“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:

Our Vision

“I can plan my care with people who work together to understand me and my carers, allow me control, and bring together services to achieve the outcomes important to me”
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.
## Join 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

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<tr>
<td><strong>Electronic record and data sharing</strong></td>
<td>&quot;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&quot;</td>
<td>Limited sharing of information between integrated health &amp; social care teams to improve coordinator in community and hospital settings</td>
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<td><strong>Early identification</strong></td>
<td>&quot;I receive the right care, in the right place to prevent escalation in my care needs.&quot;</td>
<td>Limited use of risk stratification to identify people with high-risk of admission to hospital within 6-12 months</td>
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<td><strong>Value for money</strong></td>
<td>&quot;I receive the best possible level of care from the NHS and local authority&quot;</td>
<td>Most community services funded through pooled budgets</td>
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<td><strong>Assessment and care planning</strong></td>
<td>&quot;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&quot;</td>
<td>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</td>
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<td><strong>Integrated community care</strong></td>
<td>&quot;My GP, social worker or carer work with me to decide what level of care I need, and make sure I receive it&quot;</td>
<td>Integrated community service models developed around the needs of those with complex care needs</td>
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<td><strong>Timely and safe discharges</strong></td>
<td>&quot;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&quot;</td>
<td>Ongoing integration of discharge teams in acute hospitals</td>
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<td><strong>Integrated urgent care</strong></td>
<td>&quot;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&quot;</td>
<td>Joint rapid response services provided to prevent admissions to hospital</td>
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**Specialist Care at Home service commissioned**

Greater joint working with primary care

**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 care organisations.

**Improved coordination between health and social care**

Use of risk stratification to identify people with high-risk of admission to hospital within 6-12 months.

**Trials of ‘My Plan’ – a national shared care plan template.**

Streamlined points of access to care services

**Shared assessment**

Integrated personal commissioning of direct payments and individual budgets

**Integrated care services**

A joint approach to care co-ordination and not just crisis interventions

**Adapting the health and social care data systems for integrated care**

Streamlined transitions between adult and children’s services

**Adapting the health and social care data systems for integrated care**

A preventative approach to care co-ordination and not just crisis interventions

**Comparative data sharing**

Streamlined transitions between adult and children’s services

**Joint care services**

Enhanced care in care homes developed by the Vanguard

**Integrated personal commissioning of direct payments and individual budgets**

Enhanced care in care homes developed by the Vanguard

**Joint rapid response services provided to prevent admissions to hospital**

Integrated Personal Commissioning

**Successful piloting of early intervention vehicle**

Integrated Personal Commissioning

**Link social care workers in A&E to prevent admissions**

Joint rapid response services provided to prevent admissions to hospital

**Health and social care workers in hospitals able to carry out certain elements of each others’ roles**

Joint rapid response services provided to prevent admissions to hospital

**Use of multi-disciplinary teams in all areas**

Joint rapid response services provided to prevent admissions to hospital

**Integrated community teams providing timely interventions keeping people safe & at home**

Joint rapid response services provided to prevent admissions to hospital

**Wider roll-out of early intervention vehicle and other integrated models**

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**Improved co-ordination of out of hours services including NHS 111.**

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