

CCN

COUNTY COUNCILS NETWORK

Delivering the Better Care Fund in Counties

May 2014



About CCN

CCN is a network of 37 County Councils and Unitary authorities that serve county areas. CCN is a cross party organisation whose views carry particular weight for a large proportion of the country outside the big conurbations: its 37 member councils, with over 2,500 Councillors, serve over 23 million people or 47% of the population, over 45 thousand square miles or 86% of England.

CCN is a member-led organisation, and works on an inclusive and all party basis. CCN Council and Executive Committee include Councillors from each of our member authorities. CCN recognises that member authorities must have the right to respond to their communities in different ways and seeks to make representations to government which can be supported by all member authorities. CCN is a Special Interest Group (SIG) of the Local Government Association (LGA).

Methodology

The February 2014 survey was sent to 37 county councils and county unitary authorities in England. In total CCN received 30 responses, representing a response rate of 82%. The survey was to be completed, on behalf of the local authority, by the Director of Adult Social Care or a nominated substitute. The survey was an online multiple-choice questionnaire, with respondents able to provide additional comments and information.

Further Information

For further information on this paper please contact:

James Maker, Policy Officer on 020 7664 3009 (james.maker2@local.gov.uk)

For media enquiries please contact:

Phil Baker, Policy & Communications Officer on 020 7664 3010 (philip.baker@local.gov.uk)

If you would like further information on CCN - including the latest policy briefings, publications, news & media and conference & events please visit our website.

Website

www.countycouncilsnetwork.org.uk

E-mail

countycouncilsnetwork@local.gov.uk

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Foreword

Cllr Paul Carter CBE, CCN Spokesman for Health & Social Care Integration
& Leader Kent County Council

At the risk of sounding over the top, we might just be standing on the cusp of new era for health and social care integration, with Counties in the vanguard of establishing a new way of working for the sole purpose of delivering better health and social care services for residents at a time of reduced funding.

The unprecedented financial pressures facing local authorities and the demand-led pressures created by an ageing population mean we fundamentally have to change the way care and support is provided. Faced with the implications of the Care Bill, local government has therefore worked with Government to create the largest ever pooled integration fund to date between health and local authorities in the shape of the Better Care Fund (BCF). Following months of negotiation with local health partners, there is a growing recognition that the BCF is leading to the step change necessary in health and social care integration and cautious optimism that it could achieve its aims. I believe that this publication teaches us three key lessons on why the BCF could succeed.

Firstly, contributions to this publication are demonstrating that integrated funds on the scale of the BCF can shift the focus of care and support services increasingly towards joined up community health and social care based services that support prevention and early intervention, making more effective use of how every pound is spent. I have argued tirelessly for a radical change in the provision of health services, one that takes difficult political decisions to move provision closer to the community and away from acute and unnecessary hospital treatment. This is ultimately how we will improve outcomes for service users and make the necessary long-term savings across public services. All over the country, in places like Surrey, Dorset and my own authority of Kent, we are proving the validity of radical care integration and cross sector collaboration as a way of improving services for our communities whilst simultaneously reducing costs.

Secondly, it is evident that a key driver of the impetus to transform services through the BCF is the scale of the financial commitment made by both health and social care. Pooled budgets on the scale of the £3.8bn BCF provide an opportunity to help place adult social care funding on a more sustainable footing in the face of unprecedented service demand. Although the bulk of respondents to the CCN survey were yet to be convinced that the fund can lead to greater sustainability in adult social care funding, a third of CCN member councils agree that the BCF will help stabilise adult social care funding in the short-term.

Thirdly, finance isn't the only challenge we have faced locally but we are demonstrating a willingness to acknowledge them and work hard to overcome them. For instance, the complexity of the provider landscape in county health economies brings the need to ensure that care remains accountable and transparent to local people. For care integration to succeed, we need to bring service users with us. There also remains the need for a new common working culture between health and social care services, which can be developed through Health and Wellbeing Boards.

So challenges remain, but so does the confidence of CCN members in meeting them. What is new is the strong consensus that the BCF is an essential tool in doing so. I hope our member councils and the wider sector learn from the early experiences outlined in this publication and ensure this consensus on health and social care integration isn't broken. Over the remainder of this parliament, and the next, CCN will continue to work with members to put forward a compelling case for an increased allocation of pooled funding, alongside proposals for public sector reform that place health and social care at their heart.

Introduction

There is now a broad consensus on the need to radically integrate health and social care.

Over the past three years adult social care budgets have been reduced by £2.68bn, some 20%¹. As funding has reduced, increases in life expectancy and better healthcare mean that the demand for adult social care services will continue to rise. Demographic pressures already account approximately 3% of total adult social care expenditure per year and this will continue to grow well into next decade and beyond.²

Reforms to the provision of social care in England are set to dramatically intensify these demand-led pressures. The Care Bill, currently before parliament, will for the first time in England introduce a £72,000 lifetime cap on the costs of care, simplify and strengthen service user rights, and extend access to state support and services, particularly amongst those that currently arrange and fund their own care.

Following negotiations between the Government, Local Government Association (LGA) & Association of Directors of Adult Social Services (ADASS), the Chancellor announced in June 2013 the largest ever pooled integration fund between health and local government of £3.8bn from 2015/16 to help meet the challenges facing adult social care. This came in addition to the £859m transferred from the NHS to local authorities in 2013/14 and the £1.1bn to be transferred during 2014/15.

Since the announcement by the Chancellor on the newly renamed **Better Care Fund** (BCF), there has been intense activity at a local level in counties to develop joint plans. Action on the ground has progressed rapidly since guidance was published in December and initial plans were submitted in February 14th 2014. Our recent stocktake with CCN member councils on their BCF plans showed 80% of CCN member councils describe their progress on developing plans with health partners as 'advanced' or 'very advanced'.

Our research has shown that the focus on integration, brought forward by the BCF and other initiatives, alongside pre-existing activity and well established cross-sector collaboration, have been key drivers of initial activity. For authorities such as Kent County Council, featured in this document, pioneer status for health and social care integration has helped provide a structure to BCF discussions with health. For others outside of the pioneer pilot areas, such as Cambridgeshire, Lincolnshire and Oxfordshire, they have built on long traditions of joint-working with health partners. In our survey 57% of CCN member councils agreed, and a further 23% strongly agreed, that the BCF will help improve health and adult social care integration. Our research and contributions to this publication show that the process of developing BCF plans has accelerated collaboration, with evidence suggesting it has energised partners and provided an impetus to work together more than ever before.

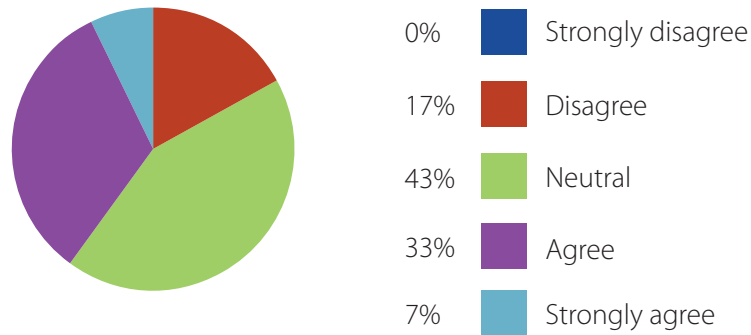
Significantly, for the first time the BCF is pooling budgets on a real and substantial scale, including £1.9bn from the NHS, with an explicit commitment that local plans must demonstrate how their share of the £3.8bn will 'protect' adult social care services. The need to leverage additional investment into adult social care is unambiguous, with 87% of CCN member councils describing their adult social care budgetary pressures as either 'severe' or 'critical' in our recent survey. Early analysis of BCF plans has revealed the total amount pooled could reach £5.2bn during 2015/16, with local authorities and CCGs pooling an additional £1.4bn. The CCN member councils of

1 ADASS. ADASS Budget Survey 2013 (2013)

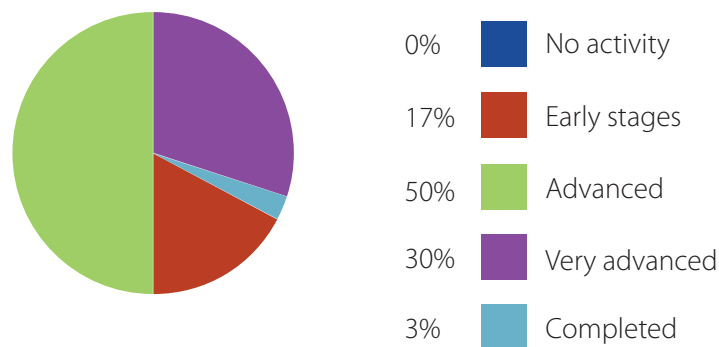
2 ADASS. ADASS Budget Survey 2013 (2013)

Lincolnshire and Hertfordshire are two authorities pooling in excess of £100m, with the former initially pooling £197m and the latter £239m. Faced with monumental funding challenges, some 33% of CCN member councils agree the BCF will help place adult social funding on a more sustainable baseline. However, 17% disagree and a further 43% remain to be convinced.

The BCF will help your authority place current adult social care funding on a more sustainable baseline.



How would you describe your progress on your BCF plans with health partners?



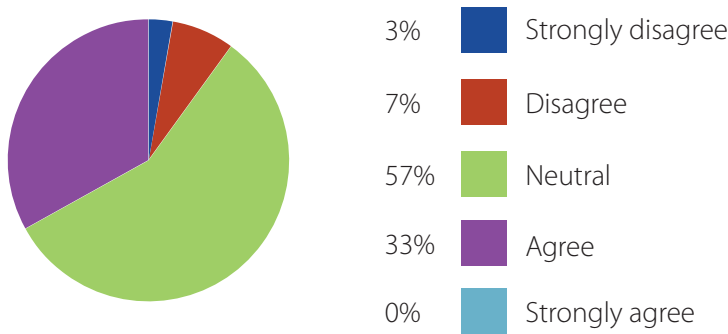
Pooled funding without a reinvention in integrated service delivery will not lead to the necessary long-term recurring savings in health and social care, or improvements in services. Crucially, our research and the contributions to his publication show that the BCF is providing counties and their partners with the platform for setting out joint-vision and shared intent, with partners focusing on shifting local services from acute provision to community based commissioning and prevention.

CCN have long-argued for the need to shift services towards prevention and early intervention. To reduce the long-term cost of caring for an ageing population on local government and the health service, preventative services need to support people to remain out of the adult social care system for as long as possible, particularly permanent residential care, and reduce the unnecessary reactive costs on hospitals and acute services. Surrey's BCF focus of enabling people to stay well for longer, within their own home and returning from hospital sooner is reflected across all the examples presented further on and is synonymous with joint BCF activity to move social care closer to the home and away from hospitals.

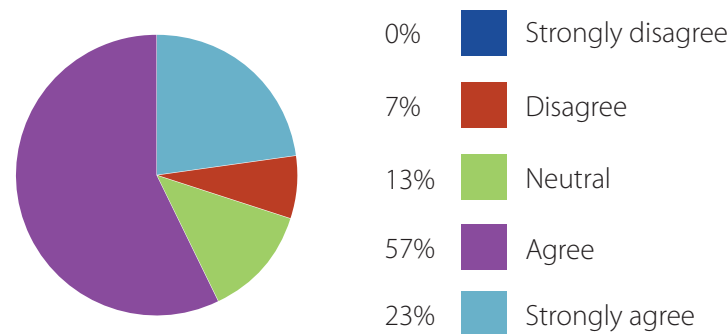
For success to endure there needs to be a long-term willingness to commission services in a different way, with pooled funds and services focusing on managing demand more effectively across sectors. This will help drive fundamental change

rather than simply replacing packages of care for the elderly or moving public money around the system with little join-up prevention across health and social care. As Dorset argue in their case study, without change across health and local government the increasing demands of an ageing population will make services unsustainable in the longer term, especially to local authorities. In an early sign support for improving integration and preventive activity through the BCF, only 7% of CCN member councils disagree that the BCF will lead to significant improvement in adult social care services, with 36% agreeing or strongly agreeing.

The BCF will lead to significant improvements in adult social care services.

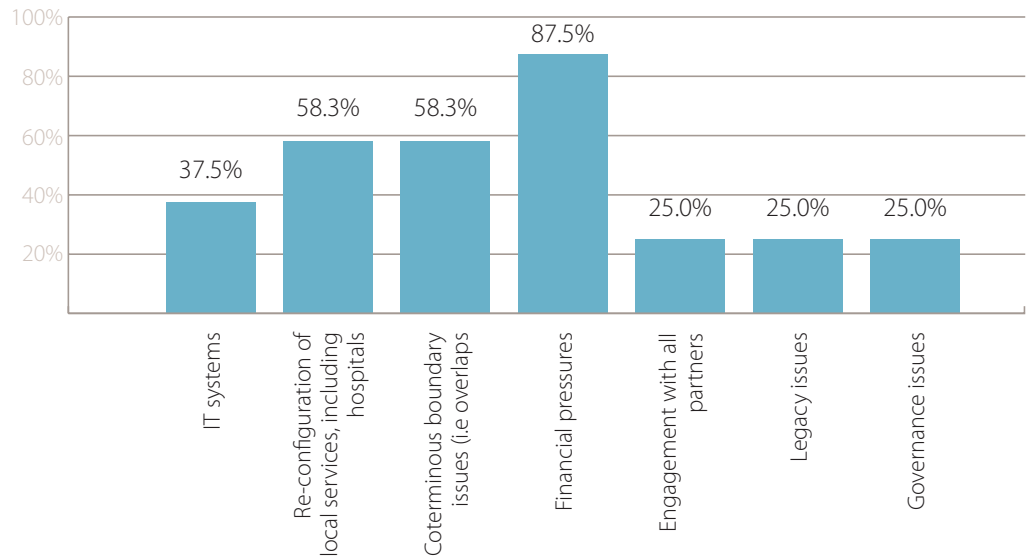


The BCF will help improve health and social care integration.



Whilst the BCF creates opportunities to drastically improve health and social care integration, we cannot ignore the significant challenges to achieving improved user outcomes. Our research and the case studies presented further on have identified some significant barriers to developing local plans, with 'financial pressures' unsurprisingly regarded by CCN member councils as the biggest challenge. The BCF does not represent new money from the Treasury and is made up of existing funding streams across health and social care. This means difficult investment decisions over existing NHS financial commitments, at a time when both sectors are absorbing large savings. Councils have stressed the need to work up details of investment and activity changes to implement pooled budgets, with these clearly early days in respect of implementing jointly agreed plans. The inclusion of £185m of Care Bill funding within the BCF, as our recent *Counties & the Care Bill* research showed, is undoubtedly creating additional complexity to financial negotiations with CCGs. It is essential that any funding provided through the BCF to implement the Care Bill represents new money to avoid unnecessary local tensions and ensures BCF negotiations do not lose their focus.

Are you experiencing any significant barriers to developing local BCF plans with CCGs (please tick all those that apply)?



The complexity of service provision within counties, and cross sector re-configuration of local services, is also regarded as barriers to developing plans. As many of the articles in this publication allude to, large numbers of CCGs, acute trusts, hospitals, and district councils add complexity to negotiations in county areas and dictate that Health & Wellbeing Boards oversee multi-layered governance and accountability structures. Moreover, as Richard Humphries argues in his contribution, the necessary remodelling of local services can create cultural, organisational, and increasingly, public opposition. Remodelling services at a local level would be a challenge at any time, let alone one dominated by financial restraint and increasing demand.

But as Cambridgeshire argue later in this document, at a time of tightening budgets and increasing demand, large-scale projects such as the BCF have the potential to create divisions *unless* officers work hard to foster strong professional links and engage thoroughly with all stakeholders. Past experiences of pan-public sector integration and pooled budgeting has been beset by concerns over structures and governance; cultural differences between health and local government; and a failure to take tough decisions over services in the face of local opposition. It is encouraging that despite complex geography partner engagement and governance are only regarded as barriers by 25% of respondents.

This publication demonstrates that the consensus on the need to radically integrate health and social care extends to counties. Indeed, the demographic pressures of county populations and pending implications of the Care Bill heighten both the desire and necessity for change in county areas. The BCF is an important development in transforming the way we integrate services to address the long-term financial sustainability of social care services. **But it's only a first step.** Some 77% of CCN member councils either agree or strongly agree that pooled health and social care funding should be a permanent feature of health and adult social care funding, and the clear implications of our research is that the Government's commitment to long-term pooled budgets could be even more ambitious. This publication shows that there is now a compelling case for an increased allocation of pooled funding, alongside proposals for public sector reform that strengthen the role of Counties in integrating and commissioning health and social care services.

Integration is not a 'nice to have' but a necessity

Brandon Lewis MP, Parliamentary Under Secretary of State DCLG
& Norman Lamb MP, Care Minister

The demographic and financial pressures speak for themselves: we are all living far longer than previous generations could have dreamed. And while we may welcome our increased longevity, longer lives means more and increasingly complex conditions, multiplying as we approach old age. The level of care and the cost of its delivery can only increase and we have no choice but to meet this challenge head on.

That's why the Better Care Fund was launched last year with such a profound sense of purpose - a demonstration of intent that the better integration of health and care services is not a 'nice to have' but a necessity. And while this intent stems from national priorities, it is only through concerted action at local level that we can deliver truly joined up, coordinated, person-centred care. We know the will is out there at county level and we thank you for your enthusiastic response to the challenge. The work of the 14 integration pioneers, as well as the many others working hard to innovate and elevate best practice throughout the system, is testament to this fact.

As the people living and working in local areas, you are clearly best placed to develop the most effective ways to join up local services. We know all areas are working in partnership across social care and health to agree and implement their Better Care plans. We hope the £200 million additional NHS transfer funding provided for 2014/15 to smooth the transition to better joined up services will help you make the most of the £3.8 billion due for the first full year of the fund in 2015/16.

It is why this **Delivering the Better Care Fund in Counties** publication is so welcome and timely. It's a reminder not only of why the Better Care Fund exists, but also an encouragement to share your experiences and learning within and between your regions. This is an important opportunity to build and strengthen engagement with local partners to harmonise processes and working relationships - not just between social care and health services, but also within the NHS and within local authorities as well. For example, we want to encourage closer and more effective collaboration between acute and primary care services and between adult social care and housing. Contributions from the Association of County Chief Executives, Local Government Association and The Kings Fund underline this positive consensus and the will to succeed.

But lasting service transformation has to be about more than just money – it's about how we do things to improve outcomes and people's lives, not just how much it costs. We have no choice but to do more with the resources we have – something the system has already proved it can do - as the case studies in this publication demonstrate.

We know we will have succeeded when we have a health and care system that delivers high quality services to the people who need it - when and where they need it. When people know the name of the person responsible for making sure they receive that care based on timely, comprehensive and up-to-date information about their health and personal circumstances.

Above all we want to keep people healthier, happier and at home for longer, where they can continue to be looked after with dignity and respect. And when they do become ill, we want them home from hospital sooner rather than later. Better still, we want to prevent them developing complex care needs in the first place. We look forward to continuing to work with you to make this vision of better integrated health and care a reality.



Opportunities & Challenges – The BCF in Counties

Richard Humphries, Assistant Director Policy, the Kings Fund



Across the world of health and social care there has been general support for the opportunities of the Better Care Fund (BCF) to address some of the immediate pressures on social care services and make faster progress on integrating care. But opinions are mixed – in our last monitoring survey most Directors of Adult Social Services thought the Fund would help their organisation; CCG leaders were rather less optimistic at 38%, but nearly a half of acute hospital finance directors thought the Fund would actually hinder their organisation's performance. This highlights the fact that the £3.8bn pooled fund is not new and is largely NHS money that would otherwise have been spent on hospitals.

Local government leaders need no reminder of the scale of their own financial challenges but money pressures in the NHS are growing too – at least a fifth of hospitals are in financial trouble, so no wonder many are nervous about the impact of the BCF. This is fiscal climate change. The NHS and local government really are in it together.

In the grip of austerity, making the BCF work in county councils and county unitaries has some particular opportunities and challenges.

One is the complexity of the organisational architecture through which plans need to be steered, agreed and delivered. In the county council dominated South East of England alone, responsibility for commissioning health and social care sits with over 60 separate organisations, rising to 116 if the strategic housing role of district councils are included – and there is a strong argument they should. It is doubtful whether the cost and complexity of this fragmented commissioning landscape is sustainable, yet there is no appetite for further structural change. Collaboration and shared decision-making across organisational boundaries will be at premium. This will test the capabilities of fledgling health and wellbeing boards, barely a year old.

For individual authorities, much will depend on the state of their own health economy. The BCF approximates to about £10m per CCG. If the Fund is successful in shifting the balance of care closer to home, this should see less hospital activity – and therefore income. That spells trouble for financially challenged trusts, and has political dimensions (locally and nationally) as the next general election draws ever closer. Shifting care away from hospitals is very difficult to do, and success in reversing the remorseless rise in hospital admissions are thin on the ground. Expectations of what the Fund can achieve are pitched high, for good reason, but there should be no illusion about scale of the challenge.

Whilst leaders in health and local government usually agree on the need for major change in how and where care is delivered, public understanding and acceptance of these issues is way behind. The geographical spread and diversity of shire counties makes task of engaging with public and disparate communities of place and interest about the case for change much harder. Challenging the notion that every hospital can do everything everywhere is tough when the nearest hospital is already thirty miles away and transport links are poor. And producing a BCF plan that accommodates a mixture of urban, rural and mixed populations – whilst satisfying tough national conditions for receipt of the money – is tougher still.

But on the plus side, county councils have a strong identity and years of experience in managing complex issues at scale. They are much bigger organisations with a stronger critical mass than their health counterparts and enjoy greater organisational stability. Many authorities have years of experience of managing pooled budgets far bigger than the BCF, for example for learning disability services. With mature leadership – developed in tandem with local CCGs - these can be formidable strengths.

So how should county councils and their county unitary neighbours proceed?

One tip is avoid over-focusing on the short term and very immediate requirements to have submitted a signed-off two year plan by April 4th. Smart Councils will view this a short-term stepping stone towards a much more ambitious vision of what they want local services to look like and leading conversations with health colleagues about longer term plans. The evidence about what works in integrated care is clear – it takes time. A second pointer is the importance of engaging with acute hospitals - especially councils that have big Foundation Trusts that often will be offering specialist tertiary services to a much wider national and sometimes international population. It will be impossible to achieve local change without their information, ideas, expertise and buy-in. The current separation of commissioning and provider roles within the NHS should not be allowed to impede local conversations about developing a shared view about what good looks like and how it could be achieved.

A third issue is that in many places the scale of service change needed will exceed the geographical footprint of individual Health and Wellbeing Boards, for example of unitary councils that sit within county councils and adjoining councils. This calls for some kind of collaborative mechanism, which could range from simply sharing information through to adopting a single, shared view on key issues and strategies.

Finally the role and contribution of district councils to these issues extends well beyond the arrangements required by the BCF for the disabled facilities grant. Districts are responsible for some key services that make a pivotal contribution to healthy communities and lifestyles. Housing, in particular, is attracting increasing policy interest as the third leg of the integrated care tripod, alongside health and social care. For older people especially, decent housing that is appropriately located, well designed, warm and affordable is vital in reducing demand for health and care services. So the engagement of district councils as equal partners is essential and it is encouraging to see this reflected in many of the Health Wellbeing Boards led by county councils.



The Better Care Fund offers hope in meeting escalating demand, but it's not enough

Debbie Ward, ACCE Lead Advisor for Health & Social Care Integration and Chief Executive, Dorset County Council

Without exception county and unitary councils are steering an uncertain course through the perfect storm of social care funding.

The squeeze on our budgets has led to a significant reduction in the money available for these services. ADASS reports a £2.68bn reduction in the last three years, a staggering 20% drop in funding, at a time when demand is growing by virtue of demographic change, there is pressure from challenges to restricting access to care and improved service quality continues to be required.

Against this background it is no surprise that the Care Bill has been eagerly anticipated, any funding comments forensically examined, and the announcement of the Better Care Fund (BCF) the focus of all our attention.

The Care Bill will, without doubt, increase pressures on services and budgets and with the inclusion of housing investment through Disabled Facilities Grants, brings all Local Government tiers into the storm.

In a county with the demographic of Dorset, 25% of the population over the age of 65, some of the highest life expectancy in the Country and a high percentage of those funding their own care, the financial consequences from the Care Bill and the £72k cap, are only too obvious. This is replicated across the Country and whilst we can model the financial consequences, this can only give us an indication of the pressures we face.

Many of us looked to the innovation of BCF with some optimism that it could help shift us to a more sustainable footing. It wasn't a view shared by all, but having steered through many pooled budget discussions with a variety of health partners the requirement for the parties to come to the table is a significant step forward, and we are all getting on with completing and implementing spending plans with our health partners.

Planning how the BCF could be used has required local government and health to have a joint focus on prevention and early intervention. This has created a stronger momentum to bring those who weren't working well together and reinforced the resolve of those who were already placing population health and wellbeing at the core of the health and care systems and building new models of delivery.

With few exceptions BCF plans have been agreed and the funding is being used in innovative ways to promote new and improved whole system thinking. At its best BCF drives service change, absorbs some of the increased demographic demand and is bringing care and health systems into greater harmony to meet peoples' needs and not separate them into artificial service user and patient categories. However, the financial case that BCF investment will lead to substantial cash savings is not compelling and few are convinced that this puts funding at anywhere near the level of resource needed for the expectations of the care system.

The BCF was intended to drive integration and improve outcomes for people, and it is doing that at pace, but it has most chance of supporting sustainable change if it is used as a short term investment to achieve much more radical and long term ambition. It can support joint vision for building new service models crossing health and social care. With budget pressures hitting health for the first time in any comparable level to local government our partners will be feeling the squeeze too and bringing Clinical Commissioning Groups, Health & Wellbeing Boards together with provider trusts around a single vision needs to be part of all our longer term ambition.

We recognise and appreciate the value of Better Care Funding but it can only be part of the mix, it doesn't deliver the answers to achieving a financially sustainable social care service



Catalyst for a once-in-a-generation opportunity

Andrew Webster, Director for Integrated Care at the Local Government Association and Health & Care Lead for the Public Service Transformation Network.

The Better Care Fund (BCF) is the catalyst for a once-in-a-generation opportunity to transform the lives of people who use health and social care services. The vision is the right one for our society and the goal is both a better quality of life for people with health and care needs, and a more balanced and sustainable health and care system for the future.

On 4 April Health and Wellbeing Boards (HWBs) across England submitted their next iteration of their BCF plans. This is key milestone in a process that included the submission of draft plans on 14 February, through which we have learned how councils and their NHS partners are working across their local areas to:

- Integrate and improve health and care services;
- Address the huge challenges to improve services with less money;
- Pool resources most effectively to protect care services and reduce demand on unplanned care.

However, 4 April is anything but the end of the process. HWBs and their local health and care systems will continue to develop their local BCF plans iteratively as they tackle the challenges in transforming for the long-term the way residents' health and care needs are provided for.

This publication by CCN is a helpful contribution that reinforces the messages that we have been hearing from local areas too. Here are five things we have learned through the process so far.

1. Everyone's doing it

Every one of the 151 HWBs has committed a great deal of energy and ambition to this vision and, in collaboration with their local partners, have all completed their BCF plans. On the evidence of their 14 February draft plans, their primary focus is on people who need better care, redesigning support around them, their families and their communities. Strategically, most areas are planning to invest in prevention, keeping people well and cared for at home, which will help address the problem of unplanned hospital admissions. This examples within this report clearly demonstrate how counties are engaging positively with the BCF planning process as a catalyst for change.

2. Everyone must change (and we all know it)

Everyone has a responsibility for, and interest in, the transformation that the BCF plans represent. Local commissioners, providers, hospitals, GPs, councils and all other related services need to work with each other and, crucially, with residents to genuinely share this endeavour and effect change. This will clearly continue to be a priority for county areas as they work with acute providers and other partners locally.

3. Money matters

We are effecting this change in the context of unprecedented financial challenges for both local government and the NHS. In 2015/16, despite the BCF, most councils will be forced to spend less on social care than in 2014/15. And many local health

economies are facing profound financial challenges. There is not the money in the local system both to invest in preventative care services and continue to pay for unplanned hospital admissions. Ensuring the movement of money keeps pace with the shift in service demand is one of the opportunities of the pooled BCF budget. It is therefore encouraging that local areas have planned to pool a total of at least £5.2bn – 37% cent more than the £3.8bn minimum, with several county areas pooling significantly more than their minimum budget.

4. Overcoming barriers

There are many challenges and barriers to change, including timescales, complexity of local systems, changes to the workforce (those employed to deliver services) and supporting IT systems. We know that in many county areas the complexity of local systems and geography makes the challenge of transformation even more acute, and underlines the importance of continuing to develop close working relationships. However, most areas are confident that they will:

- be able to use a patient's unique NHS number to share information;
- provide services seven days a week;
- identify a lead professional for each of the most needy people.

5. Time: the short and the long term

The timescale for developing and implementing BCF plans by April 2015 is unquestionably challenging, but if local areas stick at it and maintain a focus on the long-term aims, the efforts will pay off. The changes that localities are planning are the start of a profound shift from treatment to prevention that puts people and families at the centre of our thinking, changes what we do and how we do it, and shares money, risk and power.

We know the scale and pace of transformation isn't easy, but it's vital that local areas, including counties, continue to be ambitious and seize the opportunities of the BCF, and work together to deliver lasting change that changes lives for the better.



The District Council Perspective on the Better Care Fund

Cllr Tony Ball, District Councils' Network Lead for Housing

The introduction of the Better Care Fund (BCF) has marked a change in the thinking around supporting vulnerable residents to remain independent. Disabled Facilities Grants (DFGs) have been included in the BCF but the statutory duty to provide adaptations for vulnerable people's homes, including children and older people, has remained with district councils.

The District Councils' Network has been championing the role of housing in health and wellbeing for some time. The housing that people live in can have a massive impact on their health (both physical and mental), and the impact can be severely detrimental if housing is not fit for purpose. Including DFGs in the BCF means that housing is part of the debate.

The BCF begins in April 2015 and councils and CCGs must agree plans to spend the funds. For the first two years the Disabled Facilities Grant aspect of the Fund will be pass-ported back to district councils as a defined sum, so district councils can fulfil the statutory duty to provide housing adaptations. At the end of these two years what happens to DFGs needs careful consideration as the statutory duty will remain with district councils. Districts seek the opportunity to work with county councils and central government to identify a way to ensure the duty is met, whilst enabling it to contribute to the wider BCF plans.

The benefits of joined-up working

District councils are committed to working with county council colleagues to enable DFGs and housing services to play a strong role in BCF plans and successes. Providing integrated services can ensure:

- An improved patient and customer experience - through greater flexibility to enable both a more bespoke and responsive support service, and the widening of this offer to people who cannot currently access this kind of support, which could provide a source of income.
- Reduced reliance on long-term health and social care services through the delivery of effective prevention and early intervention, including measures to address affordable warmth issues and provision of handyperson services.
- A reduction in the amount of time people spend in hospital through removing the barriers to discharge.
- A reduction in the number of hospital admissions – in particular for respiratory and cardiovascular diseases, and falls, through interventions such as energy efficient insulation, adapted homes, and tele-health care.
- Increased efficiency across the health and social care economy - joint approaches will eliminate duplication and ensure services are provided in a more cost effective way in the short-term and over the long-term to reduce demand.
- The development of communities as resources rather than solely as the drivers of demand for resources.

Bringing housing into BCF plans can help provide practical support to people in a number of different areas. These include: tackling fuel poverty, helping people reduce their fuel bills, supporting people to consider carefully their housing needs and options as they age, and having a fit for purpose private rented sector.

Integrated solutions allow resources to be focused where they will provide maximum benefit and impact. Bringing partners together boosts knowledge, opportunities for delivery and pools resources.

Setting aside funding for prevention services such as housing pay off in the long term through a reduction in the number of people requesting more expensive healthcare and social services. For example, dedicated housing staff can work with hospitals to remove the barriers that prevent discharge from hospital, which costs the healthcare millions of pounds every year.

Working with district councils to get people's housing right enables us all to work with people whilst they are still residents rather than patients.

Case Study: Cumbria

In Cumbria, the total budget for the BCF for 2015/16 is £40.183m. The 'Closer to Home' health agenda adapts homes to meet the needs of residents and is delivered through DFGs. County council Occupational Therapists and housing officers in district councils working closely together to make the process of delivering adaptations to meet residents' mobility and health needs as easy as possible and reduce waiting times. In other parts of the country district councils may provide handyman services or tele-healthcare, or work with housing landlords or home improvement agencies to enable residents to access these. These interventions are important as they help people to retain their independence for longer, which boosts their mental health and general wellbeing, and together with Reablement Services provided by county councils reduce reliance on Disabled Facilities Grants.

Cambridgeshire County Council

The project to deliver the Better Care Fund (BCF) in Cambridgeshire has benefitted from a very high level of engagement with providers, community groups, voluntary organisations, service users and other interested parties. Senior managers have taken the lead in publicising this important scheme to ensure that as many people as possible have been able to engage in the process, give their feedback and take advantage of the new opportunities around joint commissioning.

Consultation responses were received from service users, carers and voluntary groups, and the feedback was overwhelmingly in favour of a move to better joint commissioning. Providers have also responded well to the scheme: 129 proposals were received, mainly from local voluntary and community groups or from local chapters of national charities. Many of the proposals received from charity groups showed innovation and a desire for transformation, from expanding the use of telecare to providing handyman services for older people living in supported housing. Proposals were also received from Cambridgeshire County Council and the Cambridge and Peterborough Clinical Commissioning Group. All groups of service users were represented in the proposals, from frail older people living at home or in supported housing to people with mental health needs, physically disabled people, survivors of sexual assault and carers. Workshops are now being set up to bring potential providers together and to draw out a list of 'must have' key projects.

Working relations with the Clinical Commissioning Group have been positive, thanks in part to a long tradition of close links and increasing sharing of information and skills. In a time of tightening budgets and increasing demand, however, large-scale projects such as the Better Care Fund have the potential to create divisions. Council officers have worked hard to negotiate, set up meeting and foster strong professional links to minimise the effect of any disruption. Colleagues across the Council and the CCG are also working in close partnership with NHS England.

There are also some questions still to answer about how joint commissioning might work in practice, including the impact on services which are already jointly commissioned, and how BCF resources and plans should dovetail with change projects that are already gearing up for delivery.

In our experience, taking a bottom-up approach to engagement is important if the BCF and joint commissioning practices are to succeed. Involving as many parties as possible from an early stage in the project has allowed us to develop a huge range of potential schemes, better understand some of the challenges involved with joint commissioning, and take into account the views of residents whose lives could be improved by better joining-up of health and social care services. However, we also need to reconcile a bottom-up approach with necessary strategic direction in order to give some structure to our final proposal and to allow the BCF in Cambridgeshire to be as successful as possible. Working closely with NHS England has given us the high-level steer that we need to engage senior managers, while also preventing us from getting too caught up in the details of our scheme.

Dorset County Council

The people living in the Dorset area (defined as the places within the Borough of Poole, Bournemouth Borough Council and the County of Dorset) access health and social care services via 13 primary healthcare localities which in turn mainly access four NHS hospital trusts and a number of smaller community hospitals. Care services, particularly around support for independent living (housing) are accessed through the six district councils that make up the County of Dorset, as well as the three first-tier councils.

The NHS and three local authorities together enjoy the existence of a single Clinical Commissioning Group which is the third largest in the country.

Funding streams and local arrangements are fragmented reflecting single agency approaches with a relatively low use of pooled budgets or aligned commissioning.

All parties recognise that without change the increasing demands placed on the health and social care services by Dorset's ageing population will make those services unsustainable in the longer term, financially and in terms of available resources, skills and expertise especially to local authorities.

Funding reductions and Government initiatives such as the Better Care Fund (BCF) aim to re-model services and funding streams, this creates stress and shortage in particular areas which cannot be addressed by individual organisations – they require change across the system

The Dorset-area Partnership will progress integration based on evidence of what works nationally and locally. The development of integrated locality health and social care teams will be fundamental in addressing the increasing emergency attendances and admissions and supporting the work of the Dorset Urgent Care Board.

The core components of the new system will be:

- A. Increasing the pace and scale of initiatives aiming to provide 'care closer to home' to achieve targets on shifting from institutional care to self-help and community based systems.
- B. Developing whole-systems outcome-based commissioning to reflect best value.
- C. Developing new ways of working within and between agencies which aim to maximise and measure the added value of providing direct support to people who need help.
- D. Working with communities and individuals to help themselves by providing timely enabling interventions which reduce the need for crisis or longer-term statutory services.
- E. Informed by evidence of what works locally, nationally and internationally and from the experience of our populations and people who use our services when developing new approaches.

Challenges

The timeframe for preparing the BCF plan was extremely tight considering the scale of the task. Ensuring sufficient engagement with providers and other key stakeholders including Councillors and Health and Well Being Board members requires an early consensus on the plan. Fortunately the work described above provided an extremely

useful context for these difficult discussions. The complexity of financial modelling and mapping out the detailed cost benefits for the BCF plan is still work to do.

The BCF template is supported by a Better Together business plan and there is a commitment to jointly plan our combined resources. This is reflected in an intention to go beyond the minimum pooled by of £54m to £344m. This will be one of the biggest pooled commitments nationally. We recognise that this will not result in a single pooled budget but do expect to develop specific pooled budgets to support the work of the programme. The identified resources not in a pooled budget will be expected to form part of the aligned resource planning across agencies. Pooled budgets are therefore seen as a tool for co-ordinated resource planning rather than an end in themselves.

Next steps

A Chief Executive Better Together Sponsor Board is already in place and will oversee the transformation work, the BCF plan and a complementary review of clinical services especially covering the Acute Hospital and Secondary Care Community Health services. This overview is required to manage the movement of resources from high cost institutional and hospital care to lower cost preventative and care at home provision. The work is supported by the Systems Leadership Programme for the LGA and Public Services Transformation Network.

Kent County Council

Kent has a complex internal geography and organisational structure with one County Council, twelve district authorities, seven clinical commissioning groups, four acute hospital trusts, a mental health trust, a community health trust and the regional ambulance trust. In acknowledgment of the need to localise consideration of health and wellbeing in such a large county the Kent Health and Wellbeing Board has established 7 formal sub-committees based on CCG geography. This complexity presents obvious challenges for developing and co-ordinating a coherent approach across the county.

Kent was successful in its bid to become a Health and Social Care Integrated Pioneer. All elements of the health and social care system in Kent are now committed to ensuring a fully integrated health and social care system by 2018. This will be based on a clear understanding of "The Kent Pound" (the total financial resources of the organisations that contribute to the health and social care of the people in Kent) and how it can best be aggregated, pooled and spent for the benefit of those that need it. The announcement of the Better Care fund (BCF) has accelerated this process and the structure established to deliver the Kent Pioneer programme has been given the responsibility to co-ordinate the county wide approach to the BCF under the auspices of the Kent Health and Wellbeing Board. The BCF for Kent, comprising the contributions from all the CCGs, amounts to a minimum of £101m.

As a Pioneer Kent has taken the opportunity that the BCF provides to deliver services in a way that improves outcomes, improves experience of care and makes best use of resources. Using the BCF the citizens of Kent can expect:

- Good preventative and community health services.
- Good, improved access – co-designed integrated teams working 24/7 around GP practices - 'Team around patient', 'team around GP'.
- Increased independence – supported by agencies working together.
- More control – empowerment for citizens to self-manage.

- Improved care at home – 15% reduction for acute admissions and long term care placements, rapid community response particularly for people with dementia.
- To live and die safely at home – supported by anticipatory care plans.
- No information about me without me – the citizen in control of electronic information sharing.
- Good use of information intelligence – evidence based integrated commissioning.

Challenges

One of the challenges in preparing the BCF plan has been to ensure that the multiplicity of providers in Kent are properly engaged. This essentially requires that the BCF and other commissioning plans are capable of being understood on an “in-county” health and care economy geography as well at county and CCG levels. The county splits into three such economies; West where a single large CCG is effectively responsible for the relationship with one major acute trust; North where two CCGs have a relationship with two acute trusts one of which is a foundation trust sited in a neighbouring authority; and East where four CCGs relate to a large foundation trust spread over three major sites. The mental health, community health and ambulance trusts cover all three local economies.

This complexity has combined with the very short time-scales involved and the level of detail expected to ensure that production of the BCF plan has been a major undertaking. The need for a sophisticated plan to be understood at all the different geographical and organisational levels has required the application of a great deal of effort and determination to achieve in the timeframe given.

Solutions

Despite all these potential difficulties Kent responded enthusiastically to the BCF as a way to accelerate the pace and scale of achieving the vision expressed in our Pioneer submission. The Kent Health and Wellbeing Board have been keen to adopt a leadership role in developing the BCF plan. Where difficulties from some of the challenges outlined above have arisen the Board has sought to devise solutions that can be implemented quickly to address them. A case in point is the linked issues around the engagement of providers and the complicated geography at a health economy level. Led by the Board, and with the direct involvement of the KCC Leader and Portfolio Holder, meetings have been convened to bring this together and ensure that local plans are properly explored and the potential implications identified with the key providers. This process is also being used to identify where extra funding from KCC could be applied to the BCF budget to enhance the programmes being adopted.

Also, the Kent Innovation Hub was launched in December as a means of connecting stakeholders across Kent on the issues of integration. This has included being part of an international event on teletechnology, hosting an online questionnaire on the BCF and launching a Tweet chat on information governance on 19 March 2014. The Innovation Hub will provide a mechanism to engage the public and others in helping establishing an integrated health and social care system and barrier busting.

Plans

Beyond this each CCG has been responsible for providing the detailed plans for their area as part of their two and five year commissioning plans and strategies. These have been discussed at the local (CCG based) Health and Wellbeing Boards before being brought to the Kent Board for approval to submit. In this way District Councils and other local stakeholders have been involved in how the plans are developed and how they meet local need. Local Healthwatch will also have been involved in a number of these discussions. Other existing mechanisms such as health economy wide whole systems groups have also been used to discuss and develop the plans

with stakeholders and to ensure that there is “proper fit” between the CCG plans. The Integrated Pioneer Steering Group established to lead the Pioneer programme has also provided an extremely useful focus for BCF related business.

Not surprisingly the programmes each CCG has identified for the BCF show a great deal of similarity across the County. Most are designed to enhance the capacity of primary and community care to treat more patients with more complex conditions outside of hospital with others to ensure that hospital capacity is freed up for those that need it.

Next Steps

Some further work still remains concerning the detailed analysis of the financial implications of the proposals, the exact measures of the impact expected and how we will all mitigate the inherent risks from implementation of the plan. Governance generally but specifically relating to the management of potentially seven different s75 pooled budget arrangements will need to be established and existing structures will no doubt have to be adapted to tackle these issues. Not everything will go smoothly and it will be important that the established relationships between partners continue as we move from plan to delivery. A key challenge is ensuring the plan is implemented as intended and that it takes the necessary transitional steps towards the transformation of health and social care in Kent as part of the Pioneer programme.

Lancashire County Council

Lancashire is a large two-tier authority partnered by 12 District Councils and with six CCGs. In terms of the health economy activity centres around six hospitals. Two of the CCGs share a hospital with another local authority so planning has had to align. This has added a very real layer of complexity onto our Better Care Fund (BCF) planning processes.

We had agreed at the County Wide Health and Wellbeing board that five BCF plans would be produced to reflect health economies by two CCGs producing a combined plan and that this could be submitted with a brief overarching synopsis.

For us the fund represents an opportunity to accelerate existing programmes that promote wellness and recovery and seek to maximise the resilience and capacity of individuals, families and communities. We want to focus on sustainable, integrated service delivery and move activity from the acute sector to Primary and Community. We will focus on existing programmes and use the BCF to accelerate transformational changes already agreed.

Common themes of the CCG plans are to:

- **Develop our Local Area Coordination offer, connecting people to local assets** working in partnership with voluntary, community and long-term conditions groups.
- **Invest in developing personalised budgets** working with patients, service users and professionals to empower people to make informed decisions around their care.
- **Invest in Reablement** through a new joint approach to Community Independence, reducing hospital admissions and nursing and residential care costs.
- **Develop community based infrastructure to avoid admissions and step up and down peoples care** through the development of integrated intermediate tier services.

- **Reduce Delayed Discharges** through improved 7-day social care provision in hospitals and reducing emergency admissions to hospital and length of stays.
- **Integrate NHS and social care systems** around the NHS number to give professionals access to all of the records and information they need.
- **A full review of use of technology** to share information, support prevention, boost self-management, improve customer experience, and free up resources for priority cases.
- **Roll out the Whole Systems Integrated Neighbour Teams Care model** and build on existing care planning and co-ordination, including local Area Coordination.
- **Invest in 7-day GP access** in each locality and deliver on the new provision of the General Medical Services Contract.
- **Review existing services**, including services commissioned under existing section 256 agreements, and re-procure services where necessary – including current investment in VCFS and low-level/universal services to strengthen gains made through Local Area Coordination.
- **Create integrated quality improvement systems** focussed on improving outcomes through transforming the quality, consistency and co-ordination of care across nursing and care homes.
- **Review and support our commitment to Safeguarding** – supporting changes in the Care Bill to put the Adult Safeguarding Board on a statutory footing.

Planning on this scale has been difficult for a number of reasons detailed below, however the unit of planning now expected has been the main challenge. Shortly before submission we were informed by NHS England that one single plan was expected and that performance measures and targets would need to be agreed and delivered at a County (rather than individual CCG level).

We are now having to refocus our planning towards a countywide and more collaborative view point, but the CCGs are clearly anxious about the risks of a county approach to meeting targets. For example on residential care admissions, performance ranges from very high to very low admissions. These will now have to be achieved by careful risk sharing agreements.

In many cases, Performance Metrics have yet to be fully agreed (e.g. the single “patient experience”), and are unhelpful or unrelated to the wider transformational change we’re aiming for in Lancashire. CCGs are seeking clarity around their own reported hospital admission figures and which sets they use. There appears to be some technically perverse areas that although we would describe them as diversionary, risk being classed as “admissions”

Others don’t particularly reflect whether the system is delivering better outcomes e.g. local authority funded admissions to residential care will need to be supplemented by hard to get information r.e. self-funders, other local authority placements etc. (though this intelligence will improve with Care Bill implementation).

Having one plan across CCGs will mean that we will need to agree one local measure. The benefits of consistency notwithstanding, we would prefer more flexibility to develop rewarded meaningful local measures and shape services that meet the needs of specific neighbourhood populations.

Mandatory shared targets could lead to risk-averse behaviour rather than transformation as partner organisations opt for the safer choice of unambitious aims. We’re not yet very clear of the consequences if targets are missed – and even, in some instances, what “missed” means. Related performance payments are yet to be resolved and there are concerns regarding the degree to which an individual CCG will be held to account for the performance of another.

Published government guidance did of course come late and has been open to interpretation, which has meant that for Lancashire we are now faced with agreeing a very different sort of product with a central plan and a number of locality delivery plans. This is not at all undoable but clearly timescales are short.

Lincolnshire County Council

In June 2013, the Chancellor announced a £3.8bn pooled fund to encourage the integration of health and social care services. This coincided with the Government's announcement to identify a number of 'integration pioneers'. In October early national guidance was produced detailing how the then Integration Transformation Fund would be allocated and what it included. In December the newly titled final Better Care Fund (BCF) guidance was produced.

In Lincolnshire an initial bid to become an Integration Pioneer proved unsuccessful. However, health (4 CCGs), public health and social care commissioners had already agreed in parallel to commission a Sustainable Services Review (LSSR) with the support of Price Waterhouse Coopers (PWC). Phase 1, undertaken during Summer and Autumn 2013, provided an analysis of the health and social care system in Lincolnshire. In conclusion the analysis said that quality in NHS services (notably the Acute provider) was not good, outcomes were poor and the financial viability of the whole system was not sustainable. This was presented to the Health and Wellbeing Board in late 2013 by Tony Hill, Director of Public Health who chairs the LSSR Governance Board on behalf of all stakeholders. It has also been formally agreed by all four CCGs and the Executive of Lincolnshire County Council. Phase 2 commenced in February 2014 and will take approximately three months to conclude the 'design phase' prior to public consultation and then implementation later from 2014.

In October a Task Group was established to develop the necessary plan to satisfy the early ITF guidance. This group included all Chief Officers of the four CCGs, colleagues from public health and finance (health and social care), the Director of Children's Services and was chaired by the Director of Adult Social Services (DASS). The Task Group met on six occasions between November and the end of January (with a liberal sprinkling of midnight oil) when the 'First Cut' submission was presented to and approved by the Health & Wellbeing Board.

The NHS England representative on the H&W Board was approached to act as a critical friend in the production of the submission. In addition, several DASS Regional colleagues were approached on a 'you show me your BCF document and I'll show you mine' basis. This proved particularly helpful given the national guidance published in December (just before Christmas!) included a 'Tri-borough' draft submission that did not reflect the national template.

The connection between the eventual BCF submission and the LSSR 'Blueprint' is critical. In other words if the LSSR is a 5 year plan to transform health and social care in Lincolnshire then the BCF describes the first two years of that plan. It is also where national policy and local ambition coalesce.

One particular challenge in producing the BCF was timing. The LSSR has a timeline that was agreed by all major stakeholders prior to the advent of the ITF or BCF. In effect the BCF planning guidance generated the need for an early interpretation of what the LSSR in Phase 2 would produce: it forced our hand. Notwithstanding this though the LSSR created a template and overarching strategic direction that framed all BCF discussions – thus we had a common understanding of what needed to be done across the entire health and social care economy.

To reconcile the two elements (BCF and LSSR) a number of 'early implementers' were agreed against which funding and pooled budget arrangements would be developed. This allowed us to agree what first steps we would take together. The early implementers were agreed with the LSSR Governance Board (which includes health and social care providers) and, at an early presentation to the H&W Board along with the County Councils Executive and four CCG Boards. As such the document was well 'socialised'. The demands on officer time to satisfy this level of engagement however was considerable and a typical feature of two-tier areas. A learning point for us.

There are 5 'early implementers' chosen that connect the national performance expectations detailed in the BCF guidance, the requirement to be ambitious about pooled budget arrangements, to develop integrated services that will address the financial deficit at an early stage – notably in the acute health economy – and reflect the broader context detailed in the LSSR.

The early implementers are **neighbourhood teams, prevention, intermediate care, 7 day working** and what we term **enablers** such as ICT estates. In several areas there is some pre-existing architecture which is already performing well but where further effort will deliver more benefit and have a direct effect on hospital emergency admissions such as prevention and, intermediate care.

At the same time a joint commissioning structure has been developed across the County Council (involving Finance, Public Health, Children's Services and Adult Care), the four CCGs (so each Chief Officer takes a clear lead for all in an agreed area) and, NHS England to provide a joint governance structure and a way of programme managing the early implementers and ensuring a level of 'read-across' different plans. Each is ultimately accountable to the Health and wellbeing Board.

One early lesson was that with the full involvement of the County Council - including the Chief Executive and all Corporate Management Board colleagues added considerable value. A wider range of skills and contributions than would otherwise have been the case became accessible eg, programme management and the ability to host staff/consultants and procure in a way that facilitated progress where CCGs were more restrained (eg. management overheads) or just lacked the capacity to take something forward. This has also helped secure full support from the Executive of the County Council which in turn has helped with the necessary engagement of MPs.

Whilst colleagues across the health and social care economy in Lincolnshire would not describe ourselves as being at the forefront the level of collective ownership both across the Council and, with health partners provides a level of assurance that our great adventure is slightly less scary than we might otherwise anticipate.

Oxfordshire County Council

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group already have well established and effective working relationships, and an ongoing commitment to further integrate services. We have the largest pooled budget arrangements in the country with over £330m currently committed across all client groups, representing a third of Clinical Commissioning Group resources and 99% of adult social care funding.

This includes a significantly expanded pool covering care for older people, and others to improve care and outcomes in physical disability, learning disability and mental health and wellbeing. We have joint commissioning strategies that set out our shared intentions and mature risk sharing arrangements that mean we have truly pooled budgets, and in the case of older people we believe this to be unique in the country.

The Council and Clinical Commissioning Group have worked together in establishing strong governance arrangements, including the Health and Wellbeing Board and Joint Management Groups overseeing the pooled budgets that engage commissioners, GPs, clinicians, providers and service users / carers in decision making.

This allowed the development of Better Care Fund (BCF) plans to start from a strong base, and to build on existing agreement about the strategic priorities facing the county and established ways of working. The focus of our BCF plan is predominantly on meeting the needs of older people, given this is the most significant pressure facing both health and social care in Oxfordshire. However, some cross-cutting initiatives will benefit adults of all ages including people with mental health needs.

Our approach will be based on furthering the aims and objectives in Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016 and the Clinical Commissioning Group and Oxfordshire County Council Older People's Commissioning Strategy 2013 – 2016. Both of these are based in part on the Joint Strategic Needs Assessment and were developed in partnership with wide partner and user engagement.

We will also develop and implement a single assessment process reducing the need for people to be assessed more than once when transitioning between health and social care services and making the process smoother for service users. It is also proposed that the Council front line social work and occupational therapy teams join up with the community provision delivered by Oxford Health and further develop links with primary care including GPs. This will avoid duplication, reduce waste and bureaucracy, minimise delays in care and give people the right support at an earlier stage so they are less likely to experience worsening of their condition. This is not a new development – it reflects discussions that have been taking place over the last two years. It is also one of the targets in the current Health and Wellbeing Strategy, and changes will be made to the key performance indicators in the Strategy when it is refreshed later in the year to ensure full alignment with those in the Better Care Fund.

Investment will be targeted in the following areas:

- Information and advice
- Equipment and assistive technology
- Creating a more personalised approach to home support which will include removing short visits for personal care for older people
- Integrated support for hospital admission avoidance
- Investment in Carers Breaks jointly funded and accessed via GPs
- Support to people with dementia
- Reablement and rehabilitation
- Support for people to die at home / in residential care

Further detailed work will be required throughout 2014/15 to develop these proposals fully, including quantifying the financial benefits of each. The plan will also be reviewed and updated to reflect performance in the year, and any emerging pressures and priorities. Our proposals therefore include a contingency of approximately £4.6m that will be used to fund emerging priorities, and allow further investment in areas that are proving particularly effective in achieving the outcomes in the fund.

It is recognised that because the resources for the Fund have to come from existing spending on health and social care, this will be a significant challenge for the health and social care system in Oxfordshire given the current pressures it faces. We also recognise the need for further alignment of plans across the whole health and social care system, so we working with our key providers to consider how best to ensure effective delivery of these plans.

Surrey County Council

The Better Care Fund (BCF) is designed to improve outcomes for vulnerable people through better integrated care and support and a significant expansion of care in community settings. It will achieve this by shifting resources from acute services into preventative services in primary care, community health and social care.

How the Fund will work

The fund is made up of a number of existing elements of funding, most of which will come from health budgets. The announcement covered two financial years:

- For 2014/15, the expected Whole Systems Funding for Surrey = £18.3m. This will be transferred to Surrey County Council (SCC) with joint investment decisions being made.
- For 2015/16, the Better Care Funding total position for Surrey is expected to be a revenue allocation of £65.5m + capital of £6.0m = £71.5m in total. We are considering putting this into a pooled budget under Section 75 joint governance arrangements between Clinical Commissioning Groups and the County Council. The details of this will be consistent with further national guidance and will be finalised by the Better Care Board.

Figure 1 – Element of 2015/16 Better Care Fund

	Nationally £m	Surrey £m
New Care Bill duties	135	2.56
Carers breaks	130	2.46
Reablement	300	5.68
Whole systems	1,100	18.30
Balance for allocation	1,795	36.50
	3,460	65.50
Capital general	134	2.30
Disabled Facilities Grant	220	3.70
	354	6.00

One of the main conditions of the BCF is to 'protect' social care services. 'Protect' is the government's word - we would prefer 'sustain'. We have agreed that plans will be drawn up on the basis that "the system across Surrey has committed to jointly investing the Better Care Fund to improve services and outcomes for patients and to creating financial benefit as a result. We have agreed to share this benefit for further investment in services and to ensure the sustainable delivery of better care for the future. In 2015/16 we expect the benefit to social care to be £25m.

Engagement

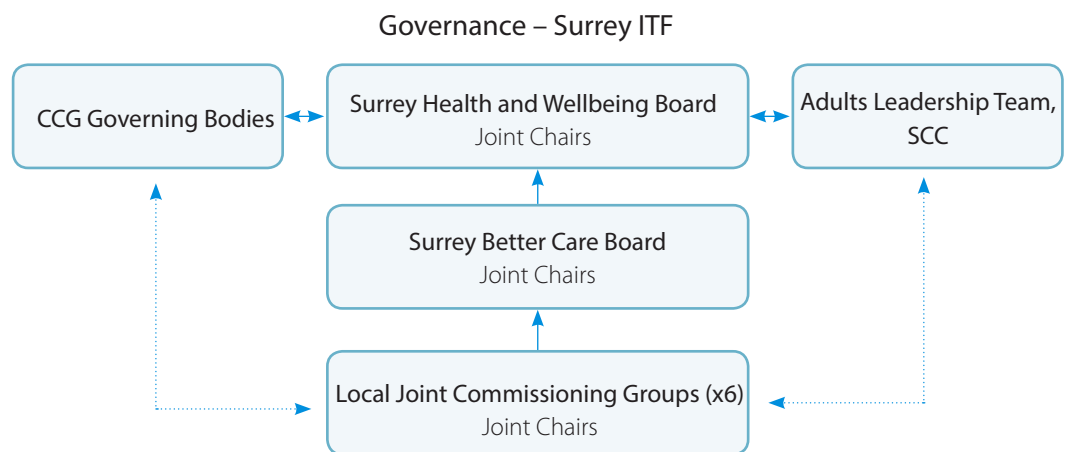
Throughout 2013/14, health and social care providers have been engaged in developing an integrated vision for out of hospital care in each local area through the five Local Transformation Boards. Patients, people who use services and the public have been involved through a number of partnership boards and via local engagement events held during 2013.

Work on the Surrey BCF began in Autumn 2013, with joint workshops held in November, January and February. Each of the Local Joint Commissioning Groups is developing a local BCF Plan setting out their joint health and social care work programme. The decision to develop local joint work programmes is designed to enable each area to address the range of different communities in Surrey, as well as the need for local ownership and leadership.

Governance

The governance arrangements in place will be as follows:

- There will be six Local Joint Commissioning Groups in Surrey – one for each of the six local CCG areas - with membership drawn from Adult Social Care, the CCG and other local stakeholders.
- The Local Joint Commissioning Groups will be responsible for all Better Care Fund investment decisions and for overseeing the operational delivery of the schemes set out in their local joint work programme. These investment decisions will be made jointly by health and social care partners at a local level.
- The Surrey Better Care Board will provide strategic leadership across the Surrey health and social care system. The Board will challenge and support the Local Joint Commissioning Groups to deliver improved outcomes for local people. Membership will be drawn from Adult Social Care and the CCGs.
- Surrey's Health and Wellbeing Board will continue to set the overarching strategy across the Surrey health and social care system.



The Surrey BCF

- The Surrey-wide BCF Plan is a composite Surrey-wide plan. It provides an overview of key themes from each of the six local joint work programmes and gives examples of the enhanced and integrated model of community based health and social care in Surrey. The three key themes in the plan are:
 1. Enabling people to stay well: Maximising independence and wellbeing through transformed prevention and early intervention for people at risk of being unable to manage their physical health, mental health and social care needs.
 2. Enabling people to stay at home: Integrated care delivered seven days a week through enhanced primary and community services which are safe and effective and increase public confidence to remain out of hospital or residential/nursing care.
 3. Enabling people to return home sooner from hospital: Excellent hospital care and post-hospital support for people with acute, specialist or complex needs supported by a proactive discharge system which enables a prompt return home.

The Surrey Health and Wellbeing Board signed-off the 'draft' Surrey-wide BCF plan and submitted it to NHS England by the 14 February 2014 deadline. The 'final' Surrey-wide BCF plan was submitted as part of the overall NHS planning round by 4 April 2014.

Wiltshire Council

Wiltshire has relatively straightforward commissioning arrangements, with one unitary council and one Clinical Commissioning Group. There are three acute hospital trusts serving the population, although two have their main sites outside the county boundaries (in Swindon and Bath) and the third, in Salisbury, is less accessible to residents north of the Salisbury Plain. Alongside this, there are community hospitals, the Avon & Wiltshire Mental Health Partnership and the South West Ambulance Services Trust – which all play an important part in health service delivery in Wiltshire. The Better Care Fund (BCF) for Wiltshire amounted to an initial allocation of £27m for 2015/16.

Challenges

One of the challenges in preparing the Better Care Plan has been ensuring all the key stakeholders in Wiltshire are properly involved against a tight timescale. Similarly, the rural nature of the county and a population which is ageing more rapidly than the rest of the country mean that there is real urgency to ensure services are designed in such a way to meet people's needs. The fact that acute providers cater to the populations of a number of local authority areas can make service reconfiguration and integration with council services more difficult.

Solutions

We have developed our Better Care Plan in close cooperation with Wiltshire Clinical Commissioning Group and in consultation with a wide range of local stakeholders. Wiltshire's Health and Wellbeing Board includes all the main provider representatives as non-voting members of the Board, alongside the commissioners from public health, NHS, children's and adults' social care and the Police. This enables fully informed discussion on the implications of the proposed changes.

We have also engaged providers through a Health and Wellbeing Board hosted event on the Better Care plan attended by community health provider, Social Care providers, Mental Health provider and voluntary sector. In addition, the Wiltshire Care Partnership, the membership organisation for social care providers, has contributed and the CCG have included consultation on the Plan as part of the work developing their own 5 Year Plan. Our area boards have been provided with local versions of the Joint Strategic Assessment to stimulate discussion on health priorities.

We have committed to increasing our pooled budgets and redesigning care pathways so that our vision of joined-up services with care as close to home as possible, with home always as the first option, can be delivered.

Plans

We are developing a joint integration programme team, led by a jointly-appointed programme director and including specialist capacity from the council's system thinking team. The joint integration programme team will lead joint commissioning and joint delivery and ensure we work with providers to achieve the objectives set out within the Better Care Plan. This will include joint commissioning for learning disabilities and mental health and the development of a joint workforce strategy across acute, community, mental health and social care providers.

The team will also be implementing new information sharing systems and undertaking a systems review of the pathway of care for older people to reduce delayed discharges and shift resources to prevention.

The governance of the Better Care Fund will rest with the Wiltshire Health and Wellbeing Board.

Two key elements which are distinctive to Wiltshire's Plan include the way in which the growth in demand as a result of demographic change will be addressed and our plans for delivering a proposed single assessment and support plan for health and social care.

Growth in demand as a result of demographic change and an ageing population

People over 65 make up 20% of the county's population and will make up 22.5% of the county's population within the next seven years and the number of older people is rising much faster than the overall population of the county. Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS resources (47.4%) are consumed by people aged over 65. Much of this resource is needed for frail and vulnerable older people. Dementia in particular can affect people of any age, but is most common in older people. One in 14 people over 65 has a form of dementia and one in six people over 80 has a form of dementia.

Commissioners are setting an ambition of minimising the impact of demographic growth which equates to approximately 2%. This will be achieved by reducing the level of inappropriate admissions through the enhancement of health and social care services to support people more effectively in the community. This will include an enhanced community response to supporting clients in crisis situations. Wiltshire's Better Care Plan also includes a contribution from Wiltshire Council to the overall fund of **£1.833m** to deal with the anticipated demographic growth over the next couple of years. Wiltshire's Health and Wellbeing Board will oversee how this funding is used to address the challenges.

Single assessment and support plan for health and social care

To deliver our vision of joined up care and reducing duplication of effort we will be developing shared assessments and support plans, with appropriate information-sharing systems, and support plans owned by the individuals that they support. This will be piloted during 2014/15 and fully implemented by 2015/16. With the growth in assessments anticipated as a result of the Care Bill and guidance expected on areas where joint assessments are compulsory this is an important commitment. It will be delivered with a contribution of £0.7m from Wiltshire Council to the fund, as well as support from our information management teams.

Next Steps

Throughout the life of the Better Care Plan, we intend to strengthen our patient and service user involvement in service development. We will use the Council's Research Team and will also commission Healthwatch to understand what people really think about current services and what they want to see in the future. Wiltshire Council and CCG will also continue to work through a Joint Commissioning Board to deliver increased pooled budgets, s75 agreements and jointly commissioned services. The Better Care Plan sets out the full range of activity that will be delivered over the next couple of years.

Further Information

For further information on this paper please contact:

James Maker, Policy Officer on 020 7664 3009 (james.maker2@local.gov.uk)

For media enquiries please contact:

Phil Baker, Policy & Communications Officer on 020 7664 3010 (philip.baker@local.gov.uk)

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Website

www.countycouncilsnetwork.org.uk

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