North Tyneside
Health & Wellbeing Board Report
Date: 28 April 2016

ITEM 8

Title: Better Care Fund Plan for 2016/17

Report from : North Tyneside Council & North Tyneside CCG

Report Author: Kevin Allan (Tel: 07958 055 897)

1. Purpose:

This report presents a proposed plan for the Better Care Fund covering the financial year 2015/16.

2. Recommendation(s):

The Board is recommended to

a) endorse the general principles of the use of the Better Care Fund, set out in the report; and

b) authorise the Chair of the Health and Wellbeing Board to authorise any further revisions to the submission on behalf of the Board, before the deadline for submission to NHS England on 3rd May 2016.

3. Policy Framework

This item relates to the following objectives of the Joint Health and Wellbeing Strategy 2013-23:

- To continually seek and develop new ways to improve the health and wellbeing of the population
- To shift investment to focus on evidence based prevention and early intervention where possible
- To reduce the difference in life expectancy and healthy life expectancy between the most affluent and most deprived areas of the borough;
- To shift investment to focus on evidence based prevention and early intervention;
- To build resilience in local communities through focussed interventions and
- ownership of local initiatives to improve health and wellbeing; and
- To integrate services where there is an opportunity for better outcomes for the public and better use of public money

4. Information:

Government have confirmed that the BCF will continue in 2016/17. The NHS planning guidance sets out he following goal relating to health and social care integration.

> "Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. "

The BCF Policy Framework sets out the key requirements for BCF planning:

- Plans to be jointly agreed;
- Maintain provision of social care services;
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- Better data sharing between health and social care, based on the NHS number;
- 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;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

Council and CCG officers have worked together through the BCF Partnership Board to prepare an updated BCF plan for 2016/17, which is attached to this paper as Appendix A.

As well as consideration by the Health and Wellbeing Board, the BCF plan will be separately considered by the Council Cabinet and by NHS North Tyneside Clinical Commissioning Group.

Key features of the proposed plan

The plan represents a natural progression from the 2015/16 plan, with some changes to take into account progress that has been made. The plan includes:

- Implementation of the **CarePoint** service, which brings together a number of previously-separate services which aim to prevent admission to hospital and facilitate discharge from hospital. The predecessor services were:
    - North Tyneside Council's reablement service, including immediate response and overnight home care
    - North Tyneside Council's hospital-based social workers
    - Northumbria Healthcare FT's admission avoidance resource team
    - Northumbria Healthcare FT's "hospital to home service"

Implementation of the **CarePlus** service in the Whitley Bay locality. Our 2015/16 BCF plan outlined our intention to introduce such a model which is an example of "New Models of Care". A team is now in place comprising GPs, geriatricians, nurses, social workers, and admin support, serving the Whitley Bay locality of North Tyneside. Arrangements are in place to share patient records with the patients' registered GP

The service has four key components:

- Coordination of Care – to ensure patients actually receive the care they need when they need it and to eliminate waste and duplication.
- Standardised Care - to drive consistency and high quality while leveraging systems that encourage clinicians to find the most cost effective solutions to meet patient needs.
- Matching patients need with an appropriate care delivery model – Patients with complex chronic diseases need a different kind of care than patients with injuries or simple episodic diseases and therefore the philosophy of directing patients into the right care model or delivery channel applies to clinicians as well.
- Facilitate the development of health literacy- which will ensure that patients are supported to develop the confidence and knowledge to manage their own conditions.

CarePlus will bring improved outcomes for both patients and the health economy through:

- Patient centred care: the system comes to them
- The patient tells their story once
- Better, quicker, more consistent care across the whole system
- Caring for patients at home and within the community
- Reducing avoidable admissions
- A more efficient productive health economy with less duplication and waste

CarePlus will look after patients with the greatest needs in a different way. Patients with multiple/ poly-chronic long term conditions will be offered proactive care planning from a core MDT, a rapid response service in line with escalation plans and a "pull service" to support early possible discharge when patients have needed hospital care.

A team is in place comprising GPs, geriatricians, nurses, social workers, and admin support, serving the Whitley Bay locality of North Tyneside. Arrangements are in place to share patient records with the patients' registered GP.

An additional element of the service provides support through personal independence coordinators, recruited and managed by Age UK North Tyneside. Their role is to:

- Build a strong supportive relationship with the patient
- Address social isolation through connecting with the community
- Be the point of contact for the patient and their family/ carer
- Responsible for self-management support (patient activation)
- Bridge the gap between the clinician and the patient
- Assist in navigation of the health and social care system
- Facilitate patient independence

The plan also includes a new focus on **intermediate care**. The Department of Health describes[1] intermediate care as

[1] DH 2001. Intermediate Care Health service/local authority circular HSC 2001/001 LAC (2001)1. DH 2009. Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities.

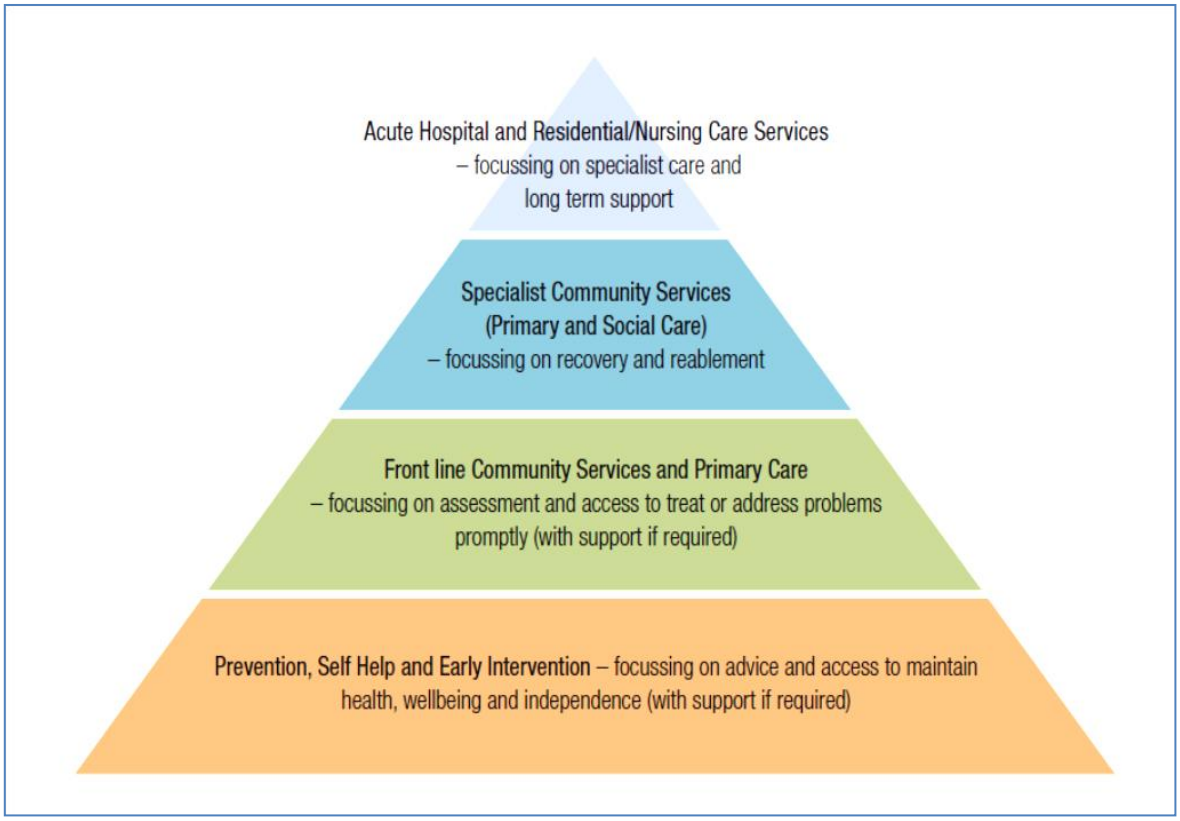
"a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living." .... "a function rather than a discrete service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It should support anyone with a health-related need through periods of transition, operating between other service units, so will need to adapt in response to any changes in the surrounding services. It is part of a continuum, spanning acute and long-term care, linking with social care reablement."

The Older Peoples Programme Board identified that a new model of intermediate care is required which:

- Provides an adequate number of "step-up" beds, for people in the community who are at risk of an inappropriate acute hospital admission.
- Provides "discharge to assess" beds, with appropriate therapy input, which would support the timely discharge of patients from an acute ward into an intermediate care facility, enabling a period of rehabilitation whilst CHC assessments are being carried out or decisions are being made about the appropriateness of permanent placements into residential or nursing homes, or designing the optimal package of community-based care which can support the person in their own home.
- Utilises high-quality accommodation
- Defines clinical responsibility for all intermediate care beds whether GP, nurse, or consultant led.

Relationship to the Health and Wellbeing Strategy

The Health and Wellbeing Strategy states that we will work within the four levels of service delivery, shown below, to achieve better service integration.



The table below shows how the BCF plan aligns to the layers referred to in the Health and Wellbeing Strategy:

	BCF services	Other relevant initiatives
Acute hospital and residential/nursing care services – focussing on specialist care and long term support	End of life care Liaison psychiatry	GP enhanced service for care homes
Specialist community services (primary and social care) – focussing on recovery and reablement	• Careplus (New Models of Care) • Proactive Care and Avoiding Admissions • Carepoint • CareCall / Telecare • Adaptations and Loan Equipment Service • Intermediate Care Beds	• Mental health community pathways

Front line community services and primary care – focussing on assessment and access to treat or address problems promptly (with support if required)	• Seven-day social work
	• Community-based services
	  • older people
	  • dementia
	  • mental health
	  • drug and alcohol
	  • homelessness	

Prevention, self-help and early intervention – focussing on advice and access to maintain health, wellbeing and independence (with support if required)	• Improving access to advice and information • Support for Carers	• NT Sign • Care and Connect

5. Decision options:

The Board may either:-

a) Endorse the general principles of the use of the Better Care Fund, set out in the report and authorise the Chair of the Health and Wellbeing Board to authorise any further revisions to the submission, before the deadline for submission to NHS England on 3rd May 2016, or
b) request relevant officers, in consultation with the Chair and Deputy of the Board, to undertake further work to make changes to the submission taking into account the comments and suggestions made by the Board at the meeting.

6. Reasons for recommended option:

The Board are recommended to agree option a). The continuation of the Better Care Fund presents a major opportunity to take forward the principles of the Health and Wellbeing Strategy. Delay in agreeing a plan for use of the Fund will lead to delay in the release of funds by NHS England

COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

7 Financial Implications

The financial implications for the Council and the Clinical Commissioning Group will be considered separately by each organisation as part of their approval processes.

8. Legal Implications

The NHS Act 2006, as amended, gives NHS England the powers to attach conditions to the payment of the Better Care Fund Plan. In 2016/17 NHS England have set a requirement that Health and Wellbeing Boards jointly agree plans on how the money will be spent and plans must be signed off by the relevant local authority and clinical commissioning group.

9. Equalities and diversity

There are no equality and diversity implications arising directly from this report.

10. Risk management

A risk assessment has been undertaken and included in Appendix A

11. Crime and disorder

There are no crime and disorder implications directly arising from this report.

SIGN OFF

Director of Public Health	X
Chair/Deputy Chair of the Board	X
Chief Finance Officer	X
Head of Law & Governance	X