a co-operative council

Telford & Wrekin COUNCIL

Addenbrooke House Ironmasters Way Telford TF3 4NT

HEALTH AND WELLBEING BOARD

Date	**Wednesday, 15 June 2016**	Time	**2.00pm**
Venue	**Room G3/G4, Ground Floor, Addenbrooke House, Telford TF3 4NT**		

Enquiries Regarding this Agenda:		
Democratic Services	Jayne Clarke	01952 383205
Media Enquiries	Corporate Communications	01952 382403
Lead Officer	Jon Power	01952 380141

Committee Membership:

Cllr R A Overton **(Chairman)**	Cabinet Member – Housing, Public Health & Protection
Dr J Leahy **(Vice-Chairman)**	Chair, Telford & Wrekin CCG
Cllr K Tomlinson	Lib Dem / Independent Group
Cllr E A Clare	Cabinet Member – Leisure Services & Culture
J Chaplin	Healthwatch
Cllr A R H England	Cabinet Member – Adult Social Care
D Evans	Chief Operating Officer, Telford & Wrekin CCG
D Harrison	Non-Executive Director, Telford & Wrekin CCG
C Jones	Director: Children's & Adult Services
L Noakes	Director of Public Health, TWC
Cllr J M Seymour	Conservative Group
R Smith	(Interim) Assistant Director: Early Help & Support
J Tozer	Community Safety Partnership
Cllr P R Watling	Cabinet Member – Children, Young People & Families
R Woods	NHS England (North Midlands – Shropshire & Staffordshire)

AGENDA

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1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes** Appendix **A** 4
   To confirm the minutes of the meeting of the Health and Wellbeing Board held on 9 March 2016.

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Future Meeting Dates:

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Wednesday, 8 March 2017

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HEALTH AND WELLBEING BOARD

A

Minutes of a meeting of the Health & Wellbeing Board held on Wednesday, 9 March 2016 at 2.00pm in Meeting Rooms G3 and G4, Ground Floor, Addenbrooke House, Ironmasters Way, Telford, TF3 4NT

PRESENT: Cllr R Overton (Chair) (Telford and Wrekin Council), Dr M Innes (Vice-Chair) (Clinical Commissioning Group), Cllr K Blundell (Telford and Wrekin Council), J Chaplin (Healthwatch Telford and Wrekin), Cllr E Clare (Telford and Wrekin Council), Cllr A England (Telford and Wrekin Council), D Evans (Chief Operating Officer, Telford & Wrekin CCG), C Jones (Director Children's & Adult Services), L Noakes (Telford and Wrekin Council), Cllr J Seymour (Telford and Wrekin Council), R Smith (Interim Assistant Director: Early Help & Support) and Cllr P Watling (Telford and Wrekin Council).

ALSO PRESENT:

C Harland (Public Health Commissioner), A Mason (Independent Chair, TWSAB & TWLSCB), L Mills (Service Delivery Manager Health Improvement)

OFFICERS: J Eatough (Assistant Director: Legal, Procurement & Commissioning), J Power (Delivery & Planning Manager) and J Clarke (Democratic Services Support Officer)

The Chair informed the Board that this would be the last meeting attended by Dr Mike Innes (Vice-Chair), as he was stepping down as the Chair of the Telford & Wrekin CCG. The Chair, on behalf of the HWBB, thanked the Vice-Chair for all of his time, effort and dedication during his time on the Board.

HWB-35 MINUTES

RESOLVED – that the minutes of the meeting of the Health and Wellbeing Board held on 9 December 2015 be confirmed and signed by the Chairman.

HWB-36 APOLOGIES FOR ABSENCE

J Tozer (Community Safety Partnership)

HWB-37 DECLARATIONS OF INTEREST

None

HWB-38 PUBLIC SPEAKING

No Members of the public had registered to speak.

HWB-39 HEALTH AND WELLBEING STRATEGY UPDATE

The Assistant Director: Health and Wellbeing presented the update report on the Health and Wellbeing Strategy.

The purpose of the Health and Wellbeing Board (HWBB) was to bring together key partner organisations to improve the health and wellbeing of the Borough's population. The key vehicle for achieving this aim was to set the HWS with key priorities and ensure partners make progress against these.

The Strategy demonstrated a shared vision which would enable residents to have healthier, happier, longer lives and better mental health and wellbeing.

The Delivery & Planning Manager gave a presentation with key feedback from the consultation including:

- Consultation approach with the public
- Consultation approach with partners and stakeholders
- Responses to the consultation
- Key issues on:
    - Strengthening our communities
    - Encourage healthier lifestyles
    - Improving mental wellbeing
- Key themes from both public and stakeholder feedback
- Next Steps

The final Health and Wellbeing Board Strategy was before the Board for approval.

A discussion took place including:

- The replacement of the BCF Board with the Stronger Communities Board and its governance arrangements
- Cross-cutting priorities
- Emotional wellbeing of the community

On being put to the vote it was:

RESOLVED – that:

a) **the final Health and Wellbeing Strategy be approved;**

b) **the proposed Governance arrangement as set out at section 1.3.5 of the report be approved; and**

c) **the timetable for the publication of the final strategy be approved.**

HWB-40 COMMISSIONING PRIORITIES 2016/17

The Service Delivery Manager Health Improvement presented the Commissioning Priorities 2016/17 for the Council and the CCG.

The purpose of the report was to describe how commissioning programmes for both the Council and the CCG supported the delivery of the Health and Wellbeing Strategy and promoted an integrated approach to improving health and wellbeing.

The CCG, Public Health and Vulnerable People Commissioning Teams had worked with Lead Officers to bring together details of their commissioning intentions together with a summary of the progress in order to align the intentions of the Council and the CCG, which would be consistent with the HWBB's approach.

The Commissioning activity also set out the approach to improving health and wellbeing including:

- empowering people to take control of their own health
- supporting communities to grow in order they can better support people
- creating a place that enables people to make healthier choices
- adopting the principle that home is normal
- promoting wellbeing and independence across the communities whatever their level of need
- working in a systemic way to manage demand away from high cost health and social care and promote independence
- make good use of all resources available across the whole system
- using outcome based commissioning

During the discussion it was concluded that this was the closest alignment of the Local Authority and the CCG's commissioning intentions to date and it set out really clear grounds which could be used to deliver the prevention agenda and build a stronger community and would enable self-care and self-help and deliver right care, right place.

Discussion took place that agreed that working together and co-aligning priorities will achieve better outcomes.

Getting a joint vision right was very important and this meant that subsequent strategies would also share a very powerful alignment. Further work, however, to deepen the alignments was needed.

Following the discussion it was:

RESOLVED – that the report be noted.

HWB-41 MENTAL HEALTH COMMISSIONING STRATEGY 2016-19 ACTION PLAN

The Public Health Commissioner presented the Mental Health Commissioning Strategy 2016-2019 – Action Plan.

The HWBB approved the Mental Health Strategy for Telford & Wrekin in December 2015 as part of a three stage review. Since the last meeting of the HWBB commissioners from Health & Social Care had met with stakeholders to develop

governance arrangements and a forum on which to develop the actions plan and monitor its implementation.

The Strategy was based on 3 key ambitions:

- Supportive Communities
- To ensure early intervention
- To commission Quality Services

The report highlighted some of the key actions that were being undertaken which included:

- A Mental Health Summit in April 2016
- Mental Health Challenge
- Mental Health Champions

The Mental Health Stakeholders Group would continue to meet on a monthly basis at present in order to further develop and update the action plan.

Cllr A England had been asked to sign up as a Mental Health Champion on behalf of the Council.

There was still work to be undertaken around formalising reporting templates and delivering the model and a further report would be brought to the September 2016 HWBB meeting.

Cllr A England confirmed that he had been keen to adopt and take on the role of Mental Health Champion. He reported that he had already attended 1 meeting and a further meeting had been arranged. The role of the Mental Health Champion could be found at Appendix 2 (Page 2) to the report. It was hoped that work could be focussed around 1 priority. Meetings took place quarterly but in the meantime Cllr England hoped to get out into the community in order to meet and greet members of the public and signpost people to the correct service area.

A discussion took place including:

- Right help at the right time approach
- The Action Plan was moving in the right direction but the challenge was to get delivery on the ground
- Better dialogue across the CCG/Partners/Council
- Children's Mental Health/Early Help

Following the discussion it was:

<u>RESOLVED</u> – that:

a) **Members comments on the draft of the Mental Health Action Plan be noted; and**

b) Members support the Mental Health Challenge.

HWB-42 PUBLIC HEALTH ANNUAL REPORT 2015/16: LIVING WELL FOR LONGER IN TELFORD AND WREKIN

The Statutory Director of Public Health gave the HWBB a presentation on the Public Health Annual Report 2015/16: Living well for Longer in Telford and Wrekin. A short video was also played which would be available on YouTube in the coming weeks.

The report focussed on ageing well to improve health and wellbeing for people in their mid-life ie 50s, 60s and 70s in the following areas:

- Looking after Yourself – Healthier Lifestyles
- Recognising and Supporting those in Difficulty
- Valuing Contributions
- Staying Well

The report, which was available to the public, was interactive in style and included video clips and infographic links which could be accessed from the document.

The recommendations contained within the report would, if approved, be used to shape the Living Well and Ageing Well programme that would support the delivery of the new Health & Wellbeing Strategy.

The population of adults living well into their 70s and 80s in Telford & Wrekin was growing and would continue to grow with the average life expectancy for males being 79 and for females 82. By 2020 people over the age of 50 would comprise almost 32% (a third) of the working age population and 48% (almost half) of the adult population.

The focus of the Annual Public Health Report for 2016/17 was improving health in mid-life with the aim of challenging myths associated with ageing and recognising that ill-health can be prevented or delayed and that everyone could take steps to stay well for as long as possible.

A discussion took place including:

- The Public Health outcomes Framework included in Appendix E included a summary of changes such as early death from heart disease and stroke had fallen was was now at the national average
- Concern around cancer death rates still being high
- Importance of living in good health for longer
- Working better together
- Changing behaviour in order for life expectancy rates to improve and reduce periods of poor health
- Hip fractures in women
- Promoting the messages
- Video to be used by partners in various settings

Following the discussion it was:

<u>RESOLVED</u> – that the Board support the recommendations of the Director of Public Health contined in her 2015/2016 Annual Report and as detailed below:

a) **Action should be taken by the Council and partners to encourage and support people over 50 to adopt healthy lifestyle behaviours, which incorporate opportunities to volunteer and ensure advice, signposting into services by health and social care professionals is systematic;**

b) **The Council's Public Health Team should work with key partners to develop the wider public health workforce to expand our local capacity and capability to improve the health and wellbeing for our ageing population;**

c) **Action should be taken by the Council, NHS Telford and Wrekin Clinical Commissioning Group and partners to ensure good access to healthy lifestyle support for the most vulnerable adults, such as those with long term conditions or mental health illness;**

d) **The Council, its partners and communities should support and promote a range of group, one-to-one and volunteering activities that meet the needs and interests of local older people;**

e) **Building on work already underway, the Council and partners should take a community-centred approach to improving the health and wellbeing of our ageing population;**

f) **Action should be undertaken by the Council with local employers to raise awareness of the links between work, healthy lifestyles and wellbeing and the action employers can take to increasing employment opportunities and retention for older people; and**

g) **Action should be taken, by NHS Telford & Wrekin CCG with the Council and other partners to maximise every opportunity for awareness raising and early detection of risk factors and symptoms, ensuring early diagnosis and treatment for cancer, cardiovascular disease (heart disease and stroke) and Type 2 Diabetes.**

HWB-43 SUSTAINABILITY AND TRANSFORMATION PLAN

The Chief Officer, Telford & Wrekin CCG presented the report on the Sustainability Transformation Plan (STP).

The report gave an update on the planning guidance for the NHS up to 2020/21 and set out the requirement for partners across the system to deliver against one jointly owned plan.

The current plan was for 1 year and it was to be used as a footprint and planning for a 5 year plan following a comprehensive spending review that would be based around the "Five Year Forward View".

STPs were to be submitted by 30th June 2016 and would be formally assessed in July 2016. The Transformation agenda would deliver against core standards and constitution rights around Health and Social Care.

Work had been undertaken to identify a local footprint of Shropshire and Telford & Wrekin for the planning of health for a minimum population of 500,000. Both CCGs were in agreement with this being taken forward and would build on and be complementary to work that was already underway, ie:

- Future Fit
- Community Fit
- Deficit Reduction Plan
- Primary Care Strategies
- Rural Urgent Care Services

Part of the CCG's core strategy was the health economy's debt recovery plan and this was the basis for the STP and addressing the debt was very important. The chance of getting funding would be influenced by the quality of the STP.

A further draft of the STP would be brought back to the HWBB at the June meeting.

A discussion took place including:

- Need to use the T&W Health & Wellbeing Strategy to inform STP
- GP Practices
- The development of Primary Care Estates Strategies
- Significant workforce challenge
- STP Footprint and prevention planning
- Commissioning to reduce the impact of loneliness – ie "buddy system"
- Commissioning of local Pharmacy services
- Prevention agenda in older people
- Patient representation on Future Fit
- Governance
- Changing public perception on using services
- Need to ensure T&W place-based narrative and work is built upon

- Being imaginative with the services already provided rather than inventing new services

RESOLVED – that the Board note the planning guidance and take it into consideration in future business for the Board and its partners.

HWB-44 EARLY HELP UPDATE REPORT

The Service Delivery Manager Health Improvement presented the Early Help Update Report.

The report summarised the progress of implementing the Early Help Strategy and set out the work programme that would be undertaken locally in order to provide early help to children and their families.

Following a consultation exercise six priorities had been identified for immediate action in order to improve outcomes for children, young people and families. These priorities could be found on Page 1 of the report. Performance against the outcomes was monitored by the Early Help Partnership Board and the current performance outcomes could be found at Appendix A to the report. There were still concerns regarding overweight children and self-harm rates in children and young people.

An Early Help Impact Assessment had been completed by lead professionals and this was an Ofsted requirement. A good service was currently on offer but there was further work to be done with regards to recording and monitoring impact. This work would be undertaken along with partners.

Looking back at what had been achieved, this was a positive story, such as falling smoking in pregnancy and excess weight rates, showing that the Early Help offer was working well with good multi-agency engagement which would be sustained and continue to look at new priorities.

A discussion took place including:

- Good news stories
- CM644 (P87 of the Agenda) % of children (u16) living in poverty
- Recognising the importance of Universal Services
- Promotion of CAMHS
- The role of schools
- Upskilling of the workforce
- Self-harm figures / national best practice
- Cross-cutting themes
- Youth Unemployment rates
- NEET rates

RESOLVED – that:

a) **progress made by Early Help Partnership organisations towards improving outcomes for children and families be acknowledged; and**

b) the challenges in measuring and monitoring the impact of our Early Help Offer be acknowledged.

HWB-45 ANNUAL UPDATE OF THE TELFORD AND WREKIN SAFEGUARDING ADULT BOARD (TWSAB) & LOCAL SAFEGUARDING CHILDREN BOARD (TWLSCB)

The Independent Chair presented the annual update of the Telford and Wrekin Safeguarding Adult Board (TWSAB) and Local Safeguarding Children Board (TWLSCB).

He informed the Board that the Adult Safeguarding Board was less than 1 year old and was set up to comply with statutory requirements.

The Children's' Board was more established, although this could be changed following a review by Government. The LSCB was concentrating more on challenging and giving assurance rather than publication and promotion.

Work was being undertaken to look at how the 2 Boards could work better together and a priority sub-group had been formed to look at domestic abuse with a further 2 sub groups being set up to undertake other areas of work.

NICE Guidance had been issued regarding children in transition and this was currently being looked at to see if transition arrangements could be improved.

Some 20 schools had now signed up to help develop Safeguarding services and there had been a good response from parents, children and carers with regard to neglect.

A discussion took place including:

- LSCB – positive multi-agency Board which picked up issues quickly when needed
- Funding
- Inclusive Board which needed to be kept focussed and "lean"

RESOLVED – that:

a) progress of the TWSAB and TWSCB over the last 12 months be noted;

b) information be cascaded via the respective Commissioning and Transformation Partnership (CATP) Chairs to ensure linkages and consistency in approach;

c) individuals who are representatives on both the HWBB and TWSAB and/or TWSCB ensure that they provide regular updates to the respective Boards as and when appropriate.

The meeting ended at 3.47pm

Chairman: .....

Date: .....

B

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

15th JUNE 2015

REVIEW OF THE TERMS OF REFERENCE OF THE HEALTH AND WELLBEING BOARD

REPORT OF: JONATHAN EATOUGH, ASSISTANT DIRECTOR; GOVERNANCE, COMMISSIONING AND PROCUREMENT

LEAD CABINET MEMBER – CLLR R. OVERTON

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

This report reviews the terms of reference for the Health and Wellbeing Board ('the Board'), and recommends some changes to streamline and update the terms of reference in the light of experience since the inception of the Health & Well-Being Board in 2012.

2. RECOMMENDATIONS

That the Board review and agree the proposed terms of reference attached at Appendix 1.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	The review ensures that the terms of reference are up to date and relevant to the work of the Board
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	The review contributes to the Council meeting the 'Health and Wellbeing' objective.
	Will the proposals impact on specific groups of people?	
	No	
TARGET	If the Board recommends any changes to the	

COMPLETION/DELIVERY DATE	terms of reference; they will proceed to Council Constitution Committee and then, if approved, onto full Council at the earliest opportunity.	
FINANCIAL/VALUE FOR MONEY IMPACT	No	There are no financial implications arising as there are no proposed changes to the current terms of reference. Any proposed changes agreed at the HWB meeting may impact on the frequency and administration of future Board meetings which may impact on future costs but it is anticipated that this would be minimal and within the existing resources available. Any financial implications resulting from significant developments as a result of the enactment of legislation will be detailed within a future report.
LEGAL ISSUES	Yes	Section 194 of The Health and Social Care Act 2012 requires the Council to establish a Health and Wellbeing Board as a formal committee of the Council in accordance with section 102 of the Local Government Act 1972 (subject to some exceptions). Accordingly the conduct and procedure of the Board must comply with the appropriate statutory requirements that relate to matters such as the publication of the meeting agenda and publishing of reports. In order to give effect to any changes full Council has to approve the changes which will result in the consequent amendment to the Council's constitution to incorporate the new arrangements. Council Constitution Committee also has involvement in the structure and content of the Committee terms of reference and procedures.
EQUALITY & DIVERSITY	No	
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	No	
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	It is recommended that the Board take the opportunity to review their Terms of Reference on at least an

		annual basis.

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

It is now twelve months since the Board undertook the last review when no changes were made.

Attached at appendix 1 are the proposed terms of reference and the existing terms of reference for comparison purposes.

The proposals streamline the current terms of reference to make them more consistent with the terms of reference of other Council committees and to recognise the greater flexibility that more general terms of reference and give the Board – moving away from the more prescriptive terms of reference that were more appropriate for a new committee and a new committee membership.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

The proposed drafting is less prescriptive and recognises the maturity of the committee and its growing influence on the development of health and care services across Telford & Wrekin.

3. PREVIOUS MINUTES

17th July 2013 – Health and Wellbeing Board, HWB - 22
15th May 2014 – Health and Wellbeing Board, HWB - 64
10th June 2014 – Health & Wellbeing Board, HWB - 5

4. BACKGROUND PAPERS

- Health and Wellbeing Boards – A practical guide to governance and constitutional issues. Issued by the Local Government Association, March 2013
- The Health and Social Care Act 2012
- http://www.legislation.gov.uk/ukpga/2012/7/contents

Report prepared by Jonathan Eatough, Assistant Director: Governance, Commissioning & Procurement, Telephone: 01952 383200

Appendix 1

Telford & Wrekin Health and Wellbeing Board Terms of Reference

The Committee has the responsibility for public health and health and wellbeing responsibilities within the Borough.

TERMS OF REFERENCE

1. The Health and Wellbeing Board is responsible for
   1.1. the development of a joint Health & Wellbeing Strategy for Telford & Wrekin based upon the needs identified in the Joint Strategic Needs Assessment (JSNA)
   1.2. the ongoing development of the JSNA and the development, review and oversight of the delivery of actions identified in the joint health and wellbeing strategy and other key plans and strategies that may be developed from time to time
   1.3. the encouragement of joint and co-commissioning between health and care sectors, including Telford and Wrekin CCG, Telford and Wrekin Council, and NHS England and ensuring that commissioning activity of the relevant organisations are aligned with the priorities set out in the Health & Wellbeing Strategy
   1.4. the general oversight of the Council's Public Health responsibilities and receiving the annual report of the Council's Director of Public Health
   1.5. the receiving of reports from and making recommendations to Full Council, NHS England, and the Clinical Commissioning Group Board and Boards and sub-committees that it may establish (and delegate functions to) and from other Boards and organisations involved in the provision of that influence of health and well-being outcomes for the whole population within the Borough.

2. The Health and Wellbeing Board will link to the Local Strategic Partnership and local Adults and Childrens' Safe-guarding Boards

3. General

3.1. At the first meeting after the Annual Council Meeting and in response to any further guidance consider its terms of reference, structure, membership and activities.

PROCEDURE

4. **General**

Unless specifically provided for in these Terms of Reference the Council Procedure Rules govern the way that committees operate but these may be varied or suspended[1] at the discretion of the Chairman of the Committee in the interests of efficient and effective management of the committee

5. **Membership**

5.1. Members of the Health and Wellbeing Board will comprise representatives from the Telford & Wrekin Clinical Commissioning Group, Telford & Wrekin

Council, HealthWatch and NHS England Local Area Team. The core members are:

5.2. Cabinet Member responsible for Housing, Leisure & Health (Chairman of the Health and Wellbeing Board)

5.3. Cabinet Member for Adult Social Care & Older People

5.4. Cabinet Member for Children, Young People and Communities

5.5. Cabinet Member for Culture , Sports, Parks & Green Spaces

5.6. Director responsible for Adult Social Care

5.7. Director responsible for Children's Services

5.8. Director of Public Health

5.9. NHS England Local Area Team representative

5.10. Chair of Telford and Wrekin Clinical Commissioning Group (CCG) (Vice Chair Health and Wellbeing Board)

5.11. Non-Executive Director from Clinical Commissioning Group

5.12. Chief Officer from Clinical Commissioning Group

5.13. Representative of local HealthWatch

5.14. Chair of the Community Safety Partnership

5.15. Each opposition Group with 4 or more elected members shall have one place on the Health and Wellbeing Board with voting rights.

5.16. Such other persons, or representatives of such other persons, as the Local Authority thinks appropriate

5.17. The members of the Board will be advised and supported by officers from the local authority and CCG.

5.18. Members agree to share all relevant information and data, to allow performance, and other joint working arrangements, to be properly monitored and managed.

6. **Quorum**

6.1. Quorum of one quarter is required, with a minimum of one Councillor Board member from Telford & Wrekin Council and one Board member from the CCG required in attendance.

7. **Disqualification for Membership**

7.1. Any person who would be disqualified from being able to stand for election as a councillor will be disqualified from being a member of a committee or sub-committee of a local authority. The regulations state that these disqualifications will be retained for Health and Wellbeing Board, but the regulations will ensure the disqualifications do not apply to Health and Wellbeing Board in so far as they cover disqualifications in respect of members of the board holding any paid employment or office in the local authority – this allows the Directors of Adult Social Services, Children's Services and Public Health to be formal members of the Health and Wellbeing Board.

7.2. The following disqualifications will be retained for members of the Health and Wellbeing Board:

7.3. Being the subject of a bankruptcy restrictions order or interim order

7.4. Having been convicted in the United Kingdom, the Channel Islands or the Isle of Man of any offence and has had passed a sentence of imprisonment

(whether suspended or not) for a period of not less than three months without the option of a fine.

8. **Voting Rights**
   8.1. All Members of the Health and Wellbeing Board will be able to vote alongside the elected representatives. This applies to any additional board members appointed in addition to the statutory membership set out in the Health and Social Care Act 2012.

9. **Meetings**
   9.1. The Health and Wellbeing Board will meet quarterly and in public. Dates and times of meetings will be agreed and published in advance. Note - the press and public may be excluded during consideration of any matter which would involve the disclosure of confidential or exempt information.
   9.2. Agendas and supporting papers will be issued at least five clear days before each meeting and action notes will be produced, confirmed as a true record of the meeting and signed by the Chair. Note - documents that may disclose confidential or exempt information, will be made available for public inspection five days before the meeting.
   9.3. Members of the public and press will have access to the meetings and there will be provision for public speaking section at each Health and Wellbeing Board meeting. A procedure for public speaking at the Health and Wellbeing Board is in place and is available on the Council's website or by contacting Democratic Services.

10. **Code of Conduct and Declaration of Interest**
    10.1. The Health and Wellbeing Board will adopt the Council's code of conduct. Any interests in item(s) on the agenda should be declared at the start of the meeting.

11. **Reporting Mechanisms/Accountability**
    11.1. The actions of the Health and Wellbeing Board will be subject to independent scrutiny by the relevant Scrutiny Committee of the Council.

C

TELFORD & WREKIN COUNCIL

HEALTH & WELL-BEING BOARD – 15th JUNE 2016

DELIVERY OF THE HEALTH AND WELLBEING STRATEGY

REPORT OF: LIZ NOAKES: ASSISTANT DIRECTOR HEALTH AND WELL-BEING

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

To present to the Board a model for the delivery of its strategic priorities as outlined in the Health and Wellbeing Strategy.

2. RECOMMENDATIONS

That the Board approve the proposed:

- Model for the delivery of the HWBB priorities
- Reporting timetable
- Development of a performance framework
- 'Development sessions' for Board members

2. IMPACT OF ACTION

Following approval of the Health and Wellbeing Strategy in March 2016, it is essential that the Board approves a model for receiving updates on progress against the strategy and an agreed structure for holding CATPs to account in order to assure itself that outcomes identified within the Strategy are delivered.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	No	*However, this report outlines a proposed model for monitoring progress against the delivery of the HWB strategy and strategic priorities.*
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes	*This report proposes an approach to delivering against the priorities of the Board over the next 12 months.*
	Will the proposals impact on specific groups of people?	
	No	*N/A*
TARGET COMPLETION/DELIVERY DATE	*Please see section 1.2 for a proposed timetable for receiving update reports against the HWBB priorities. The current HWBB priorities run for three years and therefore, the proposed model will continue into 2017/18 and 2018/19.*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	*The delivery of this strategy and the detailed work programmes will need to be considered against the context of reducing resources. The Public Health grant allocation for 2016/17 details a reduction of £300k with an additional reduction of £320k anticipated in 2017/18. This is on top of a 6.2% in year reduction in 2015/16. At the same time the Council is receiving less Revenue Support Grant from the Government with £30m savings identified for 2016/17 and 2017/18 and estimates that a further £20m savings will need to be identified in the following 2 years.* *The detailed work programmes to support the delivery of this strategy will be need to be met from existing resources and this will be reported as part of future reports to this Board.*
LEGAL ISSUES	Yes	*The HWBB has a statutory obligation to encourage integrated working and to encourage commissioners of health-related services to work closely with the HWBB (section 195, Health and Social Care Act 2012).*

		Accordingly, the proposals in this report will assist the HWBB in meeting its legal obligations. This continuing commitment to integrated working is also a requirement of the HWBB's terms of reference.
EQUALITY & DIVERSITY	No	*None*
IMPACT ON SPECIFIC WARDS	No	*None*
PATIENTS & PUBLIC ENGAGEMENT	No	*Public consultation has already been undertaken in relation to the priorities – this was outlined in previous reports to the Board.* *However, we do propose to hold a stakeholder event in late June to share the attached work programmes in order to capture any shared initiatives/work which could help to deliver the priorities.*
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	*Any risks to achieving the work programmes attached at appendix one will be highlighted as part of the regular reporting proposed in this report. A stakeholder event in late June will help to identify any opportunities for joint/collaborative working with our key stakeholders and identifying how they may contribute to achieving the HWBB priorities.*

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1 Delivery of the Board's strategic priorities

The Board approved the Health and Wellbeing Strategy 2016-2019 in March 2016 which identified three key priorities:

- ***Encourage healthier lifestyles***
- ***Improve mental wellbeing and mental health***
- ***Strengthen our communities and community based support***

The following sets out a proposed model for delivery of the Board's strategic priorities:

A. ***Commissioning and Transformation Partnerships (CATPS)*** will continue to be the core mechanism to deliver the strategy. Each of the existing CATPs (Early Help, Living Well Network and the Community Safety Partnership) have considered the priorities of the Board and identified in their work programmes how they will deliver against the priorities as well as beginning to develop a performance framework against which to measure progress. The new priorities are cross cutting and have not been allocated to one CATP, instead, as highlighted by the work programmes at ***Appendix 1***, each CATP will contribute to all of the priorities. This is taken into account in the proposed reporting model set out at section 1.2 below.

B. In addition to the work of the CATPs, ***the Mental Health Strategy and action plan*** has been produced to develop and deliver a new model of mental health services to our communities. The approaches and themes highlighted in the new strategy are in line with, and consistent with the Health and Wellbeing priorities. The associated action plan for delivering the Mental Health Strategy was presented to the Board in March 2016 and will be reported again in September 2016. It is proposed that the reporting arrangements for the strategy and associated action plan remain in place with regular reporting to the board on progress (see section 1.2 below).

The attached work programme will continue to develop to take account of progress made and new areas of work highlighted by the Board. As previously highlighted to the Board in the Strategy report in March 2016, a stakeholder event will be held on 30th June 2016 to share the CATP work programmes and seek the views and input of our key stakeholders – this may result in amendments and developments to the attached work programmes. Any such developments will be highlighted to the Board as part of the regular reports from CATPs (See section 1.2 below).

1.2 Progress reporting and Governance arrangements

In order for the Board to hold the CATPs and Mental Health Strategy to account, the following reporting arrangements (as illustrated at ***Appendix 2***) are proposed for the three remaining meetings of this municipal year:-

- ***Progress report against each priority*** (with contributions from each CATP) as follows:-

- ***September 2016*** – Improve Mental Wellbeing and Mental Health (Mental Health Strategy Action Plan)
- ***December 2016*** – Encourage Healthier Lifestyles
- ***March 2017*** – Strengthen Our Communities and Community Based Support

- ***Highlight reports*** from individual CATPS on their wider work programme as follows:-

  - ***September 2016*** – Living Well Network
  - ***December 2016*** – Community Safety Partnership
  - ***March 2017*** – Early Help Partnership

- ***Annual Performance Report***- setting out progress made against the performance measures identified for each of the priorities. It is proposed that a draft performance framework is presented to the September Board with an update against the framework reported in March 2017 (see next steps section at 1.3 below)

- ***Board Development Sessions*** to support the Board in its role of holding CATPs and the Mental Health Strategy to account by providing an opportunity to discuss themes/issues and barriers in more detail. It is proposed that two early evening development sessions are held in October 2016 (focussing on the development of community based support) and January 2017 (focussing on healthier lifestyles).

1.3 Next Steps

- It is recognised that further developments are needed in order to progress the priority of 'Strengthen Our Communities and Community Based Support'. There is currently no CATP to lead on this and it is recognised that although there are initiatives/projects being delivered which contribute to this priority, there is no central point of co-ordination. The local Sustainability Transformation Plan (STP) has key links to this area and therefore further work is needed to agree a consistent and effective way of managing these areas of work.

- A performance framework needs to be developed to support and monitor progress of the Board in progressing its priorities and meeting its objectives. The work programmes at Appendix 1 highlight some key measures within the 'outcomes' column – these will be used as the basis of a performance framework against which the Board will receive annual updates. A proposed framework will be brought to the September Board.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

None –see section 4 above.

3. PREVIOUS MINUTES

- HWB Strategy Development and JSNA presented on 23rd January 2013

- HWB Strategy Development and JSNA (including sign off of final strategy) presented on 13th March 2013

- A progress update against the Health & Wellbeing Strategy priority ‘asset mapping’ process was presented to the Board on 13th May 2013.

- Joint Health and Wellbeing Strategy Performance and Partnership Framework presented on 17th July 2013 and 18th September 2013

- Joint Health and Wellbeing Board Strategy Performance presented 22nd January 2014

- Health and Wellbeing Board Strategy Refresh presented 10th June 2015

- Health and Wellbeing Board Strategy Update presented 9th December 2015

- Health and Wellbeing Strategy Update presented 9th March 2016

4. BACKGROUND PAPERS

None.

Report prepared by Jo Winborn, Partnership & Planning Officer, Organisational Delivery & Development Telephone: 01952 380672

Appendix 1: Emerging HWBB Work Programme: By HWBB Priority

The following work programme summarises the key objectives and outcomes for each of the CATPs by Priority area. The table below indicates in the end column which CATP is responsible for the objective.

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
Encourage Healthier Lifestyles	Implementation of the **breastfeeding** action plan: • Ensure professionals and volunteers working directly with pregnant women and fathers have access to breastfeeding information and are suitably trained to know how to raise • Working with SaTH to improve recording at initiation • Ensure all Health Visitors and midwives have completed UNICEF training • Taking action to improve uptake in areas where attendance is low • Working with the Health Visiting team to further develop their role in supervising peer support and building community capacity • Development and local delivery of a social media campaign	Vicki Pike TWC	• Improved breastfeeding initiation • Increased breastfeeding prevalence at 6-8 weeks	**Early Help**
	Reduce the prevalence of **excess weight** in 4-5 and 10-11 year olds through: • Improving National Child Measurement Programme data sharing between schools, the school nursing team and the Healthy Families team to improve targeting of resources and support • Continued delivery of the Healthy mums, HENRY Programme, Healthy Kids, Healthy Juniors and cooking bus activities • Reviewing current service delivery models	Vicki Pike / Rebecca Lancaster TWC	• Reduced excess weight in 4-5 and 10-11 year olds	**Early Help**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	and service user • Increase uptake of those eligible for 'free school meals' • Promotion of the national Change4Life Campaign • Working with partners to achieve a borough that makes it easier for children and families to make healthier choices			
Encourage Healthier Lifestyles	Implementation and assurance monitoring of the **Teenage Pregnancy** and **sexual health** action plan to deliver improvements in: • Early intervention for young people at increased risk of teenage pregnancy and poorer sexual health • Effective use of local data • Access to high quality contraception and Sexual Health Services • Providing high quality relationship and sex education provision, advice and guidance • Workforce training across key organisations	Stacey Norwood / Rebecca Lancaster (TWC)	• Reduce under 18 conceptions • Reduce under 18 conceptions: conceptions in those aged under 16	**Early Help**
Encourage Healthier Lifestyles	Increase the number of people who engage in sport and activity, not for its own sake but for the wider benefits it can bring, in terms of physical and mental wellbeing and individual, community and economic development – targeted activity to include a focus on • **Tackling inactivity -** Target groups include women and girls, people from lower socio-economic groups, older people, disabled people, people from particular ethnic groups and those with long-term health conditions. Need to work with partners who best understand these groups.	Rachael Thredgold (TWC)	• Increase the number of people who engage in sport and activity	**Living Well Network**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	• **Children & Young People** - children and young people active from the age of five to help them build a positive attitude to sport and activity as the foundations of an active life. Engaging C&YP through family activity as a focus • **Currently Active -** helping those who are active now to carry on, but at lower cost to the public purse. Supporting the sport sector to put customers at the heart of everything they do including making provision welcoming and inclusive, especially of those groups currently under-represented in sport. • **Partnerships** – extending reach and partnerships beyond traditional sports networks to working with a wider range of partners (wider than sport i.e. Macmillan & Mind) • **Volunteering** - Focus is around encouraging volunteering for its own sake as well as an enabler for others to engage. • **Local delivery** – taking a place-based approach to increasing activity levels			
Encourage Healthier Lifestyles	The Smoke Free Telford & Wrekin action plan is our evidence-based, whole-system approach to tobacco control. based around the following themes: • Prevention • Communicating Well • Illicit tobacco • Supporting Our Professionals	Helen Onions TWC	The Smoke Free Telford & Wrekin ambition will deliver progress against the following outcome measures: • Reduce the numbers of people who smoke • To prevent the initiation of smoking by young people - maintaining the prevalence at 5% or lower • Maintain our high smoking quit rates	**Living Well Network**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	• Smoke Free Places		• Reduce the number of women smoking in pregnancy • Reduce smoking-related hospital admissions and associated costs • Reduce social care costs related to smoking • Reduce smoking-related deaths • Improve life expectancy	
Encourage Healthier Lifestyles	Work towards the ambition for a **Smoke Free** Telford & Wrekin for **smoking cessation in pregnant women** and families: • Continued delivery and monitoring of the commissioned stop smoking in pregnancy service • Continued monitoring of referrals to quit smoking services • Further work with midwives to increase the percentage of women giving a CO reading at booking and 24 weeks • A strengthened role for Health Visitors ensuring smoking in pregnancy is raised at every antenatal health promoting visit • Smoking harms awareness and signposting work with young people in schools. • Brief advice training for staff groups working directly with children and young people • Development of 'Smoke Free Children' – comprising Smoke Free Homes, Smoke Free Schools and Smoke Free Parks	Vicki Pike, Public Health/CCG/Health Visitors/SaTH Maternity Services/SaTH Hospital Stop Smoking Service/Stop 4 Life	• Reduce prevalence of smoking in pregnancy to 12% (England average) by 2020 • Ensure all pregnant women who smoke are supported to quit via compulsory CO reading and opt-out referral to specialist smoking cessation service • Pregnant women and families to be aware of the specialist support available and know how to access • Pregnant women and families to adopt Smoke Free homes • Staff (Midwives and Health Visitors) to maintain 100% MECC training completion rates.	**Early Help**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
Encourage Healthier Lifestyles	The Telford & Wrekin Drugs & Alcohol Strategy action plan is our whole-system approach to reducing harm cause by drugs and alcohol. The plan is based around evidence-based actions across the following: • Reducing Risk and Demand • Restricting Supply • Building Recovery and Reducing Harm	Helen Onions TWC	The Telford & Wrekin Drugs & Alcohol Strategy will deliver progress against the following high level outcome measures: • Reduction in the numbers of harmful and hazardous drinkers • Reduction in the number of problematic drug users • Improvement treatment completion rates for opiate clients and non-opiate clients and alcohol clients • Reduction in alcohol and drug-related hospital admissions and associated costs • Reduction in social care costs related to substance misuse • Reduction in both alcohol and drug related deaths • Reduction in alcohol and drug-related crime • Improvement in life expectancy	**DAAT/CSP**
Improve Mental Wellbeing	To improve the **emotional health and wellbeing** of children, young people, families and carers through: • Development of a new 0-25 years Emotional Health and Wellbeing Service. • Redesigning the existing CAMHs provision • Designing and delivering a programme of training, development and peer support for our Early Help and preventative workforce • Jointly commissioning a community eating disorder service for children and young people • Improving perinatal support through training of professionals and enhancing the existing Public Health activity. • Development of a self harm pathway with	Anna Hammond Louise Mills	• 14 Learning Behaviour Mentors to provide training and peer mentoring support across the early help and targeted workforce including schools (multi-agency) • An Emotional Health and Wellbeing lead in each of our primary and secondary schools – our 2016 / 2017 target is 55 practitioners. • Fewer children accessing mental health services as their needs will be met within a universal service or through any early help or targeted support they receive.	**Early Help**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	supporting guidance and protocols.			
Improve Mental Wellbeing **& Encourage Healthier Lifestyles**	➢ To work towards the ambition for a Smoke Free Telford & Wrekin – Supporting Professionals: • Pilot project with Sutton Hill Medical Practice and MIND to support people with mental health diagnosis to stop smoking, if successful, this model may be extended to other GP practices	CCG Mental Health Commissioners/MIND/Stop Smoking Service providers	• To promote a specialist stop smoking service to all patients registered with a mental health diagnosis • Ensure routine identification and referral of patients in GP • Produce a menu of smoking cessation support options • Extend the standard 12-week programme to meet the needs of people with mental health issues	**Living Well Network**
Improve Mental Wellbeing	To work collaboratively with the CCG and partners to coordinate the prevention element of the Mental Health Strategy (Supportive Communities)	Steph Wain / Clare Harland	• We have an evidence-informed approach to reducing suicides • The key messages of the Five Ways to Wellbeing are understood and residents and communities are actively seeking opportunities to Be Active, Connect, Learn, Give and Take Notice • Emerging mental health needs are met within the community by a growing voluntary sector delivering evidenced based programmes and initiatives that are known to improve emotional health and wellbeing	**Living Well Network**
Improve Mental Wellbeing	➢ To work towards further implementation of the Telford & Wrekin Drugs & Alcohol Strategy: • Improve links between substance misuse/ recovery services and prison to support discharge • Review all relevant policies/procedures ensuring clear pathways are in place e.g.	Lyn Stepanian TWC/IOM Lyn Stepanian TWC Bhavna Taank/Barbara	• Increase in the number of referrals into substance misuse services from prisons • Increase in the number of families at risk receiving support for drug and alcohol issues	**DAAT/CSP**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	strengthening families, domestic violence, hidden harm agenda • Improve effective joint working for people with complex issues such as dual diagnosis, mental health and substance misuse issues	Jones (DARS)	• Decrease in the number of children in care where parental substance misuse is a factor • New pathway for dual diagnosis implemented	
Strengthen Our Communities	Improve the prospects of children and young people in Telford & Wrekin through: • Local delivery of the 'Reaching a Positive Destination' project for young people not attending school in year 11 • Promotion of the 'Life Ready Work Ready' campaign to get young people work ready • Enhancement of work experience opportunities using an on line system to measure value from work experience • Delivery of an annual 'Apprenticeship Show' to promote and increase uptake of Apprenticeship opportunities • Provision of help and support through Job Junctions and Job Box mentors • Provision of an increased range of community learning courses including English and Maths • Working with Colleges and providers for successful post 18 progression and support	Sue Marston TWC	• Reduce Not in education, employment or training (NEET's) • Raise Employment (18-24)	**Early Help**
Strengthen Our Communities	Building community capacity to deliver early help and preventative support through: • Reconfiguration of service delivery - that is outcome focussed, place based and co-produced with residents and providers • Development of a Early Help Provider Network and Community Service Directory	Louise Mills & Debbie Lloyd TWC	• Early Help Performance Framework	**Early Help**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	for early help and preventative services • Identification of Early Help Champions (amongst residents, professionals, businesses & organisations) • Local delivery of the Locality Advisory Board action plans • Development and implementation of a training programme for voluntary sector providers • Developing the 'Your Community' role of Health Visitors to promote healthy lifestyles and work with communities to build and use the strengths within those communities to improve health and well being and reduce inequalities. • Working with key partners, identify opportunities to pilot and evaluate intergenerational practice.			
Encourage healthier Lifestyles and **Strengthen Our Communities**	To adopt a community centred approach to developing further our Healthy Lifestyles programme through: • Local delivery of the national 'One You' Campaign to raise local awareness of the actions individuals can take to 'stay healthy' • Coordination of the Health Champions Programme • Implementing a 'social prescribing approach'. This will include connecting individuals with non-clinical or social needs or those with mild to moderate mental health problems to opportunities for social interaction, support, learning and healthy lifestyle activities • Delivery of the Making Every Contact Count, brief advice training programme to frontline professionals (including volunteers)	Clare Harland/ Rachael Thredgold	• Service user profiling and performance reports demonstrate increased uptake by adults living in the most deprived areas of the borough • Each local community has a group of Health Champions working across generations and making a difference to the locally identified health needs of their area • Our frontline workforce (including that of our key partners) have attended Making Every Contact Count training – our workforce is equipped with skills and knowledge and feel confident to raise and respond to lifestyle issues within their routine contacts with members of the	**Living Well Network**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
			public	
Encourage Healthier Lifestyles and **Improve Mental Wellbeing**	Local delivery of the Work Well Programme including: • Development and promotion of the Work Well website • A series of workshops and seminars for employers	Clare Harland/TWC	• A Work Well website accessible for all employers in the borough providing access to information, signposting to support and evidence based practice • Reduced sickness absence levels across the borough • A resilient workforce reporting improved health and wellbeing • A well connected network of local businesses championing health and wellbeing and supporting each other	**Living Well Network**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
Improve Mental Wellbeing	➢ To work towards further implementation of the Telford & Wrekin Drugs & Alcohol Strategy: • Restricting Supply: closer working and between the criminal justice system and substance misuse services to improve pathways for offenders and strengthening work on the night time economy and test purchasing • Further develop and implement the substance misuse training programme Continue to improve and share data and intelligence on substance misuse treatment services • Expand delivery of social recovery and mutual aid projects through TACT etc, including links with Job Centre Plus and employees • Improve recovery pathway further to embed aftercare and relapse prevention and exit strategies • Expand GP shared care provision for substance misuse clients	Integrated Offender Management/Community Rehabilitation Company/WM Police Public Protection/Emma Trowell/Anita Hunt Lyn Stepanian Bhavna Taank Bhavna Taank Lyn Stepanian/ Bhavna Taank DARS/Inclusion	• Increase in the number of referrals from criminal justice system into treatment and recovery services, sustaining clients in service for 12+ weeks • Decrease re-offending rates • Decrease rates of alcohol-related crime • Maintain the number of test purchasing operations • Increase the numbers of professional receiving basic awareness and specialist substance misuse training • Intelligence on the substance misuse performance and outcomes framework is comprehensive for all services and well shared with partners • Increase in the numbers of people supported by recovery projects, expanding the numbers of peer volunteers. Increase the number of people with planned treatment exits, numbers completing treatment (especially the longer term clients) and reduce representations • • Increase the number of GPs trained to deliver shared care (RCGP), expanding the number of practices to offer the service • Increase the number of clients in share care	**DAAT/ Community Safety Partnership**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
Strengthen Our Communities and **Improve Mental Wellbeing**	To reduce crime and increase confidence in reporting This CSP priority contributes to the HWBB priorities in the following ways; • Overall reduction in crime • Increase public / community confidence to report crime. • To further understand the fear of crime within communities • Address ongoing community tensions • Develop partnership strategies and action plans against specific crime types which significant impact on individuals and communities alike. The CSP is working to tackle and reduce crime, through a partnership approach in effectively managing specific key areas; ○ Domestic Abuse ○ Child Sexual exploitation ○ Integrated Offender management ○ Impact of the Night time economy ○ Gypsy and Travellers	Paul Fenn / CSP	• IDVA – 1:1 support for all high risk victims of DA. • No of children exposed 3 / 5 + times to DA within 12 months • Domestic abuse crimes where alcohol / drugs are involved. • No of domestic Abuse Protection notices / Orders. • No of DA incidents involving children and pregnant women • No of MARAC and repeat MARAC cases • No of 16 / 17 year old victims and perpetrators at MARAC. • No of children discussed at MARAC. • To reduce the no of people becoming either victims / perpetrators of crime • To ensure that all young people who are at risk of CE or victims of CE, and their families, have access to appropriate support services to recover from any trauma and enable them to reach their full potential. • To ensure that young people who are identified as potential CE offenders are supported to minimise/eradicate their	**Community Safety Partnership**

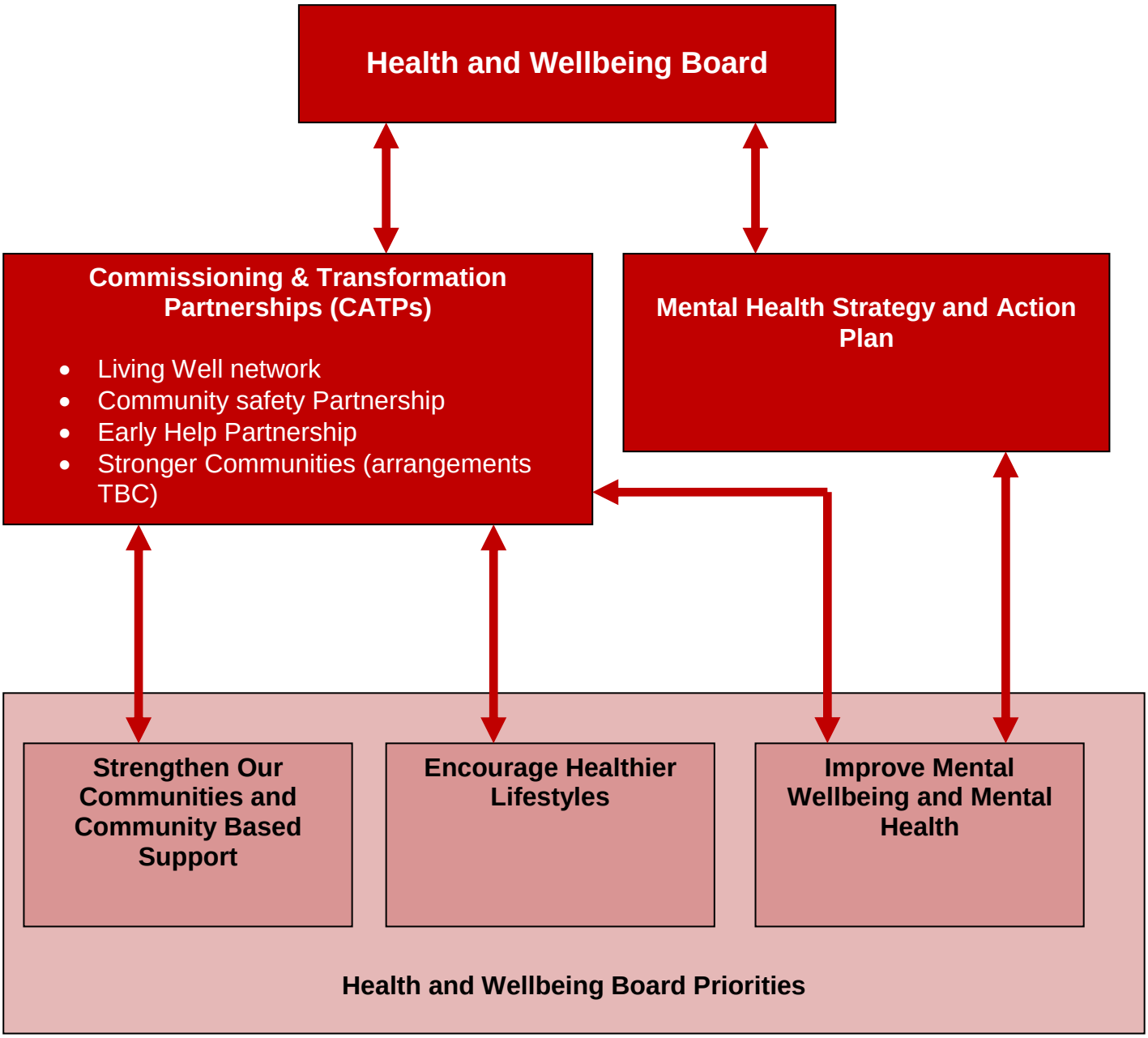
HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
			offending behaviour. • Reduction in un-authorised encampments.	
All Priorities	Reduce offending and reoffending This CSP priority contributes to the HWBB priorities in the following ways: • Reducing the pressures, particularly on mental wellbeing, on individuals and communities which crime creates • Supporting offenders to adopt healthier lifestyles – such as substance misuse which contributes to crime The CSP is working to reduce offending and reoffending through: • There are 7 identified pathways with the aim to improve the life chances of offenders. These include looking at mental health and the contributing factors such as drugs and alcohol. Offering community Payback on a structured programmes ensures that local communities are visibly aware that offenders are giving something back within local communities be that carrying out low level environmental works to snow clearing in the winter. • Neighbourhood Delivery Groups are multi agency meetings to discuss problematic people, persons and places in greater detail and develop robust action plans. These action plans are outcome focussed and evidenced based, and linked to wider information sources such as Strengthening Families data sets to	Paul Fenn / CSP	• Reduction in offending rates • Reduction in re-offending rates • To reduce no of first time entrants into Youth / Criminal Justice system	**Community Safety Partnership**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	understand high demand areas.			
All Priorities	To reduce the impact ASB and Environmental crime has on people, places and communities. This CSP priority contributes to the HWBB priorities in the following ways: • To effectively use powers and community remedies to tackle and resolve local issues. • To understand the impact that ASB and environmental crime has on local communities. • To understand the vulnerability and risks for individuals and wider communities. • To develop sustainable solutions. The CSP is working to tackle and reduce ASB and environmental crime through; • Adopting and implementing a new integrated community Management model. This model is a new partnership approach looking at working closer with Town and Parish councils to be actioned focused in key local areas of concerns. This ICM model will also underpins Town and Parish's financial contributions towards Police Community Support Officers. • Neighbourhood Delivery Groups are multi agency meetings to discuss problematic people, persons and places in greater detail and develop robust action plans. • ASB Reporting Line – to provide a 'one	Paul Fenn / CSP / Environmental Enforcement	To tackle and resolve; • Rowdy and inconsiderate behaviour • Illegal us of motor vehicles • Neighbour nuisance • Playing of football games To support; • Increase in reporting • Reduction in no of fly tips • Reduction in dog fouling • Reduction in littering • Reduction in incidents of graffiti • To evaluate pre and post to ensure that scenario's are relevant. To understand what messages the children take away from the event	**Community Safety Partnership**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
	stop number' for local residents to report ASB and crime. This provides data sets to understand ASB / environmental crime patterns and trends. • Effective and proportionate use of Fixed Penalty Notices to support reducing environmental crimes • Crucial Crew- Year 6 primary school event aiming to provide children with clear 'keep safe' messages			
All Priorities	• Supporting the development of a creative network of voluntary sector partners working collaboratively with the council, taking an asset based approach and maximising the use of collective resources to promote wellbeing and reduce inequalities in health.	TWC	• Promote our assets and facilities that operate as wellbeing spaces e.g. parks, play areas, outdoor gyms, ball courts, Visitor Centre and theatre • Develop a more resilient community sector - building the longer term sustainability of programmes and groups Be Active, In Harmony, First Steps programme, Friends of groups • Review our culture and wellbeing offer for people with mental health conditions and seek a variety of funding opportunities • Exploring options to develop traded services and commercial opportunities for the Culture & Wellbeing service e.g. schools, business sector, • Continuing to work with external partners with similar outcomes to access grants e.g. culture zone, creative arts, music, parks, sports	**Living Well Network**

HWBB Priority	Key Task/Objective	Lead Officer/ Organisation	Desired outcome	Lead Partnership
			development. • Developing strong links with businesses and explore options around corporate social responsibility and social value to support sustainable work in the community	

Appendix 2: Strategy Governance Diagram



TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15th JUNE 2016

D

REPORT TITLE: SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE

REPORT OF: DAVE EVANS: CHIEF OFFICER, NHS TELFORD AND WREKIN CCG

1. RECOMMENDATIONS

That the Board note the contents of the attached report.

To
Simon Wright
Chief Executive Shrewsbury and Telford Hospital Trust

cc to
CEOs from NHS England, NHS Improvement, CQC, PHE, HEE, NICE and LGA

By email

13th May 2016

Dear Shropshire and Telford and Wrekin

Thank you for your initial STP return and for making the time to come and discuss it with the ALB CEOs last week. They have asked us to feedback on their behalf, so that we can work with you to take this forward. The panel was impressed by the commitment to develop a genuinely sustainable plan that will transform the quality of care for your population over the next five years, and the evidence of partnership working across commissioning, provision and local authorities.

This letter captures some of the key elements of our discussion, sets out what we expect to see in your plan on June 30th and the support we can offer in the intervening period. This is not exhaustive, and so should be read alongside other STP guidance and advice from your regional ALB Programme Board.

As we discussed, the plans need to simultaneously address the in-year challenge of delivering the 16/17 position as well as putting in train the actions that will be needed to ensure a high quality, financially sound health system by 2020/1. We no longer have the luxury of trading off short stability against long-term benefit and it is our collective challenge to ensure the solutions we develop for today's problems provide a bridge to our strategy for tomorrow.

We recognise that your STP is a complex geography with many moving parts, and although we did not discuss all the areas that will be part of your STP plan, in our conversation we discussed a number of key themes that we expect to be fully developed as part of your plan, including the need to:

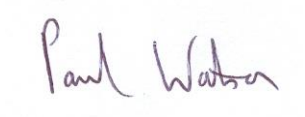
- Continue to develop a shared purpose across the footprint, using the STP to build the momentum you have already created, and drive the transformation required to close the three gaps (health, quality and finance).
- Set out a tangible/detailed model of care – including your acute services model and plans to improve primary and community services – with clearly defined choices and benefits for your population, not just in 2020/21 but working back from this for each year and in relation to your 16/17 control total, so that we can be assured it stacks up.
- This should include your plan for orthopaedics and reflect the scale of the challenge with regard to your frail elderly population.
- Set out clearly any dependencies for your plan to work – including any capital requirements (and in recognition of the current context, potential innovative options to meet them).

- Set out your plans to work with LAs and other partners to deliver not just the service changes, but the cultural changes required to support it.

To support the planning process, we will shortly release an 'indicative allocation' for 2020/1 for each footprint. These figures are – as the title suggests – indicative: final allocations will be subject to allocations decisions that are for the NHS England Board to make in due course. Overall the funding available for the healthcare system will be greater in 2020/1 than it is today, although the levels of future growth may be less than the NHS has enjoyed historically. We need to be clear that this is not about 'cutting' budgets, but about identifying the best possible use of resources so that we can meet the forecast rise in demand, and wherever possible, reduce that demand by improving the population health. The point of making these indicative figures available now is to provide a basis for local conversation about the best way to drive the necessary transformation, allowing you to reverse engineer back from 2020/1 to the 16/17 position.

We will use your June STP submission as the basis for a further conversation about concrete options, impact and timelines, so that together we can develop and implement a sustainable plan for transformation at pace.

Finally, we would like to personally thank you for taking on this vital leadership role, and do let us know if there is anything else the national or regional team can do to support you.



Paul Watson

Dale Bywater

STP

Shropshire and Telford & Wrekin
Sustainability and Transformation Plan

Update for Partner Boards

This paper provides an update on the STP process so far and set out steps for agreement moving forward.

The STP is intended to be a strategic document that sets out the key priorities for the Shropshire and Telford & Wrekin footprint through to 2020/21.

It must be at a sufficient level of detail to allow tangible discussions to be held on the 2-3 big topics that are worthy of extra-ordinary effort for extra-ordinary gain. It is not expected to include every issue that systems will be dealing with over the 5 year period. It should cover how we will:

- Close the health and well-being gap – prevention, self-care, social capital
- Close the care & equality gap – models of care for acute, community, primary care
- Close the financial and efficiency – Deficit Reduction Plan

Of particular note for the HWBB will be the workstream that is being created around 'Neighbourhoods'. There will be a workstream for both Shropshire and Telford and Wrekin; each workstream will have Chief Officer Sponsorship from Clive Wright and Richard Partington respectively, along with Executive Leadership. These two workstreams will further develop solutions for place-based services, social capital and prevention and self-care. The workstreams will have a reporting line to the HWBB to ensure they develop proposals that are consistent with the priorities in the Health and Well-Being strategy, the JSNA and the Better Care Fund.

We have submitted an interim submission based on a centrally-determined template; this was not intended to be an executive summary of the final document, more an outline of work done so far and emerging priorities. We have also had a one to one session with the Chief Executive of NHS England and Chief Executive of other Arms Length Bodies (ALB); this is due to the fact that we were pre-designated as a high risk system. The feedback from this interim assurance process is attached.

A central element of the STP is the progression of the Strategic Outline Case for hospital services; following approval further work will take place on the wider models of care for the population. At a recent joint CCG board meeting the Strategic outline Case was approved by Telford & Wrekin CCG and not approved by Shropshire CCG. Further work is now in hand to describe the resourcing of the shift of activity from the acute services and the intention is for the Strategic Outline Case to be re-presented to the Shropshire CCG Governing Body for approval in June. The Strategic Outline Case needs to be approved in order to have a viable STP; the STP will be submitted by 30th June 2016. We will continue to progress the work on prevention and self-care and the Deficit Reduction Plan over the coming weeks.

It had been intended to submit the proposed STP to the Boards for the May/June cycle starting with RJAH FT Board on the 24th May 2016; we would then collate feedback and submit at the end of June. This is no longer possible because it was not approved by Shropshire CCG.

We have been informed that we will be called to another one to one session with ALB Chief Executives in July, following which we will receive feedback and guidance about how to proceed. In light of all the above, the STP will be submitted on 30th June following approval from the STP Partnership Board. Following feedback from national teams we will further refine the plan and submit to partner boards for approval of the final plan at a later date.

E

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD - 15th JUNE 2016

BETTER CARE FUND UPDATE REPORT

REPORT OF: MICHAEL BENNETT, HEAD OF COMMISSIONING: BETTER CARE FUND/CARE CLOSER TO HOME TELFORD AND WREKIN CCG

AND JONATHAN EATOUGH, ASSISTANT DIRECTOR, GOVERNANCE, PROCUREMENT & COMMISSIONING, TELFORD & WREKIN COUNCIL

LEAD CABINET MEMBER: CLLR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1.	**SUMMARY OF MAIN PROPOSALS**
1.1	This report summarises the performance and progress of the Better Care Fund progress during its first formal year of implementation. It also summarises the submitted Plan for 2016/17 to the Board for formal Approval. The full Narrative Plan with all associated submitted documents is included as an Appendix A.
1.2	The Better Care Fund (BCF) is a national programme, jointly led by NHS Telford & Wrekin Clinical Commissioning Group (CCG) and the Borough of Telford & Wrekin. The aim of the BCF programme is to transform the health and social care system: • Resilient local communities focussing on well-being and Prevention • Integrated preventative services delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent • Reduced reliance on social care services • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions
1.3	The aims are in line with the CCG vision 'Working with our patients, Telford and Wrekin CCG which aspires to have the healthiest population in England. Healthier, Happier, Longer'. And the Council vision to 'encourage healthier lifestyles, strengthened individuals and communities to support themselves'.

1.4	To deliver the BCF aims and objectives, two thematic areas and objectives have been developed over the last two years. That have been developed into three key integrated care programmes that have been jointly agreed: • Building community resilience • Developing 'Telford Neighbourhood Care Teams • Implementing Robust Intermediate care services
1.5	The key performance metrics are: • Reducing non-elective hospital admissions, re-admissions and length of stay. • Reducing permanent admissions to residential and nursing care. • Improved patient experience • Reducing delayed transfers of care. • Improving the effectiveness of reablement/rehabilitation services. • A local measure of Reducing emergency admissions in 65 years + age group (revised in 2016/17 to 70+ years)
1.6	The performance of BCF for 2015/16 was • Overall increase in admissions of +312/ 1.8% • Overall reduction in costs of - £1,169,000/ -4% • Overall length of stay reduced by 0.51 days (4.39- 3.88 days across all ages) • Delayed Transfers of Care (DToC) did not achieve BCF level of reduction but lower than last year • Permanent admissions reductions to care homes were achieved • Maintaining at home 91 days after Enablement was lower than target for the reporting periods but higher than target over the year as a whole • Interim performance of the patient experience metric is lower than target.
1.7	The Narrative Plan at Appendix A details the programme for 2016/17 and Actions to achieve throughout the year and next year.

2. RECOMMENDATIONS

2.1 The following recommendations are made

- Note the outcomes of the Better Care Fund programme for 2015/16
- HWBB to approve the BCF submission for 2016/17
- Note the progress of the development of the section 75 pooled budget Agreement
- Ensure respective organisations support and facilitate approved BCF implementation within the identified timescales

3. IMPACT OF ACTION

3.1 Key actions for the development of the Better Care programme are:

- Formal support of the Narrative Plan and associated Action Plan

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="3">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td colspan="2">Improve emotional health and wellbeing of Telford and Wrekin residents.

Support people with specific health needs to live independently for as long as possible.</td></tr>
<tr><td colspan="3">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td colspan="2">Yes</td><td>Vulnerable adults and children</td></tr>
<tr><td colspan="3">Will the proposals impact on specific groups of people?</td></tr>
<tr><td colspan="2">No</td><td>The BCF will impact on all groups.</td></tr>
<tr><td>TARGET COMPLETION/ DELIVERY DATE</td><td colspan="3">The BCF formally commenced from April 2015 with a formal Pooled Budget (section 75 Agreement) and programme of work.

The Narrative Plan includes the programme of work for 2016/17.</td></tr>
<tr><td>FINANCIAL/ VALUE FOR MONEY IMPACT</td><td>Yes</td><td colspan="2">The Better Care Fund Pooled Budget in 2015/16 will be £12.529,000 (Council contribution of £1,647,000/ CCG £10,882,000). There were two pooled funds of revenue and capital monies. The capital fund was £1.28m of which 66% was expended within the year, the remainder being rolled forward for use in 2016/17 as appropriate. The revenue funding of £11.249m was fully expended in year.

The Pooled Budget in 2016/17 is increased to £14,252,674.(Council contribution of £2,261,454/ CCG £11,991,129 , net of any carry forward from 2015/16).

The funding within the Pooled Budget relates to 4 key areas of work as set out below, with more detail shown in Section 5 of the report.

<table><tr><td>Community Resilience</td><td>£1,282,804</td></tr></table></td></tr>
</table>

		<table><tr><td>Telford Neighbourhood Care</td><td>£3,532,389</td></tr><tr><td>Intermediate Care</td><td>£6,004,400</td></tr><tr><td>Other Care</td><td>£3,432,564</td></tr></table> Whilst some additional funding has been applied to all of these areas some significant changes relate to Community resilience with increased funding of £762,149 and Disabled facilities provision (Other Care), with an increased grant of £726,312. The pooled fund will be contained within a Section 75 legal agreement which is currently in development and subject to the governance arrangements set out within the BCF plan.
LEGAL ISSUES	Yes	The BCF s75 Agreement ('The Agreement') is based on the template generic agreement drafted by Bevan Britten solicitors for NHS England in 2015. The Agreement provides the legal framework for a pooled budget between the Council and the CCG ("The Parties") and also provides for future flexibility via the likes of the optional Non-Pooled Fund which has its contributions identified but held separately and transferred between partners via separate standard agreements under s76 and s256 of the National Health Service Act 2006. The 2015/16 current Agreement sets out the terms on which the Parties have agreed to collaborate; aims and outcomes; financial contributions, risk and benefit sharing arrangements. The current Agreement was signed off in December 2016 and formally executed by both Parties. An agreed joint Governance process between the Parties to monitor the current Agreement is in place. Where changes affect the Council and CCG commissioning plans, separate reports through respective Governance structures will take place. There is a requirement for the 2016/17 Agreement to be formally signed off by 30th June 2016.
EQUALITY &	Yes	The BCF is intended to reduce risks of admissions

DIVERSITY		to groups at high risk of hospital admission as identified from local analysis.
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact
PATIENTS & PUBLIC ENGAGEMENT	Yes	Engagement takes place on a regular basis with: Carers Partnership Board Shropshire Partners in Care Council for Voluntary Services and voluntary organisations A BCF launch event took place in July 2014 with a follow up event in July 2015. The feedback highlighted the need for integrated working and increased preventative interventions.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	A risk register is included within the Submission and monitored within the BCF Pooled Budget meetings. Financial risks are identified within the Risk Sharing Agreement, and included within the section 75 Agreement.

PART B) – ADDITIONAL INFORMATION

1	**INTRODUCTION**
	The BCF programme implementation formally commenced from April 2015. This includes the requirement to achieve the agreed BCF targets and to have a section 75 agreement (pooled budget) in place. The programme has a number of national conditions that are required to be met and included in the planning for 2015/16: • Plans to be jointly agreed • Maintain provision of social care services (not spending) • Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions and improve discharge • Better data sharing between health and social care, based on the NHS number • 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 • Agreement on a local target for Delayed Transfers of Care (DToC) and develop a joint local action plan
	Two additional national conditions were indicated for 2016/17: • Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans • Agreement to invest in NHS commissioned out-of-hospital services As part of national monitoring of all 2016/17 BCF plans, DH identified 73 Key Lines of Enquiry (KLOEs) to be assured that Plans addressed the national conditions. This is set out within the Narrative Plan.
	An important change was assurance through specific KLOEs to ensure that the BCF plan was aligned to other strategic and operational plans including the Sustainability and Transformation Plan, CCG Operational Plans and Council transformation plans.
	The aim of the BCF programme is to transform the health and social care system in Telford and Wrekin: Resilient local communities focussing on well-being and Prevention • Integrated preventative services delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent • Reduced reliance on social care services • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions

2	**BCF PERFORMANCE 2015/16**
	BCF performance is set out below:
	<u>Reductions in non-elective admissions</u>

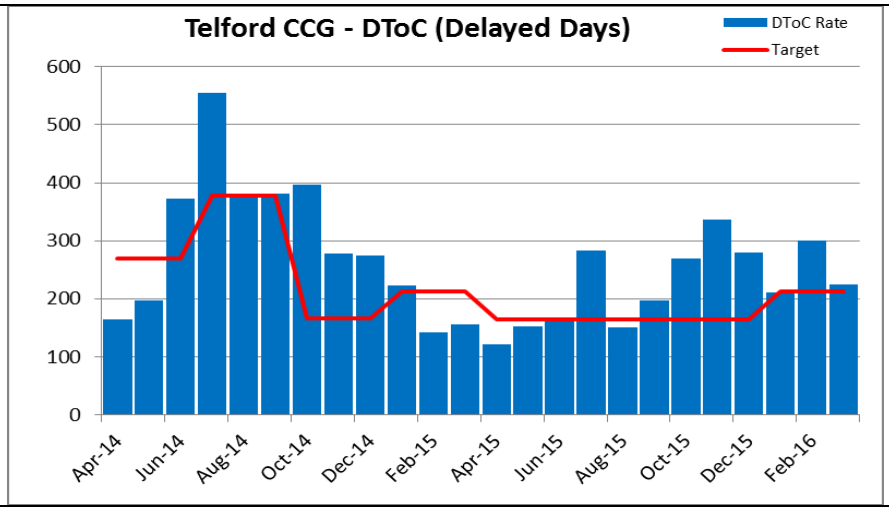
Scheme	Cost		Cost Difference		Activity		Activity Difference	
	2014/15	2015/16 (YTD)	Volume	Percentage	2014/15	2015/16 (YTD)	Volume	Percentage
Paediatric Emergency Admissions - 0-17 years	£2,847,356	£2,897,790	£50,434	2%	3476	3703	227	6.5%
Paediatric Emergency Admissions - 18 years,	£87,810	£55,382	-£32,427	-37%	99	73	-26	-26.3%
Care Homes	£2,325,761	£2,131,974	-£193,786	-8%	779	775	-4	-0.5%
UTI	£980,169	£931,936	-£48,233	-5%	416	430	14	3.4%
Respiratory Conditions	£3,862,157	£3,758,799	-£103,358	-3%	1738	1763	25	1.4%
Chest Pain	£361,152	£237,323	-£123,829	-34%	496	343	-153	-30.8%
Falls	£1,472,933	£1,570,416	£97,483	7%	538	592	54	10.0%
Cardiac	£2,764,428	£2,759,015	-£5,413	0%	1540	1641	101	6.6%
Cellullitus	£324,282	£316,568	-£7,714	-2%	168	166	-2	-1.2%
Consipation	£114,972	£123,145	£8,173	7%	86	98	12	14.0%
Diabetes	£173,491	£279,139	£105,648	61%	102	142	40	39.2%
Disorientation / dizziness	£183,312	£211,744	£28,432	16%	94	109	15	16.0%
Mental Health	£117,691	£80,489	-£37,202	-32%	103	71	-32	-31.1%
Geriatric Med	£2,831,630	£2,545,012	-£286,618	-10%	1273	1248	-25	-2.0%
General Med Under 65	£2,355,586	£2,140,332	-£215,254	-9%	1756	1670	-86	-4.9%
End of Life	£325,309	£289,136	-£36,173	-11%	72	71	-1	-1.4%
(Surgical)No Procedure	£429,336	£455,445	£26,109	6%	487	513	26	5.3%
Scheme Total	**£21,557,373**	**£20,783,645**	-£773,728	-4%	**13223**	**13408**	**185**	**1.4%**
included in any Schemes	**£7,842,565**	**£7,446,660**	-£395,906	-5%	**3693**	**3820**	**127**	**3%**
All Total	**£29,399,938**	**£28,230,304**	-£1,169,634	-4%	**16916**	**17228**	**312**	**1.8%**

The performance of BCF for 2015/16 was (using BCF profile from SUS data):

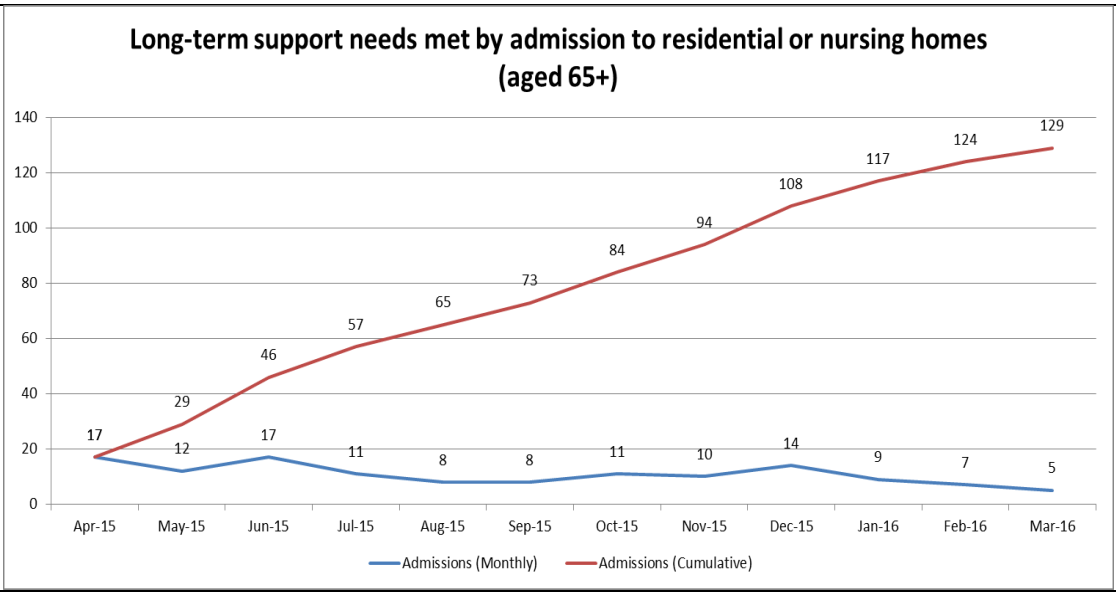
- Overall increase in admissions of +312/ 1.8% with BCF related schemes achieving +185/ +1.4%
- Overall reduction in costs of - £1,169,000/ -4% with BCF related schemes achieving -£773,000/-4%
- 0-17 years increased by 222/+6.4%
- 65+ years increased by +123/ +2% with cost reduction of
- -£615,000/-4%
- 65-74 years reduced by -152/6.2% with cost reduction of
- -687,000/-12%
- 75+ years increased by +275/+7.4% with cost increase of +£72,000/+1%

70+ years, the local metric for 2016/17 showed an increase of +221/+4.5% with cost reductions of -£204,000/-2%

Overall length of stay reduced by 0.51 days (4.39- 3.88 days across all ages). There were reductions in all age profiles with most significant age profile of reduction in 75+ years being 1.15 days (9.09- 7.94)

	<u>Delayed Transfers of Care (DToC)</u>
	The BCF target for DToC reductions was not achieved. However, there was a significant reduction in DToC days against last year (3523 against 4585 days). Only Q4 was higher than last year and 6 monthly levels were below to monthly BCF target.
	
	Key areas affecting DToC performance in 2015/16 are: • Completion of Assessment delays rose in Q2 and Q3 • Waiting for Further NHS Non-Acute Care higher in Q1-3 than last year • Waiting for care bed placements higher in second part of the year. This coincides with changes in the Discharge to Assess process • Waiting for domiciliary care higher in second part of the year. This coincides with changes in the Discharge to Assess process • Waiting for community adaptations has increased against last year • Mental health DToC increased from November 2015 There were reductions in Waiting for Residential Care placements
	<u>Reduction in permanent admissions to care homes</u>
	The target was an outturn of 140 admissions/ 100,000 population. The actual outturn was 129 admissions / 100,000 population – set out below

Discharge	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Admissions (Monthly)	17	12	17	11	8	8	11	10	14	9	7	5
Admissions (Cumulative)	17	29	46	57	65	73	84	94	108	117	124	129
Population (65+)	27,200											
ASCOF Measure	474.3											

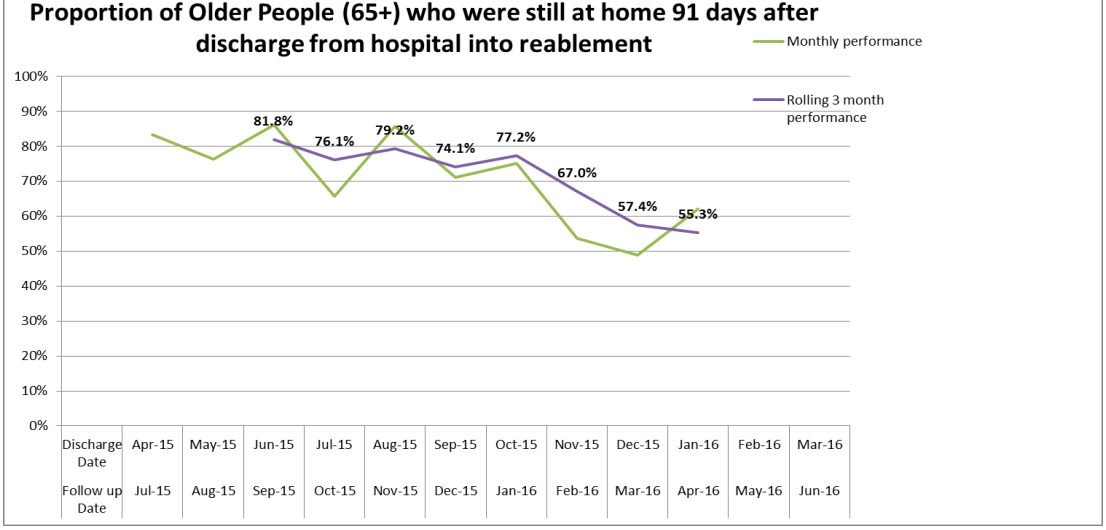


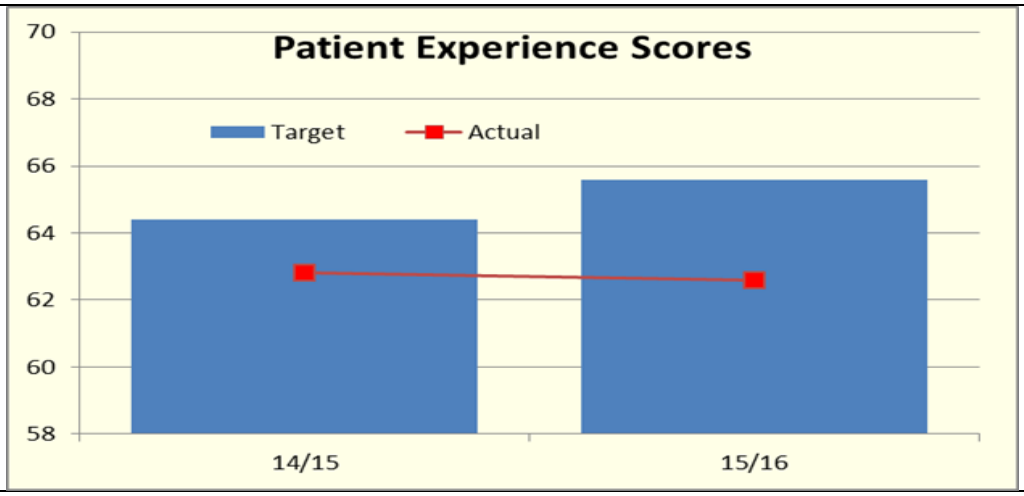
Improving the effectiveness of reablement/rehabilitation services

The performance for people maintained at home 91 days after Enablement is below. This indicator compares those people who have received reablement during a monitoring period and measures the % remaining at home 91 days later.

The monitoring period is October – December and January – March. This indicates a level of 57% against a target of 66.3%.

Discharge	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Follow up	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Number starting enablement	36	38	36	35	35	38	28	28	45	50		
Number still at home 91 days later	30	29	31	23	30	27	21	15	22	31		
Monthly performance	83%	76%	86%	66%	86%	71%	75%	54%	49%	62%		
Rolling 3 month performance			81.8%	76.1%	79.2%	74.1%	77.2%	67.0%	57.4%	55.3%		



	Taking the year overall, there has been good performance – 71% against the target of target was 66.3% The drop in performance relates to the change in use of Recovery beds during the latter part of the years where a number of patients without rehabilitation potential were placed and included within reporting. The clinical process has been revised.
	<u>Patient experience</u>
	
	The locally agreed patient experience metric was Question 32 of GP Survey (feeling supported to manage LTC). The CCG report (July 2015 publication) based on aggregated data collected from Sept-Dec 2014 and Jan-Mar 2015 was 62.8% against a baseline of 63.1%. The Planned level for 2015/16 was 65.6%. The final report on 2015/16 due to be published in July 2016. The target is unchanged for 2016/17 within BCF submission.
3	**<u>PROGRESS OF THE PROGRAMME DURING 2015/16</u>**
	There had been substantial progress made during the year. Some key process is summarised below

<u>Improvement</u>	**<u>Impact</u>**
Improved joint working across health and social care	Implementation of the Telford Integrated Community Assessment Team (TICAT) Planning across health and social care managers to implement the Integrated Care team from October 2016 Shortlisted for HSJ Integrated care category

More robust commissioning processes	Development of joint strategies and reviews including: • Joint Prevention Strategy • Development of 'The Community Centred Approaches' paper that sets out the vision for health and social care of '*Right Help, Right Time to promote Independence*' • Jointly presented Commissioning priorities to HWB Board • Joint planning and development of Community Resilience and working within independent and voluntary sector • Commissioning Emergency Response Service Planning alternative model of Recovery through extra care; not care beds
Council Brokerage team procuring all bed-based and domiciliary care	Streamlined processes for care. More responsive care in place. Management of costs.
Co-production with the independent and voluntary sector	Market Position Statement setting out future direction for permanent and domiciliary care services Clarification of vision and future needs to the sector and encouraging diversity and sustainability Joint monitoring of the Grant funded services Voluntary organisations collaborated in bids for tenders and Grants Ownership of part of sector to develop through Social Value workshops Shortlisted for HSJ award in cares category and were 'Highly Commended'
Implementation of Locality working	Improved utilisation of the voluntary sector in local communities. Developed preventative approaches

			within local communities Identification and joint management of high risk people.
4	**<u>BCF PERFORMANCE 2016/17</u>**		
	The Narrative Plan sets out the vision overall BCF programme of work.		
	The key metrics for BCF are: • Reductions in emergency admissions of 70+ years by 8% (404) • Reduced permanent admissions to care home to 155/ 100,000 • Percentage of people maintained at home 91 days after Enablement of 70% • Reduce DToC to 3285 days • Improve patient experience (feel supporting in managing long term condition) to 65.65		
	The overall programme of work is included within the Action Plan is intended to meet national KLoEs and local plans:		
		<u>Programme of work</u>	**<u>Key actions and outcomes</u>**
		Community Resilience	• Expansion of local communities to provide on well-being and Prevention and reduce demand for health and social care • Enable community development and resilience • Collaborative arrangements between providers • Strengthen communities by tackling the causes of poor health
		Neighbourhood Care	• Integrated health, social care and voluntary care services based within localities. • New relationships between primary care, Council teams, voluntary and independent sector services and NHS services – both acute and community • Increased acute services eg clinics, clinical advice, diagnostics based and delivered within local communities and primary care • Preventative and personalised approaches • Shared ownership of managing and supporting high risk patients eg Frail people, long term conditions
		Integrated Care	• A fully integrated health, social care and voluntary care team working together within a

		single service specification • Increased specialist clinical advice • Therapists and specialist teams working across acute and community services within agreed pathways to ensure people supported at home • Reduced hospital conveyances and non-elective admissions through 7 day service including from care homes
	DToC Action Plan	Achieve Action plan aligned to the 8 High Level Changes to reduce DToC targets as an economy: • Early Discharge Planning • Systems to Monitor Flow • Multi-disciplinary discharge teams • 7 day services for admission avoidance and discharge • Trusted Assessors to facilitate prompt discharge to the right level of care • Focus on Choice • Enhanced Care in Care Homes • DToC levels achieved included acute hospital indicator
	Joint Approach to assessment and care planning	• Develop a joint approach to assessment and care planning between health and social care and part of integrated teams working • Ensure effective shared process to identify and provide preventative support to high risk patients • Dementia services are a part of joint assessment and care planning
	Development of 7 day services	• Intermediate Care and Neighbourhood Care teams as 7 day services
	Achieving national metrics	• Meet all five indicated above
	Data sharing	• Utilisation of NHS number in place as identifier • Utilise health and social care data to support targeting of interventions • Integrated Clinical Digital Records developed (a sub group of the STP)
	Governance and financial management	• Assurance process, Governance arrangements and risk mitigation within the

			Action Plan, risk register and Risk Sharing Agreement • S75 Agreement to be agreed by June 2016 • Maintaining social care identified within the BCF. • Financial monitoring in place • BCF included within strategic planning eg STP

Contributing non- BCF related programmes of work

A number of programmes of work are not funding through the Pooled Budget but have potential contributions to the overall aims and outcomes of BCF:

Programme of work	**Impact and benefits**
GP at the Front Door of ED	Diverting patients to primary care who may previously be admitted
Development of Ambulatory Emergency Care pathways	Reduction of avoidable admissions
Improved pathways between West Midland Ambulance and community teams	Ensure avoidable conveyances are maintained at home with appropriate care and/ or interventions
Paediatric admission avoidance	Reductions in avoidance admissions

5 **BCF FINANCE 2016/17**

The Section 75 Pooled Budget in 2016/17 is increased to £14,252,674.

Organisation	**Contribution**	**Amounts utilised by**
Council	£2,261,454	£7,850,899
CCG	£11,991,129	£6,401,775

Section 75 Agreement - Finance Report 2016/17

Summary Statement	Annual Budget £
Intermediate Care	
Rehabilitation and Enablement	897,547
Domiciliary Care	664,057
Rehabilitation and Enablement Beds	973,288
Preventative Services	170,859
Shropshire Community Healthcare Trust	1,596,973
Shrewsbury and Telford Hospital Trust	1,655,069
LA Beds	46,607
Total Intermediate Care	**6,004,400**
Community Resilience	
Preventative Services	446,549
Carers	521,172
LA Grants	315,600
Total Community Resilience	**1,283,321**
Telford Neighbourhood Care	
Rehabilitation and Enablement	597,501
Assistive Technologies	493,595
Preventative Services	844,320
Shropshire Community Healthcare Trust	1,596,973
Total Telford Neighbourhood Care	**3,532,389**
Other Care	
Maintaining Eligibility for Clients with LTC	878,000
Management Charges	56,395
Programme Management	477,857
Care Act Implementation	445,000
Disabled Facilities	1,575,312
Total Other Care	**3,432,564**
Grand Total:	**14,252,674**

Development of the s75 Agreement for 2016/17 is in progress: to be agreed by 30th June 2016:

- The Main Body of the Agreement is in place from 2015/16 and developed to support future years with only minor amendments
- The Risk Sharing Agreement has been developed as part of the Narrative Plan
- Reporting and monitoring arrangements are in place through the monthly Pooled Budget meetings.
- Wider governance arrangements are in place through the Stronger Communities Board

The Schedules are being developed in line with the Four heading indicated above with associated outcomes measures.

6	**PREVIOUS MINUTES**
	BCF update to Health and Wellbeing Board: May 2015
7	**BACKGROUND PAPERS**
	Background papers include: • The Community centred approaches paper sets out the vision for health and social care of '*Right Help, Right Time to promote Independence*'. • The Commissioning Intentions for 2016/17 were presented jointly by the CCG and Council to the HWB Board in March 2016. • The Council Market Position Statement March 2015

Report prepared by:

Michael Bennett - Head of Commissioning: Better Care Fund/ Care Closer to Home Telford and Wrekin CCG

Legal Review
Heather Dean - Commercial Solicitor -Telford and Wrekin Council

Finance Review
Tracey Smart - Finance Manager- Telford and Wrekin Council

Appendix A - Telford and Wrekin Economy

BETTER CARE FUND NARRATIVE PLAN

Plan Summary

KLOEs

Local Authority: Telford and Wrekin Council — 1

Clinical Commissioning Groups: Telford and Wrekin Clinical Commissioning Group

Boundary differences: Co-terminous

Date agreed by Health and Well-Being Board

Financial summary

The financial contributions are set out below, within the Planning Template submission (tab 4) and p37-38 below. — A3ii,iii,iv,v

Revenue Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £
Rehabilitation and Reablement	1,495,049			**1,495,049**
Domiciliary Care	664,057			**664,057**
Rehabilitation and Reablement Bed Usage	945,816	46,607		**992,423**
Rehabilitation and Reablement Bed Usage Others			27,472	**27,472**
Assistive Technologies	493,595			**493,595**
Preventative Services	797,567			**797,567**
Preventative Services - Others			493,302	**493,302**
Others			170,859	**170,859**
Carers	197,145	324,026		**521,171**
Management Charges	56,395			**56,395**
Shropshire Community Health Trust			3,193,946	**3,193,946**
Shrewsbury and Telford Hospital			1,655,069	**1,655,069**
Programme Management			477,857	**477,857**
Voluntary Sector Grants		315,600		**315,600**
Maintaining Eligibility	878,000			**878,000**
Care Act Implementation	445,000			**445,000**
Total:	**5,972,624**	**686,233**	**6,018,505**	**12,677,362**

Capital Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £
Disabled Facilities		1,575,312		**1,575,312**
Total:	**0**	**1,575,312**	**0**	**1,575,312**

Total Better Care Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £
Total:	**5,972,624**	**2,261,545**	**6,018,505**	**14,252,674**

A3ii,iii,iv,v

A3iii full overview of funding contributions Not met (LGA) Although planning return is referenced – is that acceptable? The table above sets out the funding contributions. We believe this meets the requirements of the KLOE. — A3iii,

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

Community centered approaches final.docx	B1i,iii,v,vii B2i,ii,iii C1v
The papers further sets out the and the golden thread of • Strengthening communities • Volunteer and peer roles • Collaboration and partnerships • Access to community resources This builds on the learning of the BCF programme to date.	B1iii
The commissioning intentions for 2016/17 were presented jointly by the CCG and Council to the HWB Board in March 2016. They set out very similar vision and the integrated working across health and social care. The submission included the three integrated themes set out in the Better Care Programme section below The CCG vision is 'Working with our patients, Telford and Wrekin CCG aspires to have the healthiest population in England. Healthier, Happier, Longer'. The focus is on improved health outcomes through integrated teams through triple integration. The Council vision is similar – 'encourage healthier lifestyles, strengthened individuals and communities to support themselves'.	B1iii
'Being the Change', the Councils Managing Directors report (December 2015), sets out the need for 'enterprise, innovation and partnership working' - promoting collaborations and maximising the synergies between service. This includes • Reducing demand through strengthening families • Building communities capacity to improve outcomes and reduce demand on public services • Prevention • Working in communities This highlights the level of synchronicity between health and social care.	B1iii
The Council Market Position Statement (March 2015; currently being updated) sets out the direction of travel including: • Meeting population demand and supply – market capacity • Promoting Well-being/ Independence and Prevention (including taking forward the Joint health and social care Prevention strategy • Personalisation – more choice and control; personal budgets and flexibility of contracts to enable choice • Developing a diverse and sustainable market and sustainable business	B1iii
The Sustainability and Transformation Plan (STP) will be developed by June 2016, which is required to deliver the Five year Forward View and a one year operational plan (represented within the T&W CCG Operational Plan within C8iv below). The STP will include a: • Clear vision and plan for the area • Financial stability plan for providers and commissioners	B1iii

• Clear plan for prevention, patient activation, choice and control and community engagement and close the health and well-being gap • New care model development improving clinical priorities and roll-out of digital healthcare • Financial balance of local systems and improve efficiency of NHS services The BCF priorities, programme of work and key actions are being included within the first draft of the STP, currently in development. This will ensure that BCF is an integral part of the STP	
The planning for 2016/17 and future strategic planning leads to a future that looks like: • Resilient local communities focussing on well-being and Prevention • Integrated preventative services delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent • Reduced reliance on social care services • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions	B1iii
B.1.iii KLOE was deemed PATIALLY MET by NHSE Discusses the current state and the future vision but doesn't outline the planned state post plan delivery. The summary above sets out the correlation between vison for the future, local strategic actions and future state**. We believe this provides evidence that this KLOE is fully met**	B1iii
<u>Review of BCF performance to date</u>	
The BCF programme from April 2014 to date had a focus on • Delivering personalised health, social and independent sector care delivered through integrated services • Promoting self-help and self-care wherever and for as long as possible • Enabling those at increased risk of hospital, nursing or residential care admission to have appropriate interventions at an early stage and reduce avoidable admissions. • Ensuring financial efficiency and reduce duplication.	B2i
In addition to the national metrics the local metric was the reduction of emergency admissions for 65+ years. Targeting this population was based on JSNA and acute hospital admission data.	
Key themes of BCF performance in 2015/16 are: • The reduction in Q4 was a reduction of 5.12% (-227) • The reduction in Q1 2015/16 was 2.72% (-116) • The increase in Q2 2015/16 was +2% (+87) • The increase in Q3 2015/16 was +5%)(+210) • Previous quarters had shown a reduction in costs related to admission. Q3 showed an small decrease in costs (0.2%. £14,000) • Overall to Month 9 YTD shows a 1.4% overall increase in admissions. However, there was a 4% reduction in costs • Month 9 overall average LoS in 14/15 was 4.31. This has reduced to 3.84 this	B2i,ii,iii,iv

year. The biggest average LoS reduction was the 75+ years with 1.24 days less than last year (9.02 days/ 7.78) • 0 LoS has increased across all ages by 5.39%. Overall costs have increased for 0 LoS have increased by 5% (£132,000) • Longer length of stays have decreased overall. 3+ day LoS has decreased by over 5.4% and a cost reduction of 8%. Only 85+ years has increased overall • Paediatrics (6%) and 75+ years (9.7%) years have increased admissions. The reasons for admissions are predictable for the ages. • Reduction in beds day to date equate to c21 beds days less a day • Savings in Rehabilitation costs continue against last year • XBDs reductions are being maintained • Gross cost savings related to admissions at Month 9 were £885,000 with a year-end forecast reduction of £1,549,000	
The Planning Performance and Quality Committee (sub-group of the CCG Governance Board) reports illustrates the evidence for supporting further developments (embedded below)	
 PPQ BCF deep dive report November 15	B2i,ii,iii,iv
The developments within 2014/15 and 15/16 include:	
Enhancing out of hospital provision out of hospital including • Funding for Rapid Response nurses to provide enhanced admission avoidance, in-reach to the acute hospital and divert admissions and develop additional clinical pathways • Development of the Telford Integrated Community Assessment Team (health and social care team based at the hospital to divert admissions	B2i,ii,iii,iv
Improved 7 day working including: • Rapid Response nurses above • Funding Respiratory nurses over 7 days – which analysis indicates reduced admissions and supports discharge over 7 days	B2i,ii,iii,iv
Detailed profiling of admissions on a monthly basis by diagnosis and HRG chapter, shared with clinical teams, to track admissions against targets and develop further plans, initiatives or targeting. The analytical tool as a monthly xl report enables analysis by age profile, LoS, HRG and clinical conditions. This provides a clear understanding of the impact of teams in admission reductions. This segmentation of the data provides clarity of the impact of interventions. The Month 11 report is embedded below	B2i,ii,iii,iv
 BCF_Monthly_Profile M11.pdf	
Impact assessment on a monthly basis of which programmes and initiatives are making an impact on reducing admissions	B2i,ii,iii,iv

Local analysis indicates that early death rates from cardiovascular disease (CVD) have declined over the past decade, but still remain significantly worse than the national average. 80% of Potential Years of Life Lost to causes amenable to healthcare (PYLL) during 2011-13 were caused by CVDs, Cancers and respiratory diseases. The proportion of residents aged at least 65 is lower than national average (T&W 18.5%; England 20.7%) However, many of the older residents live in deprived areas. Local benchmarking shows higher rates of emergency admissions for (at HRG level): • Cardiac surgery and primary care conditions • Digestive systems • Respiratory conditions • Urinary tract infections Only one of T&W's general practices, in the latest reports, had a population that was in the least-deprived quintile, while 72% of practices had a population that was in the most or second-most deprived quintile.	B2ii, B2iv
Admission avoidance interventions have focussed on these conditions in order to reduce avoidable admissions and provide community based interventions. Cost reductions have been identified at Month 11 within the BCF profile in these HRG levels.	B2ii, B2iv
B.2.iv Partially met (NHSE and LGA) Some references to unmet need but very sparse. Not really established a robust case for change. More data to quantify need. Additional information is set out above. Also included within Operational Plan embedded document (C8iv) and Commissioning Priorities report to HWB Board March 2016 embedded document (B1ii) below. These are the local supporting evidence for the work programmes and agreed locally. **We believe these fully meet the requirements of the KLOE**	B2iv
Improvements to quality of care for patients that BCF programme has delivered / is aiming to deliver – from April 2014: • Delivering personalised health, social and independent sector care delivered through integrated services • Promoting self-help and self-care wherever and for as long as possible • Enabling those at increased risk of hospital, nursing or residential care admission to have appropriate interventions at an early stage and reduce avoidable admissions. • Ensuring financial efficiency and reduce duplication. Enhancing out of hospital provision out of hospital including • Funding for Rapid Response nurses to provide enhanced admission avoidance, in-reach to the acute hospital and divert admissions and develop additional clinical pathways • Development of the Telford Integrated Community Assessment Team (health and social care team based at the hospital to divert admissions Improved 7 day working including: • Rapid Response nurses above • Funding Respiratory nurses over 7 days – which analysis indicates reduced	B2ii

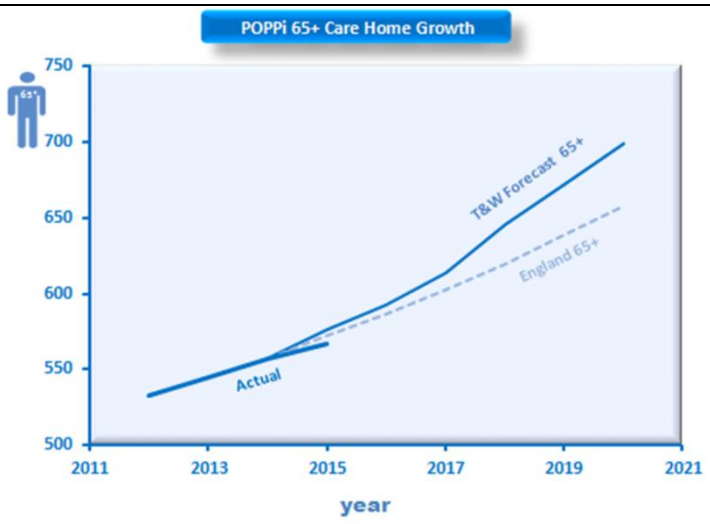
admissions and supports discharge over 7 days	
Quality improvements were measured by: • Quality Assurance visits are undertaken with providers, these site assurance visits are based on assessment against recognised regulatory standards. • An audit has been undertaken across all Nursing Homes with commissioned 're-ablement' beds:- The audit was based on a Modified Barthel Index (Shah version). The documentation and methodology of the audit was developed collaboratively with local authority colleagues and providers • The CCG coordinates a 'soft intelligence' system known locally as NHS2NHS to supplement other Quality Assurance systems and processes. • A locally developed KPI schedule of measures has been developed for all Telford and Wrekin Nursing homes.	B2ii
The development of integrated Neighbourhood Care teams provide significant opportunities to improve preventative interventions around local communities and reduce avoidable admissions Quality improvements identified within the Intermediate Care service specification and be part of the Neighbourhood Care team are based on the outcomes and Commissioner Quality Standards defined in the National Audit of Intermediate Care 2015. These include: • Achievement of person specific goals prior to discharge (based on Sunderland Model). • Ensuring patients whose dependency has maintained or improved (based on modified Barthel Index) • Patients ability to maintain social contact has improved – improved wellbeing • Maximising the number of patients discharged to their usual place of residence (minimum of 80%) • Reduction in the number of service users placed in permanent placements in care homes from acute care – ensuring an effective rehabilitation and reablement model. • Maintain or increase the percentage of older people who were still at home 91 days after discharge - ensuring an effective rehabilitation and reablement model and effective ongoing care • Maintain or increase the percentage of older people still at home and needing no on-going services 91 days after receipt of Intermediate Care intervention – ensuring effective person specific outcomes and use of voluntary sector and • Discharge from hospital over 7 days • Reduction of all emergency admissions for service users aged 70 years and over	B2ii
The planning for 2016/17 and future strategic planning leads to a future that looks like: • Resilient local communities focussing on well-being and Prevention – people living healthier lifestyles an strengthened individuals and communities to support themselves • Integrated preventative services and early support delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent	B2ii

• Re-designed care and support through co-production that prevents, delays or reduces the need for care and support • Reduced reliance on social care services • Responsive carer support • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions	
Reductions in costs have been identified through: • Reductions costs associated with admissions indicated above and Month 11 profile (embedded document above) £1,258,016/ 5% reduction against last year • Reductions in hospital based rehabilitation costs • Reductions in Excess Bed Day costs Additional potential for cost reductions and efficiencies are likely from: • Fewer ambulance conveyances to hospital • Integrated teams and processes and care – efficiencies from reduced duplication of assessment; implementation of Buurtzorg model and reduced duplication of visits • Reduced permanent admissions to care homes • Reduced demand for health and care services from developing resilient local communities that focus on well-being and Prevention – strengthened individuals and communities to support themselves • Progressing support approaches to domiciliary care that support reablement plans and reduce need for specialist therapy interventions post assesssment • Offering a range of personalised approaches to care – Individual Budgets, Supporting Planning – where local evidence indicates costs reductions and improved outcomes	B2ii
B.2.ii Partially met (NHSE) The plan discusses risk stratification but doesn't reference the opportunities to improve quality or reduce costs. The information above summarises the opportunity for quality and cost improvements. **We believe these summarises provides evidence that fully meets the requirements of the KLOE**	B2ii
<u>Further supporting the Case for Changes within the BCF programme</u>	
There are national and local strategic priorities that support innovations within the BCF. In addition, learning from the work to date supports further innovation. These include: • Five Year Forward View • Future Fit and Community Fit • JSNA data • Evidence from emergency admissions • Care homes admissions • User engagement	
<u>Further supporting the Case for Change – In line with Five Year Forward View</u>	
Local service planning is in line with the Five Year Forward View. It is demonstrated	B1ii

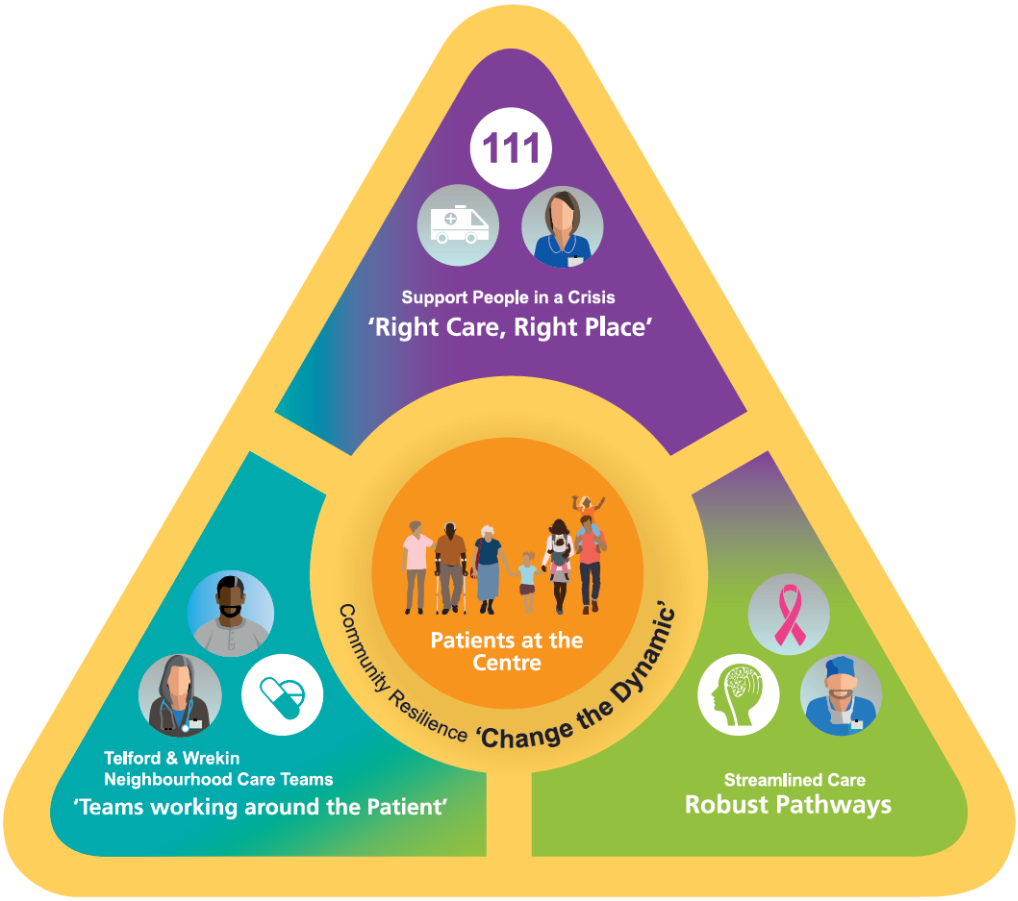
through: • Focus on Prevention specifically through the Neighbourhood Care Team • Empowering Patients specifically through the Neighbourhood Care Team • Engaging Communities as integral through the Neighbourhood Care Team, Community Resilience and Carer support • NHS as a social movement through the three key contributing integrated care programmes set out below • Improved support for frail elderly including in care homes with new models of care through the Integrated Care team; where the specification specifically focusses on 70+ years and reductions of admissions to care homes • Co-design and implementation of new models of care though Future Fit and Community Fit and the three key contributing integrated care programmes set out below • Accelerating innovation in new ways of delivering care: protoyoping Locality working before full implementation three months later; piloting Enhanced Rapid Response to reduce admissions and delivering with six weeks of planning- and evidence of reducing admissions • Funding through increasing the s75 agreement for 2016/17 in line with local agreed principles of pooling where services should be integrated to provide improves outcomes and more effective and efficient use of each 'Telford Pound'	
The Commissioning Intentions report to HWB Board March 2016 (embedded document below) sets out the high level commissioning priorities for health and social care. It was presenting by senior officers of the Council and CCG and sets out: • Commissioning activity for the CCG, Public Health and Vulnerable People Commissioning teams including: o Emotional Health and Well-being service for 0-25 years an o Children at the Edge of Care, Children in Care and Young people Leaving Care o SEND o Strengthening Families o Carers o Joint Dementia Strategy o Joint ALD strategy o Joint MH strategy o Extra Care Housing • Integrated Intermediate Care and Neighbourhood Care services • Integrated working • Collaborative commissioning • Universal support and promoting well-being • Co-production and strengthening social capital • JSNA headlines • Key programmes of work	B1ii
In addition: • The Sustainability and Transformation Plan (STP) will be developed by June 2016, is required to deliver the Five year Forward View • The T&W Operational Plan is the 2016/17 plan of the STP (embedded below) • Additional references are included within B1iii (p3); C6ii and C8iii	B1

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

need to access a range of services relevant to their needs. Furthermore, there is national evidence of variations in the quality of care and opportunities exist to improve outcomes. The Kings fund report 'Transforming the delivery of health and social care – The case for fundamental change' emphasises the need for a radical shift in where care is delivered and the relationship with health and social care professionals to: • see patients and service users as part of the care team • focus on the development of effective health and social care teams in which staff work flexibly and full use is made of the range of skills available • provide care in the right place at the right time by reducing overreliance on hospitals and care homes	
<u>Analysis of emergency admissions</u>	
Detailed profiling of admissions on a monthly basis by diagnosis and HRG chapter, shared with clinical teams provides analysis of emergency admissions. The analytical tool as a monthly xl report enables analysis by age profile, LoS, HRG and clinical conditions. This provides a clear understanding of the impact of teams in admission reductions. The pdf embedded document is above	B2i,iv
<u>Impact of care home admissions</u>	
With a local focus on reducing admissions for 65+ years in 2015/16 and those who are 70+ years in 2016/17 there has been a focus on care homes.	B2i,ii
There has been recognition locally to reduce admissions to care homes. Permanent admissions were high compared to national norms in 2014/15 and BCF performance has indicated permanent admissions to care homes	B2ii,iv
The Projected Older People Population Information (POPPI) projection below shows the forecast trajectory for care home growth in T&W. This indicates the need for more additional care home beds than national average. This would relate to the forecast additional ageing population. The Council have used fewer beds than predicted to date.	B2ii,iv,v

	
There have also been high rates of admission to acute hospitals. There were 596 emergency admissions from care homes in 2013/14. This was 11.1% of all emergency admissions to the acute hospital. In 2014/15 this was 608 (10.7%). At Month 9 2015/16 analysis showed a +2 increase (0.3%) against last year. However, there is a 12% reductions in costs related to admissions The cost of care home admissions were £1,97m in 2013/14 and £2.07m in 2014/15	B2ii,iv,v
The Council spent £24.9m in care homes and equivalent accommodation in 2014/15. Extrapolating spending in this year to date would suggest spending will reduce by 4.4% compared to last year.	B2ii,iv
The CCG spent £2.5m in CHC and complex care costs in 2014/15. 78% (£1,950,000) related to care beds. Extrapolating spending would suggest increased spending by 8% compared to last year. This relates to fast tracks and contributions to joint packages of care.	B2ii,iv
<u>Further supporting the Case for Change – user engagement</u>	
Patient and user engagement has been through a: • Consultation event in and July 2014 and July 2015; • Regular meetings with Health Roundtable • Regular meetings with Voluntary Sector Forum • Attendance at Carers Partnership Board. • Meetings with care and user representative groups including Healthwatch Healthwatch were are a member of the Programme Management Board, which overviewed the programme until the new Governance arrangement came into place Healthwatch are a member of the HWB	B1vii
A user, carer and stakeholder consultation event was held in July 2016; providing feedback from the previous event and gaining views and priorities for future development. Key priorities were identified as: • Improved primary care services	B1vii

• Increases in Preventative interventions reducing higher care costs including access to information • More referrals for admission avoidance • Focus on care at home • More person centred in terms of care delivery	
<u>Better Care Fund Programme for 2016/17</u>	
Three integrated care programmes below form the BCF programme. The local need for change within the economy is highlighted in the embedded document above – The Community centred approaches paper '*Right Help, Right Time to promote Independence*'. (embedded document	B1i,ii,iii,iv, v,vi B2i,ii,iii,iv C1
The three key contributing integrated care programmes are set out below. These formed a report to the CCG Governance Board in February 201 and supported by the Council: • Building community resilience • Developing 'Telford Neighbourhood Care Teams • Implementing Robust Intermediate care services The contents of the report are included below	B1iii B3 C1
Background	
During 2015 the CCG developed key priority areas described in the diagram below. This paper provides an over view of three key programmes of work which directly contribute to those priorities. These will form the significant part of work within the 'Integrated Care' portfolio of work for 2016. The three programmes centre around *community resilience,* the development of '*Telford Neighbourhood Care Teams'* and the implementation of *intermediate care* services.	B3



The delivery of these programmes will contribute to the progression of the 'triple integration' agenda which involves closer worker between; primary and secondary care; mental and physical health; health and social care. There is a growing evidence base to suggest that integration can improve outcomes for people. Integrated processes alone can help this improvement.

An overview of each of programme is provided below. Each table outlines; the vision and aims, who the programme involves (providers, commissioners and patient cohorts), why the change is necessary, what needs to be done, how the change will be achieved and a high level description of associated commissioning resources.

B3

1. Community Resilience

Vision and aims

B1

Telford will have strong and connected communities. The community will drive the

development of local assets and people will: • Have friends and support networks • Things to do • A feeling of being safe and belonging to their community • Confidence to go and help and ask for help • Centres or 'connecting points' to go to	
Who?	
In order to be successful, this involves the whole community, from individuals through to more formal community groups, third sector and statutory organisations Statutory organisations need to change their approach, valuing community centred approaches and truly understanding the community they serve. They also have a role in stimulating/facilitating change and occasionally leading change.	
Why?	
• Traditional models of statutory services are no longer fit for purpose: They promote dependence, they are expensive and outcomes could be better • There is a strong and growing evidence base about the importance of building confident and connected communities in improving outcomes for people. • Individuals benefit from contributing to the wellbeing of others • A growing proportion of the population are suffering from problems associated with *preventable* disease • Needs escalate and peoples health and wellbeing deteriorate because they don't have enough support in the community • People depend on services because there have very limited alternatives in their own communities	**B2**
What?	
• We need to work across Telford to facilitate a movement to build resilient communities • We need to draw on and develop the wide range of assets in the area, rather than dwell on the deficits • We need to support and build 4 different aspects of community centred approaches: 1. Strengthening communities by taking action on the causes of poor health; 2. Support volunteer/peer roles; 3. Enable collaboration and partnership in planning of services between communities and statutory organisations; 4. Connect individuals/families to community resources	**B2**
How will we achieve the change?	
A single plan will be produced across Telford and Wrekin. Sign off and ongoing monitoring will be through the new 'Stronger Communities Board' which is a sub group of the Health and Wellbeing Board. The three key officers will be Liz Noakes, Clive Jones and Anna Hammond. This change will need take place over a number of years in order to reverse the trend of paternalistic state service provision. To start we can: • Identify the local leaders who can champion change • Consider 'social isolation' and how communities can help to address it • Map all the existing assets to celebrate the diversity and identify gaps.	**B2** **B3**

• 'Kick start' the movement by funding prototypes that can illustrate what can be achieved • Develop a workforce to help us get to know our communities As this change represents more of a movement, an action log will be utilised to highlight activities across the area	
What financial resources are associated with this change?	
The very nature of this change is about the development of community driven and sustainable change. Any funding attributed to this change needs to support that notion. It is suggested that the combined grants funds of the Council and CCG support prototype development, communication exercises and fund one off costs to support the movement. Any process for bidding for resources needs to be light touch and high trust in line with the TLAP principles. Examples may include development of materials, books, equipment, games to help to gain momentum**.**	
Useful references: NHS Alliance (2014), A Charter for community development in health Public Health England (2015) A guide to community centred approaches for health and wellbeing	
2. <u>Telford Neighbourhood Care Teams</u>	
Vision and aims	
 People with an identified long term health condition will be supported to live their life to their full potential • The notion of care 'from cradle to grave' will be reinvigorated through this model. • Individual professionals will take responsibility for the delivery of as much care as possible, drawing on specialists where necessary • Professionals will work together to seek out those who would most benefit from an intervention/support • People will share their story once in a way that it right for them • People will understanding their condition and how to deal with it • People will self care/self manage where possible • Carers will be supported *N.B. this represents a starting point and could be expanded in the future*	**B1**

Who?	
Population: People with identified health risks. A large cohort will be those on practice disease registers, which currently include circa 45,000 Informal patient networks including friends, family, neighbours Professionals who support these people and form part of the virtual teams will be; • Practice teams • Community nursing teams from Shropshire Community Trust • Home workers within the Local Authority • Community teams from South Staffordshire and Shropshire NHS Trust • Third sector organisations • Outreach teams from Shrewsbury and Telford Hospitals • Carers • Local Authority support (e.g. housing)	
Why?	
• We need a much greater focus on prevention • We need to find people earlier in their disease progression so they can manage their condition better, earlier • A greater number of people have become more dependent on statutory services • Current services tend to do things to and for people, rather than promoting self-management • Multiple individuals from different organisations are providing care for any one patient at any one time. The has led to duplication, confusion and sometimes a preoccupation on where teams are based, rather than how they work together • Patients are having to tell their story multiple times • The current way of working is not the most effective way of supporting the increasing of number of people with a long term conditions • We have lost a holistic nature of care by focusing on 'tasks'. Over the years care has been 'carved up' with the tasks allocated to workers with the lowest level of skill to carry out the task. Whilst this was implemented to improve efficiency it has fragmented care	**B2**
What do we need to change?	
• We need to focus on the delivery of joined up care (not on the disaggregation of its component parts) • We need to change the culture of service provision to promote independence, shared decision making and self-care • Statutory organisations need to consider how virtual teams can function to support patient centred approaches. Effective communication between the patients, carer and professionals is essential • Statutory organisations need to shift to an asset approach, considering the wealth of informal networks in patient's lives • Move to a proactive approach, seeking out patients who would benefit from early intervention • A greater focus on delivering care for those in socially deprived areas	**B2**
How will we achieve the change?	
Virtual teams will be formed from professionals from different organisations. These will be	**B2**

grouped around natural neighbourhoods/communities of about 10-20k populations. In most cases this will around practices. These teams will: • Implement the 'Telford House of Care' • Adopt the ethos from Buurtzorg for community nurses and home workers which empowers workers to deliver all the care that patient need, rather than dividing aspects of care up and distributing tasks to different people. • Adopt the six elements of community service from Buurtzorg: 1. Holistic assessment of patients. Leading to the formation of a care plan 2. Mapping networks of informal care 3. Identifying more formal care needs 4. Care delivery 5. Supporting the patient in their usual social environment 6. Promoting self care and independence. • Utilise risk stratification • Formalise practice based MDTs including mental health, third sector organisations and local authority professionals • Consider the roles and responsibilities of these teams in end of life care The key officer will be Michael Bennett who will develop a clear project plan, including key outcomes we would hope to achieve. The main clinical lead will be Louise Warburton. A Steering group will be initiated to be chaired by Anna Hammond. This will include all key stakeholders.	**B3**
What financial resources are associated with this change?	
Staff for the virtual teams are currently funded through contracts with the following providers/groups of providers: • Primary care • Community nurses (excluding rapid response) • Admiral nurses • Carers contracts • More specialist nursing teams (eg continence) • Community mental health (N.B. whilst workers will be part of the virtual team, the budgets are difficult to disaggregate on this basis) • Local authority teams	
3. <u>Intermediate Care</u>	
Vision	

 To support patients in times of crisis, in their usual place of residence if possible, through the delivery a range of short term interventions. The service will: • Prevent unplanned admission to hospital • Reduce time spent in hospital • Provide a quick response from professionals in times of crisis (e.g. exacerbation of a long term condition, carer breakdown) • Assess and treat patients in their own home • Provide access to fast track holistic multi-disciplinary assessment • Proactively support discharge from hospital when the patient is medically stable, with the provision of short term therapy support to get people as independent as possible before reviewing long term needs.	C3i,ii,iii,iv
Who?	
Anyone who has an exacerbation of a condition who could be managed in a setting other than hospital. A high proportion of the patients will be over the age of 70 and have long term conditions including frailty and dementia Key stakeholders will be: • Practice teams • Shropshire Community NHS Trust • Shrewsbury and Telford Hospitals NHS Trust • South Staffordshire and Shropshire Healthcare NHS Trust • Local Authority • Third sector • Informal networks • Pharmacists	
Why?	
• There needs to be greater range of alternatives to hospital admission • The response times to community alternatives are not always quick enough • The aspects of intermediate care are currently fragmented across multiple teams/ providers. There is lack of clarity about roles and professionals are not always able to work together because of organisational boundaries. • Some of the services currently inadvertently promote dependence • The hospital system cannot cope with the increasing levels of emergency demand	**B2**

• Telford and Wrekin have a higher number of 'community beds' compared to the national average	
What do we need to change?	
• We need to develop a coherent pathway, that can be clearly articulated to professionals as well patients and their carers • We need to build on the wide range of skills and expertise in our community staff and bring them together • We need to agree and implement a model to ensure there is sufficient medical input at the right level to the service	**B2**
How will we achieve the change?	
The CCG will develop a single outcome based specification to be delivered by multiple providers. This will be trialled by current providers during 2016/17. Providers will be incentivised through meaningful outcomes that support 'flow' (and consequently achievement of targets) as well as financial incentives to reinvest in patient care. This specification will be launched with providers at the end of January. Anna Hammond will be the responsible officer. Organisations have supported the idea of an outcomes specification, but have requested that the CCG take a role in facilitating workshops between providers to initially aid them working together. Monitoring reports will be produced against the specification and a group will be set up between the commissioner and provider to monitor progress. This will replace elements of the BCF governance arrangements. This intermediate care service will be included within the Better Care Fund. Michael Bennett will be the lead of officer in operationalizing the change and monitoring achievement of outcomes.	**B2** **B3**
What financial resources are associated with this change?	
An overall budget will be assigned to this service. This budget will be formed from some of the existing funding used for the following *current* services: • SaTH (rehab) • Shropshire Community (rapid response, enablement, community physio) • Community bed base (i.e. beds in care homes) • LA (TBD) As there is no prime provider, there will need to be some disaggregation of the overall budget so 'service lines' can be attributed to various providers and included in existing contracts.	
The Intermediate Care service specification is embedded below	
IC spec using 1516 NHS contract v4.docx	
Key roles and functions of the Intermediate Care team will include: Implementation to the DToC action plan and achieving the DToC target (included within the embedded BCF Action Plan)	ABC
The DTOC action Plan includes (in summary form) Ensuring consistent DToC reporting on both acute hospital | April 2016	C8i;viii,ix,x ixii,

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

requirement within the Intermediate Care team.	
Information Sharing Agreement is in place to share information across teams to ensure no Governance issues delay incremental development of joint working. The intention is to have a shared process fully embedded during 2016/17	C5iii
Data Sharing and ICDR is a sub-group of the STP. This sub-group will enable full implementation of a single assessment and care planning process- when all providers have ICDR.	C5iii
C.5.iii KLOE was deemed PARTAILLY MET by NHSE and LGA Description of H&SC plans to joint assessment processes. It references "Agreed joint assessment and care planning documentation" but doesn't elaborate on this. The Narrative above and actions set out within Section 5 of the Action plan now meet the requirement of the KLOEs **and we believe is fully met.**	C5iii
Care Plans will explicitly indicate who to contact when they need timely decisions about their care such as managing an escalating LTC. The intention is to improve the process for individuals returning to their pre-existing provision.	C5vi
Risk stratification Case Management within primary care is delivered through a Direct Enhanced Service. A locally developed risk stratification process is in place. The 2% target population is 1900 people. Currently 1097 have been reviewed within primary care	C5i
In addition to Risk stratification Case Management within primary care, other clinical teams provide case management and a named care co-ordinator. These include (with potential duplication): • Clinical Caseload of community nursing team • Respiratory Nursing team • Diabetic Nursing team • Locality Social Workers managing c1800 cases • People identified with dementia • Care Navigators referred from primary care • Admiral Nurses • Identified patients on GP registers (1900) • The Neighbourhood Care team will seek to enhance co-ordination of this population.	C5i,ii,
There is recognition that many people 70+years will have some level of dementia. Actions in place or developing to support this target population include: • Rapid Response, TICAT and Enablement have significant experience in managing those conditions. Approx. 50% of users of Recovery beds have some level of dementia. • Admission avoidance supports people with dementia. The commissioned domiciliary out of hours provision is aware than some potential referrals of people who have dementia • Dementia Advisors (Admiral Nurses) work closely with primary care, Carer representatives and Council Locality teams to ensure co-ordinated responses • Specific Recovery beds have been commissioned for people with dementia • Identified staff from the Dementia team respond within 72 hours to assess	C5ii,viii

patients and also provide support, advice, joint assessments with non-mental health teams • Planning is in place to determine the future co-ordination of mental health services and general health services. • Working together with Dementia Action Alliance which has a wide inclusive membership of the community in the development of dementia friendly communities in Telford and Wrekin as well as increasing Dementia Champions	
As part of the development of the Intermediate Care Team: • Risk stratification will continue to be used to identify high risk patients within primary care and review care plans. Management of escalating conditions and admission avoidance will be through the Intermediate Care team. • Referral to a single point of access to the integrated team • Agreed joint assessment and care planning documentation • Mental health services including Dementia and RAID are closely aligned to the team to provide clinical advice and assessment in line with the mental health strategy	C5iii,vii
As part of the development of the Neighbourhood Care Team: • Risk stratification will continue to be used to identify high risk patients within primary care and review care plans and primary care supported by the Neighbourhood Care team. • Joint assessment and care planning will be carried out to identify needs • Signposting to suitable services including non –statutory services will take place to unsure support is in place • Enhance the use of preventative services including Care Navigators and Admiral Nurses to limit disease progression and ensure effective support for people with Dementia and their carers	C5iii,vii
Milestones to achieve full compliance are included within the Action Plan	C5iv
C5iv KLOE was deemed Partially met (LGA) More detail will emerge as work above progresses. The Action Plan has been updated. **We believe the KLOE is now fully met**	C5iv
<u>National conditions – Agreement of the delivery of 7 day services</u>	
Q3 submission highlights the area where 7 day services are in place: • Rapid Response nurses • Respiratory nurses • voluntary organisations to support Assisted Discharge home • Acute hospital sector senior medical support • GP support – Shropdoc • Domiciliary care is provided over 7 days for planned discharges. Some limited response at weekends from domiciliary providers to support admission avoidance. • Out of Hours domiciliary care through the Emergency Carer Response Service from April 2016	C3i

Improvements in 7-day working is part of the NHS contract for the acute provider. This includes a national CQUIN payment for community and acute hospital provider	C3iv
A national CQUIN in relation 7 day services is included within the acute hospital NHS contract to meet the four key standards for 7 day working : • Standard 2: Time to First Consultant review – within 14 hours • Standard 5: Availability of Diagnostic Services over 7 days • Standard 6: Availability of Consultant Direct Interventions 24/7 • Standard 8:On-going Consultant Review within AMU, SAU, ICU etc have consultant review twice daily The CQUIN is intended to ensure roll out within the acute hospital by the end of Q4 2016/17.	C3i C3ii
Effective 7 day services within the acute hospital are essential to support avoidable admissions. It is a requirement of the Intermediate Care Team, where the acute hospital function is an integral part of in order to reduce admissions and support early discharge. The Intermediate Care Team service specification sets out the need for 7 day services. Planning for 7 day working of Social Workers, voluntary sector workers and Brokerage is set out within the Action Plan so that they are in place during 2016/17. The expectation is that discharges from hospital of complex patients is similar at a similar level at weekends to weekdays by facilitation within the acute setting and effective processes, care delivery and capacity over 7 days	
C.3.i KLOE was deemed NOT MET by NHSE. The plan specifies those areas where 7 day services are in place but fails to reference a plan to achieve full roll-out. The Narrative and additional inclusions within the Action Plan meet the requirements of the KLOE and **we believe this KLOE is fully met** C.3.ii KLOE was deemed PARTIALLY MET by NHSE. Cites that 7 day working is included in the national contract. It doesn't expand on this. The Narrative and additional inclusions within the Action Plan meet the requirements of the KLOE and **we believe this KLOE is fully met**	C3i; C3ii
The key functions of the Intermediate Care team as set out in the service specification are: • Admission avoidance by clinical interventions and community based social care interventions • Early supported discharge from hospital including clinical interventions and community based social care interventions • Access to care to support admission avoidance or discharge from home over 7 days • Accept to step up or step down Recovery beds to support rehabilitation or re-ablement	C3iii
The Intermediate Care Team service specification sets out the requirement to develop 7-day services across health, social care and independent sector to support admission avoidance and early supported discharge. This includes initiation of care or access to step up and/ or step down facilities over 7 days rather than current mainly planned	C3ii,iii

commencement at weekends	
Social Care staff identified to be part of the Intermediate Care team do not routinely work across 7 day services currently. This is currently held by the Out of Hours team. 7 day working is being considered as part of the Council re-structure including potential demands and costs for implementation.	C3iii
The Emergency Crisis Response Service (ECRS) commenced on 1st April 2016. This provides domiciliary care within 2 hours of referral outside normal working hours including Bank Holidays to support admission avoidance.	C3iii
Providers to provide the Recovery beds (step up/ step down beds) are required to provide access over 7 days. Specifications with domiciliary care providers are being developed to have 7 day responses to initiate care.	C3iii
A Intermediate Care Team Steering group with acute hospital, community services and Council senior manager members is in place to develop and implement the service specification within agreed timescales	C3iii
C.3.iii Partially met (NHSE and LGA) References the intermediate care service specification, which will support admission avoidance and facilitate early discharge. Not very comprehensive. We believe the additional information included above, in the Action Plan and the embedded service specification **indicate that this KLOE is fully met**	C3iii
A local economy-wide Recovery plan to ensure achievement of ED performance monitors admissions, admission avoidance and discharges of complex patients over 7 days	C3ii
Priority actions are included within the Action Plan	C3iv
National metrics	
Non-elective admissions (specific)	
The BCF arget for non-elective admissions has been agreed as: 18,233 as submitted within NHSE plan of 3rd March 2016 – this has since been revised to 18394 as at 18th March 2016	E1i,
The target has been reached by using the following methodology: • Analysis of the Outcomes in 2014/15 • QIPP planning for Intermediate Care (-242 emergency admissions) • HRG analysis of admissions that could be reduced • Evaluation for the programme of work to achieve the current performance during 2015/16 – set out below • Growth of 2.3% in line with IHAM tool • (Growth of 1% has since been applied for 18th March submission in line with 15/16 growth and 1% QIPP (-184))	E1ii;iii
Performance to date has been impacted by a number of factors. These are: • Reductions in admissions in Q1	E1iii

• Increases in admissions in Q2 and Q3 particularly 0 LoS • GP at the Front Door moving to integration with Ambulatory Care • Analysis of the profiles of emergency admissions including reductions in 65-74 years; increases in 75+ years • Increases in ambulatory care admissions The BCF target for reducing emergency admissions for 70+ years is included within the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the Council, community and acute provider	
There is triangulation and alignment between the BCF plan, CCG Operating Plans and acute and community provider plans through: • CCG Specific Acute Non Elective Admissions for 16/17 are included within the Monthly Activity and Other Requirements Planning Return submitted to NHSE. These include the BCF admission avoidance figures for the Integrated Care team. This will enable consistency of reporting and monitoring • Identified admission reductions are included within the Intermediate Care service specification as a key outcome • The service specification is included within the NHS contracts in 2016/17 for the acute and community provider. • QIPP and CIPs plans shared between the CCG and acute and community providers	E1iv
<u>Admissions to residential and care homes</u>	
The BCF target for permanent admissions to residential and care homes has been agreed as 155 The figures are revised from the initial February 2016 Planning submission.	E2i,
The target has been reached by using the following methodology: • Analysis of the Outcomes in 2014/15 • Latest monitoring of 2015/16 performance against target- anticipated outturn of 165 • Evaluation for the programme of work to achieve the current performance during 2015/16 – set out below	E2ii;iii
Performance to date has been impacted by a number of factors. These are: • Increased Recovery beds for rehabilitation and reablement interventions • Clear philosophy that home is the usual destination post acute care • Council focus on preventative approaches to support at home • Working with Extra Care providers to enhance this provision and enable diversion from permanent care home placements • Council review of patients who could be supported in other, more enabling settings with appropriate support The BCF target for admissions to residential and care homes is included within the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the Council, community and acute provider	E2iii

<table>
<tr><td></td><td></td></tr>
<tr><td><u>Effectiveness of Re-ablement</u></td><td></td></tr>
<tr><td>The BCF target for Reablement has been agreed as 70%

The figures are revised from the initial February 2016 Planning submission.</td><td>E3i,</td></tr>
<tr><td>The target has been reached by using the following methodology:

• Analysis of the Outcomes in 2014/15
• Latest monitoring of 2015/16 performance against target- this is currently forecast to be 68%
• Evaluation for the programme of work to achieve the current performance during 2015/16- set out below</td><td>E3ii;iii</td></tr>
<tr><td>Performance to date has been impacted by a number of factors. These are:

• Increased Recovery beds for rehabilitation and reablement interventions
• Enhancing the model of rehabilitation to ensure this is effective
• Vacancies of senior therapists that are now being replaced

The BCF target for Reablement is included within the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the community and acute provider</td><td>E3iii</td></tr>
<tr><td><u>Local metric – reductions in 70+ years admissions</u></td><td></td></tr>
<tr><td>Local analysis and planning has led to the revision of the local metric. From April this will no longer be reductions in admissions of 65+ years. The new metric is to reduce admissions of 70+ years</td><td></td></tr>
<tr><td>The target reductions are included within the text box of the BCF Planning submission and the CCG Operational Plan submission.</td><td></td></tr>
<tr><td>The national team will need to change the template to include the new metric for Q1 reporting.</td><td></td></tr>
<tr><td><u>DTOCs</u></td><td></td></tr>
<tr><td>The BCF Target for DTOC has been agreed as:

<table><tr><th></th><th colspan="4">2016/2017</th></tr><tr><td>Population (BCF Template)</td><td>131,524</td><td>131,525</td><td>131,526</td><td>132,034</td></tr><tr><td>Qrtly DToC</td><td>695</td><td>775</td><td>935</td><td>880</td></tr><tr><td>Rate per 100,000</td><td>528.4</td><td>589.2</td><td>710.9</td><td>666.5</td></tr></table>
The Action Plan is summarised above and included within the BCF Action Plan

The figures are revised from the initial February 2016 Planning submission.</td><td>E4i,
C8i</td></tr>
</table>

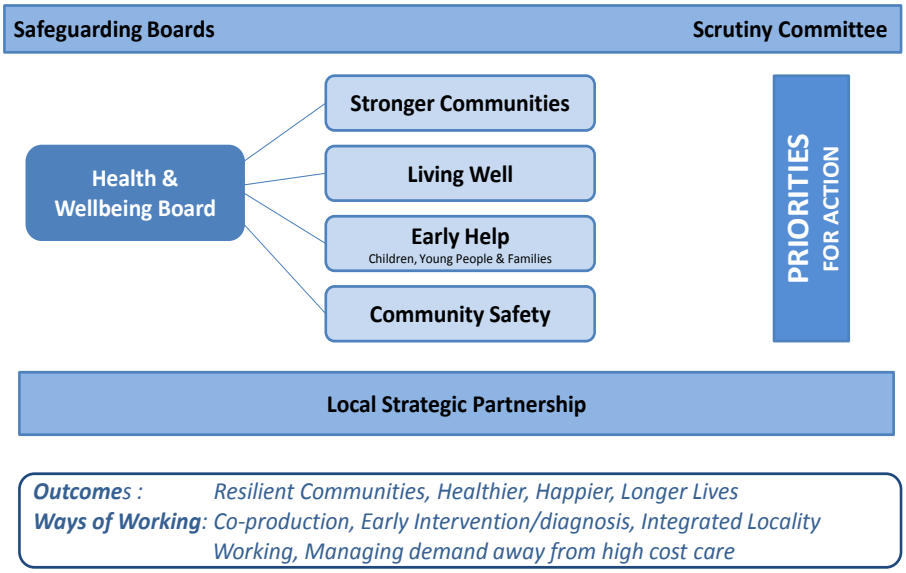
The target has been reached by using the following methodology: • Comparison based on the 15/16 performance. • Cross reference to 2015/16 performance. • Analysis of activity for all providers who contribute to DToC reports including mental health and other hospitals • Comparison against the current run rate adjustments taking into account the introduction of TICAT and the potential impact of the Intermediate Care team, • impact of the discharge to assess beds and the implementation of the formal reporting mechanism between the local authority and SSSFT.	E4ii;iii C8ii
Performance to date has been impacted by a number of factors. These are: • Development of Discharge to Assess on Pilot wards within the acute hospital. This helps initial reductions in DToC when implemented in November 2014 • Full implementation of D2A across all hospital wards from November 2015. This has attributed to subsequent increases in DTOCs • Acute hospital implementation of Discharge ward from December 2015. This has contributed to increased DtoCs • Fact Finding Assessment delays in completion • Implementation of Telford Integrated Community Assessment Team from November	E4iii C8x
The Action Plan is part of the Intermediate Care team outcomes and included within the 2016/17 NHS contract for the Council, community and acute provider. It has taken in account achieving a number of factors: • Local Health Economy Recovery Plan for achieving the 4-hour waiting time • The acute hospital achieving their 3.5% delay target and stretch target of 2.5% • The CCG target of reducing NHS attributable delays • Strategic Commissioning Group targets for reductions in MFFD • ECIP evidence of effective in improving patient experience • Current Task and Finish group work to develop effective identification of those deemed MFFD, decision-making relating to the appropriate pathway and the administrative processes to enable effective and rapid discharge.	E4iv C8iii,iv,vii; Viii; ix C8ii
Financial risks in relation to DToC are maintained within the contingency reserve within the above. This is also highlighted within section 10 below (within the sub-section detailing Risk Sharing)	B5ii C8v
Trust performance during 2015/16 was an average of 4.9%. Lowest single month was 3.2%. The 2.5% stretch target provides a significant challenge	C8ii
C.8.ii Stretch target Partially met (NHSE) Includes the DTOC target but fails to link this to the actions. The Trust target is listed as 3.5%. Providers are required to deliver 2.5% from Apr16!. The Stretch target is included and actions are highlighted within the Action Plan. W**e believe this KLOE is fully met**	C8ii
DToCs are reported to SRG though: • Tracking of admissions avoided, discharges, care package commencements,	C8iii

flow through and usage of Recovery beds based on the achieving the local Recovery Plan • Monthly reports to the economy Urgent Care Working Group – chaired by Executive Lead The embedded document below (abridged) indicates the level of detail and economy wide planning and reporting in relation to DTOC and urgent care performance	
SRG Urgent Care Update 150416 v2.pp	C8iii
C.8.iii Not met (NHSE) Partial (LGA) No link between the DTOC action plan and the SRG. Above provides and summary and extract report to SRG relating to DToC. **We believe this KLOE is fully met**	C8iii
DToC is reflected within the Operational Plan (extract below). P6 indicates BCF performance; P14 highlights A&E Access target where DToC has been a focus – also indicated in the SRG report above	C8iv
Telford Wrekin CCG operational plan 201	C8iv
C.8.iv Reflected in operational plans Partially met (NHSE) This isn't explicit. The extract from the Operational Plan is included. W**e believe this KLOE is fully met**	C8iv
The Risk Sharing Agreement and Risk Register indicates that the CCG holds the financial risk in relation to increased non –elective admissions. This is held through and identified contingency Reserve The RSA also indicates that the RSA that 'financial risks will be managed by partners within the pooled fund'.	C8v
DToC risks are also held by the CCG through tariff costs and and tracked principly through Excess Bed Day levels. These have been on a downward trajectory for the last 18 months The Integrated Care team service specification includes reductions of DToC as a required outcome as well as inclusion in the NHS contract for 2016/17 for the acute provider. Existing contractual liabilities within the NHS contract for under-performance are in place. National guidance indicates that "If there is local agreement that a risk sharing arrangement for DTOC is appropriate then local areas should consider the use of existing mechanisms. At a national level, the Care Act 2014 sets out a discretionary system whereby the NHS can seek reimbursement from a local authority (LA) if the LA does not meet its statutory duties to assess and, where appropriate, put in place care and support arrangements to allow a patient to be discharged from acute care." This is recognised locally.	C8v
C.8.v Local risk sharing agreements in terms of DTOCS Partially met (NHSE) The plan references financial risks in relation to DTOCs, but does mention existing guidance and flexibilities.	C8v

The Action Plan related to DToC is set out using the 8 high Impact Interventions: • Early Discharge Planning – including the acute hospital introducing SAFER • Systems to Monitor Patient Flow – including improved DToC reporting and efficiencies in flow through Recovery beds • MDT discharge teams – developing the Integrated Intermediate Care team • Home First – key principle as part of Trusted Assessor roll-out • Seven Day Services – highlighted above (KLOEs C3) • Trusted Assessors – full implementation and support from community staff • Focus on Choice – including information related to discharge planning, Recovery bed options and agreed processes to engage patients by acute and social care staff • Enhancing Health in Care Homes – specific community nursing In-reach to care homes; training and support to care home staff, Assistive Technologies and Actions from a strategic review to improve quality ECIP provide on-going support to the acute hospital and wider economy in the development of improving discharge processes.	C8, C8viii
C.8 High impact interventions for DToC .viii Not met (NHSE) The plan doesn't reference national guidance or best practice i.e. ECIP. Additional information is included. The action plan is structured in line with the 8 High Impact Interventions. **We believe we fully meet this KLOE**	C8, C8viii
Voluntary organisations are routinely involved in the processes to reduce DToCs. These include: • Shropshire Partners in Care (umbrella organisation funded by and representing independent sector providers) routinely highlighting need for early response to assessment and transfer to residential care. Commissioners engage through newsletters and SPIC conferences • Severn Hospice delivering EoL care as an alternative to hospital; In-reaching to the acute hospital to facilitate discharge. The Hospice are developing a rapid response-type domiciliary provision • British Red Cross Home from Hospital commissioned to facilitate transport home and support to re-settle – reducing transport delays from hospital • Council for Voluntary Services (representative body of voluntary organisations) routinely engaged in relation to admission avoidance and early discharge. Commissioners and CVS have mapped services that may be involved in supporting early discharge support.	C8ix
C.8.ix Partially met (NHSE) It mentions fast tracking discharges to Severn Hospice but its not explicit that the voluntary sector have been engaged with. The additional information indicates voluntary sector involvement. **We believe this KLOE is fully met**.	C8ix
<u>National conditions- Data sharing between health and social care based on the NHS number</u>	
Health and social care are using the NHS number and the consistent identifier. Social Care have had this in place since April 2015 within Care First	C4ii

Overarching Information Sharing Agreements are in place between all statutory partners and signed off by Caldicott Guardians, Standard Operating procedures are in place to address any specific new requests for information. This includes specific requirements to illustrate how the information will be used, stored and deleted/ disposed of when the reason for the information is completed. These were included within the 2015/16 s75 agreement and will be included within the 2016/17 agreement.	C4iv,v
A Local Health Economy Group, co-chaired by Telford and Wrekin CCG and the acute hospital Chief Executive is in place to identify systems to share data across organisations. This work is currently being scoped for implementation by April 2018	C4iii
The BCF Q3 submission indicated the current use of Open APIs. Each organisation has them in place and used internally to their organisations. There is no sharing across organisations	C4iii
Regular IG training of health and social care staff takes place and is monitored to ensure attendance. This ensures the key messages related to the legal requirements to safeguard and share data are clearly understood,	C4i,v
The IG Team are available to provide support and monitoring in relation to IG issues, ensuring effective leadership is in place. The IG team also routinely monitor to encourage the right cultures and behaviours and ensure secure and lawful storage and sharing of data	C4i
The CCG Governance Board approved two Fair Processing Notices: one for patients and a separate Notice for staff. These sets out: • How the CCG keeps personal information confidential • How, when and why information would be shared with other organisations • The right to consent to not have information shared • Rights under the DPA A Fair Processing Notices are on the CCG website	C4v
The Telford Referral and Quality Service (TRAQS) is the CCGs patient appointment booking system. It terms of use of patient information: • Use a secure system to transfer the referral details over the N3 network (using the ICG system) • All staff have to use a SmartCard to access the National eRS system • All staff have controlled/secure access to the ICG Referrals system • Recently introduced the NeoPost envelope stuffer which checks letters before inserting them into envelopes • All Call Handlers run through a series of security questions at the start of every call to check we have the right patient, etc • All Call Handlers have to have completed the IG training toolkit • All Call Handlers set out how information about them will be used • All referrals are transferred to the relevant Provider either using eRS, secure nhs.net email or fax (to Safe Havens ONLY)	C4v
C.4.v KLOE was deemed Partially met by NHSE The CCG has a Fair Processing Notice setting out how information is used. Not clear how this message is	C4v

communicated with members of the public. With the information included above **we believe this KLOE is fully met.**	
The Council operates a corporate information security policy (CSIP). This policy sets out minimum standards and common acceptable use for confidentiality, integrity and availability of information to meet internal and legal requirements. All Council officers have to fully understand and comply with the CSIP and regular mandatory training is provided. Individual advice on specific IG issues is provided by the Audit and IG team at the Council.	C4i,iv
In order to ensure that information sharing takes place in an appropriate manner, all data sharing agreements is approved by the relevant Assistant Director and comply with Information Governance requirements and the Information Commissioners. All personal information managed by the Council is covered by the Data Protection Act 1998. This provides legislation as to how personal information may be used, stored, processed and shared. It contains eight principles that the Council should conform to and also governs how information needs to be handled under certain circumstances.	C4i,iv
The CCG are developing a Local Incentive Scheme as part of the 2016/17 contract to support the community provider in putting an electronic patient record in place. This will enable implementation of IDCR across statutory services within the local economy	C4vi
The Sustainability Transformation Plan (STP), to be developed by 30th June 2016 includes development of the Digital Roadmap as part of its function. A sub-group focussing on digital transformation is in place and developing a plan.	C4vi
An integral part of developing integrated teams, based on virtual integration, is that electronic/ digital systems support assessment and care planning. This is particularly important when teams will be working in different locations and potentially entering information onto their respective organisations' systems. Development of joint assessments, joint care planning and sharing information across all relevant teams to ensure interventions in line with the *Right Help, Right Time to promote Independence*' approach is fundamental.	C4vi
Digital transformation is expected to: • Reduce duplication of assessment and care planning • Improve ease of access to patient information across locations • Improve safety and quality of care – up to date patient information available • Support integrated working • Improve patient experience by improved consultations; reduced delays • Make efficiencies due to improved systems and processes	C4vi
C.4.vi How changes will impact upon integration Partially met (NHSE) It doesn't really discuss this. It touches upon the benefits of information sharing but doesn't describe the contribution that this could make. The information above clarifies the contribution of digital transformation and **we believe fully meets the KLOE requirement**	C4vi
Governance arrangements and financial management	

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

Partnerships Planning and Quality (PPQ) Committee; a sub-group of the Governance Board. The Council is a formal member of both PPQ and Board The Council reporting process includes reporting to the Senior Leadership Team, Senior Management Team, Policy Review Meeting, Council Cabinet and the Scrutiny Committee, Health & Adult Care. The CCG and Council both report to the Joint Health & Overview Scrutiny Committee	
Plans to support joint working	B3iii
Key milestones for the BCF programme are included within the Action Plan (embedded below)	B3iv
B3iv key milestones Partially (NHSE) Intermediate care is well structured – similar detail for others would enhance. The action plan has been updated. **We believe it fully meets the KLOE requirement.**	B3iv
A comprehensive risk log is embedded below	B3v
 BCF risk register 16.17 v2.docx	
<u>National condition – Plans to be jointly agreed</u>	
The Planning template and Narrative Plan have been agreed by senior officers of the CCG and Council	A3i,ii C1i
The CCG and Council have fully engaged with providers in relation to BCF. This engagement includes: • Agreement with the model of integrated delivery with Senior managers within the Council who are members of the BCF Pooled Budget sub-group and Stronger Communities Board • Acute, community and Council providers engaged in the development and timescales for implementation of the Intermediate Care Team and Neighbourhood Care team • Explicit with NHS contracts that monies within their contract as part of the s75 agreement • Inclusion of the Intermediate Care Team and Neighbourhood Care team implementation within SDIPs of NHS contracts • Acute, community and Council providers engaged in the planning meetings to develop implementation of the Intermediate Care Team • Engagement with Council for Voluntary Services in relation to independent sector monies within the s75 and reviewing future utilisation to support community resilience • Shropshire Partners in Care (SPiC) on an on-going basis to discuss future developments; training needs; sustainability of domiciliary care and care beds, co-production of future commissioning models and approaches; progressive support models of domiciliary care; development of Market Position Statement • Provider Forums on a regular basis sharing future planning and priorities including development of future models and approaches, development of the Market Position Statement. BCF is scheduled for the Forum on 18th May 2016	C1i,ii,iii

<table>
<tr><td>

- Estates planning to ensure sustainability with future planning

Engagement usually includes both CCG and Council representation.

</td><td></td></tr>
<tr><td>

Additional work with local provides includes:

- Regional cost modelling to ensure a ‘fair price for care’. Specific local work to support this is on-going with providers

</td><td>C1ii</td></tr>
<tr><td>C1ii Engagement with providers Partially (LGA) More to be said about engagement with social care providers. Additional areas of engagement across health and social care provided. We believe this fully meets the KLOE</td><td>C1ii</td></tr>
<tr><td>

Key implications of changes to providers are summarised below:

<table>
<tr><th></th><th><u>Implications</u></th><th><u>How indicated</u></th></tr>
<tr><td>Acute hospital</td><td>Reduced admissions

Part of Intermediate Care team</td><td>Activity reductions within NHS contract
Service development within contract
Service specification</td></tr>
<tr><td>Community provider</td><td>Part of Intermediate Care and Neighbourhood Care team</td><td>Service developments within contract
Service specification</td></tr>
<tr><td>Council</td><td>Part of Intermediate Care and Neighbourhood Care team
Community resilience</td><td>Increased pooled budget
Service specification
Commissioning intentions</td></tr>
<tr><td>Voluntary organisations</td><td>Growth of sustainable voluntary organisations in line with Community Resilience</td><td>Provider Forums</td></tr>
<tr><td>Care and domiciliary providers</td><td>Progressive support model of domiciliary care

Reduced reliance on residence care</td><td>SPIC
Provider Forums
Market Position Statement</td></tr>
</table>

</td><td>C1iii</td></tr>
<tr><td>

Evidence of engagement from stakeholders includes:

- Acute hospital, community provider and Council senior managers acting as Steering group for developing the Intermediate care team
- Council senior manager leading the development of the Intermediate care team
- Council piloting extra care facility as part of recovery pathway
- Council developed locality working –preventative approaches within neighbourhoods
- Jointly presented commissioning intentions document to HWB Board
- SPIC funding tele- medicine – linking care homes to GP practices as a pilot
- Voluntary sector organisations collaborating to bid for tenders

</td><td>C1iii</td></tr>
</table>

• Care providers	
The key changes across the local economy will enable: • Resilient local communities focussing on well-being and Prevention • Integrated preventative services delivered at a neighbourhood level • A wide range of personalised approaches to support people to remain independent • Reduced reliance on social care services • Integrated teams to support diagnosing, treating and supporting people at home over 7 days up to 24 hours / day • Reduced avoidable admissions The implications for change will also be set out within the STP	C1iii
C1iii Implications of changes Not met (NHSE) Partially (LGA) As above – clearer for NHS providers, but sign up of social care to develop. Implications to stakeholders, engagement from stakeholders and the implications are summarised. **We believe this fully meets the KLOE**	C1iii
The DFG Capital Grants awarded are part of a scheme in the Better Care Fund in recognition that appropriate adaptations can help people remain independent, safe and healthy and prevent admissions and readmissions. The scheme will support the Better Care metrics particularly relating to people with long term conditions and frail older people. The Grant fund is administered by the Housing department in the Councils Commercial Services Area who work in conjunction with housing providers, social care and OT teams.	C1iv
Workforce capacity has been actively managed through the interventions being made through: • Preventative interventions within the locality teams • Commissioned services from Wrekin Housing Trust and other providers to deliver adaptations • Home Improvement Agency within the Council No capacity issues have been identified from providers	C1iv
A Housing/Aids and Adaptations Overview group is being developed and will monitor the scheme and objectives to evaluate the outcomes of major and minor adaptations in connection to BCF metrics Representation from this group will be a member of the BCF Finance group to ensure effective co-ordination takes place; understand issues in relation to prevention including demand and capacity issues. In additional, the DFG policy is being reviewed to include more flexibility around the use of DFG in accordance with the increased funding.	C1, C1iv
C1iv Not met (LGA and NHSE) Seems to refer to DFG on p23 not workforce (LGA) not mention workforce requirements or capacity. Response to capacity issues related to DFG are summarised above and indicated within the Action plan. **We believe this KLOE is fully met**	C1iv
The Community centred approaches paper sets out the longer term strategic vision for	C1v

<table>
<tr><td>health and social care of 'Right Help, Right Time to promote Independence'. (embedded document above).</td><td></td></tr>
<tr><td>Joint agreements related to the BCF and the long term plan are identified though (and detailed in other sections:

• Community Centred approaches document (Introduction p3)
• Joint commissioning intentions presented to HWB Board March 2016 (B1iii)
• BCF programme being included within STP (B1iii)
• Additional investment from CCG and Council into the pooled budget for 2016/17
• Changes to the acute hospital and community provider NHS contracts for 2016/17 and highlighted through the additional pooled budget inclusions
• 'Being the Change' Council Managing Directors report (B1iii)
• Market Position Statement (B1iii)

These indicate a clear joint direction between the Council and CCG in terms of planning and development of local services.</td><td>C1v</td></tr>
<tr><td>The impact of service changes are summarised below:</td><td>C1v</td></tr>
<tr><td><table>
<tr><td>Area</td><td>Service change consequences</td></tr>
<tr><td>Community Resilience</td><td>• Expansion of local communities to provide on well-being and Prevention and remand demand for health and social care
• Collaborative arrangements between providers
•</td></tr>
<tr><td>Neighbourhood Care</td><td>• Integrated health, social care and voluntary care services based within localities.
• New relationships between primary care, Council teams, voluntary and independent sector services and NHS services – both acute and community
• Increased acute services eg clinics, clinical advice, diagnostics based and delivered within local communities and primary care
• Shared ownership of managing and supporting high risk patients eg Frail people, long term conditions
• 7 day services
•</td></tr>
<tr><td>Integrated Care</td><td>• A fully integrated health, social care and voluntary care team working together within a single service specification
• Increased specialist clinical advice provided
• Therapists and specialist teams working across acute and community services within agreed pathways to ensure people supported at home
• Reduced hospital conveyances
• Reduced non-elective admissions
• 7 day services across for the team an</td></tr>
</table></td><td>C1v</td></tr>
<tr><td>Additional service change consequences have been highlighted. These include:</td><td>C1v</td></tr>
</table>

• Potentially less but more robust and responsive domiciliary care provider • Less care beds commissioned providing high quality care • 7 day working for all stakeholders across the economy The service change consequences have been set out within the principles of the strategic and operational documents. This has also been part of the on-going dialogue with stakeholders. Work is on-going to clarify further impacts of the BCF programme.	
A number of areas are highlighted within the Risk Register and mitigating are in place: Capacity of the voluntary sector to support self-help and prevention Financial risks and stability of the domiciliary and care bed providers Care home stability to provide high quality care	C1v
C1v Joint agreement about BCF and long term plan Partially met (LGA) Very well laid out and needs only more on 'recognition of service change consequences' - what will stop or change that HWB need to be alert to? Not met (NHSE) **The comments above and additional references fully meet the requirements of the KLOE**	C1v
Development of capacity and workforce is noted within the economy and planning of the BCF programme. It is noted that there are challenges to recruit some key posts including consultant medical staff, therapists, care workers within care homes and domiciliary care providers. Key actions to develop the programme include: • Intermediate Care team including therapists working across acute and community services • Specialist pathways and teams across acute and community: Respiratory service is already community and acute clinicians and therapists and model being considered for other clinical specialties • Skills and training development of the Buurtzorg model • Community nursing teams supporting nursing care home nursing through training, supervision and mentorship • Acute clinicians supporting primary care through advice, clinical sessions • Development of Point of Care Testing to support diagnostics in primary care and maximise use of • Potential use of GPwSI as clinical additional clinical support within the community – with additional specialist training Workforce development and mitigating actions are highlighted within the risk register.	C1vi
C1vi future capacity and workforce requirement Partially met (LGA) Referenced in action plan. **The comments above, additional inclusions within the Action Plan and Risk Register fully meet the requirements of the KLOE**	C1vi
National conditions- Agreement to invest in NHS commissioned out of hospital services	
The CCG and Council has agreed the use of the monies that was previously related to Payment for Performance. Additional monies for commissioning out of hospital services are identified within the Planning return are aligned to three key contributing integrated care programmes: Building community resilience, Developing 'Telford	C7i,ii

Neighbourhood Care Teams and Implementing Robust Intermediate care services. Additional funding includes: • Grants • Community nursing • Respiratory services in the community • Falls prevention • Medical cover for the integrated community teams • Assisted Hospital Discharge • GP support to Rehabilitation and Enablement beds (Wellington practice) • Rehabilitation and Enablement beds	
In order to protect against the possible non-delivery of the non-elective emergency admissions, the CCG has set aside a non-recurrent contingency reserve of £250,000 which is the estimated cost of these emergency admissions based on the national tariff calculation, accounting for the emergency threshold adjustment. This sum is not contained within the BCF. This has enabled the development of the three key contributing integrated care programmes with funding that has been used for community services in line with the Community centred approaches paper '*Right Help, Right Time to promote Independence*'. (embedded document).	C7iii,vi
Evidence for the development of Neighbourhood Care Teams is based on a local Council Locality working prototype that was formally evaluation before full implementation.	C7iv
Community Fit also highlights through data analysis the need for, as well as the medium and longer term strategic plan for the development of community and voluntary sector resources to support reduced hospital admissions; prevention and self-care through community resilience	C7iv;vi
The target reductions in admissions is based on analysis at HRG level of admission profiles over the last two years. The target reductions of admissions is included within the Intermediate Care team service specification and reduced admissions within the acute hospital contract for 2016/17.	C7iv
The risk sharing agreement is consistent with the national guidance. It will be included in the s75 agreement for 2016/17 and is embedded below	C7v
National conditions – Agreeing the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	
The impact of local plans have been agreed with health and social care providers. Evidence includes: • Acute, community and Council providers engaged in the development and timescales for implementation of the Intermediate Care Team and Neighbourhood Care team • Explicit with NHS contracts that monies within their contract as part of the s75 agreement • Inclusion of the Intermediate Care Team and Neighbourhood Care team	C6i

implementation within SDIPs of NHS contracts • Acute, community and Council providers engaged in the planning meetings to develop implementation of the Intermediate Care Team • HRG level reductions in emergency admissions included within the 2016/17 acute hospital contract directly related to the Intermediate Care team plan and outcomes	
B1iii above (p3) sets out the strategic vision and operational principles for the BCF programme including impact across health and social care. Highlighting more specifically the impact on social care providers: • Council provider leading the development of the Intermediate Care team • Council Locality teams integrated into the Neighbourhood Care team • Council commissioned to deliver Brokerage functions and needing to ensure domiciliary care functions are sustainable • Market Position Statement utilised as a catalyst for co-production of new models for personalised support and future commissioning models and engaging with the voluntary sector to develop community resilience – growing the sector to reduce demand for health and social care • Council and CCG working with Shropshire Partners in Care (SPiC) to ensure quality and sustainability of domiciliary care and care beds	C6i
C6i Impact of local plans Partially met (LGA) ? social care providers. The summary above sets out the impact of local plans on social care. **We believe this fully meets the requirements of the KLOE**	C6i
Patient and user engagement has been through: • Consultation event in and July 2014 and July 2015; • Regular meetings with Health Roundtable and Voluntary Sector Forum • Attendance at Carers Partnership Board. • Meetings with care and user representative groups including Healthwatch A user, carer and stakeholder consultation event was held in July 2016 identified key priorities were identified as: • Improved primary care services • Increases in Preventative interventions reducing higher care costs including access to information • More referrals for admission avoidance • Focus on care at home • More person centred in terms of care delivery	C6ii
There is significant political engagement. The Chair of the HWB Board is id the deputy Leader of the Council; the Opposition have representation of the HWB Board. The Board has approved the commissioning intentions. The Cabinet member for Social Care is engaged with the BCF developments and a member of HWB board The Local Strategic Partnership, comprising Police, Education and local business have regular updates	C6ii

Local MPs have regular briefings with the CCG Chief Officer	
C6ii KLOE Engagement and Buy-in was deemed Partially met (LGA) Political buy in? The summary above indicates engagement and **we believe this KLOE is now fully met**	C6ii
Community Fit (embedded above) highlights the medium and longer term strategic plan for the development of community and voluntary sector resources to support reduced hospital admissions; prevention and self-care through community resilience	C6iii
Long term vision has been set out within Community Fit and documents above (p2-3 KLOE B1iii) • 2016/17 commissioning intentions • Being the Change document • Market Position Statement • Community centred Approaches In addition, increased monies from health and social care into the Pooled Budget demonstrate a clear commitment to integration and joint strategic planning moving forward.	C6iii
In addition there is a requirement to develop a Sustainability and Transformation Plan (STP) by June 2016 to deliver the Five year Forward View and a one year operational plan. The STP will include a: • Clear vision and plan for the area • Financial stability plan for providers and commissioners • Clear plan for prevention, patient activation, choice and control and community engagement and close the health and well-being gap • New care model development improving clinical priorities and roll-out of digital healthcare • Financial balance of local systems and improve efficiency of NHS services The development of the STP was presented to HWB Board in March 2016 to ensure strategic support. The one year Operational Plan is the T&W CCG Operational Plan within C8iv	C6iii
The BCF priorities, programme of work and key actions are being included within the first draft of the STP, currently in development. This will ensure that BCF is an integral part of the STP	C6iii
C6iii Align provider plans for long term vision and sustainability Partially met (LGA) Social care providers? .The summary is p2-3 and above highlight long term vision across health and social care. **We believe the table above fully meets the KLOE requirement**	C6iii
Local work in relation to mental health has been to ensure the physical health needs people with mental health problems and the mental health needs of people with LTCs are proactively dealt with. Assurances to having equal consideration include: • RAID team based within the acute provider and achieve 95% I hoir response for assessments in ED	C6iv

• 150 staff trained in mental health care to support the RAID programme • RAID provide on-going training, advice and consultation • Mental health training within the acute hospital is available on an online portal to ensure ease of access • Access to mental health advice and support to the Integrated Team is in place to ensure joint assessments and care planning for frail elderly and/ or management of behavioural challenges that may otherwise lead to admission • Improved access of those with LTCs have access to psychological therapies • A principle of the mental health strategy is to have a single multi-disciplinary community team familiar with the patient • A local review of mental health is being completed	
There is alignment between the BCF plan, CCG Operating Plans and acute and community provider plans through: • BCF admission avoidance figures have been modelled and included as an integral part of the submissions to NHSE, this has ensured consistency of reporting and monitoring • Identified admission reductions are included within the Intermediate Care service specification as a key outcome • The service specification is included within the NHS contracts in 2016/17 for the acute and community provider. • QIPP and CIPs plans shared between the CCG and acute and community providers	C6v
<u>Development of the 2016/17 s75 agreement</u>	
Submission of the BCF Planning return submission includes: • The minimum contributions of the CCG and Council • Additional contributions of the Council and CCG • Narrative Plan including the assessment of the changes from 2015/16 to 2016/17 and an analysis of the impact of the changes The submission and financial contributions are summarised below	A1i,ii,iii,iv, v A2i,ii A3i,ii,iii,iv, v

Revenue Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £
Rehabilitation and Reablement	1,495,049			**1,495,049**
Domiciliary Care	664,057			**664,057**
Rehabilitation and Reablement Bed Usage	945,816	46,607		**992,423**
Rehabilitation and Reablement Bed Usage Others			27,472	**27,472**
Assistive Technologies	493,595			**493,595**
Preventative Services	797,567			**797,567**
Preventative Services - Others			493,302	**493,302**
Others			170,859	**170,859**
Carers	197,145	324,026		**521,171**
Management Charges	56,395			**56,395**
Shropshire Community Health Trust			3,193,946	**3,193,946**
Shrewsbury and Telford Hospital			1,655,069	**1,655,069**
Programme Management			477,857	**477,857**
Voluntary Sector Grants		315,600		**315,600**
Maintaining Eligibility	878,000			**878,000**
Care Act Implementation	445,000			**445,000**
Total:	**5,972,624**	**686,233**	**6,018,505**	**12,677,362**

Capital Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £
Disabled Facilities		1,575,312		**1,575,312**
Total:	**0**	**1,575,312**	**0**	**1,575,312**

Total Better Care Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £
Total:	**5,972,624**	**2,261,545**	**6,018,505**	**14,252,674**

A3ii,iii,iv,v

All monies included in the BCF Planning return submission are aligned to one of four specific areas, other than the DFG:

- Intermediate Care Team
- Neighbourhood Care Team
- Community Resilience
- Carers

The integrated care programmes have been developed between the Council and CCG due to local needs and highlighted in the embedded document above – The Community centred approaches paper 'Right Help, Right Time to promote Independence'. (embedded document)

A3iii

The changes to the s75 agreement between 2015/16 and 2016/17 are summarised below:

- Grants
- Community nursing
- Respiratory services in the community
- Falls prevention
- Medical cover for the integrated community teams
- Assisted Hospital Discharge
- GP support to Rehabilitation and Enablement beds (Wellington practice)
- Rehabilitation and Enablement beds

A3iv

When reviewing the approach to BCF based on learning from the current year, there was recognition that there was a need to have a more co-ordinated and targeted focus to: • Strengthening communities • Volunteer and peer roles • Collaboration and partnerships • Access to community resources Increasing the Pooled to support an integrated process was agreed at a strategic level through the 'Right Help, Right Time to promote Independence'. (embedded document). The Pooled Budget meeting membership then developed the detail of the financial values to be included.	
Additional contributions to the Pool are related to: <u>Intermediate Care</u> • Community nursing • Respiratory services in the community • Medical cover for the integrated community teams • Assisted Hospital Discharge • GP support to Rehabilitation and Enablement beds (Wellington practice) • Rehabilitation and Enablement beds <u>Neighbourhood Care team – preventative</u> • Community nursing • Falls prevention The additional contributions are part of existing community and acute hospital contracts. Inclusion in the s75 agreement enables joint planning and development through integrated team and targeted approaches based on evidence and data analysis. The acute community providers are fully aware of the plans and are included within their respective NHS contracts for 2016/17. <u>Community Resilience</u> • Grants The CCG carried out a Grants allocation process for two years from April 2016. The CCG and Council are now reviewing all providers jointly to agree priorities for funding from April 2017. The Council and CCG are jointly working with the voluntary and independent sector	A2iii
Each element of the minimum funding contribution is aligned to an area of the programme • Intermediate Care Team • Neighbourhood Care Team • Community Resilience • Carers and Care Act	A1vi

• Disabled Facilities Grant	
Additional contributions above the minimum level are is aligned to an area of the programme • Intermediate Care Team • Neighbourhood Care Team • Community Resilience • Carers	A2i,ii
The DFG Capital Grants awarded are part of a scheme in the Better Care Fund in recognition that appropriate adaptations is used to help people remain independent, safe and healthy and prevent admissions and readmissions. The scheme will support the Better Care metrics particularly relating to people with long term conditions and frail older people. The Grant fund is administered by the Housing department in the Councils Commercial Services Area who work in conjunction with housing providers, social care and OT teams. A Housing/Aids and Adaptations Overview group is being developed and will monitor the scheme and objectives to evaluate the outcomes of major and minor adaptations in connection to BCF metrics. This will ensure the monies meet the statutory housing requirements and that of the BCF plan. The Home Improvement Agency and Wrekin Housing Trust are members of the Falls Prevention Steering group. The focus of both teams work relate to adaptations and Assistive Technologies to reduce the risk of falls to at risk people.	A1ii,vii

Revenue Pooled Fund 16/17	Pool 2016/17 £	Pool 2015/16 £	Change £	Explanation
Rehabilitation and Reablement	1,495,049	1,478,782	16,267	Inflationary uplift.
Domiciliary Care	664,057	606,832	57,225	Inflationary uplift plus some additional investment from the
Rehabilitation and Reablement Bed	992,423	624,303	368,120	Inflationary uplift plus additional investment from the CCG.
Rehabilitation and Reablement Bed Usage Others	27,472	0	27,472	New investment from the CCG.
Assistive Technologies	493,595	488,225	5,370	Inflationary uplift.
Preventative Services	797,567	766,009	31,558	Inflationary uplift.
Preventative Services - Others	493,302	0	493,302	New investment from the CCG.
Others	170,859	0	170,859	New investment from the CCG.
Carers	521,171	515,500	5,671	Inflationary uplift.
Management Charges	56,395	55,781	614	Inflationary uplift.
Shropshire Community Health Trust	3,193,946	2,184,225	1,009,721	Additional services included - physiotherapy, OT, continence nursing, tissue viability, community stores, respiratory nursing, children's services, rapid response.
Shrewsbury and Telford Hospital	1,655,069	419,775	1,235,294	Additional services included - rehabilitation beds and respiratory service.
Programme Management	477,857	472,658	5,199	Inflationary uplift.
Voluntary Sector Grants	315,600		315,600	New investment from the Local Authority.
Continuing Healthcare		2,400,000	-2,400,000	Funding arrangements changed.
Maintaining Eligibility	878,000	878,000	0	No change.
Care Act Implementation	445,000	409,000	36,000	Increased as per the ready reckoner figure.
Total:	**12,677,362**	**11,299,090**	**1,378,272**	

Capital Pooled Fund 16/1	Pool 2016/17 £	Pool 2015/16 £	Change £	Explanation
Disabled Facilities	1,575,312	849,000	726,312	Change in national allocation figure.
Total:	**1,575,312**	**849,000**	**726,312**	

otal Better Care Fund 16/	Pool 2016/17 £	Pool 2015/16 £	Change £	Explanation
Total:	**14,252,674**	**12,148,090**	**2,104,584**	

A3iii, iv,v

The financial contributions are set out in the Planning Template submission in tab 4, above in the table and summarised in P1 of this Narrative Plan. **We believe meet the requirement of the identified KLOEs**

A3iii,iv,v

A3iii full overview of funding contributions Not met (LGA) Although planning return is referenced – is that acceptable? With the information set out above, alongside the tables, **We believe the KLOE is fully met**	A3iii, iv,v
The table above sets out the specific changes within the Pooled Budget from 2015/16 to 2016/17.	A3iv
A.3.iv KLOE Setting out changes against last year Partially met (NHSE; Not met LGA) It mentions changes to funding levels but fails to specify the amounts. **We believe the table above fully meets the KLOE requirement**	A3iv
The table above sets out the specific changes within the Pooled Budget from 2015/16 to 2016/17. It also summarises the impact of the changes: • Increased Preventative investment – supporting the development of integrated Neighbourhood Care teams • Additional services included – including specialist nursing teams, Rapid Response and therapists supports development of the Intermediate Care Team • Additional investment from the Council included for Grants – enabling a joint approach to prioritising funding and developing community resilience • Funding arrangement changed – recognising that CHC is not a priority for integrated working. Other arrangements are in place Developing the pooled budget in this way provides clear opportunities to utilise the monies differently to reflect the local priorities.	A3v
A.3.v Not met States "Narrative Plan including the assessment of the changes from 2015/16 to 2016/17 and an analysis of the impact of the changes". But no evidence provided. (BOTH) The impact of changes are set out above. **We believe the table above fully meets the KLOE requirement**	A3v
National conditions- Maintain the provision of social care services	
The financial values for the Provision of Social Care are: 2015/16 £7.334m (rebased for re-categorisation as below £ 7.661m) 2016/17 £ 5.754m The amount above has been identified from the BCF minimum contribution and maintained in real terms. The variation between the two years arises from a number of changes including: • An inflationary increase of 1.1% • an agreed re-categorisation of some schemes between areas of spend • Additional contributions to the pooled budget to support the objectives of the BCF plan. • Care Act funding of £445k is included within the budget (based on LGA Ready Reckoner estimate) The net funding increase associated with these is just under £500k. In addition £2.4m has been removed from the pooled budget in respect of continuing	C2i,ii,iii,iv C2viii C2iv/i C2iv/ii C2iv/iv C2iv/v

care for named individuals.

The plan includes a value of £521k for targeted carer's support.

This approach is fully consistent with DH guidance on the funding transfer from the NHS to social care

Provision of social care funding will continue through two integrated teams

- Neighbourhood Care team
- Intermediate Care Team

Areas of the provision of social care includes Assistive Technologies, Floating Support, Access team, Community Meals, OTs within the Neighbourhood Care team and Enablement beds, spot contracts and domiciliary care within the Intermediate Care team.

This funding supports offsetting of additional, higher costs to social care in the future by utilisation through the two integrated teams

C2vi
C2iv/i
C2iv/ii
C2iv/iii
C2iv/iv

Revenue Pooled Fund 16/17	CCG Pays Council £	Council Funds £	CCG Retains £	Total Pool £
Carers	197,145	324,026		**521,171**

C2vii

Specific funding for carers is identified above. It is also highlighted within the Finance summary and Expenditure Plan and monitored through the BCF Finance meeting. The programme of work in relation to carers are:

- Carer Services which includes Carer Centre provision
- Joint Commissioning Post
- Carer Respite which includes
- Carer Individual Payments
- Carer Creative, Well Being and Educational Workshops and provision of personalised care support
- Emergency Carer Support
- Moving and Handling Family Carer Adviser
- Carers Individual Payments

C2vii

C2vii KLOE was deemed PARTIALLY MET by LGA Carer specific funding, so could be developed. I believe this provides evidence that **this KLOE is fully met**

C2vii

The CCG and the Council agreed to commission an external review of the detailed use of the £2.4m for continuing care needs for named individuals. This review will be used to inform a new approach that could be agreed by both organisations for future years.

It was agreed that it was appropriate to remove this specific funding from the S75 Pooled budget at this stage and instead encompass it within a S256 arrangement to facilitate any change.

The combined impact of this reduction and the increases highlighted above account for the overall reduction of £1.9m in the protection of social care through the pooled budget between the 2 years

C2i,ii,iii,iv

<u>Risk Sharing Agreement</u>	
A risk sharing agreement is embedded below. It sets out the risk sharing arrangements: • Between health and social care • Risks to the acute hospital • Managing under- and overspends	B5i,ii,iii,iv
 RISK SHARE ARRANGEMENTS.doc	
The financial contributions within the Planning Template submission (tab 4) and above. This sets out the total expenditure, contributions and which organisation No monies within the pooled budget are deemed 'at risk'. All monies are committed currently to services or expenditure including agreement to invest in NHS commissioned out-of-hospital services to reduce non-elective admissions in line with the policy guidance. The RSA sets out that partners share the risks that they manage within the pooled budget. This is a consistent approach with the RSA from the 2015/16 s75 agreement. To manage the risk in relation to increased non-elective admissions and DToCs, the CCG has identified additional monies from the as non-recurring contingency reserve. The CCG have included these within the NHS financial return to NHSE. The CCG and Council are in agreement with the arrangements.	B5i
B5i what proportion of the pooled budget is 'at risk' (LGA) P29 contains reference to funding and contingencies – unclear if 'not contained within BCF' is acceptable. Further clarification of the KLOE is included above. **We believe this is fully meets the requirement of the KLOE**	B5i
In order to protect against the possible non-delivery of the non-elective emergency admissions, the CCG has set aside a non-recurrent contingency reserve of £250,000 which is the estimated cost of these emergency admissions based on the national tariff calculation, accounting for the emergency threshold adjustment. This sum is not contained within the BCF. Due to the contingency reserve being set aside, if unused it can be re-invested in the context of the overall CCG financial position	B5i,ii,iii
Financial risks in relation to DToC are maintained within the contingency reserve within the above. Reductions in XBDs are part of the DToC action plan and part of financial risk mitigation. These have reduced throughout the last two years	B5ii
The Risk Sharing Agreement (RSA) also indicates that the RSA 'financial risks will be managed by partners within the pooled fund'. Partners are in agreement with the levels of financial risk in managing the potential risk: CCG risk of non-elective	B5ii

admissions and DToC; the Council risks from increased Prevention, Brokering of care, admission avoidance and early discharge interventions; The CCG has budgeted the non-recurring contingency within its Financial Plan submitted to NHSE. Within the RSA it indicates that underspends will be used in other areas – agreed by all parties.	
Additional approaches to managing risk include the development of the integrated teams. These will be outcome focused with the requirement to achieve identified levels of reductions in non-elective admissions, DToC and other BCF metrics. Incentives are being considered for providers to achieve outcomes.	B5ii
B5ii Agreed approach to sharing risks re reducing admissions and DTOCS Partially (LGA) Evidence that sums in reserve are adequate. Also, not in BCF – how does this work for risk share? Explanation needed. **The above clarification, that the Council and CCG are in agreement with the risk sharing arrangements, indicated that this KLOE is fully met.**	B5ii
The Risk Sharing Agreement has been specifically developed to address the financial risks of the Pooled Budget. It has been developed to be included within the s75 Agreement. Other risks associated within the BCF programme are identified within the Risk Register. These include: • Ensuring effective Governance and monitoring • Integrated teams not achieving BCF objectives • Lack of engagement of stakeholders • Failure to reduce non-elective admissions • Failure to achieve other BCF metrics • Financial pressures and sustainability of domiciliary and care providers • Insufficient primary care capacity to support avoiding admissions • Lack of data sharing to support integrated working • Working capability, capacity and development Mitigating actions are in place to address these. The risk register is part of the BCF Governance process and included within reporting. High level risks are noted within the Council and CCG risk registers.	
B5iii Other risks Partially (LGA) (NHSE (Not met) Risk sharing agreements too finance focused 'Why' section in narrative can be developed to address non-financial risks more explicitly. Non-financial risks are identified above and mitigating actions and included within the risk register. **We believe this fully meets the requirements of the KLOE**	B5iii
BCF action plan	
The BCF updated action plan is embedded below	

BCF Action Plar
April 2016 17.v16

Michael Bennett
March 2016
Revised April 2016

F

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD- 15 June 2016

TRANSFORMING CARE PARTNERSHIP FOR PEOPLE WITH A LEARNING DISABILITY AND/OR AUTISM

REPORT OF: RICHARD SMITH, ASSISTANT DIRECTOR, EARLY HELP AND SUPPORT, DIRECTOR OF ADULT SOCIAL SERVICES (DASS)

LEAD CABINET MEMBER – CLLR ARNOLD ENGLAND

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 This report has been written to inform the Health and Wellbeing Board about the Transforming Care Partnership (TCP) for people with a learning disability and/or autism who may present with behaviours which can challenge and may include mental health issues. The TCP Programme is endorsed by NHS England, ADASS and LGA. It runs from July 2016 – 31st March 2019.

1.2 In summary, TCP is progressing work from the original 'Winterbourne View' situation, where people with learning disability and/or autism and behaviours which may challenge were neglected and abused. NHS England acknowledged that individuals should not live in NHS run provision. Thus, at a national level TCP is intended to reduce the number of beds provided across the country overall and ensure that when placements occur, the average length of stay is reduced to 85 days.

1.3 At a national level NHS England has established 48 'footprints' across the country, where CCGs and councils are aligned. The Shropshire Footprint covers:

- Telford and Wrekin council
- Telford and Wrekin CCG
- Shropshire council
- Shropshire CCG

1.4 Currently, NHS England Specialist Commissioning, commission 19 beds for named individuals who originated from across the footprint (16 adults and 3 young people/CAMHs). The two CCGs currently commission 7 beds. By 2019 the target reduction is 9 beds commissioned by specialist commissioning and 5 beds by local CCGs. Overall, the number of beds will reduce from 26 to 14.

1.5 Paul Taylor was appointed as the Senior Responsible Officer (SRO) for the Programme. Richard Smith has now taken over that role.

1.6 A TCP template was submitted to NHSe on the 11th April and a revised version was submitted on the 26th May. (Appendix 1). The TCP template will be in the public domain. In addition, an Easy Read and an executive summary will be produced and published on the websites of the CCGs and councils during Summer 2016.

1.7 Feedback on the Financial Excel spreadsheet was provided to the Shropshire footprint and further iterations have been submitted.

1.8 Overall, all parties and stakeholders endorse the principles and values which underpin TCP. However, all parties, and especially the two councils, who are autonomous to the NHS England have articulated concerns about potential financial risk both verbally and in writing, on several occasions. Without clarity on how the financial risks will be fully mitigated, NHSe is aware that full approval will not be given to this Programme.

1.9 In addition to targeting a reduction of individuals placed in in-patient beds, NHS England describe an additional four cohorts of people (children, young people or adults) that the TCP is expected to include:

- *Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.*
- *Who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.*
- *Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).*
- *Have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.*

1.10 There is an expectation that using a co-production approach, decision making and power will shift from existing services (health, social care, education and providers) and be shared more inclusively with the people who use services and family carers.

1.11 In addition, work will take place to engage with a wide range of stakeholders including schools, colleges, the criminal justice system, providers and the voluntary sector to ensure that the emerging strategy is sustainable and achievable.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

2.1 Note the submissions made to NHSe (Appendix 1).
2.2. Confirm endorsement of the Values and Principles of TCP (page 73 of Appendix 1) but withhold final and full approval without assurance from NHS England that no authority will experience financial risk due to delivery of the TCP.
2.3. Support the principle of collaboration across the Shropshire footprint.
2.4. Require the preparation of a statement of Commissioning Intentions for the Shropshire footprint in relation to learning disability, which has the TCP as a main work stream.
2.5. Request a further report on progress in six months time.

3. IMPACT OF ACTION

- The impact of the TCP, if fully delivered will be a transformation to how support is provided to individuals with learning disabilities and/or autism who may have behaviours that challenge, including mental health.
- At a community level, a more diverse and all age approach will support earlier identification of potential development of challenging behaviour, with appropriate support to mitigate or reduce the level and frequency of incidents.
- Schools/special schools will be central to introducing cultural/ attitudinal changes based on the TCP service model. They will be supported to develop sustainable models of working with individuals which reduce incidents of challenging behaviour.
- Schools/special schools will receive the right support from NHS funded providers to meet the needs of children and young people effectively and in a timely manner.
- Families will be supported to care for individuals or engage with services that provide support. This will provide greater assurance to family carers that the needs of the family member are met in a way which promotes overall health and well-being, and are not subjected to abuse or neglect.
- Families will also be provided with access to respite/short term breaks which enable them to maintain their caring role.
- Workforce development will support staff across the sector to have the skills, knowledge and value base to support people locally. Workforce training will be differentiated to the needs of different parts of the workforce.
- Work will take place to raise public awareness of supporting people living in the community who may at times present with behaviours that challenge (as an example, similar to the approach over dementia).
- Work will take place to encourage individuals to engage in their local communities as appropriate, and for some people, this may include opening up more opportunities for some form of employment.
- Overall, provision will be bespoke, flexible and tailored to individual needs.
- The expected outcome will be a reduction in incidents of challenging behaviour, reducing the need for high levels of staffing to support individuals and placements in NHS funded provision, thereby achieving overall efficiencies. However, this is expected to take longer to achieve than within the lifetime of this Programme.

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>If yes please state relevant priority
Young people and adults with a learning disability and/or autism including mental health, and their carers</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>Put our children and young people first: This means we will work collaboratively with schools, special schools and colleges of FE.

Improve local people’s prospects through education and skills training: TCP indicates that councils have a role to support individuals who are able to, to move towards employment (paid/voluntary).

Protect and support our vulnerable children and adults: Social Care

Ensure that neighbourhoods are <u>safe,</u> clean and well maintained: Some people with behaviours which challenge require additional steps to ensure their safety and the safety of family members and other members of the community.

Regenerate those neighbourhoods in need and work to ensure that local people gave access to <u>sustainable housing:</u> named individuals will require accommodation which is bespoke to their individual needs.

Improve the health and wellbeing of our communities and address health inequalities: work will take place with all NHS funded services to support ‘mainstreaming’ the principle of equal access to good health care, rather than ‘shadowing’ of health related illnesses under the guise of ‘learning disability’.</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>See Initial Equality Impact Assessment (Appendix 2) which shows the overall impact on specific groups of people will be positive.</td></tr>
<tr><td>TARGET COMPLETION/ DELIVERY DATE</td><td colspan="2">Programme Delivery commences in July 2016 and ends on 31st March 2019 although work is likely to extend beyond that date. The key milestones are in the TCP Template, page 37.</td></tr>
</table>

FINANCIAL/VALUE FOR MONEY IMPACT	**Yes**	There is the potential for significant financial impacts to arise from the implementation of this programme to the partner organisations. This financial comment only reflects the Local Authority implications of the bid, focussing on pressures identified and so may not identify all implications arising which may impact other partner organisations. The proposal in the submission currently considers the reduction of inpatient clients to 14 from 26. The transfer of costs from current inpatient provision to Community based care should come with funding from NHS England which should result in no ongoing net additional costs to Local Government. However, the current estimate identified in the latest template submission is that over £2.2m of costs would fall to the Local Authorities by 2018/19, and to date there is no formal confirmation of funding to follow, so this is clearly a risk which would fall in whole or part to the two Local Authorities based on the 12 clients who would be expected to move. It is not possible to estimate how much of this could fall to Telford & Wrekin Council at this stage because that would depend on where those individuals determined to live. This risk may be spread across the "Footprint" by means of a Pooled budget arrangement and locally initial discussions are happening to consider putting this arrangement in place across the four organisations, thereby supporting mitigation of risk. Recent communication with NHS England does suggest that funding for clients where care is currently delivered by NHS England will move with those clients to the Community Provision, but it is by no means certain that the funding will move in entirety and if it does flow from NHS England, it will initially be to the CCGs. Therefore, the recommendations reflect a cautious approach in 2.2 in the absence of any firm confirmation of funding from NHS England. The template also identifies the costs of implementation of the programme, transitional costs estimated at around £0.97m being new costs and the input of significant amounts of resource from existing staff etc. from partner organisations. A bid for Transitional funding to match the additional costs has been made, but nationally, applications made by TCPs far exceed available resources so the full amount is unlikely to be awarded. Any shortfall in funding could present a risk to the delivery of the programme and would necessitate the partnership revisiting their transitional plan or seeking alternative sources of funding.

		Part of the scheme submission is the identification of costs of development of a facility for community accommodation for short term admission. This is the subject of a separate bid on behalf of CCG's which is included in the submission. There is still work to do reconciling data and understanding the full cohort and numbers of patients for specialist commissioning who will move, and this may impact the financial position and costs identified which are unfunded. This work by NHS England is expected to be completed by August 2016. The financial impacts of any future developments for the delivery of services for Secure Care to patients and the delivery of care to clients cared for in the Community may present additional financial risks to the TCP's. These will need to be considered by the Partnership as they arise and more detail becomes available.
LEGAL ISSUES	**Yes**	"Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition" was published on 30 October 2015 and requires local authorities and NHS bodies to deliver against Transforming Care Partnership implementation plans from 1 April 2016 Local authorities and NHS Bodies are expected to align or pool their budgets, as appropriate and recognising the continued responsibility of Clinical Commissioning Groups for NHS Continuing Healthcare. Any pooled funding arrangements need to comply with the requirements of Sections 75 National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. In addition to clarity as to financial arrangements between local authorities and NHS Bodies, there will need to be clarity as to the governance and reporting arrangements arising from this whole service approach taking into account each agency's relevant statutory duties for adults and children and young people with a learning disability and /or autism who display behaviour that challenges [including behaviour that can lead to contact with the criminal justice system] under the

		following legislation [as amended /updated from time to time] and associated Regulations and Statutory Guidance published there under: • Local Authority Social Services Act 1970 Schedule 1[list of all local authority social services functions] • Mental Health Act 1983 • Children Act 1989 • Education Act 1996 • Crime and Disorder Act 1998 • Housing Act 2004 • Mental Capacity Act 2005 • National Health Service Act 2006 • Autism Act 2009 • Equality Act 2010 • Health and Social Care Act 2012 • Children and Families Act 2014 • Care Act 2014
EQUALITY & DIVERSITY	**Yes**	The impact will be positive. People with learning disabilities and/or autism who have behaviours that challenge including mental health will be supported to live ordinary lives in the local community, and to be valued and respected, rather than experience neglect, abuse or discrimination.
IMPACT ON SPECIFIC WARDS	**No**	This Programme has a borough wide impact in Telford and Wrekin and across Shropshire.
PATIENTS & PUBLIC ENGAGEMENT	**Yes**	TCP is based on a principle of co-production. • Face to face meetings have taken place with several family carers and there feedback has been included in the TCP submission. • The Project Worker has attended two Carers Partnership Boards and a Learning Disability Partnership Board. • Further engagement will take place and remain ongoing for the duration of the Programme. • An event is proposed for July 2016. This may well be for family carers and experts by experience across the whole footprint. • In due course, engagement will also widen to include all other main stakeholders, including schools/special schools, the criminal justice system, the voluntary sector, care and heath services/providers. • Workforce.
OTHER IMPACTS,	**Yes**	An Initial Equality impact Assessment has been done

RISKS & OPPORTUNITIES		(Appendix 2). The outcomes of TCP are positive and reviews will remain ongoing for the duration of the Programme.

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

The TCP Template provides detailed information on the full Programme. The sections of the report include:
Mobilise communities (pages 4 – 7)
Understanding the status quo (pages 8 – 14)
Develop your vision for the future (pages 15 – 19)
Implementation Planning (pages 20 – 23)
Delivery (pages 24 – 42)
Appendix 1 – Engagement (page 43)
Appendix 2 – Population Data and information (page 46)
Appendix 3 – Services in place – (page 59)
Appendix 4 – Principles of Care (page 67)

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

An Initial Impact Assessment (IIA) has been completed and a more detailed Equality Impact Assessment is not required. A copy of the IIA is attached as Appendix 2.

3. PREVIOUS MINUTES

Not applicable

4. BACKGROUND PAPERS

""Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition – Service model for commissioners of health and social care services"
https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

"Building the right support – A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition"
https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

Richard Smith
Assistant Director Early Help &Support
Director of Adult Social Services (DASS)
Tel: 01952 381011

Appendix 1 (to HWBB June 2016)

NHS England

NHS Telford and Wrekin Clinical Commissioning Group

Telford & Wrekin Council

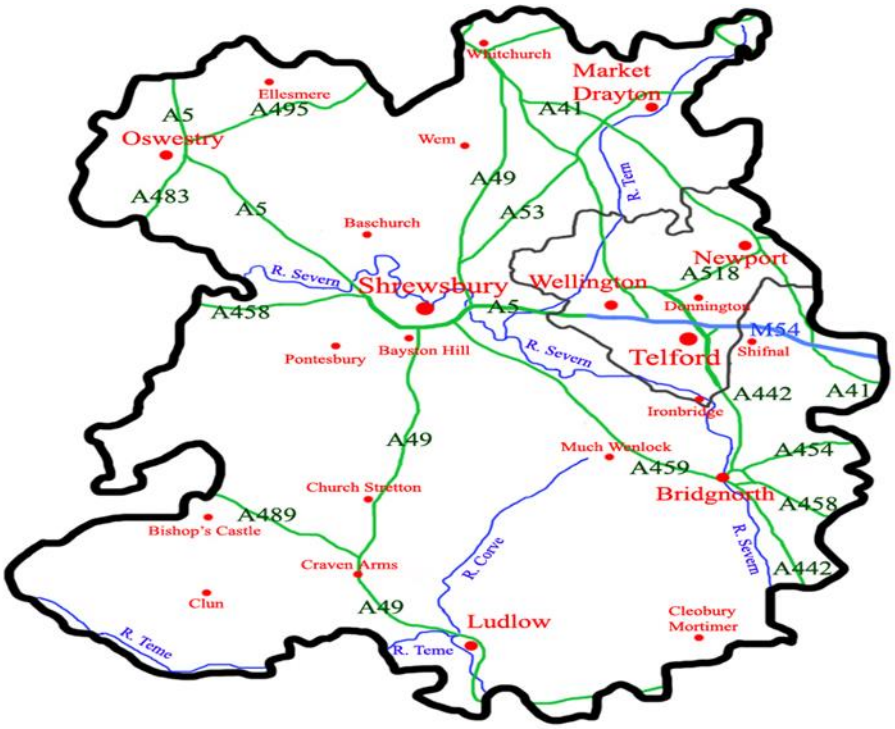
a co-operative council

Shropshire Council

NHS Shropshire Clinical Commissioning Group

Transforming Care Partnership

Shropshire Footprint



April 2016

Version FINAL

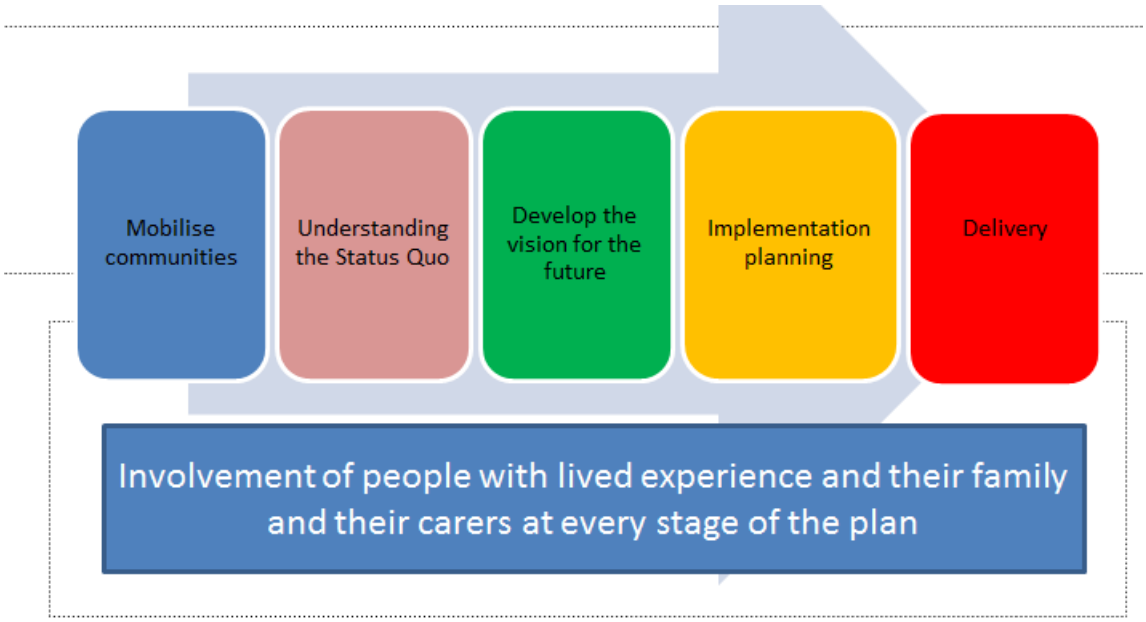
Revised 24 05 2016

Contents page

Appendices

Acronyms/Glossary	Meaning
TCP	Transforming Care Partnership
SC	Shropshire Council
TWC	Telford and Wrekin Council
SCCG	Shropshire Clinical Commissioning Group
TWCCG	Telford and Wrekin Clinical Commissioning Group
SC, TWC, SCCG & TWCCG	The Authorities
LD	Individuals referred to throughout all have a learning disability and/or Autism, and all are able to exhibit behaviours which challenge. For ease, the term used throughout the document is Learning Disability, abbreviated to LD.
EbE	Experts by Experience
NHSe	NHS England
RSL	Registered Social Landlord
LA	Local Authority
DOLs	Deprivation of Liberty
ADASS	Director of Adult Social Services
OSCA	Oswestry and Shropshire Citizen Advocacy
SSSFT	South Staffordshire and Shropshire NHS Foundation Trust
SPIC	Shropshire Partners in Care
ASC	Adult Social Care
CB	Challenging behaviour
CJS	Criminal Justice System
CTR	Care and Treatment Review
CHC	Continuing Health Care

This template as laid out in the following sections. In addition there are Appendices which provide more detail for specific areas for the plan. These provide information that will support the implementation and delivery part of the plan. Each section has been colour coded to aid the reader.



Planning template

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Introduction

Transforming Care Partnership (TCP) plan covers the Shropshire Footprint (Telford and Wrekin and Shropshire). It includes four statutory organisations:

- Shropshire Council (SC)
- Telford and Wrekin Council (TWC)
- Shropshire Clinical Commissioning Group (SCCG), and
- Telford and Wrekin Clinical Commissioning Group (TWCCG).

Collectively, throughout the report they are referred to as the Organisations.

The plan sets the context for this Programme of work, planned for July 2016 – March 2019 (33 months). Although the Programme will formally end at this time, the work of TCP will be ongoing within the footprint area. It is expected to take a further two years to fully 'bed in' the changes to culture, behaviours and beliefs so as to ensure the model way of working is sustainable and continues to evolve.

The Programme is about integration and new ways of working. The integration is between the Organisations. New ways of working is an approach to successfully meet the needs of five cohorts of people described in the service model.

The common features of the five cohorts is that the individuals referred to all have a learning disability and/or Autism, and all are able to exhibit behaviours which challenge. For ease, the term used throughout the document is Learning Disability, abbreviated to LD.

At the heart of the process of integration is a person centred approach to supporting people with LD, wherever they are – be that living at home, in the community, in hospital or specialist hospital care.

Background

Who we are:-

The Shropshire footprint covers two local authorities (Shropshire County and Telford and Wrekin) and two CCGs (Shropshire and Telford and Wrekin). It covers a population of

- 472,700 (Shropshire 306,100 (8% increase from 2001); T&W 166,600 (5% increase from 2001)

NHS provision for health care includes:-

- 62 General practices (NHS)
- One mental health trust that also supports adults with learning disabilities (FT) including one unit providing respite for individuals with complex needs
- One community trust that supports CAMHS, CAMHS LD and children neuro- development service (NHS)
- One acute trust covering two hospitals across the locality (NHS)
- Four community hospitals
- Two mental health trusts that sit outside of the footprint that support autism diagnosis.
- Two complex care teams based in CCGs
- Autism hub (joint funded- third sector)
- Continuing health care for complex patients (joint funded in some cases- independent sector)

- Small community unit for people with behaviour that challenges (independent sector joint funded)

Social care provision includes:-

- Information, advice and guidance (third sector)
- Advocacy
- Care packages
- Personal budgets and direct payments
- Accommodation commissioned via block contracts, individual/shared living; supported living; shared lives and foster carers. (N.B. During 2016-17, some changes to existing accommodation for named individuals with learning disabilities and with behaviour which can challenge will be consulted on, with the intention of providing accommodation that is better suited to the needs of the individuals and thereby providing an overall 'better quality of life').
- Day time activities accessible by all
- Some services receive support from the councils.
- Advocacy service (Taking Part and OSCA)
- Information, advice and guidance provided by a consortium of third sector providers.
- Various services which provide activities during the day time are from both the private and voluntary sector.

Education via two local authorities includes:-

- One school specifically for autism (Queensway)
- One large special school (Severndale) with a satellite in Pontesbury
- Two residential schools (Cruckton Hall and Overely)
- Several smaller special schools (Haughton, Old Hall, Southall, The Bridge and Mount Gilbert
- Mainstream children's services

How we work together:-
Collaborative commissioning arrangements are not in existence across the four Organisations. Coterminous local authorities and CCGs, have worked together to support joint funding and care packages.

Contracting with the local authorities is undertaken via block contracts and/or via individual packages. Non NHS providers are supported by Shropshire Partners in Care (SPIC) an overarching organisation to which most providers are affiliated. NHS contacts are mainly via a block with the trusts or via individual packages of care for complex patients.

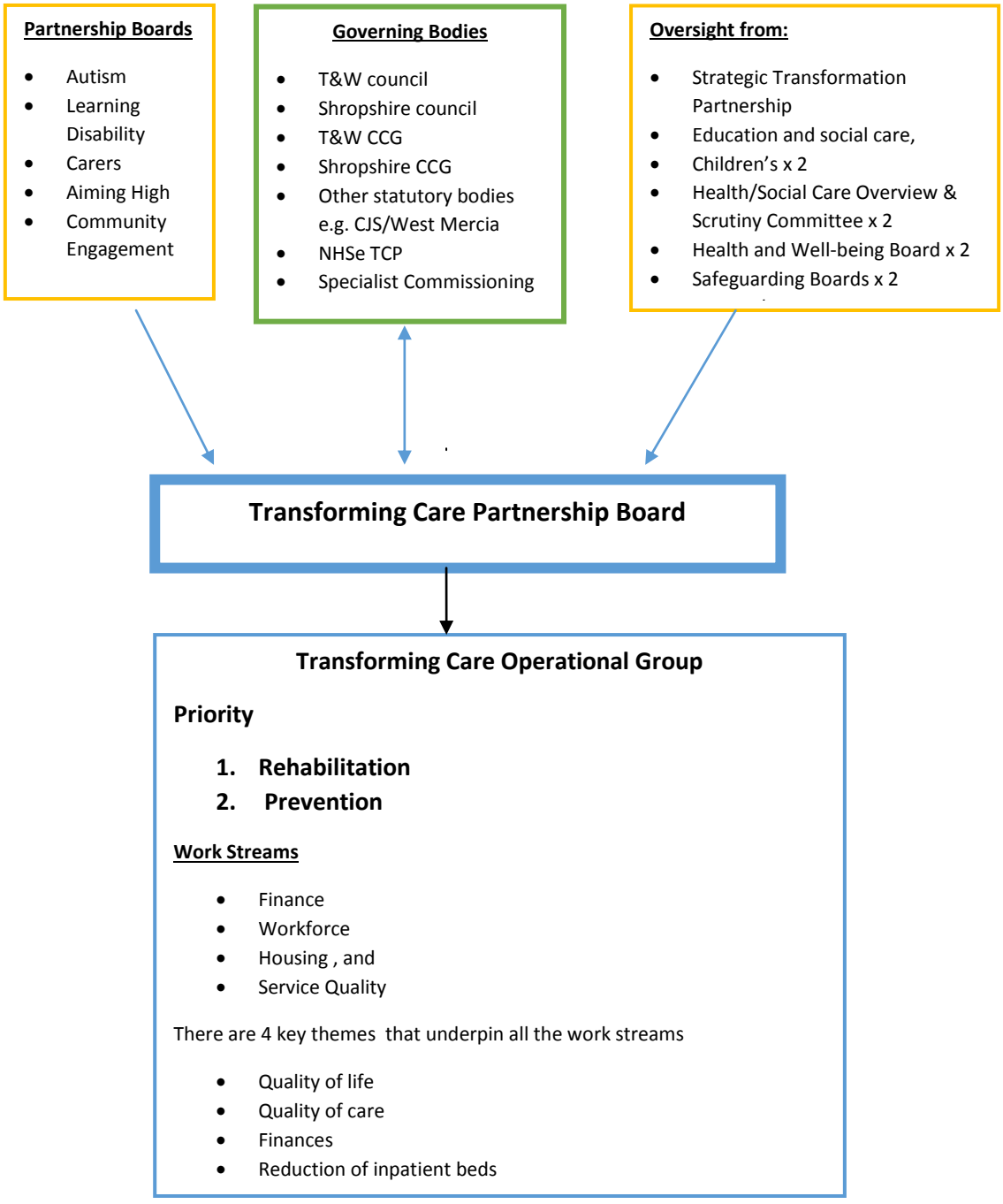
Relationships with individual commissioning organisations and providers are positive. Local authorities have good relationships with care organisations including those providing packages in homes and those providing accommodation. NHS provider relationships are developing a stronger footing as substantive posts have now been filled after 2 years of instability in commissioning in the CCGs.

Relationships between service users and carers and commissioners are strong with very proactive carers Boards, one of which was Highly commended in the 2015 HSJ Commissioning for carer's award.

Describe governance arrangements for this transformation programme

See illustration, below.

Shropshire Transforming care partnership governance structure



This plan will be ratified at the following board meetings:-

Date	Authority	Meeting
26th April	T&W CCG	PPQ
10th May	T&W CCG	Board
15 June	T&W/Shropshire	H&WBB
27th April	Shropshire CCG	QPR, 1 – 5pm
4th May	Shropshire CCG	Clinical Advisory Panel
10th June	Shropshire CCG	Board meeting (private

Whilst the action plans will be monitored via the TCP regular updates will be provided to the organisations.

Describe stakeholder engagement arrangements

The TCP:-
The core membership of the TCP Board are health and social care commissioning representatives of:

- Shropshire CCG
- Telford & Wrekin CCG
- Shropshire Council
- Telford & Wrekin Council
- NHS England Specialised Commissioning
- Supported by representative from NHSE Transforming Care Project Team.

Representatives will continue to be involved to oversee the development and monitoring of the plan and action plan. The TCP board is overseen by the following bodies:-

- Governing Bodies – providing strategic oversight
- Partnership Boards – will be informed and consulted with, as necessary.

A Transforming Care Operational Group – will be responsible for implementation of the Action Plan Leads will be allocated work streams on the different sections of the Action Plan. Service users and carers will be represented on the group.

The lead for the programme and SRO is the Director of Adult Social Care for Telford and Wrekin council. Deputy SRO is the Chief Nurse and Director of Quality for Shropshire CCG. This level of input from the organisations ensures high level commitment and the ability to share and influence across the footprint.

Service users and carers:-
There are two LD Partnership Boards within the footprint and both have had agenda items regarding the Transforming Care agenda. Both groups have had the opportunity to input into the early discussions of the plan. The Transforming care agenda will inform a large part of the work of these boards over the next 3 years.
In addition each individual organisation has well established and on going means of engaging with service users and carers. These will continue and will feed into TCP action plans.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

Discussions have taken place with Taking Part and an Expert by Experience, who sits on national boards linked to Valuing People and Learning Disability/family carers. In addition discussions have also taken place with six carers as part of developing this plan. As TCP moves forward, more work will take place to develop the TCP using a co-production approach. Further details can be found in Appendix 1.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

Baseline commissioned beds/patients are as follows:-
NHSe specialist commissioning- 16adults and 3 children (as at 31/03/16)
CCG commissioned beds/patients- 7 adults (as at 31/03/16)
Target 2019:-
NHSe reduction from 49.46 to 23.43

CCG reduction from 18.22 to 13.03

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

Work is still taking place to fully understand the population covered by programme. The TCP is an all age programme. There is substantial information held about children, both in social care and education and those not known the health or social services which needs further work to collate.
In writing the TCP we have gathered information and data from a range of sources. Key local information is used to routinely inform service improvements and design, including:

- data collected as part of the JSNA
- public health data
- social care data
- service provider data including hospital admissions, and
- Information and feedback from stakeholders and service users.

However, as recognised in the descriptions of the 'cohorts', some people are not know to services. This means that some of the plans put forward in the template may change in the future.

Nationally produced data, and information from neighbouring and comparator areas is also used by commissioners to inform service design and improvements. A summary of the key data is provided in this section.

Prevalence data would indicate the following for the total footprint of the TCP:- (for further detail see Appendix 1)

Learning disabilities prevalence					
Years	**2014**	**2015**	**2020**	**2025**	**2030**
18-64	6,843	6,839	6,760	6,689	6,562
65 plus	2,039	2,093	2,360	2,603	2,924
challenging behaviour	127	127	126	124	122

Autism by prevalence					
Year	**2014**	**2015**	**2020**	**2025**	**2030**
18-64	2,851	2,850	2,817	2,792	2,730
65 plus	915	940	1060	1178	1329
Totals	**3,766**	**3,790**	**3,877**	**3,970**	**4,059**

Locally Quality and Outcomes Framework (QoF) data for 2013-14 states that adult (18+) prevalence of learning disability on GP practice registers is :-

- 0.6% of the Shropshire
- 0.4% for Telford and Wrekin.

This accounts for 1,412 adults in Shropshire and 586 adults in Telford and Wrekin, giving a total of 1,998. However, QoF data only includes people registered as having learning disabilities and is most likely to

include people with moderate to profound learning disabilities.

The 5 cohorts:- *Children, young people or adults with a learning disability and/or autism who:*

1. Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
    - In the final quarter of 2015/16- 3 patients were supported in an inpatient mental health unit. There is no local data on those people with LD supported by community mental health teams.

2. Who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
    - Throughout 2015/16---10 patients supported in inpatient beds

3. Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).
    - There is lack of clarity regarding the numbers in those cohort but it likely to be those CAMHS (2) in transition and specialised commissioning (14) in inpatient beds

4. Have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
    - This information is currently held by a range of statutory authorities and will be collated across the footprint in due course

5. Have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.
    - Specialised commissioning- 2 dowry patients

Further details of employment status, Section 136 detentions, cares information and local authority information can be found in Appendix 2.

Analysis of inpatient usage by people from Transforming Care Partnership

NHSe specialised commissioning beds

Ref	Location	Status	Daily rate	Assumed date of move into community
Adults				
1	Brooklands, Birmingham	Low	£480.00	Mar-17
2	Ashley House	Low	£480.00	Sep-17
3	St. Andrews, Birmingham	Low	£480.00	Mar-17
4	St. Andrews, Birmingham	Low	£480.00	Sep-17
5	St, Andrews, Nottingham	Medium	£525.00	24 Months
6	St Johns House	Medium	£525.00	24 Months

7	Brooklands	Low	£480.00	Mar-17
8	Brooklands	Medium	£525.00	Sep-17
9	Ashley House	Low	£480.00	Sep-17
10	Ashley House	Low	£480.00	Mar-17
11	Ellesmere	Low	£480.00	Mar-18
12	Ellesmere	Low	£480.00	Mar-18
13	Stockton Hall	Medium	£525.00	Consider LSU next 3- 6 months
14	St Andrews, Nottingham	Medium	£525.00	Admitted to MSU 7/1/16. 24 months +
15	Stockton Hall	Medium	£525.00	
16	St John's PIC, Norfolk	Medium	£525.00	
CAMHs				
17	Alpha Hospitals Sheffield	CAMHs	£770.00	3 to 6 months
18	CWPT - Brooklands Hospital	CAMHs	£770.00	within 12 months
19	St. George's	CAMHs	£770.00	Within near future

CCG commissioned beds

No	Unit non NHS	Type of bed	No. of beds	Cost per day	No of beds commissioned by CCG
1	Annesley House	Locked rehab	2	£392.50	Spot purchased
2	Hunter Combe, Birmingham,	Locked rehab	1	£392.50	Spot purchased
3	Denshell- Wast Hills	Sec 3 treatment	1	£392.50	Spot purchased
4	Ballington House	Sec 3 Treatment	1	£392.50	Spot purchased
5	Brooklands-Birmingham	Informal admission complex care with mental health needs	1	£392.50	Spot purchased
6	Redwoods	Mental health acute	1	£347.21	Cost and volume

The footprint has repatriated many patients over the years back to the locality and has utilised few specialist LD beds out of area. The partners have many years of experience of repatriation of complex patients which it will utilise to bring the NHSe patients back to the area.

Describe the current system

The local foot print has high levels of specialised commissioned beds- 42 per 1,000,000 which is one of the highest in the region. For CCG commissioned beds the figure is 21 per 1,000,000.

Historically, there was no specialist long stay hospital in the Shropshire region. Thus, we exported people to other locations including St Margaret's, Lee Castle and Stallington. During the 1980/1990's many people were repatriated 'back home' and continue to live in area.

We have a plethora of commissioned services to support people with learning disabilities and these are described in more detail in Appendix 2
High level view of current system and flows:-

- Cohort 1- Any patients with mental health needs have access to a liaison nurse who attends

the local mental health hospital to ensure patients are reviewed and discharged as soon as possible. A recent 'Greenlight' toolkit audit showed a 37% reduction in Length of stay for people with LD and 90% reduction in incidents that harm since the introduction of LD care plans at the local mental health hospital.

- Cohort 1, 2 and 3-Robust systems and processes are now in place to ensure the continued safety and appropriateness of placements to meet individual needs, with the local mental health trust and CaMHS LD team. Meeting with commissioners and Complex Care Managers occur on a monthly basis to review the Care and Treatment Reviews and People at Risk of Admission (PARA) children and adult registers. There is an agreement in place across all stakeholders to encompass the sharing of information about all people with a learning disability and/or autism who are 'of concern' or 'at risk' of being admitted.
- Cohort- 4-Support is provided from a range of statutory services including children's' social services; looked after children; children in need; CAMHS; education services and criminal justice system including youth offending, targeted youth support, community cohesion, diversion & liaison and substance misuse.
- Cohort 5- these patients are managed by NHSE and there has been limited contact over the past few years with local commissioners regarding these patients until they are ready to step down.

Other services commissioned across the footprint to support all cohorts are:-
Health

- Spot purchasing of complex care beds as required
- Beds in a mental health hospitals- as required
- Continuing Health Care funding (see details in Appendix 1)
- Prison in reach service
- Forensic mental health team
- Psychology services
- Inter disciplinary team working to support people in their own home
- Community unit for people with behaviours that challenge (4 beds)
- NHS respite for people with learning disabilities and complex needs
- Intensive support team for people with behaviours that challenge
- Community LD service (nursing)
- Care packages- individual and bespoke
- Personal health budgets- children and adults on CHC
- CAMHS includes neuro development pathway
- CAMHS Learning disabilities
- CAMHS LD psychology
- Child development centres
- Occupational therapy to support named individuals
- Community paediatrics
- Continence team
- Annual health checks- acute liaison nurse and primary care facilitators support this work
- Learning disabilities dentistry service
- Out of hours provider (non specialist)

Local authority

- Supported living
- Personal budgets and direct payments

- Shared lives
- Single point of Access to care services for adults and children's
- Support sessions
- Autism HUBs- peer and advice support for adults with autism
- Leisure services run specific groups for people with LD including keep fit, cinema other recreational schemes
- Schools-one large specialist schools catering for all types of disability. Several smaller schools/ special schools supporting those in 1 of the 5 cohorts.
- Further education including one specialist residential college
- Employment- both local authorities have specific schemes to support people with learning disabilities into employment. (Further data included with Appendix 1)
- Housing working with social landlords: - Bromford; Sanctuary; Wrekin; Bournville.

Police-

- Hate crime: safe place scheme set up to support people with LD who may be subject to hate crime. Equality and diversity officer in place to support vulnerable adults including those with a learning disability
- Probation service
- Youth offending service

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

The overall estate for people with learning disability are provided through a range of accommodation comprising of

Health

- Dedicated specialist non NHS community based accommodation- Church parade- Community based 4 bedded unit providing support for people with behaviours that challenge- Rented from private sector-**fit for purpose for Telford and Wrekin. Insufficient supply for whole footprint.**
- There are no specialist learning disability hospital beds in the footprint.
- No intermediate care provision to prevent general hospital admission for physical health needs.
- Oak House provides 10 beds for LD for assessment and treatment for people with physical health needs and LD. **Not fit for purpose** for those with behaviours that challenge.

Local authority

- Residential- block contracts across footprint area-private and voluntary sector –**not all are fit for individual needs of** those with behaviours that challenge.
- Supported living- **Fit for purpose** as matched to individual needs **but insufficient supply.**
- Tenancy- with care packages to support- **Fit for purpose** as matched to individual needs **but insufficient supply.**

NHS has no existing interest in a property.

What is the case for change? How can the current model of care be improved?

What have service services/ carers told us about the current system?

Consultations have taken place on a 1:1 basis with several carers. In response to a range of questions the following comments were made:

There is an overall support for TCP and the principle of normalisation. The carers recognised the importance of sufficient resources to deliver community based support across all sectors (health, social

care, police and education) and across the footprint. The view is that an all age strategy offers opportunities for earlier detection and intervention. Carers felt the silos of the cohorts did not reflect the multiple needs of individuals who sometimes span more than one descriptor. This is significant when considering the needs of more complex individuals. Carers recognised that some individuals who are institutionalised into receiving care and support would need time to gain confidence in making decisions/choices.

Where there is support for PB/PHB it was also perceived as something that requires thought and planning. It may not always be welcomed. Co-production was welcomed and a recognition that one size does not 'fit all'.

Carers were keen to support the progress and welcome oversight from other existing partnership boards (Carers, LD) and they welcome ongoing engagement. Carers request that professionals keep them updated on progress in a timely manner and provide ongoing reassurance to quell concerns about isolation and being left to cope.

Workforce and housing were seen as critical elements of the TCP. It is essential staff have the right skills but even more importantly the right values to support individuals, and accommodation must match the needs of individuals. One size does not fit all.

Where individuals can progress towards employment and engage in activities, more should be done to help this happen. Concerns included being valued, listened to and the ongoing discrimination against people with learning disabilities.

Respite was seen as a critical element of support for carers and felt that this must be supported; otherwise individuals will go into institutionalised care.

This following section describes the issues and concerns that impact on the vision the TCP wishes to provide for people.

<u>Workforce</u>

Health

- A deficit in knowledge, skills and competency of health staff as illustrated in the Confidential Enquiry into Premature deaths of people with learning disabilities (CIPOLD)
- Lack of specialist LD workforce
- Lack of training places for LD workforce
- Difficulties with recruitment and retention
- Lack of research and evidence base of interventions
- Insufficient expertise within mental health workforce to support LD and autism

Local authority

- Lack of dedicated specialist social workers and commissioners
- Difficulties with recruitment and retention of skilled social workers and care staff
- Locally there is a small pool to recruit from

<u>Communication</u>

- Services are not joined up with little communication between NHSE specialised commissioning and CCGs/Local authorities.
- This is the first opportunity for the Organisations to work collaborative at a strategic and operational level on a programme of work. Processes, policies and agreements need to be developed to ensure transparent communications.

<u>Engagement</u>

- Whilst there is a real engagement with service users and carers it is not true coproduction across the adults and children's services

- Carers have told us that the system needs to be more joined up so if it doesn't work it can 'react' to support people better

Estates

- Insufficient supply of required accommodation (see section above)
- Accommodation needs to focus on supported living with less emphasis on residential care and block contracts

Finance and activity

- There is no understanding regarding the impact on each other's budgets and no way of sharing risks.
- Local councils are severely challenged by austerity measures
- CCGs are facing significant financial challenges

System Service model

- There is no articulated service model
- Lack of clear pathways- for example into criminal justice system
- Lack of clear roles and responsibilities
- Duplication of workload
- CAMHS services are not commissioned to provide a proactive model to support the reduction of crisis.
- Community nursing teams are just changing to develop an Intensive Support Team and this needs time to embed and ensure pathways are in place.
- CTR process needs more time to embed to ensure proactive consistent management of patients
- Too many patients in specialised commissioned beds out of area.
- We are not clear about the number of carers in our footprint supporting people with LD(only 28% of those people receiving LA care have details of a carer)

The system can be improved by the articulation of a new model of care and principles to underpin the model. This new model will require additional pump priming monies to develop services in the community before repatriation of patients closer to home.
The following changes in service provision will improve the offer to local patients and carers:-

- The change of service specifications for community teams, CAMHS LD, neuro developmental service (0-25);
- The re procurement of CAMHS
- Focus of accommodation to supported living and individual commissioning of care
- Increased use of personal health budgets
- Improved transition pathway to adult services
- Closer working with specialised commission, police and criminal justice system.
- Bespoke local support to the management of people with behaviours that challenge, and
- Develop a range of respite options to support both carers and service users.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

Total spend across the footprint 2015/16
CCGs **£13,235,625**
NHSe **£3,744,900**

Local authority **£15,896,479**
Shropshire total **£32,877,004**

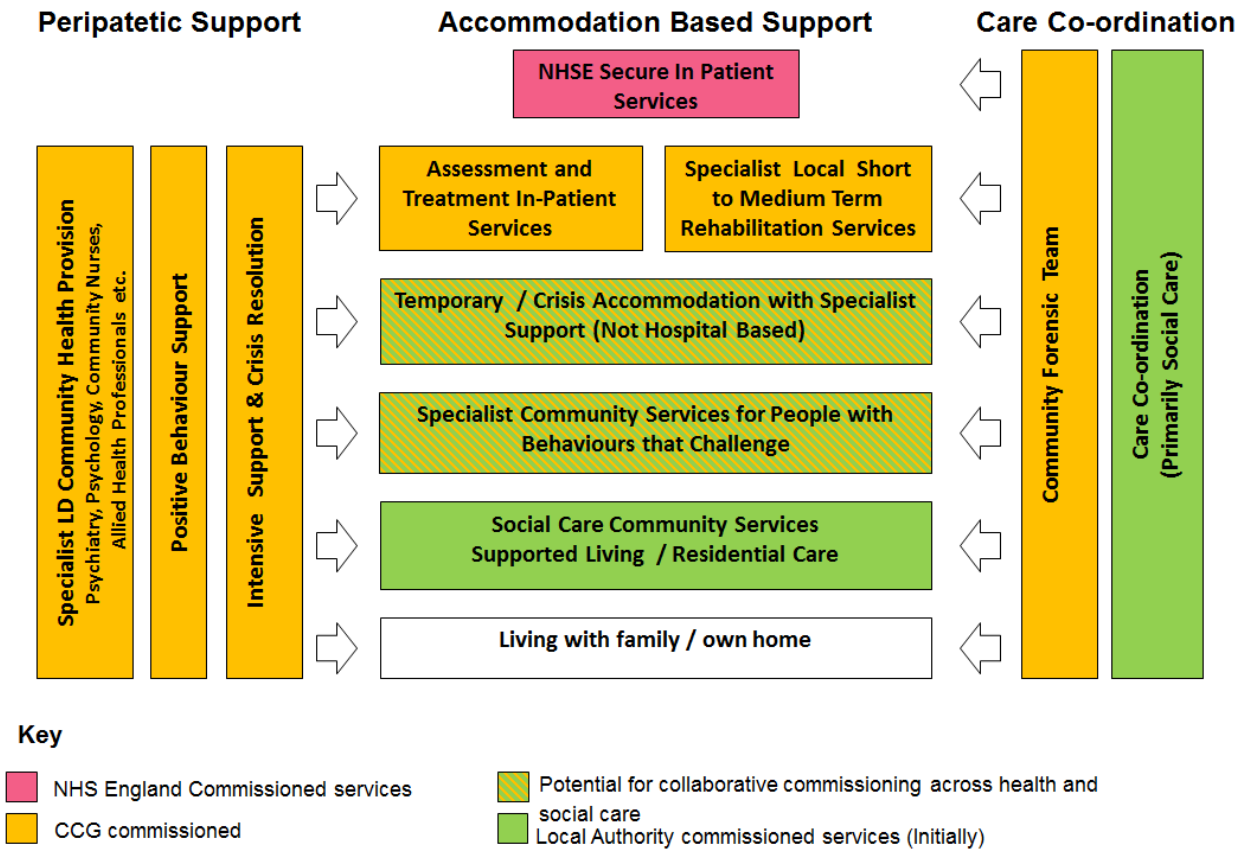
3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

By 2018/19 the TCP will ensure the provision of a fully integrated system across the Shropshire footprint for people of all ages with learning disabilities.

A system model to deliver an Integrated Learning Disability Pathway



The vision will be that people with LD/Autism with behaviours that challenge will be supported to have a good and meaningful life.

We will aim to:-
Provide proactive support to manage people in their own homes where possible. Care will be provided on an individual basis with bespoke plans for each person. It will be a rare occurrence for an individual to be admitted to a hospital for care to manage their challenging behaviour. Where this does occur it will be a managed process with plans to support the patient back at home as soon as possible. Universal services will be supported to manage people with learning disabilities whose behaviour challenges so they can remain part of our local communities.

We will ensure all organisations sign up to key principles across the TCP area:-

Respect- All people with LD will be treated with respect and valued as part of our communities.

This means that……

- Aspirations of individuals and families for their own lives will be central to all care.
- People who want to be in touch with family members will be able to do so.
- People with learning disabilities will not be ghettoised into long stay units run by health or social care, in area or out of area.
- Individuals will not be bullied, and will not be afraid. They will be in environments which are conducive to supporting them and giving them a greater sense of choice and control over their own lives.
- Carers will feel assured that their family member is being cared for and not subject to abuse of any kind.
- Individuals will be able to express themselves, feel valued and enjoy their lives.
- The health and well-being of individuals will be proactively managed.
- Locally people will be able to access flexible and diverse support services which match their needs.
- Whenever possible and appropriate, individuals will purchase the care and support they require through personal budgets and personal health budgets.
- The statutory organisations will 'take a step back', as individuals are enabled to lead their own lives.

To achieve the quality of life, quality of care and reduce reliance on inpatient services the TCP will adopt the national service model principles. (See Appendix 4)

To achieve this vision the TCP will:-

Improve quality of life by

- Greater awareness amongst the general public of LD and how to interact with people with a LD to reduce discrimination and prejudice
- Community services leisure, recreational, transport etc will understand support and accept people with LD in the community and make reasonable adjustments.
- Public health prevention programmes will have clear consideration for people with LD therefore reducing health inequalities
- Universal services will support early identification of risks which could develop into behaviours that challenge
- Parenting support is available to support positive behaviours.
- This will be measured by positive feedback from service users, cares and experts by experience that services feel safe, supportive and enabling.
-

Improve Quality of care by

- A Transformed 0-25 emotional health and wellbeing service with capacity to provide proactive support at an early stage and throughout the tiers.
- Realignment of the neuro development pathway to ensure timely diagnosis and support for both children and adults
- Ensuring all people with LD from age 14 shall have an annual health check, health action plan and a hospital passport
- When people with LD are admitted to a general hospital the liaison workers will support them and the staff to make reasonable adjustments
- General health and social care services staff will feel confident and have the required skills and competencies to make a positive difference to the life of individuals
- Across education, social care, criminal justice, independent sector and voluntary sector

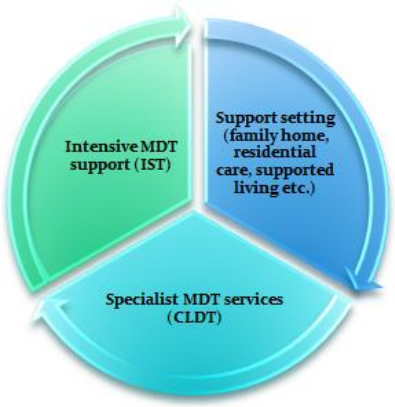
staff are aware of their role supporting and mitigating risks of challenging behaviour

- Specialist health practitioners are commissioned to support people with LD and mental health issues to manage and/or prevent escalation of behaviours that challenge.
- All people with LD will have the opportunity to hold a personal budget and/or personal health budget.
- Where advocacy is required it will be independent to the service provider.
- A sufficient suite of accommodation to match the diverse needs of the LD population that are fit for purpose
- There will be a sustainable 'market diversity' of quality providers of care for people with LD
- Employment support services will have the skills to support people with LD
- A range of alternatives for respite and short term breaks

Reduce inpatient bed usage

- A clear crisis pathway will be developed with relevant services in place

Future model – Intensive Support



- A robust, consistent Care and Treatment Review process that has access to fast track, with flexible interventions being delivered at the right place and at the right time, to avoid, where possible, admission to a hospital bed. Where admission does occur, discharge process shall be commenced immediately
- Where a safe place/support is required we will have access to community facilities in the form of step up /step down to provide fast access to the right support for as short duration as appropriate.
- Whilst we plan to reduce inpatient beds by 50% on occasions where inpatient facility is required the location will be 'as close to home' as possible and the response time will reflect the needs of the patient. (Parity of Esteem)
- A clear pathway will be developed into and out of Forensic services with clear communication including risk mitigation plans.

How will improvement against each of these domains be measured?

To ensure we know that we have achieved our vision of a good and meaningful life we will develop outcome measures that can be monitored and where we can target improvements.

These will be focused on the three priority areas:-

Improved Quality of Life measures will be developed alongside service users and family carers to ensure we measure what is important to them for their quality of life and wellbeing. It is anticipated that these

will be coproduced in Quarter 3 of 2016/17 and may include:-

Person centred planning

- Evidence of people's involvement in care planning, support and interventions/

Respite/Short breaks - including in the home

- Access to short break facilities (measure, total number, LOS)

Improvement in people's experience

- Activities and services (such as early years services, education, employment, social and sports/leisure activities)
- Education, training and employment
- Housing / accommodation measure
- Spiritual and cultural care
- Experience of clients, carers and families

Improved health outcomes

- Improvement in people feeling safe
- Improvement in people having choice and control
- Equitable outcomes
- Number of clients who have an annual health check
- Number of clients who have a Health Action Plan.

Improved Quality of care a basket of measures will be developed from the following:-

- the Health Equality Framework which looks at the five main determinants of health inequality commonly experienced by people with learning disabilities:
    - Social determinants
    - Genetic and biological determinants
    - Communication difficulties and reduced health literacy
    - Personal health behaviour and lifestyle risks
    - Deficiencies in access to and quality of health provision
- Proportion of people receiving social care primarily because of a learning disability who receive direct payments (full or in part) or a personal managed budget. (excludes people with autism but not learning disability)
- Proportion of inpatient population with a learning disability and/or autism who have a person-centred care plan, updated in the last 12 months and local care co-coordinator. Ideally, a co-production approach will be used.
- Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital
- Proportion of people with a learning disability receiving an annual health check (again, excludes people with autism who do not have a learning disability)
- Waiting times for new psychiatric referral for people with a learning disability or autism
- Proportion of looked after people with learning disability or autism for whom there is a crisis plan.
- Uptake of personal budgets/personal health budgets
- Quality monitoring visits
- Contract reviews (of providers)
- Workforce trained to minimum standard (basic) increasing linked to functionality (existing and recruited, over the duration of the project)

- Training provided to carers

Personal budgets

- Number of people with personal budgets
- Number of people with personal health budget
- Number of people with joint/integrated personal budgets
- Number of people with Direct Payments

Reduced inpatient bed usage will be measured through monitoring and recording of data including the following categories:

- Active risk register for children, young people and adults
- Reduced reliance on inpatient care (Assuring Transformation data set), specifically monitoring the:
    - CTR activity for both adults and children including 6 monthly CTRs and blue lights
    - Number of children and young people in inpatient facilities
    - Number of adults in inpatient facilities
    - Number of clients with a person centred care & crisis plan
    - Number of clients with a named liaison worker
    - Reason for admission
    - location (in or out of area);
    - age,
    - duration of stay
- Number of beds per 1,000 head of population for Assessment and Treatment (for people with mental health issues), and for Short to Medium Term Rehabilitation (people with neurological disorders).

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

Described in Section 3 and in Appendix 4

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

1. Key Assumptions

In completing the submission template the following assumptions have been made.

- No % inflationary uplift applied so the submission is based on single year cost basis (2015/16) - Increases for inflation etc will be dealt with through normal routes with associated pressures managed via a risk share agreement that the partnership will develop.
- In calculating average annual costs per community provision package for CCGs and Local Government, existing package cost details have been used with outlier costs excluded to avoid a distortion of the true 'average'
- When attributing inpatients moving in to community provision, the 10 transfers from NHS England have been attributed for planning purposes to the Local Authority funded packages line (at £183,294 per package) rather than the CCG or Joint Funded packages lines (at £138,557 and £179,911 respectively). Actual funding arrangements will be determined based on the individual patient needs at point of transfer.

- Actions relating to repatriation will commence in 2017/18, at the earliest. If new build and planning development is required, this may slip further towards 2018/19.
- Costs in the 'Finance and Activity' page reflect expected recurrent costs and therefore exclude all non-recurrent costs of implementing transformation, particularly the dual costs associated with named individuals to support repatriation. These costs form part of the non-recurrent transformation funding bid
- Transformation Funding 'bid' assumes a need for cost cover from Quarter 4 of 2016/17

2. Identified Risks

Finance representatives from all 4 partner organisations met on Wednesday 18th May 2016 to review the finance template and to identify risks inherent in both the drafted submission and overall process. Following this meeting the partnership was represented at the NHS England Finance Modelling Workshop on 19th May 2016 where some of these risks were aired and some mitigations identified. A summary of identified risks and mitigations is set out below:

2.1 NHS England unable to confirm final number of inpatients attributable to the Partnership

NHS England have confirmed that we will not know the final numbers for the potential specialised services inpatient transfers until at least August and so there will inevitably be future iterations of our returns.

In addition there are patients identified that don't have a CCG of origin and there is currently no clarity on how these patients will be 'allocated' to CCGs.

At the workshop on 19th May 2016 it was recognised that Boards are being asked to sign up to a process in June with a great deal of unknown risk – it was accepted that this was not going to work and this is to be formally raised at the TCP Board meeting on 20th May 2016.

The 26th May 2016 submission should therefore be seen as a final draft (as opposed to final) with a further review later in the year.

2.2 Basis of Dowry calculation and funding

To date there has been no clarity about how dowry funding is to be calculated. If dowries are based on actual costs of individual patients then there is no financial risk to the local partnership.

If however a dowry is calculated based on the average NHS England inpatient cost there is then a risk that actual costs of a patient are greater (or less) than the actual funding received.

Information to date has identified potentially three patients qualifying for a dowry that are attributed to the partnership.

2.3 Calculation of CCG and Local Government Average Community Provision Package cost

The finance template requires CCGs and local authorities to calculate and then use average costs of community provision as a basis for estimating future costs.

Earlier versions of the finance template used simple average calculations (total costs of patient packages divided by number of patients).

During the discussion amongst finance representatives on 18th May it was recognised that given the small numbers of patients involved a single package that was significantly different to other package costs in the relevant category could materially distort the average calculation. Consequently the average package calculations have been reviewed and outlier package costs (particularly where the outlier is a very low cost) have been removed from the calculation so that the partnership overall position is protected.

2.4 Funding arrangements for inpatients transferring in to the Community

The key assumptions section identifies that inpatients transferring from NHS England to a community based provision have been attributed for planning purposes to the Local Authority funded package line. This should not be seen as a prejudgement on the appropriate needs and associated funding of the individuals who will be transferred but more a practical recognition that in order to protect the overall partnership position the package should be reflected in the highest cost range as a means of recognising that the patients concerned will have highly complex (and costly) package requirements.

2.5 Receipt of NHS England savings in to the partnership

To date the process for transferring the NHS England 'savings' back in to the local health and social care economy have been unclear. At the Workshop held on 19th May2016 it was confirmed that:

- NHSE would not try to take savings from the budgets before transfer to CCGs.
- The funding transferred from NHSE to CCGs will be Recurrent.
- The mechanism for actioning this transfer from NHSE has yet to be agreed although it was indicated at the workshop that the mechanism should be agreed by the summer.

2.6 Funding of additional recurrent infrastructure to support transferring patients

There is a local concern that there will need to be additional infrastructure to support transferring patients. Whilst some of these costs may well be built in to the individual package costs that are put in place, an additional resource has been added in to years 2 and 3 to provide additional contingency for these costs totalling £140k in year 2 and increasing to £300k in year 3 (and recurrently thereafter)

2.7 Transfer process is not cost neutral

The final draft of the finance template submission shows that there is an additional cost between 15/16 and the end of year 3 of £734.6k (equivalent to 2.19% of total expected costs in year 3). This represents a predicted cost pressure to the local health and social care economy. This position also assumes that the NHS England savings in full are transferred into the economy. However, the NHSe draft paper (May 2016) *Transferring Care: Budget Alignment (With TCPS) states:*

> *"A reduced specialised commissioning budget would continue to be used to fund reduced activity in secure inpatient care, and larger CCGH budgets would be used to fund increased activity in community forensic services. The quantum of budget transfer will be for local negotiation, but should be proportionate to the shift in service activity agreed in the plan".* (page 3, para 6)", and
>
> *"Demand for secure LD/ASD services from one TCP (particularly the smaller TCPs) is likely to be highly volatile. Whilst the intention behind enabling TCPs to see the notional budget allocated to patients from their area is to encourage them to reduce demand for secure services, it is likely that there will be some natural volatility in demand which it will be difficult to impossible for them to control. That is partly why the proposal is for budgets to be managed at hub level, with the risk pooled across several TCPs".* (page 4, para 13)

These two extracts cause further concern. The first para indicates a limitation on how the funding transferred from specialist commissioning to local CCGs can be used. And, the second para reflects the reality facing the Shropshire footprint, as a small TCP, with one CCG in special financial measures.

This gap is based on a variety of assumptions (not least the calculation of the average cost of community based packages) and whether there is a cost pressure or not will only be known for certainty when individual transfers and associated package costs are confirmed.

When the scale of this gap was shared with NHS England at the workshop they did not appear to be overly concerned with this as a submission conclusion, but were keen to stress that there won't be any more money and the partnership will need to recycle costs locally to fit within the assumed cost neutral envelope. Locally, there is a risk as the additional costs cannot be recycled or absorbed.

An option to be explored over the coming months that may assist in the management of the overall cost position is the potential to develop a pooled budget across the partnership, alternatively there was discussion at the workshop about whether forming a larger TCP footprint with neighbouring health and social care economies may be a better way of managing any financial pressure. Locally, there is no appetite for merger with Staffordshire TCP.

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care

The new model of care is based on a fundamental paradigm shift in culture and practice which will impact on organisations, providers, communities, and individuals. This is an all age programme of care involving supporting local people, rather than promoting a dependency on institutional care. It will encompass all elements of service that people with LD may come into contact with for example Criminal justice system, police and probation.

This is a large piece of work and will exceed the timeline set by NHSE thereby ensuring changes are embedded into the culture of the footprint. It will impact on all elements of commissioning and operational delivery ultimately generating efficiencies.

What new services will you commission?

- Intensive support team to provide support in a crisis
- Additional accommodation in relation to named people, if required
- Additional buildings to support the delivery of specialist health care.
- Commissioning flexible arrangements for care and support in the community
- Support to establish micro-enterprises for individuals or small groups

What services will you stop commissioning, or commission less of?

- Complex care beds out of area will be reduced.
- In-patient services provided by Independent providers/companies
- A reduction in residential services

What existing services will change or operate in a different way?

- Review service specification for the community unit for managing people with challenging behaviour to ensure it provides short term support with outreach function.
- Community LD team service specification to ensure proactive support for people with behaviours that challenge
- Advocacy related specifically to supporting this project (i.e. over and above the limited criteria for advocacy, as defined in the Care Act 2014)
- Ensure capacity meets the demand in community based health support
- Local support and treatment services redesigned to support clear pathways for planned, crisis, and emergency care.
- Increased employment opportunities support for those who are able to progress towards employment, and wish to do so
- 'Care work force development' is commissioned to ensure staff working with the client groups identified is competent, skilled and flexible.
- Access to low level preventative services has a clear pathway for people with LD to ensure equity of access.
- An increased range and variety of activities including outside activities, particularly for people on the autistic spectrum.
- As the number of personal health budgets increase providers will need to consider their approach to market share and sustainability.
- individuals will be encouraged to have personal budgets and take more control of their lives
- All service specifications will be reviewed and clear outcome measures developed. All block

contracts will be reviewed

- Increased capacity to provide support to family carers
- A range of Short term breaks (not respite) will be commissioned for individuals
- Day services will reflect the benefits of individuals receiving bespoke and tailored support matched to their own needs.

Describe how areas will encourage the uptake of more personalised support packages

This will be an area of development, as we promote greater use of PB/PHBs. The councils have experience in PBs and this knowledge will be shared with CCGs. It is anticipated that systems and processes to manage both PH and PHBs will be integrated across organisations by the end of the programme. A PHB project will be set up within the service model work stream.
The model for developing supported living will increase peoples confidence in managing their own affairs and therefore their confidence to manage a PH or PHB, The emphasis on prevention and enablement will support this direction of travel. As we work in co-production of care packages, with service users and carers they will also grow in confidence in managing their own affairs.

SEND
Locally the SEND framework became operational on the 1st September, 2014. Within the new process the right to an Education Health and Care Plan (EHC) now exists from the age of 0-25 and will be determined through a single multi-agency resource allocation panel as part of the assessment process. It places duties on health services to work with local authorities in order to provide the health component of the EHC Plan. This includes the provision of a personal health budget where applicable.
Children with special educational needs and EHC plans in receipt of NHS funded care are also to be included within the plan. The full extent of the needs will be established to articulate the number of children who are eligible and the type and cost of care currently being provide

What will care pathways look like?

Planned, proactive and co-ordinated pathways will form part of the systems/ service model work stream, which will be co-produced throughout development and implementation of the following:
<u>Health care pathways</u>
<u>Specifically linked to the repatriation of current out of are patients:</u>
A Clinical Reference Task and Finish Group will be established involving the main provider (South Staffordshire and Shropshire NHS Foundation Trust), CCGs and council representatives. For the duration of actual repatriation. The Group will meet on a regular basis and the following will happen

- Clinical advise to ensure the right support is in place and all steps occur in a timely manner, based on the needs of the individual
- All changes occur is a way that maintains the safety of the individual and others
- All parts of the pathway for individuals will be risk assessed and mitigation will occur.
- Individuals will receive support from local health care providers as required, including GPs, community based and specialist services.
- Most importantly, repatriation will be person centred and time will be taken to ensure:
    - Planning of an appropriate package of care with funding in place – this will include double funding for staff for the duration of transition
    - Involvement of the named individual with advocacy support, as required
    - When appropriate and requested, the involvement of named family carers.
- If there is a need for crisis support during the period of change this will be provided in the

community setting

- If re-admission to impatient services is required, this will be to Redwood.
- A review will take place to learn any lessons that could have prevented or negated the need for admission, if it seems to be linked to the process of transition.

Social care pathways

- Linked to repatriation, some named individuals may require limited support from health and be ready to progress into social care support.
- Individuals will be assessed to determine the type of support required in relation to housing, engagement and staff support.
- Wherever possible, individuals will be supported to move into supported housing or shared lives.
- The intention will be to support the person to remain in the community and avoid re-admission into health care.
- If staffing levels are higher at the outset, the provider will be expected to work in a manner which leads to reduction in support within a reasonable timescale.

Planning to avoid admissions into in-patient services

- Both to support repatriation and to prevent out of area placements in the future, more work will take place to support and stimulate market growth for this particular group of individuals.
- In growing the market, the paramount issue will be to take a person centred, bottom up approach, ensuring the safety of named individuals and those in the community.
- Individuals will require different environments and different opportunities. Some individuals will require a comprehensive programme of activities throughout the week, whilst others may be more content to be able to spend time by themselves, with less intrusive support and in their own space.

Working with schools to develop a Pathway

- We will establish stronger links with schools/special schools
- Support identification of potential for challenging behaviours at the earliest point
- Ensure sufficient, appropriate support is offered, e.g. therapeutic services
- Work to mitigate or stabilise at the earliest possible time.

How will people be fully supported to make the transition from children's services to adult services?

- Both councils have systems in place to support transition and we aim to work within those structures.
- The dedicated social workers will work closely with the Transition teams, especially post 16, to ensure the support needed by individuals is identified and put in place at the right time.
- As TCP improves the sharing of information more accurate planning will take place.
- Transition can cause stress which impacts on the family, sometimes leading to family breakdown. We will support families to 'stay together' by providing support to the whole family.
- CAMHS service will become 0-25 years' service to ensure transition is undertaken later giving more time for the person to mature and time for transition

How will you commission services differently?

We will commission services across the whole footprint instead of 4 different organisations.
We will share skills and expertise in commissioning and contracting
The organisations within the TCP footprint will review the options for aligning budgets to ensure risks are shared
Where we have a provider working across more than our footprint we will ensure we have strong communications and may develop services together in the best interests of patients.

We will explore capitated budgets or year of care across NHS provision with our provider.

How will your local estate/housing base need to change?

- New development of dedicated specialist non NHS community based accommodation for Shropshire-need **new capital investment**
- **Capital required** to redevelop/ refurbish community unit to be able to support physical health needs of those with LD and behaviours that challenge
- Increased capacity for Supported living- already in discussion with local housing providers
- Increased capacity for Tenancy- new builds in development- high capital costs for those with behaviours that challenge.

Alongside service redesign (e.g. investing in prevention/early intervention/community services); transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

At this moment in time we understand there are a very small number of people in this category – possibly only 2 people. We do not know which of those people will return to Shropshire or, based on clinical assessment may need to remain in in-patient beds.
When we are informed, we will develop bespoke packages of care. A named member of staff will support the transition planning including working with providers and other key stakeholders. Double funding is likely to be required for some period during the transition.

- Detailed discussions will take place about each proposed resettlement, with support from independent advocates for individuals and if required, for carers.
- Whilst following a clear pathway to support resettlement, there will be flexibility to deliver bespoke packages of care.
- The programme to resettle people who are in long stay, out of area placements will be planned during 2016-17 and occur during 2017-2019.
- The TCP Board will maintain an overview of the planned resettlement programme.
- The ALD Co-ordinator post will maintain a detailed management plan to support all elements of transition.
- Funding will be available including double staffing during the actual period of transition
- Reviews post transition will occur on a regular and frequent basis to ensure a point of stability is achieved.
- Monthly joint communications prior to resettlement.

How does this transformation plan fit with other plans and models to form a collective system response?

Many of the key representatives on the TCP board are also part of the other transformation groups/board. These include:-

- CAMHS transformation
- Mental health crisis concordat
- PHB development
- Autism commissioning

This cross cover ensures that plans fit together and are coordinated.

Any additional information

5.Delivery

The TCP Operational Board will oversee the work of the TCP Work Streams.
This TCP Board will select one of its members to chair the Operational Board. Discussions will take place prior to appointing chairs to the work streams to ensure good representation from the Authorities and other key stakeholder groups. Chairs of each work stream will attend meetings. The Operational Board will be central to taking the work of TCP forward.
The new model of service delivery will be integrated, encompassing all ages and sectors. There will be a central hub to co-ordinate and plan programme development.

Key partners will have agreed and signed up to Terms of Reference, protocols to support interaction and collaboration. Most importantly, they will understand:

- Where they fit into the partnership
- What the other parts of the partnership are (other operational stakeholders)
- What they are expected to contribute, (how, when, where etc)
- What others are expected to contribute, (how, when, where etc)

This is fundamentally important. Experience has taught us that simply making assumptions about these things leads to break down of progress and outcomes.

In the main, we will seek to work through existing structures and systems, engaging with existing post-holders with functions which overlap with the TCP agenda (e.g. transition teams, reviewing teams). However, there will be a need to create some new posts. Our intention will be to keep this to a minimum.

- A Project Manager who works across the Shropshire Footprint
- Specialist social work posts (estimates at the moment of between 2 – 4 posts – new posts) who each carry a maximum of 15 – 20 active case loads at any point in time.
- Additional Transition support worker(s) to deal with additional demand

The intention will be to keep the TCP team focused. The major principles to inform work undertaken at an operational level will be both prevention and enablement. A key area of work in the delivery of this new way of working will be the service user and carer input, which will ensure services do improve both the quality of life and quality of care for service users and their families.

We recognise the opportunity presented by TCP being an all age Programme enabling work across sectors, agencies and providers. If incidents of potential risk can be highlighted at an early stage and preventative support introduced in a timely manner, we hope to avoid family breakdown and escalation of challenging behaviours. Based on experience, we anticipate a critical area of focus will be around the later stages of transition from children's to adult services.

What are the programmes of change/work streams needed to implement this plan?

To implement our vision we have agreed the following work streams to drive forward delivery. Each work stream will have a clear focus on finance, quality of life, quality of care and a reduction
Of inpatient beds. Each work steam will have service user/carer representatives to ensure there is a clear challenge to professionals and to develop the things that really matter to the individuals we commission services for.
Workstream delivery/action plans below will be re-written by July 2016, to reflect the re-modelled governance structure (page 6). The changes align the work of the TCP with NHSe.

No	Work stream	Project no	Descriptor- project areas	Finance	quality of life	quality of care	Reduction inpatient beds.
1	Workforce	1.1	Capacity	Y	Y	Y	Y
		1.2	Knowledge skills development	y	Y	Y	Y
		1.3	Culture and values	y	Y	Y	Y
		1.4	Explore tool to measure competencies (research)	y	Y	Y	Y
2	Strategic Communication	2.1	Governance- legal/ policy	y	Y	Y	Y
		2.2	Stakeholder awareness	y	Y	Y	Y
		2.3	Public awareness	y	Y	Y	Y
3	Engagement	3.1	Co-production development and delivery	y	Y	Y	Y
		3.2	Easy read documents	y	Y	Y	Y
4	Estates	4	Housing strategy (including new build, fit for purpose, capacity	y	Y	Y	Y
5	System service model/ comn	5.1	Good and meaningful life	y	Y	Y	Y
		5.2	Person centred, planned, proactive and coordinated	y	Y	Y	Y
		5.3	Choice and control-PHBs advocacy	y	Y	Y	Y
		5.4	Support to family and paid staff	y	Y	Y	Y
		5.5	Mainstream health services- Annual health checks, health action plans, hospital passports	y	Y	Y	Y
		5.6	Specialist health and support in community	y	Y	Y	Y
		5.7	Support to stay out of trouble	y	Y	Y	Y
		5.8	Hospital services support	y	Y	Y	Y

	Workstream One: Workforce Plan			
No	Task	Lead	Milestones	Comment
1	Establish a Work stream group	SPIC	Q2 2016/17	Additional costs for meetings, providers needing to release staff, paying EbyE and travel costs for carers
2	Establish formal links with the Skills for Care and Health and seek input - attendance	SPIC	Q2 2016/17	They may, or may not attend.
3	Agree Terms of Reference	SPIC	Q2 2016/17	Use overarching TofR, with tweaks to suit context of WFD.
4	Establish a workforce plan using the Skills for Care template	SPIC	Q2 2016/17	Work with health colleagues to link with equivalent health care template
5	Seek advice and learning from the TCP Workforce pilot	TBA by workstre	Q2 2016/17	
6	Understand and map out the existing and available workforce	As above	Q3 2016/17	Need collaboration from all relevant stakeholders
7	development needs of current workforce	SPIC	Q3 2016/17	And, what needs to be added to WFD programme specifically related to TCP
8	Access support from resources and tools produced by Skills for Health and	SPIC	Q3 2016/17	Work with commissioners who will be commissioning new service model
9	Planning and meeting needs – develop a Strategic Workforce Development	SPIC	Q3 2016/17	
10	Seek Grant funding to support development, including EU/ESF	SPIC	Ongoing	Meet objectives linked to external funding
12	Confirm workforce gaps Business case for recruitment			
12	Identidy training opportunites	TBA by workstream	Q2 2017/18	
13	Recruitment processes	TBA by workstream	Q2 2017/18	
13	Commence delivery training	TBC by workstream	Q3 2017/18	

	Work steam two:Strategic Communication			
No	Task	Lead	Milestones	Comment
1	Establish work stream steering group and get shared agreement	SRO	Q1 2016/17	Understand statutory requirements identifying shared perspectives which support integration and those which hinder and find workable solutions Timetable regular meetings/ Identify Terms of Reference
2	Agree policies/ processes in relation to finance	SRO	Q1 2016/17	Alignment across the four authorities will require detailed work to ensure the TCP progresses smoothly.
3	legal frameworks for pooled budgets	SRO	Q2 2016/17	Be clear on budgets and maintaining financial control and management Consider implications of alignment on commissioning and operations
4	Stakeholder enagement, project plan and agree target audience	SRO	Q3 2016/17 & ongoing	Understand the drivers and boundaries which operate within the two domains (CCG and social care /(children and adults))
5	Awareness raising and ongoing comms plan with stakeholders	Project manager	Q3 2016/17 & ongoing	Develop protocols to support information exchange
6	Awareness raising and ongoing comms plan for public	Project manager	Q3 2016/17 & ongoing	Communication and Engagement plan
7	Develop project plans/ identify prioities (e.g. reduce stigma)	Project manager	Q3 2016/17 & ongoing	Inform of progress and feed back - users and carers, workforce, estates, governance, commissioning, benchmarking, CJS etc

	Work stream Three: Engagement Plan			
No	Task	Lead	Milestones	Comment
1	Identify all the existing routes which are in place and can continue to be used to support communication and engagement	Project manager	Q1 2016/17	LDPB and plan to attend and keep stakeholders aware and informed Longer term, agree method of keeping the groups informed
2	Identify additional meetings to be arranged	Project manager	Q1 2016/17	On going talk with Taking Part agree how to progress, & establish co-production as 'way of working' to engage specifically with people who have LD and/or autism and behaviours which can challenge
3	work with experst by experience and carers	Project manager	Q1 2016/17	Talk with CVS / Carers PB and agree how to progress, & establish co-production as 'way of working'
4	Involve colleagues who already have contact/friendships with the individuals & who will support the process of engagement, including Taking Part.	Project manager	Q1 2016/17	
5	Establish a programme of meetings	Project manager	Q1 2016/17	
6	Seek to identify people who may be able, willing and interested in supporting the co-production approach	Project manager	Q1 2016/17	
7	Explain steps we are taking, including wanting to benchmark	Project manager	Q1 2016/17	
8	Commence programme development	Project manager	Q1 2016/17	
9	Produce programme and consult on new model	Project manager	Q2 2016/17	ensure any enagement is embedded and shared into the other work streams
10	Talk about co-production and proposal	Project manager	Q2 2016/17	a small steering sub group of some representatives (individuals and carers) to help us plan and then progress consultation
11	Develop a more comprehensive plan to support progress post December 2016.	Project manager	Q2&3 2017	
12	receive information relevant and meaningful to them	Project manager	Q3 2017	
13	Continue all aspects of engaement	Project manager	Q4 - ongoing	use feedback and support to support on going programmes, implementation, delivery and evaluation of impact

	Workstream Four: Estates Plan			
No	Task	Lead	Milestones	Comment
1	Identify named individuals to be part of Strategic Working Group	LA	Q2 2016/17	invite all relevant stakeholder orgs to join Work Stream
2	Establish a Project Group to oversee the Estates/Housing Stock and Accommodation. To remain in place for the duration of the TCP project.	LA	Q2 2016/17	
3	Terms of Reference (ToR) developed including aims, outcomes, governance, finances, links to other projects/work streams	LA	Q2 2016/17	
4	Develop a TCP Project Plan/ prioities	LA	Q2 2016/17	
5	Review/refresh the existing ALD Housing Strategies, creating a sub strategic objective around TCP covering the entire footprint..	LA	2016-2019	PID submitted to NHSe for 2017 – 2019. Planning to occur in 2016. Cover period 2016-19 for people described in the 5 cohorts;· Update to reflect changes on policy (e.g. TCP); Care Act 2014
6	Identify and map demand	LA	Q3 2016/17	
7	Assess in detail the existing supply which exists and is likely to be available across all sectors.	LA	Q4 2016/17	
8	Created Action Plan to support Strategy	LA	Q1 2017/18	
9	Identify all current Out of Area (OofA) people requiring Housing and Accommodation in the future.	LA	Q4 2016/17- Q1 2017/18	Some OofA may not want to return
12	Specifically confirm status of named individuals against the '5 cohorts' definitions.	LA	Q4 2016/17- Q1 2017/18	For repatriation, cohort 5
13	Gain understanding of the perspective of named individuals relating to their future housing and accommodation needs	LA	Q4 2016/17- Q1 2017/18	Specifically in relation to existing OofA, supported by Advocacy services and existing providers of care
14	Within the Project Plan develop a pathway to support repatriation of existing out of area placements	LA	Q4 2016/17- Q1 2017/18	a) CCG patients (12); b) Spec Commissioning (14/19); c) Local authority out of area placements (no's. TBC)
15	Understand the perspective of named carers linked to individuals due to be repatriated.	LA	Q4 2016/17- Q1 2017/18	Involve carers throughout; If families don't want to engage, involve correct statutory bodies as stated in the Care Act
16	Estates/Housing Stock and Accommodation Commissioning and procurement Strategy which is aligned to the overall learning disability strategy and reflects the current	LA	Q4 2016/17- Q1 2017/18	
10	Identification of new providers, secure housing to maximise opportinuty to meet demand	LA	Q4 2016/17- Q1 2017/18	agree standards / requirments of market management
11	Tendering work	LA	Q1 2017/18- Q3 2017/18	

project	Work stream 5- System Service model/			
No	Outcomes (tasks to be agreed with prject group)	Lead	Milestones	Comments
Have a good and meaningful life				
1	People are included in activities and services.	Local authorities	TBC with work stream	Get to know individuals. What do they like doing?
2	People have choice and control over the activities in which they participate,	Local authorities	TBC with work stream	facilitated through person-centred care and support plans/ Education, Health and Care (EHC) plans and personal budgets/personal health budgets
3	Access to education, training and employment (including supported internships) which they can access within their local area	Local authorities	TBC with work stream	
4	Training and support to mainstream service staff and/or provide support to individuals and their families/carers	Lead to be identified in each member organisatio	TBC with work stream	This enables them to participate in mainstream services, and to access education and training within local schools and colleges.Discussions with providers of education/FE about courses and support available
5	Offer good support to families/ carers, friends and others so that people are supported to take part in things they value.	identified in each member organisatio ns	TBC with work stream	
Person centered planned, procative and corodinated care and support				
6	Sophisticated risk stratification of local populations	CCG	TBC with work stream	to enable local services to anticipate and meet the needs of those people with a learning disability and/or autism.
7	Everyone will be offered a named local care and support key worker	CCG	TBC with work stream	Consistency for named person and family carers
8	People are given more choice and control over decisions to do with them and their peers,	LA & CCG	TBC with work stream	Will inculde support from independent advocates, as required.
9	Things happen in a timely manner to help stop people finding themselves in situations which lead to behaviours which challenge	LA & CCG	TBC with work stream	
Everyone has chioce and control over how their health and care needs are met				
10	Everyone receives information about their care and support in formats that they can understand.	CCG	TBC with work stream	This will apply in all circumstances – even when people lack capacity to make specific decisions, they are involved in their care and support planning discussions wherever possible and any decisions taken on their behalf will be made in their best interests.
11	The offer of personal health budgets are increased. Integrated personal budget across health and social care are developed.	CCG	TBC with work stream	Identification of TCP cohort likely to accept an offer of a PHBs
12	People are involved in deciding who provides care and support to them (recruitment), including personal care	CCG	TBC with work stream	Identification of TCP cohort likely to accept an offer of a PHBs
13	People have access to different types of independent advocacy.	CCG	TBC with work stream	Non-statutory advocacy to be increasingly offered , at key transition points including in preparation for and on leaving a specialist hospital.

Care and support in the community to reduce crisis situations				
14	Practical and emotional support and access to early intervention programmes are available	CCG	TBC with work stream	across Shropshire, including evidence-based parent training programmes, and other skills training.
15	Improved availability and access to short breaks/respite	CCG	TBC with work stream	suitable for people whose behaviour challenges at times when there is stability in the home. Different types of respite and short term breaks are available,
16	Alternative short term accommodation (for a few weeks) is available,	CCG	TBC with work stream	To be used in times of crisis or to avoid a potential crisis (eg for medication review/ changes) preventing an avoidable admission into a hospital setting
17	All paid, health and social care staff providing packages of support, to be able to deliver proactive and reactive strategies to reduce the risk of behaviour that challenges,	CCG	TBC with work stream	Staff feel confident, skilled and competent to de-escalate behaviours which challenge
18	Within Shropshire there is a clear identified list of preferred providers across health and social care,	CCG	TBC with work stream	A comprehensive list exists and is maintained by commissioner which can demonstrate minimum quality standards and competencies.
19	SPIC will, in partnership with the providers, develop competency frameworks, including requirements for staff training	SPIC/LA	TBC with work stream	Competency Framework e.g. communication and Positive Behaviour Support (PBS).
Main stream health servcies				
20	Everyone with a learning disability over the age of 14, will be offered an Annual Health Check	CCG	TBC with work stream	To inculde a Health Action Plan, which identifies how any physical and mental health needs will be met.
21	The health action plan will also include a 'Hospital Passport'	CCG	TBC with work stream	To help mainstream NHS services make the reasonable adjustments required by law (including meeting the needs of people who display behaviour that challenges) and ensure equity of health outcomes for people.
22	Review of 'liaison' workers, who have specialist knowledge and specific skills in working with people with a learning disability and/or autism which enable them to advise those services on how to make effective adjustments	CCG	TBC with work stream	Liaison workers in place with the right specialist knowledge and specific skills
23	Audit of how Shropshire Footprint NHS provider services 'quality checker' schemes are utilised to ensure that mainstream services serve them appropriately.	CCG	TBC with work stream	Improved consistency in Health Checks, to improve North/South divide
24	Audit how mainstream mental health services are meeting the needs of people with a learning disability and/or autism.	CCG	TBC with work stream	Green Light Toolkit (NDTi 2013, ring MDT together for 3 x 2 hour sessions to work through the green light toolkit together

	access specialist health and social care support in the community			
25	That everyone has readily accessible community access to integrated, community-based, specialist multidisciplinary health and social care support.	**CCG**	TBC with work stream	(including those who may have come into contact with or are at risk of coming into contact with the criminal justice system)
26	Evidence is available to demonstrate that support will be built around the needs of the individual through a **'**Collaborative Care' model,	**CCG**	TBC with work stream	combined team (e.g. all age, learning disability and autism) and that individuals receive continuity of care and support through close collaboration of services/agencies, including between specialist and mainstream services.
27	Anyone who requires additional support to prevent or manage a crisis will have access to hands-on intensive 24/7 multi-disciplinary health and social care support at home, or in other appropriate community settings,	CCG	TBC with work stream	Including schools and short break/respite settings. This support will aim to be delivered by members of highly-skilled and experienced multi-disciplinary/agency teams with specialist knowledge in managing behaviours that challenge.
28	Improved interface between specialist routine multi-disciplinary support services a	**CCG**	TBC with work stream	
29	Commissioners will ensure the availability of specialist integrated multi-disciplinary health and social care support in the community for people with a learning disability and/or autism, covering all ages.	**CCG**	TBC with work stream	
30	Commissioners will ensure this specialist health and social care support includes an intensive 24/7 support function.	**CCG**	TBC with work stream	
31	Commissioners will ensure inter-agency collaborative working, including between specialist and mainstream services	**CCG**	TBC with work stream	Specialist health and social care support is available to people.SSSFT provide a 24/7 service to support people remaining in the community
32	Understanding an asset based approach and ensuring community based services are accessible.	CCG	TBC with work stream	
	population can get the necessary support to stay out of trouble			
33	People who are at risk of coming into contact with the criminal justice system, will have access to the services aimed at preventing or reducing anti-social or 'offending' behaviour.	CJS	TBC with work stream	Commissioners expect services (including those provided by youth offending teams, liaison and diversion schemes, as well as troubled family schemes and programmes such as those for drug and alcohol misuse) to identify people with a learning disability and/or autism amongst the people they support, and to make reasonable adjustments so they can effectively support those people. This will be achieved through collaboration with specialist multi-disciplinary health and social care services for people with a learning disability and/or autism
34	Liaison and diversion schemes will seek to support people through the youth or criminal justice system 'pathway'	CJS	TBC with work stream	enabling people to exercise their rights and/or where appropriate, diverting people to appropriate support from health and social care services. Clear pathways for diversion to appropriate health and social care services will be established through local multi-agency protocols.
35	Strong links are established with all the different parts of the CJS	CJS	TBC with work stream	People receive the right support at the earliest stages to stop them becoming involved with any part of the CJS.Information on how to support and prevent links with the CJS is provided to paid carers and family carers as well as other professionals

high-quality care in hospital settings				
36	Everyone who is admitted to a hospital setting for assessment and treatment will be integrated into their broader care and support pathway,	CCG/ NHSE	TBC with wo	hospitals working closely with community mental health, learning disability/autism and other services, including those providing intensive community and/or forensic support
37	People admitted for assessment and treatment in a hospital setting will focus on proactively encouraging independence and recovery.	CCG/ NHSE	TBC with work stream	Services will seek to minimise patients' length of stay and any admissions will be supported by a clear rationale of planned assessment and treatment with measurable outcomes. Discharge planning will start from the point of admission - or earlier for a planned admission. Care and treatment should be regularly reviewed, in line with NHS England Care and Treatment Review guidance and Shropshire's local CTR policy and CPA requirements.
38	People who present an immediate risk to those around them and/or to themselves may require admission to a hospital setting when their behaviour and/or mental state is such that assessment and/or treatment is temporarily required that cannot be provided safely and effectively in the community.	CCG/ NHSE	TBC with work stream	High quality assessment and treatment in non-secure hospital services with the clear goal of returning them to live in their home will be evident.
39	Providers will make the reasonable adjustments to enable this (e.g. liaison nurses and collaborative working with learning disability and/or autism specialists).	CCG/ NHSE	TBC with work stream	
40	People whose learning disability and/or autism is more significant and who require an adapted environment and/or intensive specialist treatment and care will be admitted to a specialist unit if they require inpatient care.	CCG/ NHSE	TBC with work stream	With the right support at the right time in the community, use of inpatient services will be reduced and only for clearly defined purposes. Admission to secure inpatient services will only occur when a patient is assessed as posing a significant risk to self or others.
41	A clear consitnet CTR process in place for adults and children	CCG/ NHSE	TBC with work stream	As a result of the process all inpatient provision (secure or not) children admitted to hospital will be placed in an environment suitable for their age and must have access to education. For adults, provision of single-sex accommodation is essential

Work stream 5

Project 5.8 Hospital services

A priority for this work stream is the reduction in inpatient beds. This will have a significant impact on mainstream health services, specialist health services, hospital beds, social care and family and carers to ensure people with LD have a good and meaningful life.

Baseline Financial Figures

	Cost to CCGs (£)	Cost to NHS England (£)	Cost to local govt (£)	Total (£)
Forecast annual cost of inpatient provision used by TCP population	£1,049,672	£3,744,900		£4,794,572
Forecast annual cost of individual community support packages for former inpatients/those at risk of admission	£9,584,182		£10,174,366	£19,758,548
Forecast annual cost of community services	£2,601,771	£0	£5,722,113	£8,323,884
Total	**£13,235,625**	**£3,744,900**	**£15,896,479**	**£32,877,004**

Assumptions for in-patient discharges

Our financial plan is predicated on an assumption that actual transition will commence from April 2017, so there is time to prepare accommodation and suitable care packages. This will ensure safe, high quality discharge. We will continue to work closely with NHSe specialised commissioning for individuals whose discharge is planned before this date.

From May 2016 when NHSe specialised commissioners revert to population based commissioning, the lead from Specialised Commissioning will meet monthly with TCP clinical leads to discuss the individuals, their needs, preferences and discharge plans. This provides the opportunity to identify the level of risk of repatriation and make longer terms plans in order to keep both the individuals and communities safe.

CCGs and local authorities have not built in any additional funding requirements to support repatriation of people who have previously been the responsibility of NHSe specialist commissioning responsibility and are therefore reliant on funds following the individual. These individuals have highly complex and resource intensive needs.

Future admissions over next 3 years and link to decommissioning of in-patient beds -

Assumptions

- The CCG do not commission any inpatient beds for this cohort- they are spot purchased as required.
- As we develop more proactive community based and crisis support we will commission less in-patient beds which will have an impact on out of area providers.

Dowries

3people (Low Secure) are eligible for Dowries. Assumptions made:

- Annual revenue stream of £175,200 per patient. (Total per annum £525,600).
- At this point in time the assumption is the full cost of the current placement will be maintained at the current rate (with annual increases for inflation and fee increases from providers).
- Cost reduction will be dependent on the individual requiring less individual staff support.
- Accessing activities and engaging in the community may require further investment which will be in excess of the possible staff savings.
- This revenue stream will continue until the two people die.

Financial Risk

- Non Dowry patients- There is lack of clarity regarding how long funding from NHSe will continue into the TCP area once individuals are moved. This could have significant financial impact on the CCGs and LA circa £2.6M. Local authorities are bound by financial regulations to hold a balanced budget. Where funding ceases during the lifetime care of these individual local authorities will not have the budget to support the level of care required. This could mean cutting of other services in prevention. On this basis local authorities will not approve these plans. This impasse is likely to have a detrimental affect the partnership working across the TCP
- It is likely that the future cohort will increase in complexity. Whilst the footprint will have an increased prevention, proactive, model in place there will be some individuals who require specialist inpatient beds. The TCP is unaware of any prospective increase in baseline budgets to reflect this.
- Transport costs for the footprint will increase due to the rurality of the area. The changes in

practice will mean more staff travelling as well as individuals accessing activities and healthcare.

Section 117 aftercare

- If any of the non-dowry patients are eligible for section 117 after care, the funding details between the local authority and CCG will be calculated according to existing local policies.

Continuing Health care

- If any of the non-dowry patients are not eligible for section 117 funding, they will be assessed for CHC funding.

Investment in community infrastructure

The 2016/17 contract for LD services supports the Intensive support team and the proactive LKD team. These teams will provide support in the community for those at risk of admission and support positive behaviour management.

On the assumption of repatriation for each individual the following will need to be taken into account in order to meet the requirements of the service model:-

- Operational Staffing levels for care delivery
- Case Management
- Housing costs
- Activities
- Healthcare
- Transport
- Education
- Employment support
- Criminal justice system- police, probation etc

All of these factors require individual consideration.

Investment in individual packages of support

Based on assessment of the above factors NHSe have suggested that the transfer will be cost neutral to manage people in the community. The evidence indicates this will not be the outcome at a local level, and across the footprint, this risk cannot be mitigated.

Capital – Financial Assurance Checklist 2

Capital PID

- The Capital PID will be revisited and revised during May – June 2016.
- An updated submission will reflect cost assumptions to provide the above accommodation.
- The application PID will not require investment during 2016-17.

Capital Plans

Capital plans for 16/17 – not proposed

Capital plans for 17/18 & 18/19 will be assessed and confirmed by Autumn 2016.

Capital – community based accommodation

As an example of recent costs associated with developing provision Shropshire commissioned supported living for 9 people with complex behaviours, including repatriation from out of county settings.

- Site 1- £3.2 million including site value and development costs.
- Site 2- £370,000
- Site 3- £56,000

Review of existing estate under legal charge

NA

Work with housing organisations/local authority

Estates/Housing work stream to be established.

Unused/vacant properties

As part of above work stream.

Raise ambition for capital plans

- The ambition for the TCPs is to have fit for purpose, community bedded accommodation to provide step up, step down facilities to support those with behaviours that challenge through escalation of physical, mental and social issues.
- Quality individual tenancies for supported living for each individual
- A range of short term/respite options including accommodation

Person centred approach

An underpinning principle of this TCP is that wherever possible housing will be community based in supported living accommodation whereby people with LD will have their own tenancy, have access to benefits and are supported to live fulfilling lives in their local community as citizens. As work progresses consideration will be given to the requirement to involve court of protection and DoLs.

Understanding the financial risk for each commissioner - how to address and mitigate

(See risk register for financial risks)

Development of a local, transparent financial model

The Shropshire footprint TCP will continue to work together to produce a transparent financial model to support TCP and has in principle agreed to align budgets. Further conversations will be undertaken after May 16 when NHSe has reverted to population commissioning, to align specialised commissioning budgets.
An invitation has been extended to Specialist Commissioning to join the Shropshire footprint TCP Board.

Provider sustainability and contracting footprints

As the footprint commissions a small number of beds from a small number of providers the impact is minimal. The repatriation of individual will support the sustainability of local providers. Our footprint for some highly complex individuals may extend into neighbouring TCP areas and the TCP is in direct conversation with them.

Guidance notes; As a minimum, set out a workforce development plan, an estates plan and a communications and engagement plan

Who is leading the delivery of each of these programmes, and what is the supporting team.

Guidance notes; Who are the key enablers to success, what resources have been identified

Members of the TCP Board will be assigned to a work stream and an operational lead will be responsible for co-production and implementation of the projects.

Members of the TCP are:

- Chair: Assistant Director, Early Help and Support and Statutory Director of Adult Social Services

- Deputy Chair: Director of Nursing, Quality and Patient Experience Shropshire CCG
- Risk Mitigation Lead Nurse for Vulnerable People, Nursing, Quality, Patient Safety and Experience, Shropshire Clinical Commissioning Group (CCG)
- Commissioning Specialist / Contracts Officer, T&W Council
- Assistant Director, Shropshire Council
- Head of Commissioning for Mental Health, Learning Disabilities and Children, T&W CCG
- Project Manager

Project planning monies have been agreed to support setting up of plan. Organisations have also agreed a joint post needs to be in place to move the agenda forward. This has been put into the financial bid from the TCP

What are the key milestones – including milestones for when particular services will open/close?

Guidance notes; What are the timescales / lead times for each key milestone
Please either complete a route map – as attached, or some other project management tool to map milestones

Route Map: *<Shropshire TCP>*

Date last updated: 07/04/2016

Example Deliverables	Leads	2016/17						2017/18						2018/19				
		Jan-16	Mar-16	Jun-16	Sep-16	Dec-16	Marc `17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Notes
1) Workforce															
Develop a sustainable workforce - Capacity - Knowledge and skills devlopment - Culture and values - Explore tools to measure competencies (research)	SPIC		Establish work stream group Establish inks with skills for care and Health and seek input. Agree ToR	Workforce plan Advice and learning from workforce pilot>	Map existing workforce	Planning /engagement meetings Agree Strategy Seek grant funding	Identify Training Opportunities, plan training dates & communicate dates out	Commence to Deliver Training/ recruitment	Deliver Training	All training to be delivered					
2) Strategic Communication															
Governance	SRO		Establish work stream group Shared agreement	Policies and agreement in relation to finance	Legal framework for pooled budgets										
Stakeholder engagement	SRO		Establish work stream group	Develop project plan and agree target audience				Deliver awareness training in relation to people with LD							
Public Awareness	SRO		Establish work stream group	Develop project plans priorities e.g. reduce stigma					Public awareness launch						
3) Engagement															
Co-production development and delivery	Project Manager	Identify existing routes, enage carers. Estyablish programme	consultation on new model	Commence Programme Development	ongoing co-production			documentation shared and embedded							
Develop Easy Read documents	Project Manager		Establish work stream group	Review Current Practices	Identify Gaps	Propose New Arrangements		Produce and distribute documents							
4) Estates - Availability & Suitability															
Housing strategy	LA		Establish work stream group	Develop project plans priorities	Requirements Develop Develop / monitor Risk Registers	Agree Standards/ a pathway to support repatriation of	Identify & Map Demand Procurement Strategy			securement of new providers/ housing to meet demand	monitoring/ recruting/ implemtation processes				
5) Systems service model and commissioning															
Good and meaningful life	LA, CCG, Provider lead		Establish work stream group Agree ToR	Review Current Practices, Identify Gaps, Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Procure/ recuit to gaps idenified							
Person centred, planned, proactive and coordinated	LA, CCG, Provider lead		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications			Procure/ recuit to gaps idenified					
Choice and control-PHBs advocacy	CCG		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Procure/ recuit to gaps idenified							
Support to family and paid staff	LA, CCG, Provider lead		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Procure/ recuit to gaps idenified							
Mainstream health services- Annual health checks, health action plans, hospital passports	CCG		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Develop Uniform System Approach CTRs Early interventions	Develop systems for indivualised care / support		Agree Service specifications	Procure/ recuit to gaps idenified						
Specialist health and support in community	CCG/ NHSE		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree service specifications for community integrated teams	Agree pathways and establish gateways	Agree Service specifications	Procure/ recuit to gaps idenified							
Support to stay out of trouble	CJS		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers		Develop systems for indivualised care / support		Agree pathways and establish gateways	Agree Service specifications	Procure/ recuit to gaps idenified					
Hospital services support	CCG		Establish work stream group Agree ToR	Review Current Practices Identify Gaps Risk Registers	Agree pathways and establish gateways	Develop systems for indivualised care / support	Agree Service specifications	Agree Service specifications	Procure/ recuit to gaps idenified	Procure/ recuit to gaps idenified	Procure/ recuit to gaps idenified	Procure/ recuit to gaps idenified			

Key Milestones
Steps in Process
Delivery/Target Date
Trajectory

What are the risks, assumptions, issues and dependencies?

Guidance notes; Are there any dependencies on organisations not signatory to this plan, or external policies/changes?

The key dependencies and risks for organisations not signed up to this plan focus mainly on the criminal justice system. This includes police and probation services. The implication of managing people who are higher risk to the community will need to work through with them and pathways developed to ensure they can access crisis support quickly and easily.

Other dependences include the housing market- whilst we have providers willing to work with us to manage people with LD this may become more problematic as we bring back people who are initially at higher risk

of causing significant harm to others or property. This will require careful management on an individual basis for each client.

Whilst the local authority with their remit for education are signed up to this plan as many schools are now independent bodies we will need to work with individual schools to ensure they work with us to improve early identification and support for young people

The work involved in this plan is labour intensive and will require project management, workforce development, engagement costs and double running costs. The TCP is requesting some financial support to make this happen.

Estimated requirements for Transformation Funding:

YEAR ONE		
Programme Co-Ordination	1 WTE already paid into TCP	£0
Increase resources to manage CTR process and case management	3 case workers in Q 4 only	£37,500
Management and supervision of staff	0.2WTE manager Q4 only	£1,850
Support for care leavers and work with special schools	1 WTE case manager Q4 only	£9,375
Admin support for co-production of plan	0.5 WTE start September 16	£6,250
Workforce development - wider community	1 WTE educator in LD/autism Q4	£15,000
Advocacy/IAG/Communication	To support TCP plan, repatriation of individual, support to People at risk of admission	£21,450
Project management for capital build /estates plan	1 WTE Q4 only	£18,750
YEAR TWO		
Programme Co-Ordination	1 WTE full year effect	£50,000
Increase resources to manage CTR process and case management	3 case workers FYE	£112,500
Management and supervision of staff	0.2WTE manager FYE	£46,250
Support for care leavers and work with special schools	1 WTE case manager FYE	£60,000
Admin support for co-production of plan	0.5 WTE FYE	£22,000
Workforce development	01 E educator in LD/autism FYE	£43,200
Advocacy/IAG/Communication	To support TCP plan, repatriation of individual, support to People at risk of admission	£21,450
Project management fro capital build /estates plan	1 WTE FYE	£75,000
YEAR THREE		
As above year two	FYE	£430,400
		£970,976

Match Funding

The Shropshire TCP will match fund this bid by the following:-

Service/ support for TCP Plan implementation	**Total cost of Service applicable to TCP plan**
Commission managers 1* day per week 4 organisations at Band 8a	£43,986
Criminal justice system 20% LD	£82,837
Outreach behaviour support team	£421,747
Community LD (50% challenging behaviour)	£1,231,938
IAPT -Wellbeing services 10%	£280,249
Admitted care 10% Cluster 8 activity	£4,236
Non admitted care 10% of Cluster 8	£222,561
TOTAL 2016/17 (Year 1)	£2,287,553
TOTAL 2017/18 (Year 2)	£2,287,553
TOTAL 2018/19 (Year 3)	£2,287,553
Contributions by Organisation	
Shropshire CCG	£1,449,578
Telford & Wrekin CCG	£815,982
Shropshire Local Authority	£10,997
Telford and Wrekin Local Authority	£10,997
Total	£2,287,553
All identified matched funding is incorporated in to existing 2016/17 budgets and none is dependent on planned future investments	

What risk mitigations do you have in place?

Guidance notes; Consider reputational, legal, safety, financial and delivery, contingency plans

Risk Register

These scores are based on the interpretation of NHS risk registering scoring criteria. They are not reflective of Local Authorities level of concern in relation to the financial risks.

Risk mitigation scores will be identified within the work stream individual risk registers.

Category of Risk (e.g. financial, reputational	**Risk Include any assumptions made**	**Impact 1 - 5**	**likelihood 1 - 5**	**Risk Score 1.25**	**Mitigation Actions**
Finance	At the outset, the project will be high cost. Cost savings will only be	3	3	9	Cannot mitigate without additional, **sustainable** revenue investment to underpin a Paradigm shift in service delivery. The cost neutrality described in the WebEx

	achieved in the much longer term and not within 3 years				conference phone call **must be the reality** for local CCGs and councils as well as NHSe.
	Shropshire footprint has low 'Dowry numbers'	3	3	9	Full Dowry monies paid, with no local reduction
	Austerity measures mean fall in annual revenue to maintain existing services to ALD, and unable to accommodate growth from this project.	3	3	9	TCP prevention is resourced sufficiently to counter Austerity.
	Lack of detailed financial planning to inform assumptions	3	3	9	Information passed to TCP areas in a timely manner.
	Lack of resource to support the wide cohort of potential clients defined in the Service model, including those with potential to enter CJS.	3	3	9	NHSe/ADDASS confirm funding to underpin Programme implementation, ultimately leading to reduced costs
	Lack of detailed knowledge about the cases held by specialist commissioning which limits future planning	3	3	9	Information is shared and is comprehensive
	Level of historical disconnection between council, CCG and specialist commissioning cannot be fully addressed within the available short timescale	3	3	9	Communication improves
	Require clarification on funding mechanisms for new clients who would previously have been admitted to in-patients beds by either the CCG or specialist commissioning.	3	3	9	CCG funding able to flow into community easily
	Claw back of funds from specialist commissioning to support local involvement and attendance at case meetings.	3	3	9	Need to receive assurance this wont happen
Develop personal-ised models and impact on take up of PHB	NHS still gaining knowledge and understanding of personal health budgets RISK CCGs will have to identify funding to pay for PHBs.	2	2	4	CCGs learn from councils Councils undertake management of PHBs (at a cost) to support CCGs CCGs indicate intention to decommission services from existing block contracts to provide revenue to support PHBs
Estates	Suite of appropriate buildings to provide the right services and/or accommodation when needed.	2	3	6	Clear information of how to match the needs of the individual with the right accommodation,
Project Focus	The project is multi-faceted – requiring collaboration across organisational and professional boundaries	2	2	4	Senior Project Co-ordinator appointed from Transformational Funding Time is given to support under-pinning the project with

	a) Four main statutory authorities b) Private and voluntary sector c) Family carers and experts by experience				firm foundations Familiarisation between stakeholders and understanding the complexity of the tasks. Developing a matrix approach and understanding the interchangeable elements which impact on each other.
Programme Board Membership	Ability to establish appropriate levels of stakeholders on the Board RISK: Not having suitable stakeholders and thus not having intended levels of views and options	1	2	2	Ensure stakeholders are selected on basis of compatibility and contribution Ensure meetings are timetabled in on a regular basis, convenient time and location. Ensure support is available to members, as required. Produce information in accessible formats. Have pre-and post .meetings with experts be experience (with advocacy support)
Building costs and/or building adaptations	Plans to develop any new build must be based on accurate assessment of future need RISK Need to ensure time for all aspects of developing new build including, in summary: • purchase of land • commissioning of build to a design which is 'fit for purpose' and therefore higher spec than ordinary accommodation • commissioning of providers • Cost of building development • If PFI, managing the cost • Councils and CCGs not able to underwrite, nor cover any associated costs	3	3	9	Detailed information available to support planning assumptions and business planning. Grant application via PID approved by NHSe.
Reputation	Funding restrictions across the local health and social care economy may result in limited delivery of Transformational plan Timescales available to fully develop the plan have been limited. Elected members will wish to assure local communities that TCP is affordable at a time of austerity. Reputational damage Limited consultation Elected members are	1	2	2	Further information is provided by NHSe, the financial plan submitted in February can be reviewed Some engagement has taken place with named individuals. More work will be planned from July, onwards and be ongoing Elected members are given written and formal assurance that all costs associated with TCP are resourced directly and on an ongoing basis through savings achieved by reduction in in-patient beds.

	compromised due to failure to deliver programme at a cost neutral position.				
Safety/ Safe guarding	Information provided by NHSe spec comm is not detailed. This means repatriation plans cannot be risk assessed from the safeguarding perspective. Client and community safety is paramount RISK Discharge planning cannot take place When discharges occur, they are not safe.	2	2	4	Detailed information is gathered through CTRs involving CCGs and social care as discharge is planned for Discharge is risk assessed in terms of safeguarding of the individual and community

Risk Matrix

Risk Matrix		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
Impact	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

6.Finances

Financial assumptions

The following financial assumptions are outlined in the Excel spreadsheet and 'pasted' here, for information.

Additional information

Assumptions:-

Assumptions:-
No % inflationary uplift applied so this sheet is based on single year cost basis (2015/16)- Increases for inflation etc will be dealt with through normal routes with associated pressures managed via a risk share agreement that the partnership will develop.
10 patients transferring from NHSE beds to community based provision have packages of care in community- costs assumed at the present highest cost package of care to allow for complexity and risk.
Additional cost between 15/16 and end of yr 3 is £735k. This represents a cost pressure to the local health and social care economy after an assumption that the NHS England savings in full are transferred into the economy . This additional cost pressure cannot currently be mitigated. If the money transferred into the economy is only targeted

to support ***'increased activity in community forensic services'*** the risk to councils will increase further. This will increase the level of un-mitigated risk. (NHSe Transforming Care: Budget Alignment (with TCPS) report 09/05/2016.

Actions relating to repatriation will commence in 2017/18, at the earliest. If new build and planning development is required, this may slip further towards 2018/19.
Please note, costs in 'Finance and Activity' page exclude all costs of implementing transformation, particularly the dual costs associated with named individuals to support repatriation.
CAPITAL FUNDING:-The forecast capital investment for 15-16 is £541K, which excludes the value of land. Of the £541K, £165k relates to capital project which commenced in 14/15 and completed in 15/16. The total overall value of this project is £2.275m (including value of land at £375k).

Please complete the activity and finance template to set this out (attached as an annex).

End of planning template

Appendix 1 Engagement

Who	How	Next steps
People with learning disabilities and/or autism	Engagement post Mansell 2 and remains ongoing, but not as structured and focussed as required	Establish key people who can support co-production of TCP and help to 'take it wider' to other people who use services now, or may do in the future. Engage as experts by experience to support quality monitoring (learn from Gloucester Voices)
Family carers	Attended T&W Carers Partnership Board Met with four carers (see information below (page xxx)	Carers are a priority in TCP. Respite must be provided Establish links with Foster Carers and Shared Lives to maintain family links as individuals leave home
Learning Disability Partnership Boards (Shropshire and Telford & Wrekin)	Attended meetings of both LDPB in February and March.	Keep informed.
Health Commissioners (CCG and NHS England),	Attendance at TCP Board meetings Ongoing informal support outside meetings	TBC
NHS Providers	Meetings with SSSFT	Establish stronger links with: • SaTH • Shrop Com • GPs • Screening services • Therapeutic services • Audiology • Dentistry To better understand issues, challenges, boundaries etc and how to address the same. And, within SSSFT: • Psychiatry

		• Psychology • SALT • Physiotherapy
Clinicians		
Safeguarding	Adult safeguarding	Widen to include children's safeguarding Agree on nature and level of engagement and information sharing.
Local Authority Commissioners	Adult and Children's + Education	Ongoing. As information becomes clearer on repatriation, ensure commissioners are informed and engaged in a timely manner
Managers	• Service Delivery Managers • Operational Team Leaders • Attended briefing meetings • Ongoing conversations	Involve in case management, as required and especially at time of discharge for people due returning to area. Establish stronger links with managers from Children's services in context of TCP.
Social Care Providers	Meeting with SPIC (Shropshire Partners in Care)	Continue to work with SPIC Also, SPIC to lead on Workforce Development
CAMHS	To be confirmed	
Adult Mental Health Service Providers	To be confirmed	
Third Sector Services	Meeting with Community Voluntary Services Strong support to carers Visit to the Autism Hub (run by CVS)	Maintain contact and sharing confirmation Increase role and contribution of the voluntary sector to support TCP in the community
Education Providers	Meeting with Mount Gilbert (T&W) Severndale (Shropshire)	Establish pilot to focus on schools and TCP. Two models operating in the two areas. Identify good practice and roll out Engage schools at the centre of the service model, interfacing with all domains
Housing Commissioners and Providers (builders and developers)	Initial conversations with commissioners	During 2016-17, firm up future demand and develop plan (see below, page xxx) Through Housing commissioners, progress work with builders and developers
Youth Offending Services	Initial conversations	More engagement to occur and clearer plans for future collaboration developed.

Criminal Justice System including police and probation services	Represented on both LDPBs Links via commissioning (how strong are they)	Establish good, sustainable working relationship with relevant stakeholders (include all) Involve in Governance Lead on West Mercia/CJS work stream
Advocacy services	Taking Part	Support ongoing engagement, co-production and Easy Read (including of the TCP plan to go on website)

<u>Future co-production – additional detail.</u>

- In meeting Co-production the TCP will strive to deliver public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.
- Where activities are co-produced services and neighbourhoods will become far more effective agents of change.
- In order to achieve full co-production, we need to ensure services and local people can work together in a genuine partnership to design and deliver services and support. This TCP footprint has made excellent steps in the start of this journey.
- The TCP will ensure that any Co-production will not just be about asking people what they think and all those involved will contribute their gifts and skills as well as insights based on experience
- Any Experts by experience who support co-production will be paid
- Co-production will aim to shift perception from individuals being seen as 'problems' to problem solvers
- Starting this co-production with children and young people through the Health Champions roles has already shown positive results in Shropshire on young people's confidence and self-esteem.
- **Write to Know** is a group focusing on checking information and paperwork that is sent out locally and nationally by public bodies and organisations who offer services.
- **Right to Speak** collects information and issues from Shropshire to raise and feedback at the partnership board.
- **Taking Part** supports speaking up groups in Shropshire services.
- These 'speak out' groups have worked with Manchester University research team twice. They worked in partnership with the University and OSCA about the choices people make when thinking, what is important to them when using their personnel budgets.
- The 'speak out' group have said "*It's important to us that Shropshire LA and CCG group listen to us. We think we have a lot to offer and can help other groups.*
- *We want professionals, carers and everyone to remember: Get it right for us; get it right for all!"*
- Co-production will be included in the Communication and Engagement workstream.
- We propose to form a small sub-group of four people with learning disabilities (and experience of assessment and treatment/in-patient services) and four carers.
- Advocacy support will be provided, as required.

The sub-group will help with ongoing communication and engagement with a wider representation of people with learning disabilities and family carers. We believe this approach will work, but it needs to be:

a) confirmed by others who will be involved, and
b) If the model does not work, we will change accordingly.

Overall, the biggest changes we wish to achieve are a shift in power & control, from statutory organisations to individuals themselves and where appropriate, carers.
We will also manage risk, safeguarding individuals and others in the community

APPENDIX 2

Population Data and information

People aged 18 and over predicted to have a learning disability T&W

	2014	2015	2020	2025	2030
People aged 18-24 predicted to have a learning disability	420	422	389	379	413
People aged 25-34 predicted to have a learning disability	533	530	535	525	496
People aged 35-44 predicted to have a learning disability	540	533	515	529	538
People aged 45-54 predicted to have a learning disability	573	579	552	491	479
People aged 55-64 predicted to have a learning disability	438	440	484	530	505
Total population aged 18-64 predicted to have a learning disability	2,504	2,505	2,476	2,454	2,430
People aged 65-74 predicted to have a learning disability	346	355	387	384	423
People aged 75-84 predicted to have a learning disability	166	172	212	266	289
People aged 85 and over predicted to have a	55	57	71	93	124

learning disability

Total population aged 65 and over predicted to have a learning disability	568	585	670	743	835

Comment: *Overall, the numbers of people with learning disabilities between ages 18 – 64 is due to decline slightly by 2030, (74 people), whereas the number of people over 65 predicted to have a learning disability aged over 65 shows an increase of 267 people.*

People aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age, projected to 2030 T&W

	2014	2015	2020	2025	2030
People aged 18-24 predicted to be living with a parent	64	65	60	60	65
People aged 25-34 predicted to be living with a parent	59	59	59	58	55
People aged 35-44 predicted to be living with a parent	53	52	51	52	53
People aged 45-54 predicted to be living with a parent	30	30	28	25	25
People aged 55-64 predicted to be living with a parent	9	9	10	10	9
Total population aged 18-64 predicted to be living with a parent	214	214	207	205	207

Comment: *The prediction of numbers of people with moderate to severe learning disability shows little change with an overall reduction of 7 people. This prediction is likely to inaccurate. The increased use of Tenancies, Supported Living/Tenancies and Shared Lives is likely to mean this is under forecasting of predicted prevalence.*

People aged 18-64 predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, by age T&W

	2014	2015	2020	2025	2030
People aged 18-24 predicted to have a moderate or severe learning disability	97	98	90	89	98
People aged 25-34 predicted to have a moderate or severe learning disability	114	114	115	113	106
People aged 35-44 predicted to have a moderate or severe learning disability	136	134	129	133	135
People aged 45-54 predicted to have a moderate or severe learning disability	129	130	124	111	109
People aged 55-64 predicted to have a moderate or severe learning disability	95	95	106	115	108
Total population aged 18-64 predicted to have a moderate or severe learning disability	571	571	564	561	557
People aged 65-74 predicted to have a moderate or severe learning disability	57	58	62	62	69
People aged 75-84 predicted to have a moderate or severe learning disability	17	18	22	28	29
People aged 85 and over predicted to have a moderate or severe learning disability	5	5	7	9	11
Total population aged 65 and over predicted to have a moderate or severe learning disability	79	81	91	98	110

Comment: This table gives the number of people with moderate or severe learning disabilities. Therefore, the numbers are lower than the total learning disability population. The assumption is that these people will be in receipt of services. Again, the numbers reduce for people between the age of 18 – 64 (reduction of 14 people), and increase for people over 65 (31 people) by 2030. Due to changes introduced with the Care Act, prevention and enablement and austerity, it is likely that numbers in receipt of services will in fact slow down and reduce beyond the level predicted.

People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030 T&W

	2014	2015	2020	2025	2030
People aged 18-24 with a learning disability, predicted to display challenging behaviour	7	7	6	6	7

People aged 25-34 with a learning disability, predicted to display challenging behaviour	10	10	10	9	9
People aged 35-44 with a learning disability, predicted to display challenging behaviour	10	10	9	10	10
People aged 45-54 with a learning disability, predicted to display challenging behaviour	11	11	11	9	9
People aged 55-64 with a learning disability, predicted to display challenging behaviour	9	9	10	10	10
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	46	46	46	45	45

Comment: This table shows the numbers of adults predicted to display challenging behaviour as being low and remaining the same, with a slight decrease of 1. This information is odd. Current information from social services and CCG evidence higher numbers. This may be around classification criteria used by those predicting prevalence. However, if this is the data accessed by NHSe to inform anticipated demand, it may be a serious point of discrepancy.

People aged 18-64 predicted to have autistic spectrum disorders by age and gender, projected to 2030 T&W (1st table – males; 2nd table – females)

Males T&W	2014	2015	2020	2025	2030
Males aged 18-24 predicted to have autistic spectrum disorders	148	148	135	131	146
Males aged 25-34 predicted to have autistic spectrum disorders	193	193	196	196	184
Males aged 35-44 predicted to have autistic spectrum disorders	200	198	187	193	198
Males aged 45-54 predicted to have autistic spectrum disorders	221	225	214	189	180
Males aged 55-64 predicted to have autistic spectrum disorders	169	169	187	205	196
Total males aged 18-64 predicted to have autistic spectrum disorders	931	932	920	914	904

Females T&W	2014	2015	2020	2025	2030
Females aged 18-24 predicted to have autistic	15	15	14	14	15

spectrum disorders					
Females aged 25-34 predicted to have autistic spectrum disorders	22	21	21	21	19
Females aged 35-44 predicted to have autistic spectrum disorders	22	21	21	21	21
Females aged 45-54 predicted to have autistic spectrum disorders	25	25	23	21	20
Females aged 55-64 predicted to have autistic spectrum disorders	20	20	22	24	22
Total females aged 18-64 predicted to have autistic spectrum disorders	102	102	101	100	98

Comment: The two tables above predict as overall fall in the number of people expected to have autistic spectrum disorders. Again, this seems at odds with evidence of growth in numbers of people diagnosed on the spectrum. Further information is needed to drill down into the numbers overall and understand which of these people also have a learning disability, and/or challenging behaviour and any associated issues of mental health.

Males T&W	**2014**	**2015**	**2020**	**2025**	**2030**
Males aged 65-74 predicted to have autistic spectrum disorders	140	144	151	151	169
Males aged 75 and over predicted to have autistic spectrum disorders	85	88	113	146	164
Total males aged 65+ predicted to have autistic spectrum disorders	225	232	265	297	333

Females T&W	**2014**	**2015**	**2020**	**2025**	**2030**
Females aged 75 and over predicted to have autistic spectrum disorders	17	17	19	19	21
Females aged 75 and over predicted to have autistic spectrum disorders	13	14	16	20	2/3
Total females aged 65+ predicted to have autistic spectrum disorders	30	31	35	38	43

Comment: Overall, this table shows growth for both males and females and at a slightly higher rate for females. This probably reflects an increase in number of older people seeking a diagnosis.

Shropshire data

People aged 18-64 predicted to have a learning disability, by age Shropshire

Shropshire data	2014	2015	2020	2025	2030
People aged 18-24 predicted to have a learning disability	615	604	529	511	547
People aged 25-34 predicted to have a learning disability	819	827	857	819	757
People aged 35-44 predicted to have a learning disability	881	869	830	887	922
People aged 45-54 predicted to have a learning disability	1,094	1,093	1,020	893	859
People aged 55-64 predicted to have a learning disability	929	941	1,048	1,124	1,047
Total population aged 18-64 predicted to have a learning disability	**4,339**	**4,334**	**4,284**	**4,235**	**4,132**

People aged 65 and over predicted to have a learning disability, by age Shropshire

Shropshire data	2014	2015	2020	2025	2030
People aged 65-74 predicted to have a learning disability	842	861	911	895	1,001
People aged 75-84 predicted to have a learning disability	450	461	554	679	718

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People aged 85 and over predicted to have a learning disability	179	187	225	286	370
Total population aged 65 and over predicted to have a learning disability	**1,471**	**1,508**	**1,690**	**1,860**	**2,089**

People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030

Shropshire data	2014	2015	2020	2025	2030
People aged 18-24 with a learning disability, predicted to display challenging behaviour	10	10	9	9	9
People aged 25-34 with a learning disability, predicted to display challenging behaviour	15	15	15	15	14
People aged 35-44 with a learning disability, predicted to display challenging behaviour	16	16	15	16	17
People aged 45-54 with a learning disability, predicted to display challenging behaviour	21	21	20	17	16
People aged 55-64 with a learning disability, predicted to display challenging behaviour	18	19	21	22	21
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	**81**	**81**	**80**	**79**	**77**

Figures may not sum due to rounding

Figures may not sum due to rounding
Crown copyright 2014

LD - Living with a parent

People aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age, projected to 2030 Shropshire

Shropshire data	2014	2015	2020	2025	2030
People aged 18-24 predicted to be living with a parent	94	93	82	81	87
People aged 25-34 predicted to be living with a parent	91	92	95	90	84
People aged 35-44 predicted to be living with a parent	86	85	81	87	90
People aged 45-54 predicted to be living with a parent	56	56	51	45	45
People aged 55-64 predicted to be living with a parent	18	18	21	21	19
Total population aged 18-64 predicted to be living with a parent	**344**	**343**	**330**	**324**	**325**

Figures may not sum due to rounding

Shropshire data	2014	2015	2020	2025	2030
People aged 65-74 predicted to have a learning disability	842	861	911	895	1,001
People aged 75-84 predicted to have a learning disability	450	461	554	679	718
People aged 85 and over predicted to have a learning disability	179	187	225	286	370
Total population aged 65 and over predicted to have a learning disability	**1,471**	**1,508**	**1,690**	**1,860**	**2,089**

Figures may not sum due to rounding

Autistic spectrum disorders
People aged 18-64 predicted to have autistic spectrum disorders, by age and gender, projected to 2030

Autistic spectrum disorders by gender Shropshire data	2014	2015	2020	2025	2030
Males aged 18-24 predicted to have autistic spectrum disorders	225	220	193	187	202
Males aged 25-34 predicted to have autistic spectrum disorders	310	311	328	311	286
Males aged 35-44 predicted to have autistic spectrum disorders	322	319	304	328	344
Males aged 45-54 predicted to have autistic spectrum disorders	423	423	385	337	322
Males aged 55-64 predicted to have autistic spectrum disorders	362	367	412	443	407
Total males aged 18-64 predicted to have autistic spectrum disorders Shropshire data	**1,642**	**1,640**	**1,622**	**1,606**	**1,561**
Females aged 18-24 predicted to have autistic spectrum disorders	20	20	18	17	18
Females aged 25-34 predicted to have autistic spectrum disorders	32	32	32	31	29
Females aged 35-44 predicted to have autistic spectrum disorders	36	35	34	35	36
Females aged 45-54 predicted to have autistic spectrum disorders	47	47	44	38	37
Females aged 55-64 predicted to have autistic spectrum disorders	42	42	46	50	47
Total females aged 18-64 predicted to have autistic spectrum disorders	**176**	**176**	**174**	**172**	**167**

Custody-*Please note this information does include people with LD but they are not highlighted so we do not understand at this time the impact on the report*

Section 136 total Detentions in Custody/Redwoods Centre

	2010-11	2011-12	2012-13	2013-14	2014-15
Shrewsbury Custody	168	96	101	84	16
Malinsgate Custody	103	27	36	27	6
Wellington Custody	0	12	13	0	0
Total Custody	271	135	150	111	22

Redwoods Centre	n/a	75	178	253	244
Total	271	210	328	364	266

Section 136 Detentions – Under 18 years

	2010/11	2011/12	2012/13	2013/14	2014/15
Shrewsbury Custody	9	7	6	4	1
Malinsgate Custody	6	5	3	0	0
Wellington Custody	0	1	3	0	0
Total Custody	15	13	12	4	1
Redwoods Centre	n/a	7	12	21	14
Total	15	20	24	25	15

Employment support information

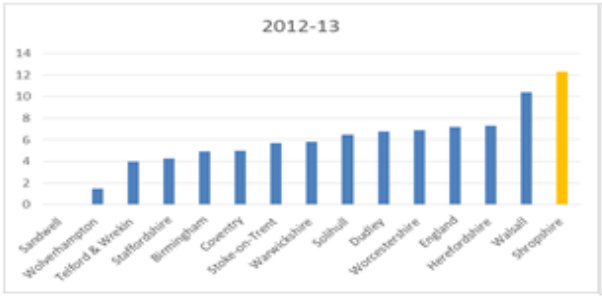
Data from ASCOF (T&W)

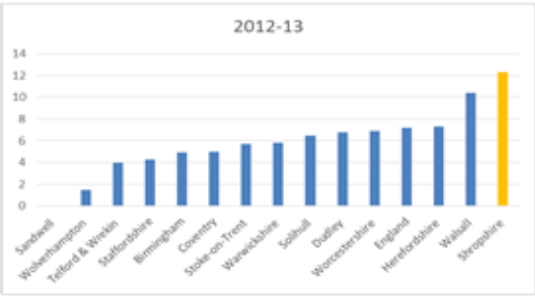
1E - ALD Employment		1G - ALD Settled Accommodation	
In employment	7	**Settled Accommodation**	135
Not in employment	138	**Unsettled Accommodation**	48
Not reviewed/ Captured this year	168	**Not reviewed/ Captured this year**	197
Not recorded	79	**Not recorded**	12
Total	392	**Total**	392
Performance	1.8%	**Performance**	34.4%

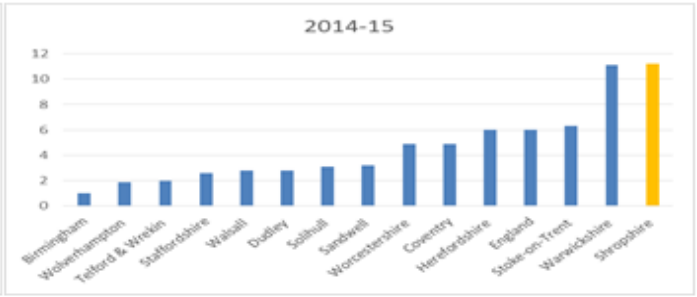
Programme	No. of people referred	No.'s in paid employment	% of sustained jobs at 13 weeks
SC LD employment	43	75	61%
SC / CCG MH employment	147	72	82%

Enable Performance Data 2015 – 16 (April to now)

Programme Shropshire	Referred since 01/04/15	People supported	Work placements	Into paid employment
Council LD	39	166	N/A	57
Council / CCG MH	94	270	N/A	45
DWP LD	52	52	N/A	13
DWP MH	77	101	N/A	22
Supported Internships	5	5	5	0







Telford and Wrekin Council – Employment Support

Data gathered internally by TWC Employment services indicates that 586 people with Asperger's, Autism, Behavioural/Emotional and Social Difficulties, Moderate Learning Difficulties and Severe Learning Difficulties receive support from Telford and Wrekin council. A 5 of these people also have behaviours which can challenge.

Team Name	Asperger's	Autistic Spectrum Disorder	Behaviour/ Emotional/ Social Dif	Moderate Learning Difficulties	Severe Learning Difficulties
Business Support	0	7	46	57	3
EEAST	20	21	8	85	4
Future Focus	0	23	124	129	18
Job Box	2	3	10	12	2
Job Box Outreach	0	1	1	8	0
Skills Delivery Area	0	0	2	0	0
Total:	**22**	**55**	**191**	**291**	**27**

Appendix 3 Services in place

Health the Shropshire footprint has :-	
Acute hospitals	Two main hospital sites. Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princes Royal Hospital (PRH) in Telford and Wrekin. Discussions continue about alternative options on where services are best located and both areas campaign vigorously to retain the hospitals
Community hospitals	Shropshire Community Health NHS Trust runs four community hospitals: Bishops Castle, Whitchurch, Ludlow and Bridgnorth. There are four Minor Injuries Units in the county. They are at: Whitchurch, Ludlow and Bridgnorth Community Hospitals and Oswestry Health Centre Both CCG's commission SCHT and SSSFT to provide services for people with learning disabilities. <u>Shropshire and South Staffordshire Foundation Trust:</u>

Mental health and learning disabilities	SSSFT provides mental health, learning disability and specialist children's services across South Staffordshire and mental health and learning disability services in Shropshire, Telford & Wrekin and Powys. A range of community and outpatient services are offered as well as specialist inpatient and day care for people with severe learning disabilities and challenging behaviour South Staffordshire and Shropshire NHS Trust (SSSFT) SSSFT headquarters is in Stafford. It is commissioned by the CCGs through a NHS Standard contract. The organisation covers the following regions: • South Staffordshire, • Shropshire, • Telford & Wrekin, and • Powys.
Community learning disabilities services	Within SSSFT, the Specialist Learning Disabilities Directorate provides the following: ➢ Community Learning Disabilities Health Teams (East Staffordshire, South Staffordshire, Shropshire, Telford and Wrekin) ➢ Challenging behaviour service (Shropshire & Telford and Wrekin) The SSSFT Challenging behaviour team is located at Mytton Oak, RSH and Diamond Jubilee, Telford. Services include: nursing, psychology, psychiatry The focus of the directorate is to provide person centred, evidence based and outcome focussed specialist health care in the community. In response to this it has developed a clinical approach designed to ensure the best quality services possible. This includes: Clinical Effectiveness Groups (CEGS) x 4: Physical health, Mental health, Autistic spectrum disorders and Positive behavioural support. Intake pathway: a new pathway to ensure a robust and consistent multi-disciplinary approach to identifying eligibility for and assessing, intervening and evaluating the needs of people referred to its services. Introduced the Health Equalities Framework to review the impact of health inequalities on people who have learning disabilities. Involving people who use services and family carers: An inclusive interview process for all new staff. They now facilitate a discussion group prior to interviews which involves people with learning disabilities, family carers and team members. Their views are included in the interview panel's final decision making process. In 2013/14 a comprehensive clinical review led to service reconfiguration to ensure services fit with: • changing demographics, • the national vision for healthcare for people who have learning disabilities, • the evidence around best practice and high quality services. Outcomes from the review included:

	• specialist nurses working in Telford and Wrekin were transferred into the SSSFT from the Shropshire Community Trust • one Shropshire CLDT nurse was moved on a short term secondment to Continuing Heath Care (CHC) to support their work
Prison in reach	The Prison In-reach Service provides mental health services to a number of local prisons. The team provides an assessment and treatment service including the transfer of people with severe mental health problems to the wider NHS and interventions for those with mental health problems whilst in custody.
Substance misuse	Inclusion substance misuse services include advice, information, harm reduction interventions, recovery planning in conjunction with a range of pharmacological, psychosocial and structured treatment programs. They work with specific needs including criminal justice, mother and baby and dual diagnosis.
Forensic	Forensic mental health team provide a local, high quality, specialised and comprehensive forensic mental health service for the mentally disordered offender and others that will benefit from the service, within the West Midlands, in partnership with other agencies.
Psychological services	Psychological services are provided directly to children, adolescents, young adults, older adults, and people with physical health needs, people with learning disabilities, people with substance misuse problems, and people who have committed criminal offences. Specialist psychological practitioners work within the clinical teams across our services
Community services (universal) and children	Shropshire Community Health NHS works closely with people with Learning Disabilities, their families and carers to ensure that they are actively involved in the planning and decision making of care delivery. They strive to ensure people with learning disabilities have access to the same community health services as everyone else. There aim is to ensure that the needs, choices and preferences of this group are understood and that services are available to reflect individual choices. SCHT have a mission that people with learning disabilities will be valued equally, participate fully in their communities and be treated with dignity and respect. Implementing all appropriate measures to ensure all people with learning disabilities accessing services have effective person-centred care, with reasonable individual adjustments delivered by staff with an enabling and positive attitude.
Inter disciplinary team	SCHT Inter Disciplinary Teams (IDT's) comprise community nurses, occupational therapists and physiotherapists who work together to deliver community health services to patients in their own homes, with the aim of preventing admission, supporting early discharge from hospital and promoting maximum independence. The care provided by the

	interdisciplinary teams is for adults (over 18 year olds) living in Shropshire, Telford and Wrekin who are unable to travel to access specific health care services from their GP or other NHS health care providers. As part of the patient's care or treatment programme care is also available for parents and carers. Services are delivered in the patient's own home or usual place of re On-going review of pathways of care to improve the experience and care of people with learning disabilities takes place and assurance given to the CCG. SCHT have identified a Lead Person within the organisation and each Division with specific responsibility to monitor the services in relation to people with learning disabilities.
Child development	**Child Development Centres** (CDC's) in Shropshire and Telford and Wrekin provide assessment of children with additional needs who are under five years old. Children can attend the child development centre for assessment, diagnosis, intervention and advice for the following impairments and disabilities: •Behavioural problems •Communication and interaction problems •Delay in their development •Impaired vision or hearing •Physical disability •Severe co-ordination problems From the age of two to two and a half years of age, children can be referred for a developmental assessment. The short assessment is for children who are thought to have difficulty in only one area of their development or who need a check on their development for medical reasons. Then there is a full assessment for children who are identified as having more complex needs and, here, a broad range of professionals will see children over a number of visits. Parents are encouraged to contribute to the assessments as their knowledge of the child is much valued. The assessment will also help to decide whether the child requires any support in their future educational provision. The full assessment process will link to the Educational Health Care Plan (EHCP) to ensure a more joined up process for parents and each child. The service is currently open Monday to Friday, 09:00 - 17:00 except Bank Holidays.
Occupational therapy	**SCHT Occupational Therapy** services are provided for children with severe / specific learning difficulties and / or complex needs attending special schools in Telford (Bridge, Haughton) and Shropshire (Severndale, Shrewsbury). The children's OT team work in partnership with the child, parent, family and carers, professionals and voluntary organisations to provide interventions that maximise the individual potential of each child personally, functionally, academically and socially. The service is available for children aged between 0-18 years (19 years if in full time education) who are registered to a GP within either Shropshire or Telford and Wrekin geographical boundaries.

Community Paediatricians	**Community Paediatricians** are specialist doctors with skills and knowledge in child health and development. The service is provided primarily to children whose GP is based in Telford & Wrekin or Shropshire County. The aim is to provide care as close to home as possible so services are based in different parts of the county, including at special schools such as the Bridge and Severndale. They offer a holistic paediatric service and focus on identifying and working with others to meet each child's needs - medical, educational and social. By providing: • medical reports as part of statutory processes for children with special educational needs, looked after children and in child protection procedures • leading the multidisciplinary developmental assessments in the Child Development Centres • being trained to use the 3di Autism assessment tool • carrying out hearing tests for children with special needs (special schools and outpatients)
Continence management service	**Continence management service** is a team of specialist nurses who provide assessment for people with continence problems. Advice and support is given to clinicians involved with children who may be carers for and their parents/ carers with learning or physical disabilities who require continence management.
Children's and Special Care Dentistry	**Children's and Special Care Dentistry** service is for children and young adults with additional needs which include a physical, intellectual, medical, emotional, sensory, mental, psychological or social impairment or disability or a combination of these factors. It is only for patients who are unable to attend the dental surgery
CAMHS Learning Disability	**CAMHS Learning Disability** service works with children and young people with a learning disability aged 0-18 in Telford and Wrekin or Shropshire. They also work with young people with learning disability who have significant problems with aggression or other challenging behaviour, and who may also have a mental health diagnosis such as an eating disorder, post-traumatic stress, anxiety or obsessive problems, depression or problems with mood, hyperactivity and attention problems or behaviours which are harmful to self or others. The team accept referrals from professionals involved with a child for example GPs, Social Workers and Teachers. A referral letter is required to provide us with relevant and up-to-date information. At present, we do not accept referrals directly from parents or carers. There are 290 young people currently on the CaMHS LD case load across Shropshire and Telford & Wrekin. One person is in specialist in-patient service. 95% of the case load is young people with LD and challenging behaviour. Only 5% have co-morbid mental health problems. The developments of this service are included within the CaMHS transformational plan. Commissioners/ partners will work closely to align the plans and developments with TCP.
CAMHS LD Psychology	**CAMHS LD Psychology** is a specialist service. Before this service get involved, children and young people will often have been seen by other services, to see whether any problems can be resolved within the community, with the support of the child's school, within primary care services (such as the GP or Health Visitor), or within services that can offer

	support to parents and carers. Psychologists will provide input to children with disabilities and their families, alongside other professionals already supporting them. Psychologists are particularly interested in understanding how children and young people with learning disability manage and cope within their unique situation and environment. This means understanding their family situation, meeting with and talking to their parents at length to see how they see the current situation, and often they will meet and talk with teachers, social workers, and other professionals to help get a thorough understanding of the wider picture. Their role is to try and reach a formulation which identifies the main issues and helps explain the factors that contribute to the current situation From the 1st September 2014, new legislation required health service providers to work with Local Authorities to publish a "Local Offer" for children and young people with Special Educational Needs/Disabilities (SEND), aged 0-25. The local offer provides information on what services children, young people and their families can expect from a range of local agencies, including education, health and social care. Knowing what is out there gives people more choice and therefore more control over what support is right for each child and young person
Out of hours medical support	Out of hours • Shropdoc works across Shropshire and Telford and Wrekin. • Initially contacted to triage/ screen the need, • The local authority duty team is contacted to provide access to the Emergency Duty Team (EDT) and if required, an Approved Mental Health Practitioner (AMH). • If there is need for emergency funding out of hours, the EDT can approve this. • Referrals to the challenging behaviour service and for acute liaison all bypass the community learning disability team process. • In some cases people do not access the multi-disciplinary assessment and review process recently introduced through our Intake pathway.

<u>Local authority provision of services</u>

Education	Schools, particularly Severndale (Shropshire) is a school for children and young people are aged 3 to 19 who have a range of learning difficulties. These include moderate, severe, complex and profound learning difficulties, those with autism, complex medical conditions, physical, mobility difficulties and behavioural difficulties arising from their condition. Severndale also makes use of an external location called Tickwood Care Farm to deliver around 22 classes per week. Severndale at Mary Webb is a satellite provision catering for pupils with Moderate Learning Difficulties. The Centre is an integral part of the Mary Webb School and provides opportunities for collaborative learning and integration. The Key-stage 3 and 4 students who attend the Centre have access to specialist facilities, teaching and the social

	inclusion aspects of a mainstream secondary school. Pupils have the chances to acquire the skills, knowledge and experiences which will enable them to develop a greater understanding of themselves, and enhance their independence skills whilst accessing a range of subjects and qualifications. Derwen College (Shropshire) is a further Education College offering vocational, educational, social and personal development. The colleges has residential, a wide range day placements, a post-college living and work programme, apprenticeships and supported internships for young people with learning difficulties and disabilities. Offering places for up to 250 young people The Bridge, Southall and Mount Gilbert (Telford), although pupils defined as categorised in the cohorts (bullet points 3 & 4) may be in main stream education. Children's services Cruckton Hall and Overely School (residential)
Support services Autism	Various services which provide activities during the day time are from both the private and voluntary sector. Some services receive support from the councils. Advocacy service Let's Talk Social work advice, professional who support; Carers assessments; Peer support sessions, Autism Hub -provides peer support and social activities pre and post diagnostic support Autism Partnership Board A multi-agency meeting, Autism SAF
Inclusively Fit	A new scheme that is trying to get people with disabilities involved in sport and physical activities

Other Agencies provision of services

West Mercia Police - Hate Crime: safe place scheme:
• 200 places across Shropshire, located in over 20 towns across the Shropshire footprint. A partnership of Shropshire Council, Telford and Wrekin council, West Mercia police, Taking Part, OSCA, Shropshire disability network, Autonomy, Mencap, the VCSA and Wrekin Housing Trust. • Includes shops, community centres, libraries, within the community where someone trained will offer support and safety until additional support provided**.**
West Mercia Police:

- The equality and diversity officer for Shropshire/ Telford and Wrekin for West Mercia Police is currently recruiting new members onto their IAG,
- they currently have a couple of members who are on the Autistic spectrum and an individual with learning disabilities, and
- they plan to increase membership in relation to a wider spectrum of disability.
- the equality and diversity officer role is available to provide support and advice in situations involving all Vulnerable Adults including those with a learning disability

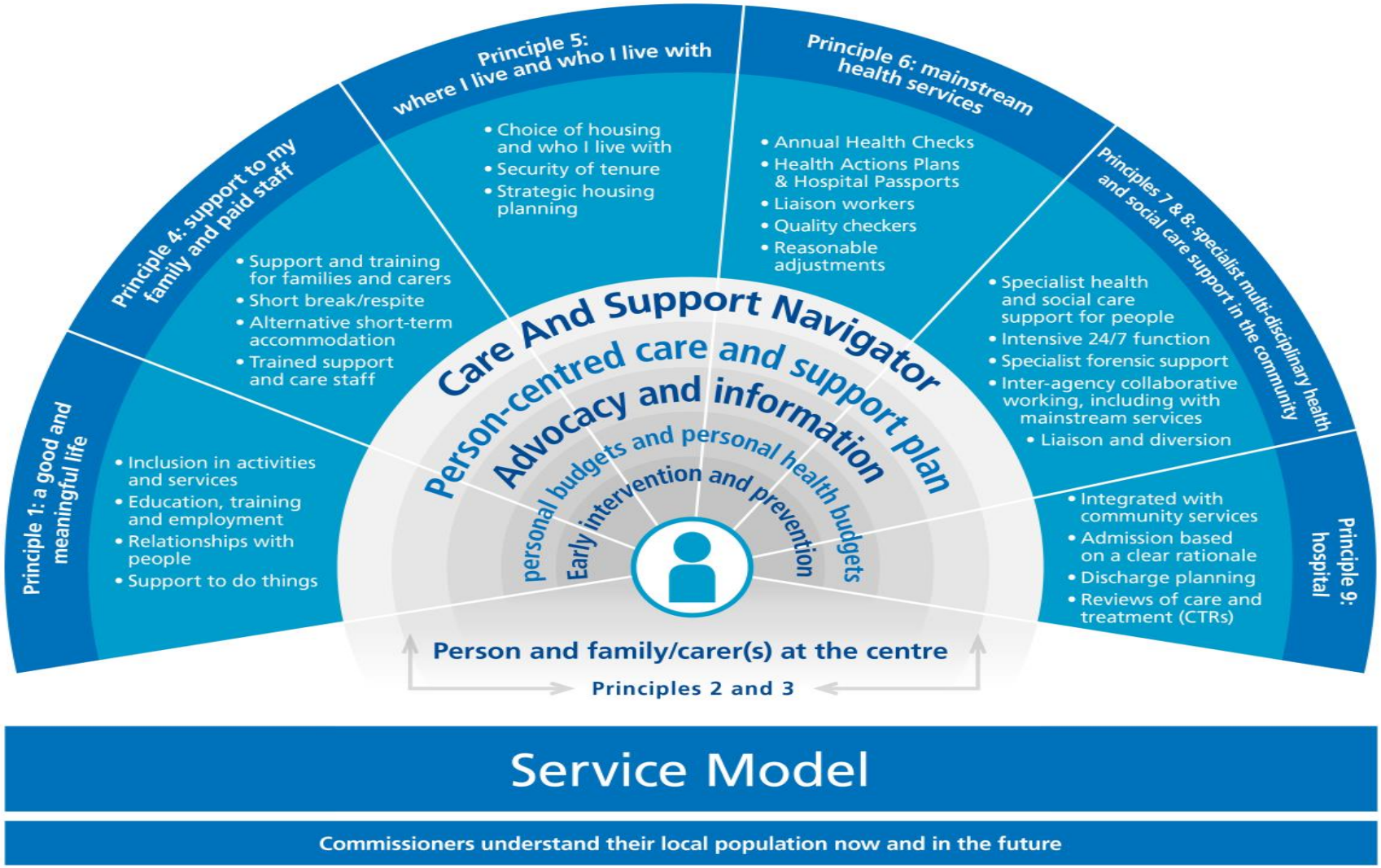
West Mercia - adjustments

- Within the police services, 'Adjustments' applies to people who have a learning disability with limited capacity and any other learning disability,
- anyone who requires an appropriate adult either to give a statement or as a suspect would be offered support
- The need for access to this service would be assessed when arrested, and also
- an officer would have to justify if an arrest was necessary or whether a voluntary attendance would be more appropriate.
- Diversion work looks at outcomes which are appropriate to the offender and the victim.
- If a prosecution is considered one of the strict legal thresholds that would need to be met is, is the prosecution in the public interest?
- This is considered in detail when dealing with an offender with Learning disabilities. The Protecting Vulnerable People unit will look at ways to deal with an outcome that could be dealt with out of court.
- This involves working with and referrals to partner agencies and programs of work which could address the offending behaviour.
- These can be formalised Conditional Cautions or Community resolutions.

Forensic Service:

- The Criminal Justice System will divert people with LD to health and social care, to prevent criminalising people with LD.
- Police will always assess capacity and request an appropriate adult for anyone with mental health need- can be family friends or social workers from local teams.
- Will require reports from psych's social workers.
- Previously a social worker which support mental health impairment team- this has not been in place for a couple of years.
- As part of this review we may consider if such a post should be reinstated, or not.

Appendix 4 Principles of care



Service Model

Commissioners understand their local population now and in the future

Appendix 2
Initial Impact Assessment Template

Please use the following template to help determine whether a community impact assessment is required.

Name of Policy
Transforming Care Partnership

Purpose and function of policy
(Please provide a brief description, for example, services affected) Building the right support - A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition" **The cohorts described in relation to TCP are described, below (extract from** 1. Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges. 2. Who display self-injurious or aggressive behaviour, not related to severe mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges. 3. Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour). 4. Have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system. 5. Have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

Who does this policy affect			
Workforce / Employees	**Y**	**Service Delivery / Communities**	**Y**

Author(s)
Richard Smith/Kit Roberts The TCP is a document that covers the NHSe defined Shropshire footprint, made up of: • Telford and Wrekin council

- Telford and Wrekin CCG
- Shropshire council
- Shropshire CCG

And will impact/involve a wide range of other stakeholders and other orgnaisations.

Job title and Service Delivery Unit
Although this IIA is undertaken by adult social care, it is in fact an all age programme of change, across the Shropshire footprint.

Date completed:
26th April 2016

Sign off (line manager) and date
If signed off by e-mail please confirm by identifying when and by whom Richard Smith, Senior Responsible Owner of the TCP Programme, across the Shropshire footpring.

A separate guidance note is available to support you through the completion of this assessment. You can find it on the intranet.

The general equality duty states that we must have due regard to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations between different groups

Complete the table below, assessing the impact of your policy on people with protected characteristics, including employees and customers. You should also consider the elements of the above general duty.

Protected Characteristic	**Positive impact**		**Negative impact**			**Reasons/evidence**
	Yes	No	High *	Low #	No	
Age	Y					The TCP programme is all age, from 0 – 99yrs. This will support interventions happening at a much earlier stage, thereby improving the quality of life for individuals and reducing the need for placement in long stay, out of area placements.
Disability	Y					The TCP is targeted at people with learning disabilities and/or autism, who have behaviours that challenge and this can include mental health. The delivery of TCP will lead to better outcomes for individuals described in the five cohorts and their family carers.
Gender (Sex)						
Gender reassignment						
Marriage/civil partnership						
Pregnancy/maternity						
Race						
Religion/belief						
Sexual Orientation						
Deprivation (inc rural/urban)						

High – there is significant evidence of adverse impact or potential for adverse impact. The policy etc has consequences for or affects significant numbers of people and/or has the potential to make a significant contribution to advancing equality.

Low – there is anecdotal or little evidence to suggest adverse impact. The policy etc operates mainly within a small unit and affects few people.

Am I required to carry out a Community Impact Assessment?

If you have ticked negative impact as High, then a Community Impact Assessment will need to be completed, available on the intranet.

If a Community Impact is not required, you are required to monitor and review the proposed changes after implementation to check they work as planned and to screen for unexpected equality impacts. Please provide details of how you will monitor evaluate or review your proposals and when the review will take place in the box below

.

Monitor and Review
Please provide details of how you will monitor evaluate or review your proposals and when the review will take place. **How will you monitor/review proposals?** • The TCP has a work plan, with a range of work streams. Highlight reports will be produced and submitted to NHSe on a regular and ongoing basis for the duration of the Programme (July 2016 – March 2019). The Highlight reports will report on reviews on outcomes and progress in delivering change. • Locally, reports will be produced and taken to relevant Boards including Learning Disability and Carer boards. • TCP is based on co-production, where 'experts by experience' and family carers play a central role is designing services for the future and informing decision making.. **When will the review take place?** As indicated above, ongoing for the duration of the Programme. And, within the reviews, monitoring of outcomes will be based on improved quality of life and individuals being treated with respect and dignity.

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

DATE: 15th June 2016

REPORT TITLE: Joint Strategic Needs Assessment (JSNA) Update

REPORT OF : Helen Potter – Research & Intelligence Manager

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

The purpose of this report is to:

- Inform the Board of current work to continue the development of an evidence based to support policy and service design;
- Highlight to the Board any significant updates to the JSNA which are relevant to its priorities.

2. RECOMMENDATIONS

That the Board:

- Agree to the proposal to provide intelligence updates every 6 months;
- Note the work that is being undertaken to improve our understanding of demand on public services and how this will contribute to the priorities of the Board.

3. IMPACT OF ACTION

By continually developing our use of intelligence, our understanding of services, communities and the demands they place on public sector organisations will improve. Intelligence led service planning and decision making will contribute to understanding the impact of actions across the Health and Wellbeing Board.

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>All priorities</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>All priority objectives</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes/No</td><td>If yes, briefly summarise any impact(s) – see separate guidance note for groups to consider</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">n/a</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes/No</td><td>There are no direct financial implications foreseen from accepting the recommendations of this report.

Information and intelligence about the demand likely to accrue to health and social care services is already in use by the Council to create financial modelling and forecasting. Data identified and developed as part of this work will be helpful in refining the future financial models necessary to identify the impacts of demand and a changing health picture on Care services. It may also help to identify the impact on the Council of changes and demands elsewhere in the public services. This information will be valuable in producing information to support future budget strategy decisions.
RP 24.5.16</td></tr>
<tr><td>LEGAL ISSUES</td><td>Yes</td><td>Section 116 of the Health Involvement in Health Act 2007 (as amended) places a duty upon the Council and PCT’s to produce a joint strategic assessment (JSNA). The JSNA must be produced in co-operation with local partners as referred to in paragraph 2 of this report, this includes the local Healthwatch organisation</td></tr>
</table>

EQUALITY & DIVERSITY	Yes	*The JSNA demonstrates inequalities in Telford and Wrekin, including variations in need due to characteristics or geographical factors*
IMPACT ON SPECIFIC WARDS	Yes	*The JSNA highlights variations in levels of need in different communities. Projects detailed below which use data to understand demand on the public sector show that demand from different communities is different.*
PATIENTS & PUBLIC ENGAGEMENT	No	
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

PART B) – ADDITIONAL INFORMATION

1 - Introduction

There is a wide variety of work being undertaken to inform evidence based decision making (a process referred to by Health & Wellbeing Boards as the Joint Strategic Needs Assessment, or JSNA). This paper seeks to:

- update the Board on projects currently underway which create and use an evidence base to understand demand on public sector services;
- update the Board on recent intelligence about the Borough;
- inform the Board of JSNA products available.

It is intended to provide the Board with a similar update every six months.

2 – Using Data to Understand Demand on the Public Sector

The Council and partners have been working to develop a more detailed understanding of people who do (or do not) use services. Our aim is to better utilise the data we hold, to develop our understanding of the social, economic and heath issues affecting our communities and how these pressures translate into demand on public sector services.

This work will continue inform the delivery of Health & Wellbeing Board priorities, particularly 'Strengthening our Communities and Community Based Support'.

Our aim of better utilising data not only involves analysis of significant amounts of data, but also has legal and practical challenges to overcome.

2.1 – 'Demand Management' Project

For the first time we have analysed contact data across the Council, rather than for individual services. This has developed our understanding of spatial patterns of who is and isn't contacting and why. When matched with other external data sets (eg socio-economic) we are developing an understanding of how these community pressures then translate in to demand on Council services.

By understanding the demands placed on Council services, these services are starting to explore where different responses could be provided to different communities.

As well as looking at Council services, preliminary work has also been undertaken with the Local Strategic Partnership (LSP) to understand where there was overlapping demand from certain communities for public sector services. A more detailed piece of work is now being undertaken in partnership with the Police to look at communities where we are experiencing high demand for both Council and Police services.

2.2 – Joining Health and Social Care Data

Midlands and Lancashire CSU (MLCSU) have developed a methodology for combining (pseudonymised) data sets for NHS and Adult Social Care services in Telford & Wrekin. As a result they have been able for the first time to start to analyse overall patterns of service utilisation and resultant costs across both health and care services. Data is starting to be analysed and will be informing the Community Fit and Better Care Fund work (for example looking at characteristics of high cost individuals).

2.3 Strategic Intelligence Assessment

A project is currently underway to refresh the Strategic Intelligence Assessment for the Community Safety Partnership. The aim of this is to understand the patterns and trends of community safety issues to inform action planning, deploy resources appropriately and identify local communities most affected by community safety issues.

3 – Intelligence Updates October '15 – April '16

3.1 – Index of Multiple Deprivation

The Index of Multiple Deprivation is a national dataset released in October 2015 by the Department of Communities and Local Government. Key messages for Telford and Wrekin were:

- Telford and Wrekin has significant pockets of deprivation, but due to the diverse nature of the Borough also has areas in the least deprived areas nationally.
- A total of 15 areas in the Borough are ranked in the 10% most deprived nationally in the wards of Woodside (x4), Malinslee & Dawley Bank (x3), Madeley & Sutton Hill (x2), Brookside (x2), Hadley & Leegomery (1), Dawley & Aqueduct (1) and College (1).
- The 2015 picture of the most deprived areas in Telford and Wrekin looks similar to 2010, with new areas in Haygate, Park and Dothill and additional areas in Hadley & Leegomery and The Nedge.
- More than a quarter (27%) of the Borough's population lives in the 20% most deprived areas nationally, an increase on 24% in 2010. 12% of the Borough's population live in the 20% least deprived areas nationally.

A full report on the Index of Multiple Deprivation will be available shortly at www.telford.gov.uk/factsandfigures

3.2 – Life Expectancy Data

A full report on 'Life Expectancy and Reducing Health Inequalities' data is to be reported at this Board meeting. Please refer to agenda item 11.

4 – JSNA Data and products

Appendix 1 contains a one page summary of JSNA products available and which have been recently updates

Appendix 2 contains a one page summary of key facts about the Borough regarding health and wellbeing from the JSNA.

For any questions or to enquire about further pieces of intelligence required please contact the Council's Research & Intelligence Team (contact details at the end of the report)

1. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

*(Where you have answered 'yes' to any part of the impact assessment in Section 4, you can add additional information here if necessary. You should ensure that there is sufficient information for members to fully understand the impacts and risks of proposals before making decisions**. Information on financial and legal impacts must be completed by an officer from Finance or Legal).***

Report prepared by Helen Potter, Research & Intelligence Manager, Telford & Wrekin Council, Telephone: 01952 381118, Email helen.potter@telford.gov.uk

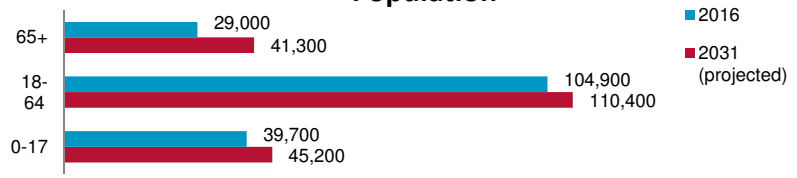
JSNA – Core Documents Available

Theme	Report	Contents	Last refresh	Next refresh	link
Population Characteristics	**Population Profile**	The Telford and Wrekin population profile contains detailed information on the following topics: Population; Households; Health; Safeguarding; Crime; Education; Economy	2015	2017	Telford and Wrekin population profile
	Index of Multiple Deprivation	The Telford and Wrekin indices of deprivation report contains details of deprivation levels at small geographical areas across the following topics: Income; Employment; Health and disability; Education, skills and training; Barriers to housing and services; Crime and disorder; Living environment; Income deprivation affecting children; Income deprivation affecting older people	**NEW**	tbc	Telford and Wrekin indices of deprivation report
	Ward Profiles	Ward Profiles - a summary of population, deprivation, housing, crime, educational attainment, employment and benefit claimants data for each of the 33 wards (pre April 2015 boundaries)	2015	2017	ward profiles
	Ward Health Profiles	Ward health profiles - a summary of health related data about each ward, including life expectancy, low birth weight babies, breastfeeding rates, obesity, adult lifestyle, bad health and causes of death.	2014	2017	Ward health profiles
Census	**2011 Census Updates**	A collection of short notes on particular themes covered by the 2011 Census: population; Internet completion; Household change; Population change by ward; Diversity; Economy and skills; Health and care; Household characteristics; Housing and accommodation	2011	2021	Census Updates
	Census Profile	The 2011 Census profile for Telford and Wrekin contains detailed local analysis across all census topics including: Population characteristics – size, change, age and gender; Diversity – ethnicity, country of birth, language, passports, religion; households and family characteristics – marital status, household structure, access to vehicle, deprivation; Housing – stock, type, size, occupancy, central heating, tenure; Communal establishments – number, type, population; Employment and economy – activity, unemployment, hours worked, industry, occupation, social grade, travel to work, students, qualifications, armed forces; Health and care – general health, long term illness or disability, carers	2011	2021	Telford and Wrekin Census Profile
	Ward Census Profiles	Ward Census profiles These profiles contain a summary of census topics, population characteristics, diversity, household and family characteristics, housing, employment & economy and health & care, for each of the 33 wards (pre May 2015).	2011	2021	Census Ward Profiles
Economy and Jobs	**Economic Profile**	Telford and Wrekin's economic profile contains detailed information on: Unemployment; Claimants; Workforce; Earnings; Business size and sector; Productivity (GVA); House price and rental	**UPDATED**	Quarterly	Telford and Wrekin Economic Profile
Health and Care	**Public Health Outcomes Framework**	The Public Health Outcomes Framework summary for Telford and Wrekin contains a range of indicators across 5 domains, including: life expectancy and healthy life expectancy; Improving the wider determinants of health; Health protection; Healthcare and preventing premature mortality	**UPDATED**	Quarterly	Public Health Outcomes Framework

Facts & Figures – Health & Wellbeing

JSNA Key Messages for Telford and Wrekin

Population



Source: Telford & Wrekin Local Plan Population Projections 2015, projection for 2016 & 2031

The population of T&W is 'younger 'than the national position, although with the fastest growth being in the 65+ age group the age profile of the borough is now much closer to the national position.

Total T&W Population (2016) **173,600**

Ethnicity

	T&W	England
BME	10.5%	20.2%

Source: Census 2011, BME refers to people of all ethnicities other than 'White British'

The population is becoming more diverse. As well as new migrants a key driver of change has been the younger age structure of BME groups leading to a greater likelihood of them having children.

Life Expectancy

	Male		Female	
	T&W	England	T&W	England
Age	78.7	79.6	81.8	83.2

Source: ONS

Male life expectancy has increased over the last decade, but has been significantly worse than England average since 2006-08. Female life expectancy has increased, but has been worse than England average since 2008-10.

Households

	T&W	England	
With dependant children	33.0%	29.1%	21,996
Lone parents with dependant children	24.4%	24.4%	5,362
Households 65+	18.5%	20.7%	12,313

Source: census 2011 Table QS113 – Household Composition

Reflective of our population, T&W has a higher proportion of households with dependent children and a lower number of households aged 65+.

Carers (Unpaid)

Age	T&W	England	
0-24	2.8%	2.5%	1,530
All ages	10.8%	10.2%	17,944

Source: census 2011 Table QS113 – Household Composition

A higher proportion of people in Telford and Wrekin report to be providing unpaid care, including 1,530 people aged under 25.

Population reporting bad or very bad health

Age	T&W	England	
0-15	0.7%	0.6%	248
16-49	3.2%	2.8%	2,528
50-64	10.7%	8.7%	3,255
65+	18.1%	15.3%	4,364

Source: Office for National Statistics, Census 20111

A higher proportion of people in Telford and Wrekin report having bad or very bad health than the England rate.

Total population reporting bad health **10,395**

Population reporting Long Term Health Problem or disability

Age	T&W	England	
0-19	5.1%	4.3%	2,719
20-44	9.2%	7.8%	5,123
45-64	23.4%	20.5%	10,011
65-74	43.7%	38.7%	6,041
75-84	66.2%	60.9%	4,797
85+	86.0	83.0	1,918

Source: Office for National Statistics, Census 2011 table LC3101- Long term health problem or disability

Total population reporting heath problem or disability **30,609**

Total adults (18-64) reporting moderate to severe disability (Estimated Prevalence) **10,400**

Deprivation

T&W is a place of socio-economic contrasts with parts of the borough amongst the most deprived nationally - comparable with inner cities – and areas amongst the least deprived nationally.
A total of 15 areas are ranked in the 10% most deprived nationally in the wards of Woodside (x4), Malinslee & Dawley Bank (x3), Madeley & Sutton Hill (x2), Brookside (x2), Hadley & Leegomery, Dawley & Aqueduct and College.
The 2015 picture of the most deprived areas in T&W looks very similar to 2010 with new areas in Haygate, Park and Dothill and additional areas in Hadley & Leegomery and The Nedge.
More than a quarter (27%) of T&W population lives in the 20% most deprived areas nationally, an increase on 24% in 2010.

Source: Index of Multiple Deprivation 2015

Produced by Organisational Delivery & Development
Date: May 2016
Status: V1 Final
(01952) 380131

www.telford.gov.uk/factsandfigures

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Facts & Figures – Health & Wellbeing

JSNA Key Messages for Telford and Wrekin

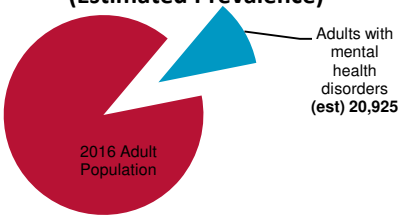
People with Dementia
(Estimated Prevalence)

Age	
Under 65	50
65-74	300
75-84	675
85+	700

Total residents with Dementia (est) **1,725**

Source: Telford & Wrekin Population Profile 2015

Adults with mental health disorders
(Estimated Prevalence)



Source: Telford & Wrekin Population Profile 2015.

Economy

The Borough's modelled rate of unemployment for October 2014 to September 2015 was 5.1%, placing us below the regional rate (5.7%) and below the national rate (5.3%). Rates of unemployment at local, regional and national level are lower than those reported one year previously (TWC down from 6.2% to 5.1%, WM down from 7.3% to 5.7%, England down from 6.5% to 5.3%).

For the year to September 2015 an estimated 4,300 of the Borough's working age population (aged 16-64) were unemployed. This is the lowest it has been since the year to June 2007.

For the period ending September 2015 the largest proportion of the borough's workforce were employed in Professional occupations (15.3%) followed by Elementary occupations (14.4%) and Associate Prof & Tech occupations (13.0%).— The 'Knowledge Economy' sector makes up 37.5% of the workforce with an estimated 29,700 employees (WM 40.6%, England 44.8%).

Source: Telford & Wrekin Economic Profile December 2015

Healthy Lifestyles

Adults overweight or obese (71.9%)	93,800
Children aged 5-6 with excess weight (25.9%)	470
Children aged 10-11 with excess weight (37.3%)	670
People not eating the recommended '5-a-day' (53.6%)	90,800
Adults classified as physically 'inactive' (28.1%)	36,700
Adults who are binge drinkers (18.7%)	24,400
Adults who are higher / increasing risk drinkers (26.2%)	34,200
Children living with a hazardous drinker (22%)	8,600
Adults 16+ who smoke (20.7%)	27,000
Women smoking at the time of delivery (18.1%)	367
Breastfeeding initiation (69.3%)	1,404
Breastfeeding at 6-8 weeks (35.8%)	564
Teenage pregnancies	31.5 per 1,000 YP

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TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD: 15TH JUNE 2016

HEALTH & WELLBEING PRIORITY UPDATE: LIFE EXPECTANCY

REPORT OF: HELEN ONIONS, CONSULTANT IN PUBLIC HEALTH, TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD PRIORITY SPONSOR: RICHARD OVERTON, DEPUTY LEADER TELFORD & WREKIN COUNCIL, HEALTH & WELLBEING BOARD CHAIR

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

- This report provides an update on the local picture of life expectancy and the main causes behind our reduced life expectancy position. Further work is being undertaken to better understand the local pattern and underlying causes.
- Life expectancy rates remain highly relevant outcome measures for the three new HWB strategy priorities.
- The relevant prevention work, led by the Council to reduce the impact of smoking, excess weight and the misuse drugs and alcohol will still be routinely reported to the HWB as part of the regular Living Well and Community Safety Partnership update reports.
- Reducing the health and wellbeing gap is one of the key aims of the Shropshire, Telford & Wrekin NHS Sustainability and Transformation Plan. This plan is strongly aligned with the HWB strategy and should contribute significantly to improving life expectancy in Telford & Wrekin.

2. RECOMMENDATIONS

The Board is recommended to:

- Acknowledge that life expectancy rates remain highly relevant outcome measures for the three new HWB strategy priorities
- Recognise that the main causes of reduced life expectancy and associated inequalities will be tackled through delivery of the HWB strategy work programmes and the NHS Sustainability and Transformation Plan process
- Agree to receive further intellgience on the causes of reduced life expectancy, as part of the JSNA updates, when further analyses have been produced

3. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="6">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority -</td></tr>
<tr><td>Yes</td><td>Although improving life expectancy rates is no longer a specific priority in the new health and wellbeing strategy, these measures remain highly relevant across the three new priorities. Life expectancy and healthy life expectancy rates should be used as overarching measures of progress towards improving local health and wellbeing.</td></tr>
<tr><td colspan="2">Do these proposals contribute to specific Co-Operative Council priority objective(s)?</td></tr>
<tr><td>Yes</td><td>To improve the health and wellbeing of our communities and address health inequalities</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>See equality and diversity section below</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2"></td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>The delivery of these strategies and the detailed work programmes will need to be considered against the context of reducing resources.

The Council currently spends £3.7m on the relevant prevention work highlighted in Section 1 of this report and other Living Well initiatives .

Further reductions in Public Health grant in future years may impact on the monies available to fund this work beyond 2016/17.

ER – 25/05/2016</td></tr>
<tr><td>LEGAL ISSUES</td><td>Yes</td><td>In respect specifically of the Health and Wellbeing Board (HWBB) responsibilities regarding work to improve life expectancy, it should be noted that section 2B of the National Health Services Act 2006 (as amended) contains a duty on local authorities to take appropriate steps to improve the health of local people in its area.
Further the HWBB has a role in co-ordinating and encouraging integrated working.
Accordingly, work undertaken to identify and investigate life expectancy issues assists the Council with undertaking its statutory responsibilities.</td></tr>
</table>

EQUALITY & DIVERSITY	Yes	The JSNA clearly demonstrates inequalities relating to life expectancy in Telford and Wrekin, including: • Geographical hot spots where life expectancy and early death rates are significantly worse than average (Appendix I)
IMPACT ON SPECIFIC WARDS	Yes	See equality and diversity section above • Male life expectancy is 7.6 years lower for men in the most deprived areas of Telford and Wrekin compared to the in the least deprived areas. • Female life expectancy is 5.2 years lower for women in the most deprived areas of Telford and Wrekin compared to the in the least deprived areas. In terms of our life expectancy inequalities gap within Telford and Wrekin between the most deprived fifth of communities and the least deprived fifth of communities: • for men 20% of the inequalities life expectancy gap is due to cardiovascular disease, 31.5% is to cancer and 10% due to respiratory disease • for women 20% of the inequalities life expectancy gap is due to cardiovascular disease, 15% is due to cancer and 22% due to respiratory disease.
PATIENTS & PUBLIC ENGAGEMENT	Yes	Patient experience is a key work stream in the improving cancer outcomes plan.
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	• Key links to the NHS Sustainability and Transformation Plan, which requires closing of the health and wellbeing gap and a radical upgrade in prevention activities across our health and care system. • The majority of causes of ill-health and premature death are due to avoidable diseases, such as: diabetes, preventable cancers and cardiovascular diseases - many of which are caused by lifestyle risk factors such as smoking, alcohol consumption and excess weight. The Board will continue to receive updates on action to tackle the underlying causes and risk factors for preventable deaths in future as part of the HWB work programme updates.

PART B) – ADDITIONAL INFORMATION

1. INFORMATION

1.1. Life expectancy figures update

The JSNA Mortality Profile 2015 gives a picture of the comparative trends for life expectancy, alongside the main causes of reduced life expectancy and premature mortality. The key headline messages for life expectancy are as follows:

- Male life expectancy at birth increased by 0.5 years during 2012-14, to 78.7 years from 78.2 years in 2011-13.
- Trends indicate that male life expectancy has increased over the last decade, but has been significantly worse than the England average since 2006-08. Despite remaining below the England average, the latest information for 2012-14 shows a narrowing of the gap between the local and national position. (Figure 1)
- Female life expectancy at birth decreased by 0.3 years during 2012-14, to 81.8 years from 81.5 years in 2011-13.
- Trends indicate that female life expectancy has increased over the past decade, but has been worse than the England average since 2008-10, with the gap between local and national figures increasing since 2007-09. Between 2009-11 and 2011-13 life expectancy for females in the Borough was declining, but the latest figure for 2012-14 shows signs of an increase. (Figure 2)
- Healthy life expectancy rates for men and women also remain significantly worse than the national average
- In terms of health inequalities the lowest rates of life expectancy and healthy life expectancy are seen in our most deprived communities. (See Equalities and Diversity and Impact of Specific Wards section on page 2 and Appendix I)

More detailed information on life expectancy rates, for 65+ years and healthy life expectancy figures are shown in Appendix II.

Figure 1 Trends in Male Life Expectancy

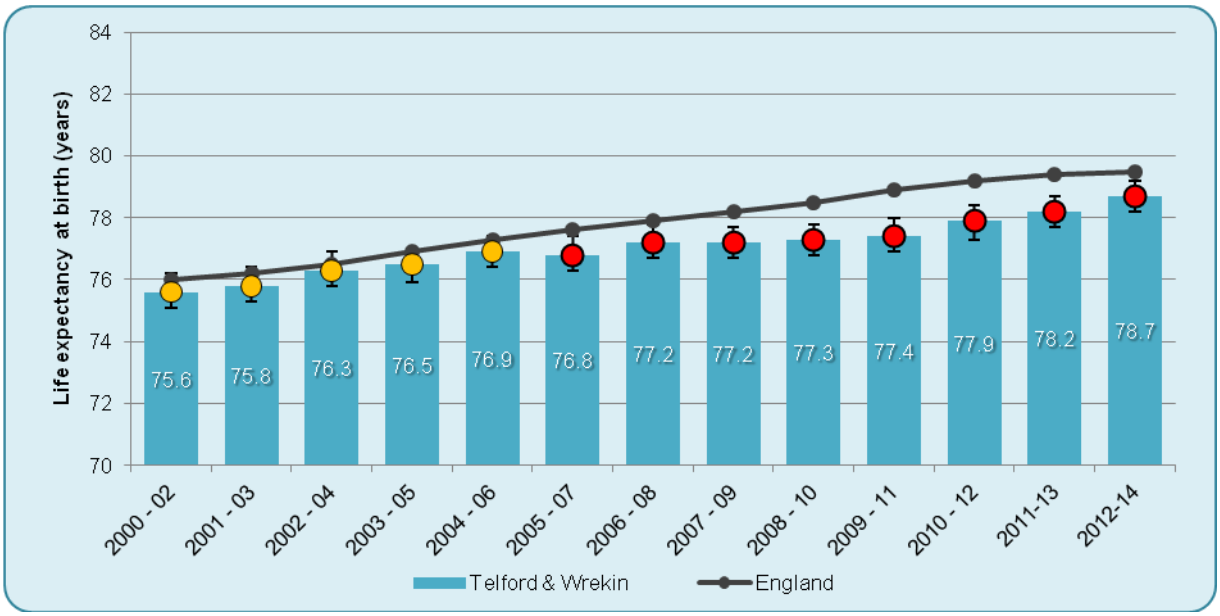
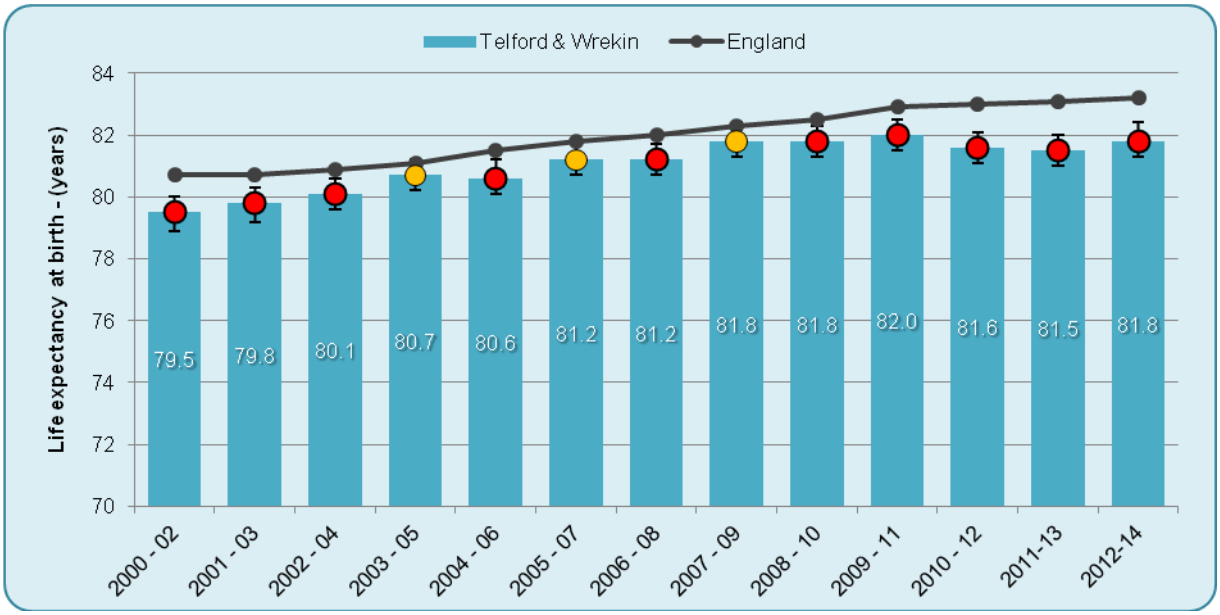


Figure 2 Trends in Female Life Expectancy



Source: Telford & Wrekin JSNA Mortality Profile 2016, Public Health Outcomes Framework, http://www.phoutcomes.info/

1.2. Overview on early deaths and causes of reduced life expectancy

The key messages for the main causes of reduced life expectancy and premature mortality from the JSNA Mortality Profile 2015 are as follows:

- Early deaths from cancers and cardiovascular diseases account for in excess of 75% of all early deaths and all years of life lost under 75 years. Cancers cause 42.1% of all early deaths under 75 years, cardiovascular diseases – CVD (heart disease and stroke) account for 20.8%.

- There has been a marked change in the ratio of cancer to CVD deaths compared to 2001-03, when cancer and cardiovascular diseases accounted for around a third of deaths under 75 within Telford and Wrekin each.

- Cardiovascular diseases: early death rates in men and women have declined markedly during the past decade, and in 2012-14 the rate was for persons was similar to the England rate rather than significantly higher for the first time. Rates for men, although falling, are double the rates in women. Almost two thirds (64%) of cardiovascular deaths are considered preventable, but the rate of early deaths considered preventable is decreasing at a faster pace than the national rate.

- Cancers: early death rates in men and women have not declined at the same rate as the national average. In 2012-14 the rate for men was worse than the national average, whereas for women the rate was similar to the national average. Over half (60%) of cancer deaths are considered preventable and early death rates for preventable cancers in men and women are static and not reducing.

Appendix III provides further information on comparative mortality rates.

1.3. Understanding our life expectancy pattern better

In 2015 the JSNA process included local analytical work on life expectancy and mortality rates, including detailed investigation of cancer mortality. However, the reasons behind the local position for female life expectancy i.e. the lack of progress over time and widening of the gap between the national average are still not clearly understood.

The Council's Public Health Team are collaborating with Public Health England West Midlands Knowledge and Information Team to investigate local life expectancy patterns and causes in more detail. This bespoke work in Telford & Wrekin has been agreed as part of PHE's pilot approach to develop place-based working with local areas.

1.4. Sustainability and Transformation Plan context

The Health & Wellbeing Board has been briefed on the NHS requirement to produce a strategic Sustainability and Transformation Plan for the Local Health Economy. The plan needs to clearly describe the local vision for Shropshire, Telford & Wrekin to deliver the ambitions of the NHS Five Year Forward View[1]. The STP will articulate how the following three gaps in healthcare will be narrowed: *the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap*.

Closing the health and wellbeing gap and associated health inequalities, which will improve life expectancy in Telford & Wrekin, requires a radical upgrade in prevention. This means we need comprehensive programmes to tackle preventable lifestyle-related illness. These programmes need to be delivered systematically at scale and embedded across health and social care and the third sector working with and in our communities.

[1] NHS Five Year Forward View Time to Deliver https://www.england.nhs.uk/2015/06/time-to-deliver/

The STP, which is currently being prepared for the June 2016 submission, prioritises three key areas for improving the health of the population which directly match the Telford & Wrekin HWB priorities. Tackling lifestyle risk factors and upgrading prevention activities to reduce cancer and cardiovascular disease is a key focus of the plan.

1.5. Tackling cardiovascular disease

Reducing the main causes of reduced life expectancy has been part of the CCG Quality Premium Potential Years of Life Lost Plan during the past two years. There have some improvements in the prevention, management and treatment of cardiovascular disease during this time. However, reducing the risk particularly through tackling diabetes and hypertension (high blood pressure), remain key priorities given the scale of these conditions in our communities.

Proposals are being put forward in the STP to systematically improve the prevention, detection, treatment and management of hypertension and diabetes, including primary and secondary prevention elements, including:

- Delivery of the diabetes prevention programme approach to identify and manage people at high risk of developing diabetes
- Improving the uptake of vascular risk assessment through NHS Health Check
- Reducing unwarranted variation across practices GP practice performance will contribute to reducing health inequalities.
- Redesigning the diabetes integrated service and treatment pathways
- Improving seasonal 'flu immunisation for people in at risk clinical groups, as well as those aged 65 years and over

1.6. Improving Cancer Outcomes

In 2014 Telford and Wrekin was ranked 190th of 203 CCGs in England for cancer survival at one year following diagnosis. In response CCG colleagues and Council's public health team have been working with Shrewsbury & Telford Hospital NHS Trust and Macmillan to produce the plan *Improving cancer survival, patient experience and quality of life: Living Well for longer in Telford & Wrekin 2016 – 2018.*

The plan has a strong collaborative, evidence-based approach and responds directly to the expectations of *Achieving World Class Cancer Outcomes - A Strategy for England 2015-2020,* published in June 2015. There is clear local governance now in place and clinical leadership is driving the plan. Patient experience and the voice of cancer survivors and families affected features strongly through active involvement of the local charity the Jayne Sargent Foundation[2].

[2] http://www.jaynesargent.co.uk/

There are clear measurable outcomes for the cancer plan and six early wins have been agreed as follows:

a) The development of a primary care based incentive scheme to improve uptake for bowel and breast cancer screening

b) CCG leadership of and primary care engagement in improving early diagnosis with the Cancer Research UK visiting programme the Macmillan GP

c) Radical upgrade in prevention, to include: increased symptom awareness to support early presentation e.g. linked to the national Be Clear on Cancer Campaign planned for July – August 2016

d) CCG Primary Care support to analyse, disseminate lessons and good practice from the cancer audits undertaken in 2014-2015 and 2015 -2016 to improve diagnosis

e) CCG and partner support for systematic and consistent implementation of all elements of the Recovery Package based on the needs and preferences of local people living with and beyond cancer

f) CCG and partner responsiveness to the needs of People Living with and Beyond Cancer

g) Higher profile, accessible one stop shop / website and or apps for people living with and beyond cancer to provide equity of access and proactively address inequalities in cancer survival.

The ambition to improve cancer outcomes is also being referenced in the STP.

2. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

See summary impact assessment section on pages 2-3 for details.

3. PREVIOUS MINUTES

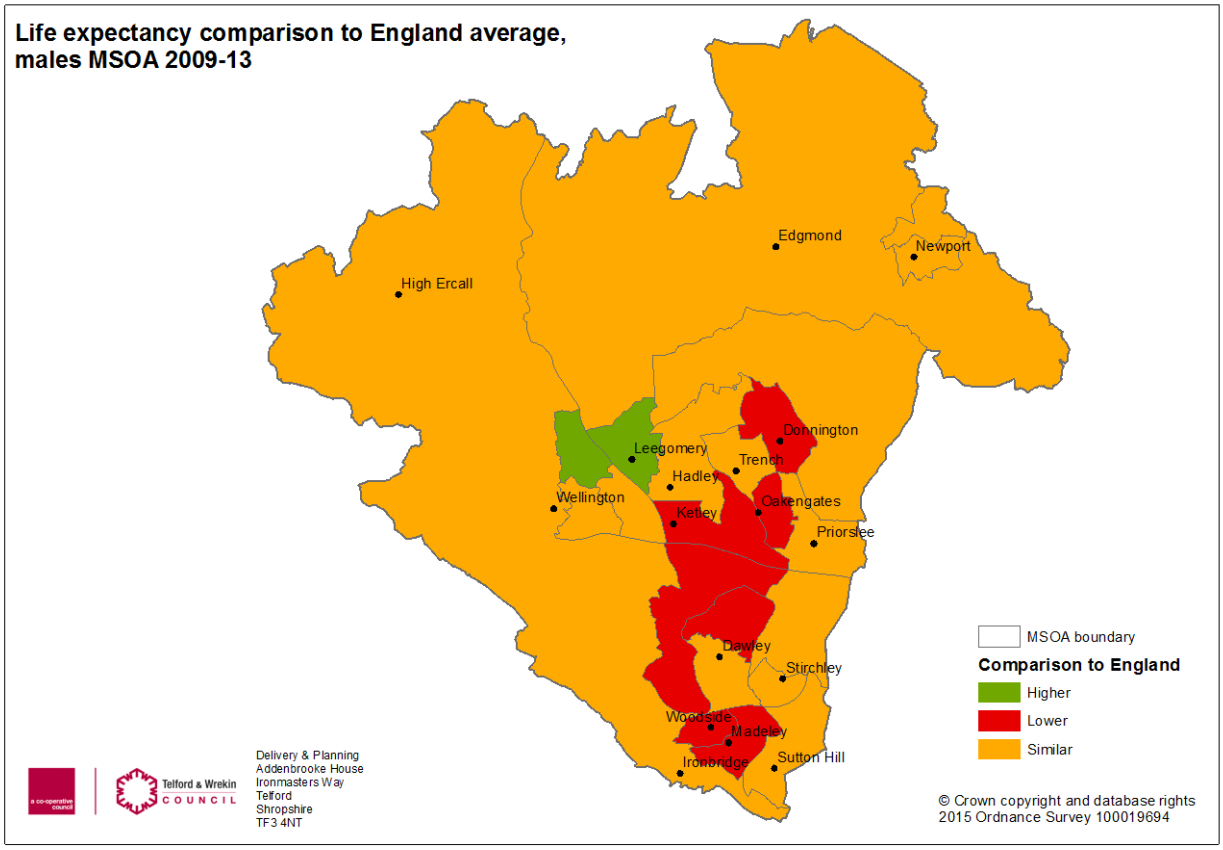
- Health & Wellbeing Priority Update: Life expectancy, 21st January 2015
- Health & Wellbeing Priority Update: Life expectancy – Focus on Cancer, 12th March 2014
- Health & Wellbeing Priority Update Report: Life expectancy and health inequalities, November 2013

4. BACKGROUND PAPERS

Report prepared by:

Helen Onions, Consultant in Public Health
Helen.Onions@telford.gov.uk

APPENDIX I


Life expectancy comparison to England average, males MSOA 2009-13
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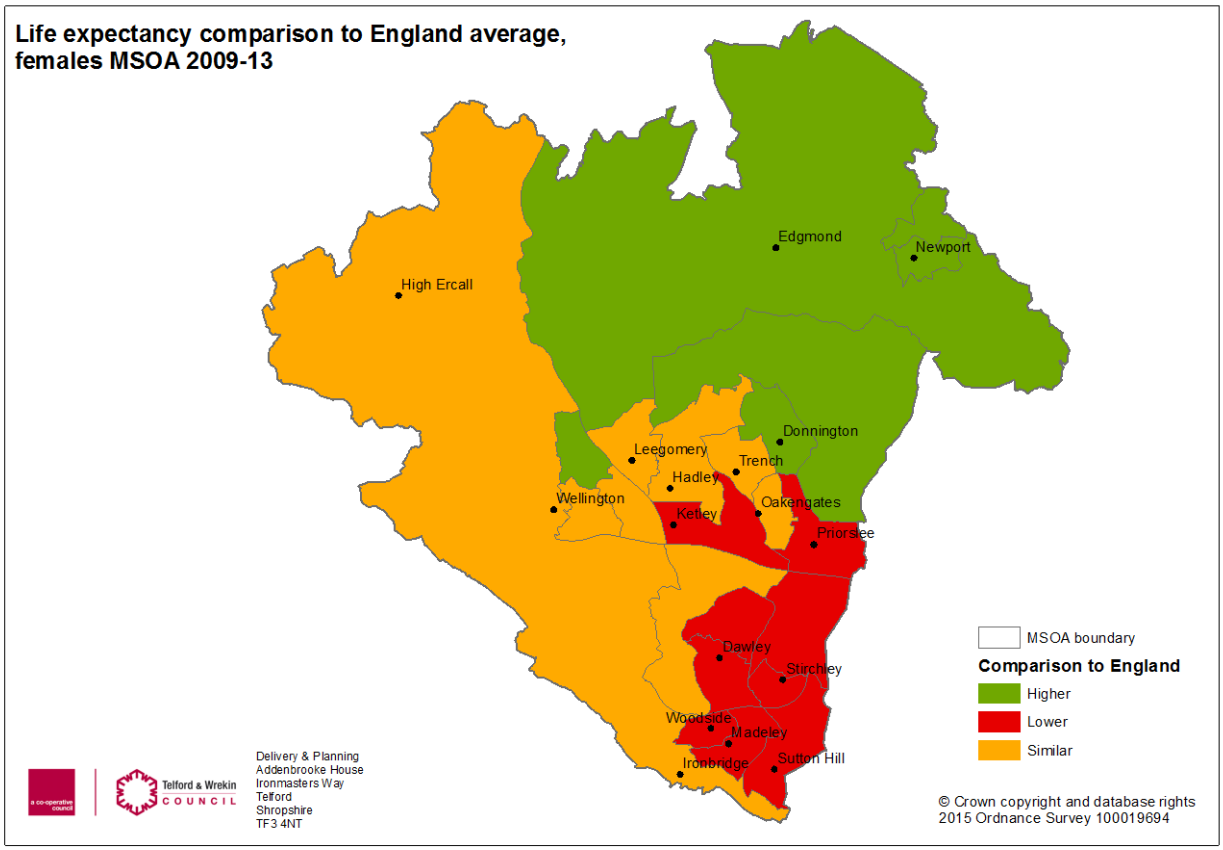
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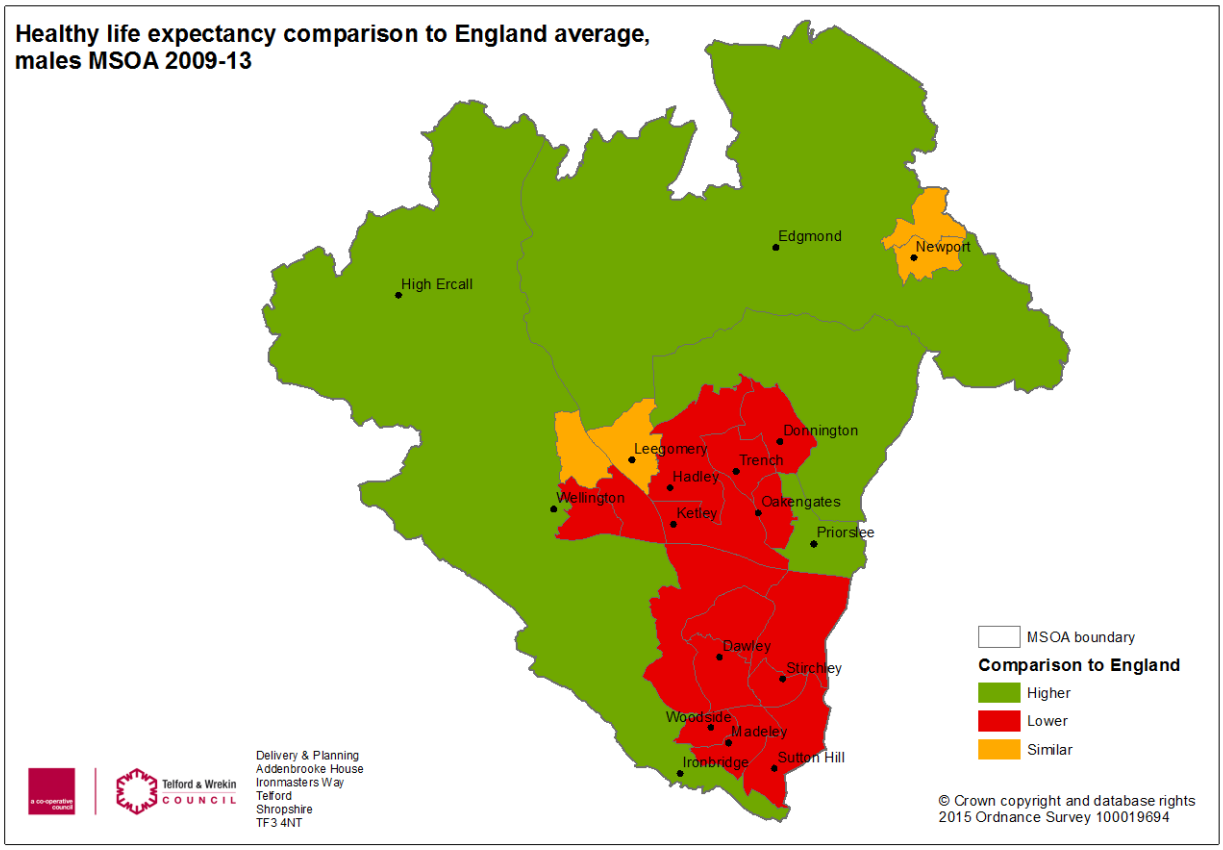
Healthy life expectancy comparison to England average, males MSOA 2009-13
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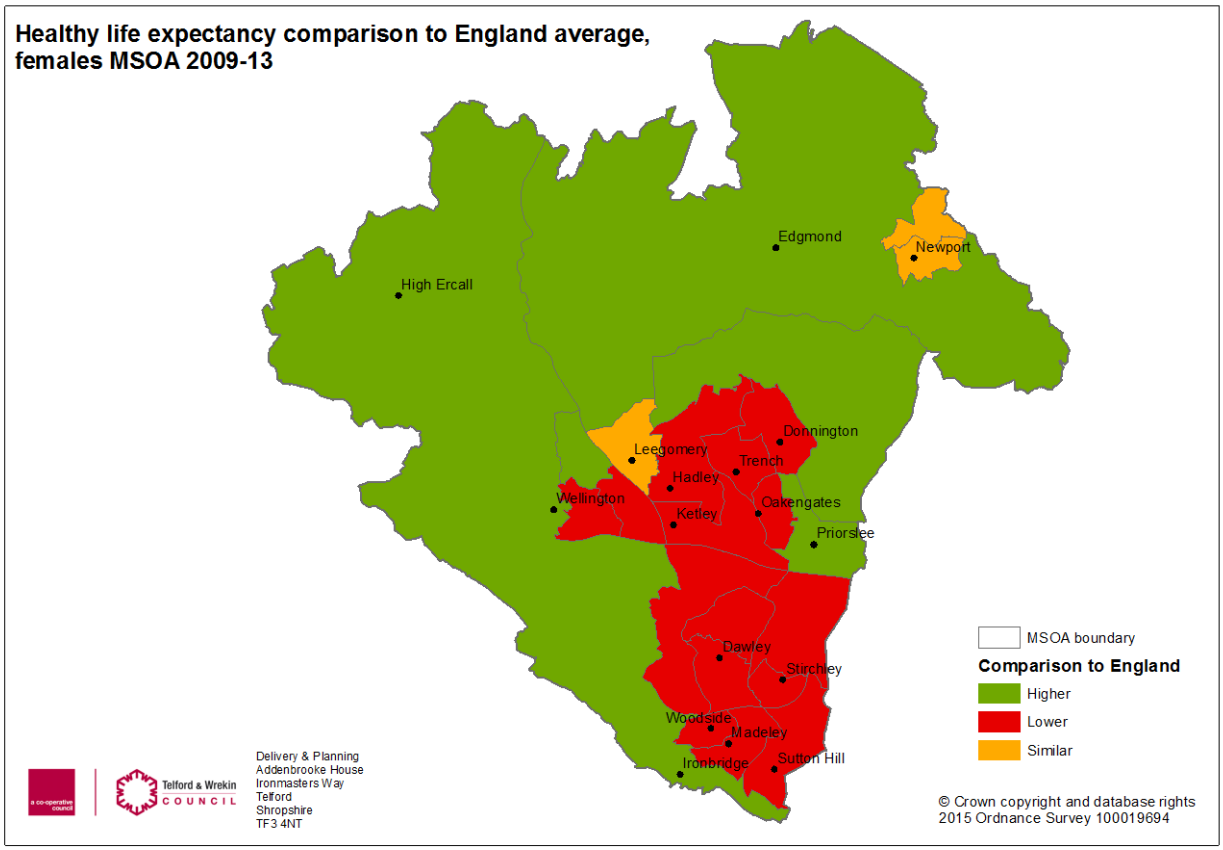
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APPENDIX II

Public Health Outcomes Framework: Life Expectancy Indicators

Key to RAG rating

Telford & Wrekin position significantly worse than the England average	Telford & Wrekin position similar to the England average	Telford & Wrekin position significantly better than the England average

The RAG rating in these tables uses the statistical significance as calculated and presented by Public Health England (PHE) in the PHOF release November .2015. Indicators without RAG ratings are those where PHE have not applied statistical comparisons.

Indicator	Telford and Wrekin	England figure	Time Period
Healthy life expectancy at birth - Male	60.11	63.27	2011 - 13
Healthy life expectancy at birth - Female	57.06	63.95	2011 - 13
Life expectancy at birth - Male	78.70	79.55	2012 - 14
Life expectancy at birth - Female	81.80	83.20	2012 - 14
Life expectancy at 65 - Male	18.20	18.77	2012 - 14
Life expectancy at 65 - Female	20.30	21.19	2012 - 14
Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area - Male	6.95	-	2012 - 14
Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area - Female	2.84	-	2012 - 14
Gap in life expectancy at birth between each local authority and England as a whole - Male	-0.85	0.00	2012 - 14
Gap in life expectancy at birth between each local authority and England as a whole - Female	-1.40	0.00	2012 - 14
Slope index of inequality in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas - Male	11.81	-	2009 - 13
Slope index of inequality in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas - Female	12.10	-	2009 - 13

Source: http://www.phoutcomes.info/ downloaded November 2015

Summary PHOF Domain 0 – Overarching Determinants of Health

The Telford & Wrekin position is significantly worse than the England average for all eight sub-indicators that have been statistically compared.

Worse than average indicators:

- Healthy life expectancy at birth (male and female)
- Life Expectancy at birth – (male and female)
- Life Expectancy at 65 – (male and female)
- Gap in life expectancy at birth between compared with England – (male and female)

APPENDIX III

Public Health Outcomes Framework: Premature Mortality Indicators

For the period 2012-14 the Telford & Wrekin rate was significantly worse than the national average for England for the following indicators:

- Mortality from causes considered preventable – all ages (persons)
- Mortality for under 75s from cancer (persons and males)
- Mortality for under 75 from cancer considered preventable (persons and males)

The rates for all other indicators was not significantly different to the England average

Indicator	Previous RAG rating and direction of travel	Telford & Wrekin	England
		Rate	Rate
Mortality rate from causes considered preventable (all ages) - Persons	▼	198.4	182.7
Mortality rate from causes considered preventable (all ages) – Males	▼	250.0	230.1
Mortality rate from causes considered preventable (all ages) – Females	▲	149.1	138.4
U-75 mortality rate from all cardiovascular disease - Persons	▼	80.3	75.7
U-75 mortality rate from all cardiovascular disease – Males	▼	112.9	106.2
U-75 mortality rate from all cardiovascular disease - Females	▼	49.1	46.9
U-75 mortality rate from all cardiovascular disease considered preventable - Persons	▼	52.0	49.2
U-75 mortality rate from all cardiovascular disease considered preventable – Males	▼	77.2	74.1
U-75 mortality rate from all cardiovascular disease considered preventable – Females	▲	27.8	25.6
U-75 mortality rate from cancer - Persons	▼	159.4	141.5
U-75 mortality rate from cancer - Males	▲	179.0	157.7
U-75 mortality rate from cancer – Females	▼	141.2	126.6
U-75 mortality rate from cancer considered preventable - Persons	▲	95.2	83.0
U-75 mortality rate from cancer considered preventable – Males	▲	108.6	90.5
U-75 mortality rate from cancer considered preventable - Females	▼	82.9	76.1
U-75 mortality rate from liver disease - Persons	▼	21.1	17.8
U-75 mortality rate from liver disease – Males	▼	25.8	23.4
U-75 mortality rate from liver disease - Females	▲	16.9	12.4
U-75 mortality rate from liver disease considered preventable - Persons	▼	18.9	15.7
U-75 mortality rate from liver disease considered preventable - Males	▼	24.4	21.0
U-75 mortality rate from liver disease considered preventable - Females	▲	13.6	10.6
U-75 mortality rate from respiratory disease - Persons	▼	32.7	32.6
U-75 mortality rate from respiratory disease – Males	▼	34.1	38.3
U-75 mortality rate from respiratory disease - Females	▼	31.3	27.4
U-75 mortality rate from respiratory disease considered preventable - Persons	▼	19.1	17.8
U-75 mortality rate from respiratory disease considered preventable - Males	▼	19.2	20.1
U-75 mortality rate from respiratory disease considered preventable - Females	▼	18.9	15.7
U-75 mortality rate from all causes considered amenable - Persons		128.9	112.1
U-75 mortality rate from all causes considered amenable - Males		154.2	135.4
U-75 mortality rate from all causes considered amenable - Females		104.86	91.2

http://www.phoutcomes.info/ downloaded November 2015

FOR INFORMATION ONLY

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD - 15TH JUNE 2016

CCG QUALITY PREMIUM 2016/17

REPORT OF: TRACEY JONES: DEPUTY EXECUTIVE QUALITY AND ENGAGEMENT: NHS TELFORD AND WREKIN CLINICAL COMMISSIONING GROUP

1. SUMMARY OF MAIN PROPOSALS

1.1 The 'quality premium' is intended to reward Clinical Commissioning Groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities.

1.2 Guidance relating to the Quality Premium (QP) Indicators for 2016/17 was published by NHS England in March 2016 .The financial reward attached to successful delivery of quality premium indicators is a maximum of £5 per head of population for full achievement of all indicators subject to financial penalties for failure to deliver NHS Constitutional Targets .

1.3 The 2016/17 scheme has been designed to support the delivery of the major priorities for the NHS, as set out in the Five Year Forward View and in the NHS Mandate. The CCG Improvement and Assessment Framework is the mechanism by which progress will be monitored; therefore NHS England considered it appropriate to align the national QP indicators with those in the CCG Improvement and Assessment Framework. By taking this approach, the QP scheme focuses on those things already identified as critical to delivering the vision.

1.4 There are four national measures and in total are worth 70% of the QP

- Cancer Early Diagnosis (20% of quality premium);
- GP Patient Survey: Experience of making an appointment (20% of quality premium);
- E-Referrals (20% of quality premium);
- Improved antibiotic prescribing in primary care

(10% of quality premium)

1.5 In line with the Guidance from NHS England, the local element of the scheme for 2016/17 is focused on the Right Care Programme. An analysis of NHS Telford and Wrekin CCG Right Care Value for Money packs enabled identification of a short list against the 80 local indicators that were available for selection.

1.6 The criteria for this initial shortlisting was based on where high scope for improvement for NHS Telford and Wrekin CCG had been identified (as this indicated areas of inequality) and where national high data timeliness existed to demonstrate change in year. The rationale was that this would highlight indicators where the CCG both needed to reduce variation and could demonstrate that this had happened. A second cross listing occurred of the indicators against the three new Health and Well Being Board Priorities.

1.7 The requirement was that three local indicators were selected. Unlike previous years the local indicators were not required to be agreed with the Health and Well Being Board (HWBB); however the Quality premium Guidance advised that the CCG may wish to consider the priorities of the HWBB. Telford and Wrekin CCG have done this and have selected aligned indicators.

1.8 The local indicators selected were

- Mental Health - Reported numbers of dementia on GP registers as a % of estimated prevalence Aligned with Health and Well Being Priority 2 Improve Mental Well Being
- Mental Health - % of people who are "moving to recovery" of those who have completed IAPT treatment Aligned with Health and Well Being Priority 2 Improve Mental Well Being
- Maternity - Number of women known to be smokers at time of delivery per 100 maternities Aligned with Health and Well Being Priority 1 Encourage Healthier Lifestyles

2. RECOMMENDATIONS

Not Applicable – For Information Only

3. IMPACT OF ACTION

Quality premium	Expected Impact

measure	
Cancers diagnosed at early stage	Cancer survival rates in England have never been higher, but we know that we often lag behind the highest performing countries in the world in international comparisons. We also know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. An indicator on the proportion of cancers diagnosed at an early stage is therefore a useful measure for assessing improvement in early diagnosis and ultimately cancer survival.
Increase in the proportion of GP referrals made by e-referrals	Increasing the use of the NHS e-Referrals Service is vital to delivering a paper free NHS. Use of the NHS e-Referrals Service benefits patients, NHS staff and NHS organisations: • Patients are empowered through having confidence and certainty about their referral, being able to exercise patient choice and experiencing reduced waiting times. • Staff are able to better ensure patient safety through reducing inconsistencies and errors in referrals processes. • CCGs and Providers are able to deliver more efficient planned care and access management information to drive service improvements
Overall experience of making a GP appointment	The GP Patient Survey (GPPS) seeks the views of 2.4 million people every year about their experience of GP services and results are published at GP practice level. The survey gives patients the opportunity to provide feedback on a number of aspects of their experience of their GP practice, and provides a rich source of quantitative data on patients' experiences of the access and quality of care they receive. Access to GP services, and, in particular, the ease of making an appointment is a key measure of patient experience, and affects the wider healthcare system as patients who find it difficult to access GP services may seek care through emergency services inappropriately. Q18 ("Overall, how would you describe your experience of making an appointment?") of the GP Patient Survey (GPPS) is the "litmus test" indicator in this regard. Attaching a quality premium payment will also ensure that the profile and importance of insight about patient experience is underlined, and it will incentivise the wider system to review and learn from the findings of

	the GPPS
Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary care	Antimicrobial resistant infections impact on patient safety and the quality of patient care. Evidence suggests that antimicrobial resistance (AMR) is driven by over-using antibiotics and prescribing them inappropriately. Reducing the inappropriate use of antibiotics will delay the development of antimicrobial resistance that leads to patient harm from infections that are harder and more costly to treat. Reducing inappropriate antibiotic use will also protect patients from healthcare acquired infections such as Clostridium difficile infections.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	*Identified for local indicators on pg 2 of this document*
	Do these proposals contribute to specific Co-Operative Council priority objective(s)?	
	Yes/No	*If yes, please list relevant Co-Operative Council objective(s)*
	Will the proposals impact on specific groups of people?	
	Yes	*Quality premium guidance to CCGs states the requirement to consider the impact of programmes of work to reduce health inequalities*
TARGET COMPLETION/DELIVERY DATE	*The QP indicators will be monitored monthly at the Planning, Prioirities and Quality Committee on a monthly basis. There is representation from Public Health at these meetings.*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	The maximum quality premium payable to the CCG for completion of all indicators is £5 per head of population, calculated using the same methodology as for CCG running costs. Deductions will be made for none achievement of indicators and failure to deliver constitutional targets.
LEGAL ISSUES	No	No
EQUALITY & DIVERSITY	Yes	This will be considered as part of the individual programmes of work that support the national and local quality indicators
IMPACT ON SPECIFIC WARDS	No	*Borough-wide impact*
PATIENTS & PUBLIC ENGAGEMENT	No	*None undertaken to inform selection of indicators , national guidance followed*
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	*None identified*