


Appendix A - Telford and Wrekin Economy



BETTER CARE FUND NARRATIVE PLAN

Plan Summary					KLOEs																																																																																										
Local Authority: Telford and Wrekin Council					1																																																																																										
Clinical Commissioning Groups: Telford and Wrekin Clinical Commissioning Group																																																																																															
Boundary differences: Co-terminous																																																																																															
Date agreed by Health and Well-Being Board																																																																																															
Financial summary																																																																																															
The financial contributions are set out below, within the Planning Template submission (tab 4) and p37-38 below.					A3ii,iii,iv,v																																																																																										
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A3iii full overview of funding contributions Not met (LGA) Although planning return is referenced – is that acceptable? The table above sets out the funding contributions. We believe this meets the requirements of the KLOE.					A3iii,																																																																																										

Signed on behalf of Telford and Wrekin Council	1iv; A3i,ii
Add electronic signatures	
Clive Jones Director	
Date	
Signed on behalf of Telford and Wrekin Clinical Commissioning Group	1iv; A3i,ii
Add electronic signatures	
David Evans Chief Officer	
Date: 3 rd May 2016	
Signed on behalf of the Telford and Wrekin Health and Wellbeing Board	1iv; A3i,ii
Add electronic signatures	
Richard Overton Chair of Health and Wellbeing Board	
Date	
The KLOEs were deemed NOT MET. The signatures now meet the requirement of the identified KLOEs	
Date of submission:	1i; 2i A3i,ii
The Planning submission and narrative plan have been submitted today-	
Clive needs to support the submission specifically by a supporting follow on e-mail relating to the submission and Narrative plan	2,ii,iv
MB to check if the Planning submission need electronic signatures	
Michael	
KLOEs were deemed NOT MET. The dates of submission included now meet the requirement of the identified KLOEs	2,ii,iv
<u>Introduction</u>	
The Community centred approaches paper sets out the vision for health and social care of ' <i>Right Help, Right Time to promote Independence</i> '. (embedded document below).	B1i
It highlights that 'Increasing demands on public services at a time of significantly reducing resources means that we must look for a new model for delivering services which continues to safeguard our most vulnerable children, young people and adults. We know that the existing model can actually create new demand and dependency and we are not always improving outcomes that matter most to people. This is no longer affordable and doesn't necessarily benefit people. In addition, we are seeing increasing need with an ageing population and ever growing expectations of public sector services. These challenges are being faced locally and mirrored nationally.'	

 <p>Community centered approaches final.docx</p>	<p>B1i,iii,v,vii B2i,ii,iii C1v</p>
<p>The papers further sets out the and the golden thread of</p> <ul style="list-style-type: none"> • Strengthening communities • Volunteer and peer roles • Collaboration and partnerships • Access to community resources <p>This builds on the learning of the BCF programme to date.</p>	<p>B1iii</p>
<p>The commissioning intentions for 2016/17 were presented jointly by the CCG and Council to the HWB Board in March 2016. They set out very similar vision and the integrated working across health and social care. The submission included the three integrated themes set out in the Better Care Programme section below</p> <p>The CCG vision is ‘Working with our patients, Telford and Wrekin CCG aspires to have the healthiest population in England. Healthier, Happier, Longer’. The focus is on improved health outcomes through integrated teams through triple integration.</p> <p>The Council vision is similar – ‘encourage healthier lifestyles, strengthened individuals and communities to support themselves’.</p>	<p>B1iii</p>
<p>‘Being the Change’, the Councils Managing Directors report (December 2015), sets out the need for ‘enterprise, innovation and partnership working’ - promoting collaborations and maximising the synergies between service. This includes</p> <ul style="list-style-type: none"> • Reducing demand through strengthening families • Building communities capacity to improve outcomes and reduce demand on public services • Prevention • Working in communities <p>This highlights the level of synchronicity between health and social care.</p>	<p>B1iii</p>
<p>The Council Market Position Statement (March 2015; currently being updated) sets out the direction of travel including:</p> <ul style="list-style-type: none"> • Meeting population demand and supply – market capacity • Promoting Well-being/ Independence and Prevention (including taking forward the Joint health and social care Prevention strategy • Personalisation – more choice and control; personal budgets and flexibility of contracts to enable choice • Developing a diverse and sustainable market and sustainable business 	<p>B1iii</p>
<p>The Sustainability and Transformation Plan (STP) will be developed by June 2016, which is required to deliver the Five year Forward View and a one year operational plan (represented within the T&W CCG Operational Plan within C8iv below). The STP will include a:</p> <ul style="list-style-type: none"> • Clear vision and plan for the area • Financial stability plan for providers and commissioners 	<p>B1iii</p>

<ul style="list-style-type: none"> • Clear plan for prevention, patient activation, choice and control and community engagement and close the health and well-being gap • New care model development improving clinical priorities and roll-out of digital healthcare • Financial balance of local systems and improve efficiency of NHS services <p>The BCF priorities, programme of work and key actions are being included within the first draft of the STP, currently in development. This will ensure that BCF is an integral part of the STP</p>	
<p>The planning for 2016/17 and future strategic planning leads to a future that looks like:</p> <ul style="list-style-type: none"> • Resilient local communities focussing on well-being and Prevention • Integrated preventative services delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent • Reduced reliance on social care services • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions 	B1iii
<p>B.1.iii KLOE was deemed PATIALLY MET by NHSE Discusses the current state and the future vision but doesn't outline the planned state post plan delivery. The summary above sets out the correlation between vision for the future, local strategic actions and future state. We believe this provides evidence that this KLOE is fully met</p>	B1iii
<p><u>Review of BCF performance to date</u></p>	
<p>The BCF programme from April 2014 to date had a focus on</p> <ul style="list-style-type: none"> • Delivering personalised health, social and independent sector care delivered through integrated services • Promoting 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 appropriate interventions at an early stage and reduce avoidable admissions. • Ensuring financial efficiency and reduce duplication. 	B2i
<p>In addition to the national metrics the local metric was the reduction of emergency admissions for 65+ years. Targeting this population was based on JSNA and acute hospital admission data.</p>	
<p>Key themes of BCF performance in 2015/16 are:</p> <ul style="list-style-type: none"> • The reduction in Q4 was a reduction of 5.12% (-227) • The reduction in Q1 2015/16 was 2.72% (-116) • The increase in Q2 2015/16 was +2% (+87) • The increase in Q3 2015/16 was +5% (+210) • Previous quarters had shown a reduction in costs related to admission. Q3 showed a small decrease in costs (0.2%. £14,000) • Overall to Month 9 YTD shows a 1.4% overall increase in admissions. However, there was a 4% reduction in costs • Month 9 overall average LoS in 14/15 was 4.31. This has reduced to 3.84 this 	B2i,ii,iii,iv



<p>year. The biggest average LoS reduction was the 75+ years with 1.24 days less than last year (9.02 days/ 7.78)</p> <ul style="list-style-type: none"> • 0 LoS has increased across all ages by 5.39%. Overall costs have increased for 0 LoS have increased by 5% (£132,000) • Longer length of stays have decreased overall. 3+ day LoS has decreased by over 5.4% and a cost reduction of 8%. Only 85+ years has increased overall • Paediatrics (6%) and 75+ years (9.7%) years have increased admissions. The reasons for admissions are predictable for the ages. • Reduction in beds day to date equate to c21 beds days less a day • Savings in Rehabilitation costs continue against last year • XBDs reductions are being maintained • Gross cost savings related to admissions at Month 9 were £885,000 with a year-end forecast reduction of £1,549,000 	
<p>The Planning Performance and Quality Committee (sub-group of the CCG Governance Board) reports illustrates the evidence for supporting further developments (embedded below)</p>	
 <p>PPQ BCF deep dive report November 15</p>	B2i,ii,iii,iv
<p>The developments within 2014/15 and 15/16 include:</p>	
<p>Enhancing out of hospital provision out of hospital including</p> <ul style="list-style-type: none"> • Funding for Rapid Response nurses to provide enhanced admission avoidance, in-reach to the acute hospital and divert admissions and develop additional clinical pathways • Development of the Telford Integrated Community Assessment Team (health and social care team based at the hospital to divert admissions 	B2i,ii,iii,iv
<p>Improved 7 day working including:</p> <ul style="list-style-type: none"> • Rapid Response nurses above • Funding Respiratory nurses over 7 days – which analysis indicates reduced admissions and supports discharge over 7 days 	B2i,ii,iii,iv
<p>Detailed profiling of admissions on a monthly basis by diagnosis and HRG chapter, shared with clinical teams, to track admissions against targets and develop further plans, initiatives or targeting. The analytical tool as a monthly xl report enables analysis by age profile, LoS, HRG and clinical conditions. This provides a clear understanding of the impact of teams in admission reductions.</p> <p>This segmentation of the data provides clarity of the impact of interventions. The Month 11 report is embedded below</p>	B2i,ii,iii,iv
 <p>BCF_Monthly_Profile M11.pdf</p>	
<p>Impact assessment on a monthly basis of which programmes and initiatives are making an impact on reducing admissions</p>	B2i,ii,iii,iv

<p>Local analysis indicates that early death rates from cardiovascular disease (CVD) have declined over the past decade, but still remain significantly worse than the national average. 80% of Potential Years of Life Lost to causes amenable to healthcare (PYLL) during 2011-13 were caused by CVDs, Cancers and respiratory diseases.</p> <p>The proportion of residents aged at least 65 is lower than national average (T&W 18.5%; England 20.7%) However, many of the older residents live in deprived areas.</p> <p>Local benchmarking shows higher rates of emergency admissions for (at HRG level):</p> <ul style="list-style-type: none"> • Cardiac surgery and primary care conditions • Digestive systems • Respiratory conditions • Urinary tract infections <p>Only one of T&W's general practices, in the latest reports, had a population that was in the least-deprived quintile, while 72% of practices had a population that was in the most or second-most deprived quintile.</p>	B2ii, B2iv
<p>Admission avoidance interventions have focussed on these conditions in order to reduce avoidable admissions and provide community based interventions. Cost reductions have been identified at Month 11 within the BCF profile in these HRG levels.</p>	B2ii, B2iv
<p>B.2.iv Partially met (NHSE and LGA) Some references to unmet need but very sparse. Not really established a robust case for change. More data to quantify need. Additional information is set out above. Also included within Operational Plan embedded document (C8iv) and Commissioning Priorities report to HWB Board March 2016 embedded document (B1ii) below. These are the local supporting evidence for the work programmes and agreed locally. We believe these fully meet the requirements of the KLOE</p>	B2iv
<p>Improvements to quality of care for patients that BCF programme has delivered / is aiming to deliver – from April 2014:</p> <ul style="list-style-type: none"> • Delivering personalised health, social and independent sector care delivered through integrated services • Promoting 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 appropriate interventions at an early stage and reduce avoidable admissions. • Ensuring financial efficiency and reduce duplication. <p>Enhancing out of hospital provision out of hospital including</p> <ul style="list-style-type: none"> • Funding for Rapid Response nurses to provide enhanced admission avoidance, in-reach to the acute hospital and divert admissions and develop additional clinical pathways • Development of the Telford Integrated Community Assessment Team (health and social care team based at the hospital to divert admissions <p>Improved 7 day working including:</p> <ul style="list-style-type: none"> • Rapid Response nurses above • Funding Respiratory nurses over 7 days – which analysis indicates reduced 	B2ii

admissions and supports discharge over 7 days	
<p>Quality improvements were measured by:</p> <ul style="list-style-type: none"> • Quality Assurance visits are undertaken with providers, these site assurance visits are based on assessment against recognised regulatory standards. • An audit has been undertaken across all Nursing Homes with commissioned 're-ablement' beds:- The audit was based on a Modified Barthel Index (Shah version). The documentation and methodology of the audit was developed collaboratively with local authority colleagues and providers • The CCG coordinates a 'soft intelligence' system known locally as NHS2NHS to supplement other Quality Assurance systems and processes. • A locally developed KPI schedule of measures has been developed for all Telford and Wrekin Nursing homes. 	B2ii
<p>The development of integrated Neighbourhood Care teams provide significant opportunities to improve preventative interventions around local communities and reduce avoidable admissions</p> <p>Quality improvements identified within the Intermediate Care service specification and be part of the Neighbourhood Care team are based on the outcomes and Commissioner Quality Standards defined in the National Audit of Intermediate Care 2015. These include:</p> <ul style="list-style-type: none"> • Achievement of person specific goals prior to discharge (based on Sunderland Model). • Ensuring patients whose dependency has maintained or improved (based on modified Barthel Index) • Patients ability to maintain social contact has improved – improved wellbeing • Maximising the number of patients discharged to their usual place of residence (minimum of 80%) • Reduction in the number of service users placed in permanent placements in care homes from acute care – ensuring an effective rehabilitation and reablement model. • Maintain or increase the percentage of older people who were still at home 91 days after discharge - ensuring an effective rehabilitation and reablement model and effective ongoing care • Maintain or increase the percentage of older people still at home and needing no on-going services 91 days after receipt of Intermediate Care intervention – ensuring effective person specific outcomes and use of voluntary sector and • Discharge from hospital over 7 days • Reduction of all emergency admissions for service users aged 70 years and over 	B2ii
<p>The planning for 2016/17 and future strategic planning leads to a future that looks like:</p> <ul style="list-style-type: none"> • Resilient local communities focussing on well-being and Prevention – people living healthier lifestyles an strengthened individuals and communities to support themselves • Integrated preventative services and early support delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent 	B2ii

<ul style="list-style-type: none"> • Re-designed care and support through co-production that prevents, delays or reduces the need for care and support • Reduced reliance on social care services • Responsive carer support • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions 	
<p>Reductions in costs have been identified through:</p> <ul style="list-style-type: none"> • Reductions costs associated with admissions indicated above and Month 11 profile (embedded document above) £1,258,016/ 5% reduction against last year • Reductions in hospital based rehabilitation costs • Reductions in Excess Bed Day costs <p>Additional potential for cost reductions and efficiencies are likely from:</p> <ul style="list-style-type: none"> • Fewer ambulance conveyances to hospital • Integrated teams and processes and care – efficiencies from reduced duplication of assessment; implementation of Buurtzorg model and reduced duplication of visits • Reduced permanent admissions to care homes • Reduced demand for health and care services from developing resilient local communities that focus on well-being and Prevention – strengthened individuals and communities to support themselves • Progressing support approaches to domiciliary care that support reablement plans and reduce need for specialist therapy interventions post assessment • Offering a range of personalised approaches to care – Individual Budgets, Supporting Planning – where local evidence indicates costs reductions and improved outcomes 	B2ii
<p>B.2.ii Partially met (NHSE) The plan discusses risk stratification but doesn't reference the opportunities to improve quality or reduce costs. The information above summarises the opportunity for quality and cost improvements. We believe these summarises provides evidence that fully meets the requirements of the KLOE</p>	B2ii
<p><u>Further supporting the Case for Changes within the BCF programme</u></p>	
<p>There are national and local strategic priorities that support innovations within the BCF. In addition, learning from the work to date supports further innovation. These include:</p> <ul style="list-style-type: none"> • Five Year Forward View • Future Fit and Community Fit • JSNA data • Evidence from emergency admissions • Care homes admissions • User engagement 	
<p><u>Further supporting the Case for Change – In line with Five Year Forward View</u></p>	
<p>Local service planning is in line with the Five Year Forward View. It is demonstrated</p>	B1ii

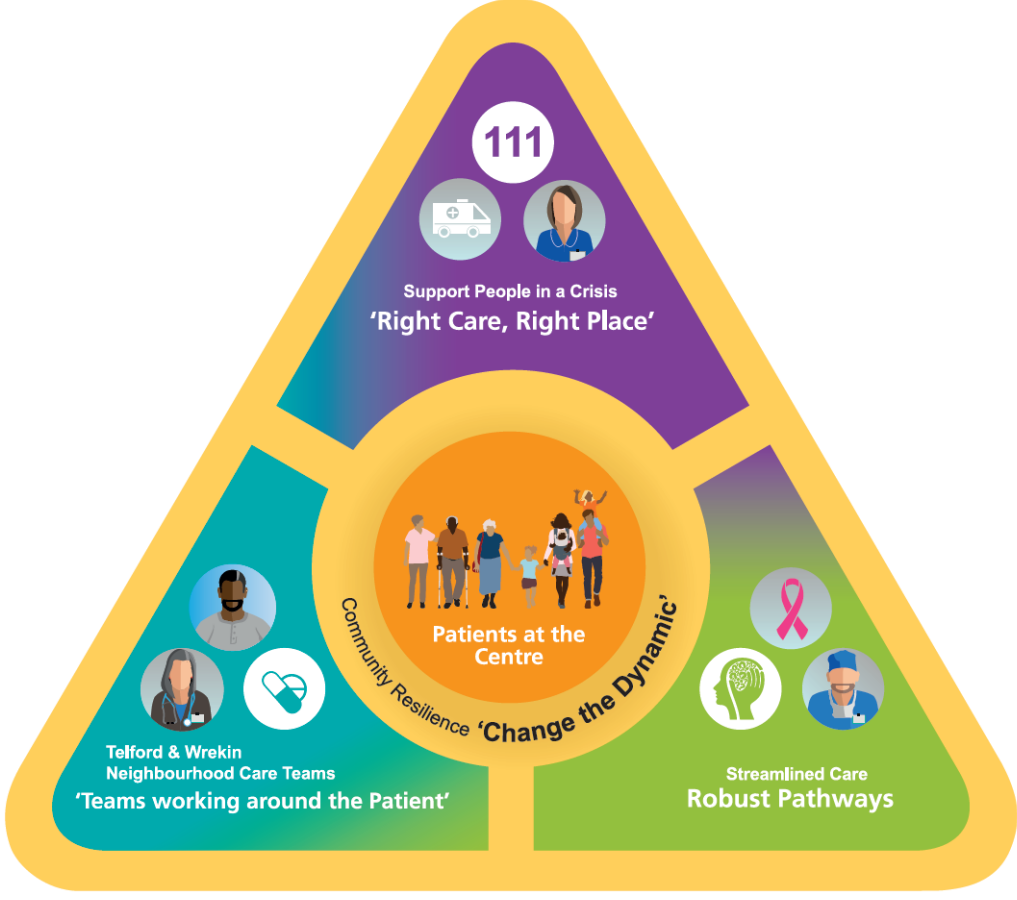

<p>through:</p> <ul style="list-style-type: none"> • <u>Focus on Prevention</u> specifically through the Neighbourhood Care Team • <u>Empowering Patients</u> specifically through the Neighbourhood Care Team • <u>Engaging Communities</u> as integral through the Neighbourhood Care Team, Community Resilience and Carer support • <u>NHS as a social movement</u> through the three key contributing integrated care programmes set out below • <u>Improved support for frail elderly including in care homes with new models of care</u> through the Integrated Care team; where the specification specifically focusses on 70+ years and reductions of admissions to care homes • <u>Co-design and implementation of new models of care</u> through Future Fit and Community Fit and the three key contributing integrated care programmes set out below • <u>Accelerating innovation in new ways of delivering care: prototyping Locality working before full implementation three months later; piloting Enhanced Rapid Response to reduce admissions and delivering with six weeks of planning- and evidence of reducing admissions</u> • <u>Funding</u> through increasing the s75 agreement for 2016/17 in line with local agreed principles of pooling where services should be integrated to provide improves outcomes and more effective and efficient use of each 'Telford Pound' 	
<p>The Commissioning Intentions report to HWB Board March 2016 (embedded document below) sets out the high level commissioning priorities for health and social care. It was presenting by senior officers of the Council and CCG and sets out:</p> <ul style="list-style-type: none"> • Commissioning activity for the CCG, Public Health and Vulnerable People Commissioning teams including: <ul style="list-style-type: none"> ○ Emotional Health and Well-being service for 0-25 years an ○ Children at the Edge of Care, Children in Care and Young people Leaving Care ○ SEND ○ Strengthening Families ○ Carers ○ Joint Dementia Strategy ○ Joint ALD strategy ○ Joint MH strategy ○ Extra Care Housing • Integrated Intermediate Care and Neighbourhood Care services • Integrated working • Collaborative commissioning • Universal support and promoting well-being • Co-production and strengthening social capital • JSNA headlines • Key programmes of work 	B1ii
<p>In addition:</p> <ul style="list-style-type: none"> • The Sustainability and Transformation Plan (STP) will be developed by June 2016, is required to deliver the Five year Forward View • The T&W Operational Plan is the 2016/17 plan of the STP (embedded below) • Additional references are included within B1iii (p3); C6ii and C8iii 	B1

	B1ii
<p>B1ii KLOE was deemed PARTIALLY MET by LGA ‘High strategic vision for H&SC could be developed further’ (LGA). We believe this provides evidence that this KLOE is fully met</p>	B1ii
<p><u>Further supporting the Case for Change – Future Fit and Community Fit</u></p>	
<p>Future Fit is the local, overarching vision of a sustainable, community based, health and social care system focused on prevention and continuity of care, delivered by integrated teams of volunteers, health and social care professionals and others, through bespoke local solutions.</p> <p>Community Fit (embedded document) was developed from Future Fit to detail how the overarching objectives would be realised. The project aims to enable safe transition from the current care model, which is heavily inpatient based, covering all aspects of care.</p> <p>All local stakeholders are represented including the acute hospital, community provider, Council, GP Federation, SPIC, patient representatives, Healthwatch, mental health provider.</p>	B1ii C6iii
 <p>Community-Fit-CCG-B oard Nov 15.pdf</p>	C6iii
<p>Community Fit clearly highlights the medium and longer term strategic plan for the development of community and voluntary sector resources to support reduced hospital admissions; prevention and self-care through community resilience.</p>	C6iii
<p><u>JSNA evidence</u></p>	
<p>Evidence from the JSNA supports the targeted approach to admission. The main users of hospitals and care homes are older people with people over 65 accounting for 62% of total bed days in hospitals in England, and 68% of emergency bed days (Imison <i>et al</i> 2012). Average length of stay in hospital is eight days for patients aged 65–74 years; 10 days for patients aged 75–84 years; and 12 days for patients aged 85 years or older (Cornwell <i>et al</i> 2012). More than three-quarters of people receiving care in registered residential and nursing accommodation in England funded by councils are aged 65 and over (with 43% aged 85 and over), and 81% of people receiving community-based home-care services are aged 65 or over (NHS Information Centre 2012).</p> <p>For Telford & Wrekin, JSNA evidence of demographic changes demonstrates that local residents aged 65 and over are an increasing proportion of the population. This age group currently represents 14.5% of the total population and is expected to increase to 17.3% by 2026, a growth of circa 9,200. Within this age group the fastest growth is within the 85+ age group which has increased by 27.3% since 2001.</p> <p>The ageing population and increased prevalence of long- term conditions and multi-morbidity require greater integration in the way in which health and social care services are organised and delivered. In particular, the separation between general practitioners (GPs) and hospital-based specialists, and between health and social care often inhibit the provision of timely and high-quality integrated care to people who</p>	B1iv

<p>need to access a range of services relevant to their needs. Furthermore, there is national evidence of variations in the quality of care and opportunities exist to improve outcomes.</p> <p>The Kings fund report 'Transforming the delivery of health and social care – The case for fundamental change' emphasises the need for a radical shift in where care is delivered and the relationship with health and social care professionals to:</p> <ul style="list-style-type: none"> • see patients and service users as part of the care team • focus on the development of effective health and social care teams in which staff work flexibly and full use is made of the range of skills available • provide care in the right place at the right time by reducing overreliance on hospitals and care homes 	
<p><u>Analysis of emergency admissions</u></p>	
<p>Detailed profiling of admissions on a monthly basis by diagnosis and HRG chapter, shared with clinical teams provides analysis of emergency admissions. The analytical tool as a monthly xl report enables analysis by age profile, LoS, HRG and clinical conditions. This provides a clear understanding of the impact of teams in admission reductions.</p> <p>The pdf embedded document is above</p>	B2i,iv
<p><u>Impact of care home admissions</u></p>	
<p>With a local focus on reducing admissions for 65+ years in 2015/16 and those who are 70+ years in 2016/17 there has been a focus on care homes.</p>	B2i,ii
<p>There has been recognition locally to reduce admissions to care homes. Permanent admissions were high compared to national norms in 2014/15 and BCF performance has indicated permanent admissions to care homes</p>	B2ii,iv
<p>The Projected Older People Population Information (POPPI) projection below shows the forecast trajectory for care home growth in T&W. This indicates the need for more additional care home beds than national average. This would relate to the forecast additional ageing population. The Council have used fewer beds than predicted to date.</p>	B2ii,iv,v

<p>POPPI 65+ Care Home Growth</p> <table border="1"> <caption>Estimated data from POPPI 65+ Care Home Growth graph</caption> <thead> <tr> <th>Year</th> <th>Actual</th> <th>T&W Forecast 65+</th> <th>England 65+</th> </tr> </thead> <tbody> <tr> <td>2011</td> <td>530</td> <td>530</td> <td>530</td> </tr> <tr> <td>2013</td> <td>550</td> <td>550</td> <td>550</td> </tr> <tr> <td>2015</td> <td>570</td> <td>580</td> <td>570</td> </tr> <tr> <td>2017</td> <td>600</td> <td>620</td> <td>600</td> </tr> <tr> <td>2019</td> <td>640</td> <td>660</td> <td>630</td> </tr> <tr> <td>2021</td> <td>680</td> <td>700</td> <td>650</td> </tr> </tbody> </table>	Year	Actual	T&W Forecast 65+	England 65+	2011	530	530	530	2013	550	550	550	2015	570	580	570	2017	600	620	600	2019	640	660	630	2021	680	700	650	
Year	Actual	T&W Forecast 65+	England 65+																										
2011	530	530	530																										
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2015	570	580	570																										
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<p>There have also been high rates of admission to acute hospitals. There were 596 emergency admissions from care homes in 2013/14. This was 11.1% of all emergency admissions to the acute hospital. In 2014/15 this was 608 (10.7%). At Month 9 2015/16 analysis showed a +2 increase (0.3%) against last year. However, there is a 12% reductions in costs related to admissions</p> <p>The cost of care home admissions were £1,97m in 2013/14 and £2.07m in 2014/15</p>	B2ii,iv,v																												
<p>The Council spent £24.9m in care homes and equivalent accommodation in 2014/15. Extrapolating spending in this year to date would suggest spending will reduce by 4.4% compared to last year.</p>	B2ii,iv																												
<p>The CCG spent £2.5m in CHC and complex care costs in 2014/15. 78% (£1,950,000) related to care beds. Extrapolating spending would suggest increased spending by 8% compared to last year. This relates to fast tracks and contributions to joint packages of care.</p>	B2ii,iv																												
<p><u>Further supporting the Case for Change – user engagement</u></p>																													
<p>Patient and user engagement has been through a:</p> <ul style="list-style-type: none"> • Consultation event in and July 2014 and July 2015; • Regular meetings with Health Roundtable • Regular meetings with Voluntary Sector Forum • Attendance at Carers Partnership Board. • Meetings with care and user representative groups including Healthwatch <p>Healthwatch were are a member of the Programme Management Board, which overviewed the programme until the new Governance arrangement came into place</p> <p>Healthwatch are a member of the HWB</p>	B1vii																												
<p>A user, carer and stakeholder consultation event was held in July 2016; providing feedback from the previous event and gaining views and priorities for future development. Key priorities were identified as:</p> <ul style="list-style-type: none"> • Improved primary care services 	B1vii																												

<ul style="list-style-type: none"> • Increases in Preventative interventions reducing higher care costs including access to information • More referrals for admission avoidance • Focus on care at home • More person centred in terms of care delivery 	
<u>Better Care Fund Programme for 2016/17</u>	
<p>Three integrated care programmes below form the BCF programme. The local need for change within the economy is highlighted in the embedded document above – The Community centred approaches paper ‘<i>Right Help, Right Time to promote Independence</i>’. (embedded document</p>	<p>B1i,ii,iii,iv, v,vi B2i,ii,iii,iv C1</p>
<p>The three key contributing integrated care programmes are set out below. These formed a report to the CCG Governance Board in February 201 and supported by the Council:</p> <ul style="list-style-type: none"> • Building community resilience • Developing ‘Telford Neighbourhood Care Teams • Implementing Robust Intermediate care services <p>The contents of the report are included below</p>	<p>B1iii B3 C1</p>
Background	
<p>During 2015 the CCG developed key priority areas described in the diagram below. This paper provides an over view of three key programmes of work which directly contribute to those priorities. These will form the significant part of work within the ‘Integrated Care’ portfolio of work for 2016. The three programmes centre around <i>community resilience</i>, the development of ‘<i>Telford Neighbourhood Care Teams</i>’ and the implementation of <i>intermediate care services</i>.</p>	<p>B3</p>


	
<p>The delivery of these programmes will contribute to the progression of the ‘triple integration’ agenda which involves closer worker between; primary and secondary care; mental and physical health; health and social care. There is a growing evidence base to suggest that integration can improve outcomes for people. Integrated processes alone can help this improvement.</p> <p>An overview of each of programme is provided below. Each table outlines; the vision and aims, who the programme involves (providers, commissioners and patient cohorts), why the change is necessary, what needs to be done, how the change will be achieved and a high level description of associated commissioning resources.</p>	<p>B3</p>
<p>1. Community Resilience</p>	
<p>Vision and aims</p>	
 <p>Telford will have strong and connected communities. The community will drive the</p>	<p>B1</p>


<p>development of local assets and people will:</p> <ul style="list-style-type: none"> • Have friends and support networks • Things to do • A feeling of being safe and belonging to their community • Confidence to go and help and ask for help • Centres or 'connecting points' to go to 	
Who?	
<p>In order to be successful, this involves the whole community, from individuals through to more formal community groups, third sector and statutory organisations</p> <p>Statutory organisations need to change their approach, valuing community centred approaches and truly understanding the community they serve. They also have a role in stimulating/facilitating change and occasionally leading change.</p>	
Why?	
<ul style="list-style-type: none"> • Traditional models of statutory services are no longer fit for purpose: They promote dependence, they are expensive and outcomes could be better • There is a strong and growing evidence base about the importance of building confident and connected communities in improving outcomes for people. • Individuals benefit from contributing to the wellbeing of others • A growing proportion of the population are suffering from problems associated with <i>preventable</i> disease • Needs escalate and peoples health and wellbeing deteriorate because they don't have enough support in the community • People depend on services because there have very limited alternatives in their own communities 	B2
What?	
<ul style="list-style-type: none"> • We need to work across Telford to facilitate a movement to build resilient communities • We need to draw on and develop the wide range of assets in the area, rather than dwell on the deficits • We need to support and build 4 different aspects of community centred approaches: <ol style="list-style-type: none"> 1. Strengthening communities by taking action on the causes of poor health; 2. Support volunteer/peer roles; 3. Enable collaboration and partnership in planning of services between communities and statutory organisations; 4. Connect individuals/families to community resources 	B2
How will we achieve the change?	
<p>A single plan will be produced across Telford and Wrekin. Sign off and ongoing monitoring will be through the new 'Stronger Communities Board' which is a sub group of the Health and Wellbeing Board. The three key officers will be Liz Noakes, Clive Jones and Anna Hammond.</p> <p>This change will need take place over a number of years in order to reverse the trend of paternalistic state service provision. To start we can:</p> <ul style="list-style-type: none"> • Identify the local leaders who can champion change • Consider 'social isolation' and how communities can help to address it • Map all the existing assets to celebrate the diversity and identify gaps. 	B2 B3

<ul style="list-style-type: none"> • ‘Kick start’ the movement by funding prototypes that can illustrate what can be achieved • Develop a workforce to help us get to know our communities <p>As this change represents more of a movement, an action log will be utilised to highlight activities across the area</p>	
<p>What financial resources are associated with this change?</p>	
<p>The very nature of this change is about the development of community driven and sustainable change. Any funding attributed to this change needs to support that notion. It is suggested that the combined grants funds of the Council and CCG support prototype development, communication exercises and fund one off costs to support the movement. Any process for bidding for resources needs to be light touch and high trust in line with the TLAP principles. Examples may include development of materials, books, equipment, games to help to gain momentum.</p>	
<p><i>Useful references:</i> NHS Alliance (2014), A Charter for community development in health Public Health England (2015) A guide to community centred approaches for health and wellbeing</p>	
<p>2. <u>Telford Neighbourhood Care Teams</u></p>	
<p>Vision and aims</p>	
<div data-bbox="497 1025 960 1451" data-label="Image"> </div> <p>People with an identified long term health condition will be supported to live their life to their full potential</p> <ul style="list-style-type: none"> • The notion of care ‘from cradle to grave’ will be reinvigorated through this model. • Individual professionals will take responsibility for the delivery of as much care as possible, drawing on specialists where necessary • Professionals will work together to seek out those who would most benefit from an intervention/support • People will share their story once in a way that it right for them • People will understanding their condition and how to deal with it • People will self care/self manage where possible • Carers will be supported <p><i>N.B. this represents a starting point and could be expanded in the future</i></p>	<p>B1</p>

Who?	
<p>Population: People with identified health risks. A large cohort will be those on practice disease registers, which currently include circa 45,000</p> <p>Informal patient networks including friends, family, neighbours</p> <p>Professionals who support these people and form part of the virtual teams will be;</p> <ul style="list-style-type: none"> • Practice teams • Community nursing teams from Shropshire Community Trust • Home workers within the Local Authority • Community teams from South Staffordshire and Shropshire NHS Trust • Third sector organisations • Outreach teams from Shrewsbury and Telford Hospitals • Carers • Local Authority support (e.g. housing) 	
Why?	
<ul style="list-style-type: none"> • We need a much greater focus on prevention • We need to find people earlier in their disease progression so they can manage their condition better, earlier • A greater number of people have become more dependent on statutory services • Current services tend to do things to and for people, rather than promoting self-management • Multiple individuals from different organisations are providing care for any one patient at any one time. This has led to duplication, confusion and sometimes a preoccupation on where teams are based, rather than how they work together • Patients are having to tell their story multiple times • The current way of working is not the most effective way of supporting the increasing number of people with long term conditions • We have lost a holistic nature of care by focusing on 'tasks'. Over the years care has been 'carved up' with the tasks allocated to workers with the lowest level of skill to carry out the task. Whilst this was implemented to improve efficiency it has fragmented care 	B2
What do we need to change?	
<ul style="list-style-type: none"> • We need to focus on the delivery of joined up care (not on the disaggregation of its component parts) • We need to change the culture of service provision to promote independence, shared decision making and self-care • Statutory organisations need to consider how virtual teams can function to support patient centred approaches. Effective communication between the patients, carer and professionals is essential • Statutory organisations need to shift to an asset approach, considering the wealth of informal networks in patient's lives • Move to a proactive approach, seeking out patients who would benefit from early intervention • A greater focus on delivering care for those in socially deprived areas 	B2
How will we achieve the change?	
Virtual teams will be formed from professionals from different organisations. These will be	B2

<p>grouped around natural neighbourhoods/communities of about 10-20k populations. In most cases this will around practices. These teams will:</p> <ul style="list-style-type: none"> • Implement the ‘Telford House of Care’ • Adopt the ethos from Buurtzorg for community nurses and home workers which empowers workers to deliver all the care that patient need, rather than dividing aspects of care up and distributing tasks to different people. • Adopt the six elements of community service from Buurtzorg: <ol style="list-style-type: none"> 1. Holistic assessment of patients. Leading to the formation of a care plan 2. Mapping networks of informal care 3. Identifying more formal care needs 4. Care delivery 5. Supporting the patient in their usual social environment 6. Promoting self care and independence. • Utilise risk stratification • Formalise practice based MDTs including mental health, third sector organisations and local authority professionals • Consider the roles and responsibilities of these teams in end of life care <p>The key officer will be Michael Bennett who will develop a clear project plan, including key outcomes we would hope to achieve. The main clinical lead will be Louise Warburton. A Steering group will be initiated to be chaired by Anna Hammond. This will include all key stakeholders.</p>	B3
What financial resources are associated with this change?	
<p>Staff for the virtual teams are currently funded through contracts with the following providers/groups of providers:</p> <ul style="list-style-type: none"> • Primary care • Community nurses (excluding rapid response) • Admiral nurses • Carers contracts • More specialist nursing teams (eg continence) • Community mental health (N.B. whilst workers will be part of the virtual team, the budgets are difficult to disaggregate on this basis) • Local authority teams 	
3. <u>Intermediate Care</u>	
Vision	

 <p data-bbox="167 750 1284 817">To support patients in times of crisis, in their usual place of residence if possible, through the delivery a range of short term interventions. The service will:</p> <ul data-bbox="215 824 1292 1153" style="list-style-type: none"> • Prevent unplanned admission to hospital • Reduce time spent in hospital • Provide a quick response from professionals in times of crisis (e.g. exacerbation of a long term condition, carer breakdown) • Assess and treat patients in their own home • Provide access to fast track holistic multi-disciplinary assessment • Proactively support discharge from hospital when the patient is medically stable, with the provision of short term therapy support to get people as independent as possible before reviewing long term needs. 	<p data-bbox="1324 197 1460 235">C3i,ii,iii,iv</p>
<p data-bbox="167 1191 247 1220">Who?</p> <p data-bbox="167 1227 1300 1332">Anyone who has an exacerbation of a condition who could be managed in a setting other than hospital. A high proportion of the patients will be over the age of 70 and have long term conditions including frailty and dementia</p> <p data-bbox="167 1366 470 1400">Key stakeholders will be:</p> <ul data-bbox="215 1406 949 1702" style="list-style-type: none"> • Practice teams • Shropshire Community NHS Trust • Shrewsbury and Telford Hospitals NHS Trust • South Staffordshire and Shropshire Healthcare NHS Trust • Local Authority • Third sector • Informal networks • Pharmacists 	
<p data-bbox="167 1742 247 1774">Why?</p> <ul data-bbox="215 1780 1284 2027" style="list-style-type: none"> • There needs to be greater range of alternatives to hospital admission • The response times to community alternatives are not always quick enough • The aspects of intermediate care are currently fragmented across multiple teams/ providers. There is lack of clarity about roles and professionals are not always able to work together because of organisational boundaries. • Some of the services currently inadvertently promote dependence • The hospital system cannot cope with the increasing levels of emergency demand 	<p data-bbox="1324 1780 1364 1814">B2</p>

<ul style="list-style-type: none"> Telford and Wrekin have a higher number of 'community beds' compared to the national average 			
What do we need to change?			
<ul style="list-style-type: none"> We need to develop a coherent pathway, that can be clearly articulated to professionals as well patients and their carers We need to build on the wide range of skills and expertise in our community staff and bring them together We need to agree and implement a model to ensure there is sufficient medical input at the right level to the service 	B2		
How will we achieve the change?			
<p>The CCG will develop a single outcome based specification to be delivered by multiple providers. This will be trialled by current providers during 2016/17. Providers will be incentivised through meaningful outcomes that support 'flow' (and consequently achievement of targets) as well as financial incentives to reinvest in patient care.</p> <p>This specification will be launched with providers at the end of January. Anna Hammond will be the responsible officer. Organisations have supported the idea of an outcomes specification, but have requested that the CCG take a role in facilitating workshops between providers to initially aid them working together. Monitoring reports will be produced against the specification and a group will be set up between the commissioner and provider to monitor progress. This will replace elements of the BCF governance arrangements. This intermediate care service will be included within the Better Care Fund. Michael Bennett will be the lead of officer in operationalizing the change and monitoring achievement of outcomes.</p>	B2 B3		
What financial resources are associated with this change?			
<p>An overall budget will be assigned to this service. This budget will be formed from some of the existing funding used for the following <i>current</i> services:</p> <ul style="list-style-type: none"> SaTH (rehab) Shropshire Community (rapid response, enablement, community physio) Community bed base (i.e. beds in care homes) LA (TBD) <p>As there is no prime provider, there will need to be some disaggregation of the overall budget so 'service lines' can be attributed to various providers and included in existing contracts.</p>			
The Intermediate Care service specification is embedded below			
 <p>IC spec using 1516 NHS contract v4.docx</p>			
<p>Key roles and functions of the Intermediate Care team will include:</p> <p>Implementation to the DToC action plan and achieving the DToC target (included within the embedded BCF Action Plan)</p>	ABC		
The DTOC action Plan includes (in summary form)	C8i;viii,ix,x ixii,		
<table border="1"> <tr> <td>Ensuring consistent DToC reporting on both acute hospital</td> <td>April 2016</td> </tr> </table>	Ensuring consistent DToC reporting on both acute hospital	April 2016	
Ensuring consistent DToC reporting on both acute hospital	April 2016		

sites			
Formal monthly reporting of mental health related DtoCs on a monthly basis	April 2016		
Specific targets for mental health related delays in place	April – June 2016		
Completion of Recovery bed quality audit to review validity of referral, outcomes and patient experience	May 2016		
Achieve outputs from the Task and Finish Group to reduce DtoCs	March – October 2016		
SaTH completion of the Fact Finding Assessment at the point of being identified as MTTD	June 2016		
Improve the flow through Recovery beds to an average LoS of 30 days	June 2016		
Reduce the daily number on the DToC list to 12 each day average	July 2016		
Develop community capacity (care packages and Recovery beds and pathways) to ensure discharge within 2 days of being MFFD	March – October 2016		
Pilot Fast Track domiciliary care with Severn Hospice to accelerate discharge process from hospital	July 2016		
Maintain reductions in XBDs at 5% of the previous year	On-going		
<u>National conditions- Ensure a joint approach to assessment and care planning</u>			
Joint assessment and care planning will be an integral part of the Neighbourhood Care Team and Intermediate Care team. This is included within the Intermediate Care team service specification and key principles to improve patient experience and outcomes		C5iii	
It is recognised that there is currently no electronic patient record to support joint assessment and care planning process. Specific work is being undertaken by the Council and community provider within the TICAT team to develop a system to enable this as an interim solution		C5iii,v	
Process maps are in place that indicate the joint approach being taken to assessment and care planning. Weekly and on-going meeting are in place to implement the process. This will be aligned to joint location of teams and support the current 'Green Folders' – patient information retained at the patients usual place of residence and utilised by all workers involved in the patients care.		C5iii	
Currently each person within the TICAT team or community provider with a care package in place has an identified accountable professional. This is also a		C5iii	

requirement within the Intermediate Care team.	
Information Sharing Agreement is in place to share information across teams to ensure no Governance issues delay incremental development of joint working. The intention is to have a shared process fully embedded during 2016/17	C5iii
Data Sharing and ICDR is a sub-group of the STP. This sub-group will enable full implementation of a single assessment and care planning process- when all providers have ICDR.	C5iii
C.5.iii KLOE was deemed PARTAILLY MET by NHSE and LGA Description of H&SC plans to joint assessment processes. It references "Agreed joint assessment and care planning documentation" but doesn't elaborate on this. The Narrative above and actions set out within Section 5 of the Action plan now meet the requirement of the KLOEs and we believe is fully met.	C5iii
Care Plans will explicitly indicate who to contact when they need timely decisions about their care such as managing an escalating LTC. The intention is to improve the process for individuals returning to their pre-existing provision.	C5vi
Risk stratification Case Management within primary care is delivered through a Direct Enhanced Service. A locally developed risk stratification process is in place. The 2% target population is 1900 people. Currently 1097 have been reviewed within primary care	C5i
In addition to Risk stratification Case Management within primary care, other clinical teams provide case management and a named care co-ordinator. These include (with potential duplication): <ul style="list-style-type: none"> • Clinical Caseload of community nursing team • Respiratory Nursing team • Diabetic Nursing team • Locality Social Workers managing c1800 cases • People identified with dementia • Care Navigators referred from primary care • Admiral Nurses • Identified patients on GP registers (1900) • The Neighbourhood Care team will seek to enhance co-ordination of this population.	C5i,ii,
There is recognition that many people 70+years will have some level of dementia. Actions in place or developing to support this target population include: <ul style="list-style-type: none"> • Rapid Response, TICAT and Enablement have significant experience in managing those conditions. Approx. 50% of users of Recovery beds have some level of dementia. • Admission avoidance supports people with dementia. The commissioned domiciliary out of hours provision is aware than some potential referrals of people who have dementia • Dementia Advisors (Admiral Nurses) work closely with primary care, Carer representatives and Council Locality teams to ensure co-ordinated responses • Specific Recovery beds have been commissioned for people with dementia • Identified staff from the Dementia team respond within 72 hours to assess 	C5ii,viii

<p>patients and also provide support, advice, joint assessments with non-mental health teams</p> <ul style="list-style-type: none"> • Planning is in place to determine the future co-ordination of mental health services and general health services. • Working together with Dementia Action Alliance which has a wide inclusive membership of the community in the development of dementia friendly communities in Telford and Wrekin as well as increasing Dementia Champions 	
<p>As part of the development of the Intermediate Care Team:</p> <ul style="list-style-type: none"> • Risk stratification will continue to be used to identify high risk patients within primary care and review care plans. Management of escalating conditions and admission avoidance will be through the Intermediate Care team. • Referral to a single point of access to the integrated team • Agreed joint assessment and care planning documentation • Mental health services including Dementia and RAID are closely aligned to the team to provide clinical advice and assessment in line with the mental health strategy 	C5iii,vii
<p>As part of the development of the Neighbourhood Care Team:</p> <ul style="list-style-type: none"> • Risk stratification will continue to be used to identify high risk patients within primary care and review care plans and primary care supported by the Neighbourhood Care team. • Joint assessment and care planning will be carried out to identify needs • Signposting to suitable services including non –statutory services will take place to unsure support is in place • Enhance the use of preventative services including Care Navigators and Admiral Nurses to limit disease progression and ensure effective support for people with Dementia and their carers 	C5iii,vii
<p>Milestones to achieve full compliance are included within the Action Plan</p>	C5iv
<p>C5iv KLOE was deemed Partially met (LGA) More detail will emerge as work above progresses. The Action Plan has been updated. We believe the KLOE is now fully met</p>	C5iv
<p><u>National conditions – Agreement of the delivery of 7 day services</u></p>	
<p>Q3 submission highlights the area where 7 day services are in place:</p> <ul style="list-style-type: none"> • Rapid Response nurses • Respiratory nurses • voluntary organisations to support Assisted Discharge home • Acute hospital sector senior medical support • GP support – Shropdoc • Domiciliary care is provided over 7 days for planned discharges. Some limited response at weekends from domiciliary providers to support admission avoidance. • Out of Hours domiciliary care through the Emergency Carer Response Service from April 2016 	C3i



<p>Improvements in 7-day working is part of the NHS contract for the acute provider. This includes a national CQUIN payment for community and acute hospital provider</p>	C3iv
<p>A national CQUIN in relation 7 day services is included within the acute hospital NHS contract to meet the four key standards for 7 day working :</p> <ul style="list-style-type: none"> • Standard 2: Time to First Consultant review – within 14 hours • Standard 5: Availability of Diagnostic Services over 7 days • Standard 6: Availability of Consultant Direct Interventions 24/7 • Standard 8: On-going Consultant Review within AMU, SAU, ICU etc have consultant review twice daily <p>The CQUIN is intended to ensure roll out within the acute hospital by the end of Q4 2016/17.</p>	C3i C3ii
<p>Effective 7 day services within the acute hospital are essential to support avoidable admissions. It is a requirement of the Intermediate Care Team, where the acute hospital function is an integral part of in order to reduce admissions and support early discharge.</p> <p>The Intermediate Care Team service specification sets out the need for 7 day services. Planning for 7 day working of Social Workers, voluntary sector workers and Brokerage is set out within the Action Plan so that they are in place during 2016/17.</p> <p>The expectation is that discharges from hospital of complex patients is similar at a similar level at weekends to weekdays by facilitation within the acute setting and effective processes, care delivery and capacity over 7 days</p>	
<p>C.3.i KLOE was deemed NOT MET by NHSE. The plan specifies those areas where 7 day services are in place but fails to reference a plan to achieve full roll-out. The Narrative and additional inclusions within the Action Plan meet the requirements of the KLOE and we believe this KLOE is fully met</p> <p>C.3.ii KLOE was deemed PARTIALLY MET by NHSE. Cites that 7 day working is included in the national contract. It doesn't expand on this. The Narrative and additional inclusions within the Action Plan meet the requirements of the KLOE and we believe this KLOE is fully met</p>	C3i; C3ii
<p>The key functions of the Intermediate Care team as set out in the service specification are:</p> <ul style="list-style-type: none"> • Admission avoidance by clinical interventions and community based social care interventions • Early supported discharge from hospital including clinical interventions and community based social care interventions • Access to care to support admission avoidance or discharge from home over 7 days • Accept to step up or step down Recovery beds to support rehabilitation or re-ablement 	C3iii
<p>The Intermediate Care Team service specification sets out the requirement to develop 7-day services across health, social care and independent sector to support admission avoidance and early supported discharge. This includes initiation of care or access to step up and/ or step down facilities over 7 days rather than current mainly planned</p>	C3ii,iii

commencement at weekends	
Social Care staff identified to be part of the Intermediate Care team do not routinely work across 7 day services currently. This is currently held by the Out of Hours team. 7 day working is being considered as part of the Council re-structure including potential demands and costs for implementation.	C3iii
The Emergency Crisis Response Service (ECRS) commenced on 1 st April 2016. This provides domiciliary care within 2 hours of referral outside normal working hours including Bank Holidays to support admission avoidance.	C3iii
Providers to provide the Recovery beds (step up/ step down beds) are required to provide access over 7 days. Specifications with domiciliary care providers are being developed to have 7 day responses to initiate care.	C3iii
A Intermediate Care Team Steering group with acute hospital, community services and Council senior manager members is in place to develop and implement the service specification within agreed timescales	C3iii
C.3.iii Partially met (NHSE and LGA) References the intermediate care service specification, which will support admission avoidance and facilitate early discharge. Not very comprehensive. We believe the additional information included above, in the Action Plan and the embedded service specification indicate that this KLOE is fully met	C3iii
A local economy-wide Recovery plan to ensure achievement of ED performance monitors admissions, admission avoidance and discharges of complex patients over 7 days	C3ii
Priority actions are included within the Action Plan	C3iv
<u>National metrics</u>	
<u>Non-elective admissions (specific)</u>	
The BCF arget for non-elective admissions has been agreed as: 18,233 as submitted within NHSE plan of 3 rd March 2016 – this has since been revised to 18394 as at 18 th March 2016	E1i,
The target has been reached by using the following methodology: <ul style="list-style-type: none"> • Analysis of the Outcomes in 2014/15 • QIPP planning for Intermediate Care (-242 emergency admissions) • HRG analysis of admissions that could be reduced • Evaluation for the programme of work to achieve the current performance during 2015/16 – set out below • Growth of 2.3% in line with IHAM tool • (Growth of 1% has since been applied for 18th March submission in line with 15/16 growth and 1% QIPP (-184)) 	E1ii;iii
Performance to date has been impacted by a number of factors. These are: <ul style="list-style-type: none"> • Reductions in admissions in Q1 	E1iii

<ul style="list-style-type: none"> • Increases in admissions in Q2 and Q3 particularly 0 LoS • GP at the Front Door moving to integration with Ambulatory Care • Analysis of the profiles of emergency admissions including reductions in 65-74 years; increases in 75+ years • Increases in ambulatory care admissions <p>The BCF target for reducing emergency admissions for 70+ years is included within the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the Council, community and acute provider</p>	
<p>There is triangulation and alignment between the BCF plan, CCG Operating Plans and acute and community provider plans through:</p> <ul style="list-style-type: none"> • CCG Specific Acute Non Elective Admissions for 16/17 are included within the Monthly Activity and Other Requirements Planning Return submitted to NHSE. These include the BCF admission avoidance figures for the Integrated Care team. This will enable consistency of reporting and monitoring • Identified admission reductions are included within the Intermediate Care service specification as a key outcome • The service specification is included within the NHS contracts in 2016/17 for the acute and community provider. • QIPP and CIPs plans shared between the CCG and acute and community providers 	E1iv
<p><u>Admissions to residential and care homes</u></p>	
<p>The BCF target for permanent admissions to residential and care homes has been agreed as 155</p> <p>The figures are revised from the initial February 2016 Planning submission.</p>	E2i,
<p>The target has been reached by using the following methodology:</p> <ul style="list-style-type: none"> • Analysis of the Outcomes in 2014/15 • Latest monitoring of 2015/16 performance against target- anticipated outturn of 165 • Evaluation for the programme of work to achieve the current performance during 2015/16 – set out below 	E2ii;iii
<p>Performance to date has been impacted by a number of factors. These are:</p> <ul style="list-style-type: none"> • Increased Recovery beds for rehabilitation and reablement interventions • Clear philosophy that home is the usual destination post acute care • Council focus on preventative approaches to support at home • Working with Extra Care providers to enhance this provision and enable diversion from permanent care home placements • Council review of patients who could be supported in other, more enabling settings with appropriate support <p>The BCF target for admissions to residential and care homes is included within the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the Council, community and acute provider</p>	E2iii

<u>Effectiveness of Re-ablement</u>																						
The BCF target for Reablement has been agreed as 70%		E3i,																				
The figures are revised from the initial February 2016 Planning submission.																						
The target has been reached by using the following methodology:		E3ii;iii																				
<ul style="list-style-type: none"> • Analysis of the Outcomes in 2014/15 • Latest monitoring of 2015/16 performance against target- this is currently forecast to be 68% • Evaluation for the programme of work to achieve the current performance during 2015/16- set out below 																						
Performance to date has been impacted by a number of factors. These are:		E3iii																				
<ul style="list-style-type: none"> • Increased Recovery beds for rehabilitation and reablement interventions • Enhancing the model of rehabilitation to ensure this is effective • Vacancies of senior therapists that are now being replaced <p>The BCF target for Reablement is included within the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the community and acute provider</p>																						
<u>Local metric – reductions in 70+ years admissions</u>																						
Local analysis and planning has led to the revision of the local metric. From April this will no longer be reductions in admissions of 65+ years. The new metric is to reduce admissions of 70+ years																						
The target reductions are included within the text box of the BCF Planning submission and the CCG Operational Plan submission.																						
The national team will need to change the template to include the new metric for Q1 reporting.																						
<u>DTOCs</u>																						
The BCF Target for DTOC has been agreed as:		E4i, C8i																				
	<table border="1"> <thead> <tr> <th></th> <th colspan="4">2016/2017</th> </tr> </thead> <tbody> <tr> <td>Population (BCF Template)</td> <td>131,524</td> <td>131,525</td> <td>131,526</td> <td>132,034</td> </tr> <tr> <td>Qrtly DToC</td> <td>695</td> <td>775</td> <td>935</td> <td>880</td> </tr> <tr> <td>Rate per 100,000</td> <td>528.4</td> <td>589.2</td> <td>710.9</td> <td>666.5</td> </tr> </tbody> </table>		2016/2017				Population (BCF Template)	131,524	131,525	131,526	132,034	Qrtly DToC	695	775	935	880	Rate per 100,000	528.4	589.2	710.9	666.5	
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<p>The target has been reached by using the following methodology:</p> <ul style="list-style-type: none"> • Comparison based on the 15/16 performance. • Cross reference to 2015/16 performance. • Analysis of activity for all providers who contribute to DToC reports including mental health and other hospitals • Comparison against the current run rate adjustments taking into account the introduction of TICAT and the potential impact of the Intermediate Care team, • impact of the discharge to assess beds and the implementation of the formal reporting mechanism between the local authority and SSSFT. 	<p>E4ii;iii C8ii</p>
<p>Performance to date has been impacted by a number of factors. These are:</p> <ul style="list-style-type: none"> • Development of Discharge to Assess on Pilot wards within the acute hospital. This helps initial reductions in DToC when implemented in November 2014 • Full implementation of D2A across all hospital wards from November 2015. This has attributed to subsequent increases in DTOCs • Acute hospital implementation of Discharge ward from December 2015. This has contributed to increased DtoCs • Fact Finding Assessment delays in completion • Implementation of Telford Integrated Community Assessment Team from November 	<p>E4iii C8x</p>
<p>The Action Plan is part of the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the Council, community and acute provider. It has taken in account achieving a number of factors:</p> <ul style="list-style-type: none"> • Local Health Economy Recovery Plan for achieving the 4-hour waiting time • The acute hospital achieving their 3.5% delay target and stretch target of 2.5% • The CCG target of reducing NHS attributable delays • Strategic Commissioning Group targets for reductions in MFFD • ECIP evidence of effective in improving patient experience • Current Task and Finish group work to develop effective identification of those deemed MFFD, decision-making relating to the appropriate pathway and the administrative processes to enable effective and rapid discharge. 	<p>E4iv C8iii,iv,vii; Viii; ix C8ii</p>
<p>Financial risks in relation to DToC are maintained within the contingency reserve within the above.</p> <p>This is also highlighted within section 10 below (within the sub-section detailing Risk Sharing)</p>	<p>B5ii C8v</p>
<p>Trust performance during 2015/16 was an average of 4.9%. Lowest single month was 3.2%. The 2.5% stretch target provides a significant challenge</p>	<p>C8ii</p>
<p>C.8.ii Stretch target Partially met (NHSE) Includes the DTOC target but fails to link this to the actions. The Trust target is listed as 3.5%. Providers are required to deliver 2.5% from Apr16!. The Stretch target is included and actions are highlighted within the Action Plan. We believe this KLOE is fully met</p>	<p>C8ii</p>
<p>DToCs are reported to SRG though:</p> <ul style="list-style-type: none"> • Tracking of admissions avoided, discharges, care package commencements, 	<p>C8iii</p>


<p>flow through and usage of Recovery beds based on the achieving the local Recovery Plan</p> <ul style="list-style-type: none"> • Monthly reports to the economy Urgent Care Working Group – chaired by Executive Lead <p>The embedded document below (abridged) indicates the level of detail and economy wide planning and reporting in relation to DTOC and urgent care performance</p>	
 <p>SRG Urgent Care Update 150416 v2.pr</p>	C8iii
<p>C.8.iii Not met (NHSE) Partial (LGA) No link between the DTOC action plan and the SRG. Above provides and summary and extract report to SRG relating to DToC. We believe this KLOE is fully met</p>	C8iii
<p>DToC is reflected within the Operational Plan (extract below). P6 indicates BCF performance; P14 highlights A&E Access target where DToC has been a focus – also indicated in the SRG report above</p>	C8iv
 <p>Telford Wrekin CCG operational plan 2016</p>	C8iv
<p>C.8.iv Reflected in operational plans Partially met (NHSE) This isn't explicit. The extract from the Operational Plan is included. We believe this KLOE is fully met</p>	C8iv
<p>The Risk Sharing Agreement and Risk Register indicates that the CCG holds the financial risk in relation to increased non –elective admissions. This is held through and identified contingency Reserve</p> <p>The RSA also indicates that the RSA that ‘financial risks will be managed by partners within the pooled fund’.</p>	C8v
<p>DToC risks are also held by the CCG through tariff costs and and tracked principally through Excess Bed Day levels. These have been on a downward trajectory for the last 18 months</p> <p>The Integrated Care team service specification includes reductions of DToC as a required outcome as well as inclusion in the NHS contract for 2016/17 for the acute provider. Existing contractual liabilities within the NHS contract for under-performance are in place.</p> <p>National guidance indicates that “If there is local agreement that a risk sharing arrangement for DTOC is appropriate then local areas should consider the use of existing mechanisms. At a national level, the Care Act 2014 sets out a discretionary system whereby the NHS can seek reimbursement from a local authority (LA) if the LA does not meet its statutory duties to assess and, where appropriate, put in place care and support arrangements to allow a patient to be discharged from acute care.” This is recognised locally.</p>	C8v
<p>C.8.v Local risk sharing agreements in terms of DTOCS Partially met (NHSE) The plan references financial risks in relation to DTOCs, but does mention existing guidance and flexibilities.</p>	C8v

<p>The Action Plan related to DToC is set out using the 8 high Impact Interventions:</p> <ul style="list-style-type: none"> • Early Discharge Planning – including the acute hospital introducing SAFER • Systems to Monitor Patient Flow – including improved DToC reporting and efficiencies in flow through Recovery beds • MDT discharge teams – developing the Integrated Intermediate Care team • Home First – key principle as part of Trusted Assessor roll-out • Seven Day Services – highlighted above (KLOEs C3) • Trusted Assessors – full implementation and support from community staff • Focus on Choice – including information related to discharge planning, Recovery bed options and agreed processes to engage patients by acute and social care staff • Enhancing Health in Care Homes – specific community nursing In-reach to care homes; training and support to care home staff, Assistive Technologies and Actions from a strategic review to improve quality <p>ECIP provide on-going support to the acute hospital and wider economy in the development of improving discharge processes.</p>	C8, C8viii
<p>C.8 High impact interventions for DToC .viii Not met (NHSE) The plan doesn't reference national guidance or best practice i.e. ECIP. Additional information is included. The action plan is structured in line with the 8 High Impact Interventions. We believe we fully meet this KLOE</p>	C8, C8viii
<p>Voluntary organisations are routinely involved in the processes to reduce DToCs. These include:</p> <ul style="list-style-type: none"> • Shropshire Partners in Care (umbrella organisation funded by and representing independent sector providers) routinely highlighting need for early response to assessment and transfer to residential care. Commissioners engage through newsletters and SPIC conferences • Severn Hospice delivering EoL care as an alternative to hospital; In-reaching to the acute hospital to facilitate discharge. The Hospice are developing a rapid response-type domiciliary provision • British Red Cross Home from Hospital commissioned to facilitate transport home and support to re-settle – reducing transport delays from hospital • Council for Voluntary Services (representative body of voluntary organisations) routinely engaged in relation to admission avoidance and early discharge. Commissioners and CVS have mapped services that may be involved in supporting early discharge support. 	C8ix
<p>C.8.ix Partially met (NHSE) It mentions fast tracking discharges to Severn Hospice but its not explicit that the voluntary sector have been engaged with. The additional information indicates voluntary sector involvement. We believe this KLOE is fully met.</p>	C8ix
<p><u>National conditions- Data sharing between health and social care based on the NHS number</u></p>	
<p>Health and social care are using the NHS number and the consistent identifier. Social Care have had this in place since April 2015 within Care First</p>	C4ii

<p>Overarching Information Sharing Agreements are in place between all statutory partners and signed off by Caldicott Guardians, Standard Operating procedures are in place to address any specific new requests for information. This includes specific requirements to illustrate how the information will be used, stored and deleted/ disposed of when the reason for the information is completed.</p> <p>These were included within the 2015/16 s75 agreement and will be included within the 2016/17 agreement.</p>	C4iv,v
<p>A Local Health Economy Group, co-chaired by Telford and Wrekin CCG and the acute hospital Chief Executive is in place to identify systems to share data across organisations. This work is currently being scoped for implementation by April 2018</p>	C4iii
<p>The BCF Q3 submission indicated the current use of Open APIs. Each organisation has them in place and used internally to their organisations. There is no sharing across organisations</p>	C4iii
<p>Regular IG training of health and social care staff takes place and is monitored to ensure attendance. This ensures the key messages related to the legal requirements to safeguard and share data are clearly understood,</p>	C4i,v
<p>The IG Team are available to provide support and monitoring in relation to IG issues, ensuring effective leadership is in place. The IG team also routinely monitor to encourage the right cultures and behaviours and ensure secure and lawful storage and sharing of data</p>	C4i
<p>The CCG Governance Board approved two Fair Processing Notices: one for patients and a separate Notice for staff. These sets out:</p> <ul style="list-style-type: none"> • How the CCG keeps personal information confidential • How, when and why information would be shared with other organisations • The right to consent to not have information shared • Rights under the DPA <p>A Fair Processing Notices are on the CCG website</p>	C4v
<p>The Telford Referral and Quality Service (TRAQS) is the CCGs patient appointment booking system. It terms of use of patient information:</p> <ul style="list-style-type: none"> • Use a secure system to transfer the referral details over the N3 network (using the ICG system) • All staff have to use a SmartCard to access the National eRS system • All staff have controlled/secure access to the ICG Referrals system • Recently introduced the NeoPost envelope stuffer which checks letters before inserting them into envelopes • All Call Handlers run through a series of security questions at the start of every call to check we have the right patient, etc • All Call Handlers have to have completed the IG training toolkit • All Call Handlers set out how information about them will be used • All referrals are transferred to the relevant Provider either using eRS, secure nhs.net email or fax (to Safe Havens ONLY) 	C4v
<p>C.4.v KLOE was deemed Partially met by NHSE The CCG has a Fair Processing Notice setting out how information is used. Not clear how this message is</p>	C4v

communicated with members of the public. With the information included above we believe this KLOE is fully met.	
<p>The Council operates a corporate information security policy (CSIP). This policy sets out minimum standards and common acceptable use for confidentiality, integrity and availability of information to meet internal and legal requirements.</p> <p>All Council officers have to fully understand and comply with the CSIP and regular mandatory training is provided. Individual advice on specific IG issues is provided by the Audit and IG team at the Council.</p>	C4i,iv
<p>In order to ensure that information sharing takes place in an appropriate manner, all data sharing agreements is approved by the relevant Assistant Director and comply with Information Governance requirements and the Information Commissioners.</p> <p>All personal information managed by the Council is covered by the Data Protection Act 1998. This provides legislation as to how personal information may be used, stored, processed and shared. It contains eight principles that the Council should conform to and also governs how information needs to be handled under certain circumstances.</p>	C4i,iv
The CCG are developing a Local Incentive Scheme as part of the 2016/17 contract to support the community provider in putting an electronic patient record in place. This will enable implementation of IDCR across statutory services within the local economy	C4vi
The Sustainability Transformation Plan (STP), to be developed by 30 th June 2016 includes development of the Digital Roadmap as part of its function. A sub-group focussing on digital transformation is in place and developing a plan.	C4vi
<p>An integral part of developing integrated teams, based on virtual integration, is that electronic/ digital systems support assessment and care planning. This is particularly important when teams will be working in different locations and potentially entering information onto their respective organisations' systems.</p> <p>Development of joint assessments, joint care planning and sharing information across all relevant teams to ensure interventions in line with the <i>Right Help, Right Time to promote Independence</i>' approach is fundamental.</p>	C4vi
<p>Digital transformation is expected to:</p> <ul style="list-style-type: none"> • Reduce duplication of assessment and care planning • Improve ease of access to patient information across locations • Improve safety and quality of care – up to date patient information available • Support integrated working • Improve patient experience by improved consultations; reduced delays • Make efficiencies due to improved systems and processes 	C4vi
C.4.vi How changes will impact upon integration Partially met (NHSE) It doesn't really discuss this. It touches upon the benefits of information sharing but doesn't describe the contribution that this could make. The information above clarifies the contribution of digital transformation and we believe fully meets the KLOE requirement	C4vi
Governance arrangements and financial management	

<p><u>Governance arrangements</u></p>	
<p>BCF reports to the ‘Stronger Communities’ Board, which is comprised of Executive officers of the CCG and Senior Managers of the Council. This Board is a sub-group of the Health & Wellbeing Board and reports to it directly</p> <p>The Board’s draft Health & Wellbeing Strategy 2016-19 has selected three cross cutting priorities: encourage healthier lifestyles, improve mental wellbeing and strengthen our communities. The three BCF key contributing integrated care programmes are in line with the HWB Board priorities</p> <p>The proposed governance structure is shown below.</p> <p style="text-align: center;">Better Together</p> <p><i>Outcomes: Resilient Communities, Healthier, Happier, Longer Lives</i> <i>Ways of Working: Co-production, Early Intervention/diagnosis, Integrated Locality Working, Managing demand away from high cost care</i></p>	<p>B3i</p>
<p>Operational groups report into the Stronger Communities Board. These include the BCF Pooled Budget Group and Carers Partnership Board</p> <p>In addition, a specific A Housing/Aids and Adaptations Overview group is being developed to ensure a more integrated approach to of the monies in order to support BCF objectives.</p>	<p>B3ii</p>
<p>Operational management and oversight of the BCF programme is through the BCF Pooled Budget group. Its Terms of Reference include monitoring the performance and finance monitoring. Senior Commissioning, Performance and Finance Managers from the Council are voting members. A Senior Operational Manager from the Council is a non-voting member</p> <p>This group considers all BCF related developments.</p> <p>The CCG Head of Commissioning for BCF provides support across health and social care for all BCF related programmes of work.</p> <p>As well as reporting to the Stronger Communities Board, BCF reports to the CCG</p>	<p>B3ii,iii</p>

<p>Partnerships Planning and Quality (PPQ) Committee; a sub-group of the Governance Board. The Council is a formal member of both PPQ and Board</p> <p>The Council reporting process includes reporting to the Senior Leadership Team, Senior Management Team, Policy Review Meeting, Council Cabinet and the Scrutiny Committee, Health & Adult Care.</p> <p>The CCG and Council both report to the Joint Health & Overview Scrutiny Committee</p>	
<p>Plans to support joint working</p>	<p>B3iii</p>
<p>Key milestones for the BCF programme are included within the Action Plan (embedded below)</p>	<p>B3iv</p>
<p>B3iv key milestones Partially (NHSE) Intermediate care is well structured – similar detail for others would enhance. The action plan has been updated. We believe it fully meets the KLOE requirement.</p>	<p>B3iv</p>
<p>A comprehensive risk log is embedded below</p>	<p>B3v</p>
<p> BCF risk register 16.17 v2.docx</p>	
<p><u>National condition – Plans to be jointly agreed</u></p>	
<p>The Planning template and Narrative Plan have been agreed by senior officers of the CCG and Council</p>	<p>A3i,ii C1i</p>
<p>The CCG and Council have fully engaged with providers in relation to BCF. This engagement includes:</p> <ul style="list-style-type: none"> • Agreement with the model of integrated delivery with Senior managers within the Council who are members of the BCF Pooled Budget sub-group and Stronger Communities Board • Acute, community and Council providers engaged in the development and timescales for implementation of the Intermediate Care Team and Neighbourhood Care team • Explicit with NHS contracts that monies within their contract as part of the s75 agreement • Inclusion of the Intermediate Care Team and Neighbourhood Care team implementation within SDIPs of NHS contracts • Acute, community and Council providers engaged in the planning meetings to develop implementation of the Intermediate Care Team • Engagement with Council for Voluntary Services in relation to independent sector monies within the s75 and reviewing future utilisation to support community resilience • Shropshire Partners in Care (SPiC) on an on-going basis to discuss future developments; training needs; sustainability of domiciliary care and care beds, co-production of future commissioning models and approaches; progressive support models of domiciliary care; development of Market Position Statement • Provider Forums on a regular basis sharing future planning and priorities including development of future models and approaches, development of the Market Position Statement. BCF is scheduled for the Forum on 18th May 2016 	<p>C1i,ii,iii</p>

<ul style="list-style-type: none"> Estates planning to ensure sustainability with future planning <p>Engagement usually includes both CCG and Council representation.</p>																			
<p>Additional work with local provides includes:</p> <ul style="list-style-type: none"> Regional cost modelling to ensure a 'fair price for care'. Specific local work to support this is on-going with providers 	C1ii																		
<p>C1ii Engagement with providers Partially (LGA) More to be said about engagement with social care providers. Additional areas of engagement across health and social care provided. We believe this fully meets the KLOE</p>	C1ii																		
<p>Key implications of changes to providers are summarised below:</p> <table border="1" data-bbox="167 701 1297 1619"> <thead> <tr> <th></th> <th><u>Implications</u></th> <th><u>How indicated</u></th> </tr> </thead> <tbody> <tr> <td>Acute hospital</td> <td>Reduced admissions Part of Intermediate Care team</td> <td>Activity reductions within NHS contract Service development within contract Service specification</td> </tr> <tr> <td>Community provider</td> <td>Part of Intermediate Care and Neighbourhood Care team</td> <td>Service developments within contract Service specification</td> </tr> <tr> <td>Council</td> <td>Part of Intermediate Care and Neighbourhood Care team Community resilience</td> <td>Increased pooled budget Service specification Commissioning intentions</td> </tr> <tr> <td>Voluntary organisations</td> <td>Growth of sustainable voluntary organisations in line with Community Resilience</td> <td>Provider Forums</td> </tr> <tr> <td>Care and domiciliary providers</td> <td>Progressive support model of domiciliary care Reduced reliance on residence care</td> <td>SPIC Provider Forums Market Position Statement</td> </tr> </tbody> </table>		<u>Implications</u>	<u>How indicated</u>	Acute hospital	Reduced admissions Part of Intermediate Care team	Activity reductions within NHS contract Service development within contract Service specification	Community provider	Part of Intermediate Care and Neighbourhood Care team	Service developments within contract Service specification	Council	Part of Intermediate Care and Neighbourhood Care team Community resilience	Increased pooled budget Service specification Commissioning intentions	Voluntary organisations	Growth of sustainable voluntary organisations in line with Community Resilience	Provider Forums	Care and domiciliary providers	Progressive support model of domiciliary care Reduced reliance on residence care	SPIC Provider Forums Market Position Statement	C1iii
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<p>Evidence of engagement from stakeholders includes:</p> <ul style="list-style-type: none"> Acute hospital, community provider and Council senior managers acting as Steering group for developing the Intermediate care team Council senior manager leading the development of the Intermediate care team Council piloting extra care facility as part of recovery pathway Council developed locality working –preventative approaches within neighbourhoods Jointly presented commissioning intentions document to HWB Board SPIC funding tele- medicine – linking care homes to GP practices as a pilot Voluntary sector organisations collaborating to bid for tenders 	C1iii																		

<ul style="list-style-type: none"> Care providers 	
<p>The key changes across the local economy will enable:</p> <ul style="list-style-type: none"> Resilient local communities focussing on well-being and Prevention Integrated preventative services delivered at a neighbourhood level A wide range of personalised approaches to support people to remain independent Reduced reliance on social care services Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day Reduced avoidable admissions <p>The implications for change will also be set out within the STP</p>	C1iii
<p>C1iii Implications of changes Not met (NHSE) Partially (LGA) As above – clearer for NHS providers, but sign up of social care to develop. Implications to stakeholders, engagement from stakeholders and the implications are summarised. We believe this fully meets the KLOE</p>	C1iii
<p>The DFG Capital Grants awarded are part of a scheme in the Better Care Fund in recognition that appropriate adaptations can help people remain independent, safe and healthy and prevent admissions and readmissions. The scheme will support the Better Care metrics particularly relating to people with long term conditions and frail older people. The Grant fund is administered by the Housing department in the Councils Commercial Services Area who work in conjunction with housing providers, social care and OT teams.</p>	C1iv
<p>Workforce capacity has been actively managed through the interventions being made through:</p> <ul style="list-style-type: none"> Preventative interventions within the locality teams Commissioned services from Wrekin Housing Trust and other providers to deliver adaptations Home Improvement Agency within the Council <p>No capacity issues have been identified from providers</p>	C1iv
<p>A Housing/Aids and Adaptations Overview group is being developed and will monitor the scheme and objectives to evaluate the outcomes of major and minor adaptations in connection to BCF metrics</p> <p>Representation from this group will be a member of the BCF Finance group to ensure effective co-ordination takes place; understand issues in relation to prevention including demand and capacity issues.</p> <p>In additional, the DFG policy is being reviewed to include more flexibility around the use of DFG in accordance with the increased funding.</p>	C1, C1iv
<p>C1iv Not met (LGA and NHSE) Seems to refer to DFG on p23 not workforce (LGA) not mention workforce requirements or capacity. Response to capacity issues related to DFG are summarised above and indicated within the Action plan. We believe this KLOE is fully met</p>	C1iv
<p>The Community centred approaches paper sets out the longer term strategic vision for</p>	C1v

health and social care of ' <i>Right Help, Right Time to promote Independence</i> '. (embedded document above).		
<p>Joint agreements related to the BCF and the long term plan are identified though (and detailed in other sections:</p> <ul style="list-style-type: none"> • Community Centred approaches document (Introduction p3) • Joint commissioning intentions presented to HWB Board March 2016 (B1iii) • BCF programme being included within STP (B1iii) • Additional investment from CCG and Council into the pooled budget for 2016/17 • Changes to the acute hospital and community provider NHS contracts for 2016/17 and highlighted through the additional pooled budget inclusions • 'Being the Change' Council Managing Directors report (B1iii) • Market Position Statement (B1iii) <p>These indicate a clear joint direction between the Council and CCG in terms of planning and development of local services.</p>		C1v
The impact of service changes are summarised below:		C1v
Area	Service change consequences	C1v
Community Resilience	<ul style="list-style-type: none"> • Expansion of local communities to provide on well-being and Prevention and remand demand for health and social care • Collaborative arrangements between providers • 	
Neighbourhood Care	<ul style="list-style-type: none"> • Integrated health, social care and voluntary care services based within localities. • New relationships between primary care, Council teams, voluntary and independent sector services and NHS services – both acute and community • Increased acute services eg clinics, clinical advice, diagnostics based and delivered within local communities and primary care • Shared ownership of managing and supporting high risk patients eg Frail people, long term conditions • 7 day services • 	
Integrated Care	<ul style="list-style-type: none"> • A fully integrated health, social care and voluntary care team working together within a single service specification • Increased specialist clinical advice provided • Therapists and specialist teams working across acute and community services within agreed pathways to ensure people supported at home • Reduced hospital conveyances • Reduced non-elective admissions • 7 day services across for the team an 	
Additional service change consequences have been highlighted. These include:		C1v

<ul style="list-style-type: none"> • Potentially less but more robust and responsive domiciliary care provider • Less care beds commissioned providing high quality care • 7 day working for all stakeholders across the economy <p>The service change consequences have been set out within the principles of the strategic and operational documents. This has also been part of the on-going dialogue with stakeholders.</p> <p>Work is on-going to clarify further impacts of the BCF programme.</p>	
<p>A number of areas are highlighted within the Risk Register and mitigating are in place:</p> <p>Capacity of the voluntary sector to support self-help and prevention Financial risks and stability of the domiciliary and care bed providers Care home stability to provide high quality care</p>	C1v
<p>C1v Joint agreement about BCF and long term plan Partially met (LGA) Very well laid out and needs only more on 'recognition of service change consequences' - what will stop or change that HWB need to be alert to? Not met (NHSE) The comments above and additional references fully meet the requirements of the KLOE</p>	C1v
<p>Development of capacity and workforce is noted within the economy and planning of the BCF programme. It is noted that there are challenges to recruit some key posts including consultant medical staff, therapists, care workers within care homes and domiciliary care providers. Key actions to develop the programme include:</p> <ul style="list-style-type: none"> • Intermediate Care team including therapists working across acute and community services • Specialist pathways and teams across acute and community: Respiratory service is already community and acute clinicians and therapists and model being considered for other clinical specialties • Skills and training development of the Buurtzorg model • Community nursing teams supporting nursing care home nursing through training, supervision and mentorship • Acute clinicians supporting primary care through advice, clinical sessions • Development of Point of Care Testing to support diagnostics in primary care and maximise use of • Potential use of GPwSI as clinical additional clinical support within the community – with additional specialist training <p>Workforce development and mitigating actions are highlighted within the risk register.</p>	C1vi
<p>C1vi future capacity and workforce requirement Partially met (LGA) Referenced in action plan. The comments above, additional inclusions within the Action Plan and Risk Register fully meet the requirements of the KLOE</p>	C1vi
<p><u>National conditions- Agreement to invest in NHS commissioned out of hospital services</u></p>	
<p>The CCG and Council has agreed the use of the monies that was previously related to Payment for Performance. Additional monies for commissioning out of hospital services are identified within the Planning return are aligned to three key contributing integrated care programmes: Building community resilience, Developing 'Telford</p>	C7i,ii

<p>Neighbourhood Care Teams and Implementing Robust Intermediate care services. Additional funding includes:</p> <ul style="list-style-type: none"> • Grants • Community nursing • Respiratory services in the community • Falls prevention • Medical cover for the integrated community teams • Assisted Hospital Discharge • GP support to Rehabilitation and Enablement beds (Wellington practice) • Rehabilitation and Enablement beds 	
<p>In order to protect against the possible non-delivery of the non-elective emergency admissions, the CCG has set aside a non-recurrent contingency reserve of £250,000 which is the estimated cost of these emergency admissions based on the national tariff calculation, accounting for the emergency threshold adjustment. This sum is not contained within the BCF.</p> <p>This has enabled the development of the three key contributing integrated care programmes with funding that has been used for community services in line with the Community centred approaches paper '<i>Right Help, Right Time to promote Independence</i>'. (embedded document).</p>	C7iii,vi
<p>Evidence for the development of Neighbourhood Care Teams is based on a local Council Locality working prototype that was formally evaluation before full implementation.</p>	C7iv
<p>Community Fit also highlights through data analysis the need for, as well as the medium and longer term strategic plan for the development of community and voluntary sector resources to support reduced hospital admissions; prevention and self-care through community resilience</p>	C7iv;vi
<p>The target reductions in admissions is based on analysis at HRG level of admission profiles over the last two years. The target reductions of admissions is included within the Intermediate Care team service specification and reduced admissions within the acute hospital contract for 2016/17.</p>	C7iv
<p>The risk sharing agreement is consistent with the national guidance. It will be included in the s75 agreement for 2016/17 and is embedded below</p>	C7v
<p><u>National conditions – Agreeing the consequential impact of changes on the providers that are predicted to be substantially affected by the plans</u></p>	
<p>The impact of local plans have been agreed with health and social care providers. Evidence includes:</p> <ul style="list-style-type: none"> • Acute, community and Council providers engaged in the development and timescales for implementation of the Intermediate Care Team and Neighbourhood Care team • Explicit with NHS contracts that monies within their contract as part of the s75 agreement • Inclusion of the Intermediate Care Team and Neighbourhood Care team 	C6i

<p>implementation within SDIPs of NHS contracts</p> <ul style="list-style-type: none"> • Acute, community and Council providers engaged in the planning meetings to develop implementation of the Intermediate Care Team • HRG level reductions in emergency admissions included within the 2016/17 acute hospital contract directly related to the Intermediate Care team plan and outcomes 	
<p>B1iii above (p3) sets out the strategic vision and operational principles for the BCF programme including impact across health and social care. Highlighting more specifically the impact on social care providers:</p> <ul style="list-style-type: none"> • Council provider leading the development of the Intermediate Care team • Council Locality teams integrated into the Neighbourhood Care team • Council commissioned to deliver Brokerage functions and needing to ensure domiciliary care functions are sustainable • Market Position Statement utilised as a catalyst for co-production of new models for personalised support and future commissioning models and engaging with the voluntary sector to develop community resilience – growing the sector to reduce demand for health and social care • Council and CCG working with Shropshire Partners in Care (SPiC) to ensure quality and sustainability of domiciliary care and care beds 	C6i
<p>C6i Impact of local plans Partially met (LGA) ? social care providers. The summary above sets out the impact of local plans on social care. We believe this fully meets the requirements of the KLOE</p>	C6i
<p>Patient and user engagement has been through:</p> <ul style="list-style-type: none"> • Consultation event in and July 2014 and July 2015; • Regular meetings with Health Roundtable and Voluntary Sector Forum • Attendance at Carers Partnership Board. • Meetings with care and user representative groups including Healthwatch <p>A user, carer and stakeholder consultation event was held in July 2016 identified key priorities were identified as:</p> <ul style="list-style-type: none"> • Improved primary care services • Increases in Preventative interventions reducing higher care costs including access to information • More referrals for admission avoidance • Focus on care at home • More person centred in terms of care delivery 	C6ii
<p>There is significant political engagement. The Chair of the HWB Board is id the deputy Leader of the Council; the Opposition have representation of the HWB Board. The Board has approved the commissioning intentions.</p> <p>The Cabinet member for Social Care is engaged with the BCF developments and a member of HWB board</p> <p>The Local Strategic Partnership, comprising Police, Education and local business have regular updates</p>	C6ii

Local MPs have regular briefings with the CCG Chief Officer	
C6ii KLOE Engagement and Buy-in was deemed Partially met (LGA) Political buy in? The summary above indicates engagement and we believe this KLOE is now fully met	C6ii
Community Fit (embedded above) highlights the medium and longer term strategic plan for the development of community and voluntary sector resources to support reduced hospital admissions; prevention and self-care through community resilience	C6iii
<p>Long term vision has been set out within Community Fit and documents above (p2-3 KLOE B1iii)</p> <ul style="list-style-type: none"> • 2016/17 commissioning intentions • Being the Change document • Market Position Statement • Community centred Approaches <p>In addition, increased monies from health and social care into the Pooled Budget demonstrate a clear commitment to integration and joint strategic planning moving forward.</p>	C6iii
<p>In addition there is a requirement to develop a Sustainability and Transformation Plan (STP) by June 2016 to deliver the Five year Forward View and a one year operational plan. The STP will include a:</p> <ul style="list-style-type: none"> • Clear vision and plan for the area • Financial stability plan for providers and commissioners • Clear plan for prevention, patient activation, choice and control and community engagement and close the health and well-being gap • New care model development improving clinical priorities and roll-out of digital healthcare • Financial balance of local systems and improve efficiency of NHS services <p>The development of the STP was presented to HWB Board in March 2016 to ensure strategic support.</p> <p>The one year Operational Plan is the T&W CCG Operational Plan within C8iv</p>	C6iii
The BCF priorities, programme of work and key actions are being included within the first draft of the STP, currently in development. This will ensure that BCF is an integral part of the STP	C6iii
C6iii Align provider plans for long term vision and sustainability Partially met (LGA) Social care providers? .The summary is p2-3 and above highlight long term vision across health and social care. We believe the table above fully meets the KLOE requirement	C6iii
<p>Local work in relation to mental health has been to ensure the physical health needs people with mental health problems and the mental health needs of people with LTCs are proactively dealt with. Assurances to having equal consideration include:</p> <ul style="list-style-type: none"> • RAID team based within the acute provider and achieve 95% I hoir response for assessments in ED 	C6iv

<ul style="list-style-type: none"> • 150 staff trained in mental health care to support the RAID programme • RAID provide on-going training, advice and consultation • Mental health training within the acute hospital is available on an online portal to ensure ease of access • Access to mental health advice and support to the Integrated Team is in place to ensure joint assessments and care planning for frail elderly and/ or management of behavioural challenges that may otherwise lead to admission • Improved access of those with LTCs have access to psychological therapies • A principle of the mental health strategy is to have a single multi-disciplinary community team familiar with the patient • A local review of mental health is being completed 	
<p>There is alignment between the BCF plan, CCG Operating Plans and acute and community provider plans through:</p> <ul style="list-style-type: none"> • BCF admission avoidance figures have been modelled and included as an integral part of the submissions to NHSE, this has ensured consistency of reporting and monitoring • Identified admission reductions are included within the Intermediate Care service specification as a key outcome • The service specification is included within the NHS contracts in 2016/17 for the acute and community provider. • QIPP and CIPs plans shared between the CCG and acute and community providers 	C6v
<p><u>Development of the 2016/17 s75 agreement</u></p>	
<p>Submission of the BCF Planning return submission includes:</p> <ul style="list-style-type: none"> • The minimum contributions of the CCG and Council • Additional contributions of the Council and CCG • Narrative Plan including the assessment of the changes from 2015/16 to 2016/17 and an analysis of the impact of the changes <p>The submission and financial contributions are summarised below</p>	A1 i,ii,iii,iv, v A2i,ii A3i,ii,iii,iv, v

Revenue Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £	A3ii,iii,iv,v
Rehabilitation and Reablement	1,495,049			1,495,049	
Domiciliary Care	664,057			664,057	
Rehabilitation and Reablement Bed Usage	945,816	46,607		992,423	
Rehabilitation and Reablement Bed Usage Others			27,472	27,472	
Assistive Technologies	493,595			493,595	
Preventative Services	797,567			797,567	
Preventative Services - Others			493,302	493,302	
Others			170,859	170,859	
Carers	197,145	324,026		521,171	
Management Charges	56,395			56,395	
Shropshire Community Health Trust			3,193,946	3,193,946	
Shrewsbury and Telford Hospital			1,655,069	1,655,069	
Programme Management			477,857	477,857	
Total:	5,972,624	686,233	6,018,505	12,677,362	
Capital Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £	
Disabled Facilities		1,575,312		1,575,312	
Total:	0	1,575,312	0	1,575,312	
Total Better Care Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £	
Total:	5,972,624	2,261,545	6,018,505	14,252,674	
<p>All monies included in the BCF Planning return submission are aligned to one of four specific areas, other than the DFG:</p> <ul style="list-style-type: none"> • Intermediate Care Team • Neighbourhood Care Team • Community Resilience • Carers <p>The integrated care programmes have been developed between the Council and CCG due to local needs and highlighted in the embedded document above – The Community centred approaches paper ‘Right Help, Right Time to promote Independence’. (embedded document)</p>					A3iii
<p>The changes to the s75 agreement between 2015/16 and 2016/17 are summarised below:</p> <ul style="list-style-type: none"> • Grants • Community nursing • Respiratory services in the community • Falls prevention • Medical cover for the integrated community teams • Assisted Hospital Discharge • GP support to Rehabilitation and Enablement beds (Wellington practice) • Rehabilitation and Enablement beds 					A3iv


<p>When reviewing the approach to BCF based on learning from the current year, there was recognition that there was a need to have a more co-ordinated and targeted focus to:</p> <ul style="list-style-type: none"> • Strengthening communities • Volunteer and peer roles • Collaboration and partnerships • Access to community resources <p>Increasing the Pooled to support an integrated process was agreed at a strategic level through the 'Right Help, Right Time to promote Independence'. (embedded document).</p> <p>The Pooled Budget meeting membership then developed the detail of the financial values to be included.</p>	
<p>Additional contributions to the Pool are related to:</p> <p><u>Intermediate Care</u></p> <ul style="list-style-type: none"> • Community nursing • Respiratory services in the community • Medical cover for the integrated community teams • Assisted Hospital Discharge • GP support to Rehabilitation and Enablement beds (Wellington practice) • Rehabilitation and Enablement beds <p><u>Neighbourhood Care team – preventative</u></p> <ul style="list-style-type: none"> • Community nursing • Falls prevention <p>The additional contributions are part of existing community and acute hospital contracts. Inclusion in the s75 agreement enables joint planning and development through integrated team and targeted approaches based on evidence and data analysis. The acute community providers are fully aware of the plans and are included within their respective NHS contracts for 2016/17.</p> <p><u>Community Resilience</u></p> <ul style="list-style-type: none"> • Grants <p>The CCG carried out a Grants allocation process for two years from April 2016. The CCG and Council are now reviewing all providers jointly to agree priorities for funding from April 2017. The Council and CCG are jointly working with the voluntary and independent sector</p>	A2iii
<p>Each element of the minimum funding contribution is aligned to an area of the programme</p> <ul style="list-style-type: none"> • Intermediate Care Team • Neighbourhood Care Team • Community Resilience • Carers and Care Act 	A1vi

<ul style="list-style-type: none"> • Disabled Facilities Grant 	
<p>Additional contributions above the minimum level are is aligned to an area of the programme</p> <ul style="list-style-type: none"> • Intermediate Care Team • Neighbourhood Care Team • Community Resilience • Carers 	A2i,ii
<p>The DFG Capital Grants awarded are part of a scheme in the Better Care Fund in recognition that appropriate adaptations is used to help people remain independent, safe and healthy and prevent admissions and readmissions. The scheme will support the Better Care metrics particularly relating to people with long term conditions and frail older people.</p> <p>The Grant fund is administered by the Housing department in the Councils Commercial Services Area who work in conjunction with housing providers, social care and OT teams.</p> <p>A Housing/Aids and Adaptations Overview group is being developed and will monitor the scheme and objectives to evaluate the outcomes of major and minor adaptations in connection to BCF metrics. This will ensure the monies meet the statutory housing requirements and that of the BCF plan.</p> <p>The Home Improvement Agency and Wrekin Housing Trust are members of the Falls Prevention Steering group. The focus of both teams work relate to adaptations and Assistive Technologies to reduce the risk of falls to at risk people.</p>	A1ii,vii

Revenue Pooled Fund 16/17	Pool 2016/17 £	Pool 2015/16 £	Change £	Explanation	A3iii, iv,v
Rehabilitation and Reablement	1,495,049	1,478,782	16,267	Inflationary uplift.	
Domiciliary Care	664,057	606,832	57,225	Inflationary uplift plus some additional investment from the	
Rehabilitation and Reablement Bed	992,423	624,303	368,120	Inflationary uplift plus additional investment from the CCG.	
Rehabilitation and Reablement Bed Usage Others	27,472	0	27,472	New investment from the CCG.	
Assistive Technologies	493,595	488,225	5,370	Inflationary uplift.	
Preventative Services	797,567	766,009	31,558	Inflationary uplift.	
Preventative Services - Others	493,302	0	493,302	New investment from the CCG.	
Others	170,859	0	170,859	New investment from the CCG.	
Carers	521,171	515,500	5,671	Inflationary uplift.	
Management Charges	56,395	55,781	614	Inflationary uplift.	
Shropshire Community Health Trust	3,193,946	2,184,225	1,009,721	Additional services included - physiotherapy, OT, continence nursing, tissue viability, community stores, respiratory nursing, children's services, rapid response.	
Shrewsbury and Telford Hospital	1,655,069	419,775	1,235,294	Additional services included - rehabilitation beds and respiratory service.	
Programme Management	477,857	472,658	5,199	Inflationary uplift.	
Voluntary Sector Grants	315,600		315,600	New investment from the Local Authority.	
Continuing Healthcare		2,400,000	-2,400,000	Funding arrangements changed.	
Maintaining Eligibility	878,000	878,000	0	No change.	
Care Act Implementation	445,000	409,000	36,000	Increased as per the ready reckoner figure.	
Total:	12,677,362	11,299,090	1,378,272		
Capital Pooled Fund 16/17	Pool 2016/17 £	Pool 2015/16 £	Change £	Explanation	
Disabled Facilities	1,575,312	849,000	726,312	Change in national allocation figure.	
Total:	1,575,312	849,000	726,312		
Total Better Care Fund 16/17	Pool 2016/17 £	Pool 2015/16 £	Change £	Explanation	
Total:	14,252,674	12,148,090	2,104,584		
<p>The financial contributions are set out in the Planning Template submission in tab 4, above in the table and summarised in P1 of this Narrative Plan. We believe meet the requirement of the identified KLOEs</p>					A3iii,iv,v

<p>A3iii full overview of funding contributions Not met (LGA) Although planning return is referenced – is that acceptable? With the information set out above, alongside the tables, We believe the KLOE is fully met</p>	<p>A3iii, iv,v</p>
<p>The table above sets out the specific changes within the Pooled Budget from 2015/16 to 2016/17.</p>	<p>A3iv</p>
<p>A.3.iv KLOE Setting out changes against last year Partially met (NHSE; Not met LGA) It mentions changes to funding levels but fails to specify the amounts. We believe the table above fully meets the KLOE requirement</p>	<p>A3iv</p>
<p>The table above sets out the specific changes within the Pooled Budget from 2015/16 to 2016/17. It also summarises the impact of the changes:</p> <ul style="list-style-type: none"> • Increased Preventative investment – supporting the development of integrated Neighbourhood Care teams • Additional services included – including specialist nursing teams, Rapid Response and therapists supports development of the Intermediate Care Team • Additional investment from the Council included for Grants – enabling a joint approach to prioritising funding and developing community resilience • Funding arrangement changed – recognising that CHC is not a priority for integrated working. Other arrangements are in place <p>Developing the pooled budget in this way provides clear opportunities to utilise the monies differently to reflect the local priorities.</p>	<p>A3v</p>
<p>A.3.v Not met States "Narrative Plan including the assessment of the changes from 2015/16 to 2016/17 and an analysis of the impact of the changes". But no evidence provided. (BOTH) The impact of changes are set out above. We believe the table above fully meets the KLOE requirement</p>	<p>A3v</p>
<p><u>National conditions- Maintain the provision of social care services</u></p>	
<p>The financial values for the Provision of Social Care are: 2015/16 £7.334m (rebased for re-categorisation as below £ 7.661m) 2016/17 £ 5.754m</p> <p>The amount above has been identified from the BCF minimum contribution and maintained in real terms. The variation between the two years arises from a number of changes including:</p> <ul style="list-style-type: none"> • An inflationary increase of 1.1% • an agreed re-categorisation of some schemes between areas of spend • Additional contributions to the pooled budget to support the objectives of the BCF plan. • Care Act funding of £445k is included within the budget (based on LGA Ready Reckoner estimate) <p>The net funding increase associated with these is just under £500k.</p> <p>In addition £2.4m has been removed from the pooled budget in respect of continuing</p>	<p>C2i,ii,iii,iv C2viii C2iv/i C2iv/ii C2iv/iv C2iv/v</p>

<p>care for named individuals.</p> <p>The plan includes a value of £521k for targeted carer's support.</p> <p>This approach is fully consistent with DH guidance on the funding transfer from the NHS to social care</p>															
<p>Provision of social care funding will continue through two integrated teams</p> <ul style="list-style-type: none"> • Neighbourhood Care team • Intermediate Care Team <p>Areas of the provision of social care includes Assistive Technologies, Floating Support, Access team, Community Meals, OTs within the Neighbourhood Care team and Enablement beds, spot contracts and domiciliary care within the Intermediate Care team.</p> <p>This funding supports offsetting of additional, higher costs to social care in the future by utilisation through the two integrated teams</p>					<p>C2vi C2iv/i C2iv/ii C2iv/iii C2iv/iv</p>										
<table border="1"> <thead> <tr> <th style="background-color: #92d050;">Revenue Pooled Fund 16/17</th> <th style="background-color: #92d050;">CCG Pays Council £</th> <th style="background-color: #92d050;">Council Funds £</th> <th style="background-color: #92d050;">CCG Retains £</th> <th style="background-color: #92d050;">Total Pool £</th> </tr> </thead> <tbody> <tr> <td>Carers</td> <td>197,145</td> <td>324,026</td> <td></td> <td>521,171</td> </tr> </tbody> </table>					Revenue Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £	Carers	197,145	324,026		521,171	C2vii
Revenue Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £											
Carers	197,145	324,026		521,171											
<p>Specific funding for carers is identified above. It is also highlighted within the Finance summary and Expenditure Plan and monitored through the BCF Finance meeting. The programme of work in relation to carers are:</p> <ul style="list-style-type: none"> • Carer Services which includes Carer Centre provision • Joint Commissioning Post • Carer Respite which includes • Carer Individual Payments • Carer Creative, Well Being and Educational Workshops and provision of personalised care support • Emergency Carer Support • Moving and Handling Family Carer Adviser • Carers Individual Payments 					C2vii										
<p>C2vii KLOE was deemed PARTIALLY MET by LGA Carer specific funding, so could be developed. I believe this provides evidence that this KLOE is fully met</p>					C2vii										
<p>The CCG and the Council agreed to commission an external review of the detailed use of the £2.4m for continuing care needs for named individuals. This review will be used to inform a new approach that could be agreed by both organisations for future years.</p> <p>It was agreed that it was appropriate to remove this specific funding from the S75 Pooled budget at this stage and instead encompass it within a S256 arrangement to facilitate any change.</p> <p>The combined impact of this reduction and the increases highlighted above account for the overall reduction of £1.9m in the protection of social care through the pooled budget between the 2 years</p>					C2i,ii,iii,iv										

<u>Risk Sharing Agreement</u>	
<p>A risk sharing agreement is embedded below. It sets out the risk sharing arrangements:</p> <ul style="list-style-type: none"> • Between health and social care • Risks to the acute hospital • Managing under- and overspends 	B5i,ii,iii,iv
 <p>RISK SHARE ARRANGEMENTS.doc</p>	
<p>The financial contributions within the Planning Template submission (tab 4) and above. This sets out the total expenditure, contributions and which organisation</p> <p>No monies within the pooled budget are deemed 'at risk'. All monies are committed currently to services or expenditure including agreement to invest in NHS commissioned out-of-hospital services to reduce non-elective admissions in line with the policy guidance.</p> <p>The RSA sets out that partners share the risks that they manage within the pooled budget. This is a consistent approach with the RSA from the 2015/16 s75 agreement.</p> <p>To manage the risk in relation to increased non-elective admissions and DToCs, the CCG has identified additional monies from the as non-recurring contingency reserve. The CCG have included these within the NHS financial return to NHSE.</p> <p>The CCG and Council are in agreement with the arrangements.</p>	B5i
<p>B5i what proportion of the pooled budget is 'at risk' (LGA) P29 contains reference to funding and contingencies – unclear if 'not contained within BCF' is acceptable. Further clarification of the KLOE is included above. We believe this is fully meets the requirement of the KLOE</p>	B5i
<p>In order to protect against the possible non-delivery of the non-elective emergency admissions, the CCG has set aside a non-recurrent contingency reserve of £250,000 which is the estimated cost of these emergency admissions based on the national tariff calculation, accounting for the emergency threshold adjustment. This sum is not contained within the BCF.</p> <p>Due to the contingency reserve being set aside, if unused it can be re-invested in the context of the overall CCG financial position</p>	B5i,ii,iii
<p>Financial risks in relation to DToC are maintained within the contingency reserve within the above.</p> <p>Reductions in XBDs are part of the DToC action plan and part of financial risk mitigation. These have reduced throughout the last two years</p>	B5ii
<p>The Risk Sharing Agreement (RSA) also indicates that the RSA 'financial risks will be managed by partners within the pooled fund'. Partners are in agreement with the levels of financial risk in managing the potential risk: CCG risk of non-elective</p>	B5ii

<p>admissions and DToC; the Council risks from increased Prevention, Brokering of care, admission avoidance and early discharge interventions;</p> <p>The CCG has budgeted the non-recurring contingency within its Financial Plan submitted to NHSE.</p> <p>Within the RSA it indicates that underspends will be used in other areas – agreed by all parties.</p>	
<p>Additional approaches to managing risk include the development of the integrated teams. These will be outcome focused with the requirement to achieve identified levels of reductions in non-elective admissions, DToC and other BCF metrics. Incentives are being considered for providers to achieve outcomes.</p>	B5ii
<p>B5ii Agreed approach to sharing risks re reducing admissions and DTOCS Partially (LGA) Evidence that sums in reserve are adequate. Also, not in BCF – how does this work for risk share? Explanation needed. The above clarification, that the Council and CCG are in agreement with the risk sharing arrangements, indicated that this KLOE is fully met.</p>	B5ii
<p>The Risk Sharing Agreement has been specifically developed to address the financial risks of the Pooled Budget. It has been developed to be included within the s75 Agreement.</p> <p>Other risks associated within the BCF programme are identified within the Risk Register. These include:</p> <ul style="list-style-type: none"> • Ensuring effective Governance and monitoring • Integrated teams not achieving BCF objectives • Lack of engagement of stakeholders • Failure to reduce non-elective admissions • Failure to achieve other BCF metrics • Financial pressures and sustainability of domiciliary and care providers • Insufficient primary care capacity to support avoiding admissions • Lack of data sharing to support integrated working • Working capability, capacity and development <p>Mitigating actions are in place to address these.</p> <p>The risk register is part of the BCF Governance process and included within reporting. High level risks are noted within the Council and CCG risk registers.</p>	
<p>B5iii Other risks Partially (LGA) (NHSE (Not met) Risk sharing agreements too finance focused 'Why' section in narrative can be developed to address non-financial risks more explicitly. Non-financial risks are identified above and mitigating actions and included within the risk register. We believe this fully meets the requirements of the KLOE</p>	B5iii
<p><u>BCF action plan</u></p>	
<p>The BCF updated action plan is embedded below</p>	



BCF Action Plan
April 2016-17 v16

Michael Bennett
March 2016
Revised April 2016