Health and Wellbeing Board
Hertfordshire

Agenda Item No.

5

**HERTFORDSHIRE COUNTY COUNCIL**

**HEALTH AND WELLBEING BOARD**
**WEDNESDAY, 14 JUNE AT 10:00AM**

# 2017-19 BETTER CARE FUND PLAN

*Report of:*

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## 1.0 Purpose of report

1.1. To provide an overview and obtain comments on the proposed vision, principles and priorities in the 2017-19 BCF plan in preparation for submission to NHS England (NHSE) once dates have been confirmed.

## 2.1 Background

2.1.1 The Better Care Fund (BCF) was announced by the Government in June 2013, and a local plan agreed in Hertfordshire between Hertfordshire County Council (HCC), East & North Clinical Commissioning Group (EHNCCG), Herts Valleys Clinical Commissioning Group (HVCCG) and Cambridgeshire & Peterborough Clinical Commissioning Group (CPCCG) in April 2014. The national policy requires the establishment of a single pooled budget (the BCF) to enable delivery of the local BCF plan to integrate health and social care services.

## 2.2 2017-19 Better Care Fund

2.2.1 **Planning Guidance**: In line with last year, Hertfordshire is required to submit an updated BCF Plan but covering the next two financial years from April 2017. As well as outlining spend, it must:

- Set out Hertfordshire's vision for further integration of health and social care by 2020
- Detail an evidence-based and jointly approached plan
- Demonstrate compliance with four National Conditions (see appendix 1).

- Outline how the BCF will meet its performance metrics, including admissions to hospitals, care homes and delayed transfers of care from hospital (see appendix 1)
- Have clear accountability and governance arrangements between Local Authority and NHS partners
- Involve partners in developing the Plan including housing
- Alignment with Sustainability and Transformation Plans (STPs), which are also encouraging greater coordination of local services to meet future financial pressures in the NHS

2.2.2 Although 2017-19 Better Care Fund Policy Framework was released in March, national delays publishing remaining guidance has meant that some aspects of the Plan – including financial contributions and BCF performance metric targets – cannot yet be confirmed. The 2017-19 BCF will remain in draft form until guidance is released and submission dates have been confirmed.

2.2.3 Final sign-off of the Plan must be undertaken by the Health and Wellbeing Board. A paper submitted to March's Board asked that this role be delegated to the Health & Wellbeing Board Chair in consultation with Hertfordshire County Council and CCG Chief Executive and Accountable Officers given that submission was unlikely to coincide with scheduled meetings.

2.2.4 **2017-19 BCF Plan**:

2.2.5 **Vision and delivery plan:** The top-level vision for health and social care integration, as in previous years, remains 'a system that delivers the right care and support at the right time and in the right place'. Hertfordshire's 2017-19 BCF Plan therefore focuses its priorities and actions around the person-centred 'Integration Standard', developed by NHSE to show what an integrated health and social care system looks like (see appendix 2). Hertfordshire's BCF vision diagram is included in appendix 3. Delivery plans, which have been developed in consultation with other plans including the STP, have been broken down with examples as follows:

1. **Electronic record & data sharing** – digital shared care record, linked datasets, networking care homes
2. **Early identification –** wider use of risk stratification to prevent admissions and other service escalations and expanding prevention
3. **Value for money** – developing collaborative commissioning, roll out of the Home Improvement Agency, joint data analysis
4. **Assessment & care planning** – roll out of the locality-based approach, shared assessment infrastructures, integrated personal commissioning and continuation of the multi-speciality approach

5. **Integrated community care** – improved shared leadership, better involvement of the voluntary sector in statutory services, continuation of and mainstreaming of the Vanguard Programme
6. **Timely and safe discharges** – implementing all 8 areas of the High Impact Change Model (see appendix 1), 7 day working, live urgent care dashboard
7. **Integrated Urgent Care** – greater use of multi-disciplinary teams, continued rapid response functions within integrated community teams, improved out-of-hours service

2.2.6 **Finances**: Although amounts are awaiting confirmation, minimum CCG contributions are likely be similar to last year's £69m. As in last year, the BCF pool will extend more widely that this, including the majority of CCG and Hertfordshire County Council older people out-of-hospital budgets meaning a similar total figure to that of last year's £304m.

2.2.7 The wider BCF also includes the Improved BCF (iBCF), a new social care grant allocation to provide stability and extra capacity in local systems as well as support delivery of the High Impact Change model to reduce transfer delays. It totals £13m in 2017-18 and 11.6m in 2018-19. Use of the iBCF has been agreed between Hertfordshire County Council and CCGs with spend supporting at least one of the following areas: stabilising the market, meeting current needs, reducing NHS pressures and supporting discharge.

2.2.8 The Disabled Facilities Grant (DFG) is allocated through the BCF to encourage areas to think jointly and more strategically about the use of home adaptations. Hertfordshire's Home Improvement Agency, to launch in the autumn of 2017, will introduce a more collaborative model for the DFG. The agency is bringing together the housing authorities, who have statutory duty to deliver adaptation grants to people with disabilities, and Hertfordshire County Council, who have responsibility for ensuring people's homes are suitable to meet their needs, in the delivery of an end-to-end service.

2.2.9 Pooled arrangements between health and social care continues to be underpinned by the Section 75 Agreement which provides the legal framework for the BCF and other pooled funds, and which will be reviewed and updated in June.

2.2.10 **Performance**: Although 2017-19 performance metric targets cannot be confirmed prior to the publication of further guidance, they will tie into existing work across Hertfordshire County Council and CCGs. Although the BCF is still required to report on the top four metrics (non-elective admissions, delayed transfers of care, permanent admissions to care homes, effectiveness of reablement), the two local metric (service user engagement, dementia diagnosis) will no longer be monitored centrally.

3.1 **Recommendation**

3.1 That the Board :

- provide **comments** on the 2017-19 BCF Plan from the information provided in this document and the accompanying presentation. A draft of the narrative plan will also be sent to HWB members for comment once final guidance is received from NHS England.

- **formally sign-off** the proposed vision, principles and priorities in the 2017-19 BCF plan ahead of the submission to NHS England (as this is likely to be the last time that HWB meets before the Plan is submitted by the Chairperson).

3,2 For the BCF 2017-19 locally defined performance metrics – that the HWB agree to:

- remove the local 'Service User Engagement' performance metric (based on the HCS Enablement Survey),as this survey is only being continued for BCF monitoring purposes.
- continue monitoring dementia diagnosis as a useful measure of progress in this area, and a recognition of the importance of dementia services in integration plans.

| | |
|---|---|
| **Report signed off by** | Colette Wyatt-Lowe, HWB Chair |
| **Sponsoring HWB Member/s** | Iain MacBeath, Beverley Flowers, Nicolas Small |
| **Hertfordshire HWB Strategy priorities supported by this report** | The Better Care Fund proposals relate to all 4 Health & Wellbeing Strategy priority areas |

**Needs assessment** (activity taken)
The Better Care Fund identifies initial priorities for integration based on our understanding of both need in the area and future demographic challenges, which is why the priorities include:

- Support to frail elderly populations
- Long term conditions
- Dementia

**Consultation/public involvement** (activity taken or planned)
The 2015-16 BCF Plan, which forms the basis of this year's Plan, was created further to extensive consultation activity around the BCF process, with patient groups, statutory bodies, provider organisations and the voluntary and community sector. Individual integration projects have also often carried out their own consultation and engagement exercises.

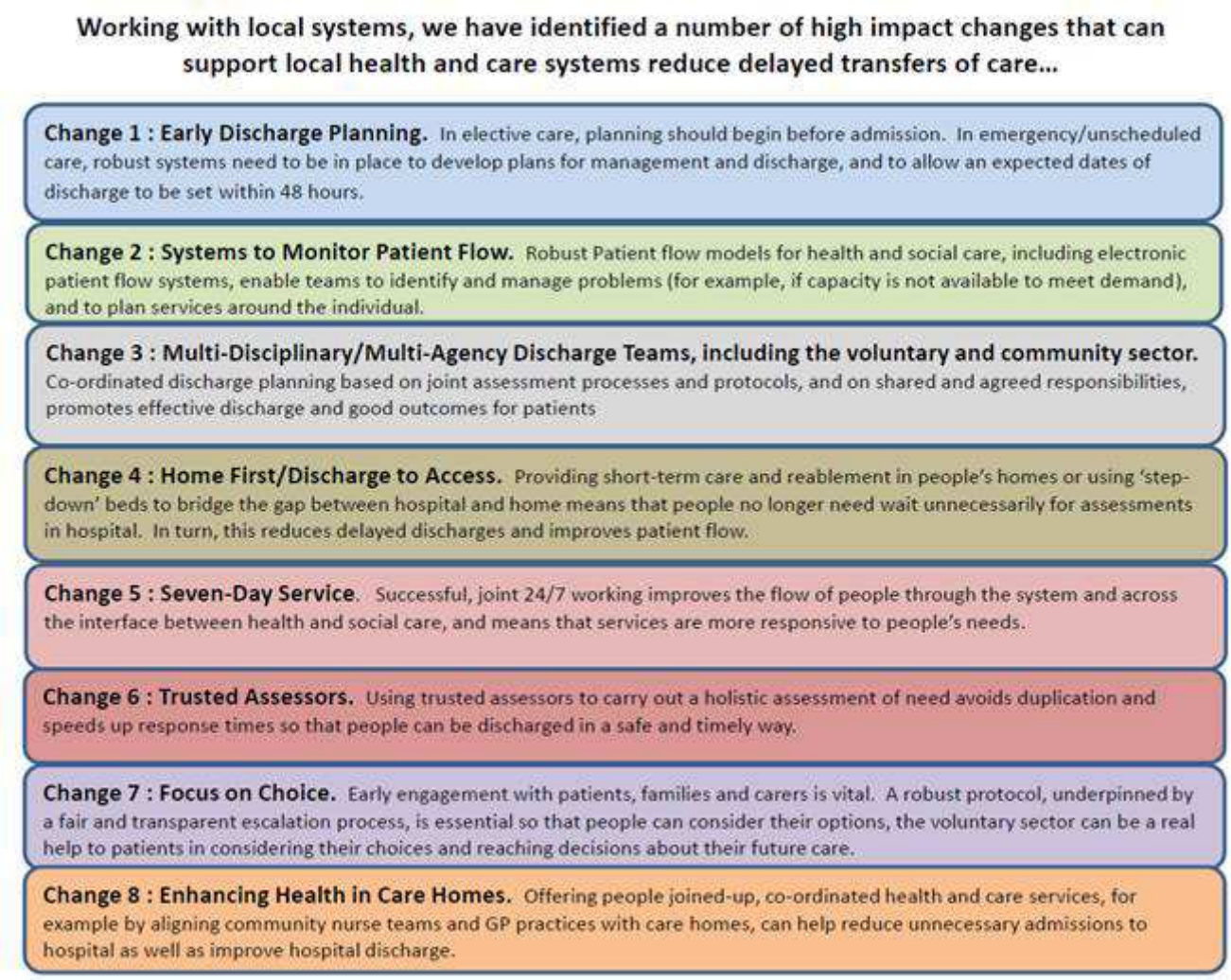
**Equality and diversity implications**
Each project that is delivered as part of the Better Care Fund work will be subject to robust equality impact assessments, to ensure the impact on different groups is understood and where necessary mitigated against.

**Acronyms or terms used. eg:**

| Initials | In full |
|---|---|
| BCF | Better Care Fund |
| CCG | Clinical Commissioning Group |
| HCC | Hertfordshire County Council |
| HCS | Health and Community Services |
| HWB | Health & Wellbeing Board |
| NHSE | NHS England |

**Appendix 1 – 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'




**<u>BCF Metrics (to be confirmed)</u>**

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 a reablement or rehabilitation service).

5. *Service user engagement (locally agreed metric) – an increase in satisfaction rates for the Health & Community Services enablement survey – not monitored centrally.*
6. *An increase in the dementia diagnosis rate (locally agreed metric) – not monitored centrally.*

**Appendix 2 – Integration Standard** (under review by Social Care Institute for Excellence [SCIE])

| | Objective | Improvement to person's experience | System change needed to deliver this objective |
|---|---|---|---|
| 1 | **Digital inter-operability** | "I have access to a Digital Integrated Care Record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data)" | • Areas reach **digital maturity**, including universal use of the NHS number as the primary identifier and fully interoperable IT across providers and commissioners. |
| 2 | **Resource targeted at key cohorts to prevent crises and maintain wellbeing** | "If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital."<br><br>"If it would benefit me, I will be able to access a personal budget, giving me greater control over money spent on my care." | • Areas use health and social care data to **risk stratify** their populations, identifying those most at risk of unplanned admissions and allocating resources according to need.<br>• Areas will allow greater access to **Integrated Personal Commissioning**, for identified groups who could benefit.<br>• Areas use **capitated budgets** where appropriate |
| 3 | **Value for money** | "I receive the best possible level of care from the NHS and my Local Authority." | • Areas deliver against a **clear plan for making efficiencies** across health and care, through integration. |
| 4 | **Single assessment and care plans** | "If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care." | • Areas use **multi-disciplinary integrated teams** and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week. |
| 5 | **Integrated community care** | "My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it." | |
| 6 | **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." | |
| 7 | **Social care embedded in urgent and emergency 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". | |

# Joined Up Care 2020 – vision and priorities

| | 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 at 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 care services | • 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<br>• MedeAnalytics tools developed to inform commissioning | • **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. 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 Vanguard programme | • 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 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 carry out certain elements of each others' roles | • 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 . |