Health and Wellbeing Board
23rd May, 2018

HWBB Joint Commissioning Report - Better Care Fund 19/20

Responsible Officers
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1. Summary

1.1 This report provides an update on the progress on the Better Care Fund (BCF), and development of the Better Care Fund for 19/20; it includes:

- 1.1.1 Non-elective admissions analysis paper (Appendix A) – for information
- 1.1.2 Summary national Policy Framework for the BCF 19/20 (full policy framework attached as Appendix B) – for information
- 1.1.3 Statement of intent to strengthen the integrated approach across Shropshire Council and Shropshire CCG (Appendix C) – for endorsement
- 1.1.4 Proposed key areas of development for 19/20, section 1.5 below – for endorsement
- 1.1.5 Quarter 4 18/19 Return (Appendix D) – for information

1.2 At the January HWBB the Board requested an analysis of Shropshire's non-elective admissions target, as we had not met the quarter 2 target. Appendix A attached, assesses a number of reasons that could account for this including demographics, care home admissions, adverse weather, and working practices. It highlights further work to be done to reduce admissions through improved working with care homes, care closer to home, and the Integrated Community Services team and helps inform planning for 19/20 BCF development.

1.3 The 19/20 National Policy Framework is summarised in the report below and emphasises that the BCF will retain the same National Conditions as in 2017-19. Areas will be required to set out how the National Conditions will be met through jointly agreed BCF Plans signed off by the Health and Wellbeing Board. The national guidance has yet to be published, but it is anticipated that the plan development will be streamlined, with a reduced narrative, and a focus on scheme highlights and delivery. In light of this, our local planning is focussing on demonstrating improvement through measurable outcomes aligned with the strategic direction of the STP/ ICS.

1.4 To build on local planning for integrated services, attached in Appendix C is a Statement of Intent that has been jointly developed by Shropshire CCG and Shropshire Council. Its purpose is to strengthen integrated working across health and care, to add context to our Partnership Agreement (section 75), and to guide and support our decision making for the BCF 19/20.

1.5 Based on the Statement of Intent the key areas that we will focus on for the coming year pooled arrangements include:

- 1.5.1 Prevention – community referral including Social Prescribing, Dementia Companions, sustainable support for the voluntary and community sector, population health management
- 1.5.2 Admissions Avoidance/ developing services in place – out of hospital focus (Care Closer to Home, Integrated Community Service (ICS), Continuing Healthcare (CHC), Children's Centre hubs, Children's complex cases
- 1.5.3 Delayed Transfers – Development of a joint equipment contract, estate planning, ICT infrastructure, Integrated Community Service, Red Bag scheme

2. Recommendations

2.1 The HWBB endorse the Statement of Intent (Appendix C);
2.2 The HWBB endorse the key areas of development for the 19/20 (outlined in section 1.5 above) with the caveat that the guidance has yet to be published.

REPORT

3. Risk Assessment and Opportunities Appraisal

3.1. (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)
3.2. The HWB Strategy requires that the health and care system work to reduce inequalities in Shropshire. All decisions and discussions by the Board must take into account reducing inequalities.
3.3. The schemes of the BCF and other system planning have been done by engaging with stakeholders, service users, and patients. This has been done in a variety of ways including through patient groups, focus groups, ethnographic research.

4. Background

4.1 The BCF Policy Guidance summarised:

1. The BCF in 2019-20 will retain the same National Conditions as in 2017-19, areas will be required to set out how the National Conditions will be met in jointly agreed BCF Plans signed off by Health and Wellbeing Boards.

National Conditions & Metrics for 2019-20 2.15

- For 2019-20, there continue to be four National Conditions, in line with the vision for integrated care:
  (i) Plans to be jointly agreed
  (ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution
  (iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care
  (iv) Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces

- Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care – adopt the centrally-set expectations for reducing or maintaining rates of DToC in the BCF plans.
- Beyond this, areas have flexibility how the BCF is spent over health, care and housing schemes or services, but need to agree how the spend will improve in:
  - Delayed Transfers of Care;
  - Non-elective admissions (General and Acute);
  - Admissions to residential and care homes; and
  - Effectiveness of reablement.

2. NHS England to put in place arrangements for CCGs to pool a mandated minimum amount of funding. CCGs were advised that the uplift would be c. 1.79%, but I asked the regional lead yesterday who said the minimum contribution will be made on a HWBB basis, not a flat rate nationally, and that the range sit somewhere between 1.7%-5.2%.
3. The Government will require local authorities to continue to pool grant funding from the improved Better Care Fund, Winter Pressures funding and the Disabled Facilities Grant.

4. 2019-20 is to be a year of **minimal change** for the Better Care Fund. Any major changes from the BCF Review will be from 2020 onwards.
5. The only notable changes for 2019-20 are that requirements for narrative plans have been simplified, with more meaningful information on the impact of the BCF to be collected through the planning process. This will be determined through the template submissions. Further information on how this will work in practice will be set out in the Planning Requirements.

Funding and conditions of access for 2019-20 – (covers 2019-20 only).

6. The mandate to NHS England and the annual remit for NHS Improvement for 2019-20 will include an expectation of a minimum CCG contribution, to establish the BCF in 2019-20 (the amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations).
7. NHS England is to look to include conditions that allows for the recovery of funding where the National Conditions are not met. (this does not apply to the amounts paid directly from Government to local authorities).
8. Allocations of improved Better Care Fund, Winter Pressures funding and Disabled Facilities Grant will be paid directly from Government to local authorities. Any future year's allocations will be decided through the 2019 Spending Review.
9. As in previous years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement and for the provision of carers' breaks also remains in the NHS contribution.
10. The local flexibility to pool more than the mandatory amount will remain.

The assurance and approval of local Better Care Fund plans for 2019-20

11. Plans should align with (not duplicate) other strategic documents such as plans set out for local Strategic Transformation Partnerships/Integrated Care Systems.
12. Final decisions on plan approval and permission to spend from the CCG ringfenced contribution will be made by NHS England (as the Accountable Body for the BCF) having consulted the respective Secretaries of State for Health and Social Care, and Housing, Communities and Local Government.

5. **Financial Implications**

5.1 The minimum required budget for the BCF has yet to be published (it will be published with the guidance expected in June), however it will likely be similar to previous years with some uplift. The final plan, including all financial requirements, will be brought the HWBB for approval as soon as possible.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) **For the final BCF plan please see HWBB paper here**
Cabinet Member (Portfolio Holder) **Cllr Lee Chapman**
Local Member n/a
Appendices Appendix A: Non-elective admissions analysis paper Appendix B: BCF 19/20 Policy Framework Appendix C: Statement of Intent Appendix D: BCF Quarter 4 18/19 Return

Appendix A -
BCF Target - Non- elective Admissions Activity Trend Analysis.

Background

1 A number of nationally described metrics are used to determine the performance of the Better Care Fund (BCF), one such metric is the number of Non-Elective Admissions (NEAs) that take place.

2 This metric can be considered on a number of different levels; for the purpose of the BCF the NEA activity target is considered at CCG level. The metrics description is for Shropshire patients aged 65+ years, that:

> ***it is believed that through effective delivery of those services commissioned within the BCF, a number of NEAs are avoided; this is known as Admission Avoidance (AA).***

3 At the outset of each financial year the AA target is set centrally relative to expected growth in demand. All BCF these targets are quarterly and are shared with NHS England (NHSE).

4 Shropshire CCG has been able to meet its AA target, however in Q2 of 18/19 the NEA target was missed, the system however rebounded in Q3 to meet the target, however, it is estimated that there will be a further shortfall for Q4. There are a number of potential causes for the NEA target being missed, these are:

- Widespread cause of increased ill-health across the Shropshire population (increased need demand)
- Reduction in effectiveness of community-based services including the Integrated Community Service and Care Home admissions, due to demand and increasing complexity
- Flawed target-setting methodology, increasing age profile, with static service provision

5 The purpose of this paper is to present the reasons for why this activity shift may have occurred and whether it is likely to continue.

Scope of Data / Modes of Analysis

6 The analysis triangulates a number of data sources, some at the national level and local level data. NEA activity has been derived via NHS digital, whereas population data has been drawn from the Office for National Statistics (ONS).

7 Local-level NEA target data has been derived through interrogation of local NHSE BCF return data sources.

8 Provider activity data is taken from CCG held data-sources

9 The data from the report takes into account quality assured data to end Q2 18/19 and makes estimates for final end of year calculations.

Shropshire CCG Population

10 The volume of 65+ people living in the Shropshire contributes considerably to the number of NEAs observed. Table 1 provides an overview of population growth (2013-2019) coupled with the percentile weighting of the 65+ population.

Table 1 - Percentage of Shropshire Population Aged 65+ 2013-2019

Year	Total Population	Total on-year Population Growth (%)	Cumulative Population Growth %	% 65+	65+ Population	65+ Population Growth (%)	65+ Cumulative Population Growth %
2013	308,567			22.25%	68,668		
2014	310,121	0.50%	0.50%	22.86%	70,883	3.23%	3.23%
2015	311,380	0.41%	0.91%	23.34%	72,685	2.54%	5.77%
2016	313,373	0.64%	1.55%	23.70%	74,277	2.19%	7.96%
2017	315,400	0.32%	2.20%	24%	75,696	1.91%	9.87%
2018	316,700	0.41%	2.61%	24.5%	77,592	2.50%	12.37%

(Source: the Office for National Statistics online resources, years 2017-2019 are ONS projections based upon 2016 data).

11 Table 1 demonstrates how the population of Shropshire has seen a cumulative rate of growth of 2.61% over the last 5 years; whilst the 65+ population has seen a rate of growth nearly 10% above this figure. This could be a contributory factor to increase in the NEA activity shift observed this 2018-19 financial year.

Working with partial 2018/19 data.

12 At the time of writing for 2018-19 only Apr-Nov qualified data was available for NEA activity. Table 2 takes this period of activity and considers it over the period 2013 to 2018. Extrapolating forward suggests the outturn position for Shropshire, based on Apr –Nov (M8). Table 2 suggests that the end of year activity for NEA will be 33,739

Table 2 - Whole-year/Nov-Apr comparison 2013/14 – 2017/18

Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
NEA Actual	27,788	28,642	30,194	31,448	31,917	**33,739**
NEA Actual Apr-Nov	18,093	18,843	19,898	20,746	21,135	22,442
Apr-Nov (% of whole year)	65.11%	65.79%	65.90%	65.97%	66.22%	**66.51%**

NEA vs BCF NEA Target

13 Based upon the information in Table 2, Table 3 displays NEA target figures against NEA actual activity (including the 18/19 extrapolated figure). N.B. winter period for 2018-19 has been extremely busy for emergency admissions.

Table 3 - NEA activity vs NEA target – count

Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
NEA Target/ Plan		27,631	30,449	32,262	33,611	34,349
NEA Actual	27,788	28,642	30,194	31,448	31,917	**33,739**
Variance		-1,011	255	814	1,694	**610**

Possible Target Development methodology

14 Table 3 demonstrates the relationship between the NEA BCF target and NEA activity. What is unclear is how the 2014-15 NEA target was set. Shropshire over performed against NEA target 2014-15 by 1,011.

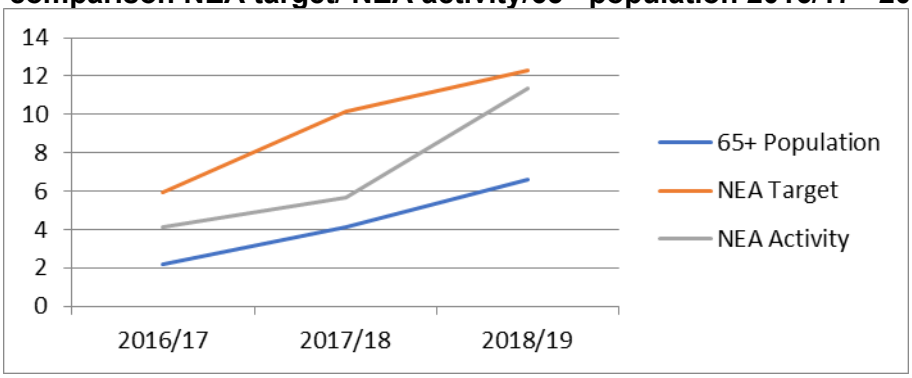
15 Table 4 demonstrates 10.2% uplift on the targeted activity to the previous year, following which point a relationship between targets set and the previous year's NEA activity emerges.

Table 4 - NEA activity vs NEA target – growth 2014/15

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
NEA Target growth (on-year)		10.20%	5.95%	4.18%	2.20%	**6.3%**
NEA Actual growth (on-year)	3.07%	5.42%	4.15%	1.49%	5.71%	
Variance (target/previous year actual)			0.54%	0.03%	0.70%	**0.59%**

16 Methodology for target development appears broadly based upon previous year's activity with some form of uplift applied (variance figure outlined in the bottom row). Extrapolating this variance enables a projected target growth figure to emerge for 2019/20.

Figure 1 - Growth comparison NEA target/ NEA activity/65+ population 2016/17 - 2018/19



17 Figure 1 demonstrates a progressive rise in the 65+ age group over a three year period along with a progressive rise in NEA activity, noticeably a significant rise is seen in 18/19 (green line).

18 Conversely, whilst also increasing, the NEA target begins to level-out in 2018/19. Table 3 demonstrates a marked reduction in terms of variance between the NEA target and NEA activity seen in between 2017/18 and 2018/19.

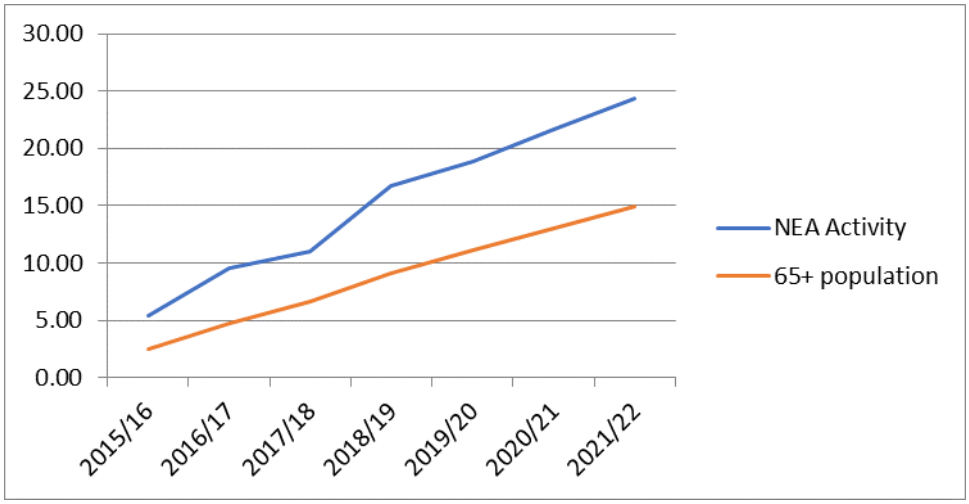
19 However, Table 4 identifies a trend/methodology for target setting, which if broadly applicable, should result in a 2019/20 NEA target of around 36,500. Considering this against other statistical information presented within this document, it becomes increasingly likely that positive performance against the 19/20 NEA target will resume.

Future projections

20 It appears that there is some correlation between the rise in the 65+ population and NEA activity. Using the population information in Table 1 and the NEA activity information in Table 3; a variance can be estimated, which can be used to create a trend line.

21 Using Office for National Statistics population projections, it is possible to use the extrapolated trend line to project NEA activity. Figure 2 illustrates the respective correlation between projected rates of growth.

Figure 2 - Projected correlations between 65+ Population growth and NEA activity based upon 2013 - /18 Table 2 activity data and ONS 2016 projections.



22 Based upon 2013/18 activity data and the it relationship with 65+ population statistics, Figure 2 illustrates how an increased volume of 65+ population is likely to translate into NEA-type demand, following present model remaining unchanged over the next 3 years. This trajectory is concerning given that the projection indicates the rise in NEA activity is forecasting acceleration compared to projected growth of the population over in Shropshire.

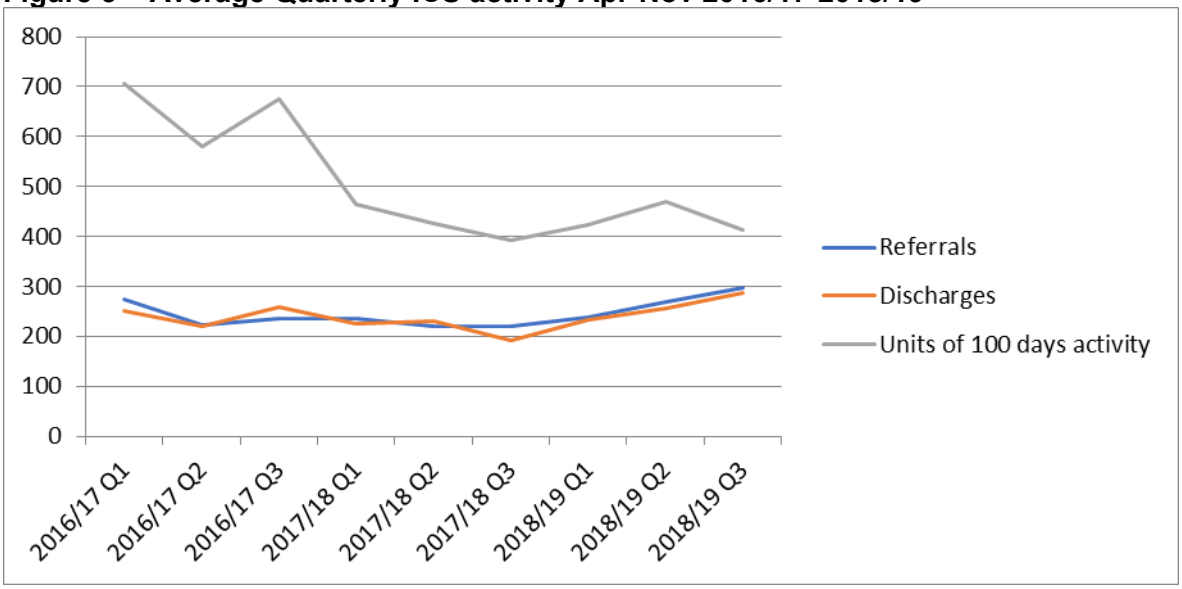
Intermediate Care Service (ICS) Performance

23 The admission avoidance specification for Integrated Care Services (ICS) is currently being redeveloped.

24 Shropshire Community Health Trust (SCHT- the provider) has shared an activity report with the CCG; data available to 16/17. (Note for a year-on-year comparison to extend into 18/19, only the months Apr-Nov are included within the analysis presented here).

25 Comparing the numbers of people referred into service each month, with the numbers who have been closed, it becomes apparent that the numbers of referral do not include those who have been refused service (inappropriate referrals). Based upon this information, the average monthly length of stay has enabled an overview of activity to emerge.

Figure 3 – Average Quarterly ICS activity Apr-Nov 2016/17-2018/19



26 Figure 3 demonstrates an increase in referral activity having taken place, 2018 – 19 year to date, compared to the previous year, suggesting that referrals have increased since Q2 17/18.

Wide spread cause of ill health across Shropshire

28 A widespread cause of ill health may have contributed to a large increase in NEAs, such as significant meteorological factors (e.g. an exceptionally hot summer). High temperatures and pollen-counts are known antagonists for UTIs and respiratory complaints. Previous cohort analysis of NEA activity identifies these condition cohorts among the most common. Further work is required to understand if this might have affected admission avoidance, as corresponding data of reablement targets, have demonstrated that Shropshire has routinely achieved its target of 82% of people being home 91 days after they have been discharged.

Additional Information

29 The **Frailty Board** monitors +65 admissions to hospital, length of stay and a number of other indicators through the Frailty Dashboard. This dashboard demonstrates that there is a 7.9% rise year to date (Figure 4 below), on NEAs from 17/18. Telford and Wrekin show a 27.08% rise for the same period(Figure 5 below) . One notable difference between the two hospitals is that the Royal Shrewsbury Hospital (RSH) has implemented Phase one of Care Closer to Home; Frailty at the Front Door. This service works to keep those frail and vulnerable out of hospital, if possible and appropriate. Additional data from the Frailty Dashboard demonstrates that the readmissions rate is similar to previous years, this together with the reablement data discussed in 28 above, provides further information as we work to understand the volume of NEAs in the system.

Figure 4 – Shropshire CCG trend analysis NEA admissions +65

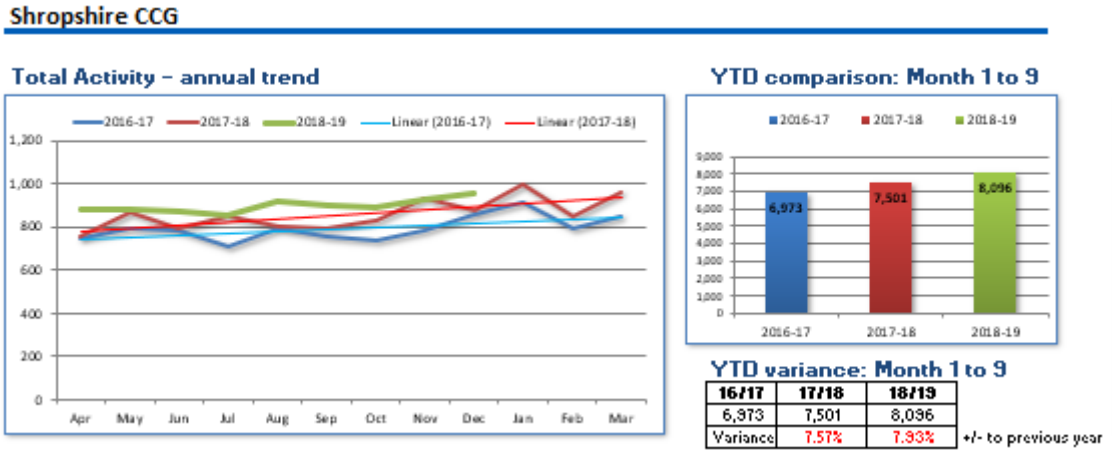
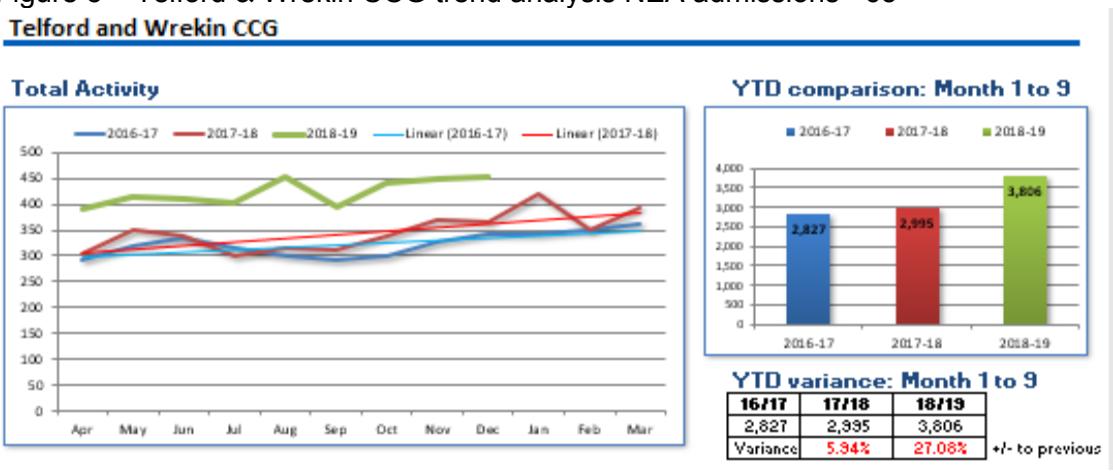
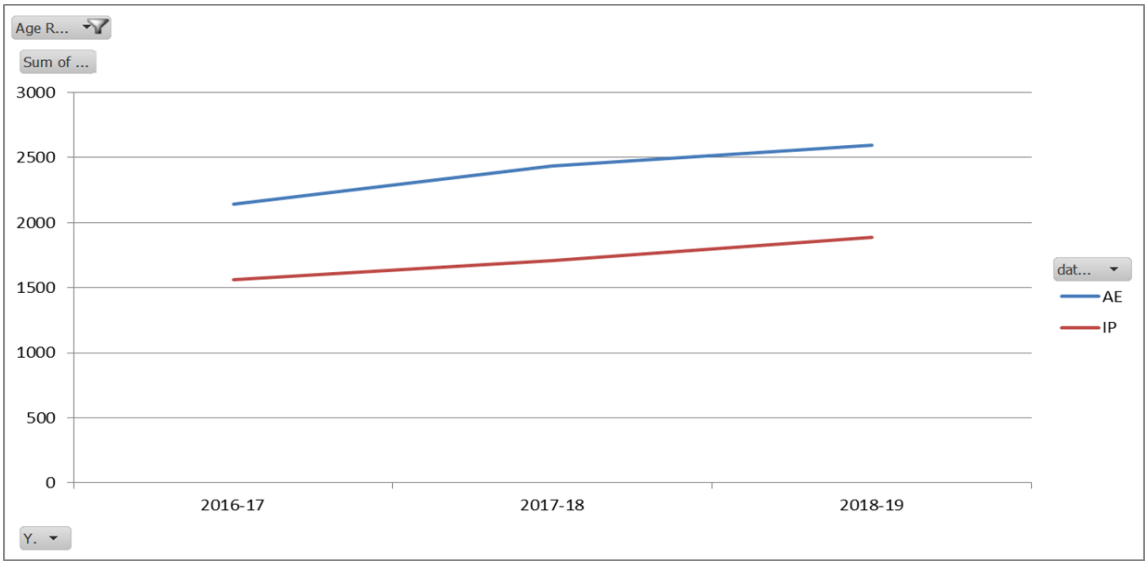


Figure 5 – Telford & Wrekin CCG trend analysis NEA admissions +65



Admissions from Care Homes

29 There has been a year on year increase in A&E attendance and Non Elective Admissions from Care Homes.
There are a number of schemes in place to support the care of residents and the Care Closer to Home transformation programme will enhance this support.
For 2019/20 it is planned to consolidate the work to date, ensure there is alignment to Care Closer to Home and the NHSE Enhanced Health in Care Homes Framework, this will also give the opportunity of identifying if there is additional improvements that can be made to reduce the number of NEL from Care Homes.



Year	A&E attendance	NEL	Total
2016/17	2145	1565	3710
2017/18	2435	1709	4144
2018/19	2598	1889	4487
Totals	7178	5163	12341

Conclusion

30 In terms of understanding why Shropshire BCF NEA target was not achieved in Q2, and why it is not likely to be achieved again in Q4, the causality is likely to be multi-faceted. Whilst the methodology for target setting has been shown to exhibit flaws, the average NEA activity growth has been identified as above that of the previous year.

31 This means a widespread cause may have contributed such as an exceptionally hot summer. High temperatures and pollen-counts are known antagonists for UTIs and respiratory complaints. Previous cohort analysis of NEA activity identifies these condition cohorts among the most common.

32 Additionally it has been identified that there has been a year on year increase of NEAs from care homes.

33 Additional work needs to be carried out to support the development of the model of delivery for Admission Avoidance; this work must connect with the out of hospital work developing as Care Closer to Home. As well continual improvement and support for care homes is required to ensure that we can reduce the number of admissions and support care homes as the preferred place to keep people well and comfortable when needed.

34 Based upon this analysis, it is recommended that the focus of BCF commissioning intentions should be around promoting Admission Avoidance.

Appendix B – 2019/20 BCF Policy Framework

1. Introduction

Person-centred Integrated Care

1.1 The Government is committed to the aim of person-centred integrated care, with health, social care, housing and other public services working seamlessly together to provide better care. This type of integrated care is the key to strong, sustainable local health and care systems which prevent ill-health (where possible) and the need for care, and avoid unnecessary hospital admissions. It also ensures that people receive high-quality care and support in the community. For people who need both health and social care services, this means only having to tell their story once and getting a clear and comprehensive assessment of all their needs with plans put in place to support them. This means they get the right care, in the right place, at the right time.

Progress on the Better Care Fund and Integration

1.2 Since 2015, the Government's aims around integrating health, social care and housing, through the Better Care Fund (BCF), have played a key role in the journey towards person-centred integrated care. This is because these aims have provided a context in which the NHS and local authorities work together, as equal partners, with shared objectives. The plans produced are owned by Health and Wellbeing Boards, representing a single, local plan for the integration of health and social care in all parts of the country.

1.3 In every year of its operation, most local areas have agreed that the BCF has improved joint working and had a positive impact on integration. In 2017-18, for example, 93% of local areas agreed that delivery of the BCF had improved joint working between health and social care in their locality, whilst 91% agreed that delivery of BCF plans had a positive impact on the integration of health and social care. Additionally, since its inception, local areas have voluntarily pooled at least £1.5 billion above the minimum required, in each year, with approximately £2.1 billion planned in voluntary pooled funding in 2018-19.

1.4 There are signs of real progress in joining up care and wider integration:

(a) The **New Care Model Vanguards** have provided valuable lessons for Sustainability and Transformation Partnerships, which are now being taken to the next stage by the emerging Integrated Care Systems. The Vanguards have seen a positive impact on emergency admissions, with community

models demonstrating the benefits of a more proactive approach that helps keep people independent for longer. Vanguards made progress in reducing the pressure on A&E. Emergency admissions in Vanguards on average grew by 0.9% in Multispecialty Community Providers and 2.6% in Primary and
Acute Care Systems compared with 6.9% in the rest of the NHS. For Enhanced Health in Care Home Vanguards, emergency admissions from care residents flatlined compared with an increase of 9% for care homes that were not part of a Vanguard.

(b) The **Integration Accelerator Sites**, building on the work previously conducted through the Integrated Personalised Commissioning programme, continue to make encouraging progress in empowering people to manage their healthcare, and the better integration of services across health, social care and the voluntary and community sector. Integrated personal budgets are one way of delivering more integrated and personalised care. Covering both health and social care, they have been developed based on the lessons learned through personal budgets, personal health budgets, and direct payments. NHS England has now published Universal Personalised Care: Implementing the Comprehensive Model - co-produced with partners in social care - which sets out the road map to deliver the Long Term Plan's objective to deliver the Comprehensive Model for Personalised Care to 2.5 million people by 2023-24.

(c) We are committed to creating a technology infrastructure that allows systems to communicate securely, using open standards for data and interoperability. This will enable health and care professionals to have access to the information they need to provide care. We are encouraging local areas to ensure data is collected consistently and made available to support joined-up and safer patient care by investing in the development of Local Health and Care Record Exemplars. This will enable data to be accessed as patients move between different parts of the NHS and social care. The first five Exemplars cover 23.5 million people and will each receive up to a total of £7.5 million over two years.

(d) Both the NHS and social care have been working hard to **reduce delays and free up beds**. Since February 2017, more than 2,280 beds per day have been freed up nationally by reducing NHS and social care delays. This has been supported by the Better Care Fund and targeted funding from Government through the improved Better Care Fund (iBCF).

1.5 The Shifting the Centre of Gravity report on making person-centred, place-based integrated care a reality was published in October 2018, and produced by the Association of Directors of Adult Social Services, Association of Directors of Public Health NHS Confederation, NHS Clinical Commissioners, NHS Providers and the Local Government Association. The report noted that there are now many more examples of joined-up working across the country than there were at the time of the previous report, Stepping up to the Place, in June 2016.

1.6 The NHS Long Term Plan outlines objectives for joined-up care across the system with commitments to increased investment in primary medical and community health services to support new service models including an urgent response standard for urgent community support; integrated multi-disciplinary teams; NHS support to people living in care homes; the NHS Personalised Care model; an integration index; reducing Delayed Transfers of Care; and supporting local approaches to blend health and social care budgets, amongst other initiatives.

1.7 The forthcoming Adult Social Care Green Paper will also build on the approach to joined-up, person-centred integrated care.

2. The Better Care Fund in 2019-20

What the BCF will look like in 2019-20

2.1 The BCF in 2019-20 will retain the same National Conditions as in 2017-19. Areas will be required to set out how the National Conditions will be met in jointly agreed BCF Plans signed off by Health and Wellbeing Boards. The Government will continue to require NHS England to put in place arrangements for CCGs to pool a mandated minimum amount of funding. The Government will also require local authorities to continue to pool grant funding from the improved Better Care Fund, Winter Pressures funding and the Disabled Facilities Grant.

2.2 2019-20 is to be a year of minimal change for the Better Care Fund. Any major changes from the BCF Review will be from 2020 onwards. The only notable changes for 2019-20 are that requirements for narrative plans have been simplified with areas not required to repeat information they previously provided in their 2017-19 plans, and for more meaningful information on the impact of the BCF to be collected through the planning process.

2.3 Further information on how this will work in practice will be set out in the Planning Requirements.

Funding and conditions of access for 2019-20

2.4 This Policy Framework covers 2019-20.

2.5 The mandate to NHS England and the annual remit for NHS Improvement for 2019-20 will include an expectation of a minimum CCG contribution of £3.84 billion to establish the BCF in 2019-20. The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations. NHS England will look to include conditions that allow the recovery of funding, in consultation with the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, where the National Conditions are not met. These powers do not apply to the amounts paid directly from Government to local authorities. The expectation remains that in any decisions around BCF Plans and funding, Ministers from both aforementioned departments will be consulted.

2.6 Allocations of improved Better Care Fund, Winter Pressures funding and Disabled Facilities Grant will be paid directly from Government to local authorities. Any future year's allocations will be decided through the 2019 Spending Review.

2.7 As in previous years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300 million) and for the provision of carers' breaks (£130 million) also remains in the NHS contribution.

2.8 The local flexibility to pool more than the mandatory amount will remain.

2.9 Further details of the financial breakdown are set out in Table 1.

Table 1 – BCF funding contributions in 2019-20

BCF funding contribution	2019-20
Minimum NHS (Clinical Commissioning Groups) contribution	£3.840bn
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.505bn
Grant allocation for adult social care (improved Better Care Fund). Combined amounts were announced at Spending Review 2015 and Spring Budget 2017.	£1.837bn
Winter Pressures grant funding	£0.240bn
Total	£6.422bn

Disabled Facilities Grant (DFG)

2.10 Funding for the DFG in 2019-20 will be £505 million. This will be paid to local government via a section 31 grant. The DFG capital grant must be spent in accordance with an approved joint BCF plan, developed in keeping with this Policy Framework and Planning Requirements that will follow.

2.11 In two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. Full details will be set out in the DFG Grant Determination Letter.

Winter Pressures funding

2.12 This money will be paid to local government, via a Local Government Act 2003 section 31 grant. Government will attach a set of conditions, requiring the funding to be used to alleviate pressures on the NHS over winter, and to ensure it is pooled into the BCF. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care. The Grant Determination will be issued in April 2019. Reporting in relation to this funding will be managed through wider BCF reporting. Health and Wellbeing Boards will be required to confirm plans for the use of this funding in their BCF plans.

Improved Better Care Fund (iBCF) Funding

2.13 The iBCF grant will again be paid to local government, via a section 31 grant. The total allocation of the iBCF in 2019-20 will be £1.837 billion. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

2.14 The Government will attach a set of conditions to the section 31 grant to ensure it is pooled in the BCF at local level and spent on adult social care. The final conditions will be issued in April 2019. As part of our ambition to maintain continuity in 2019-20, the iBCF will not have any additional conditions of usage above what has previously been set out. The grant is to be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

National Conditions & Metrics for 2019-20

2.15 For 2019-20, there continue to be four National Conditions, in line with our vision for integrated care:

(i) Plans to be jointly agreed

(ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG Minimum Contribution

(iii) Agreement to invest in NHS commissioned out-of-hospital services, which may include 7-day services and adult social care

(iv) Managing Transfers of Care: A clear plan for improved integrated services at the interface between health and social care that reduces Delayed Transfers of Care (DToC), encompassing the High Impact Change Model for Managing Transfers of Care. As part of this all Health and Wellbeing Boards adopt the centrally-set expectations for reducing or maintaining rates of DToC during 2019-20 into their BCF plans.

2.16 Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance (for example by agreeing ambitious expectations across the metrics with plans setting out how the ambitions will be met) in the following four BCF 2019-20 metrics: **Delayed Transfers of Care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

2.17 Since June 2018, local health systems have been tasked with reducing the number of extended stays in hospital. This has required changes to the way that hospitals work but is also affected by what happens outside of acute hospital when patients are fit to go home. The BCF should continue to support the aim to reduce the number of patients who remain in acute hospitals for an extended period (21 days or more) by continuing ongoing work to implement and embed the High Impact Change Model for Managing Transfers of Care that support this ambition.

2.18 Across the country, areas have made strong progress in reducing Delayed Transfers of Care. From February 2017 to January 2019, there have been more than 2,280 fewer people delayed in an NHS bed per day. We believe that no-one should stay in a hospital bed longer than necessary as it removes people's dignity and can lead to poorer health and care outcomes. We want to continue to drive down Delayed Transfers of Care and for 2019-20 the national ambition will remain for no more than 4,000 delayed days per day (reported as 'DTOC beds').

The assurance and approval of local Better Care Fund plans for 2019-20

2.19 Plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and CCG(s). In order to reduce planning burdens we will collect narrative elements and confirmation of agreements through a set template, rather than freeform narrative. Areas should look to align with, and not duplicate, other strategic documents such as plans set out for local Strategic Transformation

Partnerships/Integrated Care Systems. BCF plans will need to set out priorities for embedding implementation of the High Impact Change Model (National Condition four), and update their local visions and approaches to integration - see paragraph 3.1. Areas will need to submit full planning templates, confirming that the HWB has signed them off, in order for the National Conditions to be assured. Plans will be assured and moderated regionally in line with the operational planning assurance process set out in the Better Care Fund Planning Requirements. As in 2017-19, there will be one round of assurance, after which plans deemed compliant by assurers at regional level will be put forward for approval.

2.20 Final decisions on plan approval and permission to spend from the CCG ringfenced contribution will be made by NHS England (as the Accountable Body for the BCF) having consulted the respective Secretaries of State for Health and Social Care, and Housing, Communities and Local Government.

2.21 The NHS Act 2006 allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed and agreed with Ministers.

2.22 Local authorities are legally obliged to comply with section 31 grant conditions.

3. The Better Care Fund, Housing and Wider Integration Initiatives

3.1 The BCF offers a good opportunity to support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has agreed a Sustainability and Transformation Plan (STP) and formed a delivery partnership, providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall approach to integrated care within BCF plans and local STP plans are fully aligned.

3.2 The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, along with NHS England, the Local Government Association, and the Association of Directors of Adult Social Services are currently reviewing the BCF beyond 2020. We intend to provide an update on the future of the BCF shortly.

3.3 STPs and Integrated Care Systems (ICSs) will be required to agree new plans during the first half of 2019-20. We expect every STP and ICS plan to cover their work on Integrated Care; and for Health & Wellbeing Boards, and STP/ICS colleagues to engage proactively in producing this. Where these collaborative strategies exist, we will allow them to form the basis of integration narratives in planning for the BCF (or alternative programme, depending on the review of the BCF) for the following years. Graduation as previously set out has not been possible to date. As part of our review, Government will consider the use of graduation.

3.4 The Long Term Plan also sets out proposals on integration including investing in models of care that strengthen links between primary care networks and local care homes, such as the roll-out of Enhanced Health in Care Homes. The Government will encourage and support the NHS to use this as an opportunity to involve local government in the implementation of the Long Term Plan.

3.5 Building on previous work, a refreshed memorandum of understanding (MoU) 'Improving health and care through the home' was published by Public Health England in March 2018. This MoU, signed by over 25 stakeholders, emphasises the importance of housing in supporting people's health and sets out a shared commitment to joint action across Government and health, social care, and housing sectors in England.

3.6 There is an increasing range of material available to support local systems with the practical development of joint integration strategies and integrated services. The NHS England Integrating Better project recently produced a practical guide based on learning from 16 areas, which is available to health and care practitioners as part of the STP/ICS library of good practice (access requires a login). The Local Government Association also provide a range of support, tools and case studies, such as through a recently published evidence review and case studies of integrated care or the support provided through its Care and Health Improvement Programme.

3.7 Although the Disabled Facilities Grant (DFG) has been part of the BCF since 2015, it was last reviewed in 2008. Following calls from the sector and local authorities to ensure that it continues to provide help and meet users' needs as effectively as possible, the Government commissioned an independent review in February 2018. This was conducted by the University of the West of England in conjunction with several other partners, and both the main report and executive summary were published in December 2018. There are 45 recommendations and Government is carefully considering the detailed findings and will issue a response in due course.

Appendix C:

Statement of Intent
Shropshire CCG and Shropshire Local Authority 2019/20

1. Background

Nationally as well as locally there is a move for greater partnership working across health and care and community support. The move towards integrated care has been in place for some time across Shropshire, and there is a renewed vigour to develop this further. Transformation work streams to deliver an integrated approach to out of hospital care are in place where health and care are co-operating to develop intermediate care services.

The implementation of the Better Care Fund (BCF) provided a platform to enable and facilitate joint working and joint decision making; the success of this has ranged from a successful accounting exercise to improved joint working, communication and improved delivery. More recently Sustainability and Transformation Partnerships have brought about a whole system focus on integrated care, and further developments are on the horizon as STPs morph into Integrated Care Partnerships.

In Shropshire the approach to the delivery of the initiatives as set out in the Better Care Fund has also demonstrably improved our delayed transfer of care. However, we recognise that more work could be done to develop this partnership over the coming year.

Strong place-based working and asset-based approaches exist in abundance in Shropshire, as well as good infrastructure and working relationships with the voluntary and community sector. Further collaborative development of these relationships and ways of working can be a real strength for transforming service going forward.

Benefits to closer working, joint delivery and decision making, can be considered in a number of ways, most notably improved outcomes for people and improved efficiency for the system. Across the health and social care system, we have taken some steps to improve how we design, develop and deliver care, however more can be done.

As well as the Section 75 Partnership agreement, we have entered into an Alliance Agreement on 24 January 2019, bringing together commissioners and providers. To further this stepped approach, this statement of intention reflects the principles as set out in our previous agreements and works to embed better ways of working across health and care.

2. Potential areas for co-operation 2019/20

Building on the good work of the BCF, Shropshire Care Closer to Home, and Integrated Community Services, there is more that can be done to join up planning and delivery of our out of hospital services.

Potential areas to connect and reframe as the health and care transformation to improve outcomes, efficiency and effectiveness:

1. Reframe out of hospital focus to an all age programme focussing on vulnerability
    - Community referral/signposting - All out of hospital developments have a degree of utilisation of community referral. This is done routinely through Shropshire Council's First Point of Contact (FPOC), through Let's Talk Local, through GPs, nurses and the Primary Care Community Care Coordinators. Additionally, the CCG working with SATH is looking at how community hubs for midwifery services can be developed effectively as well as referral for living well and beyond cancer. A well evaluated model of Social Prescribing has been developed and the out of hospital programme has self-care as a focus. If we consider these developments along with the development of primary care networks and a joint approach with the voluntary community sector; there are plenty of opportunities to join up this work.
    - Primary Care - We will also work with the developing primary care networks and individual GPs specifically on admission avoidance linking to the work of the

development of an integrated care system, e.g. develop routine risk stratification and prevention interventions for all ages
    - Development of multi-disciplinary teams to focus on admission avoidance (case management, rapid response, crisis, hospital at home) (care closer to home)
    - Embedding Social Prescribing across the county
    - Development of a joint equipment contract
2. Admission avoidance and transfers
    - Developing the ICS model as a whole system opportunity to smooth transfer out of hospital, drawing in specialities as needed (such as stroke rehab); in addition developing the ICS model in tune with the Care Closer to Home work to ensure that people are supported to remain in their own homes as much as possible.
    - Developing a whole system falls prevention model, linking with community referral, delivering early prevention through Elevate, and secondary prevention through fracture liaison and a dedicated falls service.
3. Development of closer working and sustainable support for the voluntary and community sector
    - Developing a better understanding of how the VCS can support people in place and sufficiently resourcing the sector to provide this support
4. Development of service in place; joining up the out of hospital offer in places where people and services coalesce. This will require working with:
    - estate planning,
    - children's service transformation,
    - adult social care and
    - ICT requirements
    - Voluntary and Community Sector
5. Continuing Healthcare and complex care
    - Continuing Healthcare (adults, children and young people) – specifically the development of a joint approach to the assessment and procurement of packages of care. The nursing team within CHC are working closely with social workers to ensure that there is the most effective care package delivered and reviewed. Our approach is one of joint co-operation and setting strategic direction rather than shifting costs. We also will review current and legacy issues between the CCG and the Council.
    - Following the initial assessment of an audit of 30+ CHC cases the CCG and Council, that should hopefully prove the delivery of more effective care; an agreed joint framework would be developed and then implemented during 2019/20. This framework would also include a risk and gain share agreement and address how both parties would address the funding increases of packages of care. It would be our aim during 2019/20 to move to joint commissioning of services.
    - Integrating a children's social worker within complex care team – developing joint packages of care

3. Enabling programmes

The need to work together to support significant transformation across the system is recognised. The demands upon finance, estates, business intelligence and workforce planning require that we will need to work jointly on solutions. Key areas being:

1. Use Business Intelligence/ Population health management approach to drive decision making

- The CCG has a small team of analysts supporting the broad responsibilities of the CCG. The Council similarly has a relatively small team supporting change initiatives and public health. The intent would be to work together to explore how we can work more closely to support the development of predictive analytics, scenario planning and modelling. This would include remodelling and co-design of the analysis and use of relevant public health data.
- Connect with the NHS population health programme to pick an area in Shropshire that we really want to take an intelligence and evidence-based approach to transforming and, together with a multi-disciplinary team, develop through the population health academy offer.

2. Estates
    - Social care services are delivered in sites across Shropshire including schools, community centres, children's centres with the opportunity of possible other sites currently owned by Shropshire Council. Advice is also provided in libraries and other council-owned buildings. Health also is provided in community hospitals and health centres, clinics and hospitals.
    - We intend to work together to realise how we can effectively utilise our estate to deliver a broad spectrum of health, social care and community referral services. This will require joint work on a feasibility study on a joint programme of estate development and utilisation that supports our joint strategic aims
    - Areas for possible joint work include accommodation support to health and social care staff and patient hotels. We recognise the need to build broader links with housing services to create innovative solutions that focusses on early intervention and prevention.
3. Workforce
    - Ensure the joining up of workforce planning across health and care to include the independent and voluntary and community sectors. E.g. we could work with the VCS to implement a VCS managed agency scheme for health and care to match skills to the new ways of working in communities

4. Better care fund

The BCF can be seen as an enabler in delivering integrated care. Its focus should remain prevention, admission avoidance and delayed transfers, in line with national developments. Both Shropshire Council and Shropshire CCG are committed to working together to implement the findings of the review and reflect how we can work more effectively via the BCF and its successor to support out of hospital care.

We have worked closely on the development of a section 75 agreement in 2018/19. It was recognised however that further work on the development of the BCF and specifically the review initiatives to support our joint strategic goals. A review of the BCF was completed in 2018/19 which identified areas for joint review and development during 2019/20.

5. Our approach to joint working

Although the various programme boards will be considering the approach, coordinated strategic solutions will need to be aligned between the local NHS and local government. The opportunities for joint development of community referral initiatives are significant, and both the Shropshire Council and the Shropshire CCG intend to work cooperatively and align initiatives where possible

This document reflects the need to maintain the impetus on building on the good work to date between the CCG and the Council. There is a recognised risk that the internal issues on structures and potential change of personnel will result in a loss of traction. The six-month priorities detailed below aims to ensure that all focus on these priorities during a period of change.

We will ensure that both health and social care jointly engages locally with elected members to greater effect; using the H&WBB and Scrutiny effectively, taking full advantage of communication opportunities and taking as many opportunities as possible to speak publicly with one voice. We will also prove the efficacy of partnership working by 'doing' and demonstrating results.