Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Reading BC	TBC	2,814,280	749,000	1,595,000
North and West Reading CCG				
South Reading CCG				
Above CCG's	TBC		9,024,000	9,024,000
BCF Total		**2,814,280**	9,773,000	10,619,000

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

These plans are currently in development.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Better Care Fund planning template - Reading - February 14 - Part 2

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

Scheme No*	BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits		Notes
			Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	
i	Bed Based Intermediate Care Scheme	RBC	*378,812*				*378,812*				1
ii	Social Care - Intermediate Care Team	RBC	*373,826*				*373,826*				1
iii	Community re-ablment Team	RBC	*1,066,125*				*1,066,125*				1
iv	Mental Health Re-ablement and recovery Team	RBC	*150,000*				*150,000*				1
v	Specialist Nursing Placements (to support hospital discharges)	RBC	*138,830*				*138,830*				1
vi	Additional Intermediate Care and Re-ablement resources to support H@H, delayed discharges	RBC	*367,687*				*367,687*				1
vii	Community Equipment and Minor Adaptations	RBC	*35,000*				*35,000*				1
1	Hospital at Home (Cost based on Business case with costs shared across the West of Berkshire)	Berkshire West CCG's	*0*				*776,000*		*1,852,380*		2
2	Support to Residential and Nursing Homes (Cost based on Business case with costs shared across the West of Berkshire)	Berkshire West CCG's	*0*	*172,711*			*175,000*		*900,000*		3
3	Health and Social Care ICT interoperability	All partners									4
5	Seven Day Integrated Health and Social Care Neighborhood Teams	RBC and CCG	*0*	*TBC*			*1,883,000*		*1,980,000*		5
4	Time to think Beds	RBC					*1,154,720*				6
viii	Protection of Social Care service	RBC					*1,039,000*				7
ix	Care Bill Costs						*662,000*				8
x	Contingency						*182,000*				9
xi	Carers Funding	CCG	*337,000*				*337,000*				10
xii	Carers Funding - Grants	RBC	*214,000*				*214,000*				11
xiii	Carers Funding - respite/ DPs	RBC	*90,000*				*90,000*				12
xiv	Reablemnet funding	CCG	*779,000*				*779,000*				13
xv	DFG	RBC					*432,000*				14
xvi	DFG (extra investment)	RBC					*68,000*				15
xvii	Social care Capital Grant	RBC					*317,000*				16
xviii	Increase in Extra Care Housing	RBC									17
	Total		*3,930,280*	*172,711*	*0*	*0*	*10,619,000*	*0*	*4,732,380*	*0*	

* Schemes 1-5 inc are described in full with this numbering in section 2 (c.) of the Part 1 template

Note 1 (schemes i-vii)	These costs are the resources agreed by the Reading HWB for the use of the S256 in 13/14, with an increase for particular schemes that are subject to formal agreement
Note 2 (scheme 1)	Based on CCG business case
Note 3 (scheme 2)	Based on CCG business case
Note 4 (scheme 3)	There are no specific costs identified as the hope is the cost of this would be part funded (if appropriate) via the 14/15 social care capital grant
Note 5 (scheme 5)	The exact details of this are being worked on and this is a n estimate of likely costs

Note 6 (Scheme 4)	This would support clients that are on the fit to discharge list to be transferred for a short period to non acute beds with a multi dispalinary team to support the move to more appropriate accommodation/home
Note 7 (scheme viii)	This is an estimate of key service that could be impacted by "efficiency measures" in 15/16 that would impact the deliver of these changes. The Council is committed to maintaining adult services but will need some support to prevent further reductions in capacity
Note 8 (scheme ix)	Care Bill costs are calculated based on the national guidance that £135m of the £1.1bn would need to be identified to cover this liability
Note 9 (scheme x)	As per national guidance
Note 10	Identified by CCG as current funding
Note 11	Funding provide by RBC mainly to Vol sector to provide carer support service
Note 12	Funding used to support individual carers
Note 13	As per CCG Schedule
Note 14	As by national allocation guidance
Note 15	Expected additional funding from RBC
Note 16	As by national allocation guidance
Note 17	The Council over the next two Years is seeking to bring on line 80 additional extra care units. 40 should be available mid 2014, with a further 44 subject to a procurement exercise and would hope to be available in early 2016. Cost of care in these would be funded from exiting Council funding and built on existing Council land.
Benefits	These are a pro rota of the CCG QUIPP savings. This has been allocated on the basis of the "allocation of the pool to each Council Area". Whilst this has been allocated to certain lines the £1.98 million attached to the frail elderly pathway work is likely to require other schemes to deliver this.

Scheme No	Reconciliation		
	New BCF funding		
8	Hospital at Home	776,000	
9	Care Home support	175,000	
10	n/a		
11	Seven day working	1,883,000	
12	Time to think beds	680,000	(£680k from BCF and £474k from existing RBC funding)
13	Protection of Social care service	1,039,000	
14	Care Bill Costs	662,000	
15	Contingency	180,000	
	Total	**5,395,000**	
	CCG vr2 template	5,395,000	
	Variance	0	

Scheme No	**Total BCF**	
	From CCG vr 2 schedule	9,773,000
	from above	10,619,000
	Variance	**-846,000**
	Reason for variance - RBC funding	
12	Time to think beds	474,000
17	Carers Funding - Grants	214,000
18	Carers Funding - respite	90,000
21	DFG (extra investment)	68,000
	Total	**846,000**

Better Care Fund planning template - Reading - February 14 - Part 2

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metric - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

The partnerships' intention is to support greater numbers of clients in their own homes. By strengthing multi-agency support out of hospital, we will reduce the numbers of people needing to turn to nursing and care home placements, older people being the group most affected. Permanent care home placements often follow lengthy periods of hospitalisation, and so reducing dependency on institutionalised care following acute episodes will be key to our success. An integrated health and social care intermediate care team is already in place, and will be expanded to support the range of emerging schemes identified to reduce hospital admission further and facilitate early discharge. The development of extra care housing units within Reading will enhance our ability to support older people at home, with the opening of a further 40 units in 2014 and additional sites under consideration. Of the units opened in 2014, 33% will be for clients with high needs (specifically diverted away from residential care) and 33% for clients with medium needs (likely in the medium term to need residential care in the absence of alternative supported accommodation).

Metric - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

The partnership has been working effectively over the last few years to develop pathways and support that enable clients to be discharged appropriately and then supported to regain maximum capacity and independence at home. Integrated teams delivering intermediate care (bed based and social care based), community re-ablement, and mental health re-ablement & recovery are already in place. Intermediate care resource will be increased, including to support the hospital at home service. Specialist nursing placements have been commmissioned which support hospital discharge, as does the community equipment and minor adpatations service. Re-ablement support is enhanced through Council services to offer appropriate housing for older people from minor adaptations and 'handyman' support through to DFGs, sheltered and extra care schemes. Additional out-of-hospital support for those coming through re-ablement will be delivered through the integrated 7 day clusters across health and social care.

Metric - Delayed transfers of care from hospital per 100,000 population (average per month)

The partnership is working to improve the pathways to support faster discharges. Improved data sharing, the appointment of accountable lead professionals and improving access to health and social care staff on a 7 day basis will all improve the ability to take appropriate care decisions as early as possible so people can then progress to the next phase of their care. The introduction of the Time to Think beds will allow a sub acute step down into 15 new bed spaces, and facilitate earlier discharge for more complex patients.

Metric - Avoidable emergency admissions (composite measure)

The schemes described in this plan will together reduce the number of admissions into the acute hospital. Achieving this objective is dependent on our successfully supporting people to manage their emotional and physical condition, and offering accessible alternatives to hospital admission at key stages. Support to residential and nursing care homes will be a key part of this, but all of the schemes will contribute to strengthening care pathways so as to offer multiple routes back to home as the preferred setting for care to be given.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Reading will use the national metric (under development)

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The performance measures are all routinely reported. A Performance Group will monitor outcomes on a regular basis, and performance reporting is an embedded procedure throughout the Council and the CCGs. The Partnership will jointly monitor the progress of the Better Carer Fund schemes specifically through the Reading Health and Social Care Board, with exceptions reported to the Health and Wellbeing Board.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	960.89	N/A	700
	Numerator	172		
	Denominator	17900		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	84.51%	N/A	90%
	Numerator	60		
	Denominator	71		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	6.01		
	Numerator	7		
	Denominator	17900		
		(April 2012 - March 2013)	*(April-December 2014)*	*(January-June 2015*
Avoidable emergency admissions (composite measure): This data is currently available at CCG rather than LA level. Reading baseline and targets remain under discussion. Admissions for 2012/13 for South Reading CCG (all within Reading UA) were 1,546 and for North & West Reading CCG (covers both Reading and West Berkshire UAs) were 1,506	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience - Reading will use the national metric (under development)			N/A	
		(insert time period)		*(insert time period)*
A 'Fit To Go' list is compiled and circulated daily by the acute hospital, from which patients can be identified by local authority area. Patients on the list are those who have been assessed as medically fit for discharge but remain in hospital the day after such assessment. Enhancing integrated health and social care support out of hospital will facilitate earlier discharge for those with a need for ongoing support. We will therefore use reductions in the Fit to Go list as our local measure of success.	*Metric Value*	18	7	5
	Numerator			
	Denominator			
		2013 average	*Jan-Mar 2015 average*	*Jun-Aug 2015 average*