Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Telford and Wrekin CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	Telford and Wrekin Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

There is 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.

Various formal partnerships including all local organisations have been involved in steering the development of the plan to date, and these will continue to be closely involved:

- Health and Wellbeing Board
- Urgent Care Working Group
- Winter planning group
- Optimising capacity group
- Stakeholder partnership groups led by the Council/CCG involving users, carers, independent and voluntary sector providers

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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:

1. A range of joint strategies in place for several years, driven by a joint commissioning approach
2. 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
3. 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.
4. '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.

5. A review of the Multi-Agency Carer's Strategy led by the Carer's Partnership.
6. A major conference as part of 'The Call for Action' on local healthcare provision. This served as the culmination of several months consultation informed by over 3,000 of the Shropshire/Telford & Wrekin population, and over 200 clinicians. .
7. 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 configuration of hospital based care, but which will be informed by progress of this plan to provide out of hospital care wherever appropriate.
8. This may lead to recommendations for further reconfiguration of hospital services and 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 services that leads to confusion and potential duplication and/or fragmentation 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

No additional specific engagement has been completed at this stage for BCF. We will build on the above and expect to engage people in an iterative process over coming months as this plan will inform the Strategic Clinical Review of hospital care and vice versa. It is essential that we clarify 'what' can be provided out of hospital, and 'how much of it', at the same time as determining how to reconfigure acute services

e) 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.

The draft Implementation Plan is attached. Local strategies linked to integrated working are also summarised and included.

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 Health and Wellbeing Board 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) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Telford & Wrekin Health & Wellbeing Board has developed a 3 year Health & Wellbeing Strategy to improve 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 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 Better Care Fund 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. 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 Better Care Fund, is to transform public 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 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 or 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, and 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 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 we can

design a service model that both strengthens community capital and delivers public services that are integrated, efficient, and 'skill mixed', we will achieve a more cost effective, sustainable option for delivering care in the future.

Our initial approach will focus on the themes outlined below. Both organisations recognise that greater integration of commissioning, management & administrative support and 'all age' service provision is possible in the future, where we can demonstrate that this would be in the interests of the population of our Borough and both our organisations.

Our Better Care Fund will be focused on two key themes:

1 To 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.

2 To deliver a viable alternative to in-patient hospital care for people who can be cared for closer to home. We will build on our existing integrated community health and social care Enablement/Rehabilitation model by transferring capacity from the acute sector so that we offer a viable alternative community service rather than hospital bed based care.

In five years time, we will have:

Theme one – Building Community Capacity in Telford and Wrekin

- A strong voluntary sector infrastructure, with strong links with our 'Teams around Practices'
- A significant increase, based on modelling data, (*tbc as a target*) in people volunteering
- Community networks in every locality in the Borough offering support as a 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.

With a view to reducing the number of people who need to access ongoing care support and/or treatment

Theme two – 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.

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.

With improved 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 continuing care in the community.
We expect to see the following outcomes:

- Improved levels of confidence in self care
- Fewer avoidable admissions through better management of long term conditions
- Carers feeling better supported
- Enhanced Community involvement
- Reduced unnecessary emergency admissions
- Reduced delayed transfers of care
- Improved, expanded and effective support services facilitating more people in independent living
- Delayed admission to residential care/nursing home care
- Better end of life care experiences, with more people able to die in a place of their choice.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The Better Care Fund 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
- Promote 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 systems in place to get help at an early stage.
- Ensuring financial efficiency

Five performance measures will be used to monitor progress :

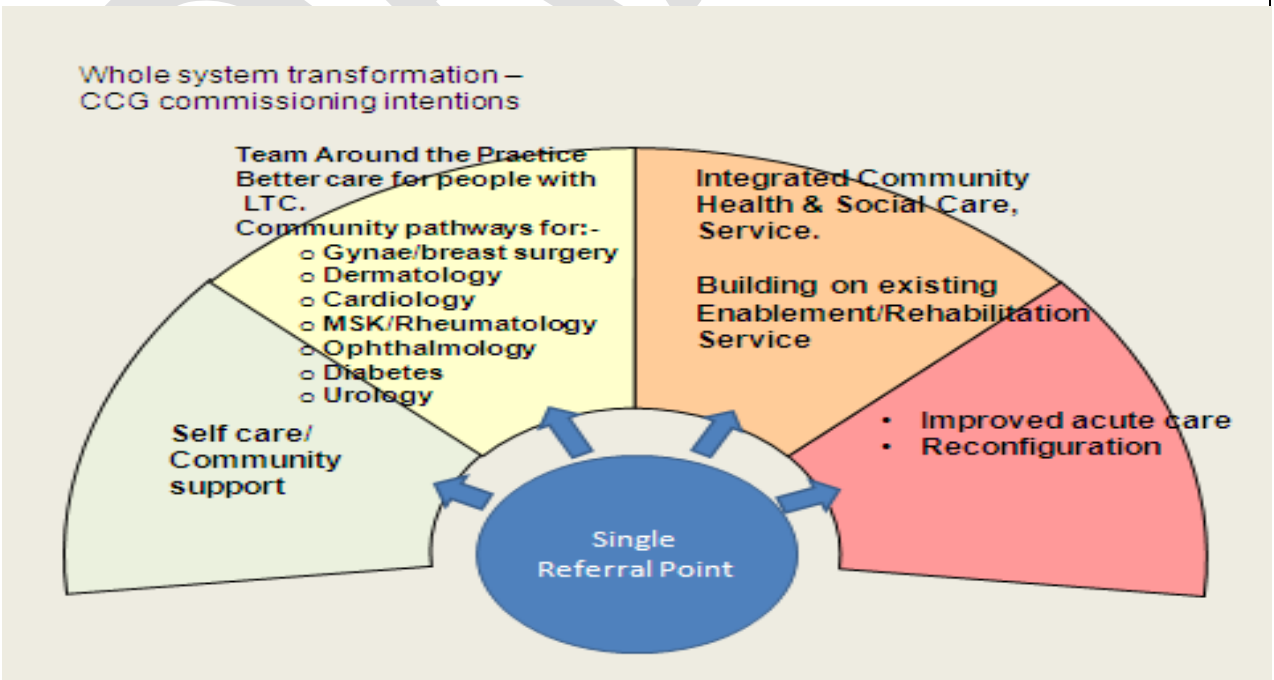
- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.

This 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 people needing support. There is evidence that the historic approach can disable people, is risk averse and leads to an over prescription of support, whilst discouraging innovative, personalised and more cost effective interventions.

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:

1. Universal Information, Advice & Living Well
2. Community Support to facilitate self-help
3. Single point of access for specialist advice & support
4. Prevention & Enablement to maximise independence and avoid or reduce need for ongoing care and support
5. Personal budgets to give greater choice & control for those who need ongoing support

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



The four elements in the CCG commissioning strategy include:

1. Stronger communities – to strengthen communities, develop greater capacity for patients to 'self-care', and to offer support to families and carers.
2. A Team around the GP Practice – to strengthen primary care with a multi-disciplinary approach to proactive support of patients with Long Term Conditions, particularly those who are vulnerable.
3. 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.
4. Improved Hospital care– ensuring acute hospital services have 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 we have the following objectives:

Theme 1 - Building Community Capacity in Telford and Wrekin

1. To review current spend by both organisations on voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
2. To support improvements in the infrastructure of the voluntary sector
3. To jointly design and procure a range of support services that can be delivered by voluntary and community organisations
4. 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
5. To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.

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

1. To review how existing services funded by the resources being pooled in the BCF can improve to enhance quality, value for money, and outcomes.
2. To complete modelling to confirm how many people can be supported in Out of Hospital care, what staff are required and what the costs will be.
3. To establish an enhanced and expanded integrated and multi-disciplinary 'Out of Hospital Service' which will provide a comprehensive continuum of services from admissions avoidance to end of life care.
4. To bid for an element of the 1.5% transformation monies in the CCG allocation for 14/15 to 'Invest to save' in staff to allow a longer term transfer of acute staff to the community in line with modelling completed by the CCG.
5. To establish processes for referrals/access/assessment and support by the enhanced integrated service including the establishment of a Single Referral Point.

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

Non-Financial Benefits

- 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 help they need when they need it
- More people benefit from Intermediate care
- People only spend the time in hospital that is needed
- People are enabled to recover and regain their independence
- Improved transfers of responsibility of care – 'passing the baton', ensuring a smoother and more coordinated journey.
- More people are enabled to recover and regain their independence
- 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
- Reduction in the number of patients leaving acute hospital who are admitted to residential or nursing home care
- Achieving cultural change within our community, encouraging and supporting self help and self care
- Increased engagement of volunteers
- Maintaining people in employment longer

Financial benefits

- Increase in uptake of carer assessments and support services
- Reduced duplication, through single points of access, assessment and potentially, intervention.
- 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 Delayed Transfers of Care
- Reduction in need for longer episodes of more intensive 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

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery

- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Planned changes for theme one- *Building Community Capacity in Telford and Wrekin*

Prevention enables people to maintain good physical and mental health and live independent and fulfilling lives. A key element of our integrated model is to strengthen communities, develop greater capacity for patients to 'self-care', and to offer support to families and carers.

We plan to develop the ability of people and communities to manage their own care, by ensuring that there is good information and support available to people and their carers. We will build community capacity by supporting the development of, and improving links with mutual support organisations. We will ensure education and better information for early support to prevent more costly interventions in the future.

There is no new money for this, but by combining the resources of the two organisations we will improve service specifications, procurement and rigour around contract monitoring to ensure optimal delivery. Through this focus we will provide facilitation to communities and strengthen the ability of Self-Help groups in providing information, support and guidance.

Care of long term and other conditions will increasingly be based on a shift of responsibility from professional to citizen. The ideas of self-care and expert patient are not new, and as personal health budgets and appropriate assistive technology emerge we will explore opportunities to take the principles of self-care to the next stage.

Investment in relevant housing related support including physical building related adjustments as well as low level support will remain an important preventive component.

This work stream is being progressed through the positive interface with the voluntary and community sectors, through the Chief Officer's Group and an existing Local Authority -led Information and Advice project. There is productive engagement with Advocacy and User-led organisations to ensure robust service user and carer involvement.

Although still to be explored we envisage a key role for Healthwatch Telford & Wrekin and the CCG Roundtable in supporting this theme.

Planned changes for theme two: *Enhanced community services for Telford and Wrekin as an alternative to hospital provision*

Integrated teams have been established to deliver effective rehabilitation and enablement services in the community. Re-ablement focuses on preventing or delaying a downward spiral of increasing dependence, declining physical and mental health and poorer quality of life. Interventions address physical aspects (e.g. mobility, physical functioning, pain management etc) and mental health and the factors which promote it (e.g. social relationships and support, self-esteem, self-efficacy).

Re-ablement not only helps individuals to recover and achieve their full potential but is also a good investment for health care and social care, including, preventing decline. Rehabilitation enables individuals the interventions to return to the level of function prior

to illness or surgery. After rehabilitation and enablement, it may be possible to remove the need for on-going care, and to establish independence and coping skills more effectively so future crises can be avoided.

The existing integrated Enablement Team in Telford & Wrekin already includes Social Workers, Domiciliary Carers, Nurses and Therapists, with a local authority management lead. The proposed model is to enhance the service by integrating elements of other existing services to create additional capacity. MCAP audit data will be used to inform this work.

The most critical action for this plan to work is to model exactly what capacity is needed to provide a viable 'out of hospital' service which will enable the CCG to reduce activity levels in the acute contract to divert both money and staff into the new service.
This must include the social care component which has yet to be fully modelled and costed. We are exploring what support the Central Midlands CSU can provide to help with this.

We now have access to detailed benchmarking data for District Nurses and will use this for modelling community nurse capacity.

The development of the Joint Health and Wellbeing priorities were determined from JSNA evidence and activity trends including rates of child obesity and demographic changes for older people. The development of strategies earlier including for Rehabilitation and Reablement, Dementia and Carers all include JSNA analysis and projected increases in demand. The analysis supported the action plans from the strategies.

Activity assumptions related to Theme Two include projected numbers of people 65+ who need will need health and social care services and associated increased in demand. This was recognised within the Urgent Care High Level Projects in 2013. The economy agreed a model for Optimising capacity on Discharge to reduce length of stay in hospital; giving additional acute capacity. This model has been developed through Commissioning plans for the CCG and Council to the Enhanced Community model.

The JSNA also highlights likely numbers in need of some level of support for LTCs that may, in the future, need enhanced health and social care services. This information will support the demand and capacity modelling for Theme One.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The plan proposes reduced activity within the acute sector. These include reduced admissions and length of stay. Current modelling (to be further revised within the action plan) highlights 845 reduced admissions (utilised MCAP audit data) 1500- 2000 early discharges. This includes reduced admissions related falls and End of Life care within the community from enhanced services. Most NHS rehabilitation will be community based

rather than within the acute setting.

Indicative saving are £2.1 – £4.5m full year effect on activity reductions. Commissioning intentions for 2014/15 include a £3m reduction to the acute hospital to be included within the BCF.

The model within Theme Two includes acute clinical capacity working within the community – medical, OT, physiotherapy – to ensure sufficient specialists skills are available to avoid emergency admissions. This will also develop further community capacity to support planned care reductions within the acute sector where possible.

Risks associated with savings not being realised are highlighted within the risk matrix.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The CCG is accountable to NHS England for performance, and the council to the population through elected members and the Cabinet. We are actively exploring a more significant role for the Health and Wellbeing Board. We will be suggesting that the Board prioritises the Integration agenda and the management of what will become a significant pooled budget.

It is proposed that the Programme Management Group for the Better Care Fund will report into the Strategic Commissioning Group which in turn will report into the Health and Wellbeing Board.

The H&WB will provide strong joined up governance for the formal pooled BCF budget. The BCF will be delivered through a strong Programme Management approach. The PM Group will have clear goals, a robust plan, work-streams and clearly identified resources. The H&WB will receive assurance on progress from the PM Group.

The Health & Wellbeing Board will be responsible and accountable for monitoring the spend of pooled budget, scrutinising delivery of programmes plans, and performance managing progress.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Social Care have statutory duties including carrying out statutory assessments and meeting eligible needs in a person centred way. We will maintain the availability and quality of services which keep people safe. The focus will be to ensure, as far as possible, that people remain independent within their own home.

From carrying out the of statutory assessment of need, a range of options will be utilised: accessing a range of voluntary and community resources; signposting to partner agencies including Council services, housing and by providing a range of interventions to meet assessed eligible need.

We will increase the level of self-help and low level prevention to support the whole population This includes prevention programmes, reablement 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.

Please explain how local social care services will be protected within your plans.

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” , which otherwise would not be possible “in the absence of the funding transfer”.

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 plan builds on the existing integrated working of 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.

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.

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

These will be revised and enhanced to maximise independence and self-help. 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.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

All organisations have developed 7 day working in response to our current Winter Plans. The local Hospital Provider SaTH (Shrewsbury and Telford Hospitals Trust) is developing 7 day services, including medical cover. Social Care has extended Hospital from Home Service and the Community Trust is in the process of extending key services, e.g. Community Equipment.

Proactive discussions with the Care/Nursing Home sector are underway as our analysis demonstrates delays. A more consistent approach is needed to the transferring of patients at weekends.

Within the new model people will be able to be discharged from hospital at the weekend through the staff medically approving, planning and initiating discharge. This includes the link-up with suitable providers if there are on-going care needs. This will involve SaTH and SCT changing their staffing patterns and rotas.

The integrated Enablement service already operates 7 days a week, although health input tends to be limited to Monday- Friday - this will be addressed through the planned expansion. Further modelling and pilots will be considered to ensure the optimum effectiveness and efficiency.

Strategic commitment 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

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

We are not using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Currently the NHS number is used inconsistently across social care, although the council database 'Care First' does include a field for it. We are currently reviewing the Information Sharing protocols (which had been signed by the PCT so out of date) with the intention of re-signing these in early 2014.

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

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.

This is potentially very large piece of work that service areas would need to complete and a risk is being added to the risk register that without a framework this may not be adequately completed.

The project team is exploring the implications of extending data sharing to more voluntary organisations as the sector is currently challenged by lack of capacity and technical knowledge. Plus there is a risk that the voluntary sector may not be compliant with Local Authority or NHS Information Governance standards

Please confirm that you are committed to 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 to allow information to be exchanged between systems through open standard interfaces, supported by open Application programming Interfaces where necessary.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise 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.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The current integrated Enablement team have a lead professional to case manage based on identified need.

Within the enhanced model the lead professional will be determined by a Single Assessment Process - this will identify the most appropriate individual to take that role. This assessment will also determine levels of risk and the support plan. Consultant medical capacity and additional OTs, physiotherapy, social work and nursing will be within the team.

Changes to the GP contract will require us to build on existing risk stratification and develop robust care plans for high risk groups. Our health 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. This work will inform approaches to risk stratification. GPs will therefore support the identification of those high risk patients who need a joint care plan and lead professional.

Through BCF we 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 public 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.

The target population has not been reduced further. This is to ensure this 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.

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).

RISKS

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

System: Better Care Fund (BCF)	**Assessment Conducted by:** Michael Bennett and Lezli Feeney
Vision: '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 log as possible'	**Date:** 04/02/14 **Review Date:** 01/04/14

Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor (*T&W Council risk grading in italics and brackets)*	Actions	Residual Risk	Responsible Person/ Implementation Date
£3m of capacity must be moved from SaTH during 2014/15 to provide the financial resources for the BCF. Reduce reliance on acute hospital beds by community investment.	Failure to release this funding, e.g. by failure of SaTH to reduce activity, will mean that sustainable service change in the community cannot be delivered.	Commitment in principle to the BCF BCF Project Plan Local health and social care economy BCF Steering Group Call for Action – Strategic Clinical Review Defined contract activity changes	Possible x catastrophic = high 13 *(High x likely = key risk 8)*	Development and in year activity of the BCF Steering Group Further innovations as part of the action plan within year to further reduce admissions and LoS	Catastrophic and Unlikely = High 12 *(High x likely = key risk 8)*	Michael Bennett

Effective change management achieved at SaTH, SCT and Council Trust to facilitate reduction of activity at SaTH and create the capacity and skills to undertake additional work in the community.	Teams within organisations may continue to work in existing patterns; cultural change will not be achieved and patients will not receive joined up, personalised care closer to home. This risk may be exacerbated by 'change fatigue'.	As above	Major x possible = high 11 *(High x medium = key risk 7)*	Skills audit of SaTH, SCT and Enablement Re-deployment of SaTH and SCT into the Virtual team as part of integrated model Some redeployment of staff from SaTH to the Community Trust to TAP Recruitment of additional staff Further innovations to promote new ways of evidence-based interventions	Major x unlikely = Moderate 8 *(High x Unlikely = key risk 6)*	Michael Bennett
Inconsistency of interpretation between the Council and CCG relating to the levels of CHC funding.	The BCF template will not be approved by the HWB Board. Financial pressures remain highlighted and unresolved	DH guidelines for CHC BCF financial modelling Negotiations between the Council and CCG re: funding for people in their own homes and care	Moderate x possible = moderate 8 *(medium likelihood 5)*	Continued negotiations related to the level of the BCF pooled budget	Moderate x unlikely = Low 6 *(medium x unlikely = 3)*	David Evans

		homes				
Programme management capacity	Insufficient resource to effectively manage the BCF programme will exacerbate challenges to its success. This risk is exacerbated by reduced management structures across the local health and social care economy. Other responsibilities cause distraction.	Council lead: SDM Transformation/ CCG lead: Head of Commissioning, Integrated Care	Major x possible = high 11 *(High x medium = key risk 7)*	Proposed programme management structure and staff being considered. Steering group bring developed	Major x possible = high 11 *(High x medium = key risk 7)*	Fran Beck/ Clive Jones
High level technical modelling and analytical skills to model activity and provide monitoring data.	There is insufficient assurance that the available data, national metrics and skills resource are sufficient to ensure meaningful modelling and monitoring of activity flows to define proposed and actual activity. The urgency to address this risk is exacerbated by the need to include meaningful data in the programme submission to the Area Team.	CM and SL CSUs and Council data analysts Project Group	Major x possible = high 11 *(High x medium = key risk 7)*	Understanding of the available data and an evidence base of activity will develop over time. Therefore close data monitoring must be maintained.	Major x unlikely = Moderate 9 *(High x Unlikely = key risk 6)*	Michael Bennett

Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor	Actions		CCG Responsible Person/ Implementation Date
Insufficient capacity within the local community, principally the voluntary sector, to support self help/ self care. There is a need for significantly more community capacity in this area Current providers include: Red Cross, Age UK and Community Service Volunteers (CSV)	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. Increased financial risk	Contracts with current voluntary sector providers Call for Action Working together Events in Telford and Wrekin	Major x possible = high 11 *(High x medium = key risk 7)*	Provide support to the voluntary sector to develop the leadership, capacity and skills to fulfil their role in the delivery of the BCF. Establish voluntary sector links to 'Teams Around Practices' Implement communication and engagement strategy as identified within the Implementation plan	Major x unlikely = Moderate 9 *(High x Unlikely = key risk 6)*	Michael Bennett
Patients and the wider community need to feel that service delivery under the BCF effectively meets	Failure to 'win hearts and minds' will result in failure by patients to engage with care provided under the BCF programme. Failure to implement the	BCF Project Plan Call for Action – common messages	Major x possible = high 11 *(High x medium = key risk 7)*	Patient and public engagement in the BFC programme. Meaningful communication	Major x unlikely = Moderate 9 *(High x Unlikely = key*	Michael Bennett

their needs.	BCF will challenge the CCG's ability to address the common messages of consultative exercises.			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.	*risk 6)*	
Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor	Actions		CCG Responsible Person/ Implementation Date
Integrated care pathways that empower patients and address the needs of the local demographic.	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	BCF Project Plan BCF Steering Group JSNA CCG and the Council's commissioning	Major x possible = high 11 *(High x medium = key risk 7)*	Joint working within the Steering Group to inform change in partner organisations Act upon the findings of the	Major x Unlikely = Moderate 9 *(High x Unlikely = key risk 6)*	Michael Bennett and David Evans

		intentions		‘Optimising Capacity on Discharge’ audit Implement ‘Single Referral Point’ and single triage and assessment		

Risk Grading Matrix

	Consequences				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Almost certain	LOW 6	LOW 7	MODERATE 10	HIGH 13	HIGH 15
Likely	LOW 5	LOW 6	MODERATE 9	HIGH 12	HIGH 14
Possible	VERY LOW 4	LOW 5	MODERATE 8	HIGH 11	HIGH 13
Unlikely	VERY LOW 3	VERY LOW 4	LOW 6	MODERATE 9	HIGH 12
Rare	VERY LOW 2	VERY LOW 3	LOW 5	MODERATE 8	HIGH 11

Qualitative Measures of Likelihood:

Likelihood	**Example**
Almost certain	Will undoubtedly happen or recur, possibly frequently
Likely	Will probably happen or recur but it is not a persistent issue
Possible	Might happen or recur occasionally
Unlikely	Do not expect it to happen or recur
Rare	Will probably never / happen or recur