Appendix 1

Better Care Fund planning template – Part 1

Please note there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Hertfordshire County Council**
Clinical Commissioning Groups	**Herts Valleys CCG**
	East & North Herts CCG
	Cambridge and Peterborough CCG
Boundary Differences	**3 GP practices in Royston are part of Cambridgeshire and Peterborough CCG but receive social care from HCC. It has been agreed that they join the Hertfordshire Better Care Fund commissioning pool. They will therefore play a role in the Hertfordshire health and social care system on behalf of the three practices in Royston.**
Date agreed at Health and Well-Being Board:	**28th March 2014**
Minimum required value of ITF budget: 2014/15	**£18,949,402**
2015/16	**£70,982,000**
Total agreed value of budget: 2014/15	**£18, 949, 402** **(excluding existing section 75 agreements of circa £300m)**
Total agreed value of pooled budget	**£240m**

2015/16	

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Herts Valleys CCG
By	Nicola Bell
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	East & North Herts CCG
By	Lesley Watts
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Council	Hertfordshire County Council
By	Iain MacBeath
Position	Director of Health and Community Services
Date	14th February 2014

Signed on behalf of the Health and Wellbeing Board	Hertfordshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Colette Wyatt-Lowe
Date	14th February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This draft 'Better Care Fund' (application provides us with an opportunity to pull together a number of existing strategic programmes currently being delivered. All have actively engaged relevant providers in development work across health and social care in support of future plans. The Better Care Fund is seen as a real opportunity to deliver integration at scale and pace, building on years of effective partnership working.

As part of provide engagement process when developing the Better Care Fund, there has been:

- A number of workshops taking place across Hertfordshire throughout 2013/14
- Bespoke engagement events that have brought together the collective strategic vision of providers within the system to ensure a joined-up strategy for the coming years
- Meetings between individual providers and commissioners from the CCG and social care have taken place at a senior level
- To ensure that the Better Care Fund is successful, effective and serves the needs of our population, it has been developed with a wide group of GP members, nurses, healthcare professionals, other local authorities and other statutory bodies, voluntary and community sector.

Similarly, both CCGs have engaged on their strategic intentions as part of the development of their 5 year strategic plans. These have been produced in collaboration

with clinical staff, professionals in social care, local health and care providers and local people. Programme structures for service transformation are in place across both Hertfordshire CCGs, that include relevant representation from health and social care professionals.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Evidence shows the benefit of engaging patients, their carers and families about their care and treatment – they are likely to experience greater satisfaction, have fewer unwanted treatments and achieve better outcomes

One of Hertfordshire's guiding principles in designing the Better Care Fund plan has been to engage with patients and carers of all ages through workshops and engagement events that empower them to take an active part in designing services and supporting their own care. We have developed this plan through a continuous process of engagement with service users and the public ensuring to ensure the plan has validity and is owned by the whole of Hertfordshire. Their input will continue to sit at the heart of what we do, and how we draw-up and implement more detailed plans, and we will seek and respond to feedback on what's working well and what's not. Dedicated Better Care Fund engagement events have taken place across the County to inform the development of the plan, with good representation from patients, service-users, and the voluntary sector. In addition, both Hertfordshire CCGs have run a series of events and workshops to engage in their 5-year strategic plans.

Hertfordshire's current joint commissioning arrangements are supported via a series of strategic commissioning groups on which service users and carers input into the future service design and commissioning decisions and patient and service user forums throughout the county.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Hertfordshire's Health and Wellbeing Strategy 2012 – 2015	The Strategy sets out our priorities for a healthier and happier Hertfordshire. Our Aim: "With all partners working together we will reduce health inequalities and improve the health and wellbeing of our people in Hertfordshire"
Delivering a Healthy Herts Valleys	This is NHS Herts Valleys Clinical Commissioning Group's (HVCCG) first clinical strategy and sets out a framework for commissioning services over the next 5-7 years. It will guide us in our decision-making so that we commission high quality, sustainable and

	affordable services in a planned way to secure the best possible care for our patients and public.
East and North Hertfordshire 5-year strategic plan	The plan sets out East and North Clinical Commissioning Group's framework for commissioning services over the next 5 years. Its key strategic priorities are: - consistent high-quality patient services - right care, right time, irrespective of place - empowering self-management - controlled costs - co-ordinated and personalised services linked to planned care
Ageing Well Strategy	Led by the County Council, the strategy has been developed by the multi agency ***Older People and Dementia Strategic Commissioning Group*** that includes membership from providers, carers, service users, Healthwatch Hertfordshire, and Health and Social care.
Joint Market Position Statements	A series of Joint Health and Social Care Market Position Statements have been developed to support commissioners developing the appropriate service to support, metal health, learning disabilities, older peoples and complex needs and physical disabilities. These will support driving forward a joint approach to future challenges.
Hertfordshire County Council's Corporate Plan	This sets out the Council's strategic priorities and objectives.
Hertfordshire Joint Strategic Needs Assessment (JSNA)	Web-based resource with data and intelligence designed to inform commissioning decisions.
Hertfordshire Commitment to Carers	This document provides a system wider commitment across health and social care across Hertfordshire and the actions we will take to deliver.

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Shared Vision

The Health and Well-being Board's long term vision for health and social care services is 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. We will work together to help individuals and their families and carers support themselves wherever possible. We want all services to be coordinated around people's needs, helping to identify problems early or preventing them happening in the first place and helping people live as independently as possible, for as long as possible. We will ensure organisational boundaries do not get in the way of the best possible care of people. We will have a workforce that is skilled and able to deliver quality, compassionate care, and that is motivated and empowered to work and develop across the Hertfordshire health and social care system.

1. Services work together to maximise the independence of people in Hertfordshire

We will work together to develop integrated pathways to reduce the reliance on acute care and residential care. This will include:

- implementing the Ageing Well in Hertfordshire strategy to support the holistic needs of older people to help them remain independent and able to contribute to the community
- investing in and developing services that prevent people from being admitted to hospital unnecessarily,
- developing pathways and commissioning services that facilitate individuals leaving acute settings in a timely manner so that the chances of regaining independence are maximised. This will include integrated discharge arrangements, new flexible models of homecare, and the development of discharge to assess models in all acute sites
- working together to support carers' well-being, with all sectors of the health and social care system working together to collectively support carers

2. Effective integrated community services built around primary care

We will work together to invest in and develop community social, physical and mental health services that are based around primary care. This will mean implementing integrated health and social care teams around G.P clusters that

- provide **single assessment** of an individual's needs and **accountable professional** responsible for coordinating their care
- **risk stratifies** populations to identify those individuals in need of proactive community support

- deliver a **rapid response** function to prevent unnecessary admissions through providing timely health and social care services
- provide a responsive and rapidly accessible service that facilitates **timely discharge** from acute settings, for example Early Supported Discharge for stroke patients to maximise their rehabilitation potential and support them regain independence as quickly as possible
- work collaboratively with local voluntary sector services

3. Jointly commission services around individuals and their needs
We will work together to ensure it is individuals' needs that drive the services and care they receive, not organisational and service boundaries. To do this we will:

- **jointly commission** a greater range of services removing organisational boundaries, for example community bed-based provision, end of life care. Together we will pool £240m of funds for our Better Care Fund. Our commissioning decisions will be informed by our JSNA
- ensure individuals have a **lead or accountable professional** who navigate our health and social care system behalf of the individual
- responsibly **share data and information** on patients so all the individuals and professionals involved in the care of a person understand the individual holistic needs

The current funding arrangements supporting mental health and learning disability services in Hertfordshire are commissioned via a section 75 with Hertfordshire County Council. The contract is a 3 year arrangement from 2013 to 2016, providing assurance, protection and commitment across the partnership to support the sustainability and of these services for the future.

Mental health and learning disability services are essential to the success and delivery of the outcomes of the Better Care Fund and will be embedded in future plans.

4. An integrated workforce, appropriately skilled and able to work across organisational boundaries
We will work together in developing our health and social care workforce, so that we have the most appropriate and competent staff caring for individuals in the most appropriate setting. We will ensure organisational boundaries and professional identities do not get in the way of this aspiration. Together, we will:

- develop **new roles** that will be needed to make the vision for our system a reality and financially sustainable, for example hybrid homecare and rehabilitation assistant roles
- develop **7-day working** across the health and social are system
- agree strategic approach to **retention and development** of Hertfordshire health and social care workforce
- empower our workforce to work across organisational boundaries, for example by implementing **Trusted Assessment** model

The Better Care Fund and the Shared Vision
We will use the Better Care Fund as a means for helping us deliver this vision. We have collectively agreed to pool all out of hospital monies relating to older people's care,

including community health provision (including intermediate care, palliative care, District Nursing, community beds), Continuing Healthcare Funding, and the Older People's budgets for homecare and residential care. We have undertaken to jointly commission and transform any services that are in the pool, to develop more effective, efficient, and integrated services for older people.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims and Objectives of our Integrated System:

Although the specific population needs vary across the two CCG areas, there are common system aims and objectives for integrated care that collectively will help us deliver our vision. The first 4 objectives focus on outcomes for Older People through their journey through our services, and an overall aspiration to improve life expectancy and disability-free living. The final two are condition-specific issues which we collectively agree are the priorities for integrated working to deliver improved outcomes.

1. **Improved life expectancy at 75 with narrowing variation across the County** and reducing the number of years spent with illness or disability – We will deliver preventative health interventions, effective treatment of specific conditions, and effectively manage Long Term Conditions. We will work with Public Health colleagues and all partners to put in place a range of measures to help prevent elderly people and their carers developing conditions that will reduce their independence.

   Measures:

   - Disability-free life expectancy at 65
   - Life-expectancy at 65
   - Potential Years of Life Lost
   - Smoking and obesity metrics, TBC

2. **Reduce admissions of 65 and overs to acute care and maintain people's independence for as long as possible** - Reduce avoidable emergency admissions and residential care placements through effective preventative work and high quality primary, community health and social care services, jointly manage Long Term Conditions to reduce avoidable admissions from that patient group.

   Measures:

   - Avoidable emergency admissions (mandated Better Care Fund metric)
   - Admission to residential and care homes (mandated Better Care Fund metric)
   - Number of hospital spells for over 75s following an emergency admission
   - Number of spells with length of stay <2 days,

- % of bed days for people with long term conditions.

3. **People are re-abled and rehabilitated as effectively and quickly as possible after a crisis or exacerbation** – We will improve integrated pathways so people's stay in acute care is minimised, and they are able to return home wherever possible with appropriate health and social care support. We will maximise people's re-ablement and rehabilitation potential, reducing our level of residential placements.

Measures:

- Avoidable emergency admissions (mandated Better Care Fund metric)
- Admission to residential and care homes (mandated Better Care Fund metric)Number of hospital spells for over 75s following an emergency admission
- Number of spells with length of stay <2 days
- % of bed days for people long term conditions.

4. **People die in their place of choice –** through effective joint commissioning, advanced care planning and integrated delivery of care, support patients to die in their place of choice.

Measures:

- % of people who die in their place of choice
- Number of hospital visits in last 30 days of life
- Family and carer satisfaction

CONDITION-SPECIFIC PRIORITIES FOR INTEGRATED WORKING

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5. **There is quality care for people with dementia –** There will be timely diagnosis, quality community care, and support for carers and families.

Measures:

- A year on year increased diagnosis rate of dementia across Hertfordshire as measured by GP QOF.

6. **Stroke patients receive timely and quality acute care, and their rehabilitation potential is maximised –** There will be an integrated health and social care stroke pathway, from acute to community with a reduced length of stay in acute care, and community rehabilitation that meets national guidelines and maximises rehabilitation potential.

Measures:

- 90% of patients admitted to stroke unit within 4 hours,30 day mortality, 90% of time on stroke unit
- 95% of patient receiving a 6 month review
- % of patients receiving NICE guidelines levels of rehabilitation in community, ie. % of patients rehabilitated in stroke skilled unit, % patients receiving Early Supported Discharge
- Stroke patient admissions to residential placements
- Average cost of care packages for stroke patients post-discharge

c) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

A number of planned changes have already been agreed, and other will be developed as part of our commitment to jointly commission all out of hospital services for older people. Our planned changes are summarised below:

Integrated health and community teams clustered around primary care

We are committed to rolling-out integrated health and social care services, based around G.P. practices that are currently being piloted in two Hertfordshire localities: Hertsmere in Herts Valleys and Lower Lea Valley in East and North Hertfordshire. The services started in January 2013 and include integrated teams of community matrons, district nurses, therapists, social workers and homecare workers. There are two elements of the service, a proactive virtual ward which manages patients at high risk of an unplanned hospital admission and a reactive rapid response service which responds to patients in crisis within 60 minutes, with both health and social care interventions.

Both services have recently been evaluated which has shown a positive impact on quality and satisfaction and it has shown promising signs that there has been an impact on unplanned admissions.

We are currently planning extensions to both pilots. We will roll-out integrated social care and community health services into this new way of working which aligns to the CCGs' and social care commissioning plans as well as the principles and priorities outlined in the Joint Health and Wellbeing Strategy. We are also planning how best to integrate mental health services within the model. The intention is to roll out the new model for working across the whole county by April 2015, in East and North Hertfordshire this will take the form of Homefirst teams, in Herts Valley this will form part of Primary Care Plus.

Rapid response homecare/enablement

A range of new models of rapidly accessible homecare have been commissioned to provide quality, and if necessary complex care, to service-users who have been discharged from hospital. Homecare budgets will be pooled as part of the Better Care Fund. Our future commissioning model has been built on the following key ambitions to:

- provide services users and their families with a wider range of support that can flex to meet their needs without having to change providers
- build more resilience into the health and social care system – targeting resources where they are most needed and up skilling the workforce
- provide better value for money by optimising the use of voluntary sector and universal

services
- integrate pathways of care with health, and to commission with health to support these pathways
- encourage innovation, working with providers and service users to find solutions to existing and future challenges.

The 2014/15 Better Care Fund funds are being used to support some of these new innovative forms of homecare, including

- Home from hospital - this provides social care with an enhanced service for supporting discharge from hospital and enabling individuals to become more independent and reduce the risk of de-compensation. A manager from the provider is in on site at the acute setting to facilitate 'pull' from the acute, and packages can be started 7 days a week.
- Rural homecare – specific contracts with providers to deliver quickly accessible homecare in areas poorly served by mainstream providers
- Delirium/complex care – specialist homecare that serves individual with delirium or other complex needs

Work is underway to develop trusted assessment models to allow acute hospital staff to refer into these homecare types directly. This will be an important element of a new model of post-acute working, the so-called Discharge-to-Assess model of working.

Flexible Hospital Team and Delayed Discharge Teams

A peripatetic social work team that can be deployed at acute hospital sites to deal with peaks in delayed discharge activities will be introduced across the county. Work is ongoing with the major acute sites to develop 'discharge to assess' models of discharge. In addition we will introduce Trusted Assessment models, to ensure a wider range of staff can quickly commission social care packages. Securing effective I.T infrastructure to facilitate better data-sharing will be pivotal to this work.

Care Navigators

We will enhance our current Care Navigator service in Herts Valleys that provide 'local navigators' who will be trained on social care services and voluntary sectors in their local areas including HertsHelp (our telephone service for identifying local and relevant VCS support for individuals). This will provide swift access to community support services enabling people to receive the right service at the right time.

Early Supported Discharge for Stroke

Both Hertfordshire CCGs and the County Council will develop a fully integrated health and social care Early Supported Discharge service to provide quality care and rehabilitation for stroke patients on discharge from acute settings. This is likely to involve dedicated social work capacity, and a new model of homecare support for stroke patients that combines homecare and rehabilitation roles.

Clinical navigators

Clinical navigators are senior nurses or therapists that work in the acute Emergency

Department to help prevent patients presenting at A and E from being admitted. Clinical navigators are already operating at one acute site and proving successful. The service will be developed so that Navigators have trusted assessment status so that they can commission homecare and enablement directly 7 days a week.

Community beds

CCG and the Council's funding that pays for intermediate care, short stay and enablement beds will be pooled into the Better Care Fund. Work has already begun on a review of these beds and a proposal for a fully integrated model of beds, with no distinction between 'health' and 'social-care' beds. The new model will aim to deliver a phased reduction in beds, clear pathways for patients' post-acute care, increased step-up capacity and a flexible model where care will change depending on the needs of the patient during their rehabilitation.

End of Life

Health and social care funds for end of life care in the community will be pooled into the BETTER CARE FUND. To help realise the ambition to increase the percentage of people who die at their place of choice, a fully integrated health and care strategy around end of life will be agreed. This will include dedicated integrated health and social care resource.

Care Homes

Joint work will be delivered on care practice within residential and nursing homes. This work will focus on improving care, but also on reducing the amount of A and E attendances and admissions from care homes. Better Care Fund funding has already been allocated to fund a Care Home premium, paid to care homes who care for the highest acuity of service-users, in return for reaching accreditation on issues such as falls management, nutrition, medication practice etc. In addition E and N CCG are implementing a new model to enhance GP support to care homes. Work will begin to examine how the synergies between CCG quality teams and County Council care home monitoring teams can be fully exploited.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Across Hertfordshire unscheduled and unplanned emergency care accounts for almost a quarter of CCG commissioning budgets. Urgent care is delivered in a variety of settings, but all too often people are being treated in A&E departments when more appropriate services are available in primary or community care, often because of lack of understanding, access and signposting. As outlined in the vision and aims and objectives above, better integration to improve the flow of patients through the urgent care system, plus better availability and access to primary care-based services and community support, has the potential to increase the quality of care, patient experience and service efficiency dramatically.

We want more people being treated where it is most appropriate, such as in primary care or community settings whether they walk in themselves or are brought by ambulance. A&E focusing on treating patients who need their services and doing this speedily, improving outcomes and experience for patients. Patients who need to be admitted to hospital flowing seamlessly through, in line with the expected pathway, and being discharged home as soon as possible. The health and social care system effectively predicts demand and manages flow throughout the year. Integrated 24/7 health and social care rapid response support available across the area so that GPs and primary care colleagues can help keep people at home. Health and social care providers working in an integrated way with shared pathways that focus on patients' needs.

Our vision through the Better Care Fund has clear impacts on the acute in the following ways :

- Develop a fully integrated hospital discharge system, as part of our commitment to keeping people independent at home as long as possible

- Review and implement new urgent care pathways, as part of the commitment to prevention of admission work

- Develop a primary care, community care and social care rapid response access service in the community, as part of our proposals for integrated teams around G.P. practices.

- Develop a control centre approach to monitoring and escalating emergency care issues

- Develop a public education programme to raise awareness of the better alternatives so A&E is not used as a front line service for primary care

Across Hertfordshire QIPP savings of £39m are, planned for 2014/15 and between 2.5% c3.5% pa which if not delivered will have significant impact on the health and social care economy in Hertfordshire. For this reason the Better Care Fund strategy to invest in Primary Care Plus and Homefirst alongside enhanced homecare and hospital discharge services will aid the delivery of these challenging targets, as long as admissions and length of stay are reduced.

If we do not deliver the required outcomes within this strategy there will be a significant deficit.

There will be significant workforce changes as a result of these plans across the the health and social care system. The LETBE will be involved in this strategic planning. Although it is not clear what the exact nature of the changes will be, the strategic issues are outlined below:

- likely shift of activity into the community, necessitating further nursing and therapy capacity
- likely increase demand for social workers and Community Care Officers, especially in the short-term to meet legislative requirement of the Care Bill

- requirement for more hybrid-roles, and existing professional groups trained to deliver assessments or care on behalf of other professional disciplines
- potential to develop role of homecarers, given increasing acuity of individuals that will be cared for at home. This will necessitate further development of career development and progression pathways that operate across health and social care boundaries

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Across Hertfordshire we have strong governance structures to support commissioning of services under the Health and Wellbeing Board, where relationships are positive at senior levels. Investment has been made by all H&WBB members in development days to come to an understanding of how to support the people of Hertfordshire to the best of their ability.

The Better Care Fund, however, provides an opportunity to take this one step further and deepen the relationship between it constituent parts. In the light of current pressure in the system requiring a greater need for integration, the H&WBB are reviewing the current strategy to re-focus on the integration agenda and support the delivery of the Better Care Fund and wider opportunities above and beyond.

Regular briefing to members of the H&WBB will take place including cabinet, district and borough councils, CCG boards, Health Watch Hertfordshire and local VCS organisations.

Oversight and co-ordination of the integration agenda will be provided through the Health and Wellbeing Board, and a system-wide integration board will be set up to bring all programmes together into a manageable work plan enabling all committed outcomes to be delivered on. Plans are already being developed for new joint commissioning arrangements to ensure appropriate governance of the pooled monies. The development and implementation of the integration agenda will be aided by the appointment of two Assistant Directors for Health and Social Care integration jointly appointed and funded by the County Council and respective CCGs

Both Hertfordshire CCGs have a series of programme approaches to managing change, and crucially relevant programme boards have representation and full engagement of senior social care commissioners, and these are outlined below:

In Herts Valleys, the five clinical programmes, which span the full range of services commissioned by us, are:

- Older People and Complex Care
- Mental Health and Learning Disability
- Children, Maternity and Young People
- Urgent Care
- Planned and Primary Care

In East and North Hertfordshire the programme boards are structures in the following ways, and similarly engage senior managers in health and social care as well as G.Ps

- Out of Hospital Care
- Urgent Care
- Planned Care
- Joint Commissioning and Partnerships

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Protecting social care services in Hertfordshire means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures.

Delivering high quality social care services is challenging, and it will become more so in the coming years. Our population is ageing. More people in our area, both young and old, will be living with complex health and social care needs. There will be opportunities to improve care through technological developments and the desire to develop more personalised care.

Meeting these challenges requires transformation of the health and social care system and the way it delivers services, the quality and the cost effectiveness of care. It is no longer feasible to commission services independently of each other. Instead, we will:

- work with partners to develop and provide integrated services, e.g. intermediate care, bed-based community services, stroke care etc
- Commission services differently to provide innovative services in out of hospital settings
- work in ways to ensure that primary care and social care interact in an effective, efficient way in the interests of the service user

New homecare models

Our future commissioning model has been built on the following key ambitions:

- provide services users and their families with a wider range of support that can flex to meet their needs without having to change providers
- build more resilience in to the health and social care system – targeting resources where they are most needed and up skilling the workforce
- provide better value for money by optimising the use of voluntary sector and universal services
- integrate pathways of care with health, and to commission with health to support these pathways
- encourage innovation, working with providers and service users to find solutions to existing and future challenges.

Some examples of improving home care services and delivering new ways of working are below:

Complex Care Needs

- Commission a Nurse Led service with a dedicated provider (with a proven track record of specialist support)
- Reduce the impact of Service Users going into rehabilitation or nursing homes
- Link with Integrated Discharge Team/care
- Reduce delays between different levels of care

- Improved outcomes for Service Users (reducing length of stay in hospitals)

Rural Care

- Reduce waiting times for care packages in rural areas (either through Hospital Discharges and or community packages)
- Block purchase from dedicated provider(s)
- Alleviate pressure on families caring for Service Users until appropriate care is in place

Delirium Care Pathway

- To support Service Users diagnosed with Delirium
- Reduce prolonged hospital stays
- Reduction in level of long term placements
- intensive support programme in place
- 3 week review - checklist & assessment of needs undertaken

By taking this approach we will create opportunities to deliver healthcare in different ways, in particular putting in place greater levels of integration and personalisation – so that patients can receive care in ways that are most appropriate to them and we achieve better outcomes, improved experience, more choice, control and better access.

Please explain how local social care services will be protected within your plans.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services. Both the CCGs and the local authorities agree that by pooling resources and joint commissioning and then transforming services, significant efficiencies can be achieved in the system which can jointly benefit all organisations.

Agreement has already been reached on the allocation of BETTER CARE FUND funds that are being allocated in 2014/15, with priorities being rapidly accessible enablement and homecare packages that facilitate hospital discharge, funding to support social care element of integrated community teams, and support to care home to reduce admissions.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Hertfordshire has shown its commitment by having this in place over the last year in the main Acute sites. We instigated prior to the introduction of the Better Care Fund and will be expanding this throughout our plans into 14/15, with monies already allocated from the Better Care Fund funds that are payable from 2014/15 set-aside for this purpose. As 7 day working intensifies in the acute sector it will be important for social care to react quickly to this to ensure whole-system activity functions efficiently over the 7-day week.

Currently, 7 day working is delivered in the form of:

- Social workers being present on acute hospital sites 7 days of the week
- Able to take referrals from smaller hospital sites within Hertfordshire
- Spending time on the weekend interfacing with wards to ensure that packages of care are implemented in a swift manner.
- Social care packages are able to begin during the weekend

All Hertfordshire County Council homecare commissioned providers are required to provide a 7 day per week service in relation to accepting packages of care. However, this is not always practically possible. All the Council's homecare contracts are being let in 2014/15, and 7 day working will be a core element of the service. Commissioners are working with providers of residential care to enforce contractual commitments around 7-day working.

In addition a Trusted Assessment pilot will begin in March, which will allow acute hospital staff to refer directly into Home from Hospital care packages, this will aid flow across the week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence. Social care are in the process of adopting this and have a high rate of recording of NHS numbers (e.g. over 85%), and we are committed to ensuring this adoption is universal across all social care services in Hertfordshire.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

This will be in place for all patients by April 2015. An Integrated Information Technology Group involving teams from within CCG's, providers and social care has been created, and one of its roles will be ensuring that professionals across Hertfordshire are all working to one single patient identifier. Agreement has already been reached about ways that social care can more easily access the national database of NHS numbers from the Spine to reconcile its records.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The Integrated Information Sharing and Technology Group will lead on delivering these national conditions, including adopting systems based upon Open APIs and Open Standards. The work will focus on 4 main areas:

1. Sharing **intelligence at a strategic commissioning** level to inform joint system-wide commissioning decisions. Social care, both Hertfordshire CCGs and the Community Trust, have already invested in, and use, Care and Health Trak which includes social care, acute, and community data and is used to inform strategic commissioning, and supports risk-stratification
2. Sharing timely and **accurate performance data** that is important to the running of the health and social care system (including the Better Care Fund national indicators)
3. Access to **care records** from different organisations
4. I.T infrastructure that facilitate efficient and effective integrated working, e.g. co-location

We are seeking to develop the Medical Interoperability Gateway (MIG) which will be implemented during 2014. This will allow partner providers (Trusts, hospices, social care) to view various versions of the GP record in real time. This can be the whole GP record or subsets of data. This access is securely managed and works on a 'consent to view' basis. This would allow a view of the patient information for any provider working over an N3 line (or suitable approved alternative).

In addition the HVCCG is exploring products such as Patchwork, a simple networking application, designed to support the necessary culture changes to underpin MDT working in virtual teams. As part of the developing EOLC strategy, such an approach will be piloted alongside EOLC Registers as the trigger to the client being added to Patchwork. The average number of professionals involved with someone at EOL is 9, and experience shows that there are often problems for such professionals in knowing who else is in the 'virtual team'. Patchwork also allows for a client's own *subjective view of what is important to be shared across the virtual team.*

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

This work will be overseen by the Integrated Information Sharing and Technology Group. We have already committed to agreeing over-arching information sharing agreements, with appropriate controls in place and concordance with Caldicott 2

The principles of these arrangements will be based on:

- Confidential information about service users or patients should be treated confidentially and respectfully

- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual
- Information that is shared for the benefit of the community should be anonymised
- An individual's right to object to the sharing of confidential information about them should be respected
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Joint assessment and an accountable lead professional are in place in our emerging models of integrated health and social care teams, Homefirst and Primary Care Plus. The lead professional is determined based on which professional has the most appropriate skill-set for the patient at the time. In both pilots we have joint core assessments, multi-disciplinary team meetings and joint care plans.

<u>Risk Stratification</u>

We have processes and systems in place to risk stratify patients for unplanned hospital admissions using secondary care, social care and community services data. We use CareTrak to carry out the risk stratification which is based on the Devon algorithm.

Our aim is to identify the top 0.5% of the population at risk of an unplanned hospital admission this way. This system has been used to underpin risk-stratification and admission to the Virtual Ward in the Homefirst pilots. In East and North Hertfordshire, all GP surgeries are using risk stratification to help identify patients who may need proactive support to prevent an avoidable hospital admission.

Our intention is to expand the number of patients identified in this manner to the top 2% of the population at risk of an unplanned admission. We also plan to expand risk stratification to identify service users who may require a high intensity social care package or are at risk of being admitted into residential care.

Further work will take place to ensure that joint assessments are carried out across all integrated services, alongside the development of trusted services across the system.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
The shift of resource from health to social care creating destabilisation within the system.	HIGH	A thorough risk assessment process will be conducted to ensure that the risk to decisions in one part of the system are mitigated or managed throughout the planning process of the Better Care Fund All plans will be developed as an integrated system ensuring agreement of all parties, jointly understood impact of investment and disinvestment decisions.
Lack of high quality data to benchmark ourselves against, potentially resulting in loss of funding for services.	HIGH	To invest in 14/15 on reviewing and developing robust data processes ensuring that future benchmarking is accurate and reflects current position.
Failure to deliver operational schemes within the year to enable efficiencies to be made across the acute sector.	Medium	Develop strong commissioning plans that are project managed and delivered within time frames required to begin seeing impact on services and outcomes for service users.
Individual service provider's financial positions alongside future efficiency plans being un-manageable.	High	A co-ordinated approach through the Integrated Board approach manages provider risk and the maintenance of quality when delivering year on year Cash Releasing Efficiency Savings.
Failure to make sufficient progress against national / local metrics resulting in loss of funding	Medium	Regular monitoring of metrics to identify lack of progress and identify areas for improvement
Requirement to set up new services whilst continuing to run existing services leading to increased costs to the health / social care system in the short term.	Medium	Identification of services where dual running is required and the timescale. Identification of funding. Close management of services to minimise risk.