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Key Issues Briefing Note

Health & Wellbeing Select Committee March 2016

B&NES Better Care Fund Plan 2016/17

Context

The 2015 Autumn Spending Review set out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. The Better Care Fund (BCF) is seen as a key enabler for local integration of health and care services, which, are less well progressed in many other parts of the Country than they are in Bath and North East Somerset.

Further details on how the BCF is to be used in 2016/17 were set out by NHS England in the 2016/17 Better Care Fund Policy Framework with detailed guidance on the requirements published on 23rd February 2016. Local BCF Plans must be jointly agreed and signed-off by the Health and Wellbeing Board. Timescales for developing, agreeing and submitting plans are challenging with the requirement for a "brief narrative plan" to be submitted on 21st March and final submissions due on 25th April 2016.

Bath and North East Somerset's Better Care Plan 2014/15-2018/19 was agreed by the Health and Wellbeing Board on the 17th September 2014, this led to the plan being approved and recognised as an example of best practice through the NHS England national assurance process. The Health and Wellbeing Board agreed at its meeting on 25th March 2015 to put in place a formal agreement setting out funding transfers, governance and risk share arrangements under Section 75 of the NHS Act 2006. This agreement was entered into by the Council and Clinical Commissioning Group (CCG) on 1st April 2015.

B&NES BCF Plan 2016/17, which was presented in draft form to B&NES Health and Wellbeing Board on 23rd March, reflects the vision and strategic priorities for integrated health and care set out in and evidenced by existing plans including the Better Care Plan 2014/15-2018/19, CCG 5-Year Strategic Plan 2014/15-2018/19, Health and Wellbeing Strategy and plans associated with the Council and CCG's joint review of Community Services **"*your care, your way*"** (see www.yourcareyourway.org).

In this wider context, our 2016/17 BCF plan focuses on the new conditions as set out in the Policy Frame and planning guidance. As summarised in paragraph 1.3, these are: investment in NHS commissioned out-of-hospital services; a DTOC Action Plan; and a locally agreed target for reducing DTOCs.

The national funding allocations into the BCF remain consistent with the 2015/16 with a small reduction in the CCG minimum contribution this has taken BCF funding from £12.049m in 2015/16 to £12m in 2016/17.

Investment in Out-of-Hospital Services

The Better Care Fund Plan for B&NES continues its investment in a range of integrated services, designed to enable people to remain independent and in control of their lives. However, there are also a number of changes to schemes this year, following a review of activity, outcomes and value for money.

The changes outlined below reflect the new expectations of the Better Care Fund in 2016/17 to reduce delayed transfers of care and to invest further in out of hospital services. They support the required delayed transfer of care (DTOC) action plan which is outlined below. The changes also reflect the further development of integration detailed in ***your care, your way***.

Within the Home from Hospital schemes heading, the Handyperson service which expedites **minor adaptations in the home to support hospital discharge** is to transfer from the current provider, Somerset Care and Repair to an alternative provider, West of England Care and Repair under an established framework contract to secure the level of service needed and achieve improved value for money. This change follows a review of the pilot service provided by Somerset Care and Repair. There will be no adverse impact on the service and, indeed, the change of provider may result in an improvement to the number of people accessing the service as a result of greater awareness of the service and a simplified referral pathway. Similarly, the support provided to the Royal United Hospital and hospital discharge process will not change.

An **urgent domiciliary care response service**, supporting people waiting to be discharged from hospital to home will be commissioned to further test an approach piloted on a small scale in 2015/16. The service will complement the reablement and Discharge to Assess schemes and the aim is to reduce the number of days that patients are delayed in hospital, waiting for their care package to begin. Building on the 2015/16 pilot, the intention is to further develop and test this approach during 2016/17 to evidence its impact and value.

A key element of the Better Care Fund in 2016/17 will be a **greater focus on the use of technology and assistive technology** in particular. This additional investment will enable teams to work alongside service users and carers and try different forms of assistive technology during assessment such as that undertaken, for example, as a core element of the reablement service, or as part of Discharge to Assess.

This will allow teams the time and space to test out equipment with people with the benefit and back up of care which will help assess whether equipment such as medicine dispensers, door alerts and movement sensors that can support people to remain at home, provide reassurance to carers and family members and can help highlight risks that can then be addressed. Equipment will also be introduced to enable practitioners to evidence the risk of people remaining at home and it is expected that this will be required before any proposal to move into permanent care is made. This proposed change in practice is one that would reflect the seriousness of a life-changing event such as moving into a care home and the importance of exploring alternative options and enabling individuals to make informed decisions.

The Integrated Enablement Service, which provides reablement to residents of care homes and extra-care housing, is being re-shaped to develop a **falls prevention and response service**. This change is being introduced as the prevalence of falls within the

community and in care homes in particular is one of the major causes of admission to hospital. The aim is to support people who fall whilst living in a care home to enable their assessment to be carried out locally where clinically appropriate, rather than being admitted to hospital.

Delayed Transfers of Care Action Plan

The DTOC action plan has been developed using feedback from a recent multi-agency review of managing hospital discharges over the Christmas and New Year period. Its title ***"Everyone's Issue"*** was coined at the event and describes the nature of the plan, which sees accountability and responsibility for improving the numbers of patients delayed in hospital shared across a range of agencies.

It sets out plans for: improving capacity within key services such as domiciliary care and reablement; supporting complex discharges; and agreeing escalation procedures so that when the answers are not straightforward, the issue can be escalated to senior managers to make a decision. It starts with a recommendation that patients delayed in all aspects of services are counted, rather than just in acute and community hospital beds. This will allow the true picture and capacity required to be clear to all partners and plans to be strengthened as a result.

Governance and oversight of the DTOC Action Plan have been agreed by the multi-agency Systems Resilience Group. This will be one of the most critical levers of the plan as ownership and visibility of actions are critical to its delivery.