Appendix 1

Bath & North East Somerset

Better Care Plan 2014/15 – 2018/19

Summary Revisions September 2014

Contents

Chapter 1 Our Vision

Our vision is to provide care and support to the people of Bath & North East Somerset (B&NES), in their homes and in their communities, with services that support people to take control of their lives and reach their potential and are characterised by:

- Empowered individuals, carers and communities who are supported, confident and able to:
  - take increasing responsibility for their own health and wellbeing;
  - manage their long term conditions;
  - be part of designing health and social care services that work for the people that use them.

- Enhanced and integrated primary, community and mental health services, support and expertise working 24/7 with clusters of populations in order to respond to health and wellbeing needs close to home and ensure that hospital admissions are driven by the need for specialist and emergency treatments

- Innovative and widely integrated and utilised pathways of care understood for each long term condition and including self-management, transition, urgent and contingency planning elements as routine

- A focus on the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age

- Local people of all ages who have worked with clinicians and practitioners to design, inform and then have access to information that enables them to be confident in the quality and safety of services and, where they are not confident, to voice and raise concerns easily

- Integrated information and care record systems that facilitate the delivery of integrated health and care services

- Services that represent excellent value for money, measure by quality and effectiveness of outcomes as experienced by the people who use them.

This vision has been drawn from a variety of engagement processes including engagement with members of the public and key stakeholders on the Joint Health & Wellbeing Strategy for B&NES and the recent development of the CCG's 5 year Strategic plan.

These changes are aimed at supporting the increasing local demographic pressures in the B&NES population with our older population. By 2021 we will see a 27% increase in the number of patients aged 75-79 and a 38% increase in those aged over 90. The wider health and social care community needs to continue to develop a comprehensive range of responsive services to meet the needs of this growing population with a high level of need.

Our overarching aim is to further develop integrated, sustainable models of care that will deliver a greater proportion of care and support to people in their own homes and communities with services that:

- Co-ordinate around individuals, providing person centred care and support that is experienced as seamless by those individuals;
- Maximise independence and community inclusion through an increased focus on early intervention, prevention, self-care and peer support; and
- Empower people to remain in control of their own lives by extending self-directed support and ensuring access to information, advice and advocacy.

Our Joint Objectives are:

- Proactively identify people who are at most risk of loss of independence or hospital admission and put in place an integrated, Personalised Care Plan, including intensive community support.

- Integrated services that support and safeguard older and vulnerable people to remain independent though timely interventions that contain, stabilise, decrease and/or de-escalate emerging risks, care and support needs.

- Maximised use of health and social care resources through an integrated approach that responds in a sustainable way to the increasing volume, complexity and acuity of older people and those with long-term conditions.

- Further development and embedding of our integrated commissioning and provision to encompass not only mental health, physical health, social care, public health and housing but also further alignment of the resources, services and partners that influence the wider determinants of health and wellbeing.

- A Transformation Programme that responds to the wider strategic landscape of the Better Care Plan, Joint Health & Wellbeing Strategy, the Care Act, the Council and CCG's wider strategic priorities (especially reducing avoidable admissions and facilitating discharges and reliance on acute care), and the NHS *"A Call to Action".*

The Better Care Fund will support a number of initiatives that contribute to our joint programme of enhanced service provision and transformation. Services will be provided by a range of providers including voluntary and third sector partners. Over this period the provision of community health and social care services is due to be re-tendered and therefore the mix of provider provision may change.

The intended patient outcomes are illustrated through two service user stories set out below.

End State Objective: - *Enhanced and integrated primary, community and mental health services, support and expertise working 24/7 with clusters of populations in order to respond to health and wellbeing needs close to home and ensure that hospital admissions are driven by the need for specialist and emergency treatments*

Stephen was terminally ill and with the support of his GP agreed his preference was to die at home. Even when very ill, Stephen had remained independent, walking to the pharmacist to collect his medication and cleaning the car on Sundays. He wanted to remain at home to die with his family around him. However, he deteriorated more quickly than was expected and his family knew him to be in great pain. In the early hours they called 999 for him to be taken to hospital. A carefully documented care plan, appropriate support from community services and strong competent decision making between the paramedics and the GP supported Stephen and his family in these difficult circumstances enabling him to be cared for and to die at home as planned.

End State Objective: - A *focus on the most vulnerable, at risk, frail or excluded citizens as a matter of priority regardless of age*

Mrs. S developed a pressure ulcer on her sacrum. This was noticed when Mrs. S was admitted to hospital after a fall. During admission to hospital, Mrs. S was assessed by a specialist nurse who advised the ward nurses which equipment to use and which dressing to apply to her pressure ulcer. This made the healing process quicker and the ulcer was almost healed by the time Mrs. S went back to the care home.

As a result of a greater focus on meeting the needs of frail older people, local GPs and nurses will have the resources and time to work proactively with care homes to assess and treat patients who are frail, preventing the development of pressure ulcers and the exacerbation of other conditions. Admissions to hospitals from residential homes are prevented as a result of such changes.

Both these case studies illustrate that the further development of integrated support in the community and enhanced services for carers will help mitigate against avoidable admissions to the acute sector.

The Better Care Fund is a key enabler supporting the CCG's and Council's plans for whole system integration. It is ambitious and groundbreaking, reflecting and building on the established integration of commissioning and provision. Our plans encompass not only mental health, physical health, social care, public health and housing but also further alignment of the resources, services and partners that influence the wider determinants of health and wellbeing. We aim to look beyond service and organisational boundaries to ensure community connectivity, mutual learning and support.

To this end, we will maintain a focus on developing patterns of behaviour in our communities that promote active aging, positive reablement and strong, empowered citizens.

The BCF plan in B&NES: -

- Consolidates funding and allows for expansion of some existing initiatives
- Supports projects that have been funded on a temporary basis or are being piloted to test their impact
- Contributes to the protection of adults social care provision in B&NES
- Allows for the expansion of 7 day service provision in key priority areas
- Support Integrated Reablement & Hospital Discharge & Admission Avoidance
- Supports our aproach to Early Intervention & Prevention

We have already begun to make progress on our programme of change. During 2013/14 the CCG and Council have made two significant changes to local service provision. These include the development of Community Cluster Teams and a re-designed social care pathway: -

Community Cluster Team Model

This model delivers an integrated approach from virtual teams which are aligned with the five practice clusters in B&NES in order to respond in a sustainable way to the increasing volume, complexity and acuity of older people and those with long term conditions. The key objectives are to:

- Provide better coordinated services giving GPs and community staff more time to provide face to face care for those with greater need
- Increase focus on early intervention to prevent people's health and social circumstances deteriorating
- Utilize the risk stratification tool proactively to identify people who are at most risk of loss of independence or hospital admission
- Develop a sustainable model of care that responds to the growing pressure of more and sicker people being cared for in the community
- Prevent hospital admission and admission to long term institutional care as well as facilitating timely and safe discharges from acute and community hospitals
- Support patients with long term conditions to self-care and feel self-empowered in the management of their condition

Social Care Pathway Redesign

The overarching aim is to deliver an integrated service that will support and safeguard older and vulnerable people to remain independent through timely interventions that contain, stabilise, decrease and/or de-escalate emerging risks, care and support needs. This will involve a shift in focus and of resources to the 'front end' of the social care pathway to place greater emphasis on prevention and early intervention.

For those who appear to be in need of social care services, within the current eligibility framework, a short-term, intensive period of integrated reablement to reduce or delay the need for a long term package of care and support will be offered. This significant expansion of the reablement service is being funded from the Better Care Fund pooled budget, with early implementation, from July 2014, funded from Council reserves.

For those with the most complex needs the model will focus on in depth assessment, support planning and regular review to avoid the need for hospital/residential admission or escalation of need.

In facilitating these fundamental changes in the adult social care pathway, the key objectives are to:

- Enhance opportunities for co-producing solutions with potential service users and carers
- Be explicit about the intended outcomes of interventions, placing a stronger emphasis on the achievement of independence
- Prioritise the development of enabling approaches, in the broadest sense, as well as specific service interventions to support recovery

- Challenge the assumption that services will always continue at the same level for relatively long periods of time
- Promote a culture within adult social care that engenders independence and community inclusion
- Empower people to remain in control of their own lives by extending self-directed support and direct payments

There is a high degree of inter-operability between the community cluster model and social care pathway redesign, which includes increased Social Work capacity funded from the Better Care Fund ensuring input into integrated, personal care plans and multi-disciplinary planning.

Looking to the future we are aiming to further develop and frame our approach to whole system integration in the context of an emerging "House of Care" model for B&NES. This is based on the Kings Fund Report 'Delivering Better Services for people with Long-term conditions – Building the House of Care'.

This approach sets out four interdependent components, which, if delivered together, will achieve patient centered, co-ordinated care for people living with long-term conditions and their carers.

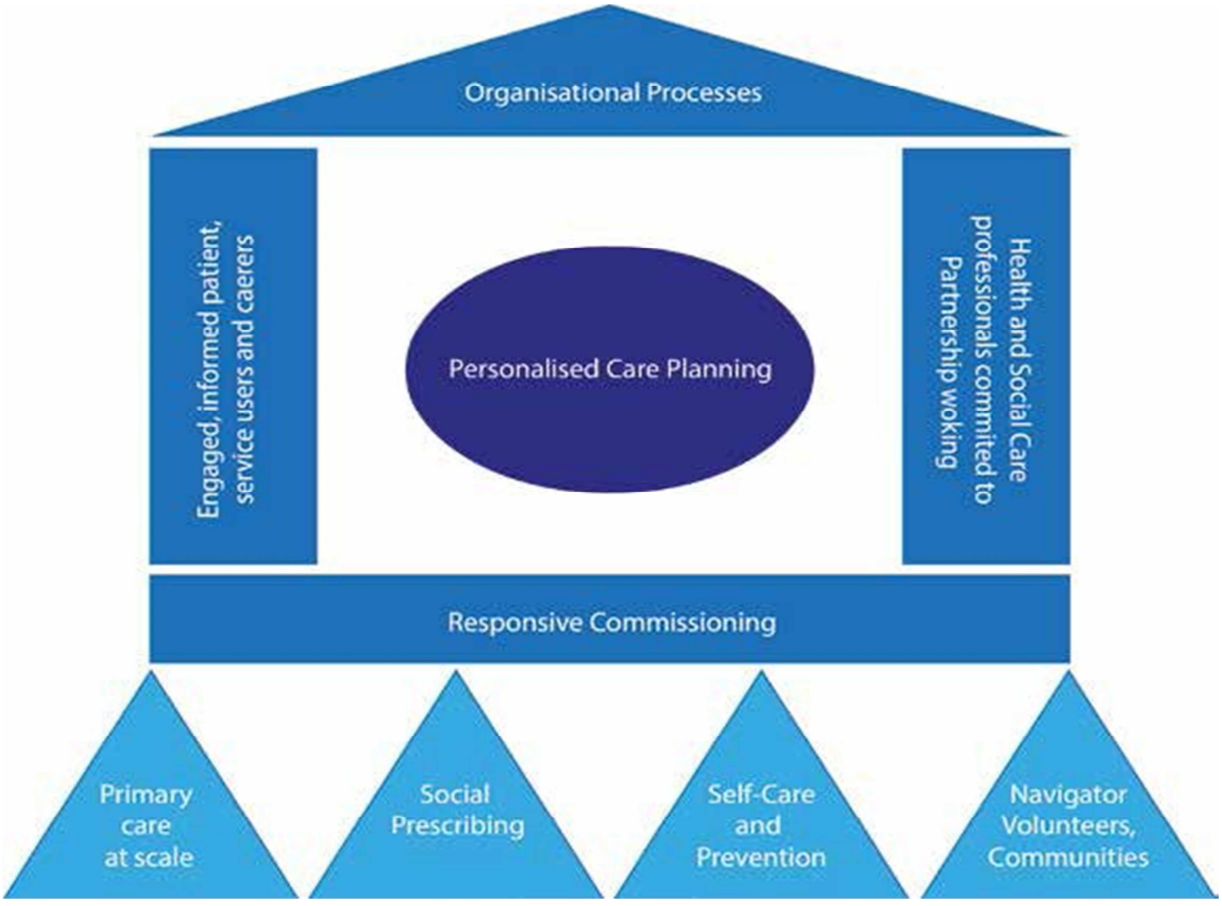


Figure 1: The House of Care Model in BaNES

Whilst this work is at its formative stages, we will utilise the Better Care Fund as a key enabler to develop and enhance integrated services. Linked to this approach is our vision for the development of integrated community services based around the

individual shown in the diagram below. Building on the Community Cluster model further services in BaNES will be grouped into five clusters that centre around GP practices with patients, service users and carers at the centre.

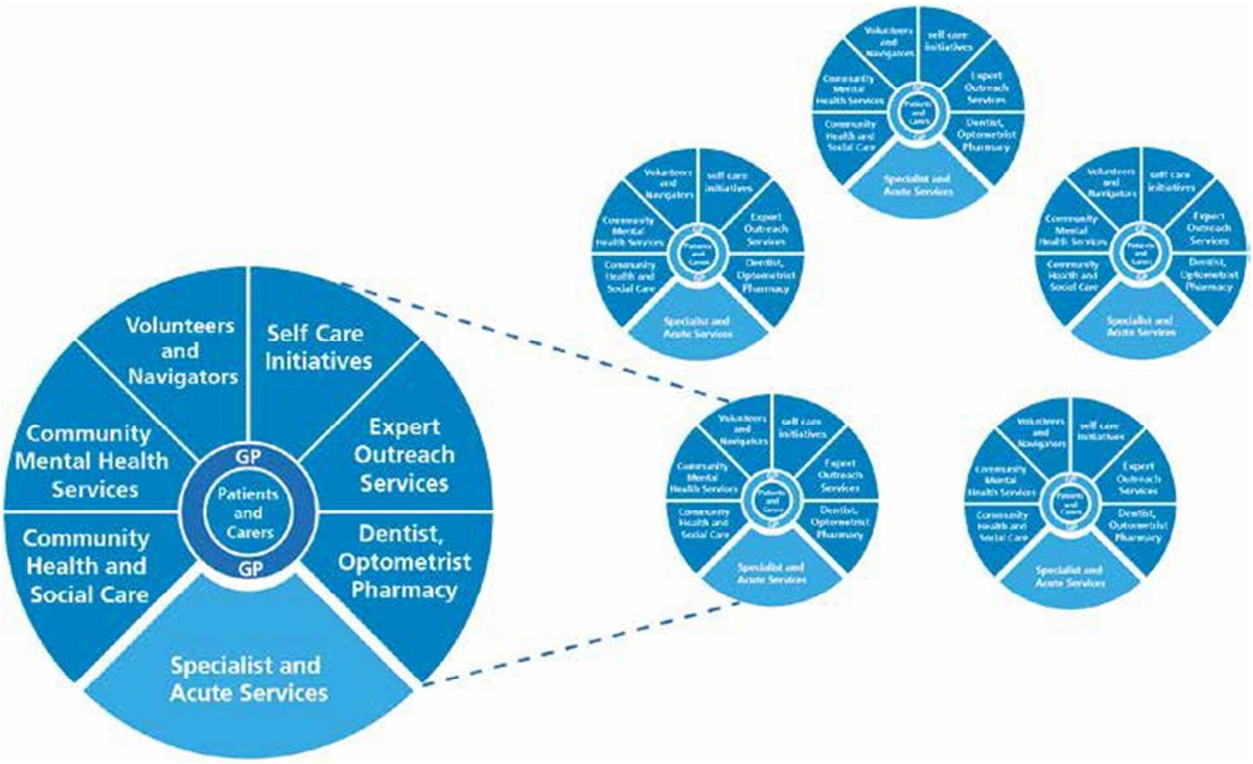


Figure 2: Building and integrating Services in Clusters

The BCF will support a number of components of our integrated system and safeguard key services including: -

- 7 Day working
- Protection of Social Care
- Increased capacity in Approved Mental Health Practitioner and DOLS
- Increased capacity in the Learning Disabilities Social Work Service
- Support for Integrated reablement
- Social care pathway redesign
- Expansion of Social prescribing
- Mental health reablement beds pilot
- Hospital discharge initiatives
    - Intensive home from hospital support
    - Step down accommodation
- Support for carers
- Disabled Facilities Grants

These schemes support our approach to bring care closer to home, Enhancing integrated primary, community and mental health services and empowering individuals, carers and communities to be supported, confident and able to take increasing responsibility for their own health and wellbeing.

Chapter 2 The Case for Change

The Council and CCG have established a range of integrated arrangements (teams, systems, processes and budgets) already and have evidence of their successful contribution to value for money and quality improvements in health and wellbeing services for the population of B&NES. The Better Care Fund is, for us, an opportunity to build on this to meet the challenges of an increasing population with increasing needs (frail elderly people, people with long term conditions, multi-morbidity, more acute and complex care needs falling on less carers) and to continue to address areas for improvement in the current system (ease of navigation, person-centred care).

Our focus, therefore, is on consolidating and expanding successful schemes, arrangements and relationships and implementing additional schemes to enhance care in key areas and for key target groups, ensuring that we retain the full alignment and coherence with wider CCG and Council plans which has in the past delivered significant benefits to both organisations and, more importantly to our population.

The case for change is grounded in analytical evidence of population trends; of those groups within our population who have most need of care; of the costs associated with rising demand for care at increasingly complex levels; and of the expected impact of planned interventions. Our sources of evidence include the Joint Strategic Needs Assessment (JSNA); public health analysis; cost and activity trend analysis and modelling; risk stratification; and performance monitoring of existing integrated schemes.

Chapter 3 Delivering Our Vision

Delivering our Vision – Our Plan for Change

Our plans for transformational change are designed to build on the high levels of integrated care and support already in place and well embedded. Since agreeing our Better Care Plan 2014/15-2018/19 in March 2014, we have already acted on our plans with the Council, for example, funding early implementation of the expanded, integrated reablement service and the redesigned adult social care pathway, which went live on the 1st July 2014. This early action will enable us to learn from this first year of operation, evaluate and make the best possible case for our model of integrated, personalised care.

The BCF Plan has interdependencies with the CCG's 5 Year Strategy and the re-design and re-commissioning of community health and social care services.

The CCG's 5 Year strategy has six priority work programmes: -

- Increasing the focus on prevention, self-care and personal responsibility.
- Improving the coordination of holistic, multi-disciplinary Long Term Condition management (focusing initially on Diabetes).
- Creating a stable and sustainable Urgent Care System that can respond to changes in demand.
- Commissioning safe, compassionate and integrated care for frail older people.
- Re-designing musculo-skeletal services to improve their efficiency.
- Ensuring the interoperability of IT systems across the health and care system

The table over the page sets out the key **milestones** for the BCF and related projects, highlighting key interdependencies.

Better Care Fund Key Milestones

Task	Inter-dependencies	Year 1 2013/14				Year 2 2014/15				Year 3 2015/16				Year 4 2016/17			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Community Cluster Team Model Goes Live					Feb-14												
Roll out of personal care planning & risk stratification						Apr-14											
Care Pathway & Expansion of Integrated Reablement Service							Jul-14										
Wellbeing College Pilot launched								Oct-14									
Start re-commission of social prescribing							Aug-14										
Extended Social Care Prescribing Service in Place									Jan-15								
Approved Mental Health Practitioner/DOLS Assessment Capacity in place				Sep-14													
LD Social Work Capacity in place				Sep-14													
Mental Health Pre-crisis/Respite Beds goes live				Dec-14													
Utilisation of £5 per head monies in Primary Care	X							Nov-14									
TLB Mobilised to oversee CCG Strategic Priorities	X							Dec-14									
Care Act Implementation										Apr-15							
Complete Option Appraisal of Inter-operability										Jun-15							
Re-procurement of Social Care IT System				Oct-14													
New IT System in Place													Feb-16				
Community Services Re-procurement	X										Jul-15						
Health and Well-being Board Review of BCF										Jun-15				Jun-16			
Adapt Community Cluster & Reablement models										Apr-15							

Governance

Integrated health and social care structures have been in place in BaNES since 2009, with commissioning arrangements implemented in that year and provider arrangements consolidated by the creation of an integrated health and social care provider in 2011. The commissioning arrangements were reviewed and redesigned in 2013 in response to the creation of the CCG and the reaffirmation of the commitment by both CCG and Council to joint working and to the integrated commissioning and provision of services.

Integrated arrangements are overseen by the Health and Wellbeing Board (HWB), which was developed from a previously existing Health and Wellbeing Partnership Board which oversaw joint working arrangements between the Council and the PCT. This has created an embedded recognition of the contribution of joint working in delivering optimal outcomes at best value, within the wider remit of the HWB. The HWB has also created a sub-group (the

Strategic Advisory Group) of large providers, whose remit includes collaboration on whole system solutions for care and support.

The operation of joint working arrangements, including the operation of pooled funds and the exercise of functions by either body on behalf of the partner body, is overseen by a Joint Committee for the Oversight of Joint Working. This is constituted as a joint committee of the CCG and Council with membership at elected member/Board member level and reports to the HWB, Council and CCG.

The governance and operational structures are underpinned by a Joint Working Framework, adopted by both the CCG and the Council, which sets out the commitment, aims and practical supporting arrangements for joint working, and is underpinned by legal agreements as follows:

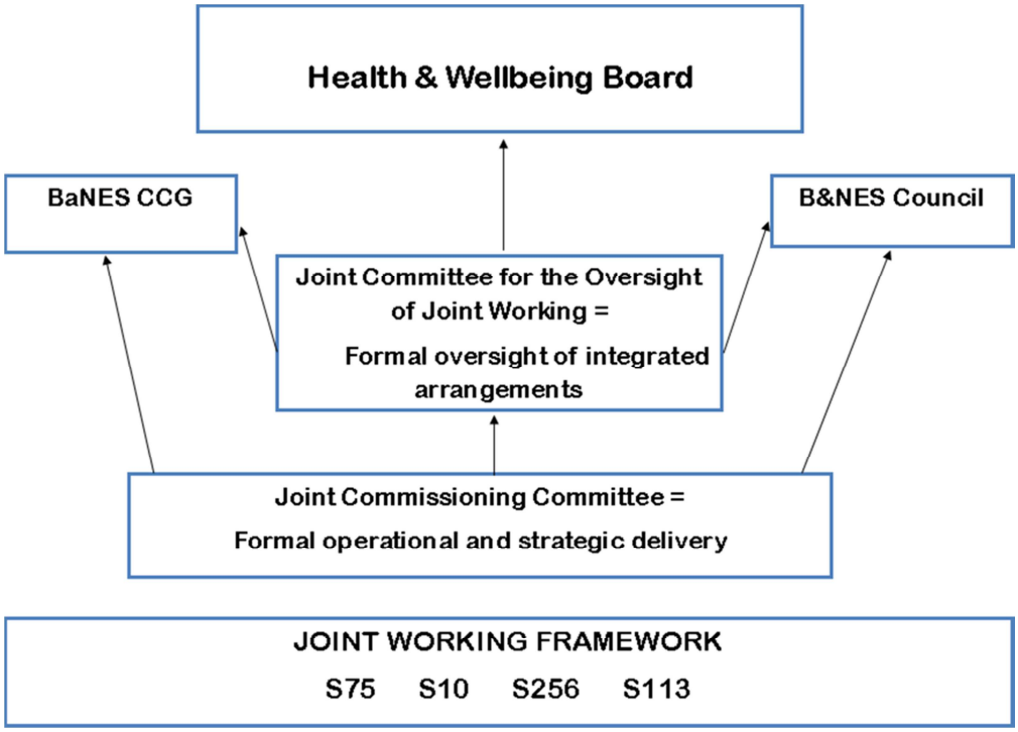
- S113 agreements allowing managers with joint responsibility employed by either body to perform functions for and be accountable to the other body within an agreed HR framework and within the Schemes of Delegation of each organisation

- S75 and s10 pooled budget agreements to allow pooling of resources managed by joint commissioners to support integrated commissioning and provision

- S256 agreements (both nationally required and local) to support expenditure on social care which has a benefit for health services

A further arrangement agreed by the CCG and the Council and due to be implemented from October 2014 is the creation of a Joint Commissioning Committee, replacing the previous structure of two separate and one joint committee. The CCG's Constitution and the People and Communities governance structure have been amended to allow this. The new Committee will have a formal governance and operational leadership role across health, social care and public health commissioning in respect of strategic planning, performance management and decision-making. The Committee is a formal Committee of the CCG Governing Body and is accountable to Cabinet Members within the Council, and has a reporting line to the Joint Committee for the Oversight of Joint Working.

The diagram below whos the governance structure in full.



Management and Oversight of Delivery

Within its 5 Year Strategic Plan, and with the support of partner organisations, the CCG has established a full programme management structure which will oversee and support delivery of the priority workstreams identified in the Strategic Plan. A clear rationale was identified for including the Better Care Fund as one of the priority workstreams alongside the CCG's six transformational change areas. This took into account efficiency of structure and process; equity of importance and contribution to delivery of the Plan; and level of interdependency between the Better Care Fund and other workstreams.

The CCG has established a project management structure for each workstream with accountability for delivery to a project board. These structures vary dependent on the nature of the individual project and the opportunities for efficient use of existing arrangements. For the Better Care Fund, the Joint Commissioning Committee which becomes operational in October 2014 will act as the project board. Given the operational leadership role across health, social care and public health commissioning in respect of strategic planning, performance management and decision-making which this Committee holds, it is well placed to oversee delivery of the Better Care Plan and to direct any remedial actions required should the plans go off track.

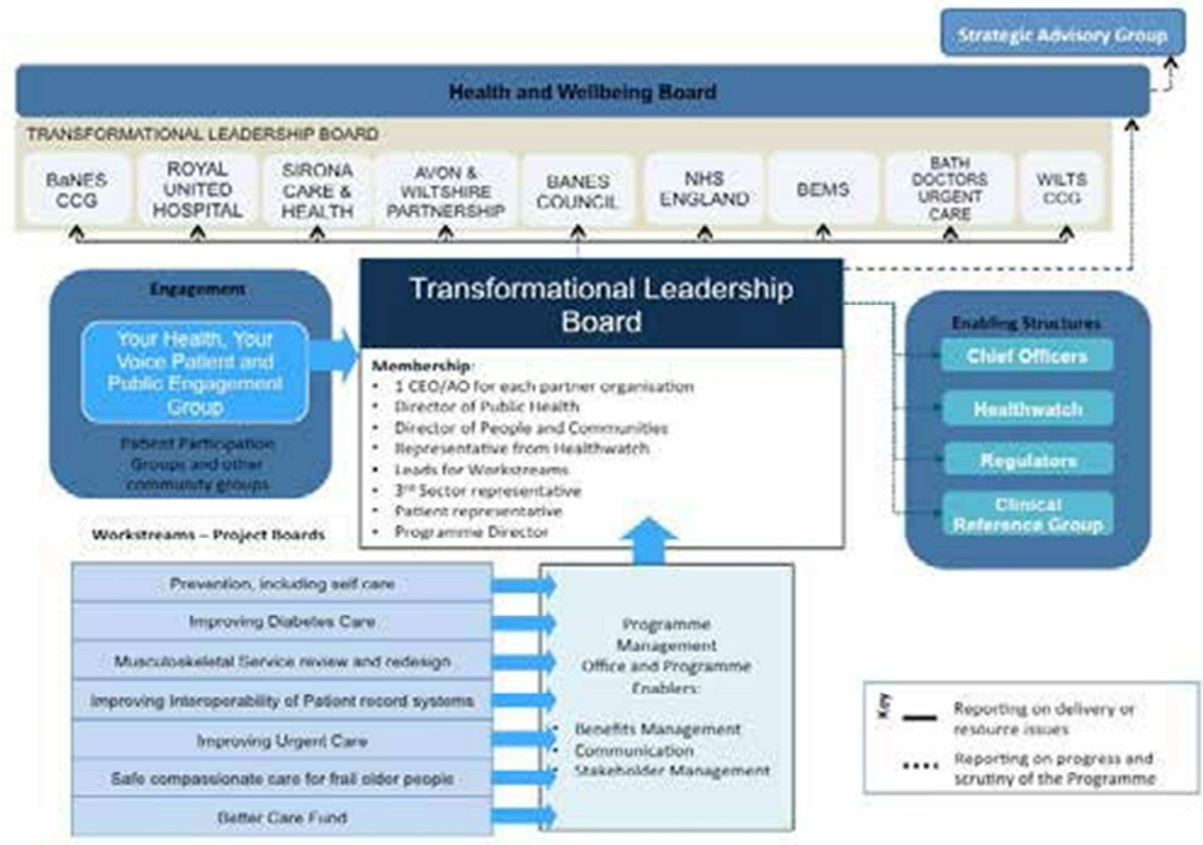
Each project within the overall Better Care Fund workstream has a named senior commissioner as lead, with overall project leadership and the Senior Responsible Officer role provided by the Deputy Director Adult Care and Health Strategy and Commissioning, a joint postholder who is a member of the Joint Commissioning Committee.

The programme is overseen by a Transformational Leadership Board (TLB), to which each of the project boards is accountable for delivery. The TLB will comprise a multidisciplinary group of Directors and Clinical Leaders from the constituent organisations of the health and social care community. The TLB is accountable to the participating organisations' governing bodies and will also report to the Health and Wellbeing Board.

Delivery of the programme will be supported by a Programme Management Office (PMO) led by a programme director. The PMO will ensure that progress and benefits of the work streams are tracked and variances, risks, dependencies and issues are identified and addressed.

An integrated performance and delivery monitoring dashboard for the Better Care Plan is in development .

The diagram below sets out the overall programme structure, showing how the Better Care Fund workstream sits within it.



Chapter 4 Engagement

Our vision and plan for whole system integration has drawn from a variety of engagement process, including patients, service-users and the public, representative groups and partner organisations, including: The Care Forum, host of Healthwatch B&NES; the Royal United Hospital (RUH) Bath; Dorothy House Hospice; Sirona Care & Health CIC; Curo Housing Group; Age UK B&NES; Avon & Wiltshire Mental Health Partnership NHS Trust (AWP); B&NES Council and BaNES Clinical Commissioning Group.

Patient, Service User and Public Engagement

Our vision for whole system integrated care is based on what people have told us is most important to them.

The Joint Health and Wellbeing Strategy, which was agreed in September 2013, was informed and shaped by a formal consultation period, which launched on 30 April and ran until 7 June 2013. Consultation responses were received from a range of stakeholders including health and social care providers and VCSE (Voluntary, Community and Social Enterprise) sector organisations, members of the public and service users. Our Better Care Plan wholly reflects the aims and intentions of the Health and Wellbeing Strategy.

Key schemes described in this submission and supporting documentation, including the Community Cluster Team Model, Wellbeing College, Social Prescribing Initiative and integrated intensive Reablement Service were informed, developed and, in some instances, co-designed through embedded models of service user, carer and patient feedback, including networks and groups supported by the Care Forum, partnered with HealthWatch, and the Carers Centre as well as specific events, for example the What Works Mental Health Conference, which took place in October 2013.

Specific patient, service user and public engagement on our Better Care Fund plan has been aligned with consultation on the CCG's Operational and Strategic Plan, in the context of our long-established Joint Working Agreement and integrated commissioning and provision. Engagement events held with representatives of the public, the Health & Wellbeing Board (HWB) and other key stakeholders including Healthwatch were held between October 2013 and March 2013 to share and test our understanding of the case for change and gather support from across the health and care community. A Health & Wellbeing Board Network event in May 2014 created an opportunity to focus in more detail on two of the priority areas identified – Prevention and Self Care; and Care for Frail Older People.

On-going engagement with patients, service users and the public will be through the Health & Wellbeing Board Network, the embedded models of feedback described earlier in this section, the newly established, Patient and Public Involvement Group. "Your Health, Your Voice".

Health and Care Provider Engagement

Specific provider engagement on our Better Care Fund plan has been aligned with consultation on the CCG's Operational and Strategic Plan, in the context of our long-established Joint Working Agreement and integrated commissioning and provision. Engagement events held with providers, including the RUH, AWP, BaNES Emergency Medical Services (BEMS) and Bath Doctors Urgent Care (BDUC), Sirona Care & Health, and other key stakeholders were held between October 2013 and March 2013 to share and test our understanding of the case for change and gather support from across the health and care community.

Engagement on the BCF with BaNES System Resilience Group (SRG), which includes senior representation from the RUH, AWP and Sirona in August 2014 helped inform its further development and, also, to ensure alignment with both individual organisational plans and, also, BaNES' system-wide operational resilience and capacity planning for 2014/15 and future years.

Chapter 5 Risk & Contingency

The total value of funding designated by the revised BCF guidance as either ringfenced or performance related is £3.2m, with £0.938m designated as a performance related payment linked with a successful target reduction in emergency admissions. The guidance requires this funding to be withheld by the CCG if target reductions are not met, and to be spent as determined by the CCG in consultation with the HWB. The implication is that the first call on such funds may be to fund the costs of emergency admissions above target levels.

The Better Care plan is required to identify which elements will be 'at risk' if performance related payments are not secured, with the agreed approach endorsed by the HWB. It is proposed that the performance related payments are linked with the NHS commissioned element of the social care pathway re-design, which offers health and social care benefits through an integrated approach to reablement.

The approach to risk management is informed by the Council's and CCG's commitment to supporting effective integrated working, in that both parties would wish to continue funding this initiative, providing it is proving successful, even if the specific target relating to reduced emergency admissions is not being achieved. The proposal is therefore that the risk of any funding shortfall is borne equally; that is, 50% each by Council and CCG.

This will be mitigated by an agreement with the provider of the social care pathway to review the success of the model as a whole and to adjust financial contributions if delivery of the range of desired outcomes were not demonstrated.

Contingency funding for the management of financial risk, including the specific risk associated with non-achievement of the target reduction in emergency admissions, is included in both CCG and Council financial plans, based on assumptions consistent with those in the Better Care Plan.