BCF Refresh 2017/18

Review of Better Care Fund Schemes

BCF Scheme	Description	2017/18 £000	2018/19 £'000
Unified Prevention Offer			
First Contact Plus	Aims to facilitate early help via information, advice or onward referral to a broad range of preventative services. A new web-based referral system which will also be public facing & will therefore enable 'self-help' or self-referral. The new model includes an initial 'triage' conversation plus follow up calls at weeks 6 & 12. A priority in 2016/17 was to further engage with all GP Practices across Leics & integrate FC Plus referral process across other health partners	164.8	165.5
Sub Total		***164.8***	***165.5***
Integrated Locality Teams			
Carers Services			
Care Act Support Pathway (protection due to national BCF condition)	Part of the BCF includes specific resources allocated for aspects of the Care Act, including carers' assessments. Following assessment, carers who are eligible for social care support will be offered targeted advice and information and specific support from the countywide carer support service.	454.0	454.0
Carers Health and Wellbeing Service *Recommendation at IE workshop to decommission from BCF*	Working with countywide GP surgeries, the service identifies and support carers, promoting the range of support on offer to carers in Leicestershire. The service is currently provided by Voluntary Action South Leicestershire (VASL).	13.8	0.0
Proactive Care Model	Support people with LTCs to maintain the maximum level of independence and self-care possible. This involves risk stratification & care planning, with primary & community based support planned around the patient, carer and family. Risk stratification identifies those individuals most at risk of being admitted to hospital or those who are likely to experience a health crisis.	540.0	540.0
Integrated Care Teams		430.0	430.0
Sub Total		***1,437.8***	***1,424.0***
Dementia Workstream			
Memory Support Service (Apr-Sept 2017)	The service provides advice, information, one to one support, carers groups and dementia cafes across Leicestershire. The service is commissioned from the voluntary sector, currently provided by Alzheimer's Society, and has been in operation since October 2014.	159.3	0.0
Hospital Dementia Support Service (Apr-Sept 2017)	The purpose of the service is to improve service user and carer experience, facilitate timely and effective discharge and help, and, where possible, to avoid unnecessary admission. It has been identified that length of stay for a person over 65 years of age with dementia is around twice as long as those without dementia, and that specialist support for those with dementia can be sporadic and limited.	33.4	0.0
Post Diagnostic Support Community and In-Reach Service for People affected by Dementia (Oct 2017 onwards)	Joint Health and Social Care Post Diagnostic Support Community and In-Reach Service for People affected by Dementia (across City and County) to start October 2017.	192.7	385.4
Sub Total		***385.4***	***385.4***
Home First - Housing			
Assistive Technology	Providing telecare and standalone equipment to service users to support them living at home in their community to avoid admission to permanent residential care, reduce the need for more costly services and reduce hospital admissions.	760.0	680.0
Lightbulb - Housing Discharge Enabler	The Hospital Housing Enabler service involves housing specialists working directly with patients and hospital staff to identify and resolve housing issues that are a potential barrier to timely discharge and to help prevent re-admissions. This is an LLR wide service and works across the 3 hospital sites and the Bradgate mental health unit. Community based low level housing related support is also available through the project to assist with the transition from hospital to home, for example to provide support with setting up new tenancies or managing within the existing home. Project staff have access to funding for a range of interventions where necessary, to facilitate discharge.	114.0	0.0
Disabled Facilities Grants	Capital grants provided by District Councils to adapt homes making them suitable for disabled people. The 2015 Autumn Statement indicated that the national pot would increase from £394m in 2016/17 to £500m by 2019/20. This gives indicative allocations for Leics. of: £3.3m for 2017/18 £3.6m for 2018/19 £3.9m for 2019/20 The current funding levels shown are based on the 2016/17 allocation, and will be reviewed once guidance has been released.		
Blaby DC		450.0	450.0
Charnwood BC		772.4	772.4
Harborough BC		350.0	350.0
Hinckley & Bosworth BC		406.5	406.5
Melton BC		237.3	237.3
North West Leics BC		323.1	323.1
Oadby & Wigston BC		316.6	316.6
DFG Sub Total		*2,855.9*	*2,855.9*
Sub Total		***3,729.9***	***3,535.9***
Home First - Reablement			

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Review of Better Care Fund Schemes

BCF Scheme	Description	2017/18 £000	2018/19 £'000
Intermediate Care	LPT's intermediate care team co-works with the County Council's HART service to support hospital discharges, prevent avoidable readmissions and reduce the risk of falls.	580.0	580.0
Reablement (NHS) - *protected*	The overall aim of the programme is to maximise the recovery and independence of patients who would require supported discharge to leave a hospital setting.	4,132.0	4,132.0
ICS phase 1 (NHS) - *protected*	ICS is a virtual ward service provided by LPT's community based teams. 48 virtual ward places are dedicated to providing interventions that keep people out of hospital by treating them at home.	1,821.0	1,821.0
Step Down (NHS) - *protected*	The overall aim of this service is to integrate discharge and reablement support, in order to maximise recovery and independence.	529.0	529.0
Help to Live at Home			
Community Based Review Team	Funding for elements of the new domiciliary service. Agreed as part of the HTLAH section 75 agreement.	412.5	412.5
CCG Reablement *Further analysis to be completed by end of March which may identify savings*		1,181.6	1,181.6
Back office support		100.0	100.0
Sub Total		***8,756.1***	***8,756.1***
Home First - Other			
Residential Respite Service (SC) - protected	Ongoing provision of residential respite care for c20 service users per week. This service provides support to carers of service users with complex and challenging needs, giving them a break from their caring responsibilities.	742.6	742.6
Health and Social Care Protocol Training	Provides practice guidance for health and social care staff on the operational arrangements needed to provide care in a co-ordinated and effective way to the benefit of individuals in receipt of services and their carers.	102.3	25.5
Increased demand for Nursing Care Packages (SC) - protected	Ongoing provision of c300 nursing care packages enabling these high dependency service users to remain safely in stable placements.	3,599.3	3,599.3
Increased demand for Home Care Services (SC) - protected	The provision of home care services to vulnerable adults is a cost effective way of meeting service user needs in their own home and helps to maintain their independence in the community. Demand for this service is increasing as more community based services are being commissioned. The funding ensures the delivery of c740,000 hours of home care to 1,420 service users.	11,044.0	11,044.0
Sub Total		***15,488.2***	***15,411.4***
Urgent Care Model			
ICRS NNS (EoL)	The original ICRS night sitting service model set out to provide care overnight for frail older people in crisis (requiring step up care) who would otherwise be admitted to an acute or community hospital due to their perceived or unknown overnight nursing needs. However, once the service got underway it was clear that this service was meeting an unmet need for EoL care. Time has been taken this year to determine the care needs of patients who are reaching EoL, therefore it is right to acknowledge the HNA findings and align current commissioned services to meet care needs during the overnight period, using the experienced LPT CHS team at a reduced cost of £400,000.	400.0	400.0
Crisis Response Service (CRS) - Social Care Element	CRS provides short-term support at the point of crisis that will help to maintain someone in their own home, preventing admission to hospital or long-term residential care. The support is usually provided within 2 hours and can last up to 3 days.	565.6	571.3
Older Persons Unit (Decommissioned in Sept 2016)	Currently listed are the existing integrated urgent care schemes funding in the BCF in 2016/17. This section will be updated when the outcome of the new urgent care model procurement process has been confirmed.	500.0	500.0
Enhanced Clinical Pathways at LUCC	The OPU service was decommissioned in September 2016 - the funds originally allocated to the OPU may be required in the new model and therefore are currently ring-fenced.	390.0	390.0
Reallocation of Rapid Assessment for Older People Fund (ELRCCG)		776.0	776.0
Weekend Working (WLCCG)		427.5	427.5
Acute Visiting Service (WLCCG)		851.0	851.0
Integrated 7 day community care (with additional AVS capacity) - ELRCCG		622.5	622.5
Sub Total		***4,532.6***	***4,538.3***
Integrated Discharge			

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BCF Scheme	Description	2017/18 £000	2018/19 £'000
Discharge Pathway 3 - Non-weight bearing pathway	The NWB was developed in 2011 to support patients who were in plaster of Paris recovering from a fracture. At that time it was agreed that patients would be considered for a number of service options. These include ongoing treatment/rehab at community hospitals, placements in residential care where it was deemed necessary or return home with health care support (where the only presenting need was the fracture) or with health and social care support where the patient had previous social care needs. It has been agreed that working alongside the complex discharge and therapy leads in UHL, LCC would provide a case management function to support patients to access placements and make appropriate arrangements for exiting the service. This BCF funds the case management function.	85.4	85.4
Community Hospital Link Workers	Community Hospital Link workers are a regular presence in community hospitals to support discharge through timely completion of assessment and support plans, attendance of MDT meetings for continuing healthcare assessments, the provision of information and advice to hospital staff and to act as an interface between social care teams and other relevant agencies.	209.0	209.0
Primary Care Coordinators (NHS) - *protected*	Primary Care Coordinators target those with complex discharge needs, primarily frail older people/those with multiple LTCs, and will benefit from the improved housing expertise and offer that is within Unified Prevention Offer.	392.0	392.0
Assessment & Review (SC) - *protected*	Dedicated social work teams based across Leicestershire and in acute hospitals to ensure that service users and carers are assessed or reviewed in an appropriate timescale ensuring that needs are identified and, where appropriate, services are commissioned to meet outcomes.	1,639.9	1,639.9
Improving Mental Health Discharge	Approved Mental Health Professionals (AMHP) to carry out assessments and meet increasing demands. Predominantly based in hospital and crisis teams, the team provides adult social care input for inpatient areas to facilitate early discharge and avoid delayed discharges. The BCF also funds a full-time AMHP, to capture/experience in the area of mental health/learning disability, including developing specialist skills in the forensic work elements, especially around the Mental Health Act. The BCF funds six additional FTE staff to increase capacity within the social care team.	271.6	271.6
Sub Total		***2,597.9***	***2,597.9***
Integrated Commissioning			
Improving Quality in Care Homes			
Quality Improvement Team (QIT)	An integrated social care and health team to improve quality in residential care homes, responding quickly and proactively to any breaches and reducing the number of safeguarding incident. The BCF funds the QIT team and provides an	314.4	317.6
Safeguarding Team (protection due to national BCF condition)		193.8	195.8
Nursing and Care Home Placements	A project to deliver integrated commissioning residential and nursing homes placements. The funding is required for: 1. To provide project management and NHS commissioning expertise. 2. The CCG element of the Project Management Office costs.	91.0	12.0
Sub Total		***599.2***	***525.4***
BCT Learning Disabilities			
LD Short Breaks (NHS) - protected services	The BCF funds the LD short breaks contract which allows parents and family carers to get a complete break for people with LD and for people with LD to get a break with real opportunities & choices.	844.0	844.0
Sub Total		***844.0***	***844.0***
BCT Long Term Conditions			
LTC QIPP	Integrated Cardiorespiratory community service - reduction in emergency admission through end to end integrated pathway, including ambulatory clinics, i.e. rapid access HF clinic, rapid access AF clinic and breathlessness clinic. There is also a planned community respiratory crisis response service to enable early intervention and support with exacerbations . Embedded within this service is the CDU low risk ambulatory service (UHL), stream patients into two groups from the outset – those that are likely to go home on the same day, and those that will be admitted, so that those going home same day can benefit from rapid decision making and effective care planning back into the community. The ELRCCG has been reduced on direction from ELRCCG, who do not plan to commission the CDU element.	442.3	442.3
LLR Community Stroke & Neurology Rehabilitation Service	To provide in the community, a comprehensive stroke specialist service, for stroke survivors who need it after their initial period of rehabilitation in hospital or Early Supported Discharge Service (ESDS), and for patients with other neurological conditions who require rehabilitation and have achievable goals	278.3	278.3
Sub Total		***720.6***	***720.6***
Integrated Data			
PI Care and Healthtrak	An integrated data tool from PI Ltd. The NHS and council partners across LLR can analyse the journeys taken by local people across the whole health and care system. The tool helps to plan and measure the impact of services.	70.0	70.0
Sub Total		***70.0***	***70.0***

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Review of Better Care Fund Schemes

BCF Scheme	Description	2017/18 £000	2018/19 £'000
BCF Enablers			
Care Act Enablers			
Independent Mental Health Advocacy	These schemes contribute towards the BCF requirement to provide additional funding to implement the Care Act.	57.7	57.7
Veterans GIP		17.4	17.4
Programme Management	Programme management for the following posts (including on-costs) on a recurrent basis: • Director of Care & Integration (joint funded by LCC) • Personal Assistant • Programme Manager • Design & Performance Specialist – Unified Prevention • Lead Analyst • Finance Lead • Communications Officer (part-time)	399.4	403.4
Sub Total		***474.5***	***478.5***
BCF SCHEMES TOTAL		***39,801.0***	***39,453.0***
Contingency			
CCG Contingency		1,000.0	1,000.0
Risk Pool		1,000.0	1,000.0
Cost Improvement Target		-1,343.5	-964.6
CONTINGENCY TOTAL		***656.5***	***1,035.4***
BETTER CARE FUND TOTAL		**40,457.5**	**40,488.4**

Better Care Fund Allocation			
	CCG BCF Funding Allocation	36,675.0	37,368.0
	DFG Allocation**	3,067.3	3,067.3
	LCC Miscellaneous Contribution	52.6	53.1
	LCC DFG Uplift	662.6	0.0
	Total Allocation	**40,457.5**	**40,488.4**
	Over/Under Commitment	**0.0**	**0.0**

**DFG allocation assumed to be same as 2016/17
(to be revised following release of national BCF guidance)