TELFORD & WREKIN COUNCIL

HEALTH AND WELLBEING BOARD – VIRTUAL UPDATE

BETTER CARE FUND UPDATE REPORT

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PART A) – SUMMARY REPORT

	SUMMARY OF MAIN PROPOSALS
1	The Better Care Update report was presented on 6th September 2017 which can be found at the following link: http://apps.telford.gov.uk/CouncilAndDdemocracy/Meetings/Meeting/MTU3Mw%3d%3d The report summarises the performance and progress of the Better Care Fund progress during 2016/17. The full draft Better Care Plan Narrative Plan has been finalised and submitted with key associated documents and has been incorporated into this update, which supplements the report presented on 6th September 2017.

Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

Area	Telford and Wrekin
Constituent Health and Wellbeing Boards	Telford and Wrekin Health and Wellbeing Board
Constituent CCGs	Telford and Wrekin Clinical Commissioning Group

Contents

General 3
Introduction / Foreword 4
What is the local vision and approach for health and social care integration? 5
Background and context to the plan 14
Progress to date 20
Evidence base and local priorities to support plan for integration 24
Better Care Fund plan 25
Risk 40
National Conditions 43
National Conditions (continued) 45
Overview of funding contributions 52
Programme Governance 56
Assessment of Risk and Risk Management 59
National Metrics 60
Delayed transfers of care 62
Approval and sign off 64

General

This template is a guide to help you to draft a BCF narrative plan for your area. You do not need to use this template or follow this structure but it has been provided to assist areas to cover all the requirements for the BCF in their narrative plan.
Your narrative plan should build on approved plans from 16/17, demonstrating that local partners have reviewed progress and used this information in developing plans for 17/19. The template will be complemented by the planning template, which has been circulated to all areas, and should be completed with reference to the BCF Policy Framework and Planning Guidance. Local areas are also advised to use the key lines of enquiry (KLOEs) that will be used to assess the BCF narrative plans.

Please refer to the notes section below for each section for brief guidance on what to include in each section. Areas can use more than one page for each section and add diagrams and tables where helpful.
The BCF narrative plans must set out:

- The local vision and model for the integration of health and social care;
- A coordinated and integrated plan of action for delivering the vision, supported by evidence;
- A clear articulation of how the plan meets each national condition; and
- An agreed approach to performance and risk management, including financial risk management

Please note that referencing and use of hyperlinks to existing documents is advisable rather than copying content into your narrative submission. However, please try to signpost documents as comprehensively as possible e.g, include the citation reference (e.g page number and relevant section).

Introduction / Foreword

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

The CCG and Local Authority remain committed to move towards integration in line with the intention documented in 2015. This is illustrated through the progress made on a number of areas which have seen demonstrable improvement in outcomes for people as a result of working together to spend the Telford Pound. For example joint ventures around mental health (with the introduction of Branches) and housing.

The two organisations have informal joint commissioning responsibilities and are exploring more formal joint commissioning roles. Senior leaders have also visited other areas in the Country to discover more about suitable integration models. In day to day functioning, this is demonstrated in the implementation of joint teams for Intermediate Care and is being rolled out with the development of strong multidisciplinary neighbourhoods working. This is firmly rooted in the STP.

This vision is set out in more detail below
Planning Requirement 6/ KLoE 15

Community centered approaches final.docx

The Community centred approaches paper sets out the vision for health and social care of '*Right Help, Right Time to promote Independence*'.

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.

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.

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. Planning Requirement 6/ KLoE 14

Community Resilience: Vision and aims

Telford will have strong and connected communities. The community will drive the development of local assets and people will:

- 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

In order to be successful, this involves the whole community, from individuals through to more formal community groups, third sector and statutory organisations

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.

Changes are needed because:

- 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 preventable 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

The actions taken across Telford will facilitate a movement to build resilient communities; draw on and develop the wide range of assets in the area, rather than dwell on the deficits and build on four different aspects of community centred approaches:

- Strengthening communities by taking action on the causes of poor health;
- Support volunteer/peer roles;
- Enable collaboration and partnership in planning of services between communities and statutory organisations;
- Connect individuals/families to community resources

A single plan has been produced across Telford and Wrekin. Sign off and ongoing monitoring is through the Joint Strategic Commissioning Group

This change will need take place over a number of years in order to reverse the trend of paternalistic state service provision. Initial actions are to:

- 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.
- '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

Planning Requirement 6/ KLoE 14

Telford Neighbourhood Care Team: Vision and aims

People with an identified long term health condition will be supported to live their life to their full potential

- 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

This is a population wide plan focussing on people with identified health risks. A large cohort will be those on practice disease registers, which currently include circa 45,000

Professionals who support these people and form part of the virtual teams will be:

- 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)

Changes are needed because:

- There needs to be a much greater focus on prevention
- There is a 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. The 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 of number of people with a long term conditions
- There has been a loss in 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

Changes needed are:

- A focus on the delivery of joined up care (not on the disaggregation of its component parts)
- A 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

The change is achieved by Virtual teams being formed from professionals from different organisations. These will be grouped around natural neighbourhoods/communities of about 10-20k populations. In most cases this will around practices.

These teams formalise MDTs including mental health, third sector organisations and local authority professionals; utilise risk stratification to target levels of care including end of life 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 and adopt the six elements of community service from Buurtzorg:

- Holistic assessment of patients. Leading to the formation of a care plan
- Mapping networks of informal care
- Identifying more formal care needs
- Care delivery
- Supporting the patient in their usual social environment
- Promoting self care and independence.

Planning Requirement 6/ KLoE 14

Intermediate Care: Vision and Aims

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:

- 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.

This function will be for 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

Key stakeholders will be:

- 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

Changes are needed because:

- 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

Changes needed are:

- Development of a coherent pathway, that can be clearly articulated to professionals as well patients and their carers
- Build on the wide range of skills and expertise in our community staff and bring them together
- Agree and implement a model to ensure there is sufficient medical input at the right level to the service
- Build on the single outcome based specification being delivered by multiple providers. This will be further implemented through a number of integrated teams or arrangements:

    - Intermediate Care Team supporting alternatives to admission and early discharge and supported development of an Integrated Discharge Team
    - Care Home Team provided dedicated training, advice and rapid assessment
    - Frailty Programme which will develop and integrated pathway from early identification, through primary care, community interventions, admission and early discharge

These programmes will be developed to ensure fully integrated health and social care delivery approaches.
Planning Requirement 6 KLoE 14, KLoE 15

BCF planning is fully aligned to the priorities of the Shropshire A&E Delivery Board (SAED). Top Three Priority Actions of SAED are below with associated BCF programmes.

A&E Streaming / non-admitted breaches

- Implement GP streaming in PRH

Internal Flow

- Frailty programme Frailty Team at Front Door supporting admission avoidance and reducing LoS
- Frailty programme Additional interventions to improve flow
- Frailty programme Discharge to Assess

Discharge to Assess

- Intermediate Care Team
- Frailty programme Frailty Team at Front Door
- Frailty programme Discharge to Assess including improved FFA process

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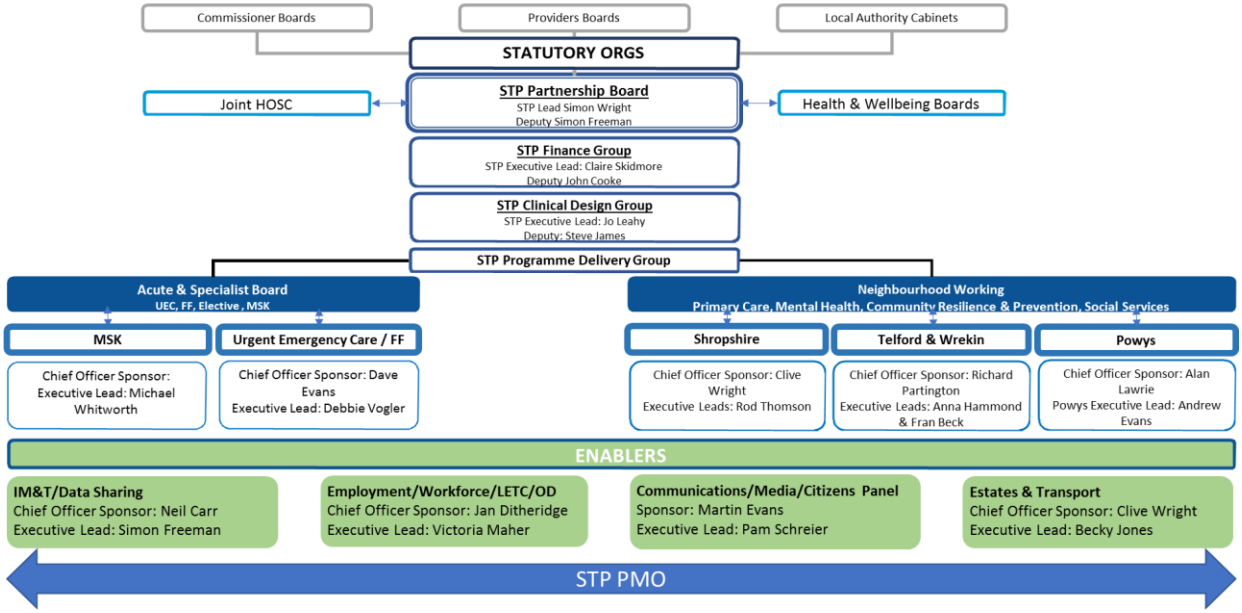
Planning Requirement 15 KLoE 36

BCF planning is fully aligned with the Sustainability and Transformation Plan. The STP Governance Structure below illustrates formal reporting for Neighbourhood working. *The STP Neighbourhood – Telford* programme of work below includes BCF planning and/ or funded areas and set out in the BCF Plan for 2017-19:

- Sustainable Communities
- Falls
- Frail older people and LTCs
- Integrated staffing models including crisis teams
- Improved support in care homes
- Trusted Assessors
- 7 day services
- Early discharge planning
- Reduced length of stay
- Reablement ‘Lets Talk’ sessions to aid discharge
- Frailty Team at the front Door

STP GOVERNANCE STRUCTURE



STP Neighbourhoods – Telford

Fit & Well	Maximising Independence	Receiving Care	System Flow	Planned Care
Population health management	Sustainable Communities	Frail older People & Long Term Conditions		New models of care for outpatients
Use of digital platforms and technology	Living made easy through technology	MSK		Diagnostics
Social prescribing	Prevention programmes – long term conditions, falls	Building the primary care offer including Clinical Pharmacists ,Physician Associates and Treatment Nurses		Early discharge planning
Investment in Prevention	CVD Risk	Dementia model		Reduced LOS
Health Checks	Falls	Community Hubs		Reablement Let's talk sessions to aid discharge
Healthy Aging	Memory service	Integrated staffing models including Crisis Teams		Urgent Care Centres
Suicide prevention	Dementia Companions	Trusted assessor		Ophthalmology
Community PSI		Improved support to care homes		ENT
Networks/Innovators		Specialist provision (inc mental health)		Urology
Health & Wellbeing Centres		Triage & GP Nurse Triage		Theatre
		7 day services		Frailty Team at Front Door
Enablers : Risk identification, care navigation, care planning, single point of access, carer support/champions				
Cross cutting themes: Workforce redesign, digital solutions, single care record, primary care development, estates, patient and public engagement				

Planning Requirement 6/ KLoE 14 Planning Requirement 15 KLoE 36

The BCF vison and planning is also fully in line with the The Future Fit Proposed model of care. The Future Fit Programme for the reconfiguration of acute hospital services was established in 2013 from the outcome of the Call to Action Survey. Over the past 4 years it has been very much a clinically led and engaging process as solutions have been developed for the health system's pressing need to address the serious shortfall in workforce across a number of specialties. The new model of care began its development in 2014

Their principles and practices emerged from the clinical design work across all areas of care and specialties in 2014 as being necessary and fundamental components of an efficient, safe resilient and integrated health and social care system. These principles continue to be reflected in 2017 through the work of the STP partners:

- **'Home is normal'** describes the principle of matching people's needs with the correct level of care,
- **Empowerment** where patients who want to be empowered so they can remain autonomous and independent, even when they are ill; clinicians who want to do the job they were trained to do, and not spend too much of their time trying to navigate a poorly designed and inefficient system on behalf of their patients; communities who want to be empowered so that citizens can help each other to live 'a life well lived' in an environment that minimises isolation, vulnerability and inequality.
- **Sustainable workforce** solutions with consolidation of some services to make posts more attractive by improving the quality of work; development of novel roles to fill gaps created by recruitment issues and new models of care; working in an integrated and collaborative way to accommodate patient journeys.
- **Needs led service**s in which patient access to care is dependent on the level of care they require Quality, safety and achieving the best outcomes may come before choice.
- **Integrated care** that improves the co-ordination, collaboration and consistency of care across time and care settings
- **Digital enabled working practices** as a fundamental component of an efficient, safe resilient and integrated health and social care system.

Planning Requirement 6/ KLoE 14 KLoE 15

Background and context to the plan

- Joint Strategic needs Assessment
- Marker Position Statement
- Data analysis and modelling of 'left shift'

The local population characteristics, from JSNA analysis, is set out below. The HWB Board are fully sited on the detail of the JSNA. The overall BCF programme is working within this local context and seeks to improve patient outcomes and experience.

The population is 'younger':

- Telford & Wrekin has an estimated population of 170,200. The population is younger than the national picture, with a greater proportion of the population aged under 20 (T&W 25.8%,England 23.7%).

The population is growing, changing and ageing:

- The proportion of the population who are aged under 20 is decreasing (26.1% in 2010, 25.8% in 2015), as is the working age population (65.2% in 2010, 63.2% in 2015).
- The proportion of the population aged over 65 is increasing (14.3% in 2010, 15.9% in 2015), with 27,200 residents now in this age group.
- The population of the borough is projected to grow at a faster rate than the England population (T&W 13.4%, England 10.2%) and is projected to grow to 196,900 by 2031, an increase of some 23,300 people.
- Over half of the population increase will be in the over 65 age group (12,300 people), with the 85+ age group more than doubling (+117.6%) and the 65-84 age group increasing by a third (33.1%).
- There were a total of 2,075 live births to mothers living in Telford and Wrekin during 2015. Over the past six years the total fertility rate has fallen from 2.00 to 1.82. The National trend is similar, falling from 2.22 to 1.93.

The population is becoming more diverse:

- The majority of the population's ethnicity is white British, with the borough having lower BME rates in all age groups than England. The highest proportion of BME groups is found in the 0- 24 age group (T&W 13.1%, England 25.4%).
- The proportion of school age children from a BME background is increasing (13.7% in 2012, 18.5% in 2016).

Households are more likely to contain dependent children and/or carers:

- Almost 22,000 households contain dependent children, around a third of all borough households.
- Around 18,000 people provide unpaid care - 1,530 young people aged 0-24 provide unpaid care, around 12,700 adults aged 25-64 and around 3,670 aged over 65. Nearly 5,000 people provide unpaid care for over 50 hours per week

The population has higher rates of poor health:

- Residents report higher levels of bad or very bad health compared to England (T&W 6.2%, England 5.5%), around 10,395 people.
- Life-expectancy at birth is significantly worse than England rates at 78.1 years for males (79.3 England) and 81.8 years for females (83.0 England).

- Early mortality rates from causes considered preventable are declining in Telford and Wrekin, but remain above the England average. The standardised mortality ratio for people aged under 75 is higher than the national ratio for cancer, liver disease and respiratory disease, and similar to the national ratio for cardiovascular disease.
- Across all age groups there are higher rates of people reporting a long term limiting health problem or disability that limits their daily activity (T&W 18.2%, England 17.2%), around 31,000 people.

The population don't always make healthy lifestyle choices:

- 7.9% of all births had a low birth weight (less than 2,500g), similar to the England rate.
- After many years of the rate of conceptions in those aged 15-17 (under 18) being significantly higher than the rate in England, the rate has now dropped to be similar to the England rate (2014: 32.6, 2015: 25.0).
- 18.1% (366) of mothers were smoking at delivery, significantly worse than England. Breastfeeding initiation rates have increased a little from 65.1% in 2010-11 to 67.5% in 2014-15, although remain worse than England.
- The prevalence of smoking in those aged 18 & over has decreased to 18.2%, similar to England, having previously been higher. The prevalence of opiate and/or crack use was estimated to have declined and is now lower than England, and the prevalence of drug injectors has declined to a level similar to England.
- The proportion of children in reception with excess weight increased to 25.5%, worse than the England (22.1%). In Year Six children with excess weight increased to 37.4%, worse than England (34.2%).
- Levels of excess weight in adults are 71.1% and obesity 26.5%, both worse than England.
- 18.7% of residents aged 16 & over are binge drinkers and 28.5% of adults are inactive, both similar to England rates.

Hospital admissions rates for a number of causes are higher than England:

- For all ages, the Standardised Admissions Ratio of emergency admissions for all causes is worse than national. This ratio is also worse than national for Coronary Heart Disease, stroke, Myocardial Infarction (heart attack), Chronic Obstructive Pulmonary Disease (COPD). The ratio is similar to national for hip fractures and alcohol attributable conditions.

National prevalence rates enable an estimation of the number of residents with other health conditions:

- Around 1,000 children aged 5-10 and 1,400 aged 11-16 with a mental health disorder. Around 17,400 adults aged 16-64 with a common mental health disorder and around 7,700 adults aged 16-64 with two or more psychiatric disorders.
- Around 700 older people aged 65 & over have severe depression. Around 1,800 residents aged 65 & over suffering from dementia.
- Around 4,000 residents have a learning disability. Around 1,400 residents have Autism

Planning Requirement 7 KLoE 17

Detailed data analysis has highlighted the potential of enhancing community services and teams (Neighbourhoods, Intermediate Care Team and Frailty). Analysis from metrics from the Neighbourhood programme set out the background to the plan:

<u>The outcomes of Neighbourhood working will achieve (patient, activity, finance etc.)</u>

There are a number of high level programme outcomes. In addition, each of the projects has a more specific set of outcomes, outputs and measures, many of which are person centred and quality related. The key indicators outlined below are some of the overarching measures. The CCG and Council are keen to explore the possibility of an innovative and robust evaluation strategy to help assess outcomes and further define the programme as it develops.

Key indicators:

- Increase in proportions of expected to actual prevalence of disease (as defined in the practice diseased registers)
- Reduction in non-elective activity
- A primary care related indicator to indicate the changes at practice level (detail to be determined)
- Reduction in permanent admissions to care homes
- Systematic identification of people who would benefit from care planning
- Reduction in spend on acute care by neighbourhood (as defined in 'neighbourhood' budgets)

The programme will help to improve health, enhance the support for people in early stages of illness (from the community as well as statutory services) and increase the community based alternatives therefore the number of patients attending hospital will reduce. One of the most significant reductions will be in the number of unplanned hospital admissions (non-elective activity). The CCG has considered national evidence, local intelligence and current plans to produce high level modelling to assess the impact of change in hospital activity This local modelling estimates this potential reduction to be 2,365 admissions. This is summarised by neighbourhood in the table below:

Neighbourhood	Spells
Central Telford	615
South East Telford	713
Newport	260
TelWell	777
Total	**2365**

This figure is broken down further by intervention, cohort of patients and category e.g. (ACS- Ambulatory Care Sensitive Conditions) below:

Table A summarising admissions avoided through 'Community Urgent Response', split into categories (rows) and patient cohorts (columns)

	End Of Life **(based on patients who died in hospital)**	***GP Management*** **(Patients with Long Term Conditions)**	***Multi-Disciplinary Team*** **(Complex Patients)**	**All other patients**	**Grand Total**
STARRs (Patient attendances with no procedure)	68	127	28	970	1192
Ambulatory Care Sensitive Conditions	68	108	25	520	720
Ambulatory Care Sensitive Conditions (Zero Length of Stay)	11	7	1	223	242

Non elective admission (Zero Length Of Stay)	8	2	1	94	106
Total	**155**	**244**	**54**	**1807**	**2260**

Table B: Activity for patients not included in the table above who may benefit from care planning in neighbourhood teams (N.B. the split for this activity is artificially low, but has been done to avoid duplication of counting)

	***End Of Life* (based on patients who died in hospital)**	***GP Management* (Patients with Long Term Conditions)**	***Multi- Disciplinary Team* (Complex Patients)**	**All other patients**	**Grand Total**
Cohort Based	35	21	49		105
Total	**35**	**21**	**49**	**0**	**105**

Planning Requirement 7 KLoE 17

Market Position Statement (MPS) Summary

Telford and Wrekin is a place of contrasts: a distinctive blend of urban and rural areas, with green open spaces alongside contemporary housing developments and traditional market towns. On the face of it, the borough is a prosperous place but there are clear differences across the borough. Some neighbourhoods and communities in the borough are among the most deprived areas nationally, whereas equally some communities are amongst the more affluent in England.

The population of the borough continues to grow at above the national rates – driven by the expansion of the local economy and record levels of housing growth. As the population grows, it has continued to change in line with national trends, with the population becoming more diverse and ageing. Although the population is ageing, it is younger than the national structure – with concentrations of younger population in south Telford. However, over half the population increase between now and 2031 will be in the 65+ age group.

One of the biggest challenges for the borough remains health inequalities. It is important though to emphasise that the health of the borough is improving overall, however, for a number of key measures the health of the population are poorer than the national average. This gap against the national position is most evident in the most deprived communities of the borough with key challenges including a lower life expectancy, higher rates of long term illness and disabilities, high obesity rates and high rates of admissions to hospital for a variety of reasons.

Demand in adult social care

Managing sufficiency of care in the local home care market will continue to raise challenges both currently and into the future. Recent data highlights that weekly hours and visits to provide care and support to clients (per week) have been consistent since the summer of 2016 and have averaged between 16,000 hours of Care per week, equal to the number of visits (per week), which have reduced number due to limiting short calls e.g. 15 min calls. Annually, the volume of Dom Care hours experienced in Telford & Wrekin have reached 832,000 (16/17) and is

anticipated to increase further as we support more people to remain in their own home and maintain their independence.

The increase in demand is expected to impact in the following ways:

1) Hospital to home, we anticipate to support more people to return home from a period in hospital through re-enablement.
2) Manage provision in our rural areas. It is becoming increasingly difficult to ensure that there is adequate provision across the Borough of Telford & Wrekin's rural areas. To ensure that this is addressed we will need to commission services to ensure appropriate provision is in place.

Sufficiency of Home Care across the Borough:

Rural / Low Population Areas of Care are persistently difficult areas in ensuring that supply of Support and Care is regularly available. The Council welcomes Providers who wish to develop their business, or new Providers from outside of the Borough, to work with us on developing solutions for pockets of Telford & Wrekin that have traditionally been difficult to ensure Support and Care. Postcodes, such as SY4, TF6, TF8 and TF10, are traditionally difficult areas to place packages of Support and Care, but there over 460 hours of Care delivered per week within these postcodes.

Residential and Nursing Care Demand

During 2016/17, demand for residential, nursing placements requiring a minimum of 462, (down 14% in the previous year, as outlined in the statistics below) for beds to aid recovery. The Council continues to promote and support individual choice and control through personalisation and independence with the aim is for all individuals to be assisted in a community setting rather than a long term residential placement.

This provides the care sector with the knowledge that there is still significant potential for business opportunity for self-funding individuals across client groups as well as Council purchasing arrangements.

Although alternative community provision is preferred there remains a demand for nursing provision for older people particularly with complex dementia and mental health needs. There is a limited supply of nursing provision for individuals with dementia and mental health issues and we wish to ensure alternative community based service provision is developed. A mixed provision is likely to be required to include short-term rehabilitative provision is available as well as appropriate long term provision.

Telford & Wrekin Council Funded Residential/Nursing Placements March 2017

Telford & Wrekin Council Funded Residential Placements	Residential		
	31 March 2016	31 March 2017	Difference
Adults with a Physical or Sensory Disability (PSD) under 65 years of age	9	9	
Adults with Learning Disabilities (ALD) under 65 years of age	75	62	-13

Adults with Mental Health issues under 65 years of age	17	14	-3
Older People - 65+	264	228	-36
Total	365	313	-52

Telford & Wrekin Council Funded Nursing Placements	Nursing		
	31 March 2016	31 March 2017	Difference
Adults with a Physical or Sensory Disability (PSD) under 65 years of age	15	9	-6
Adults with Learning Disabilities (ALD) under 65 years of age	3	3	
Adults with Mental Health issues under 65 years of age	2	4	+2
Older People - 65+	151	133	-18
Total	171	149	-22

Key Issues and challenges the MPS aims to address:

As we manage demand more effectively and aim to help people to continue to live in their neighbourhood and community (where this is feasible and affordable) we will be continuing to meet their assessed needs increasingly in a community based setting.

We will be considering community resources so that people can meet their care needs within their own families, their communities and within themselves. We will work with voluntary organisations, service users, partners and our staff to help find creative solutions to meet the outcomes that they wish to achieve.

We will also promote independence and where possible use community based solutions which include the following care and support provision from independent providers- assistive technology, other forms of technology, community equipment, domiciliary care, access to day opportunities, provision of meals, short term breaks (respite) to live in their neighbourhood and community where this is feasible and affordable. We seek to reduce admissions of people to residential care and ensure that the person is getting the right health, housing and support alongside their social care.

However, the exact future demand and supply will need to be collaboratively taken forward and involve the review of population aspirations, review of existing commissioning strategies and intentions and be aligned to supply that promotes wellbeing, independence and prevention and reduce and delay of care needs arising or worsening. The strategic approach is:

Care and Support Sector Provision - Managing Demand and Supply

The way forward that will affect market supply is how the Council will commission and operate will be developed and detailed within the *'Wellbeing and Prevention Strategy***.'**.

Increasing community based Prevention based services

To increasingly support individuals and their families through the range of preventative services within a creative and innovative locality based operating model of community facing services

Reducing and Delaying Care Needs

Targeting resources and services to support individuals and families that are at a higher risk of experiencing inequalities which may lead to poorer outcomes and as such require a more targeted approach to prevention dependent on the needs identified.

Planning Requirement 7 KLoE 17
Planning Requirement 8 KLoE 19

Progress to date


Appendix E_Better Care Fund Update.doc

A summary of progress within 2016/17 was presented to HWB Board on 5th September 2017:
Achievements in key metrics

- Reductions in admissions related to care homes, chest pain, end of life, general medical conditions and related to 75+ years.
- Recognised DTOC pressure related to mental health and Community provider from provider profiling. Targeted work to address identified factors.
- Achieved targets for 91 days Enablement and permanent admissions.

Community Resilience

- Continued partnership collaborations within the care sector and utilised SPIC leadership to ensure co-production.
- Facilitated community stakeholders to encourage delivery of 'Care Supply Provider Networks' - care and support providers focusing on the provision and sustainability of care – and voluntary sector and microenterprise development to support development more resilient communities
- Workshops to develop 'Wellington Pilot' - Care and Wellbeing Networks
- Joint Grants and Commissioned voluntary services process in place. Funded 16 additional small providers through 'Supporting Communities' funding (up to 500 pounds).
- Revision of the Market Position Statement

Neighbourhood Care

- Multi- stakeholder Steering group in place. Strong partnership working across all sectors committed to aligning services to localities.

- Locality plans for the identified four localities in place. 19 projects in place with reporting into the STP across four localities.
- Formally reports to STP on progress.

Integrated Care

- Steering Group with Senior Managers from the acute Trust, Community Provider and Council developed process map and additional on-going meetings of all providers to improve implementation of the Intermediate Care Team.
- Reviewed the level of implementation of the service specification and process map revised.
- Reviewed use of Recovery beds to ensure D2A destination accuracy after audits of usage. Reviewed therapy input to ensure optimisation of enablement. Reduced delays discharge from Enablement beds.
- Additional senior nursing support to D2A process and links to community services. Supported reductions in Pathway 2 and 3 utilisation.
- Council revision of TICAT function to give enhanced dedicated capacity to ICT.
- Commissioned Enablement Packages to support Pathway 1 discharges (home with care) since Jan 2017. Quantifiable improvement in pathways 1 discharges and 95%+ response discharge within 48 hours

DToC Action Plan

- Daily clinical Hub escalates delays to resolve and minimise delays and ensure flow; ensure utilisation of step down beds and ensure Trusted Assessors utilise appropriate pathways. Additional senior nursing and SW capacity to support discharge destination as promote Home First.
- Reviewed use of Recovery beds to ensure D2A destination accuracy. Previously 30% could have utilised other pathways – home or non-Recovery based placements. Now less than 10%.
- Additional weekly planning meeting to reduce delays from Recovery beds
- Commissioned Enablement Packages provision across Zones from Jan 2017. Quantifiable improvement in pathways 1 discharges
- Piloting Hospice Rapid Response interventions to support Fast Track early discharge and admission avoidance.
- Reviewing D2A process as part of A&E Delivery Plan
- Analysis at provider level to reduce DToC levels to 3.5%. Planning related to mental health and Community Trust.

Development of 7 day services

- Rapid Response – part of Intermediate Care Team – in place 7 days week 8am-10pm.
- Utilised commissioned Out of Hours domiciliary care in place to avoid admissions.
- Development of 7day services within the NHS contracts and progress monitored on a quarterly basis.
- Resourced 7 day working at key times which highlighted challenges within acute setting to facilitate weekend discharges of complex patients.

Disabled Facilities Grant

The DFG Capital Grants awarded supported frailer older people to remain independent, safe and healthy and prevent admissions and readmissions.

The Grant fund was administered by the Housing department in the Councils Commercial Services Area who work in conjunction with housing providers, social care and OT teams.
Interventions have been made through:

- Preventative interventions within the locality teams
- Commissioned services from Wrekin Housing Trust (housing provider) and other providers to deliver adaptations
- Home Improvement Agency within the Council supporting adaptations including falls prevention support

In June 2016 a new Housing Assistance Policy was adopted to show how DFGs we be delivered to residents within the Borough. This also added an additional support through Wellbeing Assistance which provides up to £5000 for those on passporting benefits that require work on their home which if not completed would mean they would be admitted into hospital or care or prevented from being in hospital or care.

In June 2017 the Council lifted the means test criteria from this grant for an initial 6 month period to enable more clients to be supported and referrals are accepted through occupational therapists or other health professionals.

In 2017/2018 the Council we will continue monitor the uptake of all the Housing Assistance policy and the numbers coming through for adaptations. Where financially possible the Council will continue with the Wellbeing Grant with the benefit restrictions being lifted, especially for recommended adaptations through the Occupational Therapists for lower cost but essential adaptations such as stair lifts, ceiling track hoists and access to bathing and toileting.

<u>Care Act</u>

The Care Act instils duties to ensure wide accessibility for carers and our most vulnerable groups including frail elderly people to gain information, advice and guidance.

Services have been commissioned to include carers and the voluntary sector with aim of self-help, assist in wellbeing and promoting independence in the community.

Care Act Outcomes Position at August 2017:

- Resolution of calls for information and advice has performed at 88.5%
- Provision of low level Assistive Technology and equipment provided with positive outcomes
- Welfare benefits advice to the public of around £500K value – this quarter
- This model within T&W enables more ‘reach’ between people and voluntary services to prevent/delay need for formal funded support
- Excellent service links i.e. into strategy formulation work, and the link to the commissioning of a wider range of support options within communities
- Significant volunteer input

- Development of further links to Fire service, and GP surgeries as part of social prescribing in multiple sites across T&W, re: prevention and enabling independence.

In January 2018 a review of commissioned services will be taken forward. The main aims will include the effective provision of wider information and advice and promote independence to include technology in the community.

Governance and financial management

- Joint Strategic Commissioning Group in place
- S75 Agreement signed off. Monthly detailed financial and performance monitoring in place.

These programmes have been developed in line with existing planning timescales set out within the BCF Plan section.
Planning Requirement 7 KLoE 17 Planning Requirement 8 KLoE 19

Evidence base and local priorities to support plan for integration

Evidence base and local priorities for the Plan includes

Demographics within the JSNA and MPS Summary Community (above)
Successes identified in the Progress to Date section (above)

In addition:
Planning for 2017/18 and beyond took place within 2016/17 to ensure development of the key programmes:

- Joint vision in 2015 shaping the future of service development. This approach has been maintained, supported by joint Governance arrrangements


Community centered approaches final.docx

- Development of Intermediate Care Team was co-produced with the acute and community provider and included within the NHS contracts for both organisations. The process map (operational delivery of the team) was also co-produced.


ICT process map v11.pdf

- Neighbourhood working supported through through the STP Governance and project monitoring arrangement
- Frailty identified as a priority by the Shropshire A&E Delivery Board. There was recognition of previous initiatives with and across the economy aimed at reduce Frailty related admissions and improve care within the acute setting including:

    - Economy-wide Frail and Complex programme in 2012 leading to a prototype Frailty service
    - Economy-wide ATOS Urgent Care High Level Projects in 2013
    - ECIP support for SaTH in 2016

- Community Resilience programme building on through enabling community development and resilience; encouraging collaborative arrangements between providers and strengthening communities; promoting new community based groups and delivery of projects through community organisations. This includes piloting Care and Wellbeing Networks

There are no significant changes in direction from the 2016/ 17 plan

Financial challenges identified within Future Fit and Community Fit
Planning Requirement 8 KLoE 19

Better Care Fund plan

The work programme for 2017-19 develops the work from 2015/16 will remain around the existing themes detailed in 3 above, with future work programme detailed below and set out in more detail within the draft Narrative Plan. There is significant inter-relationship between BCF programmes and integrated working as part of with other programmes of work such as Frailty; A&E Delivery Board and STP.

- Community Resilience
- Neighbourhood Care
- Integrated Care and Team working including Managing Transfers of Care/ High Impact Changes) and the Frailty programme of work

Programmes of work: Community Resilience

This programme is seeking to ensure the local economy has strong and connected communities. This will be achieved through enabling community development and resilience;
encouraging collaborative arrangements between providers; strengthening communities by tackling the causes of poor health; supporting volunteering; peer support; expanding local communities to provide Well-being and Prevention and reduce demand for health and social care; promote new community based groups and delivery of projects through community organisations;

Key actions are:

- Investment in a community development role, supported and managed by Community Support to stimulate and support new small, community based businesses. This is aimed at expanding the range of locally accessible support options.
- Community Catalyst CIC leading on a community based initative called Enterprising Communities. The local catalyst will work with localities to identify new business initiatives which benefit the community and its citizens focusing around health and social care.
- A targeted approach to increasing the number of personal assistants by up to 30 across localities by end of financial year. Locality working with community partnerships to energise local people to consider being a PA.
- A targeted increase in the number of people choosing to take their personal budget as a direct payment
- Development of Care and Wellbeing Networks aimed at enabling a better support offer to local people via care and support providers forming networks across a locality. This includes the development of equipment, technology and preventative services.
- Development of an improved offer to access equipment, assistive technology and prevention.
- Dementia strategy includes a range of ambitions, including to increase the number of dementia friendly communities, provision of targeted support, supporting people to live as independently, healthily and happily as possible. Local Dementia Action Plan will set local ambition for those with dementia and their carers. Monitored through Health Economy Steering Group.

- Carers resilience: Increase awareness around carer offer at an earlier stage.
- Improved links with General Practices and provide information, advice and support prior to and during inpatient journey.
- The appointment of a Hospital Liaison Worker for Carers will assist to support this model. Delivered by Carers Centre
- Flexible Night Support: On call domiciliary support available from 10 pm to 7am as a three month initiative. Interventions to be booked 24 hours in advance.
- Personalised Carer Support: Access to 25 hours free support for family carers to support and build up resilience and well-being levels.
- Additional Admiral Nurse commenced 1st June 2017.Our compliment is three nurses.
- Additional Moving and Handling Family Carer Adviser (22 hours) to support safe moving and handling activities.
- Raising Carer Awareness through publicity distributed by Pharmacies. This initiative came out of the Carers Voices project; Co produced with carers and NHS England.
- Implementing a grants process to support community resilience
- Commissioning Mental Health Hub/ Branches
- Proactive promotion of technology
- Development of Wellbeing HUBs to better connect care providers & volunteers
- Developing the Community role within cancer survivorship.
- Developing peer support networks including Health Champions
- Establish a system to capture assets to support social prescribing, signposting and support workers

Programme: Neighbourhood Care

The Neighbourhood working approach to developing community centred approaches, being led by the Council and the CCG together with the people of Telford and Wrekin, has been in development for approximately 12 months. It include initiatives that range from development of peer led roles right through to the design and implementation of NHS services in community settings. This approach evolved naturally in response to a number of issues, one of the most significant of which was to challenge the current deficit based model of care which promotes dependency.

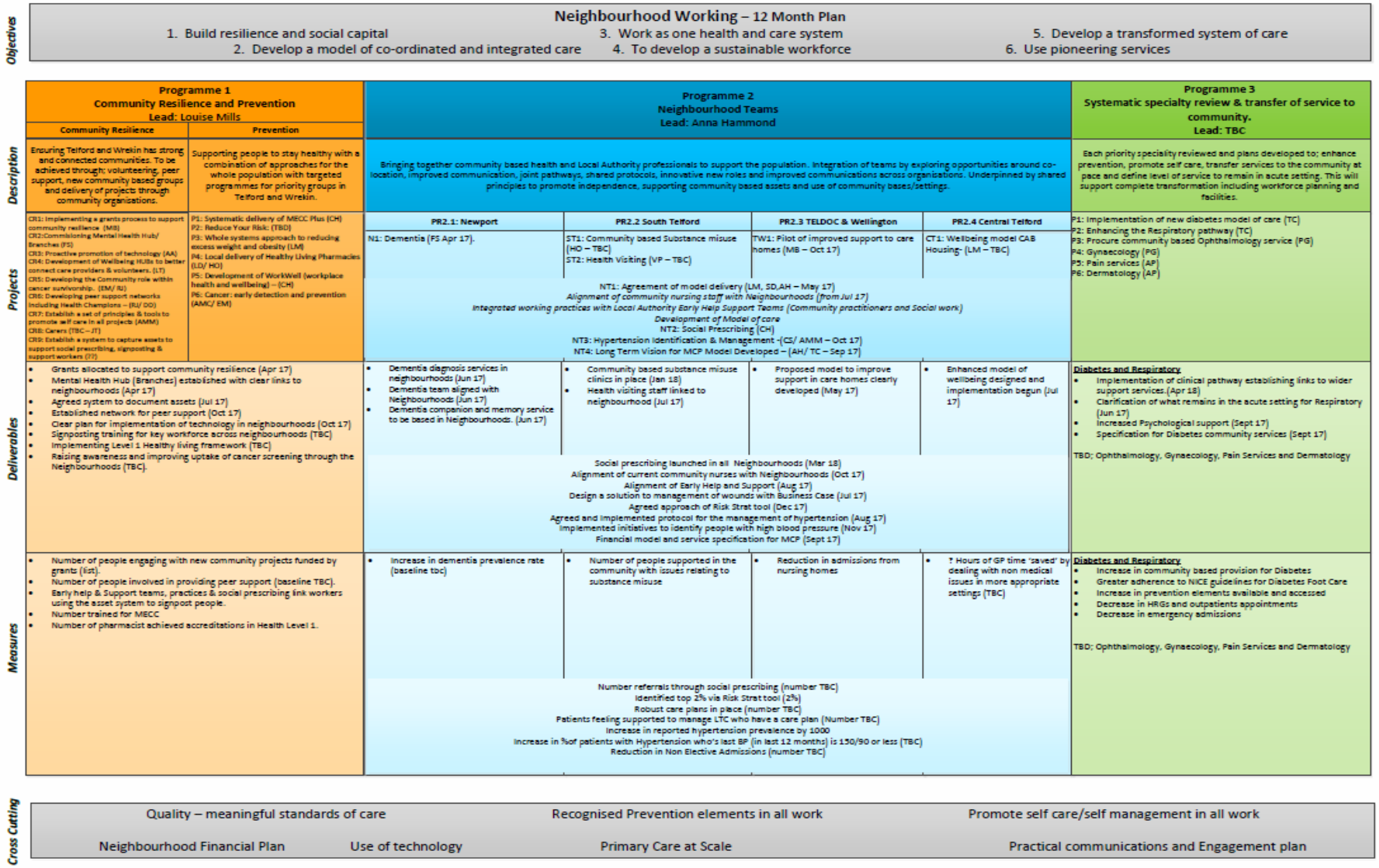
Key actions

- Implementation of the 22 work programmes
- Locality agreement of new models of care
- Produce clear articulation of what the requirements across the four neighbourhoods eg
    - Community Nursing
    - Over-arching medical input to support Intermediate Care
    - Mental Health
    - Early Help and Support
    - Third Sector

- Identify which functions would be pan CCG and which would be local
- Access to expert interpretation of diagnostics
- Continue progression of some aspects of work within the neighbourhoods e.g. social prescribing.
- Alignment of community based staff statutory and voluntary services around local communities

- Increased acute services e.g. clinics, clinical advice, diagnostics based and delivered within local communities and primary care
- Preventative and personalised approaches e.g. Social Prescribing in Newport
- Shared ownership of managing and supporting high risk patients e.g. Frail people, long term conditions, respiratory conditions, diabetes
- Agree a consistent platform will be used to share information i.e. My Life, “Wikipedia” project and how this will link with Directory of Services (DOS);
- Agree processes for immediate linkages with Early Help and Support Teams e.g. link workers for each practice, drop in sessions with bookable appointments.

Planning Requirement 8 KLoE 19
Planning Requirement 15 KLoE 36


Objectives
Neighbourhood Working – 12 Month Plan
1. Build resilience and social capital
2. Develop a model of co-ordinated and integrated care
3. Work as one health and care system
4. To develop a sustainable workforce
5. Develop a transformed system of care
6. Use pioneering services
Programme 1
Community Resilience and Prevention
Lead: Louise Mills
Community Resilience
Prevention
Programme 2
Neighbourhood Teams
Lead: Anna Hammond
Programme 3
Systematic specialty review & transfer of service to community.
Lead: TBC
Description
Ensuring Telford and Wrekin has strong and connected communities. To be achieved through: volunteering, peer support, new community based groups and delivery of projects through community organisations.
Supporting people to stay healthy with a combination of approaches for the whole population with targeted programmes for priority groups in Telford and Wrekin.
Bringing together community based health and Local Authority professionals to support the population. Integration of teams by exploring opportunities around co-location, improved communication, joint pathways, shared protocols, innovative new roles and improved communications across organisations. Underpinned by shared principles to promote independence, supporting community based assets and use of community bases/settings.
Each priority speciality reviewed and plans developed to; enhance prevention, promote self care, transfer services to the community at pace and define level of service to remain in acute setting. This will support complete transformation including workforce planning and facilities.
Projects
CR1: Implementing a grants process to support community resilience (MB)
CR2:Commissioning Mental Health Hub/ Branches (FS)
CR3: Proactive promotion of technology (AA)
CR4: Development of Wellbeing HUBs to better connect care providers & volunteers. (LT)
CR5: Developing the Community role within cancer survivorship. (EM/ RJ)
CR6: Developing peer support networks including Health Champions – (RJ/ DD)
CR7: Establish a set of principles & tools to promote self care in all projects (AMM)
CR8: Carers (TBC – JT)
CR9: Establish a system to capture assets to support social prescribing, signposting & support workers (??)
P1: Systematic delivery of MECC Plus (CH)
P2: Reduce Your Risk: (TBD)
P3: Whole systems approach to reducing excess weight and obesity (LM)
P4: Local delivery of Healthy Living Pharmacies (LD/ HO)
P5: Development of WorkWell (workplace health and wellbeing) – (CH)
P6: Cancer: early detection and prevention (AMC/ EM)
PR2.1: Newport
PR2.2 South Telford
PR2.3 TELDOC & Wellington
PR2.4 Central Telford
N1: Dementia (FS Apr 17).
ST1: Community based Substance misuse (HO – TBC)
ST2: Health Visiting (VP – TBC)
TW1: Pilot of improved support to care homes (MB – Oct 17)
CT1: Wellbeing model CAB Housing- (LM – TBC)
NT1: Agreement of model delivery (LM, SD,AH – May 17)
Alignment of community nursing staff with Neighbourhoods (from Jul 17)
Integrated working practices with Local Authority Early Help Support Teams (Community practitioners and Social work)
Development of Model of care
NT2: Social Prescribing (CH)
NT3: Hypertension Identification & Management -(CS/ AMM – Oct 17)
NT4: Long Term Vision for MCP Model Developed – (AH/ TC – Sep 17)
P1: Implementation of new diabetes model of care (TC)
P2: Enhancing the Respiratory pathway (TC)
P3: Procure community based Ophthalmology service (PG)
P4: Gynaecology (PG)
P5: Pain services (AP)
P6: Dermatology (AP)
Deliverables
Grants allocated to support community resilience (Apr 17)
Mental Health Hub (Branches) established with clear links to neighbourhoods (Apr 17)
Agreed system to document assets (Jul 17)
Established network for peer support (Oct 17)
Clear plan for implementation of technology in neighbourhoods (Oct 17)
Signposting training for key workforce across neighbourhoods (TBC)
Implementing Level 1 Healthy living framework (TBC)
Raising awareness and improving uptake of cancer screening through the Neighbourhoods (TBC).
Dementia diagnosis services in neighbourhoods (Jun 17)
Dementia team aligned with Neighbourhoods (Jun 17)
Dementia companion and memory service to be based in Neighbourhoods. (Jun 17)
Community based substance misuse clinics in place (Jan 18)
Health visiting staff linked to neighbourhood (Jul 17)
Proposed model to improve support in care homes clearly developed (May 17)
Enhanced model of wellbeing designed and implementation begun (Jul 17)
Social prescribing launched in all Neighbourhoods (Mar 18)
Alignment of current community nurses with Neighbourhoods (Oct 17)
Alignment of Early Help and Support (Aug 17)
Design a solution to management of wounds with Business Case (Jul 17)
Agreed approach of Risk Strat tool (Dec 17)
Agreed and implemented protocol for the management of hypertension (Aug 17)
Implemented initiatives to identify people with high blood pressure (Nov 17)
Financial model and service specification for MCP (Sept 17)
Diabetes and Respiratory
Implementation of clinical pathway establishing links to wider support services.(Apr 18)
Clarification of what remains in the acute setting for Respiratory (Jun 17)
Increased Psychological support (Sept 17)
Specification for Diabetes community services (Sept 17)
TBD; Ophthalmology, Gynaecology, Pain Services and Dermatology
Measures
Number of people engaging with new community projects funded by grants (list).
Number of people involved in providing peer support (baseline TBC).
Early help & Support teams, practices & social prescribing link workers using the asset system to signpost people.
Number trained for MECC
Number of pharmacist achieved accreditations in Health Level 1.
Increase in dementia prevalence rate (baseline tbc)
Number of people supported in the community with issues relating to substance misuse
Reduction in admissions from nursing homes
? Hours of GP time 'saved' by dealing with non medical issues in more appropriate settings (TBC)
Number referrals through social prescribing (number TBC)
Identified top 2% via Risk Strat tool (2%)
Robust care plans in place (number TBC)
Patients feeling supported to manage LTC who have a care plan (Number TBC)
Increase in reported hypertension prevalence by 1000
Increase in %of patients with Hypertension who's last BP (in last 12 months) is 150/90 or less (TBC)
Reduction in Non Elective Admissions (number TBC)
Diabetes and Respiratory
Increase in community based provision for Diabetes
Greater adherence to NICE guidelines for Diabetes Foot Care
Increase in prevention elements available and accessed
Decrease in HRGs and outpatients appointments
Decrease in emergency admissions
TBD; Ophthalmology, Gynaecology, Pain Services and Dermatology
Cross Cutting
Quality – meaningful standards of care
Recognised Prevention elements in all work
Promote self care/self management in all work
Neighbourhood Financial Plan
Use of technology
Primary Care at Scale
Practical communications and Engagement plan
March 2017_V3

Programme: Integrated Care

Over the past 18 months the CCG team has been progressing the development of an Intermediate Care Service. A service specification was designed for delivery by three key organisations: SaTH, Telford and Wrekin Council and Shropshire Community Trust. Key individuals within the three providers have been working together with CCG to implement the content of the service specification with the aim of achieving the key outcomes included.

Key actions

- A fully integrated health, social care and voluntary care team working together within a single service specification
- Development with acute hospital to develop an economy-wide Comprehensive Frailty Assessment
- Improved integrated working with the Clinical Hub and support early discharge in line with HIC and DToC plans
- Improved relationship with Neighbourhood teams to ensure seamless transition/ pathway between proactive and reactive care
- Development of the Care home MDT to reduce care home admissions and improve quality of care
- Reduced hospital conveyances and non-elective admissions through 7 day service including from care homes
- Reduce LoS within Recovery beds to 26 days
- Develop Point of Care Testing to support avoidable admissions
- Further development of the joint assessment and care planning process to reduce duplication and improve care
- Further development of admission avoidance pathways for identified conditions – falls, UTIs, end of life, respiratory conditions
- Achieve the target reductions in admissions


Intermediate Care measures and metric .


TICAT Process Map V11.pdf

The Intermediate Care Team is included as part of the overall Frailty programme and also monitored through the Frailty Programme Board

Care Home 70+ Years - 17_18 QIPP

5095	12 mths NEL Admissions for 70+ Yrs	20310	12mths NEL Admissions for all Ages		6203
544	Intermediate Care QIPP Reductions 70+	544			744
11%	% Reduction	3%			12%
					223.2

Reduction of 223 Emergency Admissions from Care Homes for 70+ Years in addition to existing reductions identified for Intermediate Care

HRG Code	Description	Activity	Tariff 16_17	Overall Savings
DZ11A	Lobar, Atypical or Viral Pneumonia with Major CC	33	£ 3,090	£ 101,970
DZ11B	Lobar, Atypical or Viral Pneumonia with CC	5	£ 2,150	£ 10,750
DZ22A	Unspecified Acute Lower Respiratory Infection with Major CC	7	£ 2,579	£ 18,053
DZ22B	Unspecified Acute Lower Respiratory Infection with CC	1	£ 1,749	£ 1,749
DZ23A	Bronchopneumonia with Major CC	1	£ 3,119	£ 3,119
DZ24A	Inhalation Lung Injury or Foreign Body with Major CC	6	£ 3,985	£ 23,910
LA04D	Kidney or Urinary Tract Infections with length of stay 2 days or mo	25	£ 3,604	£ 90,100
LA04E	Kidney or Urinary Tract Infections with length of stay 2 days or mo	5	£ 2,023	£ 10,115
LA04F	Kidney or Urinary Tract Infections with length of stay 2 days or mo	1	£ 1,331	£ 1,331
LA04G	Kidney or Urinary Tract Infections with length of stay 1 day or less	10	£ 423	£ 4,230
AA26A	Muscular Balance Cranial or Peripheral Nerve disorders; Epilepsy; I	1	£ 1,194	£ 1,194
CZ21V	Minor Head, Neck and Ear Disorders 19 years and over with CC	1	£ 694	£ 694
HA12B	Major Hip Procedures Category 1 for Trauma with CC	5	£ 8,274	£ 41,370
HA12C	Major Hip Procedures Category 1 for Trauma without CC	10	£ 6,216	£ 62,160
HA13A	Intermediate Hip Procedures for Trauma with Major CC	2	£ 6,900	£ 13,800
HA13B	Intermediate Hip Procedures for Trauma with Intermediate CC	2	£ 5,538	£ 11,076
HA13C	Intermediate Hip Procedures for Trauma without CC	2	£ 5,537	£ 11,074
HA56A	Minor Hand Procedures for Trauma Level Category 1 19 years and	1	£ 1,031	£ 1,031
HA81B	Sprains, Strains, or Minor Open Wounds with CC	1	£ 1,500	£ 1,500
HA81C	Sprains, Strains, or Minor Open Wounds without CC	1	£ 621	£ 621
HA92Z	Knee Trauma Diagnosis without Procedure	2	£ 1,016	£ 2,032
HA95Z	Hand Trauma Diagnosis without Procedure	1	£ 570	£ 570
JC06A	Minor Skin Procedures category 2 with Major CC	1	£ 1,062	£ 1,062
AA26A	Muscular Balance Cranial or Peripheral Nerve disorders; Epilepsy; I	3	£ 1,194	£ 3,582
AA26B	Muscular Balance Cranial or Peripheral Nerve disorders; Epilepsy; I	1	£ 590	£ 590
EB08H	Syncope or Collapse with CC	4	£ 1,986	£ 7,944
WA18V	Admission for unexplained symptoms with Major CC	13	£ 3,089	£ 40,157
EB03H	Heart Failure or Shock with CC	4	£ 3,270	£ 13,080
EB03I	Heart Failure or Shock without CC	3	£ 2,039	£ 6,117
QZ20Z	Deep Vein Thrombosis	4	£ 562	£ 2,248
FZ38F	Gastrointestinal Bleed with length of stay 1 day or less	5	£ 438	£ 2,190
FZ43A	Non-Malignant Stomach or Duodenum Disorders with length of sta	1	£ 2,918	£ 2,918
FZ36F	Intestinal Infectious Disorders with length of stay 1 day or less	1	£ 436	£ 436
FZ47C	Non-Malignant General Abdominal Disorders with length of stay 1	2	£ 687	£ 1,374
DZ21H	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV	4	£ 2,768	£ 11,072
DZ21J	Chronic Obstructive Pulmonary Disease or Bronchitis without NIV	4	£ 2,116	£ 8,464
LA07E	Acute Kidney Injury with Major CC without Interventions	7	£ 3,332	£ 23,324
AA22A	Non-Transient Stroke or Cerebrovascular Accident Nervous system	3	£ 3,781	£ 11,343
JD03A	Intermediate Skin disorders category 2 with Major CC	2	£ 2,879	£ 5,758
JD03B	Intermediate Skin disorders category 2 with Intermediate CC	1	£ 1,230	£ 1,230
JD04A	Intermediate Skin disorders category 1 with Major CC	1	£ 2,245	£ 2,245
WA09W	Other non-viral infection with CC	1	£ 2,961	£ 2,961
KC05A	Fluid and Electrolyte Disorders 70 years and over with Major CC	3	£ 3,124	£ 9,372
KC05B	Fluid and Electrolyte Disorders 70 years and over with Intermediat	2	£ 1,896	£ 3,792
KC05E	Fluid and Electrolyte Disorders 69 years and under with Intermedia	1	£ 1,465	£ 1,465
EB01Z	Non interventional acquired cardiac conditions	1	£ 544	£ 544
FZ47B	Non-Malignant General Abdominal Disorders with length of stay 2	1	£ 687	£ 687
HD21B	Soft Tissue Disorders with CC	1	£ 434	£ 434
HD26A	Musculoskeletal Signs and Symptoms with Major CC	1	£ 2,840	£ 2,840
HD26B	Musculoskeletal Signs and Symptoms with CC	1	£ 1,157	£ 1,157
HD21A	Soft Tissue Disorders with Major CC	1	£ 1,987	£ 1,987
HD21B	Soft Tissue Disorders with CC	4	£ 434	£ 1,736
SA04D	Iron Deficiency Anaemia with CC	2	£ 1,962	£ 3,924
SA09D	Other Red Blood Cell Disorders with CC	4	£ 2,269	£ 9,076
FZ45A	Non-Malignant Large Intestinal Disorders with length of stay 2 day	2	£ 2,851	£ 5,702
FZ50Z	Intermediate Large Intestine Procedures 19 years and over	1	£ 703	£ 703
AA27A	Medical Care of Patients with Alzheimers Disease with CC	3	£ 4,611	£ 13,833
WD11Z	All Patients older than 69 years with a Mental Health Primary Diag	4	#N/A	£ -
EB07I	Arrhythmia or Conduction Disorders without CC	1	£ 625	£ 625
WA18V	Admission for unexplained symptoms with Major CC	1	£ 3,089	£ 3,089
WA23V	Falls without specific cause with Major CC	1	£ 3,365	£ 3,365
Grand Total		223		£ 624,875

Programme Budget Description	total Activi	ductions identifi
Problems of the Respiratory System	159	51
Problems of Genito Urinary System	102	40
Problems Due to Trauma and Injuries	82	30
Neurological	68	20
Problems of Circulation	37	10
Upper GI	30	6
Problems of the Gastro Intestinal System	27	3
Obstructive Airways Disease	24	8
Infectious Diseases	22	7
Renal Problems	21	7
Cerebrovascular Disease	18	3
Problems of the Skin	15	5
Chronic Pain	15	5
Endocrine, Nutritional and Metabolic Pro	15	5
Problems of the Musculo Skeletal System	13	5
Disorders of Blood	9	6
Organic Mental Disorders	7	7
Lower GI	7	3
Problems of Rhythm	5	1
Other	3	1
	679	223

Planning Requirement 8 KLoE 19 KLoE 20
Planning Requirement 15 KLoE 36

Programme: Integrated care – Frailty Programme

There have been a number of initiatives with and across the economy aimed at reduce Frailty related admissions and improve care within the acute setting including:

- Economy-wide Frail and Complex programme in 2012 leading to a prototype Frailty service
- Economy-wide ATOS Urgent Care High Level Projects in 2013

- ECIP support for SaTH in 2016

The A&E Delivery Board highlighted the need to prioritise Frailty in order to support whole system change and support constitutional targets. A facilitated review highlighted that the local current system does NOT provide the best care for patients. It was based on medical models; had a fragmented system; was over-reliant on beds and too risk averse

The workshops identified key areas that would have a positive impact on the economy – improved experience; pathway and outcomes. Five programmes of work with associated projects and metrics were identified.

<u>High ratio of emergency admissions</u>
Attendances at Emergency Departments are increasing with the greatest increase seen in those over 75. In addition, over 85's are nearly 10 times more likely to have an emergency admission than those aged 20-40. However, the profile of admissions, LOS and overall bed occupancy of those over 75 (used as a proxy for Frailty) below highlights the challenge within the acute hospital – a quarter of admissions use nearly half of all beds.

Age profile	**% Admissions**	**Ave LoS**	**% Bed occupancy**
0-74 years	76%	Ave 2.65 days	51%
75+ years	24%	Ave 8.10 days	49%

<u>Under-utilisation of alternatives to hospital</u>
There is significant evidence to demonstrate that some patients who are admitted could have been treated in alternative settings. Differing methodologies (summarised below highlight that at least 14% of frailty related admissions could be maintained in different settings. In additional, there is evidence of patients who are admitted remain longer than clinically necessary. With frail patients, if admitted, their re-admission rate is high and admission is often associated with physical deconditioning

Review	**Potential reductions**	**Methodology**
Oak Group	Nationally across 151 hospitals Oak Group identify *'Non-Qualified on Admission'* (not needing admission) was 25% for all admissions (incl short stay) and on wards was 16%. The *'Non -Qualified rate for patients in the wards for their day of stay'* (no longer needing an acute bed post treatment) was 50%. 15% of patients 70% aged 70+ years *Non-Qualified on admission* 48% were *Non - Qualified rate for patients in the wards for their day of stay'* in SaTH (August 2013)	MCAP tool

CSU Strategic Unit	14% reduction in emergency admissions could be supported in other settings outside an acute hospital across all ages.	Clinical identification of HRGs of who could 'sometimes' and 'usually' be treated without admission
Harrow Complex patients Review	29% of complex admissions could have been avoided if alternative interventions were offered 36% of complex admissions could have been prevented if earlier intervention been in place	Harrow model

The CSU Strategic Unit data is a separate document.

<u>Frailty attendance and admissions and the impact on performance</u>
The current A&E Delivery Plan is unlikely to achieve the DTOC or 95% A&E target levels without additional interventions. Metrics within the Frailty projects support admission avoidance; improved flow and discharge planning and reduced length of stay.

	DToC	Breaches	Admission	Discharges	LOS
May-16	3.1%	81.16%	2818	2791	6.19
Aug-16	5.8%	78.96%	2709	2702	6.40
Sep-16	5.2%	78.54%	2756	2761	6.11
Nov-16	3.3%	75.89%	2861	2902	6.32
Dec-16	4.2%	*73.86%*	*2926*	*2979*	5.88
Apr-17		80.50%			

Objectives, five programmes of work with associated projects and metrics were identified:

Programmes of work	**Objectives**	**Measures and metrics**
•Prevention and Primary care ➢ Development of 'Frailty' or My Health card ➢ Electronic frailty assessment within primary care ➢ Proactive care planning and case management •Crisis/ Admission Avoidance ➢ Full implementation of Integrated teams ➢ Dedicated Frailty, Falls and care home admission avoidance interventions as part of integrated teams ➢ Implementation of Comprehensive Frailty Assessment (CFA)	•Improved identification of Frail patients •Improved care planning and preventative support •Enhanced admission avoidance interventions within community and acute services •Reduce avoidable admissions and length of stay while improving outcomes •Dedicated staffing to support Frail patients	•Development and patient identification through a frailty tool •Increased ACPs and EOL care planning •Reduced conveyance to hospital •Overall reductions in admissions including falls, care home and end of life related •Completion of CGA for identified patients •Reduce outliers to 0 people

•Flow through the acute hospital ➢ Frailty Team from Front Door to discharge ➢ Improved processes to reduce avoidable admissions and length of stay •Effective Discharge ➢ D2A reflecting P1/2/3 ratio of 60: 30: 10 ➢ Frailty Team as part of the community integrated teams •Improved End of Life ➢ Improved identification and end of life care for fail people	within acute hospital to improve patient journey and experience •Reinforcing integrated working across primary, community and acute services •Support achieving Constitutional targets	•Reduce avoidable admissions and overall length of stay •Reduced bed base by 48 •Achieve 95% ED performance

Planning Requirement 8 KLoE 19 KLoE 20
Planning Requirement 15 KLoE 36

Frailty Modelling projections

Modelling of Frailty related admissions using the Oak group evidence from their national profile average identified *'Non-Qualified on Admission'* (not needing to be admitted) was 25% for all admissions (incl short stay) and on wards was 16%. The *'Non -Qualified rate for patients in the wards for their day of stay'* (no longer needing an acute bed post treatment) was 50%. This was in line with the audit carried on in 2013 locally.

The CSU Strategic Unit used a different approach - clinicians reviewed HRGs and identified those and the % that could be 'sometimes' and 'usually' be treated in other settings outside the acute hospital across all ages. They identified 14% reduction in emergency admissions could be supported in other settings outside an acute hospital.

FrailElderly_v4jp.pptx MB Admissions.xlsx Care Home Reductions.xlsx

The CSU strategic Unit has identified the potential for reduced admissions related to conditions or HRGs across all ages of frailty related conditions. For the 64-75+ years the biggest potential for emergency reductions and associated costs are:

- Urinary conditions
- Respiratory conditions
- Diseases of the intestines
- Conditions related to cognitive perception
- Muscular skeletal conditions

More detailed work, to HRG level has been carried out in T&W, and shared with Shropshire colleagues to identify likely reductions related to Intermediate Care and Care Homes as part of QIPP monitoring and planning. This is being analysed further to assure likely achievement of investment.

Key Actions

- Implementation of 11 projects supporting early identification, assessment and care planning; preventative interventions; admission avoidance; reducing LoS and early discharge; improved end of life care
- Development of Frailty Team at RSH to reduce admissions and LoS and more integrated acute and community alignment

Frailty Front Door Rapid Evaluation v7.

- Primary Care Streaming At Front Door at PRH to divert to other appropriate services

Planning Requirement 8 KLoE 19. KLoE 20

Objectives	**Frailty programme April 2017 – March 2018** 1 Improved identification of Frail patients 2. Improved care planning and preventative support 3. Enhanced admission avoidance interventions within community and acute services 4. Reduce avoidable admissions and length of stay while improving outcomes 5. Dedicated staffing to support Frail patients within acute hospital to improve patient journey and experience 6. Reinforcing integrated working across primary, community and acute services 7. Support achieving Constitutional targets				
	Programme 1 **Prevention and Primary Care**	Programme 2 **Proactive Care and Crisis/ Admission Avoidance**	Programme 3 **Flow through the acute hospital**	Programme 4 **Discharge**	Programme 5 End of Life care
Description	Enhanced primary care to enable earlier identification of frail patients/ people through active case finding and improved care planning to reduce risk of avoidable admissions	Enhancing the integrated community teams to improve admission avoidance interventions of frail patients, high risk patients in care homes	Improving flow through the acute hospital by ensuring targeted interventions from ED to discharge improve effectivenss and effiency of care and ensuring avoidable admission are re-directed to community services	Improved internal discharge processes support 'Home is Best' and the frailty team acts as an integral part of ICS/ ICT	Improving end of life care for frail people to ensure identification of need and dignity in death
Projects	PPC1:Development of 'Frailty' (My Health) card PPC2:Electronic frailty assessment within primary care PPC3:Proactice Care Planning and case management of high risk frail patients	CCA: Full implementation of ICS (Shropshire) and Intermediate Care Team in line with service specifications CCA2: Dedicated Frailty, Falls and care home admission avoidance interventions as part of ICS/ ICT CAA3: Implementation of Comprehensive Frailty Assessment (CFA)	F1: Frailty Team working from Front Door (assessment in ED) to discharge F2: Improved processes to reduce avoidable admissions and reduced length of stay	D1: Effective Discharge to Assess process reflecting P1/2/3 ratio of 60: 30: 10 D2: Frailty Team discharge, place and support within P1-3 as part of integrated working (ICS/ ICT)	EoL1: Improved identification and end of life care for frail people
Deliverables	•IDT/ community input into nursing care homes (October 2017) •Development and testing of 'Frailty' (My Health) card (April –June2017) •All practices to have access and utilise the CSU risk stratification tool (June 2017) •All practices have active e-frailty pop up tool (September 2017) •Locality based arrangements/ pathways agreed with primary care agree ACPs for identified patients October 2017) •Development of palliative care registers (September 2017)	•Medical support to ICS/ ICT from SaTH clinicians (April 2017) •Evaluation of ICS and ICT service specification (April 2017) •Identify actions to achieve specifications (April – June 2017) •WMAS review approach to conveyance and entering hospital of ambulant patients (June- August 2017) •CFA methodology in place and completed by ICS/ ICT (Septeber2017) •Falls pathway in place with WMAS to avoid admissions (September 2017) (T&W) •Ambulatory Care Admission Avoidance Pathway (September 2017) (T&W) •Development of integrated frailty pathway (September 2017) •Identify approach and capacity for targeted MDT interventions to care homes and high risk frail patients (September 2017) (T&W)	•Completion and approval of Frailty Business Case (June 2017) •Acute staff aligned to ICS/ ICTs for integrated working (June 2017) •Point Prevalence audit tool in place (September /October 2017) •Enhanced Frailty Team in place to provide dedicated interventions from ED to discharge – effective case management within acute hospital (July 2017) •Enhanced Frailty team support to wards/ departments to deliver evidence-based practice to optimise recovery timescales and reduce potential delays (July 2017) •Identified, implementable evidence-based interventions to reduce admissions and/ or improve flow (September 2017) •Enhanced Frailty Team in place and integrated working with ICS/ ICT to support patients following discharge (July 2017) •Frailty 72 hour/60 hour Care Pathway (September 2017)	•Evaluation of D2A process (June 2017) •Evaluation of SAFER (June 2017) •Identified programme of training and support to ward staff on D2A process (July 2017) •Enhanced Frailty Team/ approach in place and integrated working with ICS/ ICT following discharged patients to P1-3 (September 2017)	•Identification of the Frailty related EOL needs (July 2017) •Engagement with existing programmes / projects related to EoL (June 2017) •Economy-wide EOL strategy in place (October 2017) •Improved EOL pathways for non- cancer patients (July – September 2017) •Identification of additional EOL related actions for planned implementation (October 2017)
Measures	•Frail patients identified via frailty tool •Patients identified as frail vis e-frailty tool •Increased ACPs •Improved EOL care planning •Increased WMAS referrals to neighbourhood care team and ICS/ ICT	•Reduced conveyance to hospital by 10% •Reduced admissions (across Programme 2 and 3) •Reduced falls admissions by 30% •Reduce care home conveyance and admissions from 11% to 5.5% of emergency admissions) •Reduced end of life admissions by 30% •Completion of CGA for identified patients	•Reduced outliers to from c20 to 0 people •Reduced avoidable admissions from c15% - 5% max •Reduced length of stay from 7 -5 days for 70+ years •Reduced bed base by 48 beds /17,520 OBDs •Achieve 95% ED performance •Achieve 90% overall bed occupancy	•Achieve 60:30:10 use of designated Intermediate Care beds •Frailty team discharging via P1-3 and following patients as part of integrated working •Reduced DToCs to 3.5%	•Reduced expected End of Life deaths in hospital •Increased identification of Frailty related EOL care
Connected areas	A&E Delivery Plan STP/ Neighbourhood Working programme of work Frailty training/ awareness raising delivered across the economy Community resilience programme of work Better Care Fund/ iBCF Increased use of Assistive Technologies to enhance self-help/ self-care Development of a Single Referral Hub Directory of Services				

Potential Frail admission reductions Optimity/ Strategic CSU
based on 15/16 data 65 years+.

CCG	Potential reduction	OBDs	Admission costs
Shropshire	2966	28,523	£1,448,027
T&W	1444	13,252	£3,340,980
	4410	41,795	£10,714,901

Activity equates to a reduction of 12 patients per day (Shropshire 7/ day:
T&W 5 / day: 1.5 per GP practice/ week)

Conditions that could Usually or Sometimes be managed in the community (economy-wide):

Diagnosis (Usually managed)	Number	%age	OBDs	Costs 000,s
Urinary system	1003	35%	12,084	£2,999,
Respiratory conditions	457	16%	3,844	£941,
Nervous and muscular skeletal system	388	14%	3,813	£988,
Cognition and perception	239	9%	2,475	£632,
Endocrine, nutrition and metabolic	225	8%	1,725	£447,
Other	485	17%	3,958	£903,

Diagnosis (Sometimes managed)	Number	%age	OBDs	Costs
Chronic lower respiratory diseases	667	41%	5,554	£1,487,
Other diseases of intestines	171	11%	1,483	£621,

Modelling assumptions:

Reduce bed base by 24 beds 8,760 OBDs
Reduce bed base by 48 beds 17,520 OBDs

Frailty patients ave LoS 9.5 days (41,975/4410)

75+ admission account for 25% of emergency admissions and c75% of OBDs

SaTH Frailty Team 832 reduced admissions 7904 OBDs (832 x 9.5)

Reduction in 7% of emergency admissions (half the Frailty modelling number) would result in:

2205 reduced admissions (1483 Shropshire/ 722 T&W)
20,897 OBD reduction (14,261 Shropshire/ 6626 T&W)
£5,357,450 admission cost reductions (£1,6670,490 Shropshire/ £724,401 T&W)

SaTH Frailty Team 832 reduced admissions 7904 OBDs (832 x 9.5)

Reductions in LoS will have a positive impact on performance

	DToC	Breaches	Admissions	Discharges	LOS
May-16	3.1%	81.16%	2818	2791	6.19
Aug-16	5.8%	78.96%	2709	2702	6.40
Sep-16	5.2%	78.54%	2756	2761	6.11
Nov-16	3.3%	75.89%	2861	2902	6.32
Dec-16	4.2%	*73.86%*	*2926*	*2979*	5.88
Apr-17		80.50%			

Urinary system	153	9%	1,010	£281,
Other Respiratory conditions	147	9%	1,483	£370,
Circulatory system	143	9%	837	£182,
Lung diseases due to external agents	104	6%	1,465	£587,
Other	228	15%	2,064	£286,

Programme: Integrated Care – Managing Transfers of Care/ High Impact Changes)
Deliver Actions identified in the DTOC Action Plan and 8 High Level Changes Self-Assessment to:

- Reduce DToC targets to nationally derived targets
- Further develop 7 day services for admission avoidance and discharge
- Improve MDT discharge planning and support
- Develop Trusted Assessor role to facilitate prompt identification of correct pathway

This is detailed in national Condition 4 section Managing Transfers of Care


Enc 3 -8 high impact joint action plan.docx


HIC and DToC Action Plan for BCF submissic

Planning Requirement 5. KLoE 11 KLoE 12. KLoE 13

Maintaining progress in relation to Data sharing

Shropshire STP Digital Enabling Group is a sub-group of the STP. There are three workstreams in place.

The Clinical Reference Group is working on an outline functional specification to be used to produce a project mandate and an estimated budget.

The Design Authority are looking at two primary options for providing access to information from multiple systems:

- A central copy of information from all systems available for reference by individuals in organisations with the appropriate information sharing agreement,
- The information kept within the source EPR, and read-only access granted with local user-authentication checks and access audit trails.

The Information Governance Group are investigating (with the Design Authority) a central register documenting the information sharing agreements in place between to organisations to support the requirements above.

The community provider is implementing the roll-out of Rio, so will have an electronic clinical record later this year. This will be an additional catalyst to implementation.
Planning Requirement 6/ KLoE 16

Maintaining progress in relation to Joint assessment and planning
Development of joint assessment and joint planning is included within the NHS contract with community provider. The development of a fully integrated health, social care and voluntary care team working together within a single service specification supported joint assessment and planning processes.

The MDT includes Rapid Response nursing, Community Matron based as part of the Discharge support team, SW, OT, Physiotherapists and Care Navigator. Team members are accommodated across a number of locations to improve integrated working.
Further actions as part of integrated working includes:

- Development of a single base to fully integrate an embed the Team
- Daily conference calls to plan all P1, P2 and P3 patients
- Weekly team meetings
- Working with the STP Digital Enabling Group to identify digital sharing of assessments and care plans

This area is monitored via the Frailty programme
Planning Requirement 6/ KLoE 16

Maintaining progress in relation to 7 day services across health and social care
Building on the existing 7 day working Rapid Response – part of Intermediate Care Team – in place 7 days week 8am-10pm and commissioned Out of Hours domiciliary care in place to avoid admissions, future actions are

- Progress development of 7day services within the NHS contracts and progress monitored on a quarterly basis.
- Use of iBCF monies for social work and therapists to deliver 7 day working within the Intermediate Care Team
- Use of iBCF monies for social work and therapists to deliver 7 day working within the Neighbourhood Care Team
- Commission domiciliary care to commence new care over 7 days for admission avoidance and discharge from hospital
- Additional Brokerage capacity to support 7 day Brokerage Home MDT to support admission avoidance over 7 days
- Develop the Frailty team within the acute hospital over 7 days to support early discharge; reduced length of stay and improve flow

This area highlighted in the HIC and DToC action plan; monitored through the DTOC working group in relation to HIC and DToC action Plan and the A&E Delivery Board
Planning Requirement 6/ KLoE 16

Risk

BCF Risk Register 2017.18 v3.docx

Risk identified within the BCF programme are included in the Risk Register and summarised below:

- Delivery of programmes and deliver targets and transformational change within acute and community services
- Integrated teams do not embrace the new ways of working to achieve the BCF objectives eg
    - Increased referrals for bed- based rehabilitation
    - Increased admissions
    - Increased DToCs

- Lack of engagement and representation by independent and voluntary sector providers to ensure ownership
- Insufficient voluntary sector capacity to support BCF objectives
- Failure to reduce admissions with the subsequent costs to the CCG and Council
- Failure to achieve BCF metrics in line with BCF submission targets
- Financial risks or pressures affecting stakeholders which reduce likelihood of achieving BCF outcomes including
    - Acute hospital workforce processes
    - Funding Living Wage
    - Social care budget allocation
    - Domiciliary and bed-based care Provider instability due to lower levels of funding

- Insufficient primary care capacity to support admission avoidance interventions
- Lack of effective processes to share data and clinical records will inhibit the development of integrated working
- Workforce capability, capacity and development may inhibit development of the BCF programme – lack of ability to recruit key staff, skills and/ or capacity

Risks are included within the CCG Risk Registers and within respective provider organisations. Specific areas of risk are also captured within the Frailty, Neighbourhood Programme Boards and the A&E Delivery Board.

The Risk Sharing Agreement, agreed between the Council and CCG, is part of the Section 75 Agreement – set out below. There is no risk to the minimum contribution to social care or the iBCF monies within the RSA.
Planning Requirement 9 KLoE 21 KLoE 22

RISK SHARE ARRANGEMENTS
The key principles of the BCF plan are to enable transformation to facilitate self-help/self-care by service users and to deliver transformation by integrating health and social care services with the aim of leading to a reduction in non-elective emergency admissions and improvements in other key performance areas.

The Partners have identified that there are a number of specific financial risks associated with delivery of the BCF.

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 based on the estimated cost of non- elective emergency admissions based on the national tariff calculation, accounting for the emergency threshold adjustment. This sum is not contained within the BCF.

This schedule sets out the Partners' financial plans for delivery of the BCF Plan and the risk sharing principles agreed between them, including an agreed approach to deal with over and under spends.

The partners have agreed as follows:

- The Partners will share financial risks and gains, as set out in this Schedule in order to support the more effective use of financial contributions and in order to deliver the BCF Plan aims and objectives.
- Both partners shall support the best use of resources in order to deliver the aims and objectives of the BCF Plan.
- Mitigation of and responsibility for over and underspends in relation to a service and contingency planning shall be addressed where the risk was incurred (i.e. by the Partner who is the provider of the relevant service or the party to the relevant service contract). This will enable risks to be effectively managed by the Partners and shall ensure that the most appropriate mitigation is implemented. It may be necessary that the nature of the risk arising requires further examination at the BCF pooled budget meeting depending on the issue that is incurring the risk eg outcomes based services which may require additional funding to the original agreed budget. Apportionment of risk in this manner also embeds accountability at the relevant point within the health and social care system. This approach supports the shared commitment of Partners for the delivery of the BCF Plan.
- The services shall be delivered in order to ensure that the statutory responsibilities of each partner organisation can be met. The CCG has a responsibility for funding services in exercise of the NHS Functions and the Council's statutory responsibility in the assessment of patients and the provision of care to meet the eligible needs of its resident population in exercise of the Health Related functions. Where monies within the Pooled Funds are potentially available to fund additional services in excess of those required to enable the partners to meet their respective statutory obligations, decisions on the allocations of those monies will be made by the Partnership Board in consideration of the level of risk to each partner organisation and their financial contributions to the Pooled Fund.
- All stakeholders employed/engaged by the Partner organisations in relation to their services shall be responsible for the financial risk of those services within their respective organisations and in accordance with the terms of any relevant service contract.

The Partnership Board will monitor the performance of the Pooled Fund in detail in accordance with the Key Performance Indicators included in the BCF Plan. Any significant changes in performance (as defined in the performance report for each individual Key Performance Indicator) that potentially increases risk to a Partner organisation will be brought to the attention of the Partnership Board by the relevant Partner representatives

who will agree actions for dealing with them. Changes in performance will be monitored to address their immediate impact and to ensure performance is in line with target levels.

Monitoring will include:

- Identifying the risk and impact.
- Developing a plan to address the immediate effect and address the underlying cause.
- Agreeing the plan of action.
- Putting that action plan in place.

Risk Sharing

- All stakeholders who are employed/engaged by Partner organisations in respect of services have a collective responsibility for the delivery of the BCF Plan (via service contracts) and its outcomes and the efficient use of financial contributions made to the Pooled Fund.
- Financial risks will be managed by Partners within the Pooled Fund.
- Financial risk to the Pooled Fund will be managed by the CCG monitoring of Key Performance Metrics and through the monitoring of individual schemes through the Partnership Board (reporting to the Health and Well Being Board).
- The services commissioned through the individual schemes will directly impact on the delivery of the BCF performance metrics as set out in the BCF Plan. Any failure to deliver on BCF performance metrics will be a shared risk as between the Partners with financial consequences for them both.

Overspends

Where an overspend in relation to financial contributions to the Pooled Fund arises or is likely to arise, an action plan will be developed, agreed, and put in place by the Partners. It is crucial that timely and accurate financial information is produced and monitored by the Partnership Board so that any potential overspends can be identified and appropriate action taken.

Underspends

Where underspends occur they will be used to fund other services that are agreed by the Partners as being likely to be in relation/support of:

- Increased acute activity.
- Increased social care costs related to the BCF Plan.
- Increased community capacity.
-

Unspent financial contributions at any year-end during the term of this Agreement will remain within the Pooled Fund for use the following year of the term, such financial contributions to be carried forward by the Council in its capacity as Host Partner.
Planning Requirement 9 KLoE 22. KLoE 23

National Conditions

National condition 1: jointly agreed plan
The BCF Narrative plan was presented to HWB Board on 9th September and was formally approved

Lead Officers of the HWB Board, CCG and Council have signed the document (see Approval and sing off
Planning Requirement 1 KLoE 1

The CCG and Council have fully engaged with providers in relation to BCF. This engagement includes:

- 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
- Housing providers and Council Planning particularly in relation to alternatives to residential care eg Extra Care
  Home Improvement Agency to support DFG planning and improve integrated working for prevention and home adaptations across providers
- 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.
- Estates planning to ensure sustainability with future planning

Engagement includes both CCG and Council representation.
Planning Requirement 1 KLoE 2

There is significant political engagement. The Cabinet member for Social Care is engaged with the BCF developments and Chairs the of HWB Board; the Opposition have representation of the HWB Board. The Board has approved the commissioning intentions.

The Local Strategic Partnership, comprising Police, Education and local business have regular updates. Local MPs have regular briefings with the CCG Chief Officer

Planning Requirement 1 KLoE 2

National Conditions (continued)

National condition 2: social care maintenance

Planned spend on Social Care from the CCG minimum contribution is in line with requirements. This is set out within the Planning Template and set out below

BCF Expenditure on Social Care from Minimum CCG Contribution	2016/17	2017/18	2018/19
Minimum Mandated Expenditure on Social Care from the CCG minimum		£5,437,697	£5,541,013
Planned Social Care expenditure from the CCG minimum	£5,342,074	£5,488,729	£5,593,016
Annual % Uplift Planned		**2.7%**	**1.9%**
Minimum mandated uplift % (Based on inflation)		**1.79%**	**1.90%**

Planning Requirement 3 KLoE 4

Within 2017/18 there is a £51,032 over the minimum Mandated expenditure level. Within 2018/19 the value is £52,003. These values have been budgeted within the CCG and part of the monthly transfer to the Council. This is fully affordable to the CCG. The values have been agreed within the CCGs Medium Term Financial Plan

Planning Requirement 3 KLoE 5

The overall BCF plan and financial values for 2017/18 and 2017/19 have been agreed with the Joint Strategic Commissioning Group, taking account of the whole health and social care system needs. Planning is explicitly to ensure a robust health and social care system and includes acute, community, independent and voluntary sector stakeholders within overall BCF planning

Planning Requirement 3 KLoE 6

The areas of spend on social care services that have health benefits are identified within planned spend in Intermediate Care, Community Resilience and Neighbourhood working budget lines:

Intermediate Care

- Rehabilitation and Enablement
- Domiciliary Care
- Rehabilitation and Enablement Beds
- Preventative Services
- LA Beds

Community Resilience

- Preventative Services
- Carers
- LA Grants

Telford Neighbourhood Care

- Assistive Technologies
- Preventative Services

Other

- Maintaining Eligibility for patients with LTCs

Monthly reporting within the BCF Pooled Budget meeting is in place (set out in Governance arrangement below) The allocations for each budget line is set out in more detail within Overall Funding Contributions below. This includes maintenance of social care services including specifically Maintaining Eligibility for patients with LTCs.
Planning Requirement 3 KLoE 7

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

Planned spend on NHS Commissioned Out of Hospital Services from the CCG minimum contribution is in line with requirements. This is set out within the Planning Template and set out below

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)	2017/18 Expenditure	2018/19 Expenditure
Mental Health	£0	£0
Community Health	£3,372,549	£3,436,818
Continuing Care	£0	£0
Primary Care	£27,964	£28,493
Social Care	£321,535	£328,162
Other	£0	£0
Total	**£3,722,048**	**£3,793,473**
NHS Commissioned OOH Ringfence	£3,061,839	£3,120,014

The Services that are NHS commissioned services are

- Intermediate Care Team including Rapid Response
- Community Inter-disciplinary teams including Nurses, Occupational and Physiotherapists
- Recovery/ Intermediate Care beds
- GP clinical assessment of Recovery bed patients
- Preventative interventions
- Assistive Technologies

The schedule sets out detailed funding for services. It is being revised for the 2017/18 s75 Agreement

BCF s 75 Agreement 2016 17 Schedule for

Planning Requirement 4 KLoE 8

No Contingency fund has been developed. Monthly monitoring of Pooled Budget expenditure is ongoing. Analysis to determine reasons for significant under- or over-spends takes place routinely. Remedial actions are identified where necessary.

The CCG has a non-recurrent Contingency Reserve to respond to costs pressures related to any increased costs from NEL activity or costs

Planning Requirement 4 KLoE 10

National Condition 4: Managing Transfers of Care

Managing Transfers of care addresses the High Impact Changes (HIC) Self-Assessment and delayed transfers of care for the locality and whole Shropshire economy.

HIC self-assessment was completed locally and then across the economy to areas for development and agree both local and economy-wide actions. Areas identified locally were:

- No early discharge planning in community of elective admissions
- Red/ Green Days in place – based on achieved identified action rather than focus on achieving EDD. 10-20% of complex discharges in line with EDD
- Tracking of simple and complex discharges and reporting to ED Delivery Board
- Levels of high escalation predictable through the week eg Tuesday/ Wednesday at Internal L4 even with capacity increases
- Council commissioned 5 care packages / day to support P1 discharge within 48. hours of MFFD. Additional spot purchasing of beds in place
- Discharge Hub in place to support complex discharges Community Matron and SW support discharge planning. MDT/Board round does not include community or voluntary services routinely.
- TICAT includes Care Navigator and Assisted Discharge. BRC report under-utilisation of referral from SaTH
- CHC assessments routinely take place outside the hospital
- Home First promoted across the acute hospital. FFA promoting Home First. Therapy review of patients at days 1,4 and 11 to ensure enablement is maximized post discharge.
- Developed Pathway 4 process (Outlier beds) to support rehabilitation/ reablement of those who would previously been placed in permanent care. Targets being achieved
- Rapid Response 7 days 8am -10pm and out of hours Domiciliary care in place
- Workforce contraints delay acute hospital implementation of 7 day working
- Established Clinical Hub established and Trusted Assessor in place across SaTH but still under-developed. Ratio of P1:2:3 (currently 48:25:27).
- Community Teams (OT/ physio) accept assessments of SATH disciplines
- Care providers assess patients before accepting which causes delays in transfer
- Need to develop a Choice protocol
- Care homes support variable from GPs.
- 11% of emergency admissions from care homes.
- Established training programme of skills development for care home staff but variable quality remains

Local actions included:

- Develop robust validation of DTOCs
- Develop robust monitoring on mental health related DToCs
- Review of Trusted Assessor process and provide support and training
- Review of FFA documentation to support discharge notification
- Use of iBCF monies for social work and therapists to deliver 7 day working within the Intermediate Care Team
- Use of iBCF monies for social work and therapists to deliver 7 day working within the Neighbourhood Care Team
- Commission domiciliary care to commence new care over 7 days for admission avoidance and discharge from hospital
- Additional Brokerage capacity to support 7 day Brokerage Home MDT to support admission avoidance over 7 days

- Develop the Frailty team within the acute hospital over 7 days to support early discharge; reduced length of stay and improve flow
- Deliver the commissioned Care Home MDT – to commence from December 2017

All local actions have been included with the economy-wide The HIC and DTOC action plan. Actions and timescales for action are included in line with the STP 30/60/90 day timescales. This is monitored through the economy-wide DTOC working group. It reports to the A&E Delivery Board:

Change 1: Early Discharge Planning

Outcome 1 - Early discharge planning – non elective admissions

- Identify level of problem via joint Shropshire and T&W audit
- Develop systems for early discharge planning that connect to current hospital and community solutions
- Further strengthen plans for early identification of individuals with complex health and social care needs
- Recruitment of 2 year posts to support development of present systems and ensure they are embedded. Allowing development of services which are 'running hot'

Outcome 2 - Emergency admissions to hospital

- Develop system for discharge planning for emergency admissions will begin as early as possible (in A&E) and will understood by all those involved in the health and care of the patient
- Working across 7 days in all systems, health. Social care and external provision

Outcome 3 – Monitoring delayed discharge

- Monitoring performance across all providers

Change 2: Systems to monitor patient flow

Outcome 1 – SaTH Internal Demand and Capacity development

2.1.1 Needs analysis re internal capacity

2.1.2 Reducing length of stay in the acute and community hospitals including block and spot purchased discharge beds

2.1.3 Consistent management, reporting and agreement of DTOC

Outcome 2 – External demand flow

- Clarity required over time line for Future Fit reconfiguration and link to community services, and other transformation programmes. This must include all information and links to community are robust, eg all equipment, clothing, shoes are available for transfer
- Discharge from Community Beds before midday
- Ensuring that Pathway identification in the acute is robust and supported with evidence that is based on professional judgement and risk assessed on sound knowledge.
- Ensure all provision in community is suitable and focussed on continued support in the right place, at the right time. The provision will be available to support admission avoidance and transfer from hospital

Outcome 3 – Draw together independent pieces of work on patient flow to provide needs analysis

- Needs analysis to include - safer bundle and red to green work taking this forward – capacity and demand modelling
- Models Understanding analysis of post hospital discharge. Best practice and research of post hospital recovery period and how this is managed

Outcome 4 – IBCF

- IBCF funded teams will introduce Let's Talk Local sessions and social workers on wards to aid with discharge, assessment and reablement planning
- Identification of best use of existing staff as resource.

Change 3: Multi-disciplinary admission avoidance /multi – agency discharge teams

Outcome 1 – Integrated Discharge hub

- Clarify the scope and function of an integrated hub and clarify how it can link into or reconfigure what we already have – ICS (Shropshire) ICT (Telford),
- Link multidisciplinary teams to community services transformation and admission avoidance and readmission avoidance

Outcome 2 - VCS - T&W needs to further develop VCS role in discharge teams

- T&W Develop improved contracting and working relationships with the VCS

Outcome 3 - Develop understanding of long delays in relation to CHC decision making

- Audit - why do some take as long as they do? Is it possible to shorten the time it takes for a decision? – could be a placement issue
- Reduce CHC decision making time for complex cases

Outcome 4 - Admission Avoidance and Discharge teams are linked with care navigators/ community care coordinators

- Develop system Community care coordination/ care navigators that provide links to social prescribing, voluntary and community sector, social care

Change 4: Home first/Discharge to Access

Outcome 1 – 48 hour target

- Improve performance against 48 hours discharge following FFA – enhance and develop the trusted assessor – connect up with demand and capacity modelling from WG
- Further key actions see sections

Outcome 2 – Trusted Assessor work with SPIC

- Develop trusted assessor role for all care homes

Change 5: Seven-day service

Outcome 1 – Workforce and service design – link to ADMISSIONS AVOIDANCE 90 day plan – see this plan for timescales

- Long term service redesign to deliver improvements – for 7 day working – for admissions avoidance and discharge – whole system response needed – links to work in SATH – safer bundle/ red to green
- ICS – service specification and contract – currently being reviewed to ensure 7 day working for Admissions avoidance and discharge – link to SaTH internal workforce plan moving to 7 day working – workforce issues remain barrier IBCF have identified monies to support 7 day working

Outcome 2 – Contracting

- Contracting - all contracts will be reviewed for assessment and starting care at the weekend– IBCF initiatives

Change 5: Trusted Assessors

Outcome 1 –Implement competency based Trusted Assessor approach

- Trusted assessor approach for pathways 1, 2 and 3 embedded in practice including integrated MDT working (Integrated Discharge Team) flexible working across all organisations to include some rotational posts especially in therapies

Outcome 2 – Brokerage

- Care providers and Brokerage function to operate across a 7 days and holiday periods to smooth flow of discharge throughout the year a week to increase weekend assessments NS discharges

Change 7: Focused on Choice

Outcome 1 – Workforce

- Workforce development – we have the tools but how do we deliver it to patients? Proactive discharge – red to green and trusted assessor will help
  - communication
  - developing the workforce
  - ward rounds,

Outcome 2 – Communication

- Developing good communication practices between organisation and with patients/ service users – connected to neighbourhoods and care navigator role

Outcome 3 – Develop Protocol

- Community Trust Protocol development needed – next level of proactive response needed- as per above - promoting choice policy

Change 8: Enhancing Health in Care Homes

Outcome 1 - Developing consistent and coordinated primary and community care

- Audit -– enhanced clinical input established but there is variation – audit of care home initiatives needed
- Shropshire – commissioner led plan

Outcome 2 - Care home planning as part of wider system plan

- Systematically linking care homes into wider system planning

Outcome 3 – Trusted assessor model for care homes


HIC and DToC Action Plan for BCF submissic


Enc 3 -8 high impact joint action plan.docx

Planning Requirement 5. KLoE 11 KLoE 12. KLoE 13

Overview of funding contributions

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

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

The Pooled Budget for 2016/17 was £14,252,675.

Organisation	**Contribution**
Council	£2,261,691
CCG	£11,990,984

The pooled budget for 2017/19 has been identified below. There is national requirement for increases to the minimum contribution in line with inflation; increases in the Disabled Facilities Grant and the iBCF monies. The values indicated are in line with national requirements:

	2017/18	**2018/19**
Council excluding iBCF	£2,428,199	£2,589,807
iBCF monies	£4,019,858	£5,487,290
Minimum CCG contribution	£10,774,611	£10,979,329
Additional CCG contribution	£861,290	£877,394
TOTAL	£18,083,958	£19,933,820

Planning Requirement 10/ KLoE 24

The funding within the profile of Pooled Budget relates to the key areas of work is set out below across the three years:

Summary Statement	2016/17 Annual Budget £	2017/18 Annual Budget £	2018/19 Annual Budget £
Intermediate Care			
Rehabilitation and Enablement	897,547	1,849,267	1,884,218
Domiciliary Care	664,057	772,279	786,875
Rehabilitation and Enablement Beds	973,288	596,164	607,981
Preventative Services	170,859	0	0
Shropshire Community Healthcare Trust	1,596,973	1,625,558	1,656,281
Shrewsbury and Telford Hospital Trust	1,655,069	1,684,695	1,716,536
LA Beds	46,607	0	0
Total Intermediate Care	**6,004,400**	**6,527,963**	**6,651,892**
Community Resilience			
Preventative Services	446,549	267,907	272,970
Carers	521,172	530,500	540,526
LA Grants	315,600	321,249	327,321
Total Community Resilience	**1,283,321**	**1,119,656**	**1,140,817**
Telford Neighbourhood Care			
Rehabilitation and Enablement	597,501	0	0
Assistive Technologies	493,595	503,103	512,612
Preventative Services	844,320	438,783	447,076
Shropshire Community Healthcare Trust	1,596,974	1,853,963	1,889,357
Total Telford Neighbourhood Care	**3,532,390**	**2,795,849**	**2,849,044**
Other Care			
iBCF	0	4,019,859	5,487,290
Maintaining Eligibility for Clients with LTC	878,000	893,716	910,607
Management Charges	56,395	57,404	58,489
Programme Management	477,857	486,410	495,603
Care Act Implementation	445,000	453,418	461,988
Disabled Facilities	1,575,312	1,729,682	1,878,089
Total Other Care	**3,432,564**	**7,640,489**	**9,292,066**
Grand Total:	**14,252,675**	**18,083,957**	**19,933,819**

The summary above indicates the level of funding as use. These are specifically set out in line with requirements:

- Implementation of Care Act duties
- Funding for Reablement
- Disabled Facilities Grant. The Council is a Unitary Aut
- How contributions to social care are utilised
- How NHS commissioned out of hospital services are utilised

BCF s 75 Agreement 2016 17 Schedule for

The schedule above details the use of monies for all programme areas. It is being revised for 2017/18 within the s75 Agreement

Planning Requirement 10 KLoE 24, KLoE 25 KLOE 26

The Council is a Unitary Authority so DFG monies do not pass to other Districts

Planning Requirement 2 KLoE 3

Utilisation of the monies including iBCF monies has been agreed through the BCF Finance meeting and Joint Strategic Commissioning Group.

Providers have also agreed use of the monies. BCF developments are within the NHS Contracts for the Shrewsbury and Telford Hospitals NHS Trust and Shropshire Community NHS Trust through

- Intermediate Care service specifications
- Service Development Improvement Plans for Integrated Care and Neighbourhood working
- National CQUIN for Shropshire Community NHS Trust related Discharge to Assess

Planning Requirement 10/ KLoE 24, KLoE 25

Utilisation of the iBCF monies has been agreed between the CCG and Council and agreed usage is being implemented. The areas of usage are in line with purposes set out within the Grant determination – supporting Social Services capacity and focusing on HICs. There is a specific focus on delayed transfers of care. The areas for utilisation are set out below; the formal Council report is included. Use of iBCF monies are being presented to Councils Cabinet on 21st September 2017.

	Delivery against High Impact Changes
Adult Social Services capacity to protect social care services.	
Additional Brokerage , Procurement and Commissioning capacity to support implementation of out of hospital activities	
Community Resilience re-design	HIC 3 and HIC 7
Trusted Assessor	HIC 6, HIC 1 and HIC 4
Additional Social Work and Occupational Therapy capacity to deliver the Intermediate Care Team over 7 days – supporting early discharge and reducing delayed transfers	HIC 3, HIC 1, HIC 5, HIC 4
Additional Social Work and Occupational Therapy capacity to support delivery the Neighbourhood working 7 days – supporting preventative interventions, Assistive Technologies early interventions within an integration function	HIC 3 and HIC 5

High Impact Changes
Change 1 – Early discharge planning
Change 2 – Systems to monitor patient flow
Change 3 – Multi-disciplinary/multi-agency discharge teams
Change 4 – Home first/discharge to access
Change 5 – Seven-day service

Change 6 – Trusted assessors
Change 7 – Focus on choice
Change 8 – Enhancing health in care homes

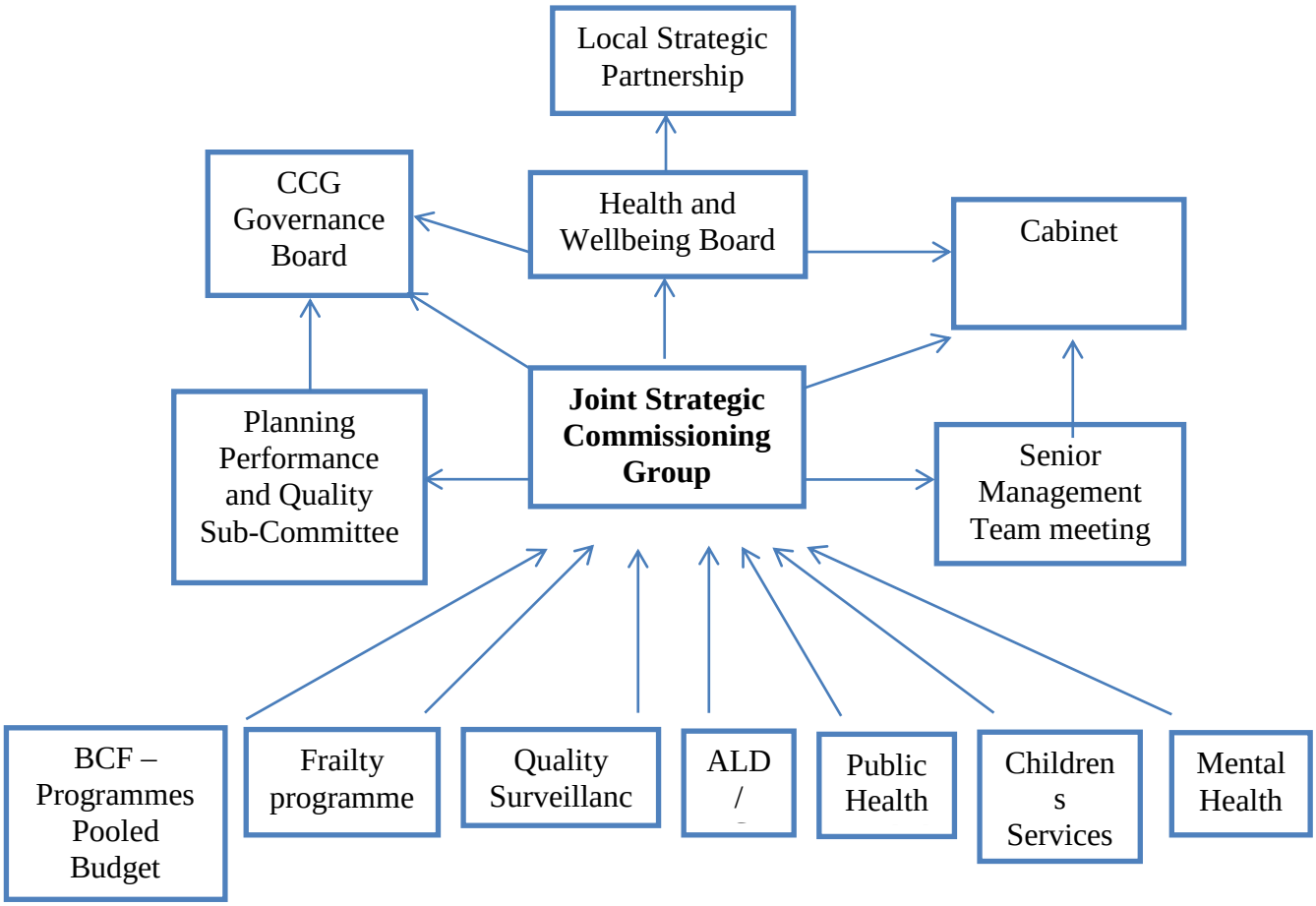
Planning Requirement 10/ KLoE 26 KLoE 27

Programme Governance

JCG ToR v8.docx

Programme Governance is through the Better Care Fund Pooled Budget Monitoring Working (Finance meeting), reporting the Joint Strategic Commissioning Group (JSCG) that reports to the HWB Board

The JSCG diagrammatical representation below also highlights the Council and CCGs reporting and accountabilities within their respective organisations



Direct oversight of the BCF process is though the BCF Pooled Budget Finance meeting. It focuses on Programmes, Performance and Finance meeting.

Better Care Fund
BCF Finance meeting
Terms of Reference

Purpose and scope

The Pooled Budget Finance meeting will provide scrutiny and assurance to the Joint Strategic Commissioning Group and Health and Well-Being Board on the development and expenditure of the section 75 agreement (known as Pooled Budget) in relation to the Better Care Fund and performance of the BCF related programmes and metrics

Background of the Pooled Budget Finance meeting
The Health and Social Care Act, 2012 set out expectations around greater integration of health and social care services to provide more effective pathways and better outcomes and value for patients/service users. DH guidance suggested a step change in current arrangements to share information, share staff, share money and share risk.

The BCF will be allocated to local areas where monies will be put into a pooled budget. Specific monies are required to be included within the Pooled Budget where the use of the overall fund will be jointly agreed:

The Pooled Budget Finance meeting is a formal joint arrangement set up in pursuant to regulation 10(2) of the section 75 Regulations with delegated authority from the Parties to take decisions. Each Party agrees that it has amended its Scheme of Delegation to allow for delegation to the meeting.

Objectives of the Pooled Budget Finance meeting
The meeting will agree, monitor and evaluate the implementation of pooled budget monies in the following ways:

- Determine the use of money within the Pooled Fund
- Agree levels of increases and/ or reduction in spend in any area(s) leading to:
    - Efficiencies (shared between the two parties based on contribution of where the funding originates from)
    - Investment in the new approaches to better care stated objectives and outcome through agreed (to be developed) approaches
    - Will this be based on Business cases submitted; led by partner who holds monies; bidding process?
- Monitor the performance of the BCF metrics
- Monitor the performance and delivery of the BCF programmes
- Provide monthly report on the Budget in the form of agreed detailed financial breakdowns
- Consider action in regard to any overspends or underspends and report on such to the Partners
- Undertake reviews of the BCF programme
- Identify risk to the BCF programme and highlight to the Joint Strategic Commissioning Group and respective organisations
- Produce reports to the Joint Strategic Commissioning Group and Health and Well-being Board
- Consider disputes referred to it in the first instance pursuant to Clause 13.2

Membership
Deputy Executive Lead for Commissioning T&W CCG (Chair)
Assistant Director Governance, Procurement & Commissioning T&W Council
Head of Commissioning: Better Care Fund/ Care Closer to Home Care T&W CCG
Finance representative(s) on behalf of the Chief Finance Officer T&W CCG
Service Delivery Manager Finance T&W Council

Service Delivery Manager Governance, Procurement & Commissioning T&W Council
Business Information Analyst Commissioning Support Unit
Business Information Analyst Commissioning T&W Council

If a member of the Finance meeting is unavailable to attend a meeting, they may send an alternative representative to contribute to the quorum and shall be entitled to vote, where necessary.

Other representation will be by invitation

Quoracy
The Work-stream will be considered quorate when 6 members are in attendance – 3 representatives from each organisation.

The Quorum should be made up of an equal number of Council and CGG members.

Decision- making
Decisions in relation to the use, under-spend or over-spend will be agreed by the following process:

- **Is this a decision-making, recommending or reporting group?**
- **Who makes decisions on spending?**
- **What delegated limits?**

Reporting and Accountability
The Pooled Budget Finance meeting will provide a monthly report to the Joint Strategic Commissioning group.

Formal reporting from the Joint Strategic Commissioning group to Health and Well-Being Board, Council Senior Managers meeting and CCG Governance Board are in place to receive regular reports. Each organisation will have its own organisational reporting, governance and reporting systems

Frequency of meetings
The meetings will be held on a monthly basis

Review
End of September
Planning Requirement 8/ KLoE 18
Monthly reporting included monitoring of performance metrics (below)

BCF performance position 2017/18 Month 3/4		
Metric	**Performance comments**	**RAG Fore cast**
Reduction in non-elective admissions	Target for 2017/18 is 18,896. Month 4 actual was 6361 against plan of 6250 (+111/ + 1.74%). Pressures driven by increased 0-16 years admissions by 10% against last year; 75+ years 5% increased admissions against last year, increased 3+ day LOS across all age groups (9% increase against last year) HRGs driving the increases are sepsis, pneumonias, UTIs, heart failure . Cost are over plan by £751,385 (+6.3%)	Amber
DToCs	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). The annual target of DToC days is 3285 days. Month 12 shows 3318 days (32 days over target). M12 shows a reduction against last year of 205 days. At end of June 9.8 delay days per day (CCG attributable 5.5/ Council 2.5/ Joint 1.9) against target from September of 9.6 (CCG 4.4/ Council 2.5/ Joint 1.9). NHS attributable pressure mainly due to mental health patients awaiting Specialised Commissioning / secure placements from ICU. Joint delays relate to P2 and 3 bed flow. A Joint Action Plan is in place to achieve mandated 2017/18 targets.	Amber
Local measure – reductions in 70+ admissions	The target identified within the QIPP plan is a reduction from implementation of Intermediate Care Team programme of reducing 70+ admissions by 272 spells against identified HRGs Key programmes to support achieving the target are further development of the Intermediate Care Team, Frailty programme, Commissioned Care Home MDT and Neighbourhood working.	Amber
Rate of permanent admissions to care homes	Rate of permanent admissions to residential care per 100,000 population (65+) The target for 2016/17 is 540.6/100,000 (155 people). The final position is current position is 383.4/100,000 (104 People). This is good performance against year and national average of 628.2/ 100,000. Target for 2017/18 is 356.5/ 100,000 (105 people). Performance to June was 20 people. Performance at Q1 in 2016/17 was 18 people.	Amber
Rehabilitation	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services The target proportion maintained at home in 2017/18 is 80% - below last years national outturns but will demonstrate continued improvement at a local level and an increase of 9 percentage points from 2016/17 Performance up to June is 76.7%.	Amber

Assessment of Risk and Risk Management

Refer to risk section above

National Metrics

Metric for non-elective admissions

The metric for non-elective admissions is set out below:

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
HWB Non-Elective Admission Plan* Totals	4,673	4,664	4,822	4,827	4,696	4,687	4,847	4,852	18,986	19,082

The target for 2017/18 is 18,986 admissions. It has been set after analysing:

- Reviewed contracted PbR emergency admission outturn for 16/17
- Added growth at 3.2%
- Considered impact of the initial implementation of the Intermediate Care Team reducing admissions for 70+ years (-86 against a target of -352)
- Assumed a further reduction from implementation of Intermediate Care Team programme of reducing 70+ admissions by 272 spells
- Potential impact of additional planned developments including Neighbourhood working and Frailty programme

Detailed analysis of likely impact and trajectories of BCF programmes (set out above in BCF Plan). This work has supported the current target.

Any future changes will be agreed through usual contracting process after agreement with provider orgnisations. These will be based on the impact of implemented programmes or work
Planning requirement 11 KLoE 28. KLoE Planning requirement 12 KLoE 30

No further reductions in addition to the CCG Operating target have been identified. No metric has been set
Planning requirement 11 KLoE 29 Planning Requirement 4 KLoE 9

Metric for reducing permanent admissions to residential care

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	460.3	540.6	353.1	331.9
	Numerator	129	155	104	100
	Denominator	28,025	28,673	29,456	30,129

National average performance is c628 per 100,000 population. The local plan for 2016/ 17 was 560.6 per 100,000. Actual performance was equivalent to 104 people (382.4 per 100,000 population)

Planning targets has taken into account of local performance last year and high achieving against national baselines. In addition, with the increasing population locally, maintaining at c105 people per year would be an improvement in performance. Achieving planned targets for the next two years will be challenging. Specific areas of the BCF Plan will support achievement of this target:

- DFG
- Community Resilience
- Neighbourhood working
- Integrated Team working including Frailty
- Transfers of Care including the HIC/ DToC action plan

Actions to support are include within the combined HIC and DTOC action plan
Planning requirement 13 KLoE 31

Metric for the number of people still at home 91 days after discharge from hospital

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	57.4%	70.0%	80.0%	83.0%
	Numerator	58	70	80	83
	Denominator	101	100	100	100

The target proportion maintained at home in 2017/18 is 80% - below last years national outturns but will demonstrate continued improvement at a local level and an increase of 9 percentage points from 2016/17. This approximates to the equivalent of 80 out of 100 people still at home 91 days after Enablement interventions

The target for 18/19 will be 83%. This will take the locally in line with current national performance.

This will be achieved through maintaining the approach that the majority of individuals discharged from hospital within our Discharge to Assess pathways, will received a rehabilitation assessment using an outcome based plan.

Actions to support are include within the combined HIC and DTOC action plan
Planning Requirement 14 KLoE 32

Delayed transfers of care

The DTOC metric is fully in line with the expected reductions in DToC for social care, NHS and jointly attributed reductions for the HWB area set out in the DTOC template:

Metric	Total	CCG attributable	Council attributable	Jointly attributable
Total days delays per day	9.6	4.4	3.5	1.7
Total days delays per day per 100,000	7.2	3.3	2.6	1.3

DToC Action planning is to ensure DToC performance is achieved and maintained from Q2. This will ensure achieving the national requirement of reductions from September 2017. Detailed monthly performance monitoring is in place (below). This includes DTOC by provider and trend analysis.

DToC Calculation for Telford - Revised in consultation with NHSE Head of Assurance

CCG	CCG Target, Sept 17 NHS-attributable DTOCs	Indicative LA Expectation	Joint DToC	TOTAL	Population Q1- Q3	Population Q4
Telford CCG	4.4	3.5	1.7	9.6	132,713	133,453
Shropshire CCG	8.3	6.6	7.6	22.5	254,742	256,126

Telford and Wrekin	July	August	September	October	November	December	January	February	March
NHS Element T&W	132.2	132.2	127.9	132.2	127.9	132.2	132.2	119.4	132.2
NHS Element Shrops/Telford	4.5	4.5	4.3	4.5	4.3	4.5	4.5	4.1	4.5
LA Expectation	107.7	107.7	104.2	107.7	104.20	107.7	107.7	97.3	107.7
Joint	53.1	53.1	51.4	53.1	51.4	53.1	53.1	48.0	53.1
TOTAL DELAYED DAYS PER MONTH TARGET	297.5	297.5	287.9	297.5	287.9	297.5	297.5	268.7	297.5
Template									
Population Projection	132713	132713	132713	132713	132713	132713	133453	133453	133453
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	224.1	224.1	216.9	224.1	216.9	224.1	222.9	201.3	222.9
Average delays per day per month	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6

9.85 delays per day on initial submission. Have adjusted Telford CCG

Telford and Wrekin	July	August	September	October	November
NHS Element T&W	132.2	132.2	127.9	132.2	127.9
NHS Element Shrops/Telford	4.5	4.5	4.3	4.5	4.3
LA Expectation	108.5	108.5	105.0	108.5	105.0
Joint	53.1	53.1	51.4	53.1	51.4
TOTAL DELAYED DAYS PER MONTH TARGET	298.3	298.3	288.7	298.3	288.7

Planning Requirement 15/ KLoE 33. KLoE 34, KLoE 35, KLoE 38

Metrics and monitoring processes have been agreed by all stakeholders. DToC performance is monitored through the BCF Finance meeting as part of monthly performance.

A Shropshire economy-wide DTOC Working group (Telford and Wrekin and Shropshire CCG and Council and all provider organisations) focuses on DToC and functions that supports achieving it. These include completion of the High Impact Changes self-assessments (HIC); development of Trusted Assessor processes and DTOC performance. All stakeholders are engaged in the development, implementation and monitoring of DToC

The economy-wide A&E Delivery Board has formal monthly reporting from the DToC Working group of actions to achieve DToC performance. DTOC one of the Top 3 priorities. The HIC and DToC action plan is structured to complete actions within 30, 60 and 90 days in line with SAED and STP requirements to support winter planning

LGA High Impact Change model baselin

SAED Presentation 25 July 17_ Final.pptx

Planning Requirement 15/ KLoE 37

Completion of the HIC has provided evidence and a clear rationale for changes within the combined HIC and DToC action plan. The areas for local development were highlighted in National Condition 4: Managing Transfers of Care

Planning Requirement 15/ KLoE 35

Planning Requirement 5. KLoE 11 KLoE 12. KLoE 13

HIC Action Plan for BCF submission v2.dc

Planning Requirement 15 KLoE 33 KLoE 34 KLoE 36 KLoE 37

2018/19 Trajectory

2018/19											
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
127.6	131.9	127.6	131.9	131.9	127.6	131.9	127.6	131.9	131.9	119.1	131.9
4.3	4.5	4.3	4.5	4.5	4.3	4.5	4.3	4.5	4.5	4.1	4.5
104.2	107.7	104.2	107.7	107.7	104.2	107.7	104.2	107.7	107.7	97.3	107.7
51.4	53.1	51.4	53.1	53.1	51.4	53.1	51.4	53.1	53.1	48.0	53.1
287.6	297.2	287.6	297.2	297.2	287.6	297.2	287.6	297.2	297.2	268.4	297.2
133453	133453	133453	133453	133453	133453	133453	133453	133453	134193	134193	134193
215.5	222.7	215.5	222.7	222.7	215.5	222.7	215.5	222.7	221.4	200.0	221.4
9.59	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6	9.6
		872			882			882			863

2018/19 target is based on

- The same trajectory as 2017/18
- An additional day reduction each month
- Increase in the patient population in Q4 of 20181/9

Approval and sign off

Provide confirmation of who has signed up to the BCF plan
Provide the date of Health and Wellbeing agreement (for the second submission of plan)

Signed on behalf of the Telford and Wrekin Health and Wellbeing Board

Arnold England Chair of Health and Wellbeing Board
Date:

Signed on behalf of Telford and Wrekin Council

Clive Jones Director
Date:

Signed on behalf of Telford and Wrekin Clinical Commissioning Group

David Evans Chief Officer
Date: 11/9/17
Planning Requirement 1/ KLoE 1

Report prepared by:

- **Michael Bennett - Head of Commissioning: Better Care Fund/ Care Closer to Home Telford and Wrekin CCG**
- **Jonathan Eatough – Assistant Director – Governance, Procurement & Commissioning**
- **Legal Review - Kirsty Fisher -Telford and Wrekin Council**
- **Finance Review-Tracey Smart - Finance Manager- Telford and Wrekin Council**