Better Care Fund update

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Purpose of Report:

This report summarises work undertaken regarding the Better Care Fund plan.

1. Background

The Better Care Fund (BCF) was introduced in the government spending round of June 2013. It is viewed as an enabler to drive forward further integration of health and social care services. Nationally the value of the fund equated to £3.8 billion of funding. The sum allocated for Milton Keynes is £14.4m. This report provides an update on the previous reports presented to the Health and Wellbeing Board in January, March and September 2014.

In each Health and Wellbeing Board area, the local authority and NHS Clinical Commissioning Group (CCG) were required to develop a plan for the use of the BCF to: reduce hospital admissions; develop more robust and sustainable community health and social care services; and promote independent living.

As was required Milton Keynes submitted a BCF plan in April 2014. The plan consisted of 18 proposed schemes to be phased in over three years. There were also a series of prescribed conditions, outcomes measures and targets to achieve.

The allocation of funding for Milton Keynes is made up from several contributions:

£9.5m from the Milton Keynes CCG
£3.95m from the Funding transfer from NHS England
£484k from the Disabled Facilities Grant
£506k from the Adult Social Care Capital Grant

Nationally some considerable revision of the BCF process and requirements took place during the summer of 2014 with new guidance and templates being issued with an expectation that plans were be re-submitted in September 2014. The new templates required considerably more detail in specific areas, including the proposed schemes themselves. Following submission in September 2014 a considerable amount of work was undertaken regarding the scrutiny and final acceptance of the plan. This was a nationally driven process led by NHS England and the Local Government Association and actioned through the BCF Taskforce. The Milton Keynes BCF plan received ‘full approval’ in February 2015. The

following link details the final BCF plan - http://www.milton-keynes.gov.uk/social-care-and-health/health-and-wellbeing-board

2. Recommendation(s)

That the Health and Wellbeing Board notes and supports the progress being made towards the delivery of the BCF plan.

3. Key Issues

Performance framework

The BCF guidance has included a clear expectation that a proportion of the CCG contribution to the BCF (for Milton Keynes £1.5m) is to be subject to achieving a minimum of a 3.5% reduction in unplanned emergency hospital admissions.

Any under achievement of the target will see the funding remain within the CCG. It is expected that this money will be used to pay for unplanned emergency admission costs. The total £14.4m will in effect remain in the Milton Keynes health and social care 'economy'.

Whilst no other financially driven performance targets are to be applied the plan is monitored by NHS England against:

Reduction in nursing and residential admissions
Reduction in delayed transfer of care
Reablement
Patient/service user experience
And a local metric related to telehealth/telecare

There is a risk that if the target for reducing unplanned emergency hospital admissions is not achieved; this could lead to a reduced amount of funding available for the BCF schemes. However, a continuation of our partnership approach is a key factor and will be the means to mitigate risks and provide a coherent approach.

Governance

A BCF Delivery Group, which includes representation from local providers of health, social care and the voluntary sector, has been established to jointly develop, own, drive and deliver the proposed schemes. Where appropriate projects have been created to deliver the aims of the BCF plan, supported through relevant project management mechanisms. These projects interface with appropriate CCG Programme Boards, local implementation groups and partnership boards to ensure actions can be endorsed across the partnerships.

The BCF Delivery Group reports regularly to the Joint Commissioning Board and leads on promoting quality and achieving delivery within the financial envelope. The Delivery Group leads innovation and change, recognising the

relationships within the health and care system. A smaller working group meets to progress activity between meetings.

Partnership arrangements

The new Care Act 2014 places a duty upon local authorities to carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services.

Furthermore, the use of the BCF requires that the fund is pooled within a Health and Wellbeing area under Section 75 arrangements of the NHS Act 2006. In respect of Milton Keynes this is between Milton Keynes Council and Milton Keynes CCG. A Memorandum of Understanding between both organisations had initially been agreed in anticipation of the Section 75 arrangement which has now been developed.

4. How the fund is deployed

A series of schemes have been designed across an integrated pathway to cover multiple care groups, prevention activities, admission avoidance, supported discharge and promotion of independence. A number of these schemes are or will become live during 2015/16:

24/7 Rapid Response

A 24/7 rapid response admission avoidance model based on best practice models elsewhere has been developed with support from local clinicians. The full funding for this scheme will not become available until 2016/17 so aspects of the model are being tested with Central and North West London NHS Foundation Trust, the local providers of community health services. They will initially provide a day time service commencing during the summer, working collaboratively and with existing services

Locality Multi-Disciplinary Teams

A BCF funded Geriatrician post has now been established to work across the hospital, community and primary care pathways leading a number of community focused initiatives.

The Geriatrician provides clinical leadership to the Multi-Disciplinary Team model now being piloted across the South and East of Milton Keynes. The scheme provides an opportunity for practices to come together with colleagues across the voluntary sector, community and hospital services, to jointly identify and care plan for people with complex health and social care needs. A co-ordinator is now in post. Early challenges related to data sharing have now been addressed; however a longer term sustainable shared record/ care plan remains a priority. Planned phased roll out across the North and West of Milton Keynes will have been completed by the autumn.

Wellbeing Assessment

A Wellbeing Assessment pilot ran through the winter period until the end of March. Led by three voluntary sector partners the scheme provided wellbeing and prevention sign posting opportunities, with an identified group of patients

registered at four GP practices. The evaluation has now concluded, and whilst the short nature of the pilot limited potential outcomes there is evidence of a reduction in GP attendances and broad support for the programme. A working group is currently reviewing the model to propose an expanded approach to cover a larger population.

Recuperation Pathway

This scheme is designed to develop a range of services that can support people in the community, who are not yet ready for reablement but require recuperation care and support i.e. a period of convalescence. This is mainly designed for patients discharged from hospital but will take community based referrals too

The work to date has concentrated on the following:

The provision of domiciliary care to provide recuperation, for a period of 4 weeks, accessed via the Intermediate Care Services single point of access. Users of this service have mainly come directly from Milton Keynes Hospital. Initially this was piloted over winter 2014/15, but a longer term service is currently being commissioned.

The commissioning of five recuperation beds, specifically for those not immediately able to return home. This service is accessed via the Intermediate Care Services single point of access.

Enhancements to the Reablement and Hospital Discharge Team to facilitate access to the recuperation pathway.

A strategic review of Domiciliary Care services across Milton Keynes is underway and will further inform the future model(s) required.

Community Equipment

Investment to existing service now operational

Alcohol Liaison

Investment to existing service now operational

High Impact Team for care homes

This scheme, piloted during 2014, is designed to provide planned and reactive support to residential care homes to provide admission avoidance activities and clinical support. The scheme was evaluated in January 2015 and was demonstrated to have successfully reduced hospital admissions by 30% during the pilot period. The scope of the scheme has been amended following learning from the pilot and a procurement process is currently underway to deliver the scheme from October 2015, when the existing contract arrangements end.

Community Dementia service

Investment proposal for the first year will support the programme of work planned to increase early diagnosis of dementia, and support to individuals and their families.

Community based Falls Prevention pathway

A new service model has been developed and is to be commissioned during the summer. The model provides a clinically led single point of access to receive and triage all referrals from across the system and to have oversight of all people reported to have fallen or be at significant risk of falling. The scheme will additionally link to prevention services and will expand the availability of exercise programmes in the community.

Social Isolation research

(2014/15 scheme) Research programme now completed and final report is due for publication. Recommendations from the research will be considered within the 2016/17 planning.

4. Next steps

Planning for the development of 16/17 schemes has now commenced.

Performance of 15/16 schemes will be monitored closely and reviewed as required.

Background Papers: PREVIOUS REPORTS TO HWB IN JAN, MARCH AND SEPT 2014