Shropshire Council

Date: Thursday, 11 September 2014

Time: 9.30 am

Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Contact: Karen Nixon, Committee Officer
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Email: karen.nixon@shropshire.gov.uk

HEALTH AND WELLBEING BOARD

TO FOLLOW REPORT (S)

3 Better Care Fund: Shropshire Submission (to include the Section 256 Agreement) (Pages 1 - 24)

A report by the Better Care Fund Manager and the Head of Planning and Partnerships (Shropshire CCG) is attached, marked 3.

Contact: Kerrie Allward, Tel 01743 253095 or 01743 277500 ext 2092 (Better Care Fund Manager)

Contact: Sam Tilley, Tel 01743 277500 (Head of Planning and Partnerships (Shropshire CCG)

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Health & Wellbeing Board
Better Care Fund

11th September 2014

Vision for Health & Social Care Services

- Coordinated and integrated pattern of care, with less duplication
- Increased focus on prevention
- Better support of carers
- Systematic shift towards supporting more people at home and in their community
- A reduced dependency on hospitals
- Increased choice and control for patients/services users and their carers.
- Reducing dependence on paid support
- Enabling and maximising individual independence
- Developing resilient communities
- Use of experts by experience to inform the development of services

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Case for Change

Drivers

- Policy Change
- Changing pattern of illness
- Higher expectations
- Reducing budgets
- Changes in population profile
- Rurality & access
- Quality & Safety
- Two site working
- Workforce
- Technology

Our Local Drivers

- Falls
- Increase in long term conditions
- Increase of people living with dementia
- Increase in hospital admissions and delayed discharges
- Parity of esteem between physical and mental health
- Poor health in carers
- People not dying in the place of their choice

Plan of Action

Four Strategic Themes

- Prevention
- Early Intervention (Case Management)
- Supporting People in Crisis
- Supporting People to Live Independently for Longer

Eleven Transformation Schemes

- Integrated Falls Prevention
- Dementia Strategy
- Proactive Care Programme
- Community & Care Coordinators
- Care Home Advanced Scheme
- Team Around the Practice
- Integrated Community Services
- Mental Health Crisis Care
- Resilient Communities
- Integrated Carers Support
- End of Life Coordination

The Better Care Fund – Plan on a Page v11

Health and Wellbeing Vision

"Everyone living in Shropshire is able to flourish by leading healthy lives, reaching their full potential and making a positive contribution to their communities"

Outcomes that the Health & Wellbeing Board will strive to achieve

Outcome 1
Health inequalities are reduced

Outcome 2
People are empowered to make better health and lifestyle choices

Outcome 3
Better emotional, mental health and wellbeing for all

Outcome 4
Older people and those with long term conditions remain independent for longer

Outcome 5
Health, Social care and wellbeing services are accessible, good quality and seamless

The Challenge: To improve services and outcomes for the people of Shropshire and make the local health and wellbeing system financially sustainable for the future

Better Care Fund Strategic Themes

	Prevention	Early Intervention (Case Management)	Supporting People in Crisis	Supporting People to Live Independently for Longer
Governance	**Clinical Lead/Sponsor:** Rod Thomson **Lead Officer**: Kevin Lewis	**Clinical Lead/Sponsor:** Colin Stanford **Lead Officer**: Kerrie Allward	**Clinical Lead/Sponsor:** Colin Stanford **Lead Officer**: Kerrie Allward	**Clinical Lead/Sponsor:** Sal Riding **Lead Officer**: Sam Tilley
Theme Objectives	Empowering people to make better lifestyle and health choices for their own and their families health and wellbeing, preventing the prevalence of ill health and the need for intervention.	The identification of 'at risk' groups of people and the approach to support those people through a process of joint assessment, allocation of a 'key-worker' joint care planning and active case management	In the event that an individual finds themselves in crisis, rapid, focused intervention with a view to helping a person remain in their own home or return there as quickly as possible.	Reducing dependence on paid support and enabling independence. Maximising the use of community resources and natural support to develop
Existing Integrated Activity	• Prevention Services • Osteoarthritis Prototype • Diabetes Prevention • Pulmonary Rehab	• 1st phase Care Home Advanced Scheme • 1st Phase Community & Care Coordinators	• Mental Health Support Services • Specialist rehab	• Housing, Equipment & Adaptations • Supported Housing Development • Carers Support • End of Life Support
Transformation Schemes	Scheme: A1 - Integrated Fall Prevention — Lead: Miranda Ashwell	Scheme: B1 - Proactive Care programme — Lead: Nina White Scheme: B2 - Community & Care Coordinators — Lead: Tracey Savage Scheme: B3 - Care Home Advanced Scheme — Lead: Tracey Savage Scheme: B4 - Team Around the Practice — Lead: Nina White	Scheme: C1 - Integrated Community Services — Lead: Emma Pyrah Scheme: C2 - Mental Health Crisis Care Services — Lead: Paul Cooper	Scheme: D1 – Resilient Communities — Lead: Kate Garner Scheme: D2 – Integrated Carers Support — Lead: David Whiting Scheme: D3 - End of Life Coordination — Lead: David Whiting Scheme: D4 - Dementia Strategy — Lead: Louise Jones

Cross Cutting Themes

- Communities
- Workforce
- Information Technology
- Quality & Safety
- Communication & Engagement
- 7 Day Working

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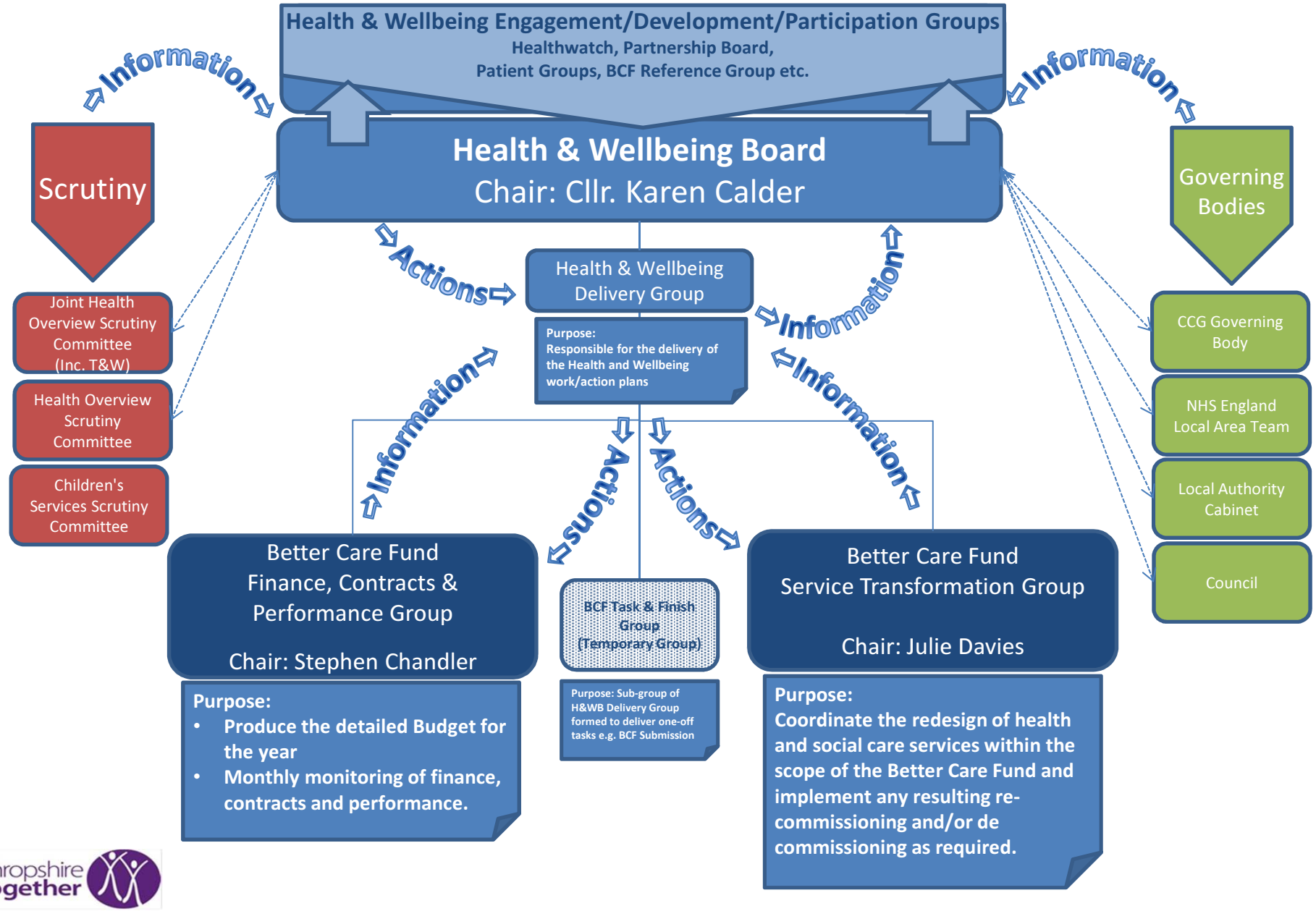
Plan of Action

- Governance Structure
- Scheme Descriptions – *Papers available*
- Scheme Overview
- Programme Plan

Better Care Fund Governance Structure v10



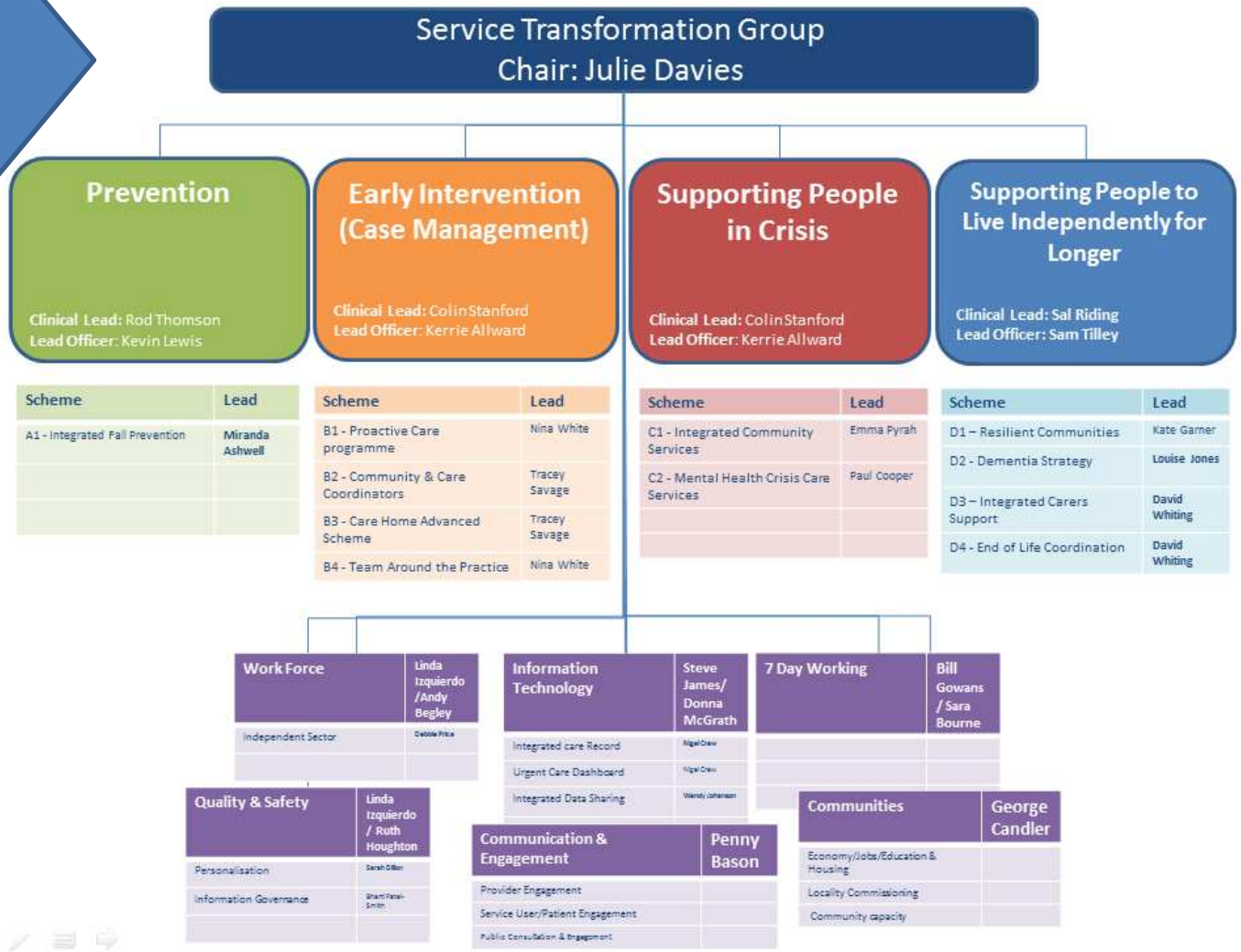
Better Care Fund Governance Structure v10
Service Transformation Group

Core Group:
- CCG Director of Strategy & Service Redesign
- CCG Head of Programmes & Redesign
- CCG Clinical Director for the BCF
- Better Care Fund Manager
- Patient/public representative
- Head of Service: Improvement and Efficiency – Adult Services
- Director of Preventative Health Programmes
- Head of Children's Social Care & Safeguarding
- Commissioning Manager – People
- Clinical Leads
- Lead Officers & Scheme Leads (by invite)
- Chair of Finance, Contracts & Performance Group
- VCSA & Providers (by invite)

Strategic Themes

Transformation Schemes

Cross-cutting Schemes



Better Care Fund Governance Structure v10
Finance, Contracts & Performance Group

Core Group:
Deputy Director of Finance, CCG
Finance Lead LA
Contracts Leads CSU/LA
Performance Leads CSU/LA
Patient/Public Representative
Better Care Fund Manager
Strategic Theme Lead Officers
Chair of Service Transformation Group

Finance, Contracts and Performance Group
Chair: Stephen Chandler

Purpose: Produce and monitor the detailed budget for the year and monthly performance monitoring of finance, contracts and Performance. Report finance, contracts and performance monitoring information to the H&WB Board

Finance

Transformation Projects

Performance

Transformation Projects

Contracts

Transformation Projects

BCF Scheme Overview v6 10/09/2014

Theme	Scheme ID	Scheme Title	Brief Scheme Description	Lead	Scheme Status	Key Milestone/ Actions	Baseline Data	Target Outcomes	Total investment required 14/16) ennstimated
Prevention	A1	Integrated Falls Prevention	Public Health Review across local health & social care economy of full spectrum of falls prevention activity. Next phase: Dec 2014: development of whole system approach to identify and reduce risk of primary and secondary falls including reform of existing services and falls and fracture pathways, community-based postural stability exercise and widening of identification and risk reduction for primary prevention. Wording to change to reflect descriptor in narrative	Miranda Ashwell	Scoping	**Sept 2nd** - Stakeholder Consultation, T&F groups established. **Sept - Nov '14** - Outline Business Planning - Stakeholder Engagement **Dec' 14** - Development of 'Detailed Business Plan' **Dec '14** - Completion of detailed business plan - stakeholder consultation for implementation. **Jan '15** - Whole system falls action plan Phase 1: Care Homes **April '15** - Phase 2: Risk assessment/referral pathways **July '15** Phase 3: Exercise continuum. **October '15** Evaluation	Baseline to be established in 'Detailed Business Plan' phase in following areas: 1.In-patient and emergency admission for falls/fragility fractures (acute and community hospitals) 2. Hospital admissions from care homes 3.No. of falls risk assessments 4.No of people receiving intervention to reduce falls risk,(by intervention)	Targets to be determined in 'Detailed Business Plan Phase for following outcomes: 1. Increase number of falls risk assessments 2. Increase in number of people receiving falls risk reduction interventions 3. Reduction against baseline in falls admissions (acute) 4. Reduction against baseline of admissions from care homes	Investment required to be determined in 'Detailed Business Plan' phase. Initial estimates from scoping: 2014/15 Pump priming for: £30k postural stability exercise development £25k risk assessment £25k evaluation
Supporting people to live independently for longer	A2	Dementia Strategy	A range of work streams that aim to: 1. Increase diagnosis rates, increase post diagnosis support, and provide integrated assessment, care planning and partnership delivery of support. 2. Enable patients with dementia and their carers to live well and independently in their own homes and help avoid avoidable hospital admissions 3. Building a 'dementia friendly' Shropshire 4. Primary prevention work with Public Health tonalse public awareness of reducing lifestyle risks which may increase the risk of dementia. Wording to change to reflect descriptor in narrative	Louise Jones	Outline business plan	**Sept '14** - Detailed Business Planning - Initial stakeholder engagement to agree the detail of project objectives in each of the identified work streams. End September - Detailed Business Plan completed - including the evaluation tools/methods, e.g. memory service patient satisfaction survey and Practice team survey. **Oct '14** - Prototype Phase 1 Implementation - First memory service clinics arranged and/or referrals to be received for home treatment team where appropriate. **Nov '14** - Prototype Phase 2 - Review and evaluate work to date and explore options for further roll out to other practices. **Jan '15** - Interim evaluation **Feb' 15** - Protype Phase 3 **Jan '16** - Evaluation	Baseline to be established in 'Detailed Business Plan' phase in following areas: 1. Numbers of referrals into memory service. 2.Time from referral to diagnosis. 3. Numbers of people admitted to Redwoods with diagnosis of dementia 4. Survey feedback on carers of people with dementia quality of life 5. Survey feedback of practice team	Targets to be determined in 'Detailed Business Plan Phase for following outcomes: 1. Increased numbers of referrals to the memory service to support a more timely diagnosis and prompt referral for appropriate treatment and supportive interventinos. 2. Carers and patients to feel well supported throughout the care pathway pre diagnosis and post diagnosis. 3. Number of positive responses from practice team survey. 4. Reduction in time from referral to diagnosis. 5. Reduction in people with dementia being admitted to Redwoods	Investment required to be determined in 'Detailed Business Plan' phase.
Early Intervention/Case Management	B1	Proactive Care Programme	This enhanced service (ES) is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or readmission. The ES should be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions. SCCG is committed to the principle of care planning and is supportive of application beyond the 2% requirement of the ES. Wording to change to reflect descriptor in narrative	Nina White	Outline business plan	**1 April 2014** -Enhanced service commenced for one year subject to review **30 April 2014**- CCG workshops completed with localities **31 May 2014**- Practices confirmed participation in the ES **31 July 2014**- Telephone access/ by pass numbers confirmed and communicated **30 September 2014**- Personalised care plans in place for all patients initially added to the register **30 April 2015** -Practices submit final end of year report **June 2015** - Evaluation	1. A&E attendances for practice populations 2. Emergency admissions for practice population	1. Contribute to a reduction in A&E attendances and unplanned admissions to hospital 2.Reduce readmissions to hospital within 91 days. 3. Identification of an improvement plan for hospital discharge processes	The funding to support this service has been taken from the retirement of the quality and productivity (QP) domain of the Quality and Outcomes Framework (QOF) and the 2013/14 Risk Profiling and Care Management ES which ceased on 31 March 2014. Funding requirement for risk stratification for 2015 TBC.
			The strategic objective of the Community and Care			**Sept '14** continue roll out and	An initial prototype has been in	1. Reduce A&E attendances	

Programme Overview v6 10/09/2014

		Date	01/09/2014				Group Name	Better Care Fund										
		Originator	K. Allward				Version	v1.1										
Scheme	Milestone	Scheme Status	Sept '14	Oct '14	Nov '14	Dec '14	Jan '15	Feb '15	Mar '15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Scheme Leads				
A1 - Integrated Fall Prevention		Scoping												Miranda Ashwell				
	Launch 'Outline Business Planning' - Stakeholder event																	
	Development of Detailed Business Plan including setting of targets against baseline data and identifying investment required																	
	Prototype Phase - Phase 1 implementation																	
	Prototype Phase - Phase 2 implementation																	
	Prototype Phase - Phase 3 implementation																	
	Interim evaluation																	
B1 - Proactive Care Programme		Prototype												Nina White				
	Personalised care plans in place for patients added to the register																	
	Evaluation																	
	Closure - Close down or agree recurrent funding & commissioning specification																	
B2- Community & Care Coordinators		Evaluation												Tracey Savage				
B3- Care Home Advanced Scheme		Evaluation												Tracey Savage				
B4 - Team around the practice		Scoping												Nina White				
	Scoping exercise																	
	Outline Business Plan developed																	
	Development of detailed business plan																	
	Phase 1 prototype																	

Risks & Contingency

Partnership agreement to be developed by October 2014.
Principles that are likely to be included:

Contingencies

- Non commitment of Pay for Performance element of the fund
- Integration efficiencies
- Review and renewal of contracts
- In year slippage through phased implementation

Risk Sharing

- Collective responsibility for delivery
- Financial risks managed within pool in first instance
- Financial risks shared on basis of relative contributions
- Shared risk of maintaining other services if related activity levels continue to grow
- H&WB Board will make recommendations to trigger new risk share agreements

Alignment

- Brings together existing integrated activity & transformation schemes
- Aligns CCG 2yr Operational and 5yr Strategic Plans, Council Business Plan & Financial Strategy and the Health & Wellbeing Strategy
- Alignment with Primary Co-commissioned
  - Home is normal
  - Sustainability of services
  - Empowerment of patients, clinicians and communities
  - Future proofing our future through new ways of working

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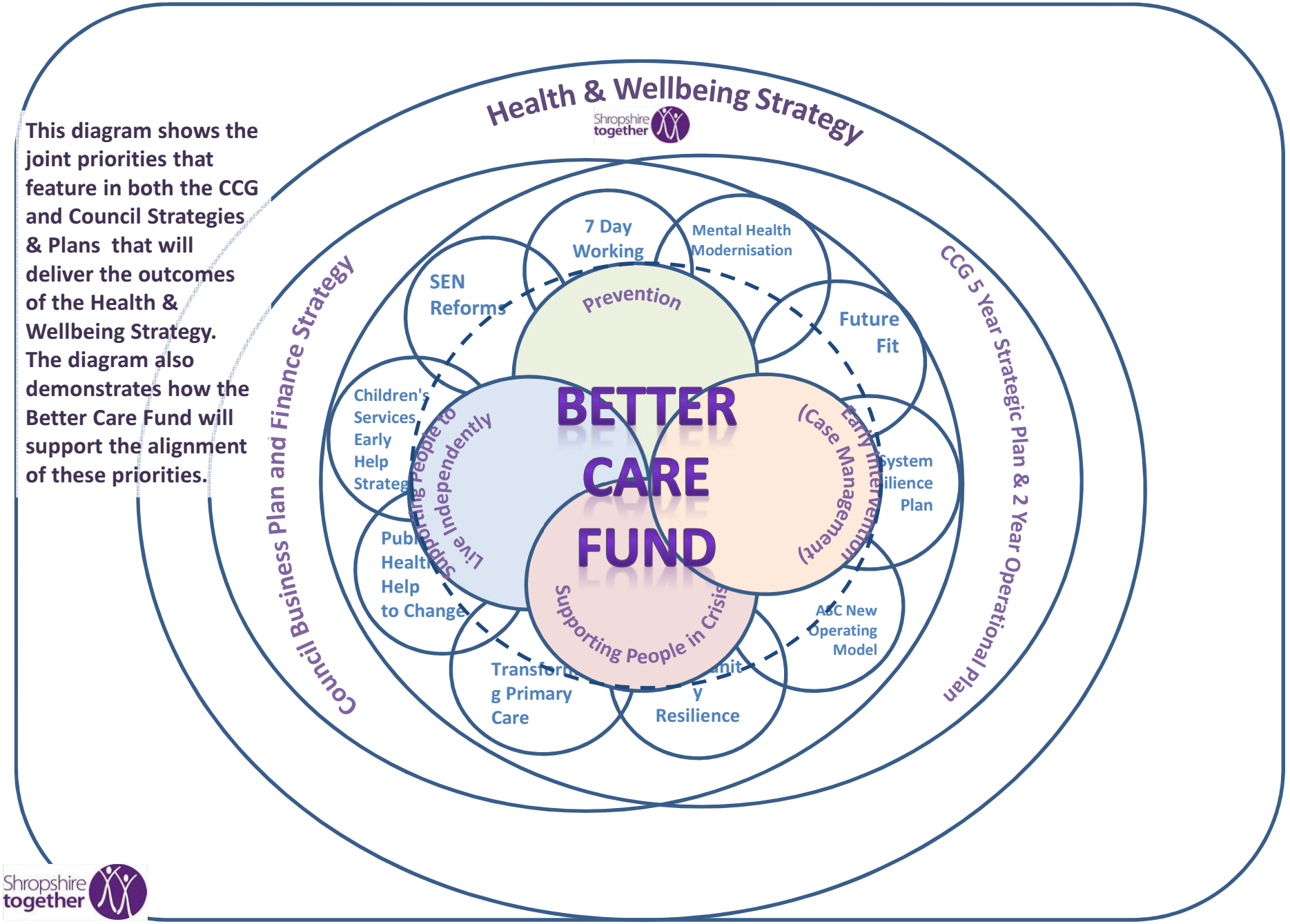
Local Health & Social Care Economy Alignment v10

This diagram shows the joint priorities that feature in both the CCG and Council Strategies & Plans that will deliver the outcomes of the Health & Wellbeing Strategy. The diagram also demonstrates how the Better Care Fund will support the alignment of these priorities.



National Conditions
Protecting Social Care Services

- Maintaining eligibility
- Protecting services for most vulnerable
- Better Care Fund supports local authority priorities:
  - Supporting people with dementia
  - Support for carers
  - Promoting independence
  - Resilient communities
  - Early intervention and prevention
- £758,000 Care Act implementation costs supported through BCF
- Resources dedicated to carer specific support

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National Conditions
7 Day Services to Support Discharge

- Evidence of engagement with the action plan to deliver 7 Day services from all providers
- Services in BCF aligned to provide support over 7 Days to support discharge
- Output from cross – economy workshop

National Conditions
Data Sharing

- Plans in place across organisations to use NHS Number as primary identifier
- IG Controls in place to cover NHS standard contract requirements
- Health & Social Care pilot launched to accelerate sharing of pseudonymised data
- Bid for Integrated Care Record in progress

National Conditions
Joint Assessment & Accountable Lead

- All 44 Practices registered to participate in Enhanced Service – Proactive Care Programme
- Processes in place to identify most at risk patient at practice level.
- Processes developing for joint assessment/care planning and allocation of a lead professional – some more advanced than others
- Transformation Schemes prioritised in the Early Intervention (Case Management) Strategic Theme support this approach

Engagement

- Engagement with Patient & Service Users through established engagement channels:
  - Website
  - Healthwatch
  - Health & Wellbeing Alliance
  - Call to Action
  - Patient Participation Groups & Young Health Champions
  - Live Life Your Way
  - Making it Real

- Engagement with providers through:
  - Development of Transformation Schemes
  - Better Care Fund Reference Groups
  - Health Economy Board Chairs and Non – Executive Group
  - Primary Care Locality Board Meetings

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Finance & Performance Template

- Budgets Aligned: 14/15 - £12,128 & 15/16 - £21,451
- Payment for Performance linked to non-elective admissions £2.8m
- Economy plan to reduce non-elective admissions by 6.1% (3.1% Net of growth) This equates to 1766 admissions
- Supporting targets (proposed) – see next slide
- Local Metrics

Residential Admissions Target

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**749.2**	**671.5**	**623.7**
	Numerator	500	476	453
	Denominator	66,475	70,883	72,635
		Annual change in admissions	*-24*	*-23*
		Annual change in admissions %	*-4.8%*	*-4.8%*

Reablement Target

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**76.8**	**80.6**	**81.9**
	Numerator	120	125	127
	Denominator	155	155	155
		Annual change in proportion	*3.8*	*1.3*
		Annual change in proportion %	*5.0%*	*1.6%*

Delayed Transfers of Care Target

Delayed transfers of care

Metric		13-14 Baseline Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	14/15 plans Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 plans Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	919.7	697.2	433.3	662.3	919.6	697.1	433.0	662.2	919.4	696.7	432.7	661.9
	Numerator	2,286	1,733	1,077	1,658	2,302	1,745	1,084	1,668	2,316	1,755	1,090	1,677
	Denominator	248,550	248,550	248,550	250,337	250,337	250,337	250,337	251,893	251,893	251,893	251,893	253,354
								Annual change in admissions	*45*			*Annual change in admissions*	*39*
								Annual change in admissions %	*0.7%*			*Annual change in admissions %*	*0.6%*

14/15 plans Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 plans Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
919.6	697.1	433.0	662.2	919.4	696.7	432.7	661.9
2,302	1,745	1,084	1,668	2,316	1,755	1,090	1,677
250,337	250,337	250,337	251,893	251,893	251,893	251,893	253,354
		Annual change in admissions	*45*			*Annual change in admissions*	*39*
		Annual change in admissions %	*0.7%*			*Annual change in admissions %*	*0.6%*

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Finance & Performance Template

- 2 Local measures to be agreed
- Patient/Service User Experience metric
  - Mental Health Crisis Care Out of Hours Contact – Baseline 5/10 (CQC Mental Health Survey)
  - Support received to support with long term condition – Baseline 64% (GP Patient Survey)
  - Enough help and support by the health care team at the actual time of death? – Baseline 59.7 (GP Patient Survey)
  - Hospital staff discussing if health or social care services were required on discharge from hospital Baseline 8/10 (CQC Inpatients Survey)
- Dementia Measure
  - Number of people admitted to Redwoods with a diagnosis of Dementia – Baseline TBC
  - % of People screened and referred onto specialist dementia services on admission to hospital