**HERTFORDSHIRE COUNTY COUNCIL**

**ADULT CARE AND HEALTH CABINET PANEL**
**MONDAY 3 JULY 2017 at 2.00pm**

Agenda Item No.

**6**

# JOINED UP CARE: ALIGNING ADULT SOCIAL CARE WITH HEALTH

*Report of the Director of Adult Care Services*

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Executive Member/s:- Colette Wyatt-Lowe,

## 1. Purpose of report

1.1 To outline to Panel the Council's medium term priorities for joined up care for adults with the NHS, in order to guide partnerships with local health organisations and inform the next Hertfordshire Better Care Fund (BCF), which will cover the period 2017-19

## 2. Summary

2.1 Given both the changing local and national context, it is an appropriate time to review the priorities and benefits for joint working between the Council's and NHS services.

2.2 The top-level vision for integration, as outlined in the 2016-17 Better Care Fund Plan, remains relevant:

*"A system that delivers the right care and support at the right time and in the right place for individuals, their families and their carers"*

2.3 Appendix 1 sets out a recommended set of priorities against a set of 'Integration Standards' developed by health and social care regulators. For each of these standards, the progress and achievements to date have been outlined, as well as the ambitions and targets for 2020. This provides a clear sense as to the practical changes expected across the system in the next three years.

2.4 The Council is working to build a culture of prevention. This culture underpins the work being undertaken to integrate health and social care. The intention is to improve the health of the population within available resources and work with the wider system, including partners in the NHS, to help Hertfordshire residents avoid preventable health and social problems. Prevention has also been prioritised as a key theme in the Hertfordshire and West Essex Sustainability and Transformation Plan.

## 3. Recommendation/s

3.1 Panel is asked to note and comment on the Report and recommend to Cabinet that it approves the Council's medium term priorities for joined up care with the NHS as outlined in Appendix 1 to the report.

## 4. Background

4.1 Closer joint working with health services has been a strategic priority for the Council for a number of years, predating recent national policy initiatives including the Better Care Fund and Sustainability and Transformation Plans. Over this time, the Council has fostered good relationships with health partners, and it has developed a national reputation as a leader on health and social care integration. This includes winning a Local Government Chronicle award for HomeFirst services, being recognised as a 'vanguard' area for work to support care homes, and winning the 2017 Health Service Journal award, which recognises excellence in care, for Workforce Efficiency for the Vanguard's Complex Care Premium scheme. It also includes the utilisation of 'pooled budgets' to jointly plan and commission services such as arrangements for the joint commissioning of mental health services.

4.2 The Health and Social Care environment has evolved since better integration was made a key theme of the Health & Social Care Act 2012 and the Better Care Fund (BCF) was first launched in 2013. The BCF, a single pooled budget of largely existing funding, has driven closer joint working between the Council and the NHS. In 2016-17, as in the previous year, the Council and the NHS pooled a wider range of service budgets than nationally required to maximise opportunities for joint working, commissioning and financial planning. This resulted in a BCF of £304m, one of the largest in the country, jointly pooled between the Council, Herts Valleys CCG (HVCCG), East & North Herts CCG (ENHCCG) and Cambridgeshire & Peterborough CCG (CPCCG).

4.3 The Hertfordshire and West Essex Sustainability and Transformation Plan outlines the high-level ambitions for the local area. Integration and specifically closer and more collaborative working across health and social care is recognised within the plan as a key means of achieving improved outcomes and doing so within a more constrained financial environment.

4.4 The vision for joined up care supports the Council's ambition to support and maximise independence for older people and adults in Hertfordshire, as well as empowering individuals and working together with partners. Improved joint working between health and social care is also consistently fed back as a priority from service users and carers at engagement events and feedback on services. For service users and staff, integration should offer:

- A greater ability to target collective resources and understand the needs of service users so that appropriate support is provided to the right people

and to the best effect. This is enabled through better sharing information to improve operational and strategic decision making.

- Alignment of similar or complementary services. This reduces gaps in provision for the service user, minimises duplication and should allow an improved experience for staff and service users. This is enabled by bringing local teams and services together to enable better joint working.

- A clearer and more efficient allocation of financial resources, enhancing the ability to reduce expenditure and enhancing the value for money of spend. This is enabled through the further development of joint or integrated commissioning arrangements.

- The opportunity to lead on and enhance the system leadership role, ensuring that the views of service users, carers and residents and communities more widely shape the development of health and social care services in Hertfordshire.

4.5 As a mark of historically strong and mature relationships, since 2015, the Clinical Commissioning Groups and the County Council have reached an agreement to transfer funds additional to the BCF from NHS budgets to maintain investment in social care services in the face of reductions in Council budgets. This is in recognition of the level of interdependence between the adequate provision of social support to frail or vulnerable adults, and the pressures on health services. In March, the CCGs made a decision to end this financial support from April 2018 and make a reduced sum available from April 2017. It is important to note that, despite the reduced contributions to social care in 2017-18, any level of support of social care by local health commissioners beyond the Better Care Fund is very uncommon.

**Table 1 - Additional CCG Contributions for the protection of social care**

| | 2015-16 (£'000) | 2016-17 (£'000) | 2017-18 (£'000) |
|---|---|---|---|
| ENHCCG | 5,000 | 8,500 | 4,500 |
| HVCCG | 5,000 | 8,500 | 4,500 |

4.6 The Council is required to submit a joint Better Care Fund Plan with the CCGs on approval of the Health & Wellbeing Board covering a two-year period from April 2017. This must include:

- Setting out Hertfordshire's vision for further integration of health and social care by 2020, which will use a similar version of the document at Appendix 1.
- Demonstrating compliance with four National Conditions (see Appendix 2).
- An outline of how the BCF will meet its performance metrics, including admissions to hospitals, care homes and delayed transfers of care from hospital.

- Clear accountability and governance arrangements between Local Authority and NHS partners.
- Involvement with partners including housing authorities representatives in developing the Plan reflecting growing recognition of the contribution of housing to integration
- Detail regarding how the County Council will improve support for carers
- Details as to how the BCF will be aligned with Sustainability and Transformation Plans (STPs), which are also encouraging greater coordination of local services to meet future financial pressures in the NHS.

4.7 The 2017-19 Better Care Fund Policy Framework was released on 31st March. Although an update on the Plan was taken to the Health and Wellbeing Board (HWB) on 14th June, final drafting is awaiting the release of additional delayed guidance although no dates have yet been confirmed.

## 5. Equality Impact Assessment

5.1 When considering proposals placed before Members it is important that they are fully aware of, and have themselves rigorously considered the Equality implications of the decision that they are making.

5.2 Rigorous consideration will ensure that proper appreciation of any potential impact of that decision on the County Council's statutory obligations under the Public Sector Equality Duty. As a minimum this requires decision makers to read and carefully consider the content of any Equalities Impact Assessment (EqIA) produced by officers.

5.3 The Equality Act 2010 requires the County Council when exercising its functions to have due regard to the need to (a) eliminate discrimination, harassment, victimisation and other conduct prohibited under the Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. The protected characteristics under the Equality Act 2010 are age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief, sex and sexual orientation.

5.4 An EQIA is attached to the Report as Appendix 3.

## 6. Financial Implications

6.1 None

Background Documents

Appendix 1- Joined Up Care Priorities
Appendix 2- BCF National Conditions

Are included within this report

Appendix 3- Equalities Impact Assessment

Is attached as a separate document

**Appendix 1 – Joined Up Care Priorities**

# Joined Up Care 2020 – vision and priorities

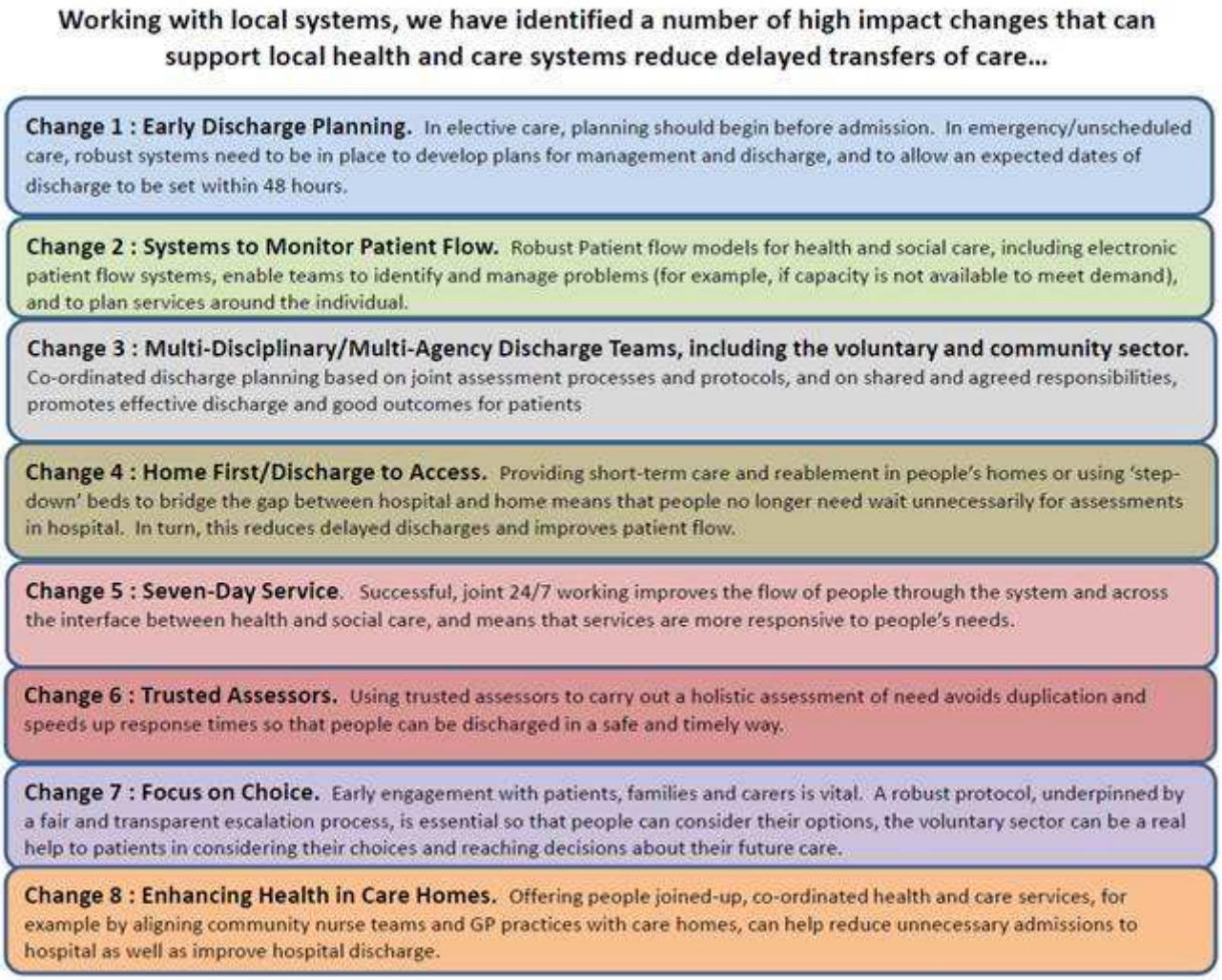
A system that delivers the right care and support at the right time and in the right place for individuals, their families and their carers

Developing a culture of prevention - to improve the health of the population and help our residents to avoid preventable health and social problems

| | Vision for Service User | Current Position and Achievements | 2020 Targets |
|---|---|---|---|
| Electronic record and data sharing | "I and all professionals involved in my care can access my digital shared care plan – this means I only need to tell my story once" | Limited sharing of information between integrated health & social care teams to improve coordinator in community and hospital settings<br>Prioritisation & resource of a business case on development of a shared care record between health & care organisations. | A **digital shared care record** accessible by health and social care professionals<br>Adapting the health and social care data systems for integrated care<br>Increasing **data sharing** between health & social care, including hospitals & GPs<br>**Networking the care home** market to enable the use of enhanced technology |
| Early identification | "I receive the right care, in the right place to prevent escalation in my care needs"<br>"I, my family or carer know where to go for support to manage my care needs" | Limited use of risk stratification to identify people with high-risk of admission to hospital within 6-12 months<br>Services in place across Herts to jointly plan and co-ordinate care for people with multiple or complex needs<br>Limited adoption of integrated points of access and 'named professionals' representing health and social | Wider use of **risk stratification** to target specific groups<br>A **preventative approach** to care co-ordination and not just crisis interventions<br>Streamlined **points of access** to care services<br>Smooth transitions between adult and children's services |
| Value for money | "I receive the best possible level of care from the NHS and local authority"<br>"The quality of my care does not change if I move between different services" | Most community services funded through pooled budgets<br>Joint commissioning of mental health and learning disabilities services, and some intermediate care beds<br>Improved use of the Disabled Facilities Grant through plans for a shared Home Improvement Agency | Using **joint commissioning** for shared contracts, market stimulation and budgets<br>A joint approach to **Continuing Healthcare** services<br>Commissioning decisions supported by more powerful tools for **joint analysis** of health and social care needs / demands of local populations<br>An operational **Home Improvement Agency** |
| Assessment and care planning | "The NHS and social care work together to assess my care needs and agree a single care plan to cover all of the different aspects of my care" | Joint care planning used by integrated community services e.g. HomeFirst and Multi-Specialty Teams.<br>Trials of 'My Plan' – a national shared care plan template.<br>Limited piloting of joint assessment forms and triage for integrated services | A **shared infrastructure** and culture of outcomes-based planning<br>**Integrated personal commissioning** of direct payments and individual budgets<br>**Trusted assessment** between health and social care professionals for a range of services |
| Integrated community care | "My GP, social worker or carer work with me to decide what level of care I need, and make sure I receive it"<br>"I only need to approach one point of contact to get my care needs met" | Integrated community service models developed around the needs of those with complex care needs<br>Improved coordination between health and social care services and the voluntary and community sector<br>Support to care homes improved through the | More colocation, single lines of reporting, and shared leadership<br>Greater joint working with **primary care**<br>Greater understanding and use of the **voluntary sector** and community assets<br>Rolling out **enhanced care in care homes** developed by the Vanguard |
| Timely and safe discharges | "If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be, even if waiting for an assessment" | Ongoing integration of discharge teams in acute hospitals<br>Specialist Care at Home service commissioned<br>Limited use of discharge to assess models to short-term care home placements; trialling of enabling models of bed based care | Further adoption of **integrated tools & working structures** e.g. live urgent care dashboards to track the movement of patients between services<br>Shared **enablement** approach across health and social care partners minimising dependency across the area |
| Integrated urgent care | "If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them" | Joint rapid response services provided to prevent admissions to hospital<br>Successful piloting of early intervention vehicle<br>Link social care workers in A&E to prevent admissions<br>Health and social care workers in hospitals able to | Use of **multi-disciplinary teams** in all areas<br>**Rapid response** functions joined up with integrated community teams<br>Wider roll-out of **early intervention vehicle** and other integrated models<br>Improved co-ordination of out of hours services including NHS 111 . |

**Appendix 2 – BCF National Conditions**

**Condition 1:** Plans to be jointly agreed, signed off by the HWB
**Condition 2:** NHS contribution to adult social care is maintained in line with inflation
**Condition 3:** Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care – this includes agreeing how Hertfordshire will use its share of the £1,018bn in 2017-18 and £1,037bn in 2018-19 previously used for the payment for performance fund in 2015-16, with appropriate risk shares
**Condition 4:** Managing transfers of care – this includes implementation of the below 'High Impact Change Model'




**BCF Metrics**

1. A reduction in non-elective admissions
2. A reduction in delayed transfers of care
3. A reduction in permanent admissions to residential or nursing homes
4. An increase in the effectiveness of reablement (an increase in the number of 65+ discharged from hospital into an reablement or rehabilitation service)
5. *An increase in satisfaction rates for the ACS enablement survey – not to be monitored centrally and unlikely to continue in 2017-19*
6. *An increase in dementia diagnosis rate (locally agreed metric) – not monitored centrally in 2017-19*