# BETTER CARE FUND PLAN 2021/2022

# HALTON

# Contents

# Background to the BCF Plan

This Better Care Fund Plan for 2021/2022 covers **Halton** Health and Wellbeing Board.

***How have you gone about involving stakeholders?***

Our Local Vision - In 2017 the Health and Wellbeing Board published a five-year One Halton Health and Wellbeing Strategy. The strategy was jointly developed after extensive consultation with a wide range of partners and stakeholders across the Borough, including HBC, NHS Halton CCG, GPs, voluntary sector, Community Health Services, Healthwatch, statutory partners, housing, local community groups, patients and the public. The purpose of the strategy is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them. The strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention.

With partners being fully involved with the development of the Health and Wellbeing Strategy, the BCF plan for 2021/22 runs parallel to this and all members of the Health and Wellbeing Board will approve the plan and the ambitions for the metrics, which for this current year the targets are aligned to the NHS Halton CCG agreed planning assumptions. The main trusts that we work alongside and that are members of the HWBB are:

- Bridgewater Community Healthcare NHS Foundation Trust
- Merseycare NHS Foundation Trust
- St Helens and Knowsley Teaching Hospital NHS Trust
- Warrington and Halton Hospital NHS Foundation Trust

In addition to the above acute trusts, Halton Borough Council and NHS Halton CCG, the Board also involves the following organisations within Halton:

- Cheshire Constabulary
- Cheshire Fire and Rescue Service
- Halton Children's Trust
- Halton Housing Trust
- Halton and St Helens Voluntary and Community Action
- Healthwatch Halton

In addition to the HWBB, work continues as part of two hospital system footprints to reduce key performance metrics, as detailed in the BCF Plan, including Admission Avoidance and Lengths of Stay. Contract meetings with the respective trusts take place on a regular basis.

# 1.0 Executive Summary

The BCF aligns to the wider integration landscape including One Halton which is a local system partnership where by all priority areas are shared and prioritised via a structured governance process. One Halton's vision is:

"Working together to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives".

With the establishment of the One Halton Place Based Partnership (PBP), in line with the White Paper *Integrating Care: Next Steps to building strong and effective integrated care systems across England* published in February 2021, we are working together to transform services across the health and social care system to deliver sustainable change with maximum benefits to communities, residents and patients/users of services. This includes joint accountability and decision-making, improved commissioning and a move to integrated service delivery.

The Integrated approach for the BCF enables the local commissioners and providers to develop plans that support local placed-based delivery and system-wide strategic transformation. The development of the Cheshire and Merseyside Integrated Care System (CMICS) supports the place and programme developments and creates an opportunity to work on tactical, operational and strategic approaches.

The ***One Halton Plan – Longer, Happier and Healthier Lives, 2019 – 2024,*** identifies six priority areas where the opportunities are greatest to transform our healthcare delivery, these are:

- Children and Young People: Improved levels of early child development;
- Generally Well - increased levels of physical activity and healthy eating and reduction in harm from alcohol;
- Long-term conditions - reduction in levels of heart disease and stroke;
- Mental Health - (including LD and dementia) improved prevention, early detection and treatment;
- Cancer - reduced level of premature death;
- Older People - improved quality of life.

The priority areas take a life course approach and have a strategic fit with the NHS Long Term Plan and the C&M ICS. Work is ongoing with the wider system to ensure local transformation, commissioning intentions and provider redesign support opportunities to improve outcomes.

# 2.0 Governance

## 2.1 Current Governance Arrangements

Internal governance arrangements from 2019/2020 will continue for the majority of 2021/22, transferring into the new governance arrangements set out by the One Halton PBP. The current arrangements including the Better Care Development Group (BCDG) (formerly the Operational Commissioning Committee) meets on a monthly basis and the Executive Partnership Board (EPB) meets quarterly. As set out in the Joint Working Agreement, the role and function of the BCDG is:

• To be responsible for oversight of the management, monitoring and use of the Pooled Fund by the Pool Manager, through monthly reports from the Pool Manager, and for reporting to the Better Care Board and Parties in all matters relating to the Pooled Fund.

• To be responsible for the monitoring contractual relationships with Providers financed by the Pooled Fund through the implementation of a performance management framework and for reporting to the Executive Partnership Board in all matters relating to such monitoring, including those associated with the Better Care Fund.

• To develop and prepare the performance management framework.

• To be responsible for the implementation of the decisions of the Executive Partnership Board relating to the strategic objectives for the commissioning of the Services and for the operational delivery of those Services including those outlined in the Better Care Fund Plan.

• To prepare detailed planning proposals for the Services and present to the Executive Partnership Board for discussion and approval.

Halton BC and the NHS Halton CCG have in place a Section 75 Joint Working Agreement and as part of that undertake to share the risks jointly in Complex Care.

One of the main roles of the Executive Partnership Board is to ensure that any on-going risks associated with the process which might impact on the success of the agreement are identified and appropriate risk control measures established to mitigate against them. Halton BC and the NHS Halton CCG work together to ensure the appropriate and robust implementation of the BCF to maintain and enhance health and wellbeing in Halton. The 2021/2022 pooled fund arrangement for the BCF funds and the governance around this pool include appropriate risk sharing arrangements as outlined in the Joint Working Agreement. Sound financial systems and procedures, including a robust ledger and budgetary control systems are in place across both Halton BC and the NHS Halton CCG. Expertise in forecasting and budget-setting are key skills which the finance teams share. The Finance Teams from both organisations hold monthly meetings. Through the Executive Partnership Board and the Better Care Development Group, regular financial reports are presented to ensure that any financial risks are highlighted in a timely fashion and dealt with under the Joint Working Agreement. There are regular Executive to Executive meetings with the NHS Halton CCG, Acute Trusts and community providers where risk sharing issues are discussed. There is a

formal contract monitoring arrangement between the NHS Halton CCG and Trusts as appropriate. All providers have a Contract Review process in place which review and assess the risk of contract over performance. Both Halton BC and the NHS Halton CCG engages in this process and works with the relevant co-ordinating commissioner to mitigate the financial risks associated with contract variation and the overall financial viability of the Trusts.

## 2.2 New Governance Arrangements – One Halton Place Based Partnership

Work is underway on developing new arrangements in line with national and regional guidance on the emerging Place Based approach and ICS / ICB. These will incorporate the requirements of the BCF for 2022/23.

## 3.0 Overall Approach to Integration

We want people to live longer, healthier and happier lives. We are acutely aware that we are working within scarce resources. It is a well-known fact that over the next five years NHS Halton CCG, Halton BC and our partners face significant financial challenges. These financial challenges are driving us to do things differently and transform all aspects of health, social care and wellbeing in Halton, and by working together through the establishment of the Place Based Partnership, will strengthen our overall approach to integration across all key stakeholders within the borough. Through a range of contracts, both within the BCF and outside the Voluntary and Community Sector are engaged in supporting pathways of care.

Halton continuously analyses a wide range of data and evidence to identify where opportunities exist for the health and social care economy to change the configuration and delivery of services to provide better outcomes and value for money whilst ensuring that acute services only need to be used by people in acute need. Most of this analysis is available in the Joint Strategic Needs Assessment (JSNA), but additional sources of information are also used such as Right Care's Commissioning for value pack, Getting it Right First Time (GIRFT), primary care QoFF data, local intelligence from Aristotle, VENN capacity and demand data, local insight through patient engagement and local analysis of trend data. The analysis highlighted that our NeL activity, ambulance data, AEC activity are areas where significant pressures have been identified at both Acute providers. A&E attendances and hospital admissions for certain conditions, most notably respiratory, mental health and frailty were significant areas where opportunities for change existed. Opportunities also existed in improving cancer outcomes especially with regard to screening and length of time to start treatment. Other areas highlighted included prevention work around obesity, gastro, childhood accidents, health checks and child development. The use of hospital services by frail older people is also identified as a key opportunity in both providing alternative pathways of care and reducing length of stay where admission occurs.

By redesigning primary care access we aim to enable 7 day GP access to same day appointments, working with our Primary Care Networks (PCNs) we aim to prioritise our plans and reduce unwarranted variation. By integrating Acute and Community services in local integrated community hubs through the Place Based Integration (PBI) project, we aim to align clinical pathways enabling a seamless approach to patient care. Focusing on the vulnerable through Multi-Disciplinary Teams (MDT) will allow for significant efficiencies. The BCF will play a key role in these areas.

Building on these innovative solutions and experiences, the people of Halton will experience a fully integrated system that puts people at the heart of decision making about their care.

## 4.0 Supporting Discharge (National Condition 4)

The Halton population accesses elective and non-elective care at two main hospitals, St Helens and Knowsley NHS Teaching Hospital Trust and Warrington and Halton Hospitals NHS Foundation Trust. Both Trusts have processes in place for the early identification of discharge needs and monitoring the flow through the in-patient episode. Both have regular length of stay processes which the multi-disciplinary discharge teams are engaged in. This is supported by regular senior management input from Halton. Both trusts have commenced transfer to assess processes utilising community based services to continue the assessment of need (this includes supporting <15% of CHC assessments undertaken in an acute environment).

In 19/20 we reviewed Intermediate Care Services and planned to develop a new model of care. The pandemic delayed the implementation of this. However the changing models developed during the pandemic have enabled a speedier transition to the new models and incorporated both the 2 hour crisis response and a local frailty pilot. It is anticipated that the revised model will be commenced in December 2021 with full implementation by March 2022 (subject to recruitment).

All intermediate care and social care services are available and accessible 7 days a week with a programme of work commenced exploring 'trusted assessor' model for care homes. A single coordinating provider for domiciliary care in the borough will play a crucial role in expediting hospital discharge whilst the 'reablement first' approach will link directly to transfer to assess and hospital discharge.

Both hospital trusts use a discharge to assess (D2A) model. Increases in capacity in the discharge teams, continuing healthcare team and Intermediate Care will go some way to the management of long lengths of stay and preventing hospital admission.

## Disabled Facilities Grant and Wider Services

Halton's Home Assistance Policy describes how we use our powers under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 to provide home adaptations for disabled people. The policy aims to ensure that residents with disabilities are provided with support to adapt their home so that it meets their needs and they are able to continue living safely and independently at home. The assistance offered through this policy is funded through the Disabled Facilities Grant (DFG) allocation.

The DFG is used as a means of financing a wide range of equipment and adaptations within and around the home to ease accessibility, aid independence and promote wellbeing. As a result of transformation the fund can be allocated in a variety of ways including grants, loans, equity release, subsidies (e.g. 50/50 funding agreements with registered social landlord or housing associations) or a combination of these. The Council works collaboratively with service users in a person-centred way to meet their care and support needs.

Halton have traditionally used mandatory grants for:

• External access - to get into and out of the home e.g. widening doors, ramps, rails
• Safety – e.g. improved lighting, a room made safe so a disabled person can be left for a period unattended
• Internal access – to make it easier to get into the living room
• Washing/bathing/cooking/sleeping - to provide/ improve access to the bedroom/kitchen/toilet/ washbasin/bath/shower e.g. by altering the layout, installing a stair lift, providing a downstairs WC or putting in an accessible shower
• Heating – improving/providing a heating system suitable to the disabled person's needs
• Ease of use – e.g. adapting heating or lighting controls to make them easier to use
• Facilitate caring - to enable the disabled person to care for someone else who lives in the property, such as a spouse/partner, child or other person
• Garden access – this was added in 2008 with the aim of providing access to and from a garden or to make a garden safe (in practice this may only cover a limited amount of larger gardens).

As part of the developments and transformation of the fund we now also use it to cover repairing, improving, extending, converting or adapting housing accommodation. This creates schemes that help disabled people in a more responsive and accessible way and can include:

• Providing a 'fast track' scheme for low level adaptations not requiring a full social care assessment or a means test or for those facing end of life.
• The effective utilisation of new technologies to support independence e.g. telehealthcare.
• Provision of relocation grants to help people to move to a more accessible home.
• Dealing with small repairs and heating problems, allowing people to live well in their home for longer and/or helping people to return to their home faster (e.g. hospital discharge)
• Issue of aids and equipment which allow people to maintain their independence for longer – including mobility aids and personal care equipment

The scope for use of the DFG is aligned to schemes and facilities which support prevention of more complex intervention, promotion of independence and delay transfers into care.

This grant and associated capital expenditure are also being used to improve the range of specialist accommodation available in the borough, notably in respect of Adults with LD/Autism, and also care home provision for older people.

## 5.0 Equality and Health Inequalities

The ***One Halton Plan – Longer, Happier and Healthier Lives 2019 – 2024,*** sets out how, as a system, we are aiming to work together to develop pro-active prevention, health promotion and identifying people at risk early, when physical and / or mental health issues become evident, will be at the core of all our developments, with the outcome of a measurable improvement in our population's general health and wellbeing.

The Local Authority and the CCG are working together to develop services centred around care homes, including medication and dementia screening and strengthening clinical nursing support for residents and staff alike.

Choice, partnership and control will continue to be developed based on integrated approaches to needs assessment. Bringing care out of acute settings and closer to home will be an essential part of providing health and social care over the next five years. We also use a Choice Protocol in both Trusts to proactively challenge people.