HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Claire Jackson Programme Director Integrated Commissioning
DATE:	21st June 2016

SUBJECT: Better Care Fund- quarter 4 submission and 2016/17 plan

1. PURPOSE

The purpose of this report is to:

- Provide Health and Wellbeing Board (HWBB) members with an overview of Better Care Fund (BCF) performance reporting for quarter 4 (January-March 2016) including progress in relation to delivery of the plan since the previous report to Board members in March 2016
- Provide HWBB members with an update on 2016/17 BCF plan submission

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- Note the BCF quarter 4 submission and progress made against delivering the BCF plan
- Note the submission of the 2016/17 Better Care Fund plan

3. BACKGROUND

The Blackburn with Darwen Better Care Fund plan submission was made on behalf of the Health and Wellbeing Board on 19th September 2015. Quarterly updates have been provided to Health and Wellbeing Board members to outline delivery progress to date and next steps. An update on planning requirements for 2016/17 was presented to HWBB members in March 2016.

4. RATIONALE

As outlined within previous reports to the HWBB, the case for integrated care as an approach is well evidenced. Rising demand for services, coupled with the need to reduce public expenditure, provides a compelling argument for greater collaboration across health, care and the voluntary sector.

The Spending Review set out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. This is reflected in the NHS Planning Guidance 2016/17-2020/21 Delivering the Forward View. The Better Care Fund remains a key policy driver to support integration of health and care services at a local level.

5. KEY ISSUES

Quarter 4 submission

The quarter 4 submission was made on 27th May following agreement with Joint Commissioning and Recommendations Group members and the vice chair of the Health and Wellbeing Board.

The template included a request for an additional section which allowed local areas to provide an overview

of delivery against national requirements. These included;

Statement	Response
Our BCF schemes were implemented as planned in 2015/16	Strongly agree
The delivery of our BCF plan in 2015/16 had a positive impact on the integration of health and social care in our locality	Strongly agree
The delivery of our BCF has a positive impact on reducing Delayed Transfers of Care	Agree
The delivery of our BCF plan had a positive impact in reducing the proportion of older people who were still at home after 91 days following discharge from hospital into rehabilitation and reablement services	Agree
The delivery of our BCF plan has had a positive impact in reducing the rate of permanent admissions of older people to residential and nursing care	Agree
The overall delivery of our BCF plan in 2015/16 has improved joint working between health and care in our locality	Strongly agree
The implementation of a pooled budget through a Section 75 agreement in 2015/16 has improved joint working between health and social care in our locality	Strongly agree
The expenditure from the fund in 2015-16 has been in line with our agreed plan	Strongly agree

Local areas were also required to provide feedback on the successes and challenges faced throughout 2015/16 in relation to delivery of the BCF plan. Following discussions at Joint Commissioning and Recommendations Group the following responses were submitted on behalf of the Health and Wellbeing Board.

Success 1	Delivering excellent on the ground care centred around the individual
Success 2	Developing organisations to enable effective collaborative health and care working relationships
Success 3	Leading and managing successful better care implementation
Challenge 1	Attributing the impact of individual schemes on outcomes
Challenge 2	Whilst emergency admissions have reduced we have seen an increase in costs. This is also reflected on the cost and complexity of social care packages
Challenge 3	There remains significant system wide pressure and capacity issues across health and care

Appendix 1 outlines delivery progress of BCF schemes during quarter 4.

2016/17 BCF plan

The Blackburn with Darwen 2016/17 BCF plan was submitted to NHS England on the 3rd May 2016, following sign off from the chair of the HWBB. The plan contains details of the following;

- Local vision for health and social care
- An evidence base supporting the case for change
- Narrative review of 2015/16 schemes
- A clear articulation of how we plan to meet national conditions
- Agreement of a local action plan to reduce delayed transfers of care and improve patient flow

- An agreed approach to financial risk share and contingency
- An overview of funding contributions to Better Care Fund
- A clear plan of how we will achieve national targets

The main addition to the 2016/17 planning process is the requirement to develop a local action plan to reduce delayed transfers of care and improve patient flow. A locally agreed plan was submitted which includes a 3% reduction in delayed transfers of care. This equates to a reduction of 134 bed days over a 12 month period.

Feedback on the plan, including the approval category, is expected to be received from NHS England during June 2016. Following this feedback, the Blackburn with Darwen BCF plan will be circulated to HWBB members and published in line with national requirements.

6. POLICY IMPLICATIONS

The key policy drivers are outlined within the main body of this report and within previous BCF papers presented to HWBB members. Local areas are expected to fulfil these requirements.

7. FINANCIAL IMPLICATIONS

Financial implications for 2016/17 were reported in the March 2016 update to HWBB members.

8. LEGAL IMPLICATIONS

Legal implications associated with the Better Care Fund governance and delivery has been presented to Health and Wellbeing Board members in previous reports. A Section 75 agreement is in place between the Local Authority and CCG which outlines risk sharing arrangements associated with the Better Care Fund and other funding streams aligned to integrated delivery locally.

9. RESOURCE IMPLICATIONS

Resource implications relating to the Better Care Fund plan have considered and reported to Health and Wellbeing Board members as part of the initial plan submission. Any further resource implications will be reported as they arise.

10. EQUALITY AND HEALTH IMPLICATIONS

Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.

Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care schemes, including new business cases and are integral to service transformation plans.

11. CONSULTATIONS

The details of engagement and consultation with service providers, patients, service users and the public have been reported to Health and Wellbeing Board members throughout development of the local BCF plan. Consultation and engagement will form part of business case development for any new BCF schemes.

VERSION:	**V3**

CONTACT OFFICER:	Claire Jackson
DATE:	6th June 2016
BACKGROUND PAPER:	Previous BCF reports to HWBB members

Appendix 1 – BCF Narrative quarter 4 2015/16

Our BCF Plan is currently on track to deliver against the Plan submitted to NHS England. Progress has been made in the following areas:

Early Intervention and Prevention

Building capacity within the voluntary sector (VCF) – The joint model of Information, Advice and Guidance services is fully operational and a single point of access for voluntary sector services is in place. Data shows the number of people supported through the integrated work has increased. There is now a single route of access into services and shared assessment process to accelerate support. Services are better aligned to the localities with representation on the Integrated Locality Teams.

Providers are working together to access external funding. A quarterly monitoring process is in place and there is joint working with commissioners to further strengthen the measurement of improvement of outcomes. The next phase in the single point of contract approach has been through procurement process and will see the integration of services for carers, information and support for isolated older people, and services to build resilience and empower vulnerable young people and adults such as those with substance misuse problems. Services will be in place from July 2016.

Further developments for phase 3 have commenced with the aim of implementing a fully integrated offer of voluntary sector services in localities, the work will be progressed through a stakeholder steering group.

Delivery of Age UK ' Here to Help' Integrated Care Programme has continued since July and included the piloting of in reach into hospital to identify patients awaiting discharge who may be appropriate for the programme. The programme sits alongside health and social care services, providing voluntary support through working as part of Integrated Locality Teams. Personal Independence Coordinators are assigned to carry out a home visit, complete a full assessment and coordinate all non-medical needs. The programme is targeted at patients with 2 or more long term conditions and who have experienced at least 2 emergency admissions in a 12 month period or meet other high risk criteria, and will be evaluated by the Nuffield Trust.

Co-ordination of dementia services - A dementia co-ordinator is leading the delivery of a joint plan to develop a Dementia Friendly Community in BwD. This has resulted in a significant increase in the number of Dementia Friends in the Borough from 471 in September 2014 to 2,802 in December 2015. There are now 72 dementia champions compared with 17 in September 2014. Dementia awareness sessions are being delivered regularly to professionals, individuals and organisations including residential homes. Businesses and GPs are becoming recognised as dementia friendly organisations. An annual report of progress and recommendations for future delivery was published in November 2015. This workstream is being reviewed as part of a wider service review of Dementia services across Pennine Lancashire.

Integrated Carers service - review of existing carers services undertaken, joint service specification developed and delivery has commenced. An integrated life course approach to Carers services will be in place from July 2016 as part of the phase 2 VCF redesign with the aim of fully integrating the carers offer with wider VCF services, reducing duplication and increasing reach. Engagement work with carers and professionals working with carers has taken place to inform these developments and the contract has now been awarded to the Families Health and Wellbeing Consortium who are also delivering the VCF activity referred to above.

Integrated Locality Teams (ILTs)

4 Integrated Health and Social Care teams (with links to Specialist Services, Mental Health and VCF services) have been established and continue to build relationships with Primary Care teams. A process

has been established to review existing care plans and use an agreed risk stratification tool to identify service users who require proactive care planning and intervention. Work is underway to develop a common case management framework that is underpinned by a single assessment and discharge process. Progress has been made and case management processes are in place and will be formalised through the framework between January and March 2016 and will be aligned to wider system developments across Pennine Lancashire. Considerable work has been undertaken to identify suitable office accommodation to house the ILTs across 4 localities to align the teams to bases close to the GP practice population.

Memory assessment services are now offering scheduled appointments in agreed GP surgeries across the 4 localities and are aligning to ILT working to improve access and quality of services offered to patients living with dementia.

BwD CCG and Borough Council are working together to link the 4 ILTs housing interventions that will potentially deliver health and wider social improvements. The interventions will be delivered by the Borough's DASH (Decent And Safe Homes) service.

Intermediate Care including integrated discharge and discharge to assess

An Integrated Discharge Service model commenced operation in September 2015. The emerging model supports the role of trusted assessor, aligning health and care assessment activity. Work has commenced in BwD to develop an out of hospital single point of access to enable more timely discharges and increase capacity in the hospital.

Additional health and social care capacity is in place to support 7 day discharge. The capacity is being utilised to support discharges and to prevent admissions. Intermediate care provision has been reviewed and the model of care has been aligned for sub-acute, intermediate care and discharges to assess beds commissioned by CCG and Local Authority. Flexible use beds have been commissioned, which can offer a more responsive approach to the delivery of sub-acute and intermediate care dependant on need. The new model of care will ensure that all commissioned beds can be utilised flexibly. The main principle for intermediate care will be that a patient's own bed be the first option considered and care be provided in a residential setting.

Intensive Home Support

The service was reviewed in November 2015 to ensure greater utilisation and has been further developed to promote a more streamlined pathway supporting 7 day discharge and admission avoidance. Plans are now in place to blend the IHS model with ILTs in the community, to utilise the Rapid Assessment Teams within the hospital to deflect admissions, make greater use of the community Intravenous antibiotic team to deliver in the community and supporting early discharge. A specialist Chronic Obstructive Pulmonary Disease team are in place and complex case managers are being recruited to proactively identify patients at risk of hospital admission and manage in the community. GP Medical oversight model for Intensive Home Support is in place and access to the service is via the Care Navigation Hub.

Care Navigation Hub/Directory of Services (DoS)

Launched December 2014 and provides a single contact point to support Health and Social Care services across Pennine Lancashire, working with ILT's in local delivery of services through detailed DoS, including more than 800 services, to identify service options or make referrals as required. The navigation hub provides prompt, clinical advice to support navigation through out of hospital services and is being utilised by health and social care services to mobilise services and triage and carry out assessment for access into Intensive Home Support Services.

Better Care Fund 2016/17

2016/17 plan with the joint agreement of commissioning intentions across CCG and Local Authority has been submitted to NHS England. Commissioning intentions issued by the CCG signal to providers how

services will be further integrated to support joined up local delivery. Across Pennine Lancashire, work is underway to further align plans and provide a consistent out of hospital offer to support residents across a wider health and care footprint, whilst ensuing that localities and general practice receive the support required to reflect population need.