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Better Care Fund

A step-by-step methodology to developing a robust programme and addressing risk

September 2014

Contents

This document provides a 'how to' guide in certain key areas for local areas who are developing their BCF plans.

Introduction

This document is designed to act as a 'how to' guide for local areas in developing their BCF plans, building on our experience of the exemplar BCF plans and in other Health and Social Care economies.

This case study focuses on seven key topics as indicated in the contents on the left and provides advice and guidance on how to develop a robust case to support your BCF programme and individual interventions of choice. This document is not a guide to inform filling in the whole BCF template but provides short, focused, practical examples of how to undertake certain elements of the planning required.

The document utilises examples and experiences we have had over the last several months in working with some of the fast track Health & Well-Being Boards (HWBBs) as well as other areas across the UK.

The case study starts with the assumption that your local area has already undertaken preliminary risk stratification and patient segmentation to identify the challenge that you local economy is facing. Additionally, we start with the assumption that you have identified your preferred interventions to address the aforementioned needs and will be using this document to help strengthen your individual schemes as well as you overarching BCF Programme.

Aligning Interventions with BCF impact requirements (Section 2b & 3)

Define the expected impact and interdependency of each intervention towards addressing the BCF impact requirements

Setting the Scene

Over the last 12-16 months, you (CCG's) have been working in partnership with your local authorities to develop your plans relating to the Better Care Fund (BCF) in order to improve and safeguard health and social care services. Most of you are in the final stages of developing your submission and are looking for guidance to strengthen your identified interventions and the BCF submission as a whole.

With HWBB areas we have recently been working with, they have found it useful to start by creating a high level overview of the areas identified interventions and map their impact and relation to the BCF payment for performance, supporting and locally identified performance metrics.

As the schemes are aligned toward achieving impact, the interdependency and programme deliver chain becomes clear and enables the CCGs and Local Authorities to strengthen the "golden thread" tying the programme together as well as highlighting the areas which need further development and strengthen in the "run-up" to the final submission.

The following slide shows how this was applied to an "urban" HWWB area in recent months., and the process that has ensued in several areas to strengthen their submissions

BCF Performance Metrics

Payment for Performance (P4P)

- Total non elective admissions in to hospital (general & acute), all age, per 100,000 population

HWWB Supporting Metrics

- Permanent admissions of older people to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed transfers of care from hospital per 100,000 population
- Patient/service user experience

Locally Provided Metric

- Local Metric

Aligning Interventions with BCF impact requirements (Section 2b & 3) – (2/2)

Define the expected impact and interdependency of each intervention towards addressing the BCF impact requirements

Starts telling "**The Story**" of the "Programme" and how the benefits & improvements to care will be delivered and achieved.

Evidences where the impact will be seen for delivery and benefits realisation vs. what is required investment to enable delivery

Further detail could be added to show the coefficient of delivery / % of expected impact

Helps Identify risk of delivery where 1 or 2 interventions are delivering the change

Template Requirement

Will the schemes impact on the metrics, and is the data to measure these available?

"Any HWBB"	Total non elective admissions in to hospital (general & acute), all age, per 100,000 population	Permanent admissions of older people to residential and nursing care homes, per 100,000 population	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilit	Delayed transfers of care from hospital per 100,000 population	Patient/service user experience	Local Metric
1. Hospital at Home	Yes				Yes	
2. Enhanced Care and Nursing Home Support	Yes			Yes	Yes	Yes
3. Connecting Care	enabler	enabler	enabler	enabler	enabler	enabler
4. Discharge to Assess		Yes	Yes	Yes	Yes	Yes
5. Whole System, Whole Week						
5a. H&SC Hub	enabler			enabler	enabler	enabler
5b. Neighbourhood Clusters	enabler		Yes	Yes	Yes	Yes
5c. Extended GP practice hours				Yes	Yes	

Evidencing the Appropriateness of the Intervention (Annex one)

Look broadly for the right case study and tailor it to the needs of your local area

"Urban" HWBB example

Intervention: Hospital at Home.

A wide range of schemes fall under the Hospital at Home / Virtual Wards umbrella. There are many case studies across the NHS that share similar features. Not all will be suitable for local adaptation despite the commonalities. Carefully screen the literature to ensure you address the system challenge, not just the symptom.

Research international case studies to select the most appropriate intervention. For this example, Case studies were found in the programs developed by John Hopkins in the United States and the Hospital in the Home intervention by the Royal Melbourne Hospital in Australia.

Learnings:

- Recognising that one of the biggest challenges in this type of scheme is health engaging social services at the point of admission.
- Robust planning and risk management is essential, given that the management of acutely unwell patients is highly risky. The risk can be managed with appropriate resourcing, well skilled staff, governance in place, etc.
- **Additional learning gathered from case studies applicable to your system should be elevated and clearly articulated**

Advice and guidance to local areas

Explore international case studies that may be applicable to the model of your intervention

Select and make clear the case study based on local requirements

Identify those elements that make the case study applicable to your scheme

Identify any limitations of the case studies and any gaps in knowledge. Develop implementation and appropriate risk mitigation plans

Use the case studies to support your evidence base

Refining & focusing the challenge statements (Section 3 & Annex one) - (1/2)

Define the Performance, Quality and Financial challenge which each interventions is designed to solve for all key stakeholders

Urban Area example

In the planning process HWBBs need to set performance metrics for each of the BCF schemes, where possible. For those schemes that are not finalised, you should articulate the intended approach to measuring the outcomes.

To set metrics that are appropriate, relevant and able to be measured, a HWBB could uses a spreadsheet with two tables: one that articulates the challenge statement by scheme and by stakeholder; and one that determines the metrics, the source, the baseline and the target or anticipated impact based on the challenge statement (see following slide for more detail).

Stake-holder	Metrics	1. Hospital @ Home
CCG	Performance	1. Decrease admissions for acute infections where the patient is clinically stable 2. Decrease admissions relating to deteriorating LTCs 3. Decrease admissions for conditions such as dehydration UTI's, etc...
	Quality	1. Increase patients feeling supportedw/LTCs in the communtiy 2. Increased independence by preventing institutional admissions 3. Avoid Re-admissions to hospital 4. minimise loss of physical capacity due to hospital admission
	Financial	Reduce Financial Expenditure on NEL admissions
Local Auth	Performance	1. Decrease admission to residential homes as a step down from an acute admission 2. decreased escalation in home care packages following and acute admission
	Quality	1. Increase independence and home living
	Financial	1. Decrease admission to residential homes as a step down from an acute admission
Secondary Care	Performance	1. Decreased -readmission stemming from Acute, but clinically stable, episodes 2. Decrease bed utilisation by those that could be treated at home to enable better bed availability for A&E performance.
	Quality	
	Financial	1. Decrease loss of income due to readmission penalties

Advice and guidance to local areas

Articulate the challenge statement by clearly outlining in a table the problem to be addressed, by scheme, for the CCGs, local authorities and acute care providers. Define these problems in terms of performance, quality and finances. (see previous slide)

Using this table, determine what the organisational objectives of the BCF are for each stakeholder and determine what the overall objectives are for each scheme.

Use the challenge statement to define relevant and appropriate metrics that address key issues within the local health economy and that demonstrate the desired outcomes have been achieved

Include alongside each metric: the source of the data to measure, the baseline and the target or anticipated impact.

Refining & focusing the challenge statements (Section 3 & Annex one) - (2/2)

Define the Performance, Quality and Financial challenge which each interventions is designed to solve for all key stakeholders

Ensuring challenges are defined in each of the three categories aids in the development of the delivery chain and performance monitoring of the scheme(s)

Setting specific performance indicators helps to identify the data to be measured and the source from which to extract from

Problem to be addressed in each of the schemes

Stake-holder	Metrics	1. Hospital @ Home
CCG	Performance	**1.** Decrease admissions for acute infections where the patient is clinically stable **2.** Decrease admissions relating to deteriorating LTCs **3.** Decrease admissions for conditions such as dehydration UTI's, etc…
	Quality	**1.** Increase patients feeling supportedw/LTCs in the communtiy **2.** Increased independence by preventing institutional admissions **3.** Avoid Re-admissions to hospital **4.** minimise loss of physical capacity due to hospital admission
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Secondary Care	Performance	**1.** Decreased -readmission stemming from Acute, but clinically stable, episodes **2.** Decrease bed utilisation by those that could be treated at home to enable better bed availability for A&E performance.
	Quality	
	Financial	**1.** Decrease loss of income due to readmission penalties

To aid in system alignment for delivery – all stakeholders in the project should have a challenge identified which the scheme is working to address

This supports telling "**The Story**" of what each stakeholder can expect to achieve from the "Programme" and each individual scheme

Refining & focusing on measurable outcomes (Section 3 & Annex one) - (1/2)

Define the performance metrics used to measure the impact of each of your interventions based on the problem to be solved

Urban Area example

It is essential, that as the challenges to be addressed are defined for the target population, that KPI's for quality, performance and finance are identified and that the metrics and data sources to track delivery and benefit realisation are clearly identified and relevant, available and reliable, in both quality and regularity.

Additionally, in the agenda to improve the quality of care, outcomes metrics must be paired with activity and financial metrics. (see next slide for further detail)

What are the metrics in this scheme going to measure?

		Metric	Source	Baseline	Target/ Impact
1. Hospital @ Home	Performance	1. Reduction in NEL admissions for specified conditions (cohort that meet the criteria for H@H) 2. % discharged back to home care post acute admission 3. % discharged from acute care to residential care packagess 4. Patients assessed in the RBH and transferred onto the service within 4 hours 5. Rate/number of avoidable readmissions back to hospital 6. Bed days for target cohort 7. LOS for Target cohort	1. SUS 2. SUS - discharge destination 2b. Hospital @ home admissions data 3. SUS - dischare destination 3b. Residential home admissions data 4. Hospital @ Home activity data 5. SUS - readmissions activity (will need to identify cohort in acute system to calcutale baseline and track) 6. SUS - (as Above) 7. SUS - (as Above)	1. 2. 3. 4. 5. 6. 7.	1. 84% reduction (2,810 patients) 2. 3. 4. 5. 6. 7.
	Quality	1. Increase patients feeling supported w/LTCs in the communtiy 2.% of patients on a home care package that are admitted to hospital or convert to a residential package following an admission. 3. Re-admissions to hospital 4. Reablement requirements post Acute admissions (expect a decrease in intensity and duration)	1. NHS Patient Survey 2. Tiaingulaltion of SUS and LA Datasource 3. SUS 4. Local Authority Reablement activity	1. 2. 3. 4.	1. 2. 3. 4.
	Financial	1. NEL admissions for Specified HRG's and ICD10's 2. CHC costs 3. Social care package costs	1. SUS - Post monthly reconcilliation 2. CHC budget line 3. Local authority Finacial activity	1. 2. 3.	1. Gross savings target in 15/16 is £3.9 million 2. 3.

Advice and guidance to local areas

Articulate the challenge statement by clearly outlining in a table the problem to be addressed, by scheme, for the CCGs, local authorities and acute care providers. Define these problems in terms of performance, quality and finances.

Using this table, determine what the organisational objectives of the BCF are for each stakeholder and determine what the overall objectives are for each scheme.

Use the challenge statement to define relevant and appropriate metrics that address key issues within the local health economy and that demonstrate the desired outcomes have been achieved

Include alongside each metric: the source of the data to measure, the baseline and the target or anticipated impact.

Refining & focusing on measurable outcomes (Section 3 & Annex one) - (2/2)

Define the performance metrics used to measure the impact of each of your interventions based on the problem to be solved

This helps to consolidate the specific metrics and data requirements from all key stakeholders and aids the development of a "*Programme*" ***and*** *"Project"* Dashboard

What are the metrics in this scheme going to measure?

		Metric	Source	Baseline	Target/ Impact
1. Hospital @ Home	Performance	**1.** Reduction in NEL admissions for specified conditions (cohort that meet the criteria for H@H) **2.** % discharged back to home care post acute admission **3.** % discharged from acute care to residential care packagess **4.** Patients assessed in the RBH and transferred onto the service within 4 hours **5.** Rate/number of avoidable readmissions back to hospital **6.** Bed days for target cohort **7.** LOS for Target cohort	**1.** SUS **2.** SUS - discharge destination **2b.** Hospital @ home admissions data **3.** SUS - dischare destination **3b.** Residential home admissions data **4.** Hospital @ Home activity data **5.** SUS - readmissions activity (will need to identify cohort in acute system to calcutale baseline and track) **6.** SUS - (as Above) **7.** SUS - (as Above)	**1.** **2.** **3.** **4.** **5.**	**1.** 84% reduction (2,810 patients) **2.** **3.** **4.**
	Quality	**1.** Increase patients feeling supported w/LTCs in the communtiy **2.**% of patients on a home care package that are admitted to hospital or convert to a residential package following an admission. **3.** Re-admissions to hospital **4.** Reablement requirements post Acute admissions (expect a decrease in intensity and duration)	**1.** NHS Patient Survey **2.** Tiaingulaltion of SUS and LA Datasource **3.** SUS **4.** Local Authority Reablement activity	**1.** **2.** **3.** **4.**	**1.** **2.** **3.** **4.**
	Financial	**1.** NEL admissions for Specified HRG's and ICD10's **2.** CHC costs **3.** Social care package costs	**1.** SUS - Post monthly reconcilliation **2.** CHC budget line **3.** Local authority Finacial activity	**1.** **2.** **3.**	**1.** Gross savings target in 15/16 is £3.9 million **2.** **3.**

Each metric should have a clearly specified source

This supports telling "**The Story**" of what the scheme(s) will deliver for the Health and Social Economy

Determine the financial benefits of the intervention (Annex one)

Determine the likely number of patients accessing your intervention, drawing on knowledge from within your local teams (to be undertaken in conjunction with slides 6-9)

Urban HWBB example

Hospital at Home targets a cohort of patients that meet a set of defined inclusion and exclusion criteria to determine their suitability for treatment at home. The criteria includes factors such as the patient's age, their National Early Warning Score (i.e. being a score of 5 or less) and whether they are in a stable condition.

To determine the cost of the scheme over a year, CCG's should take current baseline financial and performances data and remove those HRG chapters that are unsuitable for the scheme, such as trauma, obstetrics, etc. Patients that do not meet the suitability criteria should also have their activity and costs removed. The remaining total costs are the potential savings for the scheme. An example from one area in the UK with a population of circa 300k , this equated to £7.8 million. Additionally it was determined that those patients averaged at an HRG value (PbR Tariff) of £2,700.

Determine the provider costs for the scheme given the capacity (in the aforementioned example, the local authorities agreed 30 beds). Determine the financial benefit of the scheme by offsetting costs against savings.

Learnings:

- Patients typically stay in hospital for longer than anticipated for conditions ordinarily considered short stay
- Medication administered by medical staff in the home is more expensive than at hospital, e.g. fast-acting antibiotics

Advice and guidance to local areas

Define the patient cohort you are targeting

↓

Gather baseline activity data by HRG chapter

↓

Remove HRG chapters that are unsuitable for the scheme

↓

Remove patient activity and costs that do not meet the suitability criteria

↓

Determine the potential savings for the scheme

Saving calculations must be based upon the systems capacity for delivery (workforce and infrastructure

↓

Calculate costs, including staff, cost of pharmaceuticals, capital equipment, etc. Give consideration to higher costs

This is an essential requirement for each Business Case and PID

↓

Determine financial benefit of the scheme

Identifying and Mitigating Programme Risk (Section 5) - (1/2)

Development, delivery and financial risk must be concisely identified and mitigated with a risk log to be contributed to and coordinated between HWBB members.

Developing a Risk Log

Managing the risk for the BCF programme is a key component of the delivery chain and is critical to ensuring achievement of the targeted objectives, thereby enabling the release of the P4P funding.

Building upon the previous work, each individual intervention project lead and the BCF programme lead will have captured the relevant risks relating to:

Quality
Development
Delivery and
Financial

As the risks are entered, most CCG's start to recognise themes and areas which require more dedicated and focused risk mitigation. Within the BCF Programmes, the areas require further development and dedicated works streams relate to the risk of non-delivery (operational and performance) and financial risk.

As a result, the development of a practical and realistic delivery chain and programme plan and a risk log and risk sharing agreement are essential requirements for the BCF submission (section 4 & 5)

To support this task, several key risks are highlighted on the following slides, as is an outline of a risk share agreement to accompany a Section 75 Agreement.

Advice and guidance to local areas

Specify the risk (e.g. Pooled Budget arrangements - Organisations do not reach agreement of who holds the budgets and the impact of any under or overspends)

↓

Calculate the Impact this risk has on the success of the programme. (normally 1 -5 with 5 being a catastrophic event)

↓

Calculate the likelihood of the risk materialising with the current controls and mitigations steps in place (normally 1-5 will 5 being almost certain to occur)

↓

Combine the two (2) scores to determine the risk level (High – Medium – Low)

↓

Detail mitigation actions to be taken to minimise the impact or likelihood of the risk materialising (e.g. LA and CCG to firm up the risk sharing agreement scheme by scheme taking into account interdependencies, and organisational risks. It is anticipated that a draft risk sharing agreement will be in place for submission, which will be finalised by the required deadlines)

↓

Recalculate the risk

Identifying and Mitigating Programme Risk (Section 5) - (2/2)

Define the Performance, Quality and Financial challenge which each interventions is designed to solve

Area of work	Risk Description	Impact	Likelihood	Risk Rating	Mitigation
Finance	Pooled Budget arrangements - Organisations do not reach agreement of who holds the budgets and the impact of any under or overspends	5	3	High	LA and CCG to firm up the risk sharing agreement scheme by scheme taking into account interdependencies, and organisational risks. It is anticipated that a draft risk sharing agreement will be in place for submission, which will be finalised by the required deadlines
Finance	The potential for increase in volume of use (Unplanned activity) may lead to overspends.	4 (£**Xm**)	2	Medium	Discussions underway for the performance fund will be used to fund any overspends in 2º; The CCGs have a robust process for monitoring activity monthly through QIPP and Finance against contracted levels and actions taken to mitigate growth are also reviewed there.
Finance	The overall BCF funding (£5.2m) is dependent on the CCG delivering on its overall QIPP programme	4 (£**Ym**)	4	High	The CCGs have a programme of QIPP schemes which are monitored monthly via QIPP and Finance and where if a scheme is going off then remedial action is taken. Planning for QIPP schemes outside of the BCF which underpin the achievement of the performance around NELs for 2015/16 is already in train.
Finance	A risk that funding identified in the BCF will not be sufficient to cover the cost of the Care Act (on top of the money from DCLG to cover the impact)	3 (£**Zm**)	3	Medium	Local agreement has so far identified £**X**m to support this area. Local authority are working to understand the impact of the Care Act
Performance	Schemes identified do not deliver expected reduction in activity	5	3	High	A clear performance framework with KPIs is in development to be monitored regularly and to track if there are issues The CCGs have a programme of QIPP schemes which are monitored monthly via QIPP and Finance and where if a scheme is going off then remedial action is taken. Planning for QIPP schemes outside of the BCF which underpin the achievement of the performance around NELs for 2015/16 is already in train.

Pooled Budgets and Risk Sharing (Section 5) – (1/2)

Define the Performance, Quality and Financial challenge which each interventions is designed to solve

By its nature a **pooled budget** provides an **appropriate vehicle** for **sharing risk** between the **associated parties**. The general principles for risk-sharing are:

1. *The financial impact of unpredictable incidences on system wide deliverables should be shared proportionality, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effectively delivery of the schemes*
2. *Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the impact.*

In developing a risk sharing agreement for the BCF Pooled budget, the content will need to be developed collaboratively and address the following minimum m criteria:

1. Introduction
2. Scope of Agreement
3. Risk Categories
- **3.1. Financial Risk**
- **3.2 Delivery Risk**
- **3.3 Performance Risk**
- **3.4 Reputational Risk**

4. Risk Management Framework & Governance Arrangements
5. Accounting Arrangement
Appendix:
Table 1: Pooled Budget Responsibility

Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board). E.g. where budgets are held locally for services outside the BCF but are for the same services as in the Better care Fund e.g. Carers)

As most of the Better Care Fund is provided from CCG budgets the principle financial risks to the Local Authorities include the failure to earn the performance elements of the fund. To fully mitigate this risk for the Local Authority, the performance element of the fund is held by the CCGs and should not factor into the Local Authority expenditure plans. This also avoids the opportunity costs and effort in trying to earn this additional payment that may be disproportionate to the influence and benefit that the LA can gain from the achievement of the **XX**% reduction in non-elective activity.

A comprehensive risk log will be in place to manage or mitigate known and emerging risks associated with the development and implementation of the Better Care Fund Plan
The Risk Log will be reviewed by groups that are responsible for the individual identified risks, in both Health and Social care governance structures

Pooled Budgets and Risk Sharing (Section 5) – (2/2)

Define the Performance, Quality and Financial challenge which each interventions is designed to solve

Central to the risk share is **Section 3: Risk Categories** of the recommended contents, and as seen below:

Risk Categories

1. **Financial Risk**
2. **Delivery Risk**
3. **Performance Risk**
4. **Reputational Risk**

In order to address these at a high level, a recommended starting point for each risk follows:

Financial Risk

- Financial overspends on each element of the BCF scheme are the responsibility of the authorising organisation and will not be funded through the BCF, unless agreed by all parties.
- Financial underspends on each element of the BCF scheme will be retained by the Pooled budget for use within the pool in year, and returned to the partners in proportion to their contribution, at year end.
- Under achievement of planned savings and KPIs will be met from contingency and retained performance fund.

Delivery Risk

- Failure to deliver the inputs required to deliver KPIs should be borne by the organisation failing to deliver.

Performance Risk

- Failure to achieve the non-elective admissions reduction will mean that the performance element of the fund is not payable to the LA.
- Achievement will be on a proportionate basis:-
  - **100% achievement**
    100% performance fund payable
  - **75-99% achievement**
    75% performance fund payable
  - **50-74% achievement**
    50% performance fund payable
  - **25-49% achievement**
    25% performance fund payable
  - **< 25% achievement**
    No performance fund payable
- The performance fund remaining for non/reduced performance will be used by CCGs to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector.

Reputational Risk

- Reputational risk will be managed through an aligned communications and engagement plan

Contact us

If you require further information on the BCF Programmes or guidance on Development, Delivery or Financial alignment for your Health & social economy, please contact the Deloitte Health and Social care team

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