Shropshire Council

Better Care Fund Planning Template – Part 1

Final Draft April 2016

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Shropshire Council**
Clinical Commissioning Groups	**Shropshire CCG**
Boundary Differences	**The Council and CCG share the same boundaries. However all of our provider organisations are not co-terminus and work across Shropshire and Telford & Wrekin boundaries**
Date agreed at Health and Well-Being Board:	**21 April 2016**
Date submitted:	**25 April 2016**
Minimum required value of BCF pooled budget: 2015/16	**£21,451,000**
2016/17	**£21,800,189**
Total agreed value of pooled budget: 2015/16	**£21,750,000**
2016/17	**£22,873,582**

b. Authorisation and sign off

KLOE Reference: A3i, A3ii, C1i

Signed on behalf of the Clinical Commissioning Group	
By	Dave Evans
Position	Accountable Officer
Date	25 April 2016

Signed on behalf of the Council	
By	Andy Begley
Position	Interim Director of Adult Services
Date	25 April 2016

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Karen Calder
Date	25 April 2016

c. Related documentation

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

Document or information title	Synopsis and links
Visuals Pack	 BCF Visuals updated for 16.17.ppt
Terms of Reference – Health & Wellbeing Delivery Group	 HWB Delivery GroupTerms of Refere
Terms of Reference – System Resilience Group	 ToR System Reslience Group 28 Au
Terms of Reference – Health & Wellbeing Board	 HWBB TOR APPROVED 25 FEB 201
Terms of Reference- Health and Wellbeing Prevention Group	 Terms of Reference - Prevention Subgroup 1
Better Care Fund Reference Group	 Draft ToR Reference Group March 16.doc
BCF Local Performance Report	 Copy of BCF Local performance report M
Whole system presentation	 Whole System Approach.ppt

2) VISION FOR HEALTH AND CARE SERVICES

KLOE Reference: B1i, B1iv, B1vii, B2iv, B3i, B3ii, B3iii, B3vi, B3Vii, B3Viii, B3ix

As politicians, executives, clinicians and local residents of Shropshire we continue to stand united behind the principle that we need to focus on what is best for Shropshire now and in the future. Collectively both the local authority and CCG face the same challenges that are identified through our JSNA & JHWS and which are discussed greater detail throughout this document. This document sets the context of how these challenges manifest themselves locally, our resolve to address them and our vision for achieving sustainable change.

The challenges we face encompass solutions where we focus on prevention of illness rather than treatment; where we care for patients and residents in the community more than we do within formal hospital settings; and where we focus on the correct level of care for the individual rather than placing patients in care settings that are of a higher dependency than their needs require. They also require us to make radical changes to how we apportion our funding and on what services we focus our scarce resources and on building community capacity and resilience to help people and communities help themselves. They require us to work even better together.

We envisage a system where, through working together, we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire. We propose to tackle the challenges we face responsibly, creatively and with a passion for what matters most. Ensuring that we engage our citizens, users of services patients and other stakeholders in redesigning and transforming health and social care services.

The Better Care Fund presents an opportunity to do this and is a catalyst to the transformation required to address the challenges we face. We envisage that the Better Care Fund will enable us to improve services and outcomes of people in Shropshire and make the local health and wellbeing system financially sustainable for the future.

We recognise that we need a skilled workforce across all areas of the health and social care economy and will continue our joint commitment to training and workforce development. Health and social care is an important aspect of our local business economy and we will work together to continue to develop career opportunities for the workforce employed within it.

How we will work towards our Vision

The Better Care Fund, whilst presenting significant challenges around developing more sophisticated arrangements for joint planning, sharing resources, (both financial and human across Shropshire CCG and Shropshire Council) and transforming services to create better outcomes for the population of Shropshire, also presents significant opportunities in these areas. The mature relationship between Shropshire Council and Shropshire CCG has proved to be a sound foundation from which to commence this work.

It is the aspiration of Shropshire Council and Shropshire CCG to continue to utilise the opportunity the Fund presents to make transformational changes to the provision of local services which are founded on the best health and wellbeing outcomes for individuals.

As our confidence as a partnership has developed we have refined our BCF governance structures to strip out organisational duplication and give a greater role to the joint Health & Wellbeing structures we have in place to do our business. This has been aided by a refresh of our Health & Wellbeing Strategy and a change to the Health & Wellbeing Board membership to include key provider organisations. Both Shropshire CCG and Shropshire Council continue to actively work with and support our vibrant local Voluntary and Community Sector Assembly as key partners in delivering our vision and objectives as well as the business sector.

The BCF Governance structure diagram set out below shows how the delivery of the BCF plan, its metrics and its budget are managed, with the H&WB Delivery Group having delegated authority from the H&WBB to manage the day to day operational requirements of the BCF plan. Sitting beneath this are a number of sub groups who manage delivery of the BCF themed areas of work. All groups are multi agency. The attached Terms of Reference for these groups and the H&WBB demonstrate the joint approach to management of and accountability for the BCF plan

The strategic themes adopted in year one of the Better Care Fund (set out below) will remain the focus of our key work streams for 2016/17. However these will be more firmly linked to the system focus on admissions avoidance and building community capacity.

- Prevention
- Early Intervention (case management)
- Supporting people in crisis
- Supporting people to live independently for longer

This document sets out how our Better Care Fund plans will address the challenges we face, deliver our vision and build on our learning from year one and the differences we hope this will make to the residents of Shropshire. The key themes and their relationship to one another are set out in our BCF Plan on a Page below.

The Better Care Fund – Plan on a Page

Health and Wellbeing Vision

"For Shropshire people to be the healthiest and most fulfilled in England"

Outcomes that the Health & Wellbeing Board will strive to achieve

Outcome 1
Health inequalities are reduced

Outcome 2
Increase healthy life expectancy

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	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:** Gemma McIver	**Clinical Lead/Sponsor:** Colin Stanford **Lead Officer:** Gemma McIver	**Clinical Lead/Sponsor:** Colin Stanford **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.	Identification of 'at risk' groups of people and the approach to support them through 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 community resilience.
Existing Integrated Activity	• Prevention Services	• Care Home Advanced Scheme • Community & Care Coordinators	• Mental Health Support Services • Specialist rehab • Integrated Community Services	• Housing, Equipment & Adaptations • Supported Housing Development • Carers Support • End of Life Support

Transformation Schemes

Scheme	Lead
A1 - Integrated Falls Prevention	Miranda Ashwell
A2 – Future Planning	Tom Brettell
A3- Detection and management of risk factors for stroke	Kevin Lewis

Scheme	Lead
B1 - Proactive Care programme	Nina White
B2 - Community & Care Coordinators	Adrian Johnson
B3 – 0-25 Emotional Health and wellbeing	Fiona Ellis
B4 – Housing	Laura Fisher
B5- Strengthening Families	Kay Smallbone
B6- Social Prescribing	Kevin Lewis

Scheme	Lead
C1 - Integrated Community Services	Gemma McIver
C2 - Mental Health Crisis Care	Richard Kubilius
C3- Alcohol Liaison Service	Jayne Randall
C4- RAID	Gemma McIver
C5- High Intensity Users Model (HIU)	Emma Pyrah

Scheme	Lead
D1 – Resilient Communities	Kate Garner
D2- Dementia Strategy	Pete Downer
D3 – Integrated Carers Support	David Whiting
D4- End of Life Co-ordination	David Whiting

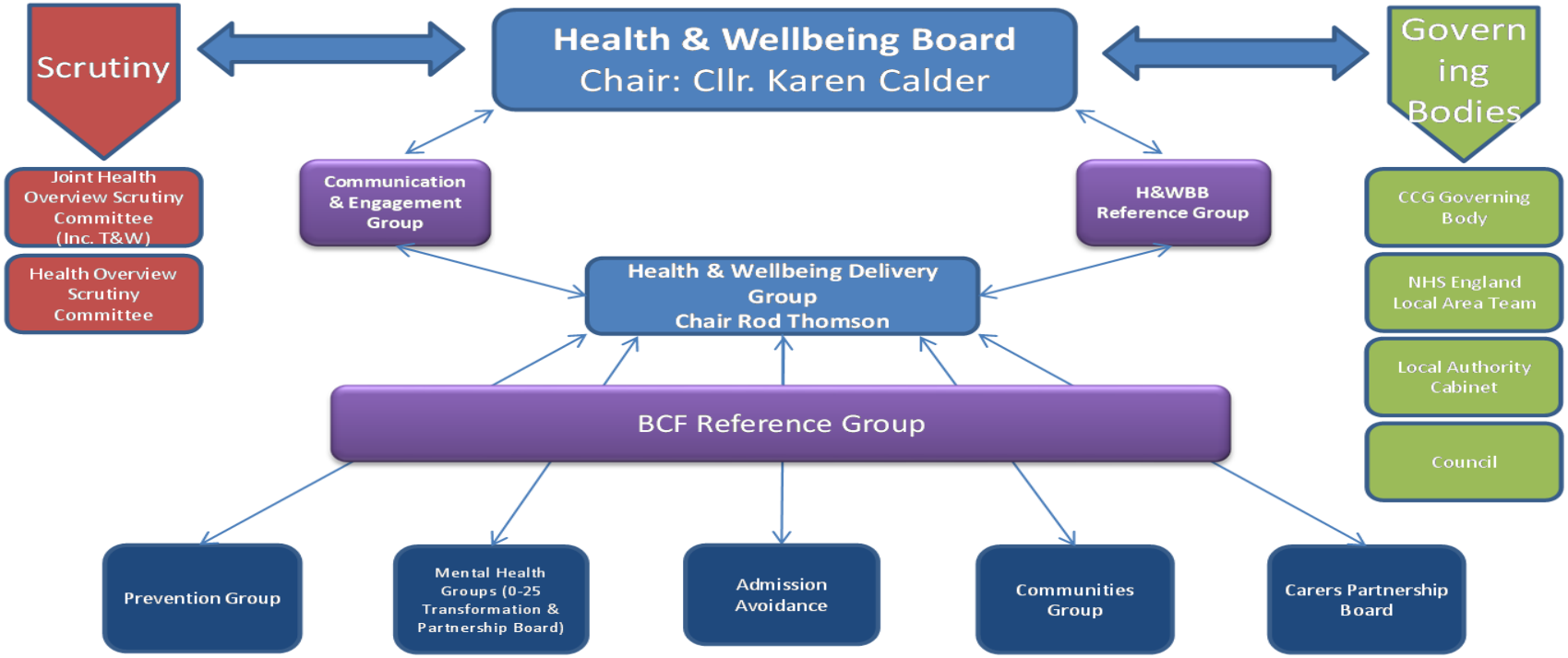
Principles

- Empowerment
- Compassion
- Social Value
- Flexible Infrastructure
- Respect
- Evidence
- Communication & Engagement
- Governance & accountability

Shropshire together

Shropshire together

Better Care Fund Governance Structure



Shropshire together

Shropshire together

What difference will this make to patient and service user outcomes?
KLOE Reference: B1iii, B1vii

Read as a whole this Better Care Fund Plan sets out the context of the health and social care challenges faced by the population of Shropshire, the evidence to demonstrate this, the vision for transforming the health and care landscape and gives details of the evidenced based schemes that will deliver these changes. These schemes are anchored to wider strategic transformation programmes that have been undertaken, (mental health modernisation) are underway (Future Fit, CAMHs transformation) or are just beginning (Primary Care transformation, Community Fit) each of which is being undertaken with a partnership approach across the county.

Simply put, the difference made through the Better Care Fund (in the context of a system wide transformation programme) is that outcomes for patients/service users will improve and that wherever possible care will be delivered closer to home and in local communities.

The details of the components of this improvement and the difference that will be made are as follows:

- A far more coordinated and integrated pattern of care, across the NHS, social care and the voluntary sector, with reduced duplication and better placing of the patient/service user at the centre of care
- A pattern of services that better meets population needs, by bringing teams together for more hours of the day and more days of the week.
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care, ensuring that we make the best use of our built environment across the public sector estate
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making
- Empowerment of the patient to make choices in their health and care needs supported by a system that is responsive and supportive of this
- Reducing dependence upon paid support and enabling and maximising individual independence.
- Services that are responsive with quick decision making at the closest possible point to the person.
- Developing resilient communities that are better able to help themselves via the development of local resources, support networks, embedded specialist facilitated by the CCG, Council and Voluntary sector in partnership
- A focus on the use of volunteers and particularly those that have lived experience of using services.

- Better supporting and enabling carers to continue with their vital role whilst establishing and maximising the use of peer support.
- Fewer people requiring treatment in hospital and for those who do need treatment more of them receiving it whilst continuing to function at home
- An increased focus on prevention leading to a general improvement in population health, emotional health and a reduction in health inequalities for our population

What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded works contribute to this?
KLOE Reference: B1iii, B1vii, B2i

The Better Care Fund sits within a unique whole system transformation plan for Shropshire in which there will be fundamental redesign of the health and care landscape over the next five years and beyond. Whilst the Better Care Fund itself will focus on developing services in the community there is an underlying interdependence of all the local transformation schemes to achieving success. The Better Care Fund plan will form a key work stream within our local Sustainability and Transformation Plan as it develops in the early part of 2016. The Health and Wellbeing Board is the vehicle through which the local health and care economy ensures alignment of these transformation schemes across the local footprint as the underperformance of one will directly impact on the success of the others and vice versa.

In light of the above, this section not only sets out core changes that will be delivered via the Better Care Fund itself but also notes areas of particular interdependency with other transformation schemes where they added value to the Better Care Fund objectives. The Better Care Fund Governance structure, outlined later in the document, will directly monitor the impact of Better Care Fund schemes on the delivery of our intended outcomes and achievement of the Better Care Fund metrics. However, it will also draw information from wider work in the health and care economy that impact on these outcomes.

Delivery of Change

We have a clear BCF programme plan to deliver our vision. The objectives of the four Strategic Themes are:

- **Prevention** - 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

- **Early Intervention (Case Management)** - 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

- **Supporting People in Crisis -** 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.

- **Supporting People to Live Independently for Longer -** Reducing dependence on paid support and enabling independence. Maximising the use of community resources and natural support to develop community resilience.

Our Delivery plan focuses on work streams aligned to the key themes above to in order to deliver the greatest impact on admissions avoidance and building community capacity. These High Impact Schemes are set out below and are phased in terms of their carry forward from 2015/6, alignment for 2016/17 and development during 2016/17:

Strategic Theme - Prevention
- Integrated Falls Prevention
- Future Planning
- Atrial Fibrillation programme

Strategic Theme - Early Intervention (Case Management)
- Proactive Care Programme
- Community & Care Coordinators
- 0-25 Emotional Health and Wellbeing (CAMH's transformation)
- Housing Scheme
- Strengthening Families
- Social Prescribing

Strategic Theme - Supporting People in Crisis
- Integrated Community Services
- Mental Health Crisis Care
- Alcohol Liaison Service
- Rapid Access and Interface to Discharge (RAID)
- High Intensity Users Model

Strategic Theme - Supporting People to Live Independently for Longer
- Resilient Communities
- Dementia Strategy
- Integrated Carers Support
- End of Life Coordination

Alignment

Describe how your Better Care Fund Plan contributes to the local implementation of the Five Year Forward View and moves fully towards integration of Health and social care services

KLOE Reference: B1ii, B1viii

The Five Year Forward View sets out in detail the case for change for the NHS. The preceding section of Shropshire's Better Care Fund Plan sets out a collective vision for the future of health and social care in Shropshire and the following section of the plan sets out a personalised case for change for Shropshire that echo's the case set out in the Five Year Forward View.

Developing a future model of health and social care services that meets the changing needs of Shropshire's population, is sustainable financially and results in the best outcomes for Shropshire residents requires a joined up, co-ordinated approach and a multi-agency commitment to achieving these outcomes. For this to occur many parts of a complex system need to align. Shropshire has made great strides along this road and 2016/17 will be a significant year in the development of this ambition.

The development of a broad based Partnership Board structure to manage the development of the Future Fit programme shows a significant commitment from a plethora of agencies to rise to the local challenge of re-designing health and social care provision so it is fit for the future. Building on this the development of Sustainability and Transformation plans for June 2016 further galvanizes this commitment. Within this Shropshire's Better Care Fund Plan takes ownership of a specific set of deliverables, as set out in the forthcoming sections of this document.

Other strands of work are also key in designing the future state for Shropshire. These include Integration Plans to be developed during 2016/17 between Shropshire Council and Shropshire CCG, discussions and plans regarding One Public Estate, Council plans related to the devolution agenda, the prioritisation locally of the radical upgrade in prevention and building community capacity, the development of a Primary Care Strategy and the development of our Community Fit programme.

The development of our Sustainability and Transformation plan will be a significant step in bringing these important strands together and considering how we work more closely with our neighbouring Council and CCG in Telford & Wrekin, taking into account our common provider organisations.

The development work undertaken during 2015/16 in relation to Shropshire's Health & Wellbeing Board to broaden its membership and refresh its strategy has placed us in a good position to take the forward the collaborative discussions needed to co-design solutions to our collective challenges. The detail of this work continues through the on-going development of all these strands of work, of which the Better Care Fund Plan plays a significant role.

The scheme descriptors set out later in this document set out in detail work that will deliver against the ambitions of the Five Year Forward View. Coupled with this the Better Care Fund cross cutting themes of workforce development, embracing technology, community empowerment, developing new models of care and increasing the focus on prevention align directly with the sentiments of the strategic planning guidance of innovation, the role of information technology, developing new models of care and developing a new relationship with patients and communities, all under a more aligned leadership structure.

In particular, the Better Care Fund Plan in will bring together a range of initiatives and work streams from Shropshire Council and Shropshire CCG at varying stages of development into a single programme of activity, working towards an agreed set of outcomes, under a single governance structure.

The High Impact Schemes have been determined in order to address the challenges that face both Shropshire Council (SC) and Shropshire CCG (SCCG) in particular but the wider system in general and therefore naturally align with SC and SCCG priorities.

Looking at our system in the broadest sense there are many initiatives currently underway that are not delivered through the Better Care Fund but nevertheless there is a clear interdependency or alignment between what they aim to achieve and what the BCF plan aims to achieve. These include:

Strategic Housing Authority – Shropshire Council

The key strategic drivers around housing that support the Better Care Fund priorities include: access to appropriate, sustainable housing; affordable warmth; and the condition of the home environment.

Housing provides core services which support the Better Care Fund priorities through prevention and early intervention, specifically: access to appropriate, sustainable housing; affordable warmth and the condition of the home environment; and prevention of homelessness including homelessness for Families, Young People and Care Leavers.

Strategic housing objectives translating from higher level commitments include:

- Supporting provision of extra-care housing in collaboration with local delivery partners
- Addressing the health and care impacts of excess cold and by extension poor property condition, for example through the provision of the multi-agency one-stop Heatsavers service, located within the Housing Service
- Delivery of the statutory DFG programme in the context of and complementary to the Better Care Fund partnerships.
- Commitment to 'resilience at home' (linked to 'home is normal') through continuing financial/ core funding support via Housing for the Countywide Home Improvement Agency and Handyperson Service, both of which are able to assist with and facilitate transfer home from hospital or residential care, undertake and/or facilitate adaptations and install equipment, carry out falls risk assessments and associated remedial works, and deliver emergency heating solutions etc.
- Strategic Countywide commissioning of targeted housing support services which meet diverse needs/ deliver sustainable outcomes at locality level ('home is normal')
- The commitment to and ongoing development of supported living properties for adults with learning disabilities which enable them with the appropriate support to live with in local communities closer to family and friends. This a core principle of our Transforming Care plan.

The importance of the link between Housing status and admission to hospital as well as discharge from hospital has been firmly acknowledged during 2015/16 and to this end a High Impact Scheme will be developed during the first part of 2016/17 to galvanise housing services

around a focussed piece of work on admissions avoidance and improving discharges

Community Hubs

The Shropshire PLC continues to develop Community Hubs focussing on a collective and integrated approach, reducing the size of the traditional public sector "footprint" by integrating buildings, staff, and back office systems within a mixed economy of providers. Our Community Hubs will provide the focus for a new way of working that builds on local community capacity and places the emphasis on early help and prevention. This prototype provides a platform to the **Resilient Communities** transformation scheme and links to the 'One Public Estate' discussions taking place across the sector

Let's Talk Local – Provided by People2People
The first response to contact with Adult Social Care, Let's Talk Local describes the solution-focused conversation with each caller directing people outside of the service where appropriate to community-based support and resources. The conversation is based upon an asset-based or strengths approach that focuses upon the individual's personal resilience and local community opportunities that will positively contribute to the overall outcomes required.

The approach is based upon building independence in a sustainable way and will not build any unnecessary dependence. The approach focuses, wherever possible, on self-management and responsibility. Where a further conversation or intervention is required there will bookable 'Let's Talk Local' sessions which are based in communities and bring together in one place:

- Social work advice,
- Key partners advice e.g. Housing support e.g. Sustain, benefits advice,
- Carers assessments,
- Peer support sessions,
- Occupational therapy advice
- Assistive technology demo's
- Public health advice and workshops
- Financial advice for self-funders
- Keeping independent for longer workshops delivered by peer supporters alongside OT.

This new approach supports the **Resilient Communities** High Impact scheme and the on-going development of our Community and Care Co-ordinators.

Targeted Mental Health Programme for Schools TaMHS

Through the Transformation Plan for the emotional health and wellbeing of children and young people, the TAMHS programme in Shropshire has been extended. The work now includes training, advice and support for non-education based settings/groups as well as all education based settings in Shropshire. The aim of the extended programme is to up-skill professionals and volunteers working with children in order for them to better identify any emotional health and wellbeing issues early on and provide them with the skills to be able to offer effective early support.

Children's Services Early Help Strategy – Strengthening Families through Early Help 2016-2018

This vision for children and families sits within the wider council and partnership approach to focus on prevention and well-being through the offer of advice, support and assistance to the people and communities of Shropshire to help them help themselves.
This vision sees the home and community as the first place to look for enabling care and support including promoting engagement of the community and the voluntary sector to identify and meet the needs of their local community.
A child-centred and coordinated approach, working with the whole family to enable prevention and early assistance where the voice of the child is heard and the family voice is visible and their experience of life is understood by all professionals working with them.

This refresh of the Early Help Strategy for Shropshire takes into account and reflects on local and national developments, including:-

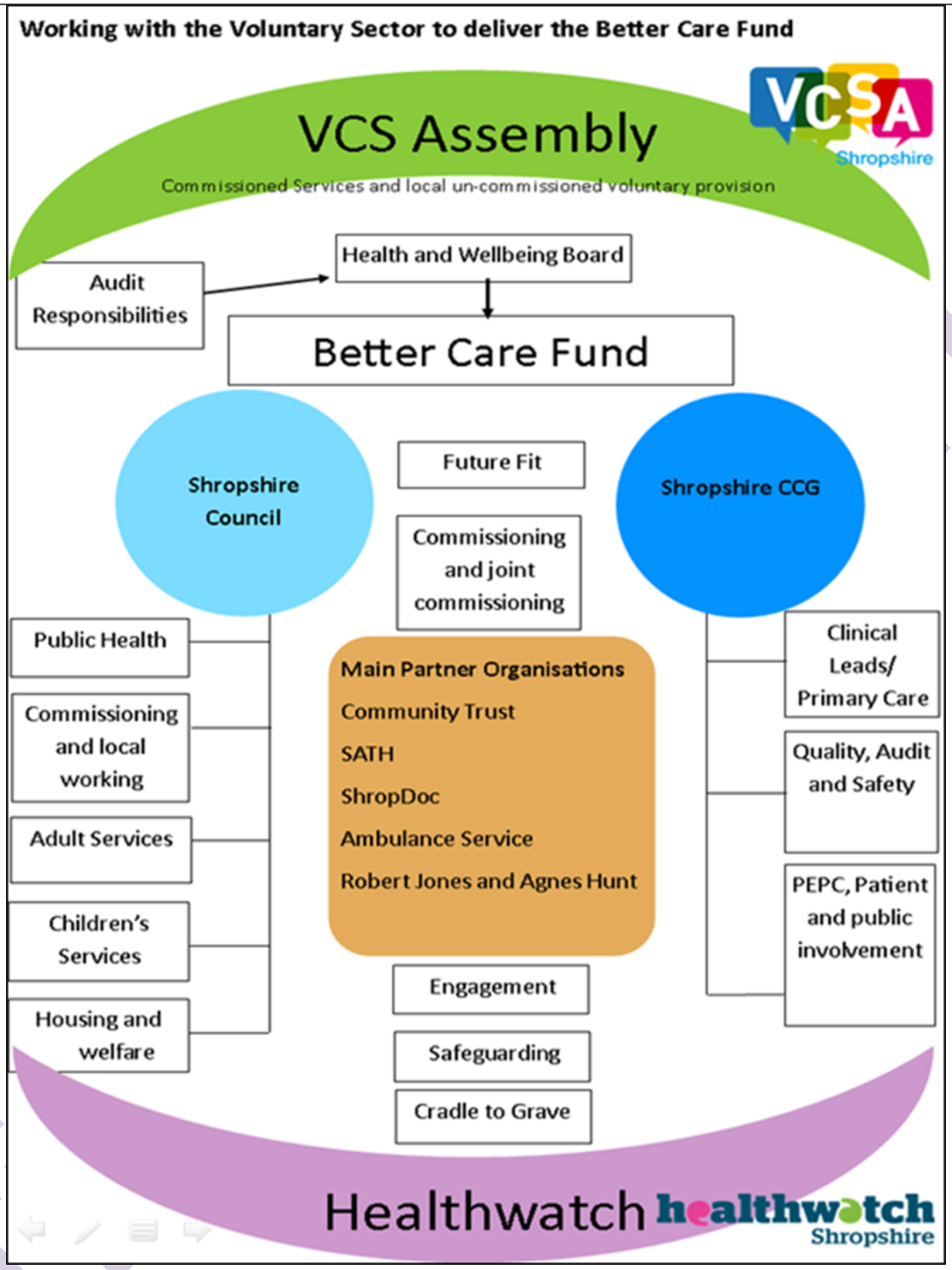
- Ofsted thematic inspection: Early Help – Whose Responsibility 2015
- Troubled Families Phase 2 – Strengthening Families
- Shropshire Early Help Effectiveness Report 2015
- Health and Well-Being Board 2015
- Shropshire Council Financial Strategy 2016-2020
- LGA Peer Review Findings and Recommendations 2015

The Troubled Families programme phase 2, known as Strengthening Families (in Shropshire), has a role in integrating early help process and provision to align to the aims, essentials and principles of strengthening families and work towards the jointly agreed strategic goals of this programme.
The intention being to further develop and succeed in ways of working that strengthen families at the earliest stage to make positive changes and build resilience to prevent further problems from arising or escalating.

Alignment with the Voluntary & Community Sector Assembly and Healthwatch.

The Voluntary and Community Sector Assembly and Healthwatch are both members of the Health and Wellbeing Board and as such have been involved in discussions and decision making around the Better Care Fund from its inception. Both organisations have representation on the BCF Reference Group and the Health Economy Board Chairs and Non – Executive Group, where operational planning and risk planning have been identified and deliberated. The Voluntary sector and Healthwatch have been instrumental in a number of our 2016/17 focussed BCF planning sessions

The VCSA and Healthwatch produced this diagram for our original BCF plan to show how they are aligned to the BCF and it remains relevant into 2016/17.


Working with the Voluntary Sector to deliver the Better Care Fund
VCS Assembly
VCSA Shropshire
Commissioned Services and local un-commissioned voluntary provision
Audit Responsibilities
Health and Wellbeing Board
Better Care Fund
Shropshire Council
Future Fit
Commissioning and joint commissioning
Shropshire CCG
Public Health
Commissioning and local working
Adult Services
Children's Services
Housing and welfare
Main Partner Organisations
Community Trust
SATH
ShropDoc
Ambulance Service
Robert Jones and Agnes Hunt
Clinical Leads/ Primary Care
Quality, Audit and Safety
PEPC, Patient and public involvement
Engagement
Safeguarding
Cradle to Grave
Healthwatch healthwatch Shropshire

3) CASE FOR CHANGE

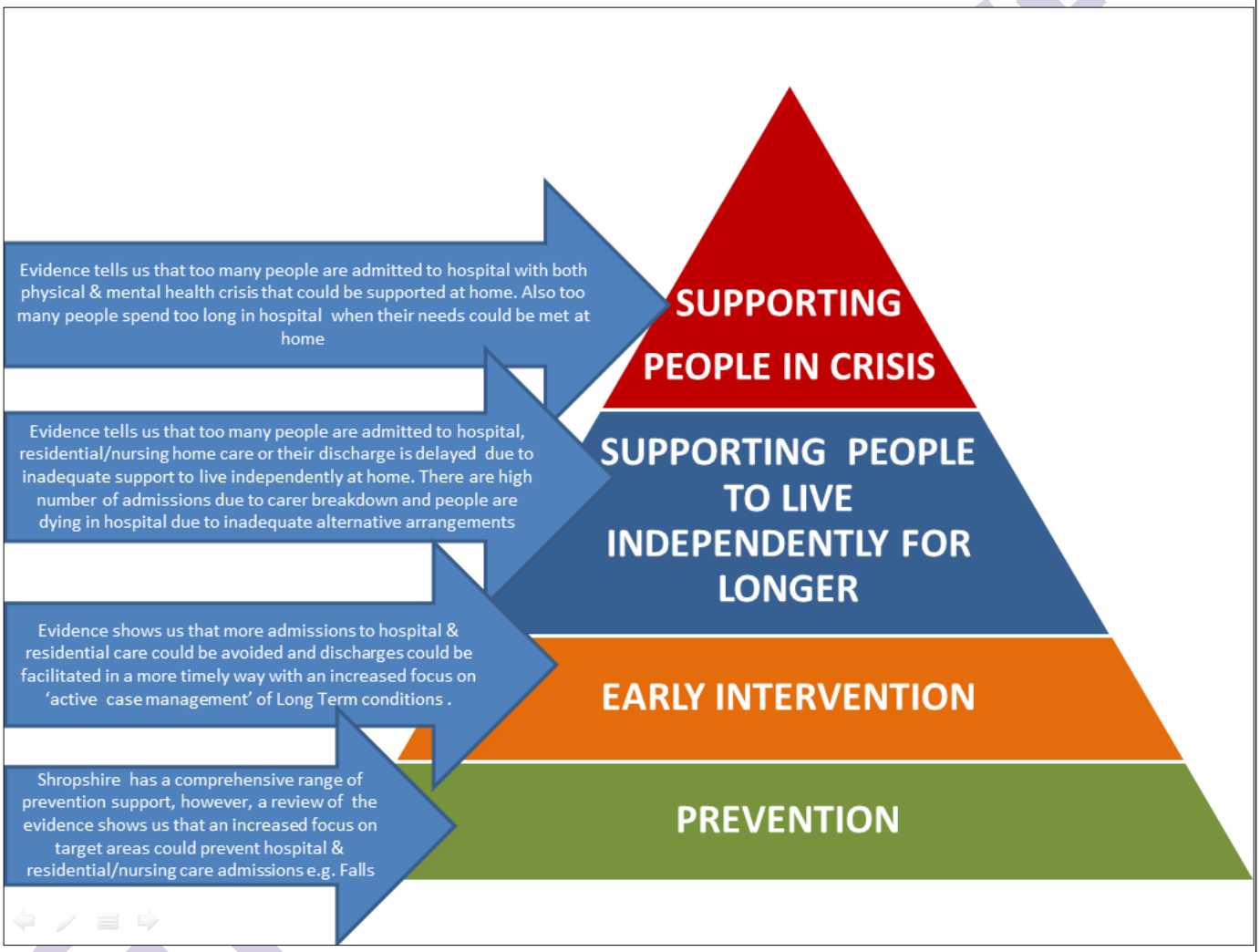
Set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.
KLOE Reference: B1iv, B1v, B2ii, B2iii

The case for change in Shropshire has been informed by a range of risk stratification approaches (at both primary care and population level), including audits, prototypes and studies into the needs of the population. The findings from this analysis and supporting national evidence, have led us to develop a clear case for change. The analysis is far reaching, conducted over a number of years across the whole health & social care economy but in summary, some of the exercises referenced in this document include:

- Joint Strategic Needs Assessment (JSNA)
- Primary Care Risk Stratification – Tool provided by the CSU which supports practices to identify the most vulnerable 6% of their practice population. Details of this can be found in Part 7d of this document
- Oak Group Study of in-patients at acute & community hospitals – In-depth snap-shot study of patients receiving acute and community hospital care to determine they were at the appropriate level of care. Details of this can be found in Annex 1 – Integrated Community Services
- Future Fit Modelling – In-depth study of all elective, non-elective and primary care activity across Shropshire. Some of the findings can be found later in this section.
- Community Fit Modelling
- Joint Health & Social Care Data Set
- Residential Care Analysis – Local study into the reasons why people are admitted to residential care settings.
- Evaluation of Community & Care Coordinators. Details of this can be found in Annex 1 – Community & Care Coordinators.
- Community Nurse Review – Review of Community Nursing Services conducted by the Shropshire Community Health Trust
- Mental Health Crisis Care Review – Details can be found in Annex 1 – Mental Health Crisis Care.
- Learning from Compassionate Communities Prototype
- Carers UK Survey 2014 and feedback from the local Carers Partnership Board– Details can be found in Annex 1 – Integrated Carers Service
- VOICES National Survey – National bereavement survey. Details can be found in Annex 1 – End of Life Coordination
- Commissioning Support Unit Benchmarking data
- NHS Any Town planning resources,
- Adult Social Care Outcomes Framework data
- Commissioning for Prevention Toolkit
- Health & Wellbeing Peer Review and strategy refresh
- Transforming Care Partnership – building better communities for people with learning disabilities
- Learning from BCF year 1
- Right Care programme

A review of all of the available evidence led us to an understanding of the priorities of our population and to focus our improvement on four Areas; Prevention, Early Intervention, Supporting people in crisis and Supporting People to Live Independently for Longer. The diagram below summarises this.

A summary of the Case for Change



The Strategic Context in Shropshire

The Shropshire area is served by Shropshire Clinical Commissioning Group which is responsible for commissioning the following services:

- Community health services.
- GP out of hour's services.
- Ambulance services.
- Mental health services.
- Specialist health services for people with learning disabilities which is being developed further through our transforming care plan
- Acute hospital services.

Shropshire has a population of approximately 310,000. The most recent Mid-Year Estimates (2014) estimate that Shropshire has seen a total population increase of 1% since the 2011 Census from 306,100 to 310,121. However, the population aged 65 plus is estimated to have increased by 12% from 63,400 in the Census 2011 to 70,883 in the Mid-Year Estimates 2014.
Source: Annual Mid-Year Population Estimates for the UK, Office for National Statistics, 2015

Shropshire has approximately 59,800 children and young people under the age of 18 (0-17 inclusive) live in Shropshire representing 19.3% of overall population.

Shropshire is a large rural county. The county town of Shrewsbury is central to the county with a number of market towns geographically spread across the area. Shropshire Clinical Commissioning Group has co-terminus boundaries with Shropshire Council and the two agencies work closely together

Shropshire's Unitary Council is responsible for several key public service areas including:

- Community and living,
- Education and learning,
- Environment and planning,
- Housing,
- Leisure and culture
- Health and social care.
- Public Health

The latter of these areas includes Public Health, Adult Social Care services and Children's and Young People's services. Shropshire Council has 74 Councillors.

Shropshire is served by a single Health and Wellbeing Board (HWBB). Established under the Health and Social Care Act 2012, This Board is a key part of plans to modernise the way NHS and social care services work together assisted by the Better Care Fund.

The Health and Wellbeing strategy describes the vision for Shropshire:

Our Aim:
To improve the population's health and wellbeing; to reduce health inequalities that can cause unfair and avoidable differences in people's health; to help as many people as possible live long, happy and productive lives by promoting health and wellbeing at all stages of life.

Our Vision:
For Shropshire people to be the healthiest and most fulfilled in England

The Strategy sets out how the Board will galvanise a range of partners, across sectors in Shropshire to achieve the best outcomes in all elements of wellbeing. Resources will be targeted to areas of greatest need via a number of focused exemplar projects (Prevention, Weight management and diabetes, carers and mental health) and outlines how they will be developed and delivered in partnership by a whole range of organisations across the private, public and voluntary and community sectors, with the Better Care Fund acting as an enabler and driver for the majority part of this strategy.

Provider Landscape

- **South Staffordshire and Shropshire Healthcare NHS Foundation Trust** provide adult and older people's mental health services in the county. Multidisciplinary and multi-agency teams work in partnership with local councils and closely with the voluntary sector, and independent and private organisations to promote the independence, rehabilitation, social inclusion and recovery of people with a mental illness. Facilities include the Redwoods Centre in Shrewsbury which opened in 2012 and provides 80 adult mental health beds for Shropshire, Telford and Wrekin and Powys and 23 low secure beds for the West Midlands and the provision of a memory clinic in support of Dementia services as well as services for people with learning disabilities.

- **The Shrewsbury and Telford Hospital NHS Trust (SaTH)** is the main provider of district general hospital services for half a million people living in Shropshire, Telford and Wrekin and mid Wales, Services are delivered from two main acute sites: Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. Total bed capacity across the two hospitals is 700.

- **The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH**) is a leading orthopaedic centre of excellence. The Trust provides a comprehensive range of musculoskeletal surgical, medical and rehabilitation services; locally, regionally and nationally from a single site hospital based in Oswestry, Shropshire, close to the border with Wales. As such, the Trust serves the people of England and Wales, as well as acting as a national healthcare provider. It also hosts some local services which support the communities in and around Oswestry.

- **Shropshire Community Health NHS Trust** provides community health services to people across Shropshire in their own homes, local clinics, health centres and GP surgeries. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, and support to patients with diabetes, respiratory conditions and other long-term health problems. In addition, it provides a range of children's services, including specialist child and adolescent mental health services. Shropshire's four community hospitals have a total of 97 beds with an additional 27 independent sector step down beds.

- There are **44 GP practices** in Shropshire and Local practices have recently formed a GP Federation. In the last year the single Walk in Centre has been co-located with A&E on the Royal Shrewsbury Hospital site in order to manage emergency demand and flow into the hospital.

- **Shropdoc** – Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open, i.e. evenings, weekends and bank holidays. It provides out of hour's primary care services to 600,000 patients in Shropshire, Telford and Wrekin and Powys. Shropdoc also provides home visits and the flagging of high risk end of life and COPD patients.

- **West Midlands Ambulance Service (Foundation Trust)** - The Trust serves a population of 5.36 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Staffordshire, Warwickshire, Coventry, Birmingham and Black Country conurbation.

- **Shropshire Local Pharmaceutical Committee** – The Shropshire Local Pharmaceutical Committee is the representative statutory body for all Community Pharmacy contractors in the county of Shropshire.

- **People 2 People (P2P)** is a not-for-profit independent social work practice working with Shropshire Council to provide adult social care support to older people and those with disabilities. P2P is a community interest company with an independent board of directors, which includes individuals who use the service. The aim of P2P is to offer a different way of supporting individuals to keep their independence for as long as possible. This means helping people to plan how their independence can be improved.

- **Shropshire Partners in Care (SPIC)** is a not-for-profit company registered as a company limited by guarantee representing independent providers of care to the adults of Shropshire and Telford & Wrekin. Shropshire Partners in Care's purpose is to support the development of a high quality social care sector in the areas of Shropshire and Telford & Wrekin. SPIC works in partnership with local authorities, health and the voluntary sector to support continuous improvement and development of adult social care focusing on local need. They provide information, support training and signposting to relevant services to everyone that contacts the office.

- **The Voluntary and Community Sector Assembly (VCSA)** works to facilitate partnership between the VCSE sector and public sector. Representation work ensures that the VCS are represented on the groups led by the CCG, Shropshire Council and other partners. For example the VCS are represented on the Assistive Technology Steering Group, the Prevention Group, and Community Development Group. Members of the Voluntary and Community Sector Assembly include many of the large VCS organisations in Shropshire including Age UK, Shropshire RCC, and the Alzheimer's Society who deliver health and social care services in Shropshire.

- **Healthwatch Shropshire** Shropshire is served by a local Healthwatch service which is represented at all levels of the BCF structure.

National Picture

- **Policy Change.** The NHS belongs to the People - A call to Action (NHS England 2013) set out a number of future challenges for the NHS: Ageing society, Long Term Conditions and rising expectations. These challenges still remain and the Five Year Forward View as the key NHS strategic planning document sets out some key expectations in addressing these challenges, of which more integrated working between health and social care and the development of a cohesive system vision are headlines.

  Similarly key local government documents such as A Vision for Adult Social Care: Capable Communities and Active Citizen, (Department of Health, 16 November 2010), Making a

Strategic Shift to Prevention and Early Intervention 2008 (Putting People First) and Think Local, Act Personal, January 2011 and the Care Act 2012 note a similar context. More recently there has been the development of the Transforming Care Partnership. Shropshire is not exceptional in these trends and challenges and the JSNA supports this.

- **Changing patterns of illness.** Long-term conditions continue to rise as well, due to changing lifestyles. This means the emphasis needs to move away from services that support short-term, episodic illness and infections towards services that support prevention and earlier interventions to improve health and deliver sustained continuing support, again in the community.

- **Higher expectations.** Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day health provision or extended hours of some services and both of these require a redesign given the inevitability of resource constraints. Demand for Adult Social Care continues to increase and there are increasing numbers of young adults in transition to adult services with complex needs.

- **Reducing budgets.** Both Shropshire CCG and Shropshire Council face unprecedented financial pressures which are exacerbated by the increasing costs associated with an ageing population and the impact of increasing demand for complex, high cost care, the increasing costs of national living wage and pension pressures due to changes in legislation. The budget deficit position of Shropshire CCG and the financial pressures faced by a number of our provider organisations as well as Shropshire Council brings a level of urgency to the need to radically overhaul our health and social care provision locally

However, there are additional local challenges that must be also be considered.

Local Picture

In order to develop a local profile a number of resources have been utilised including the Joint Strategic Needs Assessment (JSNA), Commissioning Support Unit Benchmarking data, NHS Any Town planning resources, Adult Social Care Outcomes Framework data and the Commissioning for Prevention Toolkit. Further to this extensive Patient and Public engagement/ consultation has been undertaken.

- **Changes in our population profile** - The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire. It is projected that by 2025 there will be 33,957 people aged 65 and over living alone[1] in Shropshire, this is 38% of the projected population of 89,500 [2] for 2025 who are aged 65+.

  By 2025 it is projected that the total population aged 65 and over with a limiting long term illness whose day-to-day activities are limited a lot in Shropshire will be 19,833[3] - 22% of the over 65 population in Shropshire.
  It is predicted that 8% of the population aged 65 and over will have dementia[4] in 2025 (7,125 people).

  [1.] Figures are taken from the General Household Survey 2007; table 3.4 Percentage of men and women living alone by age, ONS. The General Household Survey is a continuous survey which has been running since 1971, and is based each year on a

sample of the general population resident in private households in Great Britain. Numbers have been calculated by applying percentages of men and women living alone to projected population figures. Data Source: www.poppi.org.uk version 9.0

[2] Figures are taken from Office for National Statistics (ONS) subnational population projections by persons, males and females, by single year of age. The latest subnational population projections available for England, published 29 May 2014, are full 2012-based and project forward the population from 2012 to 2037. Data Source: www.poppi.org.uk version 9.0

[3] Figures are taken from Office for National Statistics (ONS) 2011 Census, Long term health problem or disability by health by sex by age, reference DC3302EW. Numbers have been calculated by applying percentages of people with a limiting long-term illness in 2011 to projected population figures. Data Source: www.poppi.org.uk version 9.0

[4] The most recent relevant source of UK data is Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007. The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030. To calculate the prevalence rates for the 90+ population, rates from the research for the 90-94 and 95+ age groups have been applied to the England population 2006 to calculate the numbers in each age group, the sum of these groups is then expressed as a percentage of the total 90+ population to establish the predicted prevalence of the 90+ population as a whole. Data Source: www.poppi.org.uk version 9.0

The general population is anticipated to grow by at least 15,000 over the next 10 years according to ONS data. However, further to this the Shropshire Core Strategy Policy (CS10) suggests that 14,600 new homes will be built by 2026. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

- **Rurality and Access** - Shropshire is one of the largest and most rural inland counties of England. The county is characterised by a combination of large and small market towns, villages and small isolated hamlets and the county town of Shrewsbury. The geography of Shropshire County, with its long distances and travel times to acute hospitals, scattered and disproportionately elderly population and limited public transport, makes the provision of a comprehensive range and increased scale of community-based health services especially important. This becomes vital if the local health and care economy is to respond effectively to the challenge of the increasing elderly population combined with funding pressures. The geography of rural areas means particular challenges around providing services efficiently. Limited public transport increases the need for care close to home for the elderly and those from lower socio-economic groups without easy access to their own transport. Improved and timely access to services is a very real issue and one which the public sees as a high priority. There is a network of provision across Community Hospitals that is part of the redesign of services to increase local care.

- **Quality & Safety** - The Publication of the Francis Inquiry into failings at Mid Staffordshire Hospital has been one of the most significant events in the recent history of the NHS and has firmly placed quality at the top of the Health and Wellbeing agenda. Further to this the NHS Outcomes Framework sets out the improvements against which the NHS must deliver. All service development and improvement initiatives will be assessed against quality and safety standards supported by an agreed Quality Impact Assessment (QIA) Tool with quality assurance and improvement as the key guiding principles. Further to this we will all be aware of the growing focus on safeguarding and protection of vulnerable people in our communities following a number of recent high profile media cases. Shropshire Council has a made a commitment to ensure that there are sensible safeguards against the risk of abuse or neglect, whilst ensuring risk is not an excuse to limit people's freedom. Changes to the Adult Safeguarding Board structure following the implementation of the Care Act strengthen this. Shropshire CCG with its partners is driving forward the Transforming care agenda. Published information about agreed quality outcomes will support greater transparency and accountability and will support people using services in making decisions

- **Two Site working** - In Shropshire the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service. Most pressing, is the operation of two full A&E departments and workforce issues regarding recruitment and retention in key staff groups.

  Developing the future clinical services strategy for the acute Trust and any proposed change to the configuration of services across its two main sites, has to address any clinical quality, safety and sustainability issues and therefore ensure the maintenance of safe and appropriate staffing levels; it has to ensure services are designed to respond to future demands and demographic trends; and it has to ensure improvements in efficiency and productivity as well as presenting a financially viable future for the Trust.

- **Workforce** - Shropshire is not exceptional in relation to the health and care related workforce challenges it faces including issues of recruitment and retention in relation to health and care posts, particularly specialist posts. An ageing workforce and Shropshire's rural profile and the issues of access and travel distances are also a consideration. A core workforce issue for local health is the need to address a shift from an acute centred workforce to a more community centred workforce with Shropshire Council similarly moving towards its practitioners working in a flexible and mobile way with reduced reliance upon office-based working. The domiciliary care market in rural areas also experiences recruitment difficulties which can impact on available capacity as well as the general workforce issues in this sector at key times of the year when demand for services is high. Within the independent sector the recruitment and retention of qualified nursing staff in nursing care homes is also an emerging challenge.

- **Technology** - The case that technology is changing the way that we live our lives is irrefutable. The need to promote this technology to support the health and social care sector in the future has been made, but to date there is less impact than would have been expected in the way people are cared for. The need to improve the understanding of what technology can do and its limitations is something that needs collaborative working across commissioners and providers. It may also need significant changes in systems and working patterns for some areas. The CCG is leading on the development of a digital road map for the local health economy and local work includes assessing how we might better use existing practice software within the primary care setting and wider use of the NHS number as the primary identifier. The CCG also continues to explore ways of developing the use of telehealth.

Factors in Shropshire's population that impact on health

The Shropshire JSNA identifies four overarching areas that will impact on the health and well-being of the population in the future. These are:

- **The ageing population**, population projections suggest that the Shropshire population aged 65+ years will increase by over 30% by 2021 from the 2011 estimated figure. This has implications for the future Shropshire's health services provision as many long term conditions increase with age.

- **Health inequalities,** in Shropshire there is a significant difference between the most deprived and least deprived communities in a number of health indicators. With males in the most deprived areas living on average more than 5 years less than those in the least deprived areas and the difference for females are over 3 years.

- **Lifestyle risk factors to health**, smoking, diet, physical activity and alcohol consumption are some of the main causes of chronic disease. These lifestyle behaviours are also not distributed amongst the population equally and increase the impact of health inequalities. It is estimated that around a quarter of adults in Shropshire are obese and this figure is not predicted to reduce.

- **Long term conditions**, Shropshire has a higher recorded prevalence of long term conditions. As long term conditions are more prevalent in older age groups, it is likely that they will affect more people in Shropshire due to the ageing population.

These overarching issues will have an impact on the provision of health services and also impact on how they should be delivered in the future. This is also the case due to the rural nature of the county and the associated issues with accessing services. Although life expectancy has increased in Shropshire, there are many more people living with one or more long term conditions. There are also increasing numbers of frail elderly people, who require care and support from different agencies.

The JSNA highlighted healthy diet, physical activity, falls and Cardio-vascular Disease (CVD) as being issues of priority in Shropshire, these are all factors that can lead to or increase frailty. Other factors that can increase the likelihood of frailty are isolation / loneliness and managing pain.

The following table highlights the top 10 emergency admissions diagnoses in Shropshire (2014/15). Many of these admissions are more prevalent in frail elderly people and many are preventable. They also reflect many of the health issues highlighted in the JSNA as priorities. For example urinary tract infection is often a precursor for falls and fractured neck of femur is often a consequence of falls.

Collectively they contribute to a high number of admissions and a significant amount of cost in the system both in terms of acute care but also in terms of care once discharged. Similarly older people with chronic conditions are more susceptible to pneumonia and respiratory illness than those without chronic conditions. Lifestyle risk factors also have an impact on susceptibility to respiratory illness. Alcoholism, smoking, diabetes, heart failure and COPD all increase the susceptibility of pneumonia. This data has been instrumental in identifying those schemes of work which we believe will have the most impact in terms of outcomes for patients and effectiveness of the health and social care system.

Diagnosis	Emergency Admissions
Pain in throat and chest	1944
Abdominal and pelvic pain	1812
Pneumonia, organism unspecified	1495
Other disorders of urinary system	1309
Unspecified acute lower respiratory	808
Fracture of femur	764
Other chronic obstructive pulmonary	696
Syncope and collapse	626
Acute myocardial infarction	605
Cerebral infarction	579

Source: Hospital Episode Statistics, Shropshire and Staffordshire Commissioning Support Unit, 2014-15

A series of High Impact Schemes have been linked to the delivery of our Better Care Fund objectives in relation to our four priority themes: Prevention, Early Intervention, Supporting people in Crisis and Living independently for Longer. These schemes listed below are set out in detail later in the plan.

These schemes have been selected on the basis of their impact on both addressing acute need (reducing emergency admissions) and building longer term resilience, self-reliance and reducing the overall need for health and social care assistance (building community capacity) We know from a range of data sources that promoting resilience is of benefit to communities and individuals in general but in particular for the elderly and rural populations and our early interventions schemes focus on this as do our schemes in relation to end of life, carers and dementia . Our increasing prevalence of long term conditions and their correlation to increasing hospital admissions links to our focus on mental health, alcohol use and falls. We also recognise that without a more focused approach to prevention we will not change the future relationship between our population and our health and social care provision. The specific schemes identified relate to work carried out through multi agency conversations and data analysis to arrive at our priorities.

Some of these schemes, implemented in 2015/16 have begun to demonstrate impact and some have been developed in response to gaps that have been identified and will be worked up during

the first part of the year. A number of schemes depend on developing complex relationships across organisations and sectors, such as the resilient communities work, and produce less quantifiable, but nevertheless important outcomes anecdotally and create platforms for other work to flourish.

List of planned BCF schemes

Prevention	
Early Intervention	
Supporting people in crisis	
Supporting people to live independently for longer	

Ref no.	Scheme
A1	Integrated Fall Prevention
A2	Future Planning Scheme
A3	Detection and management of risk factors for Stroke
B1	Proactive Care Programme
B2	Community & Care Coordinators
B3	0-25 Emotional Health & Wellbeing
B4	Housing Scheme
B5	Strengthening Families
B6	Social Prescribing
C1	Integrated Community Services
C2	Mental Health Crisis Care Services
C3	Alcohol Liaison Service
C4	Rapid Access, Interface to Discharge (RAID)
C5	High Intensity Users Model
D1	Resilient Communities
D2	Dementia Strategy
D3	Integrated Carers Support
D4	End of Life Coordination

Summary

In order to respond to the monumental challenges describes above whilst continuing to deliver high quality support for those in need we will need to radically change our approach. What we agree on is that we cannot keep doing things in the same way and expect to meet our collective challenges. This Case for Change narrative begins to give a flavour of some of our ambitious plans to make the kinds of radical changes needed, further details of which are contained in the subsequent sections of this plan

4) Shropshire Performance

KLOE Reference: E1iii, E2iii, E3iii, E4iii

During 2015/16 Shropshire has shown variable results against the BCF Metrics. The final local performance report for the 2015/16 period is attached. The headlines of which are set out below:

- Reducing Non Elective (NEL) admissions to hospital remains a challenge. Shropshire did not meet its BCF target for the final quarter of 2015. With a cumulative variance of 2448 over plan. The implication of not meeting this target is that the payment by performance funds could not be released into the BCF pool budget to support transformation activity necessitated retention by the CCG to pay for NEL activity, a proportion of which will be supported by the input of the Integrated Community Service (ICS)
- Performance for the Admissions to Residential Care metric dipped below target in December 2015 but recovered in January. However whilst performance has in the main been rated as green for this metric, there remains some concern about the trajectory of the residential care metric moving towards exceeding the target.
- Performance against the Re-ablement metric has maintained a green position throughout the year.
- The Delayed Transfers of Care metric has remained a challenge during 2015/16 and was not met.
- Local metric: A reduction in the number of unplanned admissions to Redwoods with a diagnosis of Dementia as a proportion of those diagnosed with dementia. This target was met in 2015/16
- Patient Experience metric: Increased use of the out of hours mental health 24hr crisis helpline. Results show an improvement on the 2014/15 position and an increased number of survey respondents, but fell short of target and was rated as amber.

The H&WB Delivery Group has maintained oversight of BCF performance with a full performance report at each of its meeting which was then reported on to the H&WBB. This has allowed wider discussion with multiple partners regarding any remedial action needed and is assisting in developing joint ownership of performance issues across the sector. In addition the Delivery Group has maintained oversight of all of the BCF schemes with exception reporting at each meeting. All schemes were implemented during 2015/16 with the exception of the “Team around the Practice” which has been subsumed into Primary Care development work overseen by the Primary Care Co-Commissioning Group as Shropshire drafts its Primary Care Strategy and develops its plans for primary care transformation.

Schemes showed variable levels of impact depending in some cases on lead in times for implementation. For instance, the integrated Community Service as a complex integrated programme of work has shown some impact which with further refinements in 2016/17 could be increased. The Community and Care Co-ordinators scheme has demonstrated significant impact.

In order to determine the focus of BCF work streams for 216/17 a series of focused multi agency workshops were held in late 2015 to revisit key areas of focus and establish priority work areas for 2016/17. The schemes of work set out in this plan have resulted from the outcome of these workshops, analysis of local data sources and BCF performance.

2016/17 Metrics

KLOE Reference: E1i, E1ii, E1iii, E1iv, E2i, E2ii, E2iii, E3i, E3ii, E3iii, E4i, E4ii, E4iii, E4iv

Decisions regarding setting metrics for 2016/17 were overseen by the H&WB Delivery group and through a series of sub group discussions. These metrics have been reviewed against other plans across health and social care and aligned with contractual negotiations.

National Metrics:

Non Elective (NEL) admissions – Both reducing non elective admissions and A&E performance remain challenging for Shropshire. The local health economy has longstanding A&E performance issues and a recovery plan is in place to address the problems but sustained performance improvement has not yet been achieved. Plans continue to make improvements in 2016/17 which are set out in Shropshire CCG's operational plan for 2016/17 a number of workstreams are in train in relation to "front door" reducing admissions and "back door" activities as the system acknowledges the interdependencies of these service elements in improving performance. Much of this work is included as key activities within the BCF plan. In setting the NEL target for 2016/17 our current performance and the anticipated impact of the key worstreams have been considered. The data submitted by Shropshire CCG in relation to this target is based on a 2015/16 outturn position of 31,496 emergency admissions for General & Acute. Growth is anticipated at 827wih mitigating QIPP's in place for 327 emergency admissions. The target position for 2016/17 is therefore 32,000.

Admissions to residential and care homes – A review of current performance was undertaken and was considered alongside the impact of recent workundertaken to develop domiciliary care capacity across the sector. An annual rate consistent with the previous year was agreed based on this of 463.75

Effectiveness of Re-ablement – A review of current performance was undertaken and considered against the potential impact of schemes introduced in 2015/16 which will continue but have lesser of an impact in 2016/17. On this basis the target was set at 84.1%

Delayed Transfers of Care - A working group with included the lead commissioner for re-ablement, the lead commissioner for the Integrated Care Service and CSU data analysts reviewed current performance on DToC alongside the potential impact of schemes to be introduced or refined in 2016/17. On this basis the quarterly rates submitted in the BCF planning template were agreed as Q1: 1163.2, Q2: 1166, Q3: 1411.1, Q4: 1146.6

Local Metric: A reduction in the number of unplanned admissions to Redwoods with a diagnosis of Dementia as a proportion of those diagnosed with dementia

In 2015/16 there was a 0.37% reduction in admissions (from 1.77% in 2014/15 to 1.4% in 2015/16) as a proportion of the diagnosed population. Whilst unplanned admissions have remained fairly static over the past two years the diagnosed population has increased significantly as a result of focused work to increase diagnosis rates. Whilst this work will continue it is likely that the rate of diagnosis will slow in 2016/17 the Delivery Group therefore agreed that the level of reduction should be set at 0.2% for 2016/17

Patient Experience Metric: In 2015/16 this metric focused on the use of the out of hours mental health crisis telephone helpline and was based on the results of an annual service user survey. As a review of the telephone helpline had suggested that this model had not had the impact anticipated and taking into consideration regional developments could be provided via an alternative model if was felt that it was not appropriate to continue with this as the focus of our local model. Other options were considered with input from the CCG's Quality team who advised that it would be consistent with the BCF guidance to use the CQC inpatient survey as a basis for this metric. This survey includes a range of measures regarding "leaving hospital" which align to the current focus on improving our position regarding Delayed Transfers of Care.

Triangulation to other Plans

Across Shropshire we have endeavoured to ensure alignment between strategic plans across the sector and we continue to work closely with Shropshire Council on this. In particular the CCG's operational plan sets out the principles of the BCF plan and the alignment between key work areas such as Delayed Transfers of Care, A&E activity and reducing admissions are clear. In addition much work has been undertaken to align the H&WB Strategy with key system priorities and ensure that both the Community Fit and Future transformation agendas are linked into BCF delivery and vice versa. Further work on alignment sits within the scope of the work being undertaken to develop the local Sustainability & Transformation plan, bringing our neighbouring Telford & Wrekin Council and CCG as well as provider organisations from across the sectors into this important conversation.

5) NATIONAL CONDITIONS

KLOE Reference: B4

A description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing will be covered in the following section.

Protecting Social Care Services

KLOE Reference: C2i, C2ii, C2iii, C2iv, C2v, C2vi, C2vii,

i) Outline your agreed local definition of protecting adult social care services (not spending)

Our joint approach to protecting Adult Social Care

Shropshire Council is now operating under the Care and Support National Eligibility Criteria introduced by the Care Act in April 2015. The council continues to monitor the impact of the new eligibility criteria but to date has not experienced a significant shift in those deemed as having eligible needs.

Shropshire Council and Shropshire CCG are aligned in our priority areas to ensure that core, statutory, social care services that support the most vulnerable adults in our society continue to be delivered safely and appropriately through;

- Continued investment into supported living schemes for adults with learning disabilities and adults with mental health needs and a corresponding reduction in residential care placements for younger adults. This is further supported and being developed through the work of the Transforming Care Partnership.
- The provision of good quality nursing care and nursing care for people with dementia in a care home setting within County and as close to family and an individual's local community as possible
- A focus on developing and supporting employment opportunities for younger adults with mental health needs recognising how employment contributes to improving self-esteem and reducing isolation.
- Increasing the use of personal budgets for those people that are eligible for local authority funded support including supporting the CCG in implementing personal health budgets
- Providing support for carers that is both proportionate and appropriate to meet their needs but also promotes self-resilience and independence without compromising their caring role.
- Supporting young people and their family carers through transition ensuring that young disabled adults are supported in their local communities closer to family friends and family.
- Developing and maintaining both capacity and capability in the domiciliary care market ensuring that people are supported at home for a long as possible close to families and their local communities and also ensuring that there is sufficient capacity to support hospital discharge and admission avoidance.
- Continuing to invest in the workforce in both the statutory and independent sectors to ensure that the care workforce is skilled and able to meet the needs of Shropshire citizens whether in the community or in a care home

Social care is often a vital part of enabling people to live independent lives but it is far from being the only component to enable people to live fulfilled lives. The specific purpose of Social Care is to enable people to live independently and well for as long as possible, by maximising people's individual resilience and ability to meet their own needs, and to continue to support and develop contributions that communities can make to support the people living within them. The four strategic themes of the Better Care Fund in Shropshire of Prevention, Early Intervention, Supporting People In Crisis and

Supporting People to Live Independently for Longer also reflect both the vision and the focus for social care in Shropshire. Some of our areas of focus include:

- The provision of support services for people with dementia including nursing care home placements, skilled and responsive domiciliary care and support for carers of people with dementia
- The provision of support services for Carers to support people to live independently which is proportionate and flexible to their needs, and the level of carer support that is provided
- A focus on keeping people independent and living in their own homes for longer through the development of resilient communities, building community capacity, peer support and early intervention and prevention services.

The BCF schemes supporting these areas of focus will contribute to reducing demand on both social care and health services. Specifically for social care they further enhance the social care operating model in Shropshire which has been developed to respond to the challenges of increasing demand and significant reductions to public spend, whilst continuing to deliver high quality support that is responsive, flexible and proportionate to needs to the citizens of Shropshire

The schemes described in this plan support the delivery of social care in Shropshire as well as contributing to the wider health economy.

ii) Explain how local schemes and spending plans will support the commitment to protect social care

Context to protecting Adult Social Care

The underpinning measure of success in protecting adult services will be to ensure that the BCF supports the ASC transformation agenda, central to which is a reduction in funding over the 3 year period 2014-17 of almost £25m. This is set against an unprecedented predicted growth in demand and a £70m shortfall in the Shropshire Council budget.

The following demographic change is likely to have a significant impact on social care demand:

Older People

- In 2012, 21.6% of the Shropshire population were estimated to be aged over 65
- By 2015 it is predicted this will have increased to 23% and to 25% by 2018
- In 2012 there were 8,900 people in Shropshire aged 85 and over. This is expected to increase to 12,000 by 2020 (an increase of 34%)
- By 2020 it is anticipated that there will be around 5940 individuals aged 18-85 with learning difficulties living in Shropshire
- As of 2012, there were 19,686 individuals aged 18-64 with moderate to serious physical disabilities
- It is anticipated that by 2020 there will have been an increase of 25% in the number of individuals aged 65 and over who are unable to manage at least one self-care activity on their own. In 2012 there were 22,061 individuals who struggled with one of these activities, by 2020 it is anticipated that this figure will be 27,623
- During 2012, 26,840 individuals aged over 65 were unable to manage at least one domestic task on their own. This was 40% of the total population aged over 65
- The number of those aged 65 and over who are unable to manage at least one domestic task on their own is expected to increase by nearly 26% by 2020

Existing and predicted demand on Adult Social Care services

- As of 2012, there were 66,000 people aged 65 and over, living in Shropshire. This is an increase of 30% since the last census of 2001 (which recorded a population of 51,194 aged 65 and over) and indicates a significantly greater growth than that experienced by England and Wales as a whole (10.9% increase in those aged 65 and over from 2001-2011).
- By 2020 it is predicted that more than 25% of the population of Shropshire will be aged 65 and over. It is clear, therefore, that Shropshire has a distinct ageing population.
- In terms of those aged 85 and over, the predicted increase in population by 2020 (up by 34% from 2012) indicates that we can expect an increased demand on care services, as those in the oldest age band are the population most likely to be in receipt of some form of social care provision due to the associated rise in long-term conditions.

Age Band	2012	2015	2020
0-17	61,200	61,800	64,000
18-64	180,800	178,300	175,900
65-74	36,300	39,600	41,400
75-84	21,400	23,100	27,500
85+	8,900	9,900	12,000
All Persons	308,400	312,800	320,600

Source: *Office for National Statistics, interim 2011-based Subnational Population Projections*

Over the last decade, life expectancy has increased in the total population of Shropshire. Similarly, all age, all-cause mortality has decreased (see Shropshire's JSNA). Life expectancy is expected to continue to rise for both men and women in Shropshire.

Dementia

Due to its ageing population, Shropshire has a high proportion of individuals living with dementia. It is expected that by 2030, the population aged over 65 who are predicted to have dementia will have increased by 85% (from 4,602 in 2012, to 8,516 in 2030).

Adults with a Physical Disability

People with physical disabilities are often frail, incapacitated and/or have a physical or sensory impairment such as sight problems, hearing loss, or speech impediment.

Existing and predicted demand on Adult Social Care services:

- The latest information shows the predicted number of adults (aged 18-64) expected to have a moderate physical disability in Shropshire, is anticipated to rise by 0.7% (from 15073 in 2012 to 15,183 by 2020) between 2012 and 2020.

- The latest information shows the number of adults (aged 18-64) predicted to have a serious physical disability in Shropshire, is anticipated to rise by 2% (from 4,613 in 2012 to 4,719 in 2020).

Adults with Learning Disabilities
In comparison to the England and Wales average, Shropshire has a greater percentage of the adult population with a learning disability. There are approximately 1,000 people with a learning disability living in Shropshire and around 850 are supported by adult social care.

Existing and predicted demand on Adult Social Care services:

- The proportion of adults with a Learning Disability, living in settled accommodation, in Shropshire, in 2012-13, was 78%, compared to the England average of 73.5%.

Adults with Autism
Autism is a lifelong condition that affects how a person communicates with and relates to other people. It affects a person's social interaction, social relationships and understanding of the world. The condition can affect people in different ways; some may experience sensitivity to light, sounds, touch and taste, while others prefer to have a fixed daily routine.

Existing and predicted demand on Adult Social Care services:

- The latest information shows there are an estimated 1,800 adults with autistic spectrum disorder living in Shropshire, in 2014. This number is expected to remain fairly static over future years. However, not all of these people will require care services.

Adults with Mental Health problems
Mental health conditions are very varied and include a range of diagnosable illnesses and disorders, some of which may be present throughout most of a person's life, whilst other symptoms or problems may occur for relatively short periods of time. The severity of some mental health conditions can be significantly different depending upon our own resilience and support networks.

It is important therefore, that in Shropshire, we develop good support networks that enable people with mental health problems to feel part of, and contribute towards their local community.

Existing and predicted demand on Adult Social Care services:

- In Shropshire, it is estimated that between 26% and 32% of the population have a mental health condition with the main illnesses being depression and anxiety, alcohol related mental health problems and personality disorders.

- The percentage of adults receiving secondary mental health services, living independently, in Shropshire, in 2012-13 was 77.9%. This is well above the England average of 59.3%.

- The predicted number of adults in Shropshire anticipated to have Mental Health problems in future years is expected to remain fairly static between now and 2020.

How the Better Care Fund schemes and spending will support these priorities

Demand management and enabling people to live independently is a priority area for the local authority, the council is also focused on enabling communities and volunteers, and the social capital within communities to reduce demand on the public sector and developing a range of wider environmental place shaping schemes to enable people to live as independently as possible for as long as possible. The Resilient Communities Transformation Scheme supports these priorities by focussing on developing a sustainable community based approach with an emphasis on early help and prevention, developing and maximising the use of local assets, enabling voluntary activity and supporting the development and growth of community based initiatives and challenging peoples negative attitudes towards their circumstances and the capacity of their community.

The Local Authority is committed to enhancing and developing community capacity and community based support whilst ensuring that the most vulnerable and complex needs are met appropriately either singularly or jointly by the relevant partner. The Early Intervention Strategic Theme of the BCF Plan aims to deliver integrated, personalised care through proactive clinical care and intervention where the concept of 'home is normal' is a key element of the approach.

The Local Authority recognises the importance of a range of prevention and early intervention approaches including Telecare, community equipment and re-ablement in supporting people to remain independent. Local and National evidence points to the cost of falls to the local authority – specifically in relation to the elderly. The Falls Prevention Scheme aims to proactively identify and reduce the risk of falls and their impact on the older population through a range of targeted interventions with the most at risk groups**.**

The Local Authority is committed to integrated services that facilitate timely hospital discharge and prevent hospital admissions, to prevent people from 'decompensating' and losing independence whilst in hospital and as a result have increased needs on discharge which are costly to the local authority. The Local Authority is also committed to reducing reliance on long term social care services and supporting people to remain living independently in their own homes and local communities wherever possible. The Integrated Community Services Transformation Scheme aims to reduce the impact on acute hospital services, whilst ensuring that people are supported to maximise their independence, thus reducing the impact on ongoing Social Care resources.

iii) Indicate the total amount from the BCF that has been allocated for the protection of adult social care services and confirm the amount allocated for the implementation of the Care Act duties

Funding Allocations to support Adult Social Care

The amount allocated in the 16/17 BCF for protecting social care services is currently £6.0m and is described as follows:

- £5.2m 'Protecting Social Care Services' Allocation – this is part of the previous NHS transfer to adult social care that will be protected through BCF to support continued provision of core, statutory, eligible social care services that support the most vulnerable adults in our society.
- £0.8m CCG support to Mental Health accommodation to avoid hospital admissions.

iv) Explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

KLOE Reference: B1ix, C2iii, C2viii, C2ix

Implementation of the Care Act 2014

£609,000 is allocated for the implementation of the Care Act in Shropshire. Below we set out some of the new duties resulting from the introduction of the Care Act 2014 in April and what this means for Shropshire.

The new duties include:

1. Adults' well-being, and outcomes, is at the centre of every decision;
2. Focus on preventing and delaying needs, and integration and partnership working is reinforced;
3. Carers placed on same footing as those they care for;
4. Embedding the right to choice through care plans and personal budgets;
5. New national eligibility criteria;
6. Deferred payments scheme with wider range of opportunities;
7. Self-funders entitled to ask the local authority to procure services to meet their needs;
8. Places adult safeguarding on a statutory footing;
9. Extends the opportunity for independent advocacy
10. Fair cost of care/ sustainable market

What this means for Shropshire

In addition to the financial contribution that the BCF is expected to make to the Care Act implementation costs, the Council and the CCG recognise the significant interdependency that links the Care Act Implementation and the Better Care Fund Programme. We have sought to ensure connectivity between these programmes through the governance structures and representation at key planning groups. On a practical level, the schemes that make up the Better Care Fund are expected to support the Council to manage demand for social care services and to contribute to supporting carers which are two of the significant impacts that the Care Act will have.

As plans are reviewed the impact of the Care Act in Shropshire will be considered.

New duty from Care Act	What this means for Shropshire	How this will be met through the Better Care Fund
Increase in the number of assessments for both service users and carers	The Local Authority estimates, from working with local care providers that around 1100 care beds in Shropshire are occupied by people who fund their own care as their capital is above the current threshold of £23k, these people will require an assessment. There are an estimated 10,000 carers in Shropshire, (Census data) the Local Authority currently supports 3000, the difference of 7000 may request an assessment There is a new duty to carry out carer assessment for those caring for disabled children who are approaching their 18th birthday. Previously the needs of carers have been undertaken with the child's social work assessment.	As the implementation of part 2 of the Care Act has been delayed until 2020 the need to assess self-funders will occur when their capital diminishes below the current threshold. Integration, rationalisation and streamlining of existing carers support services commissioned across health & social care to ensure demand can be met within existing budgets. Care Act increased assessment costs met through BCF allocation
Introduction of a Universal deferred payment scheme	Shropshire currently offers a deferred payment scheme, however with national publicity the demand for this may increase. This will require additional financial assessment and legal resources and there may be an impact on cash flow	
Support for People in Prison	Shropshire has one prison - Stoke Heath	
Adult Safeguarding	Shropshire has established a new Safeguarding Adults Board (separate from Telford and Wrekin) which will have a statutory status and has appointed an independent chair and paid service	

	and support functions	
Transitional amounts and implementation costs		Costs to support implementation are partly met through the BCF
Carers	Census	Integration, rationalisation and streamlining of existing carers support services commissioned across health & social care to ensure demand can be met within existing budgets.
Information & advice	Advice and support to access and plan care, including rights to advocacy	Costs to support implementation are met through the BCF
Assessment & eligibility	Set a national minimum eligibility threshold at substantial Ensure Councils provide continuity of care for people moving into their area until reassessment	Costs to support implementation are met through the BCF
Veterans	Disregard of armed forces Guaranteed Income Payment from financial assessment	Costs to support implementation are met through the BCF
Law reform	Training social care staff in the new legal framework	Costs to support implementation are met through the BCF
Impact of DWP policies on councils/providers	Pressures relating to pensions auto enrolment (provider cost) the announced 1% increase in working age benefits in 15/16 (reduced client contributions) and the introduction of the national living wage	Costs to support implementation are partly met through the BCF
Impact of national living wage on care providers	The Care Act obliges local authorities to pay a 'fair cost of care' when procuring with the care sector. The guidance states "When commissioning services, local authorities should assure themselves and have evidence that service providers deliver services through staff remunerated so as to retain an effective workforce. Remuneration must be at least sufficient to comply with the national minimum wage legislation for hourly pay or equivalent salary." This means that the increase in the NLW will increase the cost of care for all providers and this increase in cost must be recognised and met by the Local Authority in the care	There is no specific provision within the BCF to meet these costs however, the Care Act allocation will go some way to supporting this.

	arrangements that it purchases. In Shropshire it is thought that these changes will cost in the region of £2m in 16/17. No extra funding has been received to meet this pressure.	
Changes to waking /sleeping night and national minimum wage requirements	Legislative changes surrounding the waking/sleeping night requirements mean that Shropshire Council will likely see a financial pressure arising from potentially increased night rates. The full extent of this pressure is still being established.	There is no specific provision within the BCF to meet these costs however, the Care Act allocation will go some way to supporting this.

v) Specify the level of resource that will be dedicated to carer specific support
KLOE Reference: C2iv, C2xi

Latest figures from the 2011 census in the table below show that approximately **34,300** people provide some form of unpaid care, the majority of these (nearly 23,000) provide between 1 and 19 hours per week. This compares to **3,400** carers who received a specific carer's service, as the result of a carer's assessment or review, in 2012-13 (which equates to about 10% of informal carers).

Table 2: Provision of Unpaid Care

Data relates to the following census 2011 Question:	**2011 – Shropshire**	
Do you look after, or give any help or support to family members, friends, neighbours or others because of either: - Long term physical or mental ill-health/disability? - Problems related to old age?	**number**	**% of total population**
Provides no unpaid care	271,869	88.8
Provides 1 to 19 hours unpaid care a week	22,835	7.5
Provides 20 to 49 hours unpaid care a week	4,046	1.3
Provides 50 or more hours unpaid care a week	7,379	2.4

We recognise the important role that carers have in supporting vulnerable people in Shropshire, and so see the development of further support for carers as a continuing priority. Supporting carers forms a key part of delivering our prevention agenda.

In response to the Care Act we have recently re-commissioned our support offer to carers. This has three elements:

- peer support
- advice and advocacy
- planning ahead and keeping well.

There are a number of historical services commissioned by the Local Authority and the CCG, provided by predominantly the voluntary sector but also through some NHS providers.

Better Care Fund budgets aligned to services that support carers equates to £1.108m and delivers a wide range of services supporting carers. There are also a number of local initiatives which includes the identification and support of carers for example, Resilient Communities, Community and Care Coordination, End of Life Coordination, Integrated Community services, Dementia Strategy, the detail of which is described in the scheme descriptors.

The Care Act has prompted a review of these services so that through the Better Care Fund the Integrated Carers Support scheme will identify the gaps and duplication in meeting the needs of carers, and a local carer's pathway will be developed. The pathway will integrate these new initiatives and existing services to enable a clear process of identification, assessment of need, signposting and delivery of a menu of support.

The Integrated Support for Vulnerable Carers initiative will enable the element of the pathway around assessment of need to be explored and improved as part of the wider work. A budget has been allocated to support this scheme. It is anticipated that the scheme will seek to integrate, rationalise and streamline the services provided to carers to ensure Value for Money, so that increased demand can be met within existing resources.

vi) Explain to what extent has the Local Authority's budget been affected against what was originally forecast with the original BCF plan

Care Act 2014 Budgetary Implications

£609K is allocated for the delivery on the Care Act in Shropshire. The Adult Social Care **known** financial pressures remain unchanged from the original BCF Plan. In Childrens the new duty for a separate assessment of carers places additional resource demands on the Disabled Children's Services. There remains a risk that the implications of the Care Act are not yet fully understood and may still require the CCG and the Local Authority to consider a changed position once further information is received.

7 day services to support discharge

KLOE Reference: C3i, C3ii, C3iii, C3iv, C3v, C3vi

Describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The provision of health and care services focussed on five rather than seven days of the week has an adverse impact on our ability to achieve the best health outcomes for patients. Healthcare across our country needs to change if it is to be fit for the future. Population growth and changing health needs mean we have to reconsider how we use our people, buildings and technology more wisely to deliver the highest benefit to all our patients. Shropshire's plans to create better access to health services seven days a week will be closely aligned with national safety and quality guidance and 7 day national plans.

In 2016-2017 we will work with our providers to embed the principles set out in the NHS Improving Quality document, seven day services implementation checklist which has been compiled to support local teams, organisations and health and care communities to move forward with the delivery of seven day services.

Clinical Standards for NHS Services Acute Hospital Care

NHS organisations across Shropshire will in 2016/17 continue to implement their 7 day service organisational plans in line with the following four Clinical Standards:

- Standard 2- Time to First Consultant Review
- Standard 5 – Diagnostics
- Standard 6- Intervention/key services
- Standard 8- On-going review

A baseline position has been determined in the summer of 2015. A key challenge to seven day services is the workforce challenge that the Trust faces.

The plan is being further developed through the STP process as it is recognised that a system approach is crucial to achieve true 7 day services.

The Trust is also reviewing the leadership of this work, in terms of aligning its model to the adopted Medical Director which seems to be the national approach.

I. **Evidence engagement with the Action Plan to deliver clinical standards for 7 day services (7DS) contained in the Service Development and Improvement Plan section of NHS local contracts between CCG and providers**
   - Shropshire CCG has an identified Executive and clinical lead for 7D services and these leads are working with the 7D leads in the provider organisations.
   - Monitoring and review of service development plans for 7 day services takes place at the monthly Contract Review Board meetings and the Clinical Quality Review Meetings. Workforce/clinical challenges which may potentially impact on the delivery of the plans are raised thought these forums.

- The 7D In-hospital acute care CQUINS, for 2014/5 continue to be monitored at the CQRM. An annual report for 2015/6 will be shared in May 2016, to evaluate the implementation plan for achieving the following: on-going review of patients by implementing twice daily wards rounds in AMU, SAU and critical care, daily wards rounds, 7 days per week on both sites.
- The CCG will continue work with the In-hospital acute care provider to establish the progress on the 7D diagnostic plan for implementation by March 2017.
- In-hospital acute care Trust have completed the NHS IQ 7 day services self-assessment tool in September 2015 against the four priority clinical standards to form a baseline.
- The acute care and specialist Trusts within the CCG will take part in the next review of the 4 priority clinical standards for 7 day services in April 2016. This survey will be during a single standardised 7 day period and will be based on a minimum of 280 case notes (40 notes per day) of patients admitted for urgent and emergency care.
- Shropshire CCG is an active member of the Midlands and Eastern Regional 7D working group. This provides great opportunity to keep up to date with the current national and regional work as well as the opportunity to learn and share from other providers, to inform and shape our plans.
- Shropshire CCG, with support from Midlands and Lancashire CSU, developed geographical heat maps for weekend and out of hour's pharmacy provision and extended opening hours for General practices. This baseline information will inform our further development and planning of 7 day services for 2016/17 for our local population.

II. Indicate how local partners will work together to ensure that NHS providers meet the milestones for inclusion of the Clinical Standards for 7DS? Year 1 (2014/15) – do local contracts include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan Section?

- SATH – An action plan to deliver the 4 clinical standards is included in the local contract to be completed by March the end of the 2015/16 financial year detailing the delivery and progress of the action plan will be shared at the CQRM in May 2016.
- SCHT & SSSFT – The Service Development and Implementation Plan for 2016/17 will include 7 D service action plans to be agreed with local commissioners to implement the clinical standards set out in the NHS Services. The focus for the CCG will be to provide equal access to care and greater integration of services.
- RJAH – National 7D guidance for specialist providers has become clearer during the recent months and for 2016/17 RJAH will participate in the review of the 4 priority clinical standards for 7 day services during April 2016. This baseline will be utilised to develop an action plan for 2016/17 to be agreed with local commissioners.

Community Services plans for 7 Day Services

We will continue to use the Better Care Reference Group forum to collate a cross economy picture of where 7 day services are currently delivered outside of acute hospital settings and where there are plans to deliver services over 7 day services and where there are opportunities for further development for 2016/17

Primary Care

Work to focus on access to primary care is in development via the Primary Care Co-Commissioning Group and the Primary Care Working Group via the creation of a Primary Care Strategy for Shropshire. Although the latest published GP patient survey results showed that 76% of patients were satisfied with their practices opening hours compared with a national average of 75% there is still further work to do to improve accessibility in Primary Care. This work is supported by our out of hours provider Shropdoc who are well respected in terms of their accessibility for patients when their regular practice is closed, our local pharmacies and work streams under the Prime Ministers Challenge Fund across Shropshire and Staffordshire.

7 Day Services High Level Mapping

Existing 7 day Services	Planned Developments	Opportunities

• Rapid Assessment Interface & Discharge (RAID) Mental Health
• Crisis Resolution/ Home Treatment – Mental Health Inpatients
• Social Care – Emergency Duty Team
• Short term Assessment & Re-ablement Team (START)
• Reaching Out Service – CAMHS
  ○ Consultant Psychiatrist on call
  ○ Additional support to avoid hospital admission or facilitate discharge (8-8, 6 days p/w)
• Children's Nursing Team
  ○ On call system for EOL Care 24/7
• Prison Nursing Services 24/7
• Community Hospitals
  ○ Nursing care hospital beds 24/7
  ○ MIU (except Whitchurch & BCH)
• Integrated Community Service (County Wide)
• Homelessness Services 24/7
• RJAH
  ○ Theatres and Day case Unit 6/7
  ○ Outpatients Clinic 6/7
  ○ Radiology
  ○ Physiotherapy for surgical patients & emergency on call 7/7
  ○ Pharmacy 6/7
• Age UK
  ○ Volunteer Befriending Service
  ○ Home from Hospital Service
  ○ Help at Home activity
	The following services have been identified to move to 7 days a week. These work areas will be prioritised during quarter one of 2016/17 and thereafter milestones will be established through the BCF group:
	• Community MH Team
	• Dementia Teams
	• Transfer of care Document & Training to support care home assessments over 7 days
	• Workforce development to support providers to manage needs in the community
	• Reaching Out Services CAMHS
	  ○ Additional support to avoid hospital admission or facilitate discharge – expand to 24 hrs, 7 days per week
	• Children's Nursing Team
	  ○ Expand to 7 day service to cover all aspects of acute and chronic care for children
	• RJAH – MRI scanner at weekends
	• RJAH – expansion of CT service
		Further areas will be considered during 2016/17 through the BCF:
		• Community Hospitals
		  ○ Ward clerking
		  ○ Therapists
		  ○ Diagnostics
		• Community Nursing Services Expansion of hours to 10pm
		• Age UK
		  ○ Extension of admission avoidance services
		  ○ Extension of volunteer services such as befriending

7 days service in Adult Social Care

Shropshire Council provides a 7 day social care service through the out of hours emergency duty team.

The Emergency Duty Team (EDT) in Shropshire is the out of hour's response service for both Adults and Children's Social Care. This service delivers the Council's statutory duty to provide an Approved Mental Health Practitioner and Child Protection and Adult Safeguarding practitioners on a 24 hour basis. The out of hours service currently operates between the hours of 16:45 to 09:00 Monday to Thursday nights and over the weekend from 15:45 Friday to 09:00 Monday.

The EDT officer takes calls directly from the public as well as professionals such as the police, hospitals and ShropDoc.

The EDT is made up of 5.5 Social Workers and one full-time Senior Social Worker. All have to be qualified AMHPs and also experienced in child protection. There is a senior manager on call from Adult Social Care if the EDT worker/s have queries.

EDT is primarily a reactive service, responding only to urgent & essential statutory social care needs (usually for immediate protection). The work is focused on screening and risk assessment and action is limited to safeguarding and other statutory Local Authority duties that cannot legally wait until the next working day e.g. Mental Health Act assessments; child protection; emergency social care for older people; and Appropriate Adult.

There is a real opportunity to integrate out of hours provision across the health and social care sector and during 2016/1 7 it is intended to re-commission the service to include the integration of out of hours social work provision with other out of hours services such as with key health care partners in particular GPs and Shropdoc. It will be essential however to ensure that the statutory Child Protection responsibilities of the EDT service are met within any new commissioned service

Transformation Schemes developing 7 Day Services

A significant step in the development of seven day services and central to our local developments is our Integrated Community Service. The first phase of this service development began in Shrewsbury in November 2013 focussing on early supported discharge and has now been rolled out to all areas. The scope of the service has also expanded to include admissions avoidance in line with local priorities. This work will continue to be developed under the Better Care Fund structure. ICS is delivered 8am-8pm, 7 days per week – however the care and support delivered by this team is 24/7. This service works to facilitate discharge and prevent hospital admissions in partnership with Primary Care over 7 days

Rapid Response Liaison Psychiatry service operates 24 hours a day, 7 days per week. This service supports the assessment and onward referral of patients with Mental Health crisis, attending Emergency Departments.

Data sharing

KLOE Reference: C4i, C4ii, C4iii, C4iv, C4v, C4vi, C4vii, C4xiii, C4xix, C4xxi

i) Set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The CCG, Local Authorities and NHS Providers in Shropshire are committed to the use of the NHS number as the primary identifier. This is evident in the organisational Information Management Policies and Plans across the organisations.

The most significant challenge has been introducing the NHS Number as the primary identifier on the social care database; however significant progress has now been made against this plan.

CareFirst, which is main social care data base in Shropshire, now holds the NHS number and this number is displayed on the clients record front screen. CareFirst performs a validation check against the number to ensure that it is the correct format, that the person's record has only one current NHS number recorded and that the number has not been recorded on another record. The main assessment documents have been updated to accommodate the capturing of the NHS number at the beginning of the assessment process, the NHS number is included on the print out of these documents for sharing with either the client or partner agencies.

In addition to the practitioner capturing the NHS number at the beginning of the assessment process, SQL scripts have been purchased from the application suppliers that enable batch files to be sent to MACS to find the NHS numbers on all current and recent social care clients where one does not exist in the system. The returned file from MACS can then be uploaded to update the person's record with the traced NHS number. Validation takes place when uploading the file against any NHS number that may have been manually entered in the interim. The batch file to MACS has been a monthly process. The decision to include recent social care clients who are not currently in receipt of a service was made to assist with the sharing of data for analysis of trends over recent years, when the collection of the NHS number was not previously built into the processes.

Currently the percentage of current and recent clients on CareFirst with an NHS number is **84%.** Our Aspiration for 2016/17 is to reach **90%** as a minimum

The actions that now need to be prioritised are the data quality issues on records that a) cannot in the first instance be sent to MACS as they do meet the criteria for the matching process b) records that are returned from MACS as not able to find a match. The plan is to prioritise the data quality issues identified at a) above, and then move onto the data quality issues identified at b). These are both reliant on resources available to complete the data quality work, and this will be an ongoing requirement but the numbers of records should reduce overtime.

We are aware of the pending closure of MACS and will be exploring other options for obtaining the NHS number such as the Demographic Batch Service.

Discussions are taking place with the supplier of CareFirst and, via their forum, other Local Authorities about making the NHS the primary identifier in the system. The risks associated with this are when a person presents to social care and the NHS number cannot be obtained immediately or the person does not have an NHS number, the persons record needs to be created on presenting –

therefore a system identifier will still need to be generated and used until the record can be updated with the NHS number.

Staffordshire and Lancashire CSU is looking to develop Personalised Care Planning and supported self-management through the development of a patient portal that is fully integrated with GP clinical systems, Integrated Care Record and Social Care.

The initial objectives being to:

- To develop functionality mirroring that used in the national pilot
- Year of Care, care planning templates for local use in personalised care planning
- To develop an electronic health profile which would be used as a shared decision making aid in structured education and personalised care planning consultations
- To develop secure and confidential access to personalised records and information to support personalised care planning and self-care

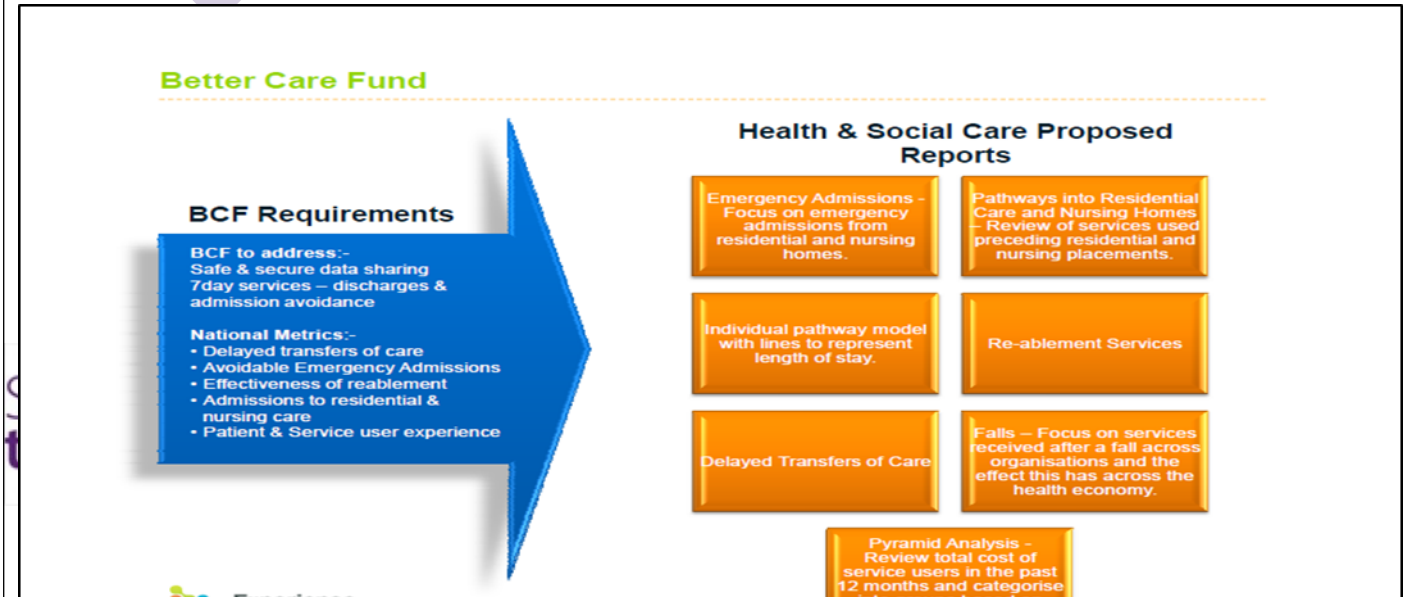
The consistent use of the NHS Number is a key enabler to the development of this.

Shropshire CCG will work with local groups and communities to highlight the importance of personal data and the NHS Number as the key personal identifier. Working through groups like Shropshire Patient Group, condition-specific forums and with groups that help the CCG engage with people from the nine protected characteristics, we will help people to understand the importance of the NHS Number. We will also work with local partner organisations and staff groups to make sure they too are conveying the importance of the NHS Number and about personal data in general and how local health and care organisations use this data to help people and to improve services.

ii) Explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The CCG, Local Authorities and NHS Providers in Shropshire are committed to adopting systems that are based on the use of Open API and Open Standards. This is evident in the organisational Information Management Policies and Plans across the organisations.

Shropshire Council and Shropshire CCG have taken part in a regional pilot to implement the sharing of pseudonymised health and social care data. This will support us with integrated monitoring of the National Metrics and useful data to support commissioning/decommissioning of services for the Better Care Fund. Please see an illustration below which shows the ambition of this work.



The initial phase has now been completed and the CCG and Council are working together to review the data this has generated to inform future planning and targeting of resources at specific areas of the system to effect the maximum impact. A joint workshop has been held and this work continues to develop

iii) Explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

Information Governance Leads from the Local Authority and the CCG are involved in the development of the Better Care Fund plan through involvement in individual Transformation Schemes and through representation at governance boards and groups. For every scheme or work programme a privacy impact assessment and checklist must be completed to enable IG leads to ensure that appropriate controls are in place.

NHS Standards Contract, IG Toolkit and Caldicott requirements are in place and monitored by the respective IG leads.

The outcome of the consultations by DoH on the Protecting Health and Care Information Regulations and HSCIC on the Code of Practice on Confidential Information will be monitored and factored into existing IG measures where required. Shropshire Council and Shropshire CCG operate similar IG frameworks and compliance regimes and engage with each other as services are developed and change. IG risks will be added to the register as they are identified.

To ensure IG is factored into service change, privacy impact assessments are undertaken at the feasibility stage of projects and reference is made to current legislative and external compliance requirements. E.g. HSCIC, LA Toolkit, PSN standards, etc.

A national problem has been identified regarding Public Health teams based in Local Authorities being given access to NHS data that would enable them to carry out their roles, including development of the Joint Strategic Needs Assessment and support to the Clinical Commissioning Groups. NHS England and Public Health England have confirmed that until they receive national authorisation they cannot provide a range of data that was previously available to public health teams when they were based in PCTs. Such data includes Practice level data regarding screening and immunisation, and Primary Care performance.

Although local arrangements have been put in place between our local Public Health Department and Commissioning Support Unit to share pseudonymised data which has been beneficial the pseudonymisation does not allow the full matching of health and social care data which remains problematic

Joint assessment and accountable lead professional for high risk populations

KLOE Reference: C5i, C5vi, C5vii

i) Specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Practices were asked to identify those most at risk of loss of independence or admission to hospital. MDTs have been identifying individuals at risk of admission through computer searches, local intelligence and clinical judgement.

Many practices use a risk stratification tool provided by the Commissioning Support Unit. The tool filters patients over 18 years of age with dementia and/or are flagged as 'Palliative care' or who have two or more long term conditions (LTC's e.g. diabetes, stroke, cancer, CHD, HF, AF, CKD and COPD). This provides the practice with approximately 6-7% of their practice population. This list is then ordered by a pre-determined priority list, for example those over 90 or those with 4 or more LTC. This tool is often used in conjunction with the other identification methods previously listed.

The schemes of work to address the needs of this section of our population's is set out below. Implementation has met all key milestones and is embedded in every day practice. Monitoring is undertaken at regular intervals and information regarding the progress in relation to the enhanced contract is received by the CCG each September and March. Regular monitoring is also carried out via the rolling programme of practice visits carried out by the practice support team.

ii) Describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

In 2013/14 the CCG supported the implementation of the enhanced service, risk profiling and care management. The CCG focus was on frail and vulnerable patients and practices were asked to identify those most at risk of loss of independence or admission to hospital. MDT meetings (including the voluntary sector) assessed the cause of that risk and developed a care plan to reduce that risk. Where appropriate care coordinators (each aligned to a practice) were allocated to support these at risk individuals with their on-going health & care needs.

This work has continued into 14/15 and 15/16. It has been developed further by ensuring communications between other providers, so, for example care homes, ambulances services and mental health teams have access to telephone numbers that act as a by-pass to the normal practice telephone system. In addition, at risk patients (those with care plans) are also given more ready access to their GP through the by-pass telephone system. This specific phone line allows a more timely response to calls for advice or visit requests

Also in 2013/14 a Care Home Advanced Scheme (CHAS) was introduced adopting pro-active care through active case management, care planning, anticipatory prescribing and multidisciplinary review for patients improving quality and outcomes as well as reducing unnecessary hospital admissions. This programme was supporting the 3,600 patients currently residing in care homes in Shropshire who have complex needs and use a large proportion of health and care provision in the

county. The scheme supports increased medical input to care homes through risk stratification of residents that may be at risk of hospitalisations and GP input through a care planning/case management approach and multidisciplinary team review. The aims include:

- Identification and risk stratification of residents in care homes at highest risk of hospitalisation
- Developing a care plan using an MDT approach
- Employing consistent documentation to 'manage me here'.
- Planned regular visits
- Medication reviews
- Flagging every patient with the 'Out of Hours' service.
- Significant event analysis in the event of an unplanned admission or intervention

This scheme of work has demonstrated an extremely positive impact and has therefore continued to be supported by the H&WBB as a key BCF scheme. A set of principles for the further development of the joint process has been agreed as set out below. However, as a well-established work stream a review of the CHAS scheme will be carried out during 2016/17 to look at how further improvements can be made to increase the impact of this work:

- The accountable professional for these patients will be the GP.
- Where the patient would benefit from care coordination/key worker these will be allocated through the care planning process.
- The care coordinator could be:
    - Specialist nurse in COPD, Heart Failure or Diabetes,
    - Community and care coordinator,
    - Social worker,
    - Care home or domiciliary care staff,
    - Clinical nurse specialist in palliative care,
    - Community matron
    - District nurse
    - A member of the practice team.

  This will be dependent on the needs of the individual and the decision of the MDT. Work is in train to enable this process which will both support individuals and integrate care.

The CSU has developed CCG self-populating templates which will support and guide the practices in delivering the 2% case management.

Further development includes moving toward a shared electronic care plan/record between all those involved in the care of an individual, accessible to the patient and carer.

It is recognised that many of these individuals have multiple reasons to be at risk. These reasons span health, social, housing, care needs, advocacy needs, isolation and loneliness.

In 2015/16 the BCF Plan built upon this foundation through implementation of the Proactive Care Programme. Practices will work with their MDT to case manage at least 2% of the population most at risk of admission (although it is acknowledged that this percentage is likely to be much higher when fully implemented). Initially the focus was on:

- The last year of life from all causes

- Frail & vulnerable individuals including those with dementia
- Patients in care homes
- Patients with Diabetes, COPD and Heart Failure (our 3 priority LTCS for 14/15)

Plans will be developed further through the work of 'Future fit' and development of the Primary Care Strategy which looks to developing 'Primary Care at scale'.

Integrated Community Services (ICS) a joint health and social care multi-disciplinary team provides quick access to multi-disciplinary input for people at risk of hospital admission or needing re-ablement on discharge for all service user groups. There are good links with primary care and access to information from primary care about existing care planning for people with long term conditions.

For those people who are outside of the ICS approach there is a First Point of Contact at Shropshire Council where individuals can access statutory Social Care and a booked appointment systems operates for Let's Talk Local which are community hubs run by People2People and featuring other voluntary and statutory sector input to enable individuals to get the response they require at the right time. The Let's Talk Local hubs are accessible by the GP Community and Care Co-ordinators and there are good links to those that they support with long term conditions to help prevent unnecessary admission to hospital

For those individuals with Mental Health problems there is a joint Community Mental Health Service with a developing single contact point for early access to interventions to prevent hospital admission. This includes access to the health led Crisis Home Treatment team and the CMHT's.

For those individuals with a learning disability there is proactive work between the CCG, Council and SSSFT to identify those who are at risk of hospital admission or admission to residential care and a regular joint assessment of these individuals as per the Transforming Care guidance.

iii) State what proportion of individuals at high risk already have a joint care plan in place

Approximately 1,500 of the 3,600 care home residents have care plans in place through the Care Home Advanced Scheme. Work continues to complete the remaining care plans alongside the review set out above.

42 of the 44 practices in Shropshire are signed up to the Proactive Care Programme enhanced service and GPs are actively working to identify their most vulnerable patients and instigate Joint Care Plans.

Agreement on the Consequential impact of changes on providers

KLOE reference: B3iv, C6i, C6ii, C6iii, C6iv, C6v, C6vi

The direction of travel set out in this BCF plan for changes to the focus and configuration of services have been reflected in contractual discussions with providers and as such reflected in 2016/17 contracts. The required position has been discussed at length at the H&WB Delivery group, supported by more strategic discussions at the Health & Wellbeing Board. Wider stakeholder engagement including service users and political representatives in this planning has been facilitated via the BCF Reference Group and Health & Wellbeing Lay Reference Group and the involvement of Healthwatch throughout. The Chair of the Health and Wellbeing Board is the portfolio holder for Health and the Health and Wellbeing board also includes in its membership the portfolio holder for Adult Social Care. As noted earlier in this document a large scale review of the Health & Wellbeing Board has been undertaken which has resulted in an extension of its membership to include provider organisations.

Whilst contracts for 2016/17 focus on delivery for that year, these sit in a context of wider discussions at the fora noted above about the strategic intent for future service provision in Shropshire to meet the needs of our population. This is further supported by extensive engagement with our Future Fit and Community Fit transformation programmes and the on-going development of our local Sustainability & Transformation plan. Further information regarding alignment with other plans is set out in the Alignment section of this plan.

In particular the Community Fit Phase 1 will report over the coming weeks on the work it has done to quantify the activity shift needed from acute to community based care and begin the discussion about how this can be facilitated.

During 2015/16 Shropshire CCG undertook, with input from Shropshire Council, a detailed re-allocation process for all its grant funding. This funding was allocated to the voluntary sector on the basis of schemes that would support delivery of the BCF priorities. All of the grant funding was allocated and quarterly monitoring of provision will be undertaken. This has been a positive step in terms of reinforcing the role of the voluntary and community sector in delivering our strategic vision but also in terms of more operational alignment of funding and resources with delivery of BCF priorities.

The impact of NEL reductions has been included in the Shrewsbury & Telford Hospital Trust contract for 2016/17and the required investment to realise these reductions is included in the contract with Shropshire Community Health Trust.

The service specification for the Integrated Community Service has been updated on the basis of the pilot over the last 6 months and includes supporting discharge, avoiding admissions and is supported by a CQUIN in both contracts.

The Local Authority has developed interactive mapping facilities to enable domiciliary care providers to respond quickly to request for care by making best use of the resources they have in the different areas of Shropshire. This has been well received by providers with all providers signed up to the portal. As a result we continue to see increased capacity as providers develop their own workforce to meet demand.

Agreement to Invest in NHS Out of Hospital Services

KLOE Reference: A1, A2, A3iii, A3vii, B5i, C1iv, C7i, C7iii, C7v, C7vi, C7vi, C7vii, C7viii

During 2015/16 Shropshire CCG's financial position has deteriorated. This has resulted in NHS England issuing Directions early in April 2016. The CCGs current financial pressures are well documented and partners have been kept informed of the financial position as it has unfolded. This sits within a health and social care economy that has broad financial challenges across providers and commissioners, across health, social care and the voluntary sector. The collective challenge has been the centre of several Health and Wellbeing Board meetings and there is a collective commitment to work to address the issue.

Within the CCG a significant focus has been placed on addressing the financial deficit and bringing the CCG back into financial balance at the earliest possible opportunity. A Turnaround Team (Deloitte) have been appointed and are working as an embedded team within the CCG to scrutinise local finances and develop plans for recovery. The schemes of work under BCF play an important part in this recovery plan. However, in drafting the 2016/17 budget proposal for the Better Care Fund the CCG has had to give consideration to both the requirements of the Better Care Fund, the requirements to improve its overall financial position and the requirement to ensure that access to patient care is maintained.

Working with Local Authority Colleagues and within the 2016/17 Better Care Fund Policy Framework the budget proposed totals £22.8m and includes the CCG minimum funding requirement of £19.302,189 (£226,000 less than its mandated minimum allocation in 2015/16) The Health & Wellbeing Delivery Group has maintained oversight of the BCF budget and a sub group of this group has focused on the development of the 2016/17 BCF budget. The Delivery group has agreed to undertake a review of the BCF budget lines for efficiencies in the first quarter of 2016/17 to ensure the budget in totality is being used to best effect. This will be linked to a number of service reviews and underlines the commitment to maintain the momentum created in 2015/16 to develop greater integration of budgets around collective priorities. In addition to this Shropshire Council have added a further £1,073,393 of investment into the BCF budget over and above their minimum required allocation to support greater alignment of work and outcomes. This work serves a precursor for work during 2016/7 to further develop our integration plans, linked to the development of our system wide Sustainability and Transformation plan. A breakdown of the overall budget makeup is set out below:

Shropshire Council (mandated DFG allocation*)	£2,498,000
Shropshire CCG (mandated allocation**)	£19,302,189
Shropshire Council additional funding	£1,073,393
Total	**£22,873,582**

** DFG allocation has increased by £343,000in 2016/17
** includes Care Act 2014 monies and former carers break funding

Shropshire Council's additional funding is made up of the following commitments:

Substance Misuse Carers service (Public Health)	£67,000
Falls Prevention Service (Public Health)	£233,000
Resilient Communities work stream	£172,320
Alcohol Liaison Service (Public Health)	£85,000
Carers Contract	£237,000
Social Prescribing scheme (Public Health)	£250,000
Re-ablement Commissioner (50%)	£28,974

The Policy Framework for 2016/17 removes the need for a Payment for Performance Fund to be set aside and instead allows the equivalent sums to be invested in risk sharing arrangements and NHS Commissioned out of hospital services, or investment in NHS out of hospital commissioned services only. Shropshire will be adopting the latter position.

The budget proposal includes an investment in the Integrated Care Service which represents a significant element of the out of hospital services commissioned. Across the combined health and social care aspects of the service the total investment by the BCF will be in the order of £3.8m.

The current Partnership Agreement will be updated to reflect his position and adopted by all parties by the 30 June deadline.

Deloitte continue to work with the CCG to develop robust QIPP schemes for 2016/17 of which some are BCF schemes:

Integrated Community Services (collectively)	£1,713,470
High Intensity Users Scheme	£447,959
End of Life Scheme	£288,000

Additional work is underway to develop QIPP savings targets against the Alcohol Liaison Scheme and the Falls Prevention Scheme in particular.

In addition we have been keen to develop work to measure the impact of our BCF developments both in terms of health and social care outcomes and the financial benefits that can be realised. These elements have been a challenge in 2015/16, particularly in relation to some of our enabling schemes such as Resilient Communities which provide a platform for other schemes to develop rather than directly contributing to the achievement of metrics. We have been successful in a bid to the BCF support team to assist us in developing methods for better capturing impact and benefits realisation. This work will be coupled with local leadership development work around the cultural changes needed to support change. This work will take place in late April to inform the way we roll out the BCF plan in 2016/17

Local Action Plan to reduce Delayed Transfers of Care

KLOE Reference: C8i, C8ii, C8iii, C8iv, C8v, C8vi, C8vii, C8viii, C8ix, C8x, C8xi, C8xii, C8xiii

This plan pulls together the work streams in place to assist in the management of Delayed Transfers of Care within the footprint of Shropshire Clinical Commissioning Group and Shropshire Council. It aims to ensure that high quality responsive care and support is given to people who have been in hospital and need support for their transfer of care when they are ready for safe discharge.

Managing DTOC is a considerable challenge for the Shropshire Health Economy with recent (15/16) performance consistently behind target. There is a clear need for a system action plan to tackle this issue and to successfully manage DTOC.

The arrangements within this plan will assist the organisations identified within it in meeting the requirements of NHS England to deliver a locally agreed action plan for inclusion within the 16/17 BCF plan.

Objectives

Develop an integrated action plan for inclusion within the 2016/17 BCF plan that ensures a timely and effective response to people who are reported as experiencing a delay in their transfer of care arrangements.
Identify a shared understanding of what constitutes a 'delay' to transfer of care which is statutorily reportable under the Care Act (2014) and to implement processes between agencies to improve the level of DTOC
Clarify the specific agency responsibilities across the health economy footprint in relation to timely managing transfer of care for people who have experienced a period of time in hospital.

Definition of Delayed Transfer of Care

The Better Care Fund planning requirements for 16/17 define a delayed transfer of care as: "when a patient is ready for transfer from a hospital bed, but is still occupying such a bed." A patient is ready for transfer when:

(a) a clinical decision has been made that the patient is ready for transfer AND
(b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND
(c) the patient is safe to discharge/transfer.

Safe to transfer" indicates that the person may be transferred to an intermediate or transitional support setting whilst awaiting service provision of the required package of care or of placement into nursing or residential care or other placements. The person will need to be over the acute phase of their illness or treatment and no longer in need of an acute hospital bed (or intermediate care/transitional bed).
For BCF DTOC is measured as total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)*

This plan is underpinned by the discharge from hospital pathway process and practice DoH 2003,

Community Care (delayed discharges etc) Act 2003 and the National Framework for Continuing Healthcare and NHS funded care (2007).

The principals of the Mental Capacity Act (2005) will apply to all people whose care arrangements are subject to the actions within this plan (excluding those subject to Section 2, 3 an d 37of the Mental Health Act 1983).

Reporting of a Delayed Discharge

The Department of Health states that "A delayed transfer of care occurs when a patient is ready for transfer from an acute hospital bed, but is still occupying such a bed".

Following the release of the 'new' guidance in September, A review of the DTOC reporting process has taken place in Shropshire led by a joint commissioner on behalf of Shropshire Council and Shropshire CCG. This work has led to a series of integrated workshops. Previously, in Shropshire there were a large amount of DTOC's under the category of 'waiting assessment.' Through support and guidance from ECIP a better understanding of how this and all category's should be used has been established and agreed locally. All key members of the local health and social care economy have been involved in re exploring the guidance and how this needs to be applied. As such all partners now understand and agree the approach to measuring and recording DTOC and therefore are joined up in reviewing progress as a whole system.

Situation analysis for Shropshire and shared DTOC plans

Since October 2014 the Shropshire and Telford Hospital (SaTH) has been in a continual period of escalation. On a daily basis SaTH escalate that medically fit for transfer patients (MFFD) occupy over 13% of the inpatient total. The system recognises that particularly over previous periods of winter pressures there has been an increase of the number of beds unavailable due to delayed transfers of care (DTOC). Through system analysis it was acknowledged that the majority of patients in SaTH are deemed MFFD for at least 4 days before discharge is implemented and during Winter 14/15 approximately 30% of the list at any one time is made up of MFFD patients who wait 7+ days for their discharge plans to be coordinated. This year following the implementation of a discharge to assess model of practice the system has shown greater resilience during the winter. Escalation processes have improved and partnership working is much more joined up. There has also been a systematic reduction in delayed patients in the acute hospital in January (see below) which is evidence that the plans implemented this year for improvement are starting to take effect and with further drive progress will strengthen.

Shrewsbury & Telford Hospital	Days delayed as a % of occupied beds. Average daily by **Month**		
	Acute	Mental Health	Community
Apr-15	3.2%	see note below	
May-15	4.1%		
Jun-15	4.9%		
Jul-15	5.7%		
Aug-15	4.3%		
Sep-15	4.7%		
Oct-15	6.7%		
Nov-15	6.3%		
Dec-15	5.2%		
Jan-16	3.8%		
Feb-16	0.0%		
Mar-16	0.0%		
Year to Date			

Copy of DToC 2015_16 (3).xlsx

Detail of current performance levels.

The A&E 4hr target remains an issue the whole health economy is focussed on and for the first time a single A&E recovery plan across the system was agreed which was approved by NHSE and TDA. This plan underpins all the core work streams and system processes that are in place to address and improve upon DTOC performance. The following areas are the high level relevant priorities within the plan that directly relate to improving DTOC and need to be implemented to ensure sustainable achievement (the below is also reflected in the CCG operational plan which highlights minimising DTOC's as a priority area):

- Development and implementation of an end-to-end frailty pathway which identifies and manages over 75's in primary/ community care with an emphasis on prevention
- Roll out of Discharge To Assess prototype across the hospital, and the shifting of required resources (e.g. from bedded care to home based support)
- Supporting the acute and community hospitals to implement enhanced bed management processes (SAFER bundle)
- Working with the Community Trust to continue developing and maximising the impact of the Integrated Community Services team both at the front door in avoiding admissions and at the back door in improving the rate and timeliness of discharge

7 day discharge is also an area for improvement locally and the commissioning arrangements for the ICS service are now 8am-8pm, 365 days a year, to support with both hospital discharge and admission avoidance. Following input and guidance from ECIP a drive to achieve 80% discharge of

the weekday rate over the weekend is a long term progressive plan. For 16/17 the CCG have implemented a 7 day discharge CQUINN for both the acute and community trust to be awarded as an additional measure and incentive to improve weekend discharges, flow across the system and avoid DTOC.

1. **DTOC Targets for 2016/17**

Based on this situation analysis system leaders across the local health and social care economy are proposing the following targets for DTOC in 16/17:

	16-17 plans			
	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Quarterly rate	1163.2	1166.0	1411.1	1146.6
Numerator	2947	2954	3575	2920
Denominator	253,354	253,354	253,354	254,656

This represents a realistic target based on performance to date and partners are all in agreement that due to the rigorous strategic and operational plans (detailed below) the target can be achieved through joint ownership and commitment.
The progress of the discharge to assess model is monitored in relation to the measure to reduce the DTOC rate to 2.5% which then will form the stretch target beyond the 3.5% standard set outlined within the NHS England DTOC planning guidance.
The following are additional local targets and performance indicators that have been implemented again through the A&E recovery plan with the intention that if the below are achieved this will ultimately deliver the planned DTOC target.

- Reduction in the number of over 75's admitted to hospital by 20%
- UCC throughput needs to be consistently over 95% of its planned capacity
- 60% of complex patients need to be discharged home via pathway one; 30% of patients into re-ablement; and approx. 10% into assessment beds outside of the acute focused on avoiding the need for long term care
- The acute hospital needs to be supported in implementing processes to discharge over 30% of patients before midday and reduce emergency bed occupancy to 90% or lower
- The community hospitals need to be helped to implement processes which will lead to a reduction in overall LoS to an average of 15 days or fewer

Action plan to reduce and manage DTOC 16/17
The attached action plan summarises many of the DTOC operational work schemes that have commenced or are planned for 16/17. They have predominantly derived from either direct work planning with ECIP or through the A&E recovery plan which is overseen by SRG. The leads for each scheme have been identified (acronym breakdown listed within appendix) and all other partners involved are also sited.

Action	Description and desired outcomes	Timescale	Lead organisation	Partners involved	Governance structure in place to monitor
Employ discharge to assess methodology for all complex discharges- Trusted assessor model	Fact finding assessments enables ward nurses and therapists to utilise a short 4 page assessment to capture both the pre- hospital needs of the patient and the level of support they require leaving hospital. This assessment comprises of a minimum data set to secure a safe discharge with wrap around support preferably within the patient's own home within 48 hours of ICS receiving the information. ICS triage all referrals and if required complete a joint review with acute staff and patient to ensure pathway is correct and share learning across community and acute services. Patients full goal planning and assessment of need commences 24 hours post discharge where they are visited mainly in their own home or bed based setting. Benefits of the approach for patients include a quicker return home where appropriate, the ability to rest and recuperate in familiar surroundings and less risk from the secondary complications that can be associated with longer hospital stays. The system benefits are a reduction in DTOC and enhanced flow.	Underway	SaTH	CCG, SC SCHT(community hospitals and ICS) SPIC Patient representation	Daily discharge hubs Urgent care working group Monthly joint commissioner meetings with ICS

Daily discharge hub meetings	Daily review of patients take place through morning ward rounds led by consultant/ senior doctors. If patient discharge cannot be organised at ward level through the trusted assessor process patients are reported to the discharge team. Each acute then feed this information into a brief MDT meeting (format has been supported by ECIP) this provides foundations for integration between discharge teams, ICS and social work intervention. The current DTOC and patients at risk of DTOC are discussed and clear plans to support with timely discharge are then implemented. If there are delays within this process it is escalated to system wide leads.	Underway	SaTH	CCG, SC SCHT(community hospitals and ICS) SPIC	
Spot Purchase policy	Increased capacity for spot purchase of nursing and residential care home interim placements and interim domiciliary care packages is in place with a whole system policy if spot purchase is required during periods of high escalation.	December 2015	CCG	CCG, SC SCHT(community hospitals and ICS) SPIC	Escalation conference calls SRG
ICS admission avoidance	ICS have now launched an admission avoidance pathway designed to provide wrap around support for patients outside of the hospital setting. Referrals are received through the care co-ordinator who triage and if acute care is not required forward to ICS for intervention. ICS have a daily presence within A&E to prevent frail and complex patients	October 2015	ICS	CCG CCC SCHT SC Primary care SPIC	Urgent care working group ICS commissioner meeting

	being formally admitted to acute care. They are also actively working with care homes and care providers to refer to service for admission avoidance support if required.				
Complex discharge manager	Shropshire CCG have established a specialist post to support with identifying barriers across the system that equate to delays, hold providers to account to secure discharge for individual patients and work with the commissioned services responsible for hospital discharge. This role is key to strengthening pathways and reviewing service design to ensure maximum efficiency across the system to manage patient flow and avoid unnecessary DTOC.	Winter 2015 extended for a further 12 months	CCG		
DTOC workshops	Following the new DTOC guidance published in September 2015 a number of local workshops have been held and supported through ECIP. This has resulted in better working relations between acute and community services and due to the clarity within the new guidance an assurance that DTOC is more accurately recorded.	September 2015	CCG	SaTH SC SCHT Housing ECIP	Any confusion or disagreements in relation to DTOC escalated to commissioners for support
System leader DTOC sessions (systems resilience group)	Monthly workshop sessions with system leaders to analyse DTOC performance and agree any mitigating action required is in place.	Monthly	CCG	SaTH SC SCHT SPIC	SRG
Whole system Dash board	A weekly whole system integrated dashboard has been implemented to map capacity across the whole system, identify pinch points and support with daily discharge planning.	April 2016	CCG	SaTH SC SCHT SPIC	SRG

	This is a mechanism to support with demand and capacity modelling and also maintain momentum on patient flow across every aspect of the patient pathway.				
Housing support	A dedicated housing officer will be based within the acute trust one day a week and available to visit community hospitals and take referrals from ICS to support with any housing challenges preventing DTOC. In addition the post will help provide a more preventative long term approach to supporting vulnerable individuals whose health and social needs could become exasperated through their housing needs.	April 2016	SC- Housing	SaTH SC Voluntary sector SPIC	DMT
Red Cross	Home from Hospital service complements and enhances care provided by statutory agencies to people needing practical and emotional support to enable them to return home following hospital discharge or support to allow an individual to remain at home following a crisis. The service operates as a planned intervention and works in partnership with other service providers to minimise disruption and ease the adjustment following a crisis or hospital stay, both for the patient and their carer. Red Cross workers already work within the ICS team however this resource was	November 2015	Voluntary sector	CCG SaTH SCHT SC	CCG receive monthly performance reports

	enhanced with additional funding to support Winter pressures				
Let's talk local	These drop-in preventative sessions are taking place in Shrewsbury, Oswestry and Ludlow, are part of a new pilot which aims to help people to get to know their options for the future, particularly for those who fund their own care. As well as offering people the opportunity to speak with People2People, the hubs enable them to access information from a range of local organisations including: long term conditions support, housing support, Age UK, occupational therapy, social work, benefits advice, assistive technology and Independent Advocacy Services.	June 2015	SC	Voluntary Sector CCG SCHT SPIC	DMT
MADE Event	MADE was a 'Multidisciplinary Accelerated Discharge Event' implemented by SaTH. The purpose of the campaign was to deliver a unified whole system approach where everyone agrees that for patients who no longer require an acute level of care the system unites to do everything possible to ensure safe discharge within 24 hours. The learning and experiences from this event have been documented and are now being explored and improved upon through a complex discharge task and finish group.	21st- 24th March (2 days at RSH and 2 days at PRH	SaTH	Voluntary Sector CCG SCHT SPIC T&W CCG	

6) ENGAGEMENT

KLOE Reference: B1vi

Patient, service user and public engagement

Describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

A key function of the Health and Wellbeing Board (HWBB) is to ensure that we work with our communities to design health and wellbeing services. Working with Shropshire residents and service users ensures that their views are central to Board decision making. Continuous and meaningful engagement with residents and service users provides an opportunity for them to understand the important role they play in keeping themselves and their communities healthy, thereby promoting resilience. In addition, residents and service users will get more control enabling services to be co-designed resulting in a more responsive service that addresses the needs of the community.

In February 2016, the new Terms of Reference of the HWBB were finalised alongside the refreshed Health and Wellbeing Strategy (HWBS). The main development in the new Terms of Reference is the inclusion of local providers on the HWBB. Therefore the three main hospital trusts, care providers (represented by Shropshire Providers in Care – umbrella organisation) and the Business Board are all now represented on the Board. This new way of working engenders a cohesive and a more joined up approach at a strategic level. In addition, new members bring a diverse point of view thereby creating an environment of rich learning opportunities representing a wider patient cohort.

Based on the ongoing development of the Joint Strategic Needs Assessment (JSNA) and strong service user engagement, the HWB Strategy's priorities include PREVENTION and SUSTAINABILITY (of services and community support). These priorities underpin the Better Care Fund priorities.

The HWBB is committed to demonstrating how user input, engagement and consultation is utilised to support Board decision making through using a 'You Said, We Did' approach to feedback on strategic priorities. The Board continues to publish feedback from all public consultation on the website (www.shropshiretogether.co.uk).

Both the Voluntary and Community Sector Assembly (VCSA) and Healthwatch Shropshire are key partners of the HWBB. Healthwatch Shropshire's primary function is to work with local people to help influence health and social care services to be the best that they can be and therefore continues to be instrumental in helping to lead engagement around the Better Care Fund.

Communication and engagement with residents and service users remains fundamental to the

Board and therefore has convened a permanent Communication and Engagement Subgroup. This aim of this group is to make sure that partners across the health, social and voluntary care economy are working together to promote the messages of the HWBB (including the BCF). Moreover, this group aims to ensure that there is robust, appropriate and proportionate engagement with residents and service users help us to develop our plans; this includes service user representation on working groups and partnership meetings. The Communication and Engagement Plan can be found on the Shropshire Together website, and the action plans demonstrates key actions in relation to the BCF. This action plan can be found here: http://www.shropshiretogether.org.uk/shropshire-health-and-wellbeing-communication-engagement/.

The HWBB and its partners have continued to work with service users on service design via the VCSA, Healthwatch, patient groups, workshops, face to face discussions and surveys to inform key programmes in Shropshire. These programmes include BCF, the Big Conversation, Future Fit, Community Fit, SEND reforms, Care Act, amongst others. The details of this work provides Shropshire with a sound base for decision making and a springboard for further engagement activity for all health and social care. The HWBB provides the Clinical Commissioning Group (CCG) and Shropshire Council with a robust mechanism for ensuring that the user voice is a key element of decision making.

Shropshire is very keen to ensure that our engagement programmes are reaching all those hard to reach, those who don't normally engage or who might feel that their voices aren't heard enough. Healthwatch Shropshire runs a programme of research grants for voluntary and community sector organisations; these grants enable decision makers access to information about what is really happening on the ground given all the changes affecting health and social care services in the county. The research projects look at the services currently in existence, whether they are meeting the needs of the people in Shropshire and identify how change can be communicated. More work can be done in this area and through the programmes of Health and Wellbeing Board and the Better Care Fund, there is a focus on working with the sectors of the population where health inequalities are most stark.

Groups such as the Shropshire Patient Group (SPG) and the Young Health Champions supported by the CCG and the Voluntary and Community Sector Assembly (VCSA) and Members of Youth Parliament, supported by Shropshire Council, provide mechanisms for ongoing engagement. With people from different communities across Shropshire thereby enabling input into decision making processes.

The Engagement Summary which can be found as an appendix to this document details much of this engagement across the commissioning functions for Shropshire.

The learning from this comprehensive programme of consultation and engagement will act as the cornerstone for the development of communication and engagement regarding service redesign linked to the Better Care Fund and for all of the health and wellbeing service transformation.

As previously discussed the priorities of this Better Care Fund plan are in strategic alignment with the HWBB priorities and in alignment with the public and patients who we have had a continuing dialogue with over recent years. Further, as Healthwatch embeds its position within Shropshire, the Health and Wellbeing Board and the Better Care Fund will work closely with Healthwatch, the Voluntary and Community Sector Assembly, service providers, and all our partners to ensure that service users are fully engaged in the drafting, design and implementation of service transformation.

Key principles around our communication and engagement include:

- Ensuring Healthwatch is a key reference point for all engagement activity;
- Working with all of our partners (including the VCSA and provider organisations) to ensure that we are including all pertinent on going consultation and engagement to inform the work that we do, including patient feedback and satisfaction surveys (helping to avoid consultation fatigue and making the most of our resources);
- Ensuring service user representation on working groups, task and finish groups, steering groups (except where absolutely not possible);
- Where possible supporting service user/ patient led forums that will feed directly into service planning, current examples include the Patient Participation Groups, the BCF Reference Group and the Shropshire Dementia Action Alliance;
- Working more effectively to access the seldom heard groups (including socially excluded and the working well); ensuring that we ask the right questions and work in a way that interests people;
- Ensuring that Stakeholders know how their input has impacted decision making ('You Said, We Did').

Key areas for further development include:

- Embedding service user feedback and all consultation and engagement responses within the JSNA, including evidence of the reaching a wide ranging group of people;
- Working with the HWBB communication and engagement subgroup to support the programmes of the HWBB and to work together to ensure that the public is informed and also understand how their views aid, impact, and mould decision making;
- Embedding engagement requirements in all contracts, including appropriate reporting and linkages to the JSNA;
- Embedding Service User Satisfaction in the BCF Metric

Tools we use include:

- Shropshire Together Newsletter
- GP Newsletter
- Patient Group Newsletter
- Social Media
- Surveys

- Working groups
- Focus groups
- Input from Healthwatch Shropshire
- Input from partners patient and service user consultation and engagement

Service provider engagement
KLOE Reference: C1ii, C1v

Describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

I. NHS Foundation Trusts and NHS Trusts

The makeup of providers in Shropshire has been set out earlier in this document. Both our main providers and a wider range of key stakeholder providers have been extensively involved with the development of many of the services set out in the scheme descriptors.

However, in relation to the development of the Better Care Fund in Shropshire specific provider workshops have been held to set the scene and share plans for 2016/17 highlighting key priority areas and learning from 2015/16. In addition to specific BCF engagement providers continue to be involved at a strategic level and in the more detailed and operational planning level. In addition to the health providers, the independent care home and domiciliary care sector were represented as well as the Voluntary and Community sector.

Regular dialogue takes place across stakeholders including providers at various levels:

- HWBB
- HWBB Lay Reference Group (elected members and NEDs)
- HWB/ BCF Reference Group
- Scheme development

<u>HWBB</u>
Throughout 2015/16 members of the HWBB have had regular opportunities to discuss the BCF performance, scheme development, planning and risks and this will continue into 2016/17.

<u>HWBB Lay Reference Group</u>
With the initiation of the BCF, the Health and Wellbeing Board was keen to ensure that while the operational discussions and planning were taking place, the Board members of our provider organisations were also provided an opportunity to engage with the BCF planning process. As such a Health Economy Board Chairs and Non – Executive Group has been established. In 2016, this group has been re-established as the HWB Lay Reference Group and discusses progress on the key development programmes in the health economy. This group is Chaired by the HWBB Chair and membership includes SaTH, SCHT, RJAH, SSSFT, Healthwatch, Shropshire Partners in Care (SPIC), and Shropshire Council Cabinet.

<u>BCF Reference Group</u>
This partnership group has a similar membership to the above but at a more operational level and also includes the Fire Service and Housing. This group meets to discuss the performance of the BCF

and the opportunities for further development of schemes. The group highlights key areas for joint working that will impact on BCF schemes and metrics.

Scheme Development

The NHS providers have been extensively involved in a number of the BCF Scheme development to date and their involvement and input will continue and evolve. The Integrated Community Service is delivered by the Shropshire Community Health Trust as an example, and the Integrated Falls Prevention Scheme, which is in its development phase has kick started the programme with a Whole System Falls Prevention workshop with representation from SaTH, SCHT, RJAH, SPIC, the Voluntary and Community Sector, People 2 People (P2P – Adult Social Care), the West Midlands Ambulance Service, First Responders, the CCG, Public Health, Shropshire Council and Community Leisure Groups.

Primary care providers

Primary care providers are key stakeholders in the transformation of services. As such primary care is at the heart of most of our transformation schemes, as is demonstrated in the scheme descriptors. The Community Care Coordinators and Proactive Case Management schemes are excellent examples of the role GPs and GP surgeries play in the health economy of Shropshire, and GPs have been at the centre of decision making around these schemes.

Also, GPs are well placed, through risk stratification and through NHS Health Checks, to highlight and communicate with the frailest in Shropshire and to ensure that the right people are accessing preventative services at the right time. Primary Care will have a key role to play in the ongoing development and delivery of the Integrated Falls Prevention scheme, Dementia services and the Detection and Management of risk factors for Stroke.

The Local Pharmaceutical Committee is a vital partner in delivering schemes in the community. As such they are a key member of the Better Care Fund's Prevention Group and have made valuable contributions to its development.

The GP Locality Boards of the CCG in the North, Central and South of the county provide an excellent opportunity for CCG members to be engaged. As demonstrated in the Health Economy Engagement Summary, these groups have been and are an important part of the engagement plan. Further to this the CCG's Clinical Advisory Panel, made up if GP representatives from across the County, provides clinical input into the development of BCF schemes with BCF a standard agenda item for these meetings. The CCG continues to have a dedicated GP clinical lead for BCF

Social care and providers from the voluntary and community sector

Providers in Shropshire, including social care, independent care homes, domiciliary care, and VCS providers have been involved with the development and delivery of health and social care services for many years. Providers have also been involved in the development of the services described in

the BCF scheme descriptors.

In relation to the Better Care Fund overarching plan, specific provider workshops were held to set the scene and develop plans for 2016/17 highlighting key priority areas and learning from 2015/16. Social care providers (including the VCS) are involved at all levels of decision making and delivery through the HWBB including:

- HWBB
- HWB Lay Reference Group
- BCF Reference Group
- Scheme delivery groups including the Prevention Group, Community care coordinators, and Compassionate Communities

HWBB, Lay Reference Group, Reference Group

The Voluntary and Community Sector Assembly and Healthwatch are both members of the Health and Wellbeing Board and as such have been involved in discussions and decision making around the Better Care Fund from its inception (as the Health Economy Engagement Summary demonstrates, there have been a number of workshops and specific Board meetings in relation to the BCF). Both organisations have representation on the BCF Reference Group and HWB Lay Reference Group, where operational planning and risk planning have been identified and deliberated.

The Health Economy Engagement Summary template demonstrates that the presentations regarding the BCF have taken place at the VCSA Board, the VCSA's Health and Wellbeing Forum of Interest, Shropshire Partners in Care (SPIC), amongst other groups, to ensure that the details of the BCF are communicated effectively and a wide range of groups have the opportunity to provide feedback.

Schemes

The Voluntary and Community Sector has a good track record of delivering services on behalf of health and social care. Organisations like Headway Shropshire, Age UK, the Rural Community Council and Homestart all deliver services to Shropshire residents to support people living in their communities and maintaining health and wellbeing.

Using the Shropshire VCS partnership structures (VCSA) the VCS are able to respond to new opportunities. The Community Care Coordinator Scheme, for example, works with the VCS to identify and communicate services best suited for the most vulnerable and frail. The VCS enables the brining together of different sources of knowledge linking health needs and social needs via the GP practices.

Shropshire statutory partners also work closely with Shropshire Partners in Care (SPIC). SPIC's purpose is to support the development of a high quality social care sector in the areas of Shropshire and Telford & Wrekin and is an important conduit for partnership working with the independent sector.

The Director of Adult Social Care and the Director of Children's services both sit as members of the H&WBB and H&WB Delivery Group with several other members of Social Care staff attending key fora and working on key streams of work under BCF

7) Risks

KLOE Reference: B3v, B3v

The following Risk log has been populated via a multi-agency approach with operational oversight from the Delivery Group and approval from the H&WBB. A review of risks takes place at each of the monthly Delivery Group meeting via a BCF risk assurance tool

Risk	Likelihood	Impact	Overall Risk Factor	Mitigating Actions
Impact on local system in particular DTOC of neighbouring Welsh Health Board policy	4	3	12	Escalation processes are in place and Powys is actively working with Shropshire CCG to reduce the FTT List by agreeing individual commissioner targets. The Accountable Officer attends regular board meetings with Montgomeryshire/Powys Health Board.
Shared providers with Telford & Wrekin CCG and differences in commissioning policy could cause operational issues for providers	4	3	12	Joint collaborative commissioner meetings in place and planned joint meetings with providers as their individual impact of BCF is more clearly defined. Joint commissioning plans and risk mitigation have been built into contractual mechanisms between Shropshire and Telford & Wrekin CCGs – in particular around non-elective activity as part of the CCG 2 year operational plans and QIPP.

Ensuring appropriate links between the Future Fit programme and the development of the BCF and Council redesign programme – otherwise could lead to a risk of fragmentation of services and the lack of a coherent vision for local services	3	4	12	Ensure progress and developments from Future Fit feed into the development of the BCF via the service transformation group. Local Authority colleagues have a place on the Future Fit programme board. Health & Wellbeing Delivery Group also consists of CCG, council leads As BCF matures over the next year – we will start considering how we can better align and integrated Future Fit programme work streams into the plan. Vice Chair of H&WB Board is also SRO for Future Fit.
Financial implications of rurality, Welsh Border issues (Net importer for A&E and MIU) Wales not covered by BCF.	4	3	12	Financial allocations for both CCG's and LA are known. Draft Budgets approved by Boards/ Cabinet. BCF target allocation for 14/15 and 15/16 are known CCG QIPP targets for both years are known HWBB to work with CCG to mitigate this risk with NHS England and other partners as part of the urgent care plans.
IT systems – Older systems in place that are not compatible with each other. Further ahead in primary care	3	3	9	Draft CCG IM&T Strategy. Joint CCG IM&T forum The BCF plan is further considering how patient and service user information can be shared across primary, community, acute and social care.

Recruitment and retention issues particularly for medical and registered nursing staff are a risk to transforming services and the workforce required to deliver them	3	4	12	Workforce forms a key strand of work under the Future Fit programme and the appropriate links will be made between this and the development of work aligned to the BCF Workforce constraints will be considered as part of all BCF scheme design, prototyping to ensure that we can train, develop and hire appropriate clinicians and practitioners to deliver the schemes. Vice chair of H&WB Board is also the Chief Clinical Officer across CCG also has direct involvement with workforce planning and contingency plans at acute trust
Plan doesn't address health inequalities across all client groups	3	3	9	Equality Impact Assessment to be completed on each service change Equality & diversity key value in all organisations
Developing different plans across Shropshire & Telford & Wrekin	3	3	9	Development of a joint STP across the Shropshire and T&W footprint, supported by: Collaborative Commissioning Forum, Executive Discussion Group, System Resilience Group

Unintended consequences of service change that affects quality	3	3	9	Complete a full quality impact assessment on every proposed service change The HWBB and the BCF reference group will have the responsibility to assure that no decisions on service changes will negatively affect current provision and quality of care or negatively impact on any partner organisation.
Service transformation does not deliver efficiencies to support Health & Social Care delivery plans (Risk to delivery of QIPP	4	4	16	Monthly Supporting Delivery meetings of the CCG review the progress of QIPP. The delivery of QIPP is directly related to the availability of the full BCF fund in 16/17. Draft QIPP Plan fully identified and signed off by CCG Governing Body for 16/17 and a high level plan for 17/18. Provider engagement at an operational and strategic level on QIPP ambitions. Majority of QIPP signed off in provider contracts Our robust BCF programme setup will allow us to adjust and revise schemes, timelines, resources accordingly based on evaluation and delivery of benefits.
Destabilisation of the Voluntary and Community Sector due to budgetary pressures, will have risks for the delivery around some schemes and 7 day services	4	3	12	Make expectations of VCSE providers clear through the commissioning and contracting processes Ensure the VCSE are included in scheme

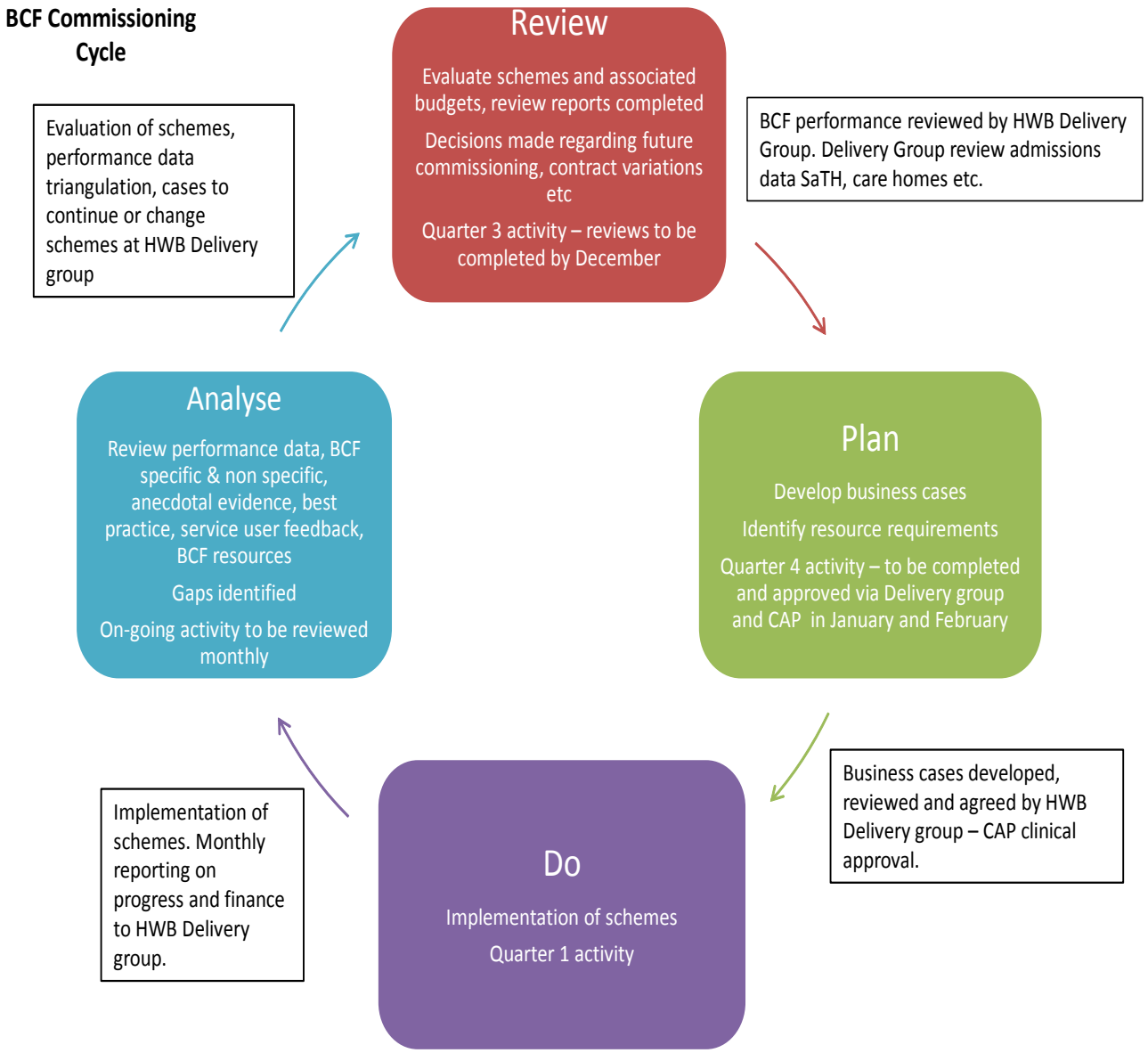
				development Map total investment and commissioned services with providers including the VCS
Relying on the non-commissioned services to deliver some projects – limited VCS resources will impact delivery as they have limited resources to recruit and manage volunteers	4	4	16	An approach that relies on the VCS needs careful consideration and understanding of availability and capability of VCS Factor VCS cost for recruitment and management into scheme development
Significant financial pressures in the system do not allow delivery of the BCF plan	4	4	16	CCG continues to work on Financial recovery plan. Turnaround team currently in situ assisting with the process
Political risk factors associated with elections in May 2017	4	1	4	Shropshire has traditionally had a very stable political landscape. Sound planning and involvement of a wide range of stakeholder means that the BCF vision is widely accepted and supported
Voluntary and Community Sector ability to provide increased expectation (through a number of schemes), particularly given system-wide budgetary pressures	4	3	12	Make expectations of VCSE providers clear through the commissioning and contracting processes Ensure the VCSE are included in scheme development

8) Delivery Summary

Annex 1 sets out the detailed scheme descriptors for the 2016/17 Better care Fund in Shropshire. Whilst there is a plethora of joint working across the county and a movement towards more integrated planning and delivery, the schemes noted below are considered to be our High Impact schemes which will have the most impact in delivering against our key themes of avoiding admission and building community capacity

Ref no.	Scheme
A1	Integrated Fall Prevention
A2	Future Planning Scheme
A3	Detection and management of risk factors for Stroke
B1	Proactive Care Programme
B2	Community & Care Coordinators
B3	0-25 Emotional Health & Wellbeing
B4	Housing Scheme
B5	Strengthening Families
B6	Social Prescribing
C1	Integrated Community Services
C2	Mental Health Crisis Care Services
C3	Alcohol Liaison Service
C4	Rapid Access, Interface to Discharge (RAID)
C5	High Intensity Users Model
D1	Resilient Communities
D2	Dementia Strategy
D3	Integrated Carers Support
D4	End of Life Coordination

The diagram below shows the local BCF Commissioning Cycle and key milestones in delivery and review during 2016/17:

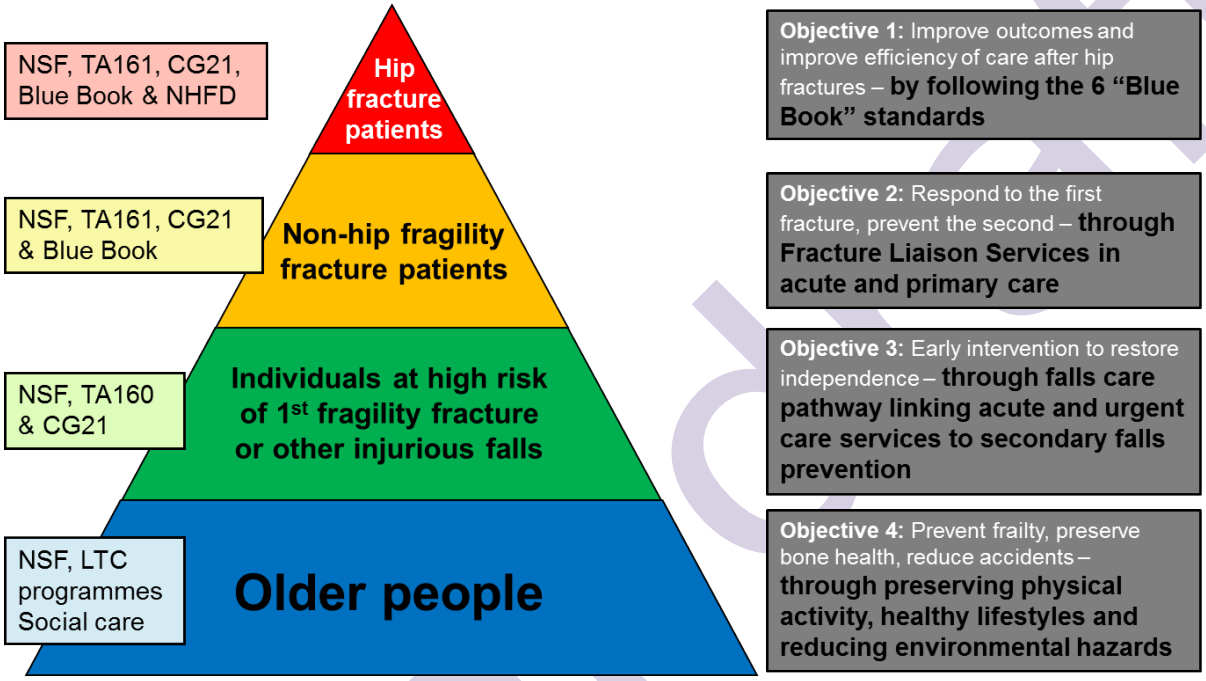


ANNEX 1 – Detailed Scheme Descriptions

Scheme reference number
A1
Scheme name
Integrated Falls Prevention
What is the strategic objective of this scheme?
These works will radically re-shape falls prevention in Shropshire through realistic and achievable changes that optimise both current and new opportunities to identify and manage risk of falls. The scheme will develop a whole system approach to falls prevention to: **1.** Improve the identification of at risk patients to prevent the first fall **2.** Improve patient outcomes and improve efficiency of care after fractures through compliance with core standards. **3.** Respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings **4.** Implement early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries and through building the capacity of partners and the community to deliver ongoing support to falls patients **5.** Prevent frailty, promote bone health and reduce accidents – through pathways into evidence-based postural stability exercise, encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards.
Overview of the scheme **Provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
There is huge potential to reduce falls and their impact in our older population. Shropshire currently has a range of services, but these are fragmented and not currently maximising their potential; opportunities to reduce falls are currently being lost. The ambition of this scheme is to embed a proactive approach to identifying risk across services and ensure pathways are in place to ensure people are able to access the right preventive service at the right time. The scheme will implement the findings of a Public Health-led whole system review throughout the

local health and social care economy and a coordinated falls prevention approach based on the Department of Health falls and fractures framework (commissioning toolkit 2009). This will widen the scope and reach of existing falls services and pathways to systematically address the four pillars of falls and fragility fracture care for secondary and primary prevention. The scale and ambition of this scheme will depend upon collaborative engagement of all stakeholders and the ability of partners to build the capacity of communities to play a key role in falls prevention.

DH Systematic approach to falls and fracture care & prevention: four key objectives



The target group for this scheme is people over 65.
The focus of the scheme will be on optimising:

- Primary prevention through:
  - falls and bone health screening (e.g. NHS Health Checks)
  - pathways to primary prevention intervention (e.g. evidence based exercise programmes)
  - effective identification of those at risk of a first fall through building capacity to identify and appropriately refer
- Falls and bone health screening and access to secondary prevention through fracture pathway development within fracture services.
- Development of a measurement framework to assess impact of falls prevention activities.

As falls risk is multifactorial, with a fall often being the result of an underlying health or broader social condition, the collection of falls data is notoriously complex. The local impact of injurious and non-injurious falls on services is therefore difficult to measure with accuracy. This will be explored

as part of any redesign in the pathway.

Work will be led by Shropshire Council Public Health and Shropshire CCG and will

- Implement a transformational model to optimise the falls prevention pathway based on DH best practice and NICE guidance
- Develop a fracture liaison service and robust links between secondary and community care
- Improve access to and choice of community based strength and balance physical activity.
- Draw together strands of current work into a coherent Falls pathway

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners and strategic leads: Shropshire Council Public Health, Shropshire CCG, Shropshire Council Adult Services
Oversight: Health and Wellbeing Board Prevention Group
Providers: Shropshire and Telford Hospital NHS Trust, West Midlands Ambulance Service, Shropshire Community Health Trust, GP practices, Voluntary and community sector, SC Adult Services, SC Leisure Services, care home sector, Shropshire Fire and Rescue Service, Shropshire Partners in Care

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and outcomes**

As highlighted in the JSNA and the Health and Wellbeing Strategy, Shropshire's population has a higher than average proportion of older people and our population is ageing. This poses significant challenges for our health and care services and is a significant factor when considering prevention interventions and access to services. Meeting the needs of older people is therefore a local imperative. The Health and Wellbeing Strategy has significant focus on keeping people independent for longer whilst ensuring access to services. As a major cause of loss of independence in older people, preventing both primary and secondary falls through pathways into the right service at the right time will make a significant contribution to achieving this element of the Health and Wellbeing Strategy vision.
Falls represent a significant public health challenge, with incidence increasing at about 2% per annum. Increased rates of falling, and the severity of the consequences, are associated with growing older and the rising rate of falls is expected to continue as the population ages.
Based on NICE guidelines and population modelling, amongst a population of 300,000 around

10,000 people per year who fall should receive a falls assessment, with a further 5,000 potentially requiring a brief screening of gait and balance. In a CCG population of 300,000 such as Shropshire:

- Over 15,000 will fall each year, over 6000 twice or more
- Most will not call for help
- Over 70/week will attend A&E or the MIU
- A similar number will call the ambulance service
- 350 hip fractures/year
- 1000 other fragility fractures
- Average combined CCG and council costs on falls are £50m per annum (DH 'Developing effective services for falls and fracture patients'). Our ageing demography means this will increase by 50% by 2020.

One third of people aged over 65, and half of those aged over 80, fall at least once a year. Many falls result in fractures, particularly in those with osteoporosis. The consequences are frequently life changing, even life threatening. Hip fractures are particularly devastating:

- 10% of people sustaining a hip fracture will die within a month of admission
- 30% of hip fracture patients will die within 1 year
- 50% of patients will no longer be able to live independently, and fewer than half return to their initial place of residence.

At an individual level, falls are the number one precipitating factor for a person losing independence and going into long term care. Falls cause loss of function, mobility, independence and confidence.

There is a significant economic cost too. Fragility fractures currently cost the NHS more than £2 billion per year. A Kings Fund report from Torbay has demonstrated just how extensive the costs associated with falls are[1]. For a cohort of 421 patients, representing about 1% of the over-65 population, the sums spent on care within the first year after the fall accounted for 4% of the hospital inpatient budget and 4% of the entire adult social care budget. Yet falls are not an inevitable consequence of ageing – they can often be predicted and prevented (For example, half of all people with a hip fracture will have had a previous fragility fracture which provided an opportunity for prevention.)

The Torbay study showed there was an intensive use of acute hospital services and community care services in the short period of time (about three months) following the fall. These costs then decline to a similar level to those before the fall. For social care services, the pattern was different, with few signs of a peak but with a higher mean cost each month throughout the 12 months after the fall.

There are a range of interventions available that have been shown to be effective and cost-effective in reducing falls and fracture risk, from balance and physical activity programmes to bone density scanning and osteoporosis treatment. Systematic identification of patients at risk can

[1] http://www.kingsfund.org.uk/publications/exploring-system-wide-costs-falls-older-people-torbay

readily be achieved through risk stratification of the GP record and through addition of a screening tool to the NHS Health Check. Given the ageing of the Shropshire population, the prevention of falls and fragility fractures will become an ever more pressing priority.
The Better Care Fund has provided us the opportunity to ensure greater joint working and to undertake a whole system review and subsequent health economy approach to falls and falls prevention. This work will keep older people (and those with long term conditions) well and physically active for longer; reduce pressure on emergency services, primary care, social care and a range of other services including those in the voluntary sector. Ultimately this work will reduce admissions to hospital.
References:
NICE guidance: Falls Assessment and prevention of falls in older people
Issued: June 2013

An emphasis on primary prevention takes a long-term approach to reducing falls risk in the population. Upstream prevention is crucial in order to reduce the scale of demand on services. Increasing the number of those at risk who can access strength and balance exercise programmes has the potential to reduce falls in the shorter term.
A coordinated whole system review of Shropshire's current falls provision has confirmed a range of disparate services meaning that there is no true visibility of falls occurrence or information on impact of falls. It is anticipated that a coordinated, integrated approached to falls prevention will result in:

- An increased number of falls risk assessments
- An increase in the number of people receiving falls risk reduction interventions
- A long term reduction against baseline in falls admissions
- A reduction against baseline of non-elective admissions
- A reduction in delayed transfers of care following a fall.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Metrics and costs will be determined in the 'Detailed Business Plan Phase.' To be competed in April 2016. The metrics are likely to include:

- Number of multifactorial falls risk assessments completed
- Number of people completing strength and balance exercise courses
- Ambulance service referrals
- Participation in evidence based exercise for falls prevention programmes
- Reduction in A&E attendance (measure to be confirmed)

- Reduction in Non elective admissions to hospital (measure to be confirmed)

The progress of the project will be monitored by the HWBB Prevention Group.

What are the key success factors for implementation of this scheme?

- Stakeholder involvement and willingness to innovate
- Consultation with over 65s, service users and carers
- Implementation of the recommendations of the review
- Development and implementation of new falls pathway
- Development and delivery of transformation plan to include:
    - Significant change within services to systematically optimise opportunities to identify and reduce falls risk through shared pathways
    - Inclusion of falls prevention in Making Every Contact Count (including community resilience) approach locally
    - Stakeholder implementation of transformation approach
    - Improvement of data recording to measure impact.

Scheme reference number
A2
Scheme name
Forward Planning- a developing scheme
What is the strategic objective of this scheme?
The strategic objectives of this scheme are to reduce non elective admissions and delayed transfers of care by: o Providing tools that encourage and enable both individuals and families to plan effectively for their futures as they age and become more likely to need healthcare and social care o Providing appropriate intervention in A&E to help minimise admission and to assist with timely and appropriate discharge o Provide a range of tools to other BCF schemes to maximise their impact on these objectives
Overview of the scheme **Provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
In the first half of 2016/17 we will design and implement a scheme that provides a range of tools that maximise opportunities to reduce non elective admissions and delayed transfers of care. We envisage that this will have several strands: • The development of an "ageing well" conversation that is delivered via a range of mechanisms including the Resilient Communities scheme, referral to Let's talk Local sessions and the developing Fire Service Wellbeing visits • The development of a project based in A&E that facilitates patients and families to think about their next steps and also facilitates referrals and links to other projects to help avoid unnecessary admission and delayed discharge • A marketing campaign encouraging people, including carers to forward plan across these arenas • Development of a range of tools to help other schemes maximise their impact on these metrics
The delivery chain **Provide evidence of a coherent delivery chain, naming the commissioners and providers involved**
It is envisaged that Shropshire CCG will be the most appropriate commissioners of the scheme. A project

group made up of appropriate partners will be formed to develop the scheme fully during the Spring of 2016.

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and outcomes**

There is lots of anecdotal evidence that the health and social care system fails to find ways to encourage people to adequately plan for the unforeseen in the same way that it does for planned procedures- e.g. a birthing plan or a hip replacement.
The current picture for NEL and DTOC in Shropshire, as nationally, is concerning. The demographic picture for Shropshire with its increasingly ageing population is such that the situation is likely to continue to worsen.
We recognise that there is significant potential to develop interventions within the community and A&E to encourage people to forward plan.
We also recognise that whilst individual schemes continue to have an impact on these metrics it is recognised that opportunities are missed to maximise their impact.

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The main metrics that we envisage that this scheme will contribute to are:

- Reducing non elective admissions
- Reducing delayed transfers of care
- Reducing residential and nursing care home admissions

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

As part of the design process for the scheme we will develop appropriate mechanisms to measure its impact on these metrics.

What are the key success factors for implementation of this scheme?

- To maximise the impact of existing schemes on non-elective admissions and delayed transfers of care
- to create new interventions where appropriate to reduce NEL and DTOC

Scheme reference number

A3

Scheme name

Detection and management of risk factors for stroke.

What is the strategic objective of this scheme?

The strategic objective of this scheme is to:

Reduce the number of strokes in Shropshire, and reduce their financial impact on the Health and Social Care economy, through improved detection and management of the following risk factors:

i. High blood pressure (HBP)
ii. Atrial Fibrillation (AF)
iii. High cardiovascular risk score (e.g. Qrisk2 > 20%)

iv) High blood pressure (hypertension) is a leading risk factor for premature death and disability, not only from stroke but also from heart attack, heart failure, chronic kidney disease and dementia.

In Shropshire, existing evidence suggests that there are approximately 86,900 people with hypertension, of whom 47,700 (54.9%) have been diagnosed and 38,200 (44.0%) are adequately controlled on treatment, which is lower than the figure for comparator CCGs.

ii) There is also evidence that Atrial Fibrillation prevalence for Shropshire is higher than the national average, with only two practices having an AF prevalence below the national average.

This scheme will investigate the potential to prevent 20 strokes per year in Shropshire by improving the detection and management of Atrial Fibrillation. This could deliver cost savings across the Health and Social Care economy in Shropshire of between £238,000 and £800,000 per year, depending on the cost calculations used.

v) Patients with a high cardiovascular risk score benefit from behavioural interventions to reduce the risk of stroke, such as stop smoking support, weight management and alcohol brief interventions, but this is not currently offered on a systematic basis to patients outside of the NHS Health Check programme. This scheme will seek to improve the behavioural support offered to patients with a high CVD risk.

Overview of the scheme

Provide a brief description of what you are proposing to do including:

- **What is the model of care and support?**

- **Which patient cohorts are being targeted?**

This scheme will support colleagues in Primary Care to improve detection and management of patients with HBP, AF and high CVD risk, including:

- Make better use of existing practice software such as the PRIMIS 'GRASP-AF' tool and link Informatica Clinical Audit software to build on existing knowledge and better detect CVD risk, HBP and AF within Shropshire practices.
- Consult with GPs to develop existing or where needed new audit software and agree and enhance intervention pathways for patients identified as being at risk.
- Improve uptake of the NHS Health Check (NHSHC) programme, which includes detection of HBP, AF and high CVD risk, by:
    - Developing the potential of providing access to NHSHC in a broader range of venues including pharmacies and community venues
    - Implementing a multi-faceted and targeted local campaign to increase the uptake of NHSHC amongst populations with low attendance and health inequality
- Offer patients on CVD risk registers an attractive range of behavioural support options, using a client relationship management approach.

The scheme will be delivered in 2 phases in the 16/17 financial year:

Phase 1: (April- June 2016)

- Undertake detailed analysis of data to establish fully up to date baseline
- Undertake analysis to fully understand use of existing practice software and where gaps exist
- Undertake analysis of the potential and the capacity for partners to deliver the NHSHC
- Complete a more detailed business case

Phase 2: (September 16- March 17)

- Commence pilot project
- Undertake full evaluation of pilot including recommended next steps

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Strategic lead: Health and Wellbeing Board Prevention Group

Commissioners: Shropshire CCG, Public Health and Shropshire Council Adult Services

Providers: Help2Change, GP practices, Pharmacies, Voluntary and Community Sector

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and**

outcomes

The Public Health England publication 'Tackling High Blood Pressure: From evidence into action' sets out the action that needs to be taken to improve detection and management of high blood pressure, and the impact that this would have on reducing stroke and other forms of cardiovascular disease: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/404881/Tackling_high_blood_pressure_-_FINAL.pdf

International comparison shows the potential for improvement. While around four in ten adults in England with high blood pressure are both diagnosed and controlled to recommended levels, the rate achieved in Canada is seven in ten (achieved with similar resources). The latest figures from Public Health England indicate that in NHS Shropshire CCG the percentage of hypertension detected and controlled to 150/90 is 44.0%. In order to match the achievement of Canada a further 19,200 people would need to receive treatment and have blood pressure controlled.

Adults should have their blood pressure measured at least once every five years. Once tested, NICE recommends that adults are re-measured within five years and, more frequently for people with high-normal blood pressure or in high risk groups. Blood pressure can be highly variable, so a diagnosis of hypertension should never be based on a single test and should normally be confirmed by ambulatory (24 hour monitoring) or home testing. The majority of diagnoses currently occur in General Practice. However, NHS Health Check, pharmacy, voluntary sector and home are also important testing venues and potential growth areas to maximise detection.

The optimal management of HBP is covered in depth in NICE hypertension guidance CG127 (2011) and the NICE quality standard for hypertension QS28 (2013), as well as in 'Tackling High Blood Pressure'. Each patient's treatment plan will be different and should include behavioural change support, as well as drug therapy where necessary. There is a role for a wide range of partners in the management of high blood pressure, including employers and the voluntary, community and social enterprise sector.

The Quality and Outcomes Framework (QOF) provides one measure to help understand how AF is being detected and managed by each general practice. This provides an opportunity to benchmark the current situation and, by using targets in the research literature, define improvements to quality and calculate potential cost savings. It is also possible to monitor on-going improvements. The Shropshire CCG QIPP report published in 2014 by the West Midlands Strategic Clinical Network and Senate uses the 2012/13 QOF dataset to benchmark the current situation across Shropshire CCG, highlighting the potential gains to be made in terms of the number of strokes that could be prevented and the cost savings to be made.

National and international guidelines are quite clear in stating that in order to prevent strokes, high risk non-valvular AF patients with CHADS2 score greater than 1 should be managed by an oral anti-coagulant (OAC). NICE guidance suggests that 93% of patients will have non-valvular AF with 87% of those being eligible to receive an OAC. In Shropshire significant recent progress has being made with this patient cohort with a 360% increase in growth of associated prescribing; as such there is a need to undertake a detailed exercise to confirm a baseline for this project.

The Sentinel Stroke National Audit Programme (SSNAP) April to June 2013 data pilot 2 found that 20.2% of all strokes across England occurred in patients with AF. Of those patients only 36.7% were receiving anticoagulant medication with 25.2% receiving no medication at all. The presence of AF often leads to a denser stroke, resulting in a longer length of stay in hospital compared to other ischaemic strokes and increasing the risk of long term disability

after stroke by almost 50%.

It is calculated that each AF stroke costs £11,900 per year (4) (however, some calculations go as high as £40,000 per year). By improving the detection and management of AF in primary care to prevent those extra 20 stokes there could be cost savings of £238,000 per year rising to £800,000 using the higher cost calculation. This potential saving needs to be calculated in further detail and needs to take account the financial impact of increased prescribing.

The Better Care Fund provides us with the opportunity to ensure greater joint working and to undertake a whole system review and subsequent health economy approach to detecting and managing AF. This work will keep AF patients well and their condition well managed, reducing premature deaths, improving quality of life and reducing pressure on emergency services, hospital admissions and social care.

Patients with a high CVD risk score (e.g. QRISK2>20%) should receive active management, including referral to behavioural support services as appropriate. Detailed guidance is provided within the Joint British Societies JBS3 guidelines and the Cardiovascular Disease Outcomes Strategy https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/217118/9387-2900853-CVD-Outcomes_web1.pdf. More integration is needed in the management of CVD risk and individual cardiovascular diseases, which recognises that all these conditions belong to the same 'family' and have common underlying risk factors. These risk factors need to be addressed by joint working across a range of stakeholders.

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The main outcomes for the scheme are:

- increased detection of HBP, AF and CVD risk
- improved management of patients with high cardiovascular risk
- reduction in the number of related strokes
- reduction of the costs to the health and social care system of these strokes

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Existing practice software and where appropriate additional support through the Informatica clinical audit tool will allow the relevant metrics to be measured and monitored through the primary care record.

Outcome metrics will include:

- detection rates of HBP, AF and CVD risk
- uptake of NHS Health Check
- compliance with NICE guidance on management of HBP, AF and CVD risk
- number of AF-related strokes

- **whole system financial impact of strokes on the health and social care economy including impact of increased prescribing through detection**
-

Baseline data and target outcomes will be agreed and monitored by the Prevention sub-group of the H&WB Delivery group.

Progress of the project will be monitored by the Health and Wellbeing Delivery Group

What are the key success factors for implementation of this scheme?

Stakeholder involvement in full project design and implementation- key to success are GP's, practice managers, pharmacies, community leaders

Effective marketing and promotion of the NHS Health Check

Agreement on data collection and reporting systems

Agreement on intervention pathways.

Scheme reference number
B1
Scheme name:
Proactive Care Programme
What is the strategic objective of this scheme?
The Scheme is as identified by NHS England Enhanced Service (ES): 'Avoiding unplanned admissions :proactive case finding and patient review for vulnerable people', now referred to as the 'Proactive Care Programme' The aims of this ES in 2016/17 are to encourage GP practices to: • Increase practice availability via timely telephone access; • Identify patients who are at high risk of avoidable unplanned admissions, establish a minimum two per cent case management register and proactively manage these patients; • Review and improve the hospital discharge process for patients on the register and coordinate delivery of care; and • Undertake internal practice reviews of emergency admissions and A&E attendances. • For CCGs it provides new opportunities to shift funding into primary care services and community health services – and is designed to bring about a step change in the quality of care for frail older people and other patients with complex needs. The local health and social care economy is committed to the principle of 'active case management' and supportive of application beyond the 2% requirement of the ES, as a mechanism for improved patient care, reduction in A&E attendances and admission avoidance.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Unplanned admissions to hospital are distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital. 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 will be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions. The ES commenced on 1 April 2014 and requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access. In addition, the practice also provides timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or accident and emergency (A&E) attendances.

The risk stratification element of the ES applies to a minimum of two per cent of adult patients (aged 18 and over) of the practice's registered list. In addition to this, any children with complex health and care needs requiring proactive case management and personalised care plans are also considered for inclusion on the register.

The practices are currently using existing risk stratification processes or the tool made available by the area team. The CCG is working towards making an improved tool available in 2015.

Patients identified as being at high risk of unplanned admission and on the case management register will be assigned a named accountable GP (and where relevant a care coordinator). This person has overall responsibility for coordinating the patients care and sharing information with them, their carer (if applicable) and, if the patient consents, other professionals and organisations involved in their care.

These patients have a personalised care plan which has been developed collaboratively between the patient, their carer (if applicable) and the named accountable GP and/or care coordinator, detailing how their ongoing health and care needs will be addressed to reduce their risk of avoidable admission to hospital. Patient care will also be reviewed at an interval agreed with the patient.

Participating practices review emergency admissions and A&E attendances of patients on the case management register (i.e. to understand why these admissions or attendances occurred and whether they could have been avoided). They also review patients newly identified as at risk and other vulnerable patients (such as those living in care or nursing homes) to identify factors which could have avoided the admission or A&E attendance, with a view to taking appropriate action to prevent future episodes. These factors include both changes that the practice can make to their management of these patients, other community support services that need to be put in place for these patients and also changes to admission and discharge processes that will be fed back by the practice to commissioners.

Learning from 2015/16
In common with many admissions avoidance initiatives, the overall benefits from this scheme are difficult to clarify due to a significant number of confounding factors. However, the ES has enabled practices to devise and further refine internal and external communications about this cohort of patients. There is an explicit link to the Community and Care coordinator in the practice especially for those patients that have been recently discharged from hospital. In most cases these patients are followed up with telephone calls/visits from the C&CC in order to check the needs of the patient and to assure signpost to the appropriate intervention if required.

The delivery chain
Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:

- Shropshire CCG ,

Providers:

- GP Practices – 44 Shropshire GP practices have enrolled for the ES.

The evidence base

Reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Guidance and audit requirements, NHS England Gateway reference 01307
NHS England specification, Gateway reference 01933

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1. Contribute to a reduction in A&E attendances and unplanned admissions to hospital.
2. Reduce readmissions to hospital within 91 days.
3. Reduced Delayed Days in acute and community hospitals (Delayed Transfer of Care)
4. The practice will share any whole system commissioning action points and recommendations identified as part of this process with the CCG and if appropriate the area team, to help inform commissioning decisions. Information shared with the CCG is in order to help CCGs work with hospitals to improve planning for discharge and to improve arrangements for hospital/practice handover at point of discharge.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Implementation & evaluation is supported by:

- The Head of Primary Care Support and Medicines Management, SCCG
- The Clinical Lead for Early Intervention (Case Management), SCCG

Monitoring:

- Baseline data and target outcomes will be agreed and monitored by the Finance, Contract and Performance sub-group of the H&WB Delivery group.
- NHSE area team
- Midlands and Lancashire CSU

Reporting to**:**

- Primary Care Working Group
- Progress of the project will be monitored by the H&WB Delivery Group
- Quarterly reports submitted to SCCG by GP practices will contribute to a final local evaluation.

Additionally the practice may also be required, to participate in peer reviews relating to assessment of the practice's implementation of this ES.

What are the key success factors for implementation of this scheme?

- Ability to link risk stratification to improved outcomes
- Appropriate technological support to ensure information flows between relevant provider and

MDTs
- Robust data
- Standardised approach
- Appropriate clinical resources and communication mechanisms to support care plans

Scheme reference number
B2
Scheme name
Community and Care Coordinators
What is the strategic objective of this scheme?
The strategic objective of the Community and Care Coordinator prototype is: To demonstrate the potential of non-clinical individuals, working as part of the practice team, to proactively case manage individuals at risk of loss of independence and hospital admission as a result of more pastoral or social unmet need. To explore the potential of such an individual supporting collaborative working between the practice, the local authority, the voluntary sector, community groups and volunteers, in effect, both recognising and creating links with existing resource in the community and supporting its growth and further development. Detailed objectives include: Increase the practice team's awareness of the services and skills provided by the voluntary sector and by volunteers in the community. Improve communication between the Local Authority, voluntary sector, community groups and the practice. Support the practice to identify frail and vulnerable patients at risk of inappropriate admission, opportunistically and proactively, through computer searches, risk stratification and communication with the wider community. These will often include patients toward the end of life, patients with dementia, patients who are lonely, isolated or who have minimal or no family or social support. To sign post individuals where necessary to statutory, non-statutory and voluntary services and to care coordinate those individuals who continue to struggle to navigate the system. To record data in relation to frail and vulnerable patients that will begin to build a bigger picture about clinical and non-clinical information relevant to their holistic care. Support the community in the development of peer groups, carers groups and volunteers. Make links between these developments and those who might benefit from what they offer.
Overview of the scheme Provide a brief description of what you are proposing to do including: What is the model of care and support? Which patient cohorts are being targeted?
The practices are funded to enable them to employ a Community and Care Coordinator (C&CC). The C&CC is employed for 1 session a week per registered population of 2000 patients (nearly two days per week for an average practice). 43 of the 44 practices across Shropshire now have a Community & care Co-ordinator attached to the practice

The C&CCs all participate in a programme of education and peer support provided by the project manager, the voluntary sector, the local authority, members of the practice, other providers and other stakeholders. The training programme is also open to the practices and the voluntary sector.

The C&CCs have two main functions:
Firstly they work within the practice to support the team to proactively identify frail and vulnerable people and to assess and sign post where appropriate. The C&CC's contact the patient by phone or visits the patient and agrees with the patient measures to meet unmet need and reduce risk. This mainly involves sign posting to voluntary sector agencies, volunteer and peer groups and the local authority. The GP remains responsible for addressing all clinical unmet need.

The second main function is within the community. The C&CC Is the practice expert in what is available in the community. They provide a conduit between the community and the voluntary sector and the practice enabling better communication about individual patients and services. They have been active in supporting the community to develop Compassionate Communities, peer groups and carers groups. Increasingly they are working in partnership with others such as the patient groups, housing support officers, the community enablement team, Age UK, Red Cross, Alzheimer's society and others, pooling resources ideas and leadership.

In particular the co-ordinators focus on people who are:
Identified as frail and vulnerable
At risk of admission to hospital and/or loss of independence
Coming toward the end of their lives
Strengthening families and protecting children

The delivery chain
Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
Shropshire CCG ,

Providers:
GP Practices – Community & Care Coordinators are non-clinical and work as part of the GP practice team

The evidence base
Reference the evidence base which you have drawn on
to support the selection and design of this scheme
to drive assumptions about impact and outcomes

There is considerable evidence that case management including care coordination of the frail and vulnerable members of society improves outcomes. This innovation looks at a non-clinical member of the practice team supporting and sign posting those individuals/ families where it is appropriate to do so as part of a multidisciplinary team. It is in line with NICE End of Life, National End of life and LTC Strategy, Kings Fund and Health Foundation research.

This work stream was introduced to explore how practices might become better able to manage the demand created by the growing older population and equally how as a health and social care economy we might pool effort and resources and work in a more integrated way to better support this very vulnerable part of our community. This within a context of increasing prevalence of older people, increasing numbers of people living 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 individuals and the health economy.

The project was evaluated and presented to the Health and Well Being Board in the summer of 2015. In summary Community and Care Coordinators are clearly valued by GPs, practice managers, patients and carers. They have increased activity within the voluntary sector and begun to support the development of peer groups and Compassionate Community volunteers in the communities.

Trend data has shown a positive change in GP appointment activity. A&E attendance and hospital admissions fell over the year. 43 out of the 44 practices have agreed to participate across Shropshire. There has been a marked increase in the number of referrals received. This year it is expected to top 5,000 referrals compared to 2,000 last year.

At an individual patient level, when compared to the three months prior to the involvement of a C&CC, all activity shows a substantial decrease in the three months after involvement of the C&CC.

Initial work on quality of life has also shown a substantial improvement in carer and cared for. As the project continues this element of the evaluation will be extended.

The impact on social costs such as care packages and care home placements is positive but the evidence is not yet robust. Keele University has offered their support in the closer evaluation of the project over the coming months.

What remains difficult to measure is the cultural and behavioural change that the project has begun to drive. The testimonials and stories demonstrate that practices have embraced the concept of a non-clinical member of the team supporting them in identifying and coordinating care for frail vulnerable patients. They demonstrate a recognition by the practice that the voluntary sector is a valuable partner in the care of older vulnerable patients and that they have “opened their doors” to a more collaborative approach. Referrals to and activity within the voluntary sector has grown considerably. The voluntary sector has been a key partner in this project and have expressed in their feedback wholescale support for its value. The project is also enabling a greater understanding between individuals across the sectors enabling us to work more closely together reducing duplication and gaps in the services we provide. It is hoped that this will be the gateway to greater co-ordination and integration of organisations’ activities.

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in

headline metrics below

Reduce GP appointments.
Reduce social care costs.
Reduce A&E attendance.
Reduce hospital admissions.
Reduce Shropdoc calls.
Reduce the cost associated with dependency.
Improve health and well-being for patients and carers.
Improve communication with and sign posting to the voluntary sector.
Increase the number of volunteer groups and Compassionate Communities.
Increase co-ordinated activity across agencies and client groups.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Implementation & evaluation is supported by:
Tracy Savage, Programme Lead, SCCG
Dr Colin Stanford, Clinical Lead for Early Intervention (Case Management), SCCG

Monitoring:
Baseline data and target outcomes will be agreed and monitored by the Finance, Contract and Performance sub-group of the H&WB Delivery group.

Reporting to:

Progress of the project will be monitored by the Transformation sub-group of the H&WB Delivery Group
Quarterly report submitted to SCCG which will contribute to a final local evaluation.

See table below

Summary of evidence from evaluation of phase 1 of the C&CC project				
Outcome	Evidence	So did	Strength	Comments

		it?	of evidence	
Reduce GP appointments	**Testimonals** **Pre and post data** **Questionnaires** **Pt stories**	**Yes** **Yes** **Yes** **Yes**	**Green**	**Pre and post data show a reduction of 60.6%**
Reduce A&E attendance	**Pre and post data**	**Yes**	**Green**	**Pre and post data show a reduction of 45.24%**
Reduce hospital admissions	**Pre and post data** **Trends** **Pt stories** **Testimonials**	**Yes** **Yes** **Yes** **Yes**	**Green**	**Pre and post data show a reduction of 47.14%**
Reduce Shropdoc calls	**Pre and post data**	**Yes**	**Green**	**Pre and post data show a reduction of 59.56%**
Reduce the costs associated with dependency	**Pre and post data** **Trends of self refs** **Testimonals** **Questionnaires** **Pt stories**	**Yes** **Yes** **Yes** **Yes** **Yes**	**Green**	**Evidence from pre and post data show a reduction of all services used, self- referrals to A&E have reduced, voluntary services being used to support rather than statutory services.**

What are the key success factors for implementation of this scheme?

Care Coordination of frail and vulnerable people at risk of admission and loss of independence where the risk is predominantly due to unmet social, housing, advocacy, care and pastoral need.
A clear link between primary care, the local authority, the voluntary sector and the community enabling integrated care and improved communication.
Facilitation and community leadership for the development of carer and peer networks.
Resilient communities

Scheme reference number
B3

Scheme name :
0-25 Emotional Health and Well Being (CAMHS transformation)
What is the strategic objective of this scheme?
The strategic objective of the 0-25 emotional health and wellbeing programme is: Over recent years feedback has been received from young people, families, local professionals and clinicians about the need to improve children and adolescent mental health services in Shropshire. In response to these comments the CCGs and Local Authorities across Shropshire and Telford and Wrekin have been working together to commission a seamless service to improve emotional health and wellbeing of those aged 0-25 years. This will include the following: • Increased support for looked after children and children on 'the edge' of care • A service that extends to young people aged 25, if that is necessary and appropriate for an individual • The development of a dedicated neurodevelopmental service separate to the core CAMHS services • Improved and easier access (including a 'no wait' ethos) • A joined up service across health and social care organisations to make a coherent offer • A strong focus on increasing resilience, rather than purely on treatment services • Much more innovative solutions: peer support, safe on line information, • An improved urgent response In order to support this change the four commissioning organisations have agreed to proceed with the procurement of a new service, to be in place by April 2017.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
We recognise that there is a considerable opportunity to work to integrate the 0-25 Emotional health and wellbeing programme and the Better Care Fund in Shropshire. We will undertake this development work in the early part of 16/17 with the potential of agreeing shared metrics, budgets, and outcomes. This opportunity is based on the recognition that many of the young people who are eligible for support through the 0-25 programme are the same young people that are frequent users of A&E, emergency services, frequent non-elective admissions and are sometimes problematic to discharge. In addition this

programme represents the planned changes as outlined within the Shropshire, Telford and Wrekin Transformation Plan for Children and Young People's Mental Health and Wellbeing 2015-2020. The plan outlines new ways of integrated working that closely align with the integration aims of the Better Care Fund.

In order to deliver this strategic plan there are 6 programmes of work supported by a cross-cutting programme. These are:

- 0-25 Emotional Health and Wellbeing Service
- Redesign of Neurodevelopmental pathways
- Development programme for workers in universal services
- Eating disorder services
- All Age psychiatric liaison service
- Improve Perinatal Support
- Cross Cutting Programmes: Needs Analysis, Engagement and Transition

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Delivery of the 0-25 Emotional Health and Wellbeing programme is managed by the 0-25 Emotional Health and Wellbeing Strategic Group which spans Shropshire, Telford and Wrekin and includes membership from a broad range of partners, including Health Commissioners (CCG and NHS England (currently represented by the West Midlands Strategic Clinical Network and Senate)), Local Authority Commissioners and Providers (Public Health, Social Care, Early Help), Safeguarding (including Police), CAMHS Providers, Adult Mental Health Service Providers, Voluntary Sector Services, Education Providers (Primary, Secondary and Further Education), Youth Offending Services and Service Users.

Each programme within this plan will have a multi-agency task and finish group, which will be accountable to the 0-25 Emotional Health and Wellbeing Strategic Group. The members of each task and finish group will be responsible for completing the actions required to deliver the relevant programme of work.

The 0-25 Emotional Health and Wellbeing Strategic Group reports up to the two Health and Wellbeing boards.

The evidence base

Reference the evidence base which you have drawn on

- to support the selection and design of this scheme to drive assumptions about impact and outcomes

Children and young people under the age of 20 years make up 21.9% of the population of Shropshire. 6.3% of school children in Shropshire are from a minority ethnic group. The health and wellbeing of children in Shropshire is generally better than the England average. Infant and child mortality rates are similar to the England average for Shropshire.

In Shropshire it is estimated that there are around 4,000 children and young people with a diagnosed mental health problem. The conditions with the highest prevalence rate in Shropshire are conduct disorders, followed by emotional disorders and then hyperkinetic disorders.
The main metrics that this project will contribute to are: - **Reducing non elective admissions** - **Reducing delayed transfers of care**
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The 0-25 Emotional Health and Wellbeing Board is responsible for overseeing individual programme outcomes and for reporting what is and is not working and systems are already in place to enable this. Development work is underway to understand the potential of integrating systems and metrics with BCF.
What are the key success factors for implementation of this scheme?
The 0-25 Emotional Health and Wellbeing Programme is in place currently. It's inclusion as a BCF scheme and inclusion in the BCF reporting and monitoring systems will further cement and increase the value of its key role in reducing the demand of this cohort of patients on the health and social care economy and in adding value to joint working.

Scheme Reference number **KLOE Reference: C1iv**
B4
Scheme name
Housing- a developing scheme
What is the strategic objective of this scheme?
Nationally it is recognised that there are significant opportunities to integrate housing initiatives with

the BCF. Further to this it is recognised by partners in Shropshire that housing and housing support services have a significant impact on the health and social care economy in the County. Housing related services are a key part of reducing the risk of people needing access to more costly interventions such as Health and Social care. This means there is a need to target and prioritise those people most at risk and to make best use of partnerships with other agencies that have the same aims. The BCF aims to develop a specific housing scheme or set of schemes for Shropshire during 2016/17 that implicitly meets these targets and ambitions.

To date, some housing related services have been included in the pooled BCF budget due to their direct contribution on BCF metrics. Currently the budget for Disabled Facilities Grants as well as the Handyperson, Home Improvement Agency and Telecare aspects are included. Ongoing, the ambition is to develop a much more substantial and integrated programme through the BCF.

Overview of the scheme

Provide a brief description of what you are proposing to do including:

- **What is the model of care and support?**
- **Which patient cohorts are being targeted?**

The current Housing Support Contracts are in the process of being extended until April 2017 and the intention is for a housing scheme or schemes related to Health and Social care to be implemented in line with this deadline. This area of work will also link very closely and add value to other BCF schemes, specifically the Care and Community Co-ordinator and Resilient Communities projects.

Key strands of work:

- *Prevention* – There is a key role for housing providers and housing support agencies to work with clients to proactively prevent escalations in an individuals' or family's needs, regardless of tenancy. This could take the form of support services in the home, adaptations to facilitate ongoing independent living, signposting to other services, and accessibility of services such as telecare.

- *Hospital Discharge* – Analysis of DTOC data for Shropshire shows a link between DTOC housing issues which warrants further investigation. This provides compelling evidence of the need to work in partnership to develop a scheme(s) that overcome these issues. This could take many forms e.g., specific adaptations to an existing property, the provision of step down properties, a package of housing support developed with partners. Early estimations identify that this work will have a significant impact on the BCF metrics, particularly on non-elective admissions and DTOC. In turn this type of work will deliver considerable savings across the Health and Social Care economy.

- *Adaptations* – The funding for Disabled Facilities Grants (DFG's) is currently channelled through the BCF, however we are looking to add significant value to the scope and impact of this programme by working with partners to re-design how adaptations are identified, accessed,

supported and delivered, regardless of tenancy.

Housing Scheme Options:

Asking the right questions at the right time:
Through partnership discussions it is recognised that suitable and sustainable accommodation for clients with Health and Social Care Needs is lacking within Shropshire. Often patients are discharged from hospital into temporary accommodation that barely meets their needs as it has not been recognised early enough by hospital staff, that housing will be a concern on discharge. The right questions need to be asked at the right time. This will enable staff within both hospital and housing settings to assess need and put in place a discharge plan if clients are unable to return home.
Action: Shropshire Council Community Housing Services to work alongside the local hospitals (both acute and community) to develop a Hospital to Home Protocol. An understanding of 'both sides of the fence' is needed as well as a re-education about the information required.

A step down housing scheme:
One of the key issues identified is a lack of suitable and sustainable accommodation for clients with Health and Social Care Needs within Shropshire. Clients may be referred to either the Housing Service for temporary accommodation or Adult Social Care for placement into residential care homes. Both options are expensive to the local authority and are not adequate to meet the needs of the patient. Temporary accommodation can be isolating for individuals that often struggle to manage to live independently. On the flip side Residential Care Homes can encourage clients to become dependent on support. Clients need to be living in as independent environment as possible, with access to both practical and wellbeing support. Long term the aim must be to ensure they return home either once they have recovered or following an adaptation of a property. It may be that a return home is not possible and in these cases the step down service allows both time and support to enable patients to move to safe, secure and suitable accommodation that meets their needs long term.
Action: Shropshire Council Housing Service and Adult Social Care to work with local Housing providers to ascertain whether there is an option of utilising Whitchurch hostel for the needs of hospital discharge clients.

Development of Disabled Facility Grants Packages:
It has long been recognised that working to enable clients to remain in or return to their own properties is fundamentally the most beneficial option. The use of DFG's to adapt homes to enable clients to return is the simplest and easiest option. However, currently the Local Authority does not have a discretionary option regarding adaptations. This means that all DFG's are means tested and if a client is considered able to pay for the works themselves this is expected. There needs to be a shift regarding this to allow options to lend monies to clients to have works completed and for charges to be put onto properties to claim back the costs when that property is sold. There is also a need for the repayment of DFG grants to be recycled into the DFG pot to enable assistance to be provided to more clients. The financial year 2016/17 has seen a significant increase in the funds allocated to Local Authorities to be used for DFG's. This shows a step towards a change in attitude by Government in regard to utilising the DFG aspect of support to enable more clients to return to and remain in their own homes.
Action: Shropshire Council Housing Service and Adult Social Care to work with the BCF to utilise the funding provided by Government for DFG's to ensure full use of the monies is made and all options for clients can be explored.

The delivery chain **Provide evidence of a coherent delivery chain, naming the commissioners and providers involved**
This developing scheme is being led by Shropshire Council's Housing Team in partnership with colleagues from ASC and from the CCG.
The evidence base **Reference the evidence base which you have drawn on** - **to support the selection and design of this scheme to drive assumptions about impact and outcomes**
There is strong national evidence around the significant contribution made by housing and housing support services to the Health & Social Care economy and BCF. There is also recognition that there is significant potential in making much more of this impact. Very early work in Shropshire shows the potential for strong outcomes and significant contribution to metrics.
Impact of scheme **Please provide any further information about anticipated outcomes that is not captured in headline metrics below**
As a developing scheme we have not identified specific outcomes as yet and a key part of the early development work will be to fully understand these and implement structures to measure these.
Feedback loop **What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?**
There is a need for intensive partnership working through the BCF between Housing Services, Adult Social Care, SCCG and ICS to identify actions regarding possible schemes going forward and how to measure the outcomes of schemes. High level support is required from the BCF via the 2016/2017 BCF plan, in order that partners in Shropshire can work together to develop a specific scheme(s) and to provide regular updates on progress through the BCF monitoring process.
What are the key success factors for implementation of this scheme?
A clear understanding of the impact of housing on the health and social care economy and the development of a strategy to maximise this. Delivery of a range of schemes developed to maximise this impact that can be measured through the BCF metric structure.

Scheme reference number
B5
Scheme name
Strengthening families
What is the strategic objective of this scheme?
The strategic objective of the Shropshire Strengthening families Programme is: o to help families live happy, healthy and safe lives by providing support when it is first needed – and reducing the chances of them needing further help in the future.
Overview of the scheme **Provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
We recognise that there is a considerable opportunity to work to integrate the Strengthening Families programme and the Better Care Fund in Shropshire. We will undertake this development work in the early

part of 16/17.

This opportunity is based on the recognition that many of the families eligible for support through Strengthening families are the same families that are frequent users of A&E, emergency services, frequent non-elective admissions and are sometimes problematic to discharge.

The national Troubled Families Programme is delivered through Shropshire Strengthening Families through Early Help. Phase 2 of the national Troubled Families programme is based on a common interest and ambition to transform the lives of Shropshire's families in need of help, to improve the services that work with them and to ensure more efficient and effective use of public money for the long-term.

Inclusion of families into the programme is based upon a cluster of six headline problems. To be eligible for the expanded programme, each family must have at least two of the following six problems:

1. Parents or children involved in crime or anti-social behaviour.
2. Children who have not been attending school regularly.
3. Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan.
4. Adults out of work or at risk of financial exclusion or young people at risk of worklessness.
5. Families affected by domestic violence and abuse.
6. Parents or children with a range of health problems.

Phase 2 of the national Troubled Families Programme has ambitious service transformation goals. In Shropshire we recognise the value of this development and continue to work toward the integration with Early Help as 'Strengthening Families'; working with families with multiple problems to take an integrated whole family approach, to help reduce demand for reactive services.

The Shropshire Strengthening Families through Early Help Outcomes Plan will provide an area-wide set of success measures applicable to all families, from which the outcomes and measures relevant to each family may then be drawn. For example, if a family has a debt problem, domestic violence problem and is unemployed at the point of engagement, then relevant outcomes would be drawn from Shropshire Strengthening Families Outcomes Plan and form the goals against which significant and sustained progress would be judged for this family.

The Department of Communities and Local Government reviewed Phase 1 and analysed what particular characteristic were present in Local Authorities that had a high level of success. Based on these key findings they advised that the following four principles capture what is meant by 'working with a family as part of the Troubled Families Programme' and they expect these to apply to all engaged families:

1. There will have been an assessment that takes into account the needs of the whole family
2. There is an action plan that takes account of all (relevant) family members
3. There is a lead worker for the family that is recognised by the family and other professionals involved with the family

4. The objectives in the family action plan are aligned to those in the area's Troubled Families Outcomes plan.

In Shropshire we are committed to ensure this is applied to all families we provided targeted support for through Strengthening Families.

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Shropshire Council is the commissioner of the Strengthening Families Programme. It is also responsible for the delivery of the programme through a multi-agency agreement.

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and outcomes**

"It is estimated that over two million children in the UK today are living in difficult family circumstances. These include children whose family lives are affected by parental drug and alcohol dependency, domestic abuse and poor mental health. It is crucial that these children and their families benefit from the best quality professional help at the earliest opportunity. For some families, without early help difficulties escalate, family circumstances deteriorate and children are more at risk of suffering significant harm" Source Ofsted (2015) Early help: whose responsibility?

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- This is an enabling scheme where learning will be utilised to assist achievement of metrics in other areas

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Strengthening Families team is responsible for measuring scheme outcomes and for reporting what is and is not working and systems are already in place to enable this.

Development work is underway to understand the potential of integrating systems and metrics with BCF.

What are the key success factors for implementation of this scheme?

Whilst the impact of this multi-agency targeted work aligns very closely with the sentiments of our BCF and will be accounted for as a key scheme impacting on our BCF priorities. In a wider sense the model and learning gained from the Strengthening Families programme has potential for application to other areas of

work. This will be explored further early in 2016/17 to see how what has worked for the Strengthening Families multi agency approach can be employed in relation to challenges elsewhere in the system

Scheme Reference number
B6
Scheme name
Social prescribing pilot programme
What is the strategic objective of this scheme?
The strategic objective of this scheme is to: Improve health and wellbeing and reduce pressure on health and care services through the development of a social prescribing programme in Shropshire. Social prescribing enables healthcare professionals to refer patients to a link worker who supports the patient to improve their health and wellbeing by accessing a range of non-clinical support services delivered in the local community, usually by the VCSE (voluntary, community and social enterprise) sector. Across the UK many social prescribing projects have been developed at a local level, for example by GP practices, which show clear potential but more evaluation is needed to evidence the impact of social prescribing on reducing demand for NHS and social care services, thereby supporting investment at scale. There is also a need to create a local model that builds on (and does not duplicate) existing Shropshire initiatives, such as care co-ordination, compassionate communities, and locality commissioning, and which provides support for the third sector in a climate of financial austerity.
Overview of the scheme

Provide a brief description of what you are proposing to do including:

- **What is the model of care and support?**
- **Which patient cohorts are being targeted?**

This scheme will provide a 'fourth option' for health professionals beyond provision of clinical advice, medication or consultant referral; they will also be able to make a 'social prescription', i.e. a non-clinical referral into a range of community-based services that are known to affect health outcomes. These services will be developed in close collaboration with the VCSE sector, providing support close to where the patient lives, taking account of local needs and the evidence base. They will likely include:

- Debt and benefits advice
- Falls buddies
- Physical activity opportunities (e.g. 'green gym' and walking groups)
- Supported volunteering
- Self-care support
- Employment support
- Housing support
- Advocacy services
- Libraries for health
- Health cafés
- Befriending schemes
- Stress management
- Counselling
- Arts and Minds
- Carer support
- Parenting support

The scheme will provide a clear and consistent referral pathway into non-clinical services, providing connectivity between clinical and non-clinical support, while taking care to avoid duplication and overlap. It will tackle health inequalities through a 'proportionate universalism' approach, offering services proportionate to need, focusing particularly on high users of health and care services.

Some flexibility will be built into the scheme to allow local communities to identify their own priorities for support.

The scheme will be subject to a robust academic evaluation, through GP records, including an economic evaluation and use of a control group to address the potential for bias in uncontrolled research (a criticism levelled at previous evaluations of social prescribing).

It is intended that the scheme will help establish a foundation for targeted investment in VCSE services at a time when funding for the third sector is increasingly under pressure, allowing existing grant funding to be directed towards areas of greatest impact, and reducing demand on NHS and social care services.

The scheme will operate further 'upstream' than some existing services in Shropshire, such as Care Co-ordinators

and Compassionate Communities, but will work closely with them and other preventive interventions such as NHS Health Check, Healthy Living Pharmacies, resilient communities and locality commissioning.

The scheme will be delivered in 2 phases in the 16/17 financial year:

Scoping phase: (April- June 2016)

- Review of evidence base
- Community needs assessment
- Stakeholder meetings
- Analysis of the potential and the capacity for partners to deliver a social prescribing programme
- Design of pilot programme and evaluation

Implementation phase: (July 16- March 17)

- Commence pilot project
- Undertake full evaluation of pilot including recommended next steps

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Strategic lead: Health and Wellbeing Board (HWBB) Prevention Group

Commissioners: Shropshire CCG, Public Health and Shropshire Council Adult Services

Providers: Help2Change, GP practices, Pharmacies, Voluntary and Community Sector

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and outcomes**

"It has been estimated that around 20% of patients consult their GP for what is primarily a social problem; in fact the Low Commission reported that 15% of GP visits were for social welfare advice. For these patients, a medical approach is inappropriate and equally frustrating for both patient and GP. At the same time, GP training places remain unfilled and insufficient numbers of GPs are applying to join general practice because of a perceived impossible workload. But it is not just GPs who are affected by the current pressures in healthcare. Healthcare professionals generally work tirelessly to do their best for their patients under ever increasing workloads.

Social prescribing can alleviate some of these pressures by addressing unmet needs of patients, whose needs are not currently met by the NHS. It can also alleviate pressure on GPs and other healthcare professionals, general practices and the health service more widely, all of whom are struggling to survive difficult times. Social prescribing goes further than that. By facilitating the patients' access to a whole range of voluntary and local services, including

becoming volunteers themselves, there is much potential to nurture local social capital and catalyse health-creating communities that strengthen their ability to care for themselves and each other. Social prescribing recognises that the third sector is a largely untapped asset that can deliver further integration between health and social care in the creation of a more responsive and efficient local health economy. Social prescribing can be used to empower the patient to look for solutions to social problems before a crisis occurs that might affect their physical or mental health."

"The purpose of a social prescribing intervention is not necessarily to get a problem fixed, but rather to building a network that enables individuals to feel confident and empowered to address problems for themselves."

Benefits of social prescribing include:

Physical & emotional health & wellbeing	Cost effectiveness & sustainability	Builds up local community	Behaviour Change	Capacity to build up the VCS	Social determinants of ill-health
• Improves resilience • Self-confidence • Self-esteem • Improve modifiable lifestyle factors • Improve mental health • Improve quality of life	• Prevention • Reduction in frequent primary care use • Savings across the care pathway • Reduced prescribing of medicines	• Increases awareness of what is available • Stronger links between VCS & HCP/bodies • Community resilience • Nurture community assets	• Lifestyle • Sustained change • Ability to self-care • Autonomy • Activation • Motivation • Learning new skills	• More volunteering • Volunteer graduates running schemes • Addressing unmet needs of patients • Enhance social infrastructure	• Better employability • Reduces isolation • Social welfare law advice • Reach marginalised groups • Increase skills

(Report of the Annual Social Prescribing Network Conference, 2016)

A pilot of social prescribing was conducted in Rotherham between 2012-2014, which included an economic analysis of return on investment:

- 28 GP practices engaged
- 1,500 referrals made during the pilot
- 808 referrals made in the first 12 months
- The types of services most frequently accessed were:
    - Community based activity
    - Information and advice
    - Befriending
    - Community transport
- The initiative used patient-level Hospital Episode Statistics which was provided by their local Commissioning Support Unit, to analyse patients' use of hospital resources (including unplanned care)
- Of the 1,500 referrals a total of 559 patients were followed up (only those where there was post-referral data available for either 6 months or 12 months were followed up)
- Reductions in three types of hospital episodes have been identified compared to the six month prior to referral:
    - Accident and Emergency attendance reduced by 20% in the 12 month cohort and 12% in the 6 month cohort
    - Where patients had been referred onto voluntary and community services funded by the initiative the reductions were even greater: 24% in the 12 month cohort and 16% in the six month cohort
    - Outpatient appointments were reduced by 21% in the 12 month cohort and 15% in the 6 month cohort
    - Again as with the Accident and Emergency attendance, where patients had been referred on to VCS funded by the initiative there was 29% in the 12 month cohort, but only 4% in the 6 month cohort
    - Inpatient admissions were reduced by 21% in the 12 month cohort and 14% in the six month cohort. For those forwarded on VCS the 12 month cohort had reductions of 25% and 22% for the 6 month cohort

- Further outcomes of patients include:
    - Patients becoming more independent and being able to access social prescribing activities with less support
    - Patients being able to manage their long term conditions better themselves
    - Social isolation felt less by individuals and their carers and enjoying more social interaction
    - A general improvement in the quality of care available to patients
- The initial cost of the scheme to set up was £1 million, with an estimate that costs of delivering the service would be recouped after 18 to 24 months
- Although the sample was insufficient to calculate statistical significance, findings indicated that after 18-24 months, the potential cost savings could be between £1.41 for every £1 invested, to £3.38 for every £1 invested.

(http://info.wirral.nhs.uk/document_uploads/evidence-reviews/Social%20Prescribing%20literature%20review%20v5.pdf)

A Social Return on Investment (SROI) study of Bristol's Wellspring Healthy Living Centre social prescribing project showed that for every pound invested in social prescribing there was a £3 social return including savings from: reduced GP attendance; prescriptions; secondary care and specialist referrals; savings from a return to employment; and adoption of caring roles.

(http://www.wellspringhlc.org/content/POV%20Final%20Report%20March%202014%20(2).pdf)

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The main outcomes for the scheme are:

- reduced GP consultation rates and prescriptions for medication
- reduced hospital referrals
- improved patient activation measures
- improved wellbeing and quality of life measures
- increased volunteering
- social return on investment

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

General practice software, and where appropriate additional support through the Informatica clinical audit tool installed in GP practices, will allow the relevant primary care metrics to be measured and monitored through the practice record. Where possible, data collated within community-based services will be fed back into the practice record.

Additional quantitative and qualitative measures will be used to ensure that the full breadth of experience and

outcomes of the scheme are collected. This will include assessment of professional and public 'buy in' to the scheme.

Academic support will be enlisted to ensure that the evaluation is robust, includes a control comparison group, and can provide an economic assessment of social return on investment.

Baseline data and target outcomes will be agreed and monitored by the HWBB Prevention Group.

Progress of the project will be monitored by the HWBB Delivery Group.

What are the key success factors for implementation of this scheme?

Stakeholder involvement in the scheme design and implementation- key to success are GPs, the CCG, Shropshire Council, the community, voluntary and social enterprise sector, community leaders and patient groups.

Effective communication and 'buy in' from clinicians.

A clear and simple pathway, supported by a 'link worker' with strong listening and motivational interviewing skills, and a robust infrastructure for managing referrals.

Agreement on data collection and evaluation methods, with support from an academic partner.

Good feedback mechanisms to all potential referrers in order to close the loop and demonstrate the benefits of referral.

Co-production of the interventions offered with the CVSE sector and patient groups.

A 'client focused' approach that respects personal autonomy and empowers clients, 'working with' people rather than 'doing to' them.

Integration with existing initiatives, and avoidance of duplication.

Reduction in health inequality.

Scheme reference number:

C1

KLOE Reference: C5iii, C5v

Scheme name:

Integrated Community Services (ICS)

What is the strategic objective of this scheme?

The strategic objectives for ICS can be described in terms of patient focussed objectives and performance and process focussed objectives:

Patient focussed

- More people maximise their capacity for independent living
- More people are able to remain living at home rather than bed based settings
- More people benefit from intermediate care
- People only spend the time in hospital needed
- People are enabled to recover, regain their independence and return to their previous state of health and wellbeing
- People are encouraged and supported to maximise the use of community resources and natural support
- Improve patient experience of complex discharges

Performance and process focussed

- Reduction in emergency admissions to hospitals and care homes
- Reduction in Length of Stay (LoS) in acute and community hospitals
- Reduction in the number of excess bed days in acute and community hospitals
- Reduction in Delayed Transfers of Care (DTOC)
- Reduction in admissions to bed based rehabilitation and long term care home placements from hospital
- Reduction in long term domiciliary care packages following a period of Intermediate Care
- Increase in uptake of carer assessments and support services
- Reduction in readmissions within 28 days of discharge from an acute or community hospital
- Increase in the number of patients who return to their original level of functioning following intermediate care and consequent reduction in increased care packages, including equipment etc.
- Increased individual resilience and reduced reliance upon paid support
- For those who still have support needs at the end of Intermediate Care the use of peer support being routine to increase numbers of people who are able to self-manage or control their own support
- Reduce the potentially avoidable harm caused to patients through prolonged stays in an acute setting
- Optimise the use and deployment of available capacity and resources in LHSE

A prototype approach has been adopted during the course of the 3 years of phased implementation of ICS which aims to use an action learning approach to understand the needs of users and develop the best service around them. The teams established in the first 2 phases were formed by bringing together nurses, occupational therapists, physiotherapists, social workers and enablement staff into a single integrated health and social care team. The skill mix of the integrated teams was determined following a detailed demand and capacity modelling exercise. The integrated teams have been formed by drawing staff from pre-existing teams such as Community IDTs, Home from Hospital Team and START supplemented by recruitment to gaps in the required skill mix.

This is a key transformational programme of work within the Local Health and Social Economy (LHSE) requiring both significant workforce redesign and reallocation of resources. The Provider is expected to demonstrate the continued development and refinement of the service and its constituent teams to deliver the optimum full service model delivery. Commissioners will need to work with the Provider to support the necessary commissioning and contractual changes required in the wider LHSE to ensure that resources and investment are realigned to follow patient activity.

Delivering ICS at full scale will enable the system to deliver care activity in a different way, which reduces the need for duplicated provision elsewhere. It offers an immediate alternative to acute/ community hospital services, plus the potential for reduction of overall ongoing care needs, particularly in the unplanned part of the system.

Overview of the scheme
Provide a brief description of what you are proposing to do including:
What is the model of care and support?
Which patient cohorts are being targeted?

ICS is a locality based health and social care, community and voluntary sector integrated team with responsibility for complex patients who require support to prevent an acute hospital admission or to facilitate discharge from an in-patient bed. Shropshire Community Health NHS Trust is the Lead Provider for the delivery of Integrated Community Services (ICS) and will enter into sub-contract arrangements with other partners including the Local Authority as required for the full delivery of the service requirements.

Service Objectives

- To provide an integrated holistic 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.
- To provide access to high quality expert decision makers as early as possible in the process (especially for older people).
- Ensure a seamless transition with services wrapped around the person and their GP practice.
- To provide a 7 day service, 365 days a year, 8am – 8pm.
- To ensure that the needs of informal family carers are identified and supported.
- To achieve integration through a new shared culture, mind-set, values, objectives, working processes and practice.
- Work collaboratively across the whole system to achieve real transformation with continuous monitoring and learning embedded to allow service evolution and improvement.

Service Model

Early Supported Discharge
An acute hospital is not the best place to assess frail older people's future needs. Assessments made in the wrong environment will potentially give the wrong solution risking patients going into long term nursing placements when, given the opportunity to recover and recuperate from their acute illness or episode combined with the opportunity to receive an assessment, rehabilitation and/or enablement they can improve their independence and remain at home with or without ongoing support.

- ICS forms part of Shropshire LHSE's model of Discharge to Assess. Discharge to assess is firmly grounded in the philosophy that the best bed is the patient's own bed and therefore home is always the default. ICS will deliver the 'Home with Support' component of Shropshire LHSE's Discharge to Assess model (Pathway 1).
- ICS will also manage the pathways of those patients discharged to 'bed based rehabilitation' including the

community hospitals and rehab beds commissioned from the independent sector (Pathway 2).

- ICS will ensure that people 18 years and over who are identified as having a health and/or social care need and are medically fit for transfer from a hospital setting are supported to discharge home or to the most appropriate community setting with the correct level of support in line with the response times set out in this specification.
- Once in the community they will receive a comprehensive assessment of their needs and be supported to develop a time limited holistic independence plan enabling individuals and their carers to remain as independent as possible, for as long as possible.
- Through development of the model in conjunction with a whole system focus on driving discharge to assess ICS have aligned themselves more closely with the acute hospital nursing and therapy teams to establish a trusted assessor function. The Trusted Assessor model is now in full implementation across both sites and has been operating successfully for the past 6 months. ICS are working very closely with SaTH to share learning and develop the model to ensure its sustainability long term. It is hoped that now the trusted assessor model has been applied this will support ICS to concentrate their capacity within the community and ensure that decisions making and rehabilitation takes place within patients own homes in a much more person centred approach.

Admission Avoidance

The service will provide rapid assessment and interventions for people 18 years or over who have an acute exacerbation of a long term condition or a rapid deterioration in health or wellbeing. The aim is to maintain them in their home to avoid an unnecessary emergency admission to an acute or community hospital. Once stabilised, the patient will receive a comprehensive assessment of their needs and be supported to develop a time limited independence plan enabling individuals and their carers to remain as independent as possible, for as long as possible.

Patient Pathways

ICS will be a short term relationship between the Provider and the patient, providing free at the point of delivery multi-disciplinary and multi-agency support until the team feels that the patient has reached their rehabilitation/enablement potential for a period up to 6 weeks. The period of time the patient receives care and support from ICS will depend on the patient's individual health and social care requirements which will be kept under review. It may be anywhere from several days up to six weeks.

Early Supported Discharge

Admission Avoidance

Exclusion Criteria

Early Supported Discharge

- Patients under 18 years of age
- End of life/palliative patients

Admission Avoidance

- Patients under 18 years of age
- End of Life care
- Where the individuals primary need is relating to:
    a. Mental Health
    b. Substance Misuse
    c. Learning Disability

The delivery chain
Provide evidence of a coherent delivery chain, naming the commissioners and providers

involved

Commissioners:
Shropshire CCG
Shropshire Council

Providers:
Shropshire Community NHS Trust
Shropshire Council
British Red Cross
Independent Domiciliary Care organisations

The evidence base
Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme**
- **to drive assumptions about impact and outcomes**

The evidence base which informed the design of the model of care was established as part of the Urgent Care Recovery High Impact Project 'Optimising Community Discharge' in 2013. The key findings from the multi-stakeholder project team's analysis are summarised below:-

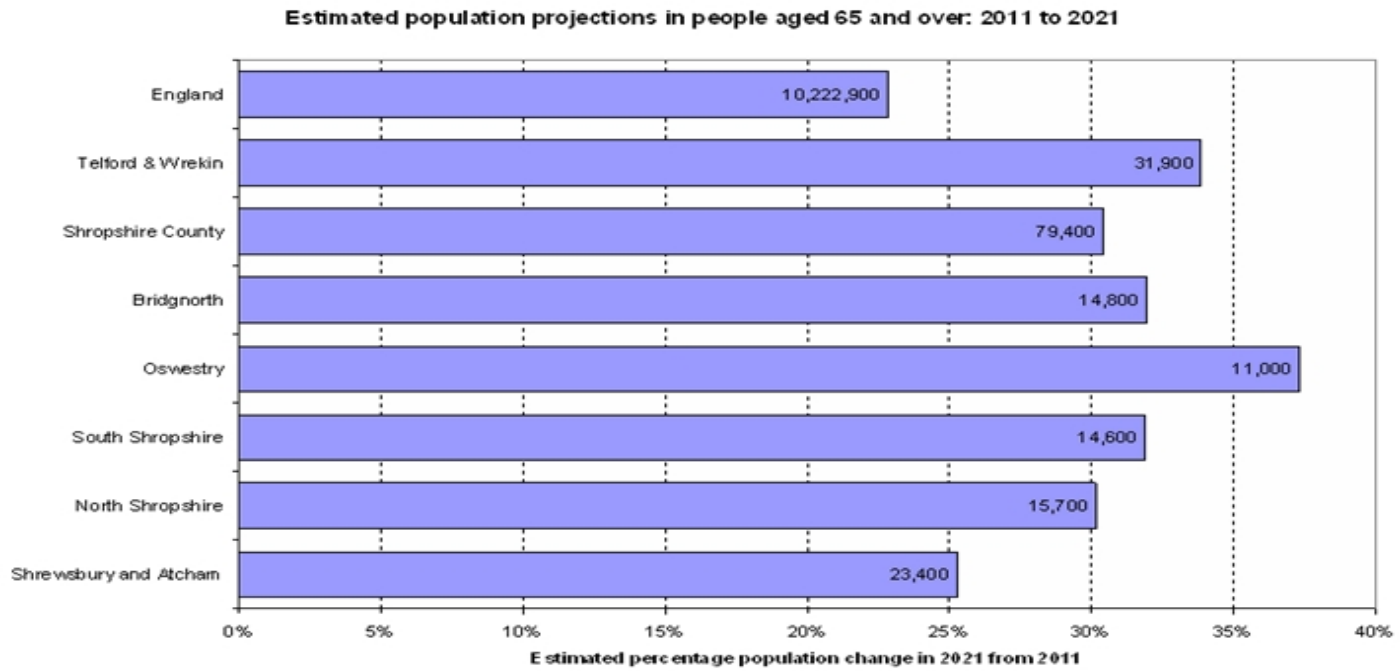
Changing demographics

It is widely recognised that the population is ageing. With current prevention and early interventions, individuals with long term conditions (LTC) will be well managed. As the population ages further, they will have further health and social care needs related to their LTC (diabetes, CVD) as they become more difficult to manage or develop acute conditions associated with old age – falls, strokes, heart attacks. Older people's health needs are therefore increasingly complex when they have a significant health need. Acute and community care are, and will manage, higher numbers of frail individuals with a range of complex health and social care needs.

The most significant future change to impact on demand is the substantial increase in the proportion and numbers of older people. The number of 65 year olds and over in Shropshire County is due to increase by 30% between the years 2011-21. In Telford and Wrekin the equivalent estimated increases are 34% between 2011-2021.

The chart below specifically highlights this and shows that the population growth of older people for the whole of Shropshire will be considerably higher than the average for the rest of England.

Estimated population projections in people aged 65 and over
Source: Director of Public health 'Transforming public health in Shropshire' Presentation October 2011



August 2013 Non-Elective In-Patient Audit (by Oak Group)

Early on in the project, the project team determined that accurate, reliable, objective information to measure demand post discharge must be gathered for the project outcomes to be achieved. An external organisation Oak Group was commissioned to conduct a point prevalence audit of non-elective patients, across acute and community hospital settings.

A total of 392 patients were studied across both acute hospitals and the 4 community hospitals (299 in SaTH and 93 in community hospitals). Specific wards in SaTH were targeted to ensure the data collection was most relevant to the outcomes of the project.

The key findings of the audit were:-

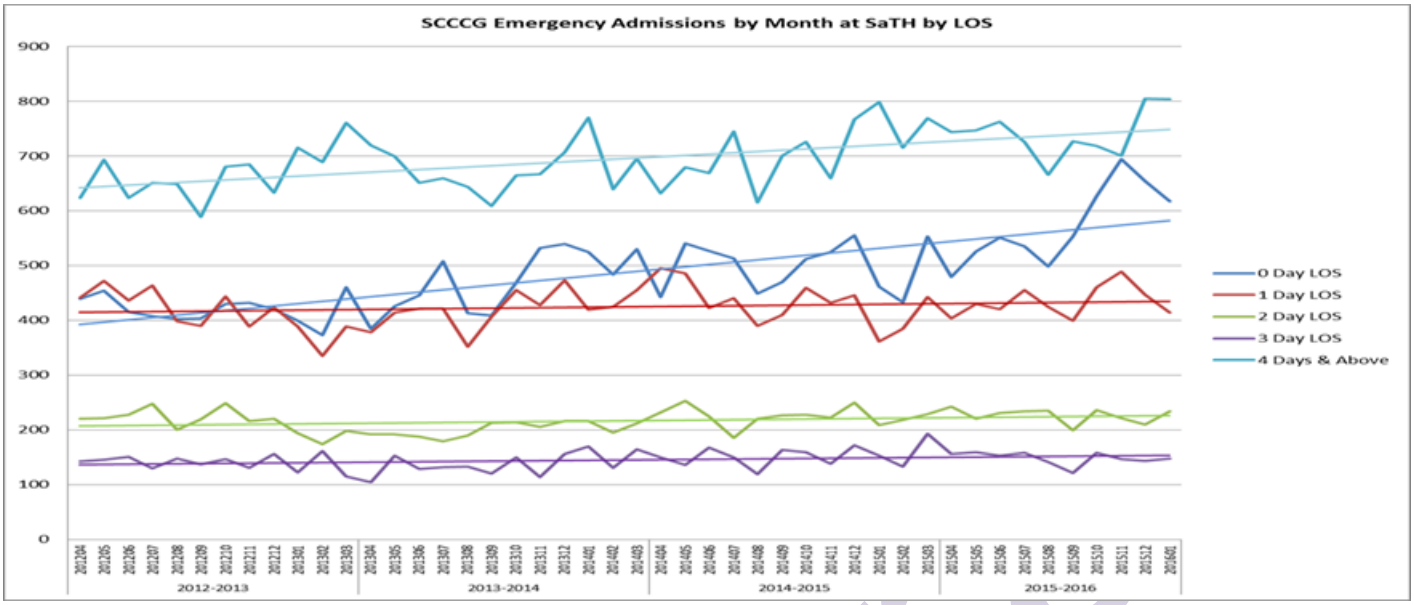
- There are a significant proportion of patients residing in non-elective in-patient beds when their care could be provided in lower levels of care. This applies to both acute and community hospitals. 50% of acute patients and 67% of community hospital patients audited could have been supported with lower levels of care in a community setting. This is based on 150 out of 299 acute patients being non-qualified for all or part of their stay (which is 50%) and 62 out of 92 community hospital patients (67%).

- 68% of reasons recorded in the audit for non-qualified days in SaTH were within the control of the hospital i.e. not waiting for external partners and 56% in community hospitals.

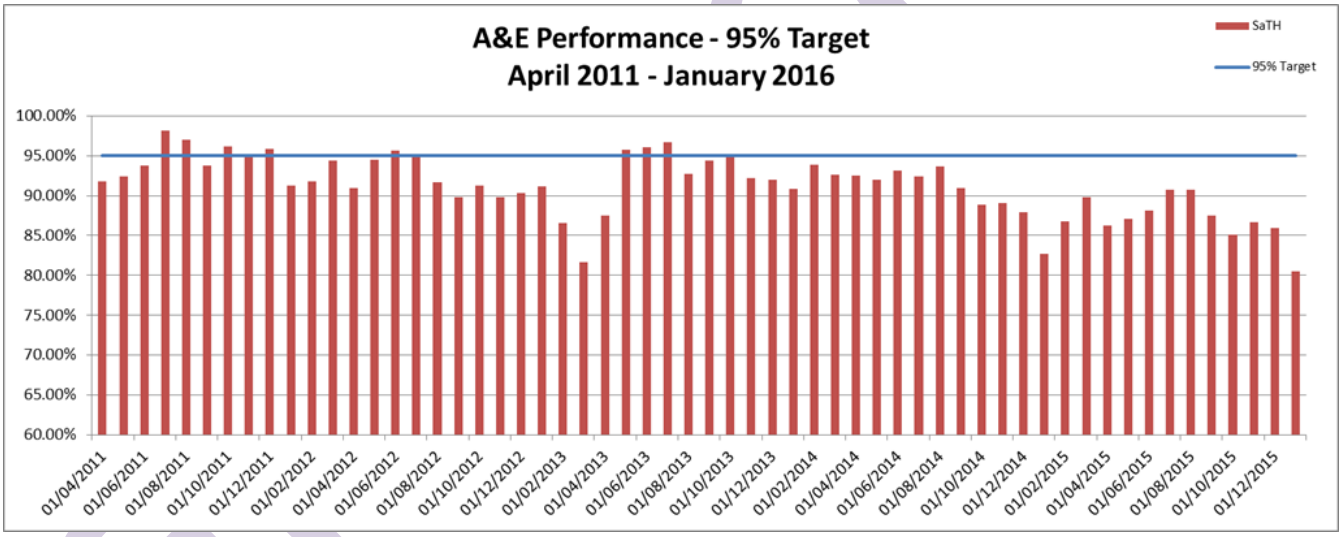
- There is clear evidence of poor discharge processes, planning and documentation in both acute and community hospital settings. These findings will be shared with the SaTH and Community Discharge project team to inform their work.

Key Performance Challenges/ Pressures

Year on year increase in demand on acute services with increases in both A&E attendances and admissions.



The LHSE continues to be unable to achieve the national 95% A&E 4 hour standard, with performance in the last year 15/16 showing a significant deterioration in performance compared to the previous year. The majority of breaches of the standard relate to admissions, particularly on the RSH site.



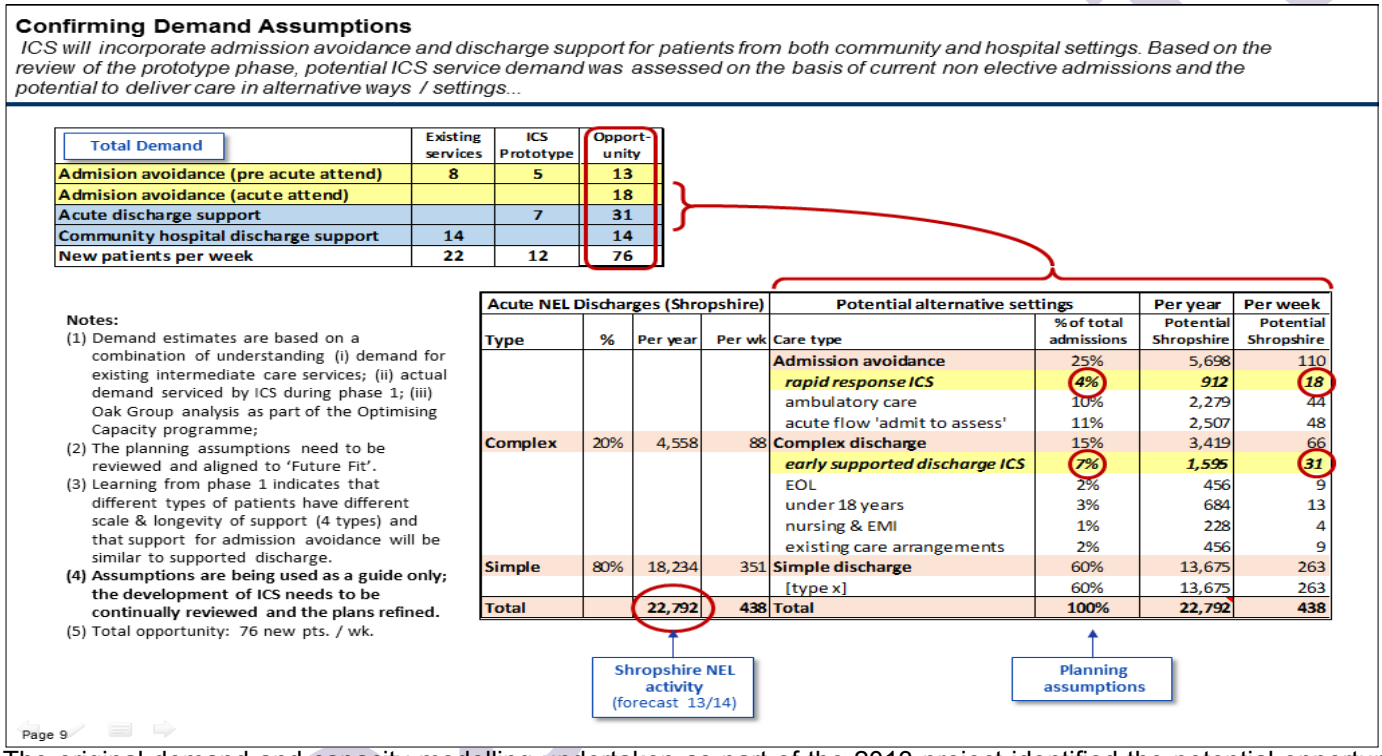
Over the last 12 months a significant risks to the delivery of the ICS model has been around access to domiciliary care. To address this both Shropshire CCG and Shropshire Council have worked in partnership to commission a 'preferred provider' contract for domiciliary care agencies. This has ensured block hours are in place across the county to manage hospital discharge and demand. The guaranteed hours for providers has enabled them to recruit more permanent staff members and has also supported ICS to develop a Re-ablement culture within the private sector through the interdependencies they now share with these providers.

Delayed Transfers of Care (DTOC)

The daily Delayed Transfers of Care report highlights that a number of patients in acute and community hospital beds do not need to be there, with the delays attributable to a variety of internal and external factors. These patients are generally the complex discharges. The national target for each economy is that DTOC levels are less than 3.5% of the total hospital bed stock. The economy has struggled to maintain this percentage on a consistent basis and this resulted in an increase in numbers of reportable lost bed days

The draft vision and model were tested with key stakeholders. There was strong support for changes to the health and social care system and for the draft vision and model. The drive for discharge to assess has aimed to not only improve outcomes/ experience for patients but also support with the plans to reduce DTOC. A whole system plan that integrates with ICS has been created alongside workshops with the acute to improve reporting in line with the guidance launched in September 2015. The whole system action plan includes a more integrated monitoring of performance between adults social care and the CCG. It also enables clear areas and responsibility around certain aspects of reasons for delays this means that relevant partners and their actions can be more easily identified in order to focus upon where areas of targeted support and intervention is required.

Demand and Capacity Modelling – Discharge to Assess Project 2015



Confirming Demand Assumptions

ICS will incorporate admission avoidance and discharge support for patients from both community and hospital settings. Based on the review of the prototype phase, potential ICS service demand was assessed on the basis of current non elective admissions and the potential to deliver care in alternative ways / settings...

Total Demand	Existing services	ICS Prototype	Opport-unity
Admision avoidance (pre acute attend)	8	5	13
Admision avoidance (acute attend)			18
Acute discharge support		7	31
Community hospital discharge support	14		14
New patients per week	22	12	76

Notes:
(1) Demand estimates are based on a combination of understanding (i) demand for existing intermediate care services; (ii) actual demand serviced by ICS during phase 1; (iii) Oak Group analysis as part of the Optimising Capacity programme;
(2) The planning assumptions need to be reviewed and aligned to 'Future Fit'.
(3) Learning from phase 1 indicates that different types of patients have different scale & longevity of support (4 types) and that support for admission avoidance will be similar to supported discharge.
(4) Assumptions are being used as a guide only; the development of ICS needs to be continually reviewed and the plans refined.
(5) Total opportunity: 76 new pts. / wk.

Acute NEL Discharges (Shropshire)				Potential alternative settings		Per year	Per week
Type	%	Per year	Per wk	Care type	% of total admissions	Potential Shropshire	Potential Shropshire
				Admission avoidance	25%	5,698	110
				rapid response ICS	*4%*	*912*	*18*
				ambulatory care	10%	2,279	44
				acute flow 'admit to assess'	11%	2,507	48
Complex	20%	4,558	88	Complex discharge	15%	3,419	66
				early supported discharge ICS	*7%*	*1,595*	*31*
				EOL	2%	456	9
				under 18 years	3%	684	13
				nursing & EMI	1%	228	4
				existing care arrangements	2%	456	9
Simple	80%	18,234	351	Simple discharge	60%	13,675	263
				[type x]	60%	13,675	263
Total		22,792	438	Total	100%	22,792	438

Shropshire NEL activity (forecast 13/14)

Planning assumptions

Page 9

The original demand and capacity modelling undertaken as part of the 2013 project identified the potential opportunity i.e. the number of referrals expected per week equates to 31 admission avoidance referrals per week and 45 hospital discharge referrals as described above. It is important to note that a proportion of this activity includes pre-existing related activity and therefore the 76 per week across both elements of the service is not all new activity.

Further demand and capacity modelling was undertaken as part of a multi-stakeholder Discharge to Assess project in 2015. The purpose of this project was to test the introduction of a pathway for patients requiring interim placement for complex assessments.

Every 'complex' patient who requires support to discharge is now allocated pathway 1, 2 or 3 depending on their presenting needs. This is an MDT decision and there is fluidity across the pathways to ensure that if at any point a patient can return home this goal is fulfilled before any other bed based setting is considered. In order to monitor and plan for future demand and capacity each month commissioners are provided with a report which indicates the initial discharge plan for the patient, the plan at the end of their hospital stay and then their actual discharge destination. This therefore maps decision making and any potential risk adverse behaviours. The report also aims to identify potential patterns of behaviour during periods of escalation and highlights if patients have discharged to destinations e.g. bed based rehab due to capacity in the system that day as opposed to the original planning for home etc. The intentions are that this intelligence will then support with future work force planning and developing the model for ICS to ensure more patients have access to support within their own homes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Now that the prototype phase is completed, a detailed service specification has been produced which includes detailed metrics and information reporting requirements. This specification will be included in the Shropshire Community Health NHS Trust contract with the CCG for 2016/17. The Provider is not currently in a position to report against all the information reporting requirements and it has proved a challenge to find an integrated IT solution to support efficient and effective data capture, analysis and reporting and therefore this remains a priority area for improvement in 2016/17.

Implementation & evaluation is supported by:

- Emma Pyrah, Urgent Care Commissioner, Shropshire CCG (Admission avoidance)
- Gemma McIver, Rehab and Re-ablement Commissioner, Shropshire CCG (Early Supported Discharge)

Monitoring:

- Monthly commissioner led monitoring and performance meetings with the providers
- Monthly contract review meeting with Shropshire Community Health NHS Trust (from 2016/17)

What are the key success factors for implementation of this scheme?

- More people maximise their capacity for independent living
- More people are able to remain living at home rather than bed based settings
- More people benefit from intermediate care
- People only spend the time in hospital needed
- People are enabled to recover, regain their independence and return to their previous state of health and wellbeing
- People are encouraged and supported to maximise the use of community resources and natural support
- Improved patient experience of complex discharges
- Simplify the pattern of services to reduce complexity and fragmentation of services.
- Create the workforce and services that offer a robust, effective alternative to bed based rehabilitation and re-ablement and recovery.
- Work collaboratively across the whole system to achieve real transformation with all key components in place and working consistently; partial implementation will not be sufficient to create significant change.

Scheme reference number

C2

Scheme name
Mental Health Crisis Care- a developing scheme
What is the strategic objective of this scheme?
To provide the most effective support to people who are experiencing mental health crisis so that they can access support as soon as possible when they are in crisis with the anticipation that it will either prevent admission or lead to early discharge whilst reducing the impact on the crisis on their long term mental health.
Overview of the scheme **Provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
The Mental Health Crisis Care project included in the 15/16 BCF plan was funded through non recurrent external funding that ended in March 2016. Detailed evaluation of the project has shown that the project has had limited added value and has highlighted significant difficulties in sustaining it beyond the pilot period. As such the project has ceased and an interim solution has been secured between SSSFT and West Mercia Police while a detailed needs assessment into how best to meet this need is undertaken by the CCG and partners. It is anticipated that this needs assessment will be complete by September 2016. The findings will lead to the development of appropriate commissioning intentions and where appropriate scheme(s) for BCF.
The delivery chain **Provide evidence of a coherent delivery chain, naming the commissioners and providers involved**
Commissioners: Shropshire CCG Shropshire Council Providers: South Staffs and Shropshire Foundation Trust Shropshire Council Third sector/Independent sector provider as determined through the tendering process
The evidence base **Please reference the evidence base which you have drawn on** - **to support the selection and design of this scheme** - **to drive assumptions about impact and outcomes**
The evidence base for this emerging scheme is currently being collated through the detailed needs assessment that will support the selection of commissioning direction and appropriate schemes for BCF. The need for mental health crisis care is backed up by a raft of evidence including “Closing the Gap: Priorities for essential change in mental health.” The central theme of this document reinforces the Principles of ensuring *Parity of Esteem* between Mental Health and other types of health provision. It sets out 25 areas in which they evidenced change was required in order to see improvements in mental health provision. Priority Area 15 states that, “no-one experiencing a mental health crisis should ever be turned away from services.” It then goes on to explain that not all services are available 7 days a week and there are particular difficulties in arranging for health places of safety for those detained under section 136 of the Mental Health Act. [The CCG and Shropshire Council, West Midlands Ambulance Service, West Mercia Police and the SSSFT are working on a separate but related

piece of work about this area].

In Shropshire in 2013-14 some 44% of those detained under section 136 because they needed immediate care and control were supported in a Police place of safety as opposed to health settings. A report by the CQC and HMIC in 2013 stated that this practice is associated with poor service user outcomes. Furthermore the Mental Health Crisis Care Concordat states that there needs to be a 50% reduction in use of Police Place of Safety in 2014-15. One of the reasons that a health place of safety is not available is owing to the time it takes to complete crisis assessments and develop a workable plan to support that individual. This model provides the crisis resolution and Home Treatment team with an alternative service that could provide intensive support to someone in their own home and thus avoid an admission and free up capacity in the health place of safety.

Closing the Gap also states that the, "Mental Health Crisis Care Concordat – Improving Outcomes for People experiencing Mental Health Crisis" (published by HM Government 18th February, 2014) would define the core principles of good mental health crisis care. The Concordat is arranged around the key elements of a good mental health crisis care service:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises.

The Concordat sets out the elements of an effective system which would support local areas to plan the changes needed to strengthen and improve responses in order to best address local circumstances. The Concordat recognised that there is no single national blueprint, as local circumstances will differ, but states services locally must take action in the following areas:

- Strengthen local relationships with key partners, ensuring roles and responsibilities are agreed and understood around mental health crisis care
- Consider the best combination of early interventions services that would support local need
- Record the frequency and use of police custody as a place of safety and review the appropriateness of each use to inform use in the future
- Ensure staff are properly trained in effective and appropriate use of restraint
- Consider local plans to deliver 24/7 crisis care, seven days a week.

The mental health crisis care service redesign group used these key themes to consider changes that they wished to propose to crisis care.

We also know from service user feedback as part of the modernisation of mental health services that patients find it hard to access health in a crisis and that there are delays in accessing support for those who are detained under section 136 of the mental health act.

Evidence of Local Need for a mental health crisis care Home Resolution Service

An initial evaluation has been undertaken on behalf of Shropshire CCG which looked at the numbers of referrals to the Psychiatric Liaison service at SATH. The outcomes of this high level piece of work suggested that further detailed work was needed. These proposals have now been shared with the CCG Clinical Advisory Panel. They support further work taking place to identify the prevalence of mental health crisis care needs so as to better inform the final new model that will go to formal consultation. This will also allow the service to be reviewed against the requirements set out in Achieving Better Access to mental Health Services by 2020

This review will include exploration of the cost of Hospital based Mental Health Crisis Care

The total cost of mental health hospital care occupied bed days in 14-15 was £7,081,793 based on a planned usage of 18,713 occupied bed days.

Investment requirements
Enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment requirements will be confirmed following the needs assessment work and confirmation of

commissioning requirements.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

In terms of the BCF metrics it is anticipated that the scheme(s) developed following the needs assessment will be specifically targeted at reducing admissions to acute Psychiatric Hospital.

This scheme(s) would then aim to enhance the repertoire of support available to people in crisis and would seek to improve the number of people who know how to access help out of hours in a mental health crisis, which is another key component of the metrics.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The scheme is in development phase and therefore more detail will be available following the needs assessment work.

Implementation & evaluation is supported by:

- Richard Kubilius, Programme Lead, SCCG
- Dr Colin Stanford, Clinical Lead for Supporting People in Crisis, SCCG
- Dr Alan Otter Clinical Lead for Mental Health

Monitoring:

- Baseline data and target outcomes will be agreed and monitored by H&WB Delivery group.

Reporting to:

- Progress of the project will be monitored by the H&WB Delivery Group
- Quarterly report submitted to SCCG which will contribute to a final local evaluation.

What are the key success factors for implementation of this scheme?

- Enhanced patient experience to be measured via Patient Rated Experience Measures
- More alternatives to Hospital admission for people in mental health crisis
- Better county wide access to support, current service has restricted accessibility due to current base
- The service needs to further strengthen relationships with Shropdoc
- Staff need to accept family member referrals and act on them
- Crisis Plans need to be more fully developed – if we get this right everyone on CPA would have a detailed crisis contingency plan that is accessible to CR/HT, community teams, GP/Shropdoc, AMHP/EDT, service user and family. This would include who should be contacted at the earliest stage possible when a crisis is emerging, how to be contacted and response to expect.
- GETTING HELP IN A CRISIS SHOULD ONLY TAKE ONE CALL
- Further training needs to focus upon creating and using Crisis Plans including listening to family
- A telephone response line needs to be created that is available out of hours and is staffed by qualified staff who can give advice/support or mobilise other resources as require

Scheme reference number
C3
Scheme name
Alcohol Liaison Nurse service (ALN)
What is the strategic objective of this scheme?
The strategic objectives of the ALN service are: o To improve the extent to which alcohol misuse is identified and effectively managed in those admitted to medical and surgical departments o To reduce the rate of attendance at accident & emergency and subsequent admission to inpatient services by problematic drinkers o Through training, to promote improved competency and confidence among medical and nursing staff in identifying and responding to alcohol misuse as part of the overall clinical management of patients. o To promote the concept of harm reduction for problematic drinkers within the general hospital setting. o To facilitate an effective and safe transition of care for individuals requiring pharmacological management of the symptoms of acute alcohol withdrawal. o To develop and improve care pathways for problematic drinkers from general hospital and community-based services. o To reduce alcohol related admissions. o To reduce the number of alcohol related occupied bed days.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The 2012 UK Alcohol Strategy recommends every acute hospital should have alcohol liaison nurses tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions. The ALN service in Shropshire should create a culture where medical and nursing staff in the general hospital environment feel more confident and competent in identifying and addressing alcohol-related needs

as part of a wider treatment plan. In order to achieve this, the role of the ALNs will be to develop systems that promote both competence and confidence. These will include:

(a) Introduction of an appropriate screening system that can be integrated into existing triage/clinical assessments in both A&E and ward based services to identify target patients.

(b) Development of mechanisms for flagging +ve screened patients for full AUDIT

(c) Training of relevant staff (for example clinical staff in ED, Gastroenterology, Acute Medicine, Fracture Clinics) in the use of the screening tools and provision of ongoing advice and support regarding its use.

(d) Development of protocols in line with relevant NICE guidelines supporting the management of alcohol misuse including:

- Assessment
- Harm reduction
- Prescribing for assisted alcohol withdrawal & vitamin supplementation
- Management of challenging behaviour, such as aggression, confusion and delirium tremens.
- Discharge or transfer of patients engaged in withdrawal management prescribing.

(e) Mapping the training needs of medical and nursing staff in respect of working with problematic drinking and drug misuse.

(f) Development and coordination of a tailored training program for medical and nursing staff.

(g) Establishment of clear pathways between the hospital and community-based care. Particularly for patients who are identified as 'high impact users' of acute services – liaising closely with the 'High Intensity Users' service.

(h) ALNs will provide specialist advice, and treatment within the hospital setting to ensure patients are not unnecessarily admitted for alcohol interventions which could be addressed in the community and if admitted to facilitate discharge into the community for continuation of treatment that can be managed in a community setting

(i) ALN's will liaise with the community team to ensure that where patients presenting at the hospital are not engaged with the community team they facilitate this process.

Further consideration will be given to options for following up patients not entering community services, Links with the Street Pastor scheme in Shrewsbury will also be explored

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Shropshire Council Substance misuse team are the commissioners of the ALN project.

ARCH Initiatives (Shropshire Recovery Partnership) are the providers of the service.

Shrewsbury and Telford Hospital Trust (SATH) are the hosts of the service and key participants in the pathway.

The evidence base

Reference the evidence base which you have drawn on

- to support the selection and design of this scheme to drive assumptions about impact and outcomes

The Update to the UK Alcohol Strategy estimates that in England and Wales there are around 8,750 alcohol-related deaths per year and 1.2 million alcohol-related hospital admissions. In one generation, the number of alcohol-related deaths in the UK has doubled from 4,023 in 1992 to 8,748 in 2011.

A majority of the deaths, around two thirds, are from liver disease. The majority of alcohol-related hospital admissions (75%) are due to chronic conditions such as cardiovascular disease, liver disease and cancer. Around 16% are for mental and behavioural disorders resulting from alcohol use and 8% are for acute illnesses including injuries. Hazardous drinking and dependence impacts heavily on secondary care health services. Nationally, 13-20% of all hospital admissions are alcohol-related, and in many areas this figure is rising, markedly so for certain groups.

Alcohol harms health in many different ways. It is a risk factor for liver disease, cardiovascular disease and cancers of the head, mouth, neck, liver, breast and bowel. It is linked to poor mental health, depression and dependence. It can cause acute toxic poisoning. It increases the risk of accidents, violence and injuries. It can harm the unborn child and reduce birth-weight. These risks affect a substantial proportion of the entire adult population: every week in Great Britain, 26% of men and 17% of women drink enough to risk suffering physical or psychological harm.

Harmful drinking is a recognised issue across public sector agencies in Shropshire and tackling both the harm to individuals and communities as well as reducing the financial burden of addressing alcohol related issues is a priority for health and social care partners. The Blue Light Project work has estimated that Shropshire has some 9,000 dependent drinkers, roughly 8,400 not engaged with services, and an additional 10,000 or more higher risk drinkers, with a similar number not engaged. As the Blue Light Project recognises, these numbers are far beyond the ability of the treatment system to manage directly.

The local alcohol strategy sets out a focused multi agency approach to addressing this issue and the Safer Stronger Communities Board has adopted alcohol as one of its priority areas. The data set out in the Shropshire Alcohol Strategy 2013 - 2016 shows that in broad terms Shropshire is average or better than average across the major alcohol measures, compared to both the region and the UK as a whole. There is of course room for further improvement.

<u>The Role of Alcohol Liaison Nurses</u>

The majority of General Hospitals in England now have some kind of ALN Service, and that number is growing. The updated (2013) National Alcohol Strategy specifically recommends such posts as does various recent good practice guidance referenced in that strategy. The exact role of ALNs varies from area to area, highlighting the key point that they have to be considered within the context of both the local alcohol strategy and treatment system, and of the local healthcare system.

The 2013 Alcohol Strategy recommends that every acute hospital should have an alcohol liaison service tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions. This requires leadership, cross-departmental collaboration and partnership with primary care and the specialist community alcohol services. These teams are concerned with the provision of appropriate treatment and care and opportunistic interventions within the hospital setting, and with preventing the further development of alcohol-related illness.

The main metrics that this project will contribute to are:

- Reducing non elective admissions
- Reducing delayed transfers of care

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The ALN service will be responsible for measuring scheme outcomes and for reporting what is and is not working. This will be undertaken through the hospital's data collection and monitoring systems where streamlining work is underway. Close liaison will take place between the commissioner of the ALN service and the BCF manager in relation to measuring the outcomes for BCF and to make any changes required.

What are the key success factors for implementation of this scheme?

The ALN service is in place currently. It's inclusion as a BCF scheme and adherence to the BCF reporting and monitoring systems will further cement and increase the value of its key role in reducing the demand of this cohort of patients on the health and social care economy. A range of recommendations from an evaluation of the scheme in March 2015 are being implemented to further increase the scheme's success. Specific targets are the reduction of alcohol related admissions by a minimum of 17 in 16/17 and a minimum of 630 bed days saved.

Scheme reference number
C4
Scheme name
Rapid Assessment, Interface and Discharge (RAID)
What is the strategic objective of this scheme?
The strategic objectives of the RAID service are: i. To improve hospital access to prompt skilled mental health assessment and treatment, including early intervention, promoting recovery and well-being. ii. To provide equitable treatment in response to the patient experience rather than being designed on the basis of professional training or subspecialty. iii. Responding to the social determinants of mental illness and previously marginalised and difficult to reach populations who often present in crisis to an acute medical hospital. iv. To provide one point of contact and access for all the acute general hospital referrals in relation to specialist assessment of mental health, substance misuse and psychological needs, including those for older people. v. To facilitate early but effective discharge from hospital for patients seen by the team. vi. To avoid unnecessary admissions to hospital. vii. To up-skill Acute Hospital Clinical Staff to be able to better manage patients with mental health needs, alcohol problems and dementia.
Overview of the scheme **Provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
The Rapid Assessment, Interface and Discharge (RAID) service originated at City Hospital in Birmingham in 2009. It provided a new model of liaison psychiatry and was awarded the Health Service Journal award (2010) for innovation in mental health. The RAID project in Birmingham has led to improved quality of care for patients and their carers. The Birmingham approach was adopted in Shropshire in 2013. It is operational 24-hour, 7 days a week at the Royal Shrewsbury Hospital (RSH). The team sees service users from aged 18+ (16+ in A&E) and provides a comprehensive range of mental health specialties, including old age, working age, postnatal mental health

and initial substance misuse advice and liaison with the substance misuse service. The service has a 1-hour target for assessing patients who present to A&E and a 24-hour target for assessing patients on all wards. The multi-professional team provides clinical involvement alongside clinical support and advice in mental health interventions for general hospital professionals. The RAID team provides formal and informal training to the acute hospital staff. This includes training on dementia, depression, delirium and dignity.

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Shropshire Clinical Commissioning Group are the commissioners of the RAID project

South Staffordshire and Shropshire NHS Mental Health Foundation Trust (SSSFT) are the providers of the service.

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and outcomes**

There is evidence that acute hospitals are increasingly experiencing a cohort of patients with complex co-morbidities. The combination of physical and mental conditions increases the acuity levels and the need for integrated approaches. Profs George Tadros and Paul Kingston et al cite, in their review of the research data these significant levels of co-morbidity are increasingly prevalent and often produce poorer outcomes for these patients. Research into prevalence rates states that 27% of patients admitted to medical wards have a co-existing mental illness. In addition to that there have been demographic changes that create more challenges in terms of meeting the mental health needs of patients in acute settings. Tadros cites that between 2001 and 2013 there was a 53% increase in the UK population who are over 65. Furthermore two thirds of hospital beds in England are occupied by elderly patients (65+). The Royal College of Psychiatrists', (Who Cares Who Wins. Improving the outcome for older people admitted to a General Hospital) state co-existing mental health and physical health problems result in increased length of stay. In addition to that this research also finds that one quarter of the elderly patients in hospital have dementia, which creates particular challenges in providing good quality care.

The first RAID team in the UK was opened at the City Hospital in Birmingham in 2009 and won the 2010 Health Service Journal Award for innovation in mental health. This service was led by Professor George Tadros. The RAID project in Birmingham has led to improved quality of care for patients and their carers. It has also benefited local hospitals by reducing bed occupancy by 44 beds per day through reducing lengths of stay and readmissions, which resulted in £3.5 million savings to the acute hospital, namely City Hospital Birmingham. The project has enhanced the ability of elderly patients to be able to go back to their own homes rather than to residential care. In the previous year, only 34% of elderly patients with mental illness managed to go back to their own homes, compared to 67% after the RAID intervention: this led the LSE to estimate that Birmingham City Council has saved around £60K/week as a result of more older people being able to go back to their own homes (With Money in Mind, 2012).
Shropshire and Telford CCG's became an early adopter of the model in 2013. The service was the subject

of a detailed evaluation by the University of Chester in April 2015. The headline findings were:

- The RAID team is a very busy and engaged team that managed to assess 2447 new cases (507 at A&E and 1940 on the Ward or AMU).
- Breaches were impressively very low (3.5%).
- RAID is effective in reducing length of stay
- The total saving is a total 5,168 bed days, this equates to 14 beds saved every day
- RAID is effective in reducing Re-admission
- RAID achieved a 27% reduction in re-admissions across the two sites.
- RAID saved a total of 5,843 readmissions.
- RAID provided effective training programme to the acute hospital staff that was very well received and seemed to be effective.
- RAID provided quality service; 95% of the patients and 97% of the acute hospital staff rated RAID as excellent or good.

The main metrics that this project will contribute to are:

- Reducing delayed transfers of care
- Reducing non elective re-admissions of this patient cohort

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The RAID service is responsible for measuring scheme outcomes and for reporting what is and is not working. This is undertaken through the hospital's data collection and monitoring systems. Close liaison will take place between the commissioner of the RAID service and the BCF manager in relation to measuring the outcomes for BCF and to make any changes required.

What are the key success factors for implementation of this scheme?

The RAID service is in place currently. It's inclusion as a BCF scheme and adherence to the BCF reporting and monitoring systems will further cement and increase the value of its key role in reducing the demand of this cohort of patients on the health and social care economy.

Scheme reference number
C5
Scheme name
High Intensity Users (HIU)
What is the strategic objective of this scheme?
To reduce the demands and costs placed on the health and social care system by high intensity users by implementing a project based on the highly successful model introduced in Blackpool. Specifically this scheme will: • anticipate and proactively manage early presentation and support personalised patient care for high intensity users of urgent and emergency care services in Shropshire. • address the needs of these patients by seeking to ensure that individual emotional and social needs are met thus reducing dependency on use of urgent and emergency services as the solution. • work with the individual to foster acceptance of responsibility and make the effort to reconcile their own issues and change their behaviour - building strengths rather than correcting weaknesses.
Overview of the scheme **Provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
Improving patient flow through the urgent care system requires 2 things – relieving pressure on the 'front door' and increasing flow out of the 'back door'. Attendance and admission avoidance are key to relieving pressure on the front door and the CCG has introduced a number of initiatives to achieve this including ICS, CHAS1&II, Admission Avoidance ES and Ambulance Hear/See & Treat. Despite this, growth in A&E attendances and emergency admissions year on year continues and therefore other approaches to reducing 999 calls, A&E attendances and emergency admissions have been explored. At a Commissioning for Value national conference earlier this year, Blackpool and Fylde CCGs showcased a successful initiative to reduce the number of high intensity users of unscheduled services, often referred to as frequent users. The results they achieved within 15 months of implementation in terms of reduction in use of urgent care services were significant. This has an impact not just in terms of the demand on urgent care services but also delivers a significant financial saving. This approach has now been adopted in Shropshire in the form of a High Intensity Users Scheme (HIU) and is delivered through a partnership between West Midlands Ambulance Service (WMAS) and Shropshire CCG through the through the following process: Step 1 – Identification of the Top 50 patients

- Using WMAS data systems identify the top 100 frequent callers. Consider including other patients presenting as vulnerable regardless of chronic ambulance calling (e.g. Self- harm, homeless etc.)

Step 2 – Personalisation

- Each patient is contacted by telephone in order to take a fresh and personalised approach to how they are managed. This occurs before any contact is made with professional teams to ensure any conversations with the patient are not preloaded with opinion.

- This initial contact will be tailored to the needs of the patient e.g. some patients may be more responsive to an initial text rather than a telephone call.

- Management of the patient focuses on the true reason for calling – emotional and social issues. Solutions are brought forward through providing 1:1 attention and active listening until the root cause of their dependence on unscheduled services is established.

- The majority of patient contact is via telephone consultation with patient visits where this will support the change in behaviours sought.

- Patients are encouraged to call the service or ask for assistance earlier, when they feel social, emotional, financial or family issues are 'emerging' rather than when it reaches crisis.

- The service will act to correct disabling thoughts midstream. This is not based on replacing every negative thought with a positive one. It is designed to be a stopgap so the caller is able to focus on right now and to prevent themselves (and others) being at risk due to paralysing thoughts. Presenting issues are often not resolved during a crisis conversation. In these circumstances the service will make contact the following day endorsing positive behaviours and teaching patience and trust that they will be called back. Any actions raised from the previous conversation are relayed to the individual who is encouraged to assume responsibility for them.

Step 3 – Preparing the patient for relapse

- The service will ensure that its approach will prepare the patient for the possibility for relapse providing a more realistic platform with which to move forward.

Step 4 – Discharge from the service

- Patients will be discharged from the service at a point which the service lead feels this is appropriate and in agreement with the patient.

- The service will work with the patient to ensure they are ready and supported for discharge. This may mean working creatively and innovatively with existing services to work differently or together in a different way to meet the needs of the patient.

- The service will optimise the use of peer support, the recovery community, volunteer groups to embed positive health and social interaction as a 'natural' way of discharging individuals from the service.

- Patients will be offered the option of making contact with the service post discharge if they feel they are at risk of relapse.

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners: Shropshire CCG

Providers: West Midlands Ambulance Service (WMAS).

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and outcomes**

The Blackpool experience showed that when the emotional and social needs of frequent callers were met, any factitious medical presentations tended to disappear. By addressing individual human need, unscheduled care contacts reduced as a by-product.

The impact of the project on this cohort of patients in the first fifteen months was:-

- 999 calls were down by 89%
- A&E attendances were down by 92%
- Admissions were down by 82%.
- 98% reduction in self-harm incidences
- 44% reduction in police calls
- Total savings of £2,757,380 over fifteen months. The pilot cost £70,000.

An analysis of the Shropshire CCG top 100 users of urgent care services in 2014-15 has been undertaken to inform this scheme. The key points from this analysis are:

A&E Attendances

The top 100 service users:

- Accounted for 1499 A&E attendances – average 15 attendances/year per patient (highest = 94 attendances).
- 48.8% of the attendances were conveyed by ambulance
- The highest number of attendances were by patients in the 40-59 and 60-79 year old age bands.
- Though the classification of patients into care home or non- care home is based on a proxy the data does indicate that care home patients are a relatively small proportion of the selected cohort.
- Of all attenders 6 patients had attended more than 30 times in the full 12 months up to 31/3/2015

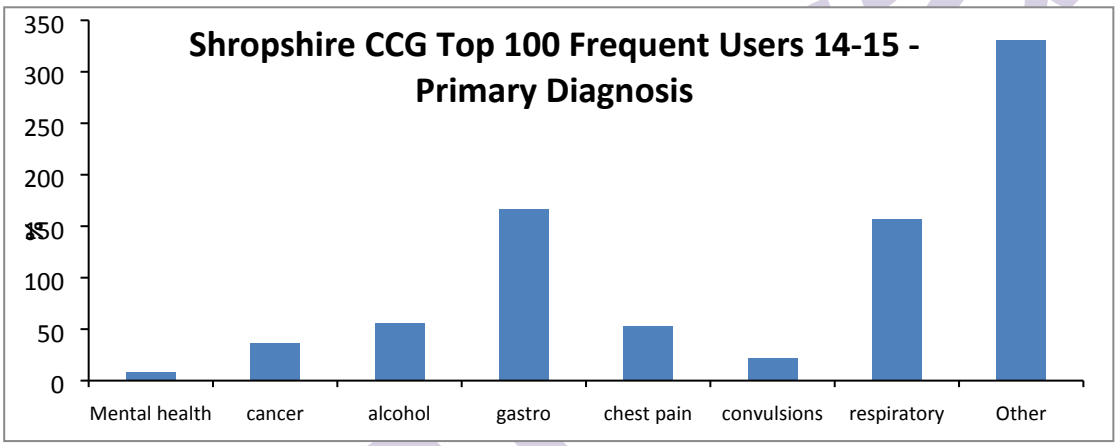
which equates to 20% (n=296) of the 1499 A&E attendances.

- The 1499 attendances at A&E resulted in a cost of £148,255.

Non-Elective Admissions

The top 100 service users:

- Accounted for 830 emergency admissions
- 72.2% of these admissions were via A&E (56.6%) or other routes (14.4%). The remainder (28.8%) were direct GP admissions.
- 36.7% (n=305) were 0-1 day LoS
- An analysis of the primary diagnosis is shown in the graph below.



- The 803 emergency admissions resulted in a cost of £1,654,383.

Information provided separately by WMAS analysing their top 10 Shropshire CCG callers (excluding care homes) indicates that in 2014/15 838 calls were made to 999 at a cost of £194,038.90 with an associated 198 hospital conveyances.

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The main outcomes for the scheme are:

- reduction in non-elective admissions of this patient cohort
- reduced demand on WMAS/ ambulance conveyances
- reduced demand on A&E and hospital services
- reduced demand on social care services for this patient cohort
- reduction of the costs to the health and social care system of these patients

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
WMAS will be responsible for measuring scheme outcomes and for reporting what is and is not working to the Urgent Commissioner at Shropshire CCG. This measuring will be undertaken through a data collection and monitoring system. Close liaison will take place between the urgent care commissioner and the BCF manager in relation to measuring the outcomes for BCF and to make any changes required.
What are the key success factors for implementation of this scheme?
The HIU service commenced in October 2015. Its' inclusion as a BCF scheme and adherence to the BCF reporting and monitoring systems will further cement and increase the value of its key role in reducing the demand of this cohort of patients on the health and social care economy.

Scheme reference number
D1
Scheme name

Resilient Communities 2016/17

What is the strategic objective of this scheme?

The strategic objective of Resilient Communities is to:

- ensure that the capacity, structures and co-ordination are in place to support families and individuals at the lowest point of need within their communities
- reduce the demand on more intensive and acute interventions by increasing the capacity of easily accessible support within the community and making it available earlier.

Our overall aim is to develop a sustainable community based approach to supporting families and individuals to have the best chances in life, to live independently, and to have active, prosperous and healthy lives. By building community resilience and developing grass roots support we will put in place the first line of support that prevents or delays escalation of need and reduces demand on acute and intensive interventions.

Resilient Communities is the cross cutting work stream that underpins and supports all aspects of the Better Care Fund Plan and its overarching vision is that, "*everyone living in Shropshire is able to flourish by leading healthy lives, reaching their full potential and making a positive contribution to their communities".*

Local residents are signposted by those working in the first points of access in health and social care to existing local community resources for support and activity that results in good outcomes. Where there is an identified gap in a needed resource or activity, the community will be supported to create the right thing for their locality to fill it.

The Resilient Communities model by its very nature continues to be an iterative and emerging process that responds to individual local circumstances and opportunities. It will continue to be developed within the context of a strong strategic and local partnership approach across the sectors of the CCG and its providers, the local authority and parish councils and the voluntary and community sector.

We believe that when an individual or family first identifies an issue of a non-acute nature with which they need assistance, there is likely to be one of three routes they can choose to seek out support:

- the health route – e.g. their GP practice
- the council route – e.g. accessing Shropshire Council's First Point of Contact or COMPASS
- the community route – e.g. through local community buildings and organisations

Once one of these routes has been accessed there are a whole range of support options available which can work in parallel and complement each other to offer a robust support network. A fundamental part of Resilient Communities is to ensure that the many local services available work with each other to provide this comprehensive support, providing low level intervention before need escalates.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Resilient Communities is made up of a number of component parts, which through this approach will be better integrated and signposted. The following narrative describes in more detail these component parts and how they work together.

Resilient Communities is based on a collective understanding that people are Shropshire's most important resource and that working together is the best way to address the challenge of supporting potentially vulnerable residents and reducing demand on public services. This can be best summarised as:

- staying independent and living at home is normal - investing in the things that create and retain people's independence
- maximising opportunities to make a difference – connecting people to the right support at the right time within their communities
- asset based community development – recognising and building on the existing capacity of the community and that it is underpinned by strong local networks, relationships and a commitment to a common cause
- a locality based approach - enabling local flexibility of approach within a set of overarching principles

The Resilient Communities work stream will:

- enable health and social care providers to more effectively link into the wider community resources and to work in a different way to ensure that potentially vulnerable residents are supported within and by their community
- facilitate early conversations with people to create independence plans that are used if they are admitted to hospital to enable them to be discharged home as soon as they able to leave the acute care environment
- work together to ensure that there are assets and resources in our communities that can be well used to create the best possible outcomes for vulnerable people
- maximise cross sector partnerships and collaborative working to achieve shared outcomes
- use local data and intelligence validated by community conversations and evaluation to build up an evidence based understanding of priorities and progress
- improve local communication, knowledge and networking to maximise the resources of the community – trying to reduce duplication by working together and filling any identified gaps

Resilient Communities activity – led by Shropshire Council's Community Enablement Team:
The following activity in a small number of communities within Harlescott, Ludlow and Oswestry has begun following confirmation by the BCF Supporting People to Live Independently Group. We have already been testing this in Craven Arms as part of earlier Resilient Communities work.

<u>Over-arching description of Resilient Communities activity</u>

1. Develop local governance that supports the maintenance and creation of Resilient Communities, e.g. local project boards linked to LJCs

2. Create the capacity within communities that maintains and creates resilience, e.g.
- the development and promotion of Community Hubs - points of contact within communities where people already go to get and offer help
- the development of Community Connectors
- the creation of hyper-local community directories
- building community activity that combats loneliness and lack of independence, such as befriending schemes like Compassionate Communities and peer support groups for people with long term conditions or dementia

3. Build up the confidence in professionals that enables them to effectively signpost people into community activities, e.g.
- Let's Talk Local – ASC & housing support team
- Strengthening Families – locality working groups
- Primary care – GP Community & Care Co-ordinators

4. Develop a methodology for measuring the impact of this activity on the high level outcomes of the Better Care Fund.

5. In 2016/17 we will lead on and facilitate the design of the 'early conversations' that lead to the creation of 'independence plans' that when implemented by individuals support the successful and timely transfer from a stay in an acute care setting back to their home. We will then design a way for these early conversations to be held locally and independence plans created.

<u>Headline activity from the local plans</u>

Activity has started in Craven Arms, Harlescott, Ludlow and Oswestry – all taking a flexible and local approach to implementing the key principles:

- Craven Arms has asked South Shropshire Furniture Scheme to lead on the Community Connector role and a local governance group supporting them and the creation and use of the hyper-local directory
- Harlescott is using an existing local partnership group for its local governance and is in early discussions to see if its activity can encompass new ways of delivering early mental health interventions
- Ludlow will be bringing the Resilient Communities work alongside work the Local Joint Committee is already doing to increase opportunities for vulnerable young people in the town. It has identified a potential organisation to be the Community Connector lead
- Oswestry has formed its local governance group and thinks that its activities will be best focussed on the community/service hubs of The Centre, the library, the SureStart Centres and the GPs

Doing all of this in a small number of places enables us to focus resources on setting up robust governance arrangements and to measure the impact of the activity. However, the Community Enablement Team will be supporting the development of Resilient Communities all over Shropshire day to day by working with colleagues, elected members and partners to build community capacity, facilitate connections between professionals and community resources and increase accessibility to community intelligence.

Community hubs
Community hubs will provide a focal point to foster greater local community activity and to bring residents, smaller organisations and the local business community together to improve the quality of life in their areas.

We think that community hubs will be neutral venues often best managed by community based organisations and will be at the centre of a diverse range of local activities. Community hubs will be buildings that are accessible to all groups in the area. They will be multi-purpose centres providing a range of high quality and cost effective services to the local community, with the potential to develop new services in response to changing community needs. A community hub will have strong working relationships with other local community services - for example, tenants' rooms, Children's Centres, nurseries, extended schools and faith groups. They will be a base for outreach and signposting people to other local services recognising that it is not the place that is important but what goes on within it and from it. Residents coming into the hubs will get the right thing at the right time – the right things often being something that family, friends and community can offer and the right time being as early as possible. The effectiveness of community hubs in reaching the people who will benefit from them, will be maximised through the development of the Community Connector role.

Community Connectors
Community Connectors will transcend services, organisations and sectors, but they will be specific to localities. They will be helpful, knowledgeable, friendly and interested people based in communities who know about everything that is going on and is available and have the attitude and aptitude to not only match people's interests and needs with these, but the ability to activate people into meaningful involvement. As part of a community's team of first line of support they will also have a knowledge and understanding of the service delivery in their locality and will have a relationship with the people delivering these services that mutually adds benefit to their work. They will be part of an early help team that could also include, amongst others, those delivering information, advice and guidance services, library staff, customer service staff, housing support officers, Community Enablement Officers, town/parish council officers, Community & Care Co-ordinators and volunteers. The role could potentially be delivered by any of these people but it would be significantly different to their existing activity and responsibilities as it demands a generic and universal way of working that is based around a locality not an organisation or a theme. Community Connectors will have the ability to be interested in everything from walking groups to job clubs and knit and natter groups to football training, to think about these things as important community resources, and most importantly, activate people to connect with them, build self-help behaviours, peer support and resilience. In 2016/17 Shropshire Council has a number of small grants available to support local groups to be lead Community Connectors in the pilot areas and also in the areas where we have transferred libraries into community managed hubs. There will be outcomes linked to these grants and the organisation taking on the role and receiving the grant will be accountable to both Shropshire Council and their local governance group for demonstrating its success in achieving these outcomes. It is envisaged that this lead Community Connector role will be carried out by local a voluntary group or an organisation working with local volunteers.

Hyper-local directories
The creation and use of very local directories of local activity for use in hubs will maximise the benefits of locality based, multi-disciplinary working. There are many excellent and useful directories of services and activity currently in use but these are often countywide so these simple

local ones, easy to update, bespoke to its community and encompassing all kinds of activity will complement these.

Local Resilient Communities teams
The local Resilient Communities teams (sitting alongside the local governance groups) will be made up of Community Enablement Officers, Community & Care Co-ordinators, the Let's Talk Local teams and the Strengthening Families local working groups. These teams will focus on the necessary service transformation around professionals feeling sufficiently and confident and knowledgeable to signpost and connect the clients and patients they are working with the existing resources available within their community.ds

Examples of previous Resilient Communities work:

Ageing Well in Church Stretton
This prototype was delivered in Church Stretton by a multi-disciplinary team (Community Health Trust, Shropshire Housing Group, local voluntary sector organisations and Shropshire Council). Within this prototype the team worked with people who had low- moderate level need, weren't FACS eligible and therefore weren't eligible for social care services.

The team worked differently to effectively identify the potential needs of people before they entered the community care pathway and to intervene with a holistic conversation as opposed to a Clinical Care Assessment or other statutory assessment. They held Ageing Well conversations that led to the creation of Independence Plans. The actions within these Plans had a strong preventative focus and enabled people to put the things in place that meant they stayed healthy and independent for as long as possible.

In total over 12 weeks the team had contact with 59 people. 42 of these contacts resulted in Ageing Well conversations. The most common action was providing information, advice and support - 97%, 40.7% needed input from the Occupational Therapist Assistant and 31% needed help to claim for AA/Benefits. In many cases people just needed information and advice.

On-going evaluation indicated that there was:
- an 8.6% increase in people's quality of life from pre to post intervention.
- a 18% increase in independence
- a 1.9% increase in confidence
- a 12.7% increase in physical activity

People felt that the interventions they received from the Ageing Well team connected them with the community, was influential, motivated them, increased their understanding, was useful, was supportive, and encouraged a positive change.

Ageing Well / Where Everyone Matters in Wem
The aim of this prototype was to develop a sustainable community based solution that supports older people to live independently, actively and healthier for longer by:
- Placing the emphasis on "prevention" within the community
- Supporting "hard to reach" and "socially isolated" groups
- Adopting a "whole person" approach that best understands and supports people's needs
- Developing and maximising the use of all local "assets" – buildings, organisations, individuals, resources

- Providing older people with a “gateway” for advice and guidance support services
- Co-ordinating voluntary activity and supporting the growth of community based initiatives
- Challenging people’s negative attitudes towards their age and health (and their community)

Through the trial development of a ‘Community Connector’ role and the delivery of weekly drop-in sessions we were able to engage with over 500 people across a 7 month period (February – September 2014). During this period we held detailed discussions with 57 individuals; these individuals completed an ‘Ageing Well’ plan, and addressed issues ranging from social isolation/loneliness to a high risk of falling (potentially resulting in hospital admission). By working with each individual in a very basic but holistic manner we were able to empower individuals to make positive life choices, choices that directly impacted upon their ability to live independently at home, and as part of the wider community for longer.

We also created a Community Directory (‘My Community’) that will enable future Community Connectors and the wider community to better access services available to them. As Shropshire Council’s direct delivery of the ‘Where Everyone Matters’ approach in Wem came to a close, members of the local community have come forward as new Community Connectors’. In a perfect example of what we mean by “resilient communities” People2People will take on the management and coordination of both volunteers, who will be ‘hosted’ within Wem Town.

Case Studies:

Mr B

- Mr B approached the Community Coordinator in his capacity as a carer to his father and mother
- Mr B had felt let down and unsupported by social services, and was left dealing with the strains and stresses of carer life without any financial or practical support from Shropshire Council
- Acting on behalf of Mr B the Community Coordinator rapidly ensured that Mr B began receiving any financial benefit he was entitled to, and set about liaising with Shropshire Council’s Adult Social Care in order to speed up the process of initial assessment
- Following this interaction Mr B found himself once again able to become part of the community
- Importantly, after seeing the good work undertaken by the Community Coordinator Mr B’s wife has become the last volunteer Coordinator to continue delivering drop-in sessions at Wem Town Hall

Mrs M

- Mrs M lives alone in Wem
- She presented herself to the Ageing Well Hub with a concern around her steadily decreasing lack of confidence in her ability to remain mobile
- After further conversation it became apparent that Mrs M was victim to a number of falls within the home (three) within the past 12 months
- The most recent fall of which resulted in a number of broken ribs and admittance into A&E services
- By working in partnership with the Community Health Trust, Age UK and Extend we have provided Mrs M with a range of support aimed at reducing falls within the home, rebuilding her physical and mental confidence/ability to access services, and levels of participation within the community through establishing new friendships

Mrs S

- Mrs S has recently moved to Wem from Cheshire to be closer to her daughter
- She is physically mobile, in relative good health and was an active member of her local community before her move to Wem
- Since her move to Wem four months ago she has lost all confidence in her ability to engage with her local community, and as a result has become increasingly isolated from the Wider community and more dependent upon her daughter for social interaction
- By adopting a person centred approach, and understanding her strengths/passions we were able to halt any potential increase in Mrs S's levels of social isolation
- We achieved this by discussing opportunities within the community, such as the Senior Club/Bowls, gained their cooperation, and have steadily increased her confidence to seek out opportunities herself

We know that to make this work we will need to transform the relationship Shropshire CCG, its providers and Shropshire Council has with locality based voluntary and community sector organisations, town and parish councils and residents generally so that we can develop our capacity together to support people within their communities.

Shropshire has a well-developed and active voluntary and community sector and network of town and parish councils and activity is taking place within these networks to develop their ability to respond to new challenges and the strategic and locality commissioning environment.

Town and parish councils are an important part of the local government infrastructure and have a significant range of powers and duties, giving them a unique and specific role within the community. Many raise local precepts for the services that they deliver. The Shropshire Association of Local Councils (SALC) supports local town and parish councils to develop their role in support of the development of self- reliant and resilient communities.

The Shropshire Voluntary and Community Sector Assembly (VCSA) works to represent Shropshire's voluntary groups and organisations and has over 280 members representing the diversity of the voluntary and community sector in Shropshire. Many members are small groups relying entirely on the dedication and commitment of volunteers, others are larger VCS organisations delivering a range of services to the people of Shropshire.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Shropshire Council and Shropshire CCG as the commissioners of health and social care services in Shropshire want to work with partners to develop an approach that maximises the use of local community assets and positively encourages and supports the development of community capacity and resilience which can be flexible to the needs of different communities across Shropshire.

Through the structures now in place to support the development and implementation of the Better Care Fund both commissioning agencies will work together through joint structures to jointly agree resources, allocate funds, review impact and undertake redesign where commissioning of services will support Community Resilience.

However, as the nature of Community Resilience suggests it is our ultimate aim that by facilitating communities and individuals to develop their abilities to help themselves our need to formally commission services in this area will be superseded by a different facilitating and enabling role. To this end we will continue to develop our role in supporting and facilitating this change.

It is not possible to state categorically who the deliverers of services will be as this involves a vast cohort of groups and organisations and will inevitably include organisations and networks yet to be established. However, we will continue to work with our well established voluntary and community sector and town and parish councils to provide support within this area.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The case for change

We know that we have to make the transformational changes described in this BCF plan now because Shropshire's future demographic and the needs that it will create will overwhelm public health and social care services as they address unprecedented on-going financial challenges.

- With a total population of 308,200 and only 0.96 persons per hectare, Shropshire is one of the most sparsely populated counties in England.
- More than a fifth of residents are aged 65 or over with the number of people of retirement age increasing by 23.8% between the 2001 and 2011 Censuses.
- People living in the most deprived areas are significantly more likely to suffer poor health outcomes compared to those in the least deprived areas.
- Wage levels, median gross weekly earnings in 2012 were £410, are low, and below the national and regional average.
- Unemployment rates are relatively low, but rose to 3.2% at the height of the recession in February 2010. The unemployment rate has now fallen back to 2.1% (October 2013).
- The planned introduction of Universal Credit and Welfare Reform provides major challenges going forward. Currently 12,826 people who claim benefit are older than 60 while 9.2% of the population is claiming out of work benefits.

In developing Resilient Communities we have taken the learning from work that has been developed, tested and delivered in Shropshire's towns and villages, some of which is described above. We have learnt that that there is a huge appetite for transformational change in Shropshire, that there is a vast amount of activity using large numbers of volunteers already taking place within our communities and that there is an overwhelming consensus that we need to be shifting the emphasis from crisis management to prevention and care within the community.

We have shown that if we want preventive and early help services to make a difference, they should:

- be co-designed with and delivered within communities

- recognise existing community leaders, assets, activity and skills and build up from these
- be based on a family approach
- involve a wide range of people in their delivery and a wide range of activity in the solutions that they suggest
- be available at the earliest possible stage and before people reach crisis, i.e. ideally have no eligibility criteria
- increase social connectedness and reduce loneliness
- be commissioned outside silos across shared outcomes that reflect individual local circumstances
- be based on closer working relationships with local GP practices and the Community & Care Coordinators

We have shown that there is a real demand and need for this type of activity and this is confirmed through the changing demographic, prevalence figure provided through the Projecting Older People Population Information System and the Projecting Adult Needs and Service Information System, and the customer response to new opportunities. We have turned this learning into our proposed Resilient Communities approach.

Alongside this we know that a considerable amount of activity that provides positive outcomes for individuals and families already takes place within Shropshire's communities and some of this is described elsewhere within this descriptor.

We believe that by transforming the way that information, advice and guidance, prevention and early help services are delivered locally we can best use existing capacity within the community to provide support for local residents within their communities.

Resilient Communities cuts across the provision of health and social care services and can therefore be seen as an early example of the integrated working that will be necessary over the coming years.

The impact and outcomes of our scheme

We have used the evidence and learning described above to help us to develop our assumptions on the impact of our approach and this is described within the following section.

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Resilient Communities is the BCF scheme that is an enabler to other schemes and activity both inside and outside the Better Care Fund. Its activity and outcomes lay the foundations within communities and service redesign that resilience and increased capacity can be built on.

We will know when we have got our Resilient Communities approach right when:

- The residents of Shropshire, particularly those with a need for early help and for support with complex and multiple needs, will access services that are better, faster, cheaper, delivered together and with a focus on prevention

- Communities maximise all the assets at their disposal to achieve the greatest benefit to local residents
- Shropshire 'plc' is able to make its funding stretch further, to achieve its objectives by working together and take on an increasingly facilitatory role
- Investment in local services and infrastructure maximises the long term business sustainability of local organisations and supports on-going growth and innovation

Resilient Communities will broadly contribute to the outcomes of the Better Care Fund. We anticipate the impact will be most felt in relation to:

- a reduction in non-elective admissions
- the proportion of people still at home 91 days after discharge from hospital into rehab/re-ablement
- a reduction in the incidence and quantity of Delayed Transfers of Care

We know this because Resilient Communities activities will:

- increase the social connectedness of people living in Shropshire which has a beneficial impact on health and well-being
- reduce the number of falls in residents aged over 65 years through the early identification of those at risk and using a much wider range of support than just professional services to carry out home safety checks, support people to remain mobile and to put in place a network of friends and neighbours who can help to reduce risk with small interventions
- increase the voluntary and community provision that supports those with dementia and their carers
- provide community based alternative routes to support for non-urgent issues which might otherwise lead to a presentation at acute services and give frontline professionals the confidence to connect people to these
- support and increase self-management of long term conditions through peer support groups
- encourage self-responsibility through a proactive attitude to being prepared for future events such as a hospital stay or the need for homes to be adapted to support independent living

This is supported by early evidence from our initial prototyping activities.

Resilient Communities is not easily pigeonholed and any number of indicators could be used to illustrate the benefits of an approach that invests in early help and support within the community.

In developing impact metrics linked to the outcomes we have applied a Cost Benefit Analysis approach developed within the New Manchester Economy model:

- target population
- affected population / predicted incidents
- level of engagement with the target population
- retention rate following the intervention
- impact of the intervention in changing skill, behaviours and attitudes
- deadweight
- optimum bias
- impact by year

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
We will report back on and monitor progress within a strategic Resilient Communities steering group. Broadly representative across sectors, and co-chaired by Shropshire Council's Director of Commissioning the Shropshire CCG's Partnership Manager, this group will directly support the delivery of Resilient Communities themes within the Better Care Fund and will in turn report to the Better Care Fund Service Transformation Group. We will develop a detailed action plan and link this to relevant metrics. Our approach will be based on the rigorous application of Cost Benefit Analysis and we will apply best practice developed within the New Manchester Economy model in order to demonstrate fiscal, financial and social benefits. We will use prevalence figures provided within POPPI and PANSI to help us understand the impact of our interventions.
What are the key success factors for implementation of this scheme?
If we are to successfully implement this scheme there are a number of important underlying principles that will be critical to its success including: • trust – particularly in times of ambiguity • strong strategic and local leadership • commitment to change from service providers • commitment to partnership working • commitment to meaningful community involvement

Scheme reference number
D2 **KLOE Reference: C5ii**
Scheme name
Dementia Strategy- a developing scheme
What is the strategic objective of this scheme?
To reduce the number of people with a diagnosis of dementia admitted to Hospital, as a % of the total number of people with a diagnosis of dementia in Shropshire by: 1. To increase diagnosis rates, increase post diagnosis support, develop shared care plan, further improve partnership working between GP practices and the memory service. 2. To enable patients with dementia and their carers to live well with dementia and live as independently within their own homes for as long as possible. Help to prevent avoidable admissions through increased knowledge and support groups.

3. Building a dementia friendly Shropshire – Raising local awareness of dementia through developing dementia friendly communities and development of the local dementia action alliance; helping to better identify those with dementia and support people with dementia in their own communities.
4. Primary prevention work with public health to raise public awareness of reducing lifestyle risks which may increase the risk of dementia. Helping to better identify those at risk of developing dementia.
5. To ensure people with dementia and their carers receive support and care from staff appropriately trained in dementia care, reducing carer crisis. Aiming to help reduce non-elective admissions and reducing nursing and residential admissions.

Overview of the scheme
Provide a brief description of what you are proposing to do including:

- **What is the model of care and support?**
  To support and implement the Shropshire dementia strategy 2014-16 which encompasses the above work streams
- **Which patient cohorts are being targeted?**
  People with dementia and their carers within Shropshire.

There was a gap in service delivery for this scheme in 15/16 due to the Dementia Commissioner position becoming vacant for several months. This post was appointed to in March 16.

The early objectives of the commissioner are to review and refresh the existing Dementia Action Plan and to align this closely with the findings of the recent system wide review undertaken by Healthwatch Shropshire.

It is expected that a range of projects will be enhanced or created to make a significant impact on dementia in Shropshire and specifically on the Better Care Fund Metrics including activity around:

- ensuring that people with dementia and their carers are supported within primary care to live well through early identification, diagnosis and intervention whereby people can obtain the broader social support they require which will enable them to live independently and well for longer, reducing carer crisis and the need for secondary care input including non-elective admissions. Good support provided within primary care including through the Memory service integration project will contribute to discharge planning and a reduced length of stay for people with dementia where admission cannot be avoided.
- Patient education and peer support for dementia: To develop education and information materials for patients and carers to access to help increase knowledge and help patients and carers to self-manage their condition more effectively. To develop peer support groups within local communities for patients and carers. By empowering people to make good decisions about their health and social care through access to quality information and peer support will contribute to reducing and/or delaying admissions to acute care and residential care.
- Continuing to build a dementia friendly Shropshire: the local Dementia Action Alliance (DAA) has been established with the aim to encourage local businesses to become members and agree an action plan outlining how they intend to make their business dementia friendly. Currently Shropshire CCG and Shropshire Council have a representative on the steering group and Shropshire Council is a member of the local DAA. Building support within communities for people with dementia and their carers will enable people to live well and independently for longer, reducing carer breakdown which often results in unplanned admissions.
- Continuing to build on primary prevention work with public health – collaborative working between Shropshire CCG and Shropshire Council's Public Health team to identify information relating to "Brain Health" which can be displayed on the public facing local "Healthy Lifestyles" website to raise public awareness and improve knowledge. Creating dementia friendly leisure centres ensuring staff are dementia friends and undertake facilitated discussions around ensuring local leisure centres and activity groups are inclusive of people with dementia and their carers. Early identification through better awareness within communities for people at risk of dementia will enable people to seek advice, treatment (where appropriate) and support earlier to reduce the risk of crisis and possible subsequent secondary care admission.
- Continued development of a training programme for the health and social care workforce: building on the collaboration with Shropshire Partners in Care to develop a modular training programme for care home staff which is based on a model delivered throughout Telford and Wrekin and commissioned by Telford and Wrekin CCG. The training programme is targeted at Care home Managers and Senior front line staff from all care homes across Shropshire. Ensuring that health and social care staff have the appropriate skills and competencies would ensure better outcomes for people with dementia and would ensure a better use of resources by reducing lengths

of stay.

The delivery chain
Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners:
- Shropshire CCG ,
- Public Health,
- Shropshire Council Adult Services,

Delivery Partners:
- Telford & Wrekin CCG
- Dementia Action Alliance
- Healthwatch Shropshire

Providers:
- GP Practices,
- South Staffordshire and Shropshire Mental Health Foundation Trust
- Shropshire Partners in Care
- Shropshire Community Health Trust
- Voluntary and community sector,
- Local Businesses

The evidence base
Reference the evidence base which you have drawn on
- **to support the selection and design of this scheme**
- **to drive assumptions about impact and outcomes**

The work streams are currently being reviewed and refreshed by the newly appointed Dementia Commissioner through a review of the Shropshire Dementia Strategy and supporting action plan.

These local priorities support the national strategic direction for dementia, outlined in the National dementia strategy 2009 and subsequent document Prime Minister's Dementia Challenge 2012.

Local evidence is provided by the Joint Strategic Needs Assessment which identifies the ageing population within Shropshire as one of the key challenges facing health and social care provision across the county and it emphasises the need for people to be supported to age well.

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Outcome measures are being further developed with the review of the Strategy and Action plan, however it is anticipated that the following outcomes will be achieved from the work streams:

1. Communities across Shropshire will have awareness and understanding of dementia.
   - Measured by numbers of "dementia friends" (data to be obtained from the Alzheimer's Society collected on a monthly basis)
2. Early access to support and intervention following an early diagnosis.
   - Measured by an increase in Shropshire CCG's diagnosis rate from 49.1% (data obtained from NHS England on a monthly basis)
   - Numbers of referrals into the memory service for assessment and diagnosis and follow up support (data obtained from Central Support Unit/South Staffordshire and Shropshire Mental Health Foundation Trust – monthly reporting through Contract and Quality Review Meetings)
3. People with dementia receive care from staff appropriately trained in dementia care:
   - Measured by patient and carer feedback (data to be obtained from existing patient and carer satisfaction

surveys from each organisation – to be further developed)
    - Numbers of health and social care staff undertaking training programme (a local programme is currently being developed and attendance data would be collected by programme organisers, also data around organisational action plans supporting leadership development and organisational change; collected by programme organisers/leads at the end of the programme via enrolment data and participant evaluation forms).
4. People with dementia and their carers feel supported to live well.
    - Measured by patient and carer feedback (data obtained from the CCG commissioned local Alzheimer's Society dementia café's, also from the practice peer support groups; from patient stories recorded by the Care and Community Coordinators)
5. Ensure people have the right information at the right time:
    - Measured by patient and carer feedback obtained from dementia café's/peer support groups and patient stories collected by voluntary sector including Rural Community Council. Also measured by numbers of carers attending and completing the Alzheimer's Society CrISP education course commissioned by Shropshire CCG. Data collected quarterly and presented to the CCG through a quarterly report and review.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Baseline data and target outcomes will be agreed and monitored by the H&WB Delivery group.

Progress of the project will be monitored by the H&WB Delivery Group

Scheme Reference Number

D3

Scheme name

Carers Support and respite care for carers

What is the strategic objective of this scheme?

Carers Support

- To provide a specialist Carer support service to adult Carers aged 18 and above.
- To enable Carers to continue in their caring role for another adult for as long as they are willing and able to.
- To prevent the likelihood of Carer breakdown.
- To provide information, advice and advocacy, including direct support to Carers.

What are the key success factors for implementation of this scheme?

The newly appointed commissioner will build on the solid foundations of integrated work across health, social care, voluntary and private sector partners to work together to support the work streams in the refreshed Strategy and Action Plan with the aim to deliver improved quality of care and health outcomes for people with dementia and their carer's.

- To link Carers to the wider local networks of support.
- To develop the activities available to Carers using a personal budget.

Respite care

Respite care for carers (but not the cared for person) was established as an NHS responsibility in the 2011-12 Operating Framework. The recent NHS England planning document 'The Forward View Into Action: Planning For 2015/16' reinforces the NHS responsibilities for carers. It states the following; we expect CCGs alongside local authorities to;

- draw up plans to identify and support carers and provide better support
- in particular, working with voluntary sector organisations and GP practices identify young carers (aged 18 plus) and carers who themselves are over 85
- plans should focus on supporting young carers and working carers through the provision of accessible services, and services for carers from vulnerable groups

These are new obligations for the NHS, where in the past these have only been considered best practice but not 'must do's'.

Overview of the scheme

Provide a brief description of what you are proposing to do including:

- **What is the model of care and support?**
- **Which patient cohorts are being targeted?**

Shropshire Council has commissioned a new carers service that will focus on the promotion of wellbeing and independence and in preventing the need for care and support and which will meet the requirements of the 2014 Care Act.

The newly commissioned services will be a range of interventions that prevent, reduce or delay the need for care and support as well as providing a responsive service when needed and also include encouraging Carers to plan ahead for both themselves and the person that they care for.

The service will comprise:

- An emergency carers service to support people to stay in their own homes following an emergency as a result of the regular Carer not being available to provide the necessary care to support a cared for individual's wellbeing.
- A carers support service to provide support to carers to enable them to continue in their caring role for as long as they are willing and able to do so. The service has four elements: peer support; advice and advocacy; planning ahead and keeping well; developing forms of

support.

- Development of a non- residential care service (sometimes referred to as respite or replacement care) that will operate to develop natural forms of support and networks for carers in local communities as an alternative to directly provided care/support to the cared for individuals.

The contracts are for an initial period of 5 years from March 2016 with the option for further extensions up to a maximum of a further 2 years.

To compliment this and to address the specific NHS responsibilities new schemes will be designed during 2016-17 to meet the specifications as laid out in the NHS 5 Year Forward Plan. The design and implementation work will be carried out in the first part of the year.

The delivery chain

Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The new service is commissioned by Shropshire Council led by the Head of Service for Improvement and Efficiency in Adult Services. The providers are:

Carers Trust for All and People2People

Respite Services will be commissioned by Shropshire CCG with the provider to be determined

The evidence base

Reference the evidence base which you have drawn on

- **to support the selection and design of this scheme to drive assumptions about impact and outcomes**

The evidence base for this scheme is fundamentally based on the policies of Shropshire Council and Shropshire CCG to recognise and value the contribution made by Carers, and to offer information, support and services, to enable them to continue to care for as long as they are willing and able. This policy position represents the Council's commitment to the requirements of the Care Act 2014 and the CCG's commitment to deliver the principles of the Five Year Forward View.

The Council undertook a Carers Strategy upon the introduction of the Care Act in 2014 which is currently being refreshed (due for completion in April 2016). This will provide a strong up to date evidence base for the most appropriate support structure for Carers. The findings of the survey work to date have shaped this scheme descriptor.

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Overall outcomes from the Service Improved well-being and resilience of Carers, enabling them to continue in their caring role for as long as they wish to and reducing the likelihood of unplanned admission to residential or hospital care for both the carer and the person they care for. Information, Advocacy and Advice Carers are better informed about services and support to give them greater choice and control over the services they receive, including those not known to statutory services. Carers are supported as required through their assessment and support planning stages Peer Support Increased service capacity, resilience and shared-learning through volunteer engagement and peer support. Localised support networks across the county which are accessible and include Carers which are typically hard to reach due to rurality or the level of care and support they provide to another adult. New funding brought into the county for the benefit of Carers through partnership bids. Planning Ahead Carers are enabled to plan ahead, reduce stress and anxiety, prevent carer breakdown, prevent the Cared For Individual having to leave their home and to ensure a sustainable role for the Carer moving forward. Sustainability of Carers' roles enabling Carers to continue for as long as they are willing and able to do so. An improvement in the general health and wellbeing of Carers. Developing forms of Support A range of community based forms of support will be available, through working with other

partners, to meet the needs of Carers and Cared For Individuals.

A range of community based forms of support will be available in each geographic area of the county.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Information, Advice and Advocacy

A Carers' newsletter will be distributed 3 times a year to the 3,500 (approximate) identified Carers in the administrative area of Shropshire Council. A survey will be undertaken through the newsletter and the analysis will be shared with the Council.

The Service Provider will submit a copy of the information pack for Carers in relation to advocacy and the level of information available to the Council within 3 months of the Commencement Date.

The Service Provider will provide a report on the number of Carers making contact, with detail on the type of support that was required

Peer Support

A minimum of 3 outreach surgeries will be held each year in the 10 main population centres.

The Service Provider will coordinate and consult with all of the groups who meet monthly and will share the analysis of an annual review held with the carers' groups, with the Council.

A minimum of 3 events will be held for Carers' Week and Carers' Rights Day and 1 event will be organised for World Mental Health Day.

The Service Provider will endeavour to recruit and develop 12 volunteers in the first year of the Contract and increase the number to 20 by the end of the second year.

The Service Provider will endeavour to increase total membership across all groups in the first year of the contract and annually thereafter.

The Service Provider will submit a copy of the information pack for Carers in relation to the Peer Support network to the Council within 3 months of the Commencement Date.

The Service Provider will report on a quarterly basis on the activity, type and level of support provided in the previous quarter which will include a breakdown by:

Peer Support usage

- Age
- Client group

- Gender
- Level of involvement - face to face, social media, telephone etc.

Locality

- Breakdown by area
- Number of sessions / hubs held

Planning Ahead

The Service Provider will report to the Council on the following on an annual basis:

- Number of plans completed (by outcome area and geographic area and time taken to complete)
- Number of plans reviewed / updated upon request (with details of area)
- Carers' details (including age, employment status etc.)
- Details of the main outcome areas detailed in the Care Act 2014 that need to be addressed within the plans
- Details of the plans which have been forwarded to the Council upon request

Developing forms of Support

The Service Provider will report to the Council on the following on an annual basis:

- Numbers of community based forms of support
- Locations of community based forms of support
- A description of the types of community based support that have been developed

The Service Provider will report to the Council annually on:

- Funding that has been attracted in for Carers Services under this Contract
- The number of Carers accessing the Service who are not in receipt of Council funded care and support
-

Within 2 months of the Commencement Date the Service Provider will produce an information pack for Carers which details the Service components which will be distributed by the Council's First Point of Contact.

Think Local Act Personal (TLAP) runs a resource (Making it Real) which aims to help organisations

move towards more personalised and community-based support by providing them with practical steps to make personalisation a reality. The Service Provider will sign up to the Making it Real principles by registering their commitment on the TLAP website and creating an action plan which will detail their chosen priorities.
What are the key success factors for implementation of this scheme?
The key success factors for implementation of this scheme are: • The commissioning of an appropriate carers support provider • Delivery of the outcomes and objectives of the schemes as detailed • Effective monitoring of provider performance and implementation of appropriate mitigation measures

Scheme reference number
D4
Scheme name
End of Life Coordination
What is the strategic objective of this scheme?
The service needs to give enough support to allow patients to stay out of hospital wherever clinically possible, this is best for patients and will free up funding to pay for the coordination and the health and social care support needed. This prototype uses additional resourcing to (i) provide better care co-ordination for patients and (ii) in doing so, reducing the number of hospital admissions with the consequent positive impact on quality and costs of care provided. To deliver a high quality service for people to allow them to die in their place of choosing, this is likely to be outside of the acute hospital setting. This prototype scheme supports patients approaching the end of life, from all causes, by a Clinical Nurse Specialist in End of Life Care who will coordinate the health and social care support required to enable the patient to die in the place of their choosing.
Overview of the scheme

Provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The CCG, in partnership with Severn Hospice, will deliver a scheme in which all individuals are supported, as they approach the end of life, by a Clinical Nurse Specialist and team. The CNS and team will work closely with the practice to support the early identification of patients as they approach the last year of life. They will attend and support the Gold Standards Meetings held in Shropshire practices and support practices in identifying patients in the last year of life at risk of admission as part of the Proactive Care Programme. They will be responsible ultimately for ensuring that all patients identified as being in the last year of life have an end of life or advanced care plan. They will be responsible for care coordinating patients in the last year of life who are identified to be at risk of admission and will be responsible for coordinating care, supported by their team, as the patient approaches the last weeks of life.

As is currently provided to individuals with a cancer diagnosis they will become involved with the patient initially about one year before end of life. At this stage they will open conversations with the individual, the family and other involved care professionals about preferences for end of life care. They will develop an end of life or advanced care plan including preferred priorities for care. They will advise about benefits, funding streams and opportunities for support in the community. They will hold discussions about the benefits of establishing lasting power of attorney, resuscitation decisions and escalation of care. If needed and in partnership with specialist nurses and community nurses they will begin to put in place support services needed.

As the needs of the individual become more complex the CNS and team will support the coordination of services to meet the needs of the individual so that the care plan can be delivered. They will bring expertise in palliative care, a comprehensive understanding of services available and funding mechanisms and sensitive sign posting and support for carers and families. Although the focus of their work would be in last few weeks of life when coordination becomes more essential they would begin their relationship with the individual early through the development and review of the care plan over the twelve month period prior to the end of life.

They will provide this service regardless of whether the individual is in a care home in their own home. If the patient is in a community hospital they will work in partnership with the community hospital discharge team to facilitate delivery of the end of life plan and the preferred priorities of care. If the patient is in an acute ward they would support the hospital based CNS, the Integrated Community Service and the discharge planning team in facilitating discharge into the community enabling always the delivery of the end of life plan and preferred priorities of care where possible.

The services in place locally to support patients in the last year of life are currently poorly integrated. Services are traditionally commissioned separately by the CCG and Local Authority. There are multiple providers with lack of clarity around responsibilities leaving gaps and duplication. There are also new initiatives described in other project descriptors such as Compassionate Communities, Community and Care Coordinators, Team Around the Practice, Single Assessment, Carers Support, Case Management, CHAS, Integrated Community Service, which add further levels of complexity.

Establishing a care coordination system for those whose needs are increasingly complex toward

the end of life is a first step in a broader programme of clarifying gaps and duplication and simplifying provision of care around an end of life pathway.

The Clinical Nurse Specialists will have a key function in mapping current services and identifying gaps duplication and blocks in the system, including those related to funding, and carers needs. This information will be used to inform the commissioning of more integrated effective care going forward.

For each patient, comprehensive records will be kept, primarily by the hospice team. These will include details of care provided, all EOL tools used (such as PPC, power of attorney, advance decisions, DNaR), outcomes of funding and care assessments, and details of whenever hospital admissions have been avoided due to the coordination work. The information can be shared with the wider team looking after the patient, utilising an Electronic Health and Care Record when in place.

Key Milestones

October 2014 – proof of concept scheme agreed by Shropshire CCG Quality, Performance and Resources Committee
November 2014 – finalise metrics and reporting structure with Severn Hospice
November 2014 – identify 2 clusters of practices (10-12 practices) to deliver the proof of concept scheme
November-December 2014 – Severn Hospice to recruit and train staff to deliver scheme
April 2015 – proof of concept scheme operational
August 2015 – third pilot area added

The delivery chain
Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner:
Shropshire CCG

Provider:
Severn Hospice

Delivery Partners:
GP Practices
Shropshire Community NHS Trust
Shropshire Community NHS Trust
Severn Hospice - Palliative Care Specialist Team

The evidence base
Reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The 2012 VOICES national survey[2] found that the overall quality of care across all services in the

last three months of life was rated by only 44% of respondents as outstanding or excellent. For those who expressed a preference, the majority preferred to die at home (81%), although only half of these actually died at home (49%). The most commonly reported place of death was a hospital (52%).

The Nuffield Trust produced a report looking at the impact of Marie Curie Nursing Service (MCNS) hospice at home services ('The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life' 2012)
The MCNS service provides care and emotional support for people in their own homes at the end of life, including discharge support from all settings to help manage patients' symptoms at home and prevent unnecessary hospital admissions. It found that;

- 76.7% of those who received MCNS care died at home, while only 7.7% died in hospital. In contrast, 35.0% of the controls died at home, while 41.6% died in hospital.
- People who received MCNS care were less likely to use all forms of hospital care than controls. 11.7% of MCNS patients had an emergency admission at the end of life, compared to 35% of controls; while 7.9% of MCNS patients had an A&E attendance, compared to 28.7% of controls. Across most types of care, MCNS patients used between a third and half of the level of hospital care of controls.
- Significant differences were found in the costs of both planned and unplanned hospital care between MCNS patients and controls. Total hospital costs for MCNS patients were £1,140 per person less than for controls from the first contact with MCNS until death (however, this figure should be considered alongside other costs, including the cost of the MCNS itself and possible impacts on other services).

This evidence indicates that a coordinated end of life service can deliver quality care and also the funds to pay for the community services, plus further savings. The established Hospice at Home service in Shropshire (which incorporates the Marie Curie Nursing Service) has delivered the same service since 2003 and provides a foundation for further development in reducing hospital admissions/deaths

Impact of scheme

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Targets will be determined in 'Detailed Business Plan' Phase for following high level outcomes:

- People are supported to die in the place that they choose
- People are not admitted to hospital during the weeks prior to death
- Improved coordination of support for people in their last year of life
- Carers supported
- Quality of life in the last year of life improved.

For each patient, comprehensive records will be kept, primarily by the hospice team. These will include details of care provided, all EOL tools used (such as PPC, power of attorney, advance decisions, DNaR), outcomes of funding and care assessments, and details of whenever hospital admissions have been avoided due to the coordination work. The information can be shared with the wider team looking after the patient, utilising an EPaCCS system when in place.

[2] National Statistics 'Statistical Bulletin - National Bereavement Survey (VOICES), 2012' 2013

A baseline for the practices involved will be used to compare the impact of the care coordination, such as numbers on the practice GSF list, numbers who died, place of death, whether they had a care plan. An estimated saving on £3,000 per patient who does not have an admission to secondary care during the last 6 weeks of life will be used as the value to measure cost effectiveness in terms of admission avoidance.
The total cost of the scheme, over 18 months as a proof of concept, is as follows. The Severn Hospice is an equal partner with the CCG in terms of planning and investment.

Year	SCCG	Hospice	Total	Admissions avoided to break even	Expected additional admissions avoided
2014-15 q4	£12.5-13.9k	£12.5-13.9k	£25-27.5k	9	4
2015-16	£50-55.5k	£50-55.5k	£100-111k	35	17
2016-17 q1	£12.5-13.9k	£12.5-13.9k	£25-27.5k	9	4

The project is expected to deliver at least 78 avoided admissions over 18 months, which equates to (78 x £3,000) £234,000 savings, £84,000 of which will cover the initial input of the CCG, whilst the rest (£150,000) will be a saving. Each patient will be tracked to understand what levels of support have been needed, what funding has been accessed, and whether/why the patient has been admitted to secondary care. Secondary care data will be provided by the CSU to measure the impact in terms of emergency admissions for people at the end of life.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Implementation & evaluation is supported by:

- David Whiting, Scheme Lead, SCCG
- Dr Julian Povey, GP Member, Clinical Director of Contracting and Performance, SCCG

Monitoring:

- Baseline data and target outcomes will be agreed and monitored by the Finance, Contract and Performance sub-group of the H&WB Delivery group.

Reporting to:

- Progress of the project will be monitored by the Transformation sub-group of the H&WB Delivery Group.

The outcomes can be measured by monitoring the uptake and input from the care coordination service (including the already in place specialist palliative care outreach team and hospice at home services).

A baseline for the practices involved will be used to compare the impact of the care coordination, such as numbers on the practice GSF list, numbers who died, place of death, whether they had a care plan. The Severn Hospice will maintain a register of supported patients so that monthly and quarterly snapshots of the impact of the project can be reported.

What are the key success factors for implementation of this scheme?

- Developing clear methods of communication and accountability between practices and the teams that support them in the community
- Shared records and care plans.
- Commissioning services in partnership with the local authority
- Assessment process spanning social and health need.
- Engagement with relevant partners
- Shared systems of record keeping supported by data sharing agreements

Further success factors to be defined as the scheme progresses to the Detailed Business Plan phase