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TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD - 15th JUNE 2016

BETTER CARE FUND UPDATE REPORT

REPORT OF: MICHAEL BENNETT, HEAD OF COMMISSIONING: BETTER CARE FUND/CARE CLOSER TO HOME TELFORD AND WREKIN CCG

AND JONATHAN EATOUGH, ASSISTANT DIRECTOR, GOVERNANCE, PROCUREMENT & COMMISSIONING, TELFORD & WREKIN COUNCIL

LEAD CABINET MEMBER: CLLR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1.	**SUMMARY OF MAIN PROPOSALS**
1.1	This report summarises the performance and progress of the Better Care Fund progress during its first formal year of implementation. It also summarises the submitted Plan for 2016/17 to the Board for formal Approval. The full Narrative Plan with all associated submitted documents is included as an Appendix A.
1.2	The Better Care Fund (BCF) is a national programme, jointly led by NHS Telford & Wrekin Clinical Commissioning Group (CCG) and the Borough of Telford & Wrekin. The aim of the BCF programme is to transform the health and social care system: • Resilient local communities focussing on well-being and Prevention • Integrated preventative services delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent • Reduced reliance on social care services • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions
1.3	The aims are in line with the CCG vision 'Working with our patients, Telford and Wrekin CCG which aspires to have the healthiest population in England. Healthier, Happier, Longer'. And the Council vision to 'encourage healthier lifestyles, strengthened individuals and communities to support themselves'.

1.4	To deliver the BCF aims and objectives, two thematic areas and objectives have been developed over the last two years. That have been developed into three key integrated care programmes that have been jointly agreed: • Building community resilience • Developing 'Telford Neighbourhood Care Teams • Implementing Robust Intermediate care services
1.5	The key performance metrics are: • 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. • A local measure of Reducing emergency admissions in 65 years + age group (revised in 2016/17 to 70+ years)
1.6	The performance of BCF for 2015/16 was • Overall increase in admissions of +312/ 1.8% • Overall reduction in costs of - £1,169,000/ -4% • Overall length of stay reduced by 0.51 days (4.39- 3.88 days across all ages) • Delayed Transfers of Care (DToC) did not achieve BCF level of reduction but lower than last year • Permanent admissions reductions to care homes were achieved • Maintaining at home 91 days after Enablement was lower than target for the reporting periods but higher than target over the year as a whole • Interim performance of the patient experience metric is lower than target.
1.7	The Narrative Plan at Appendix A details the programme for 2016/17 and Actions to achieve throughout the year and next year.

2. RECOMMENDATIONS

2.1 The following recommendations are made

- Note the outcomes of the Better Care Fund programme for 2015/16
- HWBB to approve the BCF submission for 2016/17
- Note the progress of the development of the section 75 pooled budget 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:

- Formal support of the Narrative Plan and associated Action Plan

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="3">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td colspan="2">Improve emotional health and wellbeing of Telford and Wrekin residents.

Support people with specific health needs to live independently for as long as possible.</td></tr>
<tr><td colspan="3">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td colspan="2">Yes</td><td>Vulnerable adults and children</td></tr>
<tr><td colspan="3">Will the proposals impact on specific groups of people?</td></tr>
<tr><td colspan="2">No</td><td>The BCF will impact on all groups.</td></tr>
<tr><td>TARGET COMPLETION/ DELIVERY DATE</td><td colspan="3">The BCF formally commenced from April 2015 with a formal Pooled Budget (section 75 Agreement) and programme of work.

The Narrative Plan includes the programme of work for 2016/17.</td></tr>
<tr><td>FINANCIAL/ VALUE FOR MONEY IMPACT</td><td>Yes</td><td colspan="2">The Better Care Fund Pooled Budget in 2015/16 will be £12.529,000 (Council contribution of £1,647,000/ CCG £10,882,000). There were two pooled funds of revenue and capital monies. The capital fund was £1.28m of which 66% was expended within the year, the remainder being rolled forward for use in 2016/17 as appropriate. The revenue funding of £11.249m was fully expended in year.

The Pooled Budget in 2016/17 is increased to £14,252,674.(Council contribution of £2,261,454/ CCG £11,991,129 , net of any carry forward from 2015/16).

The funding within the Pooled Budget relates to 4 key areas of work as set out below, with more detail shown in Section 5 of the report.

<table><tr><td>Community Resilience</td><td>£1,282,804</td></tr></table></td></tr>
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		<table><tr><td>Telford Neighbourhood Care</td><td>£3,532,389</td></tr><tr><td>Intermediate Care</td><td>£6,004,400</td></tr><tr><td>Other Care</td><td>£3,432,564</td></tr></table> Whilst some additional funding has been applied to all of these areas some significant changes relate to Community resilience with increased funding of £762,149 and Disabled facilities provision (Other Care), with an increased grant of £726,312. The pooled fund will be contained within a Section 75 legal agreement which is currently in development and subject to the governance arrangements set out within the BCF plan.
LEGAL ISSUES	Yes	The BCF s75 Agreement ('The Agreement') is based on the template generic agreement drafted by Bevan Britten solicitors for NHS England in 2015. The Agreement provides the legal framework for a pooled budget between the Council and the CCG ("The Parties") 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 2015/16 current Agreement sets out the terms on which the Parties have agreed to collaborate; aims and outcomes; financial contributions, risk and benefit sharing arrangements. The current Agreement was signed off in December 2016 and formally executed by both Parties. An agreed joint Governance process between the Parties to monitor the current Agreement is in place. Where changes affect the Council and CCG commissioning plans, separate reports through respective Governance structures will take place. There is a requirement for the 2016/17 Agreement to be formally signed off by 30th June 2016.
EQUALITY &	Yes	The BCF is intended to reduce risks of admissions

DIVERSITY		to groups at high risk of hospital admission as identified from local analysis.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	Yes	Engagement takes place on a regular basis with: Carers Partnership Board Shropshire Partners in Care Council for Voluntary Services and voluntary organisations A BCF launch event took place in July 2014 with a follow up event in July 2015. The feedback highlighted the need for integrated working and increased preventative interventions.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	A risk register is included within the Submission and monitored within the BCF Pooled Budget meetings. Financial risks are identified within the Risk Sharing Agreement, and included within the section 75 Agreement.

PART B) – ADDITIONAL INFORMATION

1	**INTRODUCTION**
	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. The programme has a number of national conditions that are required to be met and included in the planning for 2015/16: • Plans to be jointly agreed • Maintain provision of social care services (not spending) • Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions and improve discharge • Better data sharing between health and social care, based on the NHS number • Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional • Agreement on a local target for Delayed Transfers of Care (DToC) and develop a joint local action plan
	Two additional national conditions were indicated for 2016/17: • Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans • Agreement to invest in NHS commissioned out-of-hospital services As part of national monitoring of all 2016/17 BCF plans, DH identified 73 Key Lines of Enquiry (KLOEs) to be assured that Plans addressed the national conditions. This is set out within the Narrative Plan.
	An important change was assurance through specific KLOEs to ensure that the BCF plan was aligned to other strategic and operational plans including the Sustainability and Transformation Plan, CCG Operational Plans and Council transformation plans.
	The aim of the BCF programme is to transform the health and social care system in Telford and Wrekin: Resilient local communities focussing on well-being and Prevention • Integrated preventative services delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent • Reduced reliance on social care services • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions

2	**BCF PERFORMANCE 2015/16**
	BCF performance is set out below:
	<u>Reductions in non-elective admissions</u>

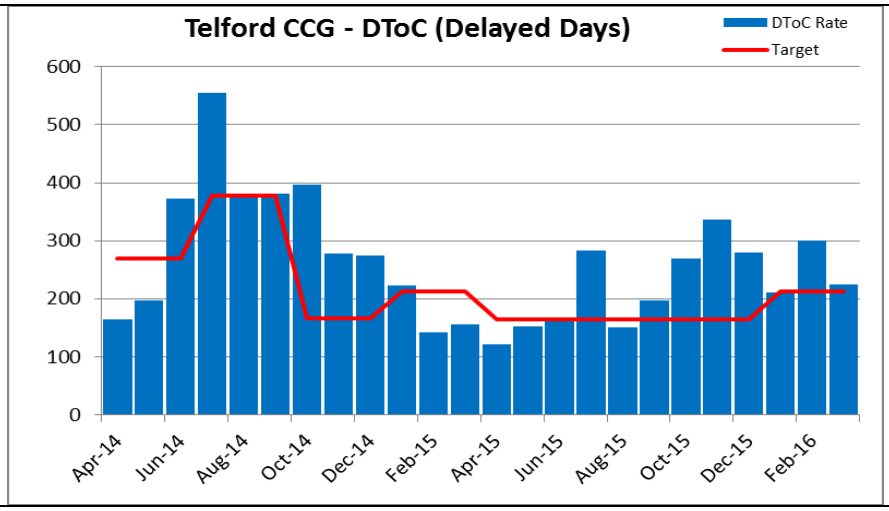
Scheme	Cost		Cost Difference		Activity		Activity Difference	
	2014/15	2015/16 (YTD)	Volume	Percentage	2014/15	2015/16 (YTD)	Volume	Percentage
Paediatric Emergency Admissions - 0-17 years	£2,847,356	£2,897,790	£50,434	2%	3476	3703	227	6.5%
Paediatric Emergency Admissions - 18 years,	£87,810	£55,382	-£32,427	-37%	99	73	-26	-26.3%
Care Homes	£2,325,761	£2,131,974	-£193,786	-8%	779	775	-4	-0.5%
UTI	£980,169	£931,936	-£48,233	-5%	416	430	14	3.4%
Respiratory Conditions	£3,862,157	£3,758,799	-£103,358	-3%	1738	1763	25	1.4%
Chest Pain	£361,152	£237,323	-£123,829	-34%	496	343	-153	-30.8%
Falls	£1,472,933	£1,570,416	£97,483	7%	538	592	54	10.0%
Cardiac	£2,764,428	£2,759,015	-£5,413	0%	1540	1641	101	6.6%
Cellullitus	£324,282	£316,568	-£7,714	-2%	168	166	-2	-1.2%
Consipation	£114,972	£123,145	£8,173	7%	86	98	12	14.0%
Diabetes	£173,491	£279,139	£105,648	61%	102	142	40	39.2%
Disorientation / dizziness	£183,312	£211,744	£28,432	16%	94	109	15	16.0%
Mental Health	£117,691	£80,489	-£37,202	-32%	103	71	-32	-31.1%
Geriatric Med	£2,831,630	£2,545,012	-£286,618	-10%	1273	1248	-25	-2.0%
General Med Under 65	£2,355,586	£2,140,332	-£215,254	-9%	1756	1670	-86	-4.9%
End of Life	£325,309	£289,136	-£36,173	-11%	72	71	-1	-1.4%
(Surgical)No Procedure	£429,336	£455,445	£26,109	6%	487	513	26	5.3%
Scheme Total	**£21,557,373**	**£20,783,645**	-£773,728	-4%	**13223**	**13408**	**185**	**1.4%**
included in any Schemes	**£7,842,565**	**£7,446,660**	-£395,906	-5%	**3693**	**3820**	**127**	**3%**
All Total	**£29,399,938**	**£28,230,304**	-£1,169,634	-4%	**16916**	**17228**	**312**	**1.8%**

The performance of BCF for 2015/16 was (using BCF profile from SUS data):

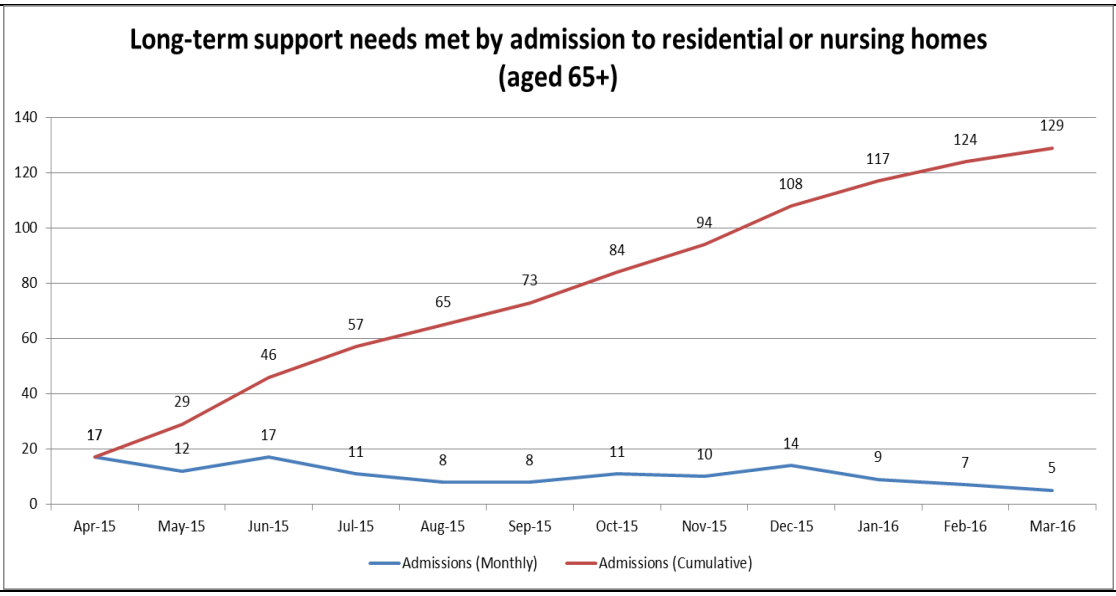
- Overall increase in admissions of +312/ 1.8% with BCF related schemes achieving +185/ +1.4%
- Overall reduction in costs of - £1,169,000/ -4% with BCF related schemes achieving -£773,000/-4%
- 0-17 years increased by 222/+6.4%
- 65+ years increased by +123/ +2% with cost reduction of
- -£615,000/-4%
- 65-74 years reduced by -152/6.2% with cost reduction of
- -687,000/-12%
- 75+ years increased by +275/+7.4% with cost increase of +£72,000/+1%

70+ years, the local metric for 2016/17 showed an increase of +221/+4.5% with cost reductions of -£204,000/-2%

Overall length of stay reduced by 0.51 days (4.39- 3.88 days across all ages). There were reductions in all age profiles with most significant age profile of reduction in 75+ years being 1.15 days (9.09- 7.94)

	<u>Delayed Transfers of Care (DToC)</u>
	The BCF target for DToC reductions was not achieved. However, there was a significant reduction in DToC days against last year (3523 against 4585 days). Only Q4 was higher than last year and 6 monthly levels were below to monthly BCF target.
	
	Key areas affecting DToC performance in 2015/16 are: • Completion of Assessment delays rose in Q2 and Q3 • Waiting for Further NHS Non-Acute Care higher in Q1-3 than last year • Waiting for care bed placements higher in second part of the year. This coincides with changes in the Discharge to Assess process • Waiting for domiciliary care higher in second part of the year. This coincides with changes in the Discharge to Assess process • Waiting for community adaptations has increased against last year • Mental health DToC increased from November 2015 There were reductions in Waiting for Residential Care placements
	<u>Reduction in permanent admissions to care homes</u>
	The target was an outturn of 140 admissions/ 100,000 population. The actual outturn was 129 admissions / 100,000 population – set out below

Discharge	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Admissions (Monthly)	17	12	17	11	8	8	11	10	14	9	7	5
Admissions (Cumulative)	17	29	46	57	65	73	84	94	108	117	124	129
Population (65+)	27,200											
ASCOF Measure	474.3											

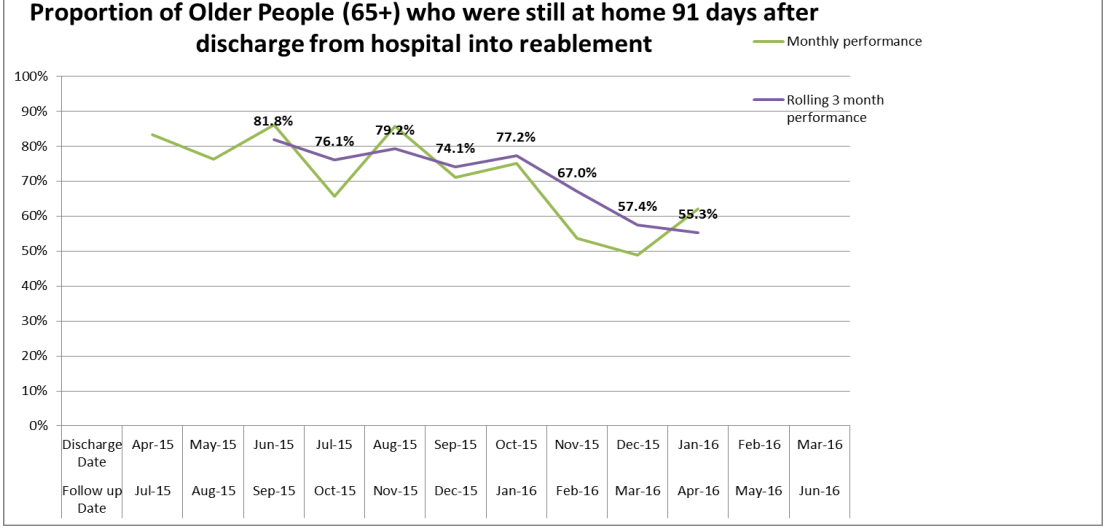


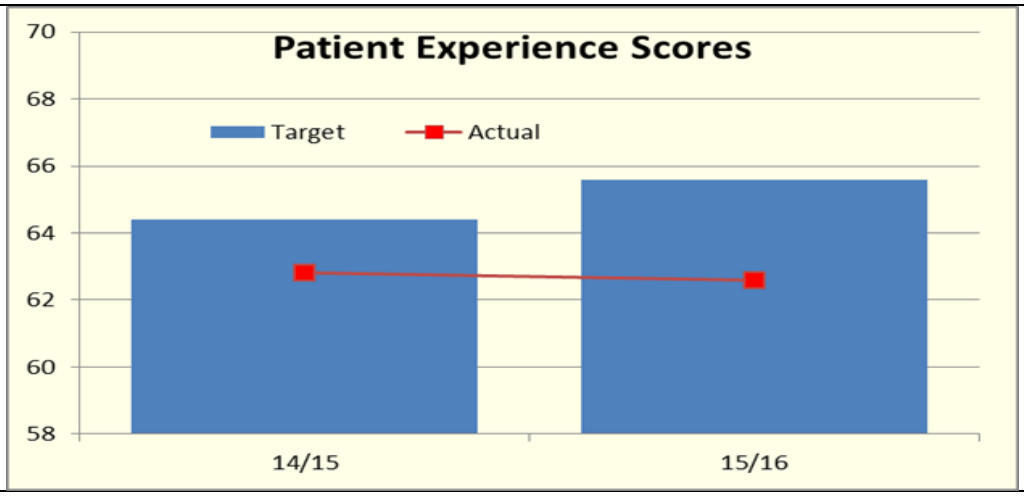
Improving the effectiveness of reablement/rehabilitation services

The performance for people maintained at home 91 days after Enablement is below. This indicator compares those people who have received reablement during a monitoring period and measures the % remaining at home 91 days later.

The monitoring period is October – December and January – March. This indicates a level of 57% against a target of 66.3%.

Discharge	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Follow up	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Number starting enablement	36	38	36	35	35	38	28	28	45	50		
Number still at home 91 days later	30	29	31	23	30	27	21	15	22	31		
Monthly performance	83%	76%	86%	66%	86%	71%	75%	54%	49%	62%		
Rolling 3 month performance			81.8%	76.1%	79.2%	74.1%	77.2%	67.0%	57.4%	55.3%		



	Taking the year overall, there has been good performance – 71% against the target of target was 66.3% The drop in performance relates to the change in use of Recovery beds during the latter part of the years where a number of patients without rehabilitation potential were placed and included within reporting. The clinical process has been revised.
	<u>Patient experience</u>
	
	The locally agreed patient experience metric was Question 32 of GP Survey (feeling supported to manage LTC). The CCG report (July 2015 publication) based on aggregated data collected from Sept-Dec 2014 and Jan-Mar 2015 was 62.8% against a baseline of 63.1%. The Planned level for 2015/16 was 65.6%. The final report on 2015/16 due to be published in July 2016. The target is unchanged for 2016/17 within BCF submission.
3	**<u>PROGRESS OF THE PROGRAMME DURING 2015/16</u>**
	There had been substantial progress made during the year. Some key process is summarised below

<u>Improvement</u>	**<u>Impact</u>**
Improved joint working across health and social care	Implementation of the Telford Integrated Community Assessment Team (TICAT) Planning across health and social care managers to implement the Integrated Care team from October 2016 Shortlisted for HSJ Integrated care category

More robust commissioning processes	Development of joint strategies and reviews including: • Joint Prevention Strategy • Development of 'The Community Centred Approaches' paper that sets out the vision for health and social care of '*Right Help, Right Time to promote Independence*' • Jointly presented Commissioning priorities to HWB Board • Joint planning and development of Community Resilience and working within independent and voluntary sector • Commissioning Emergency Response Service Planning alternative model of Recovery through extra care; not care beds
Council Brokerage team procuring all bed-based and domiciliary care	Streamlined processes for care. More responsive care in place. Management of costs.
Co-production with the independent and voluntary sector	Market Position Statement setting out future direction for permanent and domiciliary care services Clarification of vision and future needs to the sector and encouraging diversity and sustainability Joint monitoring of the Grant funded services Voluntary organisations collaborated in bids for tenders and Grants Ownership of part of sector to develop through Social Value workshops Shortlisted for HSJ award in cares category and were 'Highly Commended'
Implementation of Locality working	Improved utilisation of the voluntary sector in local communities. Developed preventative approaches

			within local communities Identification and joint management of high risk people.
4	**<u>BCF PERFORMANCE 2016/17</u>**		
	The Narrative Plan sets out the vision overall BCF programme of work.		
	The key metrics for BCF are: • Reductions in emergency admissions of 70+ years by 8% (404) • Reduced permanent admissions to care home to 155/ 100,000 • Percentage of people maintained at home 91 days after Enablement of 70% • Reduce DToC to 3285 days • Improve patient experience (feel supporting in managing long term condition) to 65.65		
	The overall programme of work is included within the Action Plan is intended to meet national KLoEs and local plans:		
		<u>Programme of work</u>	**<u>Key actions and outcomes</u>**
		Community Resilience	• Expansion of local communities to provide on well-being and Prevention and reduce demand for health and social care • Enable community development and resilience • Collaborative arrangements between providers • Strengthen communities by tackling the causes of poor health
		Neighbourhood Care	• Integrated health, social care and voluntary care services based within localities. • New relationships between primary care, Council teams, voluntary and independent sector services and NHS services – both acute and community • Increased acute services eg clinics, clinical advice, diagnostics based and delivered within local communities and primary care • Preventative and personalised approaches • Shared ownership of managing and supporting high risk patients eg Frail people, long term conditions
		Integrated Care	• A fully integrated health, social care and voluntary care team working together within a

		single service specification • Increased specialist clinical advice • Therapists and specialist teams working across acute and community services within agreed pathways to ensure people supported at home • Reduced hospital conveyances and non-elective admissions through 7 day service including from care homes
	DToC Action Plan	Achieve Action plan aligned to the 8 High Level Changes to reduce DToC targets as an economy: • Early Discharge Planning • Systems to Monitor Flow • Multi-disciplinary discharge teams • 7 day services for admission avoidance and discharge • Trusted Assessors to facilitate prompt discharge to the right level of care • Focus on Choice • Enhanced Care in Care Homes • DToC levels achieved included acute hospital indicator
	Joint Approach to assessment and care planning	• Develop a joint approach to assessment and care planning between health and social care and part of integrated teams working • Ensure effective shared process to identify and provide preventative support to high risk patients • Dementia services are a part of joint assessment and care planning
	Development of 7 day services	• Intermediate Care and Neighbourhood Care teams as 7 day services
	Achieving national metrics	• Meet all five indicated above
	Data sharing	• Utilisation of NHS number in place as identifier • Utilise health and social care data to support targeting of interventions • Integrated Clinical Digital Records developed (a sub group of the STP)
	Governance and financial management	• Assurance process, Governance arrangements and risk mitigation within the

			Action Plan, risk register and Risk Sharing Agreement • S75 Agreement to be agreed by June 2016 • Maintaining social care identified within the BCF. • Financial monitoring in place • BCF included within strategic planning eg STP

Contributing non- BCF related programmes of work

A number of programmes of work are not funding through the Pooled Budget but have potential contributions to the overall aims and outcomes of BCF:

Programme of work	**Impact and benefits**
GP at the Front Door of ED	Diverting patients to primary care who may previously be admitted
Development of Ambulatory Emergency Care pathways	Reduction of avoidable admissions
Improved pathways between West Midland Ambulance and community teams	Ensure avoidable conveyances are maintained at home with appropriate care and/ or interventions
Paediatric admission avoidance	Reductions in avoidance admissions

5 **BCF FINANCE 2016/17**

The Section 75 Pooled Budget in 2016/17 is increased to £14,252,674.

Organisation	**Contribution**	**Amounts utilised by**
Council	£2,261,454	£7,850,899
CCG	£11,991,129	£6,401,775

Section 75 Agreement - Finance Report 2016/17

Summary Statement	Annual Budget £
Intermediate Care	
Rehabilitation and Enablement	897,547
Domiciliary Care	664,057
Rehabilitation and Enablement Beds	973,288
Preventative Services	170,859
Shropshire Community Healthcare Trust	1,596,973
Shrewsbury and Telford Hospital Trust	1,655,069
LA Beds	46,607
Total Intermediate Care	**6,004,400**
Community Resilience	
Preventative Services	446,549
Carers	521,172
LA Grants	315,600
Total Community Resilience	**1,283,321**
Telford Neighbourhood Care	
Rehabilitation and Enablement	597,501
Assistive Technologies	493,595
Preventative Services	844,320
Shropshire Community Healthcare Trust	1,596,973
Total Telford Neighbourhood Care	**3,532,389**
Other Care	
Maintaining Eligibility for Clients with LTC	878,000
Management Charges	56,395
Programme Management	477,857
Care Act Implementation	445,000
Disabled Facilities	1,575,312
Total Other Care	**3,432,564**
Grand Total:	**14,252,674**

Development of the s75 Agreement for 2016/17 is in progress: to be agreed by 30th June 2016:

- The Main Body of the Agreement is in place from 2015/16 and developed to support future years with only minor amendments
- The Risk Sharing Agreement has been developed as part of the Narrative Plan
- Reporting and monitoring arrangements are in place through the monthly Pooled Budget meetings.
- Wider governance arrangements are in place through the Stronger Communities Board

The Schedules are being developed in line with the Four heading indicated above with associated outcomes measures.

6	**PREVIOUS MINUTES**
	BCF update to Health and Wellbeing Board: May 2015
7	**BACKGROUND PAPERS**
	Background papers include: • The Community centred approaches paper sets out the vision for health and social care of '*Right Help, Right Time to promote Independence*'. • The Commissioning Intentions for 2016/17 were presented jointly by the CCG and Council to the HWB Board in March 2016. • The Council Market Position Statement March 2015

Report prepared by:

Michael Bennett - Head of Commissioning: Better Care Fund/ Care Closer to Home Telford and Wrekin CCG

Legal Review
Heather Dean - Commercial Solicitor -Telford and Wrekin Council

Finance Review
Tracey Smart - Finance Manager- Telford and Wrekin Council