Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Telford and Wrekin Council**
Clinical Commissioning Groups	**Telford and Wrekin Clinical Commissioning Group**
Boundary Differences	**Co-terminous boundaries**
Date agreed at Health and Well-Being Board:	**17 September 2014 by delegated authority**
Date submitted:	**19 September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£645,000**
2015/16	**£11,690,000**
Total agreed value of pooled budget: 2014/15	**£12,908,000**
2015/16	**£12,068,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Telford and Wrekin Clinical Commissioning Group
By	David Evans
Position	Chief Officer
Date	17/09/2014

Signed on behalf of the Council	Telford and Wrekin Council
By	Paul Taylor
Position	Interim Director of Health Well-being and Care
Date	17/09/2014

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Telford and Wrekin Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Richard Overton
Date	04/04/2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment (JSNA) informs the development of priorities across the economy. The process brings together and explores a wide range of data, performance information and intelligence to identify those issues where the Borough is doing well and also those which remain a challenge and where more needs to be done. The JSNA is not one single document - individual parts of the JSNA can be found on our facts and figures page. The latest analysis from the JSNA process has been used to help identify local health and wellbeing needs,
Health & Wellbeing Strategy	This strategy sets out our commitment to working in partnership to improve the health and wellbeing of

	people living in Telford and Wrekin. The Telford and Wrekin HWBB is responsible for delivering the strategy and addressing health inequalities. http://www.telford.gov.uk/downloads/file/4123/hwb_priorities_consultation_may_2012
Urgent Care High Level project Optimising Capacity proposal supported by Chief Officers Group, approved by CCG Board.	The project reviewed issues faced by the economy in managing urgent care demands. It showed that the current network of bed capacity, resources, care pathways, teams and skills were not optimised, thus creating inefficiencies. The project set out an integrated health and social care model of working to support discharge. Key features included: Discharge home to assess as the norm; a Single point of access and referrals mechanisms; integrated triage, co-ordination and management; a shared record; rapid access to advice and 7 day working. http://www.telfordccg.nhs.uk/board-papers-9-july-2013
Multi-agency strategy for Carers 2013- 2016	This multi-agency strategy sets out the ambition for local Carer services as well as, new national priorities identified by Government. The strategy's priorities will be supported by an action plan which will inform how these priorities will be met. The monitoring of the plan will be undertaken by the Carers Partnership Board where carers actively contribute to discussions and debates. From a grass roots level, continued engagement with the Carers Forum will ensure carers have the opportunity to influence and shape future services, which affect both carers and the person for whom they care for. http://www.telford.gov.uk/downloads/file/5201/carers_strategy-draft
Older Adults strategy 2006-2016	This Joint Strategy sets out the health and social care commitment to working with older adults in Telford & Wrekin, and our partners, to ensure that every older adult can access information when they need it, is valued as a citizen and as a member of their local community, always has opportunities to improve his or her health and wellbeing, receives the care and support he or she needs to live as independently as possible and has personal choice and control over how the care and support they need is organised and provided. http://www.telford.gov.uk/downloads/file/2686/older_adults_strategy_refreshed_2010-2014
Multi-Agency Living Well with Dementia Strategy	This Joint Commissioning Strategy seeks to change the shape and quality of existing services to address

	the objectives in the National Dementia Strategy, 2009 (NDS). The purpose of the document is to drive the development of an equitable, seamless and coordinated dementia service of a good quality, using an agreed pathway served by agreed protocols and staffed by a trained, competent workforce. Implementation of the Strategy is through and Health and Social Care Economy Group for Dementia and accountable to the Health and Wellbeing Board.  Dementia Pathway - Living with Dementia !
Rehabilitation and Reablement strategy 2010-13	This strategy sets out the proposed developments and changes to rehabilitation and re-ablement services in Telford & Wrekin. The overall aim is to provide a range of services that improve the quality of life for people and enable them to live as independently as possible. To achieve this, services must be timely, accessible and organised to meet individual needs.   Rehabilitation and Reablement Strategy Rehab Action Plan 2012.doc
Integrated Community Enablement model	This paper sets out an approach to supporting frail elderly people with complex care needs through an Integrated Community Enablement model. It seeks to reduce admissions and length of stay through increased community capacity. The paper was supported by the CCG Governance Board http://www.telfordccg.nhs.uk/board-papers-12-november-2013
2-5 year Plan	http://www.telfordccg.nhs.uk/strategies
Strategic Clinical Review of hospital care and vice versa locally branded as 'Future Fit'	http://www.telfordccg.nhs.uk/future-fit
Adult Social Services Service Plan 2014/15	This plan that sets out what Adult Social Services does and the teams that currently sits in each area. Also included are the service's priorities, challenges, opportunities and key work streams for the year.  Adult Social Services 14 15 final.pdf
Council Medium Term Plan 2013/14 to 15/16	This Plan provides an opportunity to reflect on the Council's achievements over the past year as well as focusing on our future goals

	Council Plan - Council Plan - Downloads - Telford & Wrekin Council
Accelerated Pilot implementation plan	The development of the Accelerated Pilot is phase of the development of the Integrated Community Enablement Team. The Pilot was implemented from July 2014  Implementation Plan for the Accelerated P
BCF implementation Plan	The Implementation Plan in place and updated since March 2014  Better Care Fund Implementation Plan \

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

In five years time social care and health services will be fully integrated in the delivery of community based services care. The development and implementation of integrated health and care structures which will be contributing to a better patient experience/ improvement in outcomes but at a significant lower cost.

The BCF will be used to transform the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care.

The aims are:

- Delivering the best possible health and social care outcomes for individuals in a personalised way.
- Promote and encourage self-help and self-care wherever and for as long as possible
- Enabling those at increased risk of hospital, nursing or residential care admission to have easy access to systems in place, to get appropriate help at an early stage.
- Ensuring financial efficiency and reducing duplication.

Six performance measures will be used to monitor progress through the Programme Management Board:

- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Improved patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.
- Reducing emergency admissions in 65 years + age group.

The current focus for the BCF is to transform public services for adults needing high levels of health and/or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission to hospital or care home
- Discharged from hospital with a need for rehabilitation and/or enablement

This is based on JSNA evidence of demographic changes. Local residents aged 65 and over are an increasing proportion with the fastest increase since 2001 in the 85+ age group (27.3%). The 65+ population is expected to increase by 9,200, an increase of 37%. This age group currently represents 14.5% of the total population. By 2026 this will 17.3%.

However integrated services will incrementally extend the target population in line with JSNA evidence including substance misuse, cancer, obesity, smoking and diabetes. JSNA key facts and figures (above) highlights:

- Inequalities in life expectancy between our most affluent and most deprived communities are predominately due to cancers and cardiovascular diseases
- Early death rates (under 75) from bowel cancer are higher than average and the incidence of lung and mouth cancers is worse than average
- In terms of waiting and treatment times for patients with cancer, the national standard times are not consistently delivered for the main tumour sites
- The prevalence of diabetes has doubled in the last decade increasing to 6.3% in 2012/13 from 3.4% in 2004/05, this equates to 8,669 people currently with diabetes
- Smoking-related hospital admissions are higher than the national average, approx 1,500 per year
- The high levels of excess weight and increasing prevalence of diabetes coupled with our ageing population will have a significant impact on the future local demand for health services. This includes: primary care, diabetes eye screening, diabetes care services and vascular services etc
- There are variations in the quality of treatment for patients with hypertension (high blood pressure) across our GP practices

The 2-5 year plan identifies that the priorities build on the local intelligence contained with the JSNAs. Strategic thinking in relation to health and wellbeing incorporates the Health and Wellbeing priorities, as part of the work on the Better Care Fund.

An Integrated Commissioning Strategy 2015 – 2020 will incorporate all elements of activity, growing beyond the areas of focus outlined in Themes 1 and 2 of the first operational year of BCF (2015-16).

Governance arrangements will be overseen by the Better Care Programme Management Board who reports to the Health and Well-Being Board via the an overarching Strategic Commissioning and Transformation Group.Individual organisation also report into their own governance structure. A detailed Action Plan will cover the first two years of activity in detail and provide broad strategic intentions for the remaining three year period. Annual review will allow the Action Plan to remain 'live' and be flexible to respond to local trends and priorities.

Efficiencies (net of agreed QIPP/saving targets) will be achieved by a reduction in management and administration; streamlining access to services; greater integration of services. Centralisation of identified functions will support further reinvestment in the local health and social care economy. The main focus of work will remain on prevention and Enablement.

Patient and service users will be reporting high levels of satisfaction with services. Building on existing patient experience surveys, feedback engagement and co-production they will be fully engaged in the design and consultation in relation to the development of services. Evidence of user engagement is set out below.

Local people will receive care and support from Integrated services. This means that providers from the Local Authority, the acute sector (including mental health and learning

disability services), community health services will deliver care in an integrated way and in collaboration with the voluntary sector and in partnership with providers of residential care (private and voluntary sector).

Patients and service users will have been supported to develop a range of self help systems including developing community capacity to support each other. They will have been supported to become more aware of individual responsibility to address potential and anticipated health issues, thereby reducing the need for admission into public sector funded services. The main vehicle to support this programme of cultural and behavioural change will be driven by Public Health. The focus will broaden beyond conditions associated with people over the age of 65 to include other major conditions including obesity and substance misuse including smoking and alcohol, as well as other long term conditions including mental health, autism and learning disability

Patients and service users will have a greater confidence in the range of early help and preventative support services available to them and appropriately use them as opposed to acute services. Where there is a need to use acute services these will be provided in a timely manner.

Much more work will take place in collaboration with local schools to provide the early educate in relation to healthy lifestyles as part of the long term strategy of health promotion and personal responsibility.

In partnership with local media and existing and established communication networks, the general public will have increased awareness of ‘what to do’ and ‘where to go’ to gain information, advice and support relating to their own health and well-being.

The voluntary sector will have established itself as a key partner in progressing this agenda for change. Specifically, there will be greater alignment within and across the voluntary sector and an increased investment over the five year period, funded by efficiencies achieved through increased integration. This will build on the work that is currently taking place with the voluntary sector and we will seek to achieve a co-production approach to change. This is intended to ensure that the voluntary sector, as a whole, reduced the demand for health and social care services through their development.

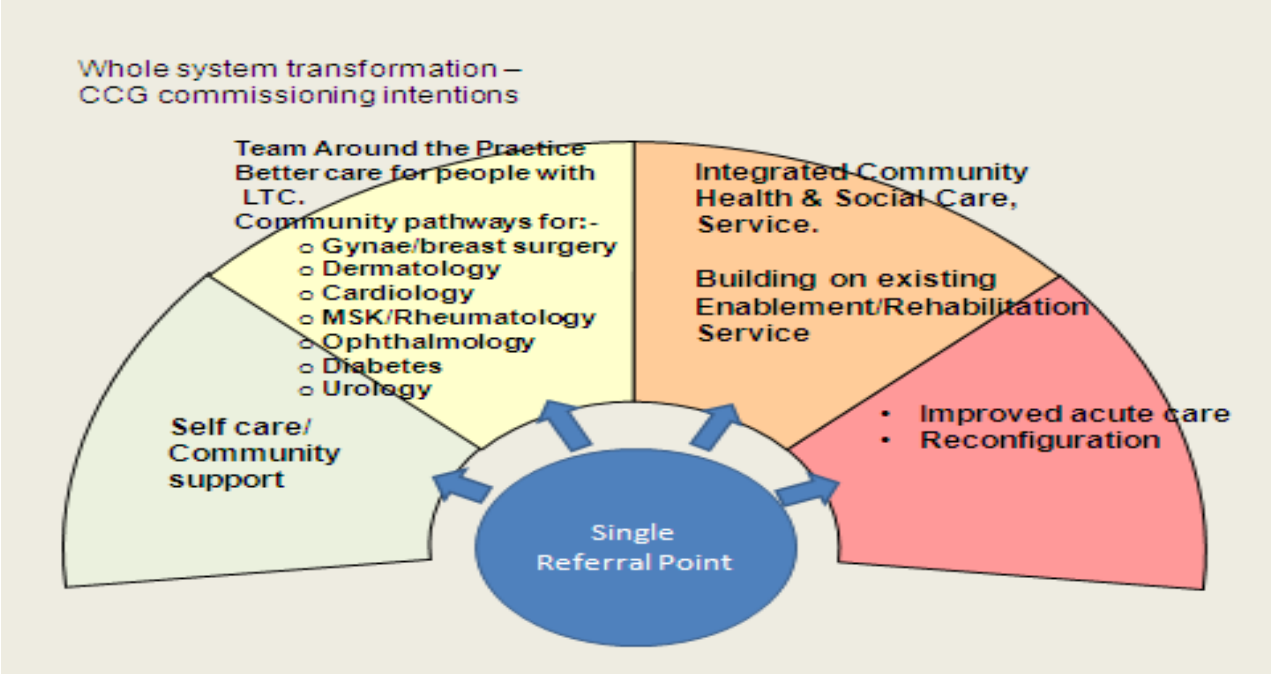
Health and social care services have been committed to transforming the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care.

Council transformation has been driven by the national personalisation agenda in Adult Social Care which recognises that the traditional ways of delivering community care services are unsustainable against a background of budget constraints and increasing numbers of frail older people needing support. There is evidence that the historic approach can disable people, create dependency, is risk averse and leads to an over prescription of support, whilst discouraging innovative, personalised and more cost effective interventions including self-help and support.

Therefore the Council’s commissioning intentions are based around a more personalised approach with the person and their family taking greater control themselves through access to:

- Universal Information, Advice & Living Well
- Community Support to facilitate self-help
- Single point of access for specialist advice & support
- Prevention & Enablement to maximise independence and avoid or reduce the need for ongoing care and support
- Personal budgets to give greater choice & control for those who need ongoing support
- A network of support brokers who can offer knowledge, expertise, guidance and planning to service users leading to the creation of a Care and Support Action Plan

Similarly the CCG demonstrates its 'high level' commissioning intentions through the model below:



The four elements in the CCG commissioning strategy include:

- Stronger communities – to strengthen communities; develop greater capacity for patients to 'self-care', and to offer support to families and carers.
- A Team around the GP Practice – strengthen primary care with a multi-disciplinary approach to proactive support patients with Long Term Conditions, particularly those who are vulnerable.
- Enhanced Integrated Enablement Team – to build on the existing Home from Hospital and Enablement Services and to broaden the remit to include a community based Falls Service, all admission avoidance; all discharge of Rehabilitation and Enablement and End of Life Care.
- Improved Hospital care– ensuring acute hospital services has effective processes from ED attendance, admission, treatment pathway to discharge to ensure quality and efficiency.

The greatest synergies between the discrete Council and CCG plans is in the shared aspirations for:

- Prevention, self-help/self-care and building Community Capital
- Maximising Independence through the Integration of Out of Hospital and Enablement Services.

To deliver these aims two thematic areas and objectives have been developed. These are the two BCF schemes:

Theme (Scheme) 1 - Building Community Capacity in Telford and Wrekin

- To review current spend by both organisations on the voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
- To support improvements in the infrastructure of the voluntary sector
- To jointly design and procure a range of support services that can be delivered by voluntary and community organisations
- To work through a robust engagement process with self-help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
- To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.
- Achieving efficiency and reducing duplication

Theme (Scheme) 2 – Enhanced community services for Telford and Wrekin as an alternative to hospital provision

- To review how existing services funded by the resources being pooled in the BCF can be maximised to improve and enhance quality, value for money, and outcomes.
- To complete modelling to confirm how many people can be supported in Out of Hospital care, what staff are required (clinical and care) and what the costs will be.
- To establish an enhanced and expanded integrated and multi-disciplinary 'Out of Hospital Service'. This will provide a comprehensive continuum of services from admissions avoidance to end of life care.
- To utilise non-recurring Transformation monies in the CCG allocation for 14/15 to 'Invest to save' in staff and processes, evaluate Pilots and innovations to reduce admissions in readiness for 2015/16.
- To establish processes for referrals/access/assessment and support by the enhanced integrated service including the establishment of a Single Referral Point.

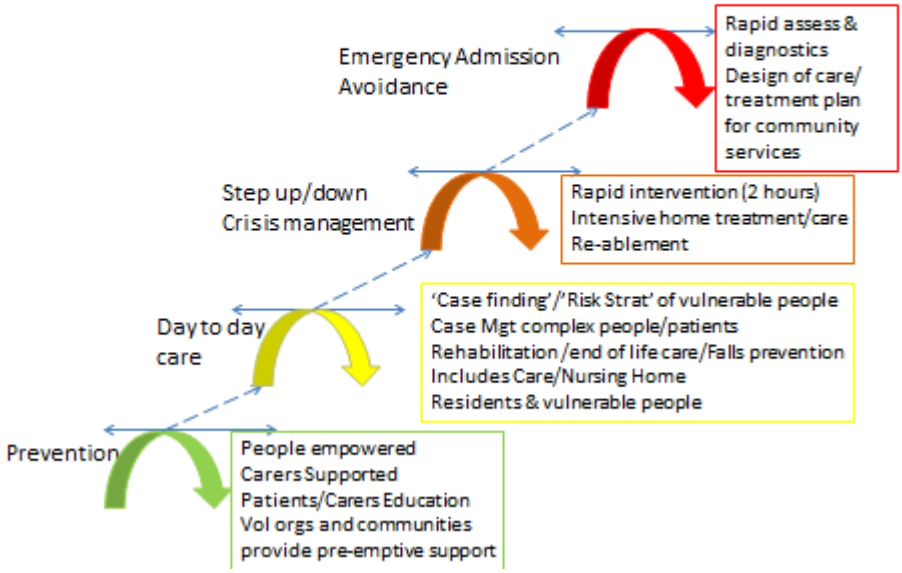
An additional area identified that will align to BCF is Team Around the GP Practice. This area connects Themes I and 2 and is also a major transformational programme within the economy. Team Around the Practice will develop a model to support primary care in reducing urgent and planned care admissions; case management of patients who are at high risk of admission or high users of NHS and / or social care services; further develop effective management of long term conditions where primary, community and/or social care interventions are needed

The two Themes/ schemes aligned with the Team Around the GP practice will enable transformation of all community services across community, primary and voluntary sector. By 2018/19 the local provision will be:

- Enhanced self- help, self-care and local community networks giving low level support minimising the need for health and social care services.
- The Team Around the Practice will providing enhanced 7 day services including planned care treatments, diagnostics and shared care with acute clinicians.
- Enhanced Community services comprising acute and community staff working together across the acute and community services to maintain people at home to reduce admissions.
- A hyper-acute provision that works with community services to admit only those who need that level of care.

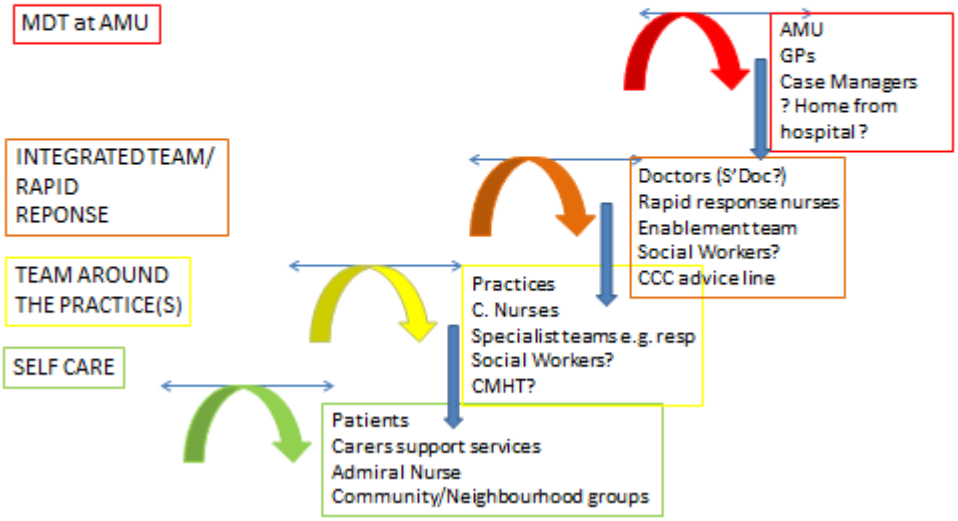
To support the implementation of the BCF schemes, a tiered approach has been developed. This sets out how services area aligned to levels of need

What would happen at each 'safety net'



Who works where?

NB model expects each 'tier' to support those below



The BCF will be developed in line with this tiered approach; identifying how services will operate and developing early intervention/preventative services for diverting service users away from high cost hospital or community care placements. By 2018/19 this approach will be fully in place.

Care and support will be delivered from community settings. A community based multi-disciplinary Enablement team is already in place which comprising nurses, occupational therapists, physiotherapists, social workers and care staff. Discussion is already under way as part of the Phase 2 development of the integrated provision

to identify accommodation for a larger integrated team. The team will have a central location, with hubs located across the Borough including named local GP surgeries. Care will be delivered along care closer to home: occurring directly in individuals homes as well as bases and places. This is to support local integration, aligning people within local support services to reduce isolation and reduce the long term need for higher level health and social care services.

Over the next five years there will be increased access to integrated care on a 24 hour, seven day week basis. The intention is to ensure the 24 hour, seven day week is a comprehensive service and includes all supporting functions to ensure ongoing delivery over weekends, evenings and bank holidays. There will be incrementally development of existing services that work out of normal office hours. Current services include:

Rapid Response is a 7day 8am -10pm provision;
Enablement is a 7 day service for care and support;
Shropdoc provides medical assessment out of hours to ensure a 24 hour medical response is available in the community.

Care and support being delivered though the development of the two schemes:

- Transformation of voluntary services to deliver more and more joined up voluntary support within communities;
- An Integrated Community Enablement team that will use evidence based interventions to avoid hospital attendance and admissions as well as support early discharge from hospital. This is set out within the Integrated model attached below.

Part of the cultural change will include increased use of Personal health and / or budgets, giving greater choice and control to individuals. The local economy will also implement a support broker model whereby a trained independent person will offer knowledge, expertise, guidance and planning which will be used to support the service user in developing a quality care and Support Action Plan which is personal to the service user.

Specific changes intended to be delivered using the Better Care Fund are:

- Achieving sustainable change
- Integrated delivery of all aspects of health and social care, so the approach will be comprehensive- currently developing plans for implementing this model (below)
- Established and adopted a multi- tiered model of care delivery and aligned capacity to meet demand in those tiers.
- Removed overlaps and duplication and to ensure timely response is given to patients requiring services. The accelerated pilot is currently testing out a new way of working. Early indications suggest the need for greater integration of services and proposals are currently being worked up to put this in place.
- Clear governance structures by creating a Better Care Programme Management Board, Strategic Commissioning Group and clear reporting lines into the Health & Wellbeing Board

Evidence of service user and public engagement is set out in the section below. In

summary: Healthwatch and voluntary organisations (through the CVS) are standing members of the Programme Management Board and each work-stream (see Terms of Reference); a service user and carer representation has also been identified, users and carers have been engaged through the Urgent Care Transformation Board, Health Roundtable and a public engagement event. A further event takes place on 24th September.

Service users and public participation was evidence within the BCF launch event. That is summarised below.

The BCF approach is based on the demographic changes, local Health and Well-Being priorities and local public health needs. The focus on the 65 years + population is in line with the broader demographic, and socio-economic changes locally. People aged 65 and over are an increasing proportion with the fastest increase since 2001 in the 85+ age group (27.3%). The 65+ population is expected to increase by 9,200, an increase of 37%. This age group will grow from 14.5% currently to 17.3% of the total population by 2026 with the very significant associated costs unless addressed.

The Integrated model attached below highlights the evidence base for the local approach. The specific change will be the co-location of the current Rapid Response team, Enablement service, community services and acute hospital staff, through a phased development, into a single integrated team. This will be managed with overall responsibility for the performance. Care and support will be community based, through a single point of access and integrated assessment.

Local people will receive care and support from a single Integrated service within their own home or in local bases and places to promote socialisation and access to local services. This means that providers from the Council, the acute sector (including mental health and learning disability services) and Community heath be aligned to deliver services in an integrated way. The integrated service will include the voluntary sector and in partnership with providers of residential care (private and voluntary sector).

Individual patients or service users will benefit from having a bespoke, personalised service which is tailored to their needs and remains in place for the required duration. Individuals will have the right, and be supported to have access to a personal budget and be in control of decisions affecting their lives.

The decision to move towards increased integration will provide a transformational approach to local practice and be one of the key critical component parts of changes linked to BCF. Without BCF, it is likely that we would have retained separate provider services with various levels of duplication and a pathway which focussed on the needs of the organisation rather than the patient/ service user.

While planning was taking place for more integration of services to BCF has accelerated thinking and timescales for development

Integrated model v4 11 8 14.docx

b) What difference will this make to patient and service user outcomes?

Patients and service users will have been supported to become more aware of individual responsibility to address potential and anticipated health issues, thereby reducing the need for admission into public sector funded services. The main vehicle to support this programme of cultural and behavioural change will be driven by Public Health. The focus will broaden beyond conditions associated with people over the age of 65 to include other major conditions including obesity and substance misuse including smoking and alcohol, as well as other long term conditions including mental health, autism and learning disability

Far more work will take place in collaboration with local schools so as to prevent addictions beginning during the formative years of our younger population.

The voluntary sector will have established itself as a key partner in progressing this agenda for change. Specifically, there will be greater alignment within and across the voluntary sector and encouragement to maximise the use of resources across the sector - efficiencies achieved through increased integration. This will build on the work that is currently taking place with the voluntary sector and we will seek to achieve a co-production approach to change

In partnership with local media and existing and established communication networks, the general public will have increased awareness of 'what to do' and 'where to go' to gain information, advice and support relating to their own health and well being.

The BCF will be used to transform the health and social care system in Telford and Wrekin, promoting greater independence for patients and service users and improving on current areas of integrated care.

The measures of benefits in terms of health gain and/ or personalisation and independence can be summarised in two categories – non-financial and financial benefits

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contributes to this?

Telford & Wrekin Health & Wellbeing Board has developed a 3 year Health & Wellbeing Strategy to improve the health and wellbeing of our communities and address health inequalities.

The Board recognises that effective commissioning and design of services is central to delivering against priorities and has agreed that the key principles of equity, accessibility, quality, financial sustainability, positive experience, safeguarding, engagement and early intervention & prevention will underpin our approach to improving health and wellbeing.

The Telford & Wrekin Vision for the BCF reflects the views of others expressed during consultations and is:

'To empower people in Telford & Wrekin to take control of their own health; to support them in caring roles, and to keep everyone as healthy and as independent for as long as

possible'.

To achieve this we will work in partnership with our communities to commission and deliver high quality integrated health and care services. In the first year the service model must address the growing demand of an aging population and people living with long term conditions (a summary of needs analysis from the JSNA)

The focus for the BCF is to transform public services for adults needing high levels of health and/or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission to hospital or care home
- Discharged from hospital with a need for rehabilitation and/or enablement

The Fund provides an opportunity to do something radically different given 'doing more of the same' is not in line with stakeholder views nor affordable. Our proposals must make better use of combined resources for service users, communities and tax payers.

Local user feedback constantly reinforces messages about the need for:

- better information to enable people to manage their own long term conditions as far as possible
- better support for carers
- services that promote independence.

An audit completed in 2013 which was commissioned as part of our Urgent Care Project Group 'Optimising Capacity on Discharge' highlighted that 15% of those admitted could have been treated in the community if the appropriate provision was in place. It also highlighted that 48% of patients in a hospital non-elective bed could have been supported with 'lower levels' of care in a community setting.

Reducing reliance on use of acute hospital beds, with increased investment in community services, is in line with feedback from our public, service users and clinicians. If the economy can design a service model that both strengthens community capital and delivers public services that are integrated, efficient, and 'skill mixed', it will achieve a more cost effective, sustainable option for delivering care in the future.

The initial approach will focus on the themes outlined below. Both organisations and all providers recognise that greater integration of commissioning, management and administrative support and ‘all age’ service provision is possible in the future, where the economy can demonstrate that this would be in the interests of the population of the economy and both statutory organisations.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

T&W CCG and TWC confirm the shared commitment to establishing the BCF and the two identified themes/ schemes:

- A national agenda which supports increased integration of provider health and social care services
- Shared co-terminous boundaries provides a context which supports increased integration
- A shared appetite by both authorities to achieve local changes in culture, behaviour and practice thereby addressing the limitations of the current configuration of services
- Demographic changes as highlighted in the JSNA and local strategic priorities as identified in the H&WB Strategy
- Cost pressures associated with demographic changes and the continued commitment to achieving sustainable efficiencies across the public sector
- Local reviews of services and the local recognised need to transform services

National reports highlight the need for further integration of care due to clinical benefits, efficiencies or improved outcomes eg:

- The Health and Social Care Act (DH 2012
- Everyone counts: planning for patients (DH 2013/14)
- Transforming Our Health Care System (Kings Fund 2013)
- Integrated care and support: our shared commitment (LGA/ NHS England 2013)
- Integrated Personal Commissioning Prospectus (NHS England, September 2014)

The report 'Integrated Care and Support: Our Shared Commitment' (August 2013) set out their planning 'vision' for how the pooling of funding would ensure a transformation in integrated health and social care and highlights the success of many professionals who have enabled us to cure or manage long term, often fatal conditions. However, the consequence of this success is increased challenges due to people living longer and often requiring 'continuous care and support, and the right systems and resources to enable that) The report also references the consequences of poor systems and care, for example citing Stafford hospital and Winterbourne View.

Therefore, the report argues for 'major change' based on a single premise of 'intergraded care for every person in England'. Overall, this approach achieves two major outcomes: better care for the individual and less pressure on the system.

This approach was endorsed locally. It provides a firm foundation to our proposals as outlined in the submission and will inform the development of a comprehensive Integrated Commissioning Strategy for 2015 – 2020. Overall, the local approach will deliver radical change which ensure services do not begin to decline, costs remain within available resources and vulnerable people are enabled and supported to maintain independence, with greater choice and control for a longer period of time

The 2011 census showed demographic changes, highlighted previously. T&W had a population of 164,400, with a younger age profile than nationally. The population is forecast to increase to 196,300 by 2026 (over 15%). However, it also highlighted that the population is ageing.

Based on this information, in the first instance (2015-16) the BCF will address the needs of local residents aged 65 and over are an increasing proportion with the fastest increase since 2001 in the 85+ age group (27.3%). The 65+ population is expected to increase by 9,200, an increase of 37%. This age group currently represents 14.5% of the total population. By 2026 this will 17.3%.

This rise in the population indicates a significant increase of people who will be frail elderly with complex needs; at risk of falls; have dementia and LTCs. Delivering services within the current configuration is not sustainable to manage the predicted increase in the population and subsequent demand on services. Analysis of the predicted increase of costs due to falls shows a £350,000 increase by 2020 and £935,000 by 2035 unless the model of delivery is changed.

In terms of local strategic direction a cross economy, three year Unscheduled Care Strategy was developed in 2011. One of the key principles was that patient journeys were simpler, shorter, safer and more effective. It was also built on key patient statements:

- Be 'joined up' and responsible for my care
- Help me understand my (urgent care) needs
- Assess and treat me promptly and in the right place
- Admit me to hospital only when necessary
- Try to care for me at home, even when I am ill

More recently, local discussions around 'Future Fit' have endorsed this message. The following key priorities have been identified and will inform the longer term strategic thinking about the BCF:

- Home is normal; matching people's needs with the correct level of care, preferably without changing their care setting
- Empowerment of;
    - Citizens to be co-responsible for managing their lives and social environment, whatever the health status
    - Clinicians working as member of fully staffed, innovative and energised teams in environment where they are valued and supported in a system that prioritises relationships, trust, co-responsibility and continuous learning.
    - Communities to influence the wider determinants of health at a local level
- Sustainability; prevention and wellbeing agenda success or failure over the next 20 years will determine will be the primary determinant of the 'disease burden'
    - Financial sustainability; financial austerity is one of the key drivers for radical change and is identified clearly as part of the 'case for change' in this programme.
    - Workforce sustainability;
        - consolidate some services
        - Utilise the available workforce

        - Prototype and implement rotating(and split) posts through different care settings
        - Improve recruitment and retention through more effective succession planning
        - Gain academic status
    - Sustainability of services; New models of care, workforce and commissioning must reflect whole patient journeys.

As part of local strategic direction, five Urgent Care High Level Projects were identified and overseen by Chief Officers of the CCG, Councils, acute and community providers Group. The projects were identified as essential in helping the local health and social care economy to better manage urgent care and improve performance: The Problem identified within the Project Charter for the groups were that the network of bed capacity, resources, care pathways, teams and skills is not optimised and/or we are unsure of the required demand. Locally, there is an economy level over-reliance on bed based services.

The Optimising Capacity to Support Discharge Project Group (Project Group) carried out some analysis of the 'Current State' (bed capacity and usage and community resources). The audit of 299 patients carried out for the Project Group during August 2013. It highlighted:

- 70% of these patients were over 70 years of age.
- 88% had significant risk factors, the most prevalent being co-occurring conditions and poor mobility.
- 16% of patients were non-qualified on admission (could be in a lower level of care ie not admitted)
- 77% of the reasons for non-qualified days (could have been discharged into lower levels of care such as residential care or home) were recorded in the audit as being within the control of SaTH.

The audit showed the high level of need of older people. It also indicated the opportunity to use lower levels of care in the community to manage those needs rather than acute beds.

The Project Group also reviewed national guidance before developing an Integrated Community Team model. This included the current Reablement Team, Home from Hospital Team, SATH resources and existing SCT teams within one integrated team. This became the basis of the Frail and Complex development and later to development of the Integrated model of the BCF (included within section 2)

The development of the integrated approach to care was determined prior to the BCF development and fundamental part of local commissioning plans from August 2013.

Limitations of the current configuration of services have been identified. It has been shown to be fragmented and not sufficiently co-ordinated. Unnecessary admissions and delays in discharge are evident. A review of the Frailty team pilot in June 2013 highlighted:

- Lack of knowledge by GPs and ambulance services of available community provisions and their responsiveness leading to unnecessary admissions and

delayed discharges.

- Lack of standardised referral and assessment processes across all providers
- Duplication of work, in particular, assessments with information remaining unshared and frustration for family carers
- Lack of timely response to facilitate early supported discharge and the delays leading to increased likelihood of dependency on public sector interventions
- Lack of capacity compounded by not making the best use of resources within and across providers
- Risk averse behaviour by staff regarding discharge leading to longer periods of time in acute services
- Inconsistent integration of health and social care
- Lack of clear roles and responsibilities for discharge planning

Service Mapping of current capacity identified inconsistency in working hours of different teams and therefore wide variation in service availability and access.

In line with the local case for change, the economy will continue to introduce change across other areas of the social and health care to address other pressing local needs. During 2015-16 the Programme Management Board will establish a process which supports learning from the work undertaken in relation to the BCF (2015-16) to inform and improve further innovation and development.

Specifically, during 2014-15 the local economy have developed robust plans, building on the submitted Implementation Plan, to support establishment of a fully integrated team co-located with clear systems and processes in place to address wider issues of shared health and social care.

While the BCF target metric relates to all admissions, there is an additional local metric focusing on 65+ years and above. This recognises the need to have a specific focus on this population:

A&E Attendances for T&W have increased by 3.9% for Quarter 1 2014/15;

	13/14	14/15	**Variance**	**% Inc/Dec**
Aged 0 - 16	2862	2919	57	1.99
Aged 17 - 64	6423	6818	395	6.15
Aged 65-74	803	855	52	6.48
Aged 75-84	680	667	-13	-1.91
Aged 85 and over	435	383	-52	-11.95
total	**11203**	**11642**	**439**	**3.92%**
Aged 16-59	6125	6509	384	6.27%

Emergency Admissions figures for T&WCCG show a rise of 3.72% (145) for Quarter 1 2014/15. The largest increase of 12.28% in the 65-74 year olds.

0-16yrs -7.80% (-63)
17-29yrs +3.02% (12)
30-64yrs + 10.11% (131)
65-74yrs +12.28% (64)

75yrs and over +0.11% (1)
Total +3.72% (145)

Specifically, during 2015- 16, this also will address the widening of the target population of the BCF in line with JSNA and local intelligence and data. This will include a wider group of people under the age of 65, substance misuse leading to longer term conditions associated with drugs, alcohol and smoking. This will be supported by moving to a single, multi-disciplinary access and assessment function ensuring vulnerable adults of all ages receive appropriate information, advice and guidance and assessments by appropriately trained professionals within appropriate response times.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

An Implementation for BCF has been in place since March 2014. Progress on Implementation Plan is included in Related Documents. Actions have been taken across all work-streams. Following a review of progress against actions the Programme Management Board has agreed to focus on key areas:

- Development of a single Single Point of Access
- Implement a single assessment and care plan process
- Implement each phase of the Integrated model
- Implement single record across health and social care
- Develop the voluntary sector

Each area will have key product outcomes and timescales and will be reviewed within the monthly Programme Management Board and work-stream meetings. These areas now have an identified Council Senior Officer lead or CCG Executive Lead to sponsor identified Project Leads. The BCF Lead retains oversight of the Programme as a whole.

The two Themes which are, in effect, the two BCF Schemes set out in Annex 1. Each Theme will have a separate work-stream and will be set out within revised Terms of Reference for the BCF:

- Building Community Capacity
- Developing the Integrated Community Enablement Service

Key actions and milestones for Building Community Capacity (Scheme 1) are set out below:

<u>October – December 2014</u>

- Profiling of the voluntary sector – range of interventions, capacity, strengths, areas for development as a sector.

<u>January – March 2015</u>

- Agree metrics, measures and data capture methodology for Theme

<u>April – June 2015</u>

- Implementation of Grants allocation to voluntary sector for CCG funded services
- Council funding of voluntary sector services

<u>July – September 2015</u>

- Develop joint process of Council and CCG to develop the commissioning of

the voluntary sector to support transformation
- Increase in Befriending schemes and volunteering evident
- Council development of community networks with the inclusion of the voluntary sector
- Development of advice and guidance and self help information

October 2015- March 2016

- Develop pooled budget for the voluntary sector
- Development of community based self- help groups

Key milestones for developing the Integrated Community Enablement Service as an alternative to hospital admission (Scheme 2) are summarised below:

October – December 2014

- Evaluation of the Accelerated Pilot
- Phase 2 implementation of the Integrated Community Enablement Service
- Development of the single assessment and care planning
- Move to single base for the Integrated Community Enablement Service
- Review of action plan to reduce care home admissions

January – March 2015

- Development of the model for community-based rehabilitation
- Development of a single Single Point of Access to services
- Development of Virtual ward model for most high risk patients
- Alignment of voluntary sector services to support the Integrated Community Enablement Service.
- Agreement of the s75 for 2015/16

April – June 2015

- Phase 3 implementation of the Integrated Community Enablement Service
- Implementation of community based rehabilitation provision – preparation for closure of acute rehabilitation unit
- Review impact on target population and revise based on local evidence
- Further development of 7 day working

July – September 2015

- Phase 4 implementation of the Integrated Community Enablement Service – integration of community rehabilitation
- Identification of additional innovations to reduce admissions
- Implement single record across health and social care
-

October 2015- March 2016

- Planning for further development of 7 day working
- Formal review of BCF performance – against metrics, local data and

evidence

Interdependencies
There are a number of interdependencies that need to be considered in developing and implemented BCF:

Other admission avoidance initiatives
A specific admission avoidance scheme is taking place currently. The 'Perfect Fortnight', placing a GP and nurse at the Front of ED seems to have reduced admissions.

As part of the Integrated model improved ambulatory care processes are essential to avoid admissions or ensure patients have a short a stay as possible.

Stakeholders can identify evidence of best practice of admission avoidance initiatives for proposed implementation.

Team Around the GP Practice
The Team Around the GP Practice connects Themes I and 2 and is also a major transformational programme within the economy. Team Around the Practice will develop a model to support primary care in reducing urgent and planned care admissions; case management of patients who are at high risk of admission or high users of NHS and / or social care services; further develop effective management of long term conditions where primary, community and/or social care interventions are needed

Mental health modernisation
Modernisation of mental health services took place in 2011- enhancing community services and development of a new, modern mental health in-patient facility, the Redwoods Centre. Reviews of the impact of modernisation have indicated improvements in community services. However, to ensure efficiencies are maintained, further reviews are taking place including the need for a nurse –led unit; cost effectiveness of RAID; use of PICU beds; alignment of mental health staff with other services including the Integrated Community Enablement Service.

Future Fit
This Shropshire-wide engagement process ffocusing particularly on the reconfiguration of local hospital services for the next 5 years. Potential benefits include:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home

- A reduced dependence on hospitals
- A more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector

Recruitment

The Shropshire economy has historically had difficulties in recruiting. Currently there is a national shortage of Geriatricians, at a time when community services have identified a specific need. Options for medical staff within the Integrated Community Enablement Service are being considered.

Resilience and Surge planning

Funding from resilience planning will support development of BCF initiatives during the winter.

b) Please articulate the overarching governance arrangements for integrated care locally

A Programme Management Board for the BCF is in place. This includes all provider organisations, representation from the voluntary and independent sector, cabinet member, Healthwatch and user representation. Terms of Reference have been agreed and include work-streams, key product outcomes and membership from organisations. Weekly meetings commenced in early March 2014. Since June the formal arrangement has been a monthly Programme Management Board and 2-weekly work-stream meetings.

Dedicated staffing has been in place since March to ensure robust Programme Management occurs, thereby supporting the two organisations in developing a firm foundation to the BCF. The Programme Management Board is chaired by co-chaired by the Executive Lead for Commissioning in the CCG and Assistant Director for Commissioning form the Council.

Identified work-streams for Service Redesign, Performance, Finance and Modelling and Communication and Engagement also meet on a 2-weekly basis and report to the Programme Management Board. Actions from the BCF Implementation Plan aligned to work-streams are progressed, reviewed and reported to the Programme Management Board

The Programme Management Board reports to the HWB Board through the Strategic Commissioning Group, which comprises officer representation from the Clinical Commissioning Group, Telford & Wrekin Council and NHS England. The group meets on a bi-monthly basis to ensure that our commissioning process delivers the Health and Wellbeing priorities whilst ensuring an integrated approach between local Health, Social Care and health related commissioners.

The Strategic Commissioning Group also aims to use the JSNA to inform commissioning intentions, ensure a strategic approach to commissioning to understand the relationship between need, demand and outcomes for service users and agree the scope of collaborative commissioning projects (prioritised by the Health and Wellbeing Board) which includes the implementation of the Better Care Fund.

The Strategic Commissioning Group reports directly to the HWB Board and receives

performance updates from each of the Commissioning and Transformation Partnerships (CATPs) for each 2-monthly meeting. There are four CATPs who are responsible for delivering against the Health and Wellbeing priorities and accountable to the Health and Wellbeing Board – the Chair of each CATP also sits on the Strategic Commissioning Group. One of the CATPs is the Better Care Fund Programme Board who provides a regular update to the Strategic Commissioning Group which in turn is reported to the Health and Wellbeing Board to whom it is accountable.

The HWB Board will confirm the outcomes of revising local priorities for 2014-19. The development of BCF will reflect and align to these priorities, introducing further innovation and collaboration to all sectors of the economy.

The CCG is accountable to NHS England for performance, and the Council to the local population through elected members and the Cabinet. The BCF will report formally into the Planning Performance and Quality Committee (sub-group of the CCG Governance Board) to ensure clear monitoring from the CCG perspective. Plans for BCF and Future Fit have been and will continue to be scrutinised by the Councils Joint scrutiny Committee. The cabinet member for Social Care also receives a monthly briefing regarding progress against plans.

BCF Governance structure 12.3.14.ppt

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

A Programme Management Board for the BCF is in place. This includes all provider organisations, representation from the voluntary and independent sector and regular meetings are in place as set out in section 4b above.

As well as the Programme Management Board and formal reporting through to the HWB Board, there is a Strategic meeting of Council and CCG senior managers with BCF leads and the HWB Officer. This meeting reviews actions and progress and acts as a troubleshooting process to ensure progress in on track; identify actions if they are not.

Following a review of BCF progress within the Programme Management Board a number of further changes have been made:

- The CCG Chief Officer and Council Director will maintain oversight of the direction/ performance through regular one-to-one meetings with senior officers / Executives representing respective organisations
- Key priority BCF actions have CCG Executive or Council senior officer sponsors. They, alongside the Programme lead for each action will be held to account for actions, timescales and progress.
- The implementation Plan will be revised to include more detailed actions and milestones

ToR for programme managment board wit

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Building Community Capacity in Telford and Wrekin
2	Enhanced community services for Telford and Wrekin as an alternative to hospital provision

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise ?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Failure to 'win hearts and minds' will result in failure by patients to engage with care provided under the BCF programme. Some of those that BCF is targeted towards may not fully appreciate the intentions of BCF. Further, failure to implement the BCF will challenge the CCG's ability to address the common messages of consultative exercises.	Possible 3	Major 5	High 15	Patient and public engagement in the BFC programme. Meaningful communication and engagement, including the use of social media, to inform the Strategic Clinical Review and BCF. Establish community networks within the Telford 'Extended Family' and self-help groups for people with Long Term Conditions. Reduce negative impacts of care on people by meetings needs in and appropriate manner in the right environment and thereby improve the 'stories' that people tell afterwards. Use existing forums, patient representative groups, support groups to actively engage with user groups. Develop

				communication and engagement with other groups which can support the BCF, for example, Local Parish Councils, the Carers Partnership Board.
Failure to reduce reliance on acute care, in particular non-elective admissions and A&E attendances, may mean that all or part of the £3 million funding required for investment in sustainable community services may not be released. Also failure to reduce A&E attendances will exacerbate the risk of the 4 hour waiting target being missed. Failure to sufficiently incentivise SaTH to participate in transformation will exacerbate this risk. Further, failure to change the culture of risk aversion within both clinical and patient populations may lead to a failure to reduce admissions.	Possible 3	Major 5	High 15	Clear communication of expectation of the changes will commence within SaTH to enable the release of money as required to support BCF. Financial cash flow spreadsheet negotiated and agreed by Directors of Finance within CCG, SaTH and the council for the release and transfer of cash on a planned, monthly basis. Development and in year activity of the BCF Programme Board. Further innovations as part of the action plan within year to further reduce admissions and LoS. Negotiate income retention based on a new model for staff outreaching into new integrated community services. Citing of the community integrated team on the PRH site.
Ineffective change management may mean that existing team may continue to work in familiar patterns within their own organisations. Cultural change will not be achieved and patients will not receive joined up,	Possible 3	Major 5	High 15	Skills audit of SaTH, SCHT, Council (Enablement) and Voluntary sector. Re-deployment of SaTH and SCHT staff into the virtual team as part of integrated model.

personalised care closer to home. This risk may be exacerbated by 'change fatigue'. There may be insufficient staffing capacity and/or capability within the community trust, the council and the voluntary sector to absorb increased demand as new pathway 'beds in'. This risk will, in part, be mitigated by the gain to Social Care of at least £490K to support implementation of Care Act, thereby reducing dependency on residential care and reducing unit costs.				Some redeployment of staff from SaTH to the Community Trust to TAP. Recruitment of additional staff. Ensure a full mapping exercise of current support available in the community by voluntary sector organisations – decreasing risk of repeating service provision. Further innovations to promote new ways of evidence-based interventions. Use of CHC stranded funds to support acute care issues. Agreement to be reached and included in section 75 agreement.
Lack of representation by SaTH on the Programme Management Board or work-stream meetings may lead to failure to achieve BCF service and financial objectives through engagement or service re-design.	Very likely 5	Major 5	Very high 25	Continued formal communication with SaTH regarding lack of communication, which has resulted in recent engagement in two services re-design meetings.
Failure by the council to effectively plan for use of transformation monies, including failure to reduce permanent admissions to residential care, may mean inhibit the development of admission avoidance interventions within the community.	Possible 3	Major 5	High 15	Continued active involvement by the council in the BCF programme.

Failure by partner organisations, including the voluntary sector, to embrace cultural change and work in a truly integrated way will challenge the quality and timeliness of services. This will lead to failure to develop and implement fully integrated care pathways that empower patients and address the needs of the local demographic.	Possible 3	Major 5	High 15	Joint working within the Programme Management Group to inform change in partner organisations. Act upon the findings of the 'Optimising Capacity on Discharge' audit. Implement 'Single Referral Point' and single triage and assessment. C&EWS to promote the benefit of engagement with BCF with named groups with the aim of promoting cultural change, including the CVS.
Insufficient capacity within the local community, principally the voluntary sector, to support self-help/ self-care may mean that self-care will not form an effective element of service redesign to provide care closer to home, self-help intervention, community support and move activity from specialist to prevention and self-help. (Current providers include: Red Cross, Age UK and Council for Voluntary Services (CVS), Senior Citizens Forum and T&W Council)	Possible 3	Major 5	High 15	Invest resources to provide support to the voluntary sector to develop the leadership, capacity and skills to fulfil their role in the delivery of the BCF. Explore opportunities to support the voluntary sector to bid for external funding grants to support the delivery of leadership, capacity and skills training. Initiate a mapping exercise of all voluntary sector organisations working within T&W, defining areas of interest (this will go beyond the current themes but support future expansion and development of BCF, post 2015. Establish voluntary sector links to 'Teams Around Practices' and all other appropriate work streams.

				Provide open dialogue and full engagement of the voluntary sector including communication between chief Officers group (COG) attendees. Implement communication and engagement strategy as identified within the Implementation plan.
Failure by all organisations to work cohesively may lead to failure to reduce delayed transfers of care; leading to cost pressures.	Possible 3	Major 5	High 15	Activity monitoring. Ensure fair representation for all participating organisations on the HWWB.
Under spending in the BCF pooled budget or ineffective use of resources may lead to: - increased demand for community services, resulting in higher waiting times for community care assessment - shifting of staff to community services, resulting in deteriorating performance against the 18-week referral-to-treatment target - increased demand for residential and domiciliary care - negative impacts on patient experience.	Possible 3	Major 5	High 15	Programme management.
Overspending or failure to secure recurrent funding or achieve QIPP savings year on year will weaken the potential for the programme to deliver significant improvements in patient experience within the planned timescale.	Possible 3	Major 5	High 15	Phased roll out. Effective financial, quality, risk and performance monitoring and action planning including: robust monthly Strategic Commissioning Group meetings with written reports that allow full and proper scrutiny of

Failure to deliver safe, high quality services, which meet programme objectives, within the financial envelope may lead to poor patient safety and exacerbation of the local health economy financial deficit.				£ and KPIs. Maintain the CCG contribution within the limited indicated in the guidance.
Lack of clearly defined project 'products' and insufficient programme management capacity or structure will exacerbate the likelihood of the risks outlined about coming to fruition. This risk is exacerbated by the lack of national evidence to inform sophisticated modelling for activity and resources.	Possible 3	Major 5	High 15	Employment of additional finance and project management support. Development of a PMO approach. Work up a detailed service specification for the new integrated service including activity levels, targets and KPIs and refinement of activity and resource modelling. Understanding of the available data and an evidence base of activity will develop over time. Therefore close data monitoring must be maintained. Consider the use of data intelligence-current outcomes measured and reported on by voluntary sector organisations. Collective ownership of the challenges by key named officers in each organisation and formulation of jointly agreed strategies to achieve desired outcomes.
Failure to ensure easy access to services, especially people with an increased risk of	Possible 3	Major 5	High 15	See risks 1-10 above.

hospitalisation, e.g. the frail and elderly, will make delivery of safe and effective care and a good patient experience difficult to deliver with BCF programmes.				
There will be inconsistency of interpretation between the Council and CCG relating to the levels of CHC funding. This may lead to failure to fund care equitably and unresolved financial pressures.	Possible 3	Moderate 3	Moderate 9	Continued negotiations related to the level of the BCF pooled budget with Council MD and CCG CEO.
Initial BCF financial modelling utilised £2,500 per admission avoided. 1260 admissions created value of pooled budget from reduced admissions. This submission uses £1,490 per admission avoided. This gives a potential gap of £1.2m in pooled fund.	Possible 3	Major 5	High 15	CCG to review level of funding at full cost and marginal cost from year end data to re-model likely value. Recognise that early evidence in the Pilot that patients are not needing the levels of contact and care modelled as is therefore potentially less expensive to reduce admissions.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The key principles of the BCF programme are the transformation of self-help/ self-care and transformation of integrated health and social care services. Reduction in admissions and other key performance areas

There are a number of risks in the development of the BCF in relation to key stakeholders - T&WCCG, TWC) and providers particularly the acute hospital. These are:

There are a number of specific financial risks associated with the BCF. These are:

Risk	Who does it impact?	Potential value of Risk	Probability of Risk	Risk Management actions

The schemes do not succeed reduce non-elective admissions	CCG Council and Providers	£1-3m	50%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Scheme is regularly monitored to ensure it performing appropriately. Further schemes are identified in strategies for rolling implementation to support the existing approach to reducing admissions eg Team Around the Practice, ED Front Door Schemes Acute provider engagement with development of the schemes to reduce admission eg phased development of the Integrated model Scheme is regularly monitored to ensure it performing appropriately Schemes maintain reduced admissions. Acute provider supported in planning in line with reduced admission to reduce fixed costs.
The schemes do not succeed in reduce admissions to residential care	Council	£2m-£3m	50%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Scheme is regularly monitored

				to ensure it performing appropriately. Further schemes are identified in strategies for rolling implementation to support the existing approach to reducing admissions eg Team Around the Practice, ED Front Door Schemes Further innovations are identified in strategies for rolling implementation to support the existing schemes.
That the schemes do not reduce delayed transfers of care	CCG Council and Providers	C£1m	75%	Specific plan developed to reduce current increase in DTOCs Scheme is regularly monitored to ensure it performing appropriately and action plan reviewed Additional innovations and interventions are developed to reduce DToCs but engagement with providers and reviewing existing systems and processes.
The schemes reduce admissions but do not enable the acute hospital to reduce fixed costs	Acute provider	£1.5m	50%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Acute provider engagement with development of the schemes to reduce admission. Scheme is regularly monitored to ensure it performing appropriately and schemes maintain reduced admissions. Payment for Performance is set

				aside to offset against admissions not being reduced
That schemes are successful and the contingency Transformation Fund is not required and remains unspent at the year end	CCG	£1m	10%	Rolling programme of scheme development and implementation will provide for any available contingency.
There is slippage in implementation of schemes leading to unspent budget at the year end.	CCG and LA	£1m	10%	Accelerated Pilot, as part of Scheme 2 is already implemented seeking to reduce admissions. This plan is to make savings to create the pool and resources to develop community services. Phase 2 of developing the Integrated model (integration of rapid Response and Council into a single base and team being developed- timescale Scheme is regularly monitored to ensure it performing appropriately. Review of the structure of Implementation Plan with Executive sponsor to ensure plans are maintained on track. Slippage on new schemes likely to be held back only as a contingency against potential cost pressures. Once cost pressures are managed the rolling programme and / or cost benefits clarified of scheme development they will be implemented.
That there are cost pressures or overspends on individual schemes within the pool not accounted for at budget setting	CCG and LA	£0.5m	10%	On-going review of schemes to ensure they are progressing and identify opportunities for efficiencies to offset against cost pressures. Payment for Performance money is set aside to offset against admissions not being reduced

				Financial agreement will include risk share for overspends/ over performances not managed within the fund.

The financial agreement will be developed to include risk share for overspends/ over performances not managed within the fund is based on a number of principles:

- Sharing risk is based on both risk sharing and gain sharing, wherever possible, to support the more effective use of monies to deliver to BCF aims and objectives

- All parties support the best use of resources to deliver the overall aims and objectives of the BCF

- It is important that mitigation and contingency are addressed where the risk was incurred. This enables the risk to be effectively managed, ensures that the most appropriate mitigation is implemented, and embeds accountability at the relevant point within the health and social care system. This supports the shared commitment for the development of the overall programme.

- The statutory responsibilities for each organisation need to be delivered. The CCG has a responsibility for funded NHS treatments; the Council statutory responsibility is the assessment of patients and providing eligible care. Decisions related to use monies within the pool to fund any over-performances will be based on ensuring those statutory responsibilities, level of risk to each organisation and the levels of contributions made to the pool.

- All stakeholders carry a level of financial risk within their respective organisations.

Relevant principles of the risk sharing agreement will also be set out within the Section 75 agreement between T&W CCG and TWC.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Like many Councils, the local Adult Social Services is facing significant financial challenges, with increasing demand and reducing resource. For local health and social care services to be sustainable there is a need for a program of accelerated change. Locally, there is a history of partnership and integration which provides sound foundations for taking forward BCF. All partners, both commissioners and providers are committed to providing care closer home improving both improved clinical outcomes and the patients experience. The Adult Social Services transformation agenda supports and compliments BCF in the following ways:

- By improving and enhancing the Information and Advice Service across both health and social care will enable vulnerable people to access low level preventative services to reduce the demand for more expensive and traditional services. As part of our preparation for the Care Act Adult Social Care will be undertaking a fundamental review the My –Life portal and locally produced fact sheets.

- A multi-disciplinary, centralised Access and Assessment Hub will provide a much more effective management of demand creating savings through self-service, one single entry point to services and speedier and more appropriate referral to other services, in particular Reablement. This will be achieved by a joint review of the current Enablement teams; building upon the Accelerated Pilot and the co-location of the current Enablement, Rapid Response and Rehabilitation into a single point of access for care services. This will be supported by a newly systems to provide robust and accurate management data.

- Managing Safeguarding Alerts and Referrals more effectively, through the Access and Assessment Hub will save a full time post and improve performance across the service by reducing inappropriate and unnecessary referrals into the wider system.

- Assessment and Case Management teams are being transformed and re-focused with an emphasis on the principle of assets based social work; teams been integrated into local communities working alongside and developing community resources and resilience. This will be underpinned by an early intervention and prevention strategy.

- The Resource Allocation System (RAS), personal budgets and personal health budgets were introduced in January 2014. While providing an equitable and transparent process for allocating resources, locally this has not lead to greater choice, control or efficiencies . Working with commissioners there will be a separation of the assessment, case management function from support planning. Support planning will be implemented by a voluntary organisation, maximising the use of community resources reducing the need for more traditional services

- With the more effective targeting of Telecare and Assistive Technology across the economy there is an aspiration for creating a community service which provides a

single point of access for Assistive Technology, Equipment, advocacy, support planning and Brokerage. This will bring together local low level preventative services into a single hub reducing demand on the health and social care economy

- The Council must also work on its Early Help/Preventative offer in a similar way. The Council wants to further develop its early help offer by working with local providers, the voluntary sector and by refocusing some of local services through the BCF with a view to improving how it manages demand for high cost social care and health interventions.

- There is a focus on greater integration or process and structure and by doing this through the BCF there is a consensus of improved outcomes and the patient experience at a lower cost.

- The Council will also separate assessment from support planning. It is currently investigating a different approach to support planning by introducing a support broker model whereby a highly skilled independent broker with knowledge and expertise works with the service user to develop a Care and Support Plans tailored to meet their needs. The broker will be working with the service user to identify creative lower cost solutions to meet needs from within their personal budgets.

- The support broker model will be supported by an evolving strong micro market of voluntary sector providers working alongside existing providers. The Council is also working with the CCG to review existing contracts/grants with the voluntary sector providers to ensure that they deliver outcomes in line with aim and priorities set out in the local BCF submission.

Resilience Plans

This is a whole system plan to ascertain the wider Shropshire community's current position, the continuing risks and how the CCGs will work in partnership with wider system partners to plan for known variations in demand in Q3 and Q4. It also addresses how the economy, as a system respond to changes in capacity through surge planning. A key focus is to ensure the whole system will work collectively to deliver against the constitutional targets of 18 weeks and 95%.

SMART plan

A SMART Plan has been developed to rapidly deliver sustainable system, process and capacity improvements by the end of September. The aim is to deliver 74 less Emergency Department breaches per week which it is calculated will enable achievement of the 95% target through a number of schemes contributing to the overall aim. Each scheme within the plan has an identified lead and defined metrics.

Single Referral and Trusted Assessor initiative

This initiative aims to improve the identification of patients who could be discharges and ensures this is expedited without delay. It includes developing a single referral document, replacing the existing notification system to the Council, in order to improve the quality of referral information, reduce confusion and inappropriate referral and avoid duplication.

This development will support the progress to a 'Trusted Assessor' status for the acute

hospital staff, whose assessments are accepted and responded to in order to facilitate discharge or transfer of care to Enablement beds or community services .

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The 2 year plan identifies that: The BCF plan was signed off by the Health & Well Being Board on 12/02/2014. There is strong engagement with T&W Local Authority and a number of formal mechanisms, including the H&WBB and BCF governance structures, allows consideration of recommendations to amend objectives and programme management arrangements.

An enhanced Enablement Team will be providing integrated health and social care to provide alternatives to admission and community based rehabilitation, enablement and end of life care (Theme two of our BCF plan).

In five years' time, the BCF is intended to deliver:

- Enhanced community services for Telford and Wrekin as an alternative to hospital provision
- Fewer hospital wards for non-elective care as we transfer capacity and activity into the community service.
- This will strengthen the ability of hospitals to focus on patients that need hyper-acute care, for example strokes and heart attacks, and to focus increasingly on planned operations.
- An Integrated Enablement/Rehabilitation Service that has a full complement of clinicians and skills, including acute Doctors, Nurses and Therapists, in addition to existing Social Care and Community health professionals able to in-reach into existing residential and social care settings.
- Access to care to support people in the community
- This service will operate 7 days a week.
- A 'Single Referral Point' for Integrated 'Step up/Step down' with patients identified by the NHS number to facilitate better information/data sharing.
- Single triage and assessment processes will be well established.
- Initial activity assumptions for the reductions in acute admissions and reductions in length of stay are below. These assumptions are based on an external organisations audit of patients with SaTH (Oak Group utilising MCAP tool) in 2013.

The CCG and Council, working with partners, will expand integrated community services, by diverting capacity from the acute sector and more traditional expensive models of care into local community care services. Recent years have seen a significant growth in reported emergency admissions, largely zero LoS admissions. The current, projections of the level of activity is unsustainable from a financial point of view and in addition the Trust has not been able to achieve Emergency Department performance on a sustained basis. BCF supports the 'integrated care model' and 'Urgent and Emergency Care' plans to avert unnecessary Emergency Department attendances and acute hospital admissions. In doing so, it improves quality of life for people with long term conditions.

An intention to develop the patient engagement strategy further with patients at the helm of this process as the economy move towards transfer of services via the BCF.

The 5 year Strategic Plan is made up of key component parts: Future Fit, Better Care Fund, Mental Health Modernisation and Adult social Care Transformation. These priorities build on the local intelligence contained with the JSNAs. Strategic thinking in relation to health and wellbeing incorporates the Health and Wellbeing priorities, as part of the work on the BCF.

For those improvement interventions that require investment in integrated health and social care services, Health and Wellbeing Boards will take lead responsibility for commissioning service transformation through the BCF.

CCG objectives align with the core service models being developed as part of our Future Fit programme: "Acute and episodic care" aligns with BCF element 3.

BCF is part of whole system synergies in the development of an Integrated Single Point of Access and access to integrated multi-disciplinary teams for community services.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Following consultation with its member practices, Telford and Wrekin CCG has been accepted to co-commission primary care at level B. This gives the CCG the role of working with member practices on their development and performance, but stops short of the contract management of individual practices.

Currently the CCG is awaiting clarification about the process for developing co-commissioning, including transfer of resources from NHS England to undertake this function.

Practices have debated and approved the CCG plan for whole system transformation, including the Team Around the Practice. In evidence of this, practices have supported the Accelerated Pilot for admission avoidance using a community response. To date, we have demonstrated average savings of admissions of about 2.5 admissions a day.

There has been some movement to cluster small practices locally and this is an ongoing discussion between the CCG and practices, which would support the delivery of the better care fund plans locally.

The CCG has consulted on the Council "Shaping Places" development plan, recognising the expansion of health and social care provision that will be necessary to support the development of Telford and Wrekin. Practices have indicated their wish to expand to support the developing town. This, again, is in keeping with the Team Around the Practice model.

It is recognised that Telford and Wrekin is substantially under-resourced in terms of General Practice. The Co-commissioning plans of the CCG set this as the number one priority for the immediate future. This is the most important intervention that would ensure success of the BCF plans locally. It also presents a risk, since recruitment to general practice is challenged nationally. Mitigation of this risk lies in the team and skill-

mix opportunities of the team around the practice.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The BCF and Integrated Strategy 2015 – 2020 will work towards achieving a reduction in the demand for avoidable unplanned acute services admissions. This will be achieved by the integration of local health and social care providers (Council, community services and acute hospital) working closely with the voluntary and private sectors. Overall, an integrated approach will deliver increased service provision within the community.

It is anticipated that the increase in demand for community services may require additional support from social care or social care services. To offset any cost of increased assessment and early interventions from social care and additional financial costs incurred, there will be an appropriate level of investment from acute to social care to align the increased activity. This will ensure that social care services are not unduly compromised to deliver the agreed assessments and early interventions within the agreed BCF programme.

The Council will also seek to strengthen arrangements for managing its front door to services. This together with our approach to our approach to promoting wellbeing (using a 'Five Ways to Wellbeing' approach through our Living Well Initiative) will offset some of the impact of identified above.

The Council in partnership with commissioners and health providers will reduce the number of single points of access across the economy Telford & Wrekin and divert resources into the access point/s. This will enable us to manage the demand for services by offering enhances information and advice, seamless and rapid assessment for appropriate enablement services,

Social Care have statutory duties including carrying out statutory assessments and meeting eligible needs in a person centred way. These duties are enhanced and increased in the Care Act 2014.

From carrying out the statutory assessment of need, a range of options will be utilised including seeking to maintain care close to home; reduction in unnecessary admissions into residential care; increased use of personal budgets; increased support to carers thereby enabling them to support the cared for to remain living at home longer. The recent decision to fully endorse and progress integration will support the intention to avoid risk to social care overall.

Through the use of personal budgets and the introduction of the support broker model, it is expected that there will be increased involvement of other key partners from the voluntary, private and community resources as well as access to information, advice and support. There is an expectation that individuals will be signposted to partner agencies including Council services, housing and by providing a range of interventions to meet

assessed eligible need.

During 2015/6 – 2018/19 there is expected be an increase the level of self-help and low level prevention to support the whole population, including those under the age of 65. This includes prevention programmes, Re-ablement and assistive technologies, practical support in the home, equipment and adaptations, carer services and support where necessary to access residential and nursing home provision.

Without this approach the need for primary and secondary care need will increase. Therefore, front-line support must be adequately resourced within a climate of reduced resources. There is a shared risk agreement in place which reflects the overall financial constraints applying to the Council and other partners including the CCG, acute and community services. There is an understanding that the risk strategy must provide a safety net for social care as well as mitigating risk for all providers as a collective whole. In other words, integration is dependent on partnership working and trust. All partners require the same level of 'protection' to support progress.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The BCF will be used to support adult social care services locally by helping the Council to protect adult social services and make a "positive difference to social care services and outcomes for service users" linked to a "health benefit" including the avoidance of admissions to NHS services, which otherwise would not be possible "in the absence of the funding transfer" and reduced admission to residential care.

The BCF is to redistribute resources to reduce the over reliance on acute services and place more emphasis on earlier help and prevention services. This will maximise the use and impact of resources to reduce costly services.

The BCF plan builds on the existing integrated working of the Enablement team who will find care solutions that meet identified needs in the cost effective way, where resources are directed to maximum benefit and impact at lowest cost.

The Council will also be able to utilise innovations from their Transformation agenda including increased use of Personal Budgets, Personal Assistants, tele-health and tele-care and Brokerage.

Social care services will be protected by understanding their statutory duties; the development of integrated models of care which will reduce duplication, streamline assessment and maximise independence and more joint commissioning focusing on outcomes; pooled resources and a reduction in the duplication of effort. Individuals will be healthier for longer before they need more extensive care packages.

It is already a requirement that the current Enablement provision maximises interventions to reduce likelihood of on-going care. Current expenditure on re-enablement and prevention through the s256 agreement provides resources for

- Community Equipment and adaptations
- Telecare
- Integrated Crisis and rapid response services

- Maintaining eligibility criteria
- Enablement services
- Bed-based Intermediate Care services
- Early Supported Discharge schemes
- Other preventative services

The wider integrated team will be more robust in maximising the use of resources. In addition, developing community capacity as set out above will delay the demand for and reduce the level of extensive care packages – being person-focused with care delivered in the right place at the right time by the right people.

Further protection of social care services will be dependent revising the agreed pooled budget and target population.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The amount within the BCF pooled fund allocated to protect adult social care services in 2014/15 is £6.925m and in 2015/16 £7.334m. This commitment is made in addition to other BCF schemes that will also be providing additional support to social care, both directly and indirectly.

The figure in 2015/16 recognises the need to identify funding to support implementation of the new duties that will come into effect from April 2015 as a result of the Care Act in line with requirements in the BCF guidance. The published national allocations indicate an amount of £409,000 is required.

Work is underway to identify the precise methodology for ensuring this funding can be made available from within the agreed pooled budget. Savings from reduced admissions would initially support the CCG contribution into the pooled budget in order to mitigate the additional cost of funding the Care Act amount of £409,000

There will also be a need to identify £150k from Social Care Capital for the IT requirements associated with the Care Act implementation.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Information on Telford and Wrekin's preparations for the implementation of the Care Act regulations:

The Council has established a Programme Implementation Board set up with representation from both Council and CCG to oversee the changes in relation to the Care Act. Work-stream leads are currently developing detailed plans identifying key actions. There is considerable synergy between BCF and the Care Act and a number of people will be members of both groups:

- Work streams (with links and alignment to BCF project workstreams):
    - Assessment and Safeguarding

- Commissioning
- Information and Advice
- Finance
- Workforce
- Infrastructure
- Communications
- Governance

The emphasis moving forward is on person centred, asset based care. In future people's care and support needs will be met by:

- harnessing existing capacity within neighbourhoods and families to provide support;
- addressing people's needs at an earlier stage and before the need for formal services;
- the provision of high quality state support based on clear national entitlements
- It also envisages that care and support will be more effectively joined up across all local services (particularly health and housing) and will work more collaboratively across local authorities, providers and other statutory organisations.

Changes to adult social care law:

- Focus on prevention and wellbeing rather than crisis intervention
- Clarify entitlement to care and support – consistency from one local authority to another
- Develop a national eligibility criteria
- Treat carers as equal to the person they care for
- Reform how care and support is funded by creating a cap on care costs payable by every individual – all 'self-funders' will need to be assessed at an early point by the LA
- Guarantees regarding service provision between LA and should a service provider fail
- Simplify the system and provide flexibilities for greater integration to achieve better results for people

v) Please specify the level of resource that will be dedicated to carer-specific support

There is a Section 75 Partnership Agreement in place that is set out below:

Services	Council £	Health £
Respite for Carers	254,000	125,000
Emergency Response Services	£54,000	57,000
Joint Post	£12,500	£12,500
Total	£320,500	£195,000

Activity Descriptor	Initiatives	Target Outcomes for 2014-15 linked to Carers Strategy Health and Well Being Priority
Planned personalised support: enabling carers feel supported in their caring role. Reduce crisis admissions to hospital/residential care/nursing care	Time limited, practical and emotional support for carers looking after someone with Dementia and/or a long term condition. Carers will be allocated a personal budget following a carers assessment. Service provision currently being tendered	Time for Me Promotion of Well Being Planning for the Future
Carer Workshops which will provide: • Time away from their caring role • build on knowledge and skills • provide practical advice, knowledge and support • promotes peer support and emotional support	Creative: Arts/Crafts/Painting/Drawing/ Singing Groups Well-being: Peer Support/Looking after yourself/Cookery Education: Dementia/First Aid/Safe Moving/Employment sessions Workshops shop providers will be allocated from Preferred Providers Framework	Time for Me Feeling Safe and Secure Promotion of Well Being Information, advice and Support

The Carers Service Delivery will be linked to four key areas set out below:

Emergency Response Carers Service: Provision of replacement support when the care is in crisis.
Replacement support can be provided up to 48 hours (Monday-Thursday) or 72 hours (Friday to Sunday/Bank Holidays) commissioning from two providers.

Moving and Handling Advice and Support
Moving and Handling Team will provide one to one consultations with family carers with regard to safe moving and handling techniques to carers, as required.

Evaluation material will be used to evidence that service remain person centred and the impact of the service, including 'Comforts scores' of the carer and the person they care for; mobility classification through an Arjo Gallery assessment and collection of carer intelligence pre- and post- service delivery.

Commissioning post for carers
The appointment of a Carers Commissioning Officer (21 hours per week) to working collaboratively across the Council and CCG.

Personalised Respite including the development of recreational opportunities for carers
As part of the NHS Operating Framework specific funding allows additional respite to be

provided to carers to enhance their physical, emotionally and psychological well-being. This will be addressed in line with the Care Act, and information above.

In addition to the above, Carers can access services which provide the following:

Admiral Nursing Service: Funded by CCG. This service provide specialist emotional, psychological support to the carer to ensure they become expert by experience in supporting the person they care for. |

Friends and Family Service: Provided by IMPACT where by those who are affected by someone's drinking and drug intake can receive information, advice and support. Funded by Public Health

Relationship Support for Carers provided by RELATE: Assists carers to adjust to changes in roles and relationships.

Pampering Sessions: Which support the enhancement of carers well-being and quality of life.

The Section 75 agreement will move into the overall Pooled Budget from 2015/16.

The Carers Commissioner will also take a lead role in the delivery of outcomes in line with the Care Act.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no change in risk from the original submission.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The strategic commitment for 7 day working has been demonstrated through the following papers:

- Health & Wellbeing Strategy
- Urgent Care High Level project Optimising Capacity proposal supported by Chief Officers Group, approved by CCG Board.
- Joint Rehabilitation and Reablement Strategy 2010- 2013
- Older Adults strategy 2006-2016
- Multi-Agency Living Well with Dementia Strategy
- Multi-agency strategy for Carers 2013- 2016
- NHS Standard contracts

Existing 7 day services
The integrated Enablement team is already a 7 day service – nurses, occupational therapists, physiotherapists and social workers working in an integrated way. Rapid

Response is also an extended hours (8am- 10pm) provision over 7 days providing post hospital nursing care and interventions including IVs – instrumental in early discharge as identified within MCAP data.

Shropdoc provides medical assessment out of hours to ensure a 24 hour medical response is available in the community.

These are set out within existing contracts with providers.

Virtual integration

Virtual integration of other services including Rapid Response and community Nursing will ensure a single location for ease of referral, communication and co-ordination of care. Inclusion of voluntary sector services that provide low level interventions is also possible. One voluntary sector provider is co-located within the Enablement team. Vertical integration through the phased implementation of the Integrated model is identified as being in place within 2014/15.

Wider implications of 7 day working include:

- Ensuring domiciliary care provision at short notice is in place
- Care homes responsiveness to assessments within the acute setting or for step-up care is available
- Access to equipment and adaptations
- Community and voluntary provision to meet basic needs (shopping, household chores)

Domiciliary and care home representation is included within the Programme Management Board through their umbrella organisations. In addition, specific engagement with voluntary organisations through umbrella organisations to develop the sector is taking place and a specific Theme of the BCF programme.

Increased 7 day provision

The establishment of 7 day care will widen during 2014/15 and 2015/16 as part of the phased development of the integrate model, to include support services within the acute sector such as Occupational Therapists and Physiotherapists, medical specialists through Shropdoc and Community services. This will ensure that the next steps in the patients care pathway is clear.

Work will also take place to establish an integrated care record which assists in mitigating the risk of emergency admissions. This is addressed in the section below.

Other services which will support 7 day care include access to support and advice from Pharmacy services (who are included within the service re-design work-stream and Transport services (ambulances – non emergency.)

The local acute provider is committed to developing 7 day services, including medical cover. This is being included within the Integrated model development, while recognising the pressures of recruitment that have. This is part of the Service Delivery Improvement Plan of the NHS contract for 2014/15.

In addition, further development as part of the Integrated model is being formulated. It is

recognised that therapy services are needed 7 days and active planning is taking place to develop integrated approaches within the acute hospital and community services to develop this.

In addition to the existing 7 day working of Rapid Response Shropshire Community Health NHS Trust is committed to rolling out access to services over the 7 day week. During 2014/15 they are planning to scope all service areas and pathways that currently do not provide this to ensure that where the evidence is available to support improved access, outcomes and patient, carer and family experience over the week they will develop the model to support its implementation. This includes the Community Equipment Service. They have, however, been able to provide this extended service during times of surge. Therefore, there is an approach that could be developed.

A number of mental health services are in place over 7 days. These include CR/HT and Dementia Home Treatment. As part of the review of service modernisation consideration about the level of integration into the Integrated Community Enablement service will take place. This could mean a level of virtual integration, co-location or referral through an agreed pathway. Closer alignment will be developed within the phased development of the Integrated team. Mental Health Services are a member of the Programme Management Board and each work-stream.

Active planning is taking place with GPs to ensure that practices will deliver 7 day working as groups of practices within an identified locality area. This will include provision of community based planned care as part of redesigned pathways, clinical and diagnostic facilities type procedures and point of care testing on a cluster basis. The current GP out of hours provision (Shropdoc) is commissioned to deliver this provision. Out of Hours services are provided within the Shropdoc base in Telford and home visits.

Further innovation is being considered to develop effective care management in primary care. National direction to focus on case management of 75 years+ is an integral part of the BCF programme to develop through a separate but linked Primary Care programme.

Ultimately, by 2015/16, within fully implemented model the objectives is that attendance and admission avoidance and early supported discharge from hospital will take over 7 days including nursing, therapies and care and support from statutory and voluntary services. Existing nursing and therapies will be maintained at the same level from the patient experience perspective. This will involve radical resign of working patterns within the acute, community, mental health and voluntary sectors to deliver this.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The Council, CCG and NHS providers are committed to the use of the NHS number as the primary identifier. This is evident in the organisational Information Management Policies and Plans across the organisations.

The most significant challenge has been introducing the NHS Number as the primary identifier within social care. However, there are developments in this area. Currently the

NHS number is used inconsistently across social care, although the council database 'Care First' does include a field for it. The council have an active project to load the NHS number into all current CareFirst client records using the Migration Analysis Cleansing Service (MACS). The project is estimated to be completed by 31st October 2014, and will include procedures to continue to match NHS numbers for new clients entering Adult Social Services, thereafter. This will enable real-time utilisation of the NHS number as the identifier.

A robust project plan to include training to facilitate cultural change for the systematic recording of the NHS number by social care professionals has been developed and being taken forward.

The acute trust has the facility to batch-match and update the PAS system with NHS numbers. Currently the NHS Number is in use in all patient data areas considered the 'unique identifier' within the acute hospital and community provider. It is recognised that, to support integration of services, wherever the NHS number is used as the unique identifier this ensures consistency and mitigates the risk of getting the 'wrong patient'

This includes clarification of the implementation timescales for the use of the NHS number as the primary personal identifier. This is a specific requirement of the BCF. It is likely that use of the NHS number will be in place before March 2015.

The plan will develop processes to share activity and performance data on key services and we need to ensure the same data sets are being shared across the partnership. If there is a change to existing sharing of data sets or sharing of new data sets then this will need to be mapped and privacy impact checklists completed alongside completion of individual data sharing agreements for each data set. The Infrastructure task and finish group is already in place and responsible for developing this area as a key produce outcome within the identified timescale.

The CSU is looking to develop Personalised Care Planning and supported self-management through the development of a patient portal that is fully integrated with GP clinical systems, Integrated Care Record and Social Care. The objectives are:

- To develop functionality mirroring that used in the national pilot
- Year of Care, care planning templates for local use in personalised care planning
- To develop an electronic health profile which would be used as a shared decision making aid in structured education and personalised care planning consultations
- To develop secure and confidential access to personalised records and information to support personalised care planning and self-care

It is noted that this information sharing is a key component of effective 7 day working.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

There is commitment within the economy to allow information to be exchanged between systems through open standard interfaces, supported by Open Application Programming Interfaces where necessary. There a number of information management policies to

support this. The relevant work-stream will focus on this area as part of its key products outcomes

T&W CCG and TWC are taking part in a regional pilot to implement the sharing of pseudonymised health and social care data this will support the economy with integrated monitoring of the national BCF metrics. It will also provide useful data to support commissioning/decommissioning of services for the BCF; with the ability to analyse cohorts and patent to population level, when IG issues are addressed at a national level.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

There is commitment to ensure appropriate IG controls are in place. Both the Council and the CCG have IG teams that provide guidance and awareness on related matters and are also the key people in completing IG Toolkit requirements.

The IG team liaise with both the Caldicott Guardian and SIRO regularly providing assurance that adequate IG controls are in place. The CCG's IG team is purchased through the Commissioning Support Unit.

There is an overarching Information Sharing Protocol (ISP) This ISP is an agreement between: Shropshire Community Health Trust, Shropshire Primary Care Trust, NHS Telford and Wrekin, SaTH, Robert Jones and Agnes Hunt FT, SSSFT, Shropshire Council and Telford and Wrekin Council. This ISP is in-line with the recommendations from the ICO. For the sharing of information between any of the above mentioned organisations an individual Information Sharing Agreement (ISA) is completed. The ISA will include the data items being shared and all the relevant information required to proceed with any information being disclosed.

Telford and Wrekin CCG submitted version 11 of the IG toolkit with a "Satisfactory" score of 84%. This submission was based on the recommendations of the CCGs internal auditors. An improvement plan is in place, approved by the CCGs Information Governance Group, for the maintenance and development of this score for the version 12 2014/15 submission of the toolkit. The CCG is supported in their compliance with the IG Toolkit and all other aspects of IG by a team based within Midlands and Lancashire Commissioning Support Unit, with a dedicated support officer based on site with the CCG on a pro-rata basis.

Telford and Wrekin Council submitted version 11 of the IG toolkit with a 'Satisfactory' score of 78%. The toolkit was completed by key stakeholders in the Council including ICT, Childrens and Adults social services and public health. The overall co-ordination and quality assuring of responses and requirements was undertaken by the Information Governance Team Leader. Work has been or is being undertaken to further improve the satisfactory score on the toolkit, ready for the next submission.

The Council has a number of policies in place in respect to IG that assist in providing a fit for purpose framework. All officers work within these policies.

The Councils IG team has a close relationship with our commissioners and have worked

together to ensure adequate terms and conditions are included in contractual documents.

All Council officers are required to complete mandatory IG training via our Learning Pool module and they have to read and agree to comply with the Corporate Information Security Policy every 90 days.

Shrewsbury and Telford Hospital NHS Trust (acute hospital) have a statement of assurance for the Information Governance Toolkit Assessment (Satisfactory).

The problem of IG controls has been identified nationally. The outcome of the recent consultations by DoH on the proposed Protecting Health and Care Information Regulations and HSCIC on the Code of Practice on Confidential Information will be monitored and factored into existing IG measures where required

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

High complexity patients with LTCs account for about 3-5% of the population (c5000 patients). Complex -Disease Specific patients with LTCs account for 15-20% (c8,500 patients). Primary care completed 4000 LTC care plans in 2013/14. This was only for respiratory and diabetic LTCs. Plans to extend this are being developed.

The care plans LES evaluation attached for 13/14 practices completed a total of 9,156 care plans. There is further clarification on the number so patients of high risk patients who need a care plan to be developed.

A local risk profiling tool was developed to identify high risk patients within primary care and ensure those patients had advanced care plans. This was included within the Direct Enhanced Service and Care Home Advanced Scheme during winter 2014/15. The criteria asked GPs to profile patients against the list below – differentiating between those most to least at risk:

- Number of admissions. Emergency admissions would be higher risk than planned
- Number of A&E attendances
- Number of GP call outs
- Number of GP phone calls
- Number of LTCs being managed
- Those Nearing end of Life

Work is ongoing with the CSU to develop a risk stratification tool.

The target population has been identified. This is to ensure the BCF is inclusive of all who are at risk or may need enhanced health and social care needs. This approach maximises the potential and impact of self-help; support to primary care for LTCs, reducing admissions and supports early discharge. This approach also provides further opportunities for joint planning and integrated working. The local metric has been devised to monitor the effectiveness in reducing admissions specifically to this target group.

The Accelerated Pilot targets population conditions and diagnoses whose admissions could be avoided if community services were available and responsive. This target population was derived from the MCAP study and has a high correlation when cross-referenced with GP, community services clinicians and acute hospital staff:

- Urinary Tract Infections
- Respiratory conditions
- Chest Pain
- Falls
- End of Life
- Generalised inability to cope at home

During July and August 2014 the Pilot has generated 70% increased referrals against last year. In addition, early evidence indicated they have reduced admissions by an average of 2-2 ½ a day. While the target is an average 4.5-5 a day, this gives an indication that the target population is being targeted and admissions can be avoided. The Accelerated Pilot is providing important intelligence to help modify the original hypotheses.

A significant target group is the 5383 admissions for 65years+ (in 2012/13). This will be reduced through self- help from building community capacity and enhanced Community services (building on the 1400 Enablement episodes in 2012/13).

Further, more detailed, population and risk profiling will be completed as part of the Implementation Plan. This is to enable widening of the target population to reduce admissions where possible. This will include analysing data from MOSAIC, acute hospital data and intelligence and community services data and intelligence.

In addition the CCG and Council are part of a Health and Social Care Population Profiling programme (supported by Midlands and Lancashire CSU and, PI, a private external company). This will provide detailed profiling of high users of services to identify high risk populations; enable stratification of risk; target interventions and future commissioning.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The current integrated Enablement team have a lead professional to case manage individual service users based on identified need from hospital or need an Enablement provision as an alternative to admission. The Rapid Response and Community Nursing teams case manage patients at risk of admission from escalating conditions that require specific nursing interventions which can be delivered in the community.

There is close working between the Enablement Team and Rapid Response. However the development of phase 2 of Theme 2 (the Integrated Community Enablement team) is intended to ensure joint assessment and planning.

Primary care case manage patients at risk of admission through:

- a LTC Direct Enhance Service - care planning and monitoring
- Risk profiling tools to identify patients who at high risk of admission

- Monthly reports from the CCG about admissions to review those who have been admitted and complete care plans

There is close working between the primary care, community nursing teams and Rapid Response. The local economy has been targeting support for residents of care and nursing homes including a Care Home Advanced Scheme completing care plans for patients at high risk of hospital admission. GPs therefore support the identification of those high risk patients who need a joint care plan and will be the lead professional.

Within the Enhanced Community Enablement Service the lead professional will be determined by a Single Assessment Process – joint assessment using a multi-factorial assessment that can be utilised by NHS, Council and / voluntary sector service. This will identify the most appropriate individual to take that role. This assessment will also determine levels of risk and inform the support plan. Consultant medical capacity and additional OTs, physiotherapy, social work and nursing will be within the Integrated Community Enablement team.

Information Sharing Protocols and development of agreed joint assessments and risk assessments will ensure that that patient information is shared appropriately and securely between teams and services. Within integrated teams delays in sharing information will be minimised.

In line with Optimising Capacity on Discharge the Home from Hospital team, previously based within the acute hospital, has aligned within the Enablement team, in order to streamline discharge. The new model, implemented from the first week of September, is that the widened Enablement team receives referrals from the acute hospital 48 hours prior to discharge. In a further initiative, Trusted Assessors (acute hospital therapists and nurses who have been trained to carry out assessments on behalf of the Enablement team) will provide clinical information to support Discharge to Assess.

A single point of referral is planned as part of the development of an integrated service. The service re-design work-stream will develop this after full consideration of the current 'single points….' within the social care, Shropshire Community Trust, Mental Health Trust and Out of Hours Services. The Programme Management Board agreement is that these areas will have a lead officer to develop this area and an Executive / Council senior officer sponsor to ensure it is delivered within the agreed timescales.

Through BCF the local economy will also focus resources on people living in the community to provide 'step up and step down' support.

The focus for the Better Care Fund is to transform services for adults needing high levels of health or social care support, particularly frail older people at risk of and/or suffering as a result of:

- Falls
- Dementia
- Long term conditions /End of Life
- High risk of admission
- Discharged with a need for rehabilitation and/or enablement

All people who are identified as high risk of admission will have an agreed accountable

lead professional.

Mental health services are a key part of the integrated provision within the acute setting. Mental health clinicians complete the Integrated Health Assessment within the acute setting to support discharge; mental health staff will support acute staff to reduce admissions and length of stay.

Mental health services are within the integrated pathway within the community. Agreed pathways between mental health teams including CR/HT and Dementia Home Treatment ensure effective joint assessment; care management where appropriate and sharing of information. Phased development of the Integrated model will facilitate ever closer alignment.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

GPs have been identifying their most vulnerable patients. The care plans LES evaluation attached for 13/14 practices completed a total of 9,156 care plans

Diabetes: 3,357
COPD: 1,695
Asthma: 4,104

This is a high risk population in relation to admission.

Approximately 200 care plans were also developed from the Care Home Advanced Scheme. This work is being developed further through the care planning of the most high risk 2% of the population.

A risk stratification template has also been recently developed for care homes to identify high risk patients. This is intended to support care homes to identify those most likely to be admitted and seek support, training or advice to improve their care.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Healthwatch is a member of the BCF Project Management Board and work-streams and acts as a valued 'critical friend' in discussions. They have attended and supported various local engagement events during the last year and will attend the next scheduled event on 26 September 2014.

There has been consultation with the Health Round Table. From that engagement a user and carer has been identified as members of the Programme Management Board.

Presentations on the BCF have been made to the Carers Partnership Board, Health Scrutiny Committee and Local Strategic Partnership

Over recent years a number of strategic exercises have engaged the public, service users, carers, clinicians and providers to steer the planning of future services.
These include:

- A range of joint strategies have been in place for several years, driven by a joint commissioning approach
- Development of the Urgent Care Strategy where key patient messages and expectations of local services included:
    - Be joined up and responsible for my care
    - Help me understand my (urgent care) needs
    - Assess and treat me promptly and in the right place
    - Admit me to hospital only when necessary
    - Try to care for me at home, even when I am ill
- A council led 'Thinking Ahead' project working group established to steer and coordinate the health and social care review of the Rehabilitation and Re-ablement Strategy.
- 'Optimising capacity' - a work stream led by a management consultancy agency ATOS which designed a model to support early discharge/better rehabilitation. Stakeholders highlighted the need for any model to support alternatives to admission and admission avoidance.
- A review of the Multi-Agency Carer's Strategy led by the Carer's Partnership Board, chaired by a local carer and attended by various organisations including the voluntary sector, senior officers from the Council and CCG, and cabinet lead for adult social care.
- A major conference as part of 'The Call for Action' on local healthcare provision. This served as the culmination of several months of consultation informed by over 3,000 of the Shropshire/Telford & Wrekin population, and over 200 clinicians reflecting the views of primary, secondary, specialist and therapeutic services.
- Our Local Health Economy has just launched the next stage to respond to 'A Call for Action' - a 'Strategic Clinical Review' which will specifically focus on the configuration of hospital based care, but which will be informed by progress of the BCF plan to provide out of hospital care, wherever possible and appropriate.

- This may lead to recommendations for further reconfiguration of hospital services. There will be ongoing and extensive engagement in accordance with the statutory engagement requirements of the 2006 NHS Act, and the so called 'Lansley' tests.

Common messages have emerged from consultative exercises to date:

- People want care close to home.
- They want it personalised to meet their specific needs.
- There is currently insufficient 'joining up' between NHS (including acute) and social care services. The impact of this is confusion and dis-satisfaction for individuals and potential duplication and/or fragmentation by NHS/social care, which is not cost effective.
- There is too much variation across parts of Telford and Wrekin particularly for access to services and/or patchy co-ordination.
- Discharges are far too slow - from user experience

The Health and Wellbeing Board have undertaken regular consultation sessions with a wide range of stakeholders over the last two years via 'Working Together' events. The next major event is planned for 26 September 2014 and will focus specifically based on a performance-based interactive session bringing the Care Act and BCF to life. The performance will cover six 'real life scenarios' and people attending the session will be asked to comment, discuss and determine the 'next steps'. The performance, called 'the Royale Family' will deal with some tricky emotional issues that occur in families linked to hospitals, health and social care. The intention is to make the session interactive, so that people can respond directly to the scenarios and have a real opportunity to reflect on 'what the changes mean'.

The whole production will be recorded, available on a DVD and used for future training. The evaluation will provide feedback on this approach and whether similar events should be planned in the future.

As a product of working together with users and carers, who are members of the planning group, to prepare this session there is a strong sense of co-production. Future, quarterly meetings will continue post the September event. The next meeting is planned for early December.

The Communication and Engagement work stream developed a BCF Launch event to engage all sectors, which took place at Enginuity on 9th July. 69 stakeholders participated including from Healthwatch, primary care, voluntary organisations, users and carer representatives, SaTH, SCT and the Council.

The event summarised the BCF, its context – Care Bill and Future Fit - expected benefits of the programme; how partner organisations can support and contribute to Better Care. In addition to a range of presentations setting out Future Fit, the Care Bill and BCF and workshop discussions, two patient stories helped to illustrate the BCF as seen through the eyes of individuals in receipt of services.

Feedback forms from 39 participants described the event as 'Interesting', 'Important' and 'Relevant'. In response to questions raised in the Evaluation participants reported that they had gained a better understanding of BCF; the videos helped highlight the benefits of the planned model of care and helped them understand how they fitted into the BCF

plan. There was a keen interest to meet again to ensure that patient and carer views continue to be taken into account.

Key feedback included:

- 'Prevention is key'
- 'Stop being so risk averse'
- 'Solution must be seven day working across the economy; nit just part of it'
- 'Stop shouting at each other, lets work together, more sharing'
- 'We all know each others problems, lets pool resources to get best value'
- 'Care follows the patients, acute phase stops, physio, OT follow the patient'
- 'To support carers both identified and not identified to prevent carer breakdown…'
- 'Respect and acknowledgement for the voluntary sector that their skills fill the gaps'
- 'Being able to trust other professionals information'
- 'Shared integrated record…. Not requiring individuals to repeat their story'

The feedback related to participant views of the event were:

Interesting 18	Important 17	Relevant 25	Complicated 5	Enjoyable 4	Clear 6
Comfortable 2	Rushed 5	Thorough 2	Confusing 5	Boring 0	Irrelevant 0

There is a plan to respond to the suggestions made on the 9 July at the launch of the BCF including by establishing a webpage linked to all stakeholder organisations. In addition feedback to stakeholders on 26th September to feedback on progress in a 'you said; we did' session.

Meetings have taken place with the voluntary sector Chief Officer Group (COG) in May and July 2014. The voluntary sector is keen to be involved in co-production of future plans. The COG is in the process of completing a matrix to map activity through levels of provision from prevention to acute and recovery. The feedback received highlighted that they wanted their contribution to be valued; were concerned about the impact of efficiencies while expecting them to develop services and support users within increasingly complex needs. While strongly committed to supporting the 'preventative' agenda they thought that more resources were required to enable this to take place. The plan is to work with the sector to achieve efficiencies which will, in part, further reinvest to support planned growth.

As an example of partnership working, the CVS has proposed that a Voluntary Sector Network is established to interface with other organisations and feedback to the Programme Management Board. The proposal is to include six organisations: British Red Cross, Age UK, Citizens Advice Bureau, Listen Not Label (ULO), Royal Voluntary Services (RVS) and Council for Voluntary Services (CVS). Monthly meetings are now planned until the end of the calendar year. In recent correspondence the head of Projects for CVS said:

'*Hopefully we can then collectively get some actions to feed into the whole BCF agenda. We'll provide feedback from those meetings to the larger COG membership. One of the tasks for the group may be to fine tune the VCS accelerated pilot model which originated from discussions with Lyn and Tina. This mimics the crisis network*

model, which is proving a great way of organisations coming together to provide collective service delivery.'

This level of engagement is to ensure a co-production approach within BCF. It has engaged people in an iterative process as this plan will inform the Strategic Clinical Review of hospital care and vice versa locally branded 'Future Fit'. It is recognised that it is essential to clarify 'what' can be provided out of hospital, and 'how much of it', at the same time as determining how to reconfigure acute services.

As part of wider engagement , BCF was presented at the Shropshire Partners in Care (SPIC) AGM on 18 September 2014. This umbrella organisation covers care homes and domiciliary care providers and gave an opportunity to highlight the BCF approach and seek views and potential roles for the sector.

As part of the BCF, a Communication and Engagement working group has met on a two-weekly regular basis. However, steps are now taking place to introduce changes which will improve effectiveness in widening the level of engagement and communication with a wider number of stakeholders. Discussions within this group have highlighted the significant cultural changes that are required amongst the population as a whole to deliver an integrated BCF care system. This is both understood and used by professionals and accepted as reasonable and appropriate to meeting individual needs as well as avoiding unnecessary admissions.

As the Council progresses work to support the introduction of the Care Act 2014, areas of overlap with the BCF are being aligned to improve overall engagement and communication on key issues.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

There has been a close partnership between all health and social care providers in the Local Health and Social Care Economy, who have worked together to improve integrated care for several years. This includes:

Various formal partnerships including all local organisations that have been involved in steering the development of the closer integration of services to date. These same groups will continue to be closely involved:

- Health and Wellbeing Board (HWBB)
- Urgent Care Working Group
- Winter Planning Group and Senior Managers Group (including representation from each commissioner and provider organisation)
- Optimising Capacity on Discharge Project Group (including representation from each commissioner and provider organisation to develop and agree the future model)

- Stakeholder partnership groups led by the Telford and Wrekin Council (Council)/ Telford and Wrekin Clinical Commissioning Group (CCG) involving users, carers, independent and voluntary sector providers
- Local Strategic Partnership

Consultation with key stakeholders took place prior to completion of the draft submission. Since then, key stakeholders, as members of the Programme Management Board provided comments and feedback in the following:

- revising the submission and re-submission
- developing the Integrated model
- shaping and agreeing the work-stream key product outcomes, and
- development of the detailed Implementation plan.

Regular stakeholder engagement events (locally branded 'Working Together') are already in place – meeting on a six monthly cycle. A further session will take place (summarised below in section 8biii) to highlight the BCF further.

As part of the development of the BCF a Launch event took place on 9th June. Managers and staff from all local NHS Trusts and Councils participated in the event.

Specific engagement with the community provider has also taken place. Their feedback to the TDA is included below as evidence of their view about engagement:

- Meetings with Executives to set out BCF principles and need for increased community activity
- Member of Programme Management Board work-streams
- Separate meetings held to consider activity assumptions methodology
- Admission avoidance workshop developing Accelerated Pilot
- Additional meetings to develop the Accelerated Pilot and monitor the performance

There has been active engagement and participation from the community provider throughout the development of the BCF programme.

Specific engagement with the acute hospital has also taken place:

- BCF presentation in February 2014 including activity assumptions
- Member of Programme Management Board work-streams
- Separate meeting held to consider activity assumptions methodology
- Admission avoidance workshop developing Accelerated Pilot
- Additional meetings to consider admission avoidance –Ambulatory care

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ii) primary care providers

GPs have been aware of the BCF programme development though a number of processes:

A CCG GP Board member is a member of the Programme Management Board and work-streams.

GP Forums
Lead GP and practice managers received updated within the formal monthly meeting. As well as regular updates on the programme, an extended presentation about the BCF took place on 16th September. GPs are aware of the key aims of the BCF programme- reduced avoidable admissions. This has been simplified to 1 ½ patients a week per practice over and above what was achieved last year.

GP newsletter
BCF has been highlighted within the newsletter that is sent to all GPs and practice managers. in addition, progress on the Accelerated Pilot, phase 1 towards an integrated model, has been shared for each of the first two months of the Pilot

Admission avoidance workshop
A workshop to focus on admission avoidance was held in June. Development of attendance avoidance (developing The Accelerated pilot) and admission avoidance eg the use of GPs in ED or AMU to stop avoidable admissions, took place. GPs and other clinical and management staff supported the target population for the Pilot and the pathways developed.

A GP has been identified to provide some clinical engagement within the Accelerated pilot. This is likely to be in place from November to support fellow GPs to avoid admissions.

Shropdoc/ CCC is the out of hours primary care provision. Shropdoc have participated in developing the Accelerated Pilot, aligned to the single point of referral to avoid admissions by working more closely with Shropshire Community Trust. There is evidence that referrals are shared between provider organisation across the agreed pathways to enable the right level of support to maintain service users at home.

West Midlands Ambulance engagement has been taking place. They attended the Admission Avoidance workshop and BCF Launch event and engaged about the development of the Accelerated Pilot. A part of hosting NHS111 there has been engagement about the pathways associated with the Pilot. The pathways have been developed and are not within the pathways of care alternating from hospital.

West Midlands Ambulance have been invited to attend future Programme Management Board meetings and expected to attend the next meeting on 19th September 2014.

iii) social care and providers from the voluntary and community sector

Social care operational staff are part of the Programme Management Board and work-streams as well as commissioners. Finance colleagues from the Council also attend and have played a critical role in the financial modelling to support BCF.

Key operational staff from social services have engaged effectively while developing the Trusted Assessor model and pathway development for the Accelerated Pilot and developing the Integrated model. They have also developed templates to support

gathering information to evidence change in patterns an outcomes.

Social care operational staff also participated in the launch event.

The Community Voluntary Service (CVS) is a member of the Programme Management Board. The CVS Chief Officers Group Chief Officers Group (COG) (the over-arching body for voluntary organisations in the Borough) has identified representatives for each work-stream within the BCF programme.

To support the development of both schemes, several meetings have taken place with the COG during the last few months and the Chief Officer of the CVS provides regular reports to the COG on the work of the BCF Programme Management Board.

In response to a range of questions put to the COG by the CCG and Council in relation to BCF, detailed discussions have taken place and the COG have provided written answers. The questions asked were:

- Do we know everything or how well the voluntary sector currently delivers services that would support BCF?
- How can the voluntary sector demonstrate/provide evidence of value for money to maintain or increase resources within the sector?
- What are the areas that could be developed further to avoid or delay use of health and/or social care services?
- Where are the key challenges for the voluntary sector that would promote or hinder engagement and development?
- How can organisations become more sustainable with less public sector funding in the future?
- How do we develop more effective partnership working.

In addition to responding to these questions, 14 of the COG member organisations have submitted a completed template outlining how they engage with:

- Preventative activity
- Team about the GP
- Rapid response
- Acute hospital
- Recovery
- Quality Marks

As an example of partnership working, the CVS has proposed that a Voluntary Sector Network is established to interface with other organisations and feedback to the Programme Management Board. The proposal is to include six organisations: British Red Cross, Age UK, Citizens Advice Bureau, Listen Not Label (ULO), Royal Voluntary Services (RVS) and Council for Voluntary Services (CVS). Monthly meetings are now planned until the end of the calendar year.

Overall, the COG is supportive of the current Accelerated Pilot. They are seeking to produce an overarching template to match the Accelerated Pilot template, showing where the voluntary sector actually interfaces with the different parts of the model. In recent correspondence the head of Projects for CVS said:

'*Hopefully we can then collectively get some actions to feed into the whole BCF agenda. We'll provide feedback from those meetings to the larger COG membership. One of the tasks for the group may be to fine tune the VCS accelerated pilot model which originated from discussions with Lyn and Tina. This mimics the crisis network model, which is proving a great way of organisations coming together to provide collective service delivery.'*

The next major event is planned for 26 September 2014 and will focus specifically based on a performance-based interactive session bringing the Care Act and BCF to life. The performance will cover six 'real life scenarios' and people attending the session will be asked to comment, discuss and determine the 'next steps'. The performance, called 'the Royale Family' will deal with some tricky emotional issues that occur in families linked to hospitals, health and social care. The intention is to make the session interactive, so that people can respond directly to the scenarios and have a real opportunity to reflect on 'what the changes mean'.

The whole production will be recorded, available on a DVD and used for future training. The evaluation will provide feedback on this approach and whether similar events should be planned in the future.

At the event, 43 organisations from the voluntary and provider sector will have stands to talk to people about their work in Telford and Wrekin.

As BCF moves forward, they wish to proactively continue to support the statutory services in supporting people to remain in the community and to support early discharge. The voluntary sector is seeking to work with us in co-production to reduce duplication and remove efficiencies in support of BCF. There is a commitment to working together to produce a Business Plan which supports some further investment in the voluntary sector to enable them to more actively support BCF as it evolves. This work will begin in Autumn 2014 and progress into 2015.

The Local Strategic Partnership (senior executive leaders across the local economy including Police, Ambulance, Probation, Education, council, CCG) has been consulted in relation to BCF. They support both the proposals and themes.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The BCF plan proposes reduced activity within the acute sector. This includes reduced admissions and length of stay. Modelling indicated c1200 reduced admissions (utilised from MCAP audit data) and 1500- 2000 early discharges. This includes reduced admissions related to respiratory conditions, UTIs, cardiac complaints, falls and increased End of Life care within the community from enhanced services. These conditions/ diagnoses also related to highest number and costs of admissions. (indicated in the chart below for 2012/13 activity). Most NHS rehabilitation will be community based

rather than within the acute setting. The CCG has given formal notice to de-commission hospital based rehabilitation.

	Age Band								
	65-74			75+			Total Activity	Total Sum of Cost	Total Average of LengthOfStay
Spell Duration	Activity	Sum of Cost	Average o	Activity	Sum of Cost	Average of LengthOfStay			
Urinary tract infection, site not specified	83	£ 192,412	6	290	£ 952,616	14	373	£ 1,145,028	12
Chest pain, unspecified	105	£ 78,761	1	128	£ 97,737	2	233	£ 176,498	2
Lobar pneumonia, unspecified	54	£ 159,318	10	139	£ 426,042	11	193	£ 585,360	11
Pneumonia, unspecified	45	£ 138,245	9	126	£ 368,433	9	171	£ 506,678	9
Unspecified acute lower respiratory infection	52	£ 106,909	6	118	£ 267,972	8	170	£ 374,881	7
Chronic obstructive pulmonary disease with acute lower resp	79	£ 182,636	5	91	£ 209,593	7	170	£ 392,229	6
Chronic obstructive pulmonary disease with acute exacerbati	60	£ 144,388	6	67	£ 153,558	7	127	£ 297,946	6
Atrial fibrillation and flutter	51	£ 70,561	3	71	£ 133,778	7	122	£ 204,339	5
Congestive heart failure	24	£ 71,390	11	94	£ 294,375	10	118	£ 365,765	11
Fracture of neck of femur	16	£ 73,661	21	99	£ 523,089	25	115	£ 596,750	25
Acute myocardial infarction, unspecified	20	£ 63,564	10	66	£ 207,306	7	86	£ 270,870	8
Cellulitis of other parts of limb	26	£ 49,116	4	56	£ 138,347	7	82	£ 187,463	6
Gastroenteritis and colitis of unspecified origin	26	£ 63,652	4	50	£ 154,234	7	76	£ 217,886	6
Acute renal failure, unspecified	20	£ 69,564	11	39	£ 132,942	11	59	£ 202,506	11
Cerebral infarction, unspecified	20	£ 64,230	10	38	£ 146,001	18	58	£ 210,231	15
Pulmonary embolism without mention of acute cor pulmonal	22	£ 57,823	8	31	£ 80,715	11	53	£ 138,538	10
Cerebral infarction due to thrombosis of cerebral arteries	14	£ 55,220	19	36	£ 127,355	19	50	£ 182,575	19
Tendency to fall, not elsewhere classified	9	£ 30,372	7	41	£ 123,850	10	50	£ 154,222	10
Disorientation, unspecified	10	£ 25,804	3	35	£ 100,781	15	45	£ 126,585	12
Pertrochanteric fracture	4	£ 26,367	28	23	£ 113,316	26	27	£ 139,683	27
Grand Total	**740**	**£1,723,993**	**7**	**1,638**	**£4,752,040**	**11**	**2,378**	**£ 6,476,033**	**10**

This level of admission reduction is indicated to the level of activity reduction required to enable to removal of fixed costs within the acute hospital It has been recognised that reductions in activity the CCG may need to continue to fund the transitional costs of reduced activity subject to the development of a Business case.

On-going discussions are taking place with the acute provider in relation to the impact of various numbers of admissions avoided and how they would manage that situation.

Indicative savings are £2.1m – £4.5m full year effect on activity reductions (dependent on Threshold costs). Commissioning intentions for 2014/15 included a £3m reduction to the acute hospital to be included within the BCF pooled budget. In practical terms, the sum was aligned to the pooled budget and would fund activity or be able to develop community services as admissions reduced.

The model within Theme Two includes acute clinical capacity working within the integrated model. This will be as part of in-reach and out-reach functions to ensure sufficient specialists skills and interventions are available, thereby avoiding emergency admissions. This will also develop further community capacity to support planned care reductions within the acute sector where possible.

In addition, the acute sector developments to support the principle aims of the BCF 2014/15 include:

- Creating an Emergency Care Centre that will include:
    - Urgent Care Centre where those who do not need emergency care can have interventions. This would be through an integrated approach including Shropdoc, primary care, community services, social services and acute hospital specialists. A 'Perfect Fortnight' planning exercise is taking place currently to ascertain awareness of the most effective approaches to urgent care for the future.
    - Ambulatory care process to ensure early diagnostics and investigations

- Creating a Care of the Elderly Centre comprising:
    - Medical Day Unit for ambulatory care where community service providers work alongside acute hospital specialists to reduce admissions through improved assessments, investigations and diagnostics
    - Elderly Care assessment and short stay unit where community service providers including social care staff work alongside acute hospital specialists to reduce length of stay

There is evidence that that these innovations can transform the functioning at the 'front door' – reducing admissions and length of stay.

Community contacts to reduce admissions and health and care needs to respond to early discharge is modelled as 300-400 contacts across health and social care (based on MCAP data) full year effect. This is and will continue to be evaluated based on evidence from the Accelerated Pilot, which is providing data of additional community based activity to avoid admissions.

Risks associated with savings not being realised are highlighted within the risk register and risk sharing agreement.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

Theme 1
ANNEX 1 – Detailed Scheme Description

Through discussion we have become aware of ‘good practice’ in other locations including Cheshire West, and will be seeking to gain more information on the approach used there, so as to assist us in making speedy, sustainable change.

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1
Scheme name
Building Community Capacity
What is the strategic objective of this scheme?
Theme/ Scheme 1 Building Capacity will develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self help groups, and individuals in both 'patient' and 'caring' roles. • A strong voluntary sector infrastructure, with strong links with our 'Teams around GP Practices' and integrated with the Integrated Community Enablement Service. • A significant increase, based on modelling data in local people volunteering. • Community networks in every locality in the Borough offering support as part of the wider Telford and Wrekin 'Extended Family'. • More Self Help groups for people with Long Term Conditions to help them manage their own health. • Access to information through a wide range of traditional and modern social media mechanisms. • Access to Advice and Guidance from health and care professionals when required. This approach is with a view to reducing the number of people who need to access ongoing care support and/or treatment from NHS and / or Council services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model for care and support is being incrementally developed through a number of inter-connected processes. Work has taken place over the last six months to support progress in developing community capacity as part of the BCF Implementation plan. Voluntary sector provision that provides support across all four safety nets is essential to reduce the demand for NHS and Council services. Detailed analysis of how voluntary organisations work within those safety nets has been carried out (attached below within the matrix / framework document).

The six areas are being progressed to design and enhance the models of support while focussing on the key objectives set out above:

- To review current spend by both organisations on the voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
- To support improvements in the infrastructure of the voluntary sector
- To jointly design and procure a range of support services that can be delivered by voluntary and community organisations
- To work through a robust engagement process with self-help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
- To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.
- Achieving efficiency and reducing duplication

Progress and further developments are set out below for each area.

<u>To review current spend by both organisations on the voluntary sector services to help improve understanding of how to improve the effectiveness of the sector</u>
Several internal meetings have taken place between the LA and the CCG to consider the level of spend on the voluntary sector. As an outcome of this work, duplication and levels of inefficiency have become evident. Equally, there is evidence that some organisation are seeking to make changes to enable them to contribute to the wider BCF agenda.

During 2014 commissioners have been trying to better understand what outcomes are currently delivered and whether the arrangements with the third sector provide value for money. The CCG inherited a variety of historical arrangements - Grants, SLA's and contracts with the voluntary sector. After reviewing the agreements and carrying out a value for money evaluation of all expenditure within the sector, the CCG have developed Grant Making process so that we can continue to fund voluntary sector organisations that are making a valuable contribution to the health within the economy.

The 'Grant Making Framework' which has been developed by the Central Midlands CSU, is being consulted on, with the sector with implementation from April 2015. This is an important focus on self-care, community engagement an strengthening the contribution of community and voluntary groups - a key theme in the BCF

The CCG and LA are proposing to take similar courses of action, but taking account of internal factors, the timescale is slightly different. In addition, under the Care Act the council has particular responsibilities in relation to Advocacy.

Overall, the Council is still reviewing their processes in relation to the sector. The underlying principle is to secure interventions which support community involvement and engagement, thereby helping to maintain individuals health and well-being, delaying the need for access to public sector services. Also, to provide support to individuals to reduce the need for higher cost funded interventions.

The longer term plan is to develop a pooled budget for voluntary services, when the processes can align.

To support improvements in the infrastructure of the voluntary sector

Detailed discussions have taken place on the importance of developing a co-production approach to future partnership working with the voluntary sector. They recognise that due to the need for efficiencies, as the public sector reduces engagement with some client groups, they are 'stepping in'. They have expressed the view that they no longer wish to simply 'be told what to do' linked to contracts, but to work with us to develop innovative solutions.

To support this, they are undertaking work themselves to better understand the nature and level of current contribution and how to record evidence which demonstrates the same. Specific tasks that will be progressed during the next 6 months includes development of a more robust voluntary sector business plan to support growth and development. They are also recognise that:

- Bidding for money takes time, effort and energy which detracts from 'what they are meant to be doing'
- Everyone is bidding for the same money
- Due to the efficiencies, less money is available.

Therefore, more collaborative and aligned work will help to reduce and remove some of these types of barriers and instead provide a more stimulating and rewarding environment for all partners to work together. The Grants and Bidding process for CCG funding, highlighted above, will focus the need for actions in this area.

To jointly design and procure a range of support services that can be delivered by voluntary and community organisations.

Meetings have taken place with the voluntary sector Chief Officer Group (COG) in May and July 2014, they agreed to undertake and have completed a matrix to map activity through levels of provision from prevention to acute and recovery. (attached below)

The voluntary sector is keen to be involved in co-production of future plans. They have been keen to see greater attention given to how they can support initiatives linked to the BCF. As an example, they have been involved in the development of the Accelerated Pilot identified how an additional template can be produced which accurately represents their current involvement and capacity to provide further support. This Pathway will be produced during the next month and shared with other stakeholder organisations.

Meetings with the voluntary sector have taken place over the last two years with various 'Working Together' engagement events. One product that will be launched in the 26 September is the Information and Guidance Charter. The Charter reflects considerable work and dialogue amongst the sector to agree on the content.

The event planned for the 26 September (described in other sections) was developed directly from voluntary sector. On the 26 September the combined programme of launching the IG Charter and delivering the interactive performance will help to ensure people are properly signposted and the sector achieve a shared understanding of the future needs from the sector.

Through on-going engagement with self- help organisations there will be further clarification on how best to strengthen them, and how to improve signposting for people to the help and support on offer. This is intended to:

- more self-help groups for people with Long Term Conditions to help them manage their own health.
- access to information through a wide range of traditional and modern social media mechanisms.
- access to Advice and Guidance from health and care professionals when required.

<u>To expand engagement with communities to understand how best to extend volunteering, neighbourhood support schemes and generate community capital.</u>
Currently, work is taking place within the Council to explore how to greater engagement in working in the voluntary sector from members of our local communities, partially to support securing efficiencies.

There is local representation at a Regional group seeking to increase community capital and recognise many people within our communities have much to contribute and are often keen to 'give something back'. Equally, the voluntary sector itself is seeking to grow through recruitment of more members. However, there is local recognition of real barriers that need to be discussed so that steps can be taken to mitigate them. For example, many unemployed people view volunteering as a means to an end in terms of gaining longer term employment. While beneficial, it also means that time, effort and resources go into supporting individuals to be skilled and trained to work within voluntary organisations only for them to 'move on'. The pool is also diminished further by older people working longer, who would have previously retired and volunteered.

This will develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self-help groups, and individuals in both 'patient' and 'caring' roles. Successful growth of the voluntary sector and the number of volunteers will also support overall health and well-being and maintaining social interaction of individuals who may be feeling isolated and yet have much to offer.

The patient population is broadly adults under and 65 years at high risk of enhanced NHS and/ or social care are the target population. This includes the frail elderly at risk of and/or suffering as a result of:

- Complex needs
- Falls
- Dementia
- Multiple long term conditions
- End of Life
- High risk of admission
- Discharged with a need for health or support care interventions

Local voluntary sector organisations will work more flexibly to identity patient populations will a level of need that, without support, would led to higher level needs from health and / or social care services.


Better Care Fund framework for July 20


05 CCG Board Aug 14 Voluntary Sector F

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
Telford and Wrekin CCG
Telford and Wrekin Council

Provider and partner organisations:
Shropshire Community Health NHS Trust – Rapid Response, community nursing teams, specialist nurses, Single Pint of Access
Telford and Wrekin Council Cohesion Services
GP practices
Shrewsbury and Telford Hospitals NHS Trust
South Staffordshire and Shropshire NHS Foundation Trust
Council for Voluntary Services
Royal Voluntary Services
Shropshire Partners in Care
West Midlands Ambulance Service
Shropdoc
NHS 111

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is an evidence base for the approach being taken in relation Theme 1. This is set out below.

Public Health guidance on community engagement highlights that involving communities in health-related activities improves health outcomes - getting communities involved in decisions that affect them, includes the planning, development and management of services. https://www.nice.org.uk/Guidance/PH9

Improving self-care support for long-term conditions has been a drive for some years: supports choice, links to Expert by Experience programme and raises the profile and message of self-management of LTCs.
https://www.nice.org.uk/savingsAndProductivityAndLocalPracticeResource?ci=http%3a%2f%2farms.evidence.nhs.uk%2fresources%2fQIPP%2f29520%3fniceorg%3dtrue

Kings Fund set out in 'Transforming our health care system: Ten priorities for commissioners' (2011) that active support for self -management needed to be a priority for commissioners.

In addition, the Kings Fund identified key success criteria for co-ordinated care for complex chronic conditions (2013):
- A holistic focus that supports patients and carers to become more functional,

independent and resilient (seeing the whole person)

- Building community awareness of and trust in care co-ordination programmes Effective communication based on good working relationships between members of the multidisciplinary team.
- Care co-ordination programmes should be localised so that they address the priorities of specific communities.
- Integrated health and social care commissioning can support longer-term strategies and provide greater stability

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

No money has been formally identified within the pooled budget monies for this programme. However, the CCG forecast spend £552,000 (2014/15) funding voluntary organisations. The Council expenditure forecast c£800,000.

There is a commitment to develop a pooled budget for voluntary organisations when the reviews of spending and commissioning for 2014/15 are completed. Planning is being carried out jointly with this specific plan.

Impact of the scheme is expected to contribute to:

- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Improved patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.
- Reducing emergency admissions in 65 years + age group.

It is recognised that it will not always be easy to provide direct evidence to support impacting on the BCF targets. Therefore the additional financial and not –financial benefits will also be considered (identified below)

The matrix mapping being completed by the COG for the voluntary sector will provide more clarity on the target population, level of performance, costs and outcomes for each provider. This will also clarify the levels of support provided across the four safety net levels indicated in section 2a is in the process of completing a matrix to map activity through levels of provision from prevention to acute and recovery.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The area was monitored via the BCF Implementation Plan. Following a review of the Implementation Plan monitoring process this areas will have an:

Executive/ Senior Officer lead: Liz Noakes -Director of Public Health
Project Lead: Kit Roberts BCF Lead - Telford Wrekin Council

All progress will be through the Programme Management Board. This will include

- Development and monitoring of metrics
- Feedback from COG
- Feedback from Voluntary Sector Network

What are the key success factors for implementation of this scheme?

The financial benefits of building community capacity are the identified outcomes:

- Improved levels of confidence in self-care
- Carers feeling better supported
- Enhanced Community involvement
- Growth of community engagement
- Increase in uptake of carer assessments and support services

The non-financial benefits of building community capacity are the identified outcomes:

- More people are empowered to manage their own condition
- More people are supported to meet their urgent care needs in the community
- People get the appropriate level of help when they need it
- People only spend the time in hospital that is needed
- More voluntary organisations become engaged
- More local people volunteer
- People become more aware of how they can 'self-care'
- People receiving care and their carers feel supported and confident and know where to go to, to access help and support rather than using ED services

Theme 2
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
2
Scheme name
Integrated Enhanced Community Services
What is the strategic objective of this scheme?
The objectives of the Integrated Enhanced Community services for Telford and Wrekin as an alternative to hospital provision are: • Fewer hospital wards for non-elective care as we transfer capacity and activity into the community service. • This will strengthen the ability of hospitals to focus on patients that need hyper-acute care, for example strokes and heart attacks, and to focus increasingly on planned operations. • An Integrated community- based Enablement/Rehabilitation Service that has a full complement of clinicians and skills, including acute doctors, nurses and therapists, mental health specialists in addition to existing social care and Community health professionals able to in-reach into existing residential and social care settings. • Access to care to support people in the community • This service will operate 7 days a week. • A 'Single Referral Point' for Integrated 'Step up/Step down' with patients identified by the NHS number to facilitate better information/data sharing. • Single triage and assessment processes will be well established. This Scheme/ Theme will deliver a viable alternative to in-patient hospital care for people who can be cared for closer to home. This will build on the existing integrated community health and social care Enablement/Rehabilitation model and Accelerated Pilot by transferring capacity from the acute sector, so that we offer a viable alternative community service rather than hospital bed based care. The vision is for fully integrated delivery of care from a single point of referral; single assessment and integrated care delivery. The case for change is consistent and articulates the need to provide services which follow the patient/client; maintain people living in the community; avoid unnecessary admissions into acute sector and where these do occur, ensuring speedy, planned discharge. The discussions are now actively taking place at a strategic and operational level across all providers (acute and community provider, voluntary sector and the Council).
Overview of the scheme Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The integrated model is included within section 2a (Vision) and attached below

Through virtual integration across existing acute, community and social care an Integrated Community Enablement Team would ultimately deliver and Inreach and Outreach approach to care devliver:

- Integrated health and social care community-led team for attendance avoidance, admission avoidance and early discharge
- Home from Hospital approach to support care at home whenever aptients conditions escalte to the point of potnetial admission or enhanced care
- Case management for complex patients eg 3+ LTCs
- Virtual ward approach to target identified very high risk patients - those who are at high risk due to the number of LTCs or with a history of frequent admissions
- Enhanced medical support (eg GPwSI, Geriatrician, Specilaity Doctor) deliver community interventions, support the Community Enablement team, Team Around the Practice, provide community-based rapid access clinics and 'Interface' at AMU.
- Interventions at the 'Front Door' of the acute hospital to provide specialist assessment and interventions to avoid admission and/ or reduce length of stay

This will be deliver through phased implementation already determined:

- Phase 2 by December 2014
- Phase 3 by April 2015
- Phase 4 by June 2015

Through the phased implementation of four key priority areas that support the development of the Integrated provision, this will ensure the phases of integrated working are achieved on time and improve patient experience, reduce duplication and achieve:

- A single Single Point of Referral
- Single assessment and care planning
- Development of the Integrated Community Enablement Service (all phases)
- Integrated record

The treatment and care delivered within the integrated Community Enablement Team will in-Reach into the hospital and be one single point of access, seven days a week, for primary, hospital, ambulance, care home, mental health or social care professionals or concerned older people or carers. The team will ultimately incorporate a range of disciplines including specialist medical staff, GPwSI, nurse specialists in case management/disease management and nurse practitioners skilled in Hospital at Home interventions, therapists, rehabilitation assistants, social workers, support staff and access to night sitters. It would also include voluntary sector organisations for signposting and support as part of the integrated team.

The current Enablement Team currently includes Social Workers, Domiciliary Carers, Nurses and Therapists as an integrated service. Additional staff to form the Community

Enablement Team would be drawn from:

- Shropshire Community Trust Community Teams – District Nurses, Rapid Response Nurses, Occupational Therapists, Physiotherapists
- Early Supported Discharge Team for Stroke
- Neuro-Rehabilitation Team
- SaTH Geriatricians/ medical staff as resource is identified
- SaTH Falls Prevention and Rehabilitation
- SaTH therapists
- GPwSI
- Additional nurses and therapists
- Additional social workers and domiciliary carers
- Voluntary sector organisations

The patient population is adults under and 65 years at high risk of enhanced NHS and/ or social care are the target population. This includes the frail elderly at risk of and/or suffering as a result of:

- Complex needs
- Falls
- Dementia
- Multiple long term conditions
- End of Life
- High risk of admission
- Discharged with a need for health or support care interventions

The target population will be expanded in line with JSNA evidence and local analysis over time.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
Telford and Wrekin CCG
Telford and Wrekin Council

Provider and partner organisations:
Shropshire Community Health NHS Trust – Rapid Response, community nursing teams, specialist nurses, Single Pint of Access
Telford and Wrekin Council
GP practices
Shrewsbury and Telford Hospitals NHS Trust
South Staffordshire and Shropshire NHS Foundation Trust
Council for Voluntary Services
Shropshire Partners in Care
West Midlands Ambulance Service
Shropdoc
NHS 111

There is significant evidence, particularly for older people, that hospital based care can have a negative impact; reducing confidence, exacerbating dementia, confusion, increasing risk of falls, and eroding levels of independence. Mental health services are in place within the acute setting to provide early assessment, advice and support. Integration to the Integrated Community Enablement service will ensure community support is maximised and, where admission to acute hospital is necessary, it is for the shortest possible duration.

Dementia Home Treatment is introducing SHIELD (Support at Home- Interventions to Enhance Life with Dementia) as a pilot. This will provide training in psychological approaches to staff within community and acute settings. Mental health services are an integral part of the BCF development as a provider and stakeholder.

Work will be undertaken in care homes to address and reduce the need for acute interventions resulting from inadequate nutrition or hydration.

With improved use of tele-health, tele- care and information technology, enhanced capacity and greater skill mixing in community services it is possible, and in line with patient feedback to offer more care out of hospital and reduce dependence on on-going care in the community.

BCF integrated model representation

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence for the development of theme 2 includes:

An audit completed in 2013 which was commissioned as part of our Urgent Care Project Group 'Optimising Capacity on Discharge' highlighted that 15% of those admitted could have been treated in the community if the appropriate provision was in place. It also highlighted that 48% of patients in a hospital non-elective bed could have been supported with 'lower levels' of care in a community setting.

The local Reablement/ Rehabilitation service is multi-disciplinary. It previously included Rapid Response and local evidence indicates it was more integrated with less duplication. It delivered a single assessment and care plan process.

The Accelerated Pilot demonstrated admission avoidance interventions are achievable. There were 30 Rapid response referrals in July 2013. The Pilot started on 7th July 2014. There were 68 referrals in July 2014.

Referrals from 7th -30th July	July 2013/14	30
	July 2014/15	61
Source Of Referral	GPs	34

	CCC 7 Council 4 SaTH 6 WMAS 2
Referrals at week-end	12/13th 0 19/20th 1 26/27th 5
Average Age	78yrs
Brokering care	Admitted into nursing beds 4 New care brokered 2 Night sitting 2 Increase in the current care packages 5

Comparison of admissions shows that there was a reduction in admissions on both PRH and RSH sites. RSH was 94% of last year (2491 in July 2013; 2365 last month); PRH 89.6% of last year below.

The evidence for August shows a similar trend. Clinical staff indicate that 2- 2 ½ patients each day were people that would have been admitted prior to the Pilot being implemented.

The target population was determined from the JSNA and MCAP data carried out by the Oak Group This was cross referenced with the acute hospital, GPs, Shropdoc and community services about those who were most likely to be avoidable admissions, Making our health and social care systems fit for the ageing population *Kings Fund* 2014

Research from published studies have helped shape the integrated model including:

Community services involvement in the discharge of older adults from hospital into the community *International Journal of integrated Care* September 2013

Health and Independence- Strategic vision and implementation plan for the Shropshire Frail and Complex Service September 2012

Making integrated out of hospital care a reality *NHS Confederation* 2012

Integrated care for high risk patients using a virtual ward *International Journal of integrated Care* November 2013

Integrated care What is it? Does it work? What does it mean for the NHS? *Kings Fund* 2011

Community Services How can they transform care *Kings Fund* 2014

Integrating services without structural change *BMA* 2012

Safe compassionate care for frail older people using an integrated care pathway *NHS*

2014

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Schemes identified within Tab 3 relate to this Theme. Funding from

- Rehabilitation and Reablement
- Support for carers
- Supporting Transformation
- Integrated Enhanced Community Service

contribute to existing services through 2s56 agreements or NHS contracts with the acute or community service providers. The intention is that services will virtually integrate.

Financial benefits for 2013/14: 430 admissions reduced.
This supports the use of the Transformation monies in reducing avoidable admissions and the creation of funding to develop community services.

Financial benefits for 2014/15 are summarised below:

Level of reduction of admissions	Number of admissions	Rationale for Figure	Impact on Scheme
3.5 %	564	Payment for Performance	If achieved can be utilised for community services; if not will fund acute services
5%	805	3rd Temperature Check projection of reduction in activity	Potential reduced community capacity to develop community services. Insufficient reduction to enable acute to reduce fixe costs. Recognise challenge to reduce admissions against previous trend of increases.
7%	1260	Target based on 15% reduction in avoidable admissions of 65+ within April 2014 submission, previous modelling and within the 2-5 year plan	Total £3m contribution to the pooled budget. Potential for acute service to reduce fixed costs.

The target of 1260 has been the focus throughout the development of the Frailty model development and then BCF Integrated model. While recognising the challenges this remains the ultimate goal for community services: 5 reduced admissions a day; 1 ½ reduced admissions a week from each GP practice over baseline activity. Monitoring against target and ensuring community capacity will be carried out through the Programme Management Board.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Programme Management Office will oversee the performance of the Programme as a whole through monthly Programme Management Board weekly work-stream meetings.

Identified work-streams for the four specific areas of development will report monthly. Each area and key outcome has an CCG Executive or Council Assistant Director sponsor and project lead to ensure progress:

- A single Single Point of Referral
- Single assessment and care planning
- Development of the Integrated Community Enablement Service
- Integrated record

Accelerated Pilot data is analysed and shared monthly.

Performance reporting for the BCF targets is already takes place. This will continue on a monthly

Two-monthly reporting to the Strategic Commissioning Group takes place and will continue. Formal reporting processes to the Council and CCG are also in place

Further development of the reporting on financial and non-financial benefits will also take place.

What are the key success factors for implementation of this scheme?

The six performance measures (detailed in Template 2) will be used to monitor progress through the Programme Management Board and work-streams :

- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.
- Reducing emergency admissions in 65 years + age group.

In addition further financial and non-financial benefits and outcomes have also been identified. Additional financial benefits are:

- Reduced unnecessary emergency admissions *by 15-25%*
- Reductions in hospital admissions

- Reductions in zero length of stay
- Reductions in 1-5 day length of stay
- Reductions in excess bed days in acute hospitals
- Reductions in admissions to care/nursing homes from hospital
- Reductions in admissions due to falls/falls in hospital
- Reduction in need for longer episodes of more intensive care.
- Reduced delayed transfers of care
- Maximising flow through enablement, monitoring periods of intervention, which may be less than 6 weeks, to maximise capacity of the service.
- Reduction in domiciliary care packages or reduce the rate of cumulative costs increase
- Improved, expanded and effective support services facilitating more people in independent living
- Delayed admission to residential care/nursing home care
- Fewer avoidable admissions through better management of long term conditions
- Increased access to community based activities that support overall health and well-being

Non-financial benefits are:

- People are enabled to recover and regain their independence
- Reduced duplication, through single points of access, assessment and potentially, intervention.
- Improved transfers of responsibility of care – 'passing the baton', ensuring a smoother and more coordinated journey.
- In-reach to care settings to reduce admissions to acute setting
- Better end of life care experiences, with more people able to die in a place of their choice
- Improved patient experience of the quality of care received
- Improved end of life care outside hospital
- Reductions in admissions due to falls and long term implications of falls
- Achieving cultural change within our community, encouraging and supporting self-help and self-care
- Increased engagement of volunteers
- Maintaining people in employment longer

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Telford and Wrekin
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	17277
	2014/15 Plan	15889
	2015/16 Plan	13661
	14/15 Change compared to 13/14 outturn	-1388 (-8%)
	15/16 Change compared to planned 14/15 outturn	-2228 (-14%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	430
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1260

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	