Lancashire health and Wellbeing Board
Meeting to be held on 29th April 2014

Electoral Division affected: All

Lancashire Better Care Fund Plan
(Appendix A refers)

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Executive Summary

Increases in demand for health and social care services, an ageing population widening health and social inequalities, and financial constraints require transformational change for all agencies working in Lancashire to shift resources to where they will make the biggest positive difference.

The Government will introduce a £3.8 billion pooled budget for health and social care services, known as the Better Care Fund to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The Fund will largely not provide new money but require a pooling of existing resources to be managed under a section 75 agreement with individual Clinical Commissioning Groups (CCGs). The allocations denote the minimum contribution that CCGs and Local Authorities must contribute but more can be added over time to facilitate the required strategic shifts. The requirement to have a Better Care pooled fund is now being enshrined in legislation through the Care Bill.

In Lancashire the allocations for the Better Care Fund 2015/16 amount to £88.930m and include allocations for Disabled Facilities Grant, and some elements of the Care Bill implementation.

The Fund requires joint plans that focus on key high impact changes that will support sustainable integrated working and service delivery to shift activity away from the Acute Hospital sector to enhanced supports being available in the Community. At the same time emphasis should be on improving the health, capacity and resilience of individuals, families and communities to avoid or delay hospital admissions and long-term care. Importantly, plans will build on existing work streams across Lancashire, which already include changing the system for long term conditions and urgent care, with the aim of using the Fund to accelerate the transformational changes already being planned.

The Health & Wellbeing Board delegated responsibility of signing-off and submitting the plans to the Chair and Deputy Chair.

Lancashire County Council

Initially the Health & Wellbeing Board, via the Chair and Deputy Chair, submitted draft plans at CCG level which had been agreed by LCC and the CCGs to NHSE in accordance of our understanding of the submission requirements. These first drafts were submitted by the Health and Wellbeing Board (HWB) to NHS England on 14 February 2014. Since then it has been clarified that Lancashire County Council and its CCG partners are required to submit one plan which covers Lancashire. After close liaison with the CCGs, the CSU and LCC and through the Joint Officers Group (JOG) we submitted our Lancashire plan to NHSE on April 4th.

The Health & Wellbeing Board expects further dialogue with NHSE around areas within the BCF plans which are still to be fully agreed upon. These will include Section 75 agreements, risk sharing, hosting arrangements and performance management.

In 2014/15 additional funds will be allocated to promote integration and delivery of the national conditions.

Plans must deliver:

- Protection for social care services; this includes preventative services that may have otherwise had to be cut, but also by reducing on-going care costs via rehabilitation and reablement, use of community assets and reduction in the use of long term residential care.
- 7-day services to support discharge from hospital
- Data sharing and the use of the NHS number
- Joint assessments and lead professionals for people with complex needs

Approximately 25% pooled funds will be performance related and expected to deliver improvements in

- Reducing delayed transfers of care
- Reducing emergency admissions
- The effectiveness of reablement
- Reducing admissions to residential and nursing care
- Patient and service-user experience – national guidance awaited
- The impact of a locally determined performance outcome measure – this will focus on levels of diagnosis for dementia.

CCGs are required to submit 5-year strategic, operational & financial plans, with the first two years at an operational level of detail and the timing for the Better Care Fund is aligned with the CCG 2-year operational plans.

Recommendation

The Health & Wellbeing Board is asked to:

i) Note the BCF submission, which has been signed off by the Chair and Deputy Chair of the Health and Wellbeing Board.

ii) Note the potential performance and financial risks to partners and the approach being taken to mitigate those risks.

Background and Advice

The Better Care Fund (BCF) plan focuses on those high impact changes that will be delivered through integrated service delivery and sustainable shifts in activity from the Acute Hospitals to the care and health interventions and support being delivered in the community. These shifts are predicated on the need to provide comprehensive and accessible universal and targeted everyday supports to people in their neighbourhoods that tackle the wider determinants of health and well-being e.g. advice and information, housing, nutrition, loneliness etc.

The emphasis will continue to be on improving the capacity and resilience of individuals, carers and families to thrive in their communities, and where people have ill-health or disability for them to receive care and support that wherever possible helps them to manage their condition.

Existing work streams will continue and there is a real opportunity to use the Fund to accelerate the transformational changes already planned. The Fund includes specific allocations for carers and provides an opportunity to review the way services support carers in the major contribution they make, which reduces the impact on statutory services significantly.

The focus of the Better Care Fund plan is on integration which is consistent with direction and requirements of the Care Bill. At this stage the focus of the required plan is on frail elderly populations and those with long term conditions such as respiratory disease and dementia. Plans have to demonstrate that people with mental health problems have equal access to the reviewed services and support structures. In future years the Lancashire BCF plan will be developed to address specific areas of mental health, children's health, and drug and alcohol issues, (although it should be noted that work continues to address these areas through individual partner strategic plans).

Although the individual CCG plans that have been produced are clearly tailored to localities in terms of delivery, there are consistent themes around the way that we need to work in the future which has implications for how some of the functions of the council may need to be structured in the future.

The Lancashire plan provides the following narrative:

Increasingly localities or neighbourhoods will be identified around registered populations for a number of GP practices. Typically, this means natural communities of 35000-50000 people.

As part of the integration, wrap around support to promote the determinants of good health and well-being will need to be developed and strengthened around existing community assets. This will be delivered by the Integrated Health and Well-being

Framework being developed which will look to remodel current services and spend across Help direct, Supporting People, and VCFS etc. at a local level.

Those populations will be supported by neighbourhood teams, compromised of health and social care professionals with easy access to this everyday support for their health and well-being (predominantly asset based) and access to reablement and rehabilitative support as a first response to people not coping with their personal care.

Neighbourhood teams working with these populations will identify those most at risk of deterioration in their health and at risk of being admitted to hospital, or long-term residential care unnecessarily. They will help them manage their long term conditions and plan appropriate and flexible responses to crises or deterioration.

Teams will need to develop new roles, skills and trusted relationships that reduce duplication of assessment, allow speedy shared access to the support people in their neighbourhood/locality need and be able to pull in more specialist services as and when needed. Those people with the most complex needs and risks will have case managers or coordinators so that individuals, carers and families have a consistent and reliable point of contact. Teams will need to be skilled in clinical areas that will be carried out in the future outside of the hospital environment, to develop the virtual ward type supports available at home.

When people are in crisis there are coordinated and accessible services to maintain people in their own home wherever possible. Out of hours GPs, Emergency Departments and crisis services will be able to access people's information via web services so that they are aware of the support already in place, can make sure they respond in a way that respects people's wishes and is compliant with people's agreed contingency plans.

For those that do require admission, early planning and safe and integrated and streamlined discharge facilities will be available across 7 days so that people stay in hospital for the least amount of time necessary. People will not be required to make long term decisions about their future from a hospital bed but can be given access to rehabilitation/recuperation services from where the next steps can be planned.

For people with complex needs the neighbourhood team will "reach into" the hospital to coordinate the discharge as they will know the person well.

The neighbourhood teams will develop more integrated practices with social care providers in their neighbourhoods. This will mean that care homes and domiciliary providers will become extended members of the team and will have access to professional support to help people maintain their independence, avoid deterioration in their health and social circumstances and avoid unnecessary hospital admission.

The range of current initiatives and functions that support care homes will be coordinated and targeted to improve quality and help reduce the amount of activity escalated under safeguarding procedures.

Funds for Disabled Facilities Grants (DFGs) will be channelled through this BCF fund. This provides an opportunity through redesign with the district councils to ensure equity of access and secure the links between the provision of adaptations and maintaining people's independence. This support will contribute to the outcomes described below.

These integrated arrangements described in the BCF are meant to reduce the reliance on inpatient hospital care and achieve:

- A reduction in delayed transfers of care from hospital
- A reduction in emergency admissions
- The demonstrable effectiveness of reablement in reducing long term care costs
- A reduction in admissions to long term residential and nursing care
- Improved patient and service-user experience
- The impact of a locally determined performance outcome measure

Sign off of the Better Care Plan for Lancashire rests with the Health and Wellbeing Board Chair and Deputy Chair and was submitted by 4th April 2014 to NHS England.

In the 1st-cut submission, LCC and the CCGs had not yet agreed the performance metrics and targets. Since then, with help from the CSU and NHSE, partners have agreed which performance metrics we will use to help to measure progress and performance and we have also agreed targets for those metrics.
The plans themselves now include agreements on certain key performance indicators (metrics), targets for those metrics at a CCG level and Lancashire level and a draft performance management and governance framework. This framework describes how performance will be reported through the host organisation and will be managed by the Health & Wellbeing Board through JOG. The Board will receive regular performance updates – on an exceptions basis – and recommendations from JOG.

Understandably, given the embryonic nature of this complicated landscape, accountability of performance, risk sharing, Section 75 agreements and the hosting of the BCF are still to be agreed and further engagement with the affected stakeholders will continue until we reach agreement. We await guidance from NHSE but will continue to engage in anticipation.

Consultations

As part of the BCF planning processes at an individual CCG level and at a county level a wide range of consultation has been undertaken. This is described in the plan but includes Health and Wellbeing Board and Partnerships, Health and Social Care Providers, VCFS, Health Watch, CCG Governing Bodies, and Patient and carers forums.

Implications:

This item has the following implications, as indicated:

Financial

For each contributing organisation, the table below lists any spending on BCF schemes in 2014/15 and also identifies the minimum and actual contributions to the pooled budgets from 2015/16.

Organisation	**Spending on BCF schemes in 2014/15 £000**	**Minimum Contribution (2015/16) £000**	**Actual Contribution (2015/16) £000**
Lancashire County Council	5,541	9,438	9,438
NHS West Lancashire CCG		7,419	7,419
NHS Lancashire North CCG		10,462	10,462
NHS Greater Preston CCG		13,223	13,223
NHS Fylde and Wyre CCG		10,961	10,961
NHS East Lancashire CCG		26,095	26,095
NHS Chorley and South Ribble CCG		11,332	11,332
BCF Total	**5,541**	**88,930**	**88,930**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. The partners are required to outline plans for maintain services if planned improvements are not achieved.

The plan for Lancashire includes two main elements i.e. planning for the effect of the holding back of any proportion of the c25% of the BCF to be paid for improving outcomes itself and the potential dual-funding required if existing services need to be maintained at the same time as the investments made in new schemes and services. The partners have agreed to collaboratively develop measures to mitigate the financial impact of these risks. These measures may include:

- A formal risk-share agreement;

- An initial contingency reserve that could be utilised to part-maintain existing services;

- On-going detailed performance management and finance monitoring to enable decisions to be taken at the earliest opportunity to enable actions to be put in place quickly which will either reduce the financial impact of any under-delivery of planned improvements or enable a re-prioritisation of available resource into those areas which are having the most significant impact on performance.

Discussions with partners to date indicate that the above measures would be actioned under five separate section 75 pooled arrangements, one for each CCG (with Chorley and South Ribble CCGs combined), however, these pools would operate under a single Lancashire framework.

Additionally, partners have recognised that the wider context of considerable reductions in Local Government funding in the medium term has the potential to adversely affect the performance indicators upon which BCF performance payments are to be based. Also, the inclusion of the funding for some elements of the impact of the Care Bill in the BCF has the potential to put additional financial pressure on the pooled finances if the allocations for these impacts are not sufficient to meet the requirements. Partners will need to keep these issues under review, and agree mitigating actions as appropriate.

Risk management

In 2015/16 the Better Care Fund (BCF) will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and the Council. A condition of accessing the money in the Fund is that CCGs and Councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

The BCF is intended to provide a means for joint investment in integrated care, which ought to reduce the pressure on social care and hospitals by providing treatment before a crisis. CCGs will have to make significant efficiencies to generate the money to invest in the BCF, and there is a risk that if BCF plans do not deliver the anticipated results, e.g. reductions in residential care admissions or reductions in emergency hospital admissions. Resources will be needed to meet this excess demand, e.g. funding care packages or extra staff for A&E.

Approximately 29% of the revenue funding in the BCF is paid for improving outcomes. Plans for maintaining services will need to be outlined for the scenario where planned improvements are not achieved. The official BCF template will capture these contingency plans.

Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be coordinated by NHS England, with the support of the Local Government Association (LGA).

If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

In addition to meeting the conditions of the fund, and achievement of performance targets, the BCF includes NHS funding for carers' breaks therefore local plans are expected to set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement.

Legal

In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and councils.

Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003. This will ensure that the DFG can be included in the Fund

Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

The Department of Health (DH) and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m nationally of which £3.073m relates to Lancashire) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

Personnel

The development of neighbourhood teams and wider workforce development will potentially change individual roles and responsibilities of some Lancashire County Council Employees. There is not yet a consistent view on how social work roles will relate to these teams and whether teams will be co-located or whether there will be integrated management arrangements. The requirement for hospital discharge to be facilitated over a seven day period will also require potential changes to working patterns and potentially terms and conditions.

Property Asset Management

The development of neighbourhood teams may mean that staff needs to be co-located with other professional groups.

Procurement

Changes in pathways and the range of out of hospital services will require ongoing commissioning and procurement activity.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
The Better care Fund for Lancashire templates 1 and 2	April 2014	Mike Banks, Adult Services, Health and Wellbeing Directorate 01772 536287

Reason for inclusion in Part II, if appropriate

N/A