Hertfordshire and Herts Valleys

Joint Decision Making in Hertfordshire across health and social care

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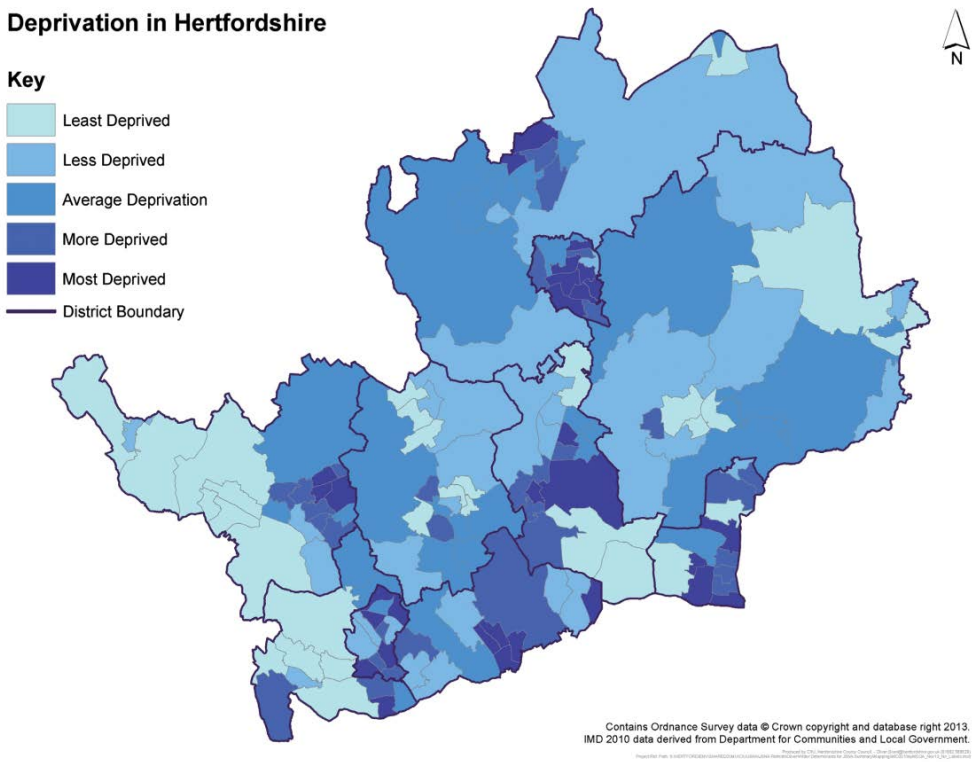
A long way from home…

Who are Herts Valleys CCG?

- Population – 600,000
- 4 NHS Localities
- 5 District Councils
- 1 Local Authority
- Strong and diverse voluntary sector
- 60 GP practices
- Mixture of providers including acute, community, mental health and private organisations
- Overall health of the population is higher than national average but we have an ageing population to support




NHS hits breaking point
HOSPITALS GO INTO MELTDOWN
OUR NHS DYING
Nurses are crying, doctors are quitting and we don't have beds for patients
RITA
Reeb viewers stick their Dra in
Wild boar kills M4 motorist
FROM £9.50
BOOKING FORM INSIDE
£98bn NHS BUDGET BUT...
THIRD WORLD A&E
10 hospitals in crisis
Worst wait in 10yrs
Car park care tent
DAILY EXPRESS
PAMPERED SPORTS STARS WHO DON'T KNOW HOW TO MAKE A CUP OF COFFEE
NATURAL CAUSES BY JAMES OSWALD FOR £1
Daily Mail
Most inspiring Fast Diet success stories ever
METRO
MAYNE MANIA
KRISTEN SO CLOSE TO GAL PAL
HOSPITALS JUST CAN'T COPE
A&E crisis is the worst in a decade
E CRISIS WORST
R TEN YEARS
Patients treated in car park tents
Choos blamed on Labour's GP contract
Cameron
11-hour wait for 999 ambulance

Community Services are key to the transformation ambitions set out in *Your Care, Your Future*. They are also fundamental to the implementation of the Hertfordshire and West Essex Sustainability and Transformation Plan

- Redesigning acute provision for West Hertfordshire
- Moving care closer to home – shifting services into communities
- Developing more integrated services
  - physical health and mental health
  - health and social care services
  - statutory services and each community's own assets
- Developing the right technology and recruiting the right workforce

The effectiveness and sustainability of the system rests on our ability to deliver more services out of a hospital setting and within more people's homes and communities

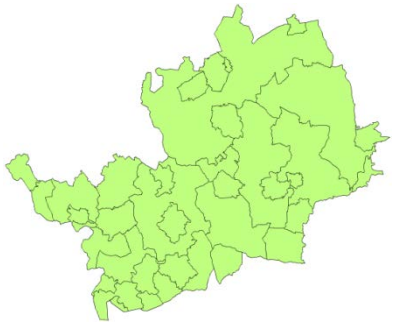
What is the Better Care Fund?

*"The Better Care Fund is a **single pooled budget** to support health and social care services to work more closely together in local areas…".*

NHS Planning Guidance, December 2013

For Hertfordshire, this means:

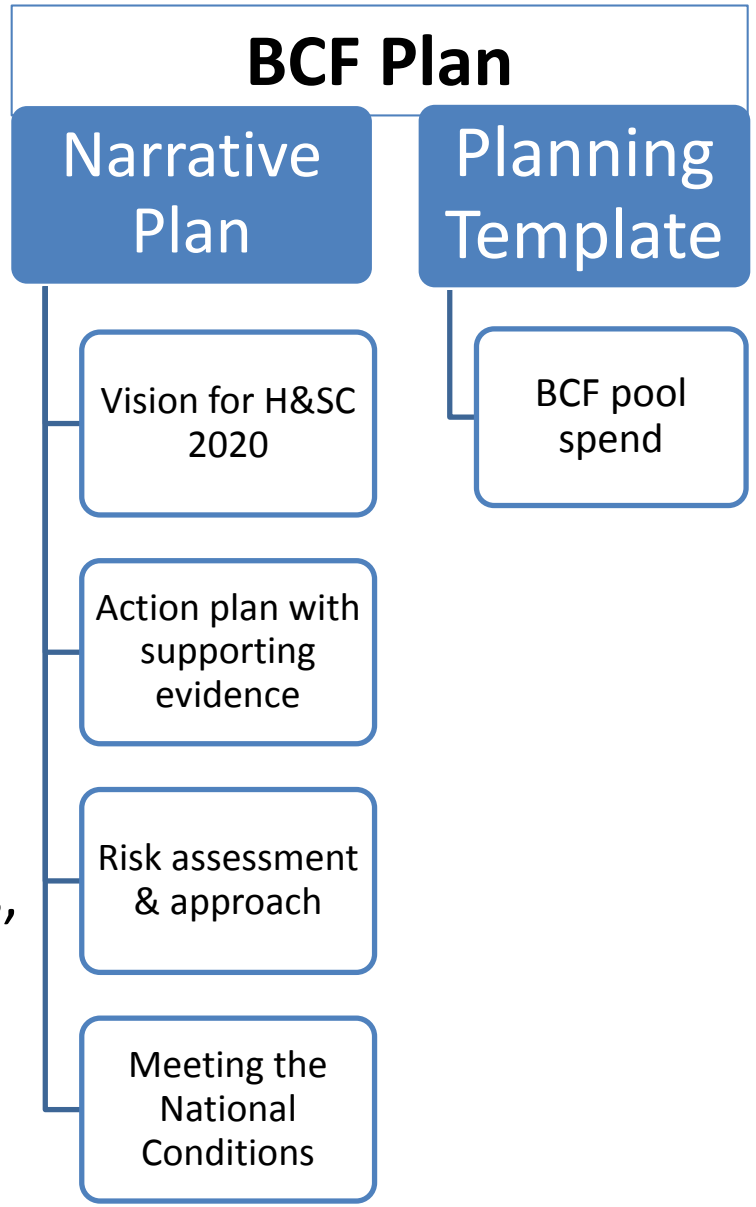
- ✓ Supporting joined up health and social care
- ✓ Bringing together CCG and social care older people budgets
- ✓ Includes Disabled Facilities Grant (**£6.3m** in 2017-18)
- ✓ Bringing together existing activity and newly agreed priorities into a single plan



The Better Care Fund Plan 2017-19

2017-19 – NHSE Guidance:

- 2 year plan – how Hertfordshire will achieve integration by 2020:
  - Local vision with patient focus
  - Alignment with STP & local plans
  - Compliance with national conditions
  - A plan of action
  - Use of the improved BCF (iBCF)
  - Jointly agreed between partners
  - Engagement with a range of partners, including providers



BCF Plan 2017-19: Vision

"A system that delivers the right care and support at the right time and in the right place for individuals, their families and their carers"

BCF Plan 2017-19: Plan of Action

Electronic record & data sharing

- A **digital shared care record** accessible by health and social care professionals
- Adapting the health and social care data systems for integrated care
- Increasing **data sharing** between health & social care, including hospitals & GPs
- **Networking the care home** market to enable the use of enhanced technology

Early identification

- Wider use of **risk stratification** to target specific groups
- A **preventative approach** to care co-ordination and not just crisis interventions
- Streamlined **points of access** to care services
- Smooth transitions between adult and children's services

Value for money

- Using **joint commissioning** for shared contracts, market stimulation and budgets
- A joint approach to **Continuing Healthcare** services
- Commissioning decisions supported by more powerful tools for **joint analysis** of health and social care needs / demands of local populations

Assessment and care planning

- A **shared infrastructure** and culture of outcomes-based planning
- **Integrated personal commissioning** of direct payments and individual budgets
- **Trusted assessment** between health and social care professionals for a range of services

BCF Plan 2017-19: Plan of Action

Integrated community care

- More colocation, single lines of reporting, and shared leadership
- Greater joint working with **primary care**
- Greater understanding and use of the **voluntary sector** and community assets
- Rolling out **enhanced care in care homes** developed by the Vanguard

Timely and safe discharges

- Further adoption of **integrated tools & working structures** e.g. live urgent care dashboards to track the movement of patients between services
- Shared **enablement** approach across health and social care partners minimising dependency across the area

Integrated urgent care

- Use of **multi-disciplinary teams** in all areas
- **Rapid response** functions joined up with integrated community teams
- Wider roll-out of **early intervention vehicle** and other integrated models
- Improved co-ordination of out of hours services including NHS 111 .

BCF Plan 2017-19: National Conditions

National Conditions

- **Plans to be agreed jointly**
- **Maintain provision of social care**
- **Investment in NHS commissioned out-of-hospital services**
- **Managing transfers of care**

Enablers:

- Agreed delivery of 7 day services
- Better data sharing
- Joint approach to assessment & care planning
- Agreed impact on providers

Performance Metrics

1. Reduce **non-elective admissions**
2. Reduce permanent **care home admissions**
3. Increased effectiveness of **reablement**
4. Reduced **delayed transfers of care**

Improved BCF (iBCF) quarterly reporting

The metrics apply to the BCF plan and the monies associated with its delivery. When we monitor against these metrics we need to consider how total BCF spend is helping to improve performance.

BCF 2017-19: Managing Transfers of Care

'High Impact Change Model' – to support systems reduce DToC:

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

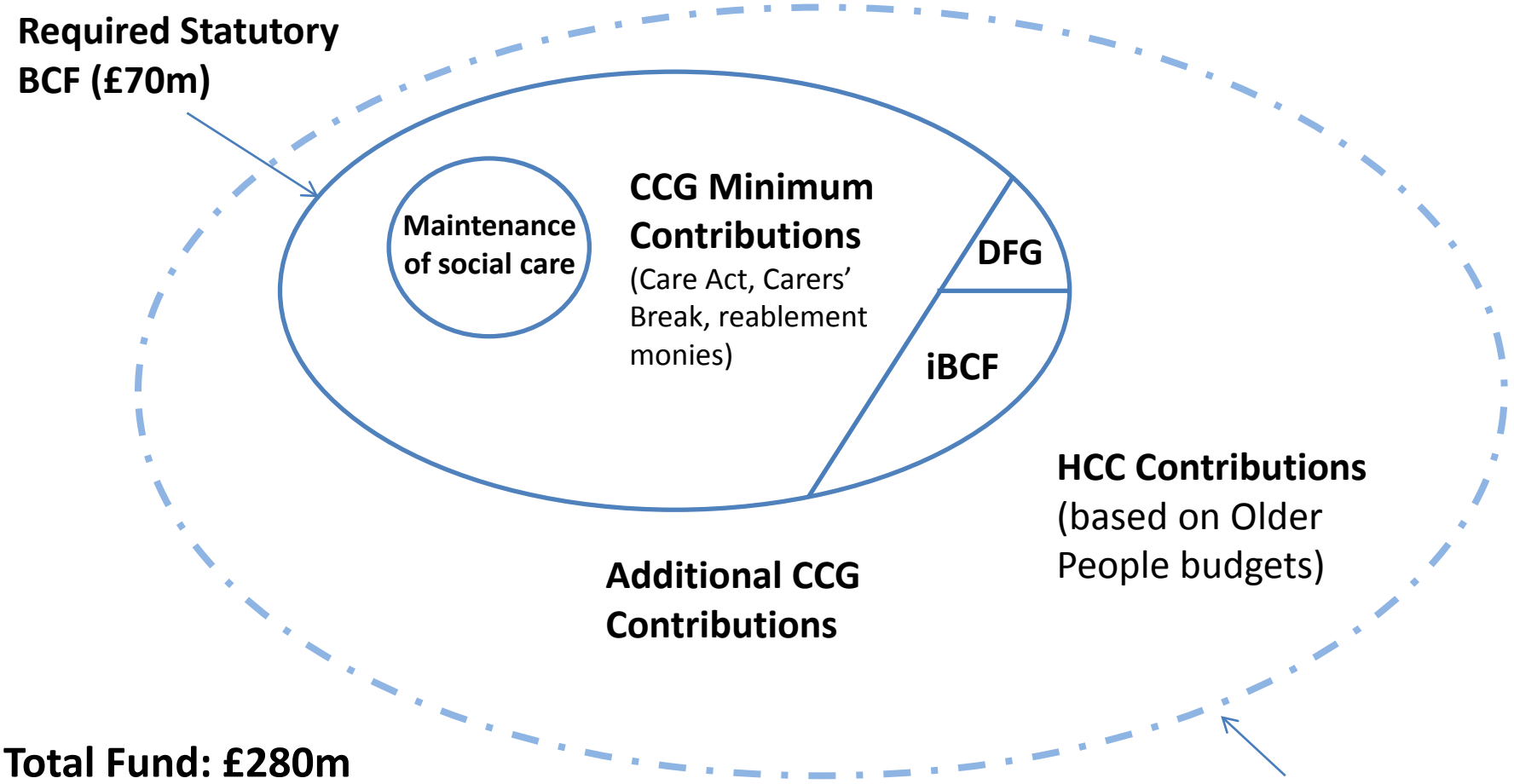
Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

BCF Plan 2017-19: Spend

Hertfordshire BCF Fund in 2017-19



Principles:

- Wider BCF includes all out-of-hospital **older people** budgets including community wellbeing
- Accountability of all parts to delivering BCF objectives

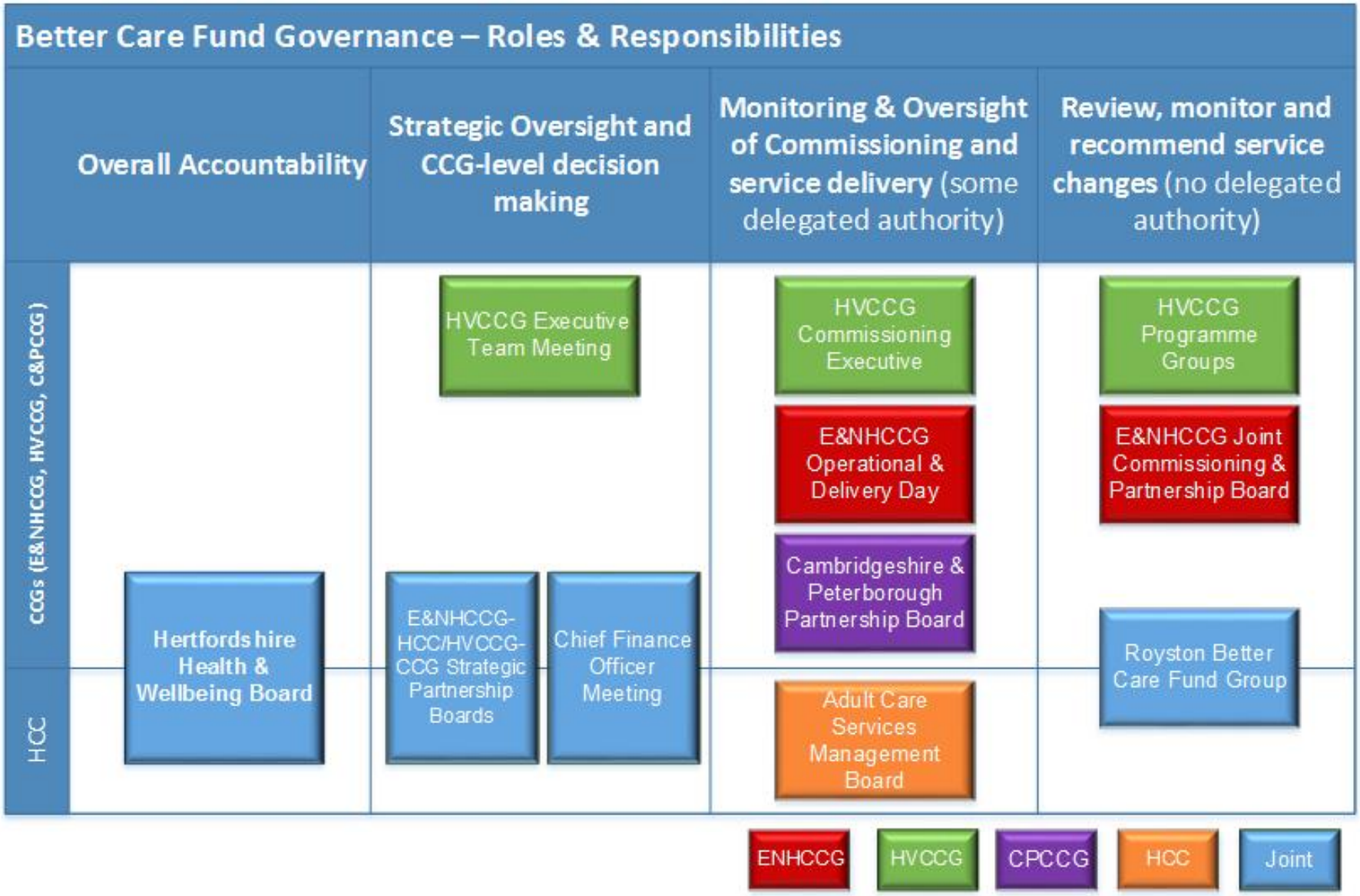
Improved BCF (iBCF)

- ✓ New non-recurrent social care grant allocation
- ✓ To be used for:
  - Stabilising the social care market
  - Meeting adult social care needs
  - Reducing pressures on NHS
  - Meeting High Impact Change model
- ✓ Must be pooled into BCF - **£13m** (£11.5m 2018-19)
- ✓ Working with CCGs and providers
- ✓ Quarterly reporting to the government

Quarterly Reports:

- Project/initiatives progress update
- HICM progress (LA perspective)
- Other metrics
- Impact on:
  - Number of care packages
  - Hours of homecare provided
  - Number of care home placements

BCF Plan 2017-19: Governance



Thank you

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