City of Westminster

Westminster Health & Wellbeing Board

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Classification:	**General Release**
Title:	**Better Care Fund Update**
Report of:	**WCC and Central and West London CCGs**
Wards Involved:	**All**
Policy Context:	**Health and Social Care Integration**
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1. Executive Summary

1.1 This paper is the regular update requested by the Health & Wellbeing Board on progress with development of the Better Care Fund (BCF).

1.2 After a brief reminder of the context of the BCF, an update on progress is provided against the six national conditions specified as expectations for BCF implementation. An overview of the way that progress with local plans will be reported nationally is then given, along with a summary of spend against the additional funds provided in Westminster for BCF implementation planning in 2014/15 and a reminder of funding arrangements in 2015/16.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to note:

a) progress of the BCF programme against the national conditions;

b) expectations for local reporting to inform national progress;

c) focus of spend for additional funds for the BCF programme in 2014/15.

3. Background

3.1 The BCF is a single pooled budget for health and social care services to work closer in local areas, based on a plan agreed between the NHS and local authorities. It is a national initiative to improve health and social care outcomes and cost-effectiveness, with an emphasis on more care at and near home.

4. Progress Update

4.1 Reviewing progress against six national conditions is an important measure of delivery, and is one of the ways in which success of the BCF will be monitored.

Background to the National Conditions

4.2 The national conditions were set out as requirements for BCF plans, and help to shape the focus for BCF delivery. They reflect national policy and priorities but need to be achieved through local implementation planning.

4.3 The ability of BCF plans to fulfil these conditions informed the *Nationally Consistent Assurance Review*, which was the process by which plans were approved. This update reflects on progress in the Triborough against each of the conditions. A full description of the conditions can be found in Appendix 1.

Condition 1: Are plans jointly agreed between health and social care?

4.4 The Triborough BCF plan is owned by the Health and Wellbeing Boards and overseen by a local BCF Board, comprising Cabinet Members for Health & Social Care, CCG Chairs, the Director of Adult Social Care and the Chief Officer of the CCGs. The Chief Executive of the acute provider leading delivery of the principal scheme (with partners across acute, community and primary healthcare) also attends part of the regular board meetings. Delivery is led by the executive teams for health and social care, which regularly meet jointly and are supported by a steering group of the officers responsible for BCF schemes.

Condition 2: Are Social Care Services (not spending) protected?

4.5 The Triborough plan seeks to protect social care services by ensuring that those most in need within the local communities continue to receive the necessary support, despite growing demand and budgetary pressures. To do this, new forms of joined up care are being developed which help ensure that individuals remain healthy and well, and have maximum independence. The main focus for this is additional investment in health and social care through the Community Independence Service (CIS) to enhance rapid response, hospital in-reach, rehabilitation and reablement services, reducing hospital admissions and residential / nursing home admissions. There is additional health investment in social care in 15/16 to support this programme.

Condition 3: Are 7-day services to support patients being discharged and prevent unnecessary admission at weekend in place and delivering?

4.6 An overarching 7-day services programme is in progress across CCGs in North West London. Extended hours for CIS access in the three boroughs complements this, and has been supported by alignment of winter resilience funding with investment in CIS requirements since April.

4.7 CIS rapid response, reablement and hospital in-reach staff across the three boroughs already work on a 7-day rota, but the new integrated service aims to develop a single model of care to replace variable specifications across existing services which will help to achieve a joint approach to assessments and care planning. Further 7-day working requirements will be agreed and rolled out after CIS service design and staff consultation.

4.8 BCF planning for 7-day services to support CIS is also supporting review of enhancements to social work components of hospital discharge. Again, 7-day social work and health discharge processes are already in place but further work is underway to enhance and standardise some of the processes across the three boroughs and integrate health and social care functions. The BCF 7-day social work discharge project is currently piloting some of these enhancements and a decision will be taken in summer 2015 as to how and what to roll out more widely.

Condition 4i: In respect of data sharing, is the NHS Number being used as the primary identifier for health and care services?

4.9 There has been good progress, and work is nearing completion to link the principal adult social care system (Frameworki) with the NHS Spine, a set of national services used by the NHS Care Record Service. However, there is more to do to enable seamless working across core systems in health and social care.

Condition 4ii: In respect of data sharing, are open APIs being pursued (i.e. systems that speak to other each)?

4.10 Systems inter-operability is being pursued and ways of increasing information flows are being developed to address practical issues associated with implementation of different BCF schemes. This includes identifying the steps towards an integrated patient record for CIS and a common assessment process for hospital discharge. However, there are not simple solutions to some systems differences and there is more to do to enable seamless working across core systems in health and social care.

Condition 4iii: In respect of data sharing, are appropriate information governance controls in place for information sharing in line with Caldicott 2?

4.11 A programme of work has been undertaken to achieve Level 2 compliance with the Department of Health's Information Governance Toolkit across the Triborough. This will be supported by further training and audit. BCF funding is helping to enable appointment of a Caldicott Support Manager to assist joint working, and ongoing work is identifying and finding ways to resolve information governance issues arising from increased integration. Where necessary, this includes additional documentation to support effective data sharing.

Condition 5: Is a joint approach to assessments and care planning taking place and, where funding is being used for integrated packages of care, is there an accountable professional?

4.12 In progress: joint processes are developing to assess risk and plan care across health and social care teams, with review by multi-disciplinary groups followed by implementation of care planning and case management where appropriate. Our integrated plan envisages GPs taking a lead in coordinating care as the agreed accountable lead professionals for people at high risk of hospital admission, but there are details to work through and the delivery model needs agreement with stakeholders including Cabinet Members. CIS aims to develop a single model of care to replace variable specifications across existing services which will help to achieve a joint approach to assessments and care planning.

4.13 From April 2015, CIS Single Point of Referral (SPoR) teams have been co-located and aligned, with health and social care staff working together on assessments, care planning and tasking. CIS service design is ongoing and a single assessment form which incorporates health and social care functions will be in place and incorporated into SPoR by September 2015.

4.14 A pilot has also started to assess the benefits of a common assessment process and more integrated working between health and social care to support hospital discharge. There is currently joint assessment and care planning in place as part of the hospital discharge pilot. The team are developing an integrated discharge pathway including acute, community health and adult social care staff. This pathway will include an integrated discharge function, with a lead professional coordinating integrated assessments and care packages in the community.

Condition 6: Is there an agreement on the consequential impact of changes in the acute sector in place?

4.15 BCF plans have been developed in conjunction with providers and are based on commissioning expectations for acute admission reductions. There is a clear history of non-elective reduction with main acute providers: 14/15 contracts with both main acute providers have included transformation incentives and risk sharing through income guarantees. For BCF deployment, the implementation and delivery model of transition to the integrated Community Independence Service has Imperial College Healthcare NHS Trust as the lead health provider, supported by partners that include Chelsea & Westminster Hospital NHS Trust.

5. National Reporting Expectations

5.1 NHS England is coordinating receipt of quarterly progress updates on delivery of BCF plans. This will be via standardised templates which will vary each quarter, but will maintain a core focus on the national conditions and the BCF's key outcome measures (such as reduction in non-elective admissions).

5.2 The next template will be circulated in early July for return by the end of August. As the Westminster Health and Wellbeing Board is not due to meet again until after submission of the next quarterly return, it is proposed that a draft of the template response will be prepared for review and approval by the Health and Wellbeing Board Chair. An update on the response will be provided to the Board in September.

6. Expenditure in 2014/15

6.1 The BCF did not come into full effect until April 2015/16, but £200m of NHS funding was made available to Health and Wellbeing Boards in 2014/15 to plan changes to health and social care that would support the expectations of the BCF plan.

6.2 Westminster Health and Wellbeing Board's share of this £200m was £1.103m, and the table below shows how this funding was used (together with allocations for Kensington & Chelsea and Hammersmith & Fulham) to support planning and implementation across the schemes in the Triborough BCF plan in 2014/15. Part of the total has been carried over from 2014/15 to continue with implementation planning in 2015/16:

BCF 14/15 Spend	**£k**
Implementation Planning	
Group A - Integrated Operational Services (CIS, Neuro Rehab, Homecare, Hospital Discharge)	366
Group B - Patient / Service User Experience (Patient/Service User Experience, Self-Care, Personal Health Budgets, Community Capacity)	87
Group C - Integrated Commissioning / Contracting (Nursing/Residential Contracting, Jointly Comissioned Services, Integrated Commissioning)	92
Group D - Delivery Enablers (IT Integration, Information Governance, Care Act Implementation)	166
Programme Management	241
Sub-total	952
BCF 14/15 Carry Over to 15/16	
Implementation Planning	
Group A - Integrated Operational Services (CIS, Neuro Rehab, Homecare, Hospital Discharge)	17
Group B - Patient / Service User Experience (Patient/Service User Experience, Self-Care, Personal Health Budgets, Community Capacity)	30
Group C - Integrated Commissioning / Contracting (Nursing/Residential Contracting, Jointly Comissioned Services, Integrated Commissioning)	13
Group D - Delivery Enablers (IT Integration, Information Governance, Care Act Implementation)	91
Sub-total	151
Total	1,103

7. Funding in 2015/16

7.1 Under the NHS Mandate for 2015/16, NHS England was required to ring-fence £3.46 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF (adding to the Social Care Capital Grant and the Disabled Facilities Grant, both of which are paid directly from the Government to local authorities). BCF allocations to local areas are based on a framework agreed with Ministers, and the local share for Westminster is £18.203m. This local share of the fund flows via CCG allocations (£13.553m from Central London CCG and £4.650m from West London CCG) into a pooled budget that may then be dispersed to individual organisations to carry out their parts in the BCF plan. An update on use of the 15/16 fund will be provided to the next meeting.

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Appendix 1: The 6 National Conditions – Full Descriptions

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)

Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number

The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

• confirm that they are using the NHS number as the primary identifier for health and care services, and if they are not, when they plan to;

• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and

• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Descriptions are taken from the NHS England Quarterly Data Collection Template.