Shropshire's Integration and Better Care Fund Narrative Plan 17/18 & 18/19

Draft V2.30

Plan Summary • Local authority: Shropshire Council (unitary) • CCG area: Shropshire • Boundary differences: co-terminus • Date plan agreed by HWBB: 6th July, 2017 – Delegated authority for draft plan given to the Joint Commissioning Group following the July HWBB, 14th September HWBB to consider draft plan as submitted	**Key Line of Enquiry (KLOE**
Sign off:	1
Signed on behalf of Shropshire Council: Andy Begley, Director of Adult Services.	
Signed on behalf of Shropshire CCG: Simon Freeman, Accountable Officer.	
Signed on behalf of Shropshire Health and wellbeing board: Cllr Lee Chapman, Chair	

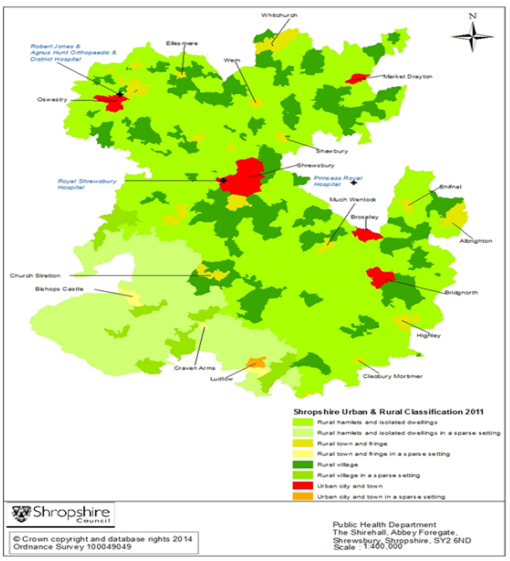
Contents

1. Shropshire Context and Challenges

Geography and demographics:

Shropshire is a fantastic place in which to live, work and visit, with a clean and beautiful natural environment, communities who look out for each other, whether in our rural areas or within one of our historic market towns, excellent schools, low crime and opportunity for everyone. The quality of life rightly brings people here, and makes people want to stay. Around 35% of Shropshire's population live in villages, hamlets and dwellings dispersed throughout the countryside. The remainder live in one of the 17 market towns and key centres of varying size, including Ludlow in the south and Oswestry in the north, or in Shrewsbury, the central county town. Key highlights:

- Shropshire's green and scenic environment helps to contribute to healthy lifestyles as well as itself being of economic value, in attracting businesses as well as in attracting people to visit here and to move here. However, there are logistical challenges in commissioning and providing services over such a large, rural geography. The population of around 310,000 is itself so spread out, across a terrain covering 319,736 hectares, that the Office for National Statistics (ONS) describes us as having less than one person per hectare
- Like many rural areas, the number of people aged 65 and over is expected to rise. By 2030 we expect 1 in 4 people to be over 65.
- Future population growth and ageing is leading to increased numbers of people with long term conditions and non-communicable diseases.
- We have an ageing population- the 2011 Census shows 63,400 people aged 65 years and over, an increase of 23.8% from 2001. This trend is continuing and is more than double national and regional growth levels.
- We have a significantly higher than average number of out of area looked after children of which 64% are placed with foster carers and 21% are with residential providers. Of these children 11% are disabled Children that require specialist provisions.



- **Over half of the population in Shropshire is living what is classified as a rural area**
- **The south west of the county has some of the most sparsely populated areas in England**

Health and wellbeing:

There are 310,100 people living in Shropshire (Office for National Statistics, 2014) which are distributed across the following age bands;

- 0 to 15 years: 16.8% (19% England average)
- 16 to 64 years: 60.4% (63.5% England average)
- 65 years and over: 22.9% (17.6% England average)

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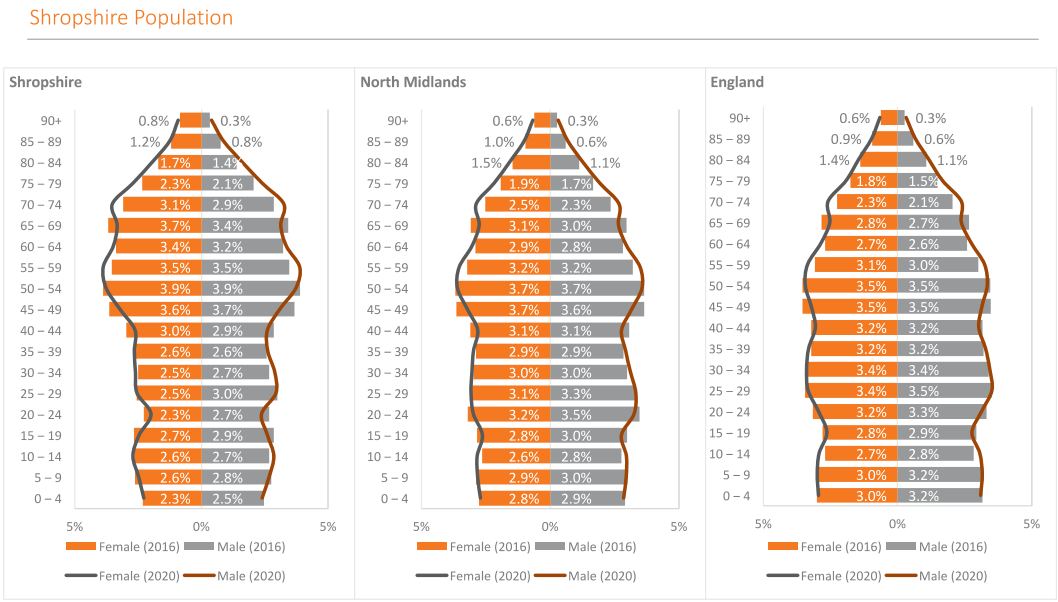
Source: ONS population estimates and projections



The Shropshire population is mainly white British, with a high proportion of over 50 year olds that is projected to increase significantly in the next decade. Health issues arise from the ageing population, significant lifestyle risk factors, long term conditions, rural inequalities in health and respiratory

issues for over 65 and 0-5 year olds. Whilst the county is fairly affluent there are areas of deprivation and the rurality means access to services can be difficult. Unemployment is low, but despite significant employment in the public sector, Shropshire can be described as a low wage economy; consequently the wider determinants of health including education, access to employment and housing are significant issues to consider when developing services that support good physical and mental health. Key highlights: • Life expectancy rates have improved steadily in the last decade; • 60% of early deaths under 75 years are due to preventable cardiovascular diseases, cancers and respiratory diseases; • Mental health, dementia and musculoskeletal conditions account for a minimum of 26% of ill health; • An alarming majority (65.2%) of adults carry excess weight. This equates to an estimated total of 200,000 adults who are at higher risk of cardiovascular diseases and certain cancers; • We have a higher than average level of inactive adults (24% are active compared to 27.7% nationally). It is estimated that almost half of type 2 diabetes cases can be attributed to obesity; • Around a quarter of adults (circa 77,000) people are higher or increasing risk drinkers and the rate of alcohol related road traffic accidents is significantly higher than the national average; • Levels of diabetes have increased rapidly in the past decade recorded prevalence doubling between 2004/05- 2014/15 (from 3.5% up to 6.6%); • High blood pressure is a significant risk factor for chronic health conditions with xxxxx people in Shropshire, currently diagnosed and recorded in primary care as having high blood pressure; • Approximately 7% of over 65 year old people have dementia; this figure is expected to increase to 8% for all people aged 65 and over by 2021; • Shropshire has more than 34,000 people currently caring for relatives, friends and neighbours with over a third who spending more than 20 hours a week caring, and over a fifth dedicate 50 hours or more a week to their caring role. There are 3,457 carers who indicated they had bad or very bad health. Three in four carers are over the age of 54; • Rightcare highlights concern around respiratory conditions for 0-4 & 65+ **System challenges and issues:** The system challenges we face as an economy are similar to those being experienced across the country. Demand on services continues to rise and outstrips the available resources, putting pressure on all services. With a growing number of elderly people in our population, many having more than one long-term health condition, there is a greater need for certain services. Much of the area we cover is very rural further stretching capacity and resources. Key system issues that the BCF can help address include: • Workforce – recruitment of clinical & nursing staff across primary and	17 17

secondary care, availability of domiciliary care in rural areas
- Higher rate of Delayed Transfers than the national average
- Managing frail elderly at home - analysis shows there is a large opportunity for improving the way frail elderly patients are cared for-a significant amount of inpatient activity delivered for patients with conditions that could be managed in the community/primary care
- Working across the system and integrating practices – system leaders believe integration will make a big difference to service users and make efficiencies, the BCF must drive forward integrated practice

The Challenge in Shropshire Summarised

Ageing Population in a rural county	**Keeping people out of hospital and independent in their own homes**	**Developing integrated practices across the whole system -**
Increased demand on services; limited transport and difficulty accessing some services; response times for emergency services	Reducing need to access hospital and Care Homes by promoting community asset support	System planning that focusses on prevention and people living well within their communities

Highest demand & spend for health and social care services:

- **Cardiovascular disease** (including heart disease and stroke from poor diet, diabetes, smoking, obesity, excess alcohol consumption and high blood pressure/cholesterol)
- **Respiratory disease** (including chronic obstructive disease and childhood asthma from smoking, occupational risks and pollution)
- **Musculoskeletal disease** (such as back pain and osteoporosis from obesity and inactivity)
- **Falls** in older people

Through system planning the Shropshire health and care system is developing proposals to ensure people are supported in the most appropriate way. This involves looking at how existing services can be provided differently and how best we can share patient information to improve services. We have needed to take into account workforce issues, difficulties in recruiting clinical staff, but also what are the skills we need to deliver new models of care.

Given this context our BCF Plan focusses on 3areas of integrated working:

- **Prevention Programme – Healthy Lives**
- **Admission Avoidance**
- **Delayed Transfers**

As part of broader system planning the programmes of work under these three main headings will address the challenges in the system. Decision makers, together with stakeholders, believe these are the most appropriate programmes of work for us to test new ways of working in an integrated way.

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It is envisaged that through each programme, commissioned services will be reviewed and opportunities for integrated working will be realised.

2. BCF Programme Summary (for full detail see Appendix A)

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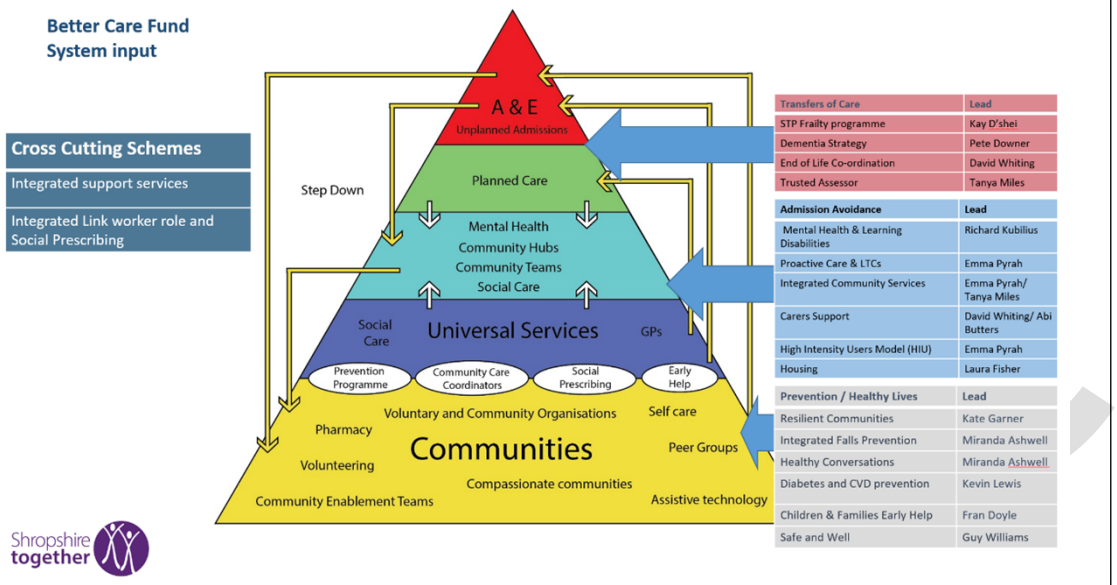
Prevention-Healthy Lives schemes & summaries	Investment	Outcomes	Measures
Resilient Communities	417,354	increase in social connectedness with beneficial impact on health and well-being	No of new vol & community groups established within the past 12 months
		Community based support for non-urgent issues avoiding presentation at acute services	No of "different" conversations being held by each professional.
			An improved score for individual LJC community resilience as measured through an assessment framework.
		Increase self-management of long term conditions through peer support group	
		Increased self-responsibility and self care including future planning	
Healthy Conversations and future planning	-	Economy is delivering consistent messages & referring to same information & support	Number of learning sessions delivered
		People are better prepared for their future	Number of people accessing learning resources
Diabetes and CVD Prevention	-	Develop pre-diabetes protocol for all practices & identify and support individuals	No of practices signed up to protocol
		Deliver a structured education programme for pre-diabetes	No of people completing programme
		Increase no of patients identified with pre-diabetes and reduce progression to type 2 diabetes.	No of patients identified
			Reduction in no of type 2 diagnoses
		Improve detection and management of HBP, AF& high CVD risk score	No of detections
		Reduce number of strokes per year.	No of strokes
Safe and Well	-	Visit vulnerable people, undertake check and support them to remain independent at home through referral to wider	No of people receiving safe and well visits
			Proportion of these visits to previously unknown people/

		system	families
		Relieve pressure of acute services	Reduction in A&E, conveyances and NEA
		Increase community resilience and support new models of care	Link to resilient communities
Admission Avoidance schemes & summaries	**Investment**	**Outcomes**	**Measures**
Mental Health & Learning Disabilities support	3,449,102	Improved health and wellbeing for people with mh and ld	Number of people accessing various services
			Reduction in S136 & acute admissions
Housing	4,996,277	Successful redesign and re-commission of equipment store service	Reduction in DTOC, admissions to care homes and NEA. Increased success of reablement activity
		Implementation of an integrated assistive technology offer	
		Full development of a locality based step down housing model	
		Agreement of protocols between housing/ hospital staff	
Carers Support	1,157,989	Improved information/ guidance for carers- e.g. benefits, employment	Number of carers assessments
			Number of carer breakdowns
		Involvement of carers in commissioning of services	
		Improvements to Carer Assessment processes particularly the provision of replacement care	
		Build integrated carer centred approach for all services	
Integrated Community Services (ICS) & reablement	6,360,827	maximise a patient's independence with the default position as home.	Reduced NEA
			Reduced DTOC
		Ensure a seamless transition services wrapped around the person and their GP practice.	Increased number of people still at home after 91 days
		Provide a 7 day service, 365 days, 8am – 8pm.	Reduction in permanent residential and nursing home admissions
High Intensity Service Users (HISU)	39,600	Proactively manage100 most frequent WMAS callers, improve their health & reduce impact on system	Reduced DTOC
			Reduced NEA
Proactive	3,446,482	Proactively manage patients	

Care and Long term conditions support		with long term conditions to keep people as well as possible and living independently which in turn reduces their impact on the health and social care economy.	Reduced NEA
Delayed Transfers – schemes & summaries	**Financial Investment**	**Outcomes**	**Measures**
STP Frailty programme	-	Overall reduction in falls	Reduced number of falls
		Impact of unavoidable falls on patient and system is reduced	Reduced NEA
			Reduced DTOC
		Better patient experience post fall	Reduced permanent admissions to residential homes
		Reduced expected end of life deaths in hospital	
			Increased success of reablement services
End of life support	1,387,217	Support people at end of life to avoid hospital and die at home/ usual place of residence	Reduction in NEA at end of life
		Improve the experience of end of life for patient and family	
Dementia Services	811,142	Diagnose dementia earlier	Reduced NEA
		Increase support in early stages of dementia	Reduced permanent admissions to residential nursing homes
		Crisis resolution team to gate-keep dementia admissions	
		Increase no of hospital based dementia support workers	
Trusted Assessor model		TBC	TBC
ICS		See AA above	See AA above
Cross cutting schemes & summaries	**Financial Investment**	**Outcomes**	**Measures**
Care Navigator/ Social Prescribing	347,000	To develop an integrated consistent approach to care navigation across the system	Reduce NEA
			Reduce DTOC
		Roll out social prescribing across Shropshire	Reduce permanent admissions to residential care
			Increase the success of reablement services
Integrated Working Support Services	117,899	Provide support services to ensure that the health and social care system and indeed broader services are fully integrated for maximum benefit	Creation of successful joint commissioning team
			No of participants in joint training increase

The key areas of work impact across different parts of the system which are described visually overleaf in diagram 1.

Diagram 1- BCF System Input



3. Our local vision of integration:

In order to deliver the plan the BCF schemes will work with system partners to deliver integrated service delivery. The Health and Wellbeing board have agreed the following statement of integration:

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"Shropshire's HWBB believes integration is about putting Shropshire people at the heart of decision making. The Board uses evidence that is gathered through data and through engagement to develop a common purpose and agreed outcomes for people, with people; it is about taking a whole system approach to leading, designing and delivering services."

The HWBB have also agreed a unified integrated system vision that by 2020 *"Shropshire people will be the healthiest and most fulfilled in England"*. To achieve this ambitious goal we have agreed specific aims and objectives that align with the developing Integration Metrics and the Integration Standard:

- a system that enables independence in older age for the majority of our population
- truly integrated person centred models of commissioning and delivery designed from a solid shared evidence base
- a workplace destination of choice for health and care professionals
- unity of purpose across our health and care sectors.
- a system where all partners embed health and wellbeing into all our work with communities to enable them to help themselves to live healthier and happier lives
- a system that helps to establish social capital, improves public

engagement and accountability and where wellness replaces a sickness paradigm.
- Fully integrated intelligence, data, technology and information sharing systems creating a single evidential view of the place-based needs of the population
- a “one public estate” philosophy to maximise the use of all our assets to the full.
- a pooled BCF budget that is a key enabler to achieve this system wide vision.
- a continuous learning culture that uses evidence from around the world to develop excellence in care and pioneering services through the use of high quality research and technologies.

4. Systems alignment:

In order to ensure that we achieve this unified vision of integration it is vital that all of our workstreams align and are mutually dependent. The essential co-dependencies are:

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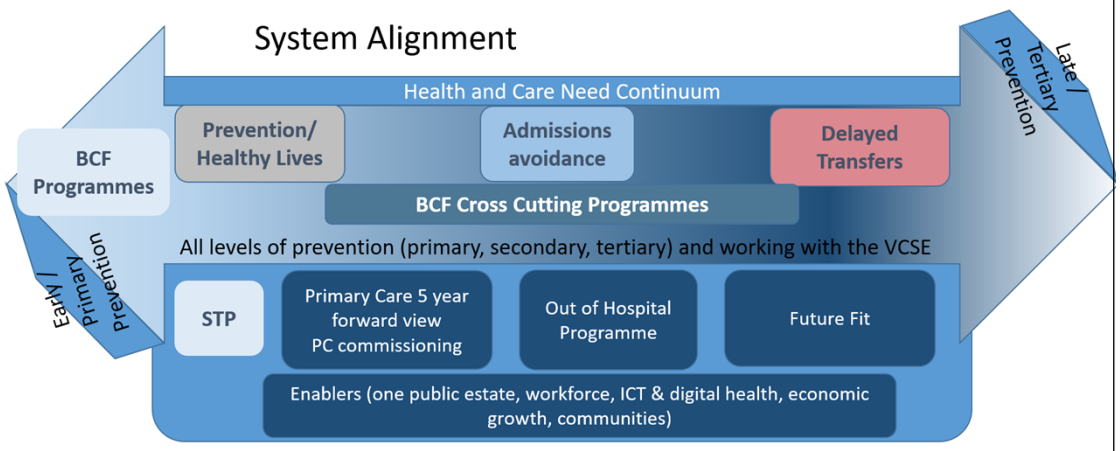
<u>HWBB and the Sustainability and Transformation Plan (Partnership)</u>:
The STP is working through a number of programmes including the BCF to drive a whole system approach to developing and transforming services as required by the HWB Strategy. The STP is working to address much of the system issues regarding hospital configuration, workforce, technology, and community solutions and the schemes of the BCF will interface with the system work as needed.
In the main, the BCF workstreams sit within the Shropshire STP Out of Hospital / neighbourhoods programme to ensure that the BCF pooled budget can be utilised effectively within the broader system context.
The Shropshire out of hospital model of care uses place based planning and service integration to reduce demand on acute and social care services by:

- Building resilient communities and developing social action
- Developing whole population prevention by linking community and clinical work – involving identification of risk and social prescribing
- Designing and delivering integrated health and social care community services that provide alternatives to hospital care for mild, moderate and severe long term conditions; rapid access urgent and crisis care
- Designing and delivering end-to-end community pathways that effectively interface community health, adult social care and children’s services with secondary care (with a focus on frail elderly and mental health)

The workstreams have been developed to ensure that key pieces of work move forward at pace, however it is clear that there is crossover and co-dependence between all of the workstreams. The integrated governance structure (see diagram below) ensures that the work is agreed at the Out of Hospital Programme Board, Neighbourhoods Board and finance at the Joint Commissioning Group.



<u>GP 5 year Forward View:</u>

Primary Care is at the centre of the transformation of our local health and care system and our vision cannot be achieved without it. The BCF will link into this work through the Out of Hospital Programme Board, the Prevention and Admission Avoidance workstreams and through the CCG Locality Managers.

Some of the key elements of the GPFV that describe this are:

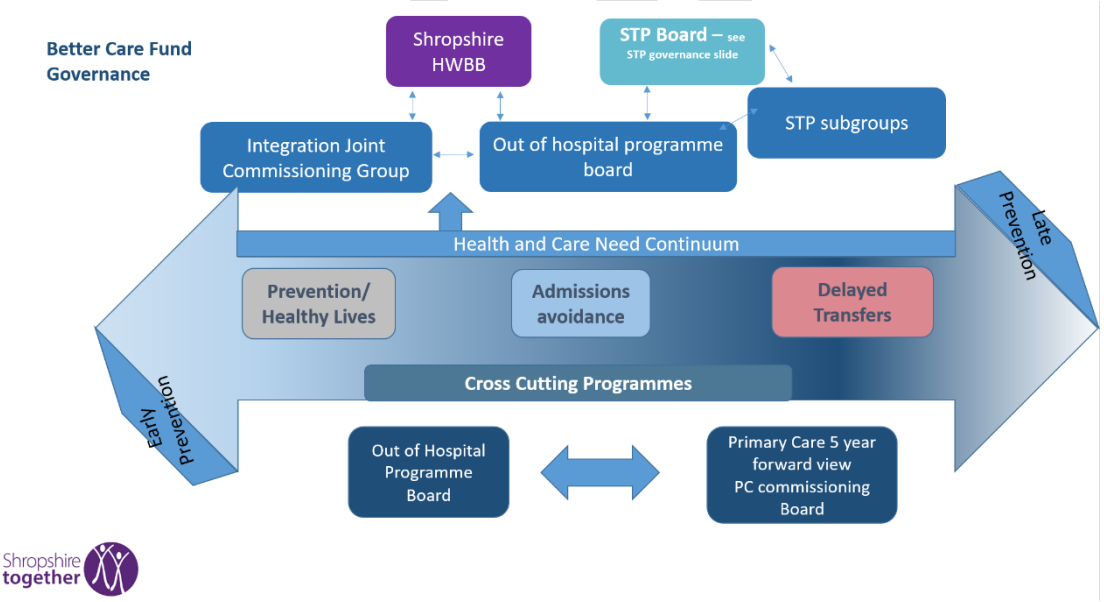
- We will ensure all practices have equal opportunity to access the funding and support they require to deliver the 10 High Impact Changes articulated in the GP Forward View vision-
    - Active signposting
    - New Consultation types
    - Reduction in DNAs
    - Developing the team
    - Productive Workflows
    - Personal Productivity
    - Partnership working
    - Social Prescribing
    - Support Self Care
    - Develop Quality Improvement Expertise
- New Models of care based on a neighbourhood based solution with the principles of:
    - Collaboration – health, social, community, mental health and voluntary organisations working together
    - Co-ordination – approaches to delivery of care that are co-ordinated between agencies across a locality

- Innovation - embracing new ways of working to offer the best support to the population with clinical and asset based approaches working hand in hand
- Accessibility – locality based provision tailored to each area
- Quality – Ensuring that transformation leads to better outcomes for patients and reduces inequalities

Prevention/ Healthy Lives

The Prevention Programme, Healthy Lives, draws together current prevention activity (from Public Health, the Health and Wellbeing Board, Better Care Fund, Adult Social Care, Shropshire CCG and Provider partners), as well as development of new prevention activity, into one programme that focuses on taking a whole system approach to reducing demand on services. This programme relies on working together in partnership and with our communities to improve Shropshire people's health and wellbeing; it will support integration across health and care as and forms a key component of our strategic planning.
Key development areas are to:

- Identifying health risks of individuals and their family and linking the individual/ family to community and service support to prevent ill health
- Implement Social Prescribing, a specific component of healthy lives that provides referral and progress tracking
- Other key programmes include:
    - Diabetes Prevention
    - Falls Prevention
    - Carers
    - Mental Health
    - Healthy Conversations
    - COPD & Respiratory

5. Integration governance and delivery arrangements: In order to achieve our vision and objectives for integration we are in the process of redesigning how we design, commission, deliver and govern our services. We are undertaking this redesign with invaluable insight and assistance from the Leadership Centre whose support is funded through the BCF national team. This input has been instrumental in helping our system leaders to agree our vision and the ingredients to achieving this. A fundamental element of our integration strategy is to create a joint commissioning team to bring together appropriate commissioning, intelligence and performance functions of the CCG and Shropshire Council. Although many services have been commissioned jointly or in partnership for many years, the creation of a single joint team, housed in the same space will accelerate our journey towards full integration and realise massive benefits quickly. The emphasis is on achieving this change at pace to realise the maximum benefit. As such we will be able to describe the full arrangements in practice for the updated plan for 18/19. The visual below (Diagram 2 – BCF Governance) illustrates the proposed joint governance and delivery arrangements: Diagram 2 – BCF Governance  	18
6. Finances and BCF Pooled budget: Full details are found on the finance template	24-27

The draft budget for 2017/18 is as follows:

Area of Spend	Schemes commissioned & Funded by the CCG	Schemes commissioned & Funded by Shropshire Council	Schemes commissioned by Shropshire Council with CCG Funding	Schemes commissioned by Shropshire Council with iBCF Funding	Total (£)
Acute	-	-	500,000	-	500,00
Mental Health	1,871,455	-	654,000	203,629	2,729,08
Comm Health	3,839,137	152,000	16,000	841,107	4,848,24
Continuing Care	2,886,257	-	111,782	-	2,998,03
Primary Care	347,000	250,000	-	-	597,00
Social Care	1,215,978	2,861,504	6,563,324	5,093,412	15,734,21
Other	1,642,765	172,320	-	55,432	1,870,51
Total	**11,802,592**	**3,435,824**	**7,845,106**	**6,193,580**	**29,277,10**

BCF Funding Summary	2016/17	2017/18
Revenue		
Schemes Commissioned and Funded by the CCG	£11,457,083	£11,802,592
Schemes Commissioned and Funded by Shropshire Council	£932,637	£699,637
Schemes Commissioned by Shropshire Council with CCG Funding	£7,845,106	£7,845,106
Schemes Commissioned by Shropshire Council with iBCF Funding	-	£6,193,580
Capital		
Disabled Facilities Grants and Social Care Capital Schemes Funded and Commissioned by Shropshire Council	£2,498,219	£2,736,187
Total BCF 2017/18	**£22,733,045**	**£29,277,102**

7. National Conditions:

National Condition 1- Plans to be jointly agreed:

Sign off: the required sign off for the plan is provided on page 1. The journey of joint development and full integration is described on pages 7-10.

Review: the HWBB have undertaken to continually review the progress towards integration in the first two years of the BCF. This review work has been and continues to be an integral component of the system wide integration work that is reflected in sections 3&4. In addition a jointly commissioned independent review of the STP Neighbourhoods work and broader integration was conducted by Optimity in the spring of 2017.


Optimity Report.pdf

In particular this plan describes an "integration journey" with 17/18 seeing a period of continued development with the expectation of the updated plan for 18/19 describing a much more integrated system with the potential of a much larger pooled budget.

Local agreement of our plan: the plan has been developed through the HWBB structure as highlighted on page 10. This structure ensures that all appropriate partners are involved in the creation of the plan including providers, social care, voluntary sector providers, communities and patients. Specifically: 1-3

- Local housing authority representatives are fully engaged with our system wide integration journey and are key to improving outcomes across the system. Individual elements of work are well underway including the development of innovative housing schemes, allocations, integration of equipment, aids and assistive technology. These are detailed in the scheme descriptor section.
- We are building stronger links with Children's services as much of our work is complimentary, often working with the same families but in a less integrated manner than ideal. Some initial children's services run through the BCF pooled budget however there is significant opportunity to integrate further.


early-help-strategy-2016-2018-v23-april-20

- VCS partners including Healthwatch Shropshire are critical to achieving our integration objectives and representation from the Voluntary Sector Assembly is secure across all forums of the HWBB, BCF and STP including specific working groups. Many of our services are delivered either by or in partnership with our voluntary sector colleagues. A report on BCF is also presented to each VCSA Health and Social Care Forum meeting.

Progress against 16/17 National Conditions: We are continuing to make progress against the 16/17 national conditions detailed in embedded

Progress on 16.17 national conditions.dc

document.

Addressing health inequalities: addressing health inequality is a key priority for Shropshire and a key principle of our integration vision is to ensure that we continue to reduce health inequalities in our area in line with the Equality act 2010 and Health and Social Care Act 2012 and our HWB Strategy. We have taken a system approach to this as detailed on our web pages: https://www.shropshire.gov.uk/joint-strategic-needs-assessment/overview/shropshire-profile/health-inequalities/

The diagram below has helped us to develop schemes that will have real impact for Shropshire people and that will reduce health inequalities.

Managing Risk

Arrangements for the management of risks associated with the BCF are set out in the BCF Partnership Agreement. These arrangements will undergo an annual review, but are based on the following principles.

- All stakeholders have a collective responsibility for the delivery of the BCF Programme outcomes and efficient use of the monies identified within the Programme.
- Financial risks should be managed within the pool in the first instance using the contingencies and slippage detailed
- The CCG and LA recognise that the financial risks/benefits associated with the performance of the fund will be shared on the basis of the relative contributions of both organisations to the fund (currently 90% CCG and 10% LA as set out within the funding sources summary). This arrangement will be reflected in the Section 75 Agreement.
- Any over or underspends within the pooled budget will be shared with in the 90-10 split outlined at year end
- The CCG and LA share the financial risk of maintaining other services if related activity levels continue to grow at historical trends.

4-7

From a governance perspective the Joint Commissioning Group is responsible for identifying and monitoring risk and for agreeing and overseeing the implementation of appropriate mitigation measures. The Joint Commissioning Board will report on risk as appropriate to the Health and Wellbeing Board who will make recommendations to the statutory organisations where there is a need to trigger risk sharing agreements. The Joint Commissioning Group is working to develop the detail regarding over and underspend in accordance with the Group's ToR (attached below). We appreciate the role of shared learning and utilising the wealth of shared resources from the BCF team (including the Better Care Exchange). Locally we have been supported by the Leadership Centre and SCIE to develop joint working. All schemes have been developed by taking a partnership approach, utilising, where possible a design approach to understand need, using evidence and developing shared purpose when implementing change. We will continue to use these approaches to develop and transform in conjunction with the STP. Our managing risk log and further information can be found in the embedded document:  risk log updated aug 17.xls  Final Joint Commissioning Grou **National Condition 2: NHS Contribution to adult social care is maintained in line with inflation:** • The draft NHS contribution to adult social care through the BCF for 2017.18 is £7.779m. This compares with £7.041m for schemes in 2016/17. (Not all of this funding is directed via the local authority.) • As detailed on page 14 the HWBB have undertaken a line by line review of the schemes funded through the BCF to ensure resources are appropriately allocated to enable Shropshire Council to meet their adult care statutory duties. • The apparently large increase in funding towards social care schemes is explained by a reclassification of schemes in 17/18 rather than a true increase in funds to this area. • As detailed throughout this plan we are continuing on our journey towards integration and envisage a greater investment in the protection of adult social care in the 18/19 pooled budget. **National Condition 3: Agreement to invest in NHS commissioned out of hospital services**	8-10 11-13

- The policy framework and 17/18 allocation establishes that a minimum of £11,802,592 of the CCG contribution to the BCF in 2017-18, will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, while supporting local integration aims.

- In Shropshire we do not plan for reductions in non-elective admissions (NEAs) beyond the CCG operational plans and as such we plan to use the full allocation to fund NHS-commissioned out-of-hospital services. These services are the same as those in 16/17 that have demonstrated impact on reducing acute activity and unplanned admissions. Work is ongoing work to refine these services to maximise this impact.
- These schemes are integral to how we are aiming to meet National Condition 4 (managing Transfers of Care) alongside other activity that is detailed later.
- As detailed earlier we are making significant progress towards full integration and the two year Integration and BCF plan enabled us to describe the journey we are on towards a much more integrated picture when we present the updated plan in the spring of 2018. The pooled finances for 18/19 will show further integration across a wider range of services and will describe a significant increase in investment into out of hospital services.

National Condition 4: Managing Transfers of Care:

Our approach involves concerted effort through the IBCF Joint Plan (inserted below) as well as a joint action plan to deliver the 8 High Impact Changes to improve DTOC. The two documents provide full detail on:

- Our joint approach to funding and implementing these changes, how we have built on and learnt from existing successful local practice and how we are tailing services to meet local circumstance.
- Our agreed set of measures to manage transfers of care and the rationale for these.
- How we will implement this model and how it will impact on our performance metrics, including Delayed Transfers of Care.
- Shropshire is committed to delivering the 8 High Impact Model and to reducing DTOC through the IBCF. It is governed through a subgroup of the A&E delivery board and the Joint Commissioning Group as required; both monitor progress through attached metrics schedule. The 8 High Impact Model Action plan that details what will be delivered by who and when is attached below.
- SaTH2home commenced on 23rd October to support a small group of patients. The LA and CCG are monitoring the impact of this service weekly. The contract should support the system to ensure people are able to return home and reduce readmissions. The key issue will be to ensure lines of communication and

understanding are clear. This work will feed into the 8 High Impact Model Action Plan.

Attached also is the revised Integrated Community Services Specification that links into both of these documents and provides further detail.

SHROPSHIRE LA DTOC PLAN AUGUST

ICS Service specification 17-18 re

8 High Impact Changes Action Plan

Maintaining Progress on the 16/17 National Conditions:

Detail on how we care continuing to make progress on the national conditions for 16/17 can be viewed in the embedded document.

Progress on 16.17 national conditions.dc

National Performance metrics:

28-37

All metrics have been agreed by the HWBB following detailed system wide work including the Leadership Sessions detailed earlier. All metrics have been agreed in the context of past and current performance using the performance management templates provided for the BCF, our collective data and intelligence, and are aligned with all appropriate plans and services across health and social care.

Metrics supporting document.docx

Shropshire DTOC Metrics Update Nov 2

Detail on how we will achieve these metrics is provided in the schemes/ services section.

Non Elective Admissions (General and acute):

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
8,327	**8,080**	**8,729**	**8,475**

Admissions to residential and care homes:

	15/16 Actual	16/17 Plan	17/18 Plan
Annual rate	573.7	626.4	600.3
Numerator	417	464	454
Denominator	72,685	74,029	75,625

Effectiveness of reablement:

	15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Annual %	80.6%	84.1%	82.0%	82.0%
Numerator	275	132	1,584	1,584
Denominator	341	157	1,932	1,932

Delayed Transfers of Care:

17-18 plans			
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
951.9	891.1	808.3	794.9
2,425	2,270	2,059	2,036
254,742	254,742	254,742	256,126

Appendix A

Integration and Scheme delivery:

17, 20

The delivery of integrated services to achieve our vision alongside the national conditions and metrics is through three principal workstreams:

- Prevention/ Healthy Lives
- Admissions avoidance
- Transfers of Care

Whilst many of the schemes will interact with the system and many workstreams, the following schemes cut across the three workstreams and are integral to the delivery of integration overall. These are:

Care Navigator/ Social Prescribing	 C&CC's v2.docx  Social Prescribing V2.docx
Integrated Working Support Services	 Integrated Working Support.docx

- The individual budgets associated with these services make up the majority of funding in the BCF pooled budget. The finance template at Appendix 1 provides the full detail.

Prevention/ Healthy Lives:

This workstream takes a whole system approach to reducing demand on services by using our intelligence to identify 'at risk' groups of people and then provide the support needed to help these people to remain well and avoid escalation.

We have been piloting this new approach in Oswestry, our second largest town, since September 2016 and have made a significant impact. We are now rolling this approach and the specific services out across the County.

Prevention/ Healthy Lives is made up of the following services. A scheme descriptor for each service can be accessed by opening the embedded document:

Resilient Communities	Resilient Communities V2.docx
Integrated falls prevention	Falls v2.docx
Healthy Conversations and future planning	Healthy Conversations and Future planning.d
Diabetes and CVD Prevention	Diabetes and CVD Prevention v2.docx
Children's Services	Children's Services.docx
Safe and Well	Safe and Well.docx

Admissions Avoidance:

The supporting independence at home workstream recognises that the right place for people to receive care is wherever possible at home.

It employs a system wide approach to providing appropriate solutions to provide this care. It is made up of the following services:

Mental Health & Learning Disabilities support	Mental Health & LD.docx
Housing	Housing v2.docx
Carers Support	Integrated Carers Support v2.docx
Integrated Community Services (ICS) & Reablement Services	ICS & Reablement services.docx

High Intensity Service Users (HISU)	HISU.docx
Proactive Care and Long term conditions support	Proactive Care and Long Term Conditions.

Transfers of Care:

This workstream employs a system wide approach to managing transfers of care. In the sometimes unavoidable event that an individual finds themselves in crisis, we will employ rapid, focused interventions with a view to helping a person remain in their own home or return there as quickly as possible. It is made up of the following services:

STP Frailty programme	Frailty.docx
End of life support	End of life v2.docx
Dementia Services	Dementia v 2.docx
Trusted Assessor model	To be developed
Integrated Community Services & reablement services works both to support Admissions Avoidance and to reduce delayed transfers	See AA above

Appendix B

Shropshire Better Care Fund Development Draft Action Plan
September 2017 – April 2018
Priorities – Prevention, Admission Avoidance, Delayed Transfers

Action	Activity	Outcomes	Measures	Timeframe	Status
Better Care Fund Plan Development	Develop BCF schemes and plan in conjunction with the STP, HWBB, following NHSE feedback	Improved collaborative working; integrated services; better health and wellbeing for Shropshire people	BCF measures and individual programme measures	September - October	
	Develop criteria for scheme evaluation	Systematic joint approach to evaluation and commissioning	Completion	September 2017	
	Jointly evaluate schemes and programmes within to ensure value for money and linkages to priorities and national conditions	Systematic joint approach to evaluation and commissioning	Commissioning and contracting	September – March 2017/18	
	Ensure linkages from BCF national conditions with system planning (STP and STP out of hospital programme)	Health and care integration	BCF and STP measures	Ongoing	TBD
	Link BCF programmes with STP to develop Communication and Engagement Plan	Better informed partners and public about health and care programmes	BCF and STP measures	Ongoing	TBD
	Leadership Development	Develop leadership plan as part of the HWBB and Leadership Centre programme	Delivery of BCF and Joint Commissioning	Ongoing	
	Develop Joint Commissioning arrangements	Improved collaborative working; integrated services; better health and wellbeing for Shropshire	BCF measures and individual programme measures	Autumn 2017	

Shropshire Better Care Fund Development Draft Action Plan
September 2017 – April 2018
Priorities – Prevention, Admission Avoidance, Delayed Transfers

Action	Activity	Outcomes	Measures	Timeframe	Status
		people			
	Developing Quarterly reporting framework	HWBB and the Joint Commissioning Group are well informed on BCF programme development	Action completed	September 2017	
	Further develop action plan to support delivery of BCF and integration of programmes	Improved collaborative working; integrated services; better health and wellbeing for Shropshire people	BCF measures	Ongoing	
Scheme monitoring – quarterly reporting on each of the priority areas to the Joint Commissioning Group: • Prevention/ Healthy Lives • Admission Avoidance • Transfers of Care regular reporting to the HWB Joint Commissioning meeting	**Healthy Lives**	Improved population health and wellbeing	Improved healthy life expectancy	Ongoing	
	• Resilient Communities • Healthy Conversations • CVD and Diabetes Prevention • Safe and Well	As described in the plan above	BCF measures as described above	Ongoing	
	Admissions Avoidance	More people cared for at home or their community	System AA measures	Ongoing	TBD
	• Mental health and LD • Housing • Carers Support • Integrated Community Services	As described in the plan above	BCF measures as described above	Ongoing	TBD

Shropshire Better Care Fund Development Draft Action Plan
September 2017 – April 2018
Priorities – Prevention, Admission Avoidance, Delayed Transfers

Action	Activity	Outcomes	Measures	Timeframe	Status
	• High intensity service users • Integrated LTC support				
	Delayed Transfers	People are not in hospital or step down facilities for any longer than absolutely necessary	System measures	Ongoing	TBD
	• STP frailty programme • Dementia support • End of Life support • Trusted Assessor model • Integrated Community Services	As described in the plan above	BCF measures as described above	Ongoing	TBD
	Cross Cutting schemes	Health and care system working in an integrated way to support Shropshire people		Ongoing	
	• Care Navigator/ Social Prescribing model • Integrated support team	As described in the plan above	BCF measures as described above	Ongoing	

Red = Significant issues, requires action required **Amber = In progress, monitor** **Green = On track, no action** **Purple = Completed**

Appendix C

Our Health and Social Care Economy:

Shropshire has a relatively complex provider landscape made up of:

- **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 **43 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 Shropshire Council's social work team who provide adult social care support to older people and those with disabilities. P2P supports individuals to keep their independence for as long as possible, by working service users to understand what is important to them and to understand how they connect to their community. P2P works to support people to keep their independence as they age and improve their health and wellbeing.

- **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.

Appendix D – Jam Jar of Integration

The Jam Jar of Integration Shropshire's Plan on a Page