"Joined Up Care" – Hertfordshire's Better Care Fund 2017-19

What is the Better Care Fund?

The Better Care Fund pools existing health and social care monies to join up the planning and delivery of services. By better integrating services, this means improved care for residents but also more value for money services as well. In Hertfordshire, our integration plan is called the 'Joined Up Care Framework' and puts the person at the centre of what we want to achieve by 2020.

Why is integrating health and social care important?

Integration means more than introducing sustainable, cost-effective services, although with rising demand and an aging population in Hertfordshire this is important. It means better, joined-up care for the resident on the ground meaning they receive both the services they need when they need them, but also have the support and advice to stay well for longer. It means more than just statutory care too with the voluntary and community sector playing a vital role in maintaining strong healthy individuals and communities.

Case Study: Community Navigators, who help vulnerable adults to access community and voluntary services – With elderly Mr Smith receiving treatment for dementia, his GP felt more could be done to support his wife and carer. The Navigator found carer support for Mrs Smith and social activities for Mr Smith. *"I now feel that I can cope and like I have a reason to live. Before I met the Community Navigator I was in an awful place. I feel so much better now I am getting a break, knowing that he [husband] is getting the support and stimulation that he needs as well."* **– Mrs Smith**

Who is involved?

Organisations required to pool funding in the Better Care Fund are Hertfordshire County Council and East & North Hertfordshire, Herts Valleys and Cambridgeshire & Peterborough Clinical Commissioning Groups. However, our partners stretch much wider than this – hospital acute trusts, community and voluntary sector groups, residents, carers and more.

What has been done so far?

Hertfordshire has a strong history of partnership working and to date has had one of the largest pooled Better Care Funds in the country (£280m). Among other things, this has led to:

- Roll-out of integrated community teams to support independence
- Integrated Discharge Teams based in acute settings to aid discharges of care
- New models of support for care homes, including East & North Hertfordshire's 'Enhanced Care in Care Homes' Vanguard Programme

What we will be doing in 2017-19?

Using the Joined Up Care Framework, Hertfordshire will be delivering integration around 7 areas, each aimed at improving patient experience. For example:

- Electronic record and data sharing between organisations
- Introducing the Hertfordshire Home Improvement Agency for home adaptations
- Greater use of our community and voluntary assets
- More integrated community models of care based around local needs and organised around neighbourhood service 'hubs'
- Improved personalised care planning including self-management and integrated personal commissioning to prevent escalation of needs
- Integrated tools and working structures around acute transfers of care

The Framework will work with other existing plans including the Sustainable Transformation Plan to deliver this.

What does integration mean for me?

Integration is about transforming the way health, social care and other groups work with each other and putting the resident at the centre of everything they do. This means local leaders planning together, front-line workers working with their health or social care colleagues more closely or shared data systems. To the resident, it means only improved, seamless care.

Find out more:

Contact the Integrated Care Programme team at integratedcare@hertfordshire.gov.uk or view the Better Care Fund Plan 2017-19 here.

Joined Up Care 2020 – vision and priorities

A system that delivers the right care and support at the right time and in the right place for individuals, their families and their carers

Developing a culture of prevention - to improve the health of the population and help our residents to avoid preventable health and social problems

	Vision for Service User	Current Position and Achievements	2020 Targets
Electronic record and data sharing	"I and all professionals involved in my care can access my digital shared care plan – this means I only need to tell my story once"	Limited sharing of information between integrated health & social care teams to improve coordinator in community and hospital settings Prioritisation & resource of a business case on development of a shared care record between health & care organisations.	A **digital shared care record** accessible by health and social care professionals Adapting the health and social care data systems for integrated care Increasing **data sharing** between health & social care, including hospitals & GPs **Networking the care home** market to enable the use of enhanced technology
Early identification	"I receive the right care, in the right place to prevent escalation in my care needs" "I, my family or carer know where to go for support to manage my care needs"	Limited use of risk stratification to identify people with high-risk of admission to hospital within 6-12 months Services in place across Herts to jointly plan and co-ordinate care for people with multiple or complex needs Limited adoption of integrated points of access and 'named professionals' representing health and social	Wider use of **risk stratification** to target specific groups A **preventative approach** to care co-ordination and not just crisis interventions Streamlined **points of access** to care services Smooth transitions between adult and children's services
Value for money	"I receive the best possible level of care from the NHS and local authority" "The quality of my care does not change if I move between different services"	Most community services funded through pooled budgets Joint commissioning of mental health and learning disabilities services, and some intermediate care beds Improved use of the Disabled Facilities Grant through plans for a shared Home Improvement Agency	Using **joint commissioning** for shared contracts, market stimulation and budgets A joint approach to **Continuing Healthcare** services Commissioning decisions supported by more powerful tools for **joint analysis** of health and social care needs / demands of local populations An operational **Home Improvement Agency**
Assessment and care planning	"The NHS and social care work together to assess my care needs and agree a single care plan to cover all of the different aspects of my care"	Joint care planning used by integrated community services e.g. HomeFirst and Multi-Specialty Teams. Trials of 'My Plan' – a national shared care plan template. Limited piloting of joint assessment forms and triage for integrated services	A **shared culture,** process and ways of working to deliver outcomes-based planning **Integrated personal commissioning** of direct payments and individual budgets **Trusted assessment** between health and social care professionals for a range of services
Integrated community care	"My GP, social worker or carer work with me to decide what level of care I need, and make sure I receive it" "I only need to approach one point of contact to get my care needs met"	Integrated community service models developed around the needs of those with complex care needs Improved coordination between health and social care services and the voluntary and community sector Support to care homes improved through the	More colocation, single lines of reporting, and shared leadership Greater joint working with **primary care** Greater understanding and use of the **voluntary sector** and community assets Rolling out **enhanced care in care homes** developed by the Vanguard
Timely and safe discharges	"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be, even if waiting for an assessment"	Ongoing integration of discharge teams in acute hospitals Specialist Care at Home service commissioned Limited use of discharge to assess models to short-term care home placements; trialling of enabling models of bed based care	Further adoption of **integrated tools & working structures** e.g. live urgent care dashboards to track the movement of patients between services Shared **enablement** approach across health and social care partners minimising dependency across the area
Integrated urgent care	"If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them"	Joint rapid response services provided to prevent admissions to hospital Successful piloting of early intervention vehicle Link social care workers in A&E to prevent admissions Health and social care workers in hospitals able to carry out certain elements of each others' roles	Use of **multi-disciplinary teams** in all areas **Integrated community teams providing timely interventions** keeping people safe & at home Wider roll-out of **early intervention vehicle** and other integrated models Improved co-ordination of out of hours services including NHS 111.

Health and Wellbeing Board Hertfordshire