td></tr>
<tr><td>FINANCIAL/ VALUE FOR MONEY IMPACT</td><td>Yes</td><td>In Telford, the Better Care Fund Pooled Budget in 2015/16 will be £12.529m.

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 the reductions are not achieved this money will flow to the acute sector to fund admission activity. This is currently the only quantifiable financial risk known. This amount is currently identified as a contingency within the Pooled Budget and will be available for repayment to the CCG of pump priming being invested in 2015/16 and investment in the Care Act up to a maximum of £409k.

The final s75 agreement will include schedules detailing the financial governance arrangements, scheme by scheme budgets and a risk share agreement.</td></tr>
<tr><td>LEGAL ISSUES</td><td>Yes</td><td>The BCF s75 Framework Partnership Agreement (“the Agreement”) is based on the template generic agreement drafted by Bevan Britten</td></tr>
</table>

		solicitors for NHS England, and released for use by any Health Service body or Council. The Agreement provides the legal framework for a pooled budget between the Council and the CCG and also provides for future flexibility via the likes of the optional Non-Pooled Fund which has its contributions identified but held separately and transferred between partners via separate standard agreements under s76 and s256 of the National Health Service Act 2006. The Agreement sets out the terms on which the Council and the CCG have agreed to collaborate and establish a framework through which they can secure the future position of health and social care services through lead commissioning arrangements. Whilst the Agreement "Commencement Date" of the 1st April 2015 has passed without the generic template being finalised it has been progressed to a first-draft stage by the Council and this has been shared with the CCG for its approval of, and/or comments on, the various amendments and populations and for its input into the Agreement schedules. Once agreed and finalised, the Agreement will be formally executed by both parties. The NHS England generic template agreement makes clear that the commencement date should be no later than the **1st April 2015**. Due to its generic nature the parties are required to agree to various optional drafting, within the template, and to formulate (and agree) the contents of its various schedules, such as aims and outcomes, financial contributions, risk and benefit sharing arrangements etc. The difficulty of not having a formal written agreement, duly agreed and executed, as of the commencement date, creates a potential contractual risk, for both parties, as to the precise terms that the parties are contractually obligated to, and their commitment to practical obligations within any draft schedules, should there be a dispute or litigation, something that Clause 23 of the Agreement clearly makes allowances for. 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 CCG 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.
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 Local Strategic Partnership Health Round Table Shropshire Partners in Care Voluntary Sector Chief Officers Group A BCF launch event took place in June 2014. A follow up event is being planned to take place in late June or early July 2015. Healthwatch are a member of the programme Management Board and all work-streams.

OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	A risk register is reviewed within the Programme Management Board

PART B) – ADDITIONAL INFORMATION

1 **INTRODUCTION**

1.1 The Better Care Fund, a nationally defined programme of integration, is intended to transform the health and social care system in Telford and Wrekin. It will promote greater independence for patients and service users and improvement on current areas of integrated care. The aims are to:

- Deliver the best possible health and social care outcomes for individuals in a personalised way.
- Promote and encourage self-help and self-care for as long as possible
- Enable 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.
- Reduce avoidable hospital admissions
- Ensuring financial efficiency and reducing duplication.

1.2 The BCF planning process and submission identified two Thematic areas for development: 'Building Community Capacity' and 'Developing the Integrated Community Enablement Service'.

1.3 In order to progress the agreed Implementation Plan a Programme Management Board has been in place since March 2014. It has monitored the following BCF targets:

- Reduction in admissions
- Reduction in Delayed Transfers of Care (DToC)
- Reduction in permanent admissions to care homes
- Reduction in admissions for 65 years + (local target)
- Improved patient experience (patients feeling supported to manage their long term condition)

1.4 The BCF programme implementation formally commenced from April 2015. This includes the requirement to achieve the agreed BCF targets and to have a section 75 agreement (pooled budget) in place.

2 **PROGRESS OF THE PROGRAMME**

2.1 There has been substantial progress made, ahead of the formal implementation of BCF including some significant improvements, but also some key challenges in relation to the BCF programme. These are summarised below

2.2 **Improvements**

- Admission avoidance pathway developed which has been in place since July 2014. This has evidenced the maintenance of more patients with more complex needs at home
- Reductions in admissions have been achieved since August 2014
- Effective partnership working with Shropshire Community Healthcare NHS Trust (SCT) who have developed care pathways to support admission avoidance; identified innovations including shadowing WMAS crews and In-reach to SaTH to divert ambulance conveyances to care at home
- Additional capacity within Rapid Response to enable immediate response to referrals
- Targeted interventions and clinical training within care homes to develop care home skills and reduce admissions
- Admission avoidance pathway included on the 111 Directory of Services to divert conveyances from hospital
- Effective development and engagement of the voluntary sector including identification of voluntary sector Providers, establishment of a BCF working group to support admission avoidance pathway and commissioning Age UK to provide and signpost low level prevention from within Rapid Response
- Recognition that other CCG initiatives also have an impact on BCF reduction of admissions and early discharge
- Collaborative working in relation to the 'Discharge to Assess' programme, enabling early discharge and reducing DToCs
- Additional commissioning and Programme support capacity
- Joint working with SaTH in relation to the Rehabilitation model following formal notice to de-commission service
- Implementation of the South Telford locality prototype has commenced within the potential of reducing demand for health and social care
- Development of a Well Being and Prevention strategy by the Council that focuses on managing demand and promoting independence
- Production of a market position statement "*what are we doing to improve people's lives"* by the Council to encourage market development and sustainability and support growth in community capacity
- Development of initiatives within partner agencies such as Shropshire Partners in Care and Care Homes to introduce "Telehealth"]
- Development of personal budgets for carers

2.3 **Challenges and Opportunities**

- Proposals are under consideration whereby the Council take over the function of brokering care identified by Rapid Response and currently brokered by them. This should improve value for money and coordinated care planning.
- No agreement has occurred between the Council and SCT to develop the Integrated team by December 2014 as originally timetabled. However, models have been developed and are in consultation between the parties.
- Development of Community Capacity is still an area for development but new provision is being commissioned that will promote personalisation and self help in the community and at home.
- There has been a lack of detail regarding existing 2014/15 pooled budget activity. This has hindered considerations of how future services could potentially be transformed to achieve better integration. However agreements have now been reached in terms of social care data/performance reporting and the analysis of flow from discharge and data from health sources.
- Lack of integrated planning for other programmes of work e.g. South Telford Locality Prototype, single point of access, single assessment and care planning

3. **DEVELOPMENTS**

3.1 There have been a range of developments. These include BCF work-streams and additional initiatives.

3.2 **BCF workstreams**

3.2.1 Progress on work-streams is summarised below

3.2.2

Work-stream	**Summary of progress against Implementation Plan**
Single Point of Access	Modelling to be completed of all single points to understand referral numbers, profile of reasons, flows across current services, destinations, overlaps and duplication.
Single assessment and care planning	Initial meeting taken place with SCT and Council. Revised milestones or timescales to be identified at next BCF Project Board.
Integrated Community Enablement Team	Initial progress to develop the integrated team such as multidisciplinary workshop, development of draft specifications, planning meetings, team location option appraisal. Agreement of final model and implementation

	will be considered at the next BCF Project Board. Integrated Community Enablement Service – proposed service model' - details the proposed model.
Rehabilitation sub-group	Formal notice provided to SaTH of the future delivery of rehabilitation via a community-based approach from July 2015. Clinical engagement in analysing potential demand, capacity needed and model for delivery. Service specification developed, consulted on and revised. Clinical model of community rehabilitation agreed – SaTH lead community-based stroke rehabilitation. Developing phased Implementation Plan. A Rehabilitation Business Case which has been shared with SaTH, SCT and Council.
Data sharing	Agreed timescales for health and social care data sharing but progress on implementation waiting for decisions over single point of access, single assessment and care plan and establishment of Integrated Community Enablement Team.
Development of voluntary sector / community capacity	CCG completed Grants framework and implemented from April 2015. Council developed Well Being and Prevention strategy. Consultation at the end of the development process. Implementation plan and timescales unspecified to date. Requested to be in line with BCF timescales. Council has commenced voluntary sector commissioning with tenders underway. New contracts to be in place on 1st September that will be co-terminus with CCG grant agreements. Personalised support planning developed through the South Telford Prototype will build community capacity.
Pooled Budget	Pooled budgets for 2014/15 has been agreed. Pooled budget (s75) in development as two schedules (one each for monies held by CCG and Council). Risk sharing Agreement has been developed and will be

	integrated into the s75 agreement. CCG monies identified within SaTH, WMAS and SCT specifically to avoid admissions as part of NHS contracts for 2015/16.

3.3 **Additional initiatives**

A number of additional initiatives that support the development of Better Care are summarised below.

3.3.1 Admission avoidance pathway and related developments

3.3.2 The Accelerated Admission pathway was developed as a pilot from July 2014 in order to learn from experience and develop further. The pathway was fully implemented from August 2014. The Admission Avoidance Evaluation' demonstrated:

- A 40% increase in referrals to the pathway compared to the previous year
- Higher acuity of patients referred to the pathway
- An increase in referrals for 90+ years patients from 5% in quarter 1 to 18% in quarter 3.
- Falls, UTIs, respiratory conditions and End of Life accounted for 50% of all referrals.
- Evidence of reduced admissions using the identified criteria

3.3.3 Additional initiatives were introduced to support admission avoidance:

- Rapid Response In-reach to SaTH and joint assessments with the SaTH Frailty team from August 2014
- Care Home helpline delivered by ShropCom from September 2014
- Rapid Response shadowing WMAS crews from November 2014
- Age UK based within Rapid Response to support admission avoidance from November 2014
- Rapid Response pilot for shadowing GPs on home visits to identify those who could be treated at home
- Care Home interventions delivered by SCT from December 2014 to provide admission avoidance interventions, care management and training in clinical skills to avoid admissions
- Winter resilience funding to provide falls prevention in care homes to avoid conveyances to SATH

3.3.4 Early discharge from hospital and Delayed Transfers of Care (DToC)

3.3.5 A key indicator of the BCF programme is to reduce DToCs. An identified process to support this was the Discharge to Assess approach with SaTH.

3.3.6 The Discharge to Assess (D2A) approach was an agreed initiative within the economy. The principle was that most patients should have a level of Intermediate care before a decision about long term care was made rather

than the decision made while in hospital. This approach identified therapists in SaTH who determine, with the clinical team, whether patients are discharged to one of three pathways:

- Home with or without care
- Stepped down to an Enablement bed
- Discharged to Assess into a nursing care level bed for more assessment and therapy before determining a final destination for longer term support.

3.3.7 There is anecdotal evidence that the demand for Enablement and D2A beds has varied depending on the judgement of the particular therapists. Additional work is on-going to ensure there is a consistent approach to determining the pathway patients are aligned to.

3.3.8 An economy-wide Working Group is in place to monitor the development of the D2A

3.3.9 <u>Development of Care Pathways and Ambulatory Care pathways</u>

3.3.10 Identified care pathways were developed as part of the admission avoidance pathway. Additional pathways need to be developed to support further admission avoidance based on conditions that are being targeted for reduced admissions and set out within the NHS Contract for SaTH.

3.3.11 Previously agreed clinical pathways are being reviewed to maximise the opportunities for effective community based care.

3.3.12 Ambulatory Emergency Care pathways are 49 nationally mandated pathways that are being developed by SaTH to further reduce avoidable admissions.

3.3.13 Economy-wide working groups and a Strategic Group are in place. Additional consideration is being given to understand how the care pathway planning can be developed across community and hospital services to ensure effective interventions are given at the right time minimise the need for higher levels of care.

3.3.14 <u>Reducing admissions from care homes</u>

3.3.15 A programme of work in care homes is taking place to reduce avoidable admissions including the reduction of falls. This includes community nurses providing:

- Clinical assessment of residents
- Supporting care homes in care planning
- Supporting reviews of residents who have been admitted
- Training in subcutaneous hydration in nursing homes
- Clinical observations in residential homes

3.3.16 Additional training is taking place in care homes delivered through the Care Workers Development Partnership. This includes end of life care

training.

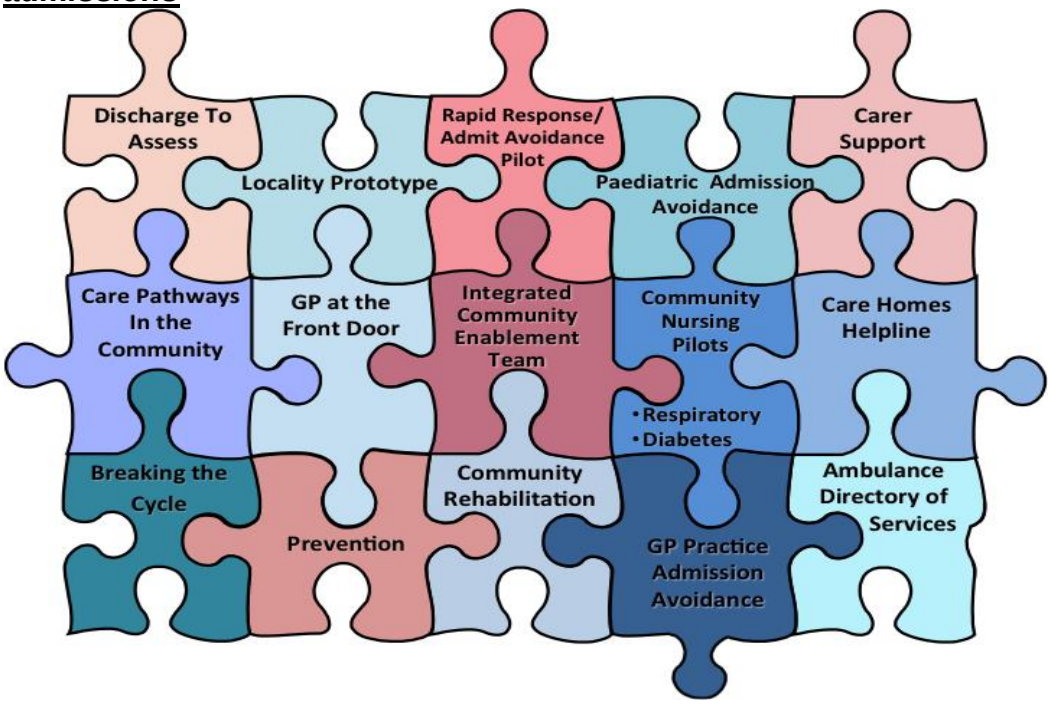
3.3.17 Winter resilience funding has been extended to support falls prevention in care homes. This includes weekly evidence-based exercise in 10 care homes and falls prevention training to care home staff. The intention is to imbed the principles and the roll out to further homes.

3.3.18 NHSE have commissioned an audit of care home admissions to support identification of approaches that may help avoid admissions. This is intended to provide the report by the end of July 2015.

3.3.19 Potential impact on non-BCF funded innovations on reducing admissions

3.3.20 There has been increased recognition that a number of initiatives have or may contribute to reducing admissions. The 'Jigsaw' below indicates these initiatives. Those highlighted in red are directly funded via BCF monies. Initiatives in blue are not BCF funded but contribute to the delivery of Better Care.

'Jigsaw' of interventions to impact admissions



3.3.21 The initiatives listed below are all CCG funded schemes (except South Telford locality prototype) that has evidenced a reduction in admissions or the potential to reduce admissions:

- Paediatric pathways have led to reduced short stay admissions Respiratory and diabetic pilots have demonstrated reductions in emergency admissions by improved planned care/care management
- South Telford Locality Prototype is seeking to create a multi-disciplinary team around a GP practice and local communities

working alongside health professionals and community groups to prevent and delay a potential crisis. It also aims to make Social Workers more accessible in their communities. The Prototype will implement Support Brokerage and support planning, whole promoting choice, control and personalised approach to achieving better outcomes. There is early evidence of avoiding high cost interventions have been avoided

- GP at the Front Door triaging and re-directing to GP practices
- GP admission avoidance schemes
- Care home helpline has reported to have reduced 130 admissions between July 2014 - March 2015
- Discharge to Assess (D2A) model refers to three identified community pathways to be discharged promptly from hospital. This has led to a reduction in DToC

4 BCF PERFORMANCE

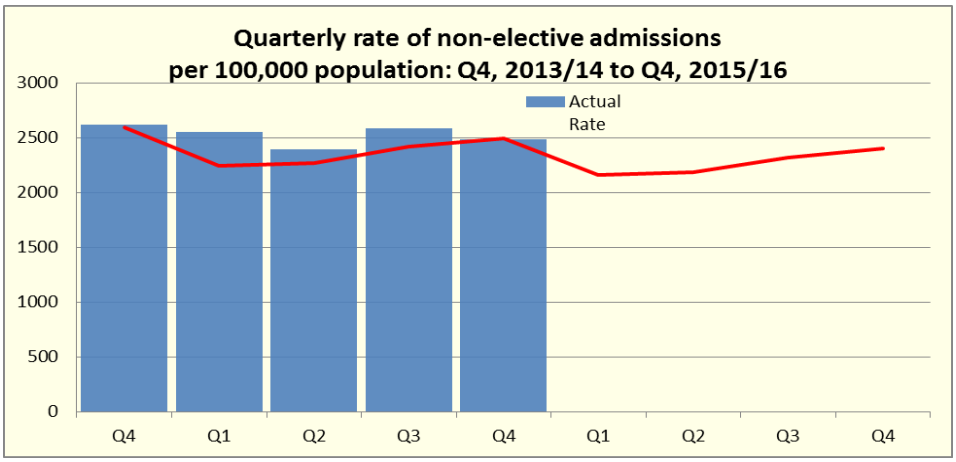
4.1 BCF performance is summarised below.

4.2 BCF target reduction in admissions

The BCF metric for reduction in admissions is specified nationally. It includes 'non-elective' admissions to all hospitals (SaTH accounts for 97% of non-elective admissions); transfers between hospitals and maternity admissions. It uses a national dataset for the projection of activity.

The chart below shows the activity to date and projected target for 2015/16

4.2.1



4.2.2 The last quarter achieved the BCF target. (4233 target/ 4216 actual).

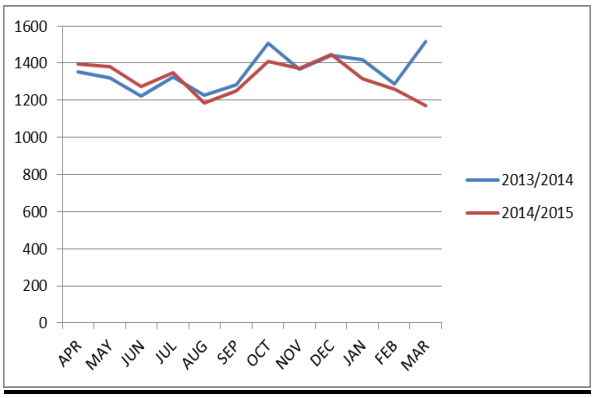
The target is 3548 for Quarter 1 of 2015/16.

4.3 Reductions in admissions against 2013/14

4.3.1 Local monitoring of emergency admissions is in place. This uses acute hospital data. The figures below demonstrate an overall reduction in

emergency admissions of 2.83% against last year (16272/ 15812 admissions). This is against a 4% year-on-year increase of emergency admissions over the previous four years.

4.3.2



APRIL	3.03%	41
MAY	4.62%	61
JUNE	4.25%	52
JULY	1.81%	24
AUGUST	-3.74%	-46
SEPTEMBER	-2.50%	-32
OCTOBER	-6.31%	-95
NOVEMBER	0.44%	6
DECEMBER	0.42%	6
JANUARY	-7.19%	-102
FEBRUARY	-2.33%	-30
MARCH	-22.73%	-345
TOTALS	-2.83%	-460
Ave reduction since August	5.49%	-638

4.3.3 If comparing activity reductions from August, when the admission avoidance pathway was fully implemented there has been a reduction in emergency admissions of 638 (11,049/10411): a reduction of 5.49% against last year.

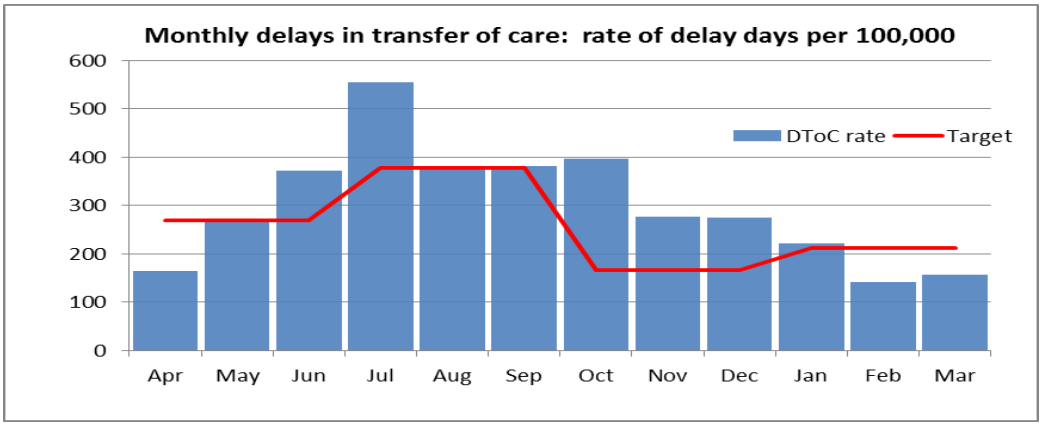
NB There will be further revisions of the figures as this data set utilises admissions.

4.3.4 To compare the national BCF metric will local monitoring data, the last quarter activity was 3748 emergency admissions. The national BCF performance metric is 4216 outturn – a difference of 468 admissions.

4.4 Reductions in Delayed Transfer of Care

4.4.1 Reductions in DToCs are summarised below

4.4.2



4.4.3

	Delay Days		Monthly rate per 100,000 population	
	13/14	14/15	Target	Actual
Apr	228	213	268.5	**163.7**
May	95	351	268.5	**269.8**
Jun	80	484	268.5	**372.0**
Jul	91	721	377.6	**554.2**
Aug	155	496	377.6	**381.2**
Sep	205	497	377.6	**379.1**
Oct	255	517	165.8	**397.4**
Nov	124	361	165.8	**277.5**
Dec	265	358	165.8	**275.2**
Jan	248	291	212.2	**222.4**
Feb	327	185	212.2	**141.4**
Mar	254	205	212.2	**156.6**

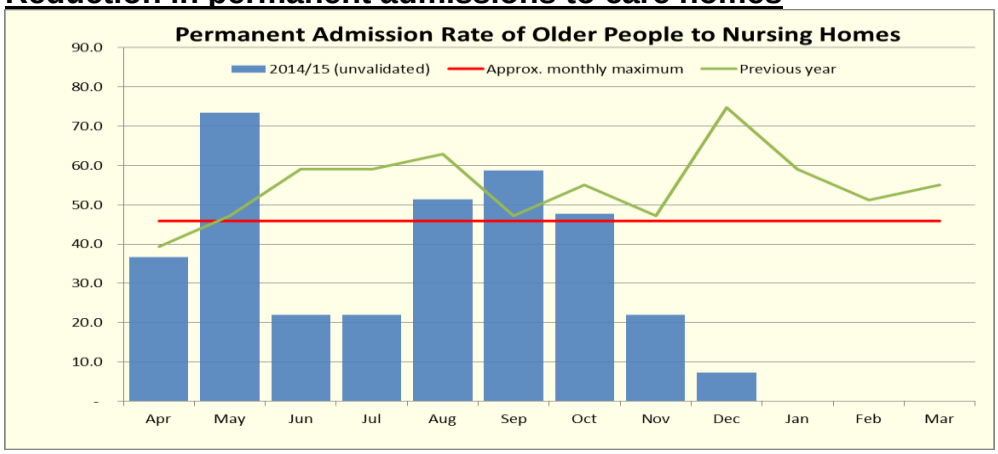
4.4.4 During the year there were of high levels of DToC the key reasons:

- Awaiting internal transfers for non-acute care
- Significant delays in completion of assessments in SaTH to medically fit to transfer
- Delays in gaining nursing and residential care beds
- Housing delays

These areas have reduced significantly in the latter part of the year.

4.5 **Reduction in permanent admissions to care homes**

4.5.1



4.5.2 This shows a reduction against target for 2014/15 from the latest data.

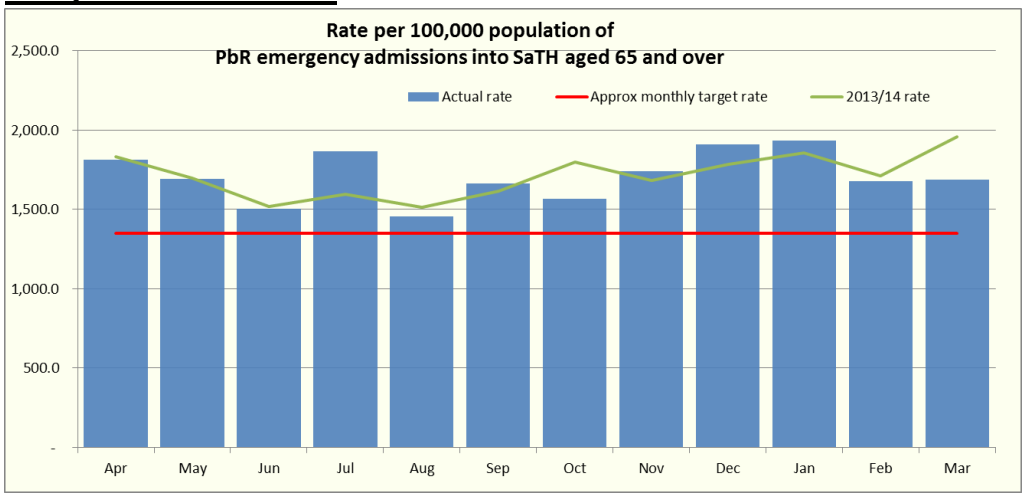
This is not due for submission until the last week of May so data quality analysis is taking place. The current outturn is 639 per 100,000 population. This equates to an increase of 9 people on the previous year.

However, the measure is different to the previous year (which was based on actual permanent admissions and excluded people in the 12 week disregard period). However this new measure counts those who planned a permanent residential or nursing care (even if they did not actually take the bed eg if they died before hand).

It is possible that the change in definitions etc. will impact on the ability to reliably measure performance on this metric.

4.6 **65+ years admissions**

4.6.1



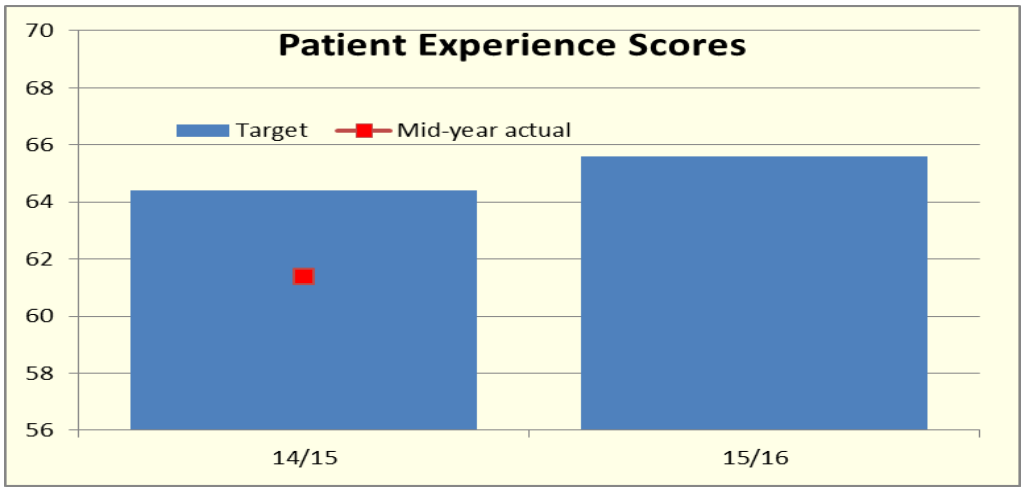
4.6.2 There has been an increase in admissions for 65+ and 75+ years. The main reasons for admissions include:

- Heart failure
- COPD
- Respiratory failure
- Non-specific conditions

4.6.3 The admission avoidance pathway had an average age of referrals of 77 years. 18% (96 of 512) have been 90 years or older.

4.7 **Patient experience**

4.7.1



4.7.2 The locally agreed patient experience metric was Question 32 of GP Survey (feeling supported to manage LTC).

The Interim GP Practice Survey - CCG report in January 2015 showed

publication a 61.38% feel supported against a national rate of 63.7%. A full report is published later in the year

4.8. **Improving the effectiveness of reablement/rehabilitation services**

4.8.1 The performance for people maintained at home 91 days after Enablement is below. It is very similar to last year's 64.9% outturn.

4.8.2

	Total - 65 and Over		OVERALL TOTAL
	Male	Female	
Number of discharges in period to rehabilitation where the intention is for the patient to go back home (1st October – 31st December)	26	60	86
Number of discharges above where person was still at home 91 days later	16	39	55
			64%

5 BCF FINANCE ISSUES AND POOLED BUDGET DEVELOPMENT

5.1 Pooled budget expenditure 2014/15

5.2 Expenditure against the Pooled budget monies has been shown a small overspend against the total budget.

5.3 Pooled budget monies aligned to the SaTH and Community Trust for NHS Contracts are identified as activity variations identified below:

5.4 SaTH relates to reduced emergency admissions:

- Reduced emergency admissions by 2.83% against last year
- Reductions were noted in specific areas including Respiratory conditions, Abdominal disorders, DVT, Heart Failure, shock and collapse, Cardiac conditions and Poisoning.

The SaTH contract is commissioned through the national Payments By Results tariff. Potential savings relate directly to reduced admissions.

5.5 Shropshire Community Trust relates to increases in community contacts. These are been identified within specific reported activity:

- Increased IDT (Rapid Response and Community Nursing) contacts
- Increased Respiratory Nursing contacts
- Increased Diabetic Nursing contacts
- Increased Tissue Viability nursing contacts

There has been increased funding for Rapid Response via CCGs Transformation monies. There has also been pilot funding for the identified teams through non-recurring monies within the CCG.

5.6 Use of transformation monies

5.7 The CCG identified non-recurring Transformation monies in 2014/15 to support BCF development.

5.8 A summary of expenditure and savings from utilisation of transformation monies is set out below. This shows direct expenditure and costs in relation to BCF.

Overall costs summary

2014/15 costs	Admission Avoidance costs	Resilience Costs	Savings
Savings from reduced admissions			YTD +£277,701 Since August 2014 -£106,585
Rapid Response admission avoidance pilot	£142,000		
Domiciliary care packages to avoid admissions	£20,423 208 packages		
Care home admissions to avoid hospital admissions	£31,974 Spot purchase admissions		
Admission avoidance low level support – Age UK	£21,000		
Fall Prevention - Fit for All		£10,000	
Total costs	**£215,397**	**£10,000**	**- £106,585**
Balance of costs			**+£118,812**

Summary of Transformation monies expenditure and savings

The Summary of Costs chart shows the expenditure in additional Rapid Response nurses and care costs to avoid admissions. Domiciliary care and care beds were procured by Rapid Response rather than the exiting Brokerage team. It is unclear if the costs could have been absorbed within the pooled budget.

5.9 While savings have been made since August from reduced admissions the overall costs have been more than the savings.

5.10 Savings due to reductions in admissions need to take account of marginal rate of savings. Reductions in admissions above the Benchmark activity level set in 2009/8 can only be calculated at 30% savings.

5.11 **Pooled budget development 2015/16**

5.12 The two pooled budgets for 2014/15 (S75s) and two s256 agreements have been agreed.

5.13 The S256 with NHSE has been formally signed off.

5.14 The Pooled Budget for 2015/16 is: £12,529,000

	Contribution	Within Schedules
Council	£1,647,000	£9,453,000
CCG	£10,882,000	£3,076,000

5.15 Development of the s75 for 2015/16 has been progressing through the Pooled Budget work-stream:

- Development of the legal agreement
- Two service specification schedules are in development: one Council- and one CCG-led schedule in respect of their respective lead commissioning arrangements
- Agreement of the high metrics and reporting has been developed

5.16 Risk Sharing Agreement has been agreed and will be included within the legal agreement

5.17 The Council-led service specification schedule will set out:

- Rehabilitation and Re-ablement to support community services
- Domiciliary care
- Rehabilitation and Re-ablement beds
- Assistive Technologies
- Maintaining eligibility of clients with long term conditions
- Preventative services
- Management costs
- Carers
- Social Care Capital
- Disabled Facilities Grant

This schedule has a value of £9,453,000

High level reporting of this schedule will be included. Detailed reporting of each scheme will be agreed.

5.18 The CCG-led service specification schedule will set out:

- Shropshire Community Trust
- SATH
- BCF Management costs

This schedule has a value of £3,076,000

High level reporting of this schedule will be included. This will be based on detailed provides through the monthly monitoring of the NHS contract Detailed reporting of each scheme will be agreed.

5.19 Once schedules and the legal agreement have been agreed locally they will be reviewed by the respective legal departments before the leaformal agreement

6 GOVERNANCE ARRANGEMENTS IN RELATION TO ALIGNED WORK PROGRAMMES

6.1 There are a number of work programmes that are interrelated with BCF objectives across the economy. Examples are indicated below:

- Care Act 2014
- South Telford locality prototype
- Council Well Being and Prevention strategy
- Ambulatory Emergency Care
- GP at Front Door
- Urgent Care Working group and economy-wide System Resilience Group (SRG)

6.2 BCF and Care Act report to the Strategic Commissioning Group, which reports to the HWB Board. However, some of these work programmes have separate Governance and Programme Management arrangements; sometimes limited understanding of their shared agendas; and no clear linkages into the BCF Programme. This was highlighted by the recent Home from Hospital visit.

6.3 There is potential to reduce duplication of meetings, improve planning and increase the rate of development and transformation by more co-ordinated working.

6.4 The Council has indicated recently that it would be helpful to ensure greater alignment between the BCF and other work programmes by having the over-arching governance via the BCF Programme Management Board that reports to SCG.

6.5 However, some meetings have wider accountabilities. For example, the SRG is economy-wide and reports to NHSE; Ambulatory Care is economy-wide and currently without Council representation, as it focuses

on medical treatments.

6.6 Further discussion will take place to improve the over-arching governance arrangements between strategic groups

7 ADDITIONAL WORK PROGRAMME RELATED TO BETTER CARE

7.1 To build on the progress to date and accelerate progress to meet the Better Care objectives additional initiatives are being taken forward:

- Completion of the s75 Pooled Budget agreement
- Developing additional strategies to increase referrals from GPs, WMAS, care homes and ShropDoc by further engagement and raising the profile of the pathway with evidence of success and benefits
- Additional clinical pathway development by aligning existing pathway development and Ambulatory Care pathways
- Development of the Integrated team
- Development of the community-based rehabilitation provision
- Further development of voluntary organisations to support admission avoidance utilising Age UK within Rapid Response to signpost
- Development of a simplified care home telephone support/ response service
- Ensure the development of the Wellbeing and Prevention strategy to support BCF objectives and timescales
- Ensure that the South Telford locality prototype is fully integrated into the BCF work programme and supports reduced demand for NHS and social care.

Further innovations to reduce admissions based on guidance, best practice or evidence will be identified.

8 Recommendations

- Note the progress of the Better Care programme
- Note the progress of the development of the section 75 Pooled Budgets agreement
- Ensure all representative statutory organisations support and facilitate approved BCF implementation within the identified timescales

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