Health and Adult Care Scrutiny Committee

# Better Care Through Integration?

## An Investigation into the Working of The Better Care Fund in Devon

Final Report

7 June 2018

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# Contents



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# Preface

In 2016 NHS organisations and local councils came together to form 44 Sustainability and Transformation Partnerships (STPs) covering the whole of England, and set out proposals to improve health and care for patients. Integrated care, close collaboration of health and social care, is firmly on the agenda and gathering pace.

In June 2013, the Government announced the Better Care Fund (BCF). Its purpose was to ensure a transformation in integrated health and social care. What made it different was that it created a single pooled budget to incentivise the NHS and local government to work more closely together.

The role of Health and Adult Social Care Scrutiny is to ask challenging questions about the way the system is structured and how it functions. As an important forerunner to an integrated care system, the Task Group was set up to come to a deeper understanding about the BCF and how it can help to inform quality working practices in this move to full integration.

I would like to thank the members of the Task Group for sharing their experiences and ideas, their insightful comments and consistent support that has helped me shape up this piece of work and write the final report. I would also like to thank the many witnesses who gave up their time graciously and talked to us openly and honesty which has enabled us to reach a better understanding of how the system works. Finally thank you Camilla de Bernhardt Lane for setting us on our way and inducting me as a new councillor into the ways of 'The Task Group' and thank you to Dan Looker for picking up the reins and helping me to finish the job.

**Councillor Hilary Ackland,**
**Chair, Better Care Fund Task Group,**
**Health and Adult Care Scrutiny Committee**

# 1. Introduction

1.1 The Task Group — Councillors Hilary Ackland (Chair), Sara Randall Johnson, Sylvia Russell and Carol Whitton — would like to place on record its gratitude to the witnesses who contributed to the review. In submitting its recommendations, the Group has sought to ensure that its findings are supported with evidence and information to substantiate its proposals.

1.2 On 19 June 2017 the Health and Adult Care Scrutiny resolved to set up the Better Care Fund Task Group. The terms of reference for the review were:

1. To appreciate the historical aims and applications of the Better Care Fund.

2. To understand the purpose and accountability of partners in integration.

3. To contribute to the future direction and monitoring of success of the outcomes of the Better Care Fund.

4. To report back to the Health and Adult Care Scrutiny Committee on the findings of the Task Group.

1.3 Time and resources necessitate that this report provides a snapshot approach to highlight significant issues. The list of witnesses to the review does not pretend to be exhaustive but it does provide insight into some of the central themes.

1.4 Therefore, the Task Group asks the Health and Adult Care Scrutiny Committee, Cabinet and Northern, Eastern and Western (NEW) Devon CCG and South Devon and Torbay CCG to endorse this report and seriously consider the recommendations tabled below.

# 2. Recommendations

## Financial

### Recommendation 1

That Devon County Council (DCC), Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG) and South Devon and Torbay CCG should request that Government generate financial models that encourage full integration of health and social care budgets.

## Measurement and Evaluation

### Recommendation 2

That the Executive Team of the STP should consider the following:

i. That beyond monitoring of targets and outcomes, ongoing evaluation of impact is built into the system and this robust evidence accrued is used to review, change and develop the system for the benefit of the service users.
ii. That the evaluation framework should include significant public engagement and involvement.
iii. That serious consideration should be given to fund external evaluation of the BCF using iBCF monies to inform the development work of creating the Integrated Care System.

## Acute / Community Services

### Recommendation 3

i. That acute and community service providers should, together recognise that risk management is shared and should result in the establishment of a common risk assessment tool.
ii. That Health and Adult Care Scrutiny Committee should add the Carers' Contract into its work programme at least every two years.
iii. That GPs and community services should explore together innovative ways of working.

## Workforce

### Recommendation 4

That DCC should use its expertise to generate a mixed economy of care businesses to help alleviate the shortage of workers by setting up feasibility studies of new business models of care delivery that would lead to the possibility of investing in innovative practices.

# Technology

## Recommendation 5

i. That DCC should consider using iBCF money to develop quality Big Data and Big Data Analytics to support strategic decision making by commissioners.
ii. That both Social Care and the CCGs should ensure that there is full access for professionals and patients across both health and adult care to patient records and explorations around common assessment tools should be encouraged.

# Mental Health

## Recommendation 6

That, moving in the direction of the NHS England national target, equal priority is given to mental health as to physical health. There is a greater recognition that healing the whole person often means professionals across mental and physical health working closer together alongside Social Care, Public Health and Housing.

# Governance

## Recommendation 7

i. That CCGs with encouragement from DCC should put into place a governance structure where they join with Social Care and Public Health under the umbrella of local democratic accountability in both policy formulation and commissioning activities.
ii. That given the BCF governance is accountable to the Health and Wellbeing Board, recommendations 2, 4 and 5 would be monitored by the Board at regular intervals.

# 3. Background / Context

3.1 The Better Care Fund (BCF) was instigated by Norman Lamb, the Minister for Care Services when he initiated the Integration Transformation Fund that became the BCF. The underlying philosophy and purpose of the Fund has not changed since its inception. He gave a speech to the King' s Fund on 23 January 2014 where he outlined his vision. He called for 4 shifts in the Health and Care systems:

- Shift One was to move from repair to prevention. 'Payments by Results incentivises activity in acute hospitals. There has not been sufficient emphasis on preventing ill health and preventing the deterioration of health to prevent crisis from occurring in the first place.'

- Shift Two was to integrate a fragmented service and to have joined up thinking shaped around the needs of the individual. 'There has been years of institutional separation mental health from physical health, primary care from secondary care, and health care from social care.'

- Shift Three was to change from a culture of paternalism. 'The systems are very paternalistic and that needs to change to something that absolutely focuses on the individual, gives them power to determine what happens to them'.

- Shift Four was to move from what he describes as a very exclusive system to one where 'there has a much richer collaboration between the statutory services and the wider community. The voluntary sector and volunteers, people in the communities doing things to support others.'

3.2 Norman Lamb had high hopes for the BCF. He told his audience, 'the BCF, it seems to me, provides an extraordinary catalyst for accelerated change and it's the biggest promotion in my view of this shift from repair to prevent and the shift from fragmented care to joined up care that we have ever seen.'

3.3 The BCF comprised of existing budgets to create a pooled budget of £3.8 billion

- £1.1 billion transfer from health to social care
- £130 million Carer's Break funding
- £300 million CCG re-ablement funding
- £350 million capital grant that included £220 million Disabled Facilities Grant
- £1.9 billion from NHS allocations

3.4 Although not new money, Brandon Lewis Under Secretary of State in the Department of Communities and Local Government, at the same conference stated the following:

'What I would say, across the sectors, is to be absolutely clear about one thing in particular. Doing the same thing in the same way but with just a new co-signed signature on the plans will not cut it. We will pick that up. It is about working together in a new way, and working together from start to finish with local authorities and clinical commissioning groups coming together as equal partners.'

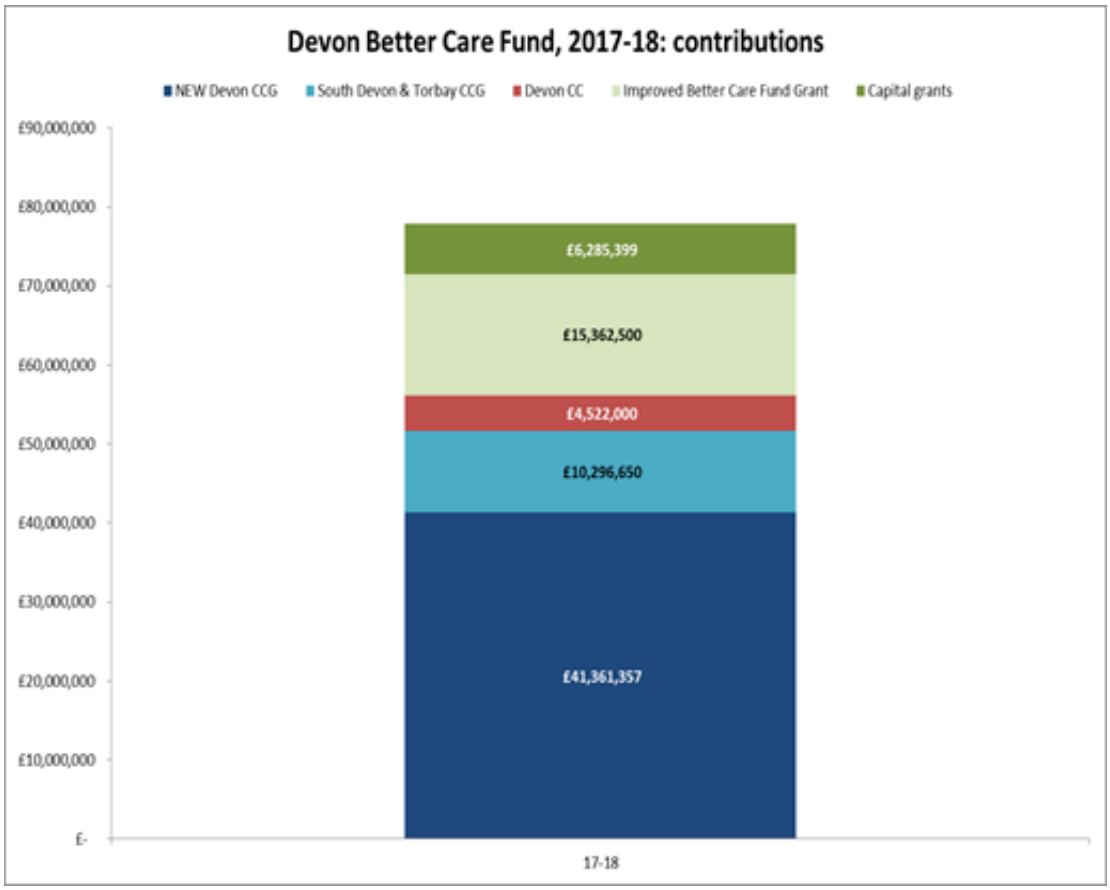
3.5 Fast forward to the present Better Care Fund 2017-2019, that is the subject of this report, we can see from its key purposes that it has remained integral to the project. In a very recent event 20/3/2018 the Deputy Programme Director of the BCF Support Team stated in her opening remarks. 'The BCF remains the main way in which government is supporting the creation of a better joined up model of integration that

aims to improve the way in which services are co-ordinated and delivered to individuals.'

3.6 Norman Lamb's shifts are reflected in the present-day policy goals of the BCF given at the event.

- Help individuals to manage their own health and wellbeing and live independently in their communities as long as possible
- Support and encourage more investment in out of hospital, preventative and personalised approaches to manage health and wellbeing
- Bring together health, social care and housing to produce joint integration plans (with a statutory underpinning)
- Create pooled budgets in every area to fund these plans
- Support an aligned cross-partner perspective on integration in all areas
- Support successful delivery of schemes towards integration and learn what works.

3.7 The size of the BCF has grown to over £7 billion each two years: 2017-2019. This includes the improved BCF Grant (over £2 billion) that is a revenue grant to give additional support to social care. This iBCF can only be used for meeting adult social care needs, reducing pressures on the NHS which includes supporting people to be discharged from hospital when they are ready and ensuring the social care provider market is supported.




3.8 The BCF is part of the bigger picture in Health and Social Care developments, the STP (Sustainability and Transformation Partnerships) and the impending Integrated Care Systems, all intent on ensuring local integration plans support and enable personalised, preventative approaches to care. The Government perceive the BCF as accelerating and making happen conversations about joint working across

agencies and therefore 'oiling the wheels' for whole system integration. There is an expectation that there will be full integration by 2020.

3.9 The individual is at the heart of the BCF ideology. It is, on the one hand, giving citizens joined up health and social care and on the other the Government is looking to find ways to have a healthier (therefore cheaper to look after) population. If a citizen becomes less healthy they will be living in a culture that expects them to stay as independent as possible, for as long as possible and to access help to stay at home surrounded by a resilient community. By rolling back the paternalistic culture-the state knows best attitude-the health system will only be there for specific and acute needs.

3.10 This Task Group was set up to investigate how the BCF plans in Devon are working and what impact it is having in integration in Devon. Therefore, it was considered important to understand how the commissioners and managers were engaging in the implementation of the BCF and how they have included the improved Better Care Fund grant.

3.11 It was felt that given the time limitation the emphasis should remain on the perspectives of the commissioners and managers. There is clearly a possible follow up report that would concentrate on the outcomes for providers and the public who use the services.

3.12 The report that follows highlights issues that have emerged through the witness interviews. It also suggests further considerations leading to recommendations. These could, potentially, improve the progress and pace of change towards a fully integrated system that appears to be the aim of the Health and Social Care leadership in Devon.

# 4. Better Care Fund in Devon

4.1 It is worth remembering that the Devon County Council area covers 2,543 square miles and has a population of over 750,000 residents.. It is largely rural with a number of small towns, scattered villages, hamlets and Exeter city, moderate as cities go with a population of around 128,000.

4.2 Devon's approach to the Better Care Fund (BCF) chimes with the underlying philosophy of the fund:

'The plan sets out our commitment to transforming care to deliver the best possible outcomes for our population; shifting our model of care so that more people are cared for in out of hospital settings-through prevention, more proactive care, and new models of care delivery-and reducing reliance on secondary care. We will take a place—based approach to wellbeing for our communities through joint working of statutory partners and the voluntary and charitable sectors.' (BCF Narrative Plan 2017/2019).

4.3 The Devon BCF is developed and agreed by the commissioning partners and signed off by the Devon Health and Wellbeing Board. The partners are Devon County Council New Devon Clinical Commissioning Group (CCG) and South Devon and Torbay CCG. During the year 2017 the two CCGs have come together to form a single strategic executive team to deal with a common set of financial and service challenges. They remain, however with two Boards. The Devon Model of Care has 3 principle elements that has been set up to put into practice the 3 priorities of the Devon Plan, targeted prevention and maintenance, support when crisis comes, and enhanced recovery and independence:

1. Comprehensive Assessment: putting a care plan in place that is designed to capture the potential need for further care in the future.
2. A single point of access to make it easier for GPs and others to get additional support when needed. It is connected to a Rapid Response service.
3. Comprehensive Rapid Response (care at home) so people can stay at home if possible and not be taken automatically to A&E should they, for example, have a fall at home. Support will be put in place for the immediate future to avoid hospital admission and support will be there for people leaving hospital if they need it for safety reasons. Reablement support will also be available alongside traditional care.

4.4 Building community resilience is also an important feature of the plan:

'Our voluntary and community partners will be at the heart of our new care model. It is vital that statutory public services and the voluntary and community groups work together if we want to improve people's health and wellbeing and reduce demand on health and care services.'

4.5 The Devon Model of Care is structured around Community Teams. Devon is divided into 4 localities (see Appendix 1) each with its own director of operations mandated to fulfil the strategic aims of the BCF. It was strongly felt that different solutions are required for different parts of Devon. Outcomes are set centrally but local solutions are sought that best fit local need.

# 5. Issues / Further Considerations

5.1 The issues arising from the witness interviews are presented here. The Better Care Fund exists within a fast-changing landscape of Health and Social Care. The interview methodology was open ended and conversations ranged over many topics. Interviewees were able to talk about the areas of work in which they were closely engaged and where the BCF fitted into their brief. Hence many of these issues were covered from different perspectives and so each issue written up here reflects the interests of more than one interviewee. Hence no attributions are given. Following issues raised by the interviews are further considerations that in our view emerge from the issues and lead to our recommendations.

# Issue 1: Financial

5.2 The BCF is divided into three separate pools, reflecting differences in the external constraints and reporting requirements of the fund; capital, the improved BCF grant and revenue. Allocations of the three pools fall into the scheme type taxonomy required by NHS England although these categories are not used locally.

5.3 The BCF pooled budget sits alongside fragmented budgets of the NHS and Social Care. It is worth mentioning here that a Scrutiny Task Group undertook a spotlight review of Fair Funding in the NHS in Devon published in January 2017 and provides information on the funding formula and situation in Devon where reference is also made to how Social Care funding is allocated.

5.4 Working under specific budget headings causes issues for managers who are spending too much of their time discussing, debating and challenging each other about who pays for what when instead they want to be dealing with the person holistically. The BCF has given a flavour of what it is like to be able to look at the person's need as a whole and therefore managing to respond proportionally to that rather than identifying specific needs that match a particular budget. Total financial integration would potentially alleviate this.

5.5 However total financial integration would require trust, openness and transparency. It would require financial responsibility and a professional, positive approach to risk management. Local Government have years of experience of working within budgets whereas the CCGs have been able to go into debt. It would involve a change of approach working with individuals as a person in a context as opposed to only working with the conditions they have and dealing with individual conditions on a piecemeal basis. This is crucial as the NHS and Social Care is dealing with more and more people with increasingly complex needs and multiple conditions: one in three people in Devon live with one or more long term conditions.

## Further Considerations

5.6 Financial integration is a means of enabling integrated care. Integrated financial approaches could possibly address and correct perverse incentives. Given the close working relationships across different organisations, legal frameworks set out centrally by government would specify the management of pooled budgets with equity and justice. A harmonisation of reporting requirements between NHS England and Department of Communities and Local Government would support the process.

5.7 However it is important to recognise that with integration, the social care budget could potentially move across into the Health budget and the local authority will become one of the funders instead of an equal partner. This is a concern within Local Government and impacts on local democratic accountability. This is discussed later in this report.

## Recommendation 1

That Devon County Council (DCC), Northern, Eastern and Western (NEW) Devon Clinical Commissioning Group (CCG) and South Devon and Torbay CCG should request that Government generate financial models that encourage full integration of health and social care budgets.

# Issue 2: Measurement and Evaluation

5.8 Delayed Transfer of Care (DTOC) occurs when a person is ready for discharge acute, non-acute or mental health care, but is still occupying a bed designated for such care. A person is ready for transfer when the following three criteria are met:

1. a clinical decision has been made that the person is ready for transfer
2. a multidisciplinary team decision has been made that a person is ready for transfer
3. the person is safe to discharge.

5.9 When the three criteria are met the clock starts ticking and there are 72 hours to sort it out. The clock pauses if one of the criteria is lost. Daily data is gathered at midnight each day. Best practice is 24/48 hour planned discharge.

5.10 The issue arising from this national measurement of DTOC is that it is skewing the work of the main principles of the BCF. The emphasis on hospital flow is causing problems. It was explained that there is an implicit misunderstanding about local context. There is a problem about what is being measured with the demanding DTOC targets difficult to meet. Government tries to simplify success as a specific target not being concerned by the complexities behind the statistic. DTOC is the first priority of the senior commissioner as there was a fear that funding would be cut if the November target has not been met. There is the receiving of daily DTOC data and the November target was met. In 2016/17 DCC rated below most comparators and regional neighbours and did worse than the national and regional averages. However, it halved between June and November 2017 and in November DCC was 93rd out 150 and was sufficient not to have funding put in jeopardy. Progress was made in all trusts, in particular the RD&E where 50% of Devon DTOC takes place. Progress has not been maintained over winter but it is worth noting that on other measures for example, length of hospital stay and re-admissions, the figures are better.

5.11 DTOC is attributed less to social care than NHS. In fact, the proportion of DTOC attributed to social care in Devon in November was half the national average. The three top reasons for DTOC in Devon are:

1. Awaiting NHS care
2. Awaiting a care package for own home
3. Awaiting a place in a residential or nursing home.

5.12 There is no robust evidence for this though it could be surmised that access to a bed in a home is not available at the right time and there are insufficient staff to process the care package in the time allowed. This highlights the need for processes and practices to be investigated. It is also interesting to note that the RD&E was praised for its exemplary plans to manage DTOC but this did not follow though in sufficiently reduced DTOC.

## Further Considerations

5.13 Further consideration should be given to setting up an evaluation model that enables operational processes to be systematically observed and recorded for discussion and forward planning. Overarching the monitoring and the reporting of the national metrics could be an evaluation framework that has the brief to explore the impact the changes put in place have had on patients' experiences of care. The possible question to ask is: Has the way the resources have been spent, and the changes implemented, improved care outcomes in terms of the overall health and well-being of the population of Devon?

5.14 As part of the evaluation process, consideration should be given to how success or otherwise of the new model of care is to be judged. Does success mean having driven DTOC down? Does success mean better services for the public? Does success mean people are more aware of health issues and are looking after themselves better? An evaluation framework that explores these questions reliably would enable judgements to be made with a feedback process built in so continuous maintenance and improvement is possible. NEW Devon CCG have had issues with respect to patient and public participation. Including significant public involvement as part of the evaluation framework, would provide evidence of a meaningful engagement with patients, carers and communities. Perhaps there is a place here for using some of the monies unallocated from iBCF to fund an independent evaluation agency.

**Recommendation 2**

That the Executive Team of the STP should consider the following:

i. That beyond monitoring of targets and outcomes, ongoing evaluation of impact is built into the system and this robust evidence accrued is used to review, change and develop the system for the benefit of the service users.
ii. That the evaluation framework should include significant public engagement and involvement.
iii. That serious consideration should be given to fund external evaluation of the BCF using iBCF monies to inform the development work of creating the Integrated Care System.

# Issue 3: Acute/Community Services: changing ideology through the commissioning process

5.15 The model of care is very much about promoting independence and supporting people to avoid crisis. Measuring pressure on the urgent care system and A&E works as a barometer to ascertain whether community services are working well or not. Community teams work to keep people well, out of hospital and in their own homes. Key members of the community are the unpaid carers who support the cared for and mitigate the need for the statutory services to step in to keep people safe. There has been over the life time of the BCF, a recognition that looking after carers' health and emotional wellbeing is crucial to de-escalation in the use of the acute services. Community service action plans seem to be working as non-elective activity is down. There is a direct correlation between increasing the treatment and support into the community and reduction of the number of people going to A&E.

5.16 There is an issue about acute/community service relationships. It is recognised that there needs to be a discussion between acute hospital staff to communicate better with community services-linking up with the patients then offering to let patients go

to community support. Consultants want to be sure that the patient can leave hospital safely but they need to let go the paternalistic stance and be confident that the community is supported, family members who see themselves as the primary carer, community and care teams alongside GPs offering a real patient centred approach.

5.17 The cultural shift to home based care from hospital based care carries risk. Risk is an issue and needs to be managed effectively. The community services need to be able, with evidence, to assess the risk to the satisfaction of the clinicians in the hospital services.

## Further Considerations

5.18 The BCF was the first national driver to move money from health care to social care. This has put the emphasis on community services and has been a catalyst to start conversations about community health and wellbeing integration on the ground seeing the hospital as the last resort for people.

5.19 As mentioned above, the key cohort of people that are crucial to the success of care at home, are the army of unpaid carers supported by community volunteers who look after family members and friends in the community day by day. The new carers contract went live on 1 May 2018 and is funded out of the BCF at £2.2 million. It is a 5-year contract to which the CCGs are also absolutely committed. Carers were closely involved in the design of the contract and so key features they asked for are included: peer support and information, advice and guidance. Helplines are also available on managing conditions and carers' training is being offered so carers can take an active role and be recognised for maintaining their cared for at home in a stable state. As it is a 5-year contract it needs to be able to be reviewed over its life span. As well as careful monitoring, qualitative evaluation of this contract to give quality support to this group of people is crucial.

5.20 A further consideration is the improvement of communication and working relationships between community services and GPs. This relationship is central to making the system work. Innovative working models between GPs and community services should be explored. One new way of working is taking place in Devon where a team of GPs have given up their independence and are working under contract to the RD&E community services.

**Recommendation 3**

i. That acute and community service providers should, together recognise that risk management is shared and should result in the establishment of a common risk assessment tool.
ii. That Health and Adult Care Scrutiny Committee should add the Carers' Contract into its work programme at least every two years.
iii. That GPs and community services should explore together innovative ways of working.

# Issue 4: Workforce

5.21 It is the role of community teams to keep people safe and to help them with their health issues outside the hospital. The teams are multi-disciplinary and have people in them who span health and social care; nurses, occupational therapists, care workers, all of whom offer services to help and support. The system moves people into it after they leave hospital for short term support-up to 7 days on average to help them get in their feet and be independent.

5.22 Teams also go into homes when health problems erupt. This is a rapid response team who can assess the situation and signpost to the appropriate service which may or may not mean hospital admission.

5.23 There is the issue within the teams of people working across the two different salary schemes of Health and Social Care with different terms and conditions, even in areas where they are doing the same job. In recent years to alleviate this situation, Rapid Response staff have been employed through Health rather than DCC, in some of the localities. These staff groups are often unqualified but with core competencies to support people with care needs at home. They are always overseen by clinicians such as community nurses and therapists.

5.24 One of the problems when people come out of hospital and received support, it is difficult to move them on if it is not possible to source help. As it is not right to leave people not safe they are continued to be supported for up to 6 weeks or more until social care can take over. This is known as 'back filling' and ties up staff who should be engaging in short term rapid response work. Hence, the issue here is the difficulty in having sufficient care staff in the system.

## Further Considerations

5.25 The new ways of working in the community that is supporting integration is creating new roles for the staff as Health and Care workers are working across boundaries.

5.26 Reaching across organisational structures to build relationships, interconnections and interdependencies is defined as boundary spanning[1]. This can be done at an individual level to develop and manage interactions and at an organisational level by setting up policies and structures that facilitate and define the relationships between individuals and their respective organisations.

5.27 A notable new role that is emerging is that of the Care Navigator. This is now established in a range of health and community settings. Their main role is to support individuals to plan, organise and access support although their remit and extent of practice varies from giving advice and signposting to a more active role in supporting people to engage in activities. Exeter, for example, has developed community facilitators: connectors and builders and introduced social prescribing. The role of the Care Navigator could compliment this work.

5.28 Turning to the issue of sufficiency, DCC is very open about the shortage of care workers across the County and particularly in Exeter. This resonates with the situation nationwide. A recent survey of half of all local authorities in England responsible for social care commissioning found that 77% had experienced provider failure in the year 2015/16 and 74% thought another failure likely in the coming year[2].

5.29 One analysis warns of the loss of 37,000 beds in the care sector by 2020/21, whilst the chairman of one of the largest providers (which rescued almost 250 care homes from Southern Cross) has recently claimed that 50% of care homes are 'non-viable[3].'

5.30 In the case of home care, three of the top five providers, (Care UK / Saga / Mitie), recently decided to pull out of the market, after struggling to make a profit following the introduction of the living wage, and tougher immigration rules making recruitment more difficult. Mitie cites 'sustained downward pressure on homecare charge rates and reductions in the volumes of care commissioned' as reasons for the sale of its healthcare business for £2[4].

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[1] Williams P (2011) "The life and times of the boundary spanner", Journal of Integrated Care, Vol. 19 Issue: 3, pp.26-33
[2] Department of Health 2016.
[3] ResPublica (2016) The Care Collapse: The imminent crisis in residential care and its impact on the NHS
[4] Telegraph Business online 10/4/2017

5.31 The improved Better Care Fund (iBCF) can be used to stabilise the market. The Care Act 2014 provides LAs with powers and duties 'to shape' the market locally in order to achieve better outcomes. This remains unachievable because of the heavy reliance of DCC on private providers to deliver services.

5.32 Marc Sandel, public philosopher, argues that markets have become detached from morals and there has been a drift from having a market economy to being a market society. As a result, markets and market values have penetrated into spheres in which they do not belong[5].

5.33 Surely the time has come to have a different approach and a more mixed economy in the care sector with organisations with a social purpose being prioritised. Oxfordshire has earmarked funding from their iBCF to create micro-enterprises and community companies to support individuals in the home care sector.

5.34 In Devon, feasibility studies should be carried out to look at new and innovative care delivery models for the home care market and develop a business model which supports partnership working with the Local Authority.

**Recommendation 4**

That DCC should use its expertise to generate a mixed economy of care businesses to help alleviate the shortage of workers by setting up feasibility studies of new business models of care delivery that would lead to the possibility of investing in innovative practices.

# Issue 5: Technology

# Information Technology

5.35 There are information technology issues that are slowing down integration development and work that integration teams are doing. Devon has not created integrated assessment tools nor are there currently integrated electronic records. There could have been more focus on prevention with quality data informing policy decisions from the Joint Strategic Needs Assessment (JSNA) as a baseline. However, in reacting to strategic imperatives the focus of the BCF has been constrained to Health and Social Care in the context of financial pressure

## Further Considerations

5.36 The sharing of data and common IT systems would encourage smoother integration. There is a call for easy access across both sectors and for a single assessment tool across both Health and Social Care. It is also felt that it needs to belong to the individual so that service users recognise their plan and know that they are the front and centre of it. The National Audit Office report on Health and Social Integration (February 2017) stated that an April 2016 review by the Local Government Association found there were no policy restraints preventing information sharing. They found from their case study visits that the local bodies were still unsure of the legal requirements for data sharing and felt this was still acting as a barrier. The Department of Health admitted they had not done enough to explain the rules around information governance.

[5] Sandel M (2012). What Money Can't Buy; the Moral Limits of Markets London: Allen Lane

5.37 The Joint Strategic Needs Assessment (JSNA) is central to the integration agenda and funded through the public health grant. The JSNA informs the health and social care system about the needs of the populace. The intention of the BCF is to increase resilience and enable a focus on preventative measures. A clear link should be developed from the JSNA to BCF spend. The Public Health Grant is ring fenced and reducing, however it would be possible through the iBCF for money invested in the development of the quality of Big Data to support strategic decision making by commissioners.

# Assistive Technology

5.38 Assistive Technology (AT) is a broad term used to describe any item, object, device or system that enables the person to perform a task that they would be unable to do, or increase the ease and safety by which certain tasks can be performed.

5.39 It is seen as a supportive, complimentary means of enabling frail and vulnerable members of society to live safely and well at home for a longer period of time.

5.40 There is a yearly budget of £0.5 million from the iBCF to innovate the use of assistive technology. AT items can be bought through the community equipment service. The AT allocation is designed to enable delivery of the strategy, to ensure that technology enabled care and support (TECS) are considered at ever point of the assessment and review. The Devon plans for the iBCF allocation cover more than the first year and some of them will take time to fully scope and complete appraisals. The budget funded hosting a 'SmartHouse' event to demonstrate the use of TECS in a home environment.

5.41 Plans for 2019-2021 include option appraisal of the 'First Responder' service to respond to alerts for those using telecare. Also developing a business case for the best use of TECS to maximise independence for adults with disabilities as well as, a second 'SmartHouse' and development of case study videos and website to promote TECS to staff service users and families.

## Further Considerations

5.42 According to the Social Care for Excellence AT for Older People research briefing, some of the key benefits of AT include:

- Increased choice, safety, independence and sense of control
- Improved quality of life
- Maintenance of ability to stay at home
- Reduced burden to carers
- Improved support for people with long term health conditions
- Reduced accidents and falls in the home

5.43 Combined with quality and consistent care and support and recognising the proposed technology must suit the individual and their unique situation, it can be a win, win for the individual and the care services.

### Recommendation 5

i. That DCC should consider using iBCF money to develop quality Big Data and Big Data Analytics to support strategic decision making by commissioners.
ii. That both Social Care and the CCGs should ensure that there is full access for professionals and patients across both health and adult care to patient records and explorations around common assessment tools should be encouraged.

# Issue 6: Mental Health

5.44 Mental illness is a huge agenda. It has been the Cinderella service. The Better Care Fund is as if money has dropped from the sky. BCF has allowed opportunities to focus on the preventative side as well as targeting ill health provision. It is hugely positive that a two year programme has been set which should allow the opportunity to look at the root causes of problems rather than just dealing with the consequences of bed blocking. (It is worth noting that in November 2017 half of the DTOC beds in non-acute settings were mental health beds) iBCF providing £2 million is helping to prevent the spiral.

5.45 Over the two-year programme the aim is to strengthen the provision across the Country and drive out areas of inequality in terms of access and quality. Teignbridge in particular has been identified as requiring more work in adult mental health. There is a crisis house in Torbay which helps to give support before things get to the point of acute. This quality of provision is going to be replicated with crisis drop-in centres in both Exeter and Barnstaple. There are mental health services in the prisons in the County at Exeter, Princetown and Channing's Wood but time did not allow the Task Group to review this.

## Further Considerations

5.46 An emphasis needs to be placed on new communities to ensure there is adequate resilience in the system. There is a need to reach out in a more robust way. BCF can certainly 'oil the wheels' as part of the process. BCF is an adult pot but it is possible to bring families into it.

5.47 Between 12 and 18 percent of all NHS expenditure on long term conditions is estimated to be linked to mental health. The Joint Commissioning Panel for Mental Health (2012) suggests that liaison services should be provided in A&E departments for patients who have a mental and physical disorder to ensure their needs are met. Rapid Assessment Interface and Discharge, a model of liaison services which includes health and social care capacity as well as specialist skills to provide a complete mental health service in an acute trust has been shown to reduce hospital bed use, particularly by older people[6].

**Recommendation 6**

That, moving in the direction of the NHS England national target, equal priority is given to mental health as to physical health. There is a greater recognition that healing the whole person often means professionals across mental and physical health working closer together alongside Social Care, Public Health and Housing.

# Issue 7: Governance

5.48 The original roots of the BCF came from existing funding streams, and this fact impacted on the approach to governance of the Fund. As it was now statutory for the budgets to be pooled it was initially seen as an administrative and bureaucratic issue and so a health and social care development group was set up to have oversight of the Fund and was originally chaired by the Cabinet member responsible for Social Care. The focus of discussion was around the deployment of the money and metrics to monitor what was going on. Public Health was involved in the

[6] Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A Long Term Conditions and Mental Health (London Kings Fund, 2012)

framework for the indicators that the BCF was hoping to achieve. The BCF reported to the Joint Commissioning Coordinating Group (JCCG) who provided quarterly reports to the Health and Wellbeing Board. This Board has to sign off the plans but it has no jurisdiction or influence on the nature of those plans as there was no direct line of accountability to the Board from the JCCG. The BCF Group is no longer convened and officers simply present the BCF plans to the Chair of the Health and Wellbeing Board who signs them. This situation is no longer considered to be a good one and plans are being put in place to have formal governance for the BCF and the iBCF together. There has been learning from 2017/2018 that indicates that the light touch approach has resulted in a lack of visibility of progress and lack of clarity about how to access funding. This is clearly an issue of accountability. A governance group is going to be set up. The issue now is that this group ultimately needs to be accountable to the Health and Wellbeing Board.

## Further Considerations

5.49 The Health and Wellbeing Board is a statutory requirement within the Local Authority and has statutory functions for the oversight of the integration of Health and Social Care. It brings together social care, public health with the local NHS, police, fire and probation services as well as district councillors and patient groups including Healthwatch. It produces the Joint Strategic Needs Assessment (JSNA) and the Health and Wellbeing Strategy for Devon. There is general agreement that the Better Care Fund has been instrumental in progressing the integration agenda and as mentioned previously, there should be a clear link between the JSNA and BCF. This would provide an evidence based approach that would be a model for STP/Social Care Integration.

5.50 At present, in Devon, the Health and Wellbeing Board has no commissioning responsibilities nor does it engage in policy formulation and is not a decision-making body. With a move towards full integration, a single integrated care system (ICS) is being developed. Within the ICS will sit a strategic commissioner who will involve the CCGs, the LA and NHS England. The lead on this is the CCGs and although they have informed the Health and Wellbeing Board what they are doing, the executive bureaucrats are moving ahead and making decisions including setting up a shadow ICS structure with the intention of then informing partners of their thinking. It would certainly be the case that the Health and Adult Care Scrutiny could challenge what the CCGs are doing but this is rather like closing the stable door after the horse has bolted. The democratically elected members are not involved in the shaping of strategy of this momentous move to full integration. Democratic accountability is missing in this scenario. Current accountability arrangements of local health services are out of date. New accountability frameworks need to be generated and cover health care, social care and public health. The structures in which to develop this exist, culminating in the Health and Wellbeing Board as an umbrella to the different levels of accountability needed for the purposes of monitoring and improving service quality and cost-effectiveness. The health and social care system is funded by public money, some of which goes direct to the local CCGs from NHS England bypassing the local democratic process. Other monies come through the LA where it is answerable to local democratic processes. There needs to be assurance that with the integration of these services public money needs to stay in public hands and not be swallowed up in NHS bureaucracy.

5.51 This situation has been recognised by the LA and plans are afoot to reconfigure the Health and Wellbeing Board to take a positive and influential role in the new health and social care system. Public transparency, public accountability and public engagement should be at the heart of our Health and Social Care system, a National Health and Care Service that is truly accountable to its local residents.

## Recommendation 7

i. That CCGs with encouragement from DCC should put into place a governance structure where they join with Social Care and Public Health under the umbrella of local democratic accountability in both policy formulation and commissioning activities.

ii. That given the BCF governance is accountable to the Health and Wellbeing Board, recommendations 2, 4 and 5 would be monitored by the Board at regular intervals.

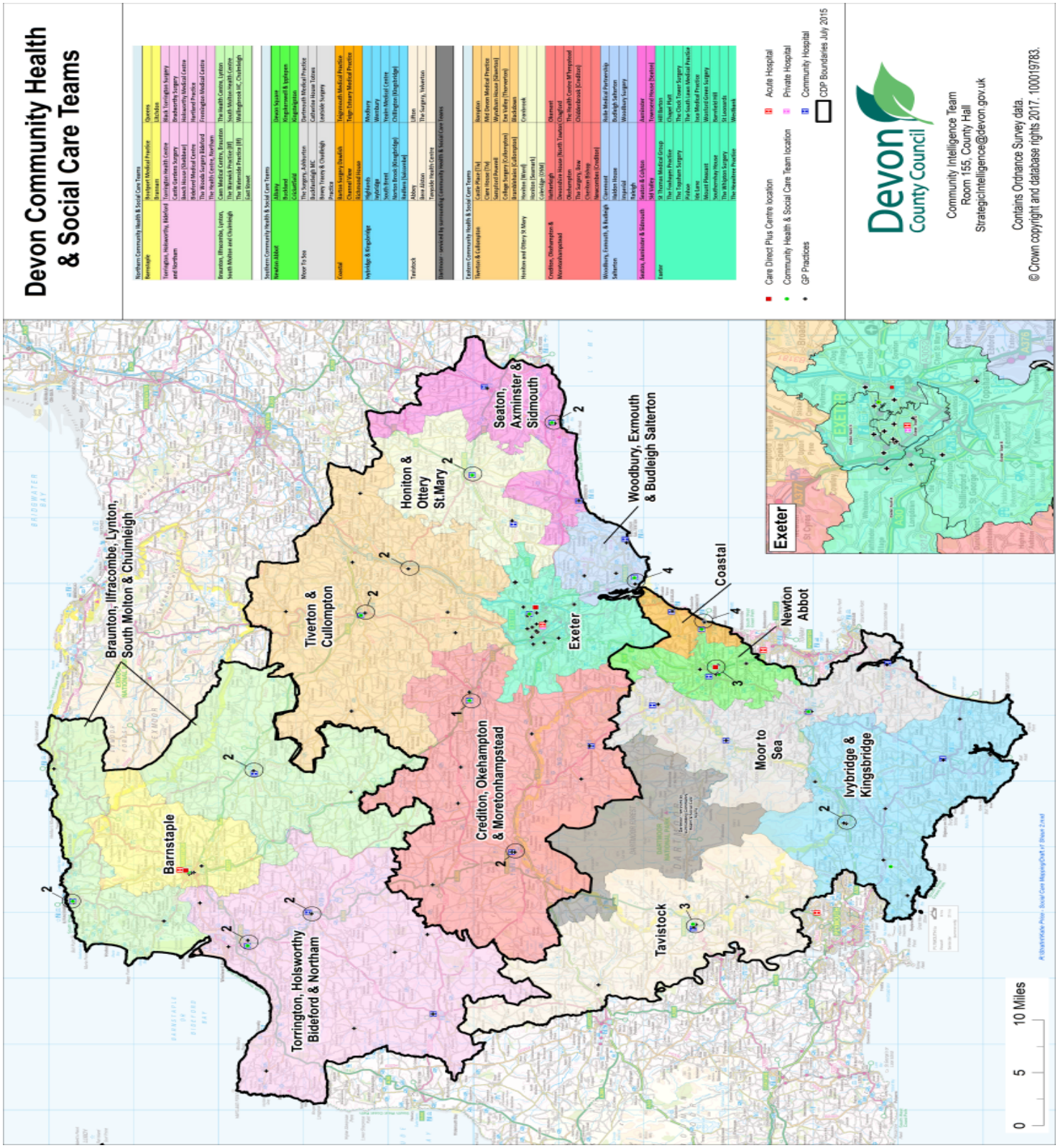
Councillors Hilary Ackland (Chair)
Sara Randall Johnson
Sylvia Russell
Carol Whitton

*Copies of this report may be obtained from the Democratic Services & Scrutiny Secretariat at County Hall, Topsham Road, Exeter, Devon, EX2 4QD or by ringing 01392 382232. It will be available also on the County Council's website at:*
http://www.devon.gov.uk/index/councildemocracy/decision_making/scrutiny/taskgroups.htm
*If you have any questions or wish to talk to anyone about this report then please contact:*

*Dan Looker*
*01392 382232/* dan.looker@devon.gov.uk

**APPENDIX 1**

# Devon Community Health & Social Care Teams



**APPENDIX 2**

# Task Group Activities

A1.1 The first meeting of the Task Group took place on **13 September 2017 to** discuss the scoping of the review with the Senior Manager (Older People), Adult Commissioning and Health.

A1.2 On **19 October 2017** members received evidence from the Chief Operating Officer NEW Devon Clinical Commissioning Group and Chief Operating Officer/ Deputy Chief Officer South Devon and Torbay Clinical Commissioning Group.

A1.3 On **7 November 2017** the Task Group met with the Head of Adult Commissioning and Health.

A1.4 On **13 November 2017** members met with Senior Project Accountant (Finance).

A1.5 On **5 December 2017** the Task Group received evidence from the Area Director (Eastern Division, Health and Social Care Services.

A1.6 On **22 January 2018** the Task Group met the Chief Officer for Communities, Public Health, Environment and Prosperity.

A1.7 On **7 February 2018** members met with the Integration Director, Royal Devon and Exeter Hospital; Senior Manager for Policy, Performance and Involvement (Adult Care and Health) and the Acting Area Director (Eastern Division) Health and Social Care Services.

A1.8 On **21 March 2018** the Task Group received evidence from the Head of Adult Care Operations and Health and the Assistant Director, Health & Social Care – Southern.

A1.9 On **23 April 2018** members met with the Senior Commissioning Manager - Market Management, Prevention, Carers and Living Well at Home and the STP Mental Health Commissioning Lead (South Devon and Torbay Clinical Commissioning Group.

A1.10 On **10 May 2018** the Task Group met to discuss the draft findings and recommendations.

**APPENDIX 3**

# Contributors / Representations to the Review

Witnesses to the review in the order that they appeared before the Task Group. Members also met with a significant number of children and young people on their school visits.

| Witness | Position | Organisation |
|---|---|---|
| Solveig Sansom | Senior Manager (Older People), Adult Commissioning and Health | Devon County Council |
| Rob Sainsbury | Chief Operating Officer | NEW Devon Clinical Commissioning Group |
| Simon Tapley | Chief Operating Officer/ Deputy Chief Officer | South Devon and Torbay Clinical Commissioning Group |
| Tim Golby | Head of Adult Commissioning & Health | Devon County Council |
| Duncan Ford | Senior Project Accountant | Devon County Council |
| Gary Patch | Area Manager (Eastern Division) | Devon County Council |
| Dr Virginia Pearson | Chief Officer for Communities, Public Health, Environment and Prosperity | Devon County Council |
| Gary Patch | Area Director (Eastern Division) Health and Social Care Services | Devon County Council |
| Adel Jones | Integration Director | Royal Devon and Exeter Hospital |
| Damian Furness | Senior Manager for Policy, Performance and Involvement (Adult Care and Health) | Devon County Council |
| Maggie Gordon | Acting Area Director (Eastern Division) Health and Social Care Services | Devon County Council |
| Keri Storey | Head of Adult Care Operations and Health | Devon County Council |
| Lee Baxter | Assistant Director, Health & Social Care - Southern | Devon County Council |
| Ian Hobbs | Senior Commissioning Manager - Market Management, Prevention, Carers and Living Well at Home | Devon County Council |
| Derek O'Toole | STP Mental Health Commissioning Lead (South Devon and Torbay Clinical Commissioning Group | Devon County Council |

**APPENDIX 4**

# Bibliography


- Devon Better Care Plan 2016-17
- Devon Better Care Fund Narrative Plan 2017-19
- Devon Health and Wellbeing Board, 'Better Care Fund: 2016/17 Fourth Quarter Return and Performance Reporting', 8 June 2017
- DoH, DCLG: '2017-19 Integration and Better Care Fund Policy Framework'
- Fair Funding in the NHS in Devon Task Group, Health & Wellbeing Scrutiny, January 2017
- LGA, NHS Confederation, Association of Directors of Adult Social Services, NHS Clinical Commissioners: 'Stepping up to the place The key to successful health and care integration'
- What Money Can't Buy; the Moral Limits of Markets London: Allen Lane, Sandel M, 2012