The Better Care Fund plan 2019-20

1. Introduction

The Better Care Fund (BCF), established in June 2013, is a single pooled budget bringing resources together to address system pressures and lay foundations for a more integrated system of health and care. It has provided health and care systems with a vehicle to consider local opportunities for integration. Integration offers an opportunity to redesign services around the needs of individuals, not organisations, and to make the best use of collective resources.

The approach in Buckinghamshire mirrored the historic spend of Section 256 funding. Our BCF is overseen by our Health and Wellbeing Board and the plan is aligned to the Buckinghamshire Health and Wellbeing Board Strategy[1]. The underlying approach has been to support the system to maintain core service levels and stability of the health and care systems. The BCF has enabled the Buckinghamshire Clinical Commissioning Group (CCG) and local authority to work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital. Our aim is to improve the way we manage transfers of care and work more effectively in partnership to prevent escalation of need.

In Buckinghamshire, we recognise that whilst we have made progress, there is still work to be done to deliver our aspirations. In order for health and social care to become fully integrated, we must work collaboratively, with pace, to shift investment from reactive services to early intervention and preventative services, looking at the whole life cycle with particular focus on transition points and person centred care. The BCF continues to be a facilitator for achieving this.

Further to this, the development of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) and emerging Buckinghamshire Integrated Care Partnership (ICP) provides the opportunity and ability for transformational planning across all three areas. It is an enabler for building on good practice, maximising opportunities, and generating efficiencies at scale.

Each iteration of the BCF has built on the last incorporating additional funding streams and grants with the aim of streamlining the processes for submitting plans and returns to the NHS England (NHSE). As of 2019-20 the BCF is made up of the following components:

- **CCG minimum contribution**
    - Mandated ring-fenced ASC spend
    - Mandated ring-fenced out of hospital spend

- **Improved Better Care Fund** (iBCF)
- **Disabled Facilities Grants** (DFG)
- **Winter Pressures Grant** (newly integrated into the BCF for 2019-20)

A review of the BCF was announced in June 2018. This is reported to be ongoing and as such the 2019-20 BCF plans are to be considered a transition year, building on the 2017-19 plans whilst we await the outcome of this review nationally to be able to pave the future pathways for integration across health and social care. There are no major changes to the 2019-20 plan and the bulk of the continued work is based on sustaining existing services whilst utilising the emerging opportunities through the ICS and ICP.

2. 2019-20 Funding Allocations

2.1 Total allocation

The 2019/20 BCF final guidance and allocation was published on Thursday 18th July 2019. The Winter Pressures Grant was confirmed at £1,671,318 the same as the 2018-19 figure and a 0.8% increase in overall BCF amount for Bucks for 2019-20.

The overall allocations as follows:

	18/19 allocation	19/20 allocation	Difference	% change
Minimum CCG Contribution	£28,458,394	£30,105,514	+£1,647,120	+5.8%
DFG	£3,320,891	£3,583,439	+£262,548	+7.9%
iBCF	£3,657,639	£3,221,362	-£436,277	-11.9%
Winter Pressures Grant*	£1,671,318	£1,671,318	£0	0.0%
Total	£37,108,242	£38,581,633	+£1,473,391	+4.0%

* Winter pressures grant was separate to BCF in 2018/19.

The minimum CCG contribution has two mandated spend areas:

	18/19 allocation	19/20 allocation	Difference	% change
ASC spend	£9,535,348	£10,087,237	+£551,889	+5.8%
Out of hospital spend	£8,087,068	£8,561,108	+£474,040	+5.9%

The proportion of funding which is received by Buckinghamshire County Council (BCC) for Adult Social Care (ASC) spend is detailed below:

	18/19 allocation	19/20 allocation	Change £	Change %
BCF	£9,535,348	£10,087,237	£551,889	+5.8%
iBCF	£3,657,639	£3,221,362	-£436,277	-11.9%

Winter Pressures	£1,671,318	£1,671,318	£0	0.0%
Total	£14,864,305	£14,979,917	£115,612	+0.8%

2.2 DFG

Due to Buckinghamshire being a two tier authority at present, though a single unitary authority from 1 April 2020, at present the full DFG funding allocation is passed down to each District Council and is split as follows:

Authority	Funding allocation
Aylesbury Vale	£968,429
Chiltern	£702,768
South Bucks	£634,507
Wycombe	£1,277,735
Buckinghamshire Total	**£3,583,439**

2.3 iBCF

The iBCF was a three year allocation, announced in the 2017 budget. In Buckinghamshire, it was agreed iBCF monies should be used for social care support to enable robust and timely discharges from hospital. The allocation for 2019-20 was announced on 29th April 2019. The iBCF grant requires the funding to be used for:

- Meeting adult social care needs
- Reducing pressures on the NHS, including support more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

The allocation is shown below:

	18/19 allocation	19/20 allocation	Difference	% change
Improved Better Care Fund	£3,657,639	£3,221,362	-£436,277	-11.8%

2.4 Winter Pressures

On 2 October 2018 Secretary of State for Health announced £240m of non-recurrent funding for social care to ease pressure on the NHS that winter. On 17 October the local authority received a letter confirming Bucks allocation as £1,671,318 for 2018-19 and later confirmed a further **£1,671,318** for 2019-20. On 29th April 2019 the formal grant determination for Winter Pressures for 2019-20 was released. The grant conditions require that winter pressures funding is used to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures. It can include interventions that support people to be

discharge from hospital who would otherwise be delayed, with the appropriate social care support in place, which helps promote independence.

The outline spend for the Winter Pressures Grant 2019-20 will form part of the Bucks ICP Winter Plan and will be agreed by partners through discussion at A and E Delivery Board and then at HWB Board.

3. Proposed spend

The proposed joint BCF plan for 2019-20 is detailed in the tables below. The plan is a continuation and consolidation of the 2017-19 schemes, with agreement across health and social care.

3.1 ASC spend from minimum contribution

This element of funding is passported to BCC. The allocation for each CCG includes funding to support the delivery of reablement, carers breaks and the implementation of duties to fund carer support under the Care Act (2014) and as such expenditure allocated to support delivery in each of these areas can be seen below.

Scheme Name	Budget 18/19	Proposed 19/20	Change	% Change	Description
7 day service and hospital discharge teams	£1,602,000	£1,694,916	+£92,916	+5.8%	Discharge support teams to reduce length of stay. Social care support to enable discharge out of hours and at weekends
Home from Hospital	£242,000	£246,338	+£4,338	+1.8%	Voluntary care sector (Red Cross) contract to support individuals to return home from hospital. Two elements – Support at Home and Transport and Settlement
Assistive technology	£312,000	£330,096	+£18,096	+5.8%	Provision of 'end to end' Technology Enabled Care service (including assessment, equipment, monitoring and response)
Dementia	£159,000	£159,000	£0.00	0.0%	Memory Support Service – works with people and their carers who are concerned about their memory, seeking a diagnosis or have been diagnosed with dementia
Intermediate services including reablement	£2,213,000	£2,341,354	+£128,354	+5.8%	Short-term support to reduce hospital admissions, help individuals to be independent following a hospital admission and to reduce the need for residential care. Resourced by BCC alongside funding from BCF

Care Act and Social Care Pressures	£3,704,520	£4,054,482	+£349,962	+9.4%	Care Act - information, advice and guidance, advocacy , Social Care Pressures - nursing spend increased by 8% over last year , Direct Payments spend increased by 16% over last year
Integrated Carers Service	£472,000	£472,000	£0.00	0.0%	Statutory information, advice and guidance service operated by Carers Bucks. They work within primary healthcare environments to support identification and signposting for carers. The service works alongside Primary Care Networks (PCNs) to offer services that support carers health and wellbeing through support groups, training, 1-1 support and counselling.
Support for care home providers to deliver quality care	£509,500	£539,051	+£29,551	+5.8%	The team was disaggregated as part of the commissioning restructure but the functions that were provided remain sitting across all of the integrated commissioning teams and robust quality assurance processes remain in place and continue.
Falls	£250,000	£250,000	£0.00	0.0%	The falls pathway aims to reduce the number of falls, and injuries caused by falls, in older people through the provision of evidence based specialist assessment where appropriate, treatment and intervention to adults primarily aged over 65 years.
Total	**£9,535,350**	**£10,087,237**	+£551,887	+5.8%	

3.2 OOH spend from minimum contribution

The remaining CCG minimum contribution is allocated towards integrated community based provision which incorporates the mandated minimum from NHSE.

Scheme Name	Budget 18/19	Proposed 19/20	Change	% Change	Description
Integrated community services • **Adult Community Health Teams** • **OPAT – home intravenous antibiotics service** • **Community Assessment and Treatment Service**	£18,923,044	£20,018,277	£1,095,233	+5.8%	The CCGs commission a range of integrated community services from BHT designed to prevent admission to acute care and when admitted to support timely discharge. These services include 24/7 Adult Community Health Teams (ACHTs) across 7 localities in Buckinghamshire; a home intravenous antibiotics service (OPAT), and the Community Assessment and Treatment Service (CATS) for Buckinghamshire residents who do not require immediate admission to an acute medical services pathway and can have care provided closer to home.

3.3 iBCF

Scheme Name	Budget 18/19	Proposed 19/20	Change	% Change	Description
Market stabilisation for domiciliary & residential and nursing care	£3,369,880.00	£2,971,362.00	-£398,518.00	-11.8%	Achieving stabilisation through uplifting payments to domiciliary care providers where required and addressing changes in law impacts and the impact of Brexit on staff retention – continuing cost of this falls to BCC
Protecting	£250,000.00	£250,000.00	£0.0	0%	To maintain the level of grant funding into

Voluntary Care Services					preventative services with a focus on deliverable outcomes to support maximising and maintaining independence.
Total	£3,657,639	£3,221,362	-£436,277	-11.8%	

3.4 Proposed Winter Pressures Grant

The winter pressures expenditure has been calculated based on utilising the budget over six months (October 19 – March 20) to enable sign off prior to usage.

Scheme Name	Estimated output	Expenditure	Description
Brokerage support in hospitals – waiving charges to patients	c13 referrals per month	£83,000	From November 18 to March 19, 87 referrals received – 7 day response offered to SMH and Wexham hospital sites
Flu vaccinations – increasing uptake by independent sector providers and wider Bucks population	All care home and preferred home care providers contacted and frontline social care staff targeted; information to general population	£15,000	Increase uptake and immunisation against flu of non-health population to improve general system resilience – 8 clinics held in 18-19, earlier start and wider scope in 19-20 to increase inclusion
Intermediate nursing care home beds - 3	To support reablement services, to offer intermediate care home beds	£234,000	To reduce targeted individuals coming out of hospital to regain their skills and independence and reduce long term care costs
Residential Placements (flexible across all service groups and models)	7 Residential 8 Nursing	£336,589	Based on average cost of £821 for a new nursing placement over 6 months Based on average cost of £901 for a new residential placement over 6 months
Home Care and Dom Care	40,367 hours	£783,129	Based on average £19.40 per hour
Personalise Care at Home – Live in care	8 live in care placements for 6 months	£219,600	24/7 live in care for 6 months

4. National conditions

There are four national conditions which have to be met as part of the BCF submission. These are:

1. Jointly agreed plan
2. Social care maintenance
3. NHS commissioned out of hospital services
4. Managing transfers of care and the High Impact Change Model

4.1 Jointly agreed plan

The BCF plan will be signed off by senior representatives of BCC and Buckinghamshire CCG. The outline plan will also be presented to the Health and Wellbeing Board on 5th September 2019. The BCF is a standing item at the system wide Health and Wellbeing Board and the Integrated Commissioning Executive Team (ICET) meetings. ICET monitors progress against the Better Care Fund metrics and any potential risks are raised and discussed. As mandated, a Section 75 agreement is in place for the transfer of the pooled funding to Bucks CC.

4.2 Social Care Maintenance

In the context of growing demand and budgetary pressures, protecting social care services in Buckinghamshire means continuing to provide the existing level of services to support the most vulnerable people in the county who meet the national eligibility criteria.

Buckinghamshire will continue to provide best practice care for people with continuing needs or illnesses. The 65+ population is projected to grow by more than a third (36%) by 2025, while the 85+ population is projected to increase by 84% over the same period[2]. It has a disproportionately high learning disability population and rapid housing growth across the county is likely to all further inflate demand for services. In order to meet this anticipated increase, it will be essential to protect social care services whilst transforming the system to manage demand by increasing prevention and early intervention.

The resource identified is £10,023,467 from the CCG minimum contribution with an additional £3,221,362 for meeting the iBCF grant conditions. This expenditure will be reaffirmed through ICET to not destabilise either health or social care services.

4.3 NHS Commissioned out of hospital services

The requirement of this funding is that spend is allocated to primary, community, social care or mental health care. It cannot be used against acute spend. Although the mandated amount for this is national condition is £8,561,108, the remainder of the CCG minimum contribution after ASC spend is deducted is invested in supporting three community based services (£20,018,277):

- Adult Community Health Teams (ACHTs)
- Home intravenous antibiotics service (OPAT)
- Community Assessment and Treatment Service (CATS)

4.3a Adult Community Healthcare Team (ACHT)

The purpose of community healthcare teams is to provide integrated care in a safe community setting for adults who are housebound. Its purpose is to provide multi-disciplinary holistic assessments to support individuals to avoid unnecessary hospital admissions and manage long term or chronic conditions at home; maximise their function, independence and quality of life; and facilitate timely discharge from acute care. The service also supports patients at the end of life and to remain in their preferred place of residence wherever possible.

4.3b Outpatient parenteral antimicrobial therapy or home intravenous antibiotics service (OPAT)

This service aims to support earlier discharge of patients from the acute setting into the community or outpatients who require a long or short course of treatment for infections that would otherwise have kept them in a hospital bed. The service is nurse led and operates all year round seven days a week. There are three pathways to the service – Early Supported Discharge from Buckinghamshire Healthcare Trust (BHT) wards, admission avoidance working with the CATS team (see below) and repatriation from another trust where appropriate.

In 2018-19 the service saved 2,057 BHT bed days and 533 repatriated bed days with an estimated system saving of £668, 525 (£841,750 with repatriated beds included).

4.3c Community Assessment and Treatment Service (CATS)

The Community Assessment and Treatment Service (CATS) is available for adults who are unwell but do not require immediate admission to an acute medical services and care can be provided closer to home. Patients treated within this service are mostly elderly but it can support any adult over 18 with sub-acute needs. The service contributes to reducing the need for emergency hospital admissions.

4.4 Manging Transfers of Care and High Impact Change Model (HICM)

Managing transfers of care continues to be a priority and core driver for activity within the BCF. The national ambition for reducing delayed transfers of care (DTOC) is for the average daily number of people who are ready to go home but are still awaiting discharge, to be less than 4,000. Local DTOC targets set in Q3 of 2018-19 remain in place for 2019-20 at 31.8 (average daily days delayed per month).

The system has good performance data to understand the causes of delays. Notably our overall performance places Buckinghamshire 9/16 within our comparator group, but when only ASC & joint bed days delayed are considered, our position moves to

2nd. Our performance is reported and scrutinised monthly at ICET and at HWB Board and used to influence our programme of work across the health and social care system. Our aim is to deliver improvements wherever possible and ensure we as a minimum maintain our position within the comparator group. Please see section 5.2 for further detail on our DTOC performance.

There have been some improvements in DTOC, particularly during the winter period of 2018-19 where our winter discharge to assess scheme led to fewer DTOCs in winter than the preceding summer. December 2018 was the only time in 2018-19 that Buckinghamshire hit their DTOC target.

However, the system recognises that there is more to do to improve the performance further. Work is ongoing to implement system changes in line with the High Impact Change Model (HICM) that will further reduce delayed transfers of care as well as preventing admissions and ensure effective discharge. This work is more established in some areas than others and the level of ambition reflects the system challenges faced.

As of April 2019, Buckinghamshire was established on four of the HICM domains and had plans in place for the remaining four. There are plans to develop all eight of the HICM domains in 2019-20 and this work will continue to be a priority into 2020-21.

The ICS is acting as an enabler to progress with implementing the HICM with a number of work streams focused around these changes. These include:

- Single point of access/integrated discharge
- Enhancing health in care homes
- Short term interventions
- Discharge to Assess

There are certain challenges faced which limits the ability to implement the HICM. The biggest overarching challenges are around changing from an organisational to a system approach and having sufficient capacity and expertise within the system to deliver and implement these changes. For example, one of the biggest challenges with adopting a discharge to assess model or home first approach is the vast cultural shift required and the additional upfront capacity required to adopt and implement changes and processes which will have benefits in the long term. As a result, agreeing a proposal that can be signed off across the system has proved challenging. Buckinghamshire's D2A approach is now split; with a service having been able to be developed to serve Buckinghamshire residents in residing in Wexham Park Hospital (WPH) funded through payments made by Frimley NHS Foundation Trust for readmissions to WPH; whilst a model is in development for the rest of Bucks.

Trusted assessors continue to be one of the most challenging of the HICM domains to implement. Elements of trusted assessor have been implemented but to date this has been largely based on skills, expertise and willing of specific individuals. The next phase of work is to develop single joint assessments which will be a step in the right direction towards developing this further.

Another challenge is around embedding a sustainable approach to seven day working. Currently, seven day working across the adult social care teams is embedded on a voluntary basis. Weekend cover is generally in place across SMH but more limited at WPH. Part of this challenge is to concurrently embed and implement a seven day working culture within the discharge teams to ensure discharges actually take place at weekends so there is a value to ASC staff being in place.

Buckinghamshire residents are served by two acute hospitals – Stoke Mandeville Hospital in Aylesbury and Wexham Park Hospital in Slough. As WPH is part of the Frimley NHS Hospitals Foundation Trust, this can result in a disparity of care and service provision for Bucks patients who attend this hospital instead of SMH and sometimes duplication of services which can cause confusion for hospital staff and patients. For example, the home from hospital service for Bucks is delivered by the British Red Cross and covers both SMH and WPH, however an additional service is in place for WPH covering Berkshire patients. There are differences in the contracts for the two services which can create competition between the two services as one is perceived to be more flexible than the other. This can also mean staff are unsure which service to refer to. Additional work is required to ensure these two services work jointly to deliver an effective home from hospital service and that this has a positive not negative impact on DTOC.

There are several key areas of work planned for 2019-20 which span a number of the HICM domains:

1) The integration of BCC reablement with BHT RRIC has been halted and a new approach developed which focuses on the integration of BCC reablement and BCC's OT service. The service will have a focus on therapy and will focus on enabling individuals to maintain their maximum level of function. Work is currently underway to integrate the triage process of reablement and occupational therapy into one and develop a single joint assessment. Once established, work will continue to better align this service with RRIC.

2) An ICS work stream around a Home First approach has been established for Bucks. This incorporates a Task and Finish Group for developing a single point of access to enable timely discharge. The aim is for there to be one point of access for all patients who no longer need acute care or can have an admission to hospital avoided. The SPA is on track to be established in Q3 of

2019-20 with a two year plan to enhance it further. The SPA will be operated by a multi-agency team including health and social care professionals.

3) Alongside this an integrated discharge model is being established with a programme of work to integrate health and care social care discharge teams. A single joint assessment is to be piloted in October for roll out in November 2019. The development of seven day working continues across health and social care with business case exploration for seven day working for discharge co-ordinators. There are ongoing discussions with care home providers about supporting greater discharge at weekends.

4) A reporting system to replace Alamac goes live in September as well as a new ward dashboard in October. The live dashboards give visibility of flow across the system and enable more effective management of demand and capacity. Alongside this, a project group has been established for improving patient flow with plans to move to BAU for system flow mechanisms including the monthly multi-agency discharge events (MADE), long length of stay reviews and top 20 directors call each week which enable trends around reasons for discharge delays to be identified.

5) Following the winter discharge to assess pilot, a D2A model has been embedded into Wexham Park Hospital from July 2019. This covers ¼ of the Bucks population. The D2A service is funded via money received from Frimley NHS Foundation Trust for readmissions into Wexham Park Hospital. The service incorporates additional domiciliary care, step down beds and a locum physio from August 2019. Capacity is to be increased as the service develops with the aim of achieving max capacity by January 2020. A Trusted assessor (GP) is utilised within this service for assessments for care home beds and is effective in managing care home bed capacity and flow as the care home then does not need to carry out an assessment. Across the rest of Bucks, the development of the SPA and integrated discharge teams against a home first approach is the predominant focus, with additional domiciliary care and placements capacity over winter being funded through the winter pressures grant.

6) Work continues on enhancing health in care homes. The red bag scheme is continuing to move forward with roll out to the remaining care homes in September 2019. A series of engagement events are planned for later in 2019 to enable care home and ward managers to link with each other and improve the integrated care pathway. Additionally, the Airedale Immedicare 24/7 nurse video consultation system is now in place in 37 of the largest care homes with the highest rates of hospital admission, covering 50% of the 4,432 care home beds in Buckinghamshire (2,219). A care home bed state capacity tracker is now live for all Buckinghamshire care home providers. An NHS Mail roll out

programme for social care providers is now underway with a target of getting 30% of care home providers on NHS Mail by March 2020.

It is anticipated that through this continued programme of work there will be a greater awareness of demand and capacity across the system, a reduction in non-elective admissions through more effective admission avoidance and improved DTOC performance through an established home first approach to discharge. The table below outlines our estimated position for each of the HICM areas by March 2020.

Table 1: Estimated position for each of the HICM areas by March 2020.

		Current position of maturity	Estimated maturity level by March 2020	Key areas of work to support this change measure
Chg 1	**Early discharge planning**	Established	Established	• Robust implementation of SAFER discharge scheme to save 24 beds per day (~5% reduction in LOS) • Multi-agency discharge events and the discharge patient tracking list enables trends to be identified which are delaying discharge. • Discharge planning begins at earliest opportunity • Programme of work to integrate health and care social care discharge teams. • Piloting removal of Section 2's and 5s in Q2 and Q3 to enable parallel discharge planning
Chg 2	**Systems to monitor patient flow**	Established	Established	• Improving patient flow project group • Move to BAU for system flow including multi-agency discharge events (MADE), long length of stay reviews and fabulous fortnight; top 20 directors call each Friday • Reporting system to replace Alamac goes live in September and new ward dashboard in October. Live dashboards give visibility of flow across the system and enables more effective management of demand and capacity • Work being undertaken on bed modelling • Community hospital beds used to reduce LOS and help flow from acute beds
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Plans in Place	Plans in place to deliver by March	• MDTs on all board rounds • MDTs in place for Wexham Park D2A service

			2020	• Working plans in place to develop integrated health and social care assessments • Ongoing work to align BCC reablement and OT teams and closer working with RRIC • Multi-agency approach to system flow continue to be adopted e.g. MADE events • Integrated discharge model being established and single point of access being remodelled operated by a multi-agency team • Multi-agency falls vehicle project over winter 2019-20
Chg 4	**Home first / discharge to assess**	Established	Established	• 2018-19 Winter Discharge to Assess scheme was successful – work ongoing to develop model further across SMH and Bucks • ICS work stream around the Home First approach across Bucks – Task and Finish Group for single point of access programme of work designed to enable timely discharge against a home first approach – working to deliver one point of access for all patients who no longer need acute care or can have an admission to hospital avoided. Estimated to save 15 beds per day alongside the integration of the discharge teams. To be established in Q3 with a 2 year plan to enhance to include 111, mental health and BCC contact centre • Winter Pressures funding to be used to support additional placements, dom care and intermediate care beds to support reablement. • D2A model embedded into Wexham Park Hospital from July 5th 2019 which covers ¼ Bucks population. Includes dom care in zones 1 (4 hours

				p/day) and 2 (7 hours p/day) and one bed in Parkfields. Increasing to max capacity in Jan 2020 – zone 1 (10 hours p/day), zone 2 (15 hours p/day) and three beds in Parkfields. Physio locum (14 hours p/wk) starts August 2019.
Chg 5	**Seven-day service**	Plans in Place	Established	• 7 day working cover with ASC staff at SMH and at a level at WPH to continue. • Business case exploration for 7 day working for Discharge co-ordinators • Ongoing discussions with care home providers about supporting greater discharge at weekends • Implemented 7 day per week consultant cover until 10pm to ensure rapid assessment and treatment in paediatrics • Implementation of a paediatric senior nurse rota until 9pm 7 days per week from September 2019 to support rapid assessment and treatment • Winter plan objective to achieve an additional 9 extra weekend discharges
Chg 6	**Trusted assessors**	Plans in Place	Plans in place	• Trusted assessor (GP) at WPH for assessments for care home beds. Continues as part of WPH D2A and is effective in managing care home bed capacity and flow. The care home then does not need to carry out an assessment. • BCC block care home beds will accept assessments from SW in the hospital. • Further development of trusted assessors planned – Review of single joint assessment form to be piloted in October for roll out in November
Chg 7	**Focus on choice**	Plans in Place	Established	• BHT choice policy revised and relaunched • Information pack to be given to patients

				• File to keep next to bed linking to the choice policy • CHC – robust equity and choice policy embedded into local practice • Brokerage service to be offered at no charge to self-funders within hospital after successful winter pilot. This in addition to adherence of the choice policy is estimated to save 4 beds per day.
Chg 8	**Enhancing health in care homes**	Established	Established	• Red bag scheme continuing to move forward with roll out to remaining care homes in September 2019. A series of engagement events are planned for later in 2019 to enable care home and ward managers to link with each other and improve the integrated care pathway • Airedale / Immedicare 24/7 nurse video consultation system in place in 37 of the largest care homes with the highest rates of hospital admission, covering 50% of the 4,432 care home beds in Buckinghamshire (2,219). • Care Home Bed State Capacity Tracker is now live for all Buckinghamshire care home providers. • NHS Mail roll out programme for social care providers is now underway. We are planning on getting 30% of care home providers on NHS Mail by March 2020. • ICP Care Home Steering group has now been established in Buckinghamshire and have identified system leads against all of the seven core areas of the EHCH framework.

5. Metrics

There are four mandated metrics to work to as part of the BCF. These are:

1. Non-elective admissions (Specific Acute)
2. Admissions to residential and care homes
3. Effectiveness of reablement
4. Delayed Transfers of Care (DTOC)

All BCF plans must include ambitions for each of the four metrics and plans for achieving these. Each of the schemes outlined in section 2 are required to detail in the planning template the impact they will have on each of the four metrics – 'low', 'medium', 'high', or 'not applicable'. The section below highlights our current level of performance against these metrics and plan for addressing these in 2019-20.

5.1 Non-elective admissions

Our performance for non-elective admissions (NEA) is consistently higher than the target. 2018/19 NEA performance for each member of the South East England Commissioning Region placed us 13/18 for performance.

Table 1: Total Non-elective admissions (days) per 100,000 population

Non elective admissions	Actual	Target
2018 –19 Q1	2658	2383
2018 –19 Q2	2581	2348
2018 –19 Q3	2840	2480
2018 –19 Q4	2767	2314
2019 –20 Q1	2722	2744*

**Revised target from NHS for Q1 2019/20 (pending sign off by NHS Digital)*

2019-20 plan for reducing NEA

A comprehensive ICS NeL programme of work has been established in Bucks which includes a number of projects to support effective delivery of the NeL demand management programme. It encompasses the following three key elements:

- Avoidable attendances to ED
- Avoidable non-elective admissions
- Facilitated discharge through a home first approach

Associated with this, are a number of key priorities set which link to reducing NEA. These include:

1. SDEC to increase to 33% by Dec 2019
2. Frailty 70 hours per week by Dec 2019
3. 100% ambulance handovers within 30 mins

4. Delivery of 95% in 4 hour ED standard (this was 83% in June)

Whilst NEA admissions continue to increase, more are being absorbed by Same Day Emergency Care (SDEC). Since October 2018, there has been an increase in SDEC admissions for adults, whereas the number of non-SDEC admissions for adults remained relatively stable. For Buckinghamshire, SDEC accounted for 44% of all NEA in May 2019. By December 2019 we expect SDEC to comprise 50% of all NEA. This is against the target of 33% set nationally.

As a result, there is considerable focus around developing community SDEC and maximising SDEC in non-acute settings. A number of key work streams and projects have been established or planned to meet these outcomes.

Single Point of Access

The development of the single point of access (SPA) will enable professionals to arrange the right care for urgent and non-urgent referrals which will contribute to preventing avoidable hospital admissions. There will be representation from senior clinicians to deal with urgent calls where a clinical/social assessment is needed. The SPA will welcome referrals from a range of health and social care professionals and be staffed by a multidisciplinary team.

The SPA will co-ordinate care delivery to enable same day discharge or admission avoidance including:

- advanced assessments within two hours for patients needing urgent health interventions and care who can remain at home (for example DN, reablement, step up beds)
- step-down to home based community nursing for longer term needs
- provision of urgent equipment to avoid acute hospital admission
- admission to community bed-based services, where appropriate
- intravenous antibiotics
- four hour response for assessment for domiciliary therapy and reablement (physiotherapy and occupational therapy)
- liaison with patient's GP to effectively manage clinical care at home and the wider health and social care system.
- Access to community falls service
- Access to non-urgent community physiotherapy
- Access to wider voluntary sector support services

The SPA is on track to be operational from Q3 of 2019-20.

Specialist 'hot clinics' and consultant coverage

Specialist hot clinics are being established to support admission avoidance. Additional capacity and consultant coverage is being established within neurology,

paediatrics and respiratory from September. In addition specialists are being placed within A&E to speed up decision making and to avoid admission where possible.

High Intensity Users

There is further role out of the High Intensity User/Personalised Care Service across several localities in Bucks. The aim of this is for collaborative system working to support those that attend A&E frequently through developing personalised care plans and identifying alternative solutions to A&E.

Pathways reviews

Care pathways are being reviewed where there are clear alternatives to acute care, which will avoid admissions. This includes IV antibiotics, non-weight bearing, and alcohol detox, where a more community based service is being developed. Within the OPAT service which involves delivering home IV therapy, a programme of work is underway to identify ways to increase the number of patients benefiting from the service which would release hospital bed capacity. A more robust pathway between OPAT and the CATS service is also being developed for further increase avoidable admissions.

Falls and Rapid Response Vehicle

Funding has been obtained from the ICS for the delivery of a falls and frailty vehicle 5 days a week for 22 weeks over the winter period. This will build on the scheme that was in place for winter 2018-19. The service aims to 19 to reduce hospital conveyance for older patients who have fallen and is delivered with a multi-system approach with input from BCC, BHT and SCAS to maximise admission avoidance opportunities.

The service provides an acute (MDT) consisting of a specialist paramedic and an advanced occupational therapist. It is intended as ‘one stop shop’ for those who have fallen and need causes of falls assessed, treated and a falls prevention plan initiated.

Airedale – Immedicare 24/7 nurse video consultation

Immedicare continues to be rolled out and is now in place in the care homes with the highest rates of hospital admissions, covering 50% of care home beds in Bucks. Preliminary evaluation has established that the service is effective in lowering GP workload and hospital admissions, with a 6.6% vs 3.5% reduction in hospital admission for care homes that have Immedicare vs those that do not.

5.2 Delayed transfers of care (per day) from hospital

We have made considerable progress in reducing the number of days delayed in respect of delayed transfers of care. However Buckinghamshire’s targets were set at a time of exceptional performance so it was only in December 2018 that

Buckinghamshire hit the national targets it had been set. This target of 31.8 days delayed remains in place for 2019-20. The CIPFA comparator group places Buckinghamshire 9/16 for all bed days delayed per 100,000 population for year to date.

Table 2: Average daily delays 2018-19 and 2019-20 to date

Actual v Plan average daily delays by NHS/ Social Care/ Joint responsibility.

		Plan				Actual			
YEAR	Month	2018-19 Plan	NHS	Social Care	Joint	ALL	NHS	Social Care	Joint
2018-19	APR	31.8	24.9	6.8	0.1	52.2	43.5	8.7	0.1
2018-19	MAY	31.8	24.9	6.8	0.1	63.5	50.8	12.6	0.1
2018-19	JUN	31.8	24.9	6.8	0.1	53.1	41.5	10.9	0.6
	Q1	**31.8**	**24.9**	**6.8**	**0.1**	56.4	45.3	10.8	0.3
2018-19	JUL	31.8	24.9	6.8	0.1	50.1	42.2	8.0	0.0
2018-19	AUG	31.8	24.9	6.8	0.1	40.2	30.9	9.1	0.2
2018-19	SEP	31.8	24.9	6.8	0.1	60.2	48.6	11.5	0.1
	Q2	**31.8**	**24.9**	**6.8**	**0.1**	50.1	40.5	9.5	0.1
2018-19	OCT	31.8	24.9	6.8	0.1	47.2	35.1	12.2	0.0
2018-19	NOV	31.8	24.9	6.8	0.1	41.4	30.4	7.8	3.1
2018-19	DEC	31.8	24.9	6.8	0.1	31.1	24.5	3.8	2.8
	Q3	**31.8**	**24.9**	**6.8**	**0.1**	39.9	30.0	7.9	2.0
2018-19	JAN	31.8	24.9	6.8	0.1	38.8	30.4	6.3	2.2
2018-19	FEB	31.8	24.9	6.8	0.1	42.4	35.3	5.4	1.7
2018-19	MAR	31.8	24.9	6.8	0.1	41.8	31.7	6.4	3.7
	Q4	**31.8**	**24.9**	**6.8**	**0.1**	41.0	32.4	6.0	2.6
Annual Daily Delays		**31.8**	**24.9**	**6.8**	**0.1**	46.8	37.0	8.6	1.2

Actual v Plan average daily delays by NHS/ Social Care/ Joint responsibility.

		Plan				Actual			
YEAR	Month	2018-19 Plan	NHS	Social Care	Joint	ALL	NHS	Social Care	Joint
2019-20	APR	31.8	24.9	6.8	0.1	44.7	35.2	6.3	3.2
2019-20	MAY	31.8	24.9	6.8	0.1	38.7	31.1	5.4	2.3
2019-20	JUN	31.8	24.9	6.8	0.1	44.2	30.5	7.5	6.3
	Q1	**31.8**	**24.9**	**6.8**	**0.1**	**42.5**	**32.3**	**6.4**	**3.9**
2019-20	JUL	31.8	24.9	6.8	0.1				
2019-20	AUG	31.8	24.9	6.8	0.1				
2019-20	SEP	31.8	24.9	6.8	0.1				
	Q2	**31.8**	**24.9**	**6.8**	**0.1**				
2019-20	OCT	31.8	24.9	6.8	0.1				
2019-20	NOV	31.8	24.9	6.8	0.1				
2019-20	DEC	31.8	24.9	6.8	0.1				
	Q3	**31.8**	**24.9**	**6.8**	**0.1**				
2019-20	JAN	31.8	24.9	6.8	0.1				
2019-20	FEB	31.8	24.9	6.8	0.1				
2019-20	MAR	31.8	24.9	6.8	0.1				
	Q4	**31.8**	**24.9**	**6.8**	**0.1**				
Year to Date		**31.8**	**24.9**	**6.8**	**0.1**	**42.5**	**32.3**	**6.4**	**3.9**

2019-20 plan for reducing DTOC

Buckinghamshire's plan to reduce DTOC links largely to with the implementation of the HICM supported by ICS level work programmes. DTOC performance continues to be above target, having last been achieved in December 2018. The most frequent

reason for NHS delay is reason C – Further non-acute NHS and for ASC delays is reason E – Care package in the home.

Due to Buckinghamshire's geographical split, approximately ¼ of patients attend Wexham Park Hospital which is part of Frimley NHS Hospitals Trust. From April to June 2019 Frimley contributed 38% of all acute delays within Buckinghamshire. As a result, a South Facing Bucks steering group has been established which focuses on the Frimley facing system. Targeted work focusing on performance within this system is underway to drive down DTOC caused by delays for patients in WPH.

As part of this a discharge to assess service piloted over winter has been implemented on an ongoing basis from July 2019. The service incorporates additional domiciliary care, step down beds and a locum physio. Capacity is to be increased as the service develops with the aim of achieving max capacity by January 2020.

More widely across Buckinghamshire, there is a considerable focus in the system to reduce overall average LOS for stays over 24 hours as well as scrutiny of patients with a LOS over 20 days. This links to the priority to achieve a 40% reduction in LLOS (21+ days) as part of the NEL demand management programme of work which will in turn improve DTOC performance.

The ambitions for 2019-20 are to implement the successful initiatives as business as usual and work as a system to reduce delays for patients and ensure care is being provided in the most appropriate setting. Initiatives include:

- check and challenge which identifies what each patient in a bed is there for and what they require in order to be discharged
- Weekly Discharge Patient Tracking List which assesses all patients in acute beds in SMH and Wycombe Hospitals for more than 20 days and allocates reason codes
- Reviews of patients in hospital longer than seven days in Wycombe, Buckingham and Amersham Hospitals.
- Multi-agency discharge events which enable trends to be identified which are causing delays in the system.

In addition, there are key areas of work to be embedded within 2019-20 which are considered to have a positive impact on DTOC performance:

New live dashboards

A new reporting system and live ward dashboards from September and October will give visibility of flow across the system and enable more effective management of demand and capacity.

Single Point of Access

The new single point of access will support improvements in DTOC through providing access to pathways for patients who are medically ready to leave hospital but cannot return home without additional support, may require nursing or therapy services in their own home, or may require management of complex long-term conditions; palliative/end- of-life care in their own home.

Integrated Discharge Team

Supplementing the SPA will be a new a single hospital discharge service through the integration of the existing BHT and BCC discharge services to enable safe and timely discharge from hospital to the most appropriate destination, with the priority being to support patients to return to their own home as soon as is possible. It is anticipated that this will enable easier liaison with ASC for provision of care packages and/or placements in the wider system which will release capacity, as well as improved joint working and more timely information within the hospital. These teams will be involved in the weekly length of stay reviews and multi-agency discharge events which are contributing to reductions in DTOC. There is an anticipated target of 2.5% of the bed base to ensure a consistent view of the impact on DTOC regardless of bed numbers.

Winter Plan

The ICS has recruited a Winter Director for 2019-20 and a detailed joint winter plan has been devised which is currently undergoing sign off. The aim is to ensure Bucks is resilient over the 19-20 period and to build on the work undertaken in 2018-19. As part of the winter plan, the spend for the Winter Pressures Grant has been considered:

Domiciliary and care home capacity

A large majority of the 2019/20 Winter pressures grant will be utilised to enable additional capacity within domiciliary care, 24/7 care and care home beds. Delay reason E – Care package in the home remains the most frequent reason for an ASC delay in Bucks (41% of ASC delays in June 2019). By utilising the funding to create additional capacity this should have a positive impact on DTOC and improve overall performance. This will also supplement the work being carried out to develop the SPA and integrated discharge teams to create capacity within the hospitals and enable a more robust home first approach to be implemented.

Intermediate Care

An additional £234k will be utilised for three intermediate care beds which will support individuals coming out of hospital to regain their skills and independence and reduce long term care costs.

Hospital Brokerage

£83,000 will be allocated for the hospital brokerage service to waive the charge for patients accessing the service. This is being reinstated after a successful pilot in 2018/19, and additional ad hoc implementation throughout the year when there is significant pressure on the system. 25 referrals were received during the two pilot (12 November 2018 – 12 January 2019) and this figure stands at 86 referrals to August 2019. As well as aiming to support self-funders to identify and source appropriate care, there is a target of 5 working days between referral and discharge which sets expectations with families and speeds up discharge for these patients. The expected outcome is 13 referrals to the service per month. Based on previous evaluation there is an estimated annual benefit gain of £2.2k per client.

Flu Immunisations

A small proportion of the Winter Pressures funding will be utilised to support the uptake of flu jabs across independent providers and the wider Bucks population which will have an overall impact on the system by reducing the number of residents who develop flu over winter and may need a hospital admission as a result.

5.3 Admissions to residential and nursing care homes (over 65s)

Our performance in reducing the rate of permanent admissions to residential care has been very strong and continues to be consistently above the 2018/19 target. 2017/18 Actual Residential Admission Rate Performance for each member of the South East puts us second from top.

Table 3: 2018/19 performance for admissions to residential and care homes, per 100,000 population

Admission to Residential and Care Homes	Actual	Target (cumulative)
2018 -19 Q1	118	130
2018-19 Q2	201	260
2018 -19 Q3	250	390
2018 –19 Q4	343	520
2019-20 Q1	80	130

The BCF planning guidance for 2019-20 stipulates that the target associated with this metric be agreed locally. Within the County Council, the Cabinet has set agreed targets including for admissions to residential homes at 400 per 100,000 population of over 65s per year. Consequently it is recommended the same target is to be used for the BCF metrics. This is a considerable decrease on the 2018 target of 520 per 100,000 population and reflects the strong performance in this area.

2019-20 plan against this metric

Buckinghamshire's performance for care home admissions continues to be above target. Performance for 2019-20 against 2018-19 shows a continued decline year on year. As such the target has been reviewed to be more ambitious but achievable for 2019-20.

The demand for residential care is decreasing as a result of implementing a home first methodology which is encouraging more people to stay in their own homes with domiciliary care support. Work to continue embedding this approach would suggest this trend will continue. This includes:

Improved planning and reducing length of stay

Planning discharge from point of admission where possible and the programme of work focused on reducing length of stay is crucial to keeping our admission numbers low as patients will be able to be discharged more quickly, and assessed in their home environment rather than in the hospital bed.

Speeding up the assessment process

There is typically a 5 day delay when waiting of a worker to be allocated and an assessment to take place. This not only impacts on our DTOC performance but can have other implications as it can lead to patient decline whilst they await assessment. A focus on improving the speed of the assessment process through single joint assessments and trusted assessors will improve this, which in turn will enable more patients to be discharged home instead of to residential care.

Strength based approach and scrutiny of placements

Embedding the Better Lives strategy across Buckinghamshire and a strengths based approach when assessing is a key focus. This aims to provide less restrictive community-based services where possible, before considering residential or nursing placements. Once in place, continued high level scrutiny of placements will take place to ensure that care is appropriate and meeting the needs of the patient.

Brokerage

Buckinghamshire's large number of self-funders has led to considerable focus around our brokerage service to ensure that residents make the right choices at the right time in regards to residential care. Investment using Winter Pressures funding to waive the brokerage fee to self-funders will further support this metric by increasing uptake of the brokerage service over the winter period.

Investment in domiciliary care

Utilising BCF funding to create capacity within domiciliary care ensures that the increased demand in this area does not undermine the ability to embed a home first approach and ability for residents to remain at home rather than that move into residential care.

Integration of CHC commissioning with BCC

The integration of the CHC commissioning function with BCC from July 2019 will enable placements to be considered on a more holistic basis with both health and social care needs of the individual taken into consideration.

5.4 Effectiveness of reablement

Our reablement performance has been below the locally agreed target of 75% for several years with the exception of 2016-17 when the target was matched but not exceeded. 2018-19's performance was an improvement on 2017-18 performance which put us bottom of the ranking against our comparator group in South East England. The 75% target is to remain for 2019-20.

Table 4: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Proportion of older people (65+) still at home 91 days after discharge	Actual	Target
2014-15	72%	75%
2015-16	66%	75%
2016-17	75%	75%
2017-18	66%	75%
2018-19	72%	75%

2019-20 plan to improve effectiveness of reablement

For 2019-20, Buckinghamshire's priority for improving reablement outcomes is focused on the integration of the Occupational Therapy and reablement teams. Previous work to align the BCC reablement and BHT RRIC services has been halted and a new approach taken.

New reablement model

A therapy based delivery model is being established and a joint remit currently being developed. This is based on the ethos of "improving and maintaining individuals at their maximum level of function so that they can live as independently as possible in their chosen communities." It is envisaged that this approach will have the most positive impact on service user abilities and ultimately reduce care demand and costs.

The new service model will incorporate the following:

- Introduction of outcome measures
- Therapy based goals
- Increased number of reablement assessors and reviewers available
- Joint OT reablement triage
- Greater clarity regarding suitability for reablement
- Review of documentation and processes to ensure efficiencies in case management

These measures aim to improve Buckinghamshire's reablement outcomes and provide quantitative and qualitative data regarding service delivery. It is envisaged that therapy delivering therapy based smart goals will have a direct improvements on reablement long and short-term outcomes including the 91 day readmissions target.

Additionally, Winter Pressures funding is to be used to supplement reablement through the provision of additional intermediate care beds.

South Bucks progress

In South Bucks a pilot is being developed to consider utilising reablement capacity in another area (Berkshire West) to reduce the delays on Bucks patients awaiting reablement. This is at initial discussion stage but there are steps to progress this further. Additionally, a WPH OT has been seconded to BCC reablement 20h p/w to March 2020 to reduce assessment delays. The domiciliary care capacity through the Wexham Park D2A service is also supporting bridging of reablement and RICC waits.

Home from Hospital Service

The Home from Hospital Service currently delivered by the British Red Cross continues to support and supplement the reablement service by providing up to six weeks of support within the home following discharge. 307 referrals to the Support at Home element of the service were received in 2018-19. The service aims to contribute to reducing readmission rates by enabling service users to regain their confidence and independence after a stay in hospital.

6 Strategic Narrative – our approach to integration

The BCF planning template asks for narrative linked to our overall approach for achieving integration of health and social care. The narrative is to build on the 2017-19 plan, focusing on how our arrangements have developed since then. The questions cover our approach to integrating care around the person, integration at Health and Wellbeing Board level and how we are aligning our approach across the system. A summary for each area is detailed in the sections below.

6.1 Integration of care around the person

Buckinghamshire has some particular demographic challenges. These include a high prevalence of learning disability, over 60% self-funders and an increasing number of older adults. It has been recognised that historically there has been too great a demand on adult social care services which in turn was having an impact on the system for example through unnecessary admissions to residential or care homes or inappropriate decision making by self-funders on what is best and affordable for their long term needs.

In 2018 the County Council developed its 'Better Lives' Strategy. It set out a vision which would enable more people to live fulfilled lives, avoid overdependence on formal social care services and to be able to maintain their independence for longer. Better Lives is established as the transformation programme which underpins the work of adult social care and commissioning within Buckinghamshire to improve adult social care services now and create services which are sustainable for our future residents.

The Better Lives Strategy has three tiers: living independently; regaining independence; and living with support. It considers the person, looking at the positives they have around them and building on these. It accepts that what works for one person might not work for another. In August 2018 48% of our focus was on living independently and 47% on living with support. By February 2019 this had shifted to 28% and 66% respectively; and continues to move in the right direction.

Buckinghamshire's brokerage service has been developed to offer support to self-funders currently within hospital. This was initially piloted from November 2018 to January 2019 and identified a potential annual benefit gain of £55k from 25 referrals. 11 self-employed brokers worked with Stoke Mandeville Hospital to support the self-funder to identify and source appropriate care and aimed to enable discharge of the patient within five working days, of which a 69% success rate was achieved. The brokerage service will continue to be delivered to the hospitals utilising the Winter Pressures Grant to waive the charge to the patient which in turn encourages greater uptake and engagement to the service.

In July 2019 Buckinghamshire integrated it's commissioning of placements for continuing healthcare funded clients. This function has been brought into Buckinghamshire County Council's placement finding team who now undertake all commissioning for these health placements. This integrated approach means offers a more streamlined service for the individual and reduces conflicts and competition between health and social care in terms of placements and prices.

Buckinghamshire is committed to increasing the use of Personal Health Budgets (PHB) where it clearly adds value to patients and contributes towards financial sustainability. All those eligible for CHC continue to be offered PHBs. The focus for 2019-20 is to continue to raise the profile of PHB provision amongst those who are eligible to ensure the continued expansion of PHB uptake. In 2018/19 it was also

identified that there was an opportunity for PHBs to replace the successful wheelchair voucher scheme. This initiative continues to be expanded during 2019/20. As part of our plans for 2020-21, we are working to align our Personal Health Budgets with our Direct Payment processes.

Prevention is a priority for investment for the Buckinghamshire ICS. There is a need in Bucks to move away from unnecessary delivery of high level interventions and support towards a more sustainable model of early support using a strengths-based approach to enable individual's to develop their own resilience. As a result, in 2018 Buckinghamshire published a market position statement (MPS) for prevention. The vision for the future aligns with the ICS' to engage individuals and communities, building on their strengths and assets, promoting resilience and independence and creating an environment that supports people to live healthy lives, feel in control and be able to care for themselves and each other.

This is only possible with good availability of easily accessible information and advice and sufficient local networks to make it as easy as possible for residents to access support when they require it to look after themselves, improve their own lives and remain independent for as long as possible. Therefore, there is a focus on ensuring sufficient provision of early support or intervention across the full range of voluntary, community, public and private provision to best suit the needs of Buckinghamshire communities.

As part of this work, the new Primary Care Network (PCN) Link Workers announced as part of the NHS Long Term Plan will be offering the opportunity to provide social prescribing to a wider group of residents.

There are several pieces of work being undertaken which facilitate an approach to integrated care around the person. Notably, within reablement, work is underway to integrate the BCC reablement and the OT service. The service will have a focus on therapy and will be based on the ethos of enabling individuals to maintain their maximum level of function. It is envisaged this approach will have the most positive impact on service user abilities, will serve as a vehicle to deliver effective preventative interventions and reduce care. A single joint assessment process will form part of this and work is currently underway to integrate the triage process of reablement and occupational therapy into one before this is merged with the triage service delivered by the Adult Early Intervention Team.

The development of a single point of access will offer one point of access for all patients in Bucks who no longer need acute care or can have an admission to hospital avoided. There is a two year plan in place to enhance this further once fully established to include mental health, 111 and the county council contact centre.

Within the Preparing for Adulthood team, a programme of work is underway to co-locate and integrate core teams from September/October 2019. This will bring

officers closer together to bring care more around the individual. Additionally dedicated SEN officers will be closely aligned with this new integrated team.

6.2 Our approach to integration at Health and Wellbeing Board level and wider services

The 2017-19 plan outlined a number of approaches to integration including joint commissioning of certain posts to enable more joined up working. Since then, a restructure has been completed to fully integrate commissioning across all ages in 2018. The commissioning function is jointly funded by BCC and Bucks CCG through a Section 75 agreement.

The newly developed integrated commissioning team includes a team with a dedicated responsibility for developing further integration with health. Part of this team's role is to support the aims and objectives of the BCF, working with health partners across the CCG and BHT to work collaboratively on pathways and schemes to improve transfers of care and non-elective admissions, as well as the effectiveness of reablement and our long term residential and care home admissions. The function also enables dedicated officer time to work alongside the BOB ICS and Buckinghamshire ICP to consider commissioning approaches and options at a wider system level.

Additional joint health and social care commissioning work across the integrated commissioning teams includes reviewing the urgent care pathway for mental health; a new integrated short breaks service and all age integrated carers service. Continuing Health Care (CHC) has been integrated within the BCC placement commissioning team to identify placements so patients can move from hospital in a more timely way.

The development of Primary Care Networks (PCNs) will support the sustainability and delivery of our ongoing out of hospital provision. The 12 PCNs across Buckinghamshire will be supported by 'fully integrated community-based health care' and are working closely with the County Council to develop wider networks across health and social care. It is also one of the key priorities of the ICS is to ensure our PCNs develop to provide collaborative, accessible, co-ordinated and more integrated primary and community care.

We are using a population health management approach to understand the needs and priorities within our PCN populations and identify target population segments with high utilisation or unmet need. Priorities will be set based on local health needs to deliver improved outcomes and efficiency, reduce unwarranted variation and drive down inequalities. As part of this, services provided locally, including those currently funded by the Better Care Fund, will be reviewed. Representatives from the wider Voluntary Sector will also be key members of these local partnerships.

BCC commissions a Voluntary and Community Sector Infrastructure service which is responsible for working with VCS organisations to help them to develop, grow and become more sustainable. The service supports the sector by delivering workshops and advice sessions on subjects such as governance and funding, supports them with volunteer recruitment and provides two way communication between the sector and local authorities. BCC is in the process of developing a VCS Strategy for the new unitary authority, working in partnership with the district councils and five large VCS organisations. This strategy will define the Council's future approach to the sector.

More specifically, Buckinghamshire has recently refreshed and relaunched its provider forums, inviting providers from across the market to engage in more regular face to face conversation with commissioners from both health and social care. The forums are attended in the majority by domiciliary and residential care services are able to listen, engage and support the development of our priorities. The most recent forum included a workshop around the enhancing health in care homes work stream to feed into the working group around the accessibility of accessing different primary care services and the challenges face. Additional work is ongoing to set up a specific workshop to engage VCS providers who may be able to support the hospital to home pathway including admission avoidance and discharge support. The first workshops are to be held in September and October 2019 jointly delivered by BCC, Bucks CCG and ICS partners. Work is also ongoing to engage prevention based VCS providers and a prevention market position statement was published via BCC in 2018.

Buckinghamshire's Joint Health and Wellbeing Strategy was developed in 2017. The Health and Wellbeing Board developed priorities, outcomes and performance indicators in five key areas:-

1. Ensure every child has the best start in life
2. Keep people healthier for longer and reduce the impact of long term conditions
3. Ensure everyone has good mental health and wellbeing
4. Protect residents from harm
5. Ensure our communities can thrive and Buckinghamshire remains a great place to live

The Buckinghamshire vision is to improve the health and wellbeing of the entire population of Buckinghamshire, whilst reducing health inequalities within and across defined population groups. The aim is to rebalance the health and social care spend in Buckinghamshire to increase support for living, ageing and staying well, and prevention and early intervention initiatives. Our BCF plan is aligned to these priorities.

6.3 Our approach to integration with wider services

Buckinghamshire County Council, along with our four District Council partners, continues to explore wider applications of the DFG which will support our shared aims. BCC and the Districts work together to review projects in the context of the 10 quality standards set out by Foundations (the national body for Home Improvements) in respect of our application of DFG in the BCF to see if there are further improvements we could initiate in Buckinghamshire. Opportunities for broader strategic developments are also being picked up through the implementation of the LGR and the creation of a unitary authority for Buckinghamshire.

In Buckinghamshire we have a Joint Housing Adaptation Group (JHAG) that meets quarterly. The membership includes all District Councils, the main Housing Associations, Integrated Commissioning and Children's and Adults Occupational Therapy. This group monitors the process from application through to delivery, intervening in the case of blockages to proactively find solutions and seeks to implement improvements as they are identified. Representation from community occupational therapists (OTs) is essential to enable an operational and strategic level discussion about how the DFG can be deployed to enable people to remain independent living in the community and thus preventing unnecessary admission into long term residential care.

A recent development was the countywide rollout of a new discretionary grant called 'Healthy Homes on Prescription' initially piloted in Wycombe, which seeks to prevent hospital admissions and assist with managing timely discharge from hospital. This initiative, funded using the DFG, accepts referrals from healthcare professionals who have identified vulnerable residents who require minor adaptations in their homes that will have a positive impact on their health. This could range from installing and repairing heating and other minor repairs, to installing electrical points for medical equipment and widening doorways to accommodate wheelchairs; all of which can assist with timely discharge from hospital. There are numerous positive case studies since its launch.

The full DFG funding allocation as set out by DCLG has been passed down to each District Council as agreed nationally and locally.

6.4 System level alignment

Buckinghamshire was one of the first of the new wave of ICSs. Since the 2017-19 plan there has been considerable development with the former Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership (STP) working towards becoming an ICS by April 2020 and the Buckinghamshire ICS moving to an Integrated Care Partnership (ICP). The BOB ICS oversees planning and commissioning across the three ICPs and provides the system leadership required. This development of our accountable care systems provides an even stronger basis for us to embed our integration approach and align

our priorities across the system. They offer the greatest opportunity for Bucks and beyond to work as a system to improve outcomes.

The ICS is acting as an enabler to progress with implementing the HICM and feeds into supporting the BCF metrics.

Urgent and Emergency Care – A&E Delivery Board

The overarching vision for urgent and emergency care is that these services will be fully integrated and that as patients become unwell, they move between health and social care providers seamlessly, accessing a responsive service, close to home and tailored to their individual needs. This incorporates the following:

- Hospital level care provided in an ambulatory setting wherever possible
- Only patients who truly require emergency department input access this
- When patients who stay in hospital are clinically optimised, they return to their home wherever possible
- Assessment for long-term care and support is undertaken out of hospital, in the most appropriate setting, and at the right time for the person

This stream of work also oversees the winter plan which is developed at an ICS level. The recruitment of an ICS Winter Director has enabled a considerable focus on work to improve patient flow and bring partners together across the system to embed these new practices as business as usual.

Furthermore, a comprehensive ICS NeL programme of work has been established which includes a number of projects to support effective delivery of the Buckinghamshire NeL demand management programme in Bucks. It amalgamates key elements including avoidable attendances to A&E, avoidable non-elective admissions and a home first approach to discharge.

Integrated Care

The integrated care portfolio has been established to build 24/7 sustainable resilience and capacity across the system by further developing primary care and community services, and will support the ICS in delivering its strategic aims/goals. This programme incorporates discharge to assess, integrated discharges, trusted assessor, integrated short term interventions, enhancing health in care homes and the development of a single point of access for rapid response to avoid admissions and support prompt discharge from A&E. Task and finish groups associated with these priorities are all underway.

Digital transformation

There are additional programmes which act as enablers for achieving these programmes and priorities. These include digital transformation where there has been work undertaken for more effective management of our capacity and demand through the development of new real time dashboards for visibility of flow across the system and 24/7 patient tracking to enable better control over demand and patient flow.

Population health management

The move to working as an ICP encourages a further focus towards to place based commissioning in Bucks along with the development of the PCNs. For example, there is a desire to embed a consistent, systematic approach to reducing health and care inequalities across the ICS and as such this forms one of the key ICS priorities. We have agreed to embed prevention, self-care and tackling inequalities in all our work streams and are using a population health management approach across the ICS to analyse needs and identify people at risk of becoming acutely unwell/experiencing longer term health inequalities. For example, reducing the inequality gap in cancer is a key target of the ICS. More targeted segments identified for focused work sits within our PCN level.

Additionally, we are developing a shared approach to social prescribing across the ICS involving health, social care and the voluntary and community sector. This will improve the range, diversity and availability of support to the public. Buckinghamshire Social Prescribing Steering Group, including organisations from local authorities and the voluntary sector is working to make our social prescribing services more accessible to the population and to raise its profile amongst professionals and the public. We are also developing a system wide action plan to tackle social isolation.

It is expected that our integration approach and system alignment will only continue to develop as we share learning and best practice across systems.

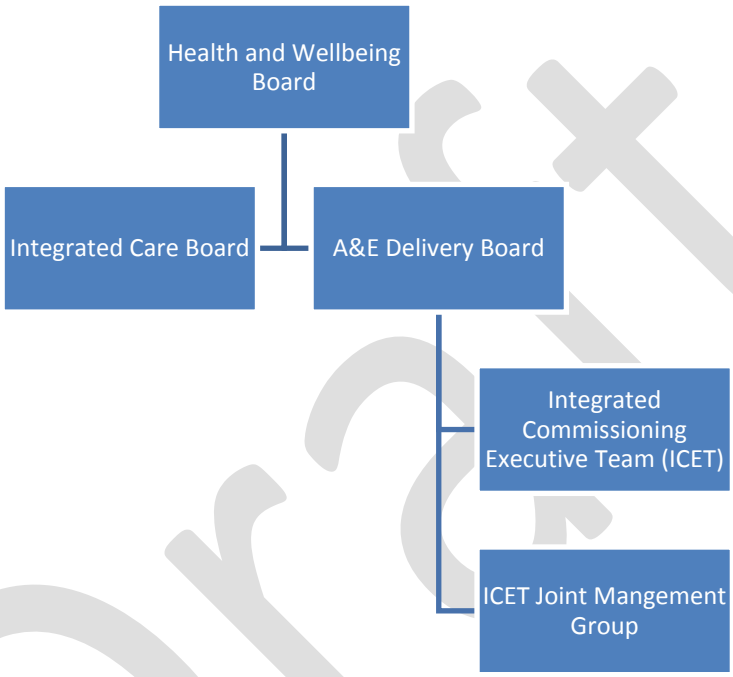
Governance

Joint governance arrangements are in place for the BCF. BCF performance is overseen by the Integrated Commissioning Executive Team (ICET) made up of BCC and CCG senior leaders. ICET provides joint accountability and oversight of the strategic direction, budget and performance of the BCF plan. Updates on performance against the metrics are taken to each ICET meeting.

ICET feeds into A&E delivery board which further scrutinises our winter plan and ensures we are working to meet system demands. Alongside this, there are several ICS boards which have a link to the BCF. These include the Integrated Care Board which oversees the delivery of the Home First and Care Homes approach and the

aforementioned A&E Delivery Board which focuses on urgent care and winter planning. These offer further system discussion, planning and guidance to formulate our priorities and strengthen the governance and oversight of our plan.

These boards feed into the overall joint Buckinghamshire Health and Wellbeing Board where the plan is formally signed off. The ICET joint management group (JMG) oversees the spending and performance of the Section 75 agreements between Buckinghamshire CCG and BCC including the BCF. The figure below shows the governance structure for the boards that the BCF plan feeds into.



**Other boards feed into these which are not listed*

7 Reporting

Report of the BCF is typically through quarterly returns submitted to NHSE. These returns cover performance in relation to the CCG minimum contribution against the metrics and national conditions. The timetable for 2019-20 is still to be confirmed, however guidance has been given that there will be no Q1 reporting due to the delay in releasing the allocations to authorities. It has also been confirmed that the Winter Pressures Grant will form part of the 2019-20 reporting but the requirements remain to be confirmed

For iBCF, the reporting requirements have been stripped back. Reporting on iBCF will only be required in Q2 and Q4 and will encompass the following:

Q2 (July – Sept) reporting (iBCF):

a) Details of the average amounts paid to external providers for care (both home care and domiciliary care) in 2018-19, and on the same basis, the average amount that you expect to pay in 2019-20.

Q4 (Jan – March) reporting (iBCF):

a) The proportion of your additional iBCF funding for 2019-20 allocated towards each of the three purposes of the funding

b) Assessment of the impact the additional funding for 19-20 has had on:

   i. Number of home care packages

   ii. Hours of home care provided

   iii. Number of care home placements

All quarterly reports are signed off via ICET who have delegated authority from the Health and Wellbeing Board. Sign off for 2019-20 will be reviewed to account for the additional Winter Pressures monitoring which is usually approved by A&E Delivery Board. The first quarterly return expected is in October 2019 to cover Q2 performance.

8 Sign off

In previous years, to enable sign-off of the BCF plan and routine data returns, if there's often little time between releases of frameworks and return dates, approval has been delegated to senior officers. However, due to the addition of the Winter Pressures grant within the BCF plan for 2019-20 the plan is being taken to a number of board meetings for comment and approval:

- CHASC Senior Management Team
- CHASC Business Unit Board
- Corporate Management Team
- Integrated Commissioning Executive Team
- A&E Delivery Board
- Buckinghamshire CCG Executive
- Buckinghamshire Health and Wellbeing Board

Once the plan has been approved and signed off by both BCC and CCG leads the plan will be submitted to NHSE for approval. The plan is then moderated and scrutinised regionally before being approved nationally. Approval letters are expected in late November 2019.

After the approval of the plan BCC and Buckinghamshire will be required to update their Section 75 agreement. This must be completed by 15 December 2019.

9 References

1. Health and Wellbeing Board Strategy: https://www.buckscc.gov.uk/media/1282/health-and-wellbeing-strategy.pdf
2. Buckinghamshire Joint Strategic Needs Assessment: https://www.buckscc.gov.uk/services/health-and-wellbeing/joint-strategic-needs-assessment-jsna/