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PUBLIC REPORT

HEALTH AND WELLBEING BOARD

26 January 2016

PLANNING FOR THE BETTER CARE FUND 2016-17

Report of the People Directorate

Strategic Aim: Meeting the health and wellbeing needs of the community

Exempt Information: No

Cabinet Member(s) Responsible: Mr R B Begy , Leader and Portfolio Holder for Culture

Contact Officer(s): Mark Andrews, Deputy Director for People | 01572 758339 mandrews@rutland.gov.uk

Ward Councillors: Not Applicable -

DECISION RECOMMENDATIONS

That the Health and Wellbeing Board (HWB):

1. Notes the process for drawing up the 2016-17 Better Care Fund plan, the associated national timetable and the HWB role in approving the plan.

2. **Notes that the current draft Better Care Fund plan is provisional and may be subject to change, as national technical guidance and funding allocations are still awaited.** The Rutland Integration Executive is also due to review the proposals on 21 January.

3. Endorses the current draft Better Care Fund plan and budget for 2016-17 for initial submission, as set out in Appendix B, potentially conditional on adjustments following HWB input.

4. Agrees the final approval process for the plan which may require the HWB to approve the plan outside its normal meeting timetable.

1 PURPOSE OF THE REPORT

1.1 The 2015-16 Rutland Better Care Fund (BCF) plan is currently three quarters of the way through implementation, and planning is underway for the 2016-17 period.

1.2 The purpose of this report is:

a) to set out the process and timetable for drawing up the 2016-17 Better Care Fund plan and to confirm its approval timetable and approach;

b) to present the draft Better Care Fund plan and budget for 2016-17 (Appendix B) for HWB feedback and initial endorsement prior to the first plan submission on 8 February 2015; and

c) to agree the final approval process for the plan, which may require the HWB to approve the plan outside its normal meeting timetable.

2 PROCESS AND TIMETABLE

2.1 The current Rutland Better Care Fund programme, which is a joint Local Authority/CCG transformation programme for health and social care, runs until the end of March 2016.

2.2 The high level timetable for agreeing the 2016-17 plan is as follows:

		National milestones	Local milestones
Evaluation and initial preparation	October 2015	National evaluation tools issued.	
	Nov-Dec 2015		Interim evaluation of 2015-16 BCF programme, including new projects workshops
	Dec 2015-early Jan 2016		First draft of 2016-17 programme
Submission round 1	? January 2016	Issue national guidance on BCF 2016-17 and confirmation of minimum budget.	
	21 January 2016		Rutland Integration Executive feed back on draft outline BCF programme 2016-17.
	26 January 2016		Rutland Health and Wellbeing Board feed back on draft outline BCF programme 2016-17.
	8 February 2016	First draft of plan submitted for assurance/moderation – high level plan.	
Submission round 2	18 February 2016		S75 Partnership Board –further refinement - budget and performance metrics. Approval in principle of the joint proposals.
	End Feb/Early March 2016		Moderation feedback received and plan updated.
	Mid March 2016	Refresh due, based on moderation feedback	NB: Date tbc, but **locally, submission after 24 March would be preferable.**
	22 March 2016		**If moderation timetable allows, sign off by Health and Wellbeing Board

	24 March 2016		S75 Partnership Board – final refinements.
Submission of signed off plans	Mid-late April 2016		**Otherwise, sign off by Health and Wellbeing Board by correspondence.
	Mid-late April 2016	Final submission, signed off by Health and Wellbeing Board	

2.3 The Health and Wellbeing Board's approval is required for the new programme.

2.4 To be able to meet the development timetable, provisional work on the 2016-17 Better Care Fund plan has been in progress since November 2015, although full technical guidance on the new BCF programmes and confirmation of budgets are still awaited. **This means that the programme as presented must be seen as provisional at this time and that any aspect may be subject to change before the next version is circulated.**

2.5 The new draft programme is presented as Appendix B. This is to enable the Health and Wellbeing Board to feed its initial views into the programme at the 26 January meeting, before the first high level submission deadline of 8 February 2015.

2.6 Following local assurance and updating, a revised programme will be presented again to the Health and Wellbeing Board for their approval. This is anticipated to be at the 22 March 2016 meeting. However, the assurance timetable at this point is not fully confirmed, and may depend on local factors which mean that this deadline cannot be met. **Therefore, if required, the Health and Wellbeing Board is asked to indicate their preference for a means to agree the programme outside the normal sequence of HWB meetings (eg. by correspondence or delegation to a subset of the Board).**

2.7 The 2016-17 Better Care Fund Policy Framework (see Background Paper) released on 8 January confirms a number of things:

a) **Funding:** The BCF in 2016/17 will comprise £3.9bn nationally, and an additional £1.5bn will be placed in the fund (via LAs) by 2019/20.

b) **Pay for Performance:** The pay for performance instrument (worth £1bn nationally) that was linked to emergency admissions in 2015-16 is being discontinued in 2016-17.

c) **DTOC and admissions avoidance:** In place of this, BCF plans will be required to have locally agreed targets and action plans for improving delayed transfers of care, and will need to demonstrate how the local allocation of the £1bn is being spent on out of hospital NHS commissioned care. This can include a wide range of community services including social care. Finalisation of the detail around this has been the cause of the delays to the issuing of national technical guidance.

d) **National conditions:** BCF plans will be subject to the same national conditions as in 2015/16 (e.g. local agreement of plans, data sharing, use of NHS number, protection of adult social care, 7 day service delivery, joint

approach to care planning, confirmation of impact on providers) plus the new DTOC and out of hospital care conditions noted above. The requirements are described in more detail in Annex A of the policy guidance background paper.

e) **Emphasis:** The twin aims of avoiding emergency admissions and accelerating transfers of care out of acute settings remain key priorities.

f) **For the DTOC condition** – a stretching local target should be set for DTOC improvement using the existing metric of delayed days per 100,000 population. Local areas are advised to consider using a DTOC risk sharing agreement especially where DTOC rates are high/rising. Local areas are to set an action plan which incorporates national guidance such as the 8 high impact changes for DTOC, and demonstrate how capacity is being maximised across the system and how provider markets are being developed in support of hospital discharge. There is also a requirement to show engagement with independent and voluntary sectors in delivery of this national condition.

g) **The planning process:** Brief narrative plans along with a finance and metrics excel template (to be published imminently) are expected to be required. Plans are to be agreed locally by Councils and CCGs and signed off by Health and Wellbeing Boards and will be subject to regional assurance. Assurance will focus on plan quality and risks to delivery. Plans may be approved, approved with support or not approved.

h) **Assurance:** Quality Assurance of plans will then take place nationally via the Integration Partnership Board which comprises DH, DCLG, NHSE, LGA and ADASS (diagram at Annex B of the guidance).

i) **Wider context:** By 2017, each BCF area must also agree a medium term plan for integration of health and social care by 2020. These will run in parallel with and need to be coherent with the NHS Sustainability and Transformation Plans (STP) 2016-2020 (the footprint of the local STP is likely to be Leicester, Leicestershire and Rutland, mapping to Better Care Together).

j) **NHS planning:** Plans need to be coherent with the wider NHS planning guidance issued in December 2015. (The plan has been developed relative to this).

2.8 The initial draft 2016-17 BCF plan is presented at Appendix B. The document sets out how the new programme was developed and what factors have been taken into account in shaping it, including:

k) regular programme monitoring and performance reports,

l) the moderated interim evaluation of the 2015-16 programme (summarised in the plan on p3-5 and in Plan Appendix 1 and informed by a national framework addressing six domains of integrated care (see Appendix A).)

m) the November/December new projects workshops (summarised in the plan on p6 and in Plan Appendix 2),

n) iterative dialogue with partners (including via the 21 January Integration Executive discussion)

o) relevant plans and strategies locally, including (notably the Health and Wellbeing Strategy, the LLR Better Care Together (BCT) programme and Urgent Care Vanguard, the Rutland Adult Social Care Strategy and the ELRCCG Community Services Strategy),

p) regional networking and relevant national health and care research.

2.9 Strong continuity is proposed with the current BCF programme, but with changes built in to build on the progress and learning secured during the current programming period.

2.10 The proposed aim of the 2016-17 programme is that: **"By 2018 there will be an integrated social and health care service that is well understood by users, providers and communities and used appropriately, has significantly reduced the demand for hospital services and puts prevention and self management at its heart, including by building on community assets."**

2.11 Four priorities are proposed, summarised in the table below, and set out in fuller detail in Appendix B (including diagrams showing the connection between current and future schemes and scheme level descriptions):

a) **Unified Prevention** - broadened and made more coherent rather than scheme based, with opportunities for more coordinated responses through a new commissioning model;

b) **Long Term Condition Management** - a key opportunity to reduce health and social care demand, therefore expanded beyond falls and dementia and strengthened through proposals for enhanced complex case management and community health and social care integration;

c) **Crisis response, transfer and reablement** - where consolidation of progress to date, including with key acute services outside LLR, is the focus to reduce non elective admissions and delayed discharges; and

d) **Enablers** - including IT, information sharing and joint commissioning.

2016-17 BCF Priorities	Proposal	Impact on service users
Unified prevention services	• Make it easier to find out what services are on offer locally to support health and wellbeing, by further developing the Rutland Information Service as a joint platform for the public, professionals and advocates. • Bring prevention services in Rutland communities into a more coherent, consistent offer, including housing expertise and support to carers, including by using a new commissioning model. Build community capacity so communities are more self sufficient. • Provide better coordination and communication of the offer in communities and via trusted primary care settings so that local people have easy access to information, help and advice.	• People keep themselves well and know where to go to get information and advice if needed about what is available in their communities. • People feel supported to live independently at home. • Delaying the need for invasive and costly care packages. • Equipment provides peace of mind for users. • Patients can manage their own care. • More self sufficient, self sustaining communities, tackling social isolation.
Long term conditions	This priority addresses the support offered by primary and community health and social care for patients with long term conditions and the frail elderly, including through: • Enhanced approaches to care management and support planning (building on the care coordinator approach), including anticipating and reducing needs. • A review of care pathways. • An integrated system spanning primary care and community based health and care services in and out of hours. • Consolidating, integrating and extending a number of Rutland's community health based services into one 24/7 service operating across health and social care – to focus on maintaining independence in the community for as long as possible.	• Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness. • Service users feel in control of their care. • Service users feel supported and that their needs are understood. • Service users are better able to manage their condition(s). • Service users are able to stay as well as possible for as long as possible.
Crisis response, transfer and reablement	• Rapid response services avoid unnecessary hospital admissions and residential care for those needing urgent assistance. • Significant improvements in the timeliness and effectiveness of discharge pathways from hospital, especially for frail older people by consolidating new approaches to transfers of care. • Optimised independence and recovery when returning home.	• Reassurance for the service user and their family that there is effective support closer to home reducing likelihood of being admitted to hospital. • If they must be hospitalised, patients return sooner to a community setting, rather than deconditioning in hospital. • People can more easily resume their normal lives on their return home, maintaining independence. • Choice for end of life patients who may want to remain at home.

		• Acute beds are freed up for acute needs.
Enablers	IT and Information Governance facilitate integrated care rather than being a barrier to it. Integrated commissioning is progressed as an important transformational enabler.	• Health and social care systems will be aligned/joined up with a common dataset so patients are asked less often to tell their story and can receive improved service. • Joint commissioning drives integration and reduces duplication, reducing overall costs of care.

3 DISCUSSION TO SUPPORT THE EVALUATION AND REPLANNING PROCESS

3.1 To support the replanning process, the views of the Health and Wellbeing Board are invited on the 2016-17 draft BCF plan.

3.2 Observations

e) We will need to work up an action plan for DTOC prevention 2016-17, building on national guidance about how to strengthen DTOC responses around both planned and unplanned hospital stays. Recent East Midlands events have prepared the ground for this work. The high use of out of area acute services is a particular aspect to address locally. In 2015-16, DTOC performance overall has been fairly good, but is not yet robust and has tended to be vulnerable to staff change or absence.

f) Further planning is needed around out of hospital services.

g) Non elective admissions remain an important focus, even though related pay for performance will cease. The increased focus on case management and long term condition management aims to increase the plan's ability to drive down emergency admissions.

h) In addition, we need to plan for more public, user and patient engagement around the new BCF plan.

3.3 Questions

a) Does the revised Better Care Fund vision reflect Rutland's health and social care needs and aims?

b) Are the proposed priorities clear, coherent, relevant, ambitious and realistic? Is anything missing from the programme?

c) Is the Better Care plan brave enough (pace, scope, innovation)?

d) Are we clear on the key success factors and are they in place? Eg. Does programme governance need to change to drive the programme more effectively and to connect into wider programmes of change (eg. BCT and the Vanguard)? Does the partnership want to consider a risk sharing agreement for DTOC?

e) How can we best engage with the public and users around the BCF plan?

4 CONSULTATION

4.1 This agenda item forms part of the consultation on the 2016-17 Better Care Fund approach.

5 ALTERNATIVE OPTIONS

5.1 The proposed new Better Care Fund plan has been informed by 2015-16 progress monitoring to date, a moderated interim evaluation of the programme, new projects workshops, wider local strategies including Better Care Together and the ELR CCG Community Services Strategy, regional learning through networking and national health and care research activities. It was also refined through iterative dialogue with partners (leading to an Integration Executive discussion on 21 January).

5.2 The current proposal offers a 'middle ground' approach where there is considerable continuity with the 2015-16 programme, but with evolution in terms of the scope, arrangement and/or funding allocation of schemes where this allows change to be progressed further in the desired direction.

5.3 In terms of the extent of change, two more extreme approaches were possible, neither of which could be recommended:

a) to continue on with the 2015-16 programme as-is, without changing its priorities and schemes, or

b) to develop a new programme from a 'blank page'.

5.4 Continuing the programme without change would mean that opportunities were missed to increase the impact of the programme and deepen local integration, whether by building on foundations created by the 2015-16 plan (eg. consolidating discharge and reablement arrangements), addressing important areas not fully addressed in earlier programmes (eg. broadening and increasing the focus on long term conditions) or adjusting the focus away from less effective measures (reducing the funding available to crisis response to better match the level of real need).

5.5 In turn, developing a new programme from scratch risked a significant negative impact on the momentum of the programme – especially given the time needed in 2015-16 for BCF schemes to get up to full speed due to the time needed, variously, to plan direction, procure services and/or to recruit and induct new personnel. It would also not be warranted in that the policy context is not changing dramatically and the programme to date has shown an overall positive performance.

5.6 Views are sought from the Health and Wellbeing Board on whether the proposed programme strikes the right balance between the two extremes.

6 FINANCIAL IMPLICATIONS

6.1 The current and next Better Care Fund programmes are an important aspect of ensuring the longer term financial sustainability of social care by aiming to reduce and better manage demand for both health and social are services, including by developing community capacity and the ability of individuals to be proactive in

managing their own health journey.

6.2 Financial allocations for the 2016-17 programme have not yet been confirmed. The 2016-17 draft budget is based on the 2015-16 programme and will be updated in due course. Any changes to the programme could create an additional pressure on the Council's General Fund and officers will be seeking to avoid any impact.

6.3 Some underspend is anticipated from the 2015-16 programme and it is proposed that some of this would be converted into a contingency fund for the BCF programme (most BCF programmes nationally have a contingency fund but the small size of Rutland's programme meant this was not set up initially). There is also the option to dedicate some underspend to increasing the budget for some 2016-17 measures where they have the potential to contribute to accelerating transformation or integration (details to be confirmed when budget allocations are known).

7 LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 The Council must agree and implement a Better Care Fund Programme for 2016-17 with ELRCCG.

7.2 The Better Care Fund has been and is likely to continue to be an enabler for changes that have been necessary for the Council to meet its obligations under the Care Act 2014. However, at this stage, most of the new Care Act obligations have been met. In some areas, eg. universal information and advice, further investment will help to ensure that relevant obligations can be met ongoing.

7.3 Where commissioning activities are required, these will be undertaken in line with procurement regulations.

8 EQUALITY IMPACT ASSESSMENT

8.1 This agenda item invites views to feed into the Better Care Fund programme. The new programme may then need to be subject to an Equality Impact Assessment if it is sufficiently different to the previous programme and presents a changed balance of impact.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 No implications.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 The Better Care Fund programme is a key instrument coordinating the work of the Council and its partners, including in the health and Voluntary, Community and Faith sectors, to impact positively and sustainably on health and wellbeing in Rutland, particularly as it relates to older people and people suffering one or more long term conditions.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 The Health and Wellbeing Board are invited to feed back on and endorse the

provisional draft 2015-16 Better Care Fund proposal set out in Appendix B.

11.2 The proposal sets out a coherent next step for health and social care integration in Rutland which builds on progress to date but still continues to challenge the partnership to progress further on its integration journey. The proposal has been developed iteratively via dialogue with key BCF partners and informed by available contextual inputs, notably the ongoing monitoring and recent evaluation of the current BCF programme, related strategic frameworks and strategies and available guidance.

11.3 The HWB is also asked to note the provisional nature of the attached proposals and the tight timetable for new programme development and approval, and to confirm the preferred sign off process as this may need the HWB to approve the final version of the plan outside the normal pattern of quarterly HWB meetings.

12 BACKGROUND PAPERS

12.1 2016-17 Better Care Fund Policy Framework, published 8 January 2016: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf

13 APPENDICES

13.1 Appendix A: BCF self assessment framework - six domains of integrated care

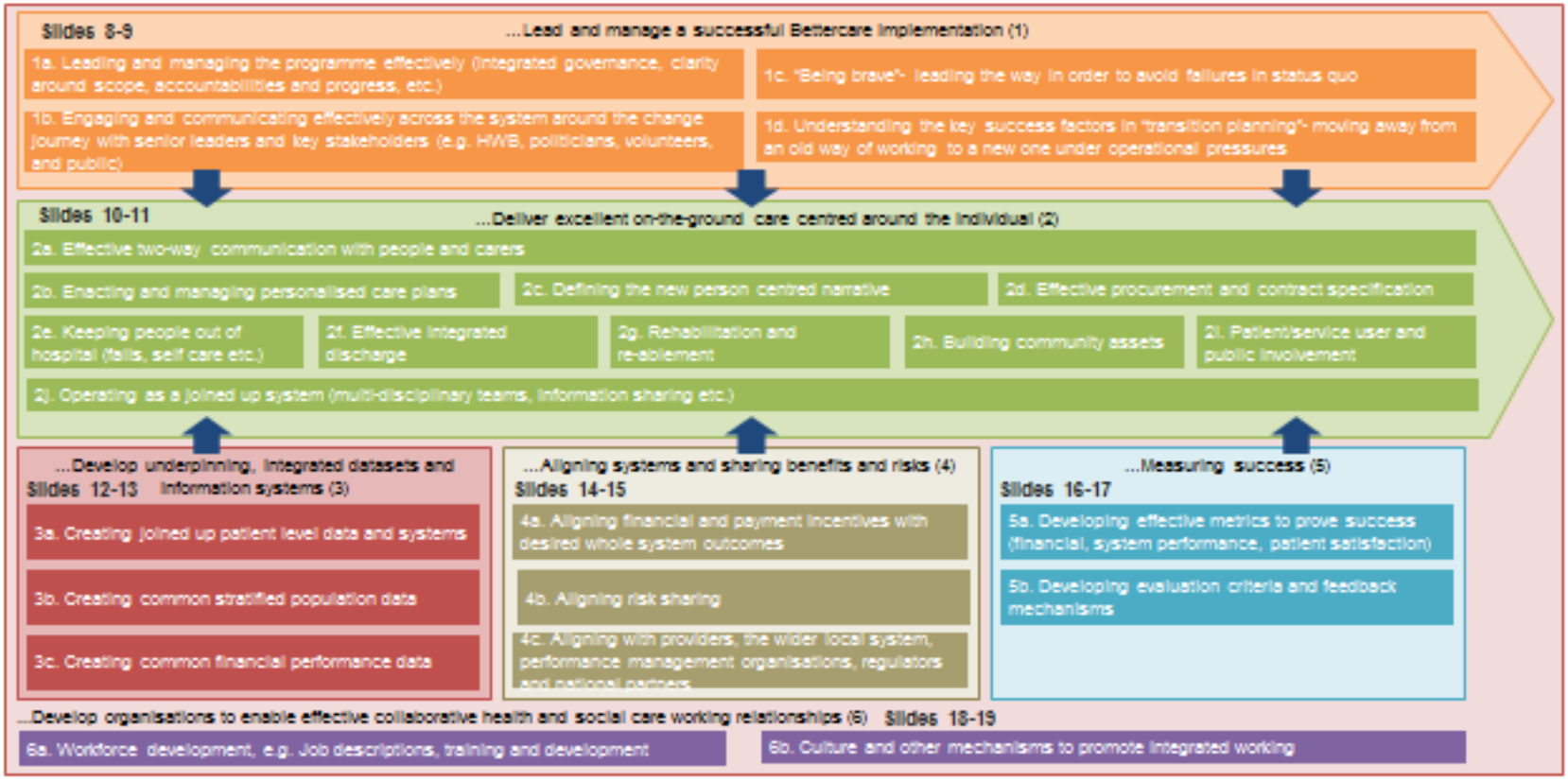
13.2 Appendix B: Rutland Better Care Fund 2016-17 - Provisional draft Plan

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577. (18pt)

14 APPENDIX A: BCF SELF ASSESSMENT FRAMEWORK - SIX DOMAINS OF INTEGRATED CARE

Self-assessment and evaluative framework

Six Domains of Integrated Care. Please refer to this for part one of this self-assessment.



APPENDIX B: RUTLAND BETTER CARE FUND 2016-17 - PROVISIONAL DRAFT PLAN