

TELFORD & WREKIN COUNCIL

**HEALTH AND WELLBEING BOARD – 6 SEPTEMBER 2017
CABINET – 14 SEPTEMBER 2017**

BETTER CARE FUND UPDATE REPORT

REPORT OF: MICHAEL BENNETT, HEAD OF COMMISSIONING: BETTER CARE FUND/CARE CLOSER TO HOME TELFORD & WREKIN CCG, AND JONATHAN EATOUGH, ASSISTANT DIRECTOR: GOVERNANCE, PROCUREMENT & COMMISSIONING

LEAD CABINET MEMBER: CLLR PAUL WATLING

PART A) – SUMMARY REPORT

1.	SUMMARY OF MAIN PROPOSALS
1.1	<p>This report summarises the performance and progress of the Better Care Fund progress during 2016/17. It also summarises the draft submitted Plan for 2017-19 to this Board for formal Approval.</p> <p>The full draft Narrative Plan with associated documents is included as part of the submission.</p>
1.2	<p>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, focussing on key objectives:</p> <ul style="list-style-type: none"> • 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	<p>The aims of the programme for 2016/17 were 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 priority to 'encourage healthier lifestyles, strengthened individuals and communities to support themselves' and the Council's Commitment Statement, refreshed this, "Right Help Right Time to Promote Independence".</p>
1.4	<p>To deliver the BCF aims and objectives, three key integrated care programmes have been jointly agreed and are currently being implemented:</p> <ul style="list-style-type: none"> • Building Community Resilience

	<ul style="list-style-type: none"> • Developing Telford Neighbourhood Care Teams • Implementing Robust Intermediate care services
1.5	<p>The key performance metrics and out-turns for 2016/17 were:</p> <ul style="list-style-type: none"> • Reducing non-elective hospital admissions, re-admissions and length of stay. Outturn- Emergency admissions for 2016/17 is 18,867. Month 12 was 17888. Reduction of -979/5.2% • Reducing permanent admissions to residential and nursing care. Outturn-Rate of permanent admissions to residential care target was 540.6/100,000 (155 people). The final position was 383.4/100,000 (104 People). • Improved patient experience Outturn – Feeling supported to manage long term conditions has a target of 65.6. Final position was 62.77 which has been an improvement but below target. • Reducing delayed transfers of care. Outturn-Delayed Transfers of Care (DToc) target was 3285 days. Month 12 shows 3318 days (32 days over target). M12 shows a reduction against last year of 205 days. • Improving the effectiveness of reablement/rehabilitation services. Outturn-Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services target was 70%. The final position was 71% (72 of 101 still at home) • A local measure of Reducing emergency admissions in 65 years + age group (revised in 2016/17 to 70+ years) Outturn-The local metric was a reduction of 352 for 70+ population against last year (1967) of identified conditions. The final position was 1778 (actual reduction of – 86); -266 short of the target
1.6	<p>BCF planning for 2017/18 has changed in a number of ways:</p> <ul style="list-style-type: none"> • BCF planning has been extended to two years (2017-2019) • Planning towards explicit integration of health and social care services is being measured • There are a reduced number of metrics, national conditions and KLOEs to provide assurance • The Council has received additional monies (Improved BCF or iBCF) through the Social Care Grant with some specific requirements of how it needs to be used <p>The BCF programme continues to have the three integrated programmes referred to above:</p>

- Building Community Resilience
- Developing Telford Neighbourhood Care Teams
- Implementing Robust Intermediate care services

The Council must develop, agree with the CCG and submit a Narrative Plan and Planning template by 12th September 2017, "the Submission". It will be subject to an Assurance process before receiving Approval.

2. RECOMMENDATIONS

2.1 The following recommendations are made:

- Note the outcomes of the Better Care Fund programme for 2016/17
- HWBB to approve the BCF draft submission for 2017-19 subject to final, minor revisions which it agrees can be agreed by the appropriately delegated officers in Telford & Wrekin Council and Telford & Wrekin CCG.
- Cabinet note and supports the proposed use of BCF and iBCF monies as detailed in this report.

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

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	Improve emotional health and wellbeing of Telford and Wrekin residents. Support people with specific health needs to live independently for as long as possible.
	Do these proposals contribute to specific Co-operative Council priority objective(s)?	
	Yes	Vulnerable adults and children
	No	The BCF will impact on all groups.
TARGET COMPLETION/ DELIVERY DATE	The draft Narrative Plan includes the programme of work for 2017/19.	

**FINANCIAL/
VALUE FOR MONEY
IMPACT**

Yes

The Better Care Fund Pooled Budget in 2016/17 was £14,252,675 (Council contribution of £2,261,545/ CCG £11,991,130). The year end position was an underspend of £159,000 which was carried forward into 2017/18 and will be available to spend on schemes within the BCF in addition to the budget below.

The Pooled Budget for 2017/19 is below with contributions from the Council and CCG:

	2017/18	2018/19
Council excl iBCF	£2,428,198	£2,589,807
iBCF monies	£4,019,858	£5,487,290
Minimum CCG contribution	£10,774,611	£10,979,329
Additional CCG contribution	£1,084,999	£1,100,885
TOTAL	£18,307,666	£20,157,311

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

Community Resilience	£1,343,365
Telford Neighbourhood Care	£2,795,849
Intermediate Care	£6,527,963
Other Care	£7,640,489

LEGAL ISSUES

Yes

The BCF is based on a s75 Agreement ('The Agreement') that 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 new agreement will establish the terms on which the Parties have agreed to collaborate including the Risk Sharing Agreement that has been developed as part of the Narrative Plan, schedules in line with the four themes, reporting and monitoring arrangements and governance arrangements.

The Agreement needs to be formally executed by both parties. The appropriate delegation is to the Director of Adult and Childrens Services to sign these agreements on behalf of the Council when they have been agreed. There is a requirement for the 2017/19 Agreement to be formally

		<p>signed off by 30th November 2017.</p> <p>There is an agreed joint Governance process between the Parties to monitor the current Agreement and these arrangements will continue. Where changes affect the Council and CCG commissioning plans, separate reports through respective Governance structures will take place.</p> <p>This year the Government have provided further 'Adult Social Care Grant', referred to as Improved Better Care Fund (iBCF) from 1st April 2017 to 31st April 2019.</p> <p>The allocation of iBCF funds (2017-2019) is provided in accordance with the ASC Grant conditions. Funds have been allocated accordingly to the BCF workstreams and requirements of Adult Social Care Needs and continuing pressures and impact on Adult Social Care Capacity and will be referred to in the 2017/19 Agreement.</p>
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 and support the development of community resilience to prevent hospital admission in the first place.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	Yes	<p>Engagement takes place on a regular basis with stakeholders including:</p> <ul style="list-style-type: none"> • Carers Partnership Board • Shropshire Partners in Care • Council for Voluntary Services and a range of voluntary and community organisations • HealthRound Table • Healthwatch
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	<p>A risk register is included within the Submission and monitored within the BCF Pooled Budget meetings.</p> <p>Financial risks are identified within a Risk Sharing Agreement between the Council and the CCG and included within the section 75 and other agreements.</p>

PART B) – ADDITIONAL INFORMATION

1	INTRODUCTION
	<p>The BCF programme implementation formally commenced in 2015 and required the Council and the CCG to agree targets and working arrangements to transform the health and social care system in Telford and Wrekin focussing on key objectives which remain central to the BCF programme:</p> <ul style="list-style-type: none"> • 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
	<p>Over the year more work has been undertaken to ensure that the BCF plan is aligned to other strategic and operational plans including the Sustainability and Transformation Plan, CCG Operational Plans and Council transformation plans.</p>
	<p>From April 2017/18 there are a number of changes within the <i>'Integration and Better Care Fund'</i> set out nationally:</p> <ul style="list-style-type: none"> • It is a two year plan (2017-19 rather than annually) • The national conditions and national metrics have been revised and the number of Key Lines of Enquiry (KLOEs) have reduced from 73 to 37. • There is a specific focus on Integration of health and social care services • Additional Improved BCF (iBCF) monies has been allocated to Councils <p>There are four national conditions (reduced from eight):</p> <ul style="list-style-type: none"> • Plans must be jointly agreed (signed off by HWBBs) • NHS contribution to adult social care is maintained in line with inflation • Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care • Managing Transfers of Care (and implementation of High Impact Changes) <p>National metrics have been reduced to four which are:</p> <ul style="list-style-type: none"> • Reductions in non-elective admissions • Reductions in DTOCs • Reductions in Permanent admissions to residential care (nursing and residential homes) • Increase in Effectiveness of Rehabilitation - remain at 91 days after discharge from hospital into reablement / rehabilitation
2	BCF PERFORMANCE 2016/17
	<p>BCF performance is set out in the accompanying table below 'BCF performance position 2016/17'</p>

BCF performance position 2016/17		
Metric	Performance comments	RAG Fore- cast
Reduction in non-elective admissions	Target for 2016/17 is 18,867. Month 12 was 17888. Reduction of -979/5.2%	Green
DToCs	<p>Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). The annual target of DToC days is 3285 days. Month 12 shows 3318 days (32 days over target). M12 shows a reduction against last year of 205 days.</p> <p>Delays of 626 days were attributable to Council- people with pre-existing or new care which does not include rehabilitation. 1,379 were Joint Council and NHS - individuals having further assessment and/ or rehabilitation. This supports reductions in permanent residential care. 1,313 were NHS mainly due to delays in transfers to specialised placements.</p> <p>In the first quarter of 2017/18, overall performance is slightly above target. The Council is meeting its targets. Joint delays are NHS are above target levels, mainly due to delays in transfers to specialised placements. A Joint Action Plan is in place to achieve mandated 2017/18 targets.</p>	Amber
Local measure – reductions in 70+ admissions	<p>The target identified within the QIPP plan is a reduction of 352 for 70+ population against last year (1967) of identified HRGs. The final position was 1778 (actual reduction of – 86) against a planned reduction of -352). This is -266 short of the target figure (Registered population of 20,303 registered patients aged 70+) Revised target rate was 1615/100 population. Actual was 7954</p> <p>Further integrated working through development of the Intermediate Care Team, Frailty programme and Neighbourhood working all support achieving this target in 2017/18.</p>	Amber
Patient experience	Positive responses to question 32 of the GP survey (feeling supported to manage LTC) is target of 65.6. Final published figure in July 2016 was 62.77. This shows an improvement from the previous report (62.2) but still below target.	No further reporting
Rate of permanent admissions to care homes	<p>Rate of permanent admissions to residential care per 100,000 population (65+)</p> <p>The target for 2016/17 is 540.6/100,000 (155 people).</p> <p>The final position is current position is 383.4/100,000 (104 People). This will change slightly when mid-year population estimates are released.</p>	Green
Rehabilitation	<p>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</p> <p>The target proportion maintained at home is 70%. The final position was 71% (72 of 101 still at home)</p>	Green

3	<u>PROGRESS OF THE PROGRAMME DURING 2016/17</u>											
There had been substantial progress made during the year. Key progress and impact is summarised below												
	<table border="1"> <thead> <tr> <th data-bbox="228 376 512 421">Initiative</th> <th data-bbox="512 376 1442 421">Progress and impact</th> </tr> </thead> <tbody> <tr> <td data-bbox="228 421 512 712">Achievements in key metrics</td> <td data-bbox="512 421 1442 712"> <p>Reductions in admissions related to care homes, chest pain, end of life, general medical conditions and related to 75+ years.</p> <p>Recognised DTOC pressure related to mental health and Community provider from provider profiling. Targeted work to address identified factors.</p> </td> </tr> <tr> <td data-bbox="228 712 512 1384">Community Resilience</td> <td data-bbox="512 712 1442 1384"> <p>Continued partnership collaborations within the care sector and utilised SPIC leadership to ensure co-production.</p> <p>Facilitated community stakeholders to encourage delivery of 'Care Supply Provider Networks' - care and support providers focusing on the provision and sustainability of care – and voluntary sector and microenterprise development to support development more resilient communities</p> <p>Workshops to develop Wellbeing Care Networks 'Wellington Pilot,' strengthening collaboration and develop flexible care provision in the community.</p> <p>Joint Grants and Commissioned voluntary services process in place. Funded 16 additional small providers through 'Supporting Communities' funding (up to 500 pounds).</p> <p>Revising the Market Position Statement</p> </td> </tr> <tr> <td data-bbox="228 1384 512 1742">Neighbourhood Care</td> <td data-bbox="512 1384 1442 1742"> <p>Multi- stakeholder Steering group in place. Strong partnership working across all sectors committed to aligning services to localities.</p> <p>Locality plans for the identified four localities in place. 19 projects in place with reporting into the STP across four localities.</p> <p>Formal links to STP on progress.</p> </td> </tr> <tr> <td data-bbox="228 1742 512 2038">Integrated Care</td> <td data-bbox="512 1742 1442 2038"> <p>Steering Group with Senior Managers from the acute Trust, Community Provider and Council developed process map and additional on-going meetings of all providers to improve implementation of the work of the Intermediate Care Team, "ICT".</p> <p>Reviewed the level of implementation of the service specification and process map revised.</p> </td> </tr> </tbody> </table>	Initiative	Progress and impact	Achievements in key metrics	<p>Reductions in admissions related to care homes, chest pain, end of life, general medical conditions and related to 75+ years.</p> <p>Recognised DTOC pressure related to mental health and Community provider from provider profiling. Targeted work to address identified factors.</p>	Community Resilience	<p>Continued partnership collaborations within the care sector and utilised SPIC leadership to ensure co-production.</p> <p>Facilitated community stakeholders to encourage delivery of 'Care Supply Provider Networks' - care and support providers focusing on the provision and sustainability of care – and voluntary sector and microenterprise development to support development more resilient communities</p> <p>Workshops to develop Wellbeing Care Networks 'Wellington Pilot,' strengthening collaboration and develop flexible care provision in the community.</p> <p>Joint Grants and Commissioned voluntary services process in place. Funded 16 additional small providers through 'Supporting Communities' funding (up to 500 pounds).</p> <p>Revising the Market Position Statement</p>	Neighbourhood Care	<p>Multi- stakeholder Steering group in place. Strong partnership working across all sectors committed to aligning services to localities.</p> <p>Locality plans for the identified four localities in place. 19 projects in place with reporting into the STP across four localities.</p> <p>Formal links to STP on progress.</p>	Integrated Care	<p>Steering Group with Senior Managers from the acute Trust, Community Provider and Council developed process map and additional on-going meetings of all providers to improve implementation of the work of the Intermediate Care Team, "ICT".</p> <p>Reviewed the level of implementation of the service specification and process map revised.</p>	
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		<p>Reviewed use of Recovery beds to ensure D2A destination accuracy after audits of usage. Reviewed therapy input to ensure optimisation of enablement. Reduced delays discharge from Enablement beds.</p> <p>Additional senior nursing support to D2A process and links to community services. Supported reductions in Pathway 2 and 3 utilisation.</p> <p>Council revision of TICAT function to give enhanced dedicated capacity to ICT.</p> <p>Commissioned Enablement Packages to support Pathway 1 discharges (home with care) since Jan 2017. Quantifiable improvement in pathways 1 discharges and 95%+ response discharge within 48 hours</p>
	<p>DToC Action Plan</p>	<p>Daily clinical Hub escalates delays to resolve and minimise delays and ensure flow; ensure utilisation of step down beds and ensure Trusted Assessors utilise appropriate pathways. Additional senior nursing and SW capacity to support discharge destination and promote Home First.</p> <p>Reviewed use of Recovery beds to ensure D2A destination accuracy. Previously 30% could have utilised other pathways – home or non-Recovery based placements. Now less than 10%.</p> <p>Additional weekly planning meeting to reduce delays from Recovery beds</p> <p>Commissioned Enablement Packages provision across Zones from Jan 2017. Quantifiable improvement in pathways 1 discharges</p> <p>Piloting Hospice Rapid Response interventions to support Fast Track early discharge and admission avoidance.</p> <p>Reviewing D2A process as part of A&E Delivery Plan</p> <p>Analysis at provider level to reduce DToC levels to 3.5%. Planning related to mental health and Community Trust.</p>
	<p>Development of 7 day services</p>	<p>Rapid Response – part of Intermediate Care Team – in place 7 days week 8am-10pm. Utilised commissioned Out of Hours domiciliary care in place to avoid admissions.</p> <p>Development of 7day services within the NHS contracts and progress monitored on a quarterly basis.</p>

		Resourced 7 day working at key times which highlighted challenges within acute setting to facilitate weekend discharges of complex patients.
	Disabled Facilities Grant	The DFG Capital Grants awarded are part of a scheme in the Better Care Fund in recognition that appropriate adaptations can help frailer older people remain independent, safe and healthy and prevent admissions and readmissions. The Grant fund is administered by the Housing department in the Councils Commercial Services Area who work in conjunction with housing providers, social care and OT teams. Interventions have been made through: <ul style="list-style-type: none"> • Preventative interventions within the locality teams • Commissioned services from Wrekin Housing Trust and other providers to deliver adaptations • Home Improvement Agency within the Council
	Care Act	The Care Act instils duties to ensure wide accessibility for carers and our most vulnerable groups including frail elderly people to gain information, advice and guidance. -Services have been commissioned to include carers and the voluntary sector with aim of self-help, assist in wellbeing and promoting independence in the community.
	Governance and Financial Management	Strategic Commissioning Group in place Monthly financial and performance monitoring in place.
4	<u>BCF PERFORMANCE 2017-19</u>	
	<p>There are a number of changes to the <i>'Integration and Better Care Fund'</i> as set out in the published planning requirements. It is a two year plan (2017-19) and all metrics, financial planning and planning reflect this. The deadline for submission of the Narrative Plan and Planning Template (financial and performance metrics) to NHSE is 12th September 2017.</p> <p>The additional Improved Better Care Fund (iBCF) monies provided directly for social care services must support social care needs but it must also reduce pressures on the NHS including supporting discharge and ensure the local provider market is supported.</p> <p>The specific focus on Integration of health and social care services continues, reinforcing the 2015 Spending Review that highlighted the Government's intention that by 2020 health and social care must be fully integrated.</p> <p>Economies can 'Graduate' from the BCF reporting processes once they can demonstrate integrating their health and social care commissioning or provision to that they exceed and continue to exceed the requirements of the BCF</p> <p>The simplification in reporting is welcomed but the narrative plans, part of the</p>	

Submission, must address what is seen nationally as key enablers to integration:

- 7 day services across health and social care;
- improved data sharing; and
- joint assessment and planning.

The four national metrics need to be agreed for the two years and there is no requirement for local metrics and none have been produced locally.

The work programme will remain around the existing themes detailed in 3 above, with future work programme detailed below and set out in more detail within the draft Narrative Plan. There is significant inter-relationship between BCF programmes and integrated working as part of with other programmes of work such as Frailty; A&E Delivery Board and STP.

Programme of work	Key actions and outcomes
Community Resilience	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Implementation of the 22 work programmes • Locality agreement of new models of care • Alignment of community based staff statutory and voluntary services around local communities • Increased acute services e.g. clinics, clinical advice, diagnostics based and delivered within local communities and primary care • Preventative and personalised approaches e.g. Social Prescribing in Newport • Shared ownership of managing and supporting high risk patients e.g. Frail people, long term conditions, respiratory conditions, diabetes
Integrated Care	<ul style="list-style-type: none"> • A fully integrated health, social care and voluntary care team working together within a single service specification • Improved relationship with Neighbourhood teams • Development of the Care home MDT to reduce care home admissions and improve quality of care • Reduced hospital conveyances and non-elective admissions through 7 day service including from care homes • Develop joint assessment and care planning process
Integrated Care –	Deliver Actions identified in the DTOC Action Plan and 8

<p>Managing Transfers of Care/ High Impact Changes)</p>	<p>High Level Changes Self- Assessment to:</p> <ul style="list-style-type: none"> • Reduce DToC targets to 3.5% • Further develop 7 day services for admission avoidance and discharge • Improve MDT discharge planning and support • Develop Trusted Assessor role to facilitate prompt identification of correct pathway
<p>Integrated Care – Frailty Programme</p>	<ul style="list-style-type: none"> • Implementation of 11 projects supporting early identification, assessment and care planning; preventative interventions; admission avoidance; reducing LoS and early discharge; improved end of life care • Development of Frailty Team at RSH to reduce admissions and LoS and more integrated acute and community alignment • Primary Care Streaming At Front Door at PRH to divert to other appropriate services
<p>Data sharing</p>	<ul style="list-style-type: none"> • 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)
<p>Governance and Financial management</p>	<ul style="list-style-type: none"> • Strategic Commissioning Group providing Assurance to HWB Board, respective organisations and STP • S75 Agreement to be agreed by November 2017 • Monitoring of performance of the overall programme; metrics; financial monitoring and reporting of BCF and iBCF monies • National reporting
	<p>The key metrics for BCF are:</p> <ul style="list-style-type: none"> • 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

5

BCF FINANCE

The Section 75 Pooled Budget in 2016/17 was £14,252,675.

Organisation	Contribution
Council	£2,261,545
CCG	£11,991,130

There was a carry forward of £159,922 underspend by the Local Authority.

The pooled budget for 2017/19 has been identified below. There was national requirement for increases to the minimum contribution in line with inflation; increases in the Disabled Facilities Grant and the iBCF monies:

	2017/18	2018/19
Council excluding iBCF	£2,428,198	£2,589,807
iBCF monies	£4,019,858	£5,487,290
Minimum CCG contribution	£10,774,611	£10,979,329
Additional CCG contribution	£1,084,999	£1,100,885
TOTAL	£18,307,666	£20,157,311

The funding within the profile of Pooled Budget relates to the key areas of work is set out below across the three years (NB The carry forward in reserves of £159,922 in 2017/18 is included below, but not in the table above)

Summary Statement		2016/17 Annual Budget £	2017/18 Annual Budget £	2018/19 Annual Budget £
<u>Intermediate Care</u>				
Rehabilitation and Enablement		897,547	1,849,267	1,884,218
Domiciliary Care		664,057	932,201	786,875
Rehabilitation and Enablement Beds		973,288	596,164	607,981
Preventative Services		170,859	0	0
Shropshire Community Healthcare Trust		1,596,973	1,625,558	1,656,281
Shrewsbury and Telford Hospital Trust		1,655,069	1,684,695	1,716,536
LA Beds		46,607	0	0
Total Intermediate Care		6,004,400	6,687,885	6,651,892
<u>Community Resilience</u>				
Preventative Services		446,549	491,616	496,461
Carers		521,172	530,500	540,526
LA Grants		315,600	321,249	327,321
Total Community Resilience		1,283,321	1,343,365	1,364,308
<u>Telford Neighbourhood Care</u>				
Rehabilitation and Enablement		597,501	0	0
Assistive Technologies		493,595	503,103	512,612
Preventative Services		844,320	438,783	447,076
Shropshire Community Healthcare Trust		1,596,974	1,853,963	1,889,357
Total Telford Neighbourhood Care		3,532,390	2,795,849	2,849,044
<u>Other Care</u>				
iBCF		0	4,019,859	5,487,290
Maintaining Eligibility for Clients with LTC		878,000	893,716	910,607
Management Charges		56,395	57,404	58,489
Programme Management		477,857	486,410	495,603
Care Act Implementation		445,000	453,418	461,988
Disabled Facilities		1,575,312	1,729,682	1,878,089
Total Other Care		3,432,564	7,640,489	9,292,066
Grand Total:		14,252,675	18,467,588	20,157,310
6	<u>PREVIOUS MINUTES</u>			
	BCF update to Health and Wellbeing Board: May 2015; June 2016			

Report prepared by:

- **Michael Bennett - Head of Commissioning: Better Care Fund/ Care Closer to Home Telford and Wrekin CCG**
- **Jonathan Eatough – Assistant Director – Governance, Procurement & Commissioning**
- **Legal Review - Kirsty Fisher -Telford and Wrekin Council**
- **Finance Review-Tracey Smart - Finance Manager- Telford and Wrekin Council**