BETTER CARE FUND: DRAFT HILLINGDON PLAN

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
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Papers with report	Appendix 1 – Proposed Draft Appendix 2 – Financial Summary

1. HEADLINE INFORMATION

Summary	This report provides the Board with proposals for the Hillingdon plan in response to the Better Care Fund (BCF), formally the Integration Transformation Fund. Detailed guidance was issued by Government on 20 December 2013 as to how the fund will be applied, the information required and the financial forecasting needed. A proposed draft is attached as Appendix 1, together with the financial summary at Appendix 2, as per the guidance. The guidance requires a “first take” of the plan to be submitted on behalf of the Health and Wellbeing Board by 14 February and a final plan to be submitted by 4 April 2014, both to NHS England.
Contribution to plans and strategies	Hillingdon’s Joint Health & Wellbeing Strategy Hillingdon’s Joint Strategic Needs Assessment Hillingdon’s Out of Hospital Strategy
Financial Cost	The announcement sets out a minimum fund of £17.991m for Hillingdon from 2015/16. The guidance also set out how this figure is arrived at, the fact that it is not new money but comes from existing budgets.
Ward(s) affected	All

2. RECOMMENDATION

2.1 The Board is asked to agree the vision and scope of the BCF plan as set out in Appendices 1 & 2, so that this can be submitted on its behalf to NHS England by 14 February 2014. In particular, the Board is asked to note that:

a) the initial plan prioritises supporting frail elderly residents as the first target group under the BCF.

b) the proposed plan is based on offering the minimum fund (of £17.991m in 2015/16) at this stage.
c) the eleven schemes set out at paragraphs 4.8 to 4.23 (and in more detail in Appendices 1 & 2) provide the starting point to develop business cases and proposals for delivery under the plan.
d) in addition to the mandatory indicators provided in the guidance and set out in detail in Appendices 1 & 2, Hillingdon sets a local indicator relating to shared care plans, all of which will support the financial reward element of the fund from 2015/16.

2.2 That an additional meeting be scheduled for 1 April 2014 to enable to Board to agree the final plan for submission by 4 April 2014.

3. INFORMATION

Reasons for recommendations

3.1. To ensure that the development of more integrated health and social care services in Hillingdon is focused on improving services for residents. In doing so, the plan also complies with the directions from Government and the NHS England on establishing the Better Care Fund (BCF) in Hillingdon.

Financial Implications

3.2. The Better Care Fund nationally amounts to £3.8billion in 2015/16 which is to be spent locally on 'adult social care services which also have a health benefit' to drive closer integration and improve outcomes for patients, service users and carers. For 2014/15, in addition to the £900m transfer already planned from the NHS to social care, a further £200m will now transfer to prepare for the implementation of the Better Care Fund in 2015/16. It should be noted that funding for 2015/16 is not new money, but reallocation of funding which is currently fully committed in both the Council and the HCCG budgets. The contributing contents of the Better Care Fund are the existing transfers to social care from heath, i.e., the s256 transfers, existing health funding, DFG capital funding and social care capital grant funding.

3.3. The s256 allocation to Hillingdon in 2014/15 amounts to £4.772m, including £3.9m previously announced for 2014/15 plus the share of additional funding amounting to £0.868m to prepare for the new Better Care Fund arrangements.

3.4. For 2014/15, the condition attached to the transfer of the additional funding of £0.868m is that both organisations must jointly agree and sign off two year plans for the Better Care Fund, which is to be provided to NHS England by 14 February 2014. The requirement for the use of the funding is that it must be used to support adult social care services within the Council which also have a health benefit, giving flexibility to determine how this investment will make a positive difference to social care services, and outcomes for service users.

3.5. For 2015/16, the allocation to Hillingdon totals £17.991m and details are set out in the table below:

	£000
Disabled Facilities Capital Grant	1,769
Social Care Capital Grant	580
Revenue Funding	15,642
Total	**17,991**

3.6. The revenue funding allocation of £15.642m includes funding for carers and reablement currently received by the CCG, and funding for the implementation of the Care Bill which have not been separately identified at a local level in the funding announcement. The Council currently receives the capital allocations for the Disabled Facilities Grant and the Social Care grant directly but, from 2015/16, legislation will be changed so that the funding goes via the NHS and is then passported to the Council through the Better Care Fund and then used in the same way as now.

3.7. In 2013/14, the Council also received revenue funding of £3.7m from the CCG through a s256 agreement to support adult social care services. This is currently allocated as follows within the Adult Social Care base budget:

Section 256 programme components	Full year budget (£k)
Telecare line service and in-house reablement	700
Demographic pressures in Older Peoples Services	2,000
Hospital social work	250
Community equipment	250
Dementia service	300
Long-term residential and nursing home care	100
Personal budgets	100
	3,700

3.8. This increases to £3.9m in 2014/15 and a further £0.868m has been provided to prepare for the Better Care Fund bringing total s256 funding to £4.8m from Health Funding. The remaining balance of revenue funding for 2015/16 of £10.8m will come from other existing Health Funding. The CCG is currently in the process of identifying which budgets will constitute this sum and have set out in the table below an early indication of the current funding that could be included in the pooled funding from 2015/16:

Programmes	Full year budget 2015/16 (£k)
Section 75 Community Equipment Programme	664
Rapid Response Programme	1,660
Integrated Care Programme	951
Community Services Programme	7,293
Qipp Programme	208
End of Life Continuing Care programme	100
Total	10,876

3.9. Currently, each partner is not automatically empowered in their own right to undertake another's duties. Therefore, the funding for 2015/16 will be managed through pooled budgets under Section 75 of the NHS Act 2006 which was introduced to allow a local authority to undertake NHS duties or the NHS to deliver local authority functions or where the partners agreed to 'pool' their resources to deliver services. It is important that the proposed Section 75 arrangements set out clearly the governance, accountability, control, risk sharing and arrangements in relation to sharing over/underspends. Either the Council or the CCG will need to hold the pooled budget.

3.10. The 2015/16 funding allocation also includes a payment for performance element which is contingent in part upon planning and performance in 2014/15 and in part on achieving specified outcomes in 2015/16. The performance element of the funding could be withdrawn if the ambitions set out in the plans are less than 70% delivered, although the guidance says that this will not happen in 2015/16. This has been identified as a key risk for each partner and therefore must be clearly recognised and mitigated through the proposed Section 75 pooling agreement.

3.11. Other risks include the possible impacts from reprioritising Health funding from acute services to preventative social care services which need to be clearly identified and mitigated.

3.12. The Council and the HCCG have good experience of Section 75 pooling agreements with two already operating in respect of Learning Disability Services and Community Equipment Services. As set out above, the Section 75 pooling relating to the provision of community equipment will from 2015/16 form part of the BCF.

3.13. The approach proposed by the two partners in Hillingdon is, initially, to pool only the minimum required funding of £17.991m. This is felt to be cautious in the face of significant uncertainty and to provide the Council and HCCG with reassurance that subsequent proposals will be affordable and subject to robust performance management and financial management, through existing accounting processes.

Legal Implications

3.14. The Borough Solicitor confirms that the legal implications are included in the body of the report.

4. BACKGROUND

4.1. The Council, the CCG and providers of health and social care services in Hillingdon have made significant strides to improve and align the services they provide in recent years. There are existing joint initiatives in place to build on; from integrated care pilots around falls to new pathways for early supported discharge from secondary care. The BCF requirements, therefore, are aligned well to this approach and are consistent with it. The BCF provides an opportunity to consolidate this partnership working and to lay the foundations for closer working in the future. It also offers a stepping stone towards new forms of potential delivery structure as a result of joint working, which the Board has indicated it may wish to consider in the future.

Published Guidance and Pro-Forma

4.2. Further guidance, technical explanatory notes and application templates were issued by Government on 20 December 2013. These set out:

- Where the funding comes from, given it is recycled money from existing budgets. Also, that the minimum level of the initial pooled funding will amount to £17.991m for Hillingdon;
- How the £3.8 billion nationally is made up for 2015/16 including how the performance related element will be applied; and
- A mechanism and metrics for agreeing measures against which performance will be assessed.

4.3. The guidance also confirms the six national conditions as being:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- a joint approach to assessments and care planning, ensuring that, where funding is used for integrated packages of care, there will be an accountable professional; and
- agreement on the consequential impact of changes in the acute sector.

4.4. Each of these conditions is addressed in the plan at Appendix 1.

Preparing for the Better Care Plan for Hillingdon

4.5. An officer and partner group, consisting of the Council, HCCG, The Hillingdon Hospital and CNWL Community Health has met to develop a broad approach and model for the BC plan in Hillingdon. The focus of the group's approach has been to identify the best ways to improve health and social care in Hillingdon, to build on strengths and good practice and to spot gaps in provision where greater attention should be given. The product of those discussions is contained in draft plan at Appendix 1.

4.6. The group has noted evidence that Hillingdon's population is growing and living longer and that the number of over 65s is set to increase rapidly over the next few years. Both the Council and the CCG have identified priorities to extend life expectancy, support independence

and to increase opportunities to enjoy old age. It was also noted that over 70% of non-elective health spend is on people aged over 75 and, together with the likely new requirements of the Care and Support Bill, services for older residents will need to develop significantly over coming years. It was identified early on, therefore, that an initial focus on services for frail older residents should be the major focus.

4.7. The existing system was mapped to identify the pathways involved across health and social care and a model developed. From this, gaps have been identified and further actions suggested which would form the basis of the Hillingdon Better Care Plan. Eleven "schemes" are proposed in the plan reflecting areas where there are identified gaps in provision and a need for closer working. These are:

Scheme one: Joined up tool for health and social care risk stratification:

4.8. Developing an existing "risk stratification" tool, which identifies people with complex health issues who are at risk of their condition deteriorating or being admitted to hospital. Thereby, identifying those people who not only have health risks but also have social risk factors, for example, change in care requirements, status of partner, social isolation, etc. This will allow services to proactively manage these risks much earlier and in a way that allows people to retain their independence and improve their overall health and wellbeing.

Scheme two: Proactive early identification of people with susceptibility to falls, dementia and social isolation

4.9. We know that people with either dementia, susceptibility to falls or who are socially isolated are disproportionately represented on our non elective admissions and in long term residential care. Most of these are identified when people reach a complex stage. In addition, most of these people are visible only to some parts of the system such as carers, social workers, GPs and alarm services. We want to ensure that the entire system understands the factors that create susceptibility to these health and social care conditions. Under Scheme 2, we will develop the frontline workforce with "brief intervention" training to identify people who are susceptible. We will define system wide responses to these issues, i.e., what do we do when we identify people with this susceptibility. One key outcome of this scheme will be to reduce the movement from lower tiers of risk into higher tiers.

Scheme three: Development of shared care plans

4.10. Hillingdon has been successfully implemented robust care plans for a proportion of identified patients with diabetes and frail elderly people with complex needs as identified through risk stratification and other means. The care plans are developed by a multidisciplinary group (MDG) of health and care professionals and will be signed-off by the service user or patient. We will extend this further to:

- scale it to all people with complex health and care needs; and
- include people with medium risk who will benefit from care planning and introduction of self-care pathways.

Scheme four: Integrated case management and care coordination

4.11. Hillingdon has a team of community matrons who manage complex cases in the community and a separate team of social workers that manage cases with complex social care needs. We have identified that a significant proportion of the 'current' workload is the same cohort of people. This comes from the fact that people with complex health needs often have social care needs and vice versa. As part of the MDG, we will develop an integrated community team with health, social care, mental health and third sector.

4.12. People who are being case managed represent cases with high risk of deterioration in health or social risk factors. These people, if not managed well in the community, may end up in the hospital or may require high level of care support or potential admission into care homes. Scheme 4 will address this.

Scheme five: Review and realignment community services to GP networks

4.13. Hillingdon has improved efficiency within community services. However, more work needs to be done to ensure that we get value for money from our existing community services, that they are much more integrated between health, social care and the third sector. Hence, we will:

- Review current community service configuration and realign resources around GP networks;
- Integrate teams based around primary care teams focused on older people. This will aim to streamline access to services by ensuring a co-ordinated response to needs at any point of entry into the service system with integrated serviced provision;
- Develop programmes to support step down from core community services to less intensive care (care bundles);
- Short term assessment and signposting services for targeted groups, e.g., older people and populations (areas with most need) - multi-agency signposting including health, housing, social care benefits; and
- Mainstream individual care planning and development of personalised care planning and patient participation with all professionals.

Scheme six: Rapid response and joined up intermediate care

4.14. Hillingdon currently runs a rapid response service within the community. This service has presence both in the A&E as well in the community and supports people to stay at home, thus avoiding inappropriate admissions to secondary care.

4.15. As part of Better Care Fund initiatives, Hillingdon will develop the model further to:

- Embed social care within the current team to ensure that joint assessments and planning is undertaken for residents;
- Include mental health liaison as part of the core offer;
- Enhance the use of the third sector in supporting residents to be transported back home and in providing support for the few hours until mainstream services commence;
- Scaling up the integrated team to ensure that every resident who could be supported at home rather than a hospital receives an opportunity to be so supported;

- Embed seven day working across all the contributors to rapid response; and
- Create a joined up, single, intermediate care team which will include reablement, community rehabilitation, equipment, telecare and homecare.

Scheme seven: Early supported discharge

4.16. Hillingdon has initiated an early supported discharge initiative in conjunction with multiple partners within the system, i.e., secondary care, community services and social care. As part of the new development, Hillingdon will:

- Scale the service to a significant impact on number of overall bed days required, delayed transfers of care and excess bed days for non elective care;
- Develop a proactive cross-service hospital discharge team with input from social care, community services and the third sector;
- Agree a discharge protocol and process that starts on the day of admission of an older person to hospital;
- Draw up appropriate risk protocols shared between hospital clinicians, community clinicians and social care with proactive case finding within the wards;
- Bring primary care fully into the discharge process; and
- Ensure that services in the community facilitate discharge out of hospital in a safe and effective way.

Scheme eight: End of life continuing care budget

4.17. We will realign and better integrate the services we provide to people towards the end of their life. Our processes will be more seamless and enable health and social care staff alongside the third sector to provide support to patients and their families and carers around end of life care.

4.18. Key components will include shared care plans, aligned budgets and common development activity. We will also work towards a trusted assessment framework and local operating model between health and social care.

Scheme nine: Care / nursing homes initiative

4.19. Too many of our admissions are from care homes directly. A number of case studies show how the level of care in care and nursing homes can be enhanced by proactive support from a multi-disciplinary team from the community.

4.20. At Hillingdon, we have initiated a number of workstreams such as provision of mental health liaison and diabetes management support but we acknowledge that a lot more needs to be done to support people within care and nursing homes to improve their quality of life and retention of independence.

Scheme ten: seven day working initiative (enabler)

4.21. We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

4.22. In liaison with all our providers, The Hillingdon Hospital is to be an “early adopter” of the seven day working model in the NHS. Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

4.23. In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide a holistic service seven days a week.

Scheme eleven: Development of IT system across health and social care with enhanced interoperability

4.24. This is an important aspect of the delivery of integrated care in Hillingdon. We aim to enhance the interoperability of IT systems across health and social care organisations. As part of information sharing and governance (as part of the ICP), Hillingdon is working towards the creation of a single client centred identifier and shared information across different providers. Further work is required to ensure that care plans are accessible to social care and other parts of the system.

Establishing Performance Metrics for the plan

4.25. The guidance sets out five national and, therefore, mandatory metrics for BCF the guidance:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient/service user experience

4.26. In addition to the five national metrics, local areas are required to choose one additional indicator that will contribute to the payment-for-performance element of the fund. It is proposed to establish a local indicator in Hillingdon which monitors the number of shared care plans achieved. All indicators will be baselined during 2014/15 and the indicative baseline from 2012/13 is included in the Appendix 2 where available.

Engaging with Service Providers, Patients and Residents

4.27. The officer group that met to develop proposals included The Hillingdon Hospital and CNWL Community Health as two of the key service providers locally. The plan also reflects our accumulated intelligence on resident and patient engagement through a variety of fora, events and engagement opportunities.

4.28. Healthwatch Hillingdon has submitted its views as to how the BC plan should reflect local need. An initial workshop with partners in the voluntary and community sector to “road test” the approach included in the plan was held on 17 January 2014. Over twenty organisations were represented. Partners attending this first workshop have agreed to form a reference group for the BC plan moving forwards. A resident facing event is also proposed during February and a communications plan has been developed.

Governance

4.29. Appendix 1 sets out a broad approach to governance of the BC fund, reflecting the role of the Health and Wellbeing Board in leading this work and the need for approval through HCCG and Council governance structures. The requirement for Section 75 schemes also provides a further process for governance.