Agenda Item No. 10

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

07 October 2015

Report title	Better Care Fund Update	
Cabinet member with lead responsibility	Councillor Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	Adult Health and Social Care	
Accountable employee(s)	Steven Marshall Tel Email	Transformation Director 01902 441 775 steven.marshall3@nhs.net
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Report to be/has been considered by	BCF Programme Board Integrated Commissioning Board	17 September 2015 17 September 2015

Recommendation(s) for action or decision:

1. None – information only update

Recommendations for comment:

The Health and Wellbeing Board is asked to:

1. Note the progress update provided in this report in relation to the Better Care Fund.
2. Note the draft out-turn position following the period 4 (end of July) monitoring and the forecast cost pressures in line with the risk sharing agreement for each organisation.
3. Note the position relating to current performance against the key Payment for Performance Indicator and relevant supporting indicators
4. Feedback comments to the report author.

1.0 Purpose

1.1 The purpose of the report is:

- To brief the Board on the development and progress of the Better Care Fund.
- To brief the board in relation to the financial risks relating to the Better Care Fund.
- To appraise the Board of next steps
- To secure continuing support from the whole Health and Social Care Economy to facilitate the successful delivery of the Better Care Programme

2.0 Background

2.1 The Better Care Fund Programme is now in the implementation phase with the aim of delivering six Outcomes:-

- Reduced delayed transfers of Care
- Reduction in avoidable emergency admissions
- Reduce admissions to residential and nursing homes
- Ensure effectiveness of reablement
- Improve patient/Service user experience
- Improve dementia Diagnosis rates

3.0 Progress, options, discussion, etc.

3.1 Better Care Fund Performance

The planned number of emergency admissions has been re-baselined due to revised 2014 actual data. Performance appeared to be improving in May but is above target in June and July. However, performance against the BCF HRG codes continues to be good.

- Work has now been done to ensure that planned performance against specific BCF HRG codes is unique to work streams and analysis is being undertaken to understand the specifics and complexities around performance in this area.

- Delayed Transfer of Care performance continues to decline with the planned number of delayed days for the whole of quarter 2 being met in July alone.

- The performance framework continues to be developed and more detailed commentary and RAG ratings provided by work stream leads will be included in future reports.

3.1.2 Current Performance

Please note the following in relation to performance monitoring:

Emergency admissions to hospital are currently being measured in two ways. The Payment for Performance (P4P) indicator is being measured using MAR (Monthly Activity Report) data that is submitted by hospitals. This measures episodes relating to admissions and an individual person admitted to hospital may have multiple episodes recorded as part of that admission.

Local plans and reporting are broken down by HRG code which gives an indication of the reasons for admission, allowing more detailed analysis. This uses SUS (Secondary Uses Service) data which is based on spells. There should only be one overarching spell per admission. This means that there will be differences in the way that the data sets are reported.

The Wolverhampton BCF plans and targets are based on mapping that involves 5 separate CCGs:

- *NHS Wolverhampton CCG – 93.7%*
- *NHS Dudley CCG – 1.5%*
- *NHS Sandwell and West Birmingham CCG – 0.1%*
- *NHS South East Staffs and Seisdon Peninsular CCG – 1.7%*
- *NHS Walsall CCG – 3.9%*

However, for ease of monthly reporting 100% of the Wolverhampton CCG figure is being used. This means that the final data used by NHSE when calculating the quarterly performance may differ slightly from what is reported locally, however any difference should not be significant.

3.1.2 Emergency Admissions

MAR and Payment for Performance

The planned number of emergency admissions has been slightly altered following revisions to the 2014 actual performance. This revision was submitted as part of the quarter 1 submission to NHSE.

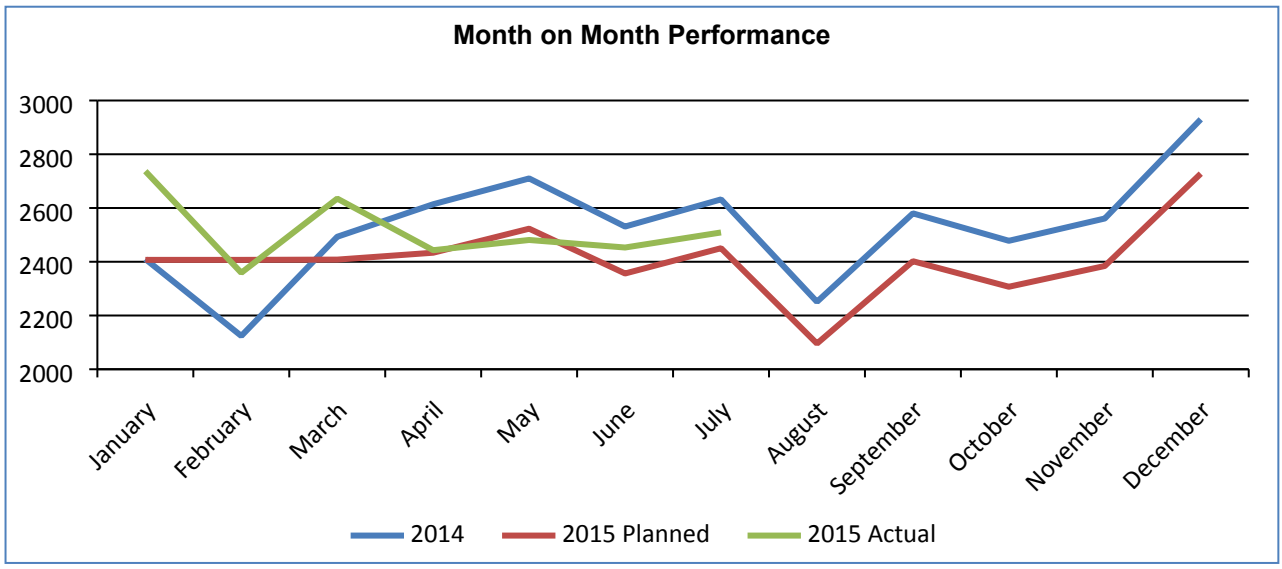
The planned and actual number of emergency admissions so far is:

Quarterly Performance	Q4	Q1	Q2	Q3
2014	7027	7855	7463	7969
2015 Planned	7222	7249	7365	7313
2015 Actual	**7731**	**7377**	**2509**	
Difference between planned and actual	509	128	-4856	
% Difference between planned and actual	7.0%	1.8%	-65.9%	

On a cumulative basis, performance is:

Quarterly Cumulative Performance	Q4	Q1	Q2	Q3
2014	7,103	14,983	22,459	30,436
2015 Planned	7222	14577	21877	29370
2015 Actual	**7731**	**15108**	**17617**	
Difference between planned and actual	509	531	-4260	-29370
% Difference between planned and actual	7.0%	3.6%	-19.5%	-100.0%

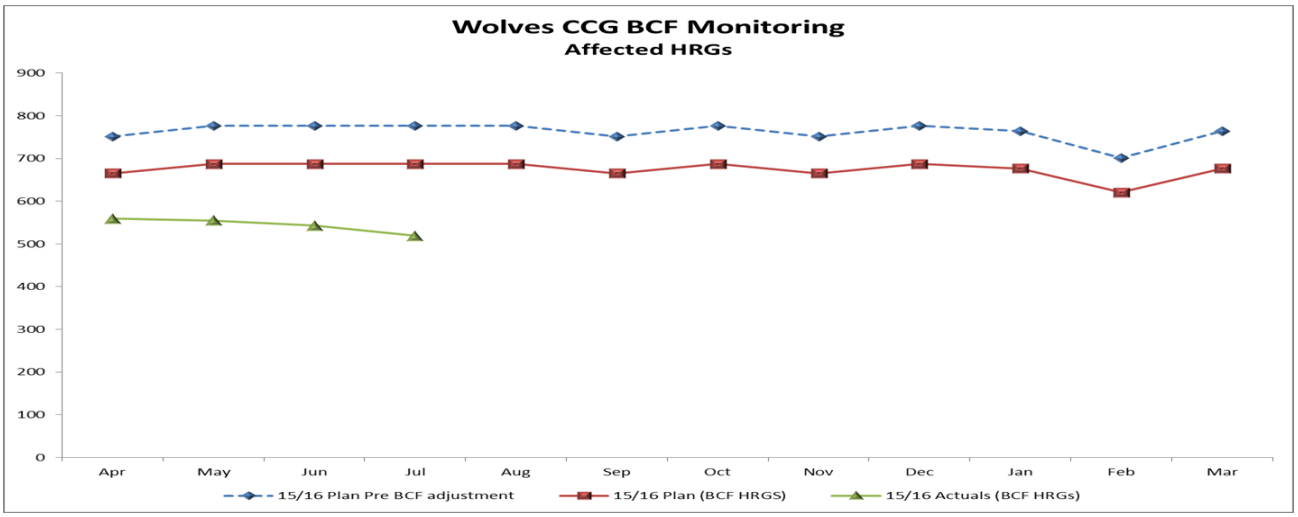
The difference is largely due to a higher number than planned admissions in January and March 2015 (as indicated by the green line in the graph below). This was not unexpected as many of the improvements and changes being instigated as part of the individual work streams did not come on line until April 2015, however, June and July have also seen admissions higher than planned numbers.



SUS and HRG Codes

A number of HRG codes have been identified as those most likely to be influenced by the Better Care Fund and planned reductions against these codes have been built into CCG plans and contracts with the Hospital Trust.

Performance against these specific codes in the first two months of the year is considerably better than planned as the graph below shows:

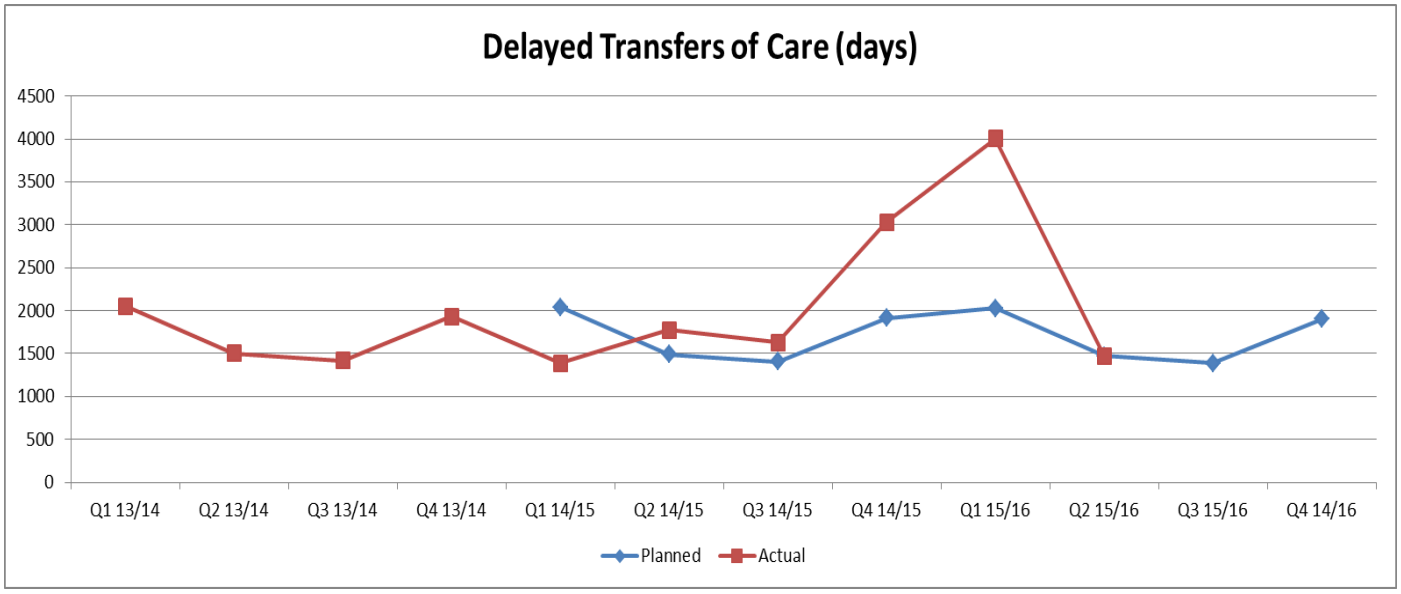


Although performance is positive against these specific HRG codes, it is a mixed picture amongst specific chapters with some performing better than others. The difference between reported SUS performance and the MAR data also re-enforces the previous assertion that there are increases in admissions against HRG codes that are not included within the BCF plans. Work has begun to analyse this area in more depth but is not yet complete.

3.1.2 Delayed Transfers of Care (DTOCS)

The table and graph below shows the number of delayed transfers of care (days) which has now been updated with June and July data.

Metric	13/14 plans (revised)	Q1 (Apr 13 - Jun 13)		Q2 (Jul 13 - Sep 13)		Q3 (Oct 13 - Dec 13)		Q4 (Jan 14 - Mar 14)	
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**1055**		**770**		**728**		**986**	
	Numerator	2054		1500		1418		1929	
	Denominator	194708		194708		194708		195605	
	14/15 plans (revised)	**Q1 (Apr 14 - Jun 14)**		**Q2 (Jul 14 - Sep 14)**		**Q3 (Oct 14 - Dec 14)**		**Q4 (Jan 15 - Mar 15)**	
		Plan	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
	Quarterly rate	**1044**	**709**	**761**	**906**	**718**	**833**	**976**	**1543**
	Numerator	2042	1386	1488	1773	1405	1630	1916	3029
	Denominator	195605		195605		195605		196274	
	15-16 plans (revised)	**Q1 (Apr 15 - Jun 15)**		**Q2 (Jul 15 - Sep 15)**		**Q3 (Oct 15 - Dec 15)**		**Q4 (Jan 16 - Mar 16)**	
		Plan	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
	Quarterly rate	**1033**	**2041**	**750**	**750**	**708**		**966**	
	Numerator	2027	4006	1473	1472	1390		1901	
	Denominator	196274		196274		196274		196857	



As the data shows, despite positive performance against the plan in the first quarter of 2014/15, in all quarters afterwards, actual performance has been seen a significantly higher number of delayed days than was planned and is increasing.

One month into quarter 2 2015/16, performance is already in line with the plan for the entire month. Price Waterhouse Cooper have recently been commissioned to undertake a review of DTOC issues within the City. The table below shows performance against plans for the other supporting indicators:

Metric		Baseline - final (2013/14)	Planned 14/15 (revised)	Actual 14/15	Planned 15/16 (revised)	Q1 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate per 100,000*	**726.9**	**682.6**	**645.4**	**638.0**	**642.7**
	Actual number of admissions	305	289	273	273	275
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**85.8**	**88.6**	**80.6**	**94.3**	**N/A - Annual Indicator**
	Actual number of people	300	310	329	330	

On an incredibly positive note, the actual 2014/15 result for the number of permanent admissions of older people to residential and nursing care homes, not only exceeded the planned 14/15 target but met the 2015/15 target (the rate is different due to different population denominators).

Although there has been a slight increase in admissions over the rolling 12 month period at the end of quarter 1, it is expected that performance will continue to improve throughout the year with the 15/16 being exceeded by year end.

On a less positive note, the proportion of older people who were still at home 91 days after discharge from hospital into reablement fell by 5.2 percentage points meaning that the ambitious 88.6% target was not met.

It is unlikely that the overly ambitious target of 94.3% will be met in 2015/16 as the reablement offer is due to be extended to a higher number of people as part of the BCF work and a reduction is effectiveness is a known result of a wider reablement offer.

3.2 Key Progress

3.2.1 Intermediate Care and Reablement

The Home In Reach Team ("HIT") has been operational for some time; however the BCF programme redesign has enabled the scheme to expand from a five day service to a seven day service and to increase the number of homes it supports. This will increase the efficiencies already demonstrated by this service.

A joint community reablement service pilot is now operational. The Community Intermediate Care Team ("CICT") and Home Assisted Reablement Team ("HARP") are jointly triaging referrals and working together to develop joint pathways of care that will enable seamless processes for patients/service users. An evaluation of the pilot will be undertaken in October and a future action plan and workforce plan for an integrated team will be developed.

The pilot is focussing on Integrated pathways and models of delivery in the first instance with a long term view to becoming fully integrated. This will enable more timely impact upon the delivery of care and subsequent efficiencies from more co-ordinated discharge and reablement pathways.

An overarching service specification is being developed between health and social care colleagues to develop a Rapid Response service that will be reactive to patients/service users need and enable them to remain in their usual place of residence avoiding emergency admissions and readmissions.

3.2.1 Primary and Community Care

Community Neighbourhood teams - This is the development of three Integrated Health and Social care teams. Core team members will be District nurses, Community matrons, Social workers and support workers all working closely with Primary care and the voluntary sector to meet the needs of individual patients and service users and carers and families.

The core team will have access to specialist teams; the aim of the teams is to prevent emergency admissions by risk stratification, prevention, promoting self- management of conditions, developing personalised management plans and, rapid response to patients with an urgent need. Whilst currently working virtually, the teams will be co-located in order to enable integrated working, multi-disciplinary team meetings and joint care planning.

End of Life - The Rapid Discharge project at Royal Wolverhampton Trust (RWT) has now gone live. This enables patients identified as end of life to be discharged promptly and appropriately back to their usual place of residence. This facilitates early discharge and enables the patients to die in their own home where this is their preference. The

development of a hospice as a hub is underway. The project has secured funding from Macmillan to provide project management support during implementation of this project.

Urinary Tract Infection ("UTI") Pathway – the UTI pathway went live on the 6 July. Patients with a UTI that previously may have been admitted to hospital are now referred to the Community Matron and social care teams in order to manage the patients in their own home.

Patients who are discharged from hospital or attend Accident and Emergency (A&E) with a UTI can also be referred to the team with the aim of preventing a re-admission. The pathway is being supported by a similar project being run by West Midlands Ambulance Service enabling the hours of the scheme to be extended until 8 p.m. in the evening, with each service able to refer to the other as appropriate.

GP Care Homes - A service specification and business case has been approved in principle by Clinical Commissioning Group ("CCG") Commissioning Committee and is in the process of being finalised. The project will see GPs allocated to all residential homes in the City.

Regular ward rounds and medication reviews will be undertaken and personalised management plans put in place for residents in order to reduce the number of emergency admissions from these homes, by working with the care home staff and ensuring the care plans give clear direction of management if the patient enters crisis.

3.2.2 Dementia

GP volunteers for each locality are now in place. The review of the use of hospital beds for people who have a dementia diagnosis is nearing completion. A detailed review of all current Dementia Support contracts has taken place which will be used to produce the commissioning direction for the next 3 years. An update on the Dementia Strategy has been submitted for October Cabinet.

3.2.3 Mental Health

The Street Triage service and Psychiatric Liaison services have been operating since the beginning of the programme, and is being embedded into the Mental Health service model as a substantive service. It is having a highly positive effect in the reduction of people with mental health challenges presenting at A&E.

Permission to undertake statutory consultation about new recovery house service is being sought. Consultation will be carried out between October 2015 and January 2016. This will be followed by staff consultation and implementation of the new model.

The resettlement programme continues to promote the move from residential and nursing care into supported housing. Twelve people have been resettled to date. Phase two resettlement activity has started.

4.0 Financial implications

4.1.1 The council and the CCG entered into a Section 75 agreement for the BCF pool fund for 2015/16. The value of the pool fund is £69.6 million revenue, of which £22.9 million are budget from the Council and £46.7 million from the CCG. It should be noted that the fund includes £6.3 million representing the NHS transfer to social care (Section 256 funding). In additional to the revenue budget, the pooled fund includes capital grant amounting to £2.1 million (Dedicated Facilities Grant and Social Care Capital Grant).

4.1.2 The Section 75 agreement made provision that the pooled fund including the risk sharing arrangements for any risks identified as a result of 2014/15 year-end closure would be negotiated between the Partners and the appropriate schedules of the Section 75 agreement would be amended accordingly.

4.1.3 Both organisations undertook a review of their year end position and as a result would revise the pool fund to £70.9 million, of which £24.2 million would be from council and £46.6 million from CCG. This is broken down into the workstreams as follows:

	CCG Contribution (£000)	Council Contribution (£000)	Total Contribution (£000)
Community and Primary Care	15,301	5,718	21,019
Dementia	4,307	299	4,606
Mental Health	6,622	2,821	9,443
Intermediate Care	20,414	15,381	35,795
Total Revenue	**46,644**	**24,219**	**70,863**
Capital Ring Fenced Grant	-	2,085	2,085

4.1.4 This would also change the risk sharing arrangements as follows:

	CCG Contribution %	Council Contribution %
Community and Primary Care	73	27
Dementia	93	7
Mental Health	70	30
Intermediate Care	57	43
Capital Ring Fenced Grant	0	100
Demographic Growth	66	34
Care Act	66	24
Performance Payment	100	0

4.1.5 The fund requires efficiencies to be realised to fund the council's demographic growth of £2 million and care act implementation funding of £964,000. The risk sharing arrangement is set out above if these effiencies are not identified by the workstreams. Detailed work is planned with the workstreams to identify how these efficiencies can be identified.

4.1.6 In addition receipt of a proportion of the BCF funding in 2015/16 is dependent on meeting the agreed performance targets, namely the reduction in the number of non-elective emergency admissions. The CCG is underwriting any non-achievement of the payment for performance in 2015/16. It should be noted that whilst in early months the target was not fully met, there is an opportunity to recoup the position over the rest of the year to mitigate the scale of the impact.

5.0 Legal implications

5.1 A Section 75 agreement is in place for the delivery of the BCF plan, which was approved in December 2014, and subsequently revised in August 2015.

5.2 Section 75 of the NHS Act 2006 (the "Act") allows local authorities and NHS bodies to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. Section 75 of the Act permits the formation of a pooled budget made up of contributions by both the Council and the CCG out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health-related functions of the local authority. The Act precludes CCGs from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of certain laser treatments and other invasive treatments and emergency ambulance services.

6.0 Equalities implications

6.1 Each individual project within the work streams has identified any Equality implications, and a full Equality Impact Analysis has been carried at work stream level.

7.0 Environmental implications

7.1 Each individual project within the work streams will identify any Environmental implications, such as the need to review Estate for colocation of teams and services.

8.0 Human resources implications

8.1 Each individual project within the work streams will identify HR implications. HR departments from both Local Authority and Acute Providers are already engaged in discussion regarding potential HR issues such as integrated working and change of base for staff.

9.0 Corporate landlord implications

9.1 Each individual project within the work streams will identify implications

10.0 Schedule of background papers

10.1 None