Bath & North East Somerset Council

Health & Wellbeing Board

Date: Wednesday, 6th September, 2017
Time: 10.30 am
Venue: Brunswick Room - Guildhall, Bath

Members: Dr Ian Orpen (Member of the Clinical Commissioning Group), Councillor Vic Pritchard (Bath & North East Somerset Council), Ashley Ayre (Bath & North East Somerset Council), Mike Bowden (Bath & North East Somerset Council), Jayne Carroll (Virgin Care), Mark Coates (Knightstone Housing), Tracey Cox (Clinical Commissioning Group), Debra Elliott (NHS England), Diana Hall Hall (Healthwatch), Steve Imrie (Avon Fire & Rescue Service), Steve Kendall (Avon and Somerset Police), Bruce Laurence (Bath & North East Somerset Council), Councillor Paul May (Bath and North East Somerset Council), Professor Bernie Morley (University of Bath), Laurel Penrose (Bath College), Jermaine Ravalier (Bath Spa University), Hayley Richards (Avon and Wiltshire Partnership Trust), James Scott (Royal United Hospital Bath NHS Trust), Andrew Smith (BEMS+ (Primary Care)), Sarah Shatwell ((VCSE Sector) - Developing Health and Independence), Jane Shayler (Bath & North East Somerset Council) and Elaine Wainwright (Bath Spa University)

Observers: Councillors Tim Ball and Eleanor Jackson

Other appropriate officers
Press and Public

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NOTES:

1. **Inspection of Papers:** Papers are available for inspection as follows:

Council's website: https://democracy.bathnes.gov.uk/ieDocHome.aspx?bcr=1
Paper copies are available for inspection at the **Public Access points:-** Reception: Civic Centre - Keynsham, Guildhall - Bath, The Hollies - Midsomer Norton. Bath Central and Midsomer Norton public libraries.

2. **Details of decisions taken at this meeting** can be found in the minutes which will be circulated with the agenda for the next meeting. In the meantime, details can be obtained by contacting as above.

3. **Recording at Meetings**:-

The Openness of Local Government Bodies Regulations 2014 now allows filming and recording by anyone attending a meeting. This is not within the Council's control.

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https://democracy.bathnes.gov.uk/ecCatDisplay.aspx?sch=doc&cat=12942

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Additional information and Protocols and procedures relating to meetings

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Health & Wellbeing Board - Wednesday, 6th September, 2017

at 10.30 am in the Brunswick Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

5. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

6. PUBLIC QUESTIONS/COMMENTS

7. MINUTES OF PREVIOUS MEETING (Pages 7 - 12)

   To confirm the minutes of the meeting held on 12 July 2017 as a correct record.

8. SUSTAINABILITY AND TRANSFORMATION PLAN (STP) UPDATE

   To receive a presentation giving an update on the Sustainability and Transformation Plan (STP).

   10:40am – 30 mins – Tracey Cox

9. B&NES/SWINDON/WILTSHIRE (BSW) SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) MENTAL HEALTH DELIVERY PLAN (Pages 13 - 52)

To consider the attached report which presents the STP Mental Health Delivery Plan to provide context for the development of the work programme of the health and Wellbeing Board. The report contains information on priority actions to deliver the Five Year Forward View for Mental Health across the B&NES/Swindon/Wiltshire area and, also, actions for each constituent part of the STP, including B&NES. It has been informed by the Joint Strategic Needs Assessment, a gap analysis against the Five Year Forward View and by previously identified local priorities, including those in local Mental Health Strategies and Plans.

11:10am – 25 mins – Jane Shayler

10. BETTER CARE FUND PLAN 2017-19 (Pages 53 - 156)

To consider the attached report. The Better Care Fund Plan sets out the vision for integrated services in B&NES up to 2020 and how the Improved Better Care Fund grant monies will be utilised to support the Better Care Fund plan.

The plan is due to be submitted to NHS England on 11 September 2017 as part of the assurance process for 2017-2019. Agreement is sought to delegate final sign off, as in previous years, to the Co-Chairs of the Health and Wellbeing Board, the final submission, following feedback received at the Board.

11:35am – 25 mins – Caroline Holmes

11. HEALTH OPTIMISATION

To receive a presentation regarding Health Optimisation.

12:00 noon – 25 mins – Ruth Grabham/Jon McFarlane

12. CLOSING REMARKS

To receive closing remarks from the Chair.

12:25pm – 5 mins

The Committee Administrator for this meeting is Marie Todd who can be contacted on 01225 394414.

HEALTH & WELLBEING BOARD

Minutes of the Meeting held

Wednesday, 12th July, 2017, 11.00 am

Dr Ian Orpen	Member of the Clinical Commissioning Group
Councillor Vic Pritchard	Bath & North East Somerset Council
Ashley Ayre	Bath & North East Somerset Council
Jayne Carroll	Virgin Care
Jocelyn Foster	Royal United Hospital (substitute for James Scott)
Diana Hall Hall	Healthwatch
Bruce Laurence	Bath & North East Somerset Council
Councillor Paul May	Bath & North East Somerset Council
Laurel Penrose	Bath College
Hayley Richards	Avon and Wiltshire Partnership Trust
Andrew Smith	BEMs+ (Primary Care)
Sarah Shatwell	(VCSE sector) – Developing Health and Independence
Jane Shayler	Bath & North East Somerset Council
Elaine Wainwright	Bath Spa University

1 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

2 EMERGENCY EVACUATION PROCEDURE

The Chair drew attention to the evacuation procedure as listed on the call to the meeting.

3 APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Mike Bowden – B&NES Council
Mark Coates – Knightstone Housing
Tracey Cox – Clinical Commissioning Group
Steve Imrie – Avon Fire and Rescue Service
Steve Kendall – Avon and Somerset Police
Bernie Morley – University of Bath
James Scott – Royal United Hospital NHS Trust – substitute Jocelyn Foster

4 DECLARATIONS OF INTEREST

Councillor Paul May declared a non-pecuniary interest as a Non-Executive Director on the Board of Sirona.

5 TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

There was no urgent business.

6 PUBLIC QUESTIONS/COMMENTS

There were no public questions or comments.

7 MINUTES OF PREVIOUS MEETING - 17 MAY 2017

The minutes of the previous meeting were approved as a correct record and signed by the Chair.

Diana Hall Hall raised an issue regarding the May payroll run for Virgin Care staff. Jayne Carroll stated that there had been some problems relating to the payment of bank staff but that these had now been resolved.

Cllr Tim Ball also expressed concern that some Virgin Care staff had not received payment and had no access to their payslips. Jayne Carroll explained that an electronic system was now in operation for payslips and confirmed that, as far as she was aware, all staff had now been paid.

8 HEALTH INEQUALITIES ACTION PLAN

The Board considered a report which highlighted some of the good practice occurring for each of the priorities identified at the health inequalities inquiry day held in May 2016.

It was noted that the Your Care Your Way commissioning of community services and the emergence of Sustainability and Transformation Plans had absorbed a great deal of time and attention. This had resulted in a lack of space and resource to carry out other cross-cutting work.

Some work was currently being carried out to address health inequalities such as:

- The creation of a virtual employment hub.
- Provision of more joined up services.
- Programmes to work with “hard to reach” groups e.g. the local programme in the Foxhill/Mulberry Park area of Bath.
- Work to encourage healthy lifestyles e.g. increasing physical activity and reducing smoking and alcohol consumption.
- CCGs and GPs were also doing work within practices located in deprived areas e.g. safeguarding.
- The public health team had also met with Healthwatch to discuss priorities.

The following issues were then discussed:

- Cllr Vic Pritchard informed that Board that he had recently attended a seminar regarding mental health where Adverse Childhood Experiences (ACES) were discussed. He welcomed the inclusion of the use of routine enquiry around ACES and felt that this should be promoted. The trauma informed care approach was gaining interest in drug-treatment services and the police force.

- Cllr Paul May stressed the need to clarify outcomes and deadlines for the future actions to enable the Board to monitor this work more effectively.

- Sarah Shatwell welcomed the explanation regarding the context of this work and highlighted the impact of work pressures on the whole of the health and social care community. She suggested that work on Adverse Childhood Experiences could join up with the Making Every Contact Count project. It was important to work together with voluntary sector organisations to join up with work already underway such as the Better Opportunities Programme.

- Ashley Ayre advised Board members to read the recently published Ofsted inspection report which highlighted the strength of the early help and childcare service in B&NES.

- Diana Hall Hall pointed out that the Bath Area Playgroup deserved credit for the work it carries out to address inequalities.

- It was noted that service user information was well developed but that further work needed to be undertaken regarding workforce data.

- It was important to ensure that families received the help they needed at the correct time. Early intervention was vital, along with a needs based response.

- The STP and inequalities actions were not mutually exclusive and work could be carried out to identify where most value could be added for B&NES residents.

- Laurel Penrose stated that further education could assist with employability and that focus should be wider than purely compulsory education.

RESOLVED:

(1) To note the existing work on health inequalities.

(2) To ask the Sustainability and Transformation Partnership Board to discuss the issue of health inequalities and to consider ways in which it can assist with this work.

(3) To receive an update on progress in 6 months' time.

9 **MAKING EVERY CONTACT COUNT**

The Board considered a report and received a presentation regarding Making Every Contact Count (MECC). This involved altering how staff interact with people through having healthy conversations and learning how to spot opportunities to talk to people about their wellbeing.

The presentation covered the following issues:

- Overview of MECC
- The local approach
- How implementation will be supported. MECC is a national initiative and is intended to be brief. It should be enabling and empowering and not forcing or telling.
- The aim is to provide a structure to help staff to undertake healthy conversations with their patients and support them in making healthy lifestyle choices.
- Training will be provided using a cascade model.
- Progress made – a co-ordinator has been appointed, a small grant application process has been set up, 12 trainers are in place and 88 staff have been trained.

The Board members were very supportive of this initiative and were happy to champion it. It was acknowledged that although older people are currently considered to be a higher priority, the programme will also aim to engage young people using a phased approach.

Elaine Wainwright stated that Bath Spa University would be keen to be involved with this project and noted that the training provided would be skills based rather than topic based.

Jayne Caroll stated that Virgin Care would welcome the opportunity to look at this from the perspective of the role of the Health Visitor.

Hayley Richards stated that a large proportion of the AWP workforce were practitioners. There was a small concern that people do not find it easy to talk about mental health issues. It was acknowledged that the evaluation of the project would not be straightforward but that the approach should become a natural part of a person's role.

A copy of the presentation slides is attached as *Appendix 1* to these minutes.

RESOLVED:

(1) To note the approach for implementing Making Every Contact Count (MECC).

(2) To agree the suggested key principles for local implementation:

- A focus on MECC Level 1: very brief intervention/healthy conversations.
- Delivering MECC Plus to include the wider determinants.
- A phased approach with identified target audiences.
- A model of cascading the training/learning.

(3) To provide high level support and commitment to MECC.

10 **MENTAL HEALTH AND WELLBEING CHARTER**

The Board received a presentation from Caroline Mellors, Charter Lead, St Mungos Bridge to Wellbeing, regarding the Mental Health and Wellbeing Charter. The contact details for Caroline Mellors are 07525 594606 or email Caroline.Mellors@mungos.org. A copy of the slides is attached as *Appendix 2* to these minutes.

The Mental Health and Wellbeing Charter provides a clear set of principles to guide people who require mental health support. Alongside the "in practice" document it promotes a shared approach between those using services, their families, friends, groups and professionals to support each person's unique mental health needs.

The presentation covered the following issues:

- Background and reasons for the Charter.
- Details of the collaborative work undertaken to create the Charter.
- How the Charter was created.
- The contents of the Charter.
- Details of the work being undertaken to embed the Charter and to provide training.
- The Charter was launched in May 2016 at an event opened by the Mayor.
- Future plans for the Charter.

The following issues were discussed:

- The Board members fully supported the Charter and thanked those involved for all the work they had undertaken to produce it.
- It was noted that the Charter could be helpful for an area wider than the B&NES boundaries and that it could be used across the whole STP area.
- There were 10 principles set out in the document and it was noted that when providing training, organisations were invited to look at the areas they particularly wished to address and to prioritise these.
- It was suggested that the Charter would be very useful to schools and could be included in the headteachers' briefing pack.
- The Board felt that the way in which the Charter was derived was particularly valuable.

RESOLVED:

(1) To endorse the Mental Health and Wellbeing Charter.

(2) To recommend that Board members take the Charter back to their respective organisations and adopt the principles set out within it.

11 **DATE OF NEXT MEETING**

It was noted that the next meeting would take place on Wednesday 6 September 2017.

The meeting ended at 12.30 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**06/09/2017**
TYPE	**An open public item**

Report summary table	
Report title	B&NES/Swindon/Wiltshire (BSW) Sustainability & Transformation Partnership (STP) Mental Health Delivery Plan
Report author	Jane Shayler, 01225 396120
List of attachments	Appendix 1: BSW STP Mental Health Delivery Plan
Background papers	The Five Year Forward View for Mental Health, February 2016, https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf The Five Year Forward View for Mental Health: One year on, February 2017, https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf
Summary	The attached STP Mental Health Delivery Plan is presented to provide context for the development of the work programme of the Health and Wellbeing Board. It contains information on priority actions to deliver the Five Year Forward View for Mental Health across the B&NES/Swindon/Wiltshire and, also, actions for each constituent part of the STP, including B&NES. It has been informed by the Joint Strategic Needs Assessment, a gap analysis against the Five Year Forward View and by previously identified local priorities, including those in local Mental Health Strategies and Plans.
Recommendations	The Board is asked to: • Note the priority actions set out in the STP Mental Health Delivery Plan; and • Identify potential opportunities for HWB to strengthen links between the work programme and priorities of the HWB and the STP Mental Health Delivery Plan.
Rationale for recommendations	There is significant overlap between the priorities in the MH Delivery Plan and the delivery of the outcomes in the Joint Health and Wellbeing Strategy as follows: Theme One - Helping people to stay healthy: • Reduced rates of alcohol misuse; • Creating healthy and sustainable places. Theme Two – Improving the quality of people's lives: • Improved support for people with long term health conditions; • Reduced rates of mental ill-health;

	• Enhanced quality of life for people with dementia; • Improved services for older people which support and encourage independent living and dying well. Theme Three – Creating fairer life chances: • Improve skills, education and employment; • Reduce the health and wellbeing consequences of domestic abuse; • Increase the resilience of people and communities including action on loneliness.
Resource implications	There are no direct resource implications associated with the recommendations/this report. There are potential opportunities to better align/utilise resources to deliver against priorities that are shared with the BSW STP and/or Wiltshire and Swindon HWB.
Statutory considerations and basis for proposal	Both the Council and the CCG have statutory responsibilities in relation to implementation of the Mental Health Five Year Forward View. In June 2017 NHS England confirmed the requirement that all Sustainability & Transformation Partnerships submit an STP Mental Health Delivery Plan for the deadline of 30 July 2017.
Consultation	No specific consultation has been undertaken in relation to this report. The development of the STP Mental Health Delivery Plan was overseen by a sub-group of the STP and includes STP members and wider partners commissioning and providing mental health services for both adults and children and young people. The Plan was approved by the STP Board on 21 July. A multi-agency workshop was held on 17 August Mental Health
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1.1 The Five Year Forward View for Mental Health (5YFV) was published in February 2016 and followed, in February 2017 by Five Year Forward View for Mental Health: One Year On. A summary of the priorities set out in the 5YFV is included on page 2 of the Mental Health Delivery Plan attached as Appendix 1.

1.2 In June 2017, NHS England (NHSE) set out the requirement for each Sustainability & Transformation Partnership to develop an STP Mental Health Delivery Plan to support the delivery of the Five Year Forward View for Mental Health. The deadline for submitting the plan was the end of June 2017.

1.3 Work to oversee the development of the Delivery Plan was agreed to sit naturally with the STP Mental Health Work Stream Group, which was convened in February 2017 to ensure that BSW STP Plans gave the same attention and focus to mental health and wellbeing for both adults and children and young people as they do for physical health.

1.4 It was recognised that the emphasis should be on promoting mental health and wellbeing, prevention and early intervention, integrating physical and mental health services and, where appropriate, adults and children and young people's services. It was acknowledged that STP wide plans should prioritise those actions where commissioning and/or providing services across the B&NES/Swindon/Wiltshire footprint add the greatest value. One of the challenges, then, is to ensure that STP-wide plans align and are coherent with priorities and plans that are being delivered locally, for example, the development of Accountable Care Systems and/or plans that are being delivered across wider footprints, for example, improvements to the s136 pathway for those experiencing a mental health crisis.

1.5 Timescales for developing and agreeing the STP-wide Mental Health Delivery Plan were very tight. The attached plan was informed by a Gap Analysis supported by NHSE and, also, by earlier work of the MH work stream group to support the identification of initial priorities for the mental health group based on benchmarking of performance, analysis of each area's mental health strategies and plans and Joint Strategic Needs Assessments. A B&NES Public Health Consultant supported this work.

1.6 The outcome of this work is summarised in the attached Delivery Plan. Priority actions for 2017/18 are summarised on page 3 of the plan. The highest impact/key priorities are shown in red. The Delivery Plan was submitted in draft form for the deadline of 30 June 2017 and approved by the STP's Board on 21 July. The Delivery Plan is high-level and detailed plans are now being developed. The first step in developing more detailed plans for wider engagement was a workshop that took place on 17 August 2017.

1.7 The workshop brought together health and social care clinicians and practitioners, commissioners and providers of both adults and children and young people's mental health and wellbeing services, subject matter experts (for example, Health Education England, the West of England Academic Health & Science Network and the SW Clinical Network).

1.8 At the workshop presentations/information shared included a summary of the gap analysis, the challenges and plans of key mental health providers, a summary of the recently published national Mental Health Workforce Strategy and SW mental health workforce information and learning from other areas – particularly in relation to prevention/early intervention. Workshop attendees also heard about potential support available to support delivery of priority actions.

1.9 Group work in the afternoon considered the following topics, which were drawn from key priorities in the Delivery Plan:

- Transition of children and young people from Child and Adolescent Health Services into adult services
- In-patient access
- Urgent and Emergency Care
- Workforce Development

1.10 In advance of write up of the outcomes of the day, some of the priority/high impact actions and "quick" wins highlighted through the group work were:

- **Urgent and Emergency Care:**
  - ✓ Early assessment, care plans and crisis plans (way earlier!)
  - ✓ Establishment of Safe Havens
  - ✓ Advice from Mental Health professionals via NHS 111 to avoid unnecessary hospital admission.
- **Improving Transitions:**
  - ✓ Flexible all age life course approach, specifically aimed at 16-25s.
  - ✓ Experience based design with relevant age group
  - ✓ Action plan for achievement of ChiMAT best practice standards
- **In-patient access:**
  - ✓ Focus on mental health Delayed Transfers of Care to reduce length of stay and improve access to in-patient services.
  - ✓ Build wider community support for families to enable people to be discharged earlier
  - ✓ Learn from care home Vanguards
- **Workforce Development:**
  - ✓ STP mental health workforce strategy to increase mental health employment, reduce turnover and high numbers of temporary staff and enthuse the workforce.

- ✓ Maximise use of apprenticeships
- ✓ Develop competency based training rather than traditional training routes
- ✓ A different style marketing approach, eg roadshow to explain the depth and breadth of a mental health career

1.11 Strong themes throughout the day were:

- Focus on prevention and early intervention
- Work collaboratively and learn from each other – experts by experience, providers and commissioners, all ages
- Develop and value the workforce
- Freely share information and communicate openly with an emphasis on listening to understand
- "Look Beyond" what is known and we believe is possible to achieve our vision of the future.

1.12 Work from the workshop is now being used to set out a more a more detailed action plan, which will include wider engagement to ensure we turn our delivery plans into improved outcomes.

Please contact the report author if you need to access this report in an alternative format

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Mental Health Delivery Plan

Draft 30th June 2017

Bath & North East Somerset, Swindon and Wiltshire STP

STP 5YFV Mental Health priorities on a page

BSW STP

NHS England

Children and Young People's Mental Health

Set out how areas will continue the expansion in access to high-quality mental health care. This should ensure the multi-agency approach agreed in the LTPs becomes business as usual. In addition to existing CCG commitments on increasing access to services and progress toward the CYP Eating Disorder standard, NHSE expectation that STPs will set out plans/KPIs for:

- The increase in access to community based services, with reduction in unwarranted variation in times for treatment Reduction in inappropriate OAPs for inpatient CAMHS (Tier 4)
- demonstrating improved capacity and capability in the CYP MH workforce
- Ensuring robust local and national data flows"

Secure Care, New Care Models and Health and Justice

- Support regional implementation activities at STP level.
- Support delivery of MH New Care Models.

Infrastructure, Finance, Workforce

- Ensure that all provider are submitting data to NHS digital and support improvement of data quality.
- Deliver the Mental Health Investment Standard.
- Develop workforce delivery plans.

Suicide Prevention

- Develop plan to reduce suicides (10% by 2020/21), with local government and other partners.

Older People and Dementia

- Meet the dementia diagnosis rate and increase the number of people being diagnosed with dementia and starting treatment, within 6 weeks of referral.
- Reduce unwarranted variations between STPs for diagnosis rate, with a special focus on BAME group.

Adult Mental Health: IAPT

- Meet the IAPT access, recovery and waiting time standards.
- Commission additional psychological therapies for people with anxiety and depression, with the majority of the increase integrated with physical healthcare.
- Develop regional and STP workforce plans to ensure sufficient numbers of trainees to meet commitments and increase numbers of employment advisors, coordinating with HEE local teams.

Perinatal Mental Health

- Demonstrate at STP and regional level existence and implementation of plans and trajectories to meet regional ambition by 2020/21, these plans notably need to demonstrate partnerships in strategic planning across multi-professional perinatal mental health pathways and delivery between community and inpatient services. Delivery against STP and Regional plans in 2017/18.

Adult Mental Health: Community, Acute and Crisis Care

- Expand capacity so that more than 50% of people experiencing a first episode of psychosis start treatment within two weeks of referral with a NICE-recommended package of care.
- Commission effective 24/7 Crisis Response and Home Treatment Teams as an alternative to acute admissions.
- Establish baseline and trajectory for elimination of out of area placements for non-specialist acute care by 2021.
- Develop plan, including trajectory, to deliver integrated physical and mental health provision to people with severe mental illness.
- Assure that service development plans are in place to meet ambition of all acute hospitals with all-age liaison services by 2020/21 and 50% meeting Core 24 service standard for adults: assurance of successful Wave 1 bidders plans.
- Take part in bidding process for Individual Placement & support transformation funding and insure preparedness for IPS expansion.

BSW STP 2017/18 Mental Health priority actions

BSW STP

NHS England

Children and Young People's Mental Health

STP Actions:

- Improve transition from CAMHS to adult mental health service by providing a more flexible transition offer to CYP aged 16+ through an STP wide review of the transitions pathway and associated protocol.
- Fully implement enhanced MH liaison model across STP in all acute hospitals.
- Develop STP wide Tier 4 commissioning plan in partnership with NHSE specialised commissioning.
- Secure improved information sharing between community CAMHS and other CYP EWMH treatment services.
- Ensure requirement to flow data is included within contracts whenever possible.
- Establish an effective digital treatment offer to provide quicker access to evidence based treatments.

Secure Care, New Care Models and Health and Justice

STP Action: Work with NHSE and key partners to support delivery of the Secure Care, New Care Models of Care and Health & Justice Agenda.

Infrastructure, Finance, Workforce

STP Actions:

- Develop a digital strategy for mental health, learning from current practice in each CCG area.
- With STP Workforce Group, develop an STP-wide MH Workforce development plan.

Suicide Prevention

STP Action: build on BSW collaborative approach to a number of areas of suicide prevention.

Older People and Dementia

STP Actions:

- Consider potential opportunities and challenges of an STP wide approach to dementia diagnosis and support.
- Assurance to STP Board that each CCG has in place a robust delivery plan in relation to Dementia Diagnosis Rate.

Adult Mental Health: IAPT

STP Actions:

- Ensure that learning from B&NES/Swindon success bid have Employment Advisors as part of IAPT services is translated throughout the STP.
- Across STP link IAPT and commissioned services, in order to ensure people have increased opportunity to access and retain employment.
- Expand the integration of physical and mental health care via increasing IAPT services to people with long term conditions.

Perinatal Mental Health

STP Actions:

- Development of new perinatal pathways and networks within each CCG in preparation for an STP wide bid to NHSE for Wave 2 Transformation funding.
- STP appointed Pathways Manager to assist with development of consistent pathways and assist with the bid.

Adult Mental Health: Community, Acute and Crisis Care

STP Actions:

- As part of the STP Parity of Esteem work, identify specific pathways that will benefit from integration of physical and mental health across the STP.
- Convene an STP wide event to examine inpatient provision and models across the STP in order to agree the STP's strategic plan to ensure value for money, local access to services, effective use of resources, and a reduction in out of area placements.
- Develop an STP wide approach to Core 24 service standard, ensuring maximum use of resources across the STP, in order to meet Core 24 requirements.
- Develop an STP wide approach to crisis avoidance and management building on the pan BSW/BNSSG STP work in progress with a wide range of partners aimed at improving the outcomes for people and organisations in relation to the use of Section 136 Places of Safety under the Mental Health Act.
- Develop an STP wide strategy for Individual Placement Support in order to prepare for targeted funding.

Our challenges: Mental Health Needs across the BSW STP area

- Adolescent emotional distress and poor mental health is increasing in prevalence and demand for services is high
- Swindon and Wiltshire have high and increasing hospital admissions for self-harm, in young people as well as adults
- Poor mental health during the perinatal period may not currently be identified and supported sufficiently
- Common mental disorders are very prevalent in all areas and increasing
- Mental wellbeing is significantly worse in more deprived areas
- Many people are not accessing any form of treatment
- Swindon has more people on GP registers with depression, and high anti-depressant prescribing
- IAPT recovery rates may be worse for BME groups, though this is based on short term data

Our challenges: Mental Health Needs across the BSW STP area

- Suicide rates have increased in recent years but are similar to national rates
- People with Severe Mental Illness (SMI) die on average 20 years earlier than the general population.
- Proportion of people with SMI who have received physical checks is low.
- On average those with mental health problems have fewer qualifications, find it harder to find and retain work, have lower incomes, and are more likely to be homeless.
- People with long term physical conditions or disabilities experience more mental health problems.
- Anxiety and depression in social care users are higher than England rates, and increasing, for each of B&NES, Swindon and Wiltshire.
- Stigma is a common issue for people living with mental illness.
- Adults in contact with mental health services are more likely to be in employment and stable accommodation than peers from other authorities, but the percentages are still small overall.

Our challenges: Mental Health Funding across the BSW STP area – B&NES

Parity of Esteem	Including LD & Dementia				Excluding LD & Dementia		
	Mental Health Spend	Programme Growth %	Growth in MH Spend %	Investment Standard Achieved?	MH Spend (Exc LD & Dementia)	Growth in MH Spend %	Investment Standard Achieved?
2017/18	32,530	2.0%	2.2%	Y	25,953	2.4%	Y
2018/19	33,179	2.0%	2.0%	Y	26,592	2.5%	Y
2016/17	31,839				25,353		

Mental Health - Spend by Category

Spend by Category	Core Mental Health		Mental Health in Other Areas		Total Mental Health		Rationale for zero plan
	2016/17 FOT	2017/18 Plan	2016/17 FOT	2017/18 Plan	2016/17 FOT	2017/18 Plan	
	£k	£k	£k	£k	£k	£k	
Children & Young People's Mental Health (excluding LD)	2,241	2,308	282	282	2,523	2,590	
Children & Young People's Eating Disorders	99	105			99	106	
Perinatal Mental Health (Community)					-	-	N/C
Improved access to psychological therapies (adult)	1,090	1,107			1,090	1,107	
A and E and Ward Liaison mental health services (adult)	1,597	1,621			1,597	1,621	
Early intervention in psychosis 'EIP' team (14 - 65)	447	454			447	454	
Crisis resolution home treatment team (adult)	1,196	1,214			1,196	1,214	
Community Mental Health	6,954	7,044			6,954	7,044	
SMI Physical Health					-	-	N/C
Secure Care Pathway					-	-	N/C
Suicide Prevention					-	-	N/A
Learning Disabilities	5,391	5,473	654	654	6,045	6,127	
Dementia	441	450			441	450	
Other adult mental health	7,247	7,339	2,320	2,455	9,567	9,794	
Primary care prescribing on mental health drugs	11	11	1,909	2,012	1,920	2,023	
TOTAL	**26,714**	**27,127**	**5,165**	**5,403**	**31,879**	**32,530**	
2016/17 Spend of non-recurrent allocations*					40		

Our challenges: Mental Health Funding across the BSW STP area – B&NES

- B&NES also has potential 2017/18 and future years cost pressures on special health care panel placements as well as Out of Area Placements through AWP although there are signs that each are reducing although the expenditure on these across the health economy are still very high.

- There are also cost pressures that may materially affect B&NES Council, for example in respect of Section 117 funding.

Our challenges: Mental Health Funding across the BSW STP area – Swindon

Per planning return – Swindon CCG Mental Health Spend			
	2017/18		2018/19
Parity of Esteem			
	£'000		£'000
Children & Young People's Mental Health (excluding LD)	2,440		2,575
Children & Young People's Eating Disorders	113		113
Improved access to psychological therapies (adult)	1,381		1,381
Community Mental Health	395		398
Learning Disabilities	3,628		3,801
Other adult mental health	19,109		19,543
TOTAL	27,066		27,811

Our challenges: Mental Health Funding across the BSW STP area - Wiltshire

Mental Health - Investment Standard

Parity of Esteem	Including LD & Dementia				Excluding LD & Dementia		
	Mental Health Spend	Programme Growth %	Growth in MH Spend %	Investment Standard Achieved?	MH Spend (Exc LD & Dementia)	Growth in MH Spend %	Investment Standard Achieved?
2017/18	55,492	2.4%	2.4%	Y	50,200	2.4%	Y
2018/19	56,824	2.4%	2.4%	Y	51,405	2.4%	Y
2016/17	54,172				49,005		

Mental Health - Spend by Category

Spend by Category	Core Mental Health		Mental Health in Other Areas		Total Mental Health		Rationale for zero plan
	2016/17 FOT	2017/18 Plan	2016/17 FOT	2017/18 Plan	2016/17 FOT	2017/18 Plan	
	£k	£k	£k	£k	£k	£k	
Children & Young People's Mental Health (excluding LD)	4,614	4,628	974	974	5,588	5,602	
Children & Young People's Eating Disorders	244	245	-	-	244	245	
Perinatal Mental Health (Community)	-	-	71	-	71	-	N/A
Improved access to psychological therapies (adult)	2,028	2,030	28	-	2,056	2,030	
A and E and Ward Liaison mental health services (adult)	233	1,266	-	-	233	1,266	
Early intervention in psychosis 'EIP' team (14 - 65)	182	847	-	-	182	847	
Crisis resolution home treatment team (adult)	2,549	2,610	-	-	2,549	2,610	
Community Mental Health	10,621	10,876	-	-	10,621	10,876	
SMI Physical Health	-	-	-	-	-	-	N/A
Secure Care Pathway	-	-	-	-	-	-	N/A
Suicide Prevention	-	-	-	-	-	-	N/A
Learning Disabilities	4,691	4,807	-	-	4,691	4,807	
Dementia	476	485	-	-	476	485	
Other adult mental health	19,719	19,476	3,729	2,931	23,448	22,407	
Primary care prescribing on mental health drugs	-	-	4,318	4,318	4,318	4,318	
TOTAL	**45,357**	**47,269**	**9,120**	**8,223**	**54,477**	**55,492**	
2016/17 Spend of non-recurrent allocations*					305		

Performance Summary: KPIs

KPI	National Target 2017/18	B&NES	Swindon	Wiltshire
Dementia Diagnosis Rate	66.70%	59.65% (May 17)	63.1% (May 17)	66.2% (May 17)
IAPT Rollout	4.2% per quarter	4.55%	7.2% (Dec 16-Feb 17)	5.40%
IAPT Recovery	50%	63%	48% (Dec 16-Feb 17)	52.50%
IAPT waiting times < 6 weeks	72%	88.50%	99% (Dec 16-Feb17)	97%
IAPT waiting times <18 weeks	95%	100%	100% (Dec16-Feb17)	100%
EIP – Psychosis treated with a NICE approved care package within 2 weeks of referral	50%	91.70%	70%	87.50%
Waiting times for urgent referrals to CYP Eating Disorder Services within 4 weeks	95%	82.80% (2016-17)	90.5% (2016-17)	84.9% (2016-17)
Waiting times for routine referrals to CYP Eating Disorder Services within 1 week	95%	70% (2016-17)	100% (2016-17)	73.9% (2016-17)
Mental Health DTOCs	STP Target: (do we have an agreed STP DTOC target?)	TBC	TBC	TBC

Summary of STP Mental Health Gap Analysis (1)

BSW STP

NHS England

Children and Young People's Mental Health

Key Planning Guidance Deliverables: 17/18

- At least 30% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.
- Commission 24/7 urgent and emergency mental health service for CYP and ensure submission of data for the baseline audit in 2017.
- All services working within the CYP IAPT programme.
- Community eating disorder teams for CYP to meet access and waiting time standards: All localities expected to baseline current performance against the new standard and start measurement against it.

Full FYFVMH Deliverables: 17/18

- Reduce the number of out of area placements for CYP and use of in-patient beds overall.
- Mobilisation and implementation of the recommendations from the Tier 4 CAMHS review.
- Monitor outcomes and progress in the new Crisis Care service models for CYP, in line with the wider Crisis Care pathway.

STP-Wide Gaps:

- Flow of data from all CCG funded CYP emotional wellbeing and mental health treatment services for access standard compliance is poor.
- Although there is 24/7 telephone advice and consultation from CAMHS practitioners, it is unclear whether there needs to be 24/7 presence in each DGH. This will clearer after the extended CYP MH Liaison offer is established.
- The CYP/IAPT training programme and approach is currently only being utilised by specialist CAMHS. Other providers have difficulty committing resources for the culture change required.
- Provision of alternative places of safety to improve Crisis Care for CYP.

B&NES & Wiltshire Gaps:

- CAMHS practitioners situated at the DGHs offer an extended, 9am-8pm service 7 days a week. There is an out of hours CAMHS service for advice, consultation and emergency assessment.

Swindon Gaps:

- CAMHS nurse will be piloted in the DGH 9am-5pm. At other times there is an out of hours CAMHS service for advice, consultation and emergency assessment.

STP-Wide Actions:

- Improve transition from CAMHS to adult mental health service by providing a more flexible transition offer to CYP aged 16+ through an STP wide review of the transitions pathway and associated protocol.
- Fully implement enhanced MH liaison model across STP in all acute hospitals.
- Assess the need for a 24/7 CAMHS presence in each DGH once the enhanced MH liaison model has been fully implemented.
- Develop STP wide Tier 4 commissioning plan in partnership with NHSE specialised commissioning.
- Secure improved information sharing between community CAMHS and other CYP EWMH treatment services.
- Ensure requirement to flow data is included within contracts whenever possible.
- Establish an effective digital treatment offer to provide quicker access to evidence based treatments.

Summary of Mental Health Gap Analysis (2)

BSW STP

NHS England

Perinatal Mental Health

Key Planning Guidance Deliverable: 17/18

- Increase access to evidence-based specialist perinatal mental health care: regional plans and trajectories in plan to meet national ambition of 2,000 additional women accessing care.
- Commission additional or expanded specialist perinatal mental health community services to deliver care to more women within the locality.

Full FYFVMH Deliverables: 17/18

- Build perinatal MH capability by developing a competence framework describing the skills needed in the workforce.

STP-Wide Gaps:

- No specialist PIMH (Perinatal Intensive Mental Health) service to provide evidence based community support for mothers with mental health problems.
- No dedicated community PIMH service.
- Although competencies have increased, there is no consistent workforce plan across the STP.

STP-Wide Actions:

- Development of new perinatal pathways and networks within each CCG in preparation for an STP wide bid to NHSE for Wave 2 Transformation funding.
- STP appointed Pathways Manager to assist with development of consistent pathways and assist with the bid.
- Implementation of a hub and spoke model.
- Development of a workforce plan across the STP.

Adult Mental Health: IAPT

Key Planning Guidance Deliverable: 17/18

- Commission additional psychological therapies for people with anxiety and depression, with the majority of the increase integrated with physical healthcare, so that at least 16.8% of people with common MH conditions access psychological therapies.
- Ensure local workforce planning includes the numbers of therapists needed and mechanisms are in place to fund trainees.

Full FYFVMH Deliverables: 17/18

- Up to £54 million in 2017/18 will go directly to training new staff and delivering new 'early implementer' integrated services. Remaining funds in 2017/18 will support further training, quality improvement and expansion of current IAPT services.
- Increase the number of employment advisors in IAPT through funding, monitoring and reporting on Employment Advisors in the IAPT project.

Wiltshire Gap:

- Gap in service for individuals with complex Post Traumatic Stress Disorder (PTSD) with a HONOS cluster below 4.

STP-Wide Actions:

- Ensure that learning from B&NES/Swindon success bid have Employment Advisors as part of IAPT services is translated throughout the STP.
- Across STP link IAPT and commissioned services, in order to ensure people have increased opportunity to access and retain employment.
- Expand the integration of physical and mental health care via increasing IAPT services to people with long term conditions.

Wiltshire Action:
(is any being taken to address gap identified above??)

Summary of Mental Health Gap Analysis (3)

BSW STP

NHS England

Adult Mental Health: Community, Acute and Crisis Care

Key Planning Guidance Deliverable: 17/18

- Expand capacity so that more than 50% of people experiencing a first episode of psychosis start treatment within two weeks of referral with a NICE-recommended package of care.
- Commission effective 24/7 CRHTTs as an alternative to acute in-patient admissions.
- Reduce the number of OAPs for non-specialist acute care: localities plans in place to eliminate appropriate OAPs by 2020/21.
- Deliver integrated physical and mental health provision to people with SMI, in line with national ambition of 140,000 people with SMI receiving a full annual physical health check.
- Assure that service development plans are in place to meet ambition of all acute hospitals with all-age liaison services by 2020/21 and 50% meeting Core 24 service standard for adults; assurance of successful Wave 1 bidders plans.
- Increased access to IPS: ensure preparedness for IPS expansion; STP areas selected for targeted funding.

STP-Wide Gaps:

- Ensure service development plans are in place to meet ambition of all acute hospitals with all-age mental health liaison services by 2020/21.

B&NES Gap:

- There are no PICU beds and current number of local inpatient beds reduced because of environment problems with wards, which has resulted in increased Out of Area placements.

STP-Wide Actions:

- As part of the STP Parity of Esteem work, identify specific pathways that will benefit from integration of physical and mental health across the STP.
- Convene an STP wide event to examine inpatient provision and models across the STP in order to agree the STP's strategic plan to ensure value for money, local access to services, effective use of resources, and a reduction in out of area placements.
- Develop an STP wide approach to Core 24 service standard, ensuring maximum use of resources across the STP, in order to meet Core 24 requirements.
- Develop an STP wide approach to crisis avoidance and management building on the pan BSW/BNSSG STP work in progress with a wide range of partners aimed at improving the outcomes for people and organisations in relation to the use of Section 136 Places of Safety under the Mental Health Act.
- Develop an STP wide strategy for Individual Placement Support in order to prepare for targeted funding.

B&NES Action:

- Longer term plan for re-provision of local in-patient unit is on hold as a consequence of constraints on NHS capital. Mitigating actions have been taken in relation to the environment problems, pending the agreement of a longer term solution (links to the STP-wide action on in-patient provision and use of OoA placements.

Summary of Mental Health Gap Analysis (4)

BSW STP

NHS England

Suicide Prevention

Planning Guidance Deliverables: 17/18

- Reduce number of suicides compared to 2016/17 levels in line with national ambition to reduce suicides by 10% by 2020/21: delivery of local implementation support which includes action to deliver the requirement that all local areas have local multi-agency suicide prevention plans by the end of 2017.

Full FYFVMH Deliverables: 17/18

- Support learning from suicides and preventing repeat events.
- Contribute to the annual multi agency suicide prevention plans review, led by PHE.
- Participate in the Prevention Concordat programme which will support the objective that all local areas have a prevention plan in place.

STP-Wide Gaps:

- Review of Q2 2016-17 data identifying worse outcomes than England Average for: "*Hospital admissions for self-harm: age standardised rate per 100,000 – ages 10-24 and 25+*"

STP-Wide Actions:

Build on BSW collaborative approach to a number of areas of suicide prevention including:

- Improving the percentage of people receiving psychosocial assessment by mental health liaison teams following hospital attendance for self-harm.
- Learning from in-depth analysis of self-harm attendances at hospital.
- Responding to the recent ONS work on higher suicide risks in certain occupational groups, and learning from the good practice in Swindon's mindful employer work.
- Sharing insights and good practice from work on gambling in Swindon.
- Making more proactive use of online tools and Apps for self-harm and suicide prevention.
- Joint work on an STP prevention plan in response to PHE new Prevention Concordat programme with publication of guidance expected later this year (2017).

JS1

Older People & Dementia

Planning Guidance Deliverables: 17/18

- CCGs continue to work towards maintaining a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.
- Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral; with a suggested improvement of at least 5% compared to 2015/16.

Full FYFVMH Deliverables: 17/18

- Monthly reporting of diagnosis rate.
- Update dementia extract.
- Reduce variation between geographies.

STP-Wide Gaps:

- Prime Minister's challenge on dementia 2010 = by 2020, 85% of people with suspected dementia will be referred to a memory service, receive a diagnosis, and start treatment within 6 weeks.
- Clarity of plans for access to post diagnosis support.

B&NES Gap:

- DDR was 59.6% in May 17.

Swindon Gap:

- DDR was 63.12% in May 17.

STP-Wide Actions:

- Consider potential opportunities and challenges of an STP wide approach to dementia diagnosis and support.
- Each CCG to provide STP Board with assurance that a robust delivery plan in relation to DDR is in place.

B&NES Action:

- Dementia diagnosis plan to be finalised.

Swindon Action:

- Dementia diagnosis plan to be finalised.

Slide 14

JS1 Potential area of good practice to highlight on final slide.
Jane Shayler, 25/06/17

Summary of Mental Health Gap Analysis (4)

BSW STP

NHS England

Infrastructure, Finance, Workforce

Planning Guidance Deliverables: 17/18

- Ensure data quality and transparency: ensure that providers are submitting a complete accurate data return for all routine collections; development of quality and outcomes measures in line with national guidance; engage with CCQ in relation with EBTPs.
- Increase digital maturity in mental health in line with the national guidance.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.

Full FYFMH Deliverables : 17/18

- Ensure that MHSDS is delivering relevant, timely and accurate data.
- Support delivery of national payment system, CQUINs and Quality premium schemes.
- Support finance collections, including on programme lines of spend.
- Develop a new annual schedule of updates to the MHSDS will allow NHS partners to work together.
- Development of oversight and assessment frameworks.

STP-Wide Gaps:

- Recruitment and retention of the mental health workforce is a significant and growing challenge across the STP area.
- A Workforce Development plan that includes specific focus on the mental health workforce is not currently in place.

STP-Wide Actions:

- Development and delivery of an STP Workforce Development Plan with specific focus on the mental health workforce.
- Early clarification roles and responsibilities for development and delivery between the STP Workforce work stream group and the MH work stream group.

Secure Care, New Care Models and Health and Justice

Full FVFVMH Deliverables: 17/18

- Developing early stage regional plans for roll out of forensic community services.
- Deliver community based alternatives to secure inpatient services such that people requiring services receive high quality care in the least restrictive setting.
- £36 million funding to support the Secure Care objective held centrally from 2017/18, allocation to specific localities will be determined through a bidding process.
- 75% of population with access to liaison and diversion.
- Support learning from suicides and preventing repeat events.
- 6 NCM sites chosen, going live in 2017 and supporting to delivery local services.

STP-Wide Gaps:

STP-Wide Actions:

- Work with NHSE and key partners to support delivery of the Secure Care, New Care Models of Care and Health & Justice Agenda.
- Clarify BSW lead contact for this work.

Delivery of the STP 5YFV Mental Health Priorities

Children and Young People's Mental Health

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Transition from CAMHS to adult mental health services.	A	31/07/2017 for identified CQUIN milestones Flexible transitions have already been piloted in B&NES and Wiltshire.	• The Transitions out of Children and Young People's Mental Health Services (CYPMHS) CQUIN 17/18 and 18/19 will incentivise improvements to the experience and outcomes for young people. The current monthly transition meeting between AWP and OHFT is now well established • The Transitions protocol between the OHFT and AWP was refreshed in 2017 • Transitions has been agreed as a key priority across the STP, particularly around the possibility of vulnerable young people continuing to receive time limited support from CAMHS. • These "Flexible Transitions " have been incorporated into the new CAMHS model /service specification across the STP footprint. • Initial discussions have taken place about newly referred 16+ young people accessing adult mental health services , when clinically appropriate.	Cultural reluctance of adult mental health providers to accept under 18 year olds into some community and in-patient settings.	Discussions will continue at the STP Mental Health Meeting in July and the STP Mental Health Delivery Plan Workshop in August 2017.

Children and Young People's Mental Health

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Implementation of enhanced MH liaison model across the STP in all acute hospitals.	A	Quarter 1 2017/2018	• To recruit 2 senior mental health CAMHS practitioners at each of the Acute Hospitals across the STP . • This will provide extended hours CYP Liaison for ED and Acute wards. • Although there is 24/7 telephone advice and consultation from CAMHS practitioners, it is unclear whether there needs to be a 24/7 presence in each District General Hospital. This will become clearer after the extended CYP MH liaison offer is established	• Recruitment of appropriately experienced staff across the STP. • Swindon funding only recently approved • Suitable physical space near each Acute ED to accommodate new staff • Service will need to be co-located and fully integrate with Adult MH Liaison Service • The self –harm protocols at each Acute Hospital need to be reviewed and standardized. Co-ordination of clinical engagement of ED staff across the STP is challenging due to large geographical area.	• As services develop, recruitment should become easier. • Senior Practitioner at RUH is already in post and will provide operational leadership across the STP area. • Mental Health Providers are well placed to provide clinical leadership across the 3 hospitals

Children and Young People's Mental Health

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Development of an STP wide Tier 4 commissioning plan in partnership with NHSE specialised commissioning.	R	2017/2018	• To develop an STP wide collaborative commissioning plan (Tier 4) in partnership with NHSE Specialised Commissioning.	• Oxford Health FT were unsuccessful in their recent bid to co-commission Tier 4 beds across the STP and the wider region. • Due to national shortage of beds, the STP are dependent on out of area provision for specialist care e.g. secure placements.	• Due to good CAMHS Outreach Service, the number of CYP requiring access to inpatient beds and the length of stay required is always kept to a minimum.

Children & Young People's Mental Health

Area	Progress	Delivery Date	High Level Actions	Risks to delivery	Risk Mitigation
Ensure robust local and national data flows.	A	2018/2019	• Secure improved information sharing between community CAMHS and other CYP EWMH treatment services.	• Flow of data from all CCG funded CYP emotional wellbeing and mental health treatment services for Access Standard compliance is poor. • Only the local CAMHS provider is providing data flows to the national MHDS. Other 'early intervention' providers are not equipped to collect and provide the necessary data. Some operate anonymous services. • Difficulty in defining exactly which services to include in data (part funded NHS services?)	• Manual counts from smaller providers could be included in returns to NHS England • Scope and review new NHS funded services and ensure requirement to flow data is included within contracts wherever possible.

Children and Young People's Mental Health

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Increase access to community based services.	G	Quarter 1 2017/2018	• There is an excellent new Community Specialist Eating Disorder service provided across the STP which should increase timely access for cyp with suspected eating disorders • To establish effective digital advice, guidance and treatment offer to provide quicker access for cyp and families. This is being developed in preparation for the new service model becoming operational in April 2018	• None identified to date • Potential over reliance on digital offer when face to face therapeutic relationships are desired	• Careful monitoring of patient experience from 2018/2019 across the STP footprint.

Perinatal Mental Health

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Improve access to perinatal mental health services in line with expectations in MH 5YFV.	A		• Development of new perinatal mental health pathways and networks within each CCG in preparation for an STP wide bid to NHSE (A local STP bid for specialist PIMH services was submitted in May 17 but was unsuccessful.) Resubmission for Wave 2 by end of July is being supported by all 3 CCGs) • B&NES to strengthen perinatal mental health pathway and reconfirm the local strategy.	• Unsuccessful bid for wave 2 funding	• Workforce has been upskilled to identify issues and can appropriately refer to adult MH services. • There are PIHM champions who have been identified and trained to cascade awareness training which will be delivered before March 2018

Progress:

- Lead PIMH Psychologist appointed, role to develop consistent pathways and pathway interfaces across BSW, and to support specialist training to wider staff groups.
- Wiltshire PIMH network established, meeting on a quarterly basis.
- New B&NES Pathway established.

Adult Mental Health: Community, Acute and Crisis Care

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Improve the integration of physical and mental health care for people with long term conditions.	A	September 2017	Following an initial scoping exercise, which identified a) medically unexplained symptoms; and b) pain management as areas that are evidenced to benefit from an integrated approach, undertake a detailed assessment of the specific pathways to focus STP-wide efforts on.	Areas of work not specified in enough detail.	Development of further detailed understanding of the areas of opportunity, including through the ongoing oversight of mental health work stream and at the planned MH Delivery Plan workshop on 17/08/2017.
Improve the integration of physical and mental health care for people with long term conditions and the physical care of people with SMI.	A	September 2017	Identification of specific LTC pathways to include ways of improving the physical health of people with SMI and agreement by STP Leadership Group that these will be the areas of focus for a pan-STP action plan.	Areas of work not specified in enough detail.	Development of further detailed understanding of the areas of opportunity, including through the ongoing oversight of mental health work stream and at the planned MH Delivery Plan workshop on 17/08/2017.

Progress:
Public Health Registrar working with PH Consultant to undertake a detailed assessment, including research and interviews.

Future actions:
Establishment of group to develop and implement STP wide action plan to improve the integration of physical and mental health care in relation to the agreed LTC pathways.

Adult Mental Health: Community, Acute and Crisis Care

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Improve access to local in-patient services and reduction in Out of Area Placements ensuring value for money and effective use of STP resources.	A This work is yet to be scoped	October 2017	Undertake initial mapping exercise to understand current provision and models and associated funding and resources.	Capacity to undertake the mapping exercise.	Agree scope and process for mapping exercise through the mental health work stream group and progression at the 17/08/17 MH Delivery Plan workshop.
Improve access to local in-patient services and reduction in OOA placement ensuring VFM & effective use of STP resources.	A	December 2017	Hold an STP wide event to examine inpatient provision and models across the STP area, explore options and agree next steps.	Options will be constrained by challenges in respect of revenue and capital funding, workforce and estate. Also by the geography of the BSW STP footprint.	Agreement of scope of work at MH workshop on 17/08/17 to inform dedicated STP system-wide event.

Adult Mental Health: Community, Acute and Crisis Care

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Develop an STP wide approach to Core 24 service standard, ensuring maximum use of resources across the STP, in order to meet Core 24 requirements.	A	November 2017 January 2018	Review previous STP bid prepared as part of the Transformation Funding process and identify areas that can be progressed jointly across the STP footprint. Develop an implementation plan with providers which ensures maximum use of resources .	Financial constraints if additional funding is required.	

Adult Mental Health: Community, Acute and Crisis Care

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Develop an STP wide approach to crisis avoidance and management building on the pan BSW/BNSSG STP work in progress with a wide range of partners aimed at improving the outcomes for people and organisations in relation to the use of Section 136 Places of Safety under the Mental Health Act.	A	January 2018	Following completion of the Phase 4 S136 work, assess whether there is further scope to take actions across the STP footprint which would assist with crisis avoidance and management.	Some actions may need to be wider than STP footprint.	Governance structure in place for pan-BSW/BNSSG S136 pathway work, with programme management provided by AWP.

Adult Mental Health: Community, Acute and Crisis Care

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Develop an STP wide strategy for Individual Placement Support in order to prepare for targeted funding.		December 2017	Review the different models used in each CCG/Council area and identify areas for learning and improvement.	Capacity	Agreement of scope of work through the MH Work stream group.

Adult Mental Health: Community, Acute and Crisis Care

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Percentage of people experiencing a first episode in psychosis treated with a NICE approved care package within two weeks of referral (50%).	G	June 2017	Already being delivered.		

Adult Mental Health: IAPT

Area	Progress	Delivery Date	B&NES Actions	Swindon Actions	Wiltshire Actions
Expand the integration of physical and mental health care via increasing IAPT services to people with long term conditions.	G	June 2017	• Recruitment to backfill experienced staff who will provide the LTC IAPT interventions. • Training of IAPT staff including IAPT courses, and LTC CPD.	• Recruitment to backfill experienced staff who will provide the LTC IAPT interventions supported by successful Early Implementers Expansion Bid. • Training of IAPT staff including IAPT courses, and LTC CPD.	• Recruitment to backfill experienced staff who will provide the LTC IAPT interventions. • Training of IAPT staff including IAPT courses, and LTC CPD.
Across STP link IAPT and commissioned services, in order to ensure people have increased opportunity to access and retain employment.	A	October 2017.	• Development of effective LTC IAPT pathways, with a strong interface with PH providers. • Development of collaborative working with LTC community and acute provision. • Establish IAPT representation at key stakeholder meetings i.e. Diabetes Programme board. • Employment Advisors being recruited to be part of IAPT service.	• Development of effective LTC IAPT pathways, with a strong interface with PH providers. • Development of collaborative working with LTC community and acute provision • Identification of further primary care clinic space to enable colocation with GPs + community-based opportunities. • 3 Employment Advisors & 1 Senior Employment Advisor being recruited to be part of IAPT service, supported by MOU between SCCG, IAPT & NHSE.	• Development of effective LTC IAPT pathways, with a strong interface with PH providers. • Development of collaborative working with LTC community and acute provision. • Identification of further primary care clinic space to enable colocation with GPs. • Establish IAPT representation at key stakeholder meetings i.e. Diabetes Programme board.

Suicide Prevention

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Reduce number of suicides compared to 2016/17 levels in line with national ambition to reduce suicides by 10% in 2020/21. All local areas have multi-agency suicide prevention plans by the end of 2017.	G	In place (June 2017)	Each STP CCG area has a multi-agency suicide prevention strategies in place with associated action plans.	Plans will be in place and actions implemented though it is not possible to guarantee these will lead to a reduced suicide rate in our population	
Support learning from suicides and preventing repeat events	G	In place (June 2017)	Each STP CCG area obtains data from local Coroner's Office to learn from deaths and applies learning through local action plans.	Swindon and Wiltshire aim to further develop the relationship with local Coroner's Office.	
Contribute to the annual multi agency suicide prevention plans review, led by PHE	G	Awaited from PHE	When the annual review is carried out we will participate fully in the self-assessment exercise.		
Participate in the Prevention Concordat programme which will support the objective that all local areas have a prevention plan in place	A	Guidance awaited from PHE	STP areas will review local progress against the guidance when published and formulate plans required to meet any significant gaps	Management capacity and lack of project resource may hamper the delivery of any new partnerships or projects	Raise awareness at Health and Wellbeing Boards of importance of this work and seek support for delivery from wider partners

Older People & Dementia

Area	Progress	Delivery Date	B&NES Actions	Swindon Actions	Wiltshire Actions
Improve Dementia Diagnosis Rate (DDR).	A	June 17	Finalise and submit dementia diagnosis delivery plan. Submitted in June – complete.	Finalise and submit dementia diagnosis delivery plan. Submitted in June – complete.	Finalise and submit dementia diagnosis delivery plan. Submitted in June – complete.
Increase access to post diagnosis support for dementia.	A	March 18	With Swindon and Wiltshire, explore opportunities and challenges of an STP-wide approach to post diagnosis support.		

Secure Care, New Care Models and Health and Justice

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Work with NHSE and key partners to support delivery of the Secure Care, New Care Models of Care and Health & Justice Agenda.		August 2017.	Identify lead for BSW to link with NHSE and represent BSW in this developing agenda.	Capacity to undertake work.	Agreement of BSW lead via MH work stream group/STP Leadership Group.

Infrastructure, Finance & Workforce

Area	Progress	Delivery Date	High level actions	Risks to delivery	Risk Mitigation
Development and delivery of a mental health workforce development plan.	R	July 17	Clarify roles and responsibilities for development and delivery between the STP Workforce work stream group and MH work stream group.	Capacity & workforce planning expertise.	STP Workforce work stream in place, lead by AWP Chief Executive
Development and delivery of mental health workforce development plan	R	Sep 17	Identification and agreement of priority areas of focus and action for STP-wide mental health workforce development.		Development of further detail of scope, priorities and actions at MH Delivery Plan workshop on 17/08/17.
Data Quality	R	Sep 17	STP work stream to receive exception reports on data quality to ensure that all providers in STP footprint submit data to NHS Digital.	Provider continue to use different data systems.	Additional scrutiny of MH work stream.

MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**06/09/2017**
TYPE	**An open public item**

Report summary table	
Report title	Better Care Fund Plan 2017-2019
Report author	Caroline Holmes – Senior Commissioning Manager – Better Care Jane Shayler, Director, Integrated Health and Care Commissioning Rebecca Paillin, Strategic Business Partner, Finance and Commissioning Jo Galloway, Performance Manager
List of attachments	Better Care Fund Narrative Plan 2017-2019 Appendix 1: 2016-2017 Performance Dashboard Appendix 2: 2017-2019 BCF Scheme Plans Appendix 3: 2017-2019 Finance Dashboard Appendix 4: 2017-2019 Summary of Funding Contributions and Schemes Appendix 5: 2017-2019 Impact of Schemes on National Metrics Appendix 6: Risk Register Appendix 7: DTOC Action Plan
Background papers	Report to the Health and Wellbeing Board and BCF Submission 2016-2017. http://moderngov/documents/s41020/Better%20Care%20Fund%20Plan%20Update.pdf
Summary	The B&NES Better Care Plan describes how the BCF is being used as an enabler for the integration of services and also the journey towards further integration with a focus on prevention. The first plan was published in 2014, followed by a revised plan in 2016/17. The later plan specifically referenced the *your care your way* community services review and the vision and priorities for our people and communities. The 2017/18 -2018/19 BCF Plan builds on this whilst also setting out how new conditions will be met, including those for Improved Better Care Fund (iBCF) adult social care grant funding. The Improved Better Care Fund (iBCF) Policy Framework was published in April 2017 and this was followed by the policy framework and technical guidance published by NHS England (NHSE) for the Better Care Fund in July 2017. The Better Care Fund plan attached to this report sets out the vision for integrated services in B&NES up to 2020 and how the Improved Better Care Fund grant monies (iBCF) will be utilised to support the Better Care Fund plan. The plan is due to be submitted to NHS England on 11th September 2017 as part of the assurance process for 2017-2019. Agreement is sought to delegate final sign off, as in previous years, to the Co-Chairs of the Health and Wellbeing Board, the final submission, following feedback received at the Board today.

Recommendations	The Board is asked: • To provide feedback on the BCF narrative plan and appendices 1-7 2017-19 • To approve the proposed utilisation of the BCF funds 201719 and also the utilisation of iBCF grant monies • To approve the DTOC action plan attached at appendix seven To delegate to the Co-Chairs of the Health and Wellbeing Board formal sign off of the final submission on 11th September 2017.
Rationale for recommendations	The Better Care Fund is a key enabler of the national and local vision of integrated health and care services. In B&NES, the journey towards closer integration is set out within the *your care your way* programme. *Your care, your way* was introduced in the BCF plan 2016-17 and the 2017-19 Better Care Fund (BCF) Plan and associated pooled budget will incorporate all of the care and health services procured under *your care your way*. The inclusion of the full range of *your care your way* services in the BCF Plan and pooled budget consolidates the commitment to invest in preventative services and further develop integrated services which is a key requirement of the BCF. This local vision is aligned with and makes a significant contribution to delivery of the outcomes in the Joint Health and Wellbeing Strategy as follows: Theme One - Helping people to stay healthy: • Reduced rates of alcohol misuse; • Creating healthy and sustainable places. Theme Two – Improving the quality of people's lives: • Improved support for people with long term health conditions; • Reduced rates of mental ill-health; • Enhanced quality of life for people with dementia; • Improved services for older people which support and encourage independent living and dying well. Theme Three – Creating fairer life chances: • Improve skills, education and employment; • Reduce the health and wellbeing consequences of domestic abuse; • Increase the resilience of people and communities including action on loneliness. A requirement of NHS England is that the plans for investing the 2017-19 BCF must be agreed by the Health and Wellbeing Board, which will then have strategic oversight of the delivery of those plans.

Resource implications	The Fund has grown in 2017-18 (year one of this two year plan) to incorporate the Virgin Care community services contract. This means it has grown from £13.5m in 2016-17 to £61.1m in 2017-18. The Fund confirms the protection of adult social care funding and also includes a risk share agreement, should non-elective admissions not be reduced by the schemes in the Plan. The value of this risk share in 2017-18 is £549,660. This plan also sees the incorporation of the new three year non-recurring Improved Better Care Fund (iBCF) adult social care grant funding. The value of this for 2017-18 is £3.428m.
Statutory considerations and basis for proposal	This report responds to the technical and planning guidance published on 4th July 2017. In order to draw down the maximum B&NES' BCF allocation, it is necessary for BCF plans and proposals to comply with this guidance.
Consultation	The local vision for integrated care and support and associated plans have been developed under the banner *your care, your way* through engagement and consultation with our community and a broad range of partners, including representatives from: provider organisations; primary care; VCSE (Voluntary, Community and Social Enterprise) sector organisations; Healthwatch B&NES; the Health and Wellbeing Board; the CCG, and the Council. IBCF proposals (section 11 of the main BCF narrative plan) reflect the priorities of B&NES Accident & Emergency Delivery Board. These proposals have been considered and supported by B&NES Joint Commissioning Committee. The Council Section 151 Officer and Monitoring Officer have been consulted in the preparation of this report.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

THE REPORT

1 SUMMARY AND INTRODUCTION

1.1 This report summarises key elements of the attached draft Better Care Fund plan 2017-19 which will be submitted to NHS England on 11th September 2017. The plan consists of an overall narrative plan and seven appendices which are as follows:

Appendix 1: 2017-19 Performance Dashboard

Appendix 2: 2017-19 BCF Scheme Plans

Appendix 3: 2017-19 Finance Dashboard

Appendix 4: 2017-19 Summary of Funding Contributions and Schemes

Appendix 5: 2017-19 Impact of Schemes on National Metrics

Appendix 6: Risk Register

Appendix 7: DTOC Action Plan

1.2 The Government is clear within the Better Care Fund Policy Framework for 2017-19 that people need health, social care, housing and other public services to work seamlessly together to delivery better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

1.3 In B&NES, the journey towards closer integration is set out within the *your care your way* programme. *Your care, your way* was introduced in the BCF plan 2016-17 and the 2017-19 Better Care Fund (BCF) Plan and associated pooled budget will incorporate all of the care and health services procured under *your care your way* under the Virgin Care community services contract. The inclusion of the full range of *your care your way* services in the BCF Plan and pooled budget consolidates the commitment to invest in preventative services and further develop integrated services which is a key requirement of the BCF.

1.4 In terms of the wider strategic agenda, next steps on the NHS Five Year Forward View (5YFV) published March 2017 acknowledges that the way STPs (Sustainability and Transformation Partnerships) work will vary according to the needs of different parts of the country. The key point is that place-based health and care systems should be defined and assessed primarily by how they practically tackle their shared local health, quality and efficiency challenges. The government does *"not want to be overly prescriptive about organisational form"*. Increasingly Accountable Care Systems are being referenced as a more flexible way of bring together a wide range of partners, including not only public sector organisations but those from the Voluntary, Community, Social Enterprise and independent sectors. It is this approach, that most closely aligns with B&NES' vision and the Health and Wellbeing Board's draft Statement of Intent.

2 THE 2017-19 INTEGRATION AND BETTER CARE FUND GRANT ALLOCATIONS POLICY FRAMEWORK

2.1 The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding and includes a new injection of grant funding for adult social care announced in the Spending Review 2015 and Spring Budget 2017 known as the Improved Better Care Fund (iBCF). The policy framework for the Fund covers two financial years.

2.2 National total amounts of adult social care grant funding announced in the Spending Review 2015 (one-off grant for 2017/18) and Spring Budget 2017 (3-years grant funding covering the period 2017/18-2019/20) are £1.115bn in 2017/18 and £1.499bn in 2018/19.

2.3 For B&NES the figures are as follows:

- 2017/18 - £3.428m*
- 2018/19 - £2.063m
- 2019/20 - £1.028m

*Total Grant allocation comprising £2.698 iBCF announced in Spring Budget and one-off £730k Adult Social Care Support Grant announced in the Spending Review 2015 but not confirmed until December 2016.

2.4 Nationally, the total amount of Better Care Fund and iBCF funding amounts to £5.128bn for 2017/18 and £5.616bn for 2018/19. B&NES has chosen to pool more BCF funding than is required, by including the services commissioned under *your care your way,* within the Virgin Care Community Services contract. As a consequence, B&NES BCF pooled budget will increase from £13.4m in 2016/17 to £61.1m in 2017/18. The BCF Plan for 2017/18-2018/19 reflects this extension of services funding from the BCF pooled budget. This is explained in section 8 of the narrative plan.

2.5 Conditions of Access to the Better Care Fund

For 2017-19, NHS England set the following conditions within the technical and planning guidance published in July 2017:

- Plans must be jointly agreed;
- The NHS contribution to adult social care is maintained in line with inflation;
- There is agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care; and
- There is a requirement to manage transfers of care between services and settings.

Sections 6 and 7 of the narrative plan outline how the BCF Plan and the iBCF grant monies intend to support these national conditions.

2.6 Measuring Success

Beyond the four national conditions set out above, areas are given flexibility on how the Fund is spent over health, care and housing schemes or services. However, the spending needs to demonstrate how it will improve performance against the four national metrics which are:

- Delayed transfers of care
- Non-elective admissions to hospital
- Admissions to residential and nursing homes
- The effectiveness of reablement.

These metrics and how we have performed against them this year are explained more in section 3 of the narrative plan.

2.7 The Improved Better Care Fund (iBCF)

Guidance on the use of new iBCF adult social care grant funding was released in April 2017 and included within the technical guidance for the BCF published in July 2017. Section 4.3 of the narrative plan sets out how the iBCF monies have been allocated in B&NES. Key requirements are:

- Grant paid to a local authority may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

- A recipient local authority must:
    a) Pool the grant funding into the BCF; and
    b) Work with the relevant CCG and providers to meet the National Condition 4 (Managing Transfers of Care) in the Policy Framework and Planning Requirements for 2017-19); and
    c) Provide quarterly reports as required by the Secretary of State.

- The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities have therefore been able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

2.8 High Impact Change Model and Managing Transfers of Care

BCF and iBCF Conditions both make explicit reference to the implementation of the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care from hospital. Section 7.4 of the narrative plan explains how B&NES is meeting the fourth national condition of the BCF on managing transfers of care and in particular, how we are meeting the requirements of the High Impact Change Model requirements.

The High Impact Change Model sets out eight high impact changes that can support local health and care systems reduce delayed transfers of care (DTOC):

- Change 1: Early Discharge Planning.
- Change 2: Systems to Monitor Patient Flow.

- Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector.
- Change 4: Home First/Discharge to Assess.
- Change 5: Seven-Day Service.
- Change 6: Trusted Assessors.
- Change 7: Focus on Choice.
- Change 8: Enhancing Health in Care Homes.

The B&NES DTOC Action Plan has also been written to respond to each High Impact Change and this is attached at appendix 7 of the Better Care Fund plan.

As part of this year's plan, B&NES has been asked to submit a number of trajectories for delayed transfers of care, estimating reductions by September 2017 and March 2018. We have been asked to plan reductions to 3.5% of all bed days for the RUH and to reduce DTOC days by 5.45% for the community hospitals. We have also been asked to reduce social care delays by two thirds compared to 2016-17. To help set trajectories in B&NES, the impact of schemes such as reablement and Home First have been assessed and estimated to help plan the reductions. Planned reductions have been tested with members of the multi-agency DTOC Action Group which monitors DTOCs and works to implement the Action Plan.

Current performance against DTOCs will be used to assure the plan when it is submitted to NHS England in September. The CCG and Council are currently assessing this as a risk against assurance for the plan, although feedback from NHS England confirms that the impact of DTOCs on the assurance process has not been fully clarified yet.

2.9 National Performance Metrics

As in 2015-16 and 2016-17, local areas are asked to agree and report metrics in the following four areas:

- Delayed transfers of care from hospital;
- Non-elective admissions in acute hospitals (using the same metric which is agreed in the CCG's Operational Plan);
- Admissions of older people (65+) to residential and care homes; and
- The effectiveness of reablement.

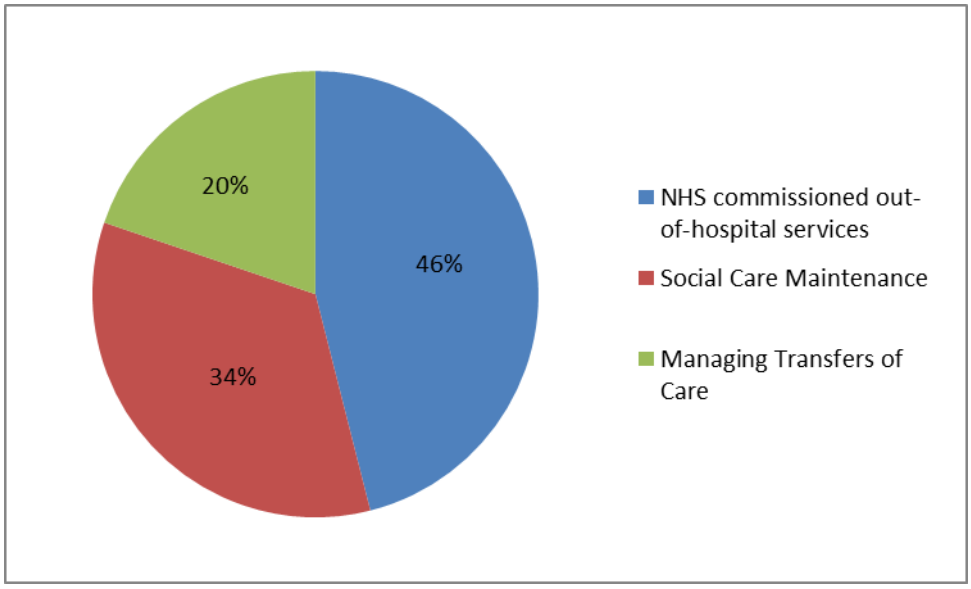
The 2016-17 performance dashboard is attached at appendix 1 of the narrative plan for information. Section 11 of the narrative plan sets out the B&NES proposals against each metric with a review of previous performance and how each scheme will impact on the 4 metrics. Section 11 also explains how B&NES is setting three local metrics which are as follows:

- Number of live in care packages (which monitors whether B&NES is offering people support in proportion to their needs)
- Volume of community equipment provided which helps to monitor all spend that supports people to stay at home, not just directly provided care.
- Length of stay in community hospitals which will help support patient flow through the community.

Appendix 5 also sets out how each BCF scheme impacts on the four national metrics.

3 B&NES 2017/18-2018/19 PLAN SCHEMES

3.1 For this year's plan, we highlight and focus on a number of existing schemes (including social prescribing, falls response and reablement) and also introduce new schemes funded by the Improved Better Care Fund. Some existing schemes already funded by the BCF have grown in priority, for example, Community Equipment are, therefore, also an area of focus. These are explained in section 4 of the narrative plan, and scheme plans setting out objectives, milestones, performance indicators and spending plans are also attached at appendix 2 of the narrative plan. Each scheme identifies which national metric it will support and the pie chart below at shows the split of the national metrics across these key schemes.



4 FINANCIAL IMPLICATIONS

4.1 Funding allocations

Section 8 of the narrative plan gives an overview of the funding contributions within the plan. The table below sets out the planned contributions for the Better Care Fund together with the previous year's figures for comparison. The first four rows are the CCG's contribution with the remaining figures being the Council's investment. The total funding by scheme is shown at appendix 4 of the narrative plan.

Section 8 also confirms the maintenance of funding for social care and the allocation of the iBCF grant monies.

Funding Source	16/17 £	17/18 £	18/19 £
Section 75 Transfers CCG To Council	£8,460,000	£8,611,434	£8,775,051
CCG NHS Commissioned Out of Hospital Services	£2,008,000	£2,043,943	£2,082,778
BCF Risk Share Contingency	£539,994	£549,660	£560,103
YCYW	£0	£24,182,014	£24,182,014
Disabilities Facilities Grant Capital	£991,000	£1,084,352	£1,084,352
Local Authority Grant	£0	£50,000	£0
Care Act Council Revenue	£1,500,000	£1,500,000	£1,500,000
IBCF	£0	£3,457,987	£2,063,000
YCYW	£0	£19,668,842	£19,668,842
Total	**£13,498,994**	**£61,148,233**	**£59,916,141**

The proposed funding has been included in both the plans and budgets of both the Council and CCG for the year 2017-19. These plans have been through the governance processes of both organisations as laid out in section 9 of the narrative plan and have been signed off by the CCG's Board and the cabinet of the Council.

The section 75 agreement has been written to cover the inclusion of the *your care,your way* community services provision and the funding mapped to individual service level documents. The use of the BCF funding is to be agreed by both the Council Section 151 officer and CCG Chief Financial Officer to give transparency on the use of funds for both organisations.

5 SUBMISSION OF PLANS AND APPROVAL PROCESS

5.1 Technical and planning guidance for the BCF and the final version of the policy framework was published in July 2017. This set out a single stage of assurance with submission on 11th September 2017. Those plans deemed to meet the requirements of the policy framework will be put forward for approval. Plans rated "approved with conditions" will be given permission to enter into Section 75 agreements on condition that an outstanding requirements are met by the date specified in the notification.

5.2 Plans will be assured by a regional process between NHS England and Local Government representatives.

5.3 The B&NES plan was submitted in draft to NHS England on 13th August 2017, and following feedback given on 22nd August, a number of small changes will be made to the plan before its final submission on 11th September 2017. Feedback from the NHS England lead was positive, confirming that only minor adaptations need to be made to the plan. Comments and input from members of the Health and Wellbeing Board are welcomed and can be incorporated into the plan before submission on 11th September 2017.

5.4 The performance of DTOCs will be taken into account when assuring the plan. This presents a moderate risk to B&NES as DTOCs have been higher than planned in July and August, triggering additional actions across agencies to speed up delays as much as possible. Final details on the impact of the DTOC position on the assurance process have not been confirmed yet – this is likely to be communicated in early September and a verbal update will be provided to the Health and Wellbeing Board.

5.5 As the final submission will be made on 11th September, agreement is therefore sought to delegate, as in previous years, to the Co-Chairs of Health and Wellbeing Board to sign off the final detailed submission.

Please contact the report author if you need to access this report in an alternative format

Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Bath and North East Somerset Better Care Fund

2017-2019

Narrative Plan

Contents

Introduction / Foreword

Bath and North East Somerset Council and Clinical Commissioning Group (B&NES) are proud to present the third Better Care Fund plan, following on from the 2014 and 2016 plans. This plan, in line with national guidance, covers 2 years from 2017-2019 and is the next chapter in the story of integration in B&NES which documents the process of the new integrated community services model following the *your care your way* review.

Because all of the services under *your care your way* are now included in the Better Care Fund pooled budget, the fund has increased from £13.5m to £61.1m. This is explained in more detail at section 5, including a narrative to understand the transition from the 2016 plan to 2017-19 plans.

This Better Care Fund plan builds on the progress made and lessons learnt locally from the 2014 and 2016 plans. It also incorporates and supports the national strategic direction to deliver integrated services which recognise the need to deliver change across the whole health, care and community system of services.

The use of the Better Care Fund and Improved Better Care Fund and the new schemes being implemented as a result of this investment are outlined at section 4 with scheme plans setting out objectives, milestones, investment and performance indicators attached at appendix 2. Existing high profile schemes also benefit from an updated scheme plan and financial dashboard to monitor their progress and provide additional scrutiny of performance. The content of the plan has been developed through an ongoing review of existing schemes and input from a range of partners on the A&E Delivery Board and the Health and Wellbeing Board which includes partner organisations and third sector colleagues.

The plan was signed off at the B&NES Health and Wellbeing Board on 6th September 2017 and by the Council and CCG Joint Commissioning Committee on 24th August 2017.

1. What is the local vision and approach for health and social care integration?

In B&NES, the journey towards closer integration is set out within the *your care your way* programme, our 2 year review and redesign of community health and care services. *Your care, your way* was introduced in the BCF plan 2016-17. The 2017-19 Better Care Fund (BCF) Plan and associated pooled budget will incorporate all of the care and health services procured under *your care your way*. The inclusion of the full range of *your care your way* services in the BCF Plan and the pooling of associated budgets consolidates the commitment to invest in preventative services and to further develop integrated services with a prime provider, Virgin Care, whose contract commenced in April 2017. The full business case for *your care your way,* including the detailed development of the vision and commissioning model can be found at www.yourcareyourway.org. The full business case sets out the needs of our population including the latest information from the Joint Strategic Needs Assessment (JSNA).

The new service model set out in *your care your way* focuses on the priorities identified by local people, whilst shifting care out of hospital and delivering effective and efficient services in the community. This aligns completely with the BCF Plan aims of reducing non-elective admissions to hospital, investing in out of hospital services and focusing on preventative services. It demonstrates why the BCF Plan is the natural vehicle to host the services included within *your care, your way*. £2.9m of existing BCF schemes are shown in Appendix 4 - Summary of Funding Contributions and Schemes – which, because of their nature already fall within the scope of the new contract. These include reablement, 7 day working, support for carers and social prescribing.

Key initiatives in the Better Care Fund Plan relate to implementation of the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care. The High Impact Change Model sets out eight high impact changes that can support local health and care systems reduce delayed transfers of care:

- Change 1: Early Discharge Planning.
- Change 2: Systems to Monitor Patient Flow.
- Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector.
- Change 4: Home First/Discharge to Assess.
- Change 5: Seven-Day Service.
- Change 6: Trusted Assessors.
- Change 7: Focus on Choice.
- Change 8: Enhancing Health in Care Homes.

Home First (also known as discharge to assess) has been identified as a key priority by the BaNES A&E Delivery Board to improve patient flow and reduce delayed transfers of care within B&NES and help the system regain four-hour performance. Home First is based upon the principle that it is aimed, where safe, for all patients to be discharged home. Here health and social care assessments can be undertaken in the most appropriate environment for the patient to assess their long term needs. If patients are unable to return home then temporary options need to exist to allow assessments to be undertaken in an environment which will meet their current need. The pathways for Home First/Discharge to Assess have been the subject of significant work across the system and, as part of this work specific Home First schemes are included in the Better Care Fund Plan (see Section 7 for further detail).

There is also a commitment by the Health and Wellbeing Board to move beyond the integration of health and social care bringing together a wide range of partners to influence the wider determinants of health including housing, education, regeneration and economic development and, perhaps most importantly, build on the assets of our people and communities.

We used the results of the *your care, your way* consultation to define the new service model and the prime provider contract and agree with Virgin Care the outcomes they will deliver and against which our community will measure the success. These are summarised below:

- People told us they want more care closer to home. Virgin Care will organise services around GP practices to provide people with access to a wider range of health and care professionals in their local community.

- People told us they want to be seen as people, not conditions. Virgin Care will place equal importance on mental and physical health, taking into account people's lives, interests and preferences to provider more holistic and personalised support.

- People told us that the separation between different services can make it harder to get the right support. Virgin Care will set up a Care Co-ordination Centre so people only need to make one call to access all the services that can help them.

- People told us they only want to tell their story once. Virgin Care has tried and tested technology that will join up health and social care records so that everyone involved in a person's care has access to the information they need.

- People told us that waiting for something to go wrong before they get the right support doesn't make sense. Virgin Care will support people to take control of their health and wellbeing to prevent ill health and reduce the amount of time people spend in hospital.

- Health and care services across the country are facing a period of unprecedented challenge. The demand for health and care services is rising relentlessly as people are living longer with multiple complex conditions.

- The selection of Virgin Care as our Prime Provider for community services marks the beginning of an essential and exciting transformation of the way we think about health and wellbeing in B&NES.

By rethinking the way we deliver health and care services across Bath and North East Somerset, we believe we can reengineer the system, building on the *your care, your way* precedent, to secure better outcomes as shown above and a more sustainable system for the future. This will include:

- An increased emphasis on prevention, early intervention and empowering individuals to be more independent;

- A further shift of investment from acute and specialist health services to support investment in community-focused provision; and

- Exploration by commissioners and providers of new approaches to sharing resources, including knowledge and expertise, where there are demonstrable benefits in doing so.

This local vision is aligned with and makes a significant contribution to delivery of the outcomes in the Joint Health and Wellbeing Strategy as follows:

Theme One - Helping people to stay healthy:

- Reduced rates of alcohol misuse;
- Creating healthy and sustainable places.

Theme Two – Improving the quality of people's lives:

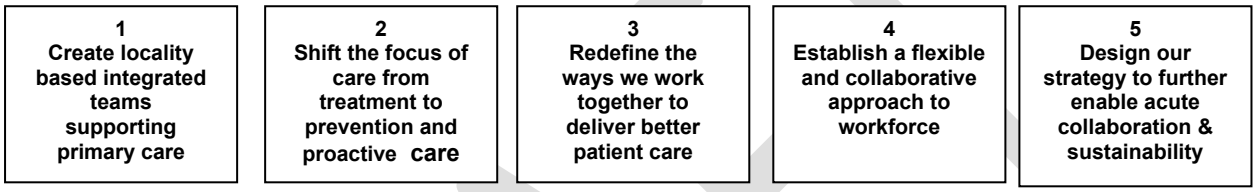
- Improved support for people with long term health conditions;
- Reduced rates of mental ill-health;
- Enhanced quality of life for people with dementia;
- Improved services for older people which support and encourage independent living and dying well.

Theme Three – Creating fairer life chances:

- Improve skills, education and employment;
- Reduce the health and wellbeing consequences of domestic abuse;
- Increase the resilience of people and communities including action on loneliness.

The B&NES Better Care Fund Plan carries forward elements of the B&NES, Swindon, Wiltshire (BSW) Sustainability and Transformation Plan (STP) which has established 5 key priorities that are set out below at Figure 1: In particular, the priority to focus on prevention, create locality based integrated teams and focus on workforce and capacity issues such as the domiciliary care workforce and care home capacity are strong themes running through the local BCF as well. The BCF Plan also complements the STP Urgent and Emergency Care Delivery Plan, particularly the national priority on hospital to home services. In B&NES the focus to meet this priority is through the Home First initiative, which is being expanded using iBCF monies. More information on the Home First initiative is in appendix 2.

Figure 1 STP Key priorities



The BCF Plan also aligns with BSW STP Mental Health Delivery Plan with priority actions reflecting the Mental Health Five Year Forward View and including improving transition from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services; expanding the integration of physical and mental health care services via increasing access to psychological therapy services to people with long term conditions; and developing an STP wide approach to crisis avoidance and management.

Further work is underway currently to develop plans for an Accountable Care System within B&NES in preparation for 2020. Plans are at an early stage but fully reflect the priority to focus on place based commissioning set out within the Five Year Forward View.

The Better Care Fund plan 2017-19 was approved by the Joint Commissioning Committee on 24th August 2017 and signed off by the Health and Wellbeing Board on 6th September 2017. More information on the governance process is at section 9.

2. Background and context to the plan

2.1 Current state of the health and adult social care market

The health and social care system in B&NES is facing a challenging time. The population is ageing, the prevalence of long term conditions is increasing and the demand for health and social care services is growing. At the same time the aspirations and needs of the community are also changing as people expect more personalised services and more choice and control over how their individual needs are met.

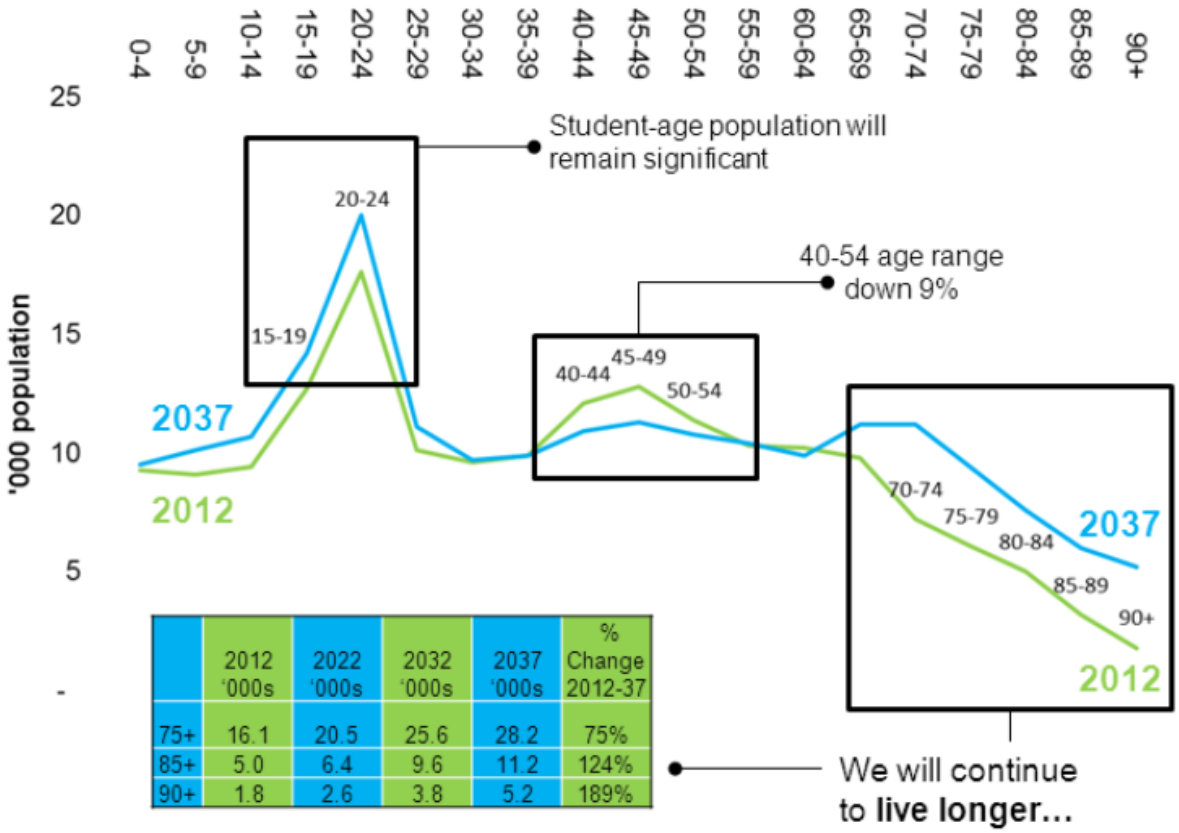
The current financial climate also places a greater imperative on the CCG and the Council to develop models of care within available resources that are both robust and sufficiently flexible to be responsive to changing needs, aspirations and technological advances over the next decade and beyond.

Within this climate, the care market in B&NES is also facing a number of challenges, which are reflective of those being faced across the country. This includes the recruitment and retention of adequate numbers of appropriately skilled, experienced staff (including nurses for nursing homes). Costs associated with recruiting and retaining staff has been a key factor in the closure of care homes with a loss of 170 beds in B&NES in the last 18 months. This equates to a 12% decrease in beds although 139 replacements beds will be in place by the end of 2017 with these including an increase of high-dependency residential care beds and complex dementia nursing care beds.

2.2 The needs of our population

As defined in Figure 2 below the Joint Strategic Needs Assessment (JSNA) indicates that there will be a 12% rise in the population to 199,100 by 2037 with the number of over 75 year olds set to increase by 75%.

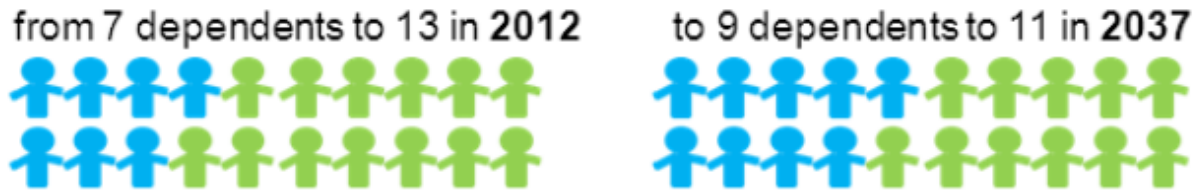
Figure 2: B&NES Population Projections



	2012 '000s	2022 '000s	2032 '000s	2037 '000s	% Change 2012-37
75+	16.1	20.5	25.6	28.2	75%
85+	5.0	6.4	9.6	11.2	124%
90+	1.8	2.6	3.8	5.2	189%

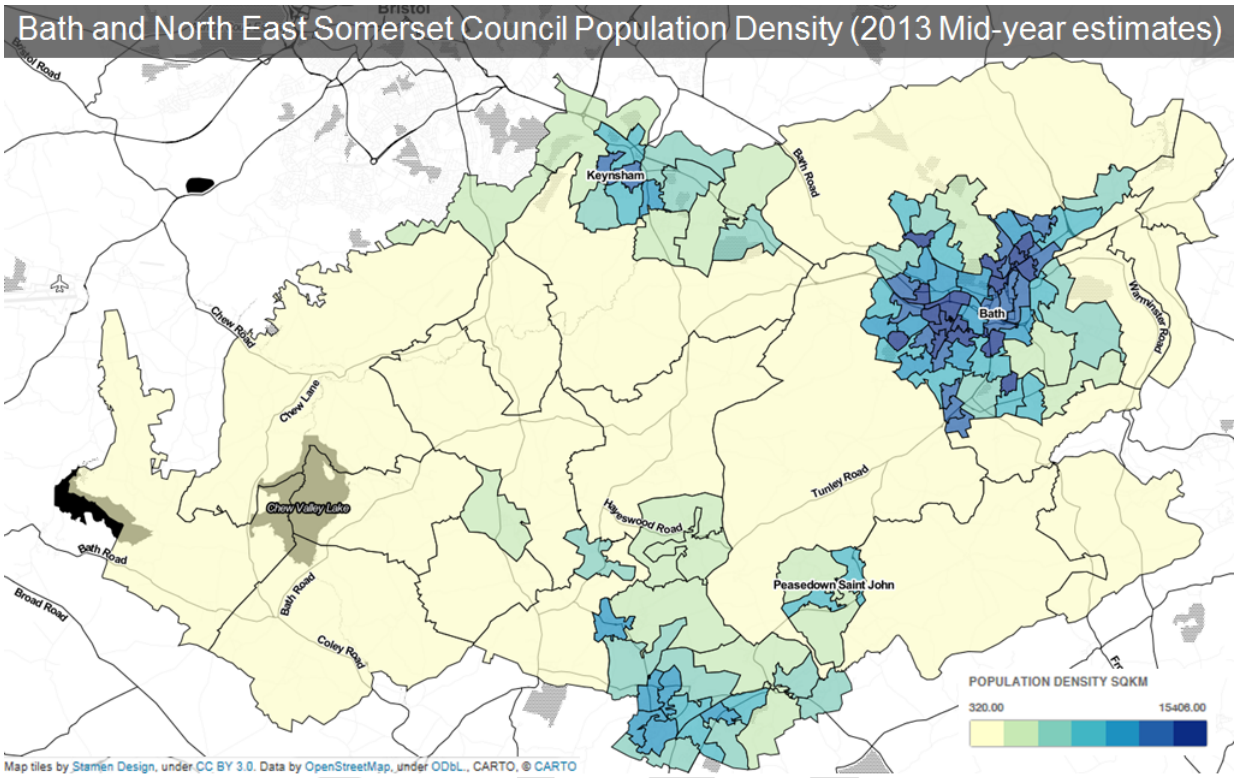
The dependency ratio of those aged 0 to 15 and 65+ when compared agsinst the working age populations is also set to increase, from a current ratio of 1:2 to 1:1 by 2037 as shown in Figure 3 below.

Figure 3: Dependency Ratio



B&NES also has a significantly higher proportion of residents (10%) aged 20-24 than nationally (7%), this can be attributed to the high student population. There are also substantial variations in population density within the B&NES area. Figure 4 demonstrates the distribution across the area.

Figure 4: Population Density



Rural communities have experienced significant social change over the last couple of decades and 14% of the local population live in dispersed rural areas or villages, this compares to 10% for England as a whole and 20% for the South West. Very often villages do not offer adequate services for the local community to access, which forces people to travel out of their community to access services such as doctor's surgeries, schools, shops and post offices. For many, private transport, either a car or taxi, is the only way of accessing these services. The increased costs of accessing services together with the increased costs of housing has led to rural living becoming less and less affordable, and for some completely unaffordable. This is particularly a problem for older people, families with young children and young people. Analysis of some of the lowest-income households in B&NES suggests that between 8% (Chew Valley South) and 18% (Bathavon West) of residents in wards outside the city of Bath and the market towns are in receipt of income-related support or tax credits.

For children and young people evidence suggests that 12% of children in B&NES live in poverty, with 34% in Twerton, 25% in Southdown and 21% in Radstock.

With regards to people with multiple needs; it is estimated that 50% of the population will suffer from two or more chronic conditions by the age of 60, with 80% of those over 85 years suffering from two chronic conditions (and 45% of people having four or more conditions). These increased levels of co-morbidity represent a greater challenge to providing safe high quality healthcare. People will be also be frailer.

Frailty is a measure of three or more symptoms from weight loss, self-reported exhaustion, low energy, slow gait speed and weak grip strength.

The new model of care set out by Virgin Care, with a focus on preventative services, social inclusion, care co-ordination and self-management will address these population changes. Alongside the new models delivered by Virgin Care, a number of other schemes supported through the iBCF funding will also help tackle the challenges outlined above. These are explained in more detail at section 4.3.

2.3 Financial imperatives

Historically a large element of the resource to fund community services has been allocated through block contracts through independent and joint commissioning arrangements across the CCG and Council.

In the future funding needs to be more flexible and designed around outcomes and this is a key feature of the new model with Virgin Care. The focus on outcomes and the flexibility that integration brings, led to the incorporation of a much wider range of services under the Better Care Fund Plan.

Although there is a strong drive to sustain community services as alternatives to hospital provision it must be recognised that the costs of care in the community are rising; needs are increasingly complex and acute; and demand on services is growing. Added to that, the financial outlook for all commissioners and providers of health and care services in the medium term means they must continue to innovate and identify further efficiencies.

The *your care, your way* Outline Business Case (Documents | your care your way) set out the financial challenge that shows that both the Council and CCG will need to meet the ongoing demographic challenges through more efficient working that will help redirect funding to frontline services.

A key component of both the CCG and Council's financial strategy is to maximise the use of resources by ensuring costs incurred are those which deliver the most effective and safe care for people at the best obtainable value.

Both the CCG and Council have challenging financial targets to meet in 2017-18; the CCG is required to deliver savings of £11.6m and the Council is required to deliver savings of £14.4m, £2.4m of which is within Adult Social Care.

Planning ahead to achieve a community delivery system that has a real impact on shifting care out of hospital and delivering quality and efficient services in the community is imperative to ensure we find a way to achieve more and better services with less money.

If unaddressed, this will result in:

- More people, especially older people, being treated in hospital which does not necessarily result in the best clinical outcomes for them.
- Proportionately less money for community services as more is necessarily spent in acute care. This increases the pressure on the acute system as less treatment is possible in the community setting.
- A system focused on responding to crisis rather than preventing crisis in the first place.

The Better Care Fund requires a reduction in non-elective admission to hospital of 3.5% and a well-designed community service model can play a pivotal role in creating strong and sustainable out of hospital care. Achievement of this target will lead to the release of risk share funding which can then be invested in further BCF schemes. This is explained more fully in section 5.2.1.

2.4 The Local Care Market

Key issues within the social care provider market include the loss of 170 care home beds in the last 18 months which has placed a great strain on the market and pushed up fees considerably. The Council has undertaken a Fair Price of Care exercise to review objectively what a fair bed rate should be and has increased the fees of those residents under this rate.

The domiciliary care market continues to be relatively stable, with B&NES paying one of the highest hourly rates for domiciliary care in the country –a reflection on the employment market locally but also of the commitment to provide high-quality care at home and value the care workforce appropriately, including through the funding of the National Living Wage. However, access to domiciliary care continues to be challenging, particularly during peak holiday periods such as summer and Christmas and in some more rurally isolated communities.

Through the usage of BCF and iBCF monies, the care market is being supported to innovate and stabilise. In particular, iBCF funding is being used to develop new models of residential and nursing care; support providers of complex and specialist packages and placements to deliver against new national requirements for sleep-in cover; and to uplift care home fees as part of implementing the outcomes of the Fair Price of Care review. These are explained further in appendix 2 with the scheme plans outlining aims, objectives, milestones and key performance indicators.

The scheme pump-priming investment into the support planning and brokerage model will also support the local care market as Commissioners and assessors will understand more closely the issues facing providers but also challenge providers to understand the pressures facing the Council and CCG.

3. Progress to date

3.1 The 2014 and 2016 plans clearly set out the case for change in B&NES and the rationale for the schemes included. As part of this approach, new schemes were introduced in the 2016 plan to focus on domiciliary care capacity and system flow.

3.2 The BCF Plan for 2016-17 described year two of the *your care your way* journey to redesign and re-commission integrated community health and care services for children, young people and adults with a real focus on commissioning outcomes identified as important to the local population. A key priority was prevention and this theme runs through the BCF and all the schemes within it. The outcome of this journey was the appointment of Virgin Care as the prime provider of integrated community health and care services, with a further responsibility to subcontract a range of connected services to deliver whole system change.

3.3 In 2016-17, alongside the *your care your way* narrative, a number of new priorities were identified, specifically to support the national conditions of the BCF and its aim to support people to live healthy and independent lives through services based in the community. These priorities included establishing a falls response service, improving capacity within domiciliary care and embedding assistive technology as a viable offer to support people to live at home for as long as possible. The BCF also included a separate plan to address Delayed Transfers of Care (DTOCs) across the whole system.

3.4 Throughout 2016-17, a dashboard of measures was monitored which showed performance improvements against the four national metrics and 2 local metrics. The quarter 4 performance dashboard is attached at appendix 1.

In summary, the full year measures showed:

National Metrics:

- Non-elective admissions – Maintained - BANES CCG were 1.2% above plan. (The BCF metric results have not yet been issued)
- Delayed transfers of care - Underperformed – 23.6% over plan
- Permanent admissions to care homes – Continued Improvement – 2% below target
- People remaining at home 91 days after reablement – Improvement – 3.4% above target

Local Metrics:

- Care and Support clients 65+ extremely or very satisfied – Maintained - 65.8% same as 2015/16 but below plan.
- Number of live-in care packages – Improvement – 22% below target.

3.5 Overall, the initiatives within the BCF were reviewed in the second half of 2016-17 with the following key recommendations:

- **Domiciliary Care:** to continue to work with providers to increase capacity and review the commissioning model for 2018 onwards. To implement the *Proud to Care* campaign to support recruitment.
- **Assistive Technology:** to develop the strategy for assistive technology and test out new ways of working within reablement and Home First, following an LGA grant award.
- **Reablement:** to continue to review this service with Virgin Care to ensure it is as efficient as possible and further develop the Home First concept.
- **Falls Response:** to continue to invest in this service which began shortly before the end of 2016-17 but is already demonstrating early success.

3.6 Review of Delayed Transfers of Care Performance:

In terms of DTOC specifically, a multi-agency DTOC Action Group was set up in B&NES to monitor the plan and deliver the changes required. In February 2017, the Royal United Hospital advised that it had not been counting all delayed days and this meant that delays for the whole of 2016-17 had been under-reported. Despite this position, a number of initiatives and actions took place which has contributed to a more robust position in addressing delayed transfers of care. These include:

- **Recording:** establishing robust recording methods and capturing data on care home and domiciliary care capacity as part of a monthly dashboard
- **From hospital to care home:** developing better relationships and communication with care home providers as a precursor to 7 day discharges and trusted assessor models. A multi-agency workshop addressing issues between hospitals and care homes was held successfully and the local Care Home Forum has been hosted by the Royal United Hospital recently.

- **Assistive Technology Showcase Event:** this event was held in November 2016 and allowed local providers and assessors to showcase their products and understand more about what technology could support independence
- **Home First:** the Home First service in B&NES was relaunched in December 2016 and since then, has also benefited from further investment and leadership across B&NES and Wiltshire with positive increases in numbers going through this service.

3.7 Reviewing and Reshaping the Plan for 2017-19

The Better Care Fund plan for 2017-19 has been refined and reshaped to reflect the award of the new contract for integrated community services in B&NES but also in response to new emerging priorities and initiatives. This is explained fully in the next section of the Plan.

4 Better Care Fund plan

As described earlier in the document, *your care your way* and the funding associated with the community health and care services is now included within the Better Care Fund. Detailed transformation plans are currently being developed with Virgin Care and will include specific projects to meet the priorities set out by local people while working to a set of principles which support the vision set out for *your care, your way* including:

- Person-centred approaches
- Promoting independence and self-care
- User and carer involvement
- Maximising the use of developing technology
- Integrated system-wide working
- Coordinated services
- Evidence-based care and interventions
- Continual improvement and innovation

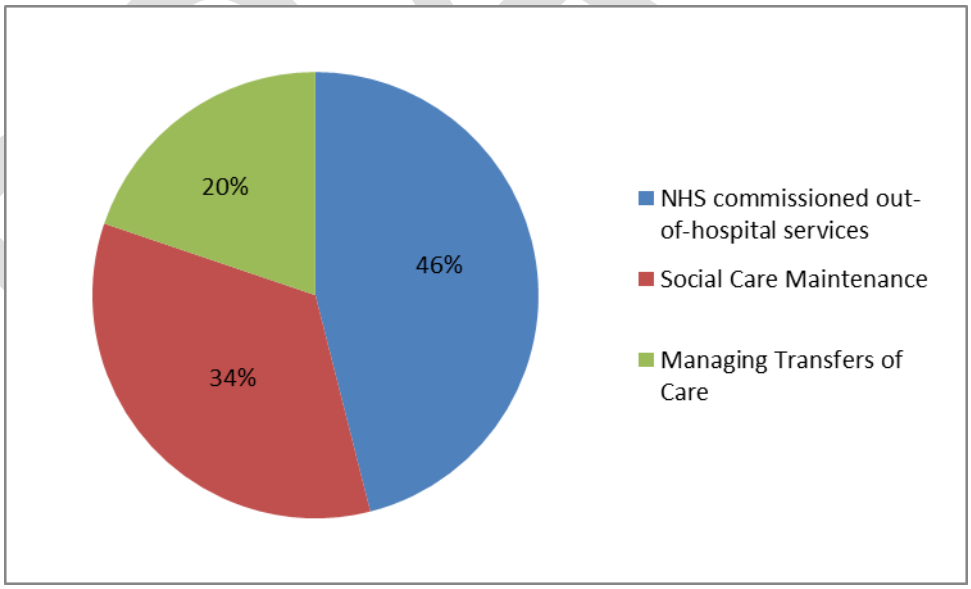
The full 3-year community services transformation plan will be available from September 2017 but the agreed areas of delivery for 2017/18 include:

A Person not a condition	Develop a comprehensive assessment that will enable a holistic care and support plan, specific to the individual and based around their personal goals. Launching a carers club Launching a citizens panel
A focus on prevention	Establish the model for locality based provision and a care co-ordination centre with clear outputs, outcomes, protocols and linkages between service areas.
Service review and development	Deliver reviews and plans for the following Prime Provider service areas: CHC, Mental Health (a commissioner led pathway review that includes other providers of mental health services as well as service users), Reablement, Home First, Care at Home, Social Care (including support planning and brokerage)
Joining up the information	Development of an integrated care and health record available to community staff, other providers, individuals and their carers.

Highlights of these deliveries will be outlined in quarterly returns for the Better Care Fund.

The transformation programme is being managed through monthly contract monitoring meetings with Virgin Care and by the monthly CCG/Council Integration and Transformation Steering Group and quarterly Community Services Joint Steering Group membership of which includes Commissioners, the Provider and representative from the community. The Council/CCG Joint Commissioning Committee, which meets monthly, monitors progress and performance. Regular update reports are made to CCG Board, Health and Wellbeing Select Committee and Health and Wellbeing Board, and Council/CCG Joint Commissioning Committee. Further detail can be found in section 9 Governance.

For this year's plan, we highlight and focus on a number of existing schemes (including social prescribing, falls response and reablement) and also introduce new schemes funded by the Improved Better Care Fund. Some existing schemes already funded by the BCF have grown in priority, for example, Community Equipment are, therefore, also an area of focus. These are explained below, with scheme plans setting out objectives, milestones, performance indicators and scheme level spending plans which are attached at appendix 2. Each scheme identifies which national metric it will support and the pie chart below shows the split of the national metrics across these key schemes.

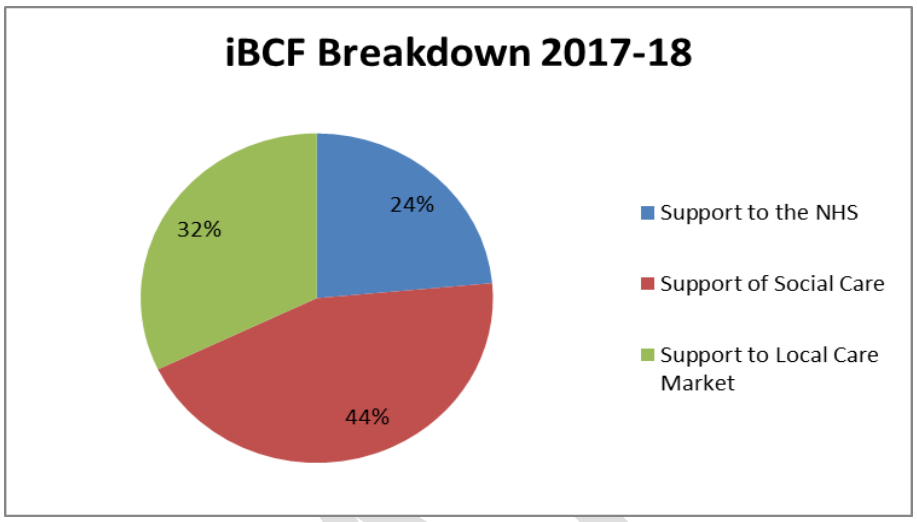


The table below lists the existing and new schemes that will be monitored. The schemes are fully populated for year 1, with the expectation that year 2 detail will be confirmed during year 1.

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Source of Funding	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
2	Discharge Liasion Nurse (Your Care, Your Way)	9. High Impact Change Model for Managing Transfer of Care	Additional CCG Contribution	£57,000	£57,000	New
3	Integrated Reablement (Your Care, Your Way)	11. Intermediate care services	CCG Minimum Contribution	£663,530	£663,530	Existing
3	Integrated Reablement (Domiciliary Care Strategic Partners)	11. Intermediate care services	CCG Minimum Contribution	£1,146,715	£1,168,502	Existing
3	Integrated Reablement (Facilitating Hospital Discharge)	11. Intermediate care services	CCG Minimum Contribution	£225,000	£229,275	Existing
3	Integrated Reablement (Your Care, Your Way and Sirona)	11. Intermediate care services	CCG Minimum Contribution	£578,862	£581,733	Existing
4	Falls Response Service	11. Intermediate care services	CCG Minimum Contribution	£224,500	£228,766	Existing
7	Integrated Care and Support Community Equipment	7. Enablers for integration	CCG Minimum Contribution	£473,011	£481,998	Existing
9	Social prescribing (Your Care, Your Way)	13. Primary prevention / Early Intervention	CCG Minimum Contribution	£100,000	£100,000	Existing
13	Strengths Based Working	10. Integrated care planning	Local Authority Contribution	£30,000	£0	New
14	Assistive Technologies	1. Assistive Technologies	Local Authority Contribution	£250,000	£0	Existing
17	Fair Price of Care	16. Other	Improved Better Care Fund	£545,000	£200,000	New
19	National Minimum Wage/Sleep-in Cover	14. Residential placements	Improved Better Care Fund	£76,000	£76,000	New
20	Support Planning and Brokerage Service	16. Other	Improved Better Care Fund	£200,000	£100,000	New
21	Transition to new Community Resource Centre Model	14. Residential placements	Improved Better Care Fund	£100,000	£0	New
22	Transition of Extra Care	14. Residential placements	Improved Better Care Fund	£180,000	£0	New
23	Home First Pathway One (D2A 5 day working) (ORCP)	9. High Impact Change Model for Managing Transfer of Care	Local Authority Contribution	£253,934	£253,934	New
23	Home First Pathway One (D2A 7 day working)	9. High Impact Change Model for Managing Transfer of Care	Improved Better Care Fund	£163,646	£163,646	New
23	Home First Transport	9. High Impact Change Model for Managing Transfer of Care	Improved Better Care Fund	£40,245	£0	New
23	Home First Pathway Three (Beds)	9. High Impact Change Model for Managing Transfer of Care	Improved Better Care Fund	£253,500	£338,000	New

4.3 Improved Better Care Fund

The B&NES Better Care Fund has made full use of its iBCF monies which were agreed and allocated against national metrics in the proportions shown in the pie chart below.



The table underneath breaks down the first year's schemes into the different priority areas, each of which has a full scheme plan detailing milestones, objectives, performance indicators and scheme level spend, plus how each scheme will contribute to the four national metrics of the Better Care Fund. This is explained further in section 11.

Support to the NHS	23.55%
Your Care, Your Way Transformation funding	
Home First Pathway - beds	
Discharge to Assess/Home First pathway 1	
Home First Transport	
Support of Social Care	44.33%
Protection of Social Care	
Your Care, Your Way Transformation funding	
Support for Council Position	
IBCF Schemes to be identified	
Support to Local Care Market	32.12%
Fair Price of Care	
Support Planning and Brokerage Service	
Transition of Extra Care	
Transition to new Community Resource Centre Model	
National Living Wage/Sleep-in Cover	

4.4 Support to the Care Homes Market

As noted earlier in this plan, the care homes market in B&NES has seen the loss of 170 beds in the last 18-months, which equates to a 12% reduction.

During 2016-17, the Council undertook a Fair Price of Care exercise, which was an objective review of care home prices to establish a fair bed fee. Investment in the care home market in response to the Fair Price of Care Exercise has been funded through iBCF monies. However, despite this investment the market remains challenged with a lack of supply impacting on the Council and CCG's ability to secure appropriate local placements at the published rates. This represents a key financial risk to the Council.

Alongside this investment, the Council and CCG are working closely with providers on a range of new models, including residential high dependency beds and discharge to assess pathway 3 beds.

iBCF monies have also been invested in the redesign of care home beds provide in the three Community Resource Centres. These care home beds are also linked to extra care housing schemes and the model of care is being redesigned to offer general nursing, high dependency residential care, nursing dementia and complex residential dementia placements. In parallel with the development of the new service model, the Council is investing capital to improve the three CRCs and enable delivery of the new model. This will help support and stabilise the market in B&NES and ensure that we are commissioning the right complexity of placements. Further information on this can be found in the scheme plans attached at appendix 2

iBCF monies are also being invested into testing a support planning and brokerage model which will support more efficient and robust negotiations within the care market and free up the time of social workers to focus on assessments.

4.5 Disabled Facilities Grant Monies

This year's Better Care Fund Plan aims to see closer working between housing, health and care commissioners and regular liaison meetings have been established to evaluate the impact of DFGs and to strengthen the links between DFGs, Community Equipment services and Assistive Technology. This will become a more prominent theme in year 2 of the BCF plan.

This year, the impact of DFGs will be measured through regular feedback from recipients, using Outcome Star methodology. The profile of Community Equipment has also risen and whilst equipment has been a fundamental part of the BCF since the beginning, this year sees a specific focus on Community Equipment, including a review of its contractual status and overlaps with housing related support such as the Home Improvement Agency contract.

This BCF will also see the further development of Assistive Technology and its growing importance in the aim to maintain as many people at home as possible and maximise resources.

5. Risk

5.1 Brief Summary of Risks

The risk register attached at appendix 6 sets out the key risks affecting the delivery of the Better Care Fund plan in 2017-19. In summary, the risks can be grouped into the following headings:

- **Financial Risks:** including the financial position for both the Council and CCG in dealing with growing demand and increased efficiency savings.
- **Market Risks:** in respect of market instability within the care home sector and corresponding rising fee levels due to restricted availability (see 5.2.2 below for more detail)
- **Performance Risks –** associated with delivery of performance improvements, particularly related to DTOCs (see 7.4 below for more detail).
- **Capacity Risks –** this relates to the capacity of teams to tackle and implement the changes required within the BCF.

Each risk has been rag-rated with a risk owner. Those risks rated 16 or above are automatically included on the CCG/Council Partnership Risk Register and reported in public.

5.2 Approach to mitigation of risks

5.2.1 Financial Risks

The existing schemes are investments in long term services provided in the main by the local authority, NHS Community services providers and Domiciliary Care Strategic Risk of the collapse of one of these providers is therefore assessed as relatively low. Financial risk, therefore, arises primarily from instability within the care home market which may result in increased costs associated with securing care home placements in a “suppliers market” and an associated failure to achieve the required savings targets. These savings targets are challenging and the scale of the challenge should not be underestimated when taking into account the state of the care market. Initiatives to stabilise and develop the care market are being progressed, including those described within the Better Care Fund Plan.

Any further mitigation required if these risks were to crystalize would be agreed in the first instance through the Joint Commissioning Committee, with recommended actions approved through the individual organisation’s Governance arrangements shown in section 9.

The *your care, your way* contract is a block payment with internal risk share arrangements with the prime provider built into the contract. It has its own risk register which is monitored on a monthly basis though contract review meetings

which escalate any risks to the Joint Commissioning Committee. Both the Council and CCG have included appropriate contingency and risk arrangements within their financial planning for 2017/18 against this significant contract.

The remaining iBCF funding is ring fenced for specific schemes which support normal delivery of services so are mitigations in themselves. For example £545k has been allocated to the implementation of the Fair Price of Care exercise as part of supporting the local care market. For Non-Elective Admissions the existing local risk share agreement between the Council and CCG has been retained. The BCF 2016/17 Technical Guidance stated that a local risk share would be needed where emergency admission reductions targets were consistently not met in 2015/16; this was to ensure that the same pound was not spent twice and the same risk has been identified during planning as remaining in 2017/18.

For B&NES the local risk share is built around the approach used in 2015/16 which created a maximum risk share fund equal to the value of non-elective admissions that original BCF plans aimed to avoid.

In 2017/18 the value of the risk share fund is £549,660. This fund is held by the CCG within the overall funding for the acute contract and will be released should the target value of non-elective admissions be achieved.. The rationale for holding this outside the fund is to ensure that BCF investment does not cause the CCG to over extend itself in financial terms and hence put the financial balance of the local health economy at risk. The figure has been uplifted in 2018/19 by 1.9% but the requirement for a local agreement will be reviewed in the first year.

The underlying Non- Elective position will be monitored quarterly through the Finance and Performance Committee of the CCG, which includes senior Council representation, and the quantity and any reinvestment proposal identified. Approval of the proposed transfer of the risk share and use of the funds will be made by the Joint Commissioning Committee (JCC).

5.2.2 The Current Market Position

In advance of publishing a current Market Position Statement (MPS), the Council and CCG are clear on the type of risks within the market following engagement with providers, particularly in terms of sustainability and priority actions that need to be taken as a result. A summary of these is provided below.

Market Sustainability Risks & Pressures

- Shortfalls in supply in the face of increasing demand and a challenged care home market is resulting in fees levels above the Value for Money rate agreed with providers as a key outcome from the Fair Price of Care exercise.
- The market in B&NES has seen loss of 170 beds in the last 18 months. Whilst 139 new beds are coming on line in 2017 a proportion of these beds are marketed primarily to self-funders and are above the agreed Value for Money rate.
- Concerns that an unintended consequence of very rigorous and robust safeguarding and regulatory action can contribute to the conditions for provider failure
- Insufficient diversity of providers in the local market for provision of care for those with complex needs.
- Providers' preference for private clients can reduce availability to take social care referrals
- Housing stock becoming outdated for modern care service requirements
- Insufficient negotiating capacity and capabilities.

In response to these pressures, the following priorities have been identified, some of which are included specifically within the BCF schemes and others are being progressed within the Council and/or CCG.

Market Development priorities

- Implementation of the Fair Price of Care exercise.
- Specific commissions for high dependency residential care and Discharge to Assess beds are underway which will support the bed mix available and ensure that more people can make decisions about their long term care needs away from a hospital setting.
- Developing extra care market delivery models including enhanced extra care as another option to standard residential care with the aim of both promoting independence and reducing the need for more intensive packages of care and placements with the benefit of greater financially sustainable for care purchasing budgets.
- Developing more options and stimulating diversity and competition in the complex and specialist care market – for example in relation to complex dementia and for those with functional mental health conditions.
- Further developing commissioner contingency planning systems and providing training for smaller providers on business continuity.

- Developing bespoke care and support options for rural communities where traditional homecare is in very short supply: especially with capacity for provision of QDS (four times a day) packages.
- Demand management through:
    - Better quality conversations with service users and families on alternative ways of meeting needs that promote independence
    - Clearer expectations from published policy positions on choice of care services, top-ups etc.
    - Better outcomes from providers being appropriately incentivised across preventative partnerships, and signposting to more creative strength based and mainstream community options to promote independence, avoid escalation of need and reduce the need for intensive packages of care and care home placements.

6. National Condition One

6.1 National condition 1: A Jointly Agreed Plan

The Better Care Fund was signed off by the Health and Wellbeing Board on 6th September 2017. The Board is co-Chaired by the Cabinet Member for Adult Social Care & Health and the CCG's Board Chair who is a GP. In addition to the Council and CCG, Board members include key health and care providers, Education providers, public sector partners, a representative of the Voluntary, Community & Social Enterprise (VCSE) sector, Healthwatch and a representative of the housing provider sector.

The iBCF investment proposals were shared at the A&E Delivery Board in April 2017 and agreed by Health and Wellbeing Board in May 2017. Usage of the iBCF monies includes support to stabilise the care market and this was agreed and confirmed by the Joint Commissioning Committee and supported by the A&E Delivery Board.

The Council was awarded £1,084k of Disabled Facilities Grant (DFG) funding in 2017-18, an increase of £93k (9.3%) on 2016-17. Within the DFG, an allocation of £200k has been set aside to support the development and roll out of assistive technology across B&NES. This has been agreed with Housing colleagues in the Council and will compliment a £50k Local Government Association (LGA) grant awarded to B&NES for 2017-18.

The remaining Disabled Facilities Grant has been allocated to the Housing Team within B&NES Council.

7. National Conditions Two to Four

7.2 National condition 2: social care maintenance

The 2017-19 BCF plan aims to maintain a consistent level of protection of social care with the BCF funding.

CCG investment of £6.38m in 2016/17 has been increased in line with the NHSE guidance on growth figures of 1.79% to £6.49m in 2017/18, and by a further 1.9% to £6.62 in 2018/19.

The existing investment has been reviewed in year and as part of the two year consultation around jointly commissioned community services. The proposed underlying schemes are shown in the table below:

Social Care Schemes funded by CCG minimum contribution								
Scheme ID	Scheme Name	Scheme Type	Sub Types	2016/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme	Comments
3	Integrated Reablement (Domiciliary Care Strategic Partners)	11. Intermediate care services	4. Reablement/ Rehabilitation services	£1,347,593	£1,146,715	£1,168,502	Existing	Review and reduction in strategic partners in 2017-18
3	Integrated Reablement (Facilitating Hospital Discharge)	11. Intermediate care services	5. Other	£0	£225,000	£229,275	New	Funding for Strategic Partners redirected to specific scheme to get people out of acute setting
3	Integrated Reablement (Your Care, Your Way and Sirona)	11. Intermediate care services	4. Reablement/ Rehabilitation services	£576,204	£578,862	£581,733	Existing	Funding aligned to new 7 year contract following community wide consultation
4	Falls Response Service	11. Intermediate care services	3. Review teams (reviewing placements/packages)	£208,000	£224,500	£228,766	Existing	Service planned to start 2016/17 but went live May 2017
5	Home from Hospital Schemes (Your Care, Your Way)	11. Intermediate care services	1. Step down	£171,000	£171,000	£171,000	Existing	Funding aligned to new 7 year contract following community wide consultation
7	Integrated Care and Support	7. Enablers for integration	10. Joint commissioning infrastructure	£0	£2,702	£19,185	Existing	
8	Protection of Social Care	16. Other		£3,546,000	£3,609,579	£3,678,161	Existing	Aligned with Council forecasts
11	Support for Carers (Your Care, Your Way)	3. Carers services	1. Carer advice and support	£266,000	£266,000	£266,000	Existing	Funding aligned to new 7 year contract following community wide consultation
12	BCF Strategic Support	7. Enablers for integration	10. Joint commissioning infrastructure	£269,530	£274,355	£279,567	Existing	
	Total			**£6,384,327**	**£6,498,713**	**£6,622,189**		

The use of this funding covers a range of schemes that will add stability to the local social and health care system, including continued investment into an integrated model of reablement. £1.2m (19%) of this investment is contained within the new contract for community services which includes planned transformational changes to the wider health and care economy. As a major provider in the local area the former incumbent was consulted throughout the process and consideration to their long term sustainability as a result of the change was a key element in planning the transition.

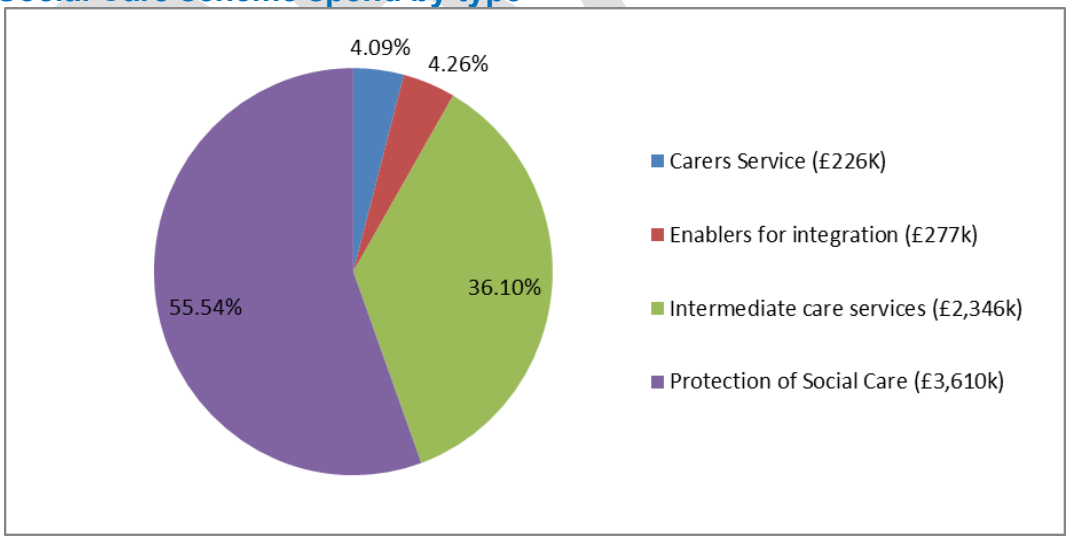
The preparation of the Better Care Fund Plan has been undertaken alongside the planning rounds of both the Council and the CCG and the funding has been aligned to both plans. The approach to planning for the Better Care Fund has been consistent with the Department of Health guidance for funding transfers to social care.

Both organisations face increasing cost pressures and savings targets. The local care market has seen a number of residential closures over the past year and demand on primary, acute and learning difficulties services continues to climb outside of demographic expectations. The schemes within the plan have therefore been identified to specifically address the area of intermediate care services which supports the aim of the plan and will mitigate these key factors.

The protection of social care covers areas of adult social care spend which have an indirect impact on prevention such as provision of good quality, fit for purpose, accessible housing, support to the care market, and reablement pathway redesign. The 2017-19 plan has built on previous years and continues to invest in schemes which support reablement and step down services such as “home from hospital”. The falls response service which went live in May 2017 is an integrated response specifically designed to reduce admissions to hospital and includes the assessment of further health and social needs at the time of response.

The chart below shows the planned expenditure and percentage of investment by type of scheme.

Social Care scheme spend by type



7.3 National condition 3: NHS commissioned out-of-hospital services

The minimum allocation for NHS commissioned out-of-hospital services for 2017/18 is £3,184k and for 2018/19 is £3,245k. The table below shows how the funding is made up within the plan and that the minimum has been exceeded for both years.

NHS Commissioned out-of-hospital services									
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Area of Spend	2016/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme	Comments
1	Integrated Delivery Infrastructure (Your Care, Your Way)	7. Enablers for integration	10. Joint commissioning infrastructure	Community Health	£500,000	£500,000	£500,000	Existing	Funding aligned to new 7 year contract following community wide consultation
3	Integrated Reablement (Your Care, Your Way)	11. Intermediate care services	4. Reablement/Rehabilitation services	Community Health	£628,000	£663,530	£663,530	Existing	Funding aligned to new 7 year contract following community wide consultation
5	Home from Hospital Schemes (Your Care, Your Way)	11. Intermediate care services	1. Step down	Community Health	£171,000	£171,000	£171,000	Existing	Funding aligned to new 7 year contract following community wide consultation
5	Home from Hospital Schemes (Your Care, Your Way)	11. Intermediate care services	1. Step down	Social Care	£171,000	£171,000	£171,000	Existing	Funding aligned to new 7 year contract following community wide consultation
7	Integrated Care and Support	7. Enablers for integration	10. Joint commissioning infrastructure	Community Health	£2,008,000	£1,520,751	£1,590,733	Existing	
7	Integrated Care and Support Community Equipment	7. Enablers for integration	10. Joint commissioning infrastructure	Community Health	£0	£473,011	£481,998	Existing	Shown seperately for 2017/19 plan
7	Integrated Care and Support	7. Enablers for integration	10. Joint commissioning infrastructure	Social Care	£0	£2,702	£19,185	Existing	Shown seperately for 2017/19 plan
9	Social prescribing (Your Care, Your Way)	13. Primary prevention / Early Intervention	1. Social Prescribing	Mental Health	£100,000	£100,000	£100,000	Existing	Funding aligned to new 7 year contract following community wide consultation
10	Mental Health Reablement Beds (Your Care, Your Way)	13. Primary prevention / Early Intervention	2. Other - Mental health /wellbeing	Mental Health	£100,000	£100,000	£100,000	Existing	Funding aligned to new 7 year contract following community wide consultation
12	BCF Strategic Support	7. Enablers for integration	10. Joint commissioning infrastructure	Social Care	£135,000	£151,202	£152,130	Existing	
100	BCF Risk Share Contingency	16. Other		Other	£539,994	£549,660	£560,103	Existing	Non Elective Admissions Avoidance risk share
	Total				**£4,352,994**	**£4,402,856**	**£4,509,679**		

The local risk share arrangement for 2016/17 has been rolled into the 2017/19 plan and is shown above against scheme number 100. It has been uplifted in line with NHSE inflators. It has been retained by the CCG and forms part of the contract to pay the local acute provider if the reduction target is not met. The calculations and how the governance around the retention or investment of this risk share can be found in section 5.2.

7.4 National Condition 4: Managing Transfers of Care

The B&NES 17/19 DTOC Action Plan, which is attached at appendix 7, sets out the B&NES approach to implementing the eight High Impact Changes for Managing Transfers of Care. This plan sets out specific actions which will be collaboratively undertaken by system partners to deliver each of the eight High Impact Changes, ensuring measured steps are taken to reduce DTOC rates within B&NES. The metrics submitted by B&NES to reduce DTOCs are set out at section 11.

The following summary provides a brief overview of the actions being undertaken in regards to each High Impact Change.

7.4.1 Early Discharge Planning

There is a focus on ensuring providers embed best practice in regards to early discharge planning for both elective and non-elective patients. Specifically there is a focus on embedding the SAFER bundle within community hospitals, to ensure all patients have an Estimated Discharge Date (EDD) applied within 24/48 hours of admission, to enable effective discharge planning.

In regards to the RUH, whilst EDD's and the SAFER bundle have been effectively embedded within practice, work is underway to develop a complex patients list which will flag patients with potentially complex discharge needs to the Integrated Discharge Service (IDS) on admission. This will allow early input from the IDS ensuring prompt and effective discharge planning.

7.4.2 Monitoring Patient Flow

Within the RUH, systems have been established to monitor patient flow which allows teams to identify problems in flow and capacities, ensuring mitigating actions are implemented.

Regarding community providers, plans are in place to better monitor patient flow to allow developed responses to variations in demand. Specific actions include undertaking a review into discharge processes and length of stay within community hospitals and a review into system blockages in the Integrated Reablement Service. Actions will be developed to respond to such processes and blockages, ensuring better patient flow and the earlier release of capacity.

7.4.3 Multi Agency/Disciplinary Teams (MDT)

Following the development of the IDS within the RUH, joint health and social care discharge teams are now well established. Within the IDS a daily huddle takes place which is attended by health and social care professionals to discuss referred patients discharge needs. Additionally IDS members regularly attend ward board rounds to provide specialist input and support into discharge planning processes.

Within community providers MDTs are currently established on a bi-weekly basis, however plans are in place to expand MDT provision to ensure discharge planning is prompt, co-ordinated and streamlined.

Finally the involvement of voluntary organisations as part of an MDT is well established within the RUH, with Care and Repair and AGE UK B&NES being represented at the daily IDS huddles to provide specialist input.

7.4.4 Home First/Discharge To Assess

Within B&NES the Home First service is well established, which supports all appropriate patients to return home with the Integrated Reablement Service to have further rehabilitation, reablement and assessments at the most appropriate time and in the most appropriate environment. Additionally a Single Point of Access has recently been developed for referral into the Home First Service, ensuring streamlined and expedited referral processes.

An assisted technology strategy is currently being drafted to assess how assisted technology can better support patients being discharged into the Home First Service and enhance assessment processes.

Regarding long term care provision, plans are in place to commission a number of Discharge to Assess beds, which will allow service users who are likely to need long term care but where needs aren't settled, to benefit from a period of recuperation, reablement and assessment.

Finally plans are in place to set out specific timescales for assessments from residential and nursing homes in the local authority care home contract.

7.4.5 Seven Day Services

Within B&NES 7 day working has been established in specific teams, such as the Discharge Liaison Nurses, to expedite assessments and referrals. Plans are currently in place to expand 7 day working to a number of additional health and social care teams.

There is a specific plan in place to expand the Home First Service to take referrals and discharges across 7 days to ensure it is responsive to system and patient discharge needs.

Finally plans are in place to negotiate with care providers to assess and start care provision across 7 days. It is noted that agreement has been reached with several domiciliary care partners to start existing and new care packages at the weekend. Weekend admissions will also form part of the new care homes contract in 2017-18.

7.4.6 Trusted Assessment

Within the Royal United Hospital Bath, an Integrated Discharge Service (IDS) exists to support assessment and discharge. A single IDS referral form has been agreed and signed off, providing a basis for subsequent referrals and assessments reducing duplication.

A number of actions have been developed in regards to care providers. For example there has been agreement with the Council commissioned Community Resource Centres (three care homes along with extra care housing) to assess on each other's behalf ensuring patients are assessed in a timely manner.

Additionally as part of plans to procure Pathway 3 (Discharge to Assess) beds, the service specification includes the utilisation of a telephone triage and assessment process for patient entering this bed base. The aim of this is to expedite and streamline referrals and assessments and allow a 24 hour turnaround from referral to discharge into the bed base. Learning from these actions will be reviewed to develop plans to spread such practices to other care providers.

Finally the B&NES DTOC Action Group will review the national guidance on the essential elements of trusted assessment, allowing specific best practice actions to be formed and included within the B&NES 17/19 DTOC Action Plan.

7.4.7 Choice Policy

Choice policies amongst all providers have been rewritten to reflect the nationally released policy. Plans are in place to ensure this policy is effectively understood and implemented by staff, with a reporting mechanism in place to assess and monitor implementation across providers.

Additionally all providers are developing information guides which outline discharge processes and are provided on admission to ensure patients and relatives have a clear, honest and realistic understanding of discharge processes (including their expected responsibilities).

7.4.8 Support For Care Homes

Regarding clinical support to care homes, plans are currently in place to align GP Practices to individual care homes, whilst discussions are underway to ensure therapy input into care homes. It is anticipated that by ensuring greater clinical support for care homes, such homes will feel confident in caring for residents with greater acuity and care needs.

Additionally a number of actions are currently in place or are planned for care homes, including a quarterly care home forum, the development of a care home link role within acute and community providers and a pilot of the Sutton ‘Red Bag Initiative’ within the 10 highest admitting care homes. It is hoped these actions will result in improved communications, relationships and trust between commissioners, health providers and care homes, allowing further actions to be developed to better support care home providers.

8. Overview of funding contributions –

The table below sets out the planned contributions for the Better Care Fund together with the previous year's figures for comparison. The first four rows are the CCG's contribution with the remaining figures being the Council's investment.

Funding Source	16/17 £	17/18 £	18/19 £
Section 75 Transfers CCG To Council	£8,460,000	£8,611,434	£8,775,051
CCG NHS Commissioned Out of Hospital Services	£2,008,000	£2,043,943	£2,082,778
BCF Risk Share Contingency	£539,994	£549,660	£560,103
YCYW	£0	£24,182,014	£24,182,014
Disabilities Facilities Grant Capital	£991,000	£1,084,352	£1,084,352
Local Authority Grant	£0	£50,000	£0
Care Act Council Revenue	£1,500,000	£1,500,000	£1,500,000
IBCF	£0	£3,457,987	£2,063,000
YCYW	£0	£19,668,842	£19,668,842
Total	**£13,498,994**	**£61,148,233**	**£59,916,141**

The proposed funding has been included in both the plans and budgets of both the Council and CCG for the year 2017-19. These plans have been through the governance processes of both organisations as laid out in section 9 and have been signed off by the CCG's Board and the cabinet of the Council.

The section 75 agreement has been written to cover the inclusion of the *your care, your way* community services provision and the funding mapped to individual service level documents. The use of the BCF funding is to be agreed by both the Council Section 151 officer and CCG Chief Financial Officer to give transparency on the use of funds for both organisations.

The *your care, your way* contract to provide community services was jointly commissioned and included a detailed funding schedule agreed by all parties to the contract at the time of signature.

The Disabilities Facilities Capital Grant (DFG) funding level has been confirmed as has the Local Authority Grant and both have conditions stipulated on their use.

Of the Care Act 2014 funding, £1.5m is held within the BCF. Just over half of this funding (£795k, 53%) contributes towards the cost of increases in referrals and activity directly related to the Care Act. The remainder is used to support the cost of posts where a high proportion of the role supports the Care Act implementation together with related training provisions, advocacy and carer's support. In 2017/18 a specific scheme has been identified from this funding which will strengthen training and best practice for social workers (strength based working) which will be monitored in line with other schemes. Further details on this scheme can be found in appendix 2.

The iBCF funding has been formally acknowledged and the plan to spend this as outlined in section 4.3 has been through formal governance through both organisations as set out in section 9 and approved by the Health and Wellbeing Board in April 2017

In addition this narrative confirms the intention to either maintain or increase funding in relation to Social Care, including reablement, and carers breaks in year under national condition 2 in section 7.2.

The total funding is shown by scheme at appendix 4 and within the planning template which has been signed off by the Health and Wellbeing Board on behalf of all stakeholders.

9. Programme Governance

9.1 Integrated Structures

Integrated health and social care structures have been in place in B&NES 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.

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.

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.
-

The Joint Commissioning Committee (in place since October 2014) further strengthens the governance of our joint commissioning arrangements. The CCG's Constitution and the People and Communities governance structure have been amended to allow this. The Committee has 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. Integrated arrangements are overseen by the Health and Wellbeing Board (HWB).

9.2 Monitoring Transformation under the new Community Services contract with Virgin Care

Because the new community services contract with Virgin Care involves a significant level of transformation, an Integration and Transformation Steering Group (ITSG) provides a structured mechanism (under delegated authority from the Joint Commissioning Committee) to generate recommendations for high impact transformational changes that will deliver integrated care across Bath and North East Somerset and to support delivery of a strategy and work plan for delivering the agreed changes in line with existing Commissioning Strategies.

The Steering Group is responsible for reporting the progress through Joint Commissioning Committee as a key part of assurance to both the CCG and Council. This membership of the group includes Senior Executives from the Council (People & Communities) and the CCG.

The members of this Steering Group are also members of the Community Services Joint Steering Group along with the Community Prime Provider Virgin and one of the Community Champions (members of the community who were part of the *your care, your way* development and procurement).

9.3 Specific BCF Schemes Monitoring and Governance

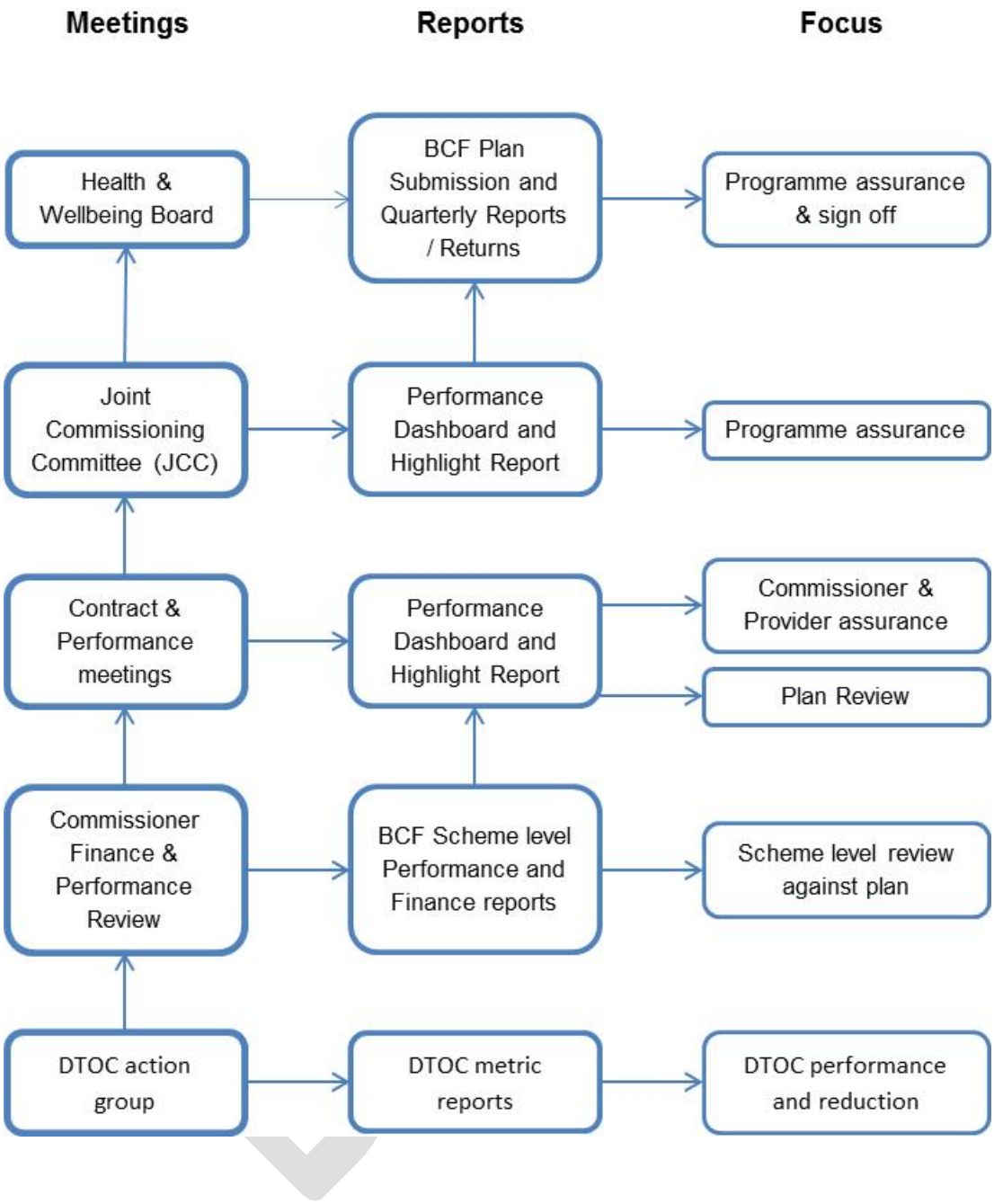
In terms of the specific schemes highlighted under the Better Care Fund plan 2017-19, monitoring of will be undertaken within the CCG and Council, led by the Senior Commissioning Manager for Better Care and supported by monthly performance dashboard and scheme level data. Delivery of the schemes and performance will be addressed through Contract and Performance meetings with providers, with the key provider being Virgin Care. Assurance of the overall delivery of the BCF will be monitored through the Joint Commissioning Committee and Health and Wellbeing Board. A diagram of this structure is set out on page 38.

9.4 The DTOC Plan

Governance and oversight of the DTOC Action Plan is delivered through a multi-agency DTOC Action Group which reports back into the A&E Delivery Board. The DTOC metrics agreed for the CCG, RUH and Virgin Care have also been shared at the A&E Delivery Board and with each organisation individually.

9.5 The Risk Register

The Risk Register for the Better Care Fund is attached at appendix 6. This sets out the key risks and planned mitigation. For those risks above with a score of 16 or above are added to the CCG/Council partnership Risk Register and reported to both the Joint Commissioning Committee and the CCG Board.


Meetings
Reports
Focus
Health & Wellbeing Board
BCF Plan Submission and Quarterly Reports / Returns
Programme assurance & sign off
Joint Commissioning Committee (JCC)
Performance Dashboard and Highlight Report
Programme assurance
Contract & Performance meetings
Performance Dashboard and Highlight Report
Commissioner & Provider assurance
Plan Review
Commissioner Finance & Performance Review
BCF Scheme level Performance and Finance reports
Scheme level review against plan
DTOC action group
DTOC metric reports
DTOC performance and reduction

10. Assessment of Risk and Risk Management

The key risks are shown at appendix 6. This also includes mitigations and how these will risks will be managed. The owners of the risk are agreed and identified on the register and it is RAG rated.

The risk register will be reviewed at monthly Joint Commissioning Committee (JCC) and if required escalated to other areas charged with governance such as the CCG's Audit and Assurance Committee dependent on the nature of the risk.

Key risks to both the CCG and Council will be identified and managed as required under their respective risk management strategies.

The CCG policy can be found at:
https://nww.banesccg.nhs.uk/documents/policies/corporate/cp007_risk_man_strategy_final_v30pdf

The Council policy can be found at:

Xxx – to follow

Further details on the approach to mitigation of risks can be found at section 5.2.

11. National Metrics

The B&NES Better Care Fund schemes support the delivery of the BCF national metrics. A summary of the impact of the schemes can be seen in Appendix 5 – 2017-19 Impact of the BCF schemes on National Metrics.

B&NES is also setting 3 local metrics to provide balance to the national metrics:

- To ensure the drive to support people to remain in their own homes does not increase the need for live-in care packages
- To provide community equipment to enable people to stay in their own home including assistive technologies within the available budget
- To monitor the length of stay in community hospitals to develop an appropriate baseline in 2017/18 for future targets and support monitoring of discharge management.

The Better Care Fund Dashboard in Appendix 1 is being redeveloped for 2017/19 to monitor both the national and local metrics.

11.1 Non-elective Admissions

The BaNES CCG operating plan for Non Elective Admissions was set following the NHS planning rules and includes IHAM (indicative hospital activity model) growth including demographic growth and a QIPP reduction with net reduction of 3.5% against the 2016/17 out turn.

This target has been set in recognition of the challenging position for B&NES. Analysis of Non Elective demand identified year on year growth in non-elective admissions for B&NES patients and the expected future impact of an aging population.

The CCG QIPP programme for Urgent Care has been grouped into two areas which link to the BaNES A&E Delivery Board 2017/18 delivery plan and were born out of the March urgent care summit.

Part A: Earlier Presentations

1. Earlier Home Visiting Service

2. Urgent Transport Service

3. Urgent Connect – provides GPs with immediate access to telephone based advice and guidance to acute consultants

4. Paediatrics

Part B: Frailty and End of Life Care

5. GP access to a Geriatrician Consultant
6. Frailty Community Nurse / Therapist
7. Rapid Falls Response Service (BCF Scheme)
8. Enhanced Discharge Service at End of Life

There are no further reductions for the Better Care fund as schemes such as Home First, Discharge to Assess beds and Reablement are noted as key interdependencies alongside the Virgin transformation plan.

2017/18 Quarter 1 has been very challenging with Non Elective admissions 15% above plan. This level of growth has been unexpected and a full investigation is being undertaken. The over performance in this quarter is unlikely to be recovered in future quarters that have their own challenging targets to meet.

In 2017-19, The following BCF schemes will impact on non-elective admissions:

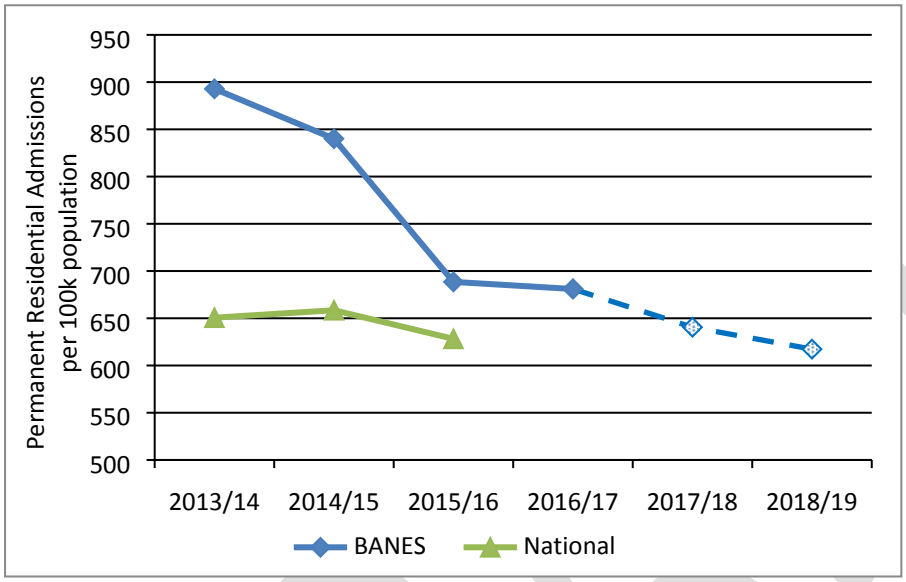
- **Falls Response:** The falls response service which is both a BCF and QIPP scheme began in May 2017 and has already successfully prevented 88 admissions in May and June. This innovative scheme, involving a paramedic and OT working in the community, is already demonstrating a significant impact in the short time it has been operating.
- **Transition of Extra Care sheltered housing :** this scheme supports vulnerable people to live in the community with well managed health and aims to prevent future emergency needs
- **Discharge to Assess Beds:** The 5 discharge to assess beds will provide time and support to ensure that people have the optimal care and support and is expected to reduce need for nursing and residential beds.
- **Reablement:** Reablement provides an admission avoidance service alongside discharge from hospital and prevention of admission to long term care.

The 2017/18 and 2018/19 plans were forecast from the actual numbers of admissions and then assessed against the schemes for reality.

11.2 Admissions to residential care homes:

B&NES has performed well with year on year improvement since the Better Care Fund metric was introduced and is now approaching the National level.

Figure 5 Admissions to residential care home trend



Y on Y reduction	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		-5.91%	-18.05%	-1.09%	-5.95%	-3.62%

B&NES continues to work hard to reduce admissions to care homes, a reduction that is particularly needed, given the loss of care home beds in the previous 18 months. In 2016-17, reablement and assistive technology played a role in reducing admissions to care homes. In 2017-19, the following schemes will impact on care home admissions

- **Reablement:** by improving the length of stay in reablement, more people will be assisted to live at home.
- **Home First:** the further expansion of Home First to include 7 day working will increase the numbers helped to return home.
- **Strengths Based Working:** through a focused training programme, social workers will be supported to assess the risks of supporting people to remain at home
- **Support Planning and Brokerage:** this scheme will offer challenge to placements, will free up the time of frontline staff to focus on assessments and will also ensure that the best negotiation on placements takes place.

- **Assistive technology:** this scheme will trial a number of products within the Home First and reablement service to support assessments to keep people at home.

The 2017/18 and 2018/19 plans were forecast from the actual numbers of admissions and then assessed against the schemes for reality.

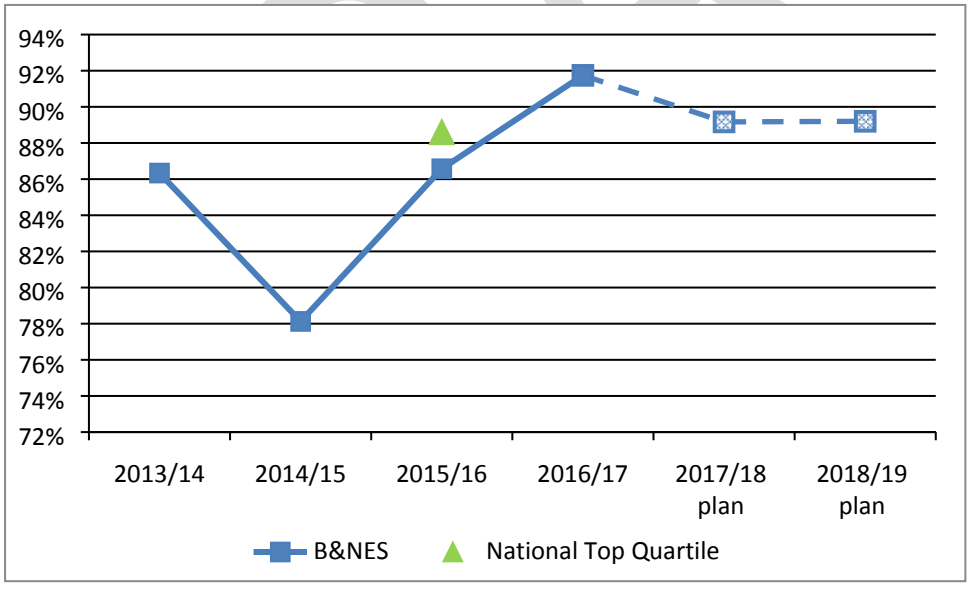
11.3 Effectiveness of reablement:

B&NES performed very well in 2016/17 with 91.7% of people discharged into reablement in Quarter 3 remaining at home.

With the significant developments planned for the Reablement service (detailed below) and particularly the Discharge to Assess programme Home First, numbers are expected to increase and client complexity increase so the plan is to maintain a high level of performance in this plan period.

The previous period of significant change was 2014/15 and this did have a short term impact on performance and this is again a risk for 2017/18 that we will be working to mitigate with regular monitoring.

Figure 6 Proportion of older people at home 91 days after discharge into reablement



The **Integrated Reablement Scheme** will be focussed on undertaking an internal reablement review jointly led by Virgin Care and commissioners during 2017-18. This will include a review of the following areas:Capacity modelling

- Operational processes to support flow and efficiency

- The current model and capacity delivered by strategic partners
- Clarity over pathways including non-weightbearers and urgent care.

In 2017-19, the following other schemes will impact on reablement performance:

- **Assistive technology**: the testing of new technology within reablement should support improved outcomes as the service is
- **Home First:** the further development of Home First to include 7 day will continue to increase the numbers of people benefitting from reablement and ultimately remaining at home but may impact the performance during development as the service is open to a wider level of complexity than previously
- **Discharge to Assess Beds:** The 5 discharge to assess beds will provide time and reablement to ensure that people have the optimal care and support to remain out of hospital
- **Strengths Based Working:** through a focused training programme, social workers will be supported to assess the risks of supporting people to remain at home

12. Delayed transfers of care

DTOC planning for 2017/18 has been produced in line with the request from NHSE and DOH which requested reduction of delays in terms of average bed days in hospitals.

In 2016/17 B&NES national DToC performance under-reported the actual numbers of delayed days and this makes setting a baseline difficult:

- The Royal United Hospitals Bath (RUH) updated their reports to align to the national guidance in February 2017 but have been able to back calculate their 2016/17 results
- The B&NES Community hospital delayed days have not been reported nationally but will be reporting from Q3 2017/18.

A baseline has been estimated and the change required to deliver the National request from this point was calculated.

The DTOC Action Plan been developed with partner agencies through the multi-agency DTOC Action Group and is attached at Appendix 7. As part of this plan, the actions that will support any reductions in days delayed have been identified as below:

Figure 7 Impact of Better Care Fund Schemes on Delayed Transfers of Care

How the Better Care Fund Schemes support improved Delayed Transfers of Care performance in 2017-19 ☑ = Direct ✓ = Enabling		Attribution of delays		Location of bed delay		
		NHS	Social Care	RUH	Virgin (Community Hospital)	AWP
Assistive Technologies		☐	☐	☐	☐	☐
14	Assistive Technologies	☑	☑	☑	☐	☐
High Impact Change Model for Managing Transfer of Care		☐	☐	☐	☐	☐
23a,b,c	Home First (Pathway One & Transport)	☑	☑	☑	☐	☐
23d	D2A Beds (Pathway Three)	☑	☑	☑	☑	☐
Intermediate Care services		☐	☐	☐	☐	☐
3	Integrated Reablement	☑	☐	☑	☑	☐
4	Falls Response	☐	✓	☐	☐	☐
Other		☐	☐	☐	☐	☐
20	Support Planning and Brokerage	☑	☑	☑	☑	☐
	CCG QIPP schemes	☑	☑	☑	☐	☐

The DTOC Action group also evaluated the schemes to estimate the impact of the schemes in terms of delayed days in September 2017 and March 2018. Some of the items in the DTOC action plan were not identified as a BCF or iBCF scheme and these include the Community Hospital Review on length of stay for example. Other CCG QIPP schemes including the enhanced discharge service were identified as contributing to the DTOC plan.

Figure 8 Forecast reduction in days delayed in September by scheme / action (national submission only i.e. does not include Community hospital – Virgin)

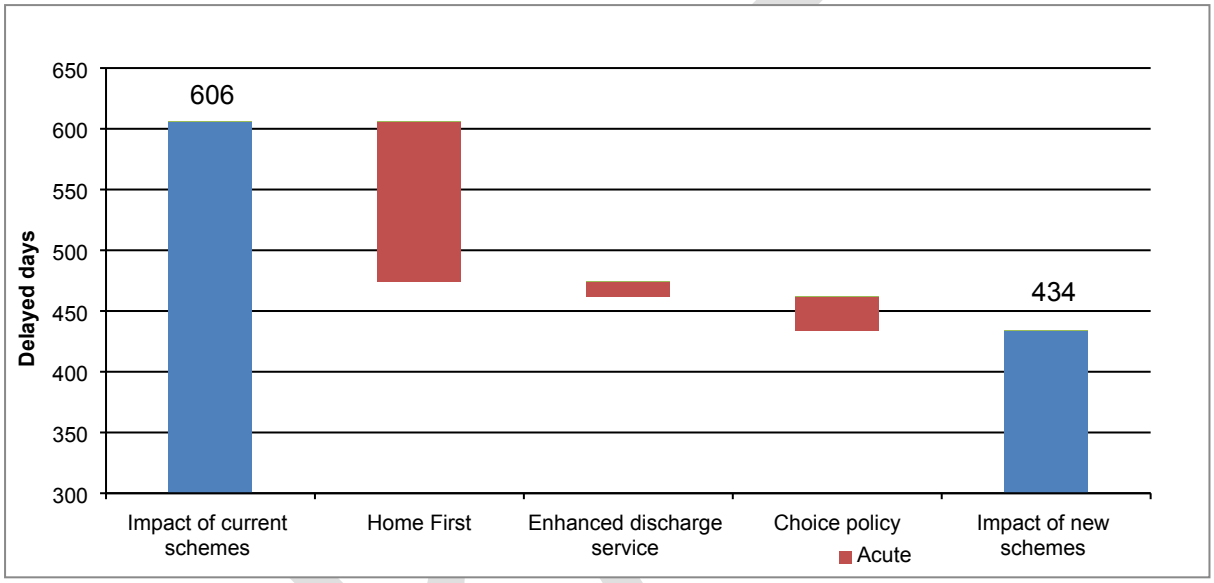
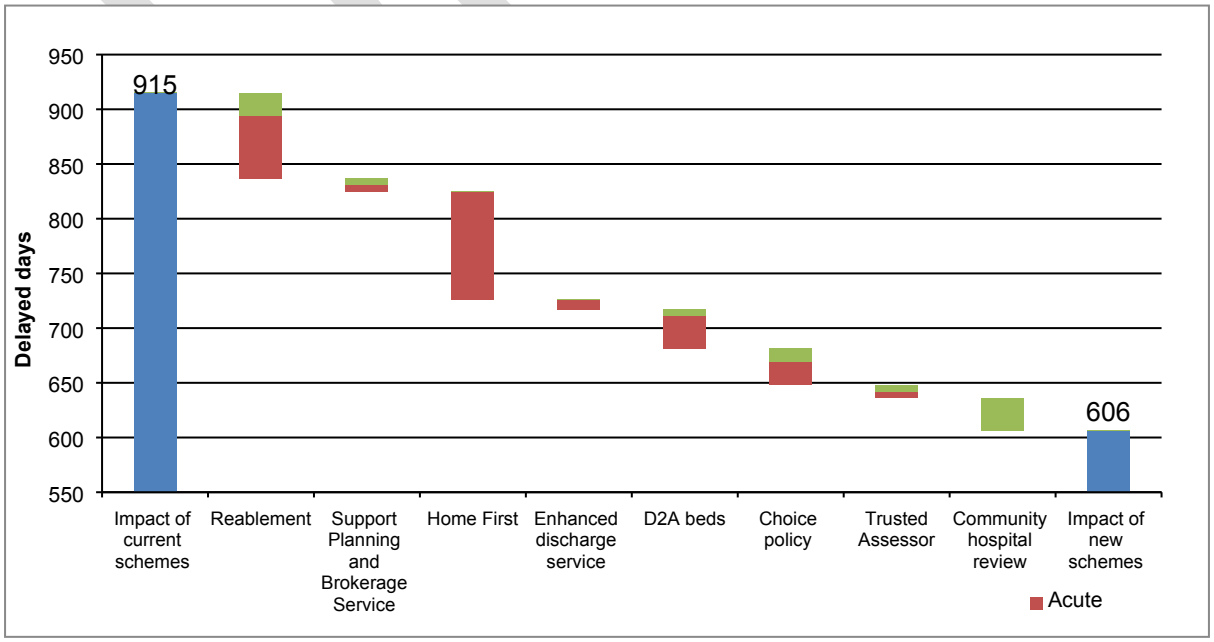


Figure 9 Forecast reduction in days delayed in March 2018 by scheme / action



The reductions identified were close to the nationally requested level for the RUH in 2017/18 but the position for the Community Hospital is more complex due to the estimated baseline and this will be monitored in 2017/18 Q3 and reviewed if further reductions are required. Ongoing review of all schemes and their impact will take place during 2017-19.

The plans were profiled to take into account pressures in the system such as Christmas where a 75% confidence level has been allowed.

The attribution of delays between NHS and Social Care is expected to change but the split in the table below shows that the requested reduction of 4 bed days attributable to social care at the RUH has not been delivered only by social care but also NHS. Many of the NHS delays that are reduced will relate to people waiting for reablement which includes iBCF funding.

Figure 10: Reduction in implied beds between baseline period and September

B&NES patients at RUH	NHS	Social Care	Total
Baseline Q4 2016/17	8.20	7.82	16.02
September 2017 trajectory	4.14	5.09	9.23
Reduction in implied beds	**4.06**	**2.73**	**6.79**

The schemes expected to deliver the most impact on volume are Integrated Reablement and Home First. To ensure that metrics are not overstated, schemes already in place this year are not expected to deliver further reductions unless there is a specific scheme in place (eg Integrated Reablement).

In 2017-19, the following schemes will impact on reablement performance:

- **Integrated Reablement**: internal service review should lead to increased capacity and more efficient discharges.
- **Home First:** the further development of Home First to include 7 day will continue to increase the numbers of people benefitting from faster discharge with assessment at home during reablement.
- **Discharge Liaison Nurse:** specific discharge support at the RUH.
- **Discharge to Assess Beds:** The 5 discharge to assess beds will provide a simpler discharge for complex cases where it is not clear is nursing care is in the patient's best interest.
- **Community Resource Centres:** Additional nursing beds with 7 day assess and admission including beds for funded Nursing Care care.

- **Fair Price of Care:** Supports care home placements.
- **Support Planning and Brokerage:** Will support finding care places and home care.

13. Approval and sign off

The Better Care Fund plan 2017-19 was signed off at the Health and Wellbeing Board on 6th September 2017 and by the following representatives:

Signed on behalf of BaNES Clinical Commissioning Group:

…… Date……..
Tracey Cox
Chief Operating Officer

Signed on behalf of B&NES Council

…… Date……

Councillor Vic Pritchard

Signed on behalf of B&NES Health and Wellbeing Board

…… Date……

Councillor Vic Pritchard

…… Date……..

Dr Ian Orpen

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Bath & North East Somerset Council

Appendix 1 - Better Care Fund 2016/2017 Performance Dashboard

NHS Bath and North East Somerset Clinical Commissioning Group

Current Reporting Period: Mar 17

Non-Elective Admissions

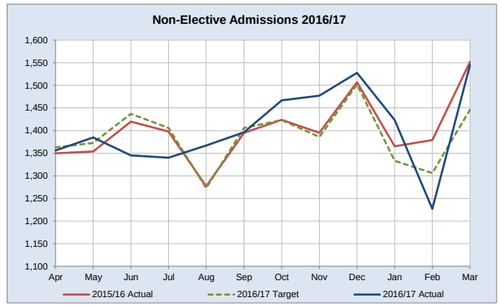
Metric (as at Mar-16)	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Ytd
2015/16 Actual	1,350	1,354	1,420	**4,124**	1,398	1,277	1,395	**4,070**	1,424	1,395	1,507	**4,326**	1,365	1,379	1,552	**4,296**	**16,810**
2016/17 Target	1,363	1,373	1,437	**4,173**	1,406	1,273	1,406	**4,085**	1,423	1,386	1,502	**4,311**	1,333	1,306	1,446	**4,085**	**16,654**
2016/17 Actual	1,356	1,385	1,345	**4,086**	1,340	1,367	1,396	**4,103**	1,467	1,477	1,528	**4,472**	1,423	1,227	1,545	**4,195**	**16,856**
Difference to Target	-7	12	-92	**-87**	-66	94	-10	**18**	44	91	26	**161**	90	-79	99	**110**	**202**
Against Target	▼	▲	▼	▼	▼	▲	▼	▲	▲	▲	▲	▲	▲	▼	▲	▲	▲
% Variance Against Target	-0.5%	0.9%	-6.4%	**-2.1%**	-4.7%	7.4%	-0.7%	**0.4%**	3.1%	6.6%	1.7%	**3.7%**	6.8%	-6.0%	6.8%	**2.7%**	**1.2%**

Total non-elective admissions in to hospital (specific acute), all-ages

Commentary

- Total non-elective admissions activity for March were 6.8% above the plan target (99 admissions).
- Q4 admissions were 2.7% above plan as the effect of winter pressure being felt in January and, despite February seeing below-plan performance, March's admissions served to effectively cancel this out.
- Year end performance was 1.2% above the plan target, with February's improved performance helping to mitigate the impact of winter pressures across the system which had resulted in increased non-elective admissions through to January.

See data note 1 below.



Delayed Transfers of Care Days

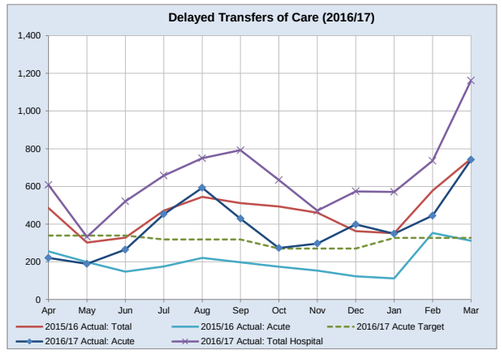
Metric (as at Mar-16)	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Ytd
2015/16 Actual: Total	486	302	329	**1,117**	471	545	512	**1,528**	494	461	363	**1,318**	352	578	747	**1,677**	**5,640**
2015/16 Actual: Acute	255	199	148	**602**	175	221	198	**594**	174	154	123	**451**	112	353	312	**777**	**2,424**
2016/17 Acute Target	339	339	339	**1,017**	319	319	319	**956**	271	271	271	**812**	326	326	326	**979**	**3,764**
2016/17 Actual: Acute	221	189	265	**675**	453	593	429	**1,475**	273	297	398	**968**	349	445	742	**1,536**	**4,654**
2016/17 Actual: Total Hospital	608	333	521	**1,462**	658	750	792	**2,200**	634	471	574	**1,679**	571	736	1,162	**2,469**	**7,810**
Variance to Target Acute	-118	-150	-74	**-342**	134	274	110	**519**	2	26	127	**156**	23	119	416	**557**	**890**
Against Target	▼	▼	▼	▼	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲	▲
% Variance Against Target	-34.8%	-44.2%	-21.8%	**-33.6%**	42.2%	86.1%	34.6%	**54.3%**	0.9%	9.7%	47.0%	**19.2%**	6.9%	36.4%	127.4%	**56.9%**	**23.6%**

Delayed transfers of care (delayed days) from hospital (aged 18+)

Commentary

- DToC days at the RUH have been under-reported for approx.3 years which means the planning for 2016/17 is not comparable to the actuals now being reported.
- Weekly escalation calls were introduced in Q2 to focus on patients delayed within community, acute and mental health beds to help to contribute to a drop in delays. Improvements in delayed days were reported through Q3 and into January. However, the actual performance will have been worse than recorded above due to the reporting issues referenced above. Data for February and March uses the new reporting method, but January is based on the incorrect method, so Q4 performance shown above does not full reflect actual performance.
- The CCG and Council are working on the DTOC trajectory for 2017/18 to take account of the actual delayed days at RUH. NHSE are aware of the data issues and understand that a baseline for 2016/17 needs to be developed based on actual performance in order to support a meaningful trajectory. The BCF return for Q4 included the DTOC position as stated here, as revised data was not available at the time of publication. Again, NHSE is aware of the situation.
- In 2016/17, the DTOC action plan has increased visibility of reporting for DTOCs and reduced flexibility around the definition of a DTOC (in line with national guidance). This has led to an increase in reported DTOCs in 2016/17, so increases in DTOC days are not wholly indicative of a deterioration in performance. The latest issue with DTOC reporting at RUH will lead to further increases in delayed days but will allow for a more accurate calculation of our DTOC baseline position from which to measure our 2017/18 performance once enough data in the new format is available.

See Data Note 2 below.

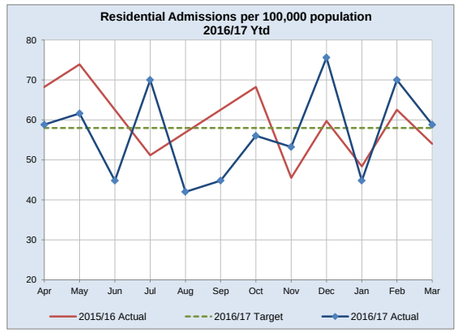


Residential Admissions

Metric (as at Mar-17)	Baseline 13/14	Full year target	Ytd Target	Ytd Actual	Target
2015/16	914	768	768	714	▼ Below Target
2016/17	-	696	696	681	
YTD Variance to target				15	
% YTD Variance to target				-2%	

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

* Aim: Ytd Actual to be **LOWER** than Ytd Target



Residential Admissions ytd to March:
- Provisionally, there have been 681 permanent admissions per 100,000 population ytd against the plan of 696. This is 243 admissions ytd compared to the plan of 249 admissions.
- Performance has improved by 11% compared to 15/16

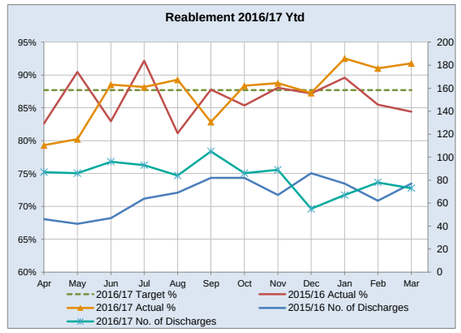
The data for March is an estimate based upon the average of M1-M11 performance, as agreed as part of the Sirona year-end reporting process.
The full year data is being validated prior to the SALT submission in light of the system changes for Social Care and the resulting complexity in reporting.

Reablement

Metric (as at Mar-17)	Baseline 13/14	Target	Ytd Actual	On Target?
2015/16	86.3%	87.8%	86.5%	▼ Below Target
2016/17	-	87.7%	87.3%	
YTD Variance to target			-0.4%	
YTD Change from 2015/16			0.8%	

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

* Aim: Ytd Actual to be **HIGHER** than Ytd Target



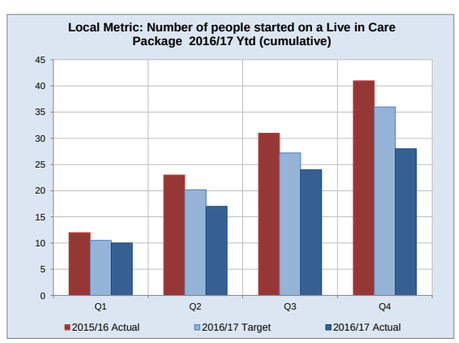
Reablement ytd March (including estimate for March):
- Only the Q4 data counts for the national ASCOF metric used by the BCF but we monitor the measure all year. The Q4 performance showed an improvement on previous quarters and provisionally is 91.3%, which will be a significant improvement on the 15/16 (86.6%) value.
- Of the 999 discharges into reablement in the full year, 870 were still at home after 91 days (87.3%). This is below the 87.7% target for the year though Q4 was significantly above target.
- The reablement service has been reviewed during the year and the Home First service commenced at the end of Q3 to support reduced DTOCs
- Sirona report that they cleansed Q4 data at year-end to remove any patients having needs met by the reablement team who were not actually receiving reablement therapies(e.g. end of

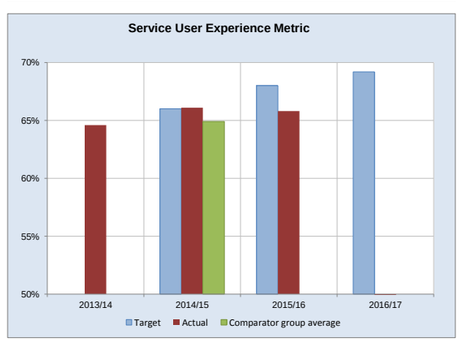
Local Metric

Metric (as at Q4-16/17)	2015/16 baseline	Planned	Ytd Target	Ytd Actual	On Target?
2015/16	41	-	-	41	▼ Below Target
2016/17	-	36	36	28	
YTD Variance to target				-8	
% YTD Variance to target				-22%	

Service users started on a Live in Care Package

* Aim: Ytd Actual to be **HIGHER** than Ytd Target





Local Metric Q4 - Live in Care Packages:
- It is very important that, as the proportion of residential placements goes down, the number of Live in Care Packages does not rise instead.
- Approximately 41 people started on a Live in Care Package in 2015/16 with the support of the reablement and assistive technology schemes, the aim is to reduce this number in 2016/17 by 5 to 36.
- There have been 28 commencements in 2016/17 against a target of 36, so performance demonstrates that the number of Live in Care Packages has been managed throughout the year. In Q4, the number of packages started was 56% below the quarterly target, which is the best quarterly performance in the year.

Service User Experience Metric

Metric (as at 2014/15)	2014/15 baseline	Planned	Ytd Actual	On Target?
2015/16	66.1%	68.0%	65.8%	TBC
2016/17	-	69.2%	TBC	
% YTD Variance to target			-	
% Annual Change in Experience Metric			-	-

How many users of care and support services said they were extremely or very satisfied with their care and support (ASCOF 3A). For respondents over 65.

* Aim: Ytd Actual to be **HIGHER** than Ytd Target

Service User experience - 2015/16
Please note: this indicator is only updated on an annual basis and was reported in June 2016.
- The 2015/16 (65.8%) results showed a small reduction on 2014/15 (66.1%).
- There is a tough target of 69.2% set for 2016/17 (set before we had the 2015/16 results) that will need to be supported by the ongoing work on the social care pathway and its processes and systems (e.g. Liquid Logic implementation) and the joint deliverable to review and improve the carers over 65's pathway.

Data note 1	Data change for 2016/17 reporting - In 2015/16 the non-elective admissions (NEA) plan assumed emergency admissions related to maternity would be included in maternity, but following the change of the maternity contract to the RUH a proportion have consistently been reported through non-elective codes. In 2015/16 the actuals were adjusted to be in line with the plan. For 2016/17, the targets have been set to include these spells and the actuals will therefore include the maternity spells, for comparison purposes the 2015/16 figures have also been restated to include these numbers.
Data note 2	From November 2015, the nationally reported figure for DTOCs is the Actual Acute. The 2016/17 target is therefore based on this figure. Total Hospital = acute hospital + community hospital. As part of the BCF DTOC action plan we are setting up whole system reporting including patients delayed in: acute hospital, community hospital and in the community. The data for delays in the community e.g. patients sat with a District nurse waiting to start a domiciliary care package is currently being transferred into the same format as the hospital data. From February 2017 the RUH revised their DTOC reporting to align with national standards, which has led to an increase in delayed days. Further, delayed days attributable to both NHS and Social Care reasons had been omitted from this report until February 2017; the dashboard has been retrospectively updated to included accurate data.

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Appendix 2 – 2017-19 BCF Scheme Plans

Better Care Fund Plan Scheme Summary

The Better Care Fund Schemes all have plans and these are aligned where relevant with CCG QIPP schemes and the Council Savings schemes. The new and existing schemes that will have most impact on the Health and Care system in BANES in 2017/19 are shown in detail in this appendix. All other schemes have been defined in previous years Better Care Fund plans.

Scheme		Plan
Assistive Technologies		
14	Assistive Technologies	Plan detail on page 2-3
Carers Service		
11	Support for Carers	Funding for Carers' Centre offering bespoke support for Carers in B&NES.
Disabled Facilities Grant - Adaptions		
14	Disabled Facilities Grant (DFG)	Disabled Facilities Grant funding supporting adaptations in the home.
Enablers for Integration		
1a	Integrated Delivery infrastructure	Supports integrated teams and social care pathway within Virgin Care, including point of access.
2a	Integrated Care and Support	Supports integrated teams (including mental health and LD) within Virgin Care.
2b	Community Equipment	Plan detail on page 4-5
High Impact Change Model for Managing Transfer of Care		
2a	Social Work 7-day Working	Investment into seven day working
2b	Discharge Liaison Nurse	Plan detail in appendix - missing at present
23a,b,c	Home First (Pathway One & Transport)	Plan detail on page 6-7
23d	D2A Beds (Pathway Three)	Plan detail on page 8-9
Integrated care planning		
13	Strengths-based Working	Plan detail on page 10-11
Intermediate Care services		
3	Integrated Reablement	Plan detail on page 12-13
4	Falls Response	Plan detail on page 14-15
5	Home From Hospital Schemes	Range of schemes including Extra Care step down beds, Age UK Home from Hospital service
Primary prevention / Early Intervention		
9	Social Prescribing	Plan detail on page 16-17
10	Mental Health Reablement beds	3 crisis support beds in the Wellbeing House for adults of working age with support for up to 4 days, 4 times a year.
Residential placements		
19	NMW/Sleep in	Plan detail on page 18-19
21	Community Resource Centres	Plan detail on page 20-21
22	Transition of ECSH	Plan detail on page 22-23
Other		
17	Fair Price of Care	Plan detail on page 24-25
20	Support Planning and Brokerage	Plan detail on page 26-27

Appendix 2 – 2017-19 BCF Scheme Plans

Assistive Technology

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☒ IBCF ☒ QIPP ☑ Council savings

BCF Scheme ref: 14

SCHEME

Name: **ASSISTIVE TECHNOLOGY (AT)**

AT describes a host of digital technologies that support people to remain as independent as possible, manage their health and care needs and remain at home safely. They provide remote monitoring, access to health and care data and enable people to self-manage. There is a huge range of AT available, with new technologies being developed all the time.
There is a project under development to rapidly increase the use of AT in B&NES particularly within reablement and develop a business case to further the implementation of AT.
This project will provide an evidence base for having AT as an integral part of a person's care and support package and is expected to demonstrate long term benefits for the person and for the council.

Commissioner: **Wendy Gyde**

Provided by: **Virgin Care and Sirona Care & Health**

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
●	Agree areas of focus for the project		●	●	
●	Finalise the requirements for a technology partner			●	●
●	Finalise redesign of reablement processes to include AT			●	●
●	Finalise the AT tools to be used and deploy		●	●	●
●	Provide training to reablement teams in the new processes and technologies		●	●	●
●	Project evaluation			●	●

Notes: The above are high level milestones taken from the more detailed project plan.

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£250,000	£0	Existing	Disabled Facilities / LGA Grant

Key:
- ● Not Started
- ● In Progress but overdue
- ● In Progress
- ● Complete

RISKS / INTERDEPENDENCIES

Risks:
- There is a risk the project will not be able to secure an AT partner who can recommend and source the equipment.
- There are risks in terms of where the project will target it's resources, as there is little data currently available to make a recommendation from.

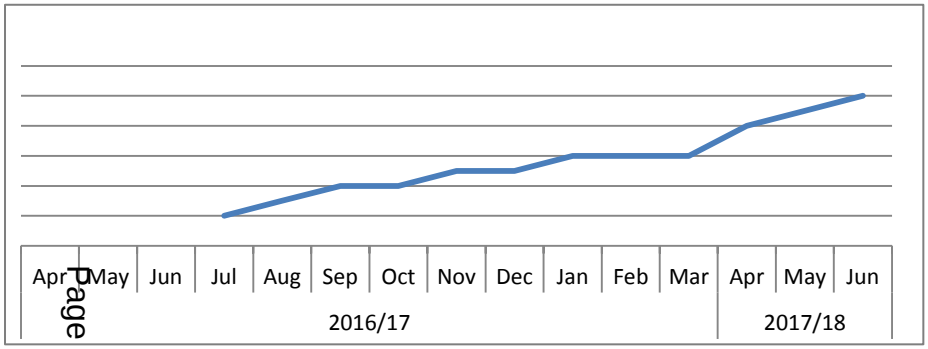
Interdependencies:
- Community equipment service (BCF scheme)
- Virgin Care Community Services transformation of Reablement and Single Point of Access for Social Care Domiciliary Care Providers.

Appendix 2 – 2017-19 BCF Scheme Plans

Assistive Technology

MEASURES

Increase the usage of Assistive Technologies



Note: Trajectory to be developed as part of the project.

Measure and improve outcomes for service users

We're developing measures as part of the project to ensure the service delivers improved outcomes for the service users, such as;

- % of service users who have AT included as part of their reablement Care and Support Plan
- % of service users whose levels of support is estimated to have been reduced by the inclusion of AT
- Estimated value of the care and support that is not required due to the inclusion of AT within the person's care and support plan

We will also gather feedback from people using the service, their families, carers/representatives, which will also support service development.

NATIONAL METRICS

This scheme will support the national metrics by supporting people receiving reablement and long-term care and support to achieve improved independence.

- Reduce non-elective admissions
- Reduce delayed transfers of care
- **Reduce permanent residential admissions**
- **Increase success of reablement**

Appendix 2 – 2017-19 BCF Scheme Plans

Community Equipment

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☒ IBCF ☒ QIPP ☑ Council savings

BCF Scheme ref: 7b

SCHEME

Name: **COMMUNITY EQUIPMENT (CE)**

The community equipment service is contracted to Sirona Care & Health until the end of March 2018. This year we will review the current provision, make recommendations for the service post March 2018 and support any procurement activity later in 2017-18.

The review aims to ensure that equipment is used optimally and appropriately to meet peoples care needs in line with the scheme to develop the use of Assistive Technology. The review also aims to ensure that equipment needs are met in a timely manner with equipment that represents good value for money.

Commissioner: **Wendy Gyde**

Provided by: **Sirona Care & Health**

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Community Health	£473,011	£481,998	Existing	CCG Minimum Contribution

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
●	Finalise current spec, understand processes around CE and map the spend	———	———		
●	Develop the requirements for April 2018 onwards		———	———	
●	Procure CE solution for April 2018 onwards			———	
●	Implement the CE solution for April 2018 onwards			———	———

Notes:

RISKS / INTERDEPENDENCIES

Risks:

- There is a risk that the project does not have enough time to complete the review and make a considered recommendation for post-March 2018.

Interdependencies:

- This work stream has interdependencies with the Assistive Technology scheme.

Appendix 2 – 2017-19 BCF Scheme Plans

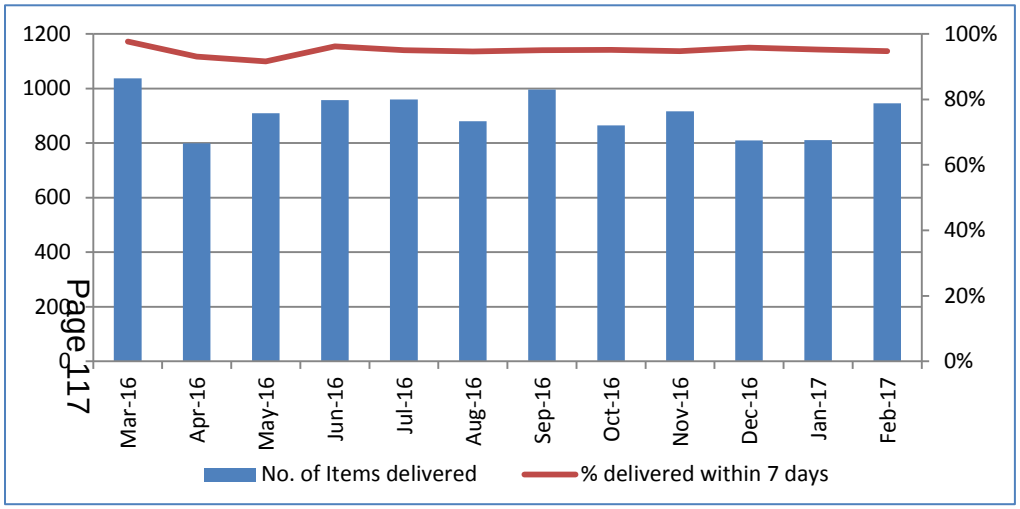
Community Equipment

Bath & North East Somerset Council

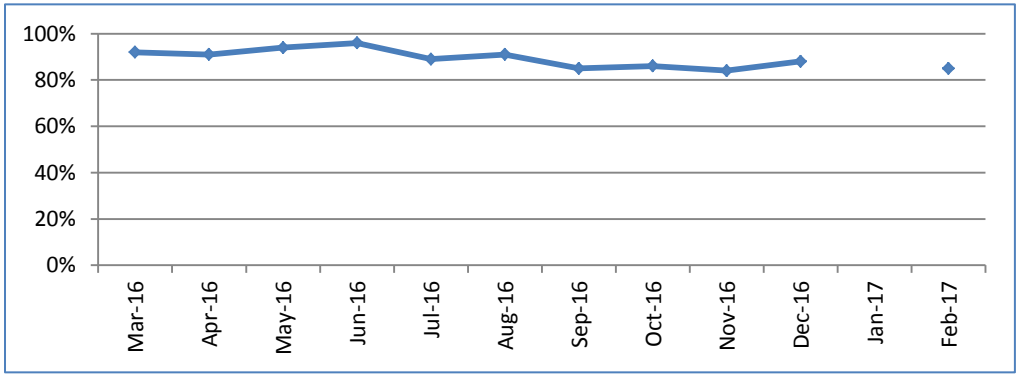
NHS Bath and North East Somerset Clinical Commissioning Group

MEASURES

Equipment deliveries and timeliness



Recycling rate



Measure and improve outcomes for service users

In 2017/18 the service performance will be managed against the existing measures while under review. The 2016/17 performance is shown in the charts to the left.

We're redeveloping measures as part of the review to ensure the service delivers improved outcomes for the service users, such as;

- % items of equipment delivered within agreed timeframe
- % items recycled
- Cost of equipment ordered by team
- Customer satisfaction with equipment

We will also gather feedback from people using the service, their families, carers/representatives, which will also support service development.

NATIONAL METRICS

This scheme will support the national metrics by enabling the schemes that keep people at home or return people home and helping to prevent future need for emergency care.

- Reduce non-elective admissions
- Reduce delayed transfers of care
- Reduce permanent residential admissions
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Home First
(Pathway One & Transport)

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☑ IBCF ☒ QIPP ☒ Council savings

BCF Scheme ref: **23**

SCHEME

Name: **HOME FIRST**

In March 17 partners within B&NES agreed to rationalise the current Discharge to Assess Service into the Home First Service for patients who are able to return home following discharge but require further H&SC assessments.
The Home First service is delivered by the Integrated Reablement Service and is commissioned to provide 20 discharge slots per week between Mon-Fri. If suitable, the service users will receive care, support and assessment to maximise independence, for up to 6 weeks.

Additionally, it was agreed in May 17 that additional iBCF funding will be provided to deliver 4 discharge slots in the Home First Service across Sat & Sun to better meet patient and system discharge needs.

Finally, iBCF funding was agreed on an interim basis to support transport into the Home First Service to ensure prompt and effective discharge and also to fund a clinical leadership position, to lead the rationalisation of the service.

Commissioner: **Angela Smith**

Provided by: **Virgin Care**

FINANCE

Area of Spend	Planned Expenditure 2017/18	Planned Expenditure 2018/19	New or Existing Scheme	Funding Source
Social Care	£253,934	£253,934	Existing	Local Authority Social Services
	£163,646	£163,646	IBCF	
	£10,258	£0	IBCF	

Key:
- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
	Transition of discharge to assess service to Home First (5 day service)				
	Continue to develop metrics to monitor service & assess outcomes				
	Business case signed off for 7 day funding.				
	Recruit staff for 7 day service and launch Sat/Sun service				
	Review Remit of Home First within Integrated Reablement Service				

Notes:

RISKS / INTERDEPENDENCIES

Risks:
- Delays may potentially occur during recruitment processes which may impact on implementation timescales for 7 day provision.
- The current Mon-Fri services is not fully delivering against its commissioned expectations and therefore there is a risk that the Sat & Sun service will not either. However this is being mitigated through a robust improvement plan which is being delivered by the Home First operational and strategic groups.
- Total costs may be more than initially anticipated due to the need to potentially increase capacity to provide a single point of access across 7 days.
- Prolonged LOS stay in Integrated Reablement service due to delays in sourcing long term packages of care and placement may reduce patient flow and service capacity However this is due to be mitigated by undertaking a in depth review into the Integrated Reablement service.

Interdependencies:
- RUH refer patients into the service
- Reablement Domiciliary Care Partners – provide care and some reablement services
- Virgin Care & B&NES Council Client Finance – provide social care assessments including financial assessments

Appendix 2 – 2017-19 BCF Scheme Plans

Home First

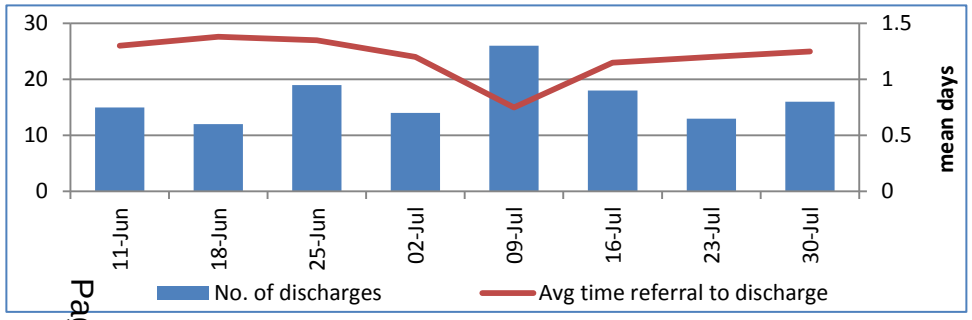
(Pathway One & Transport)

Bath & North East Somerset Council

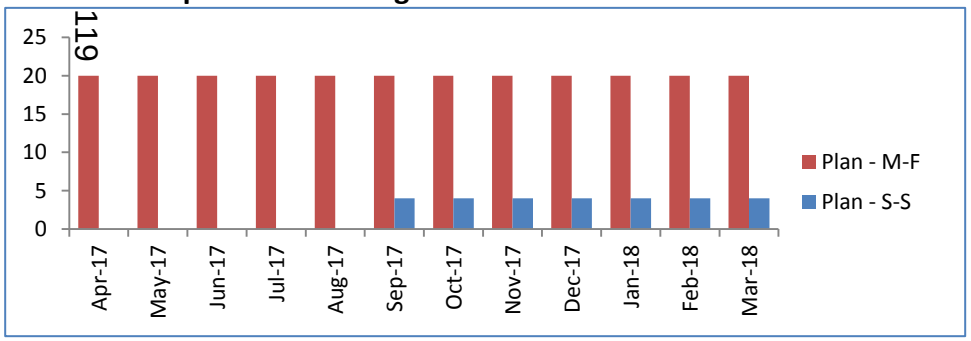
NHS Bath and North East Somerset Clinical Commissioning Group

MEASURES

Reduce the discharge time (recent performance)



Deliver the planned discharge volumes



Monthly Discharge Destination

Scheme to date outcomes	Plan	YTD
Discharged to own home with a care plan	6%	
Discharged to own home no care plan	?%	
Discharged into Residential care	19%	
Discharged into Nursing care	75%	

Measure and improve outcomes for service users

We're developing measures as part of the contract to ensure the service delivers improved outcomes for the service users, such as;

- % of service users whose levels of support has been reduced after 6 weeks in the reablement service.
- % of permanent admissions into residential and nursing homes.
- Number of discharges into the service.
- % of patients who are discharged into the service within 24 hours of ward referral.

We will also gather feedback from people using the service, their families, carers/representatives, which will also support service development.

NATIONAL METRICS

This scheme will support the national metrics by support people to go home from hospital quickly and keep people at home where appropriate.

- Reduce non-elective admissions
- **Reduce delayed transfers of care**
- **Reduce permanent residential admissions**
- **Increase success of reablement**

Appendix 2 – 2017-19 BCF Scheme Plans

Discharge to Assess Beds
(Home First Pathway Three)

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☑ IBCF ☒ QIPP ☒ Council savings

BCF Scheme ref: **23**

SCHEME

Name: **DISCHARGE TO ASSESS (D2A) BEDS**

This scheme will involve the commissioning of 5 D2A beds within a single nursing home provider to allow health & social care assessments, rehabilitation and reablement to take place in an appropriate environment, at the most appropriate time. This will ensure independence and functioning is optimised prior to decisions around long term care being made, preventing people having to make decisions about their long term care needs whilst in 'crisis'. It is predicted that by enabling adequate time for recuperation, rehabilitation and reablement, perceived long term care needs on admission may be reduced such as from nursing to residential care /Package Of Care.

A D2A bed will be available to a service user for a defined period of up to 6 weeks. The beds will be commissioned initially on a 12 month contract, with review after 6 months, to determine the long term feasibility of the beds.

Commissioner: **Vince Edwards**

Provided by: **To Be Confirmed Following Procurement Process**

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
🟢	Initial scoping of D2A model and production draft business case	●	●		
🔴	Finalise and sign off business case & draft procurement documents		●	●	
⚫	Undertake procurement process		●	●	
⚫	Contract start date with preferred bidder			●	●
⚫	Undertake evaluation of bed base.				●

Notes:

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£283,487	£338,000*	New	IBCF

* Planned only. Finances will be confirmed during business case development and following procurement processes.

Key:

- ⚫ Not Started
- 🔴 In Progress but overdue
- 🟠 In Progress
- 🟢 Complete

RISKS / INTERDEPENDENCIES

Risks:

- Procurement process and governance process delays may affect implementation timescales.
- Total costs may be more than initially planned due to the need to ring-fence Social Workers/Occupational Therapists input into bed base. However this may be offset by an underspend in 2017/18 due to slippage of implementation timescales.
- Average LOS may be greater than the 6 week period due to reasons including patient/family choice, reducing bed flow through the bed base. (Aim to mitigate through dedicated Social Worker input).
- Possible impact on community hospital length of stay needs to be assessed.

Interdependencies:

- This will require a cohesive approach by B&NES Council, RUH and Virgin Care
- Local Care Home Providers
- This scheme may be impacted by the Fair Price of Care and Care Home Market Development scheme.

Appendix 2 – 2017-19 BCF Scheme Plans

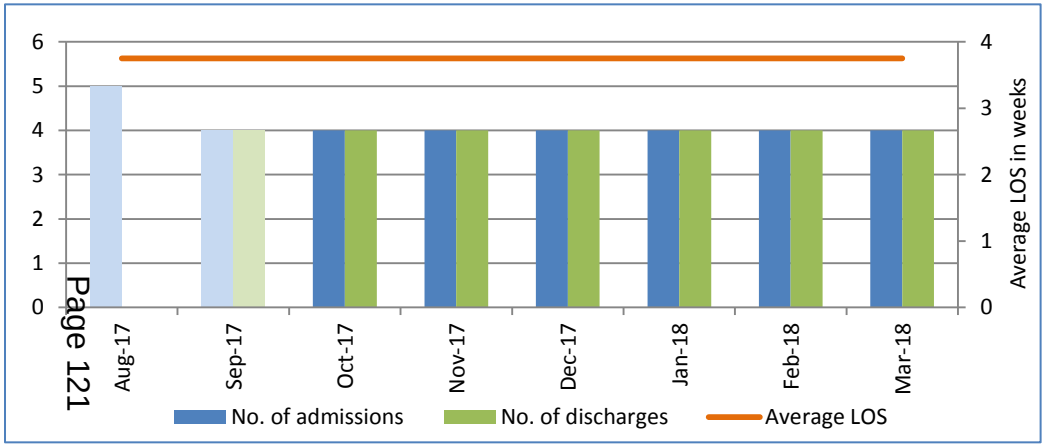
Discharge to Assess Beds
(Home First Pathway Three)

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

MEASURES

Monthly Admissions & Discharges (Inc. Average LOS)



Monthly Discharge Destination

Scheme to date outcomes	Target	YTD
Discharged to own home with a care plan	6%	
Discharged into Residential care	19%	
Discharged into Nursing care	75%	

Note: As the number of beds is so small we expect significant variations in the results which can not be planned for on a monthly basis , so the trajectories are expected averages and several months performance may be required before the results are clear.
Project due to start in August 2017 but may be delayed as mentioned in Risks

Measure and improve outcomes for service users

The activity for this scheme will be monitored for admissions to the D2A beds, discharges form the beds and length of stay (see example chart to left).

We're developing outcome measures as part of the contracting process to ensure the service delivers maximised independence for the service users, such as;

- % of service users whose levels of support has been reduced after 6 weeks in the service
- Rates of admission to long term residential and nursing home care.

Based on a similar scheme in a local CCG we are aiming for 25% of service users to have an outcome reduced from Nursing Care (see table to left)

We will also gather feedback from people using the service, their families, carers/representatives, which will also support service development.

NATIONAL METRICS

This scheme will support national metrics by increasing independence and reducing long term care needs. Additionally this scheme will add an additional community bed based resource reducing DTOC's.

- Reduce non-elective admissions
- **Reduce delayed transfers of care**
- **Reduce permanent residential admissions**
- **Increase success of reablement**

Appendix 2 – 2017-19 BCF Scheme Plans

Strengths-Based Working

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☒ IBCF ☒ QIPP ☒ Council savings

BCF Scheme ref: **13**

SCHEME

Name: **STRENGTHS-BASED WORKING**

A strengths, or asset-based approach to social work practice aims to put individuals, families and communities at the heart of care and wellbeing, and in doing so strengthen relationships between members of that community and build social capital. It is responsive to need but focuses on the positive attributes of individual lives and of neighbourhoods, recognising the capacity, skills, knowledge and potential that individuals and communities possess. The approach needs to be supported by all those that work with the individual across health and social care.

Commissioner: **Helen Wakeling**

Provided by: **Virgin Care and AWP**

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£30,000	£0	Existing	CCG Minimum Contribution

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
●	To consider the models currently being used across social care , identifying the one that would best meet our local requirements		●	●	
●	Identify dependencies across other work– to ensure that a strengths based approach underpins the work being undertaken.		●	●	
●	Develop a project plan focused on the cultural change that will be required		●	●	

Notes:

RISKS / INTERDEPENDENCIES

Risks:

- That the changes required are not fully embedded across health and social care practitioners
- The cultural change is not supported by other work being undertaken in organisation.
- The measures adopted during implementation do not support the approach being taken focusing on quantitative outputs rather than qualitative.

Interdependencies:

- Care and support planning based on a strengths based approach

MEASURES

Social Work to meet Contract Management requirements

This project is to support Social Work practice but the key metrics and outcomes will be those as requested for the service in the contract .

The service has historic poor performance in terms of managing the timeliness of assessment and reviews and a recovery plan is currently being developed. Once agreed this will include a recovery trajectory for the key activity metrics that the service will be monitored against.

Measure and improve outcomes for service users

Outcome measures will be developed as part of the project including:

- % of people who feel that their care and support plans meets outcomes they had identified
- % of people who felt they were supported to make choices about how their care and support is provided
- % of social care cases audited that recognise individual strengths and ways of maximising the person's independence in both the assessment and care and support plan.

There will need to have a strong focus on the outcomes achieved for people using the service, their families, carers/representatives, which will also support service development.

NATIONAL METRICS

This scheme will support the national metrics indirectly by supporting the timely delivery of support and care plans of high quality and personal relevance to support people to maintain their needs .

- Reduce non-elective admissions
- Reduce delayed transfers of care
- Reduce permanent residential admissions
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Integrated Reablement

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☒ IBCF ☒ QIPP ☑ Council savings

BCF Scheme ref: 3

SCHEME

Name: **INTEGRATED REABLEMENT**

Description: A short description of what the scheme encompasses and its history
The Integrated Reablement Service is directly provided by Virgin Care with subcontracted capacity within Dom care providers. This year, this model will be reviewed to maximise capacity and efficiency of the service though shorter LOS and better clarity over criteria.
The facilitating Hospital Discharge Service will also be incorporated into Reablement/Home first.

Commissioner: **Angela Smith**

Provided by: **Virgin Care and Strategic Dom Care Partners**

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Community Health	£1,242,392	£1,245,263	Existing	CCG Minimum Contribution
	£1,146,715	£1,168,502	Existing	
	£225,000	£229,275	Existing	

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES

Status	Action	Q1	Q2	Q3	Q4
	Confirm scope of review				
	Agree new measures of capacity and efficiency				
	Review and make recommendations on service model				
	Prepare for 2018-19 delivery				

Notes:

RISKS / INTERDEPENDENCIES

Risks:

- Capacity within Virgin Care to prioritise the Reablement Review
- Capacity within Commissioning to support review
- Lack of quality data to measure capacity
- Continuing pressure on service from Dom Care capacity

Interdependencies:

- Assistive Technology
- Main Virgin transformation programme

Bath & North East Somerset Council

Appendix 2 – 2017-19 BCF Scheme Plans

Integrated Reablement

NHS Bath and North East Somerset Clinical Commissioning Group

MEASURES

Increase Success of Reablement

The key measure for this scheme is the National Metric and the detail is in the National Metrics section of the Better Care fund Plan.

Measure and improve outcomes for service users

We're developing measures as part of the contract to ensure the service delivers improved outcomes for the service users, such as;

- % of service users whose levels of support has been reduced after 6 weeks in the service
- Length of stay - % over 6 weeks

We will also gather feedback from people using the service, their families, carers/representatives, which will also support service development.

- Capacity of the service within Virgin and strategic partners

NATIONAL METRICS

This scheme will support the national metrics by enabling vulnerable people to stabilise their lives and reduce the need for emergency care and health support.

- Reduce non-elective admissions
- Reduce delayed transfers of care
- Reduce permanent residential admissions
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Falls Response

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☒ IBCF ☑ QIPP ☒ Council savings

BCF Scheme ref: **4**

SCHEME

Name: **FALLS RESPONSE**

A new community based rapid-response pilot for people over the age of 65 years who fall over at home. April 2017 - March 2018.

The Falls Rapid Response Team, which includes a specialist paramedic and an occupational therapist, will respond to up to four B&NES patients per day if they have contacted the emergency services for assistance after a fall. The team will help the person get comfortable, carry out a home-based falls risk assessment, recommend any necessary interventions and put into place any further support that could help prevent future falls and admissions to hospital.

Commissioner: **Kate Parkins**

Provided by: **SWASFT, RUH & Virgin Care**

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£224,500	£228,766	Existing	CCG Minimum Contribution

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
	Set up service				
	Monitor activity and outcomes				
	Evaluate data and develop business case for 18/19				

Notes: Pilot is underway, operational group in place to discuss any issues that may occur and find solutions. Continue to collate information to monitor impact (until Q3) in preparation for business case.

RISKS / INTERDEPENDENCIES

Risks:

- Staff vacancy or short term sickness will reduce cover required and effect delivery of service
- Capacity of services to refer patients to for further support / treatment
- Vehicle will be required to respond to other immediate life threatening calls which may reduce the capacity to respond to falls .

Interdependencies:

- SWASFT, RUH and Virgin Care working together to deliver pilot
- FAST transport system
- Voluntary Sector & Community Services commissioned by CCG or local council

Appendix 2 – 2017-19 BCF Scheme Plans

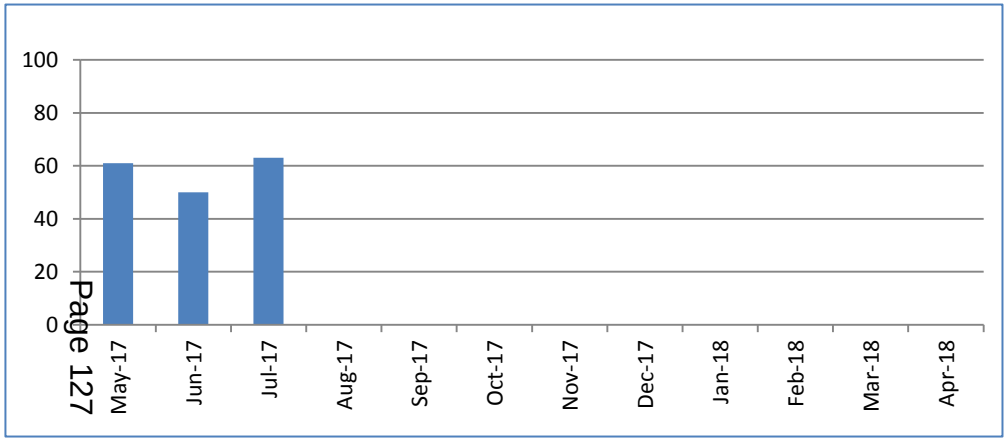
Falls Response

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

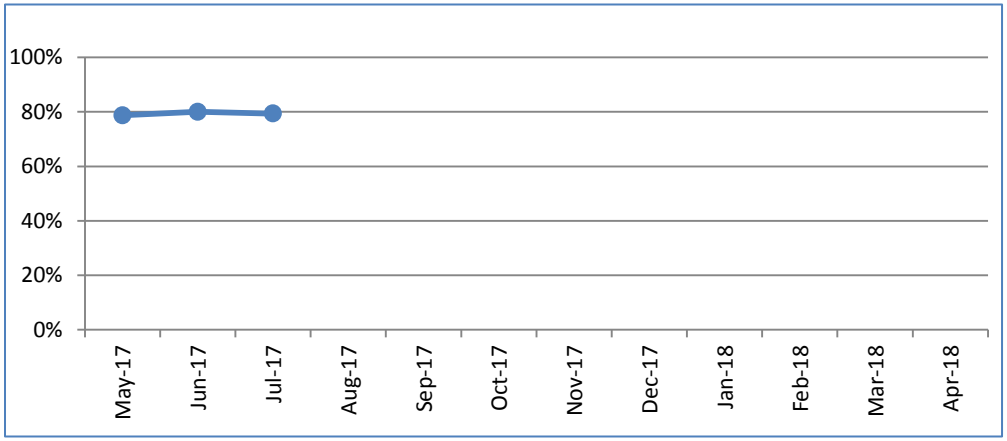
MEASURES

Delivering as expected activity during pilot



Note: No. of patient falls responded to by the Falls Rapid Response Team for

Percentage of patients for whom admission was avoided



Note: This measure is being defined as part of the pilot at the moment it is as recorded on the call .

Measure and improve outcomes for service users

The pilot is measuring the usage of the scheme and the outcomes for the patient supported. These are not specifically targeted as the pilot is the baseline period. The expected levels have been set based on capacity but will be updated during the pilot based on experience . Early months have seen the car used for other life threatening calls which is impacting the capacity which is being mitigated for in Q2 but will lengthen the time to embed.

We're gathering information as part of the pilot to enable understanding of the pilot and to identify potential commissioning opportunities, for e.g.

- Voluntary Sector impact (number of patients referred and to which service e.g. Home response)
- Reasons where patients admitted to hospital
- Referrals to community services and primary care

We will also gather feedback from people using the service, their families, carers/representatives, which will also support service development.

NATIONAL METRICS

This scheme will support the national metrics by preventing an emergency attendance / admission on the day and preventing future falls and emergency admissions supporting people to stay in their own home.

- **Reduce non-elective admissions**
- Reduce delayed transfers of care
- **Reduce permanent residential admissions**
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Social Prescribing

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☒ IBCF ☒ QIPP ☒ Council savings

BCF Scheme ref: 9

SCHEME

Name: **SOCIAL PRESCRIBING**

Social Prescribing will be responsive in addressing issues that may negatively impact on the health and wellbeing of people, who frequently make use of local GP practices, with the aim of improving the patients' quality of life, reducing the demand on costly health services, and enabling funds to be better targeted on people whose needs are purely clinical rather than practical or social.
People accessing the service may have mental health problems, long term conditions, or other practical issues which affect their mental and physical wellbeing, and who may lack support mechanisms in their lives.
The Service will operate on two levels – access through GP referral (holistic assessment), and open access for people with wellbeing needs in the community (signposting / triage), enabling people to better manage their conditions, social interaction, take-up of prescribed health related activities and access to both mainstream service and community resources. It will work alongside healthy lifestyles advisers, and have close links and working relationships with all interventions within the Wellness Service.

Commissioner: **Basil Wild**

Provided by: **DHI sub-contracted by Virgin Care**

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Mental Health	£100,000	£100,000	Existing	CCG Minimum Contribution

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
●	Develop working criteria with stakeholders which will feed into development plans for the Wellness Service		●	●	
●	Maintain presence in at least 80% of GP practices		●	●	
●	Develop and refine outcome / evaluation methodology so that it is able to demonstrate preventative as well as service outcomes		●	●	●
●	Promote the use of 'ROVa' as a social prescribing tool within the Wellness Service, and participate in its development	●	●	●	
●	Establish working practices and integration with the Healthy Lifestyle Advisers (physical health) element of the Wellness Service to achieve parity of esteem		●	●	●
●	Membership and effective participation in a Wellness Service steering / working group, and contribute to its on-going development		●	●	●
●	Contribute effectively to the development of an integrated and shared care / support plan across the Wellness Service pathway with the development of appropriate protocols	●	●		
●	Establish effective working arrangement for the cascading and uptake of information about peoples' wellbeing needs in order to develop responsive and appropriate community interventions within an integrated Wellness Service	●	●	●	

Notes:

RISKS / INTERDEPENDENCIES

Risks:

- Lack of trained and supported volunteers to a) support community activities and b) act as befrienders to support people into interventions
- Lack of appropriate community opportunities or long waiting lists to access them (social prescribing is only as good as the interventions available)
- Disruption to existing community opportunities by regular influxes of new members / participants
- Information not being cascaded through the pathway and into the development of responsive interventions

Interdependencies:

- All elements of the Wellness Service, but specifically:
  i) Wellbeing College, ii) Community Opportunities and Community Fund, iii) Volunteer Network and iv) Healthy Lifestyle Advisors
- ROVa development (the underlying system)
- Development of the proposed Virgin Care Community Hubs (a potential outlet for social prescribing)
- All elements of the Mental Health pathway (existing / new model from April 2018)

Appendix 2 – 2017-19 BCF Scheme Plans

Social Prescribing

MEASURES						
Measure	**Aim / Target**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
Support referrals from GPs and self-referrals	A minimum of 280 referrals / self-referrals a year	280				
	Referrals from >80% of GP practices	>80%	78%	99%	100%	
Achieve a responsive service.	Response rate to referrals of a maximum of 10 working days.	10				
	Response to initial appointment to average less than 3.5 weeks	<3.5				
Achieve positive outcomes for clients referred / self-referring to the service, based on the MyScript Outcomes Framework	A minimum of 55% of referrals / self-referrals will achieve a positive outcome as a result of the service, based on the MyScript Outcomes Framework	55%				
Achieve a low declined / non-engagement rate from the service	The declined / non engagement rate will be less than 30% of all referrals.	<30%				
Support people who disengage from the holistic service by providing a signposting service	More than 80% of people who disengage from the holistic service will still receive support by means of relevant signposting.	>80%				
Recruit, train and support volunteers to support the service and work with clients	A minimum of 15 volunteers will support the service over a year	15				

NATIONAL METRICS

This scheme will support the national metrics indirectly by supporting people to develop healthier lifestyles and reduce the need for care and health support.

- Reduce non-elective admissions
- Reduce delayed transfers of care
- Reduce permanent residential admissions
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

National Minimum Wage / Sleep-in

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☑ IBCF ☒ QIPP ☒ Council savings

BCF Scheme ref: 19

SCHEME

Name: **NATIONAL MINIMUM WAGE (NMW) / SLEEP-IN**

Many funded packages of care for adults with learning disabilities, in both registered care services and in a persons own home - include sleeping in provision – i.e. a member of staff is required to be present on site overnight to ensure that the person remains safe and has their needs met, however the member of staff is permitted to sleep and only attend to any needs if required. This is standard practice that has been in use for many years. Traditionally the member of staff has been paid a 'flat rate' of approximately £35-40 per night for the sleep in hours, which are usually in addition to the substantive hours of their post. Recent case law has established that "sleep-ins" are covered by the NMW regulations. So even if a worker is allowed to sleep at work, if they are required to stay at their workplace, then all their hours are covered by NMW regulations. This scheme is to meet the requirement of these National Minimum Wage regulations.

Commissioner: **Mike MacCallam**

Provided by: **All providers of Learning Disabilities services**

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
🟢	Agreeing the 3.5% uplift for packages of care with a Sleep-in element				
🟢	Communicating the decision to all providers				
🟠	Applying the uplift to all packages of care				
🟠	Working with providers to understand their cost pressures				

Notes: The above are high level milestones taken from the more detailed project plan.

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£76,000	£76,000	IBCF	Local Authority Social Services

Key:

- ⚫ Not Started
- 🔴 In Progress but overdue
- 🟠 In Progress
- 🟢 Complete

RISKS / INTERDEPENDENCIES

Risks:

- Providers might challenge the decision of the 3.5% uplift, requiring more funding
- Provider might serve notice on the package of care due to lack of funding

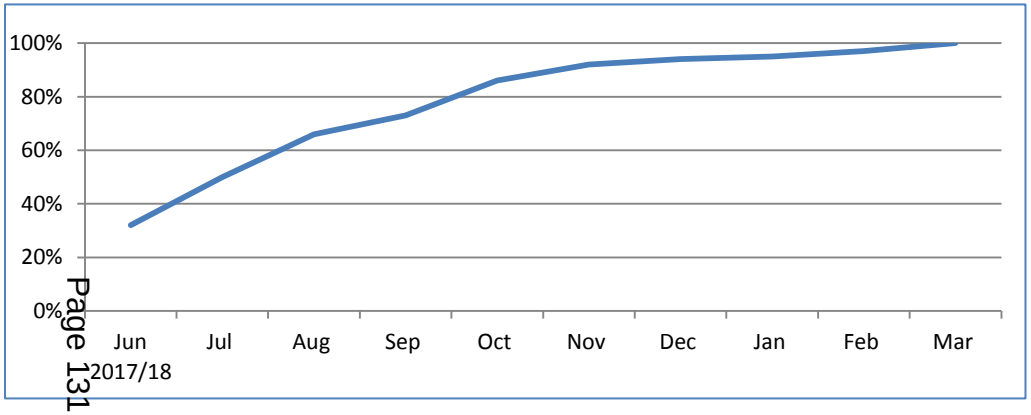
Interdependencies:

Appendix 2 – 2017-19 BCF Scheme Plans

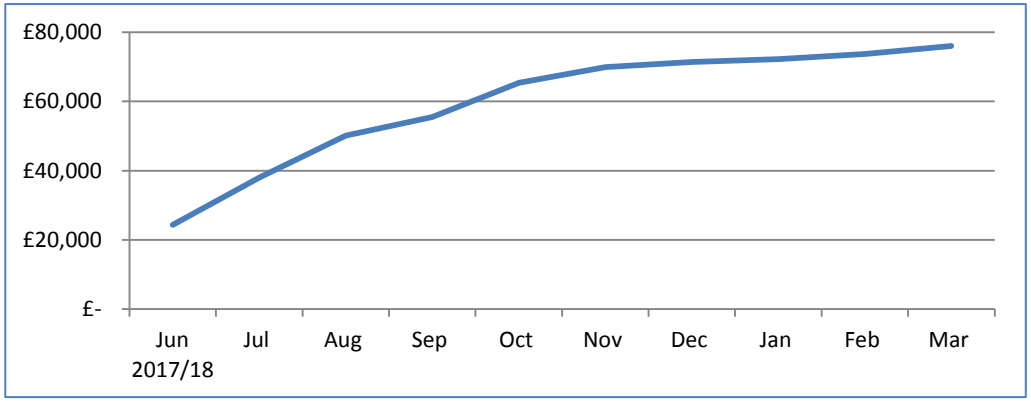
National Minimum Wage / Sleep-in

MEASURES

Packages of care receiving uplift - cumulative



Cost implication of increase (to the Council) - cumulative



Delivering the change

The success of this scheme will be measured by the delivery of the milestones. We will track the impact of these changes focussing on the delivery of the uplift to all relevant packages and the costs implication on the packages of care. The charts to the left include sample data .

NATIONAL METRICS

This scheme is to ensure current levels of support are maintained and is not expected to further support the national metrics

- Reduce non-elective admissions
- Reduce delayed transfers of care
- Reduce permanent residential admissions
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Transition of Community Resource Centres

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☑ IBCF ☒ QIPP ☒ Council savings

BCF Scheme ref: **21**

SCHEME

Name: **COMMUNITY RESOURCE CENTRES (CRCs)**

The CRC's are 3 purpose built units providing residential care, owned by the Council and leased to Sirona Care & Health. They were established as an important community asset by the Council in 2008 following extensive public consultation with service users, carers and staff. The needs of residents across B&NES have changed, this combined with the block contract arrangement and reducing levels of occupancy meant that the current model was no longer viable.

The Council and CCG have reviewed the overall strategy, future need and affordability and a reconfiguration of the type of care provided within the homes will be implemented to include general and dementia nursing:

- Cleeve Court (45 dementia residential and complex dementia residential beds)
- Coombe Lea (15 dementia nursing and 15 dementia residential beds)
- Charlton House (10 high dependency residential and 15 general nursing beds)

This scheme is to support transition to the new model and provide interim funding to develop the new nursing model .

Commissioner: **Karen Green**

Provided by: **Sirona Care & Health**

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£100,000	£0	IBCF	Local Authority Social Services

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
	Cleeve Court moves to new model				
	Charlton House moves to new model				
	Combe Lea moves to new model				

Notes:

RISKS / INTERDEPENDENCIES

Risks:

- Occupancy is required to be at 84% or above to reduce the financial risk to the council.
- Delays in hospital/transfer assessments lead to DTOC's within the community hospitals and RUH.
- Delays in admissions to the CRC's could lead to DTOC's within the community hospitals and RUH and place future residents at risk of infection.

Interdependencies:

- B&NES Council and CCG
- Community Hospital
- RUH

Appendix 2 – 2017-19 BCF Scheme Plans

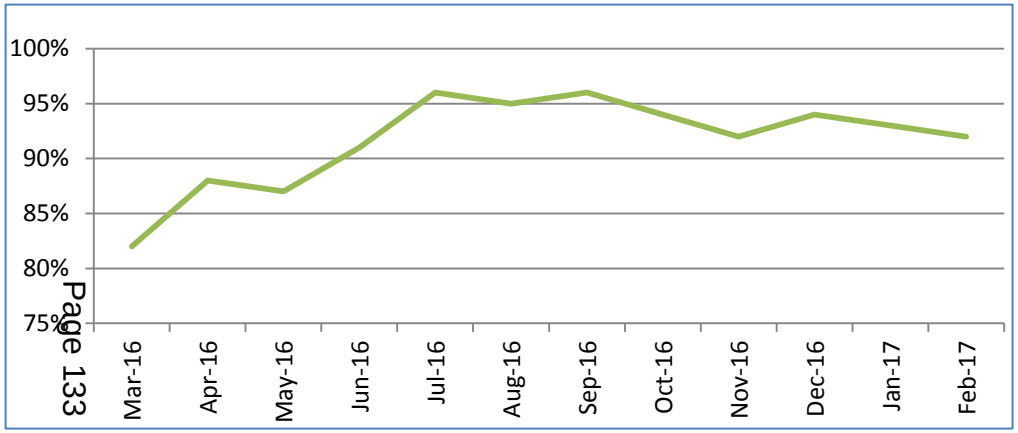
Transition of Community Resource Centres

Bath & North East Somerset Council

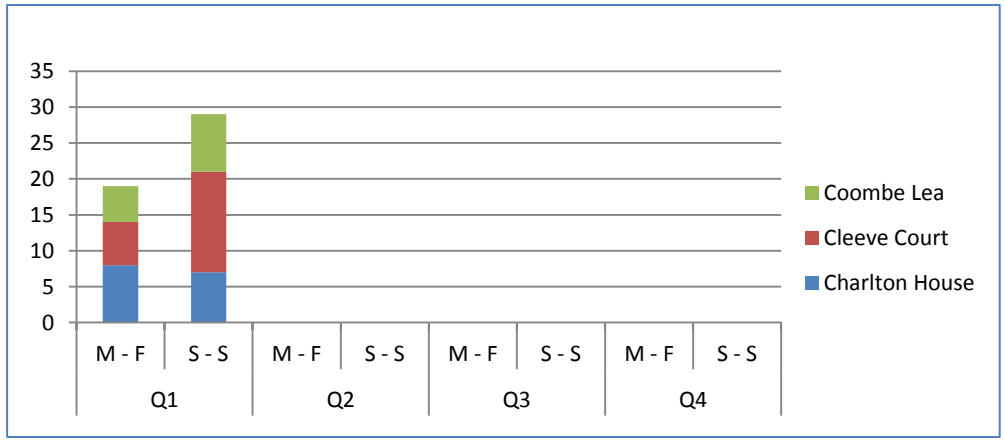
NHS Bath and North East Somerset Clinical Commissioning Group

MEASURES

Manage Occupancy



Increase weekend admissions



Further measures (in development)

We are developing quarterly measures to track assessments, admissions and occupancy in the CRC's. per quarter

- No of assessments completed Mon – Fri
- No of assessments completed at the weekend
- No of assessments accepted and admitted

- No of admissions Mon – Fri
- No of admissions at the weekend

- Occupancy levels per month – permanent, respite, by bed type, by day and by funding.

NATIONAL METRICS

This scheme will support the national metrics by providing additional nursing care places.

Reduce non-elective admissions

Reduce delayed transfers of care

Reduce permanent residential admissions

Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Transition of Extra Care Sheltered Housing

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☑ IBCF ☒ QIPP ☒ Council savings

BCF Scheme ref: 22

SCHEME

Name: **TRANSITION OF EXTRA CARE SHELTERED HOUSING (ECSH)**

An Integrated model of housing support and personal care, which can involve more than one organisation, incl. registered social landlords (RSL), care and support providers. The objective is to preserve or rebuild independent living skills, with the provision of accessible buildings that make independent living possible for people with a range of abilities.

Key characteristics:
1. Living at home, not in a home.
2. Having one-zone front door.
3. Having flexible care delivery based on individual need which can increase or diminish according to circumstance.

The service is being made more efficient and aligned with your care your way.

Commissioner: **Anne-Marie Stavert**

Provided by: **Various**

MILESTONES

Status	Action	Q1	Q2	Q3	Q4
🔴	Contract signing with Care Provider	●	●		
🟠	Provider to transition service to meet contract		●		
⚫	Review contract quarterly	●	●		

Notes:

FINANCE

Area of Spend	Planned Expenditure 2017/18	Planned Expenditure 2018/19	New or Existing Scheme	Funding Source
Social Care	£180,000	£0	IBCF	Local Authority Social Services

Notes: This is part of a block contract, which is paid monthly across the year.

Key:

- ⚫ Not Started
- 🔴 In Progress but overdue
- 🟠 In Progress
- 🟢 Complete

RISKS / INTERDEPENDENCIES

Risks:

- Failure to agree contract will affect approx. 140 tenants
- Lack of relevant referrals from Social Workers, can result in void flats, this can affect both funding authority and RSL
- Robust process required to agree relevant funding from out of area authorities

Interdependencies:

- Safe-staffing levels
- Effective partnership working between Care providers and RSL

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Bath & North East Somerset Council

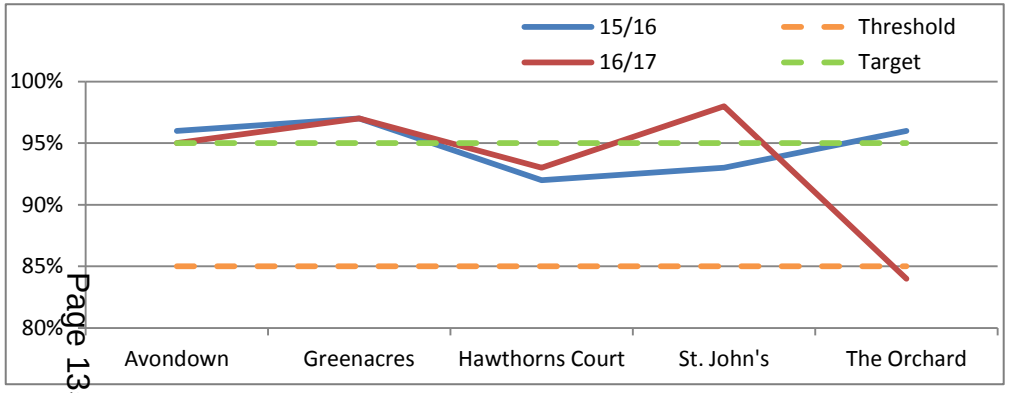
Appendix 2 – 2017-19 BCF Scheme Plans

Transition of Extra Care Sheltered Housing

NHS Bath and North East Somerset Clinical Commissioning Group

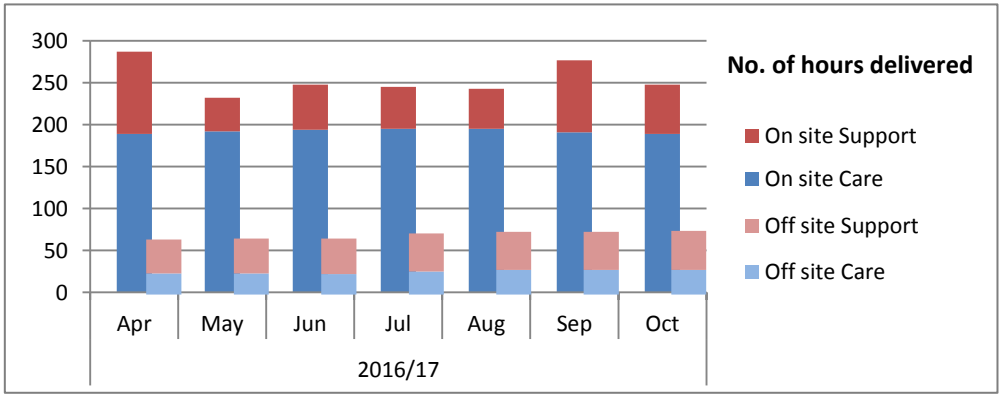
MEASURES

Maintain high occupancy of flats



Notes: Flat occupancy at The Orchard dropped below the Amber acceptance percentage in 2016/17. No service user data has been available since Sept 2016.

Deliver agreed levels of flexible care



Notes: The target for this measure will be set as part of the contract.

Measure and improve outcomes for service users

We're developing measures as part of the contract to ensure the service delivers improved outcomes for the service users, such as;

- % of service users who have a Person-Centred Care and Support Plan which is developed in consultation with them
- % of service users whose levels of support has been reduced after 6 weeks in the service

We will also gather feedback from people using the service, their families, carers/representatives, which will also support service development.

NATIONAL METRICS

This scheme will support the national metrics by enabling vulnerable people to stabilise their lives and reduce the need for emergency care and health support.

- Reduce non-elective admissions
- Reduce delayed transfers of care
- Reduce permanent residential admissions
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Fair Price of Care

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☑ IBCF ☒ QIPP ☑ Council savings

BCF Scheme ref: 17

SCHEME

Name: **FAIR PRICE OF CARE (FPoC)**

This scheme supports the Council's statutory duty to pay a 'fair price of care' (FPoC). It responds to clear recommendations from an independent analysis of care home costs for older people in B&NES.

In doing so, the scheme ensures that all care home providers in B&NES receive sufficient funding in line with the Council's duties. Alongside key interdependencies, the scheme is essential to support a sustainable care market and offer continuity of care for the community. It mitigates additional and significant legal risks (& associated costs) arising from not paying a FPoC.

The care homes market tends to be provider-driven. Establishing a FPoC position improves the Council's negotiating capabilities in the face of continued financial pressures. It increases both value for money and provider accountability; ensuring charges reflect actual care needs and client outcomes while being sustainable for the provider.

Commissioner: **Vincent Edwards**

Provided by: Independent care organisations.

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£545,000	£200,000	IBCF	Local Authority Social Services

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
	FPoC position agreed with Council executive and political leads				
	FPoC position launched to providers				
	Guidance and negotiation toolkit for social work professionals				
	Development and publication of associated policy positions				
	2017/18 projections confirmed with actuals & 2018/19 FPoC projections				

Notes: The milestones above relate to FPoC exclusively. In practice, milestones for this scheme are integrated with delivery of interdependencies 1 and 2 below.

RISKS / INTERDEPENDENCIES

Risks:

- Provider cooperation
- Too firm negotiation stance may place pressure on hospital discharge
- Insufficiently robust negotiation will add pressure to Council budgets
- Placement volumes & negotiation timeframes
- Market fluctuation in a competitive purchasing environment
- Public perception

Interdependencies:

- Care Home Market Development & Facilitation project (aligned commissioning project)
- Market Oversight & Sustainability (aligned commissioning project)
- Strengths-based Working scheme
- Support Planning & Brokerage scheme

Appendix 2 – 2017-19 BCF Scheme Plans

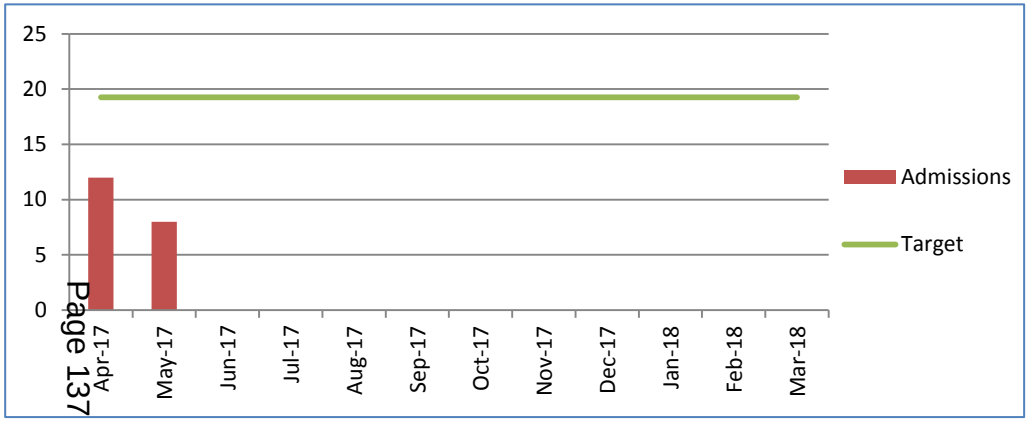
Fair Price of Care

Bath & North East Somerset Council

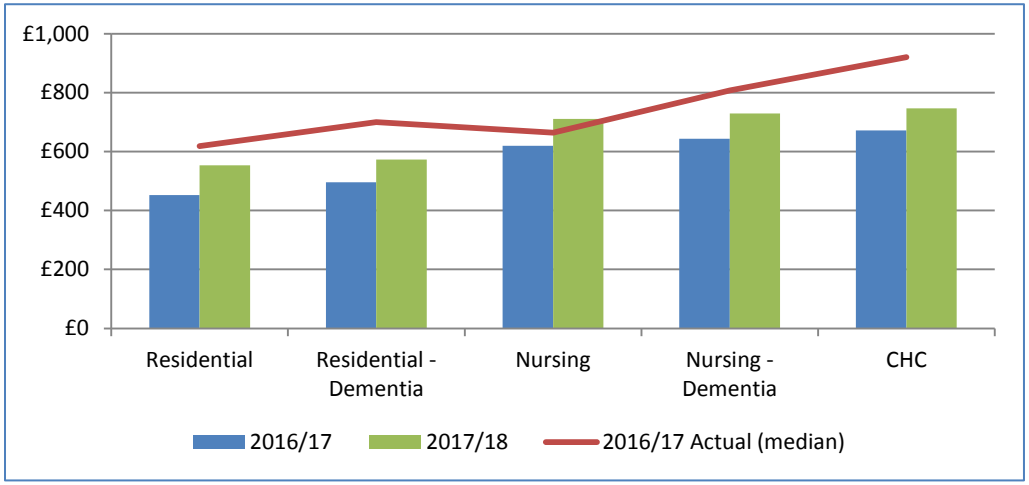
NHS Bath and North East Somerset Clinical Commissioning Group

MEASURES

Reduce the number of admissions for those aged 65 and over



B&NES Published weekly placement rates



Further measures (in development)

In 2017/18 the service performance will be managed against existing measures while the new measures are developed. The 2016/17 performance is shown in the charts to the left.

We are developing quarterly measures to track the impact of FPoC, such as;

- %age of care home placements made below the FPoC
- Risk position (RAG) of FPoC in relation to Council's statutory duty (direct impact of planned expenditure on scheme's objectives)
- Differential between FPoC rate and median unique value average of actual placement costs (by placement category)

- Level of outliers (e.g. cost at 5th and 95th percentile of all placements)
- Number of admissions to care homes
- Number of transitions from residential to nursing care
- %age of placements made at, and within 10%, of each FPoC rate

These are supported by a range of proxy indicators and metrics more geared towards the first 2 interdependencies above.

NATIONAL METRICS

This scheme will support the national metrics by supporting people who require care home placements to be set-up efficiently.

- Reduce non-elective admissions
- **Reduce delayed transfers of care**
- Reduce permanent residential admissions
- Increase success of reablement

Appendix 2 – 2017-19 BCF Scheme Plans

Support Planning and Brokerage

Bath & North East Somerset Council

NHS Bath and North East Somerset Clinical Commissioning Group

☑ IBCF ☒ QIPP ☑ Council savings

BCF Scheme ref: 20

SCHEME

Name: **SUPPORT PLANNING AND BROKERAGE**

The Brokerage function is expected to;

- Achieve a single place to manage costed care provision so that there is one clear route
- Drive out efficiency savings through better market management and reduction in purchasing budget spend
- Provide assurance the unmet needs are met in the most cost effective way
- Support of evidence based commissioning
- Ensure good social work practice is embedded across the organisation
- Highlight service deficiencies

The Care and Support Planning function is to then develop on from the foundation of brokerage during 2017/19 – key aspects of this work will include further work on utilising a strengths based approach to care and support planning across health and social care. This will require a level of cultural change across health and social care in regard to the conversations undertaken by all staff supporting people with health and social care needs.

Commissioner: **Helen Wakeling**

Provided by: **Virgin Care**

FINANCE

Area of Spend	Planned Expenditure		New or Existing Scheme	Funding Source
	2017/18	2018/19		
Social Care	£200,000	£100,000	IBCF	Local Authority Social Services

Key:

- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

Status	Action	Q1	Q2	Q3	Q4
🟢	VC: Job Descriptions for Managers (Band 7) and Brokers (Band 5/6) to be developed		●	●	
🟢	VC: To review existing resource internally to determine if anyone can be released		●	●	
🟠	Council: Potential to release in short term manager post to support set up function		●	●	
🔴	VCSL: Business Case development for Invest to Save funding, expected max appointment will be 2 years	●	●	●	●
🔴	Brokerage process in place to undertake sourcing of commissioned care and direct payments for all care and support packages provided by Virgin adult social care teams		●	●	
🟠	Agreed auditing process in place to confirm that the Council's legal requirements are being met with regard to care and support planning		●	●	
⚫	Reporting arrangements in place that identify the changes being achieved.			●	●
🔴	Budget management training provided for all Virgin managers authorising social care spend		●	●	
⚫	Development of project plan for strengths based care and support planning, to include involvement of service users and the community in the development of this resource			●	●
🔴	Consideration of extension of brokerage work to include CHC and AWP			●	●

Notes:

RISKS / INTERDEPENDENCIES

Risks:

- Lack of resources to support implementation
- Lack of appropriate services at an affordable rate to support individuals
- Information not being cascaded fully across the health and social care sector regarding the approach being adopted and the need to adhere to this
- Cultural changes required across social care and health system not being fully embedded.

Interdependencies:

- Proposed changes to social care structure
- Market development work being undertaken across health and social care
- Strengths based working being adopted across the system

Appendix 2 – 2017-19 BCF Scheme Plans

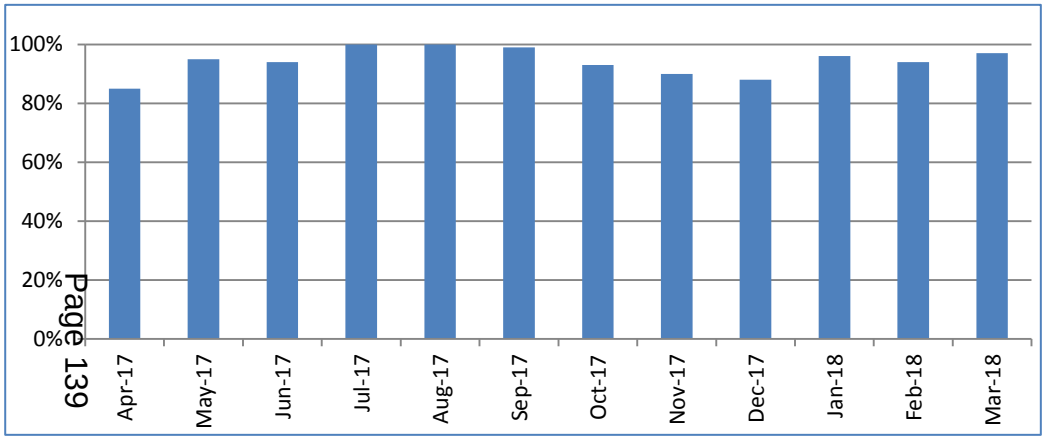
Support Planning and Brokerage

Bath & North East Somerset Council

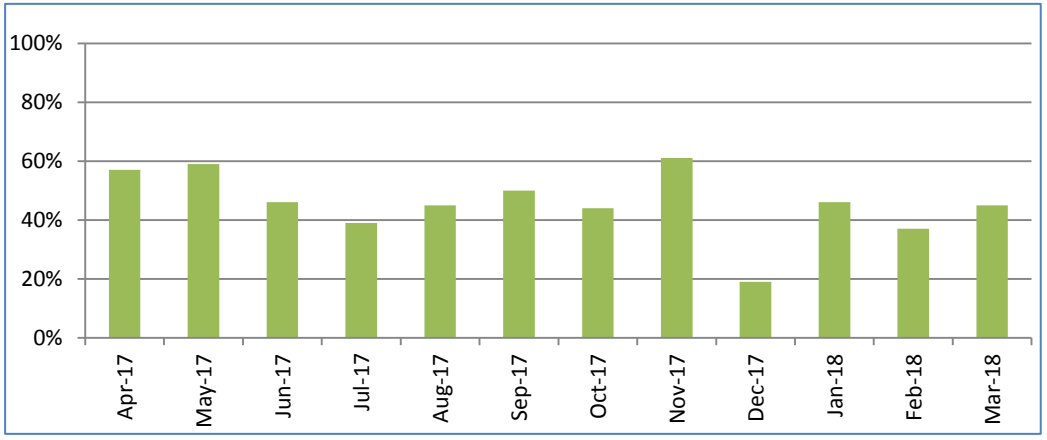
NHS Bath and North East Somerset Clinical Commissioning Group

MEASURES

Care & support plans in place within 28 days of assessment completion date



Service users receiving an individual budget as a direct payment



Measure and improve outcomes for service users

Metrics will be developed as part of the service development and are expected to support the timely setting up of care and support plans.

Improved outcomes for service users are expected to include:

- % of people who are felt they were supported to make choices about how their care and support is provided
- % of people who feel that their care and support plans meets outcomes they had identified

We will also be gathering feedback from people using the service, their families, carers/representatives, which will support the development of this work.

NATIONAL METRICS

This scheme will support the national metrics by enabling vulnerable people to stabilise their lives and reduce the need for emergency care and health support.

- Reduce non-elective admissions
- **Reduce delayed transfers of care**
- **Reduce permanent residential admissions**
- Increase success of reablement

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Bath & North East Somerset Council

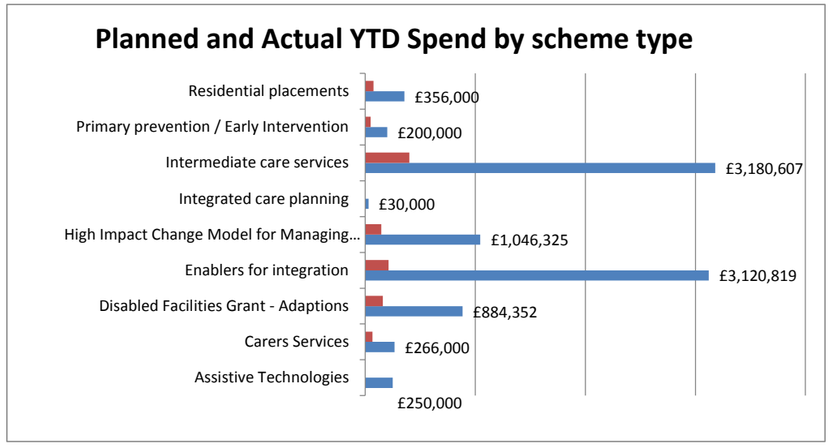
Appendix 3

NHS Bath and North East Somerset Clinical Commissioning Group

Finance Dashboard - Better Care Fund

Report Date: 10 August 2017

Funding Source	16/17 £	17/18 £	18/19 £
Section 75 Transfers CCG To Council	£8,460,000	£8,611,434	£8,775,051
CCG NHS Commissioned Out of Hospital Services	£2,008,000	£2,043,943	£2,082,778
BCF Risk Share Contingency	£539,994	£549,660	£560,103
YCYW	£0	£24,182,014	£24,182,014
Disabilities Facilities Grant Capital	£991,000	£1,084,352	£1,084,352
Local Authority Grant	£0	£50,000	£0
Care Act Council Revenue	£1,500,000	£1,500,000	£1,500,000
IBCF	£0	£3,428,000	£2,063,000
YCYW	£0	£19,668,842	£19,668,842
Total	**£13,498,994**	**£61,118,246**	**£59,916,141**

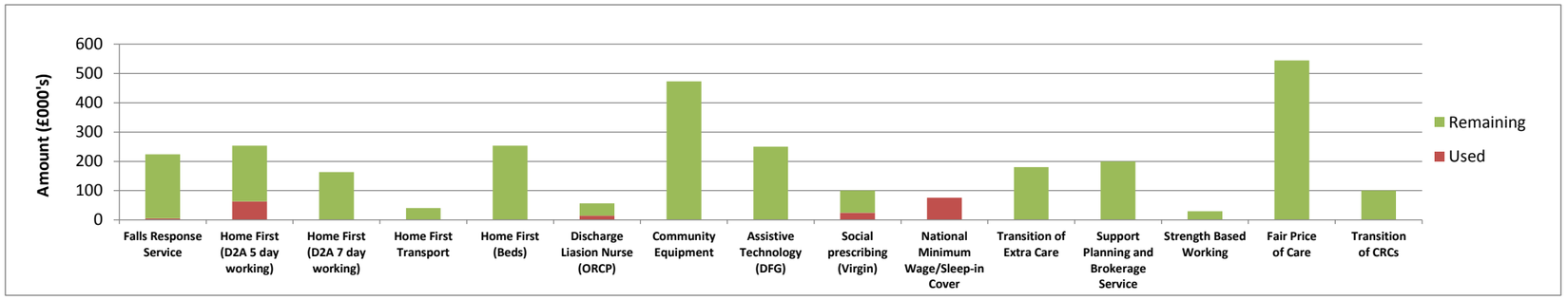


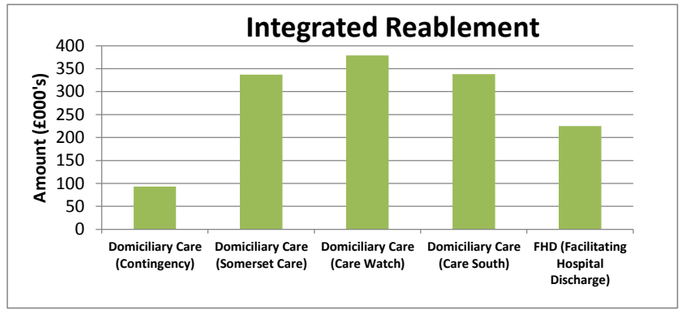
Overall RAG status (financial): Green

Scheme	Scheme No.	National Condition	RAG	Plan / Actual	17/18 £	Apr £	May £	Jun £	Jul £	Aug £	Sept £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	YTD £	FYE £	Total 18/19 £
Community Services (Virgin) excluding measured schemes	various	NHS/SC		Plan	45,288,790	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	11,322,198	46,790,982	45,288,790
				Actual / Forecast	0													0	0	
				Variance	34,088,564	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	3,774,066	11,322,198	46,790,982	
Measured Schemes	see below	see below		Plan	5,560,943	575,270	387,936	331,936	539,047	290,713	280,713	504,047	230,713	220,713	509,047	220,713	220,713	1,502,363	5,560,943	4,140,738
				Actual / Forecast	0													0	3,491,717	0
				Variance	4,841,690	438,939	106,248	250,701	534,047	285,713	275,713	499,047	225,713	215,713	504,047	215,713	215,713	1,008,110	1,844,226	0
Protection of Social Care	8	SC		Plan	4,735,704	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	1,183,926	4,735,704	4,678,161
				Actual / Forecast	0													0	1,000,000	
				Variance	4,735,704	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	394,642	1,183,926	3,735,704	
Integrated Care and Support	7	NHS		Plan	1,610,958	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	402,740	1,610,958	1,697,428
				Actual / Forecast	0													0	0	
				Variance	1,610,958	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	134,247	402,740	1,610,958	
Care Act Implementation	13	SC		Plan	1,470,000	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	367,500	1,470,000	1,500,000
				Actual / Forecast	0														924,943	
				Variance	545,057	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	122,500	490,000	545,057	
Disabled Facilities Grant	14	SC		Plan	884,352	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	221,088	884,352	1,084,352
				Actual / Forecast	0														884,352	
				Variance	723,228	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	73,696	59,964	0	
Transformation Funding	16	NHS		Plan	729,987	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	182,497	729,987	0
				Actual / Forecast	0			0										0	350,000	
				Variance	729,987	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	60,832	182,497	379,987	
BCF Risk Share Contingency	100	NHS		Plan	549,660	0	0	0	0	0	0	0	0	0	0	0	549,660	0	549,660	560,103
				Actual / Forecast	0	0	0	0										0	549,660	
				Variance	549,660	0	0	0	0	0	0	0	0	0	0	0	549,660	0	0	
BCF Strategic Support	12	NHS/SC		Plan	274,355	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	68,589	274,355	279,567
				Actual / Forecast	0	0		0										0	0	
				Variance	274,355	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	22,863	68,589	274,355	
Other	101			Plan	13,497	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	3,374	13,497	185,354
				Actual / Forecast	0	0		0										0	43,484	
				Variance	13,497	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	1,125	3,374	-29,987	
				TOTAL PLAN	**61,118,246**	**5,159,240**	**4,971,906**	**4,915,906**	**5,123,018**	**4,874,683**	**4,864,683**	**5,088,018**	**4,814,683**	**4,804,683**	**5,093,018**	**4,804,683**	**5,354,343**	**15,254,274**	**62,620,438**	**59,414,495**
				TOTAL ACTUAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,244,156**	**0**
				TOTAL VARIANCE	**48,112,700**	**5,022,909**	**4,690,218**	**3,748,604**	**5,118,018**	**4,869,683**	**4,859,683**	**5,083,018**	**4,809,683**	**4,799,683**	**5,088,018**	**4,799,683**	**5,349,343**	**13,673,954**	**55,151,282**	**0**

Additional Information

Expenditure against plan by Scheme





Scheme	Scheme No.	National Condition	RAG	Plan / Actual	17/18 £	Apr £	May £	Jun £	Jul £	Aug £	Sept £	Oct £	Nov £	Dec £	Jan £	Feb £	Mar £	YTD £	FYE £	Total 18/19 £
Integrated Reablement (Virgin and Sirona)	3	NHS		Plan	1,242,392	103,533	103,533	103,533	103,533	103,533	103,533	103,533	103,533	103,533	103,533	103,533	103,533	310,598	1,242,392	1,245,263
				Actual / Forecast	309,934	103,311	103,311	103,312										309,934	1,242,392	
				Variance	932,458	222	222	221	103,533	103,533	103,533	103,533	103,533	103,533	103,533	103,533	103,533	664	0	
Integrated Reablement (Domiciliary Care Strategic Partners)	3	SC		Plan	1,146,715	263,334	0	0	263,334	0	0	263,334	0	0	263,334	0	0	263,334	1,146,715	1,168,502
				Actual / Forecast	0	0	0	0										0	0	
				Variance	1,146,715	263,334	0	0	263,334	0	0	263,334	0	0	263,334	0	0	263,334	1,146,715	
Integrated Reablement (Facilitating Hospital Discharge)	3	NHS		Plan	225,000													0	225,000	229,275
				Actual / Forecast	0			0										0	0	
				Variance	225,000	0	0	0	0	0	0	0	0	0	0	0	0	0	225,000	
Falls Response Service	4	NHS		Plan	224,500	18,708	18,708	18,708	18,708	18,708	18,708	18,708	18,708	18,708	18,708	18,708	18,708	56,125	224,500	228,766
				Actual / Forecast	5,586	0	2,793	2,793										5,586	0	
				Variance	218,914	18,708	15,915	15,915	18,708	18,708	18,708	18,708	18,708	18,708	18,708	18,708	18,708	50,539	224,500	
Home First Pathway One (D2A 5 day working) (ORCP)	23	NHS		Plan	253,934	21,161	21,161	21,161										63,484	253,934	253,934
				Actual / Forecast	63,484		63,484	0										63,484	253,934	
				Variance	190,451	21,161	-42,322	21,161	0	0	0	0	0	0	0	0	0	0	0	
Home First Pathway One (D2A 7 day working)	23	NHS		Plan	163,646	13,637	13,637	13,637										40,912	163,646	0
				Actual / Forecast	0		0	0										0	163,646	
				Variance	163,646	13,637	13,637	13,637	0	0	0	0	0	0	0	0	0	40,912	0	
Home First Transport	23	NHS		Plan	40,245	3,354	3,354	3,354										10,061	40,245	0
				Actual / Forecast	0		0	0										0	40,245	
				Variance	40,245	3,354	3,354	3,354	0	0	0	0	0	0	0	0	0	10,061	0	
Home First Pathway One (Beds)	23	NHS		Plan	253,500	21,125	21,125	21,125										63,375	253,500	0
				Actual / Forecast	0		0	0										0	253,500	
				Variance	253,500	21,125	21,125	21,125	0	0	0	0	0	0	0	0	0	63,375	0	
Discharge Liasion Nurse (ORCP)	2	NHS		Plan	57,000	4,750	4,750	4,750										14,250	57,000	57,000
				Actual / Forecast	14,250	4,750	4,750	4,750										14,250	57,000	
				Variance	42,750	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Community Equipment	7	SC		Plan	473,011	39,418	39,418	39,418										118,253	473,011	481,998
				Actual / Forecast	0	0	0	0										0	0	
				Variance	473,011	39,418	39,418	39,418	0	0	0	0	0	0	0	0	0	118,253	473,011	
Assistive Technology (DFG)	14	SC		Plan	250,000	0	0	0	47,222	22,222	22,222	22,222	22,222	22,222	47,222	22,222	22,222	47,222	250,000	0
				Actual / Forecast	0	0	0	0										0	250,000	
				Variance	250,000	0	0	0	47,222	22,222	22,222	22,222	22,222	22,222	47,222	22,222	22,222	47,222	0	
Social prescribing (Virgin)	9	NHS		Plan	100,000	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	25,000	100,000	100,000
				Actual / Forecast	25,000	8,333	8,333	8,334	0	0	0	0	0	0	0	0	0	25,000	100,000	
				Variance	75,000	0	0	-1	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	0	0	
National Minimum/Sleep-in Cover	19	CM		Plan	76,000	0	76,000	0	0	0	0	0	0	0	0	0	0	76,000	76,000	76,000
				Actual / Forecast	76,000	0	76,000	0	0	0	0	0	0	0	0	0	0	76,000	76,000	
				Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Transition of Extra Care	22	CM		Plan	180,000	30,000	30,000	30,000	30,000	30,000	30,000	0	0	0	0	0	0	150,000	180,000	0
				Actual / Forecast	0	19,937	23,017	-42,954										0	180,000	
				Variance	180,000	10,063	6,983	72,954	30,000	30,000	30,000	0	0	0	0	0	0	150,000	0	
Support Planning and Brokerage Service	20	CM		Plan	200,000	0	0	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	200,000	100,000
				Actual / Forecast	0	0	0	0										0	200,000	
				Variance	200,000	0	0	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	20,000	0	
Strength Based Working	13b	SC		Plan	30,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	7,500	30,000	0
				Actual / Forecast	0	0	0	0										0	30,000	
				Variance	30,000	2,500	2,500	-2,500	-2,500	-2,500	-2,500	-2,500	-2,500	-2,500	-2,500	-2,500	-2,500	7,500	0	
Fair Price of Care	17	CM		Plan	545,000	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	136,250	545,000	200,000
				Actual / Forecast	0	0	0	0										0	545,000	
				Variance	545,000	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	45,417	136,250	0	
Transition to new Community Resource Centre Model	21	CM		Plan	100,000	0	0	0	0	40,000	30,000	20,000	10,000	0	0	0	0	100,000	100,000	0
				Actual / Forecast	0	0	0	0										0	100,000	
				Variance	100,000	0	0	0	0	40,000	30,000	20,000	10,000	0	0	0	0	100,000	0	
				TOTAL PLAN	**5,560,943**	**575,270**	**387,936**	**331,936**	**539,047**	**290,713**	**280,713**	**504,047**	**230,713**	**220,713**	**509,047**	**220,713**	**220,713**	**1,502,363**	**5,560,943**	**4,140,738**
				TOTAL ACTUAL	**494,253**	**136,331**	**281,688**	**76,235**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**494,253**	**3,491,717**	
				TOTAL VARIANCE	**4,841,690**	**438,939**	**106,248**	**250,701**	**534,047**	**285,713**	**275,713**	**499,047**	**225,713**	**215,713**	**504,047**	**215,713**	**215,713**	**1,008,110**	**1,844,226**	

CM = stabilising the care market
NHS = reducing pressures on the NHS
SC = Meeting social care need

Appendix 4
Better Care Fund 2017/19 Schemes

Scheme Ref	Scheme Name	Area of Spend	Planned Expenditure 2017/18 £	Planned Expenditure 2018/19 £	New or Existing Scheme
Assistive Technologies			**£250,000**	**£0**	**0.41%**
14	Assistive Technologies	Social Care	£250,000	£0	Existing
Carers Services			**£266,000**	**£266,000**	**0.44%**
11	Support for Carers (Your Care, Your Way)	Social Care	£266,000	£266,000	Existing
Disabled Facilities Grant - Adaptions			**£884,352**	**£1,084,352**	**1.45%**
14	Disabled Facilities Grant	Social Care	£884,352	£1,084,352	Existing
Enablers for integration			**£3,120,819**	**£3,308,988**	**5.11%**
1	Integrated Delivery Infrastructure (Your Care, Your Way)	Community Health	£350,000	£350,000	Existing
1	Integrated Delivery Infrastructure (Your Care, Your Way)	Community Health	£500,000	£500,000	Existing
7	Integrated Care and Support	Community Health	£1,523,453	£1,697,422	Existing
7	Integrated Care and Support Community Equipment	Community Health	£473,011	£481,998	Existing
12	BCF Strategic Support	Social Care	£274,355	£279,567	Existing
High Impact Change Model for Managing Transfer of Care			**£1,046,325**	**£1,090,580**	**1.71%**
2	7 Day Working (Your Care, Your Way)	Community Health	£278,000	£278,000	Existing
2	Discharge Liasion Nurse (Your Care, Your Way)	Community Health	£57,000	£57,000	New
23	Home First Pathway One (D2A 5 day working) (ORCP)	Social Care	£253,934	£253,934	New
23	Home First Pathway One (D2A 7 day working)	Social Care	£163,646	£163,646	New
23	Home First Transport	Social Care	£40,245	£0	New
23	Home First Pathway Three (Beds)	Social Care	£253,500	£338,000	New
Integrated care planning			**£30,000**	**£0**	**0.05%**
13	Strengths Based Working	Social Care	£30,000	£0	Existing
Intermediate care services			**£3,180,607**	**£3,213,806**	**5.20%**
3	Integrated Reablement (Your Care, Your Way and Sirona)	Community Health/Social Care	£1,242,392	£1,245,263	Existing
3	Integrated Reablement (Domiciliary Care Strategic Partners)	Social Care	£1,146,715	£1,168,502	Existing
3	Integrated Reablement (Facilitating Hospital Discharge)	Social Care	£225,000	£229,275	Existing
4	Falls Response Service	Social Care	£224,500	£228,766	Existing
5	Home from Hospital Schemes (Your Care, Your Way)	Community Health/Social Care	£342,000	£342,000	Existing

Primary prevention / Early Intervention			**£200,000**	**£200,000**	**0.33%**
9	Social prescribing (Your Care, Your Way)	Mental Health	£100,000	£100,000	Existing
10	Mental Health Reablement Beds (Your Care, Your Way)	Mental Health	£100,000	£100,000	Existing
Residential placements			**£356,000**	**£76,000**	**0.58%**
19	National Minimum Wage/Sleep-in Cover	Social Care	£76,000	£76,000	IBCF
21	Transition to new Community Resource Centre Model	Social Care	£100,000	£0	IBCF
22	Transition of Extra Care	Social Care	£180,000	£0	IBCF
Other			**£51,784,144**	**£50,676,409**	**84.73%**
6	Audiology Cost by Case (Your Care, Your Way)	Community Health	£702,253	£702,253	New
8	Protection of Social Care	Social Care	£4,609,579	£4,678,161	Existing/IBCF
13	Care Act Implementation	Social Care	£1,470,000	£1,500,000	Existing
15	Your Care, Your Way	Community Health/Social Care	£24,785,471	£24,785,471	New
15	Your Care, Your Way	Continuing Care	£625,984	£625,984	New
15	Your Care, Your Way	Mental Health	£2,922,032	£2,922,032	New
15	Your Care, Your Way	Social Care	£14,484,555	£14,397,050	New
15	Your Care, Your Way	Other	£20,000	£20,000	New
16	Your Care, Your Way Transformation funding	Community Health	£364,993	£0	IBCF
16	Your Care, Your Way Transformation funding	Social Care	£364,994	£0	IBCF
17	Fair Price of Care	Social Care	£545,000	£200,000	IBCF
18	Support for Council Position	Social Care	£126,125	£0	IBCF
20	Support Planning and Brokerage Service	Social Care	£200,000	£100,000	IBCF
	IBCF Schemes to be identified	Social Care	£13,497	£185,354	IBCF
100	BCF Risk Share Contingency	Other	£549,660	£560,103	Existing
Total BCF & IBCF			**£61,118,246**	**£59,916,133**	**100%**

B&NES Better Care Fund Plan

Appendix 5 - 2017-19 Impact of BCF Schemes on National Metrics

How the Better Care Fund Schemes impact on the National Metrics in 2017-19 ☑ = Direct ✓ = Enabling	Reduce non-elective admissions	Reduce delayed transfers of care	Reduce permanent residential admissions	Increase success of reablement
Assistive Technologies				
14 Assistive Technologies		✓	☑	☑
Carers Service				
11 Support for Carers	✓		✓	✓
Disabled Facilities Grant - Adaptions				
14 Disabled Facilities Grant (DFG)			✓	
Enablers for Integration				
1 Integrated Delivery infrastructure				
7 Integrated Care and Support				
7b Community Equipment	✓	✓	✓	✓
High Impact Change Model for Managing Transfer of Care				
2a Social Work 7-day Working		✓	✓	✓
2b Discharge Liaison Nurse		☑		
23a,b,c Home First (Pathway One & Transport)		☑	☑	☑
23d D2A Beds (Pathway Three)		☑	☑	☑
Integrated care planning				
13 Strengths-based Working	✓	✓	✓	✓
Intermediate Care services				
3 Integrated Reablement	✓	☑	☑	☑
4 Falls Response	☑		☑	
5 Home From Hospital Schemes		✓		
Primary prevention / Early Intervention				
9 Social Prescribing	✓			
10 Mental Health Reablement beds			✓	
Residential placements				
19 NMW/Sleep in				
21 Community Resource Centres		☑		
22 Transition of Extra Care Sheltered Housing	☑			
Other				
17 Fair Price of Care		☑		
20 Support Planning and Brokerage		☑	☑	

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Appendix 6 - Better Care Fund Programme Risk Register

Unique Risk No.	Status	Impact Area	Date Raised	Date of Next Review	Date Closed	Risk Title	Risk Description	Consequence	Risk Owner	Likelihood (5 = highly likely, to 1 = unlikely)	Impact (5 = catastrophic, to 1 = insignificant)	Risk Rating (Likelihood x Impact)	Current Mitigation and further planned actions
BCF01	Open	Scheme	01/04/17	*01/09/17*		Non-delivery of emergency admissions target	Further embedding and developing our established integrated care model fails to translate into the required reductions in emergency admissions in 2017/18, impacting the overall funding available to support core services and future schemes.	Financial risk impacts mainly on Council and CCG, operational risk is borne by provider.		3	4	12	The A+E Delivery Board will support system wide overview of delivering of urgent care transformation programme and system wide performance on managing urgent care activity. Alignment of other commissioning initiatives means that delivery is not wholly reliant on BCF schemes. The Joint Commissioing Committee (JCC) will regularly review progress and continuously review strategic and operational priorities. The financial risk of non-delivery has been recognised by both the CCG and Council, the Council & CCG have also identified contingency reserves within their plans to the necessary value to cover the risk. A further review on the delivery and capacity of reablement to understand and measure its benefits in the current model.
BCF02	Open	Programme	01/04/17	*01/09/17*		Benefits realisation	There is a risk that the programme completes to an agreed timetable but the expected benefits are not realised.	DTOC levels do not reduce and emergency admissions rise	Caroline Holmes	3	4	12	In line with MSP practice, each scheme has identified benefits with dependencies and benefit owners. These will be tracked regularly with regular formative evaluation throughout the programme. Development of contingency plans e.g. aligned initiatives as set out above. DTOC metric reductions have been modelled conservatively.
BCF03	Open	Scheme	01/04/17	*01/09/17*		Overlap and complexity of initiatives	There is a risk that the complexity and interrelationship of our initiatives with other related initiatives are not clearly understood.	There is confusion and duplication between the schemes	Caroline Holmes	3	4	12	Robust identification of expected impacts and of the relationship between different schemes (good programme and detailed project arrangements) and developing monitoring to match. These will be reviewed regularly by the JCC.
BCF04	Open	Programme	01/04/17	*01/09/17*		Health and social care management capacity	The complexity of the programme will stretch the management capacity of the health and social care system	Reporting will not be to the level required to deliver the scrutiny that the Programme needs	Caroline Holmes	3	3	9	The JCC will review progress on a regular basis and continuously review strategic and operational priorities. CCG and LA to engage in regular joint review of deployment of resources to deliver joint commissioning priorities.
BCF05	Open	National Conditions	01/04/17	*01/09/17*		Programme capacity	There is a lack of capacity to monitor progress and idenitfy issues with schemes	see above	Caroline Holmes	3	3	9	Ensure performance measures are deliverable by providers. Agree programme for performance reporting. New commissioning manager role will include DTOC support.
BCF06	Open	National Conditions	01/04/17	*01/09/17*		DTOC Metrics	The risk that DTOC numbers do not reduce in line with the metrics set	Flow in hospitals will continue to be compromised	Caroline Holmes	4	4	*16*	Continue to implement DTOC action plan with clear ownership and reporting in place.
BCF07	Open	Programme	01/04/17	*01/09/17*		*Your Care Your Way* capacity	The transfer to a new community provider may take up resource in commissioning and ?? Virgin Care as contracts bed in. This will affect the pace of transformation	The delivery of the schemes may be compromised	Caroline Holmes	4	4	*16*	Continue to monitor delivery of schemes and programme overall . Monitor any concerns about capacity in contract meetings.
BCF08			01/04/17	*01/09/17*		Fragility of care home market and risk of closures	170 beds have closed in BaNES in the last 18 months. This is a service risk and a continuity risk.	Financial risk to Council as fees likely to rise. Quality risk to BaNES as provision reduces. DTOC risk	Caroline Holmes	4	4	*16*	Council has increased fees (Fair Price of Care) Continue to work with providers. Trust in Pathway 3 D2A Beds to support discharges.
BCF09			01/04/17	*01/09/17*		Financial position for Council and CCG	Financial pressures in both Council and CCG are demonstrated in savings plans and efficiencies.	Pressures may impact on relationships and may cause additional priorities around savings programmes	Caroline Holmes	4	4	*16*	Range of savings plans in place for Council and CCG. iBCF support additional demand on adults budget.

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B&NES Council and BaNES CCG Better Care Fund Delayed Transfers of Care Action Plan
2017-2019
"The Next Steps"

Introduction:

This plan has been developed using feedback from the 2016/17 DTOC Action Plan and DTOC Action Group members, alongside feedback from the High Impact Change Model feedback completed by the RUH and Sirona in December 2016. The High Impact Change Model was developed by the LGA, TDA, ADASS, Monitor, NHSE and Department of Health and sets out a number of high impact changes that can reduce the likelihood of Delayed Transfers of Care (eg 7 days a week services).

This plan is entitled "The Next Steps" due to fact that despite a number of key objectives being completed in 2016/17, it is recognised that further work is needed to maintain momentum against improvements in DTOC rates.

Whilst plans are in place against all apsects of the high impact change model, within B&NES there has been system wide agreement that 17/18 priority areas will be developing a Home First/D2A ethos, building capacity and support for care homes and reducing community hospital delays. 18/19 priority areas will be developed once progress has been reviewed against 17/18 actions, with specific actions being developed.

2017/2018 - Action Plan - Updated July 2017							
Reference	**High Imact Change (Change Lead)**	**Actions to take**	**By when**	**Lead organisation (including Action Lead/s)**	**Outcomes expected**	**RAG status**	**Comments**
1	**1. Early Discharge Planning** **(Nikki Woodland)**	Embed examples of best practice (including the SAFER bundle and Red/Green days) within community hospitals.	Jul-17	Virgin Nikki Woodland	Utilisation of the SAFER bundle and Red/Green days within community hospitals to improve flow.	**A**	SAFER Bundle Plan developed, need to ensure implementation. Red/Green Days plan outstanding
2		Implement the findings from the Nov 2016 MADE (Multi Agency Discharge Event)	Jul-17	Virgin and RUH Nikki Woodland and Lee Warner Holt	Effective and responsive discharge processes, with a reduction in both external and internal delays.	**A**	To discuss 25/07/17
3		Develop the complex patients list, which will identify patients who on admission, are believed to potentially require complex discharge planning.	May-17	RUH Lee Warner Holt	Will allow early mobilisation of teams to support complex discharges, reducing the potential of the patient becoming a DTOC.	**Complete**	
4	**2. Monitoring Patient Flow.** **(Gareth Jones)**	Ensure a 16/17 baseline measure is establised and ratified against national guidence for all providers.	May-17	RUH, Virgin, AWP, B&NES CCG Gareth Jones	A clear baseline is set to allow accurate measurement of performacne and progress.	**R**	RUH was indentified as incorrectly reporting. RUH has provided revised data for 16/17 to show correct position. This has been added to nationally reported data and data from community hospitals to generate a baseline. Due to seasonal variation in this baseline (e.g. home closures in summer 2016), B&NES has adopted NHSE approach of using Q4 performance as the 16/17 baseline.
5		Establish a 17/18 reduction target for acute, mental health and community providers.	May-17	RUH, Virgin, AWP, B&NES CCG Gareth Jones	There is a clear DTOC reduction target set for all providers in B&NES.	**R**	Initial work has commenced to factor in the impact of schemes on the DTOC 16/17 baseline. This was affected by availability of revised data to understand the baseline from which reductions would be made. Initial assumptions are being shared with CCG Exec on 26/06, with focus on RUH.
6		Establish a reduction target for the green to go and stranded patient list.	Sep-17	RUH and B&NES CCG Gareth Jones and Lee Warner Holt	Ensure a reduction in delays, including those not classified as a DTOC.	**G**	21/04/17 added following DTOC action group. [**Question for group to consider: should we look at a similar % reduction to the one being used for the DTOC trajectories for each of these measures?]**
7		Develop specific metrics to record delays within reablement and community teams. (Including length, type and reason for delay)	Jul-17	Virgin and B&NES CCG Gareth Jones	There is clarity on the scale of delays and the reasons for delay, allowing actions to be taken to mitigate these.	**A**	To move away from the Bridging the Gap measure, to include more specific measures. Discussions being undertaken as part of YCYW handover. **[Can we confirm who is having these discussions?]**
8		Complete a review of system blockages which reduce flow within the Reablement service.	Nov-17	Virgin and B&NES CCG Angela Smith	A clear understanding of where delays and blockages occur within the Reablement service, with clear actions to mitigate these. This in turn will lead to greater flow within Reablement ensuring early release of capacity.	**G**	Initial review highlighted internal process delays, however further work needed to quantify scale.
9		Ensure the Green to Go List, Stranded Patient List, Complex Patient List and Community Hospital Spreadsheet are available for discussion on weekly escalation calls, where appropriate, by ensuring all required information is available in a timely manner.	May-17	Virgin and RUH - June Thompson Lee Warner Holt	Delays or delay potentials can quickly be escalated and responded to by relevant partners.	**Complete**	
10		Complete a review into discharge processes and LOS within Community Hospitals.	Aug-17	Virgin, B&NES CCG Caroline Holmes	Delay points are identified, with follow on discussions of how processes can be streamlined, leading to improvements in LOS	**G**	Community Hospital review undertaken. Report due July 17.
11		Ensure monthly care home capacity reporting, including home type, is embedded within the DTOC dashboard.	May-17	B&NES CCG Gareth Jones	The demand and capacity within care homes is clear and visible.	**Complete**	Brought over from 16/17 Action Plan. Work being led by CSU.

12	**3. Multi Agency/Disciplinary Discharge Teams** **(Caroline Holmes)**	Develop CHC assessment process actions based upon the learning identified in the CHC QIPP workstream.	Aug-17	B&NES CCG, B&NES Council, Virgin Val Janson/Sarah Jeeves (Caroline Holmes)	Process becomes more streamlined and responsive to patient need, reducing assessment delays and ensuring patients are assessed in the most appropriate environment.	**G**	
13		Review IDS integration to develop shared workload and assessment practices.	Aug-17	RUH, Virgin, AWP, B&NES Council Lee Warner Holt and Annette White (IDS Project Lead)	Joint working between health and social care, leading to a reduction in assessment delays.	**G**	
14		Feasibility review of commissioning temporary assessment beds to support pathway options for those with complex needs e.g. FNC & complex social care.	May-17	B&NES Council and BaNES CCG Ryan Doherty	There is clarity about the role temporary assessment beds may play within Home First Pathway 2/3, with clarity on funding arrangements.	**Complete**	Review complete, business case currently being written.
15		Ensure Third Sector services are utilised within all pathway options	Apr-17	B&NES CCG & Council Anne-Marie Stavert	Age UK home from hospital is an integral part of the pathway 0 + 1 offer, providing an additional support resource. Additionally support is provided for pathway 2 + 3 patients.	**Complete**	Age UK now part of Home First Steering Group
16	**4. Home First/Discharge to Assess** **(Gina Sargent)**	Undertake a review of B&NES pathway options against national guidance and examples of best practice. (D2A Quick Guide)	Jun-17	B&NES CCG & Council Ryan Doherty	B&NES offer against national guideance is clear, with a developed local response on furture commissioning strategy.	**Complete**	21/04/2017 -Gap analysis has been undertaken and review presented to CCG and Council to identify priority areas for development.
17		Develop a single point of access to facilitate ward led referals and discharges.	Jul-17	Virgin and RUH Nikki Woodland	Process is clear, with reduced steps ensuring effective and prompt referrals.	**A**	21/04/17 Work being undertaken as part of the systemwide Home First working group.
18		Undertake a review into the Reablement skill mix to ensure it can best meet the needs of pathway 1 patients.	Aug-17	Virgin and B&NES CCG Angela Smith	A clear understanding of the skill mix needed to support the Home First principal, including more medically complex patients.	**G**	Work has commenced on the Home First Performance Dashboard. This will include capturing data on what is needed to support someone to be discharged home or remain at home.
19		Continue to fund out of hospital domiciliary care offer to support Pathway 1 and integrate into Home First	Mar-18	B&NES Council Angela Smith	Block capacity will be in place to facilitate a rapid domiciliary care response to support prompt hospital discharges and avoid admission.	**G**	This will be part of the overall review of Home Care and Reablement Services with a view to establishing new framework contract arrangements with providers.
20		Embed all partners within pathway 1 including CITT & Dorothy House	May-17	RUH, Virgin, AWP Gina Sargeant	Pathway 1 is able support patients with complex needs including mental health and Eol care needs	**Complete**	CITT and Dorothy House part of the Home First Steering Group.
21		Develop metrics to show the benefits and performance of Home First (to include patients discharged on a weekly basis, delays, readmission rates and discharge destination of patients)	Apr-17	B&NES CCG & Virgin Gina Sargeant	The impact of the Home First scheme will be demonstrated through regular reporting. Blocks in the pathway will be reduced.	**R**	21/04/17 Work being undertaken as part of the systemwide Home First working group. Additionally wider Reablement metrics being review as part of YCYW transition.
22		Draft an assisted technology strategy (including the option of telecare as an assessment and support tool within pathway 1).	Sep-17	B&NES Council Wendy Gyde	Technology will become a common feature of assessment, tested during this pathway so that ongoing needs can be accurately assessed and met.	**A**	Brought over from 16/17 Action Plan - Strategy currently being written.
23		Review the community equipment contract to ensure a repsonsive offer for pathway 1 patients.	Jun-17	B&NES Council and Virgin Wendy Gyde	Teams have timely access to equipment needed to support discharges into Home First pathway 1	**A**	To be reviewed as part of community equipment contract. **[VE Update]**
24		Develop a clear communication strategy for all pathway options.	Jun-17	RUH, Virgin & B&NES Council Gina Sargeant and Emma Mooney	Patients, carers and staff are clear on the pathway options and the associated timelines.	**A**	Being led by RUH in wider system wide Home First meetings.
25		Ensure there is sign up to B&NES wide operational standards for all Home First pathways.	Jul-17	RUH, Virgin, AWP, B&NES CCG & Council Caroline Holmes, Gina Sargeant	There is clarity around the expected timelines and standards for Pathways 1,2&3.	**A**	To review the S.Glos standards to ascertain if appropriate for B&NES.
26		Review Extra Care Housing options, to understand the role such options can play within Pathway 2	Nov-17	B&NES Council Anne-Marie Stavert	There is clarity about the role Extra Care housing can play in supporting patients within Home First pathway 2.	**G**	
27		Develop and agree a long term NWB pathway with partners.	Aug-17	B&NES CCG & Council Caroline Holmes	There is an agreed pathway for NWB patients (including those with neck braces), providing clarity and reducing delays.	**G**	Meeting arranged for July between CCG, Council and Virgin to discuss long term plan.
28		Establish reasonable time frames for care home assessment (within 48 hours).	Nov-17	B&NES Council Vince Edwards	Care homes understand the need to assess promptly and this has been expressed formally by commissioners.	**G**	Could be embedded within the care home contract due Oct-17.

29	**5. Seven Day Services** **(Caroline Holmes)**	Work in partnership with care homes to identify those willing to admit across 7 days and respond to any potential barriers.	Aug-17	B&NES Council & CCG Ryan Doherty Karen Green	A greater number of care homes are confident and willing to admit at weekends.	**G**	Previous Hospital to Care Home Group completed a number of actions, however outstanding actions need oversight including a D/C checklist, follow up calls and 'what if' posters.
30		Write business case for 7 day referrals to teams within Home First pathways (Including Reablement, Therapies, Social Services and IDS)	Jun-17	B&NES CCG, Virgin and RUH Ryan Doherty and Lee Warner Holt	Understand what is required to support a 7 day service which is available for referrals, assessment and discharge into all pathway options.	**A**	Business case for 7 day Home First in draft, due to be completed by Jul.
31		Review domicillary care offer and work in partnership with providers to support those willing to accept care restarts, planned packages and unplanned packages across 7 days.	Mar-18	B&NES Council Angela Smith	A greater number of providers are willing to accept both planned and unplanned packages across 7 days.	**G**	This will form part of the future contracting arrangements with Home Care Providers.
32	**6. Trusted Assesor** **(Anita West)**	Review national guidence on trusted assessment (due soon) and develop specific actions around trusted assessment between health and social care providers.	Aug-17	B&NES CCG, B&NES Council, Virgin, RUH & AWP. Karen Green Ryan Doherty	Clarity on how trusted assessment can be effectively implemented across health and social care teams	**A**	Guidence has not yet been released, may impact timescales.
33		Develop a trusted assessor model within RUH wards for identified care homes	Nov-17	RUH Anita West	There is an understanding of how the trusted assessment model can work within B&NES, which will aid discussions around expansion to other providers.	**G**	
34		Test the St. Monica care home trusted assessor model.	Nov-17	B&NES Council and RUH Karen Green	There is an understanding of how the trusted assessment model can work within B&NES, which will aid discussions around expansion to other providers.	**G**	Chocolate quarter due to open Sept -17. Trusted assessment already in place within St Monica's and Bristol acute hospitals.
35		Develop a Care Home link role within providers.	Aug-17	RUH, Virgin, B&NES Council Anita West	Improved relationships and communication between providers and care homes.	**G**	
36	**7. Choice Policy** **(Lee Warner Holt)**	Develop information guides which are readily available to patients/representatives, outlining the discharge process.	May-17	RUH and Virgin Lee Warner Holt Nikki Woodland	Patients/Carers have a clear, honest and realistic understanding about the discharge plan and process (Inc. timescales). With patients/carers aware of their expected responsibilities within this process.	**R**	Brought over from 16/17 Action Plan. Virgin leaflets need rebranding from Sirona. **[LWH update]**
37		Develop proposals to support self-funders with timely information and advice.	Aug-17	B&NES Council and BaNES CCG Caroline Holmes	There is clarity about the offer for self funders and who will manage this process.	A	Copied from 16/17 DTOC Action Plan
38		Complete revision of choice policies to match the A&EDB agreed Wiltshire policy and ensure implementation.	Jun-17	RUH , Virgin, AWP & B&NES CCG Lee Warner Holt Nikki Woodland Chris Prangley - Griffiths	Policy is updated with a standardised model in use across B&NES and partner CCG's/Councils.	**R**	Brought over from 16/17 Action Plan. RUH policy awaiting sign off, Virgin policy in process of being written following handover.
39		Develop specific measures to ascertain choice policy implementation and effectiveness.	Jul-17	RUH , Virgin, AWP & B&NES CCG Ryan Doherty Gareth Jones Caroline Holmes	Implementation and policy effectiveness is apparent, with performance against implementation being measured.	**A**	Need to progress to meet timescale.
40	**8. Support for Care Homes** **(Vince Edwards)**	Draft an assisted technology strategy to understant the role it could play in supporting care homes, with a focus on clinical support	Sep-17	B&NES Council and BaNES CCG Wendy Gyde	The is a clear understanding of the additional clinical support assisted technology could play in terms of reducing deterioration, avoiding admission or facilitating discharge.	**G**	Part of the Assisted Technology Strategy, additionally the 'Airedale Model' currently being scoped [Update - not currently being considered]
41		Develop specific actions based on the learning from the fair price of care event to aid discussions around market shaping and sustainability.	Jun-17	B&NES Council. Vince Edwards	There is a clear plan to ensure market sustainability and plans to increase available capacity within the market.	**A**	Event held 05/04/17. **[VE Update]**
42		Review how the home contract development process can potentially be utilised as an opportunity to shape improvements within the care home sector.	Nov-17	B&NES Council & B&NES CCG Vince Edwards	There is clarity on the requirements within the contract for homes in regards to quality improvement and service responsiveness.	**G**	Contract due Oct 17.
43		Review Reablement criteria to ensure care homes can access support to reduce physical deterioration, facilitate discharge or avoid admission.	Jan-18	Virgin, B&NES CCG and B&NES Council Angela Smith	Ensure patients independence is maximised for as long as possible by ensuring appropriate support to those being admitted to care homes on either an interim or long term basis.	**G**	To be considered when Virgin have completed an internal review of the current demand on the reablement staff resource. This potentially has resource implications and needs to be further considered in the light of EY savings.

44		Undertake a pilot of the 'Red Bag Scheme' with 10 care homes within B&NES.	Sep-17	B&NES CCG, B&NES Council, Virgin and RUH Ryan Doherty	Effectiveness of the scheme is clear, with follow on discussions around expanding or continuation of the scheme. Additionally there is an improved handover of care between hospital and care homes meeting NICE guidance.	**G**	Production delays for manufacturer, additionally need to work up the standardised paperwork. However working towards Aug start date.
45		Review current options within the care home market to support patients with a range of needs including higher residential, NWB, EOL fast track and specialised provision.	Aug-17	B&NES Council & B&NES CCG Caroline Holmes	The is clarity about the ability of homes to manage a range of residents conditions, resulting in quicker identification of appropriate homes. Additionally gaps in the market will be visible.	**G**	See NHS Quick Guide: Identifying Local Care Home Placements for framework
46		Review the learning from vanguard sites which have provided greater clinical support for care homes and benchmark our current position	Sep-17	B&NES CCG Ryan Doherty	There is a clear position for the clinical support available to care homes, with plans to enhance this to esnure care homes are confident in taking discharges across 7 days alongside the support needed to avoid admission.	**G**	

Reference	High Imact Change	Actions to take	By when	Lead organisation	Outcomes expected	RAG status	Comments
1	**1. Early Discharge Planning**	Ensure national examples of best practice are embedded within all providers.	Jul-18	RUH, Virgin, AWP, B&NES CCG	Utilisation of best practice ensures discharge planning is done at the earliest and most appropriate stage, including prior to admission for elective admissions.	**G**	
2	**2. Monitoring Patient Flow.**	Ensure a 17/18 baseline measure is establised and ratified against national guidence for all providers.	Apr-18	RUH, Virgin, AWP, B&NES CCG	A clear baseline is set to allow accurate measurement of performacne and progress.	**G**	Work is being undertaken to allign recording against national guidence.
3		Establish a 18/19 reduction target for acute, mental health and community providers.	May-18	RUH, Virgin, AWP, B&NES CCG	There is a clear DTOC reduction target set for all providers in B&NES.	**G**	
4		Develop a 'live' system wide demand and capacity model.	Jun-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	All partners can clearly see demand and capacity across the system, allowing capacity to be promptly increased at times of high demand.	**G**	
5		Embed national examples of best practice around patient flow within all providers	Apr-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	Bottlenecks or flow issues rarely occur, with actions to mitigate when they do.	**G**	
6	**3. Multi Agency/Disciplinary Discharge Teams**	IDS team expanded to include third sector, strategic partners and care home partners where appropriate	Apr-18	RUH, Virgin, AWP, B&NES Council	Joint working between all partners, leading to a reduction in assessment delays.	**G**	
7		Integrate health and social care assessments.	May-18	RUH, Virgin, AWP, B&NES Council	A single, trusted assessment process exists for integrated health and social care teams, reducing assessment delays.	**G**	
8		Embed a streamlined CHC assessment process.	May-18	B&NES CCG, B&NES Council, Virgin	Reduced assessment delays and ensuring patients are assessed in the most appropriate environment.	**G**	
9	**4. Home First/Discharge to Assess**	Expand on 17/18 progress within Home First across all pathway options.	Sep-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	All patients return home and have assessments undertaken where safe, with patients unable to return home being cared for and assessed within non-acute settings.	**G**	
10		Develop provider skill mix to best meet the needs of Home First patients.	May-18	Virgin and B&NES CCG	Skill mix within providers meets Home First principals	**G**	
11		Work with care homes to establish reasonable time frames for assessment (within 24 hours).	Jul-18	B&NES Council	Care homes understand the need to assess promptly and this has been expressed formally by commissioners.	**G**	
12	**5. Seven Day Services**	Expand on 17/18 progress on 7 day working across health and social care teams including domicilary care and care home partners.	Sep-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	Delays are reduced and patients are promptly care for in the most appropriate environment.	**G**	
13	**6. Trusted Assesor**	Utilise 17/18 learning to agree a single trusted assessment format across health and social care.	Jul-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	Assessments are undertaken promptly by any system partner and such assessments are trusted by all partners.	**G**	
14		Work towards greater integration and pooling of health and social care funding streams	Sep-18	B&NES CCG and B&NES Council	Pooled funding streams result in increased collaboration and decreased delays related to funding.	**G**	
15	**7. Choice Policy**	Ensure 17/18 progress is expanded against choice policy.	Aug-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	Plans are in place to expand on 17/18 progress, further developing choice policy effectiveness.	**G**	

16		Set implementation target measures.	Aug-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	Clear performance targets for providers to ensure choice policy implementation.	**G**	
17	**8. Support for Care Homes**	Ensure 17/18 progress is expanded against care home support.	Aug-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	Plans are in place to expand on 17/18 progress, further developing support to care homes and care home residents.	**G**	
18		Work towards implementing the nursing home vanguard model	Sep-18	RUH, Virgin, AWP, B&NES CCG and B&NES Council.	Utilise national learning to esnure support for care homes within B&NES follows best practice.	**G**	

Rag Status Indicaticator

R	Action off track or significant blockers
A	Action Slippage/off track but recoverable in timeframe
G	Action On track

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