Name of Meeting: **Health and Adult Social Care Scrutiny Panel**

Date: **12 December 2017**

Title of report: **Better Care Fund (BCF)**

Purpose of Report: This report presents information about the BCF in Kirklees.

Key Decision - Is it likely to result in spending or a saving of £250k or more, or to have a significant effect on two or more electoral wards?	**N/A**
Is it in the Council's Forward Plan (Key Decisions and Private Reports)?	**N/A**
The Decision - Is it eligible for "call in" by Scrutiny?	**N/A**
Date signed off by Director and name **Is it also signed off by the Assistant Director for Financial Management, IT, Risk and Performance?** **Is it also signed off by the Assistant Director, Legal, Governance and Monitoring**	**1 December 2017 - Richard Parry** **N/A** **N/A**
Cabinet member portfolio	**Cllrs Viv Kendrick and Cathy Scott, Adults and Public Health**

Electoral wards affected: All

Ward councillors consulted: Consultation with Ward Councillors is not applicable to this report

Public or private: Public

1. Summary

1.1 The Better Care Fund (BCF) is a national programme, announced in the 2013 Spending Review, which is intended to transform local health and social care services so that they work together (based on a plan agreed jointly between the local CCG(s) and the Local Authority) to provide improved and joined up care and support.

1.2 The BCF brings together existing resources from the NHS and Local Authorities into a single pooled budget. CCGs are required to contribute minimum amounts which are pooled with the Local Authority Disabled Facilities Grant (capital funding for adaptations to the homes of disabled people). Local Authorities and CCGs can, if they wish, contribute more to the pooled budget than the minimum BCF allocations. See here for more information about the BCF.

1.3 The full Kirklees BCF Plan 2017/2019 received formal approval through the national assurance process in October 2017, this included the Fund 'Plan on a Page' which is attached in Appendix 1.
The overall population outcome the Kirklees BCF Plan is aiming to achieve is:

"People with health and social care needs feel supported and in control of their condition and care, enjoying independence for longer."

This overall outcome is underpinned by four specific person centred outcomes:

- People who need support are in control of high quality, personalised support in their own home or community that enables them to stay safe, healthy and well for as long as is possible.
- People who need care that can only be provided in a specialist setting are admitted and receive good quality specialist care only for as long as is clinically necessary.
- People who have received care regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support.
- People with ongoing support needs manage their condition/needs as well as possible.

The key performance measures that are being used to measure progress are:

- Non-elective admissions.
- Permanent admissions of older people (65 and over) to residential and nursing care homes.
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.
- Delayed transfers of care from hospital.

These measures are set nationally and subject to a quarterly assurance process.

1.4 The Kirklees BCF is being used to fund the following Schemes:

1. Aids to Daily Living

This scheme will facilitate the use of community equipment and aids to daily living, minor adaptations costing less than £1,000 (Kirklees Integrated Community Equipment Service, the Handy Persons' Scheme and assistive technology) and adaptations to property (Accessible Homes Team) provided through the Disabled Facilities Grant, to enable people with long-term conditions, disabilities, or requiring rehabilitation from acute conditions, or end of life patients to remain in their own homes. The outcomes will be:

- **Kirklees Integrated Community Equipment Service:** People with long-term conditions, disabilities, or requiring rehabilitation from acute conditions, or end of life patients are enabled to live as independently as possible in the home of their choice through the timely provision of relevant equipment and aids to daily living.
- **Handy Person Scheme**: People with long-term conditions or disabilities will receive assistance to maintain and repair their homes to a decent, safe and warm standard. This could include tasks such as changing lightbulbs, removing trip hazards, arranging for reputable tradesmen to repair a roof or to replace a boiler.
- **Assistive Technology**: People will feel more in control of their own care and support without having to depend upon, sometimes intrusive, people based services through maximising the use of assistive technology. Through the provision of technology, and possibly alongside other services, people are supported to remain independent in their own homes when otherwise they might be forced to move into other care settings.

- **Accessible Homes (Adaptations)**: Living in accessible homes will restore or enable independent living, privacy, confidence and dignity for individuals and their families through modifying disabling environments.

2. Intermediate Care and Reablement

This scheme includes intermediate care and reablement services that enable people who have received hospital care, or are at high risk of needing hospital care, to regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support. The overall aim of the scheme is to help to reduce avoidable hospital admissions, support timely discharges and prevent re-admissions. A key aim of the scheme is to develop an integrated offer that ensures the delivery of an effective cycle of care that is seamless and effective and delivers improved outcomes for patients and carers; with the following outcomes:

- Improved independence for patients and carers.
- Less dependency and the need for long term placements.
- A reduction in admissions for non-elective care.
- A reduction in excess bed days.

3. Carers Support Services

This scheme includes carers breaks (paid and volunteers), carers emotional support, self-help and enablement courses, carers assessments, carers information and advice, peer support, awareness raising, carers having a voice, carers advocacy, specialist support for carers of people with mental health concerns, support for carers of people at end of life, specialist support for carers of people with Dementia, workplace support for carers. The overall aim of the scheme is to support carers to continue caring in an informed, safe, and healthy manner; with the outcomes of:

- Reducing avoidable hospital and residential care admissions.
- Supporting timely hospital discharges and preventing readmissions.
- Preventing an escalation of future caring needs and preventing pressure on other care services.

4. Continuing Care

This scheme comprises jointly funded packages for older people and adults with a physical disability who are eligible for NHS continuing health care provision. The aims and outcomes of the scheme are to:

- Reduce duplication, making the best use of commissioning resources.
- Embed the joint commissioning strategy and commissioning intentions with the needs of the local community, based on the JSNA and comprehensive needs assessments as appropriate.
- Align investment and service development to make best use of public resources across health and social care, with increasingly integrated care pathways responding to patients and service users and their identified unmet needs.
- Ensure that strategic commissioning and service development responds to the expressed needs of the Kirklees population through a joint approach to the engagement of service users and citizens which seeks to identify gaps in service and provision, and offer suitable solutions.

5. Protecting Social Care

This scheme includes services that deliver social care packages for people who are in the high and very high risk categories, ie:

- Care management to ensure care is properly planned and co-ordinated.
- Self-directed support packages for people who are able to be supported in the community.
- Independent sector home care to enable people to continue to be supported in the community.
- Independent sector residential placements for older people and people with a learning disability who need 24 hour care.
- Required activity to support local implementation of the Care Act.

The aims and outcomes of the scheme are to:

- Reduce non-elective admissions to acute care.
- Reduce delayed transfers of care.
- Reduce permanent admissions to residential and nursing homes.
- Increase the number of people using social care services who receive self-directed support.

6. Eye Clinic Liaison Officers

The overall aim of this scheme is to achieve the best possible outcomes and quality of life for people of all ages with a visual impairment and/or at most risk of sight loss and wherever possible reduce avoidable sight loss across Kirklees. The outcomes will be that service users will:

- Have someone to talk to prior to, and at point of, diagnosis.
- Understand their eye condition and the registration process.
- Feel better able to adjust positively to their changed circumstances and cope with the changes they need to make to their lives as a result of sight loss.
- Have reduced anxiety and worry knowing that knowledgeable people are there to support and guide them.
- Have a better understanding of statutory benefits and services available to support them.
- Feel supported to manage their eye condition and make better-informed decisions about the future.
- Have increased confidence in making best use of the sight that they have and motivation to achieve goals.
- Feel healthier and happier and able to make the changes necessary to help prevent further deterioration of their eye condition.
- Feel less isolated, more able to get out and about and do things like volunteering.
- Feel less dependent on health and social care support.

7. Mental Health Contracts

This scheme brings together the Council and CCG contracts with the VCS for services for people experiencing mental health problems (18+), living within the boundaries of Kirklees including those with Dementia, learning disabilities (where criteria are met), autism, Asperger's and hidden disabilities.

The scheme will ensure improved outcomes for service users and best value for commissioners by facilitating the commissioning of services that provide a range of accessible opportunities and experiences across the communities of Kirklees, which will promote, protect and improve individuals' mental and physical health, as well as their emotional wellbeing and recovery and which will reduce the need and impact on health and social care services and treatment.

8. Supporting the Voluntary Sector

This scheme comprises funding for:

- The social prescribing service "Better in Kirklees" which is delivered via a contract with a voluntary sector organisation. Anyone over the age of 18 with a long-term health condition / social care need living in Kirklees can be referred to the service which enables them to access community support / activities that will help them to avoid or delay the need for NHS interventions.
- Capacity building in the voluntary sector to increase the provision of voluntary sector support / activities to people who have long-term health conditions / social care needs that will also benefit health by avoiding or delaying the need for NHS interventions.

1.5 The **improved Better Care Fund (iBCF)** was first announced in the 2015 Spending Review. It is paid as a 3 year direct grant to local authorities, with a condition that it is pooled into the local BCF Plan/pooled budget. The iBCF has to be spent on three purposes:

- Meeting Social Care Needs.
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready.
- Ensuring that the local social care provider market is supported.

However there is no requirement to spend across all three purposes, or to spend a set proportion on each. See here for more information about the iBCF.

1.6 The Kirklees iBCF grant allocation is being invested via the following schemes:

1. Ensure adults currently receiving a care package and their carers have the right size packages that enable them to live as independently as possible

Outcome: Timely and comprehensive reviews will ensure that adults with long-term care needs, adults with learning disabilities and carers have care packages that are up-to-date, appropriate to their needs, maximise their independence and support their carers.

This funding/scheme is also contributing to the BCF Schemes Protecting Social Care and Carers Support Services.

2. Introduce electronic call monitoring system across independent sector home care providers

Outcome: Providers and commissioners will be able to monitor the length of home care calls which will ensure that service users / the Council only pay for the service received.

This funding/scheme is also contributing towards the BCF Scheme Protecting Social Care.

3. **Support the transition from the current model of older people's day care to a more sustainable community based model**

   Outcome: The Council's MTFP identifies savings against the current model of older people's day care. The move to a fully sustainable model of community based day care needs time and investment to ensure that the needs of service users and the Council can be effectively met.

4. **Additional support to the care home sector to deal with people with more complex needs and to improve the admissions process**

   Outcome: The care home sector will be able to more effectively meet the needs of people with increasingly complex health conditions/ needs – so avoiding unnecessary admissions to hospital. The introduction of 7 day independent assessors for people in hospital who need to move to residential/ nursing care will speed up hospital discharge, reduce lengths of stay, and under occupancy in care homes and the time wasted by care home staff visiting prospective residents whose needs the home cannot meet.

5. **Support to independent sector providers to recruit care staff, develop leadership and management skills and develop new roles such as personal assistants**

   Outcome: Independent sector providers will be able to recruit more care staff and be well led and managed. Providers will therefore be more sustainable and resilient and better able to provide consistent quality of care. The market will be in a better position to meet the increasing demand for personalised care delivered by personal assistants.

   This funding/scheme is also contributing towards the BCF Scheme Protecting Social Care.

6. **Improve the capacity, effectiveness and flow of people through reablement services**

   Outcome: Improved capacity, effectiveness and flow through of services. Service users will be able to be assessed at home so avoiding unnecessary waits in hospital; people with less complex needs will be able to return home sooner and people who have moved through the short-term reablement service will receive care packages that provide ongoing support to optimise their recovery over a longer period.

   This funding/scheme is contributing towards the BCF Scheme Intermediate Care and Reablement.

7. **Remodel the hospital avoidance and discharge service**

   Service users will experience a combined service that offers increased capacity and efficiency through the ability to provide a multi-disciplinary wrap around service which will be more effective at avoiding hospital attendance and admissions and reduce the risk of people moving into residential care unnecessarily.

   This funding/scheme is contributing towards the BCF Scheme Intermediate Care and Reablement.

8. **Additional investment in community capacity building**

   More people will be identified and support provided before they hit crisis and need statutory services. More inclusive and resilient communities will support vulnerable people and targeted community based prevention and early

intervention will help to prevent or delay their need for specialist health and social care support.

9. Transformation Capacity

The Council is implementing the most significant transformation programme in many years in order to delivery improved outcomes within its reducing budgets. It has recognised that the transformation of adult social care is one of the critical areas of change. This aspect of the Council wide programme is focussed on the overall adult social care offer, all age disability, the front door, reablement and integrated commissioning.

10. Resourcing local volume and price pressures

The Council has committed substantial additional funding to ensure that more people can receive adult social care, and those organisations providing the care receive a fair price for that care. The iBCF will contribute to supporting the Council to do this.

This funding/scheme is contributing towards the BCF Scheme Protecting Social Care.

1.7 BCF and iBCF funding comprises:

BCF pooled budget	2017/18	2018/19	2019/20
BCF	£35.8m	£36.6m	tbc
iBCF Autumn Statement 2015	£0.8m	£7.1m	£12.8m
iBCFSpring Budget 2017	£8.3m	£5.3m	£2.6m
Totals	£44.9m	£49.0m	tbc

At the time of developing proposals for the use of the iBCF the allocations for the main BCF (which are for only 2 years) were still subject to confirmation from NHS England through the BCF statutory guidance. It was considered that if recurrent financial commitments were made against the iBCF it could put the Council's budget strategy at risk. Consequently the Council agreed a financial strategy for the new allocations which included commitments in 2017/18 on what is necessary to pump prime key initiatives developed in conjunction with Clinical Commissioning Group partners to respond to service and market pressures and support enabling activity to drive transformation and savings set out in the Medium Term Financial Plan for 2017/21, and to release £5.7m of base budget revenue resources in-year to support local volume and price pressures (see iBCF Scheme 10 above).

1.8 The Panel received a report in November which summarised the local plans for integration of health and social care commissioning and delivery of out-of-hospital care, available here. These plans were also included in the Better Care Fund Plan 2017-2019. The BCF narrative plan and the associated financial and performance plans are drawn wherever possible from existing plans. The intention has always been to avoid another plan with potentially competing or contradictory actions and expectations.

2. Information required to take a decision

This report is submitted for information only.

3. Implications for the Council

3.1 Early Intervention and Prevention

The BCF Schemes all have the aim of reducing or delaying the need for costly crisis support or care services and will therefore assist the Council in achieving EIP Priority 2, ie; "We will make service savings, but will reinvest in EIP to reduce or delay the need for costly crisis support or care services." Also Priority 4 "We will help more people in the most appropriate way with the money we have available."

3.2 Economic Resilience

There will be no impact arising from this report.

3.3 Improving Outcomes for Children

There will be no impact arising from this report.

3.4 Legal/Financial or Human Resources

There will be no impact arising from this report.

4. Consultees and their opinions

This report has been prepared in consultation with CCG partners in the BCF.

5. Next steps

Not applicable.

6. Officer recommendations and reasons

That this report be received.

7. Cabinet Portfolio holder recommendation

Not applicable.

8. Contact Officer

Phil Longworth, Health Policy Officer, 01484 221000
phil.longworth@kirklees.gov.uk

9. Background papers and history of decisions

Not applicable.

10. Service Director responsible

Amanda Evans, Service Director for Adult Social Care Operations, 01484 221000

Appendix 1: Kirklees Better Care Fund 2017/2019 'Plan on a Page'

Kirklees Outcomes

- People in Kirklees live independently and have control over their lives
- People in Kirklees are as well as possible for as long as possible

Kirklees 2020 Vision for our health and social care system:

*No matter **where** they live, **people in Kirklees** live their lives **confidently and responsibly**, in **better health**, for **longer** and experience **less inequality**.*

The principles underpinning the Kirklees 2020 vision are that:

- ❑ People in Kirklees are as well as possible for as long as possible, in both mind and body
- ❑ People take up opportunities that have a positive impact on their health and wellbeing
- ❑ Local people are helped to manage life challenges
- ❑ People experience seamless health and social care appropriate to their needs that is;
  - affordable and sustainable, and investment is rebalanced across the system towards activity in community settings
  - based around integrated service delivery across primary, community and social care that is available 24 hours a day and 7 days a week where relevant
  - led by fully integrated commissioning, workforce and community planning
  - clear about what difference it is making, and how it can improve
- ❑ To support the achievement of this Vision we will need to work with a wide range of partners who can influence the wider determinants of health and wellbeing, including housing, learning, income and employment.

Kirklees Better Care Fund Plan

Kirklees BCF Person centred outcomes

- People who need support are in control of high quality, personalised support in their own home or community that enables them to stay safe, healthy and well for as long as is possible
- People who need care that can only be provided in a specialist setting are admitted and receive good quality specialist care only for as long as is clinically necessary
- People who have received care regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support
- People with ongoing support needs manage their condition/needs as well as possible

Key performance measures to measure our progress

- ✓ Non-elective admissions
- ✓ Permanent admissions of older people (65 and over) to residential and nursing care homes
- ✓ Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- ✓ Delayed transfers of care from hospital

Kirklees Health & Wellbeing Plan: Priorities for Change

Areas of Transformation

- Early intervention & prevention
- Sustainability of adult social care
- Capacity & quality of primary care
- Change the configuration of acute services
- New model for continuing care
- Transforming care for people with learning disabilities
- Changing the commissioner landscape and new models of care
- Developing an adult wellness model
- Improving services for children

Enablers

- Health & Social Care Workforce
- Digital Opportunities
- One Public Estate
- Kirklees Economic Strategy

Kirklees Better Care Fund Schemes & other commissioning integration activity

2017/18

- Intermediate care and reablement
- Aids to daily living
- Carers support
- Sustainability of adult social care
- Continuing care
- Community based mental health support
- Supporting the voluntary sector

2018/19

- New frailty model
- Care home support
- Transforming care for people with learning disabilities
- Mental Health

Integration activity outside BCF

- End of Life
- Adult Wellness
- Healthy Child Programme & CAHMS Transformation
- Children and Young People – SEN, sick /looked after/vulnerable children
- Schools as Community Hubs
- New models of care in localities

Integrating out of hospital care delivery

- Local area/hub working
- Single point of access/contact
- Single trusted assessment
- Accountable lead professional/person
- Common Pathways
- Digital: telehealth/AT, mobile/agile, interoperability
- One Public Estate

NB - BCF Plan covers highlighted boxes