Isle of Wight
BETTER CARE FUND PLAN
2016/17

Resubmission of Final Version
26th May 2016

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Introduction

This document is the Better Care Fund Plan for 2016/17 and it sets out how the IOW Clinical Commissioning Group (CCG) and IOW Council will meet the Better Care Fund (BCF) requirements for 2016/17. The BCF is a single pooled budget for local health and social care services which has been created as a national requirement to drive greater integration of commissioning and provision. The funds within the pooled fund are not newly allocated money; the funding is expenditure on existing services. However the pooled fund commits the IOW CCG and the IOW Council to commissioning services in an integrated way.

There is a formal assurance process which the CCG and Council have to go through to have the plan agreed and the plan must be agreed by the Health and Wellbeing Board (HWB) and the constituent bodies. This plan is formally agreed.

There are specific requirements set nationally for the plan:

- It has to be a short narrative plan linked to the NHS planning process.
- Financial contributions have to be confirmed.
- There have to be scheme level spending plans.
- There have to be trajectories for the national metrics to measure performance.

There are also 8 national conditions:

- That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs.
- A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.
- Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge.
- Better data sharing between health and social care, based on the NHS number.
- A joint approach to assessments and care planning and to ensure that, where funding is used for integrated packages of care, there will be an accountable professional.
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans.
- That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement.
- Agreement on a local action plan to reduce delayed transfers of care.

Local Vision for Integration

The Health and Social Care system has developed a joint vision and a set of objectives and principles of how we work together. These are overarching and all health and social care organisations have signed up to this. The BCF is an important enabler which supports integrated commissioning through the pooling of commissioning resources as we move towards One Island £. Our local plans deliver the Five Year Forward View (NHS England 2015) and ensure the Isle of Wight (IOW) delivers integrated health and social care services before the 2020 deadlines set by NHS England.

System-wide Vision

Person centred, coordinated health and social care.

System-wide Objectives

- Improved health and social care outcomes.
- People have a positive experience of care.
- Person centred provision.
- Service provision and commissioning is delivered in the most efficient and cost effective way across the whole system, leading to system sustainability.
- Our staff will be proud of the work they do, the services they provide and the organisations they work for and we will be employers of choice.

System-wide Principles and Aims of working together and with others to improve services

- To work towards better integration and coordination of care across all sectors of health and social care provision.
- To reduce bureaucracy, improve efficiency and increase capacity to meet future demands for services.
- To work towards one Island budget for health and social care which makes the best use of resources.
- To ensure all care will be person centred, evidence based and delivered by the right person in the right place and at the right time.
- To jointly ensure that our resources are focused on prevention, recovery and continuing care in the community.
- To jointly ensure that people are supported to take more responsibility for their care and to be independent at home for as long as possible, reducing the need for hospital admission and long term residential care.
- To continually improve the quality of our care and improve the experience of people in contact with our services, within available resources.
- To ensure partnership working across all sectors, including the Third Sector and Independent Sector.
- To develop our workforce to enable our staff to have the right knowledge, skills and expertise that is appropriate to their role.
- To encourage staff to work beyond existing boundaries to support system wide, innovative delivery of care.
- To work towards a fully integrated IT system across primary, secondary and social care with appropriate access for staff.
- To jointly commission services with outcome focused contracts, which incentivise positive change in providers of services.
- To recognise the importance of communities and act to ensure we listen to Island people in the planning of services and responding to their concerns.

New Model of Care: My Life A Full Life

My Life A Full Life (MLAFL) is a partnership between the Island's citizens and its health, wellbeing and care related statutory, voluntary and independent sector organisations. Our new care model is aimed at **improving health and wellbeing and care of our Island population; improving care and quality outcomes, delivering appropriate care at home and in the community, and making health and wellbeing clinically and financially sustainable**.

Central to our model is an increase in integrated working across all sectors of provision. The BCF, through pooling of resources, will enable us to direct resources and commission services to support integrated provision. All partners, including providers, are signed up to more integrated provision through the MLAFL partnership.

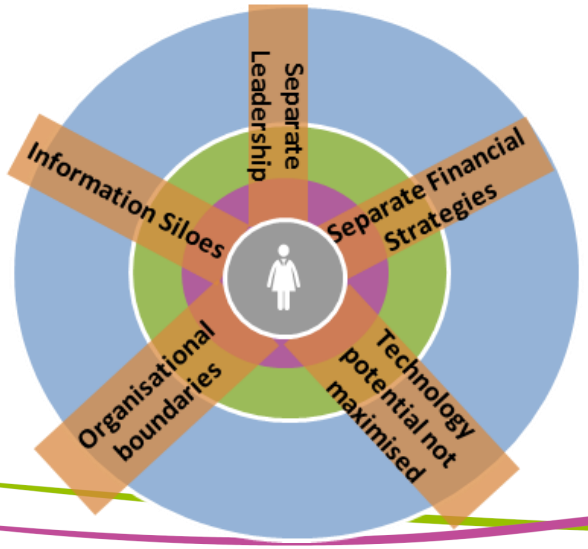
The model below shows how we are moving from a model where the focus is on statutory services to a model which supports individuals and communities to support themselves. This is in line with the Sustainability and Transformation Plans for prevention and out of hospital provision, and supports the delivery of the Care Act 2014.

The Island New Model of Care

Current Model

Currently, there is a large reliance on statutory services (outer rings).
Our model has been:

- Episode based
- Unintegrated and disjointed
- Expert led
- Does not give flexibility for where people are treated
- Financially & clinically unsustainable



Focus

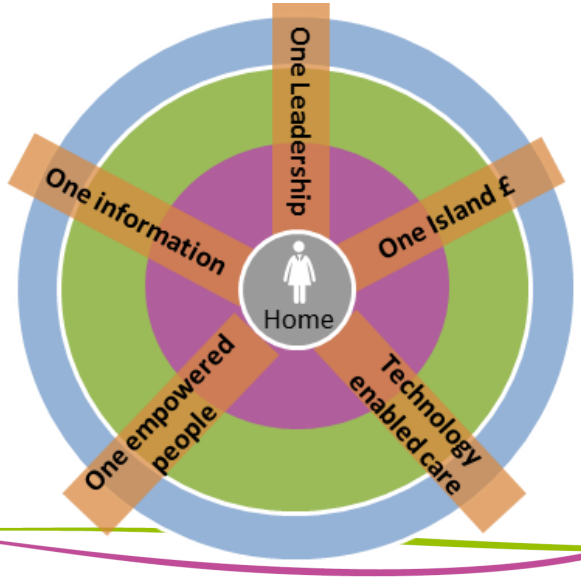
- Prevention and Early Intervention
- Integrated Access
- Integrated Localities
- Whole Integrated System Redesign

Key enablers
Intimate / Family
Friendships
Associated Life
Statutory Health & care services

Future Model

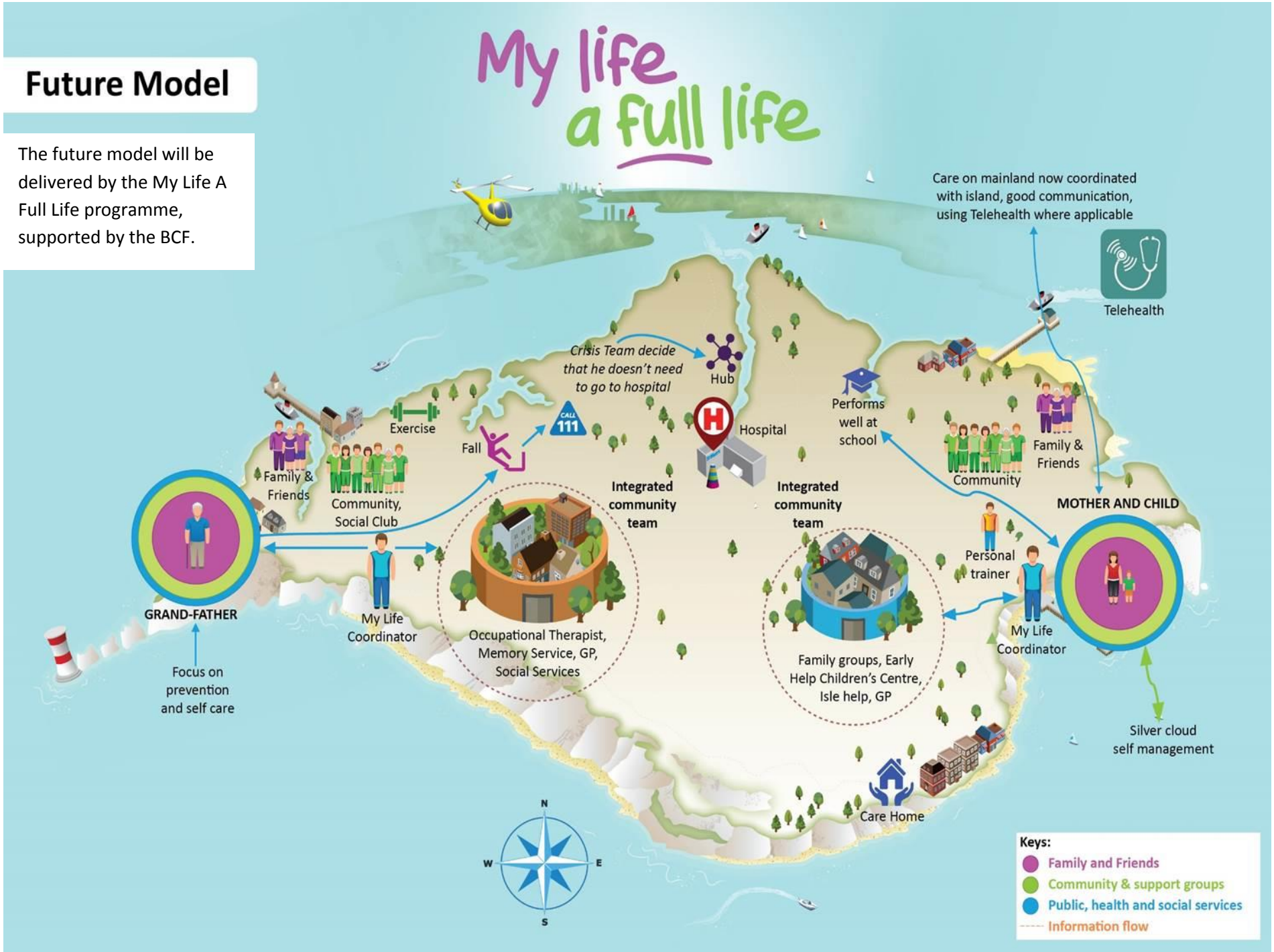
People will have greater involvement with their associate life and family/friends (inner rings). Our co-produced new care model:

- Builds on assets & mobilises social capital within communities
- Integrates services
- Is based in the community / at home
- Is a significant shift to prevention
- Reduces reliance on statutory services



Future Model

The future model will be delivered by the My Life A Full Life programme, supported by the BCF.

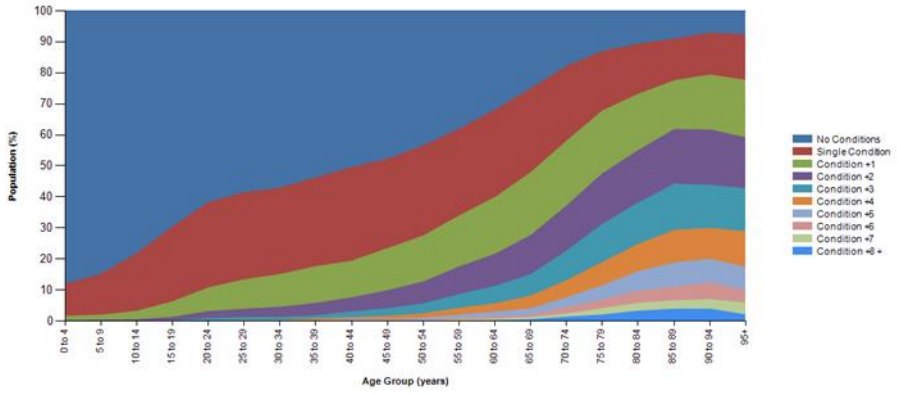


The Case for Change

We need to change because of all the pressures the statutory sector is facing:

PATIENT NEEDS ARE INCREASINGLY COMPLEX

As people get older the number of long term conditions (LTC's) they are likely to have increases. By the age of 75 they are likely to have 3 or more long term conditions.



The graph above shows how the numbers of LTC's grow with age for our Island's population using our risk stratification tool.

We know mental health and wellbeing is also influenced by levels of physical health, and vice versa.

OUR CITIZENS WANT CHANGE

People have told us they want services and organisations to work more closely together so that they don't always have to explain their needs over and over again. People also want better quality and improved choice.

DEMAND FOR HEALTH AND CARE IS INCREASING

The Island has a much higher older population compared with the rest of England. **26% of the Island's population is over 65 compared with 16.6% in England. This is set to increase significantly.**

The Island's over 65 population is how the rest of England will look in 20 years time. **1 person in 10 now acts as a carer to someone else on the Island. People need our support.**

Further information can be found in the Joint Strategic Needs Assessment (JSNA), MLAFL Case for Change and BCF 2015/16 Case for Change.

OUR SYSTEM ISN'T COPING

About 70% of hospital beds are currently occupied by people over the age of 65. Some of these people could be better cared for by integrated services in the community.

FINANCIAL PRESSURES

The financial position of the Whole System across the IOW has deteriorated significantly.

The CCG allocation is deemed to be over target by 14.11%, and therefore the allocation for 16/17 is a 1.39% increase, much lower than the national average of 3.4%. The CCG financial position is worse in 2016/17 than it was in 2015/16. Although the CCG has a savings plan of £5.8m it is only able to break even, despite the national requirement to have a £2.291m surplus.

The IOW Trust position has deteriorated as well and the Trust is declaring a deficit of £9.8m and has a savings plan of £8.5m.

The IW Council has set a balanced budget for 2016/17 but has used £4m of reserves and has a savings programme of £12.753m.

Action Plans to Deliver Change

In 2015/16 the BCF Plan included proposals to improve mental health reablement services, integrated community team development in localities, rehabilitation and reablement, crisis response and carers services. Progress has been made in all these areas.

For 2016/17 we aim to build on the work already undertaken and have clear action plans for further progress we aim to deliver. The following pages set out our plans for each scheme. We have also added Learning Disability services which is another of our key priorities for integrated development.

The pooled fund for each scheme is more comprehensive this year as both the Local Authority and CCG has committed to put in most of their out of Hospital provision as they move towards integrated commissioning.

The schemes and fund do not yet include the budgets for individual commissioning e.g. Continuing Healthcare or Personal Budgets; however, these areas are being considered and may be added in year.

The seven schemes are:

- Locality / Community Model
- Rehabilitation, Reablement and Recovery
- Integrated Mental Health Provision
- Learning Disability Transforming Care Programme
- Carers
- Care Act
- Prevention

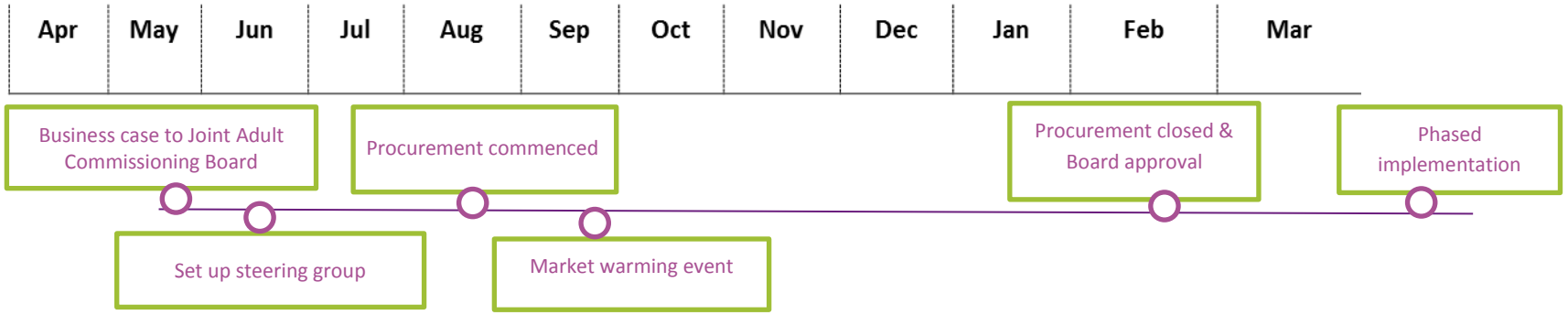
All schemes which are delivering transformational changes have a range of stakeholders on their working groups including the local CCG, the Local Authority, the NHS Trust, GPs, voluntary sector, independent sector and service users, where appropriate.

BETTER CARE FUND 2016/17

Rehabilitation, Reablement & Recovery

BCF Twelve Month Project Plan

2016/17



BCF Scheme Description: Reviews of the existing Rehabilitation and Reablement services took place during 2015/16. The existing provision for the physical rehabilitation of adult Island residents does not adequately support those with neurological deficits or those who need to return to work. Whilst the rehabilitation of older people is effective, the services does not integrate with services within the Integrated Locality model. Reconfiguration of the Rehabilitation services needs to take these deficits into account.

Rehabilitation and Reablement services could be integrated to ensure seamless working with associated economies of scale. All services need to be delivered closer to people's homes to ensure community support.

All the services included within this Better Care Fund Scheme aim to ensure that people can achieve maximum independence with their activities of daily living with the aim of remaining in their homes as long as possible, thus decreasing the need for long term care.

Synergies in provision may enable these services to work more closely together, driving efficiencies in the system through integrating pathways. The redesign and procurement of the rehabilitation, reablement and recovery pathways will be a major element of an Island-wide commissioning work programme and will involve multiple partners to deliver the changes required to ensure that the pathways are fit for the future.

Outcomes

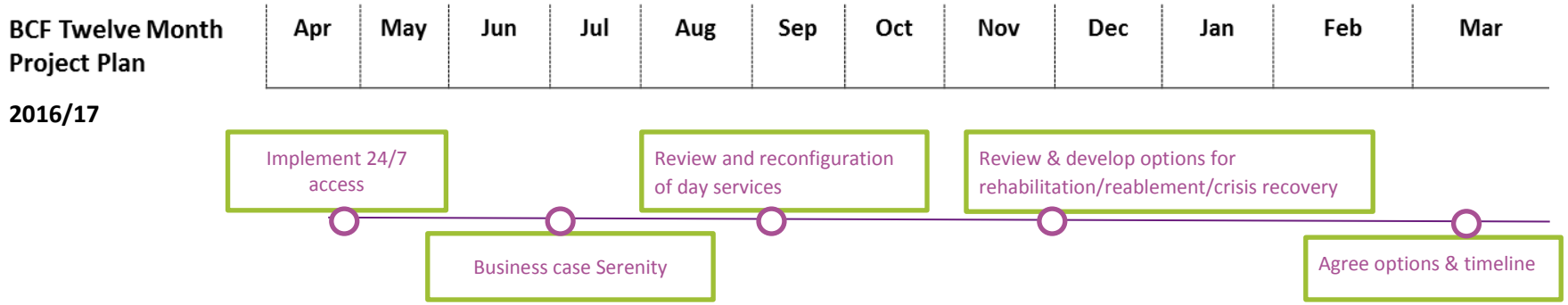
People who are identified as needing Rehabilitation, Reablement and/or Recovery (RRR) will:

- Achieve the maximum independence possible in order to enable them to live at home.
- Have a decreased need for long term care packages.
- Have their Rehabilitation, Reablement and/or Recovery needs met in the most efficient way, with resources targeted in the most cost effective way.
- Have services delivered locally as far as possible.

Financial Year 2016/2017	CCG Contribution £000	Council Contribution £000	Total £000
Rehabilitation & Reablement	7,307	3,785	11,092

BETTER CARE FUND 2016/17

Integrated Mental Health provision



BCF Scheme Description: An integrated primary, secondary health, social care and third sector mental health system built around need of individuals with agreed outcomes via an alliance model of contracting.

The Isle of Wight is implementing a redesign of adult 24/7 mental health services to deliver better outcomes which will address some of the quality issues from a patient and carer perspective.

The priority is to improve people's mental health and wellbeing by supporting the shift in services from hospital to community and ensuring the delivery of a more integrated model of support that recognises wider social networks and the importance of physical wellbeing, resilience and recovery. Deliverables:

- A comprehensive and fundamental redesign of mental health, social care and third sector care pathways that delivers demand management expectations:
  - Reconfiguration of day services to care pathway navigation and operation.
  - Crisis Recovery House.
  - Employment support.
- Service specifications, with recovery based outcomes developed through co-production
- A sustainable local Health & Social care Alliance contracting model.

Outcomes

- People with mental health needs will get timely assessment and access to treatment and support in settings that are appropriate and with the right level of support.
- People in emotional distress or in mental health crisis will be able to access support 24/7.
- People with a mental health problem will receive personalised care that is focused on recovery including employment and housing support.
- People with mental health problems will be find it easy to find information, advice and guidance; this will ensure that they feel supported to manage their own condition.
- People with mental health problems will be supported to maintain independence as long as possible.

Financial Year 2016/2017	CCG Contribution £000	Council Contribution £000	Total £000
Integrated Mental Health Provision	1,827	841	2,668

BETTER CARE FUND 2016/17

Learning Disability Transforming Care Programme

BCF Scheme Description: In November 2015 NHS England published *Building the right support*, a radical plan to develop more community services for people with a learning disability and/or autism who display behaviour that challenges support provision.

Locally we will:

- Develop, together with people with a learning disability, their family carers and other stakeholders both on the Island and across Hampshire, a sustainable Transformation Plan which locally defines and implements new models of care to enhance quality of life for all people with a learning disability living on the Island and those placed out of area.
- Refine the process to prevent unnecessary admission to specialist hospitals and lengthy hospital stays for individuals by supporting those in crisis.
- Review and develop current local accommodation and support provision to ensure it meets the current and projected future needs of the Island population.

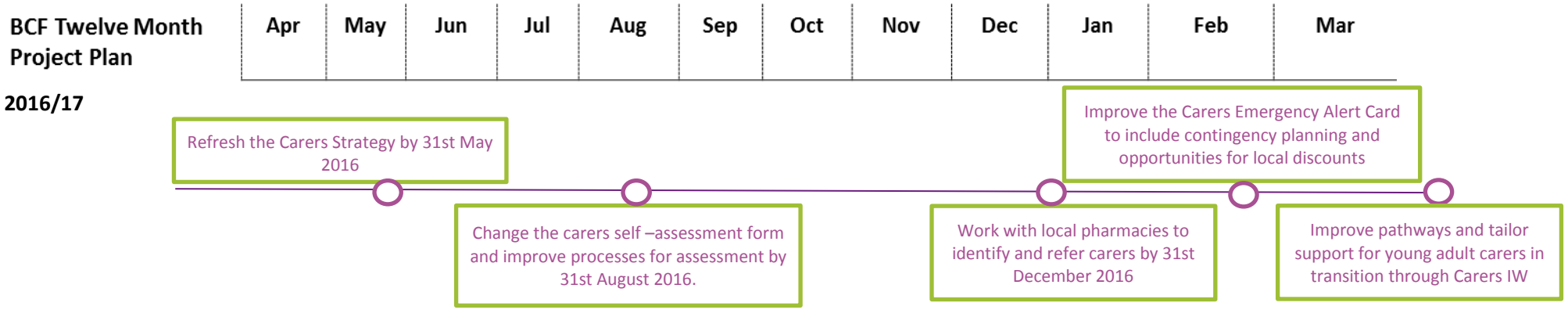
Outcomes

- People with a learning disability and their family have a better quality of life and achieve outcomes which are important to them as they are placed at the centre of planning and co-producing support around their own individual needs.
- Support options are routinely co-designed and guided by people with lived experience.
- Building carers and family resilience, reducing the need for formal support.
- Changed commissioning patterns with improved outcomes, for people with complex needs, through the creation of a greater range of support options.

Financial Year 2016/2017	CCG Contribution £000	Council Contribution £000	Total £000
LD Transforming Care	1,442	2,430	3,872

BETTER CARE FUND 2016/17

Carers



BCF Scheme Description: In 2013 **t**he IOW Council and the IOW Clinical Commissioning Group published the Working Together with Carers Strategy 2013 – 2016, reaffirming the commitment to continue to seek out and improve the lives of carers. Deliverables include:

- Refresh the Working Together with Carers strategy in partnership with both Carers IW and People Matter Group.
- Work with individual carers and carers groups to change the carer's self-assessment form and input into the personal budget processes.
- Promote Carers IW and the use of assistive technology for carers during carers week.
- Establish pathways for giving information to carers. Work with local pharmacies on the Island to identify and refer carers to Carers IW.
- Improve pathways and tailor support for young adult carers in transition through Carers IW.
- Improve the Carers Emergency Alert Card to include contingency planning and opportunities for local discounts.

Outcomes

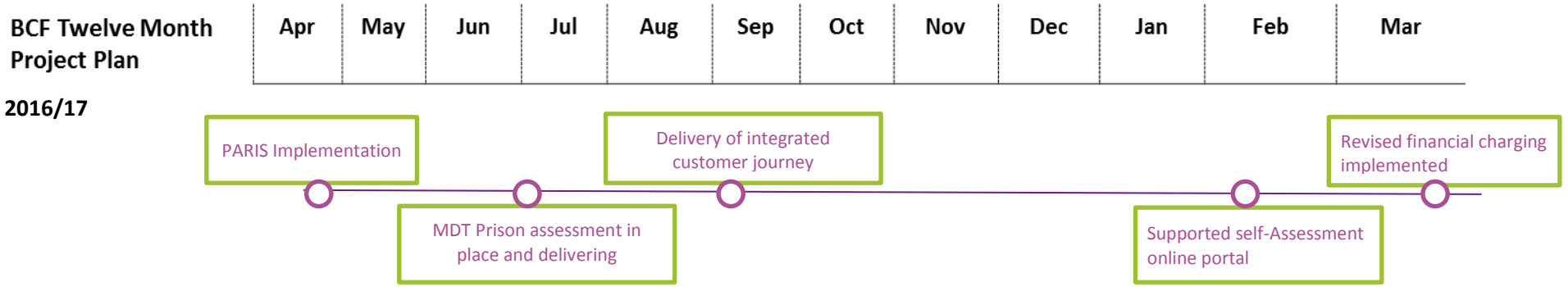
Carers will be supported in their caring role to:

- Have a life of their own.
- Be respected as expert care partners.
- Receive support that sustains their mental and physical wellbeing.
- Be treated with dignity.
- Have access to timely, appropriate, information, advice and guidance; and financial well-being and supported access to work.
- Young carers will be protected from inappropriate caring and have the support they need to learn, develop and thrive and to enjoy positive childhoods.

Financial Year 2016/2017	CCG Contribution £000	Council Contribution £000	Total £000
Carers	475		475

BETTER CARE FUND 2016/17

Care Act



BCF Scheme Description: The Care Act represents the biggest overhaul of Social Care legislation in 60 years, putting people and their carers in control of their care and support. Importantly the Care Act also changes many aspects of how support is arranged, and aims to give greater control and influence to those in need of support. Among the most significant developments are:

- National eligibility criteria which reaches those most in need.
- A change to outcomes focussed needs assessment.
- All carers are entitled to an assessment, and support for eligible needs.
- Local Prison Population included in Island population for eligibility.
- A greater emphasis on protecting the most vulnerable from abuse and neglect.
- Additions to local authorities' responsibilities to monitor and oversee local care markets and manage provider failure.
- A greater emphasis on prevention, advice and information.
- A greater emphasis on existing Personal Budgets (Direct Payments).
- A greater emphasis on the provision of advocacy services.
- Changes to when and how people will be asked to contribute towards the cost of support which has been arranged in conjunction with their local authority - most of these changes will not come into effect until 2020.
- New powers to financially assess Prison Population and carers who are eligible for receiving LA funded services.

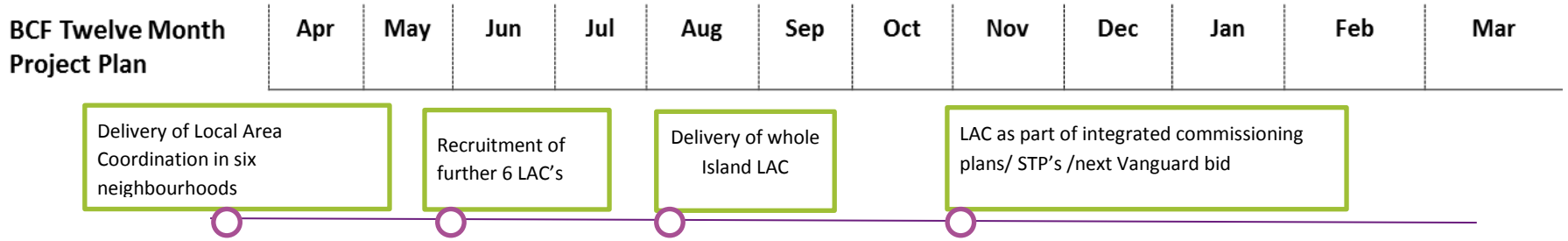
Outcomes

- Implementation of the integrated health and social care record system (PARIS).
- Multidisciplinary prison assessment across health and social care (including OT) in place and delivering full support package.
- Delivery of the integrated customer journey in line with the principles of the Strategic Partnership Agreement.
- Online portal to deliver supported and self-assessment for social care.
- Revised financial charging changes implemented.

Financial Year 2016/2017	CCG Contribution £000	Council Contribution £000	Total £000
Care Act	441	153	594

BETTER CARE FUND 2016/17

Prevention



BCF Scheme Description: The Prevention and Early intervention work stream is a delivery group of the My Life a Full Life Vanguard programme, whose aim is to shift care and wellbeing to prevention and early intervention agendas. Improving our ability to prevent illness, diagnose, and intervene early before conditions become serious has the potential to improve outcomes and reduce the long-term costs for health and social care services. Social support and strong social capital are particularly important in increasing resilience and promoting recovery. Three key areas make up the overall BCF prevention scheme

- Local Area Coordination (LAC) is a long term, evidence based approach to supporting people who may be isolated, excluded or vulnerable due to age, disability or mental health needs and their families to build and pursue their personal vision for a good life; stay strong, safe and connected as contributing citizens; find practical, non-service solutions to problems wherever possible; build more welcoming, inclusive and supportive communities.
- The scheme will ensure that people have access to peer support, information, advice and guidance appropriate to their needs. People will be supported to make best use of telecare and telehealth to choose appropriate aids and adaptations. People will be supported to make informed choices around personal budgets.
- The aim of 'No Barriers' is to empower people with a disability or a barrier to getting employment to achieve their goals, by offering training and support. For some people that may be a few hours a week working as a volunteer and for others it means a part or full time job with a mainstream employer.

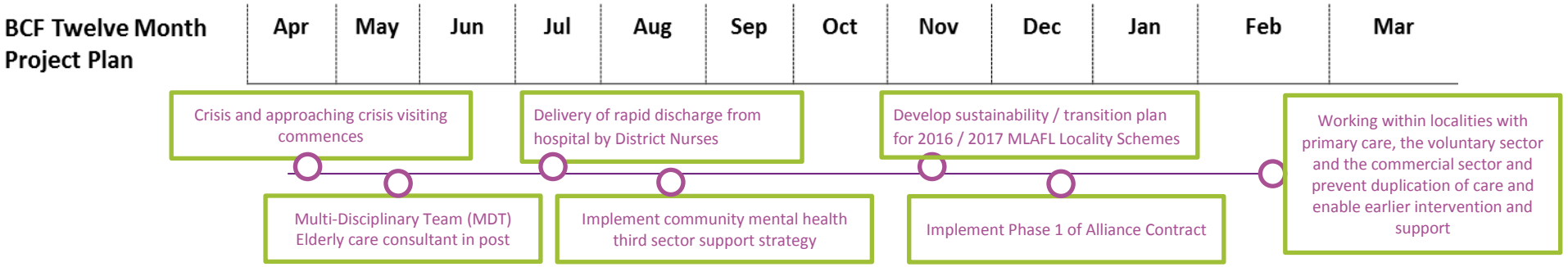
Outcomes

- Delivery of LAC in 6 neighbourhoods by May 2016
- Recruitment of further 6 LAC's by August 2016
- Whole Island delivery by March 2017
- Offer guidance and support to people with a learning disability and enable them to find and sustain a job
- People will have access (including signposting and referral)
- Offer information, advice and guidance, as well as peer support.

Financial Year 2016/2017	CCG Contribution £000	Council Contribution £000	Total £000
Prevention	81	399	480

BETTER CARE FUND 2016/17

Locality / Community Model



BCF Scheme Description: The Locality / community model scheme will provide a phased and structured approach for reviewing, aligning and integrating community services for the population of the Isle of Wight. The benefits of this change will increase the level of innovation and deliver truly integrated teams which are based upon skills needed as opposed to services currently delivered. It will also deliver system wide efficiencies and better outcomes for people.

This scheme is being undertaken by the My Life a Full Life Locality Workstream. The Workstream has delivered three integrated locality teams which are providing the foundation to delivering co-ordinated care and early intervention and prevention. The ambition is for the locality management teams to support full integration across communities and provide rapid communication across the system to empower and facilitate care and cross boundary working. Independent Providers, the Voluntary Sector and specialist services will continue to be key partners and this will be a focus for 2016-17.

The key outputs for the MLAFL workstream include, but are not limited to:

- The use of risk stratification to identify those with the highest level of need.
- Multi-Disciplinary case management for those in highest need.
- Support and training for carers and people to promote and maintain independence
- Crisis and approaching crisis prevention within the community.
- Development of 3 Health and Wellbeing Centres across the Island, enabling teams and services to be co-located and co delivered and increasing access to services for people.

Outcomes

- Improved Quality and satisfaction of care for people, through clear service navigation and easy access to integrated coordinated services closer to home.
- Improved case management which prevents and, where possible, avoids deterioration and crisis leading to non-elective admission to hospital, or admission to residential care.
- Commissioned services will be sustainable, provide value-for-money and meet the needs of the Isle of Wight population.
- Multidisciplinary teams supporting people with complex needs, including community health and social care, mental health and voluntary services.
- Reduced complexity of services.
- Services that offer an alternative to hospital stay.
- Services wrapped around primary care and the individual.
- Power of the wider community is harnessed.

	CCG Contribution £000	Council Contribution £000	Total £000
Locality / Community Model	7,658	2,782	10,440

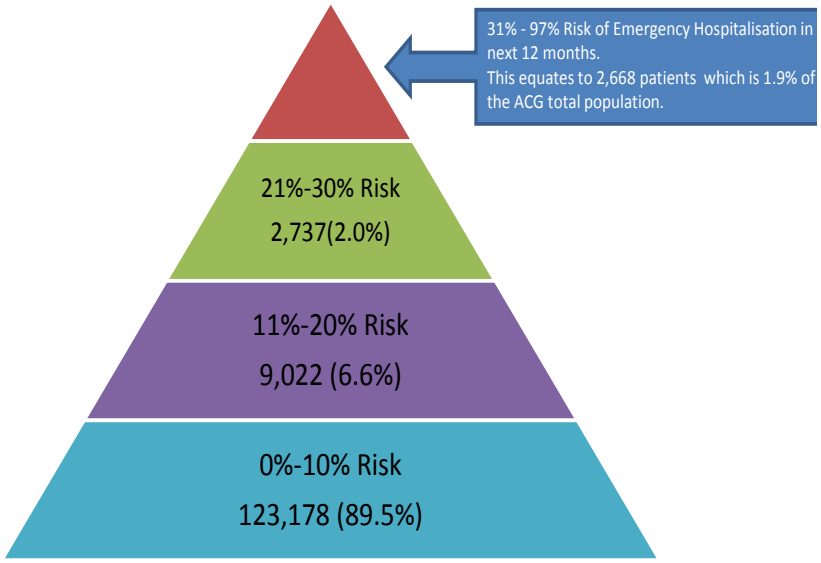
Community Model

The Community Model is centred around the person. It encourages utilisation of community resources to support individuals where they live and provides for integrated support when required.

LOCALITY SCHEME

From a risk analysis of our local population, we can see where to target our support. A key target population for the Locality Community services is people at high risk of emergency hospitalisation in the next 12 months (see below).

This demonstrates that 2,668 people have around a 1 in 3 chance or greater of being admitted to hospital as an emergency, and 761 patients have a 50% or greater chance of being admitted as an emergency.



We will be undertaking further analysis of service utilisation and risk stratification in 2016/17 to support more proactive case finding.

National Conditions for the BCF

There are eight national conditions which local areas must meet as part of the requirement for the BCF.

Maintain the Protection of Social Care Services

In 2015/16 the CCG was able to contribute to the Local Authority £3.513m which was the allocation for the NHS Support to Social Care. As well as this, the CCG gave an additional £3.1m (of which £2.1m is non-recurrent) as the Local Authority had a gap of £3.1m in the finance they were able to allocate to social care.

Despite the very difficult position of the CCG in 2016/17, set out in the case for change, the CCG has given the Local Authority £1m from its baseline funding and an estimated £711k slippage from 2015/16 has been identified in the BCF from both organisations. This therefore leaves a gap of £1.4m which needs to be addressed in order for the Council to remain within its allocated budget as agreed by members in February 2016. The CCG has also given £441k for the Care Act as required by NHS England.

At the Councils Executive meeting, members reinforced the Council could not spend more than its allocated budget and both organisations needed to work together to identify how the £1.4m gap will be resolved and risks managed (see page 26 Risk).

Joint Approach to Assessments & Care Planning

Integrated community team working is a major Workstream within our MLAFL programme under 'Locality Working'. Each locality has a GP champion lead together with a community nursing and adult social care lead. The Island uses the 'ACG' risk stratification tool (see action plans to deliver change). The teams consist of community nurses, care managers, care navigators and from April 2016 Admiral Nurses for Dementia. Work is ongoing in 2016/17 to increase integration, implement Trusted Assessments and ensure clear care co-ordination.

BCF Plans

There is a requirement to cover a minimum of the pooled Fund specified, signed off by Health and Wellbeing Boards and respective CCGs and Councils.

See overleaf for:

- Better Data Sharing using the NHS Number
- Delayed Transfers of Care - Action Plan

Changes to the Providers due to BCF Plans

Our providers are an integral part of the MLAFL partnership. All our planning is undertaken in conjunction and agreement with all our partners. We have adopted a co-production model of service development that is inclusive of service users and all stakeholders.

7 Day Services

There is now access to many community services 7 days a week. This includes: community nursing; community physiotherapy; reablement; community alarms; placements; social work duty team; 24/7 signposting triage for mental health; mobile night sitting service; crisis response service.

The Island also has an integrated communications hub which has 999, 111, Wight Care Alarms, Community Nursing advice etc. Further work is being undertaken in 2016/17 to develop and make more use of assistive technology.

The Community Equipment service will move from an on call service to 7 days a week in 2016/17. A recovery House for people with Mental Health needs will also open in 2016/17.

Monitoring the impact of 7 day services is taken forward through the System Resilience Group (SRG). Any shortfall in access to provision will be identified and addressed through the SRG process.

NHS Commissioned Out of Hospital Services

Investment was made in out of Hospital services in 2015/16 particularly to support integrated Locality working and the Community Nursing teams and care navigators, this is being maintained in 2016/17. Investment is being made in other services such as Learning Disabilities Transitional Support Nurse, which is now in the BCF.

Better Data Sharing using the NHS Number

The use of the NHS number as the primary identifier is a critical element of our transformation strategy. Within the MLAFL programme there is a work stream which includes taking forward IT interoperability and IT Governance. The NHS number is used in most health care settings and following the extended PARIS system roll out in 2016/17 it is now being used in Social Care. We undertook an audit during 2015 and this will be followed up to confirm use in all other areas.

Information sharing agreements and protocols are in place where appropriate, and through the MLAFL programme we are exploring ways of developing our systems and processes to provide assurance to partners that information is used appropriately. This is in line with the Information and Governance Alliance (IGA) ASU System. As a system we are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls. The matrix illustrates the current position and milestone dates for installation in settings are under review due to changes in funding levels from anticipated sources and alignment to wider projects. Projected go live is still expected before April 2017.

Settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	Shared via open API
	Not currently shared digitally

	To GP	**To Hospital**	**To Social Care**	**To Community**	**To Mental Health**	**To Specialised Palliative**
From GP						
From Hospital						
From Social Care						
From Community						
From Mental Health						
From Specialised Palliative						

Throughout 2015/16, significant progress has been made exploring the information and technology objectives and understanding future requirements. The Information and technology work stream embedded within MLAFL embraces stakeholders and leaders across the whole health system who will oversee projects to deliver whole system improvement to support new model of care delivery in 2016/17 by:

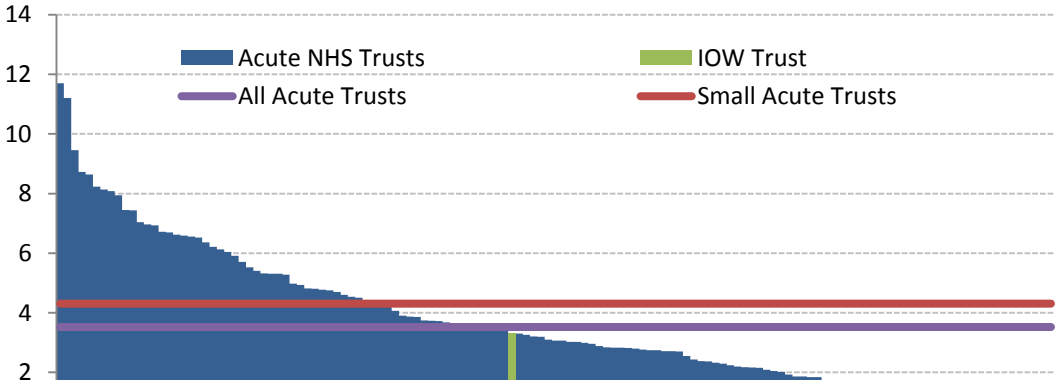
- Working closely with MLAFL work streams to understand Information Technology and sharing requirements, lead ICT projects to enable delivery.
- Scoping and specifying the further integration of systems which feed the Medical record and will be shared across disciplines, to include information governance, controls and sharing requirements.
- To review the current ICT provisions in the ICT services between the IOW NHS and IOW Council. To assist in the development of a roadmap to a future shared service.
- Review and improve the underlying IT Infrastructure, to enable smoother functioning between key organisations to include sharing of files, calendars and the ability to make use of each organisation's estate for flexible working.
- Ensure openness and clarity for patients and the public to understand how information regarding them is shared and the legal rights open to them.

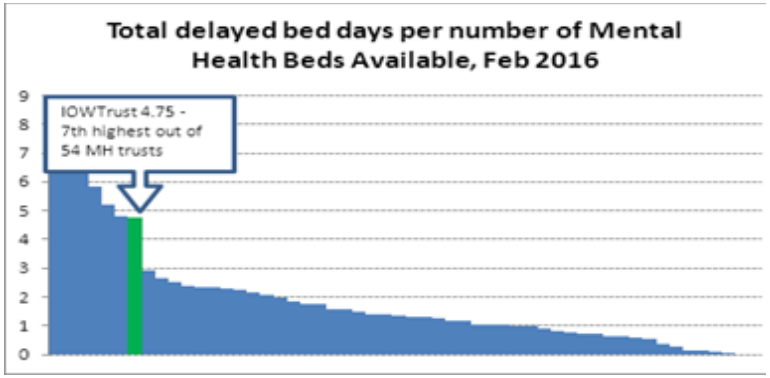
Delayed Transfers of Care

It is a national condition for the BCF to have an agreed action plan to reduce delayed transfers of care (DTOCs) from hospital. The System Resilience Group has a detailed Delivery Plan which incorporates the system-wide action plan for improving discharge processes and reducing DTOCs, summarised as set out on the following page. It has also been agreed that further work is being undertaken, and a sub-group has been established with representation from key stakeholders to review and update the hospital discharge policy and agree patient pathway improvement. A 12 week deep dive will be completed by the end of May with the new Policy to be introduced in early June 2016 and follow-up work undertaken to disseminate the new Policy and Pathways and provide support and training to key operational staff .

Based on the data that is available, we know that most delays are caused by discharges to care homes, with or without nursing, with smaller numbers of delays caused by availability of domiciliary care, or patient choice. We also know that if people could be discharged earlier into reablement, their recovery is likely to be improved, and this is reflected in the DTOC Action Plan with implementation of reconfigured capacity from May.

Figure 1: BENCHMARKING: 2015-16 Total delayed bed days per number of G&A beds available





The IOW NHS Trust (combined Trust) has only reported nationally its acute and community DTOCs, and has historically omitted to include its mental health DTOCs due to misinterpretation of guidance. Mental Health DTOCs have been included since February 2016, but this will impact on the reported figures for the IW overall during 2016-17 against the BCF baselines. Work has been undertaken to determine the Mental Health position during 2015/16, and this has allowed a benchmark to be established for target setting.

Taking into account the current performance and the national High Impact Interventions target of 2.5% DTOC against occupied bed days (OBD), the system is aiming for a 46% reduction on total delayed bed days equivalent to an overall achievement against OBD of 3.8%. This is split out as sub-targets to achieve 2.5% for acute and community against OBD; and to reduce the current performance of 12.06% against OBD, to 9.5% for mental health; both by 31 March 2017. The plan is considered stretching but achievable, despite concerns over the baseline and the significant workforce and recruitment issues that the Island is facing in all sectors of health and care provision and the level of system reconfiguration that will be implemented in year.

Delayed Discharges of Care High Level Action Plan

The governance arrangements to monitor and report on the DTOC will be through the System Resilience Group and Joint Adult Commissioning Board.

Issue	Action	Outcome	Due Date
1. Process delays	• Improve system wide delayed discharge policy and ensure clear protocols are in place for each organisation • Improve data collection following deep dive analysis • Emergency out of area placement protocol for Nursing Home beds	• Clearer understanding of roles and responsibilities regarding discharges • Improved data to inform better community capacity planning • Improved ability to respond during times of significant bed pressure	May 2016
2. Insufficient reablement capacity	• Increase availability of reablement beds within the Local Authority residential resource centre phased approach pending data and capacity requirements • Review criteria and thresholds for care for residential reablement • Domiciliary reablement to increase capacity.	• Improved outcomes for individuals • Less people needing longer term care • Improved flow of patients through the hospital	May 2016
3. Lack of domiciliary care, particularly for complex patients	• Develop new team to support Rapid Response Domiciliary Care to support discharge of people needing complex care packages from hospital • Review Occupational Therapy to ensure resources are targeted appropriately.	• Avoidance of delays due to inability to put in place complex care packages	April 2016
4. Lack of sufficient Nursing Home beds to meet fluctuations in demand and lack of dementia care home beds	• Support phased re-opening of previously unavailable beds in the nursing home sector • Support Care Homes with maintaining quality and meeting CQC requirement • Determine demand requirements for people with dementia exhibiting challenging behaviours and work with care home sector to develop plans to meet demand • Support care homes to manage people with complex needs through introduction of Admiral Nursing service	• Increase in General Nursing home bed capacity • Improved patient flow	May 2016 March 2017 June 2016 April 2016
5. Ensure rapid discharge of End of Life patients	• Continue with successful Hospice pilot scheme providing rapid domiciliary care and support	• More people to die in place of choice • Avoidance of delays	March 2017
6. Ensure people with lower level support needs do not experience delays	• Continue with Home from Hospital Scheme via voluntary sector (Age UK and Red Cross)	• Avoidance of delays	March 2017

National Metrics

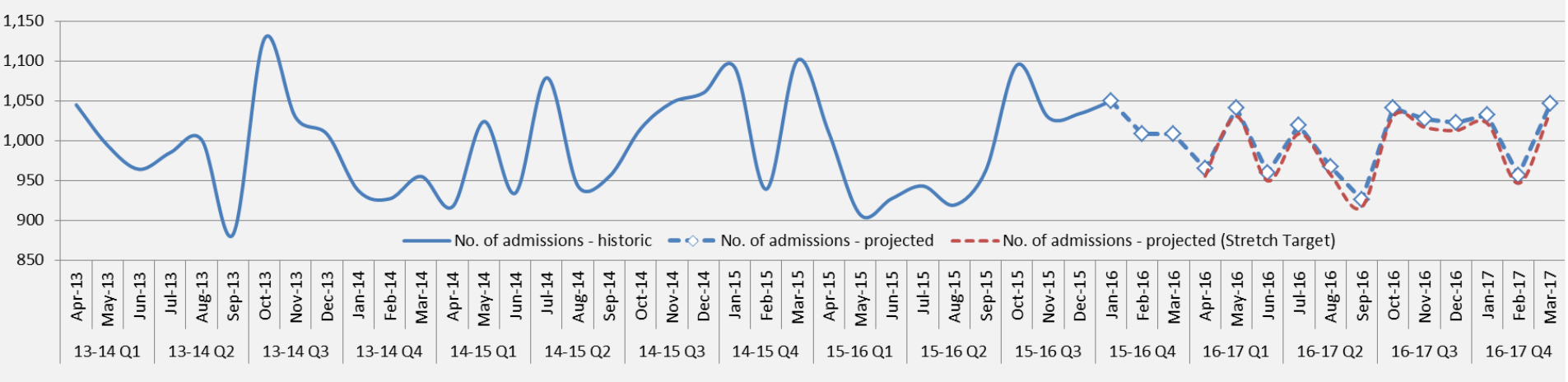
The National requirements for the BCF to monitor progress with the implementation of the fund are as follows:

- Non elective admissions (general and acute)
- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care

Trajectories for these metrics are set out below. We also have a local metric which is to reduce Occupational Therapy waiting times.

Non Elective Admissions

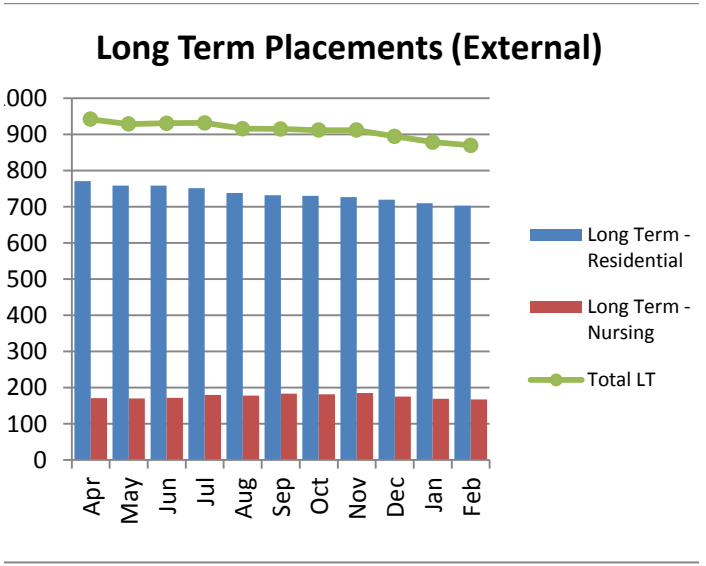
Figure 2: Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population



The non-elective activity for general and acute (G & A) specialities specifically at the IOW Trust has been reducing from a peak in 2012/13. Contributing to this achievement has been the innovative initiatives and developments delivered locally in line with delivering the national strategies agenda. Through the BCF activity we aim to continue this trend and as such we are introducing a stretch target to negate the population growth impact identified for 2016/17 and hold the current levels of activity. This represents the equivalent of preventing 120 admissions.

Admission to Residential and Care Homes

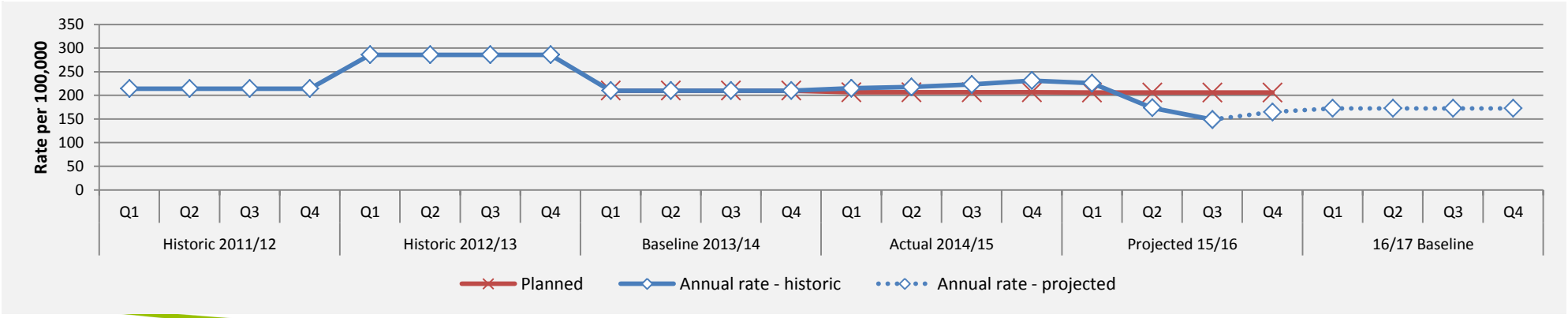
The charts to the right reflect the provision of long term placements in residential care commissioned by the IOW Council for the period 01/04/2015 to 29/02/2016. This dataset evidences that we have been able to maintain levels of permanent admissions against demographic pressure, against an increasing level of need and an increasingly ageing population. **The figures provided for the BCF measures are however, an estimate.** The additional data quality work we undertake to submit the statutory annual returns for social care has not yet been fully completed. There are additional pressures on the data integrity this year due to process changes through the care act, the significant change in recording of social care practice and activity from SWIFT to PARIS and associated migration issues that accompany a system change of this magnitude.



What has been established through the system changes is that cases recorded as long term residential care are only part of the story for social care; this needs to be offset by the level of short term residential activity that is not permanent, but is still substantial, and the impact of this on the whole health and social care system. Work will continue to review and manage the permanent admissions to residential care, and encourage other options for living in the community and meeting needs with a range of solutions. Other work streams within MLAFL e.g. reablement, will assist in the provision of alternatives to permanent admission to residential care and assist in the provision of home-based solutions.

However, due to the continued increase in demographic demand the projected outturn for 16/17 reflects the recent performance in residential care and the anticipation that this level of support will be maintained through the next year, to contain that demographic increase in real terms.

Figure 3: Rate of permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.

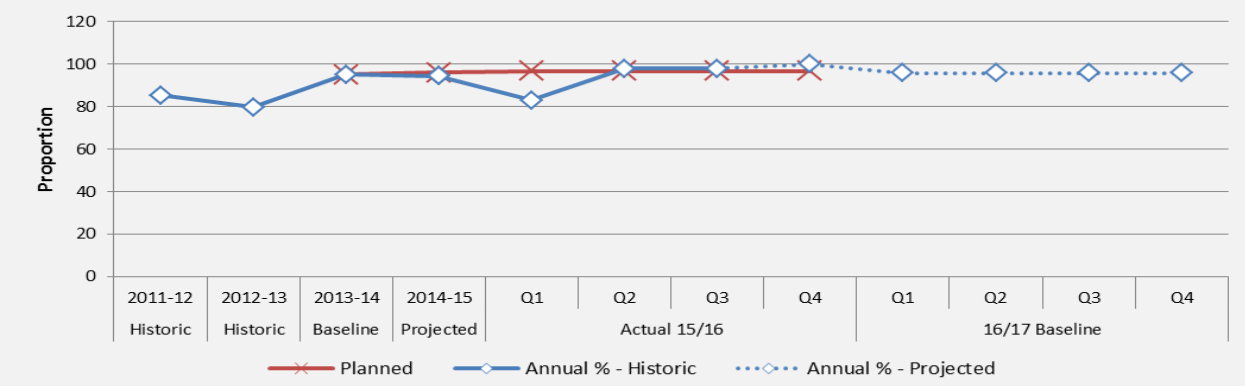


Effectiveness of Reablement

IOW Council performance in this area is significantly above the national average for 2014/15 which was 82.1%

Reablement capacity on the Island is fully stretched at present and a business case to develop the internal council provided service has been agreed. New staff are now being recruited. This development will enable more people to receive reablement.

Figure 5: Proportion of older people (65 and over) who were still at home 91 days after discharge



Delayed Transfers of Care

Historic data pre-populated in the DTOC Metric template is not reliable due to mis-interpretation of MH reporting definitions as above (Page 18) but work undertaken to assess the MH figures for 2015/16 has allowed a benchmark to be established for target setting (out-turn for 2015-16 with MH of 5,515 DTOC days). Taking into account the national target of 2.5% DTOC against occupied bed days (OBD), the system is aiming for a 46% reduction on DTOC; equivalent to a combined figure across acute, community and mental health of 3.8% on OBD. This results in an *apparent* increase against the 2015/16 plan.

Figure 7: Submitted DTOCs vs Actual DTOCs Feb 2015-Feb2016

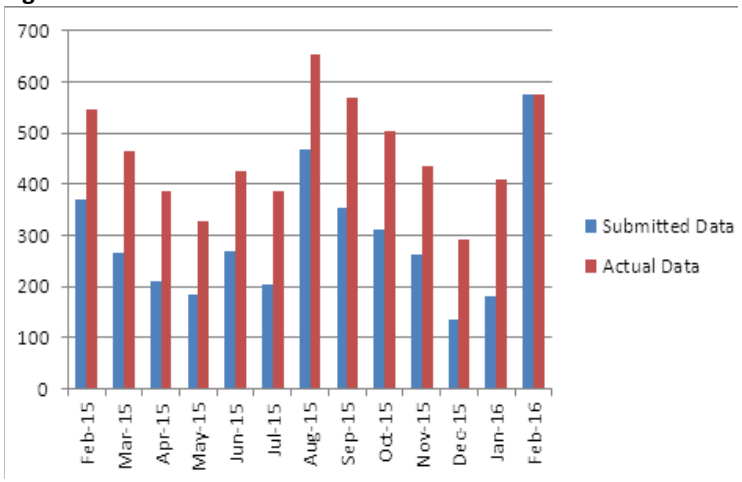
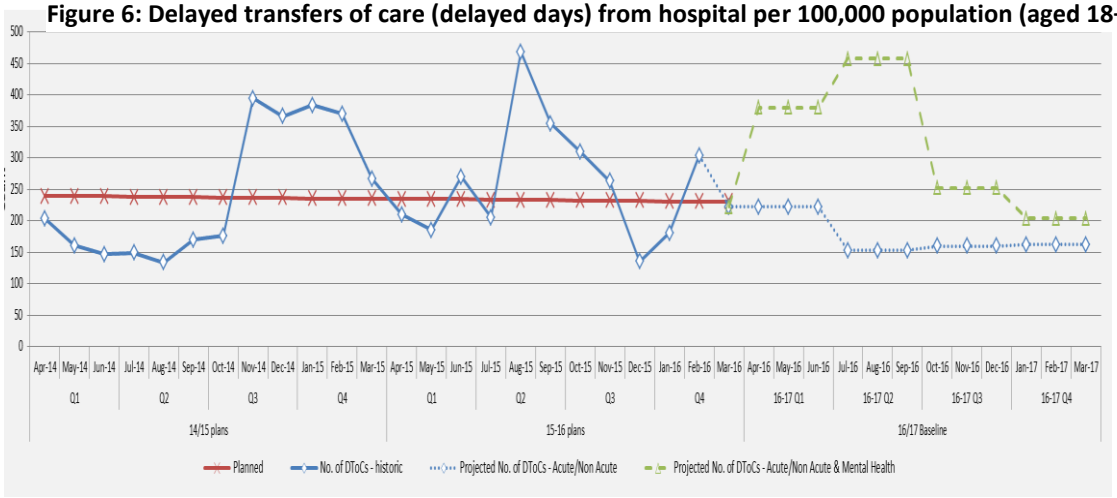
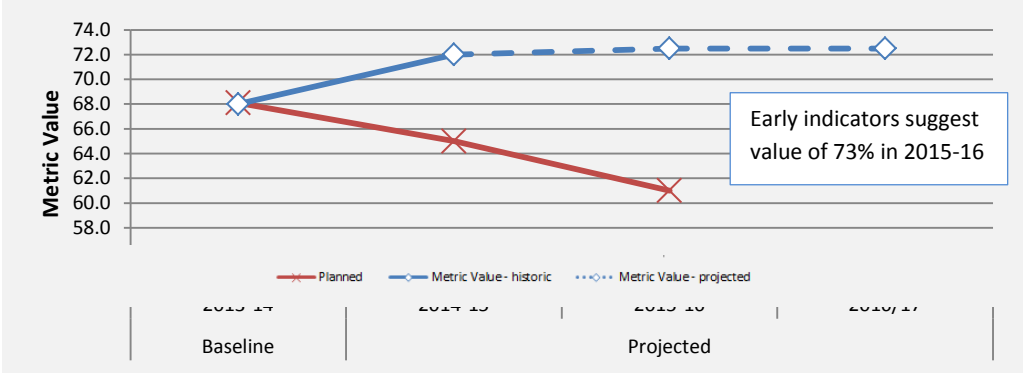


Figure 6: Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)



Patient / Service User Experience Metric

Figure 8: Overall satisfaction of people who use services with their care and support



The plan for 2014/15 took into account the potential impact of the Care Act changes and what was felt to be potentially increased expectations in relation to the national publicity around care account / care cap etc.

However, the IOW Council's performance for satisfaction was 72% for 2014/15; this was higher than anticipated and higher than the national average of 64.7%. This result took the council back up to the level of satisfaction for 2012/13 following a dip in performance in 2013/14 to 68.1%. Early indicators suggest a value of 73% in 15/16.

The target set for 2016/17 is to maintain this already high level of satisfaction with adult social care services on the Isle of Wight.

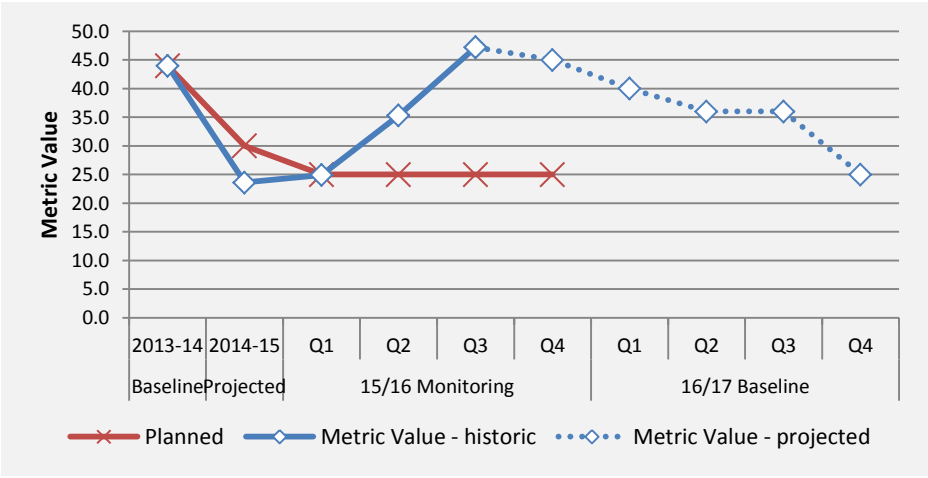
Reduction in Community Occupational Therapy waiting times

A full review of the occupational therapy (OT) service is currently being undertaken and it has been identified that currently there is excessive wait times for assessment for people screened as being at medium risk – this is now standing at 273 people with a 52 week wait. In order to address these issues a request for System Resilience funding has been agreed for locum support to undertake the backlog of outstanding assessments.

The intention of the service review is to look at possible service reconfiguration to improve customer experience and ensure waiting list reduction by:

- Increasing the numbers of Trusted Assessors to include Social Care Practitioners, Carers IW, those who support individuals within the prison service and Wightcare Responders. This process will identify people with Low Level Risks that can be resolved by simple aids and equipment that will support them with daily living enabling people to maintain their independence.
- Providing a fast track service for all people who can visit and be assessed at the Independent Living Centre (ILC).
- Support carers to use IPads for taking photos/film of areas within their home environment that are causing issues for daily living and independence. Photographs would be emailed to ILC or Housing Adaptation Team (HAT) prior to an assessment, to enable a more comprehensive assessment in a shorter timeframe.
- New locality clinics will be held jointly with the Housing and Adaptation Occupational Therapy Team and Housing Renewal Team to promote joint screening and fast track Disabled Facilities Grant work.

Figure 9: Community Occupational Therapy Waiting Times



BCF Scheme Impacts on Metrics and National Conditions

Metric	MH Services	LD Services	Rehab/Reable	Locality/Comm	Carers	Care Act	Prevention	How will BCF schemes contribute to this?
Non Elective Admissions	✓	✓	✓	✓	✓	✓	✓	Decrease in hospital attendance, admission and readmission within 30 days Reduction of A&E Admissions for over 65's Reduction in emergency admissions for COPD Supporting people to manage the symptoms of long term medical conditions that avoid hospital admission. Reduction in older people (with LTCs) attendances at GPs and A&E Increase in numbers of mental health crisis managed within the community setting. Increase in numbers of adults with diagnosed mental health illness living independently without support. Increased professional assistance and early intervention for LD to prevent hospital admission. Increasing range of respite support will also support de-escalation of need for admission.
Residential Admissions	✓	✓	✓	✓	✓	✓	✓	Increase in numbers of people with care package who are able to remain within their own homes. Prevent unnecessary care placements and support people to live independently for longer. Reduction in re-admissions following discharge from health and care services within 30 days. Increased support and respite options to support people of all ages to remain in their chosen home for longer.
Reablement	✓	✓	✓	✓	✓	✓		Increase in proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. Supporting and encouraging the person to continue with the agreed goals/outcomes which will enable the person to become more, not less, independent and enhance the chances of long term reablement. Increased support and respite options to support people of all ages to remain in their chosen home once discharged – getting the right support in the right place at the right time.
Delayed transfers of care	✓	✓	✓	✓	✓	✓	✓	Increased use of integrated Rehab/Reablement teams in-reaching from the community will enable a more efficient and effective transfer of care from the acute setting to the community. Increased use of MDT teams within the community will enable a more efficient and effective transfer of care from the acute setting to the community. Increasing identification of carers by hospital staff will ensure carers are sufficiently prepared for and supported to commence/continue with their caring role which could prevent delayed hospital discharge. Increased support and respite options ensure the right support is available in the community to facilitate discharge.
Patient / Service User Experience metrics		✓	✓		✓	✓	✓	Improvement in service user feedback. Increase in individual awareness and activation to self-directed support of those people suffering with a LTC. Increase in QALY (to be agreed following benchmarking exercise as this a longer term target). Increased choice and options for support should increase customer satisfaction.
Local Metric OT Waiting Times			✓		✓			Reduction in need for service users to refer to the Community OT, leading to reduced OT waiting times. Increased use of Trained Trusted Assessors leading to reduction in the waiting time for community OT assessment in the person's home.

Governance

System wide governance is in the process of being reviewed as there is currently duplication and some confusion. This is due to report and be agreed in June 2016.

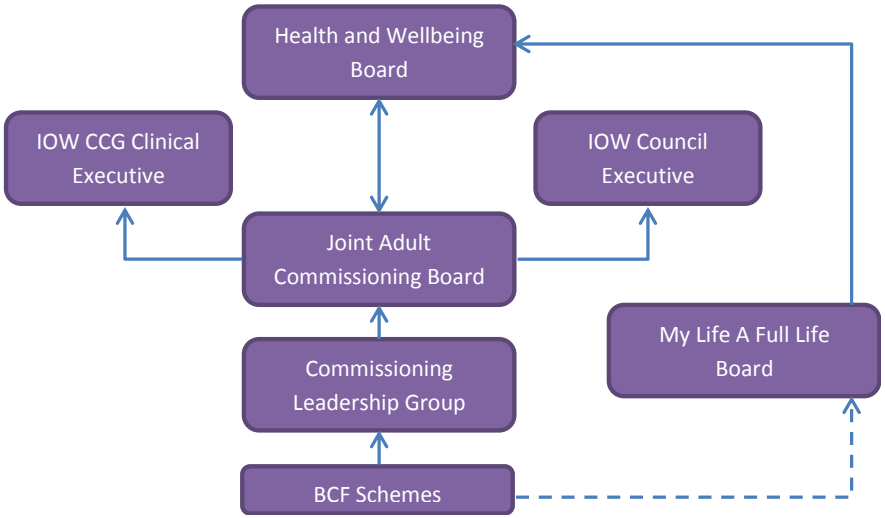
Currently, the Joint Adult Commissioning Board (JACB) reports to the Health and Wellbeing Board (HWB) as well as the constituent organisations. The MLAFL programme also reports to the HWB.

The Joint Adult Commissioning Board oversees the BCF including the finance, performance, risk and delivery of schemes. The Commissioning Leadership Group (CLG), which has senior management from the CCG, Social Care, Housing and Public Health, oversees the operational delivery and individual senior commissioning managers are responsible for individual schemes.

The BCF Schemes are taken forward through different existing groups or Boards e.g. the Mental Health Partnership Board. They report formally through the CCG to the JACB, as this is where operational commissioning issues are resolved. There are also close links to the MLAFL programme as the delivery by providers, for example the Community Model and the locality programme, is through the MLAFL programme. Where contractual changes are occurring, monitoring is also through the formal contractual process with providers.

A BCF Highlight report is produced monthly for the JACB and the more detailed scheme reports and performance dashboard are presented on a quarterly basis. Quarterly reports are produced for the HWB, including updates on schemes and dashboard on performance.

Governance Structure



Risk

The IOW has decided not to have a risk fund, as all funding is committed to the delivery of services. It has been decided that to hold a risk fund would increase the risk as we wish to be proactive in improving performance and all funds are allocated to achieve this.

The MLAFL programme has a much wider risk log which supports the integration agenda.

RISK DESCRIPTION	RISK SCORE	MITIGATING ACTIONS
Protecting Social Care		
In 2015/16 the CCG was able to give an additional £3.1m (of which £2.1m is non-recurrent) funding on top of the minimum contribution to protect social care. The CCG is not in the financial position to do this in 2016/17 and there remains a £1.4m gap.	20	• System wide review of savings programmes across all public sector bodies to determine where further cash releasing savings can be targeted. • Senior finance team from the Trust, Council and CCG meet on a monthly basis to understand each organisation's financial position, review the system financial position and provide reports and recommendations to the relevant committees. • Agreement to consider outcomes / benefits of savings programmes to ensure transfer of costs between organisations doesn't occur without system savings. • Understanding of which organisations are responsible for actual costs. • Campaign to raise profile of Island public sector financial position – 'Fight for the Wight' and NHS allocations formula to continue to be challenged.
Workforce Shortages		
Recruitment and retention of health and social care staff remains very challenging. National skill shortages are exacerbated by being an island. This is impacting on making change happen quickly and system resilience.	16	• Major workforce development programme through MLAFL involving all partners and Sustainability and Transformation plans. • System wide recruitment initiatives through MLAFL workstream. • Trusted assessment being rolled out to avoid duplication.
Non Delivery of DTOC Target		
Risk of non-reduction in DTOCs and incorrect baseline level due to historic incorrect reporting by IOW Trust, particularly for Mental Health.	12	• Revised Discharge policy being developed and due to be completed May 2016. • Clarity achieved regarding interpretation of national definitions. • Sign off by organisations, weekly, of actual delayed discharges. • Discharge action plan agreed and being implemented and monitored through System Resilience Group.
Non Delivery of Emergency Admissions Target		
The IOW has one of the lowest rates for emergency admission, which have reduced despite the national upward trend. Schemes to further reduce emergency admissions may not deliver and are linked to workforce issues, including shortage of GPs.	9	• Detailed System Resilience Plan in place and agreed by all organisations, which focusses on flow through system, including prevention of admissions. • Accountability agreement in place for Trust, LA and CCG to deliver system resilience plans. Delivery of Plans monitored monthly.
Commissioning Capacity		
There are a wide range of transformation initiatives including MLAFL, the Whole Integrated System Redesign, System Resilience, Savings programmes and the BCF. There is some overlap and duplication, but there is a danger of overload and failure to deliver on key priorities.	9	• Additional resource agreed as part of MLAFL Vanguard funding bid. • Prioritisation across system regarding current operational issues and longer term transformation plans. • Programme management processes in place for all key programmes, with robust reporting mechanisms.

Financial Summary

This is the financial summary of our BCF:

- The BCF baseline for 2015/16 was £20.607m, however, in year variation gave a final position of £22.040m
- The BCF for 2016/17 is £31.332m, this is a 42% increase
- The BCF nationally stipulated minimum requirement is £10.607m
- The CCG has contributed £20.142m to the pooled fund. This includes:
    - NHS Support for Social Care Funding - £3.573m
    - Reablement Funding - £0.462m
    - Carers Funding - £0.291m
    - Care Act Funding - £0.441m
    - Additional support for Social Care - £0.912m
- The LA has contributed £11.189m to the pooled fund. This includes:
    - Disabled Facilities Grant - £1.584m

Table 1: Better Care Fund Schemes 16/17

	CCG Contribution	Council Contribution	Total
	£000	£000	£000
MENTAL HEALTH SERVICES Most out of hospital Mental Health services to ensure a more integrated approach.	1,827	841	2,668
LEARNING DISABILITY SERVICES (LD) All community based LD services excluding individual placement costs to ensure a more integrated service.	1,442	2,430	3,872
REHABILITATION & REABLEMENT All rehabilitation and reablement services both in and out of hospital and community / domiciliary settings. The aim is to commission a more integrated service and pathway.	7,307	3,785	11,092
LOCALITY / COMMUNITY MODEL Most out of hospital health and social care services including Community Nursing and the Care Managers. This is to support the MLAFL initiatives going forwards with integrated community provision.	7,658	2,782	10,440
CARERS SERVICES All carers funding and services similar to existing scheme.	475	0	475
CARE ACT Required funding to support the Local Authority in implementation.	441	153	594
PREVENTION This includes the Local Area Co-ordinators and some work on prevention.	81	399	480
PROTECTION OF ADULT SOCIAL CARE	912	799	1,711
TOTAL	**20,142**	**11,189**	**31,332**

Signatories

Signed on behalf of the IOW Clinical Commissioning Group

…… 29 April 2016

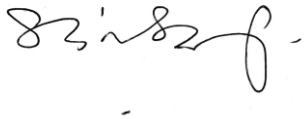
Helen Shields, Chief Executive Officer Date

Signed on behalf of the Council

…… 29 April 2016

John Metcalfe, Chief Executive Officer Date

Signed on behalf of the Health and Wellbeing Board



…… 29 April 2016…….

Councillor Steve Stubbings Date

Stakeholders

Membership of Commissioning Leadership Group:

Isle of Wight CCG

- Deputy Chief Officer
- Head of Urgent Care and Community Commissioning
- Head of Secondary Hospital Commissioning
- Head of Children, Young People, Mental Health and Learning Disability Commissioning
- Heads of Continuing Healthcare and Individual Patient Care
- Head of Primary Care and Corporate Business

Isle of Wight Council

- Director of Adult Social Services
- Director of Public Health
- Head of Public Health Strategy
- Strategic Commissioning Manager, Adult Social Care
- Market Development Commissioner
- Head of Housing and Planning
- Representatives of Children's Services, Hampshire County Council
- For Specific Issues
- Representatives of Voluntary, Community and Faith Sector

Membership of Joint Adult Commissioning Group:

Isle of Wight CCG

- Chairman
- Chief Officer
- Chief Finance Officer
- Deputy Chief Officer
- Director of Quality and Clinical Services

Isle of Wight Council

- Executive Member
- Managing Director
- Head of Adult Social Care and Community Wellbeing (Nominated Director Adult Social Care)
- Senior Finance Officer
- Director/Deputy of Public Health

My Life A Full Life Board Members:

- Isle of Wight NHS Trust
- Isle of Wight Council, including Children's Services
- Isle of Wight CCG
- One Wight Health (All 17 GP Practices)
- Voluntary Sector
- Independent Sector (Care Homes and Home Care)
- Hampshire Constabulary
- NHS England (Wessex)
- Service User Representatives

References

MLAFL Website and Value Proposition
Health and Well Being Strategy 2013-16
Joint Strategic Needs Assessment (JSNA) 2014-15
CCG Clinical Commissioning Strategy 2014-2019
CCG Operational Plan 2016/17
BCF Plan 2015/16
BCF 2016/17 Risk Log
Terms of Reference for JACB
Terms of Reference for Commissioning Leadership Group
Individual Programme Plans for MLAFL Workstream including:

- IT Integration and Governance
- Locality Working
- Integrated Commissioning
- Single Point of Access
- Prevention and Early Intervention

CASE FOR CHANGE

MLAFL Caring for Our Island – Time to Act
Better Care Fund 2015/16 – Case for Change – Section 3
ACG Risk Analysis

Abbreviations

BCF	Better Care Fund
JACB	Joint Adult Commissioning Board
ASC	Adult Social Care
LA	Local Authority
CCG	Clinical Commissioning Group