Warwickshire Health and Wellbeing Board

Agenda

11th February 2014

A meeting of the Warwickshire Health and Wellbeing Board will take place in **Committee Room 2, Shire Hall, Warwick** on **Tuesday 11th February 2014 at 13.30.**

The agenda will be:-

1. General

(1) Apologies for Absence

(2) Members' Disclosures of Pecuniary and Non-Pecuniary Interests.

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it;
- Not participate in any discussion or vote;
- Must leave the meeting room until the matter has been dealt with (Standing Order 42); and
- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting

Non-pecuniary interests must still be declared in accordance with the new Code of Conduct. These should be declared at the commencement of the meeting.

Working Together

2. Better Care Fund

Wendy Fabbro

3. Any other Business (considered urgent by the Chair)

Date of Future Meetings:

Wednesday 26th March 2014, Committee Room 2, Shire Hall, Warwick

Health and Wellbeing Board Membership

Chair: Councillor Izzi Seccombe (Warwickshire County Council)

Warwickshire County Councillors: Councillor Maggie O'Rourke, Councillor Bob Stevens, Councillor Heather Timms

Clinical Commissioning Groups: Heather Gorringe (Warwickshire North), David Spraggett (South Warwickshire), Adrian Canale-Parola (Coventry and Rugby)

Warwickshire County Council Officers: Wendy Fabbro - Strategic Director, People Group, Monica Fogarty - Strategic Director, Communities, John Linnane - Director of Public Health

NHS England: Martin Lee – Medical Director

Healthwatch Warwickshire: Deb Saunders

Borough/District Councillors: Councillor Roma Taylor (NBBC), Councillor Claire Watson (RBC), Councillor Michael Coker (WDC) , Councillor Derek Pickard (NWBC), Councillor Gillian Roache (SDC)

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Item 2

Health & Wellbeing Board

Meeting Date 11th February 2014

Better Care Fund

Recommendation(s)

That the Health & Wellbeing Board consider and make comments on the construct of the Better Care Fund and approve the attached Better Care Fund Template and endorse its submission to NHS England by 14th February 2014.

1.0 Background and Context

1.1 This paper sets out to provide an overview of what is meant by integration when we refer to the health and social care economy. It describes the conditions of the Better Care Fund (BFC) and outlines the scope and proposals for taking the integration agenda forward for Warwickshire residents.

1.2 The Better Care Fund is a central government driven initiative to further integrate health and social care so that there is; real improvement in the outcomes delivered, value for money achieved, and patients' experience of the health and social care economy improved.

1.3 Government are calling for a 'step change' and an ambition to see a fully functioning integrated model of health and social care provision. The funding, £3.8bn is to be used to support the redesign and remodelling of community services as a tangible alternative to Acute care.

1.4 Commissioning health and social care services in the public sector is complex. While the County Council is largely responsible for adult social care services, it currently works in partnership with three Clinical Commissioning Groups and the Five District and Borough Councils that collectively commission health, housing and social care respectively. The provider landscape is also extensive with; 3 Acute Trusts spread over 5 sites, one Mental Health Partnership Trust and a wide range of independent and third sector organisations as well as a range of joint initiatives with schools and further educational institutes.

1.5 There is already some good models of joint and aligned commissioning including pooled budgets, e.g. Integrated Community Equipment Services. But we recognise that there is much more that we can do together.

1.6 It is also recognised and acknowledged that there are further opportunities to deliver aligned services that are value for money and achieve improved outcomes to clients/patients. A key driver for integration is the opportunity to deliver end to end care, to find more innovative cost effective models of delivery and to increase patient and user satisfaction in their journey of care.

2 Key Issues

2.1 The Government has announced the creation of a £3.8bn pooled budget in 2015/16. This fund is described as having the following purpose: *"…We have been clear that we need to move more care out of hospitals and into the community, so that we can intervene earlier to prevent people from reaching crisis points. We need much better Integration between health and social care, so that care is centred around the person rather than the service, and to reduce the amount of money that is wasted when services do not work together effectively…".*

The table below summarises the elements of the Spending Round on the Fund:

The June 2013 Spending Round set out the following:	
2014/15 A further £241m transfer from the NHS to adult social care, in addition to the £859m transfer already planned	**2015/16** £3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: £130m Carers' Break funding £300m CCG re-ablement funding £354m Capital funding (including £220m Disabled Facilities Grant) £1.1bn existing transfer from health to adult social care.

2.2 None of the £3.8bn is fundamentally "new" money in so far as it is all part of existing Department of Health budgets and amounts to a reallocation of those budgets. This reallocation will put pressure on health budgets and this pressure will in part drive the approach of health services to the management of this money.

2.3 Existing Social Care Transfer Budget

The existing social care transfer from health to local government for spending on social care services that benefit health is £859m (£8m for Warwickshire). In 2014/15 this fund is to be increased by £241m (£2.2m). An element of this additional funding is to be spent on preparing for the implementation of the BCF.

2.4 A condition of the fund is that the Clinical Commissioning Groups and the Council will need to jointly agree plans for how the money will be spent and these plans must meet certain requirements and from 2015/16 the fund will be put into pooled budgets under Section 75 agreements.

2.5 The documentation issued to date makes repeated reference to the creation of pooled budgets. However it is not clear yet what this really means in practice. Pooled budgets at a local level generally refer to "Section 75 Agreements" (named after the section of the 2006 NHS Act which gives the power to make them). In these cases budgets are pooled into a single budget managed by one lead organisation. The references to pooled budgets give the impression that Section 75 Agreements are specifically the intention but such references could also be with the intention of promoting organisations to work more closely together whether budgets are technically pooled or not.

2.6 The Disabled Facilities Grant (DFG), currently provided directly to district and borough housing authorities, will also be included within the funds with the sole purpose of aligning and improving the strategic planning and delivery to improve outcomes for patients and services users. The partners have already agreed that this funding will continue to be transferred to housing partners reflecting current arrangements and values.

2.7 Additional Integration Fund

There is £1.9bn of new funding in 2015/16 with the following headline conditions attached to it:

"…To access this funding, all areas will need to produce local plans for how the money will be used across health and social care, signed off by the NHS and local authorities, and with a strong role for Health and Wellbeing Boards in the oversight of these. These plans must demonstrate that care and support services will be protected.
Plans must also include:

- *7-day working in health and social care, to stop people from being stuck in hospital over the weekend;*
- *better data sharing, including universal use of the NHS number as a unique identifier;*
- *a joint approach to assessment and care planning;*
- *implications for acute service redesign;*
- *support for accountable lead professionals in respect of joint care packages; and*
- *arrangements for redeploying funding that is held back in the event that outcomes are not fully delivered…"*

2.8 Of the £1.9bn additional funding, £1bn is explicitly described as being based on performance. It will be paid to local authorities in two instalments. The first half at the start of 2015/16 based upon performance in 2014/15, and the second half in the middle of 2015/16 based on performance in the year to date.

2.9 The performance schedule for the release of the fund is detailed below:

When	Percentage	Paid for
April 2015	25%	Progress against four of the national outcomes • 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 the changes on the acute sector; • Ensuring that where funding is used for integrated packages of care there will an accountable lead professional.
	25%	Progress against the local metric and two of the national metrics • Delayed transfers of care; and • Avoidable emergency admissions
October 2015	50%	Further progress against all the national and local metrics

Flexibility and Restrictions of Funding

It is difficult to predict how flexible the £3.8bn will prove to be in practice. How this develops depends upon the direction taken by the Government, the Department of Health, and NHS England. Some of the guidance issued emphases that part of the purpose of the funding is to protect services, i.e. it can underpin the funding of existing services or be used to reduce the impact of savings targets, but other guidance emphases that it should be focussed on investment in new services that improve integration and outcomes etc.

To put £3.8bn into context, it is worth noting that spending in the NHS amounts to around £110bn per year whilst spending on adult social care amounts to around £15bn. ie:. £3.8bn is a very large figure in the context of existing adult social care spending.

3 Timescales associated with the decision and next steps

3.1 When Should Plans Be Submitted?

Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by 14 February 2014, so that they can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.

3.2 The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

4.0 Completed Better Care Plan Template

4.1 Attached as Appendix 1 is the completed Better Care Hi Level Plan to be submitted to NHS England on the 14th February 2014. This plan has been completed by the Adults Joint Commissioning Board (AJCB) who will provide the governance for the implementation of the Better Care Fund and potential wider integration opportunities across the health and social care economy.

4.2 Attached as Appendix 2 is the governance structure of the AJCB which illustrates the links to the Health & Wellbeing Board who are charged with overseeing the delivery of this plan.

4.3 Attached as Appendix 3 is the draft Partnership Agreement which will be further developed in the course of the next few weeks and will be the precursor to more formal forms of agreements, such as Section 75s as this work progresses and national guidance becomes clearer.

Background papers

1. BCF Guidance letter dated 17th October 2013 (available from website below)
2. BCF website: http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

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Portfolio Holder	Cllr Jose Compton Cllr Bob Stephens	

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Warwickshire county Council**
Clinical Commissioning Groups	**Coventry & Rugby CCG**
	South Warwickshire CCG
	Warwickshire North CCG
Boundary Differences	Coventry and Rugby CCG spans two Local Authorities and two Health and Wellbeing Boards. This plan covers the Rugby population. There is a separate plan for the Coventry population
Date agreed at Health and Well-Being Board:	**11/02/2014**
Date submitted:	**14/02/14**
Minimum required value of ITF pooled budget: 2014/15	**£17462**
2015/16	**£65583**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Coventry & Rugby CCG
By	Steve Allen
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	South Warwickshire CCG
By	Gill Entwistle
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Clinical Commissioning Group	Warwickshire North CCG
By	Andrea Green
Position	Accountable Officer
Date	14th February 2014

Signed on behalf of the Council	Warwickshire County Council
By	Wendy Fabbro
Position	Strategic Director for the People Group
Date	14th February 2014>

Signed on behalf of the Health and Wellbeing Board	Warwickshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Isobel Seccombe
Date	14th February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This plan has been developed alongside the 5 year system plan as the BCF is central to the delivery of a clinically and financially sustainable care system. Therefore the strategic direction set out in this plan has been widely discussed with providers through: -

a) Routine dialogue between commissioners and providers;
b) Urgent Care Working Groups and;
c) Coventry and Warwickshire Integrated System Board that brings together leaders of the health and care system. As the specific initiatives outlined in this plan are developed in greater detail there will be focused discussions with relevant providers.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The three CCGs and Social Care have well developed engagement networks. These networks will continue to have a core role in shaping the direction of travel. Our vision for integration has been informed through engagement with a variety of stakeholders alongside the outputs of the JSNA and the Health and Wellbeing Strategy. This vision underpins the 5 year system plan and the BCF. The high level content of this plan has been shared with patient, service and user groups and they have been supportive of the direction of travel. As with service providers we will continue to engage these groups as we develop schemes in greater detail.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Health & Wellbeing Strategy	
JSNA	
Quality of Life Report	
Commissioning intentions SWCCG	
Commissioning intentions WNCCG	
Commissioning intentions CRCCG	
Warwickshire county council commissioning intentions	
Public Health Commissioning intentions	

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is nothing less than a fundamental transformation of the quality and experience of care, across all elements of commissioning and provision, and on behalf of our communities as a whole.

As a partnership we believe that joining together will make us stronger commissioners and enable us to respond so that:

Our Vision

Individuals will experience better outcomes by delivering the Right Care at the Right Time, in the Right Place – Every Time – Together.

We will know this by using the 'I' statements for example: *"I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me."*

We recognise that change on this scale will mean consistently providing care that is planned and tailored to individual capabilities and needs; care that is delivered in partnership, to the highest possible standards. This will involve putting individuals at the heart of everything we do because this is the only way we will ensure a sustainable, healthy future for the communities we serve.

We will know we have been successful in five years time through the 'I' statements for example:

Patients/users of health and social care services will feedback that services delivered to them enabled them to make good lifestyle choices in the knowledge that services will wrap around their needs at key stages throughout their life;

Patient/users and their carers will feedback that they were able to make informed decisions about their health and social care needs and were able to remain in control, directing care through personal budgets and personal health budgets. They provide feedback on the quality of services that they had commissioned and/or directed their care co-ordinator to deliver on their behalf;

Staff will equally feedback the positive contributions that they made to a patient/users care and the benefits of joint assessment and care planning;

Patients/users and their carers confidence will increase in the quality of care and the levels of satisfaction in terms of people's dignity and respect across all health and social care services would define Warwickshire as an exemplar of health and social care services.

b) Purpose and Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Purpose

The core purpose of this integrated model is to improve outcomes for all people who need health and social care services. This means:

- People will be helped in their goal to manage their own care and remain healthy and independent;
- People will have real choices and greater access in both health and social care;
- Far more services will be delivered – safely and effectively – in the community and/or at home.

Objectives:

- To build relationships with patients and our communities and determine how the voice of the public remains central to the evolution of the BFC and the associated work programme;
- To identify opportunities for prevention and to promote wellbeing as underpinning patient/user contact;
- To facilitate a risk based model and act as an enabler for people to retain their independence and autonomy;
- To re-engineer how the public and the workforce consider this revised core offer from the health and social care economy to the public;
- To systematically tackle the pressures within the health and social care system to deliver better outcomes for our people and support the transformational, transitional and transactional elements of integration, within available resources;
- To stimulate and drive innovation across the health and social care economy ensuring continued safety and quality of services;
- To build further the close working relationships between all partners to deliver improved outcomes within local resources and establish a single solution to meet need that is affordable for the whole system and each agency;
- To recognise each partners strategic priorities, constraints and responsibilities in order to achieve mutual beneficial outcomes;
- To secure strong and effective clinical and professional practice engagement and leadership across the health and social care economy;
- To demonstrate system wide projects and programmes that deliver value for money;
- To collective agree the priority work programme to deliver a system wide change in how services are commissioned and delivered on the ground.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The BCF is central to the delivery of the 5 year system plan. In the 5 year system plan we articulate how we will: -

a) Radically change our approach to wellbeing and self-management
b) Take a systematic approach to transfer activity that should be undertaken by primary care back to primary care. This will include relocating the workforce that currently sits within acute services to the community;
c) Remove the boundaries between practice staff and those working in the community to deliver team based care to individuals who need the support of care professionals to manage their care;
d) Reconfigure site based services in order to deliver safe and effective services within the constraints on the money that we have available.

The content and yearly expansion of the BCF reflects the phasing of the 5 year system plan. The 5 year plan has been developed with a bottom-up approach and builds on each CCGs plan to address the health needs of its population. There are demonstrable links to the JSNA, JHWS, NHS Outcomes Framework, Public Health Outcomes Framework and the Peoples Group Outcomes Framework, (all attached as related documentation) the basis of which will form our Joint Outcomes Framework and Success Criteria. This will be underpinned by a benefits realisation model with incorporating the key national metrics as well as some locally defined measure.

Our agreed target operating model is one which puts the patient, service user and carer at the heart. It begins and ends with their voice being heard and acknowledges the expertise that patients and services users and carers bring to a solution based integration model.

The operating model will be built on an evidenced based approach and will recognise the assets people and communities have. It will facilitate a risk based model and act as an enabler for people to retain their independence and autonomy and will re-engineer how the public and the workforce consider this revised core offer from the health and social care economy to the public.

It will be built on the premise of self service and management and will focus on acting as a support mechanism to allow people to make the right choices and decisions about their own health and wellbeing throughout their life course.

Scheme 1: Joint assessment and care planning

Prevention is part of the process of joint assessment of need. We know that approximately quarter of the population smoke across all ages, hospital admissions as a result of alcohol and just under half of the population are overweight or obese. Identification and signposting particularly through the use of the Making Every Contact

Count philosophy is an important part of the assessment process and a key of underpinning a better quality of life for patients/users. To make integration effective Warwickshire is committed to the principle of joint assessments and care planning and to do this with the patient/user at the heart. We have already begun this work with the development of the ECAT and Common Assessment Framework (CAF) as examples, but further work is required to bring more formally the process of assessment together. We will develop a joint assessment and care planning process building on the trusted assessor model and using technology in its wider capabilities. Our transactional business processes will need to be agreed and embedded across the health and social care economy. We will be investing in co-ordinated care that promotes a holistic view of an individuals need and works with people to empower them and enable them to stay as independent as possible.

We want to move towards a model of integrated assessment of need across health, public health, housing and social care needs. This will begin with empowering the public to determine their own needs and to do this in advance of their need for more formal forms of support. We anticipate that this will also act as a tool to empower people to self manage their own care within the most appropriate environment. Core will be a mobilised and competently trained workforce. A key element of the model is the introduction of housing to improve the environments within which people live either to postpone or delay their need for formal support or to ensure that they enter into more appropriate forms of support for their eligible needs. Using technology the assessment function would be available for all citizens in Warwickshire irrespective of eligibility criteria or ability to pay for a service. In other words, the assessment service would help self-funders to manage their own care and would provide a platform for those on the edge of care. This would mean one assessment shared across organisations that is visible to the patient/users and with permissions to the primary carer.

Scheme 2: Promoting Independence through Self-management and Community Resilience

We have already begun the work to support local communities to galvanise around those who need support, such as the Safer Places scheme across the County which has seen the communities and local businesses engaging in making our streets safer for vulnerable people. And as well as the MECC approach highlighted above a key to promoting individual and community resilience is our effective public mental health strategy which prioritises; the three tier approach with; universal interventions, targeted intervention and early intervention for patients/users.

We need to continue to build on our information strategies and support people by providing the right information, advice and signposting to appropriate forms of support that are available and accessible within the communities in which they live. It means shifting from a model of dependency and direct provision to one of self management and care. It means people taking some responsibility for their own health and wellbeing and reducing the recourse to formal forms of support. Incorporated into this principle is the concept of community resilience and empowering communities to support local initiatives and forms of support eg; self management programmes for people with long terms

conditions, financial advice, housing improvement schemes, building local community enterprises, peer support groups for carers, supporting the growth of voluntary activity for example through time banking. It will require investment in technology enabling people to identify and manage their own care or the care of those close to them. It will mean a different mind set to the potential of technology not just in the way we process our business but also in the way we deliver services. And the voluntary and community sector would need to reconfigure its offer to the public and build resilience to support our drive to invest in the army of informal carers.

Scheme 3: Care at Home

The main thrust of the Better Care Fund is to secure the transition of care from Acutes to Communities. This accords with the preferences of patients and users of services who confirm that they wish to remain at home, living independently for as long as possible. By improving individual health and wellbeing, and access to home and community based services, we will relieve pressures on Acute Services and help to eliminate the costs that arise from failures to provide adequate help to those at greatest risk of deterioration. We will work to reduce unnecessary admissions to hospitals and to residential and nursing care through enhanced preventative and community support in the home. Further and wider attention needs to be given to the role of GPs and Primary Care with services wrapping around the individual to avoid such admissions.

We want to create a more holistic recovery based model which promotes the independence of patients/users to enable them to lead the life they choose and reduce their dependency on packages of care and support by using a reabling/recovery model. It means commissioning a model of service interventions that is based on reablement and rehabilitation. This means working with a belief that assisting older people within their communities is an important part of the task and that providers of this service can demonstrate person centred approaches that deliver the outcomes defined by customers. It means commissioning an outcomes based model for care at home that is predicated on the ability of older people to recover (albeit it different rates). It would have an emphasis of capturing community support, would utilise equipment and assistive technology and would expect access to housing grants and home improvements to align with discharge from hospital. This multi layered approach would begin with a response from a joint emergency response unit to avoid admissions, it would be complimented by a workforce of generic health/care assistants delivering a range of outcome based home care services and it would link with the voluntary and community sector to support and sustain vulnerable people at home.

Scheme 4: Accommodation with Support

Through the provision of accommodation with support and access to efficient delivery of home improvements more older people and those with complex needs would be supported to remain at home for longer. Through the use of technology and access to equipment there would be an expectation that people would be able to return home much

more quickly and not be diverted into residential and/or nursing care as the only option.

We want to explore how to support older people to live independently by promoting the development of 'lifetime neighbourhoods'. These are places that are designed to be lived in by all people regardless of their age or disability. Part of our ambitions is to continue to develop the model of Extra Care so that people can remain in their own homes for as long as possible.

And for those who genuinely cannot live independently we will continue to build and focus on improving outcomes through transforming the quality, consistency and co-ordination of care within residential and nursing care provision across the County.

All of this, of course, links to our initiative to support people to die a place of their choosing. By supporting and enabling people to remain at home (and within this definition we include residential and nursing care) we will be supporting people to achieve their final ambitions at the end of their life.

Scheme 5: NHS Continuing Health Care

Currently health and social care are operating independently in relation to NHS CHC in terms of practice and commissioning activity. Whilst the key issues continue to be around market capacity and value for money, there are also missed opportunities in relation to personalisation (e.g.; Direct payment users), quality and choice within the market, all of which impact on the patients experience of service provision. There are opportunities through joint commissioning to;

- Develop a commissioning market strategy
- Improve the quality, diversity, and sustainability of provision

Redesign the pathway and processes for CHC across the health and social care system to improve outcomes and deliver value for money.

Some of the priorities as defined in the plan include:

- Commitment to addressing inefficiencies in CHC processes
- Securing better prices and higher quality within commissioned services
- Increased diversity in the market
- Priorities for commissioners versus demand management ie' expectation of increasing demand/need to manage down.

NHS data shows that the numbers are rising and are significantly higher than the local, regional and national benchmark. In partnership we can work together to address this and to ensure that the system(s) works for patients and carers.

We want to use the BCF to explore better more joint ways of managing Continuing Health Care

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The BCF will be included in each of the CCG's 2 year operating plan and will be part of their QIPP programme. Each CCG will be talking to their main NHS provider about the impact of the QIPP programme.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Since the inception of the Health and Wellbeing Board the council and the three clinical commissioning groups have built a strong alliance to the delivery of services within Warwickshire alongside other key partners such as; the Acute sector, Pharmacy, District and Borough Council. In addition the chief Officer of each of the Clinical Commissioning Groups and the Portfolio holders of Health and Adult Social Care respectively with the Leader of the Council meet on a quarterly basis to identify key issues and themes for partnership work. The Health & Wellbeing Board is therefore well placed to oversee the progress of the BCF plans.

The BCF and the initiatives that it encompasses will be overseen by the Warwickshire Joint Commissioning Board which is chaired by the Strategic Director for the People Group within the Council and reports progress through the Warwickshire Health and Wellbeing Board to the respective accountable bodies of the Council and the CCGs.

Where relevant we will use the scrutiny role of the council to assure ourselves of the progress and direction of travel taken.

The 5 year system plan of which the BCF is part will be overseen by the Coventry and Warwickshire Integrated System Board.

Using a Programme Approach the Local Authority and CCGs Governing Bodies will receive progress reports and outcomes achieved across the BCF programme. A governance structure chart together with the terms of reference for the Joint Commissioning Board is available on request. A Partnership Agreement is being scoped for approval and will be the precursor during 2014/15 to more formal agreed arrangements such as a Section 75.

We have already aligned the timetabling of our commissioning intentions which will assist in developing joint schemes and proposals for S256 allocation as well as opportunities for joint commissioning and pooled budget arrangements. Further work is progressing to draw together key performance data through improved data sharing. There is already a strong integrated quality assurance framework for the monitoring of quality within residential and nursing care homes. We want to review this and bring together our respective quality premium payments and CQUINs to incentivise and drive quality even further to improve outcomes and reduce the admissions to acute care.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

BCF funding will be made available to complement available, recurrent social care funding to ensure the core, statutory, 'FACS-eligible' social care services will continue to be delivered safely and appropriately, thus avoiding adverse impact on health (such as delayed discharges). And that the impact of any additional demand on social care (within the above definition) resulting from successful initiatives to transfer activity from the acute sector to community services is recognised and financed via the BCF.

We recognise that 'demand management' success is actually going to be predicated on activity largely 'outside' adult social care, because it needs to happen 'before' people come to the adult social care 'front door' as much as possible. Examples include – good housing / planning strategies, community health services, community capital and voluntary sector contracting etc.

Working with Public Health with a the focus on prevention, early help and targeted support will act as a protection from rising demand on social care, via the aim of enabling people to remain as independent and healthy as possible for as long as possible.

We have also looked at a number of national examples of 'budget management' techniques that have been used in other Local Authorities and may need to be considered unless a whole system approach continues to be maintained.

We will also build on our nationally recognised models of improving discharge processes and admission avoidance through the utilisation of Discharge to Assess Beds and Moving on Beds.

Please explain how local social care services will be protected within your plans

The BCF funding will be made available to complement available, recurrent social care funding to ensure the core, statutory, FAC eligible social care services will continue to be delivered safely and appropriately, thus avoiding adverse impact on health (such as delayed discharges or increase admissions to hospital. And that the impact of any additional demand on social care (within the above definition) resulting from successful initiatives to transfer activity from the acute sector to community services is recognised and financed via BCF.

NATIONAL CONDITIONS

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

There are already some good examples of 7 day working across the health and social care economy; emergency duty team, access to emergency short stays, re-ablement. However more can been done as we recognise that one part of the system cannot function effectively at the weekend if other parts don't, it has to be a whole system wide approach. 7 day working opportunities are being scoped across the health and social care landscape to improve performance and outcomes. Given the complexities of achieving this across the whole system further work is being progressed to scope and cost a 7 day service to reduce the pressure on the health and social care economy at key points. Some of the areas being considered and/or scoped include; 7 day access to information and advice, improvements to EDT, reablement, home care, night support and carer support.

There are clearly complexities inherent within this such as; exploring the different working patterns and changing traditional 5 day service model (37hrs per week 5 times 9-5pm shifts) to 7 day service model (37hrs per week, 4 times 8 – 6pm shifts) for social care services. However, health and social care are committed to exploring this across commissioning and operational team and work has already begun to scope extending services such as; 7 day per week hospital social care cover – full team in each hospital, Re-ablement presence in each A&E to ascertain and advise of existing support packages in place or negotiate small temporary changes with providers, to prevent admissions.

Work will commence in 2014 to build on current 7 day provision with the intention to increase 7 day working before the Autumn.

NATIONAL CONDITIONS

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

No we do not currently use the NHS number but have plans to do so in the future

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Plans developing to use the NHS number and progress will be enhanced by the review and retender of the local authorities' main data system and the implementation of the data sharing protocol.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

No we do not currently use the NHS number but have plans to do so in the future

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes

NATIONAL CONDITIONS

d) Joint assessment and accountable lead professional

Please confirm that local 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. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The Risk Model
In Warwickshire we offer the Combined Predictive model[1] which uses an algorithm developed by the Kings Fund, Health Dialog and New York University. It uses both primary and secondary care data to produce a risk score between 0 and 100% - this is the patient's risk of being admitted for an emergency chronic admission within the next 12 months.

To support the Risk profiling of patients, the Ventris report provides the following information;
NHS Number, Age, Gender
Current & Previous Risk Score (%)
Long Term Conditions/Co-morbidity
Hospitalisation (A&E)
Substance Misuse
Multiple Drug Use

The data is refreshed on a monthly basis using data feeds from GP Clinical Systems (via Apollo/MSDI), SUS and Exeter.

Access and Usage
All GP practices in Warwickshire have the ability to access Risk stratification reports via Ventris, the CSU Business Intelligence solution. Access is granted via strict data sharing agreements and 64 out of 76 (84%) practices have these agreements set up to view these reports. By locality this is;

South Warwickshire – 31/36 (86%)
North Warwickshire – 21/28 (75%)
Rugby – 12/12 (100%)

The uptake has increased significantly since the start of the Risk Profiling DES (April 2013) which recommends practices use a Risk Stratification tool to profile their most 'at risk' patients. The necessity to monitor these patients will intensify even more next year (April 2014) with the roll out of the 'Unplanned Admissions LES'[2].

Ventris usage statistics (for South Warwickshire only) for the last 2 months (Dec – Jan) show practices have accessed these reports 77 times.

[1] http://www.kingsfund.org.uk/sites/files/kf/field/field_document/PARR-combined-predictive-model-final-report-dec06.pdf

[2] http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/general-practice-contract/unplanned-admissions-2014

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Inability to meet financial challenges across the health and social care economy	16	• Agreed understanding to share wider financial envelope and challenges across the health and social care economy to better understand the respective pressures.
Failure to secure capacity, capability and quality provision from the market	12	• Renegotiate contracts based on outcomes framework and revised financial envelope. • Complete soft market testing for some niche areas. • Introduce quality premium payment for key areas e.g. dementia
Political and GP member buy in for proposed new service model	12	• Establish strong brand and key message. • Demonstrate financial viability across the economy. • Evidence value for money and outcomes to be delivered for each scheme.
Leadership and continuity of the new service model	16	• Produce robust communication strategy. • Strategic Director lead for Integration agreed and owned across the health and social care economy.
Introduction of the Care Bill, will result in a significant increase in the cost of care from April 2016 which will impact on social care funding and any associated savings plans	16	• Scoping the impact of the Care Bill is underway and will be further refined and updated as the Bill progresses through Parliament.
Moving resources to fund new joint interventions and schemes will destabilise current service providers, particularly the Acute Services.	16	• A Whole Systems integrated Care model will need to be mapped and further developed with all key stakeholders engaged and involved . • Co-design of the system including key transitional points to be mapped and agreed across all stakeholders.
Insufficient and therefore confidence in the baseline data.	9	• Further investment throughout 14/15 and beyond will ensure that data sharing and performance will improve.
Lack of understanding of the BCF function and intentions resulting in little change in behaviours/systems and outcomes forpatients/users	12	• Strong Communication Strategy needs to be developed alongside the BCF that is implemented across the whole system.

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Warwickshire County Council	Y	1,244	*1,244*	*800*
Coventry & Rugby CCG	N	2,873	*6,722*	*14,550*
South Warwickshire CCG	N	6,624	*15,500*	*32,018*
Warwickshire North CCG	N	4,716	*11,036*	*14,935*
District Councils	N	1,925	*1,925*	*1,925*
BCF Total		**17,382**	***36,427***	***64,228***

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Scheme 1 Patients/Users Journey - Joint Assessment and 7 day working		*1007*				*932*			
Scheme 2 Self Management and Community Support		*3383*				*6076*			
Scheme 3 Care at Home		*12347*				*15316*			
Scheme 4 Accommodation with Support		*500*				*1300*			
Scheme 5 CHC						*41659*			
Scheme 6 Seven day working									
Scheme 7 Whole Systems Alignment		*225*				*300*			
Total		***17462***				***65583***			

Association England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - By commissioning models of service interventions based on reablement and rehabilitation we will be able to prevent people being admitted to residential and nursing care. In addition the increased availablility of accommodation with support including the use of technology will mean more people will be supported to remain at home longer, reducing the need for admissions to care.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services - Approximately 45% of social care admissions to residential and nursing care are for people being discharged from hospital; a rehabilitation approach as well as preventing hospital admisisons will have a significant effect on reducing residential admissions.

Delayed transfers of care from hospital per 100,000 population (average per month) - Joint assessment/care planning approach will speed up the discharge process. Through the use of technology and access to equipment there will be an expectation that people are able to return home from hospital more quickly.

Avoidable emergency admissions (composite measure) - Introduction of a multi-layered approach including a joint emergency response unit to avoid admissions, complemented by a workforce of generic health/care assistants delivering a range of outcome-based home care services.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

N/A

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - Complying with the Health & Social Care Information Centre Adult Social Care Combined Activity Return guidelines for production of this measure. Warwickshire County Council has an internal audit function that routinely audits the production of annual returns.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services - Complying with the Health & Social Care Information Centre Adult Social Care Combined Activity Return guidelines for production of this measure. This combines data from health intermediate care services and council reablement services.

Delayed transfers of care from hospital per 100,000 population (average per month) - Released on a monthly basis by NHS Statistics (http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/)

Avoidable emergency admissions (composite measure) - Measure defined in "Quality Premium: 2014/15 guidance for CCGs" and published by NHS England

Patient / service user experience - Social Care related quality of life - Calculated from the annual social care survey complying with Health & Social Care Information Centre requirements for undertaking the survey

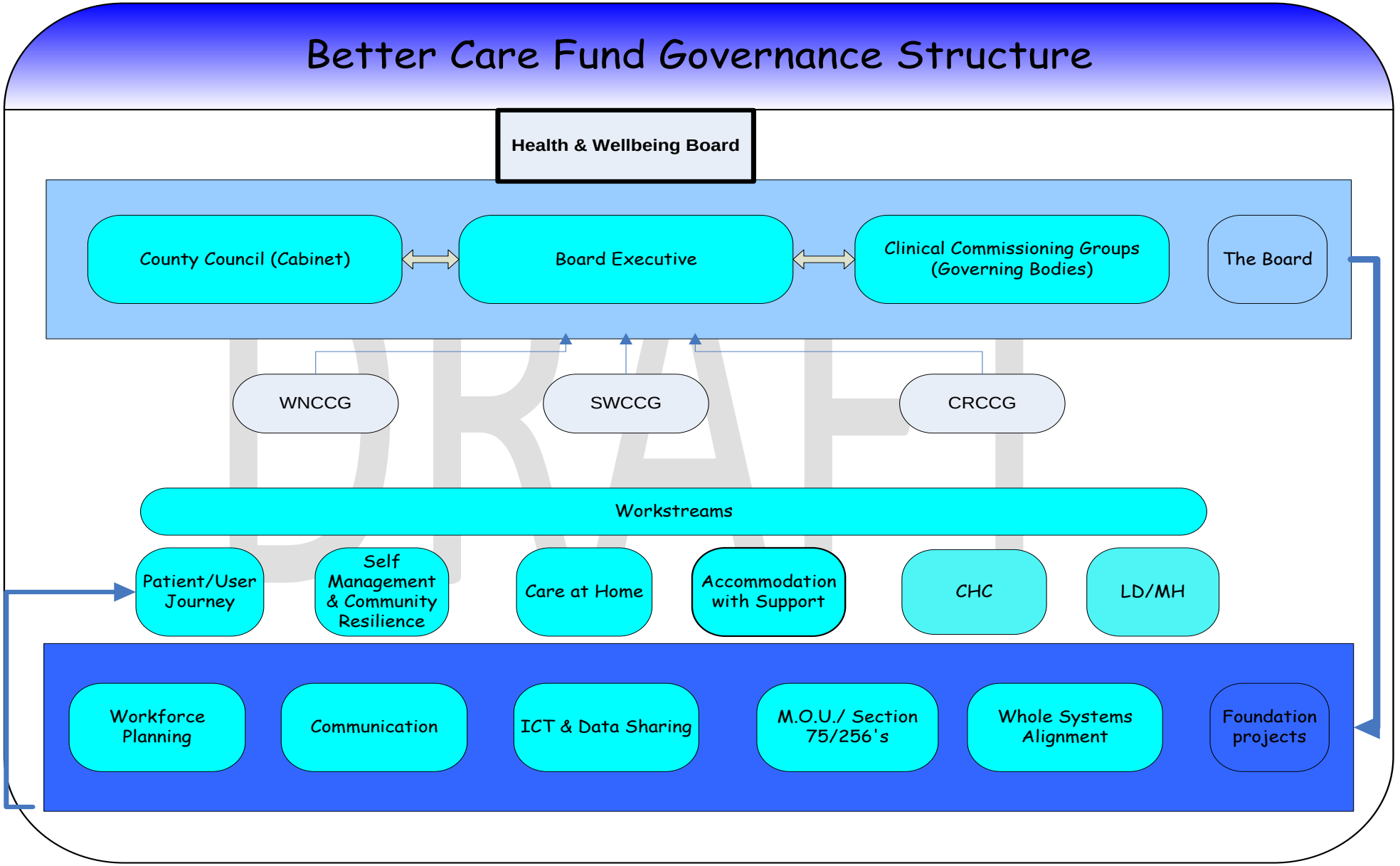
If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	673.5	N/A	
	Numerator	703		
	Denominator	104,380		
		(April 2012 - March 2013)		(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*	82.2%	N/A	
	Numerator	695		
	Denominator	845		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	9.1		
	Numerator	39.6		
	Denominator	436,100		
		(April - December 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	932.5		
	Numerator	5,110		
	Denominator	547,974		
		(April - September 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience - Social Care related quality of life	*Metric Value*	18.5	N/A	
	Numerator	82,815		
	Denominator	4,485		
		(April 2012 - March 2013)		(April 2014 - March 2015)
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

Governance Structure: Better Care Fund
Health & Wellbeing Board
Respective Governing Bodies

Adult Joint Commissioning Board		
Users Christine Lewington (Social Care) John Linnane (Public Health) Anna Burns (SWCCG) Sue Davies (CRCCG) Yee Cho (WNCCG)	**Executive** Wendy Fabbro	**Suppliers** Paul Jarvis (SWCCG Finance) Claire Hollingworth (CRCCG) Michael Burns (WNCCG) Andy Chapman (Performance) Spencer Payne (Quality) Alison Walshe/Amanda Burn

Project Manager	**PA Support**
Anne Marie Gray	Julie Quinn


Better Care Fund Governance Structure
Health & Wellbeing Board
County Council (Cabinet)
Board Executive
Clinical Commissioning Groups (Governing Bodies)
The Board
WNCCG
SWCCG
CRCCG
Workstreams
Patient/User Journey
Self Management & Community Resilience
Care at Home
Accommodation with Support
CHC
LD/MH
Workforce Planning
Communication
ICT & Data Sharing
M.O.U./ Section 75/256's
Whole Systems Alignment
Foundation projects

Better Care Fund – Scheme Programme Schedule

1. Patient/User Journey	**Senior Lead**	**Support**
2. Self Management & Community Resilience	**Senior Lead**	**Support**
3. Care at Home	**Senior Lead**	**Support**
4. Accommodation with support	**Senior Lead**	**Support**
5. Continuing Health Care	**Senior Lead**	**Support**
6. Learning Disabilities/Mental Health	**Senior Lead**	**Support**
Assurance		
i) Performance		
ii) Quality		
iii) Finance		

Foundation Projects
a) Workforce
b) Communication
c) ICT and Data Sharing
d) MOU and Section 75
e) Whole System Alignment

Better Care Fund Partnership Agreement
(DRAFT)

Purpose
The Government have established a Better Care Fund of £3.8billion to be distributed across all local authorities for health and social care, with the aim of developing a more integrated system.

The primary purpose of the Joint Commissioning Board is to: reduce inequalities in health and social care provision *and* to provide the optimum range of services to address all health and social care needs, taking full account of national and local priorities.

The Partnership comprises of:

- Warwickshire County Council
  - People Group
  - Public Health
- South Warwickshire Clinical Commissioning Group
- Warwickshire North Clinical Commissioning Group
- Coventry & Rugby Clinical Commissioning Group

Aim
To progress the integration of NHS, social care, public health and related services for the benefit of Warwickshire residents.

Objectives
The objective of this Partnership is to secure, through commissioning, effective services for the population of Warwickshire for whom the Partners have responsibilities. This agreement aims to set out clearly the undertakings given by each of the Partners and the intended basis of their relationship. It is the intention of the partners to operate the agreement in a spirit of mutual trust as Partners and to:

- Establish and maintain appropriate joint commissioning arrangements, and review their effectiveness annually.

- To achieve this, the Partners will take into account the Joint Strategic Needs Assessment and alignment to the Health and Wellbeing Strategy for Warwickshire, will develop appropriate and effective joint commissioning plans in accordance with the priorities and will ensure that services are jointly commissioned on the basis of evidence of:

  - need
  - best practice in tackling need
  - best value
  - robust financial planning and management
  - risk management
  - locally determined and agreed priorities

- Ensure that commissioned services meet the required standards and quality of care.

- The Partners will develop a Joint Performance Management Framework to ensure that the Partners know what the joint arrangements are aiming for (for example; outcomes, purpose, mission, corporate aims, strategic goals, project objectives, etc) and set out:

(ii) what the partners have to do to meet these aims (e.g. business plan, project plan, etc);
(iii) what the priorities are, and ensuring that there are sufficient resources
(iv) what the current performance is through monitoring and reporting;
(v) how to review progress, detect problems and take action in a timely manner to ensure the outcome is achieved;

- Establish and manage a contract performance management framework for those services jointly commissioned, and deliver to agreed targets.

- Create the right environment to develop a high quality innovative health and social care market that delivers value for money and achieves outcomes for patients/users of services.

- Identify and agree the budgets covered by the joint commissioning plans, and to be included in any formal arrangement under section 75 of the NHS Act 2006, and make financial decisions within an agreed scheme of delegation

- Identify individual and collective financial and other relevant risks and agree risk-sharing arrangements for each jointly commissioned service.

- Establish appropriate and rigorous financial accountability mechanisms to ensure that any formal agreement is fully implemented, and all contributed funds are used effectively for the intended purpose within agreed limits

- Recommend to the constituent partners any remedial action that needs to be taken should financial and/or service performance fall below agreed standards and performance.

- Ensure that joint commissioning developments and arrangements are aligned across all health, social care and related services to ensure effective transition arrangements where applicable

- Ensure that public, patients, service users and carers are given the opportunity to shape how services are organised and provided

- Ensure that statutory duties and responsibilities of relevant partners are discharged by jointly commissioned services, including safeguarding responsibilities in respect of Children and vulnerable adults

- Ensure that all joint commissioning meets the requirements of the Equality Act and undertake an Equality Impact Assessment for service developments or significant service changes.

Commitments of the Partners

The Partners jointly undertake:

- to jointly commission services that are responsive to the needs of the population in accordance with agreed priorities and service standards;
- to ensure the relationship between the Council and the Clinical Commissioning Groups are developed and defined;
- to develop a Joint Performance Management Framework;

- to provide the Pooled Fund with sufficient funding, resources and other support to ensure that Services can be commissioned effectively;
- to take account of each others' strategic objectives as set out in any strategic planning documents;
- to align initiatives with the intention of improving the health and well being of the general population.

Corporate Governance

The Strategic Director of the People Group will keep the Council informed of any issues requiring their attention that arise from discussions at the Joint Commissioning Board.

The Clinical Commissioning Board respective representatives will keep the CCGs governing bodies informed of any issues requiring their attention that arise from discussions at the Joint Commissioning Board.

The Joint Commissioning Board will report progress to their respective governing bodies and the Health & Wellbeing Board.

Financial Arrangements and Governance
The commissioning responsibilities of the Clinical Commissioning Groups and the Council placed into any total pool will be governed by the Joint Commissioning Board.

The Joint Commissioning Board will receive appropriate financial and performance reports to support strategic decision making and budget management.

Sharing and Handling of Information

When it obtains access to Personal Data (as defined in the DPA) obtained by or in the possession of any other Partner, each Partner and it's employees will duly observe all their obligations under the DPA which arise in connection with this Partnership.

The partners will share information about clients in order to improve the quality of care provided to that service user. This is subject to the agreement of the service user, the law and the joint information sharing protocol (attached as appendix 1).

Disputes

The Partners will use their best efforts to negotiate in good faith and settle any dispute that may arise out of or relate to this agreement. If any dispute cannot be settled amicably through ordinary negotiations then it shall be referred to the Chief Operating Office of each respective clinical commissioning group and the Strategic Director for the People Group for discussion and resolution.

In the event that such person cannot resolve the dispute between themselves within a reasonable period of time having regard to the nature of the dispute, the Partners may refer the matter to the Chief Executive of the Council and respective Chairs of the Clinical Commissioning Groups.

If the dispute remains unresolved the Partners will request the Strategic Health Authority or other relevant Regional body to agree how the matter should be decided. The decision taken as a result of this process will be binding on both Partners.