AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

17th December 2015

REPORT OF: Head of Programme and Change Management

STOCKTON BETTER CARE FUND – QUARTERLY PERFORMANCE

SUMMARY

The purpose of this paper is to update the Health and Wellbeing Board on the progress of the implementation of the Better Care Fund and to provide the Board with a copy of the quarter 2 2015/16 Better Care Fund quarterly performance submission.

RECOMMENDATIONS

It is recommended that Health and Wellbeing Board:

1. Note the progress of the implementation of the Better Care Fund
2. Note the Better Care Fund Q2 2015/16 performance submission

BACKGROUND

1. The Better Care Fund (BCF) revised document was approved by the Health and Well-being Board at its meeting on 20th September 2014 and was submitted to the Department of Health. The plan has now been 'Approved'.

DETAIL

Extension of the Better Care Fund

2. The Better Care Fund was originally set up for a year so that the impact of the fund could be measured. A letter was sent to the Chairs of Health and Well-being Boards on 16th October stating that the Better Care Fund will be extended into 2016/17.

3. As you will all be aware, the government published the Spending Review on Wednesday 25 November[1]. The important points relating to the integration of health and social care, including the Better Care Fund, include:
   - The government will continue the Better Care Fund, maintaining the NHS's mandated contribution in real terms over the Parliament.
   - From 2017, the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the Better Care Fund.

[1] Text from the weekly Better Care Fund update note from Anthony Kealy 2/12/15

- A commitment of over £500 million by 2019-20 for the Disabled Facilities Grant.
- The creation of a new social care precept to give local authorities who are responsible for social care the ability to raise new funding to spend exclusively on adult social care. This will allow local authorities the flexibility to raise council tax in their area by up to 2% above the existing threshold, to spend on adult social care.
- The intention 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. The government will not impose how local areas deliver this plan for integration, but the Spending Review sets out a number of different approaches that could be taken.

Stockton Better Care Fund Plan

4. The Stockton Better Care Fund plan is broken down into two main schemes and five enablers:

Main Schemes	Enablers
Multi-Disciplinary Service	7 day working
Dementia Pathways	Joint Assessments
	Digital Health
	Narrowing Health Inequalities
	ICT Systems and Data Sharing

Multi-Disciplinary Service (MDS)

5. Set out at appendix 1 is a diagram of the whole MDS. It is made up of a MDS Manager and a team of six Well-being Facilitators who undertake holistic well-being assessments and develop holistic care plans. A number of services will be co-located with this team to ensure the right professional support is available within the MDS.

6. Critical to the success of the Better Care Fund, and the MDS is its referral pathways. Wherever possible the MDS will refer to the Voluntary and Community Sector who have been integral in the design and development of the BCF services. A good example of this is the Stockton Welfare Advice Network who were co-located with the team from the outset and the Stockton Service Navigation Project which has supported the Well-being Facilitators to understand the VCSE services that are available.

7. The new MDS Well-being Facilitator service went live on 12th October 2015. Initially it took referrals from First Contact Adults and in addition to these, since mid-November they have been taking referrals from the Rapid Response Community Health team. From the New Year the team will start to look at the top 2% in greatest need on the GP registers.

8. We are now in the process of review further services to determine how they best link with the MDS:

    - Housing Occupational Therapy

- Intermediate Care and Reablement
- Falls Service Review (being undertaken by Public Health)
- Single Point of Access – Triage capability
- Intensive Community Liaison Service – additional services to support the MDS

Dementia Pathways

9. The Dementia Strand is developing several projects to support people with dementia and their carers through the journey of the condition and promote a greater understanding of the causes and consequences of dementia.

10. A consultation event was held in July 2015 with service providers and people with a diagnosis of dementia and their carers. From this event we have developed five pilots:

    1. A leaflet to encourage people with cognitive impairment to seek help and get a diagnosis.

    2. Funding for the existing Dementia Advisor Service for a further 12 months so that we can measure the impact and benefits of the service. It provides ongoing information, advice and support for people with undiagnosed or diagnosed dementia and their carers.

    3. We are establishing a one-to-one and group maintenance cognitive stimulation therapy service to provide meaningful activities and education to improve individuals' cognitive function and psychosocial well-being. This service also provides support for carers and gives them chance to take a few hours break to increase their resilience.

    4. There will be a project to facilitate people with dementia and their carers to become 'expert dementia champions' to promote dementia to the public and private organisations and take part in voluntary work to increase their community involvement.

    5. A tailored training programme is being developed to skill up the workforce in the community (Health, Social Care, VCSE, Private Sector) to increase their responsiveness and appropriateness in service delivery.

    Other business cases are being developed to provide services to prevent crisis and support carers.

7 Day Working and Joint Assessments

11. 7 day working and joint assessments were two of the national conditions specified as part of the BCF requirements.

12. There are a number of services which are already delivered 7 days a week and the new Well-being Facilitators will work 7 days a week from sometime early in the New Year. A piece of work is underway to look at the value and

benefits of the current 7 day services and identify any gaps which will support the following main objectives:

- prevent admission to hospital
- prevent permanent admission to nursing or care homes
- facilitate discharge from hospital

13. Holistic health and well-being assessments are being undertaken by the Well-being Facilitators.

Digital Health

14. There are two digital health pilots underway:

    - Falls prevention in Care Homes

    - Pilot of offering people with early diagnosis of dementia telecare and recommendations of home environment based on the dementia friendly design principles – to support people with dementia and their families and carers

Narrowing Health Inequalities

15. There are two projects under this strand:

    - Stockton Service Navigation Project – training and support for the Multi-Disciplinary Service
    - Warmer Homes Healthy People

ICT Systems and Data Sharing

16. An ICT strategy has been developed for the Better Care Fund. This sets out the ambition for how data can be shared across health and social care. The first priority will be the implementation of the Medical Interoperability Gateway which is a system which brings together all the primary care systems. It is hoped that this system will be implemented by June 2016.

17. A specification is being developed for the full integration of Social Care, Acute Trust, Primary Care, Community Care, Mental Health data.

18. Building on Better Care Fund and the Five Year Forward View, the National Information Board NHS England has recently published a document 'The Forward View in Action: Paper Free at the Point of Care – Preparing to Develop Local Digital Roadmaps.

19. The Five Year Forward View made a commitment that by 2020 there would be "fully interoperable electronic health records so that the patient's records are paperless".

20. By April 2016, as part of the annual Clinical Commissioning Group planning process, CCGs will be required to submit plans – local digital roadmaps – for how their local health and care economies will achieve the ambition of being paper-free at the point of care by 2020. The Better Care Fund ICT project will now be part of this project.

Governance and Accountability

21. There has been a Pooled Budget Partnership in place since April 2015. Its role is to oversee the Section 75 pooled budget and to receive performance and progress updates.

22. A requirement of the Better Care Fund is to submit quarterly performance returns to NHS England. In line with previously agreed procedure, the Chair of the Health and Well-being Board signed off the Q2 return, which was submitted on 27th November 2015, subject to Board oversight at this meeting.

23. The Quarter 2 2015/16 submission was approved by the Pooled Budget Partnership Board on 25th November 2015 and is attached at appendix 2. There are no issues to report to the Board as good progress is being made in the delivery of the plan.

24. There is now a requirement to complete a self-assessment of progress against the original Better Care Fund plan. The purpose of the self-assessment is to reflect on 2015/16 and to plan for 2016/17. It provides an opportunity to ensure that the Better Care Fund is aligned to the Clear and Credible Plan.

Communications and Engagement

25. A communications and engagement team has been established and a communications plan has been developed. The priority stakeholders for engagement are:

- Service Users / Carer and Advocates
- GP's
- Carers Services

26. A lot of consultation and engagement has already taken place, the priorities reflect those areas where more engagement is needed.

FINANCIAL AND LEGAL IMPLICATIONS

27. Financial risks have been assessed and contingency arrangements have been developed to mitigate the risk of not delivering the performance targets set out in the BCF plan.

RISK ASSESSMENT

28. The BCF requires partners to develop a shared risk register and have an agreed approach to managing and sharing risk. The BCF Plan also identifies proposed contingency arrangements in the event that the expected reductions in emergency admissions are not achieved.

COMMUNITY STRATEGY IMPLICATIONS

29. The BCF plan supports the delivery of the Stockton-on-Tees Community Strategy and Joint Health and Wellbeing Strategy. Making a significant contribution to a number of the key themes including; healthier communities and adults; helping people to remain independent; improved access to integrated health and social care services and promoting healthy living. The BCF plan also focuses on older adults, one of the key supporting themes in the community strategy.

CONSULTATION

30. The BCF plan has been jointly developed and agreed with key stakeholders from the LA, CCG, primary care and community, acute and mental health service providers. The current plan was approved by the Health and Well-being Board at its meeting on 20th September 2014. The plan has been informed by a range of engagement activities, involving service users, carers, families and the public, that were already underway focusing on a range of local health and social care services.

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APPENDIX 1 – DIAGRAM OF THE MULTI-DISCIPLINARY SERVICE