Bath & North East Somerset Council

NHS
Bath and North East Somerset Clinical Commissioning Group

Bath and North East Somerset Better Care Fund 2019-2020

Narrative Plan

Healthier. Stronger. Together.

Contents

Introduction / Foreword

The Better Care Fund provides a mechanism to support the integration of health and social care. The 2019/20 planning guidance continues to provide this mechanism to ensure that health and social care can support people to remain independent at home or to return to independence after an episode in hospital, recognising the NHS Long Term Plan and a commitment for a new NHS offer of emergency response and recovery support through expanded multidisciplinary teams in primary care networks.

The B&NES strategic approach to delivering integrated health and social care is set out in section 1 showing how the Better Care Fund supports delivery of integrating health and social care and how this aligns with the development of Primary Care Networks (PCNs), the BaNES, Swindon and Wiltshire (BSW) Commissioning Alliance and the BSW Integrated Care System (ICS).

This document, in line with national guidance, outlines the plan for B&NES for 2019/20 building on the two year plan developed in 2017, taking into account the current context at section 2 and the progress made and lessons learnt locally from both the 2014 and 2016 plans as well as the formative years of this plan. This learning is outlined in more depth in section 3 together with further details on the use of the Better Care Fund (BCF), Disabilities Facility Grant (DFG), and Winter Pressures Grant to support integrated service delivery, with scheme plans setting out objectives, milestones, investments and performance indicators attached at Appendix 1.

The B&NES Better Care Fund schemes support the delivery of the four BCF national metrics. We are also setting local metrics to provide balance to the national metrics. Full details of these metrics have been provided at section 4 and a summary of the impact of the schemes can be seen in Appendix 2.

The fund has increased in financial terms from £61.1m in 2017/18 to £71.3m in 2019/20 following increases in the Improved Better Care Fund (iBCF) grant and the inclusion in 2019 of the winter pressures grant which now supports schemes to increase capacity flexibly throughout the year. The BCF also includes additional funding to pay for the community services contract from both health and social care and includes growth funding. This is explored in more detail in section 5, including the associated financial risks. The financial Dashboard can be found at Appendix 3 with details of all schemes, funding sources and financial movement at Appendix 5.

This narrative plan in support of the schemes was agreed by JCC on 22nd August 2019 and recommended to the Health and Wellbeing Board who signed the plan off at their meeting on 17th September 2019 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 Rob Appleyard

Signed on behalf of B&NES Health and Wellbeing Board

…… **Date……**

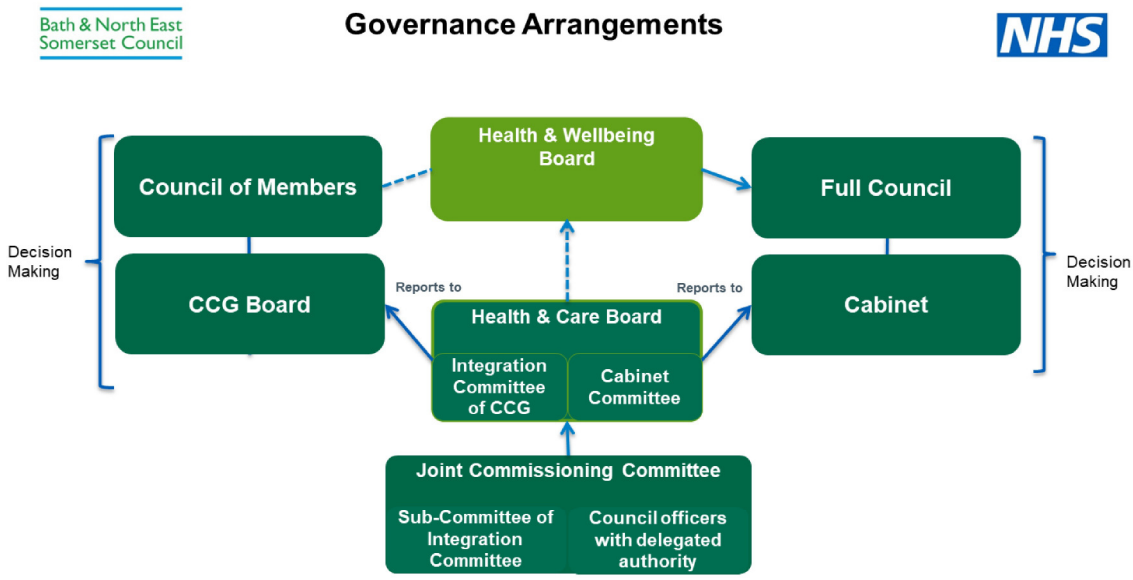
Councillor Rob Appleyard (Co chair)

…… **Date……..**

Dr Ian Orpen (Co chair)

1. Integrating Health & Social Care in B&NES

1.1 Health and Wellbeing Board



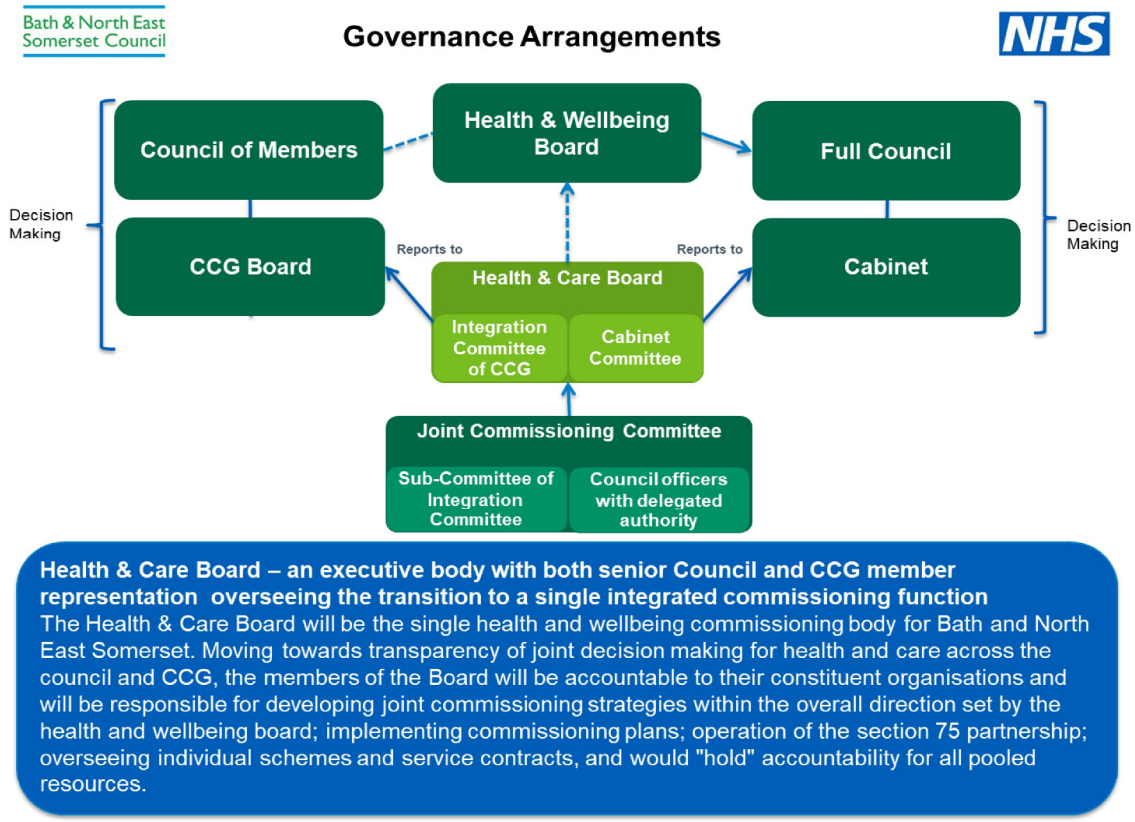
B&NES Council and the CCG have a shared ambition to work together seamlessly to plan, commission and deliver better quality services for the people of B&NES. Based on a long history of joint working, the council and CCG more recently strengthened joint commissioning arrangements through a new integrated commissioning structure as well as enhancing our joint governance through the creation of the Health and Care Board to oversee the work of the Joint Commissioning Committee. This brings together a Committee of the CCG Board with a Cabinet Committee to make decisions in respect of health and care commission as set out above.

Following the May 2019 local elections the Liberal Democrats claimed overall control, changing the political division across the council and local area, and introducing a new manifesto to inform the council's strategic direction. However, the new administration remains committed to the integration arrangements.

The B&NES Health & Wellbeing Board (HWB) first published its health and wellbeing strategy in 2013, setting out 11 key priorities for action under three headings – preventing ill health by helping people to stay healthy; improving the quality of people's lives and; tackling health inequality by creating fairer life chances.

The strategy was refreshed in 2015 to reflect the changing landscape at the time and to be clearer about the role of the HWB in leading the health and care system. The HWB was confident that the 11 priority areas were still the right ones to reduce health inequality and improve health and wellbeing and they were kept in the refreshed strategy. However, we have now reached the end of the life of the strategy and we are currently taking stock and reviewing out progress to date with the aim of reviewing the role and priorities of the HWB.

1.2 CCG & Council Integrated Commissioning Arrangements



The council and CCG aim to further develop the integrated commissioning arrangements as well as developing a place-based model of integrated care delivery in B&NES where local partners coordinate their activities around neighbourhoods of 30,000 to 50,000 people.

In October 2018 we created a blueprint for developing our integrated commissioning arrangements which was based upon the McKinsey 7S framework. This blueprint identifies the actions to deliver our aspirations for cultural change over time, with immediate priorities identified. We are therefore currently developing a joint commissioning & contract management framework, commissioning principles aligned to our jointly agreed six values, opportunities to develop joint strategies & plans, including savings plans and aligning our staff communications and learning and development programmes where possible.

During 2019/20 will see the changes in IT&M to allow access to shared information building stronger integrated communication across both organisations and the implementation is being funded from the Better care fund. A good example of integrated commissioning is where the council and CCG early in 2019/20 agreed a policy for joint funded complex discharges, reducing delays and allowing the focus to be person centred care rather than funding.

1.3 Primary Care Networks (PCNs) in B&NES

A key part of the NHS Long Term Plan (LTP) published in January 2019, primary care networks will bring general practices together to work at scale and are seen as a key building block of the Plan. PCNs will also be the footprint around which integrated community-based teams will develop, and community and mental health services will be expected to configure their services around PCN boundaries.

All GP practices are expected to come together in geographical networks covering populations of approximately 30 to 50,000 patients by June 2019 to take advantage of the additional funding attached to the new GP contract which will support the recruitment of different roles to support PCNs.

Since 1 July 2019, all except a handful of GP practices in England have come together in 1,300 PCNs. The table below shows how the B&NES 24 GP practices will be part of six PCNs. PCNs will eventually be required to deliver a set of seven national service specifications. Five will start by April 2020: structured medication reviews, enhanced health in care homes, anticipatory care, personalised care and supporting early cancer diagnosis.

The LTP includes a commitment for a new NHS offer of emergency response and recovery support through expanded MDTs in PCNs. It is expected that this will roll out from 2019/20 and although it is not a requirement that BCF funds are spent on this work, it is expected that local areas will be considering how provision across health, local government, social care providers and the voluntary sector can support the shared aims of providing better care at or close to people's home and a clear focus on prevention and population health management. Our BCF plan does support this direction of travel and as we develop our B&NES Integrated Care Alliance arrangements, the BCF will become an important enabler to our joint endeavours.

PCName	Population	GP Practices
Name to be confirmed	26,000	Batheaston, Fairfield Park Widcombe,
Name to be confirmed	30,000	Monmouth, Pulteney, University Medical Centre
Minerva	35,000	Combe Down, Grosvenor, Newbridge, Rush Hill and Weston, St Michael's Partnership
Heart of Bath	27,000	Merged practices of: St James', Oldfield, Number 18, Catherine Cottage
Three Valleys	67,000	Hope House, Westfield, St Chad's and Chilcompton, Somerton, St Mary's, Hillcrest, Elm Hayes, Harptree, Chew Medical
Keynsham	25,000	St Augustine's, Temple House, Westview

The first of the different roles coming into PCNs are clinical pharmacists and social prescribing link workers in 2019/20. In 2020/21 the scheme will be extended to include physician associates and first contact physiotherapists (FCPs), with community paramedics added in 2021/22.

In B&NES we have already started a FCP pilot to treat patients with MSK conditions in primary care. Initially this will be set up in three practices, St Chads Surgery, St Augustine's Surgery and Fairfield Park, and run by Virgin Care through the community services contract. Learning will inform how this will be rolled out across all the PCNs and will inform the recruitment of FCPs in 2020/21. The BCF will be presented to the B&NES ICA Board at which it is expected a PCN clinical director will represent all the PCNs and can help influence the strategic direction and priority of schemes in line with the NHS long term plan.

1.4 Wider Services

The Health and Wellbeing Board is commitment 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, to build on the assets of our people and communities.

By rethinking the way we deliver health and care services across Bath and North East Somerset, we believe we can reengineer the system to secure better outcomes and a more sustainable system for the future. This includes:

- An increased emphasis on prevention, early intervention and empowering individuals to be more independent including the use of adaptions and technology to support independent living;
- 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.

Underpinning this vision and translating how we can deliver on these themes are key initiatives within the Better Care Fund Plan which relate to implementation of the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care and Home First or discharge to assess.

1.5 System level alignment and Joint Governance arrangements

The NHS landscape is changing as a result of the publication of the Long Term Plan in January 2019 which signalled a smaller number of CCGs in England. On that basis the three CCGs of BaNES, Swindon and Wiltshire are working as a commissioning alliance to benefit from economies of scale. Many of the services that cover this geographical area will be commissioned at scale. However, locality-based commissioning arrangements will remain in each area to ensure the correct focus on local needs. The three CCGs have also agreed in principle to merge from April 2020 subject to the agreement of the practices and other stakeholders. Subject to this, a merger application will be made to NHS England by the end of September 2019.

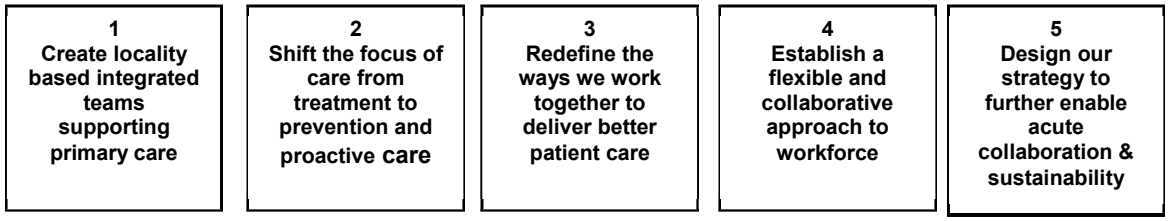
Becoming one CCG will reduce variation in care, standardise best practice, help us meet financial challenges and free up more money to be invested in frontline services and transformational projects.

A joint governance handbook outlining the new constitution has been produced in conjunction with Swindon and Wiltshire and can be found at:

https://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/nhs-banes-ccg-constitution-june-2019

The B&NES Better Care Fund Plan supports elements of the 5 key priorities identified by the new BSW Commissioning Alliance strategy 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 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 has been expanded using iBCF monies.

Figure 1 BSW Commissioning Alliance Key priorities



The BCF Plan also aligns with BSW 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 a BSW wide approach to crisis avoidance and management.

We continue to build on the engagement feedback received with our prime provider of jointly commissioned community services, Virgin Care, improving on the themes of “care closer to home”, “people, not conditions” and “only wanting to tell their story once.” The B&NES care co-ordination service which moved to its new location August 2019 will address a number of these ambitions with individuals only needing to make one call to access all the services that can help them. GPs and other health and care practitioners will be able to refer individuals to care co-ordination service to access community services as well as support with signposting to the voluntary and third sector.

The 60 services sitting within the contract are all aligned to the Joint Health and Wellbeing Strategy and are included in the Better Care Fund services. Virgin Care are working to align community based services to the new PCN’s recognising that some services will be delivered at locality (B&NES) level. The transformations of services which will continue into the fourth year (2020/21) of the contract continue to shift the focus of care from treatment to prevention and proactive care in line with all the BSW Commissioning Alliance Key priorities

2. Context for 2019/20 and beyond

The future of the Better Care Fund itself is currently uncertain with a green paper in draft. The 2019/20 plan has therefore been set amid some uncertainty, but the assumption locally is that the council and CCG will continue to be in a position to support the underlying schemes into 2020/21.

This year's plan has again been developed with local partners, including the Royal United Hospitals Bath NHS Foundation Trust and Virgin Care, and local authority service leads (including DFG and housing).

This has shown that across the wider health and care system there are common barriers to achieving sustainable high quality services for local people. The risks associated with these common themes can be grouped into the following headings:

- **Capacity Risks –** this relates to the capacity of teams to tackle and implement the changes required within the BCF (see 2.1 and 3.1 below).
- **Performance Risks –** associated with delivery of performance improvements, particularly related to DTOCs (see 2.2 and 3.2 below).
- **Financial Risks:** including the financial position for both the Council and CCG in dealing with growing demand and increased efficiency savings (see 2.3 and 3.3) below).
- **Market Risks:** in respect of market instability within the care home and home care sector and corresponding rising fee levels due to restricted availability (see 2.4 and 3.4 below).

2.1 Capacity to implement transformation

In 2017 we identified the difficulties in recruitment and retention of adequate numbers of appropriately skilled experienced staff (including nurses for nursing homes). These challenges remain in 2019/20 with the local health and care system competing for the same limited pool of staff. The pace of change required to implement the transformation needed to achieve sustainable high quality care is a further challenge with commissioners having to become experts in multiple areas and to manage numerous large projects. Our own capacity and skill set has in itself become a challenge.

2.2 Performance and the needs of our population

The Better Care Fund plan uses intelligence from the Joint Strategic Needs Assessment (JSNA) to inform our modelling. The key driver for changing need is the projected large increase in the number of older people in B&NES and the increasing demand for services to support frail older people. For example, between 2016 and 2029 the number of people aged 75 and over in the local population is projected to increase by 36% (from 16,600 to 22,600 respectively).

The number aged 90 years and over in the local population is projected to increase from 2,000 to 2,500 during the same period.

Further demographic information for B&NES is available on the population page of the Council's website.

The impacts of existing schemes which operated during the 2017-19 plan period and new schemes for 2019/20 are intended to address the needs of an ageing population. The model of care implemented by Virgin Care, with its focus on preventative services, social inclusion, care-co-ordination and self-management aims to manage the impacts of these population changes. Alongside Virgin Care's model of delivery, a number of other schemes supported through iBCF and Winter Pressures funding will also help to tackle the challenges outlined above.

However, the challenges associated with the growth in population and the corresponding increase in complexity present risks to performance against the national metrics. The national metrics are:

- Non-elective admissions
- Delayed transfers of care
- Permanent admissions to care homes for older people (per 100,000)
- Proportion of older people still at home 91 days after discharge from hospital into reablement.

While a range of schemes are targeting improvements for all measures, including through additional support over the winter, the evidence in 2018/19 (as described in section 3.2 below) indicates that managing growth in terms of both volume and complexity is difficult. The trajectories for 2019/20 show ambition to improve but they are realistic about the impact of the growing need in our population.

2.3 Financial imperatives

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 also 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.

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 2019/20; the CCG is required to deliver savings of £8.85m, with 29% of the plans to achieve this connected with commissioning and a further 25%planned around service improvement. The council is required to deliver savings of £14.31m, £2.3m of which is within Adult Social Care. The Better Care Fund plan is key in the achievement of these savings plans.

The Better Care Fund itself as a source of funding which underpins the transformational changes required to achieve sustainability is in question and may not continue past this year. This makes longer term planning difficult and risks become more acute. In addition the council faces the uncertainty of both the spending review and fairer funding review which will feed into 2020/21 budgets.

Planning ahead to achieve integrated health and care delivery that has a real impact on shifting care out of hospital and delivering quality and efficient services in the community is therefore 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 that continues to focus on responding to crisis rather than preventing crisis in the first place.

The Better Care Fund requires a reduction in non-elective admissions to hospital and a well-designed community service model can play a pivotal role in creating strong and sustainable out of hospital care. Achievement of our trajectory will lead to the release of contingency funding which can then be invested in further BCF schemes. This is explained more fully in section 5.2 Financial Risk.

2.4 The Local Care Market

The home care market continues to face challenges. B&NES pays the highest hourly rates for home care in the South West which is probably a reflection of the employment market locally but also of the commitment to provide high-quality care at home however this should be considered in light of the financial imperatives referenced in 2.3 above. Finally it is recognised that access to homecare continues to be challenging, particularly during peak holiday periods such as summer and Christmas and in some more rurally isolated communities.

The Council undertook a Fair Price of Care exercise in 2017/18 to review objectively what a fair bed rate should be and has increased the fees of those residents at or under this rate by 1% for the past three years as part of its commitment to sustain the local market. The BCF is to support a refresh of this fair price of care in 2019/20 and continues to support the care market to innovate and stabilise.

If not achieved market sustainability carries a number of risks and 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 self-funder market in B&NES is strong and these are in direct competition for beds locally and charges for this group are above the agreed Value for Money rate.
- Insufficient diversity of providers in the local market for provision of care for those with complex needs.
- Housing stock becoming outdated for modern care service requirements
- Insufficient negotiating capacity and capabilities.

In response to these pressures, market development 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. These are explored further in section 3.4.

3. Lessons learnt and schemes to mitigate risks

The 2014 and 2016 Better Care Fund 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.

The 2016/17 plan 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. Virgin Care were awarded the community health and care contract from April 2017. The BCF also included a separate plan to address Delayed Transfers of Care (DTOCs) across the whole system.

The two year 2017/19 Better Care Fund (BCF) Plan incorporated all of the care and health services procured under *your care your way* consolidating the commitment to invest in preventative services and to further develop integrated services with Virgin Care whilst continuing to support existing schemes and promote the use of iBCF to support new schemes predominantly to support social care.

For the 2019/20 plan we have continued to learn from the metric information and to build on these preventative and transformational schemes but have also added a number of new initiatives.

3.1 Capacity

We have acknowledged earlier in this report the scale of change and transformation that we face locally and that we are faced with risks in capacity to achieve these ambitions. As a small organisation we also recognise that we do not always have the skill set to bring to projects to improve services. We are overcoming this risk by learning from the wider care system and our local partners where possible but the Better Care Fund is also supporting a number of fixed term posts where it is recognised that a specific skill or support to a project is required. We are also cognisant of the pressures on our services over the winter period and have identified additional capacity in social work, commissioning and additional care home placements to mitigate these pressures.

3.1.1 Trusted Assessor (Scheme 28)

In September 2018 a Care Home Trusted Assessor (TA) was recruited in B&NES, to support the implementation of the Trusted Assessor model. This appointment has been continued for 2019/20 and during an evaluation period, which ran between December 2018 and July 2019, the TA undertook 173 assessments (new and returning residents) and did so in an average timeframe of 17.9 hours, compared to a baseline of 52.3 hours. Plans are now being developed to align this role to the Red Bag initiative.

3.1.2 OT for Assistive Technology and Community Equipment (Scheme 14)

We are currently recruiting a fixed term Occupational Therapist to work across assistive technology and community equipment. The specialist knowledge will enable us to establish the most effective equipment to purchase and to champion the use of technology across the wider health and social care community. The OT is building on last year's external review and report and will inform the redesign of Community Equipment in B&NES.

3.1.3 OT at the front door (Scheme WP6)

This scheme funded through winter pressures grant will provide an Occupational Therapist at the front door of social care to better manage individuals need in a timely manner with a view to signposting individuals to alternatives to commissioned care. This in turn will better support the utilisation of home care capacity.

3.1.4 Health Case Co-ordinator (Scheme 29)

This fixed term post to co-ordinate health-pathway discharges will help patients who leave hospital on a health funded pathway but who are not eligible for CHC to receive a quicker discharge. Clarity about the pathway across the system will avoid people waiting while eligibility and funding decisions are discussed. This will support the work carried out between the CCG and Council in 2018/19 to improve the decision making process for CHC and social care eligibility.

3.1.5 Review of double-handed packages (Scheme WP7)

This scheme is to review packages where there is a requirement for two people to deliver the care with a view to reduce this where appropriate to one person added by suitable equipment e.g. mobile hoists. This will consequently release home care staff time to be better utilised to meet demand.

3.1.6 Care Home Placements and Social Work Capacity (Schemes WP4 and WP5).

This scheme will provide two fixed term social workers employed across the community contract and mental health partners together with the purchase of block care home capacity which will increase our resilience over the winter period and early 2020 when traditionally demand is highest.

3.1.7 Home Care Commissioning and Contracts officer (Scheme WP3),

We are currently recruiting to the above post to support home care contracts from both a strategic and operational perspective which is anticipated to increase capacity through more timely and consistent contract management.

3.1.8 Community Services Contract (Scheme 15)

The CCG and council took the decision to jointly commission community services under a single block contract in 2017 and to pool resources including those of Public Health to achieve a transformation of services to meet the priorities set out by local people 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

Virgin Care through the prime provider model aims to deliver the above ambitions by working with the wider system including the voluntary sector such as Bath Mind to maximise the opportunities to join up services and to better use available capacity to enable us to achieve the challenging scale of that transformation.

3.2 Performance

The B&NES Better Care Fund schemes support the delivery of the BCF national metrics. A summary of the impact of the schemes on the national metrics is provided in Appendix 5. This also identifies which schemes will be monitored using local metrics.

Over the period 2017/19 a dashboard of measures was monitored to evidence performance against the four national metrics and selected local metrics. The Better Care Fund dashboard at Appendix 4 is being redeveloped for 2019/20 to continue to monitor the national metrics and to update local-metrics reporting.

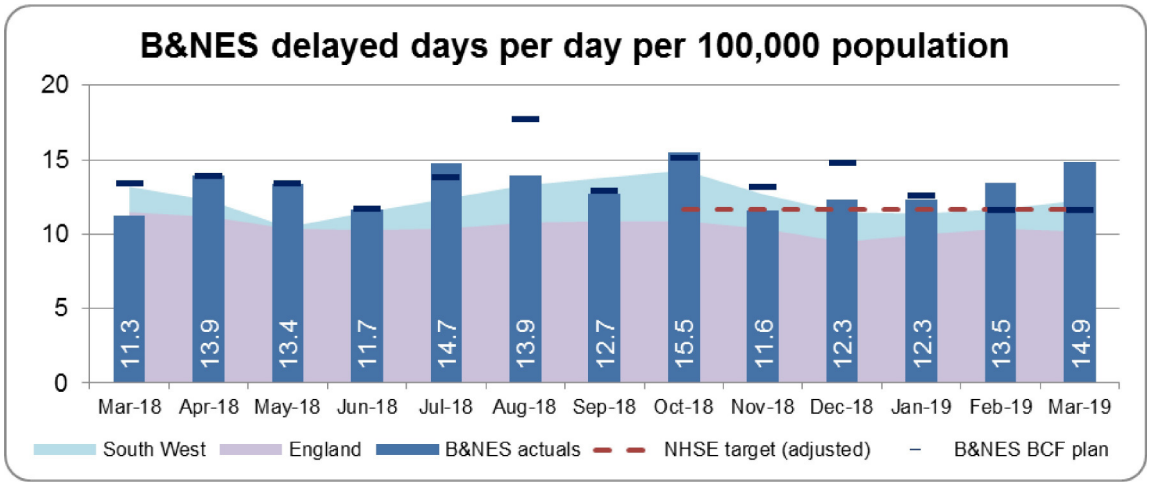
The following section sets out the lessons learnt from performance data over the last two years and our plans for delivering improved performance against the national metrics in 2019/20.

- **Non-elective admissions** – performance continued to be challenging in 2018/19 as demand remained high despite a number of schemes aiming to reduce the number of admissions, including CCG QIPP schemes. Non-elective admissions were 6.9% above the planned level over the year, with the plan trajectory achieved in three months only in year. In response to these challenges, BCF schemes in 2019/20 will be complemented by Winter Pressures and QIPP schemes which aim to reduce pressure on the system.

  The 2019/20 trajectory was set in line with NHS planning rules as part of NHS England's Operational Planning round. It was developed in recognition of the challenging position for B&NES in terms of sustained demand. However, in-year performance will be impacted by the continuing work of existing BCF schemes, the new Winter Pressure schemes (OT at the front door see 3.1.3) and initiatives outside of the BCF via the CCG's QIPP schemes.

  Continuing BCF schemes will help to avoid admissions but may see limited additional impact above what was delivered in 2018/19 given the context of growing demand. For details of these schemes see 3.2.1 – 3.2.5

- **Delayed transfers of care** - DTOC performance in the latter part of 2018/19 deviated from the HWB plan trajectory and, therefore, the adjusted DTOC target set in last year's planning round was not met as sustained pressure impacted on performance. The chart directly below outlines 2018/2019 performance against the NHS England Target, the BCF Plan and national/regional averages.



Primary causes of DTOCs in 2018/2019 were either due to individuals awaiting a residential or nursing home placement or a care package in their own home.

The 2019/20 trajectory takes account of the impact of a range of BCF and Winter Pressures schemes to deliver the target by the end of the financial year. As noted in section 4.4, plans are in place to deliver the aspiration to ensure all changes are either established or mature by the end of March 2020. In conjunction with the HICM actions, the plan to return performance to the targeted level is based upon ensuring that contracted levels of activity in existing schemes that support improved timeliness of discharge are delivered and that new schemes will secure further improvements.

The 2019/20 trajectory sees performance improve prior to winter, with the target achieved in November and then again in March, following expected winter pressure. The table below outlines the planned DTOC performance for the remainder of 2019/20, showing the anticipated rate of DTOCs for each key provider in the BaNES system. This plan has been agreed with system partners and will be signed off at the next A&E Board:

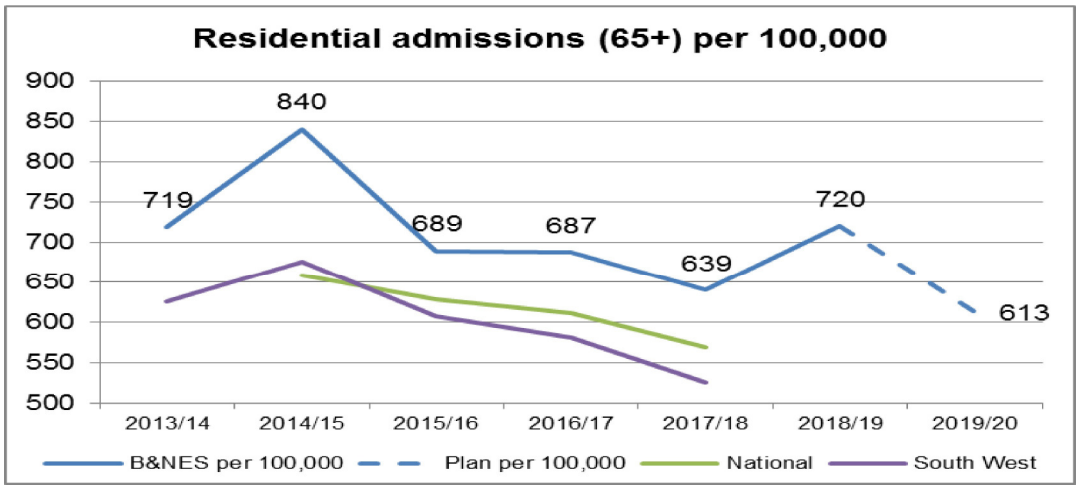
B&NES 2019/20 DTOC trajectory by provider
(average number of people delayed per day)

Setting	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RUH	7.1	7.0	6.5	6.7	6.7	6.6	6.5
Virgin Care	9.3	9.1	8.5	8.9	8.9	8.8	8.6
AWP	2.2	2.2	2.2	2.2	2.2	2.2	2.2
UHB	0.3	0.3	0.3	0.3	0.3	0.3	0.3
NBT	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Total	**19.2**	**18.9**	**17.8**	**18.4**	**18.4**	**18.2**	**17.9**
Target	17.9	17.9	17.9	17.9	17.9	17.9	17.9
Variance	1.3	1.0	-0.1	0.5	0.5	0.3	0.0

While winter pressure schemes will have a significant impact on the rate of DTOCs, the estimated reductions in the rate have been confidence adjusted to factor in potential variability in the extent of pressure depending on the specific circumstances encountered in the coming winter, such as influenza and norovirus.

Many of the BCF and winter planning schemes that were helping to manage DTOC performance in 2018/19 are continuing in 2019/20. Achieving the DTOC target would not be possible without the continuation of these schemes, such as pathway 3 beds and the delirium pathway, but the development of the trajectory for 2019/20 has largely focused on the impact of new schemes or maximising the impact of existing schemes

- **Permanent admissions to care homes** – having seen year-on-year improvement since 2014/15, performance was challenging in 2018/19 with the rate of admissions per 100,000 (65+) worse than the targeted level of 598.1 at 719.8. The actuals reported for 2018/19 represent the worst-case scenario, as data quality checking had identified that cases were being reported without being linked to an appropriate request for support or review.



Performance was affected by a spike in admissions in the summer, in part due to a significant number of people on the long term caseload of mental health social work teams who all reached a point where they could no longer remain at home. In addition, demand over winter and the flow out of hospital, coupled with increasing complexity, resulted in more people placed in care homes than was planned for over the winter.

Given the data quality issues referenced above, planning for 2019/20 has been based on improving performance against the worst-case scenario where all potential admissions have been counted as in scope of this measure. The trajectory aims to reduce admissions from a deteriorated position compared to the 2017/18 results as shown in the chart above by the dotted line.

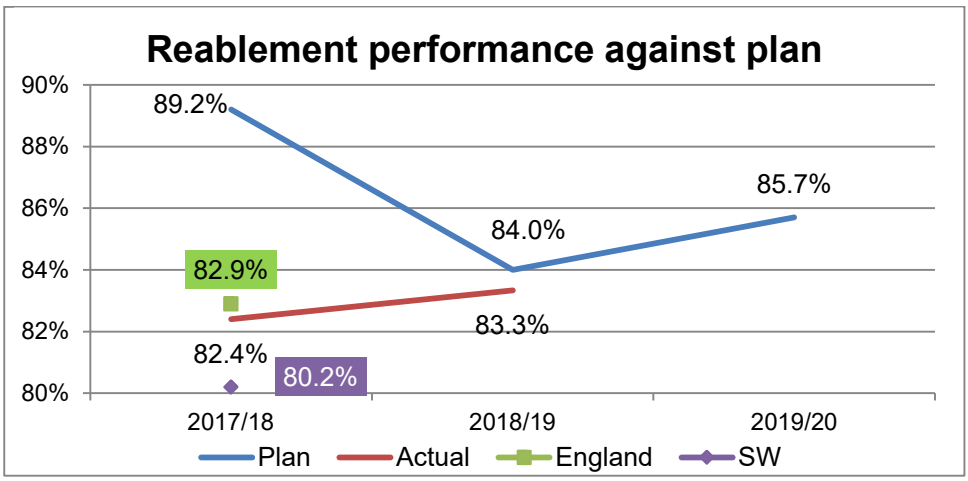
The overall aim of the BCF trajectory is to reduce average admissions per month by approximately 3 placements. While ultimately the ambition is to improve further than the trajectory rate, which is higher than the 2017/18 national average (568.5), until further investigation into data quality is concluded, any further reductions would not be realistically achievable in year alongside the projected growth in population. The rate per 100,000 for 2019/20 is set at 612.5, reducing from the 2018/19 year-end position of 719.8. The trajectory is based upon existing schemes delivering some improvement and new schemes reducing the rate further. The process of data cleansing may also rule out some admissions that have been included this year, but these have already been factored into the trajectory. Work continues with providers to ensure that all reporting is aligned to SALT guidance.

The scheme which has a significant impact on this measure is scheme 3 reablement. The service aims to reduce or delay the onset of long term care needs and, to the end of M2 2019/20, fewer people have been discharged from reablement into a care home bed than in 2018/19 and this positive trend is expected to continue. Commissioners are also working with providers to reduce the number of people waiting more than two days for a first visit so that people receive reablement as soon as possible, and so that those who may have otherwise been admitted to a care home can receive support before deconditioning adversely affects progress. Further information on the reablement service is included in the reablement national metric section below.

In addition to the impact of reablement on this measure, performance will be impacted by a range of BCF and winter pressure schemes, including: Falls Rapid Response (see 3.2.2), Pathway 3 beds (see 3.2.4), Delirium pathway (see 3.2.5), targeted rural support (see 3.4.3), the OT at the front door (see 3.1.3) and the review of double-handed packages (see 3.1.5).

- **People remaining at home 91 days after reablement** – performance improved again in 2018/19, albeit the rate was slightly below the 84% target at 83.3%. This result is better than the 2017/18 national and regional average. Statistically however more people (65+) have been through the service in 2018/19, so the actual number of people supported to remain at home has increased when compared to 2017/18. With the expanded service seeing more people, the level of complexity in the cohort is increasing, which will limit the extent of improvement for the percentage measure but our expectation is that more people will remain at home 91 days after reablement.

  B&NES improved performance in 2018/19 and the plan for 2019/20 continues this increase in the rate of people still at home 91 days after discharge into reablement, as shown in the graph below (due to recording issues, data prior to 2017/18 is not calculated on the same basis and the plan for 2017/18 was based on over-reported data).



The prime provider of reablement services, Virgin Care, is committed to a target of 85% for this measure, so the plan for 2019/20 aims to achieve this level of performance as a minimum. However, with the increase in people accessing reablement, the service is expected to see a greater level of complexity in the 2019/20 cohort. As a consequence, no further improvement above the prime provider's target has been planned for this year because, with the increased level of complexity, the reabling potential of the cohort may plateau at current rates, which means that performance against this measure will also see limited improvement only.

However, the actual number of people who are still at home after 91 days is projected to increase compared to 2018/19, so there will be improved outcomes for more people as a result of the service expansion. As a result of the reablement review (see 3.2.1), the service is expected to deliver a further increase in the number of people using reablement for the whole of 2019/20 (estimated at 12%). This increased output has been factored into the trajectory.

The ambition for this year is to increase the number of people who benefit from reablement despite the rate seeing incremental improvement. In addition, the increase in people coming into the service will help to improve DTOC rates, the number of non-elective admissions to hospital and the number of new admissions to care homes, so the overall impact on the wider system of service expansion in reablement will be evident across the range of BCF measures.

- **Local Metrics:**

In 2018/19 we have tracked a number of local measures to monitor the success of schemes and to identify pressure points within the system. For example, by tracking the number of DTOC days for people awaiting residential home and nursing home placements and home care (including reablement) packages, it was clear that these reasons were significant factors in DTOC performance. Monitoring of the proportion of reablement packages completed within 6 weeks of referral has helped to identify the impact of reablement on flow through the system. Our monitoring has facilitated informed conversations with providers so that we can work together to identify improvements.

3.2.1 Reablement Review (Scheme 3)

The Better Care Fund has since inception supported reablement services and the plan has £16m including additional funding set aside in 2019-20 as it is seen as a key enabler of an integrated sustainable health and care system. A review of the reablement service started in 2018 with three work streams responsible for improving existing services, revising the model of care and developing home care services and is due to conclude in January 2020.

The aim is to bring together all the individual services into a coherent service model which makes the most of the current workforce and the new care co-ordination centre. We are using learning from our system partners in Swindon and Wiltshire who have already restructured their reablement services to support our local model of care.

Improving existing services has seen Virgin Care, who have changed working practices and employed modern technology, increase patient facing time from 45% to 69% by July 2019.

Revising the model of care including learning from BSW models where both financial savings and readmission avoidance have been achieved and input from acute, provider voluntary bodies and patients has recommended a shorter more intensive offer of 2 weeks rather than 6 refining pathways to join up home first initiatives.

The learning from the Home First extension has also informed the new reablement model and the staff have been used not only at the “back door” but when demand allows to work on admission avoidance. The pilot which was for six months has been extended to end as the new reablement model comes into use to ensure continuity of service.

This review also aligns with a review of Community Hospital in-patient provision, which has resulted in the planned pilot of a therapy led unit to deliver more effective bed based reablement. This pilot is due to commence in mid-September 2019, for a 6 month period, with a plan to then review the outcomes and possibly expand and extend the offer. It will also learn from and influence the Pathway Three Beds pilot of 4 block reablement beds within the local area (see section 3.2.4).

At the same time we are remodelling the home care service which will see implementation of a framework and outcomes based approach including innovation contracts. Work is underway with our strategic partners supported by iBCF pump prime funding and will see the new model go live in 2020/21

It should however be noted that because the new model will not come into operation until Q4 and the national reablement metric looks at people discharged into reablement in Q3 of a given year, no significant effect of the new model has been assumed for 2019/20 performance. Beyond 2019/20, there will be limited data on the new model at the next round of BCF planning (on the assumption that planning will occur early in 2020/21), so the 2020/21 trajectory will be based upon the best information available at the time of planning.

3.2.2 Falls response (Scheme 4)

This service began shortly before the end of 2016-17 but has continued to demonstrate success in avoiding hospital admissions. It has been extended in 2019/20 and is a monitored scheme funded from CCG minimum contributions. The service is seeing an increased number of people in 2019/20 to date, with a higher percentage remaining at home than in 2018/19. This early intervention helps to reduce admissions to hospital (where this is identified as having been the likely outcome if the service wasn't in place) which in turn reduces the number of people admitted who may have then required long term support in care homes.

3.2.3 Home First (Scheme 23a)

In October 2018 the BCF funded an extension of the successful Home First service as a pilot to test demand and support Virgin Care's reablement service aiming to see an additional 6 patients per week. The learning from this has informed the new reablement model as previously noted and has also flexibly supported admission avoidance when demand for home first has not been there.

3.2.4 Pathway 3 beds (Scheme 23b)

This scheme has tested a bed-based discharge to assess model to ensure individuals are given the optimum amount of time to recover and rehabilitate prior to making long terms decisions about their care requirements. It reduces and/or delays the onset of needs which require support in a care home setting. A third of the people placed in the pathway 3 beds with an anticipated need of a having a care home placement were discharged from the bed with reduced needs that were met in the community and indicated 46% of individuals noted an improvement in care needs, having been discharged to a destination which required less care resource than was initially anticipated on their admission to the beds. Such positive initial findings resulted in the scheme being extended for 2019/20 to allow further refinement and evaluation.

3.2.5 Delirium pathway (Scheme 26)

This new pathway builds upon the Home First service by specifically supporting individuals with more complex needs who would benefit from earlier discharge to a safe setting. Patients identified as having potentially reversible delirium receive appropriate support to meet both physical and cognitive recovery. The intensive support over the first week after discharge aims to delay the onset of support needs that otherwise could only be met in a care home bed.

3.3 Financial

The original Better Care Fund (BCF) has been supporting schemes integrated health and social care initiatives financial since 2016. The original funding which is uplifted annually remains the cornerstone of the plan around which new schemes have been developed. This includes the Care Act Implementation (scheme 13) budget which supports amongst other things assessments carried out by social workers following the changes to the Care Act in 2014. It also underpins our reablement offer within the block community services contract and our contracts with strategic partners (scheme 3). In 2017 we set up schemes to support both the increase in care home costs connected with the national changes to sleep in cover (scheme 19) and our own fair price of care review (scheme 17) which aim to support the local care market. B&NES intention is to continue to recurrently support these schemes and the 2019/20 plan confirms this intention (see appendix 5).

In particular B&NES is keen to maintain support to those schemes which support social care and the use of the Disabled Facilities and Winter Pressures 2019/20 grants within the BCF demonstrates this ambition:

3.3.1 Protection of Social Care (Scheme 8)

The Council and CCG have agreed to continue recognising the Local Government funding pressures into Adult Social care along with the rising demand and purchased care market pressures noted in section 2. This is reflected in the 2019/20 Better Care Fund spending plan with £3.728m of CCG minimum funding into Social Care continuing at a consistent level and being increased for inflationary uplift in line with the NHS funding allocations. As this is a continuation of previous years funding it has been recurrently allocated in the Councils annual budget and is funding residential and nursing care packages for service users with Mental Health, Learning Disabilities, Physical Disabilities and Adult Social Care needs. In addition £0.97m of the iBCF Council Grant is allocated to core adult social care budgets which in addition to the Social Care precept on Council tax has help fund the rising cost of care packages.

3.3.2 Disabled Facilities Grant Monies (Scheme 14)

This year's Better Care Fund Plan aims to continue to strengthen the working relationship between housing, providers and health and care commissioners and regular liaison meetings take place to evaluate the impact of DFGs through regular feedback from recipients using Outcome Star methodology, to inform this year's plan and to strengthen the links between DFGs, Community Equipment services and Assistive Technology

Community Equipment whilst it has been a fundamental part of the BCF since the beginning, has been reviewed to ensure it operates efficiently and offers good value for money. As a result this year we have realigned our contracts to provide hoists and rails to be funded by the DFG to better align minor and major adaptations. This has freed up almost £100k of funding which has been redirected to the purchase of community equipment with the aim of providing access to physical aids such as mattresses for those who may not otherwise afford them to enable them to remain at home

The iBCF under Scheme 14 is further developing the use of Community Equipment and Assistive Technology and its growing importance with the aim to maintain as many people at home as possible and maximise resources. In 2018/19 we commissioned a survey as part of the BCF plan to review and propose solutions to the local demand using a full time Occupational Therapist shared across community equipment and assistive technology building on this base data and to champion the use of both across our community services teams.

The full amount of the DFG Grant (£1.27m) is held within the council housing team budget for use on adaptions to homes increasing people's independence allowing faster discharge from acute hospitals and keeping them out of care homes for longer. Further within this year's plan £120k of scheme 8 Protection of Social Care is transferred specifically to support housing initiatives within B&NES under the direction of the housing team.

3.3.3 Winter pressures grant monies

As was received in 2018/19, B&NES Council has again received a share of national winter pressures money in 2019/20 to support local winter pressures and facilitate hospital discharge from acute and community hospitals. The funding for 2019/20 was received via a Section 31 grant from the Department of Health and Social Care, with the identified funding for B&NES being £729,753, which is accessible throughout 2019/20. Spend against this grant was required to meet the following conditions:-

- Increase care capacity in the system.

- Relieve pressure on the NHS and support hospital discharge.

System partners were asked to develop and propose schemes and asked to demonstrate how they meet the requirements listed above. Following prioritisation and assessment against the grant conditions, the following schemes have been proposed for funding:-

WP1	External Brokerage contract with CHS (3m)	£ 42,000
WP2	External Brokerage contract post procurement (9m)	£233,000
WP3	Home Care Commissioning and contracts officer (fixed term)	£ 60,000
WP4	Block Care Home placements (4m)	£ 90,000
WP5	Social Work capacity for Virgin and AWP (12m)	£152,000
WP6	Occupational Therapist at front door (9m)	£ 50,000
WP7	Double-handed Occupational Therapist project (9m)	£ 65,000
WP100	Contingency	£ 37,753
Total		£729,753

It is anticipated that the above schemes will support effective and timely discharge assessment and planning through increased social work capacity and external brokerage support. Additionally schemes such as OT at the front door and double handed OT project will focus on supporting individuals to access alternatives to commissioned care e.g. equipment to ensure all available domiciliary care is utilised appropriately and effectively. Finally, block capacity will also ensure capacity in the care home market to progress discharges as required.

Of the winter pressure schemes, there will be a local measure to monitor the performance of external brokerage contract with CHS. The number of discharges per month and the average time from referral to discharge will help to identify the effect on improving the DTOC position. Other local metrics may be monitored for schemes WP6 and WP7 once detailed arrangements are confirmed.

3.4 Care Market

The iBCF funding continues to be used to develop new models of residential and nursing care; support providers of complex and specialist packages and placements to deliver against national requirements for sleep-in cover. New reviews of provision of both Domestic and Homecare are underway and the introduction of a framework agreement to increase flexibility and choice for individuals is due to come on line in year. Further market development includes a refresh of the Fair Price of Care, moving towards increase in commissioning of high dependency residential care and Discharge to Assess beds are underway which will ensure that more people can make decisions about their long term care needs away from a hospital setting.

3.4.1 Support Planning and Internal and External Brokerage (Schemes 20, WP1 and WP2)

Scheme 20 which is pump-priming investment to develop an internal support planning and brokerage model will further 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. Whilst this is a long term solution in the short term Commissioners have engaged an external brokerage provided, CHS, to support discharges from the acute hospital and have negotiated a competitive rate. This reduces both the DTOC figures and LOS and hence the cost of care. It also improves the care for the individual giving them choice of residential care and supporting them in discharge.

3.4.2 Increased Extra Care and more Complex Dementia Beds (Element of Scheme 15)

Further developments supported by the BCF in extra care market delivery models including enhanced extra care will offer alternative to standard residential care with the aim of both promoting independence and reducing the need for more intensive packages of care and placements with the benefit of greater financially sustainable for care purchasing budgets. Alongside this transformation of services within the Community Resource Centres (CRC's) to offer more complex dementia beds have been developed to meet demand modelling and transformation funding is being made available from the BCF to move to this new model.

3.4.3 Targeted Community Support and Incentive Schemes (Schemes 31 & 32)

The BCF is also supporting the development of 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 which is particularly challenging to fill. This is expected to reduce any potential deconditioning while people await packages being set up and to generally increase capacity so that, overall, people receive the right level of care sooner, so as to delay the need for longer term care.

And finally we are supporting initiatives to incentivise providers appropriately to deliver better outcomes 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.

4 National Conditions and how they have been met

4.1 National condition 1: A Jointly Agreed Plan

The Better Care Fund Plan will be signed off by the Health and Wellbeing Board on 17th September 2019.

For continuity of service for those schemes continuing into year three, the planned schemes including those to support winter pressures and the associated financial commitment was signed off by the Council and CCG Joint Commissioning Committee (JCC) on 28th February 2019. This followed individual endorsement for the iBCF by the council S151 officer and for the CCG minimum contribution by the Finance & Performance Committees under delegation of the CCG Board.

The council was awarded £1,271k of Disabled Facilities Grant (DFG) funding in 2019-20, an increase of £93k (7.9%) on 2018-19. The specific use of this and the £120k contribution from CCG minimum contribution towards housing has been agreed with housing colleagues within the council.

The three narrative 2019-20 plans in draft form for the BSW area have been shared with a view to understanding opportunities for further alignment in 2020-21 subject to changes in National direction in terms of the Better Care Fund and the NHS Long Term Plan.

4.2 National condition 2: social care maintenance

The 2017-19 BCF plan maintained a consistent level of protection of social care with the BCF funding. The 2019-20 plan has uplifted this level reflecting the growing pressure on Social Care together with a shift of 10% of the total iBCF grant funding available from “support to discharge from hospital” schemes to those which are aimed to protect social care and support the care market demonstrating that schemes support the long term strategy for sustainable services and the best use of resources is achieved. The minimum required spending on social care from the CCG minimum allocation for 2019/20 is £6.999m. The planned spend is £7.044m exceeding the minimum by £45k.

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

The minimum required spending on NHS Commissioned Out of Hospital spend from the CCG minimum allocation for 2019/20 is £3.429m. The planned spend is £6.673m exceeding the minimum by £3.244m. This reflects the local focus on reablement services and implementation of the HICM.

The local risk share arrangement for 2017/19 has been rolled into the 2019/20 plan and is shown 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..

4.4 National Condition 4: Managing Transfers of Care

The B&NES 19/20 Better Care Fund Plan aims to continue the effective implementation of the eight High Impact Changes for Managing Transfers of Care. Such plans 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 3.2. The table below shows the local self-assessment against the HICM:-

High Impact Change	Current Level (Q4 18/19)	Planned Level by March 2020
Early Discharge Planning	Established	Established
Systems to Monitor Patient Flow	Established	Established
Multi-Disciplinary/Multi Agency Discharge Teams	Established	Established
Home First/Discharge to Assess	Established	Mature
Seven Day Service	Established	Established
Trusted Assessors	Plans in Place	Established
Focus on Choice	Established	Established
Enhanced Health in Care Homes	Established	Established

The following summary provides a brief overview of the actions being undertaken in regards to each High Impact Change to deliver the ambitions set out in the self-assessment.

4.4.1 Early Discharge Planning

There is a system focus on planning for discharge at the earliest opportunities for both elective and non-elective admissions. Providers are supported to embed best practice guidance, such as the SAFER bundle, to ensure individuals have an Estimated Discharge Date (EDD) applied within 24/48 hours of admission, in turn supporting effective discharge planning.

Effective Multi-Disciplinary Team (MDT) approaches to discharge, such as the RUH Integrated Discharge Service (IDS), ensures providers proactively support discharge and ensure any blocks to discharge are appropriately escalated and managed. This MDT approach is not only prevalent in hospital settings, but also in some cases at a GP practice level, where community teams, as part of practice based MDT's, track individuals within hospital to support proactive discharge planning.

4.4.2 Monitoring Patient Flow

Within the RUH an electronic patient flow system is in place which allows effective monitoring of demand and capacity, in turn supporting teams to identify problems in patient flow, ensuring mitigating actions are implemented.

Within community providers, the Health Access Team (HAT), as part of the Care Coordination Centre, also monitor demand and capacity for community health and care services, which support the flexing of capacity as required.

At a system level there is daily monitoring of system flow based upon OPEL levels, and where levels reach agreed milestones, system escalation processes and working is put in place to coordinate patient flow across the system. This will be supported through the utilisations of the SHREWD tool and the MiDOS care home tracking tool.

4.4.3 Multi Agency/Disciplinary Discharge Teams (MDT)

The Integrated Discharge Service (IDS), based at the RUH, supports effective MDT discharge planning and is an integrated team of health and social care practitioners. The IDS holds daily huddles in which referred patients discharge needs are discussed, identified and progressed. Additionally IDS members regularly attend ward board rounds to provide specialist input and support into discharge planning processes.

Within community providers an MDT approach to discharge is in place, with a formal weekly MDT held between community health and care providers to support discharge planning.

This weekly meeting is then supplemented by more regular ward based huddles to monitor and progress agreed discharge plans.

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 as required.

4.4.4 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. This service is underpinned by clear referral processes and is delivered across a 7 day period, ensuring individuals are supported in a timely manner.

Additionally, a Home First Delirium Pathway pilot has been undertaken and will be further developed through 2019/20 to identify how individuals with a perceived reversible delirium could be cared for at home with increase care support. This aims to enable individuals to be safely care for in a more appropriate environment, supporting effective physical and cognitive reablement, ultimately aiming to reduce the need for long term care.

Where individuals are unable to return home, their care needs may further assessed in one of the BaNES Pathway 3 (Discharge to Assess) Beds. Such beds allow further recuperation and rehabilitation to take place in a more appropriate environment, aiming to reduce the need for long term care. When it is clear long term care is required, such beds allow individuals to make more measured and appropriate decisions.

Finally specific timescales for assessments from residential and nursing homes are set out in the local authority care home contract. This is supplement by the BaNES trusted assessor, who supports the care needs assessment of individuals on behalf the majority of BaNES care homes, helping to significantly improve the timelines for assessment.

4.4.5 Seven Day Services

Within B&NES a number of services support seven day working. This includes the Home First service which can take referrals and discharges across a 7 day period, ensuring it is responsive to system and patient needs. Additionally, members of the IDS team are present over a 7 day period at the RUH to support discharge planning.

Finally, members of the external brokerage service are able to support individuals and their families over the weekend to identify, view and progress care home placements and packages of care.

Seven day services also form the basis of the new care home framework/contract and the proposed home care framework/contract. This will outline the expectation to providers that it will be increasingly expected that they will accept referrals/discharges across a 7 day period. However, it should be recognised that the operationalisation of this expectation is being further negotiated and developed, with exploration of how wider health and social care services can support providers in meeting this aim.

4.4.6 Trusted Assessment

Within the RUH a single IDS referral form is in place, providing a basis for subsequent referrals and assessments helping to reduce timescales and duplication. Plans are in place to further explore assessments undertaken by health and social care practitioners with a view to ensure that where appropriate assessments can be shared, ensuring discharges are promptly progressed. This will be underpinned by a Joint Discharge Process for Adult Hospital Discharges.

Additionally as part of the Pathway 3 (Discharge to Assess) beds, the service specification includes the utilisation of a telephone triage and trusted 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, BaNES has a full time Care Home Trusted Assessor in place who undertakes new and returning resident assessments on behalf of care homes. This role helps to ensure discharges are progressed in a timely manner, whilst also ensuring individual's needs are met and that care homes assessment and registration requirements are appropriately upheld.

4.4.7 Focus on Choice

Choice policies amongst providers are in place and reflect the nationally released policy. Providers are supporting frontline teams to ensure this policy is effectively understood and implemented by staff, however further system wide training is being scoped to ensure this message is appropriately understood across the system.

Additionally providers have information guides/leaflets 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).

Finally, the BaNES external brokerage service also supports individuals and their families to consider their choices and make appropriate and informed decisions about their future care.

4.4.8 Enhancing health in Care Homes

Within BaNES nursing homes are covered by a Locally Commissioned Service for primary care which aligns GP practices to specific homes and provides proactive healthcare and support which is underpinned by routine visits to the homes. This provision is now additionally being rolled out to residential homes within BaNES, with the ultimate aim to reduce admissions through proactive management.

Nursing homes will also be supported to implement nursing home MDT's which will be ensure an MDT approach to the management of individuals with specific needs and ensure homes are best supported to meet these needs and reduce the instances where an individual may reach a crisis point.

Specific projects are additionally underway to support care homes from a quality perspective including training and support on implementing NEWS2 and End of Life Planning/Care and also the role out of the Red Bag Scheme to facilitate improved transfers of care.

Finally, the BaNES trusted assessor is also supporting homes to identify challenges with discharge processes and helping to resolve and raise these with local health providers.

5 Overview of funding contributions and financial risk

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	17/18 £	18/19 £	19/20 £
CCG Section 75 Transfer to Council	£8,611,434	£8,775,051	£8,639,857
CCG Commissioned Out of Hospital Services	£2,043,943	£2,082,778	£2,858,963
CCG Risk Share Contingency	£549,660	£560,103	£570,130
CCG Commissioned Community Services	£24,182,014	£25,458,488	£26,031,185
Disabilities Facilities Grant Capital	£1,084,352	£1,177,682	£1,270,789
iBCF	£3,155,404	£2,063,000	£1,028,000
Winter Pressures Grant	£0	£729,753	£729,753
Other Local Authority Grants	£779,987	£1,850,458	£3,001,111
Council Revenue for Care Act	£1,500,000	£1,500,000	£1,390,250
Council and Public Health Commissioned Community Services	£19,668,842	£26,576,310	£26,548,612
Total	**£61,575,637**	**£70,773,623**	**£72,068,650**

5.1 Financial Contributions

The proposed use of funding has been included in both the plans and budgets of both the Council and CCG for 2019-20. These budgets and plans have been through the governance processes of both organisations and have been signed off by the CCG's Board and the cabinet of the Council.

The BCF funding has been 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 section 75 agreement has been drawn up for the third year and will be signed following approval of the plan by the HWB.

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. The Council was awarded £1,270k of Disabled Facilities Grant (DFG) funding in 2019/20, an increase of £93k (7.9%) on 2018/19.

The Care Act 2014 funding within the BCF has been subject to council savings target and has been reduced by £110k in 2019/20 with £1.4m now held within the BCF. Just over half of this funding 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.

The iBCF funding has been formally acknowledged and the plan to spend this has been through formal governance through both organisations as set out in section 6 and approved by the JCC in February 2019

In addition this narrative confirms in section 4.2 the intention to either maintain or increase funding in relation to Social Care, in year under national condition 2. It also demonstrates in section 3.3 that Care Act duties and reablement both have schemes to ensure that funding is identified, maintained or increased annually and used appropriately as designated.

The total funding is shown by scheme at appendix 5 and within the planning template which has been signed off by the Health and Wellbeing Board on behalf of all stakeholders.

5.2 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 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 6.

The community service contract is a block payment. 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 2019-20 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 recurrently 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 continues in 2019/20. 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 2019/20 the value of the risk share fund is £570,130. 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 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).

6 Programme Governance

6.1 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. This has been further amended in 2018 to accommodate the single BSW executive.

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.

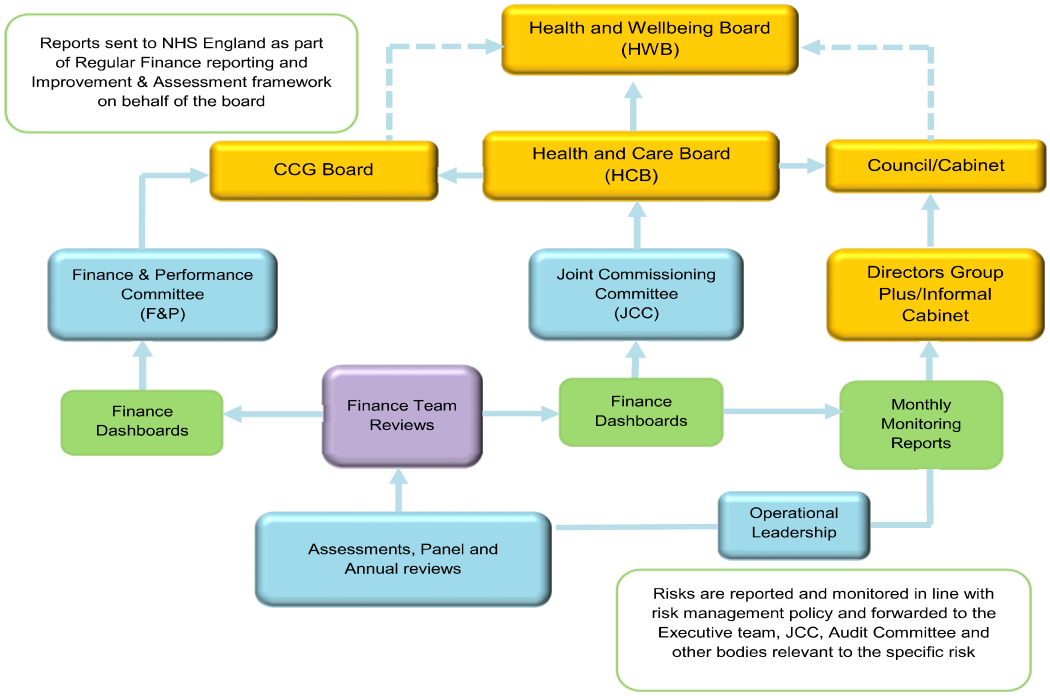
- S75 and s10 pooled budget agreements to allow pooling of resources managed by joint commissioners to support integrated commissioning and provision.

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

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).

6.2 Specific BCF Schemes Monitoring and Governance

In terms of the specific schemes highlighted under the Better Care Fund plan 2019-20, monitoring of will be undertaken within the CCG and Council by the SCM for Better Care Fund. 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, supported by a monthly report and finance dashboard supplemented by quarterly performance dashboards and scheme level data (see appendix 3 and 4) A diagram of this structure is set out below.



9.4 The Risk Register

Key risks to both the CCG and Council will be identified and managed as required under their respective risk management strategies. Risks identified with a score of 16 or above are moderated and added to the CCG/Council partnership Risk Register and reported to both the Joint Commissioning Committee and the CCG Board.