Title	**Narrative Plan for Better Care Fund 2017-19**		
Date	24th August 2017	**Version**	2.6
Notes	The BCF plan is to be submitted to NHSE 11th September 2017 after consideration and subject to agreement of the Health and Wellbeing Board (07 September 2017) The iBCF funds are within the remit of the Council (Section 151 officer) sign-off and are available to the wider health and care system and have Nationally directed conditions attached along with Conditions set at a local level. The BCF early draft submission includes a range of schemes to be distilled to those which need fuller business cases produced which will go through to the BCF Working Group for sign-off with the agreement of the BCF Board (Part 2 SCPB)		

Integration and Better Care Fund

Narrative Plan 2017/19 v2.6

Better Care Support Team

Area	Torbay
Constituent Health and Wellbeing Boards	Torbay
Constituent CCGs	South Devon and Torbay CCG

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Introduction / Foreword

The Better Care Fund brings together health and social care funding, with additional social care money identified in Spring 2017. Organisations across Torbay, and wider Devon, are in agreement in terms of having a sustainable health and care system which will improve the health and wellbeing of the population, of which the Better Care Fund is a mechanism to assist in achieving this aim.

As such, this narrative plan, together with the planning template, have been created by system partners including Devon Partnership NHS Trust, agreed by

- Torbay Council
- NHS South Devon and Torbay Clinical Commissioning Group
- Torbay and South Devon NHS Foundation Trust

and then formally approved by the Torbay Health & Wellbeing Board

There are specific conditions in terms of use of funding and the metrics by which the plan will be measured, with a particular focus on reducing the numbers of delayed transfers of care (DTOC). There are also conditions in terms of working together across organisational boundaries and in agreeing proposals for the use of the funding, which have been addressed by creating a collaborative and co-designed plan with associated schemes.

Beyond this, there has been local agreement on the areas where funding should be allocated, however each should relate to improving performance in one or more of the following four areas:

1. Delayed transfers of care
2. Non-elective admissions (General and Acute)
3. Admissions to residential and care homes
4. Effectiveness of reablement

The plan has been developed in line with the guidance which has been provided outlining how the work should assist in the following areas:

- Prevention of admissions
- Proactive liaison with care homes
- Personalised care plan and access services
- Care of individuals living with Dementia

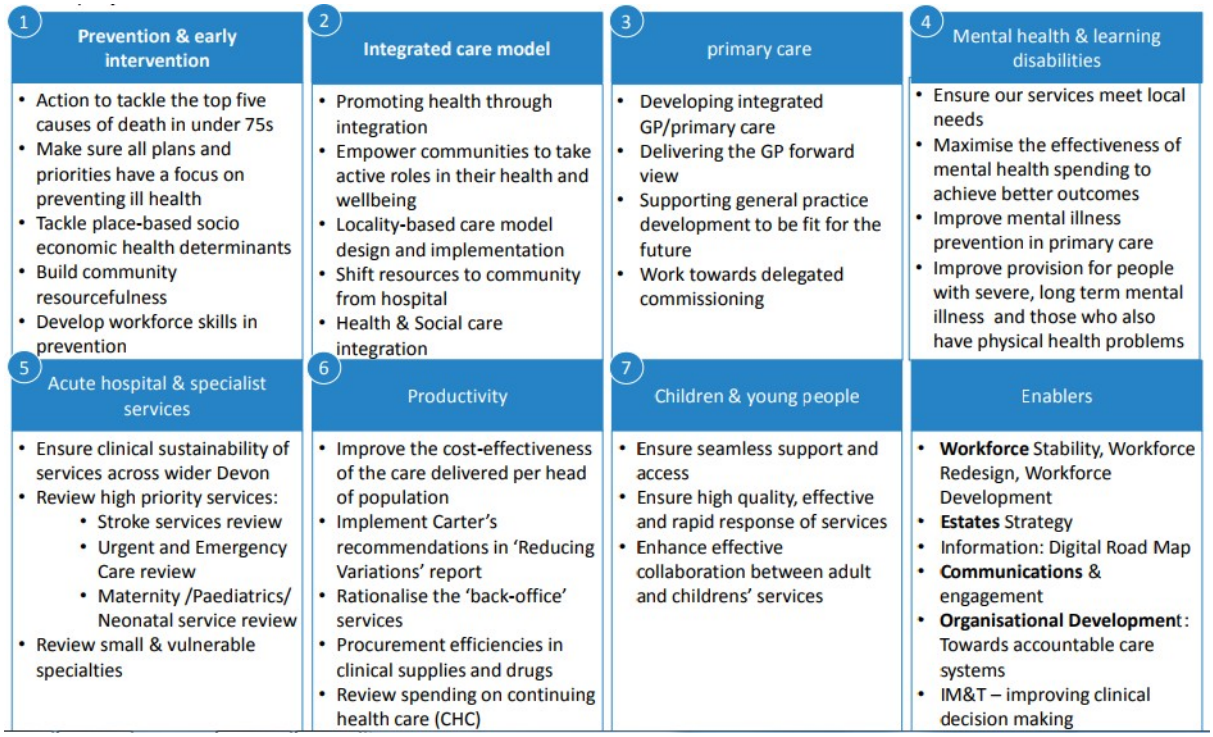
For Torbay, the additional funding announced in the spring budget 2017 amounts to:

2017/18	**2018/19**	**2019/20**
£3,815,560	£2,366,904	£1,171,936

The specific conditions, which have been met as part of the planning process, are as follows:

- Plans to be jointly agreed;
- NHS contribution to adult social care is maintained in line with inflation;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and
- Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings)

This plan will also support local system drivers as per the priorities and enablers which have been identified within the Sustainability and Transformation Plan (STP).



Schemes identified within the plan will focus on improving:

- Our population's health & wellbeing
- The experience of care
- The cost effectiveness per head of population

What is the local vision and approach for health and social care integration?

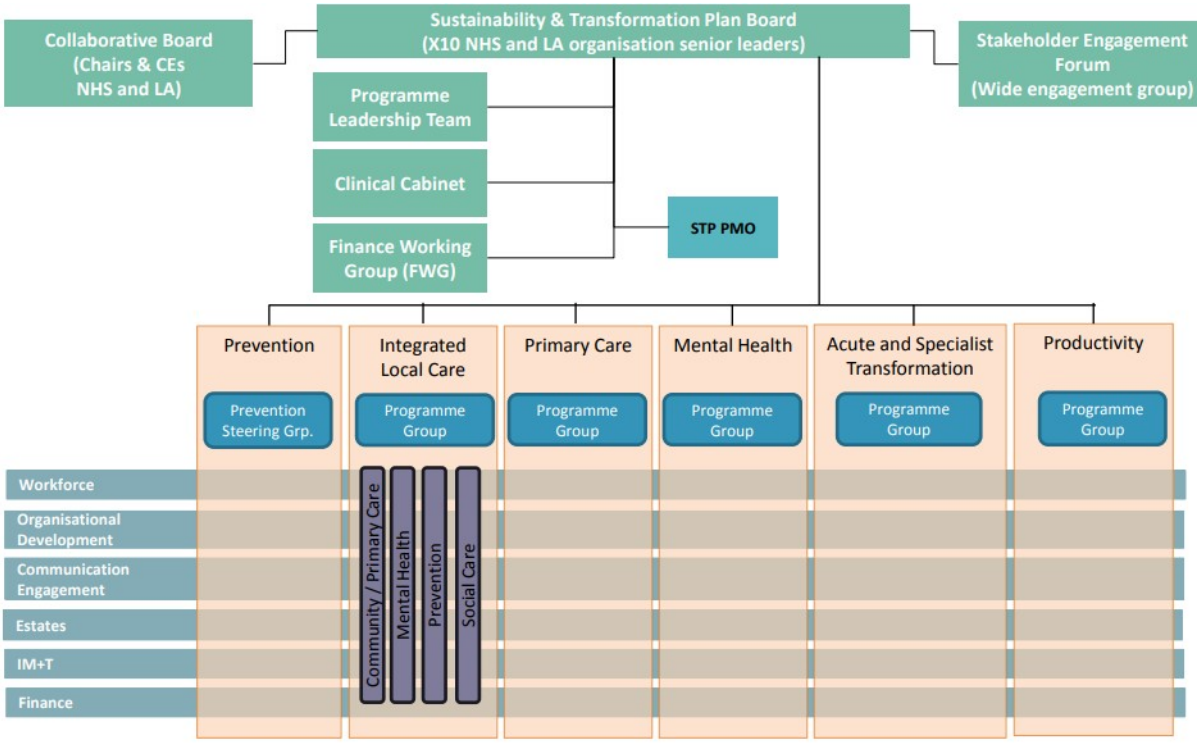
Within Torbay, there has been ongoing work to implement the New Care Model, as illustrated above. This model provides a fully integrated health and social care system involving joined-up services which deliver education and advice about how to maintain independence and stay well, with mental health and wellbeing as high a priority as physical health and wellbeing. It also aims to take a person-centred approach and build wider support around people, through making the best use of what is already available to them at home and in the community.

Our vision is to have excellent, joined up care for all. Torbay already has a model of integrated health and social care teams built around geographical clusters and primary care practices, with a single point of access. These teams provide functions to enable:

- Proactive identification of people at risk and admission to hospital or inappropriate care settings.
- Integrated assessment and personalised support planning for people with long-term conditions and/or complex care needs.
- Urgent reactive care to people in crisis to avoid immediate risk of admission.

In line with the recommendations of the Five Year Forward View Next Steps (March 2017), development Accountable Care Delivery Systems (ACDS) is in progress, which bring together commissioners and providers to deliver outcomes for the population within a budget with clear system accountability.

This is led by the STP Programme Delivery Executive Group (PDEG) with input and challenge from the STP Collaborative Board, STP Clinical Cabinet and individual STP leads. Key stakeholders are involved in these groups, including NHS providers, local authorities and commissioners.



The Sustainability and Transformation Plan (STP) will drive delivery of a major programme of transformational change and improvement which will be enabled by investment in technology, changes in workforce and ensuring that where estate/accommodation is required, it is fit for purpose. The plan, submitted in October 2016, can be found using the following link.

Background and context to the plan

Torbay is a geographically diverse area. Its population ranges across the deprivation span and its health and social care system is financially challenged, not least because of its aging population and the proportion those over 85. These challenges are increased – especially in urgent and emergency care - by the annual additional pressure on services of holidaymakers and tourists.

Inappropriate admissions and unnecessarily long periods in hospital can be harmful, for older people in particular. The longer older people remain in hospital, the harder it is for them to regain their independence and return home, and the more likely they are to be readmitted.

As mentioned above, Torbay has an ageing population which is also growing faster than the national average, increasing future demand for health and care services. If local services assist individuals to identify their strengths and link them in with appropriate support, there is potential to help them remain independent and less reliant on care. We also need to recognise that some of the support that people require can be delivered within their community and by the voluntary sector.

People with mental health conditions and those with disabilities do not always have access to the level of support they need, which impacts on their general health and wellbeing. The additional funding has been incorporated into schemes to address this inequity.

At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that to service users it feels like one service. An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements.

Whilst the New Care Model has been in place since October 2015, since the creation of the Integrated Care Organisation (Torbay and South Devon NHS Foundation Trust) and has worked to address the issues above, the Better Care Plan provides an opportunity to assist and support in the work which is already being undertaken.

Progress to date

We have previously created Better Care Fund plans as a community, the most recent of which focused on the new Model of Care and how its implementation would benefit our local population. Much work had been undertaken to ensure that this new Model supported the following areas:

- Strategic direction – the creation of the integrated care organization (ICO), with a high percentage of patient flow to one provider, supports the shared vision and outcomes for future health and social care across the existing CCG boundary, underpinned by good stakeholder relationships.
- Major Service reconfiguration – children's community health services, CAMHS transformation and rehabilitation, re-ablement and recovery require a wider network approach across Devon and engagement with key stakeholders is already underway.
- Urgent and Emergency Care – our Vanguard is largely contained within our CCG boundary but we work closely with other commissioning organisations in relation to the wider footprints covered by partner provider services such as 111 and 999.
- Primary Care, including primary care estates planning – the majority of patient flow happens within our CCG boundary, supporting our primary care services development plans and our locality based community service model.
- Integration of community health and social care services –The Better Care Fund and devolution in social care need to be part of our STP but working across a wider Devon foot print will also be necessary to work with partner organisations
- Mental Health services – achieving the vision for mental health services as set out in the Five Year Forward View will require our working in a wider mental health planning network reaching well outside our CCG boundary across our Devon footprint.
- Prevention and self-care – embracing national initiatives will be helped by working with for example our local authority and voluntary sector partners in small communities which can help drive cultural change.
- IT – our NHSE supported digital road map is co-terminus with the CCG and ICO geographical boundary.
- Workforce – the development of capacity in all areas of the market public, private, voluntary with associated training and education offers.

During 2016/17 we focused on the following areas:

Prevention:
In response to some of the challenges we face as a population, the CCG has, as its primary focus, developed a Joint Prevention Strategy which brings together the work of our two Public Health teams. Working with our partners in Devon we have mapped the level of community resilience to give us a better understanding and view of where our prevention work needs to focus and what our aims are.

We have profiled demand across social care and lifestyle services forming a baseline for both our Self Care Vanguard work in Torbay and South Devon, and the Devon County Council 'demand management' programme of which we will be part of. The demand work provides us with a common set of goals against which we will develop our implementation.

Our profile work has included not only the more traditional review of the JSNA but also includes, household profiling, goal setting, motivational interviewing and consumer preferencing. This has given us a better understanding of the person, circumstances, holistic

need and motivation, buying behaviour, their social circle, skills, knowledge etc. which will help us to understand how to frame and motivate individuals using more than just existing market segmentation.

Self-care:
Our self-care work remains a priority area. The successful urgent care Vanguard has provided an opportunity to use the learning from the previous self-care work to drive this forward.

All contacts with our system will support people to increase their levels of knowledge, skills and confidence in adopting healthy behaviours and lifestyles, managing their own health and health care, resulting in significant increases in upstream prevention; reduced demand on our urgent and emergency care services; ensuring patients are cared for at the most appropriate part of the system; and bringing about a sustained reduction in health inequalities. Health and care professionals will have a high awareness of, and confidence in, self-care, voluntary sector services, local community assets and peer support. We will achieve all of this by:

- Providing open access to a comprehensive and accurate Directory of Services;
- Using techniques such as social marketing to identify and target sections of the population with "call to action to self-care" messages that they will relate to and that will 'activate' them to self-care;
- Encourage people to make full use of the multimedia rich online tools, information and advice we will make available or signpost them to, bringing about a 'channel shift' in how people choose to interact with our services towards self-service options;
- Adopting system-wide approaches to patient & clinical activation to self-care; shared decision making; and evaluation;
- Working with the voluntary sector to create and maintain vibrant social network for health at both local community and system level; and
- Supporting Social Prescribing schemes, within the local area to further enhance opportunities to improve health and wellbeing for individuals.
- Embedding and scaling initiatives such as the strengths based approach which has been implemented with staff and Making Every Contact Counts training
- Further development of community navigator and wellbeing coordinator roles which support people to maintain their independence, develop their networks and care for themselves and those close to them

Carers:
Torbay continues to operate a whole system approach to Carers services prioritising early identification and support of Carers through a 'universal' offer of support, which provides information and advice, assessment and access to practical and emotional support for all Carers (not subject to eligibility). There are Carers Support Workers at key points in the Carers journey including in all GP surgeries, in the Discharge team at the Acute Hospital and in specialist community teams. Our services for carers aim to reduce hospital admissions and the time those cared for spend in hospital because carers are more involved in decision-making, supported to care during hospital stay and on discharge.

With the implementation of the Care Act 2014, a pool of 'trusted assessors' in primary care and the voluntary sector were trained to deliver 'light touch' Carers Assessments - the Carers Health and Wellbeing checks. They then work as enablers to help Carers find their own solutions and access community support. Carers Trust Phoenix are the voluntary sector partner who deliver these checks, and have a good background of community engagement,

and linking Carers into mutual support. This approach aims to develop community capacity, self-care and mutual support for carers. As part of the Ageing Better Big Lottery funding, both Carers Trust Phoenix and Mencap have received additional funding with regards to projects for older Carers - Circles of Support and Mutual Caring.

Torbay's Carers Services are Care Act compliant, but the biggest challenge is to thoroughly embed the ethos of whole family working and enhanced Carer support throughout adult services including mental health. On-going awareness training and social care audits will continue to ensure standards are met.

Evidence base and local priorities to support plan for integration

South Devon and Torbay is a geographically diverse area. Its population ranges across the deprivation span and its health and social care system is financially challenged, not least because of its aging population and the proportion those over 85. These challenges are increased – especially in urgent and emergency care - by the annual additional pressure on services of holidaymakers and tourists.

The area has a respected reputation for partnership working and for innovating to find more effective ways of delivering quality care. Relationships between statutory and voluntary sector organisations are well founded and there is a shared ambition to tackle problems. This extends to positive working with provider organisations whose reach is broader than South Devon and Torbay.

The creation of the Integrated Care Organisation in October 2015, Torbay and South Devon NHS Foundation Trust, was strongly supported and encouraged by both the Clinical Commissioning Group and the local authorities and this has resulted in a more effective patient journey for thousands of people.

In Torbay the model for integrated community health and adult social care was developed in 2005, with the creation of Torbay Care Trust. This model has been recognised both nationally and internationally as an excellent model of care, with a single assessment process, single care record, single information technology system and multi-disciplinary frontline teams supported by a single management structure. The role of the care coordinator in these teams, ensuring seamless care for patients, has since been replicated in many other areas.

In 2013 South Devon and Torbay became one of 14 national Pioneer sites for integration. The joint bid from the health and care community set out an ambitious goal of whole-system integration, extending beyond health and social care to encompass acute care, mental health and the voluntary sector and personal support, underpinned by the creation of an Integrated Care Organisation (ICO). The ICO formed in 2015 through the merging of South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Care Trust to create a single entity for delivery to become Torbay and South Devon NHS Foundation Trust which further widens the current model of health and social care to include acute health care provision.

Our vision for integrated health and care extends beyond the local authority boundary of Torbay into the whole CCG area, into South Devon which is within the scope of Devon County Council. The Better Care Fund sits within this longstanding programme of integration through the creation of the ICO and the development of a new model of care. We widened our scope further in 2015 when our health and care community become one of only eight groups across the country to be named as a Vanguard site for taking a pioneering new approach to urgent care and we have developed proposals to increase access to urgent care services and develop the infrastructure to support patients to choose wisely.

Better Care Fund plan

Further detail can be found within the planning template:

Disabled Facilities Grant to Districts	4. DFG - Adaptations			Social Care		Local Authority			Local Authority	Local Authority Contributio	Both 2017/18 and 2018/19	£1,631,353	£1,738,615	Existing
Protecting Adult Social Care	16. Other		Adult Social Care	Social Care		CCG			Local Authority	Minimum Contributio n	Both 2017/18 and 2018/19	£3,029,270	£3,086,827	Existing
Reablement	16. Other		Reablement Services	Communit y Health		CCG			NHS Communit y Provider	CCG Minimum Contributio	Both 2017/18 and 2018/19	£1,078,974	£1,099,475	Existing
Carers	3. Carers services	1. Carer advice and support		Communit y Health		CCG			NHS Communit y Provider	Minimum Contributio n	Both 2017/18 and 2018/19	£467,216	£476,093	Existing
Care Bill	16. Other		Care Act 2014 monies	Social Care		CCG			NHS Communit y Provider	CCG Minimum Contributio	Both 2017/18 and 2018/19	£407,160	£414,896	Existing
Other Healthcare/Reablement/Section 256	16. Other		Other	Communit y Health		CCG			NHS Communit y Provider	Minimum Contributio n	Both 2017/18 and 2018/19	£429,554	£437,715	Existing
Integrated Care Organisation	16. Other		Single Point of Contact, Frailty Care Model, Multiple LT	Communit y Health		CCG			NHS Communit y Provider	CCG Minimum Contributio	Both 2017/18 and 2018/19	£5,026,419	£5,121,921	Existing
Reablement	16. Other		Reablement Services	Social Care		CCG			NHS Communit y Provider	Minimum Contributio n	Both 2017/18 and 2018/19	£50,895	£51,862	Existing
Adult Social Care	16. Other		Adult Social Care	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£4,448,698	£6,149,188	New

IBCF Projects Identified for 2017/18 – Total Cost £596,000

No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
1.	1, 2. & 4.	Extension of TSDFT Care Home Education and Support Team (CHEST)	An expected future shortfall in capacity of skilled dementia care within community settings including, care homes, extra care housing, supported living and community home care environment. The complexity of clients being such that nursing level skills need to be developed alongside enhanced care workers	£90k	2017/18	Cathy Williams	Yes With a 3 Month Lead in	Must	Approved in Principle. Project to be fully scoped on Smart sheet Costs for 2018/19 and 2019/20 to be determined
		Proposal	Extension of Care Home Education and Support Team (CHEST) to develop Dementia expertise in care homes and to support improvement planning in homes which are strategically relevant to Torbay. To support a progression approach to facilitate 'Step Up/Down' care for people with dementia to avoid long term admissions. To extend team's cover to extra care housing, supported living and expert advice to home care providers.						
		Benefit/ Outcome	Avoidance of A&E admission and DToC. Reductions in Long Term Admissions to Residential Care CHEST is part of an admissions avoidance scheme and will be evaluated against other models. Working in care homes to avoid admissions to hospital/ reduce 121 care, admissions avoidance to nursing homes 121 reducing much faster and ending in its entirety for 121's due to CHEST support for						

		Risks/ Actions	more positive behavioural management approaches and focus on individual need and behaviour with a view to reducing care and monitoring over time Upskilling of staff generally across the care home sector Risk: That there are not sufficient staff to be able to be recruited to the CHEST Posts need to be recruited to on the basis of 3 year/ permanent contracts Current benefits evaluation is being undertaken, therefore it would be critical to see if there have been any reductions in admissions from the relevant care homes so that we could extrapolate this into a full business case. We will need to know the number of residents that this applies to and the number of admissions. Also review reductions in extra staff						
	17/08.17	SCPB/BCF response	Approved – non-recurrent funding funds released with immediate effect Conditions - Milestones for achievement to be set Resources for the delivery of the project to be articulated – Role, Name, WTE Business case – to be lodged for audit						
No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
2	All	Development of dementia pathway for	There is a Dementia pathway, however with the projected rise in population this is expected to put additional pressure on this. There is	£60k Plus 30K For	2017/18	Cathy Williams	Yes	Must	Transfer to project plan and work up

		Torbay Proposal Benefit/ Outcome	potential to purchase additional capacity via DCC contract with Alzheimer's Society to maximise value. Additional 2 dementia advisor posts to cover Torbay within DCC contract with Alzheimer's Society to ensure a wider dementia pathway with pre and post diagnostic support including, escalation, de-escalation and crisis support as well as focused support for carers when conditions change Alongside frailty/ front door have a vol sector worker to identify clients requiring extra support on discharge due to dementia/ Alzheimer's. Need to co design with voluntary sector Needs further scoping – Vikki, Alex and Chris and Alzheimer's society and Dawn Thomas liaison psychiatry Build on strong diagnosis support at the memory clinic and post diagnosis support and debrief. There is a drop-out rate following this since few patients/carers take up the offer of a course. This would improve take up and develop other support options in relation to management of progression of the disease. Better information pre diagnosis particularly for treatment escalation planning. Lasting power of attorney, DNR. (Latter relevant to all conditions and pre end of life care planning so potential to provide information and access to good support e.g. 'dying matters' web site as wider benefit)	frailty					specific costs

	17/08.17	SCPB/BCF response	Not Approved at this stage Viewed positively Requires further detail (mini business case) which is to be completed ASAP.						
No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
3	3. & 4.	Mental Health and DPT Proposal Benefit/ Outcome	Reduction of residential placements for people under 65and introduction of progression, or 'step down' model Contribute to MSB to cover mental health cost of additional assessments and worker with mental health expertise. This will include 41 assessments of people in residential care to achieve progression to community based alternative support (est. £350 per assessment). Development through supported living framework commissioning of alternative housing and support solutions support for DPT in review of care and support plans of 275 Torbay patients on subject to S117. To support this initiative DPT will identify lead practitioner to support and refocus existing housing and welfare benefits roles to support access to accommodation and on-going tenancy and employment support. Implementation of progression and asset based model within DPT, development of alternatives to residential care for people with poor mental health. Reduced long term admission to residential care and reduction in DToC. Development t of mental health expertise in	£50k £70k	2017/18 2018/19	Fran Mason		Must	Transfer to project plan and work up specific costs

			MSB and stronger links to housing and employment roles and outcomes within DPT l						
	17/08.17	SCPB/BCF response	Approved – funds available with immediate effect Conditions: clear determination of where savings accrued to ensure double counting avoided across the system and expectations of partners managed (ICO/DPT)						
No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
4	3. & 4.	Proud to Care South West Proposal Benefit/ Outcome	Professionally produced marketing campaign designed to improve capacity in the care force across the south west Fund the initiative for a further three years to embed the message and leverage the impact Funding levels are nominal even when doubled Collaboration with this as a focus is already providing dividends The ability to shape the campaign for an extended period with approach reach to different target groups including informal carers and the development of the VCSE capacity Commitment will support the business case for other stakeholders (PVI) to invest Provides longevity that will offer best chance of this being self-sustaining beyond three years in line with a robust evaluation over the extended period	£20k	2017/18 2018/19 2019/20	John Bryant	Yes	Must	Transfer to project plan
	17/08.17	SCPB/BCF response	Approved (Recurrent funding for three years of iBCF)						

			Conditions: evaluation of impact at local level as well as regional level Regional level sign up to ongoing campaign						
No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
5	3. & 4.	Leadership development in care homes Proposal Benefit/ Outcome	Improve quality, effectiveness and engagement in delivery of out of hospital care including, trusted assessment, innovation and business change. Take learning from Plymouth maximising use of skills for care support and providing professional accountancy support, contingency and succession planning to supplement CHEST operational support and further enhance the skills sets and broader management within care homes so that they are further enable d to engage, shape and deliver new forms of care to the wider system IC and trusted assessor will make this very important. Capacity in care home management with improved retention along with additional input into systems solutions	£50k £TBC	2017/18 2018/19	Fran Mason/ Jenny Turner	yes	must	Needs more work in terms of detail and links to the BCF priority areas, however agreed in principle
	17/08.17	SCPB/BCF response	Approved Condition – to fund the financial skills, input and modelling with care homes and associated fee activity Training activity excluded – work of Skills for Care, Horizon Centre with ICO on apprenticeships developing the other elements						

No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
6	All	Development of the out of hospital care system Proposal Benefit/ Outcome	Increase capacity in the short term offer in order to improve reablement and rehab to ensure people are supported to regain their independence Development of RR and reablement services in Torbay to put in 1 extra support worker in each shift – to provide wrap around care to discharge early. Provide intensive assessment and support Su Skelly/Alex Pleace	£240k TBC	2017/18 2018/19	Su Skelly	Yes	Must	Transfer to project plan and work up specific costs More detail required
	17/08.17	SCPB/BCF response	Not Approved at this stage Business case requested including read across to the John Bolton work						
No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
7	4.	IPC Proposal Benefit/ Outcome	PHB – people who have been through IPC processes to support solutions to low social care costs, prevent acute admissions and improve resilience. The model includes patient activation and accredited peer support (HOPE) Funds for actual PHBs in Torbay – to deliver system change and embed IPC methodology. Will target children in transition and social care/camhs users. Outcomes in a south Devon trial have been extremely positive for individuals, reducing use of primary and secondary care.	£10k	2017/18	Jo Williams	Yes	Must	

	17/08.17	SCPB/BCF response	Approved (Recurrent funding for three years of iBCF)with request for scaling option Conditions - request for impact additional funding beyond the approved amount would make to accelerate this scheme and what outcomes would be produced						

No	BCF Objective	Project Name	Outline of Proposal	Cost	Year	Lead	Feasibility	Must/ Should/ Could	Next Steps
8	3. & 8.	Transition Worker	Improving the management of and experience of transitions from children's services to adult services.	£46k 3 years	2017/18 2018/19 2019/20	Cathy Williams	Yes	Must	milestones and recruit
		Proposal	This is an area of developing work, linking closely to the SEND reforms. This requires additional capacity to ensure both care planning and financial planning are managed well. Previous lack of planning in this area has led to cost pressures of £500K. We would propose a band 7 Social Worker to undertake this work and that would also align with the SW workforce development strategy that is in place, developing specialist clinical skills in key areas. This role could also support the delivery of the Transforming Care Partnership agenda from a social care point of view. Recurrent funding for three years						
		Outcome	The transitions worker will impact on admissions to care homes and reablement. The transitions worker will ensure that there is more robust transitions planning and joint working with children's services at an earlier						

			point to ensure that plans being put in place do not automatically default to a residential placement, they will also challenge the appropriateness of placements at an earlier point to ensure that opportunities for reablement and progression particularly for people with learning disabilities are considered as part of this process. This worker will therefore impact upon cost, reduction in care home placements by looking for alternative ways of supporting people in the community and ensure young people are re-abled and can maximise their potential.						
	17/08.17	SCPB/BCF response	Approved – (Recurrent funding for the three years of the iBCF)funds available immediately Conditions: milestones for process versus outcomes / workplan of individual Reporting of findings, examples of impacts made during course of funding						

A further list of projects totalling £1,082,000 are under consideration by the BCF working group for determination through the agreed governance structures.

Risk

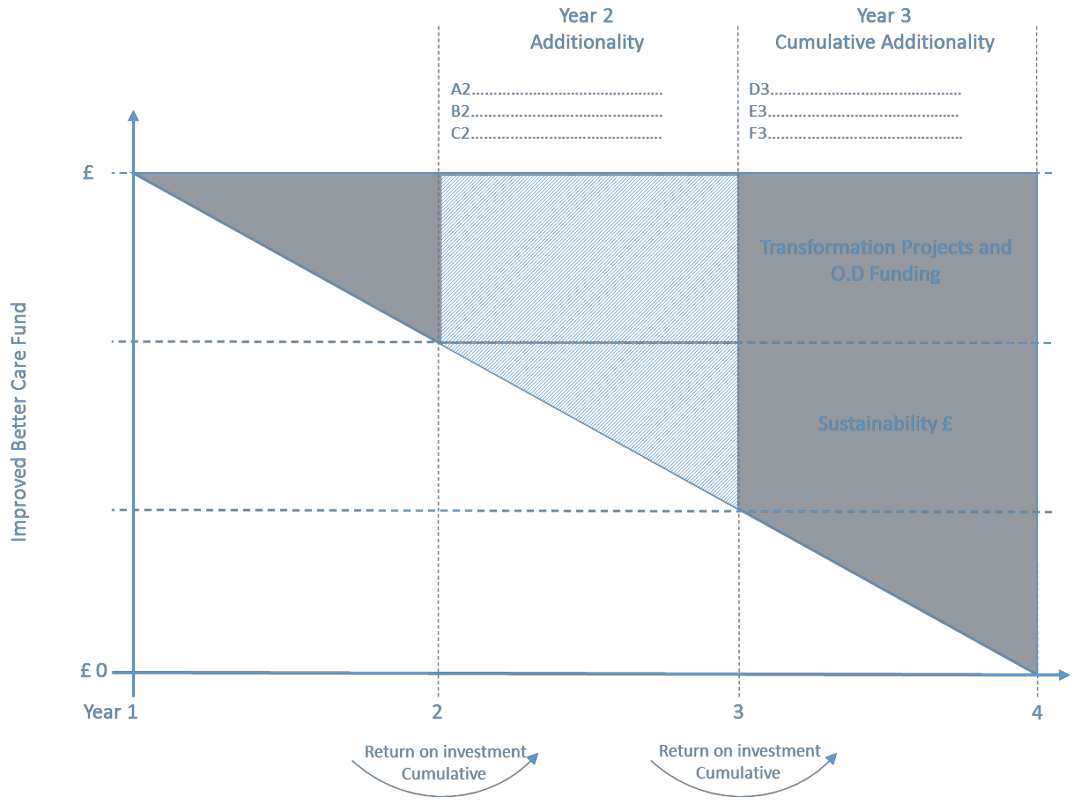
Within each of the identified projects, project leads will be expected to identify and manage risks. Going forward, these will be captured within Smartsheet, which will be the area where all information relating to the schemes will be held.

In addition, to ensure the success of the schemes, the following criteria documents have been created, which will be reviewed to ensure that there is ROI considered within the schemes. An approach as to how the Improved Better Care Funds may be considered to drive transformation and provide sustainable and recyclable change funding, including broader voluntary and community sector development appears in Figure 1.

Briefing Paper - Criteria for iBCF fund

feasibility tablev3.pptx

Figure 1:



National Conditions

National condition 1: jointly agreed plan

Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and well being board?

In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?

1. Are all parties (Local Authority and CCGs) and the HWB signed up to the plan? **Yes**
2. Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan? **Yes**
3. Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach? **Not applicable as Unitary Authority is holding the DFG Budget**

National Conditions (continued)

National condition 2: social care maintenance

Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation from their 16/17 baseline for 17/18 and 18/19*

1. Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template? **Yes**
2. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution? **Yes**
3. In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole? **Yes**
4. Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision **Yes**

National Conditions (continued)

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

Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?

1. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? **Yes**
2. If an additional target has been set for Non Elective Admissions; have the partners set out a clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid? **Yes**
3. If a contingency fund is established; Is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent? **Yes**

National Conditions (continued)

National Condition 4: Managing Transfers of Care

Is there a plan for implementing the high impact change model for managing transfers of care?

1. Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken, including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? **Yes**
2. Is there evidence that a joint plan for delivering and funding these actions has been agreed? **Yes**
3. If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information? **Yes**

Overview of funding contributions

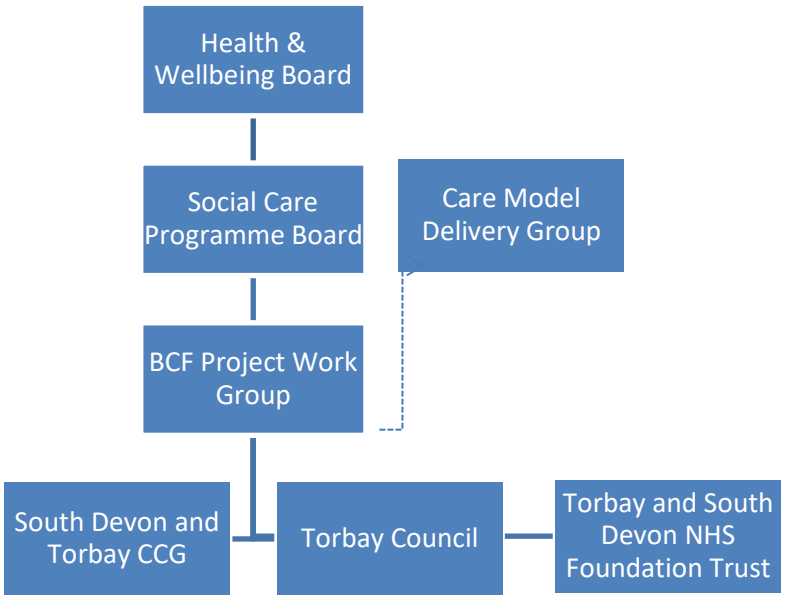
Briefly set out confirmation that the funding contributions for the BCF have been agreed and confirmed – including agreement on identification of funds for Care Act duties, reablement and carers breaks from the CCG minimum . These can be confirmed in the excel Planning Template

- *Care Act 2014 – how funding for CA implementation is being used*
- *Reablement*
- *Carer's breaks*
- *Social Care*
- *iBCF*

Please see Planning Template which confirms adherence

Programme Governance

Within Torbay the following structure has been created, with regular meetings of the Project work group planned for the next 12 months.



Assessment of Risk and Risk Management

Risks will be managed as per the Risk Management process embedded within Smartsheet which is line with the management of risk within each of the partner organisations

National Metrics

Details of this can be found within sheet four of the Planning Template, including comments on rationale.

Delayed transfers of care

We have identified a programme to maintain the DTOC target of 3.5%, as set out below.

Delayed Transfers of Care Number of days delayed As used in BCF	TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	DEVON PARTNERSHIP NHS TRUST	Torbay LA area
NHSE suggested target (days delayed) - daily	10.33	27.28	
NHSE suggested target (days delayed) - yearly	3,772	9,956	
% of organisations delays in Torbay LA (Apr16-May-17)	36.8%	6.4%	
Target for Torbay LA delays - year	1,388	640	2,027
Target for Torbay LA delays - quarter	347	160	507
Target for Torbay LA delays - month	116	53	169

In addition to the iBCF schemes already described as examples the following projects areas are part of the wider Better Care Fund:

- Discharge to Assess
- Trusted assessor (IC)
- Early complex discharge
- SAFER 2
- Pharmacy
- Transport

Pieces of work

- Single integrated discharge team
- Single referral form for community services
- New criteria for community hospitals
- Community –based decision-making for onward care and discharge destination
- Decision making flow chart for discharge

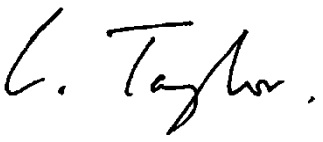
Approval and sign off

Provide confirmation of who has signed up to the BCF plan:

Role:	Title and Name:	E-mail:
Health and Wellbeing Board Chair	Director of Adult Services and Transformation & Elections Returning Officer - Caroline Taylor	caroline.taylor@torbay.gov.uk
Clinical Commissioning Group Accountable Officer (Lead)	Chief Operating Officer - Simon Tapley	simon.tapley@nhs.net
Additional Clinical Commissioning Group(s) Accountable Officers	Deputy Chief Operating Officer - Jo Turl	jo.turl@nhs.net
Local Authority Chief Executive	Chief Executive Steve Parrock	steve.parrock@torbay.gov.uk
Local Authority Director of Adult Social Services (or equivalent)	Caroline Taylor	caroline.taylor@torbay.gov.uk
LA Better Care Fund Lead Official	John Bryant	John.bryant@torbay.gov.uk
LA Section 151 officer	Martin Phillips	martin.phillips@torbay.gov.uk

Provide the date of Health and Wellbeing agreement (for the second submission of plan)

7th September 2017



Caroline Taylor

Director of Adult Services and Transformation & Elections Returning Officer

Simon Tapley

Chief Operating Officer