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

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assistive Technologies</strong></td>
<td>Plan detail on page 2-3</td>
</tr>
<tr>
<td>14 Assistive Technologies</td>
<td></td>
</tr>
<tr>
<td><strong>Carers Service</strong></td>
<td>Funding for Carers' Centre offering bespoke support for Carers in B&amp;NES.</td>
</tr>
<tr>
<td>11 Support for Carers</td>
<td></td>
</tr>
<tr>
<td><strong>Disabled Facilities Grant - Adaptions</strong></td>
<td>Disabled Facilities Grant funding supporting adaptations in the home.</td>
</tr>
<tr>
<td>14 Disabled Facilities Grant (DFG)</td>
<td></td>
</tr>
<tr>
<td><strong>Enablers for Integration</strong></td>
<td>Supports integrated teams and social care pathway within Virgin Care, including point of access.</td>
</tr>
<tr>
<td>1 Integrated Delivery infrastructure</td>
<td></td>
</tr>
<tr>
<td>7 Integrated Care and Support</td>
<td>Supports integrated teams (including mental health and LD) within Virgin Care.</td>
</tr>
<tr>
<td>7b Community Equipment</td>
<td>Plan detail on page 4-5</td>
</tr>
<tr>
<td><strong>High Impact Change Model for Managing Transfer of Care</strong></td>
<td>Investment into seven day working</td>
</tr>
<tr>
<td>2a Social Work 7-day Working</td>
<td>Plan detail in appendix - missing at present</td>
</tr>
<tr>
<td>2b Discharge Liaison Nurse</td>
<td></td>
</tr>
<tr>
<td>23a,b,c Home First (Pathway One &amp; Transport)</td>
<td>Plan detail on page 6-7</td>
</tr>
<tr>
<td>23d D2A Beds (Pathway Three)</td>
<td>Plan detail on page 8-9</td>
</tr>
<tr>
<td><strong>Integrated care planning</strong></td>
<td>Plan detail on page 10-11</td>
</tr>
<tr>
<td>13 Strengths-based Working</td>
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</tr>
<tr>
<td><strong>Intermediate Care services</strong></td>
<td>Plan detail on page 12-13</td>
</tr>
<tr>
<td>3 Integrated Reablement</td>
<td>Plan detail on page 14-15</td>
</tr>
<tr>
<td>4 Falls Response</td>
<td></td>
</tr>
<tr>
<td>5 Home From Hospital Schemes</td>
<td>Range of schemes including Extra Care step down beds, Age UK Home from Hospital service</td>
</tr>
<tr>
<td><strong>Primary prevention / Early Intervention</strong></td>
<td>Plan detail on page 16-17</td>
</tr>
<tr>
<td>9 Social Prescribing</td>
<td>3 crisis support beds in the Wellbeing House for adults of working age with support for up to 4 days, 4 times a year.</td>
</tr>
<tr>
<td>10 Mental Health Reablement beds</td>
<td></td>
</tr>
<tr>
<td><strong>Residential placements</strong></td>
<td>Plan detail on page 18-19</td>
</tr>
<tr>
<td>19 NMW/Sleep in</td>
<td>Plan detail on page 20-21</td>
</tr>
<tr>
<td>21 Community Resource Centres</td>
<td>Plan detail on page 22-23</td>
</tr>
<tr>
<td>22 Transition of ECSH</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Plan detail on page 24-25</td>
</tr>
<tr>
<td>17 Fair Price of Care</td>
<td>Plan detail on page 26-27</td>
</tr>
<tr>
<td>20 Support Planning and Brokerage</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2 – 2017-19 BCF Scheme Plans
 Assistive Technology

SCHEME
Name: ASSISTIVE TECHNOLOGY (AT)

AT describes a host of digital technologies that support people to remain as independent as possible, manage their health and care needs and remain at home safely. They provide remote monitoring, access to health and care data and enable people to self-manage. There is a huge range of AT available, with new technologies being developed all the time.

There is a project under development to rapidly increase the use of AT in B&NES particularly within reablement and develop a business case to further the implementation of AT.

This project will provide an evidence base for having AT as an integral part of a person’s care and support package and is expected to demonstrate long term benefits for the person and for the council.

Commissioner: Wendy Gyde

Provided by: Virgin Care and Sirona Care & Health

FINANCE

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>Social Care</td>
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<td>Disabled Facilities / LGA Grant</td>
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Key:
- Not Started
- In Progress but overdue
- In Progress
- Complete

MILESTONES 2017/18

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
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<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Agree areas of focus for the project</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finalise the requirements for a technology partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finalise redesign of reablement processes to include AT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finalise the AT tools to be used and deploy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide training to reablement teams in the new processes and AT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project evaluation</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

RISKS / INTERDEPENDENCIES

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

Interdependencies:
- Community equipment service (BCF scheme)
- Virgin Care Community Services transformation of Reablement and Single Point of Access for Social Care Domiciliary Care Providers.
Appendix 2 – 2017-19 BCF Scheme Plans

Assistive Technology

MEASURES

Increase the usage of Assistive Technologies

Measure and improve outcomes for service users

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

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

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

NATIONAL METRICS

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

Notes: Trajectory to be developed as part of the project.
Appendix 2 – 2017-19 BCF Scheme Plans
Community Equipment

SCHEME

Name: COMMUNITY EQUIPMENT (CE)

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

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

Commissioner: Wendy Gyde

Provided by: Sirona Care & Health

MILESTONES 2017/18

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Finalise current spec, understand processes around CE and map the spend</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Develop the requirements for April 2018 onwards</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Procure CE solution for April 2018 onwards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implement the CE solution for April 2018 onwards</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Notes:

RISKS / INTERDEPENDENCIES

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

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

FINANCE

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
</tr>
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<tbody>
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<td></td>
<td></td>
</tr>
<tr>
<td>Health</td>
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<td>Existing</td>
<td>CCG Minimum Contribution</td>
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<tr>
<td></td>
<td>£481,998</td>
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</table>
Community Equipment

MEASURES

Equipment deliveries and timeliness

Measure and improve outcomes for service users

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

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

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

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

NATIONAL METRICS

This scheme will support the national metrics by enabling the schemes that keep people at home or return people home and helping to prevent future need for emergency care.
Appendix 2 – 2017-19 BCF Scheme Plans

Home First
(Pathway One & Transport)

**SCHEME**

Name: HOME FIRST

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

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

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

Commissioner: Angela Smith

Provided by: Virgin Care

**FINANCE**

<table>
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<tr>
<th>Area of Spend</th>
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<th>Planned Expenditure 2018/19</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
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<td>Social Care</td>
<td>£253,934</td>
<td>£253,934</td>
<td>Existing</td>
<td>Local Authority Social Services</td>
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<tr>
<td></td>
<td>£163,646</td>
<td>£163,646</td>
<td>IBCF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£10,258</td>
<td>£0</td>
<td>IBCF</td>
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**MILESTONE 2017/18**

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

**RISKS / INTERDEPENDENCIES**

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

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

Reduce the discharge time (recent performance)

Measure and improve outcomes for service users

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

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

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

NATIONAL METRICS

This scheme will support the national metrics by support people to go home from hospital quickly and keep people at home where appropriate.
**Appendix 2 – 2017-19 BCF Scheme Plans**

**Discharge to Assess Beds**
*(Home First Pathway Three)*

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**MILESTONES 2017/18**

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
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<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td></td>
<td>Initial scoping of D2A model and production draft business case</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Finalise and sign off business case &amp; draft procurement documents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undertake procurement process</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contract start date with preferred bidder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Undertake evaluation of bed base.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Notes:**

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

**RISKS / INTERDEPENDENCIES**

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

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

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

**Commissioner:** Vince Edwards

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

---

**FINANCE**

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<tr>
<th>Area of Spend</th>
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<th>New or Existing Scheme</th>
<th>Funding Source</th>
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<tbody>
<tr>
<td></td>
<td>2017/18</td>
<td>2018/19</td>
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<tr>
<td>Social Care</td>
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* Planned only. Finances will be confirmed during business case development and following procurement processes.

**Key:**

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

Bath & North East Somerset Council
Appendix 2 – 2017-19 BCF Scheme Plans
Discharge to Assess Beds
(Home First Pathway Three)

MEASURES

Measure and improve outcomes for service users

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

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

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

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

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

NATIONAL METRICS

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

---

Monthly Admissions & Discharges (Inc. Average LOS)

![Graph showing monthly admissions and discharges with average LOS](image)

Monthly Discharge Destination

<table>
<thead>
<tr>
<th>Scheme to date outcomes</th>
<th>Target</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to own home with a care plan</td>
<td>6%</td>
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</tr>
<tr>
<td>Discharged into Residential care</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Discharged into Nursing care</td>
<td>75%</td>
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</table>

Note: As the number of beds is so small we expect significant variations in the results which can not be planned for on a monthly basis, so the trajectories are expected averages and several months performance may be required before the results are clear. Project due to start in August 2017 but may be delayed as mentioned in Risks.
Appendix 2 – 2017-19 BCF Scheme Plans
Strengths-Based Working

SCHEME

Name: STRENGTHS-BASED WORKING

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

Commissioner: Helen Wakeling

Provided by: Virgin Care and AWP

FINANCE

<table>
<thead>
<tr>
<th>Area of Spend</th>
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<th>Planned Expenditure 2018/19</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
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<td>Social Care</td>
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<td>CCG Minimum Contribution</td>
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MILESTONES 2017/18

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

Notes:

RISKS / INTERDEPENDENCIES

Risks:

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

Interdependencies:

• Care and support planning based on a strengths based approach

Key:

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

Social Work to meet Contract Management requirements

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

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

Measure and improve outcomes for service users

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

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

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

NATIONAL METRICS

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

Name: INTEGRATED REABLEMENT

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

Commissioner: Angela Smith

Provided by: Virgin Care and Strategic Dom Care Partners

Milestones

<table>
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<th>Status</th>
<th>Action</th>
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<th>Q2</th>
<th>Q3</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Confirm scope of review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree new measures of capacity and efficiency</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Review and make recommendations on service model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prepare for 2018-19 delivery</td>
<td></td>
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</tr>
</tbody>
</table>

Notes:

Risks / Interdependencies

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

Interdependencies:
- Assistive Technology
- Main Virgin transformation programme

Finance

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure 2017/18</th>
<th>Planned Expenditure 2018/19</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
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<tbody>
<tr>
<td>Community Health</td>
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<td>£225,000</td>
<td>£229,275</td>
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</table>

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

**MEASURES**

Increase Success of Reablement

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

Measure and improve outcomes for service users

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

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

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

- Capacity of the service within Virgin and strategic partners

**NATIONAL METRICS**

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

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

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

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

**Commissioner:** Kate Parkins

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

### Milestones 2017/18

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Set up service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor activity and outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluate data and develop business case for 18/19</td>
<td></td>
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</tbody>
</table>

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

### Risks / Interdependencies

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

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

### Finance

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017/18</td>
<td>2018/19</td>
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<tr>
<td>Social Care</td>
<td>£224,500</td>
<td>£228,766</td>
<td>CCG Minimum Contribution</td>
</tr>
</tbody>
</table>

**Key:**
- Not Started
- In Progress but overdue
- In Progress
- Complete
Appendix 2 – 2017-19 BCF Scheme Plans

Falls Response

MEASURES

Delivering as expected activity during pilot

![Bar chart showing the number of patient falls responded to by the Falls Rapid Response Team for each month from May 2017 to April 2018.]

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

Percentage of patients for whom admission was avoided

![Line chart showing the percentage of patients for whom admission was avoided each month from May 2017 to April 2018.]

Measure and improve outcomes for service users

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

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

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

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

NATIONAL METRICS

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

Note: This measure is being defined as part of the pilot at the moment it is as recorded on the call.
Appendix 2 – 2017-19 BCF Scheme Plans

Social Prescribing

SCHEME

Name: SOCIAL PRESCRIBING

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

Commissioner: Basil Wild

Provided by: DHI sub-contracted by Virgin Care

FINANCE

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>£100,000</td>
<td>Existing</td>
<td>CCG Minimum Contribution</td>
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MILESTONES 2017/18

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

Notes:

RISKS / INTERDEPENDENCIES

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

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

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

### NATIONAL METRICS

This scheme will support the national metrics indirectly by supporting people to develop healthier lifestyles and reduce the need for care and health support.
### National Minimum Wage / Sleep-in

#### Scheme

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

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

**Commissioner:** Mike MacCallam

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

### Milestones 2017/18

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Agreeing the 3.5% uplift for packages of care with a Sleep-in element</td>
</tr>
<tr>
<td></td>
<td>Communicating the decision to all providers</td>
</tr>
<tr>
<td></td>
<td>Applying the uplift to all packages of care</td>
</tr>
<tr>
<td></td>
<td>Working with providers to understand their cost pressures</td>
</tr>
</tbody>
</table>

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

### Finance

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
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<td>Local Authority Social Services</td>
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**Key:**
- Not Started
- In Progress but overdue
- In Progress
- Complete

### Risks / Interdependencies

**Risks:**

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

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

**NATIONAL METRICS**

This scheme is to ensure current levels of support are maintained and is not expected to further support the national metrics.
### MILESTONES 2017/18

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
<th>Q1</th>
<th>Q2</th>
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<tr>
<td></td>
<td>Cleeve Court moves to new model</td>
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<tr>
<td></td>
<td>Charlton House moves to new model</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>Combe Lea moves to new model</td>
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</tbody>
</table>

**Notes:**

### RISKS / INTERDEPENDENCIES

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

**Interdependencies:**
- B&NES Council and CCG
- Community Hospital
- RUH
Appendix 2 – 2017-19 BCF Scheme Plans
Transition of Community Resource Centres

Manage Occupancy

Further measures (in development)
We are developing quarterly measures to track assessments, admisions and occupancy in the CRC’s. per quarter

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

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

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

Increase weekend admissions

NATIONAL METRICS
This scheme will support the national metrics by providing additional nursing care places.
Appendix 2 – 2017-19 BCF Scheme Plans
Transition of Extra Care Sheltered Housing

**SCHEME**

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

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

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

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

Commissioner: **Anne-Marie Stavert**

Provided by: **Various**

**MILESTONES**

<table>
<thead>
<tr>
<th>Status</th>
<th>Action</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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</thead>
<tbody>
<tr>
<td>Contract signing with Care Provider</td>
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</tr>
<tr>
<td>Provider to transition service to meet contract</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Review contract quarterly</td>
<td></td>
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</tbody>
</table>

**RISKS / INTERDEPENDENCIES**

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

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

**FINANCE**

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure 2017/18</th>
<th>2018/19</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care</td>
<td>£180,000</td>
<td>0</td>
<td>IBCF</td>
<td>Local Authority Social Services</td>
</tr>
</tbody>
</table>

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

Key:
- Not Started
- In Progress but overdue
- In Progress
- Complete
Transition of Extra Care Sheltered Housing

MEASURES

Maintain high occupancy of flats

Measure and improve outcomes for service users

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

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

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

Deliver agreed levels of flexible care

NATIONAL METRICS

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

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

Notes: The target for this measure will be set as part of the contract.
**Scheme Name:** FAIR PRICE OF CARE (FPoC)

This scheme supports the Council’s statutory duty to pay a ‘fair price of care’ (FPoC). It responds to clear recommendations from an independent analysis of care home costs for older people in B&NES. In doing so, the scheme ensures that all care home providers in B&NES receive sufficient funding in line with the Council’s duties. Alongside key interdependencies, the scheme is essential to support a sustainable care market and offer continuity of care for the community. It mitigates additional and significant legal risks (& associated costs) arising from not paying a FPoC.

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

**Commissioner:** Vincent Edwards

**Provided by:** Independent care organisations.

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**Finance**

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2017/18</td>
<td>2018/19</td>
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</tr>
<tr>
<td>Social Care</td>
<td>£545,000</td>
<td>£200,000</td>
<td>IBCF</td>
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**Key:**
- Not Started
- In Progress but overdue
- In Progress
- Complete

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**Milestones 2017/18**

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

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

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**Risks & Interdependencies**

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

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

Reduce the number of admissions for those aged 65 and over

Further measures (in development)

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

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

- %age of care home placements made below the FPoC
- Risk position (RAG) of FPoC in relation to Council's statutory duty (direct impact of planned expenditure on scheme’s objectives)
- Differential between FPoC rate and median unique value average of actual placement costs (by placement category)
- Level of outliers (e.g. cost at 5th and 95th percentile of all placements)
- Number of admissions to care homes
- Number of transitions from residential to nursing care
- %age of placements made at, and within 10%, of each FPoC rate

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

NATIONAL METRICS

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

**Name:** SUPPORT PLANNING AND BROKERAGE

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

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

**Commissioner:** Helen Wakeling

**Provided by:** Virgin Care

### Finance

<table>
<thead>
<tr>
<th>Area of Spend</th>
<th>Planned Expenditure</th>
<th>New or Existing Scheme</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care</td>
<td>£200,000</td>
<td>£100,000</td>
<td>IBCF Local Authority Social Services</td>
</tr>
</tbody>
</table>

### Milestones 2017/18

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

### Risks / Interdependencies

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

**Interdependencies:**
- Proposed changes to social care structure
- Market development work being undertaken across health and social care
- Strengths based working being adopted across the system
Appendix 2 – 2017-19 BCF Scheme Plans
Support Planning and Brokerage

MEASURES

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

Measure and improve outcomes for service users

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

Improved outcomes for service users are expected to include:

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

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

Service users receiving an individual budget as a direct payment

NATIONAL METRICS

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