

Hampshire Better Care Fund

**Health and Wellbeing Board
15 March 2018**



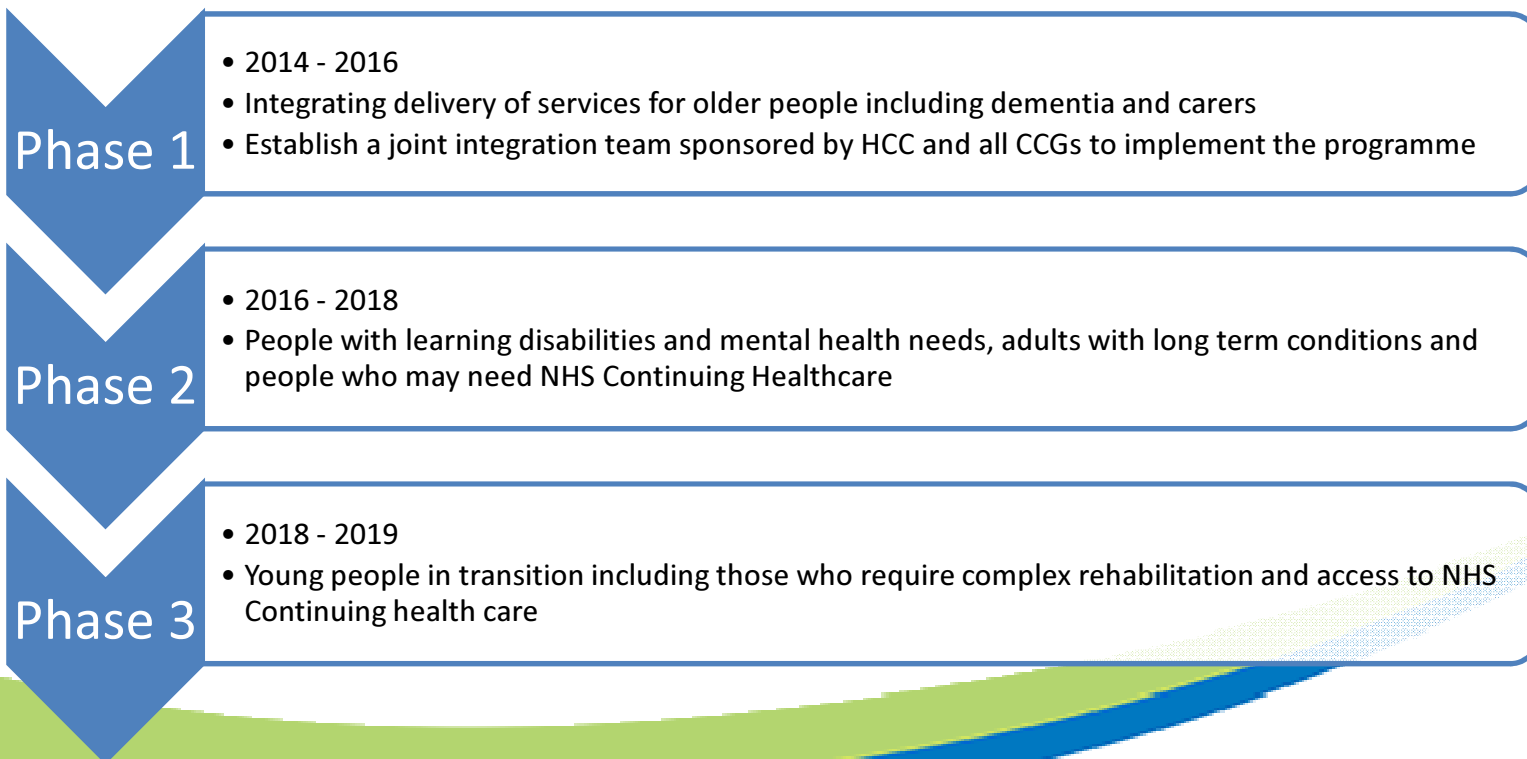
What does the Hampshire BCF aim to do?

- Support and accelerate local integration of health & care services through joint commissioning & partnership working.
- Address demographic pressures
- Facilitate the provision of more “person centred” joined-up care in the community by changing the way health and social care work together to reduce duplication and improve outcomes.

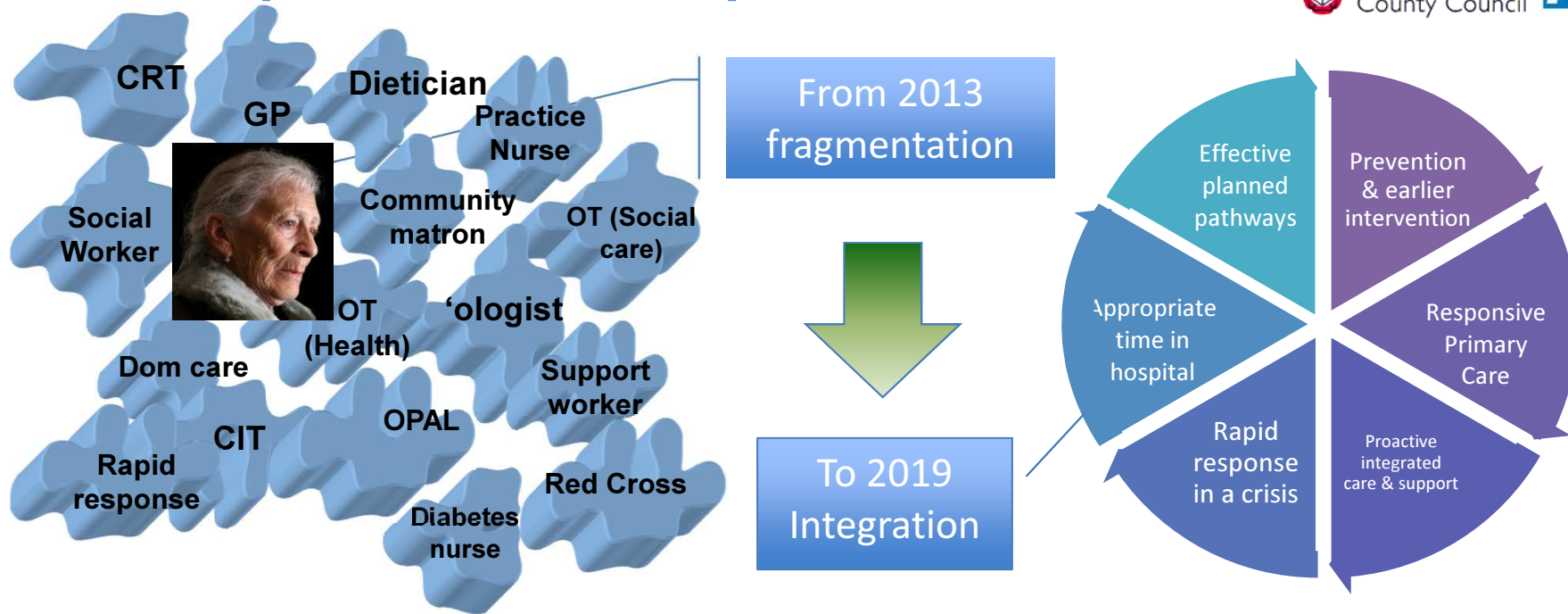


Components to our plan

Plans for the BCF implementation are being developed in key phases:



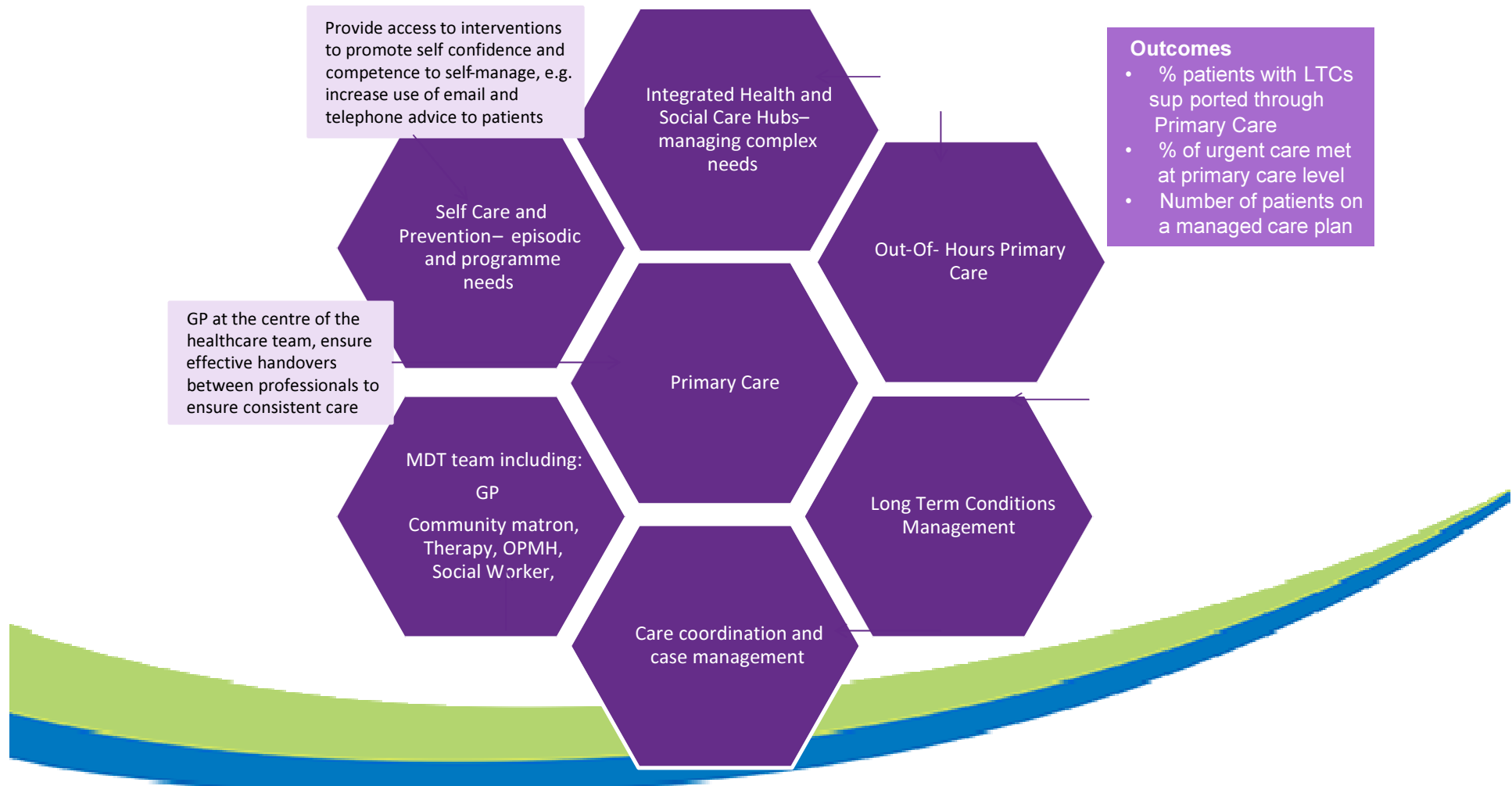
BCF plan – Out of hospital care model



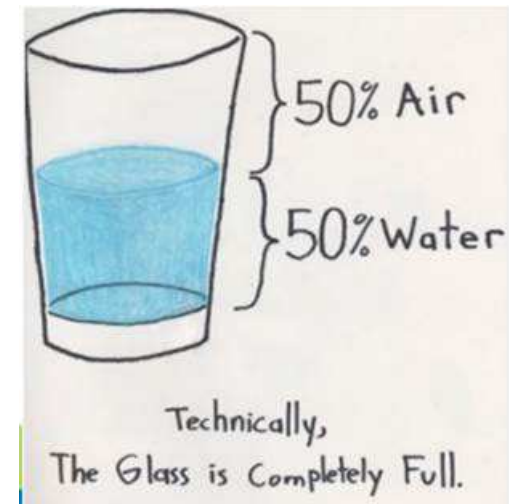
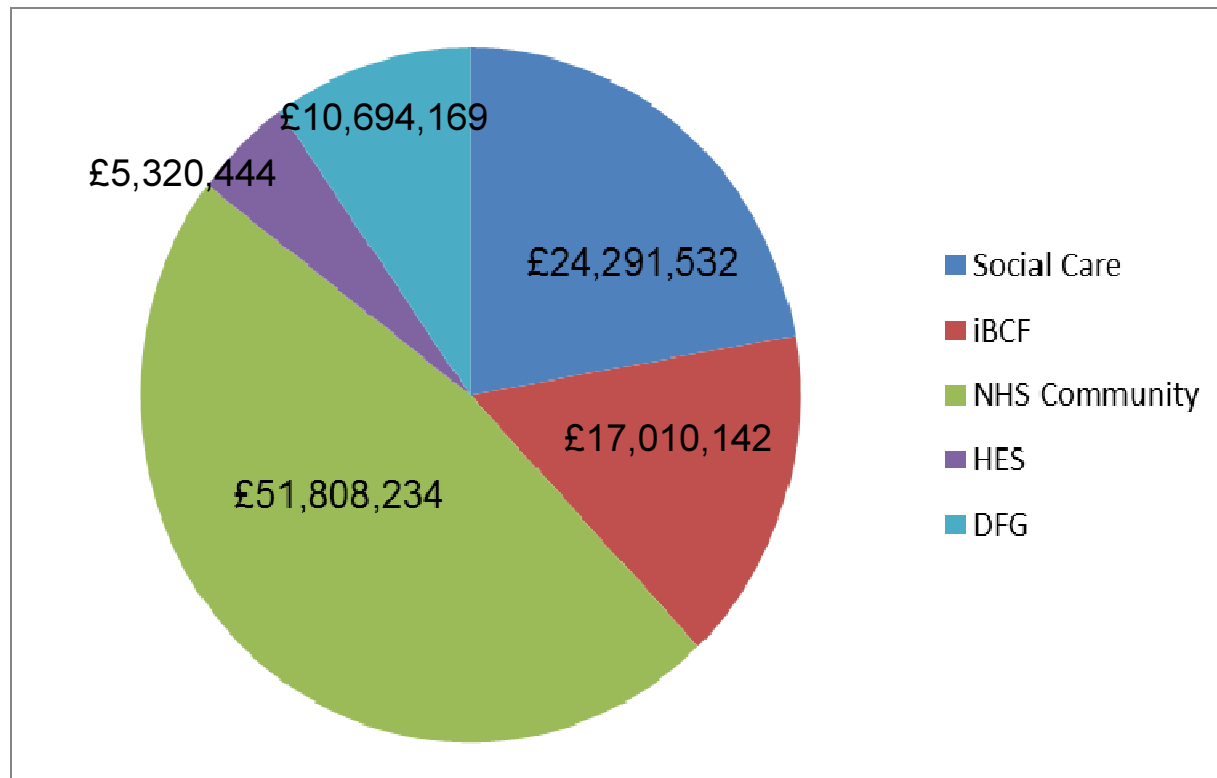
Areas of investment that achieve FLOW =



Out of hospital care model: Integrated Care Teams



The pooled fund 2017/18 - out of hospital care



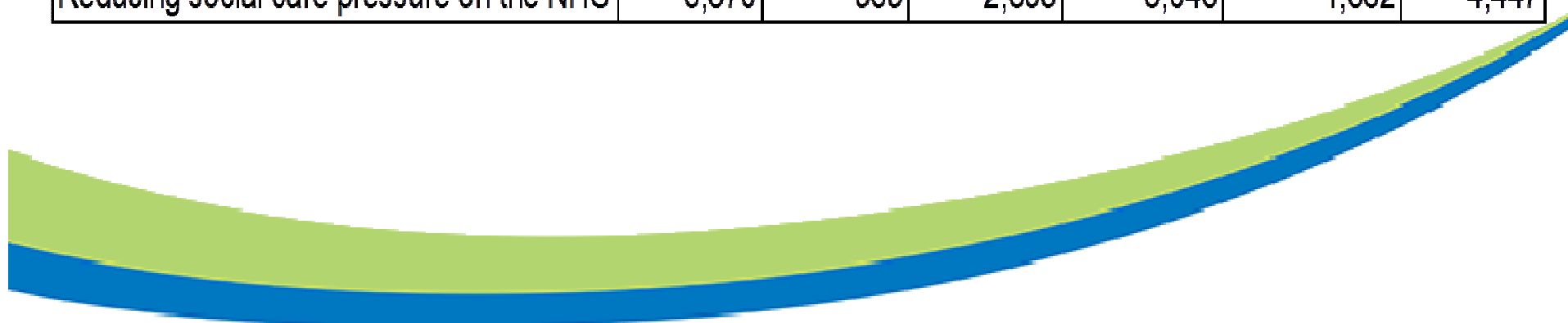
Hampshire iBCF 2017/18

Value of the Grant:

Local Authority	Additional funding for adult social care announced at Budget 2017	Additional funding for adult social care announced at Budget 2017	Additional funding for adult social care announced at Budget 2017
	2017-18	2018-19	2019-20
Hampshire	£ 17,010,142	£13,437,051	£6,697,875

Deployment of the Grant 2017/18 and fit with Grant conditions

2017/18	CCG area spend plan					
Area of spend		F&G (15%)	SE (16%)	NH (16%)	NEHF (12%)	WH (41%)
£ 000's (figures rounded)						
Responding to social care pressures	5,150	1,775	1,898	1,898	1,422	4,856
Supporting the care market	5,490	1,917	2,044	2,044	1,465	5,268
Reducing social care pressure on the NHS	6,370	969	2,396	3,046	1,662	4,447



iBCF Mapped to NHS High Impact Changes

Early Discharge Planning / MDT Schemes		
	Schemes	HIC
North East	Care workers	Medically fit for discharge
	SW ED	Systems to monitor / change flow
	Fleet hosp	MDT Discharge
	ICTs	Systems to monitor / change flow
	Pooled resource	Short term beds
	CHC	Medically Fit for discharge
North	Firs Unit	Early Discharge Planning
	Overton facilities	Early Discharge Planning
	Locum Community SW x 3	MDT Discharge
	Additional ICCM	MDT Discharge
South East	Carers in SHFT	Medically fit for discharge
	SW SCAS	Joint Admission Prevention
	Hosp SW	MDT Discharge
	Hosp prevention	Joint Admission Prevention
	Frailty SW	Medically fit for discharge
	Locum admin	Medically fit for discharge
West	Bluebird	Joint Admission Prevention
	Locum community SW x 3	MDT Discharge
	PTR 60 SW x 1	MDT Discharge
	Locum SW RHCH	MDT Discharge
	RBCH scheme	Early Discharge Planning
	Frailty	Early Discharge Planning
	CRT enhancements	Early Discharge Planning
ALL	CHC	Trusted assessor
	improving hospital teams	Trusted assessor
	Dementia Care	Enhancing care in care homes

Impact

Accepting that demonstrating immediate benefit of system change is challenging progress so far:

Reallocated acute unit for short term reablement unit to develop joint approach between H&SC in North Hampshire – five month review showed 76 people had accessed the service the majority supported for 21 days or less. Unit is supported by primary care medical services. In reach physiotherapy services have been provided by HHFT. The 91 day position of these people is part of our wider reablement performance which is in line with comparator authorities

Joint initiative with FPH – system gearing has been enhanced by the new model of care and this resource effectively bridges care demand post discharge now minimal social care day delays

Bluebird joint prevention scheme mid Hampshire – 278 people referred in 6 months, evaluation indicates not always preventing admissions to hospital and referrals tended to be complex. A lot of insight in to current system fragmentation. The review sample indicated that less than 10% of people had an eligible need for social care, many of whom were already receiving support and therefore did not demonstrate an impact on eligible social care demand.

SCAS triage social work support – initial pilot indicates potential for more than 100 people diverted (with social care intervention) on the basis of the pilot staffs view that three / four admissions being avoided per night.

Adult Mental Health - A Transformation project to realign workforce with contemporary terms and conditions with additional AMHP capacity has been resourced by IBCF to improve AMHP availability. Training and development of 9 AMHP trainees on a bespoke fast tracked course with Bournemouth University. Community MH Social Care to resource Hospital SW function in partnership with SHFT/ SABFT psychiatric acute services. Purchase of additional supported living placements with CCG to speed up discharge from hospital where necessary

Recognised risks to our plan

LOCAL:

- Different stages of development / maturity amongst partners
- “Buy in” of front line staff – they deliver the difference
- Distraction – unforeseen events requiring immediate reaction from the same group of people
- Consequences of financial extremis
- Integration itself – not easy to cede sovereignty
- Legal framework needs local interpretation e.g. NHS Contract, eligibility
- Performance and delivery in each system
- Workforce availability

NATIONAL:

- Policy leadership and change
- Hospital settings used as “currency” of national communications
- Information sharing issues
- Commissioning ‘strength’ and the national funding frameworks e.g. NHS tariff

Next Steps

- Maintain leadership focus & prioritisation of capacity
 - Strengthen communications, engagement & involvement
 - Continue to progress integrated delivery in local communities across the county
 - Whole system strategies to divert, delay or reduce reliance on publically funded care and support and 'harvest' financial savings
 - Cut through bureaucracy to enable changes whilst alternatives to existing governance and legal frameworks develop
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