

TELFORD & WREKIN COUNCIL

HEALTH AND WELLBEING BOARD – 12TH FEBRUARY 2014

BETTER CARE FUND HEALTH & SOCIAL CARE INTEGRATION

REPORT OF THE INTERIM DIRECTOR OF HEALTH, WELLBEING & CARE (TELFORD AND WREKIN COUNCIL) AND THE CHIEF OPERATING OFFICER (TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP (CCG))

LEAD CABINET MEMBER CLLR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

- 1.1 This report sets out the requirements placed upon the Council and CCG to move towards the integration of health and social care services, with particular reference to the requirements to have a Better Care Fund (BCF) agreed and in place by April 2015.
- 1.2 This report also sets out the proposed integration vision, principles and funding that need to be developed and agreed, to allow relevant budgets to be freed up during 2014/15 for inclusion in the Better Care Fund and an initial planning template has to be submitted by 14 February 2014, signed off by the Council, CCG and Health and Wellbeing Board.

2. RECOMMENDATIONS

- 2.1 The Health and Wellbeing Board note requirements to put in place a Better Care Fund.
- 2.2 The Health and Wellbeing Board approves the draft BCF plan for submission to NHS England on 14th February and delegates power to the Chair of the Health & Wellbeing Board in consultation with The Chief Operating Officer to approve the final BCF plan.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Co-operative Council priorities?	
	Yes	Vulnerable Children & Adults Health and Wellbeing
	Will the proposals impact on specific groups of people?	
	Yes	Will impact on people who are ill or disabled, who need support and on their family carers.
TARGET COMPLETION	From April 2014	

<p>/DELIVERY DATE</p> <p>FINANCIAL/VALUE FOR MONEY IMPACT</p>	<p>Yes</p>	<p>The Government have identified £3.8bn nationally in 2015/16 for the Better Care Fund (BCF). This includes the continuation of the £200m of additional national funding in 2014/15 to assist local authorities in the implementation of the BCF. The Council's share of this is £645k.</p> <p>In 2015/16 the BCF will be created from £1.9bn NHS funding and £1.9bn based on existing funding in 2014/15. The Government have stated that nationally £135m of the BCF is available to resource the implications of the Care Bill, additional Carer's assessments and the Adult Safeguarding Board. This will need to be reflected in the Plan but will potentially require a reallocation of funding to allow the Council to meet these requirements.</p> <p>In 2015/16 the Telford & Wrekin Better Care Fund (T&W BCF) minimum allocation by Government is £11.690m of which £10.410m is revenue. The Fund also includes capital funding - Disabled Facilities Grant (£849K) and the Social Care Capital Grant (£431k). The financial template included within the report sets out the proposed value of the T&W BCF for the next two financial years. This demonstrates a significant variation to the minimum allocation to an overall total of £16.674m. It should be noted that this amount of funding is dependant on the CCG and the Council working together through the BCF to ensure a shift of resources from Acute, Emergency and Inpatient Care to the community Further work is planned to review current spending on the voluntary sector and a value still to be determined will then be added to the BCF.</p> <p>The financial template to be completed not only requires the costs of the individual schemes to be identified but also indicates an expectation of financial benefits arising. Until the more detailed work is carried out on the plan a monetary value cannot be identified but the areas from which these savings will arise are identified within the Better Care Fund planning template – Part 1</p> <p>£1bn of the £3.8bn will be performance related - linked to achieving outcomes. Further clarification of the implications of failing to satisfy performance requirements is needed before any financial implications can be fully assessed. This funding will be retained by the Department of Health and</p>
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		<p>released in staged payments according to our performance as measured against the BCF plan. The Telford & Wrekin performance related funding will be approximately £2m. The template requires the identification of funding required for contingency if targets are not achieved. It is not possible to identify figures at this stage before further detailed work is completed on the overall plan. The significant shifting of resources from one sector to another will potentially carry significant risks for both the CCG and the Council if the planned outcomes are not achieved in terms of the additional costs that may arise for all organisations.</p> <p>As the pooled budget consists of funding already committed and does not include any new funding the requirements of the fund may well exceed the existing budget arrangements. The full financial implications of the BCF will need to be fully assessed as work towards implementation progresses.</p> <p>The Council is undertaking a significant transformation program in Adult Social Care which the BCF plan will complement. The Council and CCG, however, must also consider their own budget strategies and the need for significant savings delivery when considering the content and implementation of this plan.</p> <p>More detailed financial information is contained within the body of the report.</p>
LEGAL ISSUES	Yes	<p>The NHS England planning guidance (attached at Appendix 2) sets out the recommended process and format for developing a plan for the Better Care Fund. If the guidance is not followed at any point there needs to be a justifiable reason for doing so as this may jeopardise the award of funding (as outlined in the guidance).</p> <p>There will be standards for the plan which are national requirements. However, there will also be the Council's and CCG's own requirements which should be in place to ensure good governance, effective contract management and the protection of sensitive data. Further, if the plan results in any possible changes to existing service provision to people, consideration needs to be given as to whether further equalities impact and consultation work needs to be undertaken.</p>

		<p>The new integration provisions will bring significant changes to the commissioning of some Council and Clinical Commissioning Group (CCG) services. As the plan moves from being a strategic to a more operational process, officers will identify specific areas where changes to existing commissioning processes will be needed to incorporate the integration required.</p> <p>If the changes effect the Council's and CCG's commissioning plans it may require separate reports elsewhere such as Cabinet and CCG Governance Board. For example, changes to existing delegated powers may need to be made to undertake the new joint commissioning. There is reference to the potential legislative changes proposed in the Care Bill which, if implemented, will need to be complied with as part of this process. This will be monitored by officers.</p> <p>On 10 January 2014, the Department of Health published Factsheet 19 on the Care Bill. The factsheet explains how the Bill will facilitate the creation of the Better Care Fund, by providing a mechanism that will allow the sharing of NHS funding with local authorities to be made mandatory</p> <p>CCGs will make use of their powers under Section 75(2) of the National Health Service Act 2006 to set up pooled budgets with local authorities under written agreement. Money invested in a pooled budget can only be spent with the agreement of both parties on activities that benefit both health and social care.</p>
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	<p>The timeframe for submitting a draft plan by 14th February 2014 is challenging, and will require a rapid joint effort by the Council and CCG.</p> <p>The existing information governance data sharing challenges in the NHS, caused by the introduction of the Health and Social Care Act 2012, may delay implementation of data sharing to support the integration of health and social care.</p>
IMPACT ON SPECIFIC WARDS	No	

PART B) – ADDITIONAL INFORMATION

4. **INFORMATION**

- 4.1 As previously communicated, 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. The spending review at the end of June 2013 set out the requirement to set up an Integration Transformation Fund, renamed the Better Care Fund (BCF) by April 2015, with at least a minimum value of CCG and Council monies included in the ITF. The national value of this funding in 2015/16 is £3.8bn and it includes the continuation of the national 2014/15 NHS transfer to local authorities. The spending review announced an increase to this transfer in 2014/15 by £200m to help local authorities prepare for the implementation of the BCF and make early progress on priorities.
- 4.2 On 17th October, NHS England and the Local Government Association jointly released a letter titled “Next Steps on implementing the ITF”. There is an expectation that Health and Wellbeing Boards will oversee the development of a shared plan for the totality of health and social care activity within their area and that over time the level of total funding the CCG and LA will commit into the BCF will increase. The letter suggests that a fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. A further letter and guidance together with a final template was received on 20th December 2013. See Appendix 1 and 2.
- 4.3 The Council and CCG are required to put their share of £11.690m, identified as the minimum amount to be included, in the BCF. This money is not new money but there is an expectation the Council and CCG will agree to use the money to take forward a new shared approach to health and social care. The table below summarises the elements of the Spending Round Announcement on the Fund:

The June 2013 spending round set out the following:	
2014/15	2015/16
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements
In 2015/16 the fund will be created from:	
£1.9bn of NHS funding(some new funding included for new LA responsibilities in relation to Community Care)	
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise:	
<ul style="list-style-type: none"> • £130m Carers’ Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care (includes £200m transfer from the NHS to Social Care) 	

The local value of our proportion of the is set out in the table below:

Better Care Fund Proposal

	Expenditure			Expenditure			Expenditure		
	LA	CCG	Total	LA	CCG	Total	LA	CCG	Total
	£k13/14	£k13/14	£k13/14	£k14/15	£k14/15	£k14/15	£k15/16	£k15/16	£k15/16
Reablement & Prevention	3,953		3,953	4,731		4,731	206	4,525	4,731
Support for Carers	523		523	523		523	328	195	523
Bed based Intermediate care	327		327	327		327	50	277	327
Developing Integrated Community Enablement					3,000	3,000		5,413	5,413
To support the transformation of healthcare and the Council's Community Care functions.	2,800		2,800	3,800		3,800		4,400	4,400
Review of Voluntary Sector Services to build community capacity						TBD			TBD
Sub Total	7,603	0	7,603	9,381	3,000	12,381	584	14,810	15,394
ICT investment/Service transformation	430		430	431		431	431		431
Disabled facilities Grant	702		702	702		702	849		849
Total	8,735	0	8,735	10,514	3,000	13,514	1,864	14,810	16,674

4.4 The fund will be allocated to local areas where it will be put into a pooled budget under joint governance between the CCG and Council, with a condition that they must have a jointly agreed plan which meets certain requirements set nationally. There are 6 national conditions:

- Plans to be jointly agreed.
- Protection for social care services (not spending).
- 7 day services in health and social care to support patient discharge from hospital and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care based on the NHS number.
- Joint approach to assessments and care planning, funding used for integrated packages and a named accountable professional in all cases.
- Agreement on the consequential impact of changes in the acute sector.

The opportunity has been taken to enhance the contribution to this fund to support the transformation of some of the Council's Community Care Services. It needs to be recognised that the resources that the CCG are to invest in out of hospital care (circa £9.8m in 2015/16) will have implications on the acute care sector. There is also a potential risk to the Council's financial position if outcomes are not achieved and more complex needs have to be met by Social Care.

4.5 Elements of the BCF will be performance related amounting to £1 billion of the national £3.8 billion total. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

4.6 The CCG, Council and Health and Wellbeing Board will have to return the first cut of the completed Better Care Plan template by **14 February 2014**. The revised version of the BCF plan should be submitted to NHS England, as an integral part of the CCG's Strategic and Operational plans by **4 April 2014**. A detailed draft report has been developed with the CCG.

4.7 A task and finish group has been set up with nominated officers from both the CCG and Council to complete the planning template to meet the deadline set (see Appendix 3 for completed draft submission planning template part 1 and 2). Discussions continue between Officers of the CCG and Council to develop this plan for the integration of health and social care locally.

4.8 **Proposed Local Vision**

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

To achieve this we will work in partnership with our communities to commission and deliver high quality integrated health and care services. The service model must address the growing demand of an ageing population and people living with long term conditions.

The focus for the Better Care Fund is to transform public services for adults needing high levels of health or social care support, particularly frail older people.

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

- 1 Building Community Capacity (Prevention). To develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self help groups, and individuals in both 'patient' and 'caring' roles.
- 2 Enhanced community services as an alternative to hospital provision (Integration)To deliver a viable alternative to in-patient hospital care for people who can be cared for closer to home. We will build on our existing integrated community health and social care Enablement/Rehabilitation model by transferring capacity from the acute sector so that we offer a viable alternative community service rather than hospital bed based care.

The BCF will also be used to support adult social care services locally by helping the Council to protect Adult Social Services and make a “positive difference to social care services and outcomes for service users” linked to a “health benefit” , which otherwise would not be possible “in the absence of the funding transfer”.

4.9 Local Proposed Objectives for the BCF

It is proposed that we base our BCF plan on the existing joint and integrated work currently in place between the Council and CCG with the following objectives within each theme

Using Theme 1, we will pilot arrangements in 2014/15, seeking a minimum reduction of £400k in acute care costs to fund care in a community setting.

Theme 1: Building Community Capacity –prevention, self-help.self-care, support to carers and building community capital

1. To review current spend by both organisations on voluntary sector services to help improve understanding of how to improve the effectiveness of the sector
2. To support improvements in the infrastructure of the voluntary sector
3. To collaborate on commissioning a range of support services that can be delivered by voluntary and community organisations.
4. To work through a robust engagement process with self help organisations to clarify how best to strengthen them, and how to improve signposting for people to the help and support on offer
5. To expand engagement with communities to understand how best to extend volunteering, neighbour support schemes and generate community capital.

Theme 2: Enhanced community services – maximising independence through integration of out of hospital services

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

4.10 **Future scope of integration**

Whilst the Better Care Fund task and finish group are focusing on developing a plan that builds upon the integrated work currently in place particularly around adults – it recognises that the approach to commissioning and delivery being developed could be extended further in the future to encompass children and young people.

5. **IMPACT ASSESSMENT – ADDITIONAL INFORMATION**

n/a

6. **PREVIOUS MINUTES**

None.

7. **BACKGROUND PAPERS**

- 7.1 Letter inviting expression of interest for Health and Social Care Integration Pioneers - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198746/2013-05-13_Pioneers_Expression_of_Interest_FINAL.pdf
- 7.2 Health and Wellbeing Board report 13th November 2013 Health and Social Care Integration
- 7.3 Cabinet Report 12th December 2013 Health and Social Care Integration
- 7.4 CCG Board Report 14th December 2013
- 7.5 Cabinet Report 30th January 2014 Better Care Fund Health and Social Care Integration

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Department
of Health



Department for
Communities and
Local Government

Dear colleagues,

20 DEC 2013

Better Care Fund

The way we deliver health and social care services needs to change. One in three children born today expect to live to 100, so demand is only going to increase and we need to make major changes now to create seamless services fit for future generations, and to focus more effectively on preventing ill health and preventing a deterioration to health.

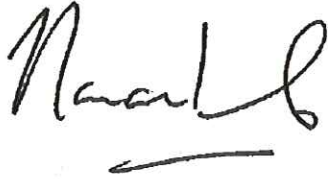
That is why, in June, we announced £3.8 billion worth of pooled budgets between health and social care, starting from April 2015. This will be a multi-year fund, as confirmed by the Autumn Statement, and is the biggest ever financial incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018.

Many places are already working collaboratively and redesigning services to meet the needs of users and communities, but we want to see faster and more widespread change. We have therefore provided an extra £200m in the pool for the transfer from health to social care in 2014/15 to streamline the process. This means that you should be well placed to take maximum advantage of the first full year of the fund in 2015/16. The £3.8 billion fund is the minimum amount to be pooled; some areas may wish to go further.

We call on every area to start planning now, with a view to having plans drafted by February 2014. We know the deadlines are tight – this is reflective of the urgency of this work. We need your plans to be innovative and ambitious – the end goal is radical transformation to provide better care.

We have come together in Whitehall so that you can work together at a local level. We need you to link your local plan to those wider determinants of health, and ensure housing and public health priorities and programmes support and enrich this work.

We are pleased to enclose full guidance and allocation information to enable you to make the most of the Better Care Fund.

A handwritten signature in black ink, appearing to read "Norman Lamb". The signature is fluid and cursive, with a horizontal line underneath the name.

NORMAN LAMB

A handwritten signature in black ink, appearing to read "Brandon Lewis". The signature is cursive and includes a long horizontal line extending to the right.

BRANDON LEWIS

Annex to the NHS England Planning Guidance

Developing Plans for the Better Care Fund
(formerly the Integration Transformation Fund)

What is the Better Care Fund?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.
2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.
3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care “pioneers” initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

What is included in the Better Care Fund and what does it cover?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.
5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	2015/16
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
<p>£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise:</p> <ul style="list-style-type: none"> • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.
7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance¹ from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:
8. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*
9. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*
10. *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*
11. *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

12. Councils should use the additional £200m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.
13. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement
14. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.
 - i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.
 - ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will be the statutory framework for the Fund?

15. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75² joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.
16. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.
17. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.
18. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local

² Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

19. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.
20. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.
21. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

How will local Fund allocations be determined?

22. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.
23. In 2014/15 the existing £900m s.256 transfer to councils for adult social care to benefit health, and the additional £200m, will continue to be distributed using the social care relative needs formula (RNF).
24. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.
25. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £200m will be transferred directly from NHS

England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

26. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

27. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the Fund?

28. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

29. Where the unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

30. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:

- aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
- assure that the national conditions have been achieved; and
- understand the performance goals and payment regimes that have been agreed in each area.

31. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is attached as a separate Word document and Excel spread sheet. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

32. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and

the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

33. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.
34. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

What are the National Conditions?

35. The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed	<p>The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups.</p> <p>In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.</p>

National Condition	Definition
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	<p>Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement.</p> <p>There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.</p>
Better data sharing between health and social care, based on the NHS number	<p>The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.</p> <p>Local areas should:</p> <ul style="list-style-type: none"> • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. <p>NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).</p>

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	<p>Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals.</p> <p>The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.</p>
Agreement on the consequential impact of changes in the acute sector	<p>Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in.</p> <p>Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.</p>

How will Councils and CCGs be rewarded for meeting goals?

36. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.
37. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.
38. The performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	Progress against four of the national conditions: <ul style="list-style-type: none"> • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: <ul style="list-style-type: none"> • delayed transfers of care; • avoidable emergency admissions; and
October 2015	£500m	Further progress against all of the national and local metrics.

National and Local Metrics

39. Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

40. The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

41. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

42. Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

43. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two of these metrics, on admissions to residential and care homes and the

effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential and care homes	N/A	Apr 2014 - Mar 2015
Effectiveness of reablement	N/A	Apr 2014 - Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan - Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient / service user experience	N/A	Details TBC

44. For the metric on patient / service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient / service user experience should be measured specifically for the purpose of the Fund.
45. In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.
46. A menu of possible local metrics selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life
Public Health Outcomes Framework	

1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as “inactive”
2.24i	Injuries due to falls in people aged 65 and over

47. Local areas must either select one of the metrics from this menu, or agree a local alternative. Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

48. Each metric will be of equal value for the payment for performance element of the Fund.

49. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

50. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

51. In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

How will plans be assured?

52. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

53. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.

54. The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

55. The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers. The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).
- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.
- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.
- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG, HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.
- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.
- Ministers will give the final sign-off to plans and the release of performance related funds.

What will be the consequences of failure to achieve improvement?

56. Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such

a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

57. If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.
58. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.
59. If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.
60. If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.
61. Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

Support for BCF Planning

62. CCGs and councils can access additional support for Better Care Fund planning from the same routes as for NHS operational and strategic plans: local support via CSUs or external providers, workshops and webinars, and specific tools and resources. Links to these, and contact details can be found on NHS England and the LGA's websites.

When should plans be submitted?

63. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by **14 February 2014**, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.
64. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Telford and Wrekin Council
Clinical Commissioning Groups	Telford and Wrekin Clinical Commissioning Group
Boundary Differences	Co-terminous boundaries
Date agreed at Health and Well-Being Board:	<dd/mm/yyyy>
Date submitted:	<dd/mm/yyyy>
Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

b) Authorisation and signoff

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

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

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

c) Service provider engagement

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

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

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

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

d) Patient, service user and public engagement

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

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

1. A range of joint strategies in place for several years, driven by a joint commissioning approach
2. Development of the Urgent Care Strategy where key patient messages and expectations of local services included:
 - Be joined up and responsible for my care
 - Help me understand my (urgent care) needs
 - Assess and treat me promptly and in the right place
 - Admit me to hospital only when necessary
 - Try to care for me at home, even when I am ill
3. A council led 'Thinking Ahead' project working group established to steer and coordinate the health and social care review of the Rehabilitation and Re-ablement Strategy.
4. 'Optimising capacity' - a work stream led by a management consultancy agency ATOS which designed a model to support early discharge/better rehabilitation. Stakeholders highlighted the need for any model to support alternatives to admission and admission avoidance.

5. A review of the Multi-Agency Carer's Strategy led by the Carer's Partnership.
6. A major conference as part of 'The Call for Action' on local healthcare provision. This served as the culmination of several months consultation informed by over 3,000 of the Shropshire/Telford & Wrekin population, and over 200 clinicians. .
7. Our Local Health Economy has just launched the next stage to respond to 'A call for action' - a 'Strategic Clinical Review' which will specifically focus on configuration of hospital based care, but which will be informed by progress of this plan to provide out of hospital care wherever appropriate.
8. This may lead to recommendations for further reconfiguration of hospital services and there will be ongoing and extensive engagement in accordance with the statutory engagement requirements of the 2006 NHS Act, and the so called 'Lansley' tests.

Common messages have emerged from consultative exercises to date:

- People want care close to home.
- They want it personalised to meet their specific needs
- There is currently insufficient 'joining up' between services that leads to confusion and potential duplication and/or fragmentation which is not cost effective.
- There is too much variation across parts of Telford and Wrekin particularly for access to services and/or patchy co-ordination.
- Discharges are far too slow - from user experience

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




e) Related documentation

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

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

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

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

	<p>has opportunities to improve his or her health and wellbeing, receives the care and support he or she needs to live as independently as possible and has personal choice and control over how the care and support they need is organised and provided.</p> <p>http://www.telford.gov.uk/downloads/file/2686/older_adults_strategy_refreshed_2010-2014</p>
<p>Multi-Agency Living Well with Dementia Strategy</p>	<p>This Joint Commissioning Strategy seeks to change the shape and quality of existing services to address the objectives in the National Dementia Strategy, 2009 (NDS). The purpose of the document is to drive the development of an equitable, seamless and coordinated dementia service of a good quality, using an agreed pathway served by agreed protocols and staffed by a trained, competent workforce. Implementation of the Strategy is through and Health and Social Care Economy Group for Dementia and accountable to the Health and Wellbeing Board.</p> <p> Dementia Pathway - Living with Dementia !</p>
<p>Rehabilitation and Reablement strategy 2010-13</p>	<p>This strategy sets out the proposed developments and changes to rehabilitation and re-ablement services in Telford & Wrekin. The overall aim is to provide a range of services that improve the quality of life for people and enable them to live as independently as possible. To achieve this, services must be timely, accessible and organised to meet individual needs.</p> <p>  Rehabilitation and Reablement Strategy Rehab Action Plan 2012.doc</p>
<p>Integrated Community Enablement model</p>	<p>This paper sets out an approach to supporting frail elderly people with complex care needs through an Integrated Community Enablement model. It seeks to reduce admissions and length of stay through increased community capacity. The paper was supported by the CCG Governance Board</p> <p>http://www.telfordccg.nhs.uk/board-papers-12-november-2013</p>

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

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

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

The Telford & Wrekin vision for the Better Care Fund is:-

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

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

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

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

The Fund provides an opportunity to do something radically different given 'Doing more of the same' is not in line with stakeholder views or affordable. Our proposals must make better use of combined resources for service users, communities and tax payers.

Local user feedback constantly reinforces messages about the need for better information to enable people to manage their own long term conditions as far as possible, better support for carers, and services that promote independence

An audit completed in 2013 which was commissioned as part of our Urgent Care Project Group 'Optimising Capacity on Discharge' highlighted that 48% of patients in a hospital non-elective bed could have been supported with 'lower levels' of care in a community setting.

Reducing reliance on use of acute hospital beds, with increased investment in community services, is in line with feedback from our public, service users and clinicians. If we can

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

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

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

- 1 To develop community capacity where individuals abilities to self-manage long term conditions, and the enormous potential of communities to provide voluntary care and support are seen as valuable assets. We will strengthen the role of the voluntary sector, community networks, self help groups, and individuals in both 'patient' and 'caring' roles.
- 2 To deliver a viable alternative to in-patient hospital care for people who can be cared for closer to home. We will build on our existing integrated community health and social care Enablement/Rehabilitation model by transferring capacity from the acute sector so that we offer a viable alternative community service rather than hospital bed based care.

In five years time, we will have:

Theme one – Building Community Capacity in Telford and Wrekin

- A strong voluntary sector infrastructure, with strong links with our 'Teams around Practices'
- A significant increase, based on modelling data, (*tbc as a target*) in people volunteering
- Community networks in every locality in the Borough offering support as a wider Telford and Wrekin 'Extended Family'
- More Self Help groups for people with Long Term Conditions to help them manage their own health.
- Access to information through a wide range of traditional and modern social media mechanisms.
- Access to Advice and Guidance from health and care professionals when required.

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

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

- Fewer hospital wards for non-elective care as we transfer capacity and activity into the community service.
- This will strengthen the ability of hospitals to focus on patients that need hyper-acute care, for example strokes and heart attacks, and to focus increasingly on planned operations.
- An Integrated Enablement/Rehabilitation Service that has a full complement of

clinicians and skills, including acute Doctors, Nurses and Therapists, in addition to existing Social Care and Community health professionals able to in-reach into existing residential and social care settings.

- Access to care to support people in the community
- This service will operate 7 days a week.
- A 'Single Referral Point' for Integrated 'Step up/Step down' with patients identified by the NHS number to facilitate better information/data sharing.
- Single triage and assessment processes will be well established.

There is significant evidence, particularly for older people, that hospital based care can have a negative impact; reducing confidence, exacerbating dementia, confusion, increasing risk of falls, and eroding levels of independence.

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

We expect to see the following outcomes:

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

b) Aims and objectives

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

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

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

The aims are:

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

Five performance measures will be used to monitor progress :

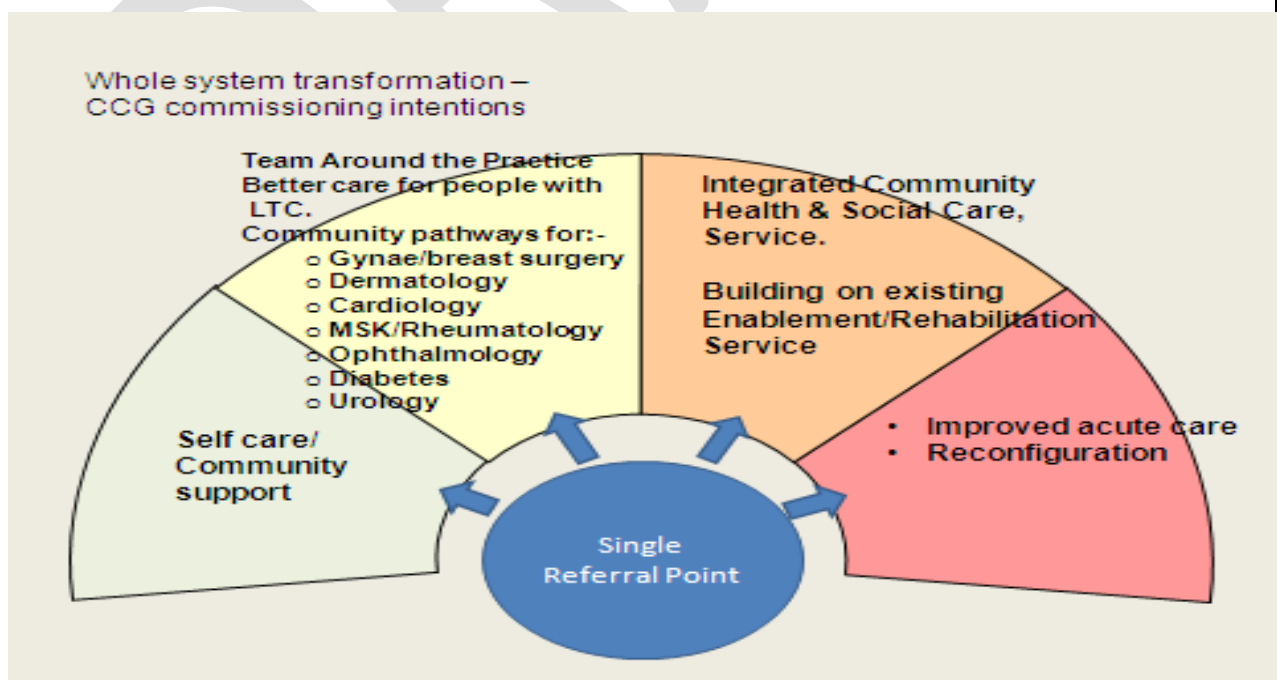
- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing permanent admissions to residential and nursing care.
- Patient experience
- Reducing delayed transfers of care.
- Improving the effectiveness of reablement/rehabilitation services.

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

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

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

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



The four elements in the CCG commissioning strategy include:

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

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

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

To deliver these aims we have the following objectives:

Theme 1 - Building Community Capacity in Telford and Wrekin

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

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

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

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

Non-Financial Benefits

- More people are empowered to manage their own condition
- More people are supported to meet their urgent care needs in the community
- People get the help they need when they need it
- More people benefit from Intermediate care
- People only spend the time in hospital that is needed
- People are enabled to recover and regain their independence
- Improved transfers of responsibility of care – ‘passing the baton’, ensuring a smoother and more coordinated journey.
- More people are enabled to recover and regain their independence
- Improved patient experience of the quality of care received
- Improved end of life care outside hospital
- Reductions in admissions due to falls and long term implications of falls
- Reduction in the number of patients leaving acute hospital who are admitted to residential or nursing home care
- Achieving cultural change within our community, encouraging and supporting self help and self care
- Increased engagement of volunteers
- Maintaining people in employment longer

Financial benefits

- Increase in uptake of carer assessments and support services
- Reduced duplication, through single points of access, assessment and potentially, intervention.
- Reductions in hospital admissions
- Reductions in zero length of stay
- Reductions in 1-5 day length of stay
- Reductions in excess bed days in acute hospitals
- Reductions in admissions to care/nursing homes from hospital
- Reductions in admissions due to falls/falls in hospital
- Reduction Delayed Transfers of Care
- Reduction in need for longer episodes of more intensive care.
- Maximising flow through enablement, monitoring periods of intervention, which may be less than 6 weeks, to maximise capacity of the service.
- Reduction in domiciliary care packages or reduce the rate of cumulative costs increase

c) Description of planned changes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d) Implications for the acute sector

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

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

rather than within the acute setting.

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

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

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

e) Governance

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

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

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

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

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

3) NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

We will increase the level of self-help and low level prevention to support the whole population This includes prevention programmes, reablement and assistive technologies, practical support in the home, equipment and adaptations, carer services and support where necessary to access residential and nursing home provision.

Without this approach the need for primary and secondary care need will increase. Therefore, front-line support must be adequately resourced within a climate of reduced resources.

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

The BCF will be used to support adult social care services locally by helping the Council to protect Adult Social Services and make a “positive difference to social care services and outcomes for service users” linked to a “health benefit” , which otherwise would not be possible “in the absence of the funding transfer”.

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

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

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

Current expenditure on re-enablement and prevention through the s256 agreement provides resources for

- Community Equipment and adaptations
- Telecare

- Integrated Crisis and rapid response services
- Maintaining eligibility criteria
- Enablement services
- Bed-based Intermediate Care services
- Early Supported Discharge schemes
- Other preventative services

These will be revised and enhanced to maximise independence and self-help. Developing community capacity as set out above will delay the demand for and reduce the level of extensive care packages – being person-focused with care delivered in the right place at the right time by the right people.

b) 7 day services to support discharge

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

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

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

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

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

Strategic commitment has been demonstrated through the following papers:

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

c) Data sharing

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

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

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

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

A robust project plan to include training to facilitate cultural change for the systematic recording of the NHS number by social care professionals is being developed. This includes clarification of the implementation timescales for the use of the NHS number as the primary personal identifier. This is a specific requirement of the BCF.

The plan will develop processes to share activity and performance data on key services and we need to ensure the same data sets are being shared across the partnership. If there is a change to existing sharing of data sets or sharing of new data sets then this will need to be mapped and privacy impact checklists completed alongside completion of individual data sharing agreements for each data set.

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

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

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

There is commitment to allow information to be exchanged between systems through open standard interfaces, supported by open Application programming Interfaces where necessary.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

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

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

d) Joint assessment and accountable lead professional

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

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

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

Changes to the GP contract will require us to build on existing risk stratification and develop robust care plans for high risk groups. Our health economy has been targeting support for residents of care and nursing homes including a Care Home Advanced Scheme completing care plans for patients at high risk of hospital admission. This work will inform approaches to risk stratification. GPs will therefore support the identification of those high risk patients who need a joint care plan and lead professional.

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

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

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

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

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

all who are at risk or may need enhanced health and social care needs. This approach maximises the potential and impact of self-help; support to primary care for LTCs, reducing admissions and supports early discharge. This approach also provides further opportunities for joint planning and integrated working.

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

RISKS

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

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System: Better Care Fund (BCF)	Assessment Conducted by: Michael Bennett and Lezli Feeney
Vision: 'To empower people in Telford & Wrekin to take control of their own health; to support them in caring roles, and to keep everyone as healthy and as independent for as long as possible'	Date: 04/02/14 Review Date: 01/04/14

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

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

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

Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor	Actions		CCG Responsible Person/ Implementation Date
<p>Insufficient capacity within the local community, principally the voluntary sector, to support self help/ self care. There is a need for significantly more community capacity in this area</p> <p>Current providers include: Red Cross, Age UK and Community Service Volunteers (CSV)</p>	<p>Self care will not form an effective element of service redesign to provide care closer to home, self help intervention, community support and move activity from specialist to prevention and self help.</p> <p>Increased financial risk</p>	<p>Contracts with current voluntary sector providers</p> <p>Call for Action</p> <p>Working together Events in Telford and Wrekin</p>	<p>Major x possible = high 11 (High x medium = key risk 7)</p>	<p>Provide support to the voluntary sector to develop the leadership, capacity and skills to fulfil their role in the delivery of the BCF.</p> <p>Establish voluntary sector links to 'Teams Around Practices'</p> <p>Implement communication and engagement strategy as identified within the Implementation plan</p>	<p>Major x unlikely = Moderate 9 (High x Unlikely = key risk 6)</p>	<p>Michael Bennett</p>
<p>Patients and the wider community need to feel that service delivery under the BCF effectively meets</p>	<p>Failure to 'win hearts and minds' will result in failure by patients to engage with care provided under the BCF programme.</p> <p>Failure to implement the</p>	<p>BCF Project Plan</p> <p>Call for Action – common messages</p>	<p>Major x possible = high 11 (High x medium = key risk 7)</p>	<p>Patient and public engagement in the BFC programme.</p> <p>Meaningful communication</p>	<p>Major x unlikely = Moderate 9 (High x Unlikely = key)</p>	<p>Michael Bennett</p>

their needs.	BCF will challenge the CCG's ability to address the common messages of consultative exercises.			and engagement, including the use of social media, to inform the Strategic Clinical Review and BCF. Establish community networks within the Telford 'Extended Family' and self help groups for people with Long Term Conditions. Reduce negative impacts of care on people.	<i>risk 6)</i>	
Activity	Risks and the people who may be affected	Current controls	Consequence x Likelihood = Risk Factor	Actions		CCG Responsible Person/ Implementation Date
Integrated care pathways that empower patients and address the needs of the local demographic.	Failure by partner organisations, including the voluntary sector, to embrace cultural change and work in a truly integrated way will challenge the quality and timeliness of services	BCF Project Plan BCF Steering Group JSNA CCG and the Council's commissioning	Major x possible = high 11 <i>(High x medium = key risk 7)</i>	Joint working within the Steering Group to inform change in partner organisations Act upon the findings of the	Major x Unlikely = Moderate 9 <i>(High x Unlikely = key risk 6)</i>	Michael Bennett and David Evans

		intentions		'Optimising Capacity on Discharge' audit Implement 'Single Referral Point' and single triage and assessment		
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Risk Grading Matrix

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

Qualitative Measures of Likelihood:

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

ASSOCIATION

DRAFT Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority Telford & Wrekin	N	10,514,000	1,280,000	1,864,000
CCG Telford & Wrekin	Y	3,000,000	10,410,000	14,810,000
BCF Total				

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

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Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD
Outcome 2	Planned savings (if targets fully achieved)	TBD	TBD
	Maximum support needed for other services (if targets not achieved)	TBD	TBD

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Reablement & Prevention		4,731,000		TBD	TBD	4,731,000	TBD	TBD	TBD
Support for Carers		523,000		TBD	TBD	523,000	TBD	TBD	TBD
Bed based Intermediate care		327,000		TBD	TBD	327,000	TBD	TBD	TBD
Developing Integrated Community Enablement		3,000,000		1,308,000	TBD	5,413,000	TBD	TBD	TBD
To support the transformation of healthcare and the Council's Community Care functions.		2,400,000	1,400,000	400,000	TBD	2,400,000	2,000,000	2,000,000	TBD
Review of Voluntary Sector Services to build community capacity		TBD		TBD	TBD	TBD	TBD	TBD	TBD

Association



DRAFT Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent Admissions This is a reduction of admissions from 166- 149 people (17 less)out of a denominator that has increased by 8%. Expected outcomes include financial and non-financial benefits including: reduced admissions; reduced residential and nursing care costs; increased independence, choice and control; more people supported within the community. This will benefit a wider target population of those who need health and social care services who are under 65 years. Other benefits of the scheme include development of the integrated Community Enablement service which will also impact on mitigating upward pressure on the domiciliary care budget.

Proportion of Older People at home 91 days discharge
Increasing the number of people who remain at home for 91 days (not including those under 65 years, palliative care or those within the community who receive enablement). This indicator monitors a cohort from Oct - Dec 2014 of those starting Enablement and followed for 91 days. Financial and non-financial benefits include: reducing admissions to residential care due to more Enablement interventions available; more people regaining independence; increased engagement with volunteers to support self care; reduced admissions to SaTH through more effective Enablement (thus maintaining the current denominator has not increased); reductions in care needs post Enablement.

Delayed Transfer of Care
The baseline data shows an average 158 days of delays per month. The target is to reduce to an average of 151 days delays per month eg reduced DTOCs by 7 days a month across each identified time period. Financial and non-financial benefits include: reduced costs due to length of stay such as reduced excess bed days; reduced LoS; more people benefit from Enablement; more people regain independence. Enhancing the Integrated Enablement services also enables reduced need for longer and more costly care.

Avoidable emergency admissions
The baseline metric has been identified as 3879 admissions from April 2012 - March 2013 across all ages. April 2015 payment metric is to reduce by 138 admissions during the identified 6 month period (275 admissions for the year). The October 2015 payment is a reduction of 106 admissions during the 6 month period (212 over the year). These relate to admissions of all ages. The CCG target group is primarily 65 years + (16% of the population). Financial and non-financial benefits include: reductions in admissions facilitated by the enhanced Integrated Community Enablement team with associated cost reductions; more self-help and prevention; more people supported to meet their urgent care needs in the community; reduced admissions to care homes

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

The intention is for the local economy to use the National Metric. In addition to the National Metric, which is being developed we will also gain patient experience from the Health Roundtable (a sub-group of the CCG Board), the Patient Participation Group Network (4 members of which sit on the Health Roundtable), the Long Term Condition Reference Group (a member also sits on the health Roundtable), Soft Intelligence Collection System (DATIX), Patient Membership Scheme and the PALS and Complaints received by the CCG.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Permanent Admissions This will be monitored through monthly reporting by the Council to the Programme Management Board. **Proportion of Older People at home 91 days discharge** evidence of achieving this metric is through the analysis at the end of the 91 days monitoring period. Monitoring in real time will be developed. Development of the Enhanced Integrated Community model with additional capacity is essential and the increase in community capacity for self help and preventative support. Assurance for the development of these will be through the monthly Programme Management meetings. **Delayed Transfers of Care** This will be monitored through monthly summaries of daily reports presented at the monthly Programme Management Board **Avoidable Emergency Admissions** - this composite indicator will be monitored by replicating the 4 underlying indicators from the SUS data and reporting on a

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

NA

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value	652.4	N/A	542.4
	Numerator	166		149
	Denominator	25445		27471
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value	53.3	N/A	63.7
	Numerator	72		86
	Denominator	135		135
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	121.3	114.8	114.2
	Numerator	1890	1355	905
	Denominator	130149	131102	132097
		April 12- March 13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	Metric Value	2305	2211.14	2152.14
	Numerator	3897	1811	1842
	Denominator	169065	0	171177
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience (for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used)		(insert time period)	N/A	(insert time period)
	(local measure - please give full description)			
	Metric Value			
	Numerator			
	Denominator			
		(insert time period)	(insert time period)	(insert time period)