Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 3 September 2015

Committee:
Health and Wellbeing Board

Date: **Friday, 11 September 2015**
Time: **9.30 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Health and Wellbeing Board

Karen Calder (Chairman)
Ann Hartley
Lee Chapman
Professor Rod Thomson
Stephen Chandler
Karen Bradshaw
Dr Caron Morton (Vice Chairman)
Dr Helen Herritty
Dr Bill Gowans
Paul Tulley
Jane Randall-Smith
Rachel Wintle

Your Committee Officer is:

Karen Nixon Committee Officer
Tel: 01743 257720
Email: karen.nixon@shropshire.gov.uk

AGENDA

1 Apologies for Absence and Substitutions

2 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes (Pages 1 - 8)

To approve as a correct record the Minutes of the previous meeting held on 31 July 2015, which are attached.

Contact Karen Nixon Tel 01743 257720.

4 Public Question Time

To receive any questions, statements or petitions from the public, notice of which has been given in accordance with Procedure Rule 14.

5 Better Care Fund Update September 2015 (Pages 9 - 30)

Urgent Care Delivery

Admission Avoidance

A progress report is attached.

Contact Stephen Chandler, Director of Adult Services Tel 01743 253704 or Sam Tilley, Head of Partnership and Planning, Shropshire CCG on 01743 277545.

6 Community & Care Co-ordinators Project (Pages 31 - 34)

A report is attached.

Contact Stephen Chandler, Director of Adult Services, Tel 01743 253704.

7 Update on Integrated Community Services (Pages 35 - 42)

A report is attached.

Contact Stephen Chandler, Director of Adult Services Tel 01743 253704 or Kerrie Allward, Service Manager, Short Term Support Tel 01743 277581.

8 Urgent Care Recovery and Delivery of Winter Access

A presentation will be made.

Contact Dr Caron Morton, Accountable Officer, Shropshire CCG Tel 01743 277581.

9 Health and Wellbeing Strategy - Progress Update

A progress will follow.

Contact: Penny Bason, Health and Wellbeing Co-ordinator Tel 01743 253978 or Stephen Chandler, Director of Adult Services Tel 01743 253704.

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Shropshire Council

Committee and Date

Health and Wellbeing Board

11 September 2015

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING
HELD ON 31 JULY 2015
9.00 - 11.00 AM

Responsible Officer: Karen Nixon
Email: karen.nixon@shropshire.gov.uk Tel: 01743 257720

Present
Professor Rod Thomson, Karen Bradshaw, Dr Caron Morton (Vice Chairman and Chair for the meeting), Paul Tulley, Jane Randall-Smith, Rachel Wintle and Ruth Houghton (substitute for Stephen Chandler).

Also in attendance/observing:
Jan Ditheridge, Ellie Johnson, Lindsay McHardy, David Sandbach, Madge Shineton and Dave Tremellen.

22 **Apologies for Absence and Substitutions**

Apologies for absence were received from Karen Calder, Stephen Chandler, Lee Chapman, Dr Bill Gowans, Dr Helen Herritty and Gerald Dakin.

Ruth Houghton substituted for Stephen Chandler.

23 **Disclosable Pecuniary Interests**

Members were reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

24 **Minutes of Previous Meeting**

RESOLVED: That the minutes of the meeting held on 19 June 2015, be approved as a correct record and signed by the Chairman.

Following the recent loss of Karen Calder's husband Robbie, the meeting held a minutes silence as a mark of respect.

25 Public Question Time

One public question was received from Mr David Sandbach on involving the local Fire and Rescue Service in delivering integrated care services. A full copy of the question and the formal response was circulated at the meeting (copy attached to the signed minutes).

By way of a Supplementary Question, Mr Sandbach asked if the Fire Service could be included in the new work stream being headed up by Cllr Lee Chapman with Community Fit. He also requested that the group consider having a representative on it from the Housing sector.

It was agreed that these suggestions would be taken forward.

26 Better Care Fund Update & Performance

The Head of Partnership and Planning, Shropshire CCG, gave a brief verbal update on progress with the work of the Better Care Fund and Performance. In doing so she confirmed that there had been no significant changes on performance data since the last meeting. Work to agree targets for non-elective admissions continued. Shropshire continued to use the agreed target from the Better Care Fund submission, following a recent review by NHS England.

Looking more widely, delayed transfer of care (dtoc) continued to be an area of concern. Work was ongoing to improve this.

27 Community Fit

The Chief Operating Officer, Shropshire CCG, introduced and amplified a report, copy attached to the signed minutes on the first phase of Community Fit; a work programme to understand and quantify the consequences to the wider health and social care economy of the proposed Future Fit hospital reconfiguration programme.

The first phase of Community Fit was about gathering data and understanding community need. A Steering Group had been convened with partner representation.

Key points raised included;

- This would be managed as part of the Future Fit Programme, but may need it's own governance in the future.
- Next phases have yet to be determined.
- Important for the Health and Wellbeing Board (H&WB) to ensure and support Community Fit links in with other programmes in the Better Care Fund.

It was noted that this first phase should be complete by the end of October/November 2015.

RESOLVED:

That the report be received by the Health and Wellbeing Board and that through the Steering Group and work stream members, the relevant linkages be made to the existing programme of work. To facilitate this, Community Fit Steering Group members include Penny Bason, Health and Wellbeing Co-ordinator and Cllr Lee Chapman who has been asked to Chair the voluntary and 3rd sector work stream.

28 Healthwatch Quarterly Update

The Chief Officer, Healthwatch, introduced and amplified a report, copy attached to the signed minutes, on the outcome of its Annual Report for 2014/15 and also on the Reflective Audit (unpublished), that had been undertaken to find out how others viewed its effectiveness to date. The findings would inform the forward work programme for 2015/16.

Main points noted were;

- Enter and View was now established and reports could be found on the website.
- Healthwatch intelligence feeds into Care Quality Commission (CQC) prioritisation.
- Carers Respite and Opthamology were recent key areas of work.

Community engagement was doing well. The challenge now was to prioritise work. It was noted that a monthly 'hot topics' approach was to be introduced, which was welcomed.

The profile of Healthwatch still appeared to be an issue and this needed to be built upon. It was suggested that through the Communication Sub-Group the profile of Healthwatch could be promoted both within the Council and with partner organisations.

RESOLVED: That the report be noted and partner organisations would help support the profile raising of Healthwatch.

29 Health and Wellbeing Board Strategy Framework

The Health and Wellbeing Co-ordinator introduced and amplified a report, copy attached to the signed minutes - on progress with the Health and Wellbeing Strategy. The Board were asked to discuss the paper and confirm how they wished this to be taken forward. There was a vision and the priorities were set out in the report. Members were asked to confirm if they endorsed this or not.

The Board first looked at how the work was to be undertaken and it was agreed that this needed to be clear. Generally the Board was happy with the new strategy and in brief, Members made the following suggestions/observations;

- That JSNA and Child Poverty should be included within the Strategy.

- It was agreed that the priorities within the Strategy could be included under the heading of prevention as prevention flowed across everything.
- The Board was keen for this to be a long-term strategy and fully endorsed Health Resilience as the number 1 priority.
- At page 7, it was requested that the language in the text around care services needed to be tweaked slightly and that Housing needed to be an enabler.
- Provider partners requested inclusion of the Strategy at their Board meetings and the Health and Wellbeing Co-ordinator confirmed that this would happen as part of the Communications and Engagement Strategy.

In addition to the recommendation from the Peer Challenge about establishing a strategic forum for mental health, it was requested that a similar forum be set up for dementia. It was pointed out that there was already a Dementia Steering Group which involved both Shropshire and Telford and Wrekin councils with the CCG and the Chair warned of setting up too many similar groups. It was generally agreed to give dementia a focus, but there was a reluctance to set up another group.

RESOLVED:

a) That subject to the foregoing, the vision, the priorities and the approach contained within the report be approved.

b) That a further progress report be made on this to the next Health and Wellbeing Board meeting on 11 September 2015.

30 **Healthy Child Programme Health Visiting Report**

A presentation by the Public Health Lead, Children and Young People Team on the Healthy Child Programme: Commissioning was received and welcomed by the Board – a copy of the presentation is attached to the signed minutes.

This outlined the HCP (Healthy Child Programme) which was the main universal health service for improving the health and wellbeing of children from birth to age 19, through health and development reviews, health promotion, parenting support and screening and immunisation programmes.

From the 1 October 2015, local authorities would take over responsibility from NHS England for planning and paying for public health services for babies and children up to 5 years old. School nursing was already commissioned through the local authority.

The Governance structure was set out and within this, the accountability structure was set out too. It was requested that a link be put in to show the connection to the Quality Surveillance Group (QSG), which was duly agreed.

Briefly HCP Public Health Commissioning in Shropshire covered;

- Health Visiting Service
- Healthy Start – Vitamin Scheme

- School Nursing Scheme
- National Child Measurement Programme

Expected outcomes were;

- Improved quality of service
- Improved experiences of services
- Improved health and wellbeing outcomes
- Contribution to improved broader outcomes

It was noted that commissioning with partners such as Children's Services, Shropshire CCG, cross-border County opportunities and the Healthy Child Programme Partnership Board took place.

It was highlighted that in re-commissioning services in future, there would be opportunities to re-design how things were done. At this point it was specifically requested that the language used in letters to parents about under and overweight children be more sensitive in future. This was noted and it was explained that previously a national letter template had to be used, but with the recent changes, it was an area that could now be looked at and improvements made.

Local JSNA Children's data was also shared with the Board and was duly noted.

In respect of reporting mechanisms, it was agreed that it would be good to receive information at 1 or 2 meetings per year to discuss this altogether and take stock of similar areas such as Looked After Children.

It was also agreed that the strategic direction of Joint Collaboration was an approach that the Board could endorse.

RESOLVED: That subject to the foregoing, the presentation be received and noted.

31 **Looked After Children**

The Board received a report on Looked After Children (LAC), Health Inequalities, and the role of the recently published statutory guidance (March 2015) – copy attached to the signed minutes - which was introduced and amplified by the Designated Nurse for LAC.

The national guidance provided a clear framework for local areas to use to work towards improving health outcomes for LAC and reduce health inequalities within this vulnerable group of children, which was welcomed by the Board.

The following areas were briefly discussed by the Board;

- LAC population of Shropshire – there was a high percentage of residential LAC in the county compared to the rest of the country and that in turn meant they often had very complex needs.
- An explanation of the reasons for inequalities in health experienced by LAC

- The key points of the statutory Guidance which comprised the inclusion of LAC in the JSNA and Health and Wellbeing Strategy.

The Chair thanked the Designated Nurse for her informative report. It was noted that adequate resources were required, especially bearing in mind the huge impact on the CCG and GP services (continuity of care) and the impact on education too.

RESOLVED: That the Health and Wellbeing Board would address the health inequalities experienced by the LAC population in Shropshire by using the framework provided by the statutory guidance – published in March 2015.

32 Young Health Champions Update

The Board received a presentation by six Young Health Champions who were part of a health project supported by Shropshire Council's Children's Services and Shropshire's Clinical Commissioning Group (CCG) in partnership with Shropshire and Telford NHS Trust and other health organisations to recruit and train 300 young people to become health champions for children and young people.

Young Health Champions are health advocates on behalf of their peers. They also act as consultants to local health providers, offering advice on how to make their services better targeted to the needs of young people through;

- working with other young people to help to set up and support new health projects.
- becoming an active and key partner working with health organisations to help shape health services for young people.
- influencing young people to live healthier and active lives and provide peer support and a voice for young people around health issues.

To highlight their work, the Young Health Champions spoke in detail about 3 main projects out of 42 health projects that they were currently working on;

- **Diabetes Project (DiaBEATit)** – looking at Type 1 and Type 2 diabetes.
- **Mission Impossible** – a bus/transport project, which included a 'digital badge' for Year 6 and 7's.
- **Adolescent Help Line** – looking at mental health, CAHMS and setting up a call line for teenagers to fill a gap in service.

The Young Health Champions welcomed the offer from the Board of promoting their diabetes project and the Helpline number and the Accountable Officer CCG offered to supply the Champions with leaflets to help young people access GP services.

RESOLVED: That the presentation be noted.

33 **Corporate Parenting Strategy (for information only)**

The Board received the report of the Director of Children's Services, containing Shropshire Council's Corporate Parenting Strategy 2014-2016 - copy attached to signed minutes.

RESOLVED: That the contents of the Corporate Parenting Strategy 2014-16 be noted.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

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Health and Wellbeing Board
11 September 2015

BETTER CARE FUND UPDATE SEPTEMBER 2015

Responsible Officer Stephen Chandler
Email: stephen.chandler@shropshire.gov.uk

1. Summary

1.1 The Better Care Fund (BCF) was officially launched in April 2015 as a mechanism for developing and improving commissioning between health and social care. The Health and Wellbeing Board will be familiar with the Better Care Fund Plan developed with Health & Wellbeing stakeholder involvement to take forward our local vision for the Fund as approved in the autumn of 2014.

1.2 This report serves to update the Board on recent developments in the implementation of the BCF plan focusing on updates from the Service Transformation Group and Finance, Contract and Performance Group.

2. Recommendations

2.1. That the Health and Wellbeing Board note the contents of this report.

REPORT

3. Service Transformation Group

3.1 Whilst the Service Transformation group has not met over the summer months, this time has been utilised to begin to develop more refined processes for the day to day management of BCF schemes, their review, approval and/ or cessation. In particular this work has focused on removing as much duplication across organisations in the bureaucracy of the scheme review and approval processes and to develop a single integrated process for this that satisfies both the CCG and the Councils governance and approvals processes. Significant progress has been made and this work will culminate in an extraordinary meeting of the BCF Task & Finish Group later in September and to finalise this process for presentation to the Heath & Wellbeing Board.

3.2 Further to this work has begun to develop potential schemes for 2016/17. One of the difficulties identified in 2015/16 is quantifying the impact of some of the current BCF schemes. Whilst all are valuable in contributing to the outcomes of the BCF plan, for a number of the schemes it has proved challenging to accurately demonstrate their impact in relation to the BCF performance metrics and it is possible that there are other schemes or potential schemes that will be more suited to this. This work will be taken forward via a focused BCF workshop early in October.

3.3 The BCF Reference group has met and agreed a new focus on regular updates and communication with providers and to secure their input into developing work around

implementation of the plan. A new schedule of meetings is being set, commencing in early October

The BCF manager post has been advertised and interviews will be held in early October

4. Performance, Finance & Contract Group

4.1 The group has continued to monitor BCF spend and performance. In particular the recent focus has been on the preparation and submission of the Q1 performance report to NHS England (attached) Local reporting continues to be undertaken on a monthly basis, the latest local report is also attached.

4.2 Performance summary:

4.2.1 As these reports show the Non Elective admissions target for Q1 was not met and as a result no payment for performance monies could be released. In addition to this the Delayed Transfers of Care target continues to be rated red. Work continues to focus on addressing both these performance metrics and this will be an area of particular focus in the BCF workshop noted earlier in this report.

4.2.2 Performance against the Residential Admissions target remains green for the second quarter in a row and the reablement target is amber.

4.2.3 Of note on the NHS England submission template is the reporting on the local metrics. As the narrative states this template asks for quarterly phasing against these targets which were not required in the original BCF submission. The local targets selected for Shropshire do not lend themselves to quarterly reporting but will result in an annual performance position. This has been highlighted and the expected date for reporting noted.

Financial monitoring demonstrates that the BCF financial plan remains on track.

5. Summary

5.1 Work continues in relation to developing processes to work in a more integrated way across the CCG and Council to deliver the BCF objectives, with a particular focus on developing the BCF offer for 2016/17. Performance against the BCF metrics remains mixed with the BCF performance summary echoing the system wide concerns regarding non elective admissions and Delayed Transfers of Care. These will continue to be subject to detailed scrutiny over the coming weeks and will be the focus in developing BCF schemes for 2016/17

Better Care Fund Performance Report - August 2015

BCF 1 - Non Elective Admissions:

	Jan - Mar 2015			Apr - Jun 2015			Jul - Sep 2015			Oct - Dec 2015		
2015/16	Actual	7199	G	Actual	7429	R	Actual			Actual		
	Plan:	7252		Plan:	7143		Plan:	6559		Plan:	6684	
	Annual Plan 27,638								Cumulative to Date		14628	

BCF 2 - Residential Admissions

	Q4 2014/5	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	548.8					239.6							

Status		Forecast	

BCF 3 - Reablement:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15						R	A	A	A	A	A	A
2015/16	A											

BCF 4 - Delayed transfers of care: delayed days

	Q4 2014/5	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	R	R	R	R									

Status	R	Forecast	R

BCF 5 - Patient / Service User Experience Metric. The next survey will be run Feb to June 2015.

	13/14 Baseline	14/15 Plan	15/16 Plan
Plan		**50%**	**70%**
Result	50.0%		
Num	146		
Denom	292		

BCF 6 - Local Metric

Local people admitted (unplanned) to Redwoods Hospital with a diagnosis of dementia as a proportion of those with a dementia diagnosis

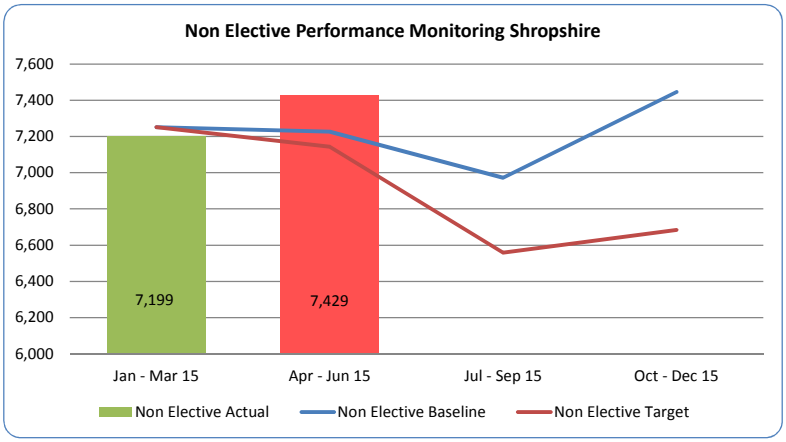
	13/14 Baseline	14/15 Plan	15/16 Plan
Plan		**1.4%**	**1.2%**
Result	1.6%	1.4%	1.2%
Num	41	40	38
Denom	2624	2936	3258

Summary:

BCF 1 - Non Elective Admissions

Emergency Admissions to hospital

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	
Target								7,252	7,143	6,559	6,684	
Actual					7,227	6,973	7,446	7,199	7,429	0	0	



Rationale:

Performance Comments: Performance for April to June is below plan. Please note data is Provisional. Year to date performance is 1.6% behind plan, performance in the 2nd half of the year needs to reduce the number of NE admissions to 13,010 in order to achieve target.

Cumulative performance plan is to achieve a reduction in Non Elective Admissions by **1260** during 2015. This measure will be reported quarterly. The revised NEL figures have now been agreed with NHS England (July 2015)

Definition: Sum of Non Elective FFCE's for the Contributing CCG's as per the BCF Template. Source: Unify2.

RAG Rating - until confirmation is received the RAG rating is; Red = non elective admissions is over target - Green = non elective admissions is under target

Definition:

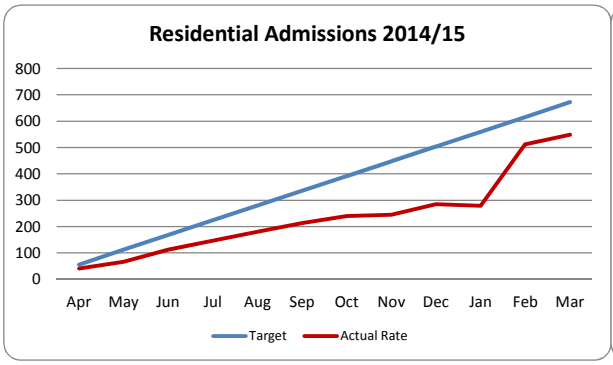
BCF 2 - Residential admissions

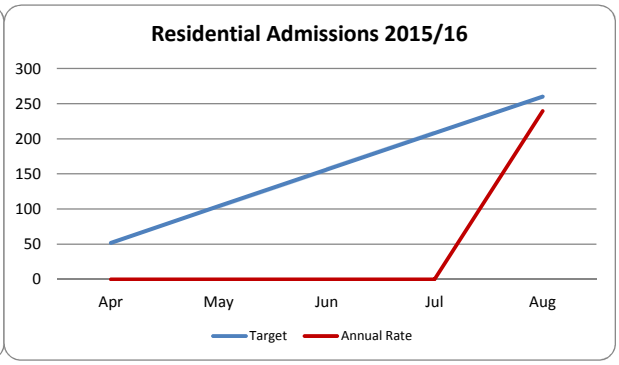
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 older population

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	52	104	156	208	260	312	364	416	468	520	572	623.7
Annual Rate	0	0	0	0	239.6	0	0	0	0	0	0	0
Number	0	0	0	0	174	0	0	0	0	0	0	0
Population	72635	72635	72635	72635	72635	72635	72635	72635	72635	72635	72635	72635

Status | Forecast

Data in accordance with new paperwork in line with the SALT Return - provisional figure shown





Rationale: Avoiding permanent admissions into care homes is a good measure of delaying dependency. Our focus, therefore, is to keep admissions as low as possible, particularly inappropriate admissions.

Performance Comments:
First available data shows that August performance is better than target. Figures are subject to data validation with the the service areas and may be revised in future reporting periods.

Definition: Rate of admissions per 100,000 people
Numerator: Number of older people aged 65+, admitted into permanent residential/nursing care, during the year. Source: SALT Return.
Denominator: Total number of older people, aged 65+, in Shropshire. Source: ONS Mid Year Estimate.

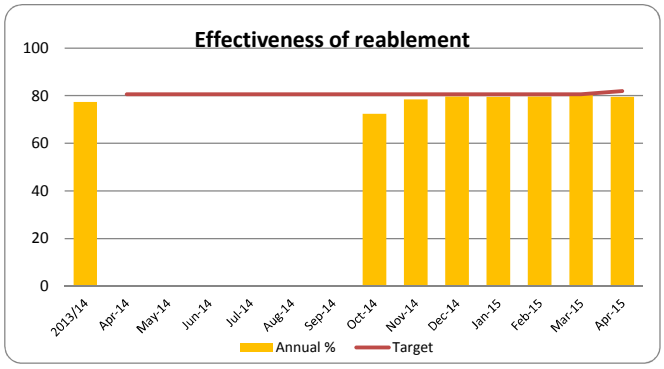
BCF 3 - Reablement

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Target	81.9	81.9	81.9	81.9	81.9	81.9	81.9	81.9	81.9	81.9	81.9	81.9
Annual %	79.5	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Number	116	0	0	0	0	0	0	0	0	0	0	0
Population	146	0	0	0	0	0	0	0	0	0	0	0

Status	A

Forecast	A



Note: In year data is **cumulative.**

Definition: Proportion of older people discharged from hospital into reablement services, who are still at home 91 days' later.
Numerator: Number of older people (65+), within the denominator, who are still at home 91 days' after their discharge.
Denominator: Total number of older people (65+) discharged from hospital into reablement services.

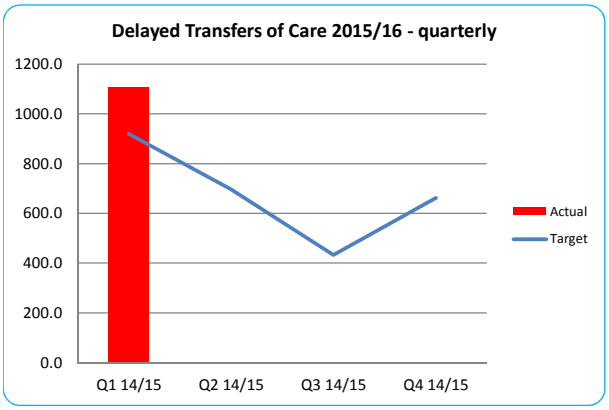
We are continuing to improve both the volume and effectiveness of our reablement service. Performance shown, is cumulative, since October, and was close to the year end target 80.3% compared to the target of 80.6% Performance in February and March was better than target.

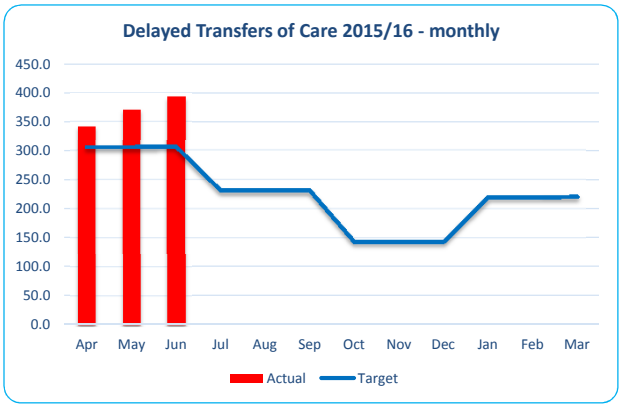
BCF 4 - Delayed transfers of care

Delayed transfers of care **(delayed days)** from hospital per 100,000 population (aged 18+). Reported one month in arrears.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	306	306	307	232	232	232	144	144	144	220	220	221
Monthly Rate	343.0	372.0	393.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Number	864	937	991	0	0	0	0	0	0	0	0	0
Population	251893	251893	251893	251893	251893	251893	251893	251893	251893	253354	253354	253354

	Q1	Q2	Q3	Q4
Target 15/16	919.4	696.7	432.7	661.9
Quarterly Rate	1108.4	0.0	0.0	0.0
Number	2792	0	0	0
Population	251893	251893	251893	253354





Rationale: This measures the effectiveness of joint working arrangements at the interface between Health and Social Care Services. Aim to keep delays to a minimum.

Performance Comments: Performance for the first quarter reporting period is lower than profile.
The RAG rating tolerance for this measure needs to be agreed.

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Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 28th August 2015

This Excel data collection template for Q1 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on local metrics. It also presents an opportunity for Health and Wellbeing Boards to register interest in support. Details on future data collection requirements and mechanisms will be announced ahead of the Q2 2015/16 data collection.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Local metrics - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) Narrative - this allows space for the description of overall progress on plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the 2014-15 Q4 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously you can selection 'Not Applicable' this time.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4. Three figures are required and one question needs to be answered:
Input actual Q1 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell L12
Input actual value of P4P payment agreed locally - Cell D23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Input actual value of unreleased funds agreed locally

This section also requires indication of the area of spend that unreleased funds have been spent on for Q4 and Q1 using a drop-down list. If no funds were left unreleased then 'Not Applicable' should be selected.

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Planned and forecast income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1
Planned and forecast expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure into the pooled fund in Q1

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Local metrics

This tab tracks performance against the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In both cases the metric is set out as defined in the approved plan for the HWB and **the following information is required for each metric:**

Confirmation that this is the same metric that you wish to continue tracking locally
Confirmation of planned performance for each quarter of 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Confirmation of actual performance for Q1 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Commentary on progress against the metric and details of any changes to the metric including reference to reasons for changing

7) Understanding Support Needs

This asks what the key barrier to integration is locally and what support might be required in delivering the six key aspects of integration set out previously. This section builds upon the information collected through the BCF Readiness Survey in March 2015. HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Comments	Any unreleased funds were used for: Q4 14/15	Any unreleased funds were used for: Q1 15/16
Yes	Yes	Yes	Yes	Yes

I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the total yearly plan and the pooled fund
Income to	Plan	Yes	Yes	Yes	Yes	Yes
	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
Expenditure From	Plan	Yes	Yes	Yes	Yes	Yes
Expenditure From	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
	Commentary	Yes				

Local Metrics

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local performance metric plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local patient experience plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Understanding Support Needs

Area of integration greatest challenge
Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

Narrative

Brief Narrative
Yes

Cover and Basic Details
Q1 2015/16

Health and Well Being Board	Shropshire
completed by:	Samantha Tilley
E-Mail:	samantha.tilley@shropshireccg.nhs.uk
Contact Number:	01743 277500
Who has signed off the report on behalf of the Health and Well Being Board:	Caron Morton, Accountable Officer Shropshire CCG, H&WBB Vice

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	21
6. Local metrics	18
7. Understanding Support Needs	13
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Shropshire

Data Submission Period:

Q1 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q4 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board:

Shropshire

Data Submission Period:

Q1 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Comment			
1) Are the plans still jointly agreed?	Yes			1	1	1
2) Are Social Care Services (not spending) being protected?	Yes			1	1	1
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	Mar-16	Currently all providers have been asked to provide 7 day services plans, whilst these are being developed none have been completed to date. There is a local multi agency working group overseeing this workstream which includes national 7 day facilitators both in a managerial and medical capacity. A mapping exercise is taking place across the county to establish a gap	1	1	1
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes			1	1	1
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes			1	1	1
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes			1	1	1
5) Is there a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes			1	1	1
6) Is there agreement on the consequential impact of changes in the acute sector in place?	Yes			1	1	1

Please select
Yes
No
No - In Progress

National Conditions - Guidance

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

1) Plans to be jointly agreed

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

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) 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

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Shropshire

	Baseline				Plan				Actual				% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment				Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16				Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16			
D. REVALIDATED: HWB version of plans to be used for future monitoring	7,252	7,227	6,973	7,446	7,252	7,143	8,559	8,684	7,199	7,429			4.4%	1,269	£1,877,400	0	84	498	1269	£0	£125,160	£816,860	£1,135,380	53	-202			£0	£0			£1,877,400	£5,577,000	£0

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify	
Cost per non-elective activity	£1,490		

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Quarterly payment taken from above	£0	£0		
Actual payment locally agreed	£0	£125,160		

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	payments are in line with plan

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggest amount of unreleased funds	£0	£125,160		
Actual amount of locally agreed unreleased funds	£0	£0		

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	not applicable	not applicable		

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 6th August 2015. Please note that the data has not been cleaned and limited validation has been undertaken.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Shropshire

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,437,500	£5,437,500	£5,437,500	£5,437,500	£21,750,000	£21,750,000
	Forecast	£5,682,250	£4,881,288	£5,373,046	£5,891,567		
	Actual*	£5,682,250					

Please comment if there is a difference between the total yearly plan and the pooled fund	

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,437,500	£5,437,500	£5,437,500	£5,437,500	£21,750,000	£21,750,000
	Forecast	£4,475,755	£5,283,453	£5,775,211	£6,293,732		
	Actual*	£4,648,000					

Please comment if there is a difference between the total yearly plan and the pooled fund	

Commentary on progress against financial plan:	Progress against plan shows that the fund is currently on track. Where pressures have bne identified in reation to individual schemes these are being addressed and are at present forecast to come in on plan by the end of the year

Footnote:

Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q4 collection previously filled in by the HWB.

Local performance metric and local defined patient experience metric

Selected Health and Well Being Board:	Shropshire
Local performance metric as described in your approved BCF plan	Number of people admitted (un-planned) to Redwoods Hospital with a diagnosis of dementia as a proportion of those with a dementia diagnosis.
Is this still the local performance metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	0	0	0	0	0	0		

Please provide commentary on progress / changes:	A Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services. Mental Health Care Clusters are 21 groupings of Mental Health patients based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment. The numerator figure that is now provided by CSU for the dementia metric has changed from the "numbers of patients admitted to the Redwoods with dementia" to the number of care cluster days (care clusters 18-21 =

Local defined patient experience metric as described in your approved BCF plan	Mental Health Crisis Care Out of Hours Contact Number. (CQC Community Mental Health Survey) This measures the number of people out of every 10 surveyed who respond that they have a number to contact in case of a MH crisis out of hours.
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	0	0	70	0	0	0		

Please provide commentary on progress / changes:	In line with the original target submitted in September 2014, this metric is based on the results of an annual survey and therefore reports only once at a fixed pint in each year. The information set out in the table above (as a percentage figure) reflects this. Performance data for 2015/16 will not be available until Q2 (September 2015). However, performance at Q2 2014/15 demonstrates a 5% improvement againts our 2013/14 baseline

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board: Shropshire

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	1.Leading and Managing successful better care implementation

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Workshops or other face to face learning opportunities	system approach. Support would be helpful in relation to sharing of best practice or innovation from other areas that have had success in implementing 7 day services in both acute and community settings (including primary care and social care) . Also it has
2. Delivering excellent on the ground care centred around the individual	No		
3. Developing underpinning integrated datasets and information systems	No		
4. Aligning systems and sharing benefits and risks	Yes	Workshops or other face to face learning opportunities	
5. Measuring success	Yes	Workshops or other face to face learning opportunities	
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Workshops or other face to face learning opportunities	be shared from areas who have made improvements in this area. In particular other areas across the country who have implemented the “Breaking the Cycle” initiative and what they learned and any implementation plans for change.

Narrative

Selected Health and Well Being Board:

Shropshire

Data Submission Period:

Q1 2015/16

Narrative	Remaining Characters	32,209

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time with reference to the information provided within this return where appropriate.
During Q2 Work has continued on implementing the BCF schemes which remain largely on track. Work has also begun on refining our local BCF processes and further streamlining processes and procedures across the Council and CCG to use the opportunity the BCF presents to best effect. A work plan has been outlined to begin work on developments for 2016/17. Of note are the comments contained in the Local metric section of this template which sets out the current developments in relation to monitoring these metrics which were originally set as annual targets.

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Health and Wellbeing Board
11th September 2015

COMMUNITY & CARE CO-ORDINATORS PROJECT

Responsible Officer
Email: Stephen.Chandler@shropshire.gov.uk Tel: 01743 253704 Fax:

COMMUNITY & CARE CO-ORDINATORS PROJECT

1. **Introduction**

1.1 The Community & Care Co-ordinators project is currently on of Shropshire's 11 Better Care Fund Schemes. The C&CC project began as a pilot in October 2012. Initially 26 practices were engaged in the project covering a population of 220,000. The project was introduced to explore how practices might better manage increased demand. It looked specifically at the growing older population and those with long-term conditions and how within the health and social care economy effort can be made to work in a more collaborative and integrated fashion to better support the most vulnerable numbers in the community and reduce demand upon the health and social care economy.

1.2 The aims of the project were founded in the context of increasing prevalence of older people, increasing numbers of people with long term conditions, increasing demand on primary care, increasing hospital admissions and a growing awareness of the impact unmet health and social care need, isolation and loneliness can have on the health and well-being of individuals. Following the presentation of the project evaluation paper of October 2013 to Shropshire CCG's Clinical Assurance Panel, it was decided in the summer of 2014 to roll the project out to as many of the 44 Shropshire practices as possible.

1.3 There are currently 40 practices (population 288,062) participating in the project although not all practices have their positions filled. The project is running with four vacant positions (10%). There are discussions with a further two practices and it is hoped that in the near future we can have 100% take up by all of Shropshire CCG practices. A more recent development has been the response of the Care Quality Commission's (CQC) inspectors when carrying out inspections of Shropshire medical practices. In the last four inspections they have highlighted the role and function of the C&CCs as 'outstanding practice' giving them specific mention in the final report.

2. Recommendations

- The Health and Wellbeing Board is asked to note the progress and positive impact of the Community & Care Co-ordinator project to date
- The Health & Wellbeing Board is asked to endorse the view from the Better Care Fund Performance, Finance and Contracts Group that the project should move to a position of recurrent funding.

REPORT

3. Purpose of Report

3.1 To provide an update on the progress of the Community & care Co-ordinators Project and to highlight the request for recurrent funding.

4. Background

4.1 The C&CC provides a focal point to build on the resources and networks of the community to support people to live independently for longer, ensure individuals receive the correct level of care rather than placing people in care settings that are of higher dependency than their needs require and have a direct impact on reducing hospital admissions. Evaluation of the project in 2013 assessed information available for 3-months pre and 3-months post intervention by the C&CC. The result of the evaluation was to secure funding to ensure roll-out to other practices in the CCG.

4.2 The current evaluation reported to Shropshire CCG's Clinical Assurance Panel and Quality Performance and Resources Committee is strengthened by virtue of the more longitudinal data available (12-months pre and post-intervention). This data can be made available on request. The evaluation shows that C&CCs have made a difference. It has proved to be a cost-effective way of channelling the unmet social care needs through to the independent and voluntary sector. It has also demonstrated that identifying unmet social care need at an early stage can reduce future demand.

4.3 There is strong evidence that the C&CCs interventions have reduced GP appointments, reduced A&E attendance, reduced hospital admissions, reduced Shropdoc calls and very significantly increased the involvement of the voluntary/independent sector in peoples' lives. However, the current non recurrent funding arrangement compromises the ability of the scheme to operate sustainably and fulfil its full potential, in particular because of the impact on staff working within the scheme.

The project has been viewed positively by NHS England with the likely roll-out nationally.

Discussions are underway with local universities to undertake an academic evaluation

5. Engagement

5.1 Patient, public and voluntary sector involvement is key to the work of this project. Engagement has been undertaken with:

- The LTC Patient Reference Group
- Patient engagement, via patient stories and testimonials

6. Risk Assessment and Opportunities Appraisal (including Equalities, Finance, Rural Issues)

6.1 Performance Implications

- Anticipated reduction in emergency admissions and A&E attendances

Increasing community and third sector involvement in supporting local population

6.2 Quality Implications

- Patients requiring support identified earlier, unmet needs are met earlier
- Regular and improved training and education for primary healthcare team, reducing variation and improved quality
- Closer working relationships to improve patient access to services
- Improved access/use of voluntary sector organisations
- Significant improvement in patient and carer experience, isolation and loneliness, as evidenced by testimonials

6.3 Financial implications

- The full costs assuming participation of all 44 Shropshire practices and including associated travel and support/training costs would be £370,433.38. This equates to £13.33 per hour or £49.72 per session.
- The project has been funded as a pilot; however, evaluation of the pilot shows anticipated cost savings in the range of **£250,000 to £700,000,** after the costs of the project are accounted for. As Community & Care Co-ordinators offer a range of support the savings made may vary from intervention to intervention. This savings range is based on estimates of interventions at these varying levels of complexity
- Recurrent funding has been requested and approved by the CCG and the BCF Finance, Performance and Contract group and the Health & Wellbeing Board is asked to support this position.
- It is also highlighted that if in the future the BCF should cease to exist the ongoing funding of the CCC scheme would revert to the CCG

6.4 HR/Personnel implications

- Currently have 8 vacancies for C&CCs in practices (35 &CCs in total at present), however, if recurrent funding is secured, this situation is likely to change very quickly

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Karen Calder
Local Member all
Appendices None

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Health and Wellbeing Board

11th September 2015

INTEGRATED COMMUNITY SERVICES (ICS) – PROGRAMME UPDATE SEPTEMBER 2015

Responsible Officer Stephen Chandler
Email:stephen.chandler@shropshire.gov.uk

1. Summary

1.1. The Integrated Community Service (ICS) prototype supports discharge from hospital or prevents an avoidable hospital admission by ensuring that people get the right level of support at the right time in order to maintain independence. A team of professionals from different disciplines employed by Shropshire Community Health Trust, Shropshire Council and British Red Cross work together under one leadership structure to support patients and ensure that they receive a seamless service.

1.2. ICS is the flagship service in the Better Care Fund Plan and one of the first models of Integrated Health and Social Care delivery within Shropshire.

1.3. This report will provide the Health and Wellbeing Board with:

1.3.1. An overview of the ICS Prototype to date and remind the board of the key components of the model.

1.3.2. An overview of introduction of the Admission Avoidance pathway that will be launched in North and South Shropshire and relaunched in Shrewsbury in October 2015.

1.3.3. An update of the Strategic Review that was undertaken in May 2015 and the subsequent delivery action plan which will inform the priorities of the ICS prototype as it enters its third and final stage of development.

2. Recommendations

- That the Health & Wellbeing Board note the content of the report and the progress to date.

3. Development of the Integrated Community Service prototype

3.1. In the summer of 2013 a cross-sector project team came together to review how capacity to support complex discharges from hospital could be optimised with the aim of reducing the number of delayed transfers of care, shortening in-patient length of stay for complex patients and increasing the number of people who are discharged home rather than to a bed based setting.

3.2. An in depth analysis of the current state and supporting evidence from studies completed by SaTH, Atos and the Oak Group led the project team to consider the case for change in detail and how services and functions could be better aligned to address some of the challenges that the analysis highlighted. The outcome of its work confirmed the position that the network of bed capacity, resources, care pathways, teams and skills was not optimised, thus creating inefficiencies. An external audit commissioned from the Oak Group also confirmed that a significant number of patients occupying acute and community beds could be cared for in alternative settings, if that capacity was available and appropriately resourced.

3.3. Using local and national research of what works well, the team developed a vision of what success should look like and produced a draft model. The key elements of this relate to addressing the fragmentation, duplication and gaps that exists in our local health and social care economy to support discharge. A health and social care integrated intermediate care model – Integrated Community Services (ICS) was launched in Shrewsbury in November 2013.

4. The ICS First Phase Prototype (November 2013 – October 2014)

4.1. It was intended that the solution would incorporate and integrate services that support discharge activity. Key features of the prototype included:

- Discharge home to assess as the norm
- Single point of access and referrals mechanisms
- Integrated triage, co-ordination and management
- Shared generic assessments that can be completed by any member of the team.
- Integrated interventions provided and/ or co-ordinated by the team
- Shared chronological notes
- Rapid access to advice and assessment
- 7 day service

4.2. The first phase of the prototype concluded in October 2014 and a specification was developed to expand the prototype to the North and South of the County and to introduce acute admission avoidance to the model, prototyping in the Shrewsbury area in the first instance.

5. ICS Operational Model in the Second Phase (November 2014 – October 2015)

5.1. In the second phase, the prototype was rolled out to be delivered across North and South Shropshire and introduced admission avoidance in Shrewsbury. The key components of the ICS Operating model were refined and are listed below.

- A locality based health and social care, community and voluntary sector integrated service with responsibility for complex patients who require health and/or social care support to prevent an acute emergency admission or to facilitate discharge from an in-patient bed.

- The exclusion criteria for the service is:

    - Patients Under 18 Years of age
    - End of Life patients
    - Patients where only a nursing/nursing EMI placement will meet their needs and there is no potential for them to improve – these patients will be assessed by ICS and appropriate alternative services arranged.
    - Patients where existing arrangements can be restarted without further assessment

- The service aim is to provide a rapid response to care delivery in the right place at the right time to maximise a patient's independence deploying the optimum skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs with the default position being for the patient to remain at, or return to, their home.

- The service will provide time limited **assessment**, **rehabilitation**, **reablement** and **treatment (or recovery)** in the community.
- The service will receive referrals through a Single Point of Access.
- The service will operate over 7 days per week, 365 days a year.
    - Operating 8am-8pm, 7 Days per week
    - 1hr or Same day for admission avoidance (indicated by referrer)
    - Discharge facilitated within 24hrs of Fit for Transfer for hospital discharge
- Maintaining people at **home** when they become ill or discharge **home** to assess will be the default position, home being the patients' usual place of residence; this should include those in residential and nursing settings.

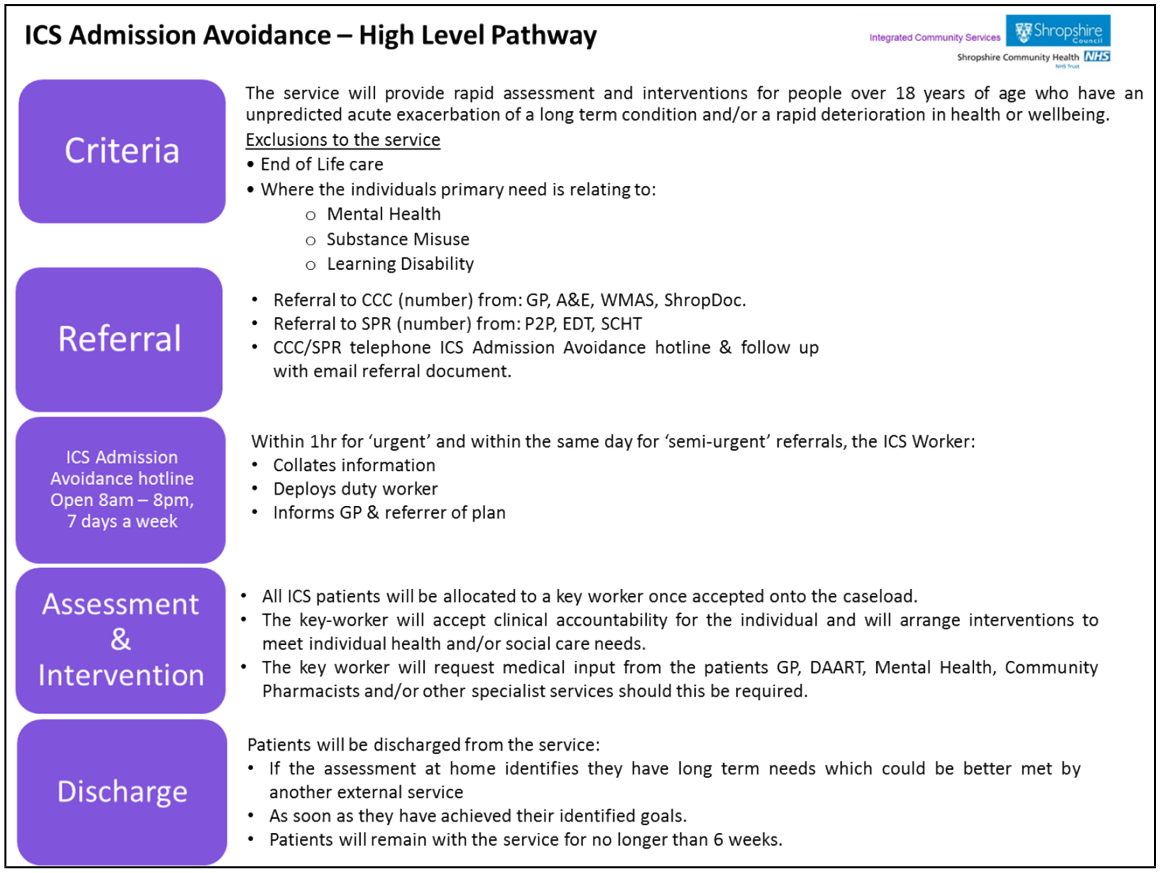
- The service will undertake shared generic assessments, to be completed by any member of the team, so that patients do not have to re-tell their story.

6. Third and final stage of ICS Prototype (October 2015 – March 2016)

6.1. As part of the Second Phase prototype Admission Avoidance was introduced in Shrewsbury in November 2014. The pathway has now been reviewed prior to the introduction of the pathway in North and

South Shropshire. The revised Admission Avoidance pathway has been developed through a multi-stakeholder group, including representatives from ICS, Inter-disciplinary Teams (IDT's), People to People (P2P), Shropshire Clinical Commissioning Group (SCCG), Pharmacy, General Practitioners (GP's), Shropdoc and Shropshire Partners in Care (SPIC).

6.2. The revised pathway now has clearer referral processes into the service and a robust procedure and pathway to be applied by the ICS team to ensure quick response times and improved patient outcomes. A high level view of this is detailed below.



6.3. It is anticipated that subject to approval of both the SCCG Clinical Assurance Panel and the SCCG Quality Department, the Admission Avoidance pathway will be implemented in the North and South of the county and relaunched in the Shrewsbury in October 2015.

7. Strategic Review to inform Third Phase developments

7.1. Further to the review and development of the Admission Avoidance pathway, in May 2015 a comprehensive strategic review of the prototype was conducted. The objectives of the review were to:

- To provide the operational leadership team with a clear understanding of the opportunities and challenges that exist within the ICS prototype.
- To develop a robust action plan to improve the delivery of the prototype within its final phase.

- To gather the information required to identify the priorities from key stakeholders in relation to ICS delivery.
- To demonstrate to commissioners that concerns that they have raised have been heard and that Shropshire Community Health Trust and Shropshire Council are committed to working in Partnership to improve the delivery of ICS.

7.2. The review was conducted over 5 days and took the form of the following:

- Staff/Stakeholder Surveys
    - 67 Staff Surveys Completed
    - 15 Stakeholder Surveys Completed
- Walk About – Check, Chase, Challenge
    - Over 10 Locations visited Inc; Community Hospitals, ICS offices in all locations, Independent sector rehab beds etc.
    - Stakeholder 'SWOT' Interviews
    - 12 group discussions with staff and stakeholders including; Commissioners, IDT Team Leaders, Ward Manager, Discharge Liaison, Leadership Teams from Social Care & Community Health etc.
- Review of Team Profile & Activity
    - Discussions with ICS Leadership Team and staff to review current team profile and activity levels in all areas.

7.3. Key Findings of the strategic review

- All stakeholders recognise that the challenges that currently exist are not due to a lack of hard work and commitment from staff.
- Team development, including formal supervision of staff requires significant improvement.
- Recruitment & retention of staff has been problematic, however, with the exception of a few posts, a robust plan to recruit to full capacity is in place.
- Recruitment/redistribution of admin support staff needs to be prioritised.
- The team has a strong sense of the concept of 'purple' and are committed but team behaviour is inconsistent with the vision.
- There are significant accommodation and IT problems across the service which impacts on the delivery of the service.
- Operational processes are not fit for purpose and significantly impacts on the team's ability to deliver against objectives.
- ICS Criteria is not applied consistently across the service.
- ICS pathways and processes are not aligned with the wider Health & Social Care economy and relationships have not been formed.
- Processes to monitor and manage team demand and capacity, budgets and performance are not consistent or robust.

- There are significant delays within the service which is having a critical impact on the ability of the team to maintain flow out of hospitals.
- Communication and engagement within the service and with stakeholders is not adequate.
- The Leadership Team of ICS has not formed or had an opportunity to develop and as a result Leadership approaches are not consistent.
- The lack of clarity over funding streams exposes the service to unacceptable financial risk.
- ICS currently uses 5 data and case recording systems. Improvement/ rationalisation of these systems is critical to the ability of the team to deliver.
- Performance of some critical elements of the service is not captured or monitored.
- An action plan has been developed to address the findings of the review. The high level actions are as follows, these are monitored through the ICS Management and Commissioning Groups.

Focus Area	High Level Actions
Team	• Develop a matrix for Staff Supervision and Peer Support and monitor level of Supervision/Appraisal undertaken. • Understand the skill/knowledge gaps within the team and develop a programme of staff development. • Review level/role/function of admin support and ensure adequate support to all teams • Develop a recruitment plan for 'hard to fill' posts • Communicate consistently about the Vision for ICS and engage staff & stakeholders in discussion regarding it. Describe/model the behaviours that are expected aligned to the Vision. • Address accommodation and IT issues.
Processes	• Review all pathways and processes and apply a PDSA approach – develop standard operating procedures for reviewed processes • Confirm ICS Criteria and communicate to staff and stakeholders • Review rota's/allocation/caseload management processes • Review Independent Sector Beds Pathways/Processes/Criteria with Commissioners and agree where responsibilities lie. • Introduce 'Business Meetings' and expectations of Team Leaders to monitor Performance/Budgets/ Demand and Capacity • Develop better relationships with wider stakeholder groups, in particular, SATH, GP's, IDT's & P2P
Programme	• Develop a plan to ensure that staff and stakeholders receive regular communication and are engaged in ICS developments • Work with Commissioners to resolve budget issues and secure recurrent funding at earliest opportunity. • Work with commissioners to plan the final evaluation of the ICS Service • Develop Partnership Agreement between SCHT & LA
Performance	• Address Data Capture and Case Recording system issues. • Develop action plans to address performance that is below target • Resolve data quality issues • Increase awareness of performance targets and expectations with staff • Develop data capture and monitoring methods in relation to responsiveness, impact and bed based rehab • Establish Commissioner/Provider process for performance reporting/monitoring

8. Performance and Impact of ICS Prototype to date.

8.1. Despite the significant challenges to delivery that were highlighted in the strategic review, ICS continue to deliver good outcomes for patients receiving the service with over 70% of individuals who receive the service regaining full independence and not requiring long term Social Care support, this is above the National Benchmark of 60%. There has also been an overall reduction in delayed transfers of care attributable to Community Services.

8.2. A copy of the ICS Impact Template showing current performance against a range of indicators is attached in the appendix of this document for your reference.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Cllr. Lee Chapman
Local Member Covers all constituencies
Appendices  ICS Template with Narrative v1.11 Augus

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