Appendix 1 – Better Care Fund - High Level Scheme Analysis and Progress

Scheme Area	Scheme Outline	Deliverables	Expected Outcomes	Current status
Scheme One Transforming Primary Care:	Transforming primary care is a key component of delivering person centred; locality based integrated health and social care with a focus on prevention and self-care. It is fundamental to responding to a rapidly growing and ageing population. This scheme has three elements. 1. Prevention and Early Intervention 2. Long-term conditions management in primary care 3. Accountable Lead Professional/GP Federations	• Establishment of integrated health and social care locality teams • Roll out and adoption of LTC SystmOne templates across all practices. • Determining the model for the lifestyle hub • Capacity within primary and community care services • Establishing robust KPIs for each scheme to effectively measure impact	Prevention and early identification of those at risk; single access point care-coordinator (named GP); Standardised high quality care consistent across all practices; Priority access rapid assessment and early diagnosis; Supported discharge self-management follow up and support and access to single patient record To ensure that care is co-ordinated, seamless and can effectively wrap around the patient, making their needs paramount	**Lifestyle Hubs:** The successful establishment of a lifestyle hub in Chiltern Vale which has been running since February 2015. Clients are pre-dominantly aged 46-55 and are referred for advice/support related to obesity. This has an approximately cost of £144 per patient. Although the benefit of this service is considered to be that it looks at the whole person. A full review of this pilot, which will include its cost effectiveness, is expected in Q4. **Accountable lead professional –** All patients over 75s have a named GP.. Provision of risk stratification tools (manual & electronic) to all General Practices **Long term conditions management in primary care:** A more standardised means of collecting data in the four disease areas- LTC Template production for SystmOne has been launched and is in use.
	Finance		The investment in Transforming Primary Care in the main comes from existing Primary Care and Public Health resources although £0.090m in 2015/16 was made available to support the creation of the Lifestyle Hubs. The forecast outturn is in line with this budget.	

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Scheme Two Integrated Rapid Response:	**Integrated Rapid Response for people with long term conditions and the frail elderly.** This includes the following areas: • Caring Together (formerly Demonstrator project) • Community Beds • Acute services in the community – Hospital at Home, Specialist Nurses (neurology) • Paediatric Urgent care • Integration of OT Services • Integration of rehab and reablement The objectives of this scheme is to: • Use resources across the whole system more effectively and efficiently to maximise investment in prevention and early intervention • Provide targeted support and information at key life stages and events to prevent or delay the need for care and support or further deterioration • Work holistically to promote health and wellbeing.	To develop locality based models that provide an integrated rapid response to urgent health and/ or social needs as an integrated team, implementing an integrated/ co-ordinated care plan. Paediatric Urgent Care to reduce A&E attendances and admissions for children and young people with lower respiratory tract infection through a targeted approach to groups of the community Integrated Rehabilitation and Re-ablement in the 4 primary care localities in Central Bedfordshire a co-located health and social care team to facilitate an integrated rehabilitation & reablement service Integrated Occupational Therapy	To place the patient at the centre of their care Deliver safe care in the right setting, at the right time Support independence and self-care Reduce avoidable hospital admissions Reduce hospital and institutional length of stay Reduce the number of patients discharged into permanent institutional care settings Reduce the number of patients referred to institutional care following hospital discharge Decrease in the number of avoidable paediatric admissions.	**Slow progress on key elements of this workstream such as** • Integration of rehabilitation and Reablement – not achieved. • Integration of occupational therapy services – early discussions are now underway. • Acute services in the community – this will be taken forward as part of the review of community health services. • **Community beds:** Significant piece of work, reviewing the pathways has been completed. A key finding was that longer stay rehabilitation (slow stream) beds are an issue. However Ward 5 at the L&D, although high cost, delivers good length of stay figures **2.5 Demonstrator project (Caring Together): Initial plans for the demonstator project stalled. This has now been superseded with the Caring Together project. This has** Introduced a Multi-Disciplinary Team (MDT) working project to provide integrated response to those patients most at risk of admission and other people who would benefit from a more joined up response. A pilot across two GP Practices in two localities, Chiltern Vale and West Mid Beds is now underway. Lessons from

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				the pilot will be used to inform the ongoing review of Community Health Services and the roll out of MDT working across Central Bedfordshire. **Dementia services:** Dementia Health Needs Assessment completed. Dementia Friendly Communities programmes initiated- Dementia project s now considered business as usual within commissioning. 280 CBC staff are dementia friends and nine care homes have gone through the CBC dementia quality mark process **Paediatric Urgent Care:** Project has been completed. It aimed to reduce urgent care admissions amongst children and young people, empower parents to recognise and manage minor ailments. It also increased staff training to manage certain conditions in the community.
	Finance		The investment in Integrated rapid Response is £7.144m in 2015/16. This includes activity through Reablement, Rapid Intervention, Community Capacity and Home from Hospital services. The projected forecast for the year is £7.220m, £0.076m above the budget. There is an over spend on Community Beds mainly offset by an under spend on the Demonstrator Project.	
Scheme Three Efficient Planned Care	To reshape the way in which planned care is provided and delivered through: • Implementation of the redeveloped community	Re-commissioned community services to work as part of a multi-disciplinary team, based on a Care Function Approach. A key design principle of this MDT will	The anticipated benefits from this scheme are a reduction of 225 non-elective admissions, a financial saving of £0.335m	**Community services** A programme of work for a complete transformation of adult and children's' community services has now commenced.

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	nursing specification • End of Life (EoL) services • Integrated falls, osteoporosis, and fracture prevention services • Integrated wheelchair, equipment and telecare services • Disabled Facilities Grant 1. Improved care co-ordination should: 2. 3. Reduction in 'unplanned' admissions into hospital or institutional care for patients 75+ initially 4. Early intervention in care, improving patient outcomes 5. Enhance patient experience and improve independence 6. Decrease in hospital length of stay 7. Increase training and education, especially for carers 8. Provide better care without unnecessary delays	be that care will be delivered holistically wherever possible, by any member of any team that has the capacity and capability. The Care Function Approach includes seven Care Functions: 1. Access and Coordination 2. Rapid Response 3. Facilitated and Supported Discharge 4. Maximising Independence 5. Complex Case Management 6. Scheduled and On-going Care 7. Specialist Input **End of Life (EoL) services** - to systematically review all the services that support End Of Life Care pathway. **Integrated falls, osteoporosis, and fracture prevention services-** With four sub-projects: 1. A Fracture Liaison Service 2. Community Falls Prevention Coordinators 3. Community Strength and Balance Exercise Classes 4. A Central Bedfordshire Physiotherapy Falls Service **Integrated wheelchair, equipment and telecare services** Streamlining and integrating these services into a co-	in 2015/16. In addition savings of £0.164m are proposed from the Telecare, Equipment and Wheelchair services as we combine service delivery. Contractual savings of £0.100m will be sought from End of Life Services.	**Falls** The full programme of work outlined in the plan has not been delivered however, work has now commenced and is linked to facilitating a reduction in non-elective admissions. Fall prevention training is being delivered to Care Homes and Domiciliary Care providers. The Council's Urgent Homes and Falls Response Service is piloting support into Care Homes. Each Care Home is to identify a Falls Champion. **End of life services** Five Step EOL training to Care Home staff, designed to not only improve EOL care but assist with best interest decision making on preferred place of death. Training provided to Ambulance staff to support non-conveyance has by month 8 resulted in 201 non-conveyances. **3.4 Integrate wheelchair, equipment and telecare services** Project on hold. **3.5 Disability facility grants** Rolling programme with quarterly monitoring – existing. To date (8th Dec), the Council have spent £1.4M on major adaptations but have £2.9M of work in progress. The

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		commissioned arrangement.		Council has £708k of BCF funding but also obtains contributions from customers and housing associations on occasion. The impact of DFG's is difficult to quantify accurately. Adaptations will improve the safety, independence and accessibility for people in their of homes, preventing falls and accidents, (particularly on stairs and in bathrooms), and assisting carers by reducing need for lifting minimising the risk of moving and handling of disabled people. Recent research by the charity Foundations concludes that DFG adaptations reduce admissions by around 4 years on average. Adaptations are undertaken within the 12 week target, however waiting times for OT assessment can impact on the DFG service. The OT service will screen each individual referral and respond promptly with appropriate recommendations where high risk is identified, facilitating and supporting DFGs with housing colleagues. Currently the average length of time from Occupational Therapy referral to DFG approval is better than 2014/15, currently at 8 weeks compared to a 2013/14 average of 10.9 weeks.
	Finance		The investment in Efficient Planned Care is £7.755m in 2015/16. This includes activity through Community Nursing & Matrons, Equipment,	

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			Telecare, Wheelchair, End of Life and additional Falls services. The projected forecast for the year is £7.373m, £0.382m under budget. The main reason for this is an under spend against the new anticipated Falls activity.	
Scheme Four Supported discharge	Co-ordinated and supported discharge from hospital with ongoing community care: • To deliver fully integrated, IT generated communication links for all patient discharges from acute hospitals, initially starting with the Luton and Dunstable Hospital. • To enable both GPs and community teams to continue the care of the patient as soon as possible following discharge, with the key aim of preventing re-admission • To enable patients to return back to their usual place of residence once confirmed medically fit	To develop a daily IT driven data flow between acute hospitals initially providing discharge information. Care Home staff to carry out an assessment on the patient within L&D Hospital, prior to arranging for the patient to be discharged. To engage a dedicated Locality Discharge Coordinator role specifically focused on providing co-ordinated discharges from acute providers for patients over the age of 18 years, for both elective and non-elective admissions. Improve support to Carers	Integrated patient care at the right time by the appropriate service. Defined and streamlined communication links Enhanced and streamlined way of working between provider services. Enabling patients to return back to their usual place of residence as soon as possible once confirmed Medically Fit. Decrease Length of stay (LOS) by 1 day for patients awaiting assessment for Restart by Care Homes. Reduction in LOS / reduction in excess bed days for patients receiving Social Care input. Reduction in LOS for any Delayed Transfer of Care (DTOC). People are supported to	**Discharge facilitation pilot in West Mid Beds –** pilot completed. Decision taken not to recommission as resulting efficiencies did not cover the cost of the service. Learning from the pilot will be used to work closely with current providers of discharge coordination to improve existing patient pathways and outcomes. **Voluntary sector support to reduce re-admission** Ongoing work to explore how the voluntary sector can help to reduce hospital admissions and to facilitate discharge from hospital to reduce delayed transfers of care. **Carer support** Care Act-Workstream established which includes response to meet carer needs. A carers' lounge has been opened at the L&D to mirror that at Bedford Hospital **Prevention and promoting independence partnership:** A multi-agency partnership established. Physical activity and

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			settle back into their own home effectively, after a hospital stay People are supported to settle back into their own home effectively, after a hospital stay Supporting the carer to enable the cared for to live at home as independently as possible.	exercise trainer programmes for frail older people is being commissioned. Time bank coordination in place. Promoting Independence Fund Scheme to be launched.
	Finance		The investment in Supported Discharge is £2.682m in 2015/16. This includes activity through providing care home placements together with discharge facilitation through hospital social work teams and discharge coordinators. The projected forecast for the year is £2.455m, £0.253m under budget. The main reason for this is an under spend against new Discharge Facilitation activity.	
Scheme Five Care Act	Councils now have a duty to consider the physical, mental and emotional wellbeing of the individual needing care and a new duty to provide preventative services to maintain people's health. This scheme incorporates four key workstreams: 1. Promoting Individual Wellbeing (Prevention, Housing & Public Health) and Information, Advice and Advocacy 2. Assessment & Eligibility and Care Planning &	**Implementation of the Care Act** Phase One.	Reducing emergency admission and delayed transfer of Care Supports for Carers - to enable them continue their caring role, remaining healthy and promoting their independence. This relates to all carers across the social care client groups: Older people; with learning disability; mental health, parent carers and young carers.	Duties set out in Phase One of the Act are now being embedded in local practice. Phase two implementation has been deferred.

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	Personalisation 3. Paying and Charging for Care 4. Quality & Safety and Care Markets		Person centred and flexible support based on assessment of carer needs Timely access to Information and advice Support to stay in employment	
	Finance		The Better Care Fund allowed for an allocation of £0.554m in 2015/16 to support the implementation of the Act. The forecast spend position is as per the budget.	
Scheme Six Better Care Fund Implementation	This scheme established a robust framework for the enablers to ensure that the other schemes can be successfully delivered including: • Robust Governance framework • Communications & engagement • Finance and performance • Information governance • Workforce and training Design and implementation	The key success factors will be: • A strong Programme Management approach • Capacity and capability of staff to deliver requirements • Strong partnership working across organisations • Strong financial management and oversight of pooled budget • Clear communication and engagement with all stakeholders • Shared Patient Record with real-time information across multiple agencies to support integrated joined up care	Senior executives from all participating organisations will be engaged at the appropriate level Communication and engagement plan developed is delivered appropriately to all audiences. Creation and monitoring of the pooled budget, Performance against the requirements is monitored and interacts with relevant projects to ensure action is taken to bring performance in line To identify, evaluate and	**6.1 Governance** Commissioning Board established. Operational delivery group in place. Provider Alliance launched Links with CCG Locality Boards established. **Communication and engagement** Stakeholder analysis- commenced & ongoing **Finance and performance** Pooled budget established and S75 agreement signed. Performance and finance monitoring framework agreed and reviewed monthly. Quarterly reporting to NHS England. **Information governance** NHS number is now used

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			agree how patient information will be shared. Thinking from patients, health and social care colleagues in order to design aspects of what the integrated care model should look like and how it should operate Ensure standardised approaches across the area and that key learnings are shared. Increase in skill, knowledge and confidence throughout workforce Improved co-ordination and efficiency between health and social care Streamlined communication	predominantly as primary identifier across all agencies and systems. Key issues remain in relation to IT solutions and data sharing to facilitate joint care planning and assessments. **Workforce and development** Staff engagement and new ways of working being explored. **Design and implementation** Creation of BCF design principle – existing. This is now being used as part of the Transforming Community Services programme.
	Finance		The allocation of £0.482m under this scheme was of a capital nature. No capital expenditure as such has been incurred during the year and therefore this allocation of £0.482m will roll forward into 2016/17.	