PAPER E

Committee	**HEALTH AND WELLBEING BOARD**
Date	**29 JUNE 2016**
Title	**BETTER CARE FUND 2017/19 PLANS AND SECTION 75**

RECOMMENDATION

1. That the Health and Wellbeing Board (HWB) approve in principle the draft proposals to pool funds between the IOW CCG and the IOW Council, under the Better Care Fund (BCF) and Improved Better Care Fund (iBCF).
2. That the Chairs of the HWB can approve the BCF plan (including iBCF) on behalf of the Board before the submission date.
3. That the final BCF Section 75 agreement is signed by the Chief Executive Officer of the Council or Chair HWB and the Chief Officer of the CCG following formal approval within each organisation.

EXECUTIVE SUMMARY

4. This paper sets out an overview of the approach and requirements for developing the BCF and iBCF for 2017/19.

5. The report requires agreement in principle to the way in which the BCF and iBCF are being developed.

6. There is a requirement for the CCG and the Local Authority to have a pooled fund to support integrated commissioning and provision. The minimum requirement for 2017-18 is £9.7m, and for 2018-19 is £10.8m subject to release of technical guidance.

7. The pooled fund is to include the iBCF, which is new funding to support transformation. For the Isle of Wight this funding totals £6.5m, which tapers off over the next 3 years.

8. The CCG and the LA are proposing a total fund of £35.878 m for 2017-18 and £36.051m for 2018-19 subject to finalisation upon receipt of the national technical guidance. The value was £31.332m in 2016/17.

9. There is a requirement to submit a high level BCF plan for 2017/19, the first draft of which is to be submitted within six weeks of the issue of the BCF Technical Guidance. Assurance and review of submitted plans is then undertaken, and local systems are able to redraft plans in advance of final submission.

10. The HWB is required to sign off the BCF Plans in advance of submission.

11. The Section 75 agreement 'the pooled fund' for 2017/19 is in development and must be in place by the final submission date, however we hope to reach agreement before this date.

BACKGROUND

12. The Better Care Fund (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. After producing detailed proposals, the Island was fully assured on its BCF by NHS England for 2016/17.

13. In March, the government confirmed additional funding for social care to be paid directly to local authorities as part of an expanded Improved Better Care Fund grant (iBCF). The grant has three purposes:
    - Meeting adult social care needs.
    - Reducing pressures on the NHS, including supporting people to be discharged from hospital when they are ready.
    - Ensuring the local social care market is supported.

14. The iBCF Allocation for the Isle of Wight is as follows:
    - 2017/18 £3.254m
    - 2018/19 £2.175m
    - 2019/20 £1.081m

15. The purposes of the money are set out in the grant determination issued by the Government and apply to both the original allocation (announced in the Spending Review in autumn 2016) and the new allocation.

16. There is a condition in the grant to require that the money is pooled into the local BCF. Following the announcement of the additional money it was agreed to include a new National Condition in the Better Care Fund. This condition requires all areas to implement the High Impact Change Model for Managing Transfers of Care to support system-wide improvements in transfers of care. There is a complementary grant condition on the iBCF requiring that it be used to implement the High Impact Change Model.

17. Key changes to the policy framework since 2016-17 include:
    - A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year.
    - The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four.

18. The BCF Technical Guidance had not been formally issued at the time of writing, although it is expected imminently. We have been instructed to anticipate a submission deadline of less than six weeks from formal release of the Technical Guidance. A draft of the guidance was released by the LGA in April 2017, and there is not expected to be substantial changes to this document.

19. The draft guidance identifies four national conditions we must meet:

- That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB 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 2017-19.
- 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, as detailed above.

20. The reduction in national conditions is intended to focus the conditionality of the BCF, but does not diminish the importance of the issues that were previously subject to conditions. These remain key enablers of integration. Narrative plans should describe how partners will continue to build on improvements locally against these formal conditions to:
    - Develop delivery of seven day services across health and social care.
    - Improve data sharing between health and social care.
    - Ensure a joint approach to assessments and care planning.

21. The Island has been making progress on the national conditions as reported in the quarterly report Q4 for 2016/17.

22. We can confirm that we are spending on NHS commissioned out of hospital care and that an action plan for delayed transfers of care is in development. The CCG is contributing £3.637m in 2017-18 as NHS support for Social Care, as nationally mandated, and an additional £1m as non-recurrent support, as a contribution to maintaining the provision of Social Care services and including the Care Act.

23. The Section 75 will commit the CCG and the LA to commissioning the services in an integrated way.

24. There is a formal assurance process which the CCG and LA have to go through to have the BCF plans agreed.

25. The BCF plan and pooled budget should be seen as an enabler to the My Life a Full Life Programme (MLAFL) rather than a separate planning process. However the National requirements for the BCF do have to be met.

<u>THE PROPOSAL FOR INTEGRATED FUNDS</u>

26. The officers within the CCG and the LA have reviewed the existing schemes within the pooled fund and have adopted a more focussed approach for 2017/19, identifying targeted BCF schemes with key deliverables 'in year', and developing new iBCF Schemes to deliver the purposes of the iBCF grant in meeting adult social care needs generally, reducing pressures on the NHS (including DTOC) and stabilising the care provider market.

27. There are now ten schemes. Existing pooled fund schemes and their budgets have been reorganised, with some services no longer included in the BCF; new iBCF schemes have been developed, some of which have been

incorporated within existing BCF Schemes (see Appendix A). Work is ongoing in finalising the funding.

28. The BCF does not include the MLAFL Vanguard funds which also support integration. It is based on existing LA and CCG commissioned / provided services.

29. The IOW Local Care Board and Operational Delivery Group will oversee the BCF, finance, performance and risk. Work within the BCF must continue to be reported to the Health and Wellbeing Board. BCF Quarterly Reports are to be submitted, signed off by HWB, to NHS England, while iBCF Quarterly Reports are to be submitted to the Department for Communities and Local Government.

NATIONAL METRICS

30. The BCF Policy Framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2016-17, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:
    - Non-elective admissions (General and Acute);
    - Admissions to residential and care homes;
    - Effectiveness of reablement;
    - Delayed transfers of care.

31. Trajectories for these Metrics are in development and will be within the final plan.

CONCLUSION

32. Due to the lateness of the guidance and the timing of the HWB meetings it is not possible to submit a final plan for approval before the national deadlines. It is hoped the direction of travel is supported and that the HWB can agree the plan on the Boards behalf as long as it is in line with proposals outlined in this paper.

33. The final plan will be presented to the next HWB in October 2017.

BCF SCHEME DESCRIPTION	EXPECTED OUTCOMEs
Locality Community Model	
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 programme, Transforming Community Services. There are already three integrated locality teams which are providing the foundation to delivering co-ordinated care and early intervention and prevention. New roles have been developed and piloted including care navigators and Locality area co-ordinators. The next phase is for services and staff to be aligned with locality and a new operating model put in place to support full integration. The key outputs for the TCS workstream include, but are not limited to: • Implementation of locality governance and organisational structures including focus on safeguarding and the vulnerable. • Implementation of integrated locality services • Implementation of case management of those at risk • Review of existing co-ordination provision in each locality • Development of community resilience and community assets in each locality • Development whole system business model and new way of contracting for community services e.g. Alliance contracting. • Development and implementation of MH Crisis Cafés	• 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.
Hospital to Home	
By improving discharge planning and patient flow, and by investing in capacity to care for patients in more appropriate and cost effective settings we will ensure that no patients stays longer in acute, community or mental health bed based care, than their clinical condition and care programme demands. The scheme will ensure that every patient has an integrated Discharge Plan, informed by their presenting condition and known social circumstances where complex needs are identified early in their journey and appropriate support models are in place to prevent readmission, reduce length of acute spells and minimises patient decompensation. The scheme will use the 8 High Impact Change self-assessment tool to determine the system baseline and will agree a time bound trajectory to move those areas forward. The scheme is further supported by iBCF additional funding of a for change/project management lead who will drive, implement and monitor the improvement plan.	• DTOC reduction achieved as per agreed trajectory based on national target. • Reduced delayed bed days by improving Home first: Discharge to Assess/ Trusted Assessment system-wide processes • Reduced long term bedded care through implementation of Home First/Discharge2Assess • Improved reported patient and carer outcomes/ experience • Reduce excess bed days across the system • Reduce acute readmissions with same condition (trajectory to be determined)

Promoting Independence (Equipment)	Outcomes
The Promoting Independence Scheme will comprise of a number of different services all aimed at supporting people to remain independent for longer by providing a structured and integrated community service for the people of the Isle of Wight. The Scheme will comprise of the following services: • Community Equipment Service • Wheelchairs Service • Independent Living Centre and User Led Organisation • Assistive Technology • Disabled Facility This BCF Scheme will incorporate the iBCF TEC Scheme which covers a number of different areas including: • Transformation of Wightcare Service • Cultural change (INTERNAL) • Culture Change (External) • Investment in additional equipment • Technology Training • Technology enabled care • Secondment opportunity for suitably qualified and experienced person with a background in rolling out Tec The iBCF proposal is focused on the use of assistive technology to meet specific needs of individuals. It is anticipated that this will enable faster discharge from hospital with less traditional care being put in place at the point of discharge. Ultimately some people may be able to return home without needing a care package and with assistive technology providing the support assessed as being required. The greater use of assistive technology should help providers to streamline their business models and better distribute their workforce.	• Building Individual & Community resilience by forming part of a holistic approach to supporting people to remain independent at home • Developing, Regaining and Sustaining Independence by providing resources and equipment to enable people to develop their personal resilience and build confidence • Living as Independently as Possible by providing help and support to those who need that help and support to remain independent at home • Earlier discharge form hospital • Ability to for a person to return home to convalesce with 24/7 support where the only other alternative may have been short stay nursing/residential placement
Rehabilitation, Reablement & Recovery	Outcomes
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 and simplifying pathways. **Specific Actions 2017/19:** • Procure new Community Rehabilitation beds • Mobilise new Rehabilitation Service • Enable implementation of iBCF Reablement Scheme	• Prevention of unnecessary care placements • Supporting people to live independently for longer. • Increase in proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. • Enhanced domiciliary care services with ability to undertake reablement

• Integrate Rehabilitation Service with Reablement Service This BCF Scheme will incorporate the iBCF Proposal for a Specialised Homebased Reablement Team which will be developed to ensure that people with complex reablement needs can receive a service which is currently not available. The Team will include Occupational Therapists, Physiotherapists and support workers who will focus on the needs of people who need double-handed carer support and also those who are in Reablement beds in the Adelaide and Gouldings. People will be able to remain in their own home longer without the need for costly domiciliary care packages. By using assistive technology as part of the main social care offer we will promote independence and maintain independence for those we serve for longer. • Promotes independence • Helps people to maintain their independence Ability to for a person to return home to convalesce with 24/7 support where the only other alternative may have been short stay nursing/residential placement	The iBCF Proposal for a Specialised Homebased Reablement Team would expect the following outcomes: • Increased throughput of people in in Reablement beds with decreased lengths of stay • Increase in the number of people with complex needs who can be supported by domiciliary care, if a face-to-face care package is required • Decrease in the number of people requiring a face-to-face care package because they can be supported by Technology Enhanced Care (TEC)
Integrated Mental Health Provision	Outcomes
An integrated primary, secondary health, social care and third sector mental health system built around need of individuals. 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: • Review and reconfiguration of mental health reablement / rehabilitation pathway (Woodlands). • Review of Mental Health Day Service Provision. • Service specifications with recovery based outcomes developed through co-creation (health, social care and third sector)	• 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 able to easily 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.
Learning Disability Transforming Care Programme	Outcomes
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: • Co-create with people with a learning disability, their family, carers and other stakeholders both on the Island and across Hampshire, the 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	**Personalisation -** To promote and develop self-directed strengths based support and approaches to personalisation that reflect the individual's preferences and aspirations, balancing this with the need to ensure resources are used cost effectively. Building individual and family resilience, reducing the need for formal support. **Choice and Control –** To increase the choice and quality in the local market for health and social care services to

for individuals by supporting those in crisis via implementation on the Care Treatment Review process. o Review of current Isle of Wight respite provision o Build workforce to develop competent, confident, critical thinking staff • Review and develop current local accommodation and support provision to ensure it meets the current and projected future needs for people with a learning disability.	ensure people with a learning disability across the island have access to a diverse range of high quality options to choose from, that are local to where they live, enhance quality of life and represent good value for money. **Quality -** Improved quality of support provided for people with a learning disability and their families, in particular ensuring that services are continually improving on person centred planning, approaches to communication and are developed with the full involvement of the people being supported. **Information -** Improve information and advice available to people with a learning disability in order to empower them to make more informed choices about the options available to them. To improve the information available with regard to population and needs to ensure intelligent commissioning strategically co-created with people with a learning disability.
Employment Support	Outcomes
In February 2016 NHS England Published the Five Year Forward View for Mental Health. Integral to this strategy is the need for alignment of an Employment Support offering across the health and care system for: • People with mental health problems • People with a learning disability • People with physical disability • People with a combination of the above. Nationally and locally, the employment rate for adults with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population Deliverables for the BCF 17 /19 scheme through alignment of existing provision: • We will increase access to psychological therapies for people: living with common mental health problems, in order to support them to find or stay in work. • We will increase access to individual placement and support programmes for people: living with severe mental illness, living with a learning disability, living with physical disability in order to support them to find and or maintain employment.	• People with learning disability will receive timely access to individual placement and support programmes in order to facilitate them to maintain or find employment through IPS mode • People with physical disability will see an improvement in their quality of life through increased opportunities of access and or maintaining employment through IPS model • People with common mental health problems and or severe will receive timely access to psychological therapies to support them to find and or maintain employment • People with common and severe mental health problems will see an improvement in their quality of life through increased opportunities of access and or maintaining employment through IPS model, including living as independently as possible.

iBCF SCHEME DESCRIPTION	EXPECTED OUTCOMEs
ASC DELIVERING CARE CLOSE TO HOME	
It is recognised that that the current model of delivery for ASC is neither efficient nor cost effective: it does not lend itself to delivering person centred care and is resulting in a significant over reliance on residential and nursing care. To address this, there is a new strategy for Adult Social Care entitled Care Close to Home. This is predicated on 7 pillars: three core delivery pillars; and four enabling pillars. The Strategy represents a wholesale programme of reform and transformation. It is predicated on the vision, principles and priorities set out in My Life a Full Life and reflect the imperatives described in the Sustainability and Transformation Programme for Southampton, Hampshire, the Isle of Wight and Portsmouth. The four enabling pillars comprise the focus of this bid and comprise: a. competent, confident critical thinking staff; commissioning for value and impact; person centred professional practice and care; and partnerships and integration. Underpinning each of these four pillars are key work streams whose full implementation will secure more effective use of resources, a remodelling of practice, culture and systems and delivery of the community services element of My Life a Full Life. Underpinning this programme is a series of key work streams: • Direct Payment Delivery Redesign • PA Market Development to support direct payment recipients providing a flexible delivery model • Pre-Paid Cards Phase two – full implementation of the pre-paid card programme for DP recipients • Non Res Charging changes – Under take a two month public consultation to consider taking into account the Higher rate of disability benefits as prescribed in the Care Act 2014 • Home Support –Implement full Individual Pricing Model • Fully implement and embed Residential/Nursing Dynamic Purchasing System • Fully implement and embed Learning Disability Dynamic Purchasing System • Explore models around effective “off island” placements as a viable alternative • Implement a robust and transparent Resource Allocation System (RAS) • High Cost Reviews ensuring best use of resource whilst delivering person centred services • S117 Review • CHC review	• Create a robust and sustainable ASC system • Maximise best use of resources • Reduce costs where possible ensuring value for money • Create a diverse and robust market place • Underpin the Care Closer to Home Strategy • Reduce DTOC’s by creating a sustainable diverse marketplace, facilitating effective and swift discharges • Create a viable Personal Assistant (PA) marketplace to support direct payment recipients • Implement a system that supports self-funders to become empowered consumers using *adam* Life (Life co.)

SUPPORT FOR PROVIDERS	Outcomes
The purpose of this bid is to provide support to all market sectors. This scheme includes the following areas: • Commercial provider secondment opportunity • VCS secondment opportunity • Sector led Safeguarding training • Sector led specialist dementia training • Provision of an Independent Chair (and administrative/co-ordinator support) for the local associations • Health and Social Care Market Day • Grant funding to nominated provider to lead on programme of improvement across all market sectors • Analysis of CQC report and findings across all market sectors to identify themes and trends	• Improving quality across all market sectors • Increasing the learning and development offer available to providers • Increasing commissioning capacity and capability • Improving provider engagement • Building strong and sustainable relationships between commissioners and providers
VOLUNTARY & COMMUNITY SERVICES (PREVENTION AND EARLY INTERVENTION)	Outcomes
The Living Well project has 4 elements for maximum impact supporting: • Older people • People living with learning disability • People living with mental health conditions • Carers Element 1: Creation of a VCS Living Well team working across the hospital, as well as being based in the community through local VCS organisations and Integrated Locality Service. Element 2: Recruitment of a specialist Learning Disability Worker, working with Social Care to alleviate pressure on ASC, reduce use of residential care and where relevant support improved transfers of care between hospital and home. Element 3: Creation of a hospital based carers support service, and GP champion role, to complement community based services. Element 4: Creation of a VCS Brokerage Scheme, helping people live well independently. Collectively, the Living Well Project will reduce pressure on ASC and support the high impact change model to better manage transfers of care between hospital and home; specifically early discharge planning, joint assessment as part of an MDT, supporting Home first/discharge to assess, trusted assessment and enable choice as well as reduce/delay the need for residential care.	A Living Well project within the VCS that will: • Support a reduction in delayed transfers of care through contribution to the high impact change model • Create community capacity to divert demand for Adult Social Care, particularly those ineligible for statutory funding (42% of enquiries) • Support people to increase their ability to self-care, live well and retain their independence • Help to reduce/delay the need for emergency admissions and a move to residential care

Committee	**HEALTH AND WELLBEING BOARD**
Date	**29 JUNE 2017**
Title	**BETTER CARE FUND QUARTERLY REPORT Q4 2016/17**

RECOMMENDATION

1. That the Better Care Fund Quarterly Report which was submitted on the 31st May 2017 be noted by the Health and Wellbeing Board.

EXECUTIVE SUMMARY

2. This report follows a previous report to the Health and Wellbeing Board (HWB) in November 2016 and provides:
   (a) A summary of the BCF Quarterly Reports for Q4 2016-17, attached as Appendix 1;
   (b) A copy of the BCF Quarterly Report for Q4 2016-17, which was submitted on the 31st May 2017, approved prior to submission by HWB Chair's Action, attached as Appendix 2.

BACKGROUND

3. The Better Care Fund (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.

4. The BCF plan and aligned budget should be seen as an enabler to the My Life A Full Life Programme (MLAFL) rather than a separate planning process; the CCG and the LA are commissioning the services in an integrated way.

5. The National requirements for the BCF do have to be met.

6. On the Island, the value of the BCF for 2016/17 was agreed by the HWB in March 2016 as £30,621,000, and amended in the final plans submitted to HWB in June 2016, to £31,332,000.

7. The Joint Commissioning Board (JCB) oversees the entire BCF, including the financial, performance and risk aspects. The work within the BCF is reported to and accountable to the Health and Wellbeing Board.

8. The IOW CCG and IOW Council have not signed the BCF Section 75 for 2016/17, however BCF Section 256 agreements are being developed. Therefore, while a pooled budget is not in place, the CCG and Council have aligned budgets and are working in an integrated way.

9. A Better Care Advisor, Andrew Cozens, has been secured to work with the CCG and Council to develop the pooled fund for 2017-19.

BCF QUARTERLY REPORTING REQUIREMENTS

10. NHS England require that the CCG submit quarterly reports detailing financial activity and performance data relating to the Better Care Fund, providing assurance on the BCF National Conditions.

11. The Health and Wellbeing Board is asked to note the second and third BCF Quarterly Report, which were agreed by HWB Chairs action for submission on the 31st May 2017, attached as Appendix 2.

Better Care Fund Quarterly Report – Q4 2016/17

Clinical Commissioning Groups and Local Authorities are required to submit Quarterly Reports on Better Care Fund (BCF) performance.

The latest BCF Quarterly Report for Quarter 4 2016/17 (January to March 2017) was submitted to NHS England on the 31st May 2017. Due to the timing of this submission, the report was signed off on behalf of the Health and Wellbeing Board (HWB) under chair's action by Cllr. Clare Mosdell and Dr. Michele Legg. This document provides the content of the Quarterly Report spreadsheet which was submitted to NHS England in a readable and printable format.

Tab 2 BUDGET ARRANGEMENTS

BCF Funds are not being pooled in 2016/17 due to the shortfall in funding, however funds have been used in an aligned way. We have secured the services of a Better Care Advisor (Andrew Cozens) to help us move forward in developing pooled arrangements for 17/19.

Tab 3 NATIONAL CONDITIONS

Eight National Conditions are to be reported against:

i. Plans to be jointly agreed
ii. Maintain provision of social care services
iii. 7 Day Services
iv. Data Sharing
v. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans
vii. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care
viii. Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan

We can confirm that all of the national conditions are in place, as per the final BCF plan, except the **Protection of Adult Social Care Services**, and **7 day services**:

- **PROTECTION OF ADULT 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 i.e. the CCG's allocation for NHS Support to Social Care. As well as this, the CCG was in a position to provide an additional £3.1m (of which £2.1m was non-recurrent) to support the Local Authority's £3.1m gap in social care funding.
  Despite the very difficult position of the CCG in 2016/17, set out in the BCF Plan Case for Change, the CCG provided the Local Authority with £1m (in addition to the £3.573m allocation for support to social care) and £711k slippage from the 2015/16 BCF has been carried forward to support 2016/17. This therefore left a social care funding gap of £1.4m which had to be

addressed in order for the Council to remain within its allocated budget as agreed by members in February 2016. In 2016/17 the CCG has also provided £441k for the Care Act as required by NHS England.

At the Council's 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 would l be resolved and risks managed (see BCF Plan Narrative, page 26, Risk). We have secured the services of Better Care Advisors (Andrew Cozens and Richard Jeavons) to help us move forward in developing pooled arrangements for 17/18. Since January 2017, the £1.4M has appeared as a budget overspend in ASC. Because of a favourable 16/17 end of year overall position, the Council has recently been able to fund the £1.4M gap in totality – using underspends in other Council areas to do so. This funding has been to support adult social care in a variety of ways including: the provision of 7 day social work provision (e.g., in terms of facilitating discharge from hospital); the introduction of a new in-house domiciliary care service providing support to those people leaving hospital in need of two carer provision (as well as filling geographical gaps in independent domiciliary care coverage); and reviewing, in January 2017, 82 short term residential placements (funded in mainpart by systems resilience funding from the CCG) and making permanent plans for the people concerned (which has also resulted in a further increase in the numbers of elders permanently admitted to residential care in 16/17).

7 DAY SERVICES

i) Seven Day Services: This has commenced with the introduction of four priority standards which are being rolled out across the country. The Island has offered to be in the second cohort to implement these standards. Good Progress has been made although some 7 day services are still in development and will take a longer timeframe to be fully established. Services in place: 7 day a week reablement ; 7 day a week night sitting service in development; 7 day a week physio services; 7 day a week 'communications hub'; 7 day a week GP; 7 day a week Crisis Response service; District nurses; Wightcare; respite services; rehabilitation beds.

We will continue to review and evaluate the introduction of 7 day services in the hospital and community.

ii) Many necessary support services are in place 7 days a week. Others are requiring further development in line with the implementation of 7 day services across health and social care and will continue to be developed.

Tab 4 INCOME & EXPENDITURE

- The BCF Aligned Fund for 2016/17 is £31.332m, this is a 42% increase on 2015/16
- Financial Performance this Quarter, and for the year.

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total
Plan	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396
Forecast	£8,870,352	£7,209,311	£7,293,188	£7,541,794	£30,914,645
Actual*	£8,448,544	£6,702,206	£6,915,998	£8,807,099	£30,873,847

The majority of the difference between the forecasted and actual annual totals with the pooled fund relate to savings directed by the NHS Turnaround Board.

Tab 5 SUPPORTING METRICS

- **NON-ELECTIVE ADMISSIONS (NEAs)**
  - No improvement in performance.
    Non Elective admissions for Quarter 4 finished 5% above plan for the year (equating to 600 spells) and 6% above the stretch target. This was driven by significantly higher admission levels than expected from December onwards.
- **PROGRESS AGAINST DELAYED TRANSFERS OF CARE METRIC**
  - No improvement in performance.
    Due to previous concerns in DTOC data accuracy, in Q4 2016-17 data cleansing and analysis has been undertaken, including forensic analysis at patient level, to identify areas within the system requiring improvement and to jointly agree DTOC numbers and attribution across the system.
    We now have accurate DTOC numbers for April 2017, which were jointly agreed across the system in advance of submission.
    A weekly system-wide group is now in place and will continue as part of the significant plans to manage DTOCs.

- **PROGRESS AGAINST PERMANENT ADMISSIONS TO RESIDENTIAL CARE METRIC**
  - No improvement in performance.
    Work across the system has been continued 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. It is recognised that there is a lack of suitable alternatives to residential care and this is a major factor in development work for the council and partners. During 2016/17 there was focused activity to reduce the number of short term placements in residential and nursing care (in number and duration) this has had an adverse impact on this measure and has resulted in the increased numbers of permanent admissions against the planned numbers for 2016/17 and now more accurately reflects the current reliance on residential care.

- **PROGRESS AGAINST REABLEMENT METRIC**
  - On track to meet target.
    IOW Council performance in this area remains consistently and significantly above the national average (82.7% for 2015/16) with IOW provisional end of year performance at 91.0%. However, it is recognised that overall only 2% of people access the service, therefore investment in new teams to increase this through put is in place for 2017/18.

- **PROGRESS AGAINST LOCAL METRIC - OCCUPATIONAL THERAPY (OT) WAITING TIMES:**

  - On track to meet target.
    Waiting times continued to increase in the quarter, up to 16.4 weeks, however this is still below the final trajectory for the year of 25 weeks.

- **PROGRESS AGAINST ADULT SOCIAL CARE OUTCOMES FRAMEWORK (ASCOF) OUTCOME 3A –** Overall satisfaction of people who use services with their care and support –
  - On track to meet target.
    The target set for 2016/17 was to maintain the already high level of satisfaction with adult social care services on the Isle of Wight. Early indications are the that the survey results for overall satisfaction for adult social care for 2016/17 (provisional non validated) outturn is 73%. Comparison for other Local Authorities is not yet available for 2016/17 but the national average for 2015/16 was 64.4%.

Tab 6 YEAR END FEEDBACK

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Joint working between health and social care in our locality continues to strengthen and improve, supported by delivery of the BCF and iBCF. We have recently appointed a joint CCG/ASC Assistant Director for Integrated Commissioning who will oversee the formal integration of all commissioning for community health services and ASC services.
2. Our BCF schemes were implemented as planned in 2016/17	Agree	Elements of all BCF Schemes were implemented as planned. The elements that were not implemented in full pertained to delays in providing 7 day provision. This has been implemented since

		December 2016 – with the DASS receiving confirmation of discharges facilitated over the weekend.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Agree	Health and social care in our locality continues to be further integrated in the development of the My Life a Full Life model for a sustainable health and care system for the Isle of Wight, supported by the Better Care Fund. The first (of 3) Integrated Locality Service went live on the 27 February 2017 with the second going live at the end of June 2017 and the final at the end of August 2017.
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Agree	Schemes within Integrated Mental Health Services, Locality/ Community Model, Rehabilitation, Reablement and Recovery, and Carers Schemes have all contributed positively to managing the levels of Non-Elective Admissions. Increased usage of 111, Crisis Team, MDT, Falls Clinic, Isle Help, Pharmacy First, Care Navigators and Local Area Coordinators have all contributed to diverting people away from Emergency Services. Data submitted to the New Care Models Team detailing levels of Non-Elective admissions revealed significant reductions in non-elective admissions against 'do nothing' trajectories.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	A November 2016 Peer Review, and the February 2017 visit by the Emergency Care Improvement Programme revealed that there was little confidence in the accuracy of the DTOC data submitted. This has been rectified and the April 2017 data represents the first month where joint sign off processes have been underpinned by agreed analysis at patient level. This reveals a significant improvement in performance. Moreover, in the past six months, ASC has implemented wholesale change in its internal processes to minimise delay in the provision of support to patients leaving hospital. This has included the establishment of a new domiciliary support service, changes to the use of ASC residential resources, increased use of DTA processes and improved assessment processes. This has been in addition to the operational implementation of Integrated Locality Services (see above), extension of the Rehabilitation, Reablement and Recovery, and Carers BCF Schemes – all of which have contributed positively to managing the levels of

		Delayed Transfers of Care.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	While IOW provisional end of year performance is 91.0%, it is recognised that overall only 2% of elders leaving hospital access the service. Moving forward, some of the iBCF funds are being used to invest in new OT led re-ablement home care teams and the CCG is increasing its investment in nursing home led rehabilitation. This will increase the % of elders accessing rehabilitation and re-ablement in 2017/18.
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Disagree	In January 2017, there was focused activity in ASC to reduce the number of short term placements in residential and nursing care (in number and duration) this has had an adverse impact on this measure and has resulted in the increased numbers of permanent admissions against the planned numbers for 2016/17 and now more accurately reflects the current reliance on residential care. The great majority of these short term placements arose from the use of systems resilience funding put into place when the hospital was experiencing acute pressures (as measured by OPEL). That is why there has been investment in creating additional capacity based in the community – and thus has impacted positively on performance in April and May 2017.

RESPONSES: Strongly Agree – Agree – Neither – Disagree – Strongly Disagree

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	Integrated Locality Service has been successfully implemented in the Island's North East Locality. Lessons learnt from this	3. Collaborative working relationships

	initial roll out can be used ensure the ILS is a success in Central & West and South localities.	
Success 2	Local Area Coordinators (LACs) are now in post, recruited by their community, with 9 LACs currently working across 3 Island localities within populations of around 10-12,000 people. Care Navigators are also in post, with 9 Care Navigators providing full island coverage, with 82% of those supported reporting improved wellbeing scores.	6. Delivering services across interfaces
Success 3	Multi-disciplined Crisis Response Team continues to deliver, wrapping 72 hrs of care around elderly and frail patients in crisis to enable them to stay in their home environment, with an average of only 11% of those seen by the Crisis Team being admitted to hospital.	3. Collaborative working relationships

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Our biggest challenge is that the BCF Section 75 will not be signed as the CCG cannot offer the additional level of support to social care to bridge their funding gap, however, this is not stopping us from continuing to implement our BCF Plans and we are working with an aligned budget. We have secured the services of a Better Care Advisor (Andrew Cozens) to help us move forward in developing pooled arrangements for 17/18.	9. Sharing risks and benefits
Challenge 2	NHSI placed the IoW NHS Trust in SM as a result of a highly critical inspection by CQC in November 2016. This means that the Trust is focussed on the development and implementation of an Improvement Plan in	2. Shared leadership and governance

	order to ensure that all patients are safe.	
Challenge 3		Please select response category

Tab 7 ADDITONAL MEASURES - NEW INTEGRATION METRICS

- **INTEGRATED DIGITAL RECORDS** – NHS Number being used as primary identifier in all settings. The digital sharing of relevant service user information is in place via Open APIs some settings. A Digital Integrated Care Record Pilot is being scoped.
- **PERSONAL HEALTH BUDGETS –** We currently have 40 personal health budgets in place, of which 100% are in receipt of NHS Continuing Healthcare.
- **USE AND PREVALENCE OF MULTI-DISCIPLINARY/INTEGRATED CARE TEAMS -** Integrated care teams (any team comprising both health and social care staff) are in place and operating in both the acute and non-acute setting through some parts of the Health and Wellbeing Board area.

Tab 8 NARRATIVE

HIGHLIGHTS & SUCCESSES

- Integrated Locality Service - During this quarter agreement was reached that the Integrated Locality Service (ILS) would be rolled out in North East locality in the first instance from the end of February 2017, as there is already a working base for colocation. This has provided the opportunity to take the lessons learnt from the initial roll-out to ensure the success of future roll-outs in Central & West and South localities. Since the February 2017 introduction of the ILS, we have undertaken detailed assessment work on patients with the most complex needs and have been providing assertive outreach (although it is too early to identify any correlation with reduced hospital attendance at A&E or DTOC reductions). .
- LD Services – The LGA undertook a peer review of learning disabilities in late January 2017 and their report was received on the 28 February 2017. The report provides for a comprehensive programme for reform whereby we need to: develop alternative community options to residential care (including supported living); promote community inclusion options including employment opportunities; and embed more personalized approaches. A comprehensive action plan has been developed and progress made in: raising the profile and influence of the Learning Disability Partnership; addressing the dental and primary health care needs of people with LD living in Council run care homes; proposals for extra care housing and supported living; early implementation of the HOLD scheme to support owner occupation amongst people with LD. In addition, a bid for £475k in Housing Technology funding has been successful and will be used to support increased take up in assistive technology, safeguard some housing units and

develop home ownership options (including shared equity) for people with a learning disability in conjunction with local housing trust.

- Prevention – At the end of Q3 6 Local Area Coordinators are working alongside 487 people. Agreement was reached in Q3 to recruit further 3 Local Area Coordinators as per Better Care Fund schedule, to cover Newport and surrounding areas to start 9th January 2017. An expression of interest has been accepted to work as one of 9 areas nationally with the New Care Models Team Empowering People and Communities work stream.
- DTOC – a February visit by the Emergency care and Improvement Programme revealed key concerns around patient streaming, patient flow and delayed transfers of care. Significant progress has been made in clarifying the data and reporting DTOCs accurately.(April 2017 was the first month where the data submitted was signed off jointly and reveals significant change in attribution and improvement in performance from previous months.

CHALLENGES & CONCERNS

Our biggest challenge is that the BCF Section 75 for 16/17 will not be signed as the CCG cannot offer the additional level of support to social care to bridge their funding gap, however, this is not stopping us from continuing to implement our BCF Plans and we are working with an aligned budget.

We have secured the services of Better Care Advisors (Andrew Cozens and Richard Jeavons) to help us move forward in developing pooled arrangements for 17/18.

Further detail is outlined under Tab 3 - National Conditions 2) Maintain Provision of Social Care Services.

Narrative

Selected Health and Well Being Board:	Isle of Wight

Remaining Characters	29,418

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

HIGHLIGHTS & SUCCESSES

• Integrated Locality Service - During this quarter agreement was reached that the Integrated Locality Service (ILS) would be rolled out in North East locality in the first instance from the end of February 2017, as there is already a working base for colocation. This has provided the opportunity to take the lessons learnt from the initial roll-out to ensure the success of future roll-outs in Central & West and South localities. Since the February 2017 introduction of the ILS, we have undertaken detailed assessment work on patients with the most complex needs and have been providing assertive outreach (although it is too early to identify any correlation with reduced hospital attendance at A&E or DTOC reductions). .

• LD Services – The LGA undertook a peer review of learning disabilities in late January 2017 and their report was received on the 28 February 2017. The report provides for a comprehensive programme for reform whereby we need to: develop alternative community options to residential care (including supported living); promote community inclusion options including employment opportunities; and embed more personalized approaches. A comprehensive action plan has been developed and progress made in: raising the profile and influence of the Learning Disability Partnership; addressing the dental and primary health care needs of people with LD living in Council run care homes; proposals for extra care housing and supported living; early implementation of the HOLD scheme to support owner occupation amongst people with LD. In addition, a bid for £475k in Housing Technology funding has been successful and will be used to support increased take up in assistive technology, safeguard some housing units and develop home ownership options (including shared equity) for people with a learning disability in conjunction with local housing trust.

• Prevention – At the end of Q3 6 Local Area Coordinators are working alongside 487 people. Agreement was reached in Q3 to recruit further 3 Local Area Coordinators as per Better Care Fund schedule, to cover Newport and surrounding areas to start 9th January 2017. An expression of interest has been accepted to work as one of 9 areas nationally with the New Care Models Team Empowering People and Communities work stream.

• DTOC – a February visit by the Emergency care and Improvement Programme revealed key concerns around patient streaming, patient flow and delayed transfers of care. Significant progress has been made in clarifying the data and reporting DTOCs accurately.(April 2017 was the first month where the data submitted was signed off jointly and reveals significant change in attribution and improvement in performance from previous months.

CHALLENGES & CONCERNS

Our biggest challenge is that the BCF Section 75 for 16/17 will not be signed as the CCG cannot offer the additional level of support to social care to bridge their funding gap, however, this is not stopping us from continuing to implement our BCF Plans and we are working with an aligned budget.

We have secured the services of Better Care Advisors (Andrew Cozens and Richard Jeavons) to help us move forward in developing pooled arrangements for 17/18.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 31st May 2017.

The BCF Q4 Data Collection

This Excel data collection template for Q4 2016-17 focuses on budget arrangements, the national conditions, non-elective admissions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.
6) Year End Feedback - a series of questions to gather feedback on impact of the BCF in 2016-17

7) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
8) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

If it had not been previously stated that the funds had been pooled can you now confirm that they have now?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income & Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1 to Q4 2016-17
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1 to Q4 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

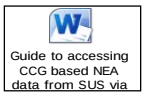
There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the six metrics for Q4 2016-17
Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a

Guidance on accessing CCG based NEA numerator data from SUS via the 'Activity and Planning Report' has been circulated in tandem with this report in order to enable areas to perform their own in year monitoring of NEA data. This guidance document can also be accessed via the embeded object below.



NEA denominator population (All ages) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Non-Elective Admissions per 100,000 population (All ages) population projections are based on a calendar year.

Delayed Transfers Of Care numerator data for actual performance has been sourced from the monthly DTOC return found here:
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

DTOC denominator population (18+) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year.

Actual and baseline data on Re-ablement and Residential Admissions can be sourced from the annual ASCOF return found here:
http://content.digital.nhs.uk/searchcatalogue?productid=22085&q=ascof

Please note these are annual measures and the latest data for 2015/16 data was published 05/10/2016. Plan data for these metrics in 2016/17 were submitted by HWBs within Submission 4 planning returns and final figures are displayed within the 'Remaining Metrics Enquiry' tab of the Submission 4 report.

6) Year End Feedback

This tab provides an opportunity to provide give additional feedback on your progress in delivering the BCF in 2016-17 through a number of survey questions. The purpose of this survey is to provide an opportunity for local areas to consider the impact of the first year of the BCF and to feed this back to the national team review the overall impact across the country. There are a total of 9 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 10 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2016/17
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)

Part 2 - Successes and Challenges

There are a total of 2 questions in this section, for which up to three responses are possible. The questions are:

8. What have been your greatest successes in delivering your BCF plan for 2016-17?
9. What have been your greatest challenges in delivering your BCF plan for 2016-17?

These are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperatability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change

Other

7) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 / Q3 2016-17). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.
For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

8) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q4 16/17.
A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Better Care Fund Template Q4 2016/17

Data collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S.75 pooled budget, by Q4? If no, date provided?
No

3. National Conditions

	1) Plans to be jointly agreed	2) Maintain provision of social care services	3 i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3 ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken?	4 i) Is the NHS Number being used as the consistent identifier for health and social care services?	4 ii) Are you pursuing Open APIs (ie system that speak to each other)?	4 iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4 iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	7) Agreement to invest in NHS commissioned out-of-hospital services	8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
	Commentary	Yes				
	Commentary					

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	NEA	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	DTOC	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Local performance metric	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	If no metric, please specify		
Patient experience metric	Yes	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Admissions to residential care	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Reablement	Yes	Yes

6. Year End Feedback

Statement:	Response:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Yes
2. Our BCF schemes were implemented as planned in 2016/17	Yes
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Yes
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Yes
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Yes
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Yes
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Yes

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response and category
Success 1	Yes
Success 2	Yes
Success 3	Yes

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response and category
Challenge 1	Yes
Challenge 2	Yes
Challenge 3	

7. Additional Measures

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

8. Narrative

Brief Narrative	Yes

Cover

Q4 2016/17

Health and Well Being Board	**Isle of Wight**
completed by:	Catherine Budden
E-Mail:	catherine.budden@iow.nhs.uk
Contact Number:	01983 552346
Who has signed off the report on behalf of the Health and Well Being Board:	Dr Michele Legg and Cllr Clare Mosdell

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	0
3. National Conditions	24
4. I&E	19
5. Supporting Metrics	13
6. Year End Feedback	12
7. Additional Measures	67
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Isle of Wight

Have the funds been pooled via a s.75 pooled budget?	No
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	No
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Isle of Wight

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	No	No	No	No	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 i.e. the CCG's allocation for NHS Support to Social Care. As well as this, the CCG was in a position to provide an additional £3.1m (of which £2.1m was non-recurrent) to support the Local Authority's £3.1m gap in social care funding. Despite the very difficult position of the CCG in 2016/17, set out in the BCF Plan Case for Change, the CCG provided the Local Authority with £1m (in addition to the £3.573m allocation for support to social care) and £711k slippage from the 2015/16 BCF has been carried forward to support 2016/17. This therefore left a social care funding gap of £1.4m which had to be addressed in order for the Council to remain within its allocated budget as agreed by members in February 2016. In 2016/17 the CCG has also provided £441k for the Care Act as required by NHS England. At the Council's 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 would l be resolved and risks managed (see BCF Plan Narrative, page 26, Risk). We have secured the services of Better Care Advisors (Andrew Cozens and Richard Jeavons) to help us move forward in developing pooled arrangements for 17/18. Since January 2017, the £1.4M has appeared as a budget overspend in ASC. Because of a favourable 16/17 end of year overall position, the Council has recently been able to fund the £1.4M gap in totality – using underspends in other Council areas to do so. This funding has been to support adult social care in a variety of ways including: the provision of 7 day social work provision (e.g., in terms of facilitating discharge from hospital); the introduction of a new in-house domiciliary care service providing support to those people leaving hospital in need of two carer provision (as well as filling geographical gaps in independent domiciliary care coverage); and reviewing, in January 2017, 82 short term residential placements (funded in mainpart by systems resilience funding from the CCG) and making permanent plans for the people concerned (which has also resulted in a further increase in the numbers of elders permanently admitted to residential care in 16/17).
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - In Progress	No - In Progress	No - In Progress	No	This has commenced with the introduction of four priority standards which are being rolled out across the country. The Island has offered to be in the second cohort to implement these standards. Good Progress has been made although some 7 day services are still in development and will take a longer timeframe to be fully established. Services in place: 7 day a week reablement ; 7 day a week night sitting service in development; 7 day a week physio services; 7 day a week 'communications hub'; 7 day a week GP; 7 day a week Crisis Response service; District nurses; Wightcare; respite services; rehabilitation beds. We will continue to review and evaluate the introduction of 7 day services in the hospital and community.
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	No - In Progress	No - In Progress	No - In Progress	No	Many necessary support services are in place 7 days a week. Others are requiring further development in line with the implementation of 7 day services across health and social care and will continue to be developed.
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes	Yes	

ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	Yes	
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	Yes	

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2016-17.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that,
Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may
Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.
This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Isle of Wight

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396	£31,332,396
	Forecast	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396	
	Actual*	£7,833,099	£7,833,099	£7,833,099			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396	£31,332,396
	Forecast	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396	
	Actual*	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396	£31,332,396
	Forecast	£8,870,352	£7,209,311	£7,293,188	£7,541,794	£30,914,645	
	Actual*	£8,448,544	£6,702,206	£6,915,998			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£7,833,099	£7,833,099	£7,833,099	£7,833,099	£31,332,396	£31,332,396
	Forecast	£8,870,352	£7,209,311	£7,293,188	£7,541,794	£30,914,645	
	Actual*	£8,448,544	£6,702,206	£6,915,998	£8,807,099	£30,873,847	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The majority of the difference between the forecasted and actual annual totals with the pooled fund relate to savings directed by the NHS Turnaround Board.

Commentary on progress against financial plan:	The majority of the final underspend against the financial plan relates to savings directed by the NHS Turnaround Boar

Footnotes:
*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board: Isle of Wight

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Performance finished 5% above plan for the year (equating to 600 spells) and 6% above the stretch target. This was driven by significantly higher admission levels than expected from December onwards.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Due to previous concerns in DTOC data accuracy, in Q4 2016-17 data cleansing and analysis has been undertaken, including forensic analysis at patient level, to identify areas within the system requiring improvement and to jointly agree DTOC numbers and attribution across the system. We now have accurate DTOC numbers for April 2017, which were jointly agreed across the system in

Local performance metric as described in your approved BCF plan	Reduction in Community Occupational Therapy waiting time in weeks to First Assessment (95% Percentile). BCF and other Schemes
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Waiting times continued to increase in the quarter, up to 16.4 weeks, however this is still below the final trajectory for the year of 25 weeks.

Local defined patient experience metric as described in your approved BCF plan	Overall satisfaction of people who use services with their care and support (ASCOF 3a)
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	The target set for 2016/17 was to maintain the already high level of satisfaction with adult social care services on the Isle of Wight. Early indications are the that the survey results for overall satisfaction for adult social care for 2016/17 (provisional non validated) outturn is 73%. Comparison for other Local Authorities is not yet available for 2016/17 but the national average for 2015/16 was 64.4%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)

Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Work across the system has been continued 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. It is recognised that there is a lack of suitable alternatives to residential care and this is a major factor in development work for the council and partners. During 2016/17 there was focused activity to reduce the number of short term placements in residential and nursing care (in number and duration) this has had an adverse impact on this measure and has resulted in the increased numbers of permanent admissions against the planned numbers for 2016/17 and now more accurately reflects the current reliance on residential care.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	IOW Council performance in this area remains consistently and significantly above the national average (82.7% for 2015/16) with IOW provisional end of year performance at 91.0%. However, it is recognised that overall only 2% of people access the service, therefore investment in new teams to increase this through put is in place for 2017/18.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board: Isle of Wight

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Joint working between health and social care in our locality continues to strengthen and improve, supported by delivery of the BCF and iBCF. We have recently appointed a joint CCG/ASC Assistant Director for Integrated Commissioning who will oversee the formal integration of all commissioning for community health services and ASC services.
2. Our BCF schemes were implemented as planned in 2016/17	Agree	Elements of all BCF Schemes were implemented as planned. The elements that were not implemented in full pertained to delays in providing 7 day provision. This has been implemented since December 2016 – with the DASS receiving confirmation of discharges facilitated over the weekend.
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Agree	Health and social care in our locality continues to be further integrated in the development of the My Life a Full Life model for a sustainable health and care system for the Isle of Wight, supported by the Better Care Fund. The first (of 3) Integrated Locality Service went live on the 27 February 2017 with the second going live at the end of June 2017 and the final at the end of August 2017.
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Agree	Schemes within Integrated Mental Health Services, Locality/ Community Model, Rehabilitation, Reablement and Recovery, and Carers Schemes have all contributed positively to managing the levels of Non-Elective Admissions. Increased usage of 111, Crisis Team, MDT, Falls Clinic, Isle Help, Pharmacy First, Care Navigators and Local Area Coordinators have all contributed to diverting people away from Emergency Services. Data submitted to the New Care Models Team detailing levels of Non-Elective admissions revealed significant reductions in non-elective admissions against 'do nothing' trajectories.
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	A November 2016 Peer Review, and the February 2017 visit by the Emergency Care Improvement Programme revealed that there was little confidence in the accuracy of the DTOC data submitted. This has been rectified and the April 2017 data represents the first month where joint sign off processes have been underpinned by agreed analysis at patient level. This reveals a significant improvement in performance. Moreover, in the past six months, ASC has implemented wholesale change in its internal processes to minimise delay in the provision of support to patients leaving hospital. This has included the establishment of a new domiciliary support service, changes to the use of ASC residential resources, increased use of DTA processes and improved assessment processes. This has been in addition to the operational implementation of Integrated Locality Services (see above), extension of the Rehabilitation, Reablement and Recovery, and Carers BCF Schemes – all of which have contributed positively to managing the levels of Delayed Transfers of Care.
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	While IOW provisional end of year performance is 91.0%, it is recognised that overall only 2% of elders leaving hospital access the service. Moving forward, some of the iBCF funds are being used to invest in new OT led re-ablement home care teams and the CCG is increasing its investment in nursing home led rehabilitation. This will increase the % of elders accessing rehabilitation and re-ablement in 2017/18.

7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Disagree	In January 2017, there was focused activity in ASC to reduce the number of short term placements in residential and nursing care (in number and duration) this has had an adverse impact on this measure and has resulted in the increased numbers of permanent admissions against the planned numbers for 2016/17 and now more accurately reflects the current reliance on residential care. The great majority of these short term placements arose from the use of systems resilience funding put into place when the hospital was experiencing acute pressures (as measured by OPEL). That is why there has been investment in creating additional capacity based in the community – and thus has impacted positively on performance in April and May 2017.

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	Integrated Locality Service has been successfullly implemented in the Island's North East Locality. Lessons learnt from this initial roll out can be used ensure the ILS is a success in Central & West and South localities.	3. Collaborative working relationships
Success 2	Local Area Coordinators (LACs) are now in post, recruited by their community, with 9 LACs currently working across 3 Island localities within populations of around 10-12,000 people. Care Navigators are also in post, with 9 Care Navigators providing full island coverage, with 82% of those supported reporting improved wellbeing scores.	6. Delivering services across interfaces
Success 3	Multi-disciplined Crisis Reponse Team continues to deliver, wrapping 72 hrs of care around elderly and frail patients in crisis to enable them to stay in their home environment, with an average of only 11% of those seen by the Crisis Team being admitted to hospital.	3. Collaborative working relationships

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Our biggest challenge is that the BCF Section 75 will not be signed as the CCG cannot offer the additional level of support to social care to bridge their funding gap, however, this is not stopping us from continuing to implement our BCF Plans and we are working with an aligned budget. We have secured the services of a Better Care Advisor (Andrew Cozens) to help us move forward in developing pooled arrangements for 17/18.	9. Sharing risks and benefits
Challenge 2	NHSI placed the IoW NHS Trust in SM as a result of a highly critical inspection by CQC in November 2016. This means that the Trust is focussed on the development and implementation of an Improvement Plan in order to ensure that all patients are safe.	2. Shared leadership and governance
Challenge 3		Please select response category

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change

Other

Additional Measures

Selected Health and Well Being Board: Isle of Wight

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	yes	yes	yes	yes	yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	yes	yes	yes	yes	yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Shared via Open API	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	40
Rate per 100,000 population	28

Number of new PHBs put in place during the quarter	2
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2017)	140,451

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:
Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.