South Norfolk Clinical Commissioning Group

Agenda Item 8.2

Subject	Integration and the Better Care Fund
Presented by	Chris Coath
Submitted to	Governing Body
Date	14th January 2014

Purpose of Paper

To provide an update to Governing Body on requirements for the submission of a Better Care Fund (formerly the Integrated Transformation Fund) plan following NHS England guidance issued in December 2013 and to recommend items for discussion and agreement.

Executive Summary

This paper summarises relevant sections of the latest guidance issued by NHS England in relation to the Better Care Fund. It includes baseline data relating to current progress on health and social care integration in South Norfolk.

It sets out a 'minimum' and 'maximum' model of how far services could be integrated for discussion, with the suggestion that the CCG should pursue a more ambitious model than the barest minimum required by the guidance. This could amount to a combined spend of c£100m, integrating or pooling the funds from the CCG's out of hospital spend with the funds used by social care.

It sets out the key issues to be considered to inform local planning mechanisms for the production of a Better Care Plan (that will cover North Norfolk, Norwich and South Norfolk CCG areas).

Recommendations

The Governing Body is asked to:

1. note the tight timescales;
2. consider its approach to the issues set out in Section 7 in order to develop, discuss and agree a joint submission of a Better Care Fund Plan with North Norfolk and Norwich CCGs (within framework of current strategic and operational planning requirements). This will include the need to:
    a. agree the preferred 'scale' of the vision of what the CCG is aiming to achieve through greater integration, with the recommendation

	that we further explore the 'maximum' model (section 4.6) with partner CCGs and Norfolk County Council; b. take a view of the key risks contained within the programme; c. consider ideas for a local outcome measure that it would wish to see adopted; d. agree to the engagement and involvement of key stakeholders.

Key Risks

Clinical	None.
Finance and performance	There are risks to finance and performance that are yet to be fully quantified but encompass: financial penalties or opportunities related to national requirements re Better Care Fund; adverse impact upon current health and social care provision; negative impact upon performance arising from transformation activities. A risk assessment will be completed before implementation and actions identified to mitigate any risk.
Equality Impact	No adverse impact upon patients is anticipated but an EQIA will be completed before implementation and actions taken to mitigate any identified risks.
Reputation	Any reputational issues likely to be more of a risk in relation to any negative impact upon acute health care services and statutory social care provision.
Legal	Policy requirement from NHS England and Local Government Association.
Resources required	Commissioning input (Integrated and Out of Hospital teams); Communication and Engagement
Reference documents	NHS Guidance on Better Care Fund http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Governance

Programme Clinical Lead	Dr Graham Clark

Agreement	Agreement of first draft of Better Care Plan for North, South and Norwich CCG areas is required by 14.02.14: agreement by CCGs, Norfolk County Council and Norfolk Health and Wellbeing Board.

1 Update

1.1 The Integration Transformation Fund has now been renamed the Better Care Fund (BCF). It is a joint programme between NHS England and the Local Government Association that will, for 2015-16, re-allocate a number of existing health and social care funding streams to a local, pooled Better Care Fund used to support greater integration between health and social care services.

1.2 Nationally, the BCF provides £3.8 billion funding in 2015/16 to be spent on health and social care with the aim of driving closer integration and improving outcomes for individuals. See **Appendix 1** for a breakdown of the fund at a national level.

1.3 The spending of the pooled budget is to be determined by agreement between CCGs, Norfolk County Council and Norfolk Health and Wellbeing Board (HWB) with the HWB having responsibility for signing off the BCF Plan. A paper has been submitted to HWB meeting on 08.01.14 with a recommendation that they agree the process of approval for the draft and final plan.

1.4 New guidance was issued on 20.12.13 that included revised timelines, funding allocations and confirmation of the required outcome measures. This paper includes relevant information from that guidance.

1.5 2014-15 is very much a baseline and preparation year for BCF; not least because some of the payment for 2015-16 is linked to progress made against outcomes in 2014-15. So, nationally, in addition to the £900 million transfer already planned from the NHS to adult social care, in 2014-15 a further £200 million will transfer (distributed using the same formula as at present) to enable preparation for the BCF in 2015/16 (so a total of £1.1 billion). The extra £200 million is to be used to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and performance measures set out in the locally agreed plan.

1.6 The Planning Unit for submission of the BCF plan is North, Norwich and South Norfolk CCGs. There is (a fairly urgent) need for the three CCGs to liaise and agree key responsibilities for the completion of the joint BCF plan within required timescales. The plan will be submitted to NHS England as part of CCGs' Strategic and Operation Plans.

2 Key principles of BCF/ Integration

2.1 There is emerging consensus (with some differences) nationally and locally on what the 'building blocks' of health and social care integration are:

- Focus on expanding community services that maximise independence and prevent unnecessary admissions to hospital and permanent residential/ nursing care and reduce time in hospital
- Big focus upon shared information and shared systems
- Shared money including considering using the whole funding available across community health and social care not just the minimum required for the fund
- Shared staff including challenging the assumptions of who delivered what
- Partnership between statutory, independent and community sectors
- Focus on cost- effective means of delivery

- Shared risk

3 Timeline

Date	Action
14 February 2014	**First draft** of BCF Plan to be submitted to NHS England as part of the CCGs' Strategic and Operational plans
4 April 2014	**Final version** of the BCF Plan to be submitted to NHS England as part of Strategic and Operational plans
September 2014	Ensure delivery of the national conditions
September 2014	Ensure delivery of agreed performance goals to secure full payment of the BCF in 2015/16. Confirm delivery of national conditions and local whole systems changes

4 Funding Allocation

4.1 NHS England has now published BCF allocations for all Health and Wellbeing Board areas for 2014-15 and 2015-16. The allocations for Norfolk are attached at **Appendix 2.**

4.2 Baseline data of current SNCCG spend on 'integrated' services is included at **Appendix 3**. This shows that SNCCG is already spending more (an estimated £5.71 million) than the total Norfolk BCF allocation for 2014-15 of £3.482 million.

4.3 The allocation of £14.02 million for SNCCG contribution to BCF represents an increase of £8.31 million against the (estimated) baseline.

4.4 There is no requirement to pool budgets for 2014-15. The same conditions apply on the transfer of money from the NHS to social care as for the 2013-14 transfer.

4.5 The latest guidance clarifies that it will be a **requirement** that the money that goes into the BCF for Disabled Facilities Grants will go back to District Councils (who have the statutory responsibility for the provision of DFGs) at the same level (as a minimum).

4.6 The guidance says that the BCF allocation for 2015-16 is the minimum amount that must be pooled i.e. local areas can decide to put more in a pooled budget. There are a range of possible options for how much money/ service delivery should be integrated over the next five years. As **an example and for consideration** we have considered what a 'minimum' and 'maximum' integration programme might look like in terms of finance and service delivery:

'**Minimum'**

Funding per annum	£14.02 million (required for BCF for 2015-16) which would cover current baseline spend + additional SNCCG spend from current commissioning budgets ('transforming' services and changing spend better to meet BCF outcomes)
Service delivery model	Key elements include: • Multi-disciplinary teams at GP practice level • Co-location of health and social care staff • Extending ICLO roles • Information sharing • Strong focus on integrated intermediate care services including reablement, intermediate care and 7 day working to support discharge
Benefits	Planned benefits include: • Easier access to the right services at the right time for patients • Less duplication and overlap of services between health and social care • 'Care closer to home' with greater focus on primary care • Patients and people who use services feel more confident and are better supported to manage their own conditions to delay or avoid times of crisis or urgent care
Steps to achieve	This would be a continuation and expansion of current integrated services and plans especially around frail older people initiatives; discussions between NCC, NCHC and NSFT for closer working; work on-going to support multi-disciplinary working and case management of people with the most complex health and social care needs
Timescale	Realistically could be achieved within 2 years

'Maximum'

Funding per annum	**Estimated** £100 million (pooling of all social care assessment services, Purchase of Care budget and SNCCG community health care spend)
Service delivery model	Key elements include: 1 Further development of multi-disciplinary teams at GP practice level: four locality clusters for older people and those with long-term conditions, to include case management; rapid response services; intense Care at Home services; seven-day access to support; focus on services that can support people's independence and ability to manage their conditions and reduce the level of care needed 2 Fully integrated social care, mental health and community health care teams, which includes shared management, pooled budgets for purchase of services; joint assessment of need and coordinated care packages; partnerships with independent sector providers and shared outcomes 3 Integrated intermediate care services to improve discharge and to support rehabilitation, reablement and recovery to reduce the risk of readmission and maximise independence 4 Information and Communication Technology to allow health and care professionals to access and update patient records and to share information effectively.
Benefits	Planned benefits would include: • 'Seamless' and flexible experience of health and social care services for those who use them
Steps to achieve	Would require quite radical transformation of current service delivery but building upon key existing work such as some of the Domino workstreams, the recommendations from the intermediate care review and the integrated models already developed in SNCCG. Seek to agree joint approach with Norwich and North Norfolk CCGs. More structured integrated/joint commissioning of pool-funded services (e.g., reablement).
Timescale	Would probably be a five-year programme

4.7 The guidance says that nationally £1 billion of BCF will be performance-related with half paid on 01.04.15 (likely to be based on performance in the previous year) and half paid in the second half of 2015/16. See **Appendix 4** for the detail contained in the guidance. This will include progress both against outcomes and six national conditions:

a/ Plan is jointly agreed between Health and Wellbeing Board, Norfolk County Council and CCGs

b/ Protecting social care services: need to have a locally agreed definition of what this means and an explanation of how local social care services (not spending) will be protected

c/ 7 day service to support discharge: evidence of strategic commitment and description of local plans for implementation of seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

d/ Data sharing

- confirmation that NHS number is being used as the primary identifier for correspondence across all health and care services
- confirmation of being committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))
- Confirmation of being committed to ensuring that the appropriate IG Controls will be in place (NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2)

e/ Joint assessment and accountable lead professional: that people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional

f/ Agreement on the impact of changes in the acute sector

5 Outcome measures

5.1 The latest guidance has confirmed the following national indicators will be used to measure progress:

- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

- Delayed transfers of care from hospital per 100,000 population (average per month)
- Avoidable emergency admissions (composite measure)
- Patient / service user experience [can choose to use: local measure **or** national metric (under development)
- A local measure : to be agreed jointly by North, Norwich and South Norfolk CCGs and Norfolk County Council and signed off by the Health and Wellbeing Board

5.2 Local areas will need to submit baseline figures for performance against each metric; set 'level of ambition' (performance target) for each and decide whether to use the national measure for patient/service user experience or use a local measure. See **Appendix 5** for information gathered so far against metrics.

5.3 The local measure should be selected from the list at **Appendix 6** gathered from relevant Outcome Frameworks or can use another suitable local metric. It is an important issue as the metric is linked to payment but it is quite challenging (advice of SNCCG business analyst) to find a measure that is meaningful but also meets conditions of being robust, good data source; gives right incentive and so on.

6 Planning across North, Norwich and South CCG areas

6.1 All the CCGs, including South Norfolk, were already engaged in work to move forward on the integration of health and social care services, albeit in somewhat different ways and at different stages of development so work to develop a BCF plan does not need to start from scratch

6.2 A paper to the Health and Wellbeing Board summarises the current planning position for each Norfolk CCG.

6.5 In South Norfolk, good progress has been made both strategically and operationally on integration including: well established frail older people initiatives; developing multi-disciplinary teams around GP practices; action plan for NCC, NCHC and NSFT integration priorities; outline Integration plan agreed by Governing Body; intermediate beds programme; communication and involvement of key stakeholders re: BCF and wider strategic plans has begun.

7 Key Issues for Consideration

7.1 The Governing Body is asked to consider, comment and advise on their preferred approach to the following.

7.2 **Outcome measures**

Views are sought on:

- the most appropriate mechanisms and approach for joint agreement of performance targets (e.g. who should decide; how 'ambitious' targets should be) for each national metric
- the most suitable local measure (will be agreed jointly with Norwich and North Norfolk CCGs). Please see Appendix 6 for details

7.3 **Consultation and involvement of key stakeholders**

Need to agree jointly activities relating to consultation and involvement of key stakeholders including provider organisations and patient/ service user groups. Communication with stakeholders in South Norfolk has begun.

7.4 **Agree a shared vision with North Norfolk and Norwich CCGs**

Very importantly, further consideration is needed as to the approach that South Norfolk might wish to take in terms of achieving integration: important to have a view of what the desired 'end point' is (taking into account, among other factors, the guidance that BCF can be considered as a 'starting point' for pooling budgets; emerging decisions by fellow CCGs about their preferred approach; and our starting point in South Norfolk which might impact upon what seems achievable)

8 Recommendations

The Governing Body is asked to:

3. note the tight timescales;
4. consider its approach to the issues set out in Section 7 in order to develop, discuss and agree a joint submission of a Better Care Fund Plan with North Norfolk and Norwich CCGs (within framework of current strategic and operational planning requirements). This will include the need to:
    a. agree the preferred 'scale' of the vision of what the CCG is aiming to achieve through greater integration, with the recommendation that we further explore the 'maximum' model (section 4.6) with partner CCGs and Norfolk County Council;
    b. take a view of the key risks contained within the programme;
    c. consider ideas for a local outcome measure that it would wish to see adopted;
    d. agree to the engagement and involvement of key stakeholders.

Appendix 1: BCF Funding Elements (from Annex to NHS Planning Guidance: Developing Plans for the Better Care Fund)

The Better Care Fund will be made up of 2 elements of funding (set out in June 2013 Spending Round):

£1.9 billion based on existing funding in 2014-15 that is already allocated across the health and wider care system:

	Amount (£ million)
Carers breaks	£130
CCG reablement funding	£300
Capital funding (including £220m of Disabled Facilities Grant)	£354
Transfer from health to social care	£1,100
Total	**£1, 884**

£1.9 billion from NHS allocations includes:

- Funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill
- £1 billion that will be performance-related with half paid on 01.04.15 (likely to be based on performance in the previous year) and half paid in the second half of 2015/16 (could be based on in-year performance).

Appendix 2: BCF allocations for Norfolk 2014-15 and 2015-16

Better Care Funding allocation for Norfolk 2014/15:

Local Authority	**2014-15 BCF**

Norfolk	£3,482,000

Better Care Funding allocation for Norfolk 2015/16:

Local Authority	DFG £000	Social Care Capital Grant £000	CCG	£ from CCG for BCF £000	Total £000	Council	Minimum BCF for DFG £000
Norfolk	3,753	2,327	West Norfolk	11,443	62,404	Breckland	535
			South Norfolk	14,020		Broadland	414
			Norwich	12,245		Great Yarmouth	567
			North Norfolk	11,553		King's Lynn and West Norfolk	759
			Great Yarmouth and Waveney	7,063		North Norfolk	595
						Norwich	472
						South Norfolk	410

Appendix 3: South Norfolk CCG Spend on Integrated Services Baseline 2013-14

Service	Provider	Cost pa	Actual A Estimate E	Coverage
Assistant Practitioner	NCC	£23,945	E	Mid Norfolk
Care Management Team	NCHC	£268,000	E	Ketts Oak
Carers Breaks	CAP	£11,702	A	SNCCG

Community geriatrician	NNUH	£43,583	A	Mid Norfolk
FOP nurses, palliative care nurse and HCAs	NCHC	£173,230	E	Mid Norfolk
Information Advice and Advocacy	Age UK Norfolk	£16,645	E	South Norfolk
Integrated Care Coordinator	NCHC	£30,908	E	Mid Norfolk
Integrated Commissioning Team	NCC and CCGs	£114,000	E	South Norfolk
Integrated Community Equipment Service	NRS	£1,049,949	A	South Norfolk
Learning Disability Joint Teams	NCC and NCHC	N/K		South Norfolk
Mental Health Commissioning Team	NCC and CCGs	£66,737	A	South Norfolk
Mental health link worker	NSFT	£50,000	E	Mid Norfolk
Reablement Service	NCC	£300,000	E	South Norfolk
Transfer of health money to social care	Transfer to NCC	£3,222,222	E	South Norfolk
Transport Plus	NCC	£10,620	E	South Norfolk
Voluntary sector contracts	Various	£329,036	E	South Norfolk
Total		**£5,710,576**	**E**	

Notes

1 Where staffing costs are estimated have taken mid salary point from NHS or NCC jobs + 30% on costs)
2 Work in hand to finalise estimated figures

Appendix 4: Payments against performance

When:	Payment for performance amount	Paid for:
April 2015	£250m	Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional

	£250m	• progress against the local metric and two of the national metrics: • delayed transfers of care; • avoidable emergency admissions; and
October 2015	£500m	Further progress against all of the national and local metrics.

Appendix 5: Outcome Measures

Metrics		**Current Baseline (as at….)**	**Performance underpinning Apr 2015 payment**	**Performance underpinning Oct 2015 payment**
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	51.7	N/A	
	Numerator	260		
	Denominator	504805		
		(Norfolk April 12 - March 13)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	88.70%	94.1% (QP target) Most recent SN DC data (Apr-Sep 13):	
	Numerator	610		
	Denominator	690		

		(Norfolk April 2012 -Mar 2013)	87.4%	(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	302		
	Numerator	2593		
	Denominator	8.57888		
		Norfolk November	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure) ***Data sources underpinning measure not all available yet***	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - Sept 2014)	(Oct 2014 - Mar 2015)
Patient / service user experience [for local measure, list actual measure to be used. Does not need to be completed if the national metric (under development) is to be used] ***Suggested: Ensuring people feel supported to manage their long term condition***		72.19%	73.6% (QP Target)	
		2013/14 (Jan-Mar 2013 and Jul-Sept 2013)		*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

Appendix 6: Guidance on Choosing a Local Metric

You should choose one additional indicator that will contribute to the payment for performance element of the fund. You are required to either select one of the following metrics or another suitable local metric to underpin both the April 2015 and the October 2015 payment:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health

	services living independently with or without support
1D	Carer-reported quality of life
Public Health Outcomes Framework	
1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as “inactive”
2.24i	Injuries due to falls in people aged 65 and over

Whatever metric is used must ensure:

- clear demonstrable link with the joint Health and Wellbeing Strategy
- data is robust and reliable with no major data quality issues (e.g. no small numbers so that it is ‘statistically insignificant’
- comes from established, reliable (ideally published) source
- timely data is available in line with requirements for pay for performance – baseline data available in 2013-14 and data must be collected more frequently than annually
- a numerator and meaningful denominator should be available to allow the metric to be produced as a meaningful proportion or a rate
- the achievement of the locally set plan is suitably challenging
- the metric creates the right incentives