

Bath and North East Somerset
Better Care Fund
2017-2019
Narrative Plan



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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 provide 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:

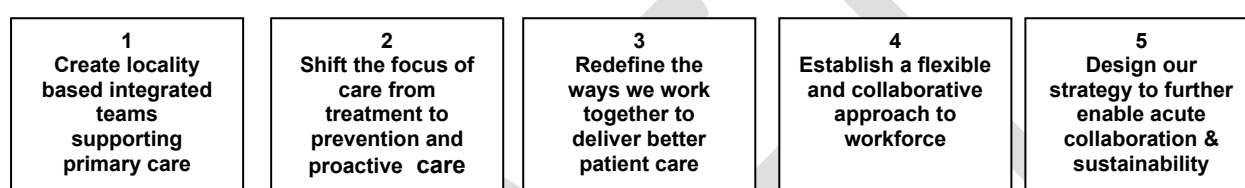
- Improved support for people with long term health conditions;
- Reduced rates of mental ill-health;
- Enhanced quality of life for people with dementia;
- Improved services for older people which support and encourage independent living and dying well.

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.

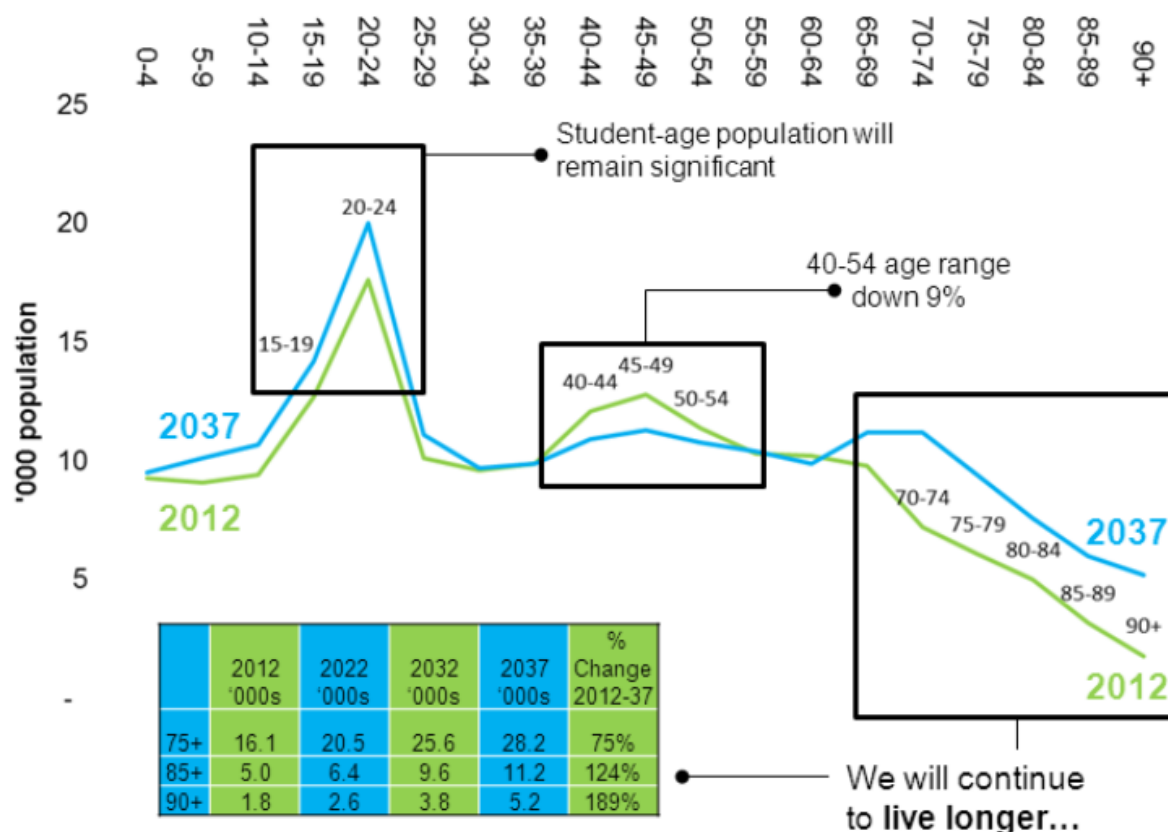
The current financial climate also places a greater imperative on the CCG and the Council to develop models of care within available resources that are both robust and sufficiently flexible to be responsive to changing needs, aspirations and technological advances over the next decade and beyond.

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



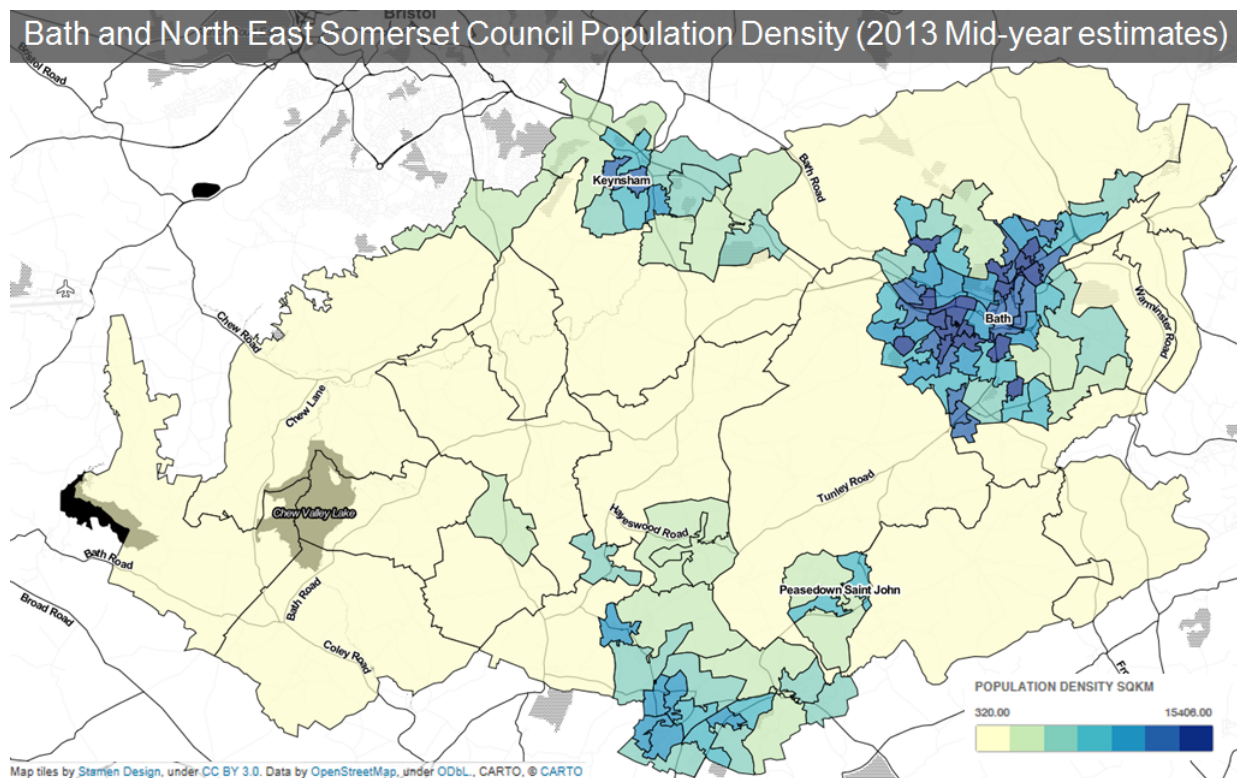
The dependency ratio of those aged 0 to 15 and 65+ when compared against the working age populations is also set to increase, from a current ratio of 1:2 to 1:1 by 2037 as shown in Figure 3 below.

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 rural 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

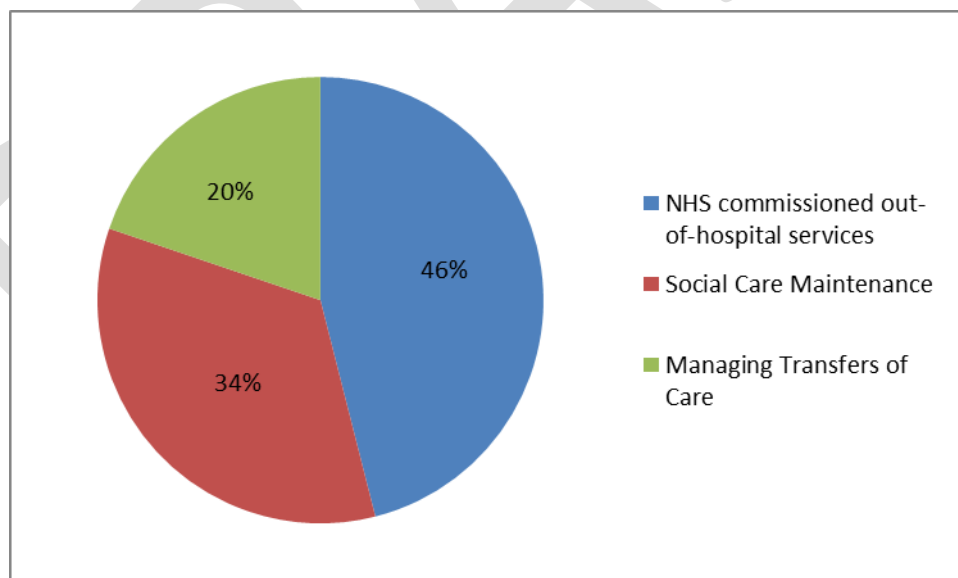
The full 3-year community services transformation plan will be available from September 2017 but the agreed areas of delivery for 2017/18 include:

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.

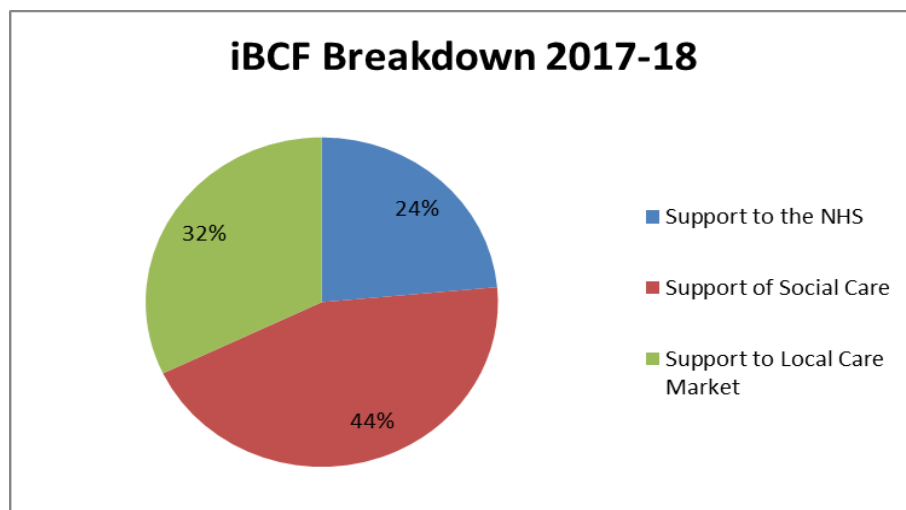


The table below lists the existing and new schemes that will be monitored. The schemes are fully populated for year 1, with the expectation that year 2 detail will be confirmed during year 1.

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 Liaison 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 financial sustainability 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.

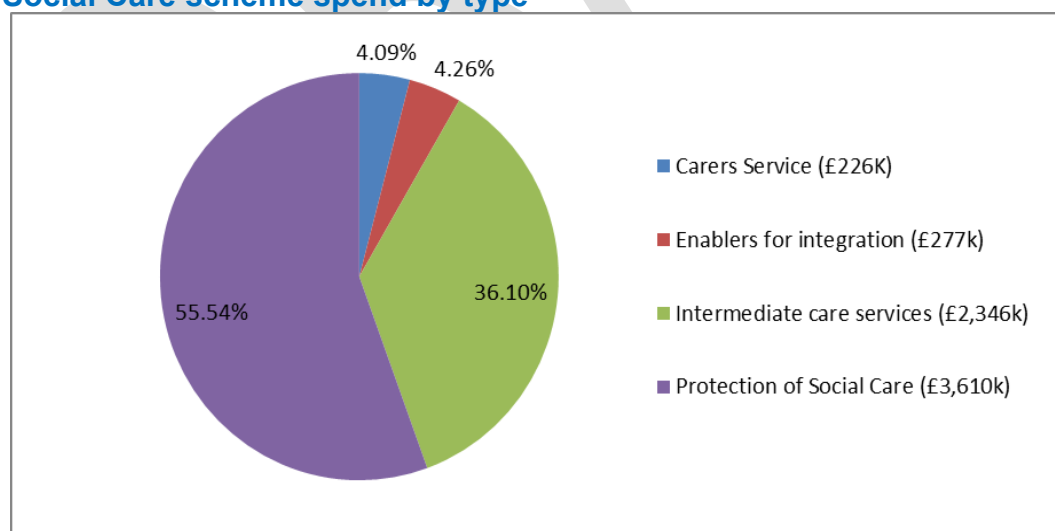
The preparation of the Better Care Fund Plan has been undertaken alongside the planning rounds of both the Council and the CCG and the funding has been aligned to both plans. The approach to planning for the Better Care Fund has been consistent with the Department of Health guidance for funding transfers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

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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

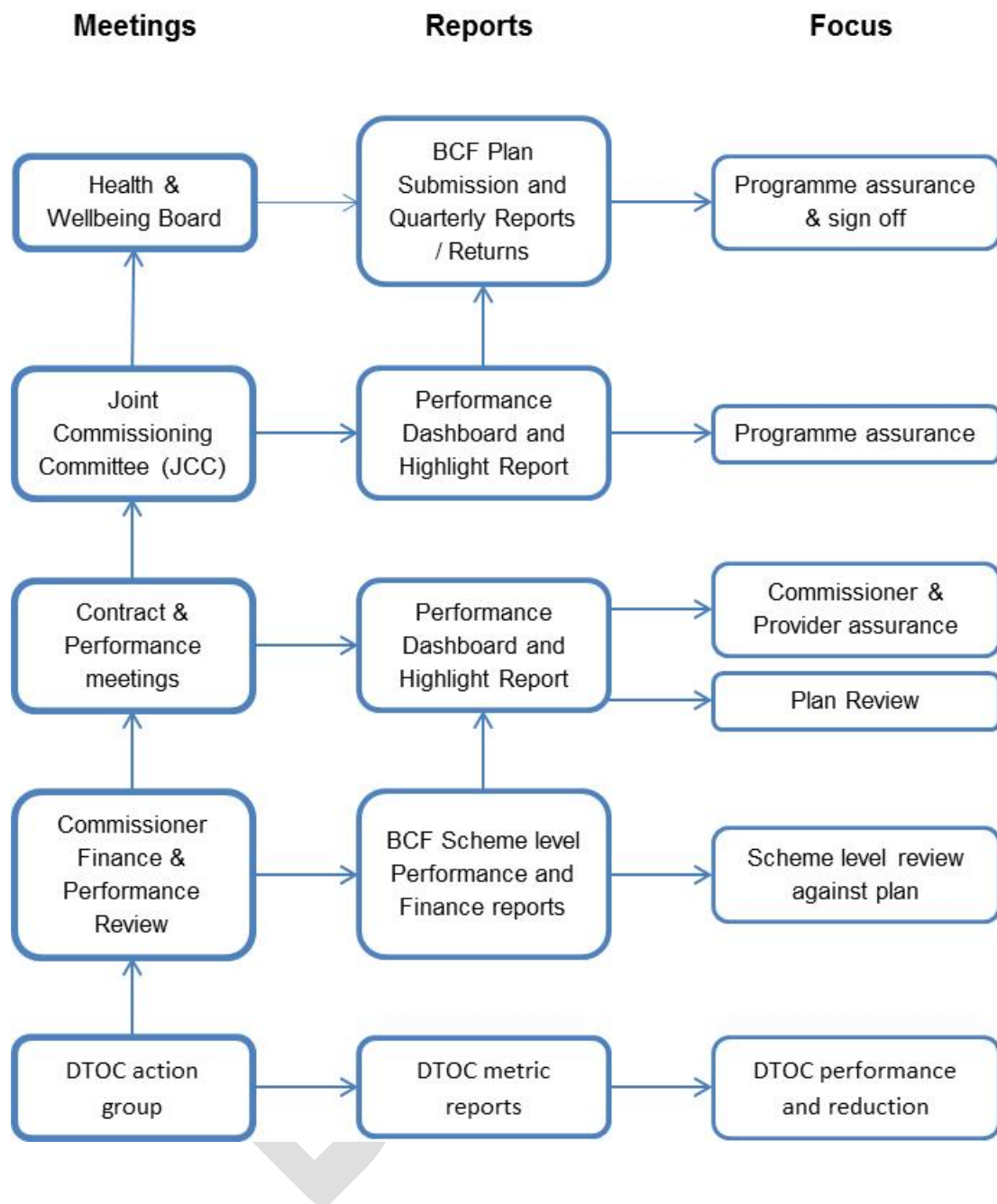
In terms of the specific schemes highlighted under the Better Care Fund plan 2017-19, monitoring of will be undertaken within the CCG and Council, led by the Senior Commissioning Manager for Better Care and supported by monthly performance dashboard and scheme level data. Delivery of the schemes and 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.



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:

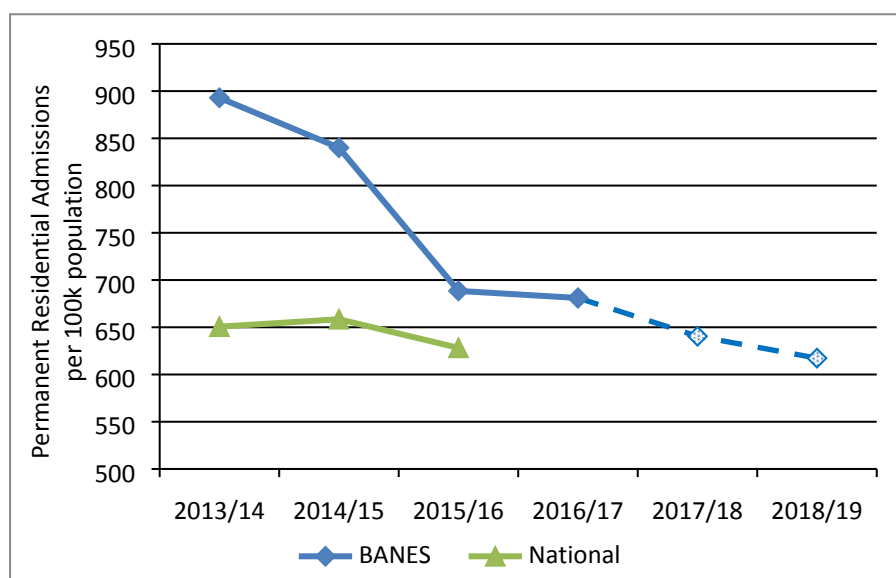
- **Falls Response:** The falls response service which is both a BCF and QIPP scheme began in May 2017 and has already successfully prevented 88 admissions in May and June. This innovative scheme, involving a paramedic and OT working in the community, is already demonstrating a significant impact in 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.

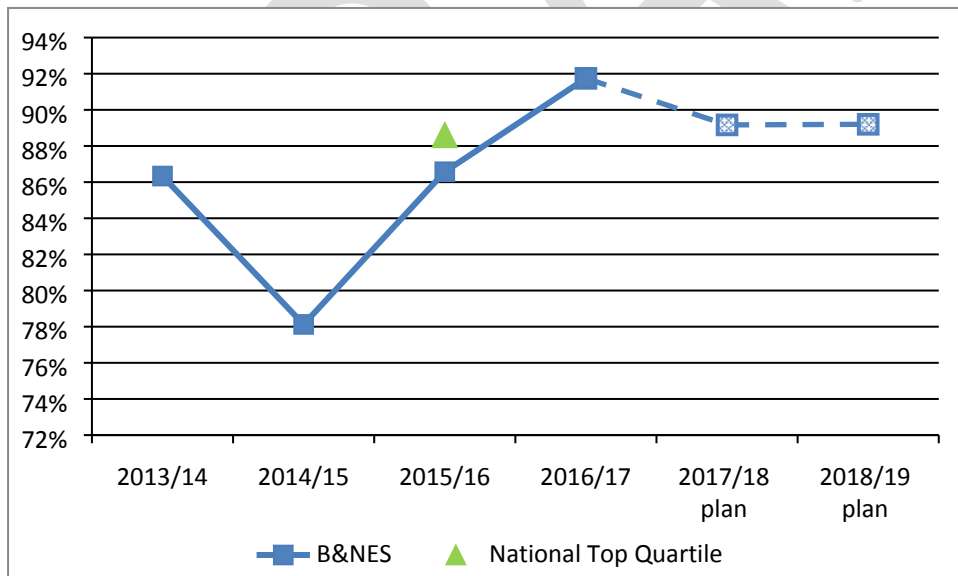
11.3 Effectiveness of reablement:

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		Attribution of delays		Location of bed delay		
<input checked="" type="checkbox"/> = Direct <input checked="" type="checkbox"/> = Enabling		NHS	Social Care	RUH	Virgin (Community Hospital)	AWP
Assistive Technologies		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Assistive Technologies	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Impact Change Model for Managing Transfer of Care		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23a,b,c	Home First (Pathway One & Transport)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23d	D2A Beds (Pathway Three)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intermediate Care services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Integrated Reablement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4	Falls Response	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Support Planning and Brokerage	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
CCG QIPP schemes		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)

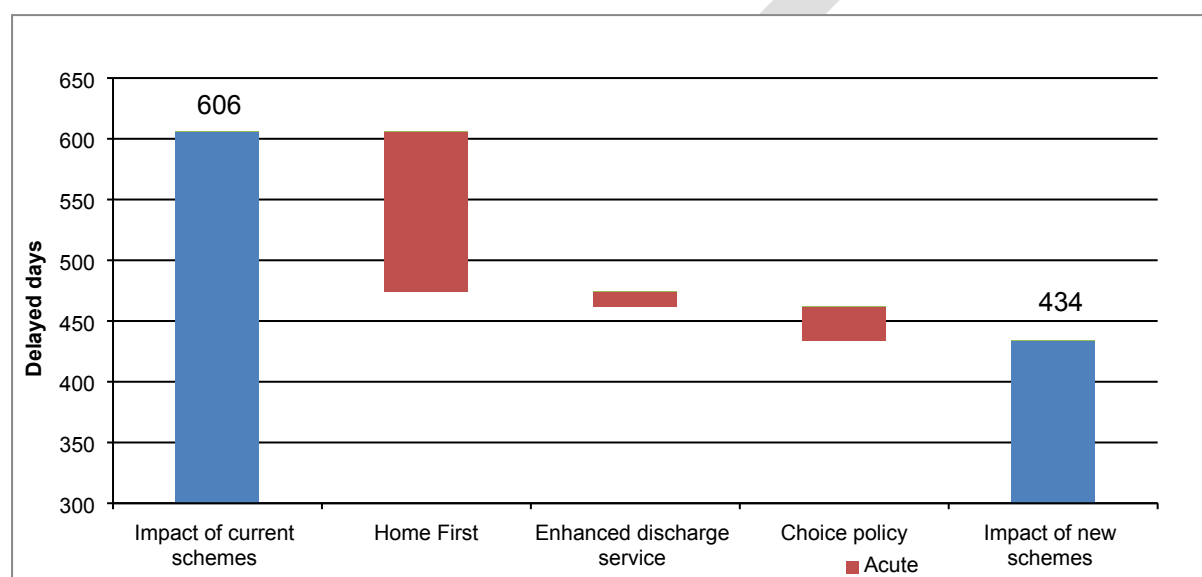
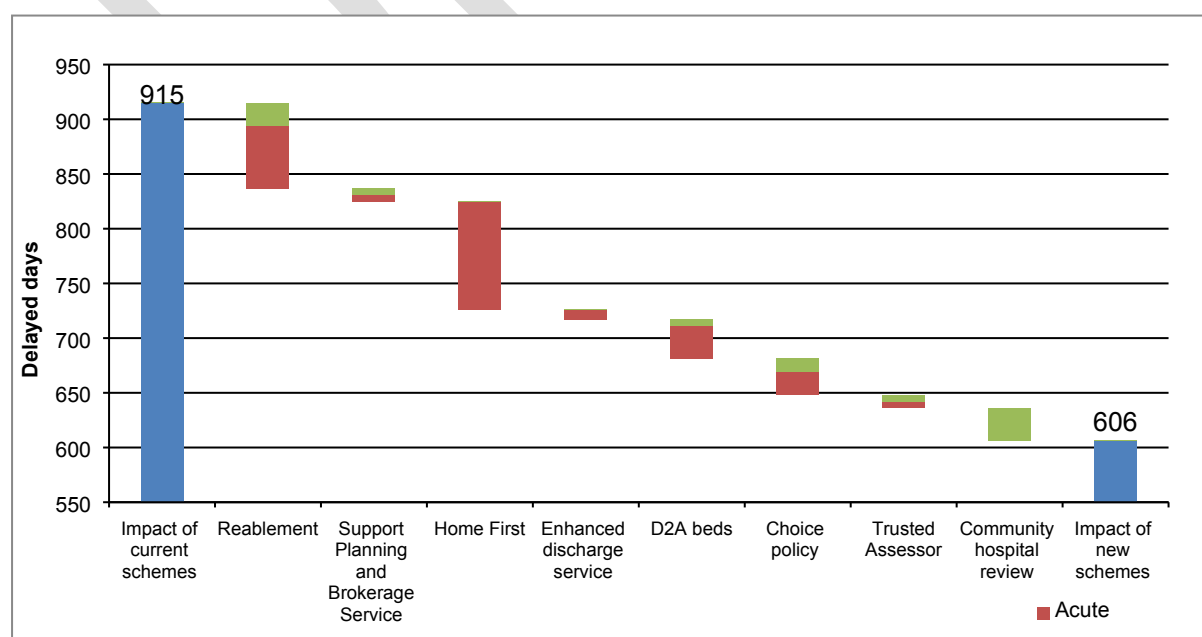


Figure 9 Forecast reduction in days delayed in March 2018 by scheme / action



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 if 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.

DRAFT

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