Agenda Item No. 12

BETTER CARE FUND 'FIRST CUT' SUBMISSION: UPDATE FOR CABINET

To:	**Cabinet**
Date:	**4th March 2014**
From:	**Executive Director: Children, Families and Adults**
Electoral division(s):	**All**
Forward Plan ref:	**2014/020** *Key decision:* **Yes**
Purpose:	**For Cabinet to note progress on the development and submission of a 'first cut' plan for the Better Care Fund for Cambridgeshire, following delegation of authority to do so at Cabinet on 17th December 2013.** **For Cabinet to note the engagement activity undertaken as part of the development of the plan, as requested by Cabinet on 17th December 2013.**
Recommendation:	**Cabinet is asked to note progress on the development and submission of a 'first cut' plan for the Better Care Fund for Cambridgeshire.**

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1. BACKGROUND

1.1 The Better Care Fund (BCF) - formerly known as the Integration Transformation Fund - was announced in the Chancellor's Autumn Statement 2013. The Fund will create pooled budgets in each upper-tier local authority area, between health and social care services, starting from April 2015. It is important to note that this is not 'new' investment from Government, but a re-allocation of money that is currently spent on existing health and social care services.

1.2 The Government required the submission of a 'first cut' plan by 14th February 2014, signed off by the Health and Wellbeing Board (HWB). At the Cabinet meeting on 17th December 2013, authority was delegated to the Portfolio Holder for Adult Services and the Executive Director: Children, Families and Adults to develop this plan with the Health and Wellbeing Board and the clinical Commissioning Group (CCG). A draft plan was presented to a special HWB meeting on 13th February 2014, approval was granted, and the plan was submitted to Government on 14th February 2014 as required. These documents are attached as Appendices 1 and 2.

1.3 The first cut plan will now go through assurance procedures with Government and other agencies ahead of the submission of a final plan by 4th April 2014. This will also involve engagement with stakeholders and providers to develop some of the detail of the plan. More information about next steps is provided below.

1.4 At its meeting on 17th December 2013, Cabinet requested an update on the engagement activity undertaken as part of the development of a first cut plan. The programme of engagement has been extensive, especially given the restricted time available, and is now generally accepted as being comprehensive and a clear strength of our approach. The programme of engagement and the key messages are presented below.

2. VISION AND AMBITION – See also Appendix 3

2.1 A 'Vision and Principles' document was developed to assist the initial discussion about the purpose and focus of the BCF. This document has proved effective in stimulating a wide cross partnership discussion about a number of issues related to the BCF.

2.2 As a result there is now recognition that the BCF:

- Is an enabler and forms part of a wider programme of work that supports the delivery of a more effective and efficient health, social care and housing/community system;
- Represents a unique opportunity to achieve a 'big change' across the health and social care system;
- Will involve complex change that will take time to deliver but the pace of transformation needs to be high to meet the financial challenges ahead;
- Is both an ambitious strategy but also a risky one; and
- Will need the active involvement of a wide range of partners.

2.3 Appendix 3 sets out a description of these issues in more detail as well as sharpening the overall vision and ambition for the BCF. The scale of the ambition is very large, aiming to achieve a fundamental shift in emphasis in the health and social care system, so that instead of needing to support people when they are in crisis with hospital or long-term social care support, personalised services provided in the community will wherever possible prevent crisis in the first place.

2.4 The challenge for the BCF is that it does not provide new or uncommitted funding. Virtually all of the money allocated to the BCF is already spent on health, social care and housing services in Cambridgeshire. This means that decisions about investment in new or different services have to be taken very carefully – we have to be sure that every change will help to prevent crisis and reduce demand for acute services.

2.5 We will therefore organise our planning for BCF around three areas:

Things that we are statutorily obliged to do

2.6 For example, Government has told us that we must meet the requirements of the new Care and Support Bill by changing the way we do social care assessments and support the introduction of the cap on social care spending.

Transformation of existing services.

2.7 For example, CCC and CCG already fund services to support carers. One of the requirements of the Care and Support Bill is to change the way that carers are assessed. Since CCC and CCG already fund services to support carers, it makes sense to consider how all carers' services are provided, not use the BCF to just 'bolt on' extensions to existing services. This will maximise the opportunity afforded by the BCF to do more joined-up planning and commissioning in support of the major changes required. Similarly there is strong alignment with the aims of the CCG Older People & Adult Community services procurement which will drive transformation of existing services.

Stimulating innovation.

2.8 Some of the ideas we have received from providers are genuinely new and offer a lot of promise. We want to support innovative ways of making our 'big change', driven by evidence of what works, and with clear mechanisms for managing risk if schemes do not deliver.

2.9 The precise areas for change are set out in the BCF form in Appendix 1. In summary, they are:

A. Support for people at home – to help people live independently at home, either preventing them from needing acute or long-term health and social care or minimising their needs

B. Support for people in need of help – to help people who have had a crisis (or who are at most risk of crisis) to get back to living independently so they don't need long-term or acute health and social care services
C. Support for people to leave hospital – to help people be discharged from hospital as quickly as is safe so they can recover at home (or another appropriate place)
D. Investment in infrastructure to support integration – to work between organisations to develop common approaches to assessment, treatment and support

2.10 The following should be noted:

- The detail under (A),(B),(C),(D) above is not a final statement of services that will be funded by the BCF
- As this is the 'first cut' of our plan there is further scope to develop and discuss what finally gets taken forward as part of the BCF
- This list is not exclusive and does not imply that any proposals not mentioned here will not continue to be developed as part of the next round of discussions
- All of the proposals submitted need further work and refinement, particularly in terms of cost, impact on performance and ability to bring about transformational change
- All the proposals submitted still need to be evaluated
- Some proposals are likely to be progressed outside of the BCF 'umbrella'.

2.11 More detail about the expected performance levels, finance and risks are included in Appendices 1 and 2 as part of the submission to Government.

3. ENGAGEMENT AND CONSULTATION

3.1 There has been extensive involvement and engagement of a wide range of partners in developing Cambridgeshire's BCF plan. Patient and service user groups have also been engaged and there remains a clear commitment to continue to involve these groups in the plan as it develops over the coming weeks. The BCF form at Appendix 1 summarises the extent of this work, which is now generally accepted as being comprehensive and a clear strength of our approach.

3.2 Throughout the planning process, we have endeavoured to engage with stakeholders as widely as possible and to ensure that the views obtained through dialogue and feedback from our stakeholders are played appropriately into our plan as it develops.

3.3 We envisage that engagement will continue as an on-going activity throughout the duration of the BCF plan so that we can assure ourselves that the initiatives we implement reflect, as far as possible, the opportunities identified as a result of engagement. We adopted three phases of work:

Phase 1: Stakeholder Engagement

In Phase 1, we developed a shared Vision and Principles and associated strategies with stakeholders, in particular, with Health and Social Care providers, public sector bodies and the community and voluntary sectors. The aim was to seek 'buy-in' to the overall proposition, clarify issues (e.g. funding, scope) and to manage expectations.

Phase 2: User, Patient and Wider Public Consultation

In Phase 2, we published a document setting out our shared Vision and Principles and sought views from patients and service users across the health and social care system.

Phase 3: Further involvement of stakeholders (providers, patients and users) to help shape final proposals and service design

Phase 3 is still underway and will continue until the end of March 2014. We continue to be guided by our work on stakeholder involvement and we have used this knowledge to design further engagement activities, for example, Healthwatch Cambridgeshire suggested a single event in each of the city/district areas 'pulling' together all relevant stakeholders for that area. In turn, this has helped (and continues to help) shape our plans.

3.4 A key part of phase 3 has been engagement with potential providers of services. We invited partner organisations and voluntary sector agencies to submit proposals to us on how they would use the BCF to bring about transformational change, and demonstrate how any change would align to the Government's requirements and Cambridgeshire's strategic framework for health and social care services.

3.5 A total of 118 proposals were submitted and have formed the basis for the development of the 4 key areas for change set out at 2.9 above. The original intention was to formally evaluate the proposals and select those that were most closely aligned to the BCF vision and were likely to have the greatest impact. Because of the large number of proposals submitted and their wide diversity, it was not possible to undertake the evaluation work required in the time available. Furthermore, it was felt some of the proposals represented potentially very different ways of doing things and it was important not to lose this transformational element in the rush to meet the deadline.

3.6 However, linking our plans for the BCF to the wider health and social care landscape in Cambridgeshire means that we can make the best use of the conversation between commissioners, providers and organisational stakeholders that has begun. We intend to keep this conversation going and expand it when possible. For example when the Older People's Programme procurement has completed, a provider will have been selected who can engage in the detailed re-design of services to develop better integration in support of our goal of more preventative, community-based support.

3.7 Overall, the response from stakeholders has been positive with a wide range of views expressed, for example:

- The need to align the work associated with the Older People's Programme procurement with that of the Better Care Fund and the potential to achieve greater synergy of transformation
- It would be sensible for providers to design transformation proposals jointly instead of each organisation putting forward its own set of ideas. There is a clear recognition of the need for alignment of resources and change management effort
- A recognition that we need to think more strategically, moving away from a bids culture to one of designing change programmes at sufficient scale to enable the health and care system to achieve the depth of transformation required to meet the significant challenge posed during the current strategic period
- The need for clarity around how the joint commissioning fund will be deployed and specifically how to mitigate the risk of transferring CCG funding to the BCF joint commissioning fund without achieving a tangible and measureable return on this investment e.g. through performance metrics
- The need for Health to receive the equivalent benefit to the value of funding to be transferred to social care. It was noted that the money to be transferred has already been invested in services and that we would all need to be clear about what the impact could be of transferring it to a pooled budget
- A recognition that all adult social care client groups form part of the BCF plan, not just older people
- Strong support for the Vision and Principles
- The need to build on our existing commitment to transformation
- Ensure that we optimise care pathways, in particular, how the social care elements of the plan inter-link with health services on the ground
- Joint working with the voluntary service sector is in place but we need to learn from examples elsewhere where voluntary and statutory sector services work particularly closely to deliver a range of services targeted at those in most need
- The Better Care Fund should take into account service users themselves, their families and their carers- both formal and informal. One service user suggested that formal carers ought to be supported to be as flexible as possible: for example, she found it difficult to arrange for a carer just for the weeks when her husband was away. Another member of the public felt that the vision and goals of the programme ought to mention individuals and families
- Efforts should be made to ensure that duplication is avoided, particularly during the assessment stages. Service users have expressed that the services they are referred to rarely seem to share information between each other
- The language of the consultation paper and the programme was mentioned by some members of the public, who were concerned that older people in particular were being framed as 'problematic'. There needs to be recognition that some people do need to be in hospital

4. NEXT STEPS

4.1 In order to develop a final version of the plan for submission to Government on 4th April 2014, work will continue on assurance and engagement.

4.2 There will be a further discussion with stakeholders, including those services and organisations that submitted proposals, to hone down on the specific 'projects' that will be taken forward as part of our final BCF plan. This work is likely to include:

- A possible series of whole systems workshops based on areas A-D, possibly broken down into further sub-areas;
- The further development of those proposals that are going to be taken forward. This will require specific information about cost, performance and impact; and
- Agreeing what other projects should be taken forward outside of the BCF 'umbrella' but will contributing to the overall transformation of services.

4.3 As the final plan begins to emerge, an outline delivery plan focusing on resources, sequencing and risk issues will be developed with a view to establishing a formal programme of work aligned to existing strategies and work programmes.

4.4 The HWB will provide strategic oversight of the development of the next submission to Government and the outline delivery plan, via development days and formal meetings.

5 ALIGNMENT WITH PRIORITIES AND WAYS OF WORKING

5.1 Developing the local economy for the benefit of all

As discussed in the previous Cabinet report, the long-term strategy of supporting people to live independently means they are able to contribute economically for longer; furthermore, services to support people to live independently encourage employment for adult social care users generally, including people under 65.

5.2 Helping people to live independent and healthy lives

The BCF has helping people to live independent and healthy lives as a central goal.

5.3 Supporting and protecting vulnerable people

The BCF sets out key strategies and interventions to support vulnerable people in crisis or who are at risk of crisis, to ensure as far as possible they are safe and healthy.

6 SIGNIFICANT IMPLICATIONS

6.1 Resources and Performance Implications

The implications for resources and performance are set out in the relevant sections in Appendices 1 and 2.

6.2 Statutory, Risk and Legal Implications

One part of the planning for BCF relates to deploying resources to make sure that the Council and the system more widely is able to meet its statutory obligations.

The key risk is that demand for acute services will not shift alongside the financial resource, and therefore even if we are successful in the long-term in the strategy of financing preventative services, in the short-term, demand for acute or long tenure social care services is not reduced and resources will have to be found to meet that demand.

As the body overseeing the BCF, the HWB has been informed of this risk. Strategies for mitigation include carefully planning proposed changes and phasing them so they do not all come into effect in 2015-16. The BCF submission includes a risk register and these risks will be closely monitored by all agencies.

6.3 Engagement and Consultation Implications

The engagement and consultation plan is set out above. Further engagement and consultation on the development of proposals will now take place.

6.4 Public Health Implications

Supporting the health of people living in Cambridgeshire, particularly older people, people with disabilities, and people at risk of crisis, is a key part of the proposals and purpose of BCF.

Source Documents	Location
Papers for item 7, Cabinet, 17 December 2013	http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Meeting.aspx?meetingID=727
Papers for item 3, Health and Wellbeing Board, 13 February 2014	http://www.cambridgeshire.gov.uk/CMSWebsite/Apps/Committees/Meeting.aspx?meetingID=781

Appendix 1 – BCF Form Part 1
Appendix 2 – BCF Form Part 2
Appendix 3 – Vision, ambition, scope for integrated health and social care services in Cambridgeshire