Appendix 1

BETTER CARE FUND PLAN (DRAFT)

Swindon Clinical Commissioning Group and Swindon Borough Council v0.3

(January 2014)

1. Introduction

The joint plan for the Better Care Fund is based on the work the NHS Swindon Clinical Commissioning Group and Swindon Borough Council have undertaken jointly to develop integrated commissioning and integrated services.

Our partnership is supported by two National Health Services 2006 Section 75 Agreements for children and adult services.

Our joint vision for people in Swindon is

To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities

We have aligned our joint resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations.

Our plan should be read in the context of the further documents:

- 'Strategy for Care' (CCG)
- 'Commissioning Intentions for 2014/15' (CCG)
- The Five year draft Plan
- One Swindon 'The Swindon Community Strategy: A Shared Vision for Swindon'
- Joint Strategic Needs Assessment
- Health and Wellbeing Strategy
- Pioneer allocation bid: Shoulder to Shoulder
- Adult Demand Strategy, Swindon Borough Council
- Joint Commissioning Plan 2013-14

This plan also needs to be aligned with the work being progressed by the One Swindon Board as part of the Public sector Transformation network.

We have been involved in discussions with public, patients, GP practices, providers, voluntary sector, other stakeholders, providers, children and young people, and the Youth

Forum in the development of the documents referred to above. The Better Care Fund Plan is a summary of jointly agreed areas of priority.

The plan requires the sign off of the Swindon Health and Wellbeing Board. The CCG has very similar boundaries to the Borough Council with the exception of the one member practice in Shrivenham which is within Oxfordshire County Council although the majority of the patient care pathways for its population are similar to the other practices. Also approximately 10% of the patients registered with Swindon GP practices are resident in Wiltshire, Berkshire and Gloucestershire.

The financial elements of this plan will follow as a separate appendix.

2. PLAN DETAILS

2.1 National conditions

The plan needs to demonstrate clearly how we will meet all the national Better Care Fund conditions, including details of expected outcomes, benefits of the schemes involved, and how the associated risks to existing NHS services will be managed.

- **Plans to be jointly agreed** – the Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area itself, broken down by Council and Clinical Commissioning Group

- **Protection for social care services** – local areas must include an explanation of how adult social care services will be protected within their plans. For Swindon this is made easier as the integrated community provider, SEQOL provides both health and social care services.

- **7 –day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekend –** for the winter 2013/14 in Swindon there are additional social care resources being used to ensure that patients are discharged from hospital at weekends when a new setting of care provides added value greater than the current setting.

- **Better data sharing between health and social care, based on the NHS number –** the safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. In Swindon plans to use of the NHS number as a primary identifier are being progressed.

- **Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional –** Swindon's approach has been developed from the joint adult demand strategy. This includes:

- Identification of those needing case management and those needing self-management through risk stratification supported by practice attached community navigators (link workers);
- Access to dedicated case managers provided by SEQOL;
- Access to a range of self-help support including a Healthy Life Plan co-ordinated by practice attached link worker supported by a database of available community, voluntary sector and neighbourhood support.

- **Agreement on the consequential impact of changes in the acute sector** – this is considered in our 'Strategy of Care' and in particular our assumptions regarding the reduction in unplanned care against the overall context of growth in planned care as required by population growth. The net assumption is an increase of 1 – 1.2% per annum in activity compared to growth in population based demand of 2.8 – 3.2%.

2.2 Service provider engagement

The service redesign programme is the main means of engagement with providers attending a range of events to address a number of Swindon specific priorities. Swindon Strategic Change Forum brings together the Clinical Commissioning Group, Swindon Borough Council, SEQOL (provider of community health and social care) and Great Western Hospital. This plan builds on the agreed priorities of:

- The Health and Wellbeing Strategy;
- The draft 5 year Plan for NHS Swindon CCG and Swindon Borough Council;
- The NHS Swindon Commissioning Intentions 2014/15, which have been discussed with providers and have been developed jointly with Swindon Borough Council;
- The Joint Commissioning Plan which brings together the priorities for both the CCG and Swindon Borough Council. The priorities of this plan have also been shared and discussed with the voluntary and community sector.

In developing the plan there was a need to engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. As part of the planning process for 2014/15 and the 5 year strategic plan we will need to assess future capacity and workforce requirements across the system.

2.3 Patient, service user and public engagement

The service redesign programme is the main mechanism for engagement in Swindon with patients, carers, service users and the public. In July 2013, in response to **A Call to Action**, we accelerated this redesign programme and developed it further to include the six

emerging themes: **prevention**, **mental and physical health and wellbeing**, **learning from the best**, putting the **patient in control**, developing and testing **future scenarios**, and enhancing the quality of life for **people with long term conditions.**

2.4 Related documentation

(1) Health and Wellbeing Strategy 2013-2016

(2) JSNA 2013-2022

(3) One Swindon- 'The Swindon Community Strategy: A Shared Vision for Swindon'

(4) Adult Care Strategy

(5) "Doing the Basics Brilliantly"

(6) "Our Health in Our Hands"

(7) "Shoulder to Shoulder"/Joint Commissioning Plan

(8) "Time to Reflect"

(9) "Sustainabilty, Capacity and Choice"

(10) "One Swindon, One Voice"

(11) "Safely in Swindon"

3. VISION AND SCHEMES

3.1 Vision

Our joint vision for people in Swindon is enshrined in the Health and Wellbeing Strategy:

To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities.

We have aligned our joint resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both Swindon CCG and SBC.

Swindon is strongly placed to deliver integrated care, with an existing Section 75 agreement in place for health and social care comprising an aligned fund of £16m CCG and £55m SBC (total £72m). We are a single unitary local authority (Swindon Borough Council), one CCG (representing 27 member practices in Swindon and Shrivenham); a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust); one integrated community health

and social care provider (SEQOL, one of the leading Social Enterprises in the country), one mental health provider (Avon and Wiltshire Partnerships NHS Trust, who have already set up a clinical directorate that just serves Swindon); one urgent care ambulance service provider (South Western Ambulance Service); and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

Integrated services for children will have brought together community health, education and social care services. These have been co-located and managed as a single service.

One Swindon is a partnership of all statutory organisations working with the private sector to deliver a single vision for Swindon which:

- Benefits the people of Swindon
- Celebrates the successes of Swindon
- Sees One Swindon working as one and is part of the national Public Sector Transformation Network as one of nine local authority areas to be designated and already has earned the reputation for delivery of joined up services and change with 12 new business cases developed for implementation during 2014.

Swindon is therefore strongly placed to implement integrated care in that the organisations currently providing local health and social care services are dealing with the same patients and communities

In preparing this plan we have already undertaken an extensive literature search on the opportunities presented through integration (particularly in the delivery of out of hospital care). From that literature search, what we observe is that the delivery of integrated care appears also to require the integration of sources of funding, planning and commissioning, otherwise the inherent differences/competitiveness built into procurement and the different payment regimes drive integrated pathways apart. We will implement models for the integration of sources of funding, resource allocation and provision across adults and children with a particular focus on enhancing the role of community based health and social care support, community navigators and community based support through the voluntary and third sector. It is our belief, based on the evidence from other community health and social care systems around the world, that to merely seek to integrate the provision of care will result in unsustainable change - it certainly will not reflect the level of ambition that the Better Care Fund seeks to achieve. We see the opportunity presented by the Better Care Fund as a step in a journey that we describe below.

We see integration as essential to the improvement of the patient's and service user experience and we will be setting out examples (as patient stories) of how genuine and ambitious care integration will achieve improvements in quality and the cost of health care delivery.

Our ambition to deliver integrated care is first and foremost driven by our daily appreciation of the delays and confusion in healthcare delivery caused by the current disintegrated model of care delivery, despite our best efforts to ensure the patient experience is right first time for everyone. The most common complaint from both patients and clinicians is that every pathway of care has too many points where care must be handed over to another organisation, that these handover stages cause confusion and delay, that delay results in poor healthcare and also discontinuity of provision, that the resulting communication between healthcare professionals is also poor and needs new systems to improve it, and that having two different definitions of choice operating along each pathway i.e. social care and health care definitions are differently applied, only adds to the confusion.

One third of those treated in hospital will be discharged still needing a social care assessment but having had no referral to social care. Recent reports regarding ITU patients highlighted that this can delay someone in ITU returning to their original functionality by an average of two years. Most commonly, the length of stay of the patient is such that there was not time to make a referral to social care before discharge, resulting in subsequent re-admission to hospital when former patients are unable to cope at home. Sometimes, social care needs are not identified during hospital stay and thus no referral is made. The consequences to the patients experience of being discharged without both health and social care needs being addressed can be dramatic – if functionality or mobility is impaired, the once familiar home can become a place of risk and danger.

3.2 Plan performance

Our intention is that the Better Care Fund is linked to achieving outcomes. Funding will be released depending on progress against four of the six national conditions and performance against a number of nationally and locally determined metrics during 2014/15. The four national conditions are:

- Protection for adult social care services
- Providing 7 – day services to support patients being discharged and prevent unnecessary admissions at weekends
- Agreement on the consequential impact of changes in the acute sector
- Ensuring that where funding is used for integrated packages of care there will be an accountable lead professional.

National guidance states that only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour. The national metrics underpinning the Fund will be:

- Admissions to residential and care homes;
- Effectiveness of reablement;
- Delayed transfers of care;
- Avoidable emergency admissions (standardised admission rates for unplanned care)
- Patient/service user feedback on their experience. (this recognised by WHO as being the recognised measure to demonstrate outcomes)

Further details on these national metrics are still to be provided. In addition to the national metrics, Swindon is expected to choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

A menu of possible local metrics selected from the NHS, Adult Social Care, and Public Health Outcomes Frameworks includes:

NHS Outcomes Framework:

- Proportion of people feeling supported to manage their (long term) condition
- Estimated diagnosis rate for people with dementia
- Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 30/120 days

Adult Social Care Outcomes Framework

- Social care-related quality of life
- Proportion of adults in contact with secondary care mental health services living independently with or without support
- Carer –reported quality of life

Public Health Outcomes Framework

- Proportion of adult social care users who have as much as social contact as they would like
- Proportion of adults classified as 'inactive'
- Injuries due to falls in people aged 65 and over

The local indicator can be selected from the above list or it can be a locally agreed alternative, possible local measures are:

- Emergency admissions of patients with a long term condition who have a personal care plan
- Percentage of population who have used rapid access services.

The local indicator must meet a number of criteria:

- It has to be clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- Data is robust and reliable with no major data quality issues;
- It comes from an established and reliable source;
- Timely data is available, in line with requirements for pay for performance;
- The achievement of the locally set level of ambition is suitably challenging; and
- It creates the right incentives.

There will be a need to agree the level of ambition for improvement against each of the national indicators and locally determined indicator. In agreeing the levels of ambition for the metrics the Health and Wellbeing Board will need to be mindful of a number of factors, such as:

- Having a clear baseline against which to compare future performance;
- Understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- Ensuring that any seasonality in the performance is taken into account; and
- Ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

A separate appendix will follow matching the criteria to the different measures proposed.

3.3 What will be different in 2019?

Swindon will have grown substantially by 2019 with a population of between 278,000 – 300,000 in the CCG. We will be delivering more services in the community.

Everybody in Swindon involved in health and social care will be working together and the workforce of different providers (statutory and voluntary) will have learned from each other. Everyone within the health and social care workforce will be working to the One Swindon values and principles where people are encouraged to think about what they can do themselves, what help they have within their family and community and what they still need

help with. All social care support will be based on a person centred assessment and plan whereby people are able to purchase support from a wide range of sources.

We will have implemented and evaluated community link workers and rolled this out to other parts of Swindon and Shrivenham.

Each patient with long term conditions will have been identified and have an agreed plan in place that has been developed with them. Patients will have used on-line information and advice to develop the plan with skilled support including expert patients. Patients know that they can find advice and support through the Information centre at Sanford House and local information points in their community including every GP practice and every school. There will be an extensive network of community based support in place.

For patients with long term conditions we have expanded the expert patient programme; be providing rapid access clinics; be making greater use of live telephone consultations and have rapid access to alternatives to hospital admissions.

Those people who live in the most deprived areas will be receiving additional signposting and support so that they are better able to care for themselves and be able to seek the most appropriate support at the right time.

Self care will be increasing important. The vast majority of health care is either self administered or a consequence of our body's ability to heal itself. Most studies identify self care as representing **98%** of the total healthcare needed across a population at any given time.

Self care can be supported in the home or the local community through informal routes such as family, friends and carers, or by more formal routes for advice from pharmacists, Swindon Borough Council Localities, the voluntary and third sector, self help groups, and the local community health and primary care teams.

Self care requires that each of us, together with our informal care network of friends, family and helpers, become experts in our own health, the determinants of health and how to cope with any long term and enduring conditions or limitations.

Developing an understanding of our own health is a key part of being a good citizen but also needs the support of our community. It requires not just the public sector but also businesses and employers, schools and colleges, retail outlets, community centres, media, charities, volunteers and faiths, neighbourhood and locality planners to adopt a coordinated approach towards developing a collective responsibility for and understanding of our personal health.

The use of health services is mainly as a consequence of a health need that cannot be met through self care, whether it is excessive pain, distress, anxiety, harm or injury, the onset of a condition or disease that requires medication, therapy or surgery, or symptoms that recur, of which someone is unsure and thus needs a professional diagnosis.