Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Shropshire Council**
Clinical Commissioning Groups	**Shropshire Clinical Commissioning Group**
Boundary Differences	**The Council and CCG share the same boundaries. However all our provider organisations are not co-terminus and work across Shropshire and Telford & Wrekin boundaries**
Date agreed at Health and Well-Being Board:	**12/2/14**
Date submitted:	**14/2/14**
Minimum required value of ITF pooled budget: 2014/15	**£6,151,000**
2015/16	**£21,451,000**
Total agreed value of pooled budget: 2014/15	**£9,358,613**
2015/16	**£21,451,000**

First Draft

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Shropshire Clinical Commissioning Group
By	Dr. Caron Morton
Position	Accountable Officer
Date	14.2.14

Signed on behalf of the Council	Shropshire Council
By	Stephen Chandler
Position	Director of Adult Services
Date	14.2.14

Signed on behalf of the Health and Wellbeing Board	Shropshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Karen Calder
Date	14.2.14

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

First Draft

Within the financial template a comprehensive list of services included in the Fund has been set out for 2014/15. Providers were extensively involved with the development of these services. However, in relation to the Better Care Fund a specific provider workshop was held to set the scene and share plans for 14/15 highlighting key priority areas. In addition to the health providers present the independent care home and domicillary care sector were represented as well as the Vountary and Community sector A further, more detailed provider workshop has also been held to begin to shape plans for 2015/16 and regular provider meetings are now planned. Wider transformational work underway in Shropshire, set out later in this paper, also include comprehensive engagement elements on which we will draw. As part of this wider engagement and consultation as specific plans are developed we will include harder to reach groups through the Learning Disability Partnership Board and Carers Partnership Board as well as building on previously successful HWB engagement workshops with citizens and stakeholders

In addition the BCF is a standing agenda item at the Health and Wellbeing Board and is discussed as necessary at the local Chief Officers meeting which is attended fortnightly by Chief Officers from provider and commissioner agencies across Shropshire including the local Authority and neighbouring authority (who commission from the same hospital trust), SATH, SSSFT, RJAH and Shropshire Community Health

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Locally there is a comprehensive programme of service user, carer and clinical engagement across both the CCG and Council. As part of the Future Fit (Clinical Services Review) work across Shropshire and Telford & Wrekin there is a comprehensive programme of consultation and engagement which will act as the cornerstone of engagement regarding service redesign linked to this Fund. As above there has been extensive engagement with patients and the public in developing the services outlined in the financial template for 2014/15 as well as clinical engagement. A clinical lead has been appointed to oversee the development of the Better Care Fund

The Health and Wellbeing outcomes and priorities are based on the JSNA and an ongoing programme of consultation and engagement. This engagement over 2013 continued to test the relevance of the priorities for the population of Shropshire. The priorities outlined as part of this Better Care Fund are in strategic alignment with the HWB priorities and in alignment with the public and patients who we have had a continuing dialogue with over recent years. Details of this consultation can be found by following the link in section e) of this document. Further, as Healthwatch embeds its position within Shropshire, the Health and Wellbeing Board will work closely with Healthwatch and all our partners to ensure that we are fully engaging with our service users to conceive, design and implement service transformation

Some specific examples of the general programme of engagement work includes work with hard to reach groups, consultation on changes to service pathways, advocacy support and easy read materials.
Work on consultation and engagement will be on going and will include building on existing work in areas related to the Fund. Consultation and Engagement will take place within available resources and will be carried out via a range of methods/ media. Key areas that will be included within the consultation and engagement process will be:

- 7 day working including agreement on a definition of what this is in Shropshire – This is currently in development and a review of the current baseline position is underway across all providers and stakeholders including local authority partners and the independent care sector
- The Clinical Commissioning Group has already begun to factor the Fund into contract discussions with providers and this work will continue
- Making it Real Board – Making it Real (MIR) is a practical tool that has been developed nationally by service users and family carers. It is designed to be used with service users and family carers to help organisations check their progress with personalisation and community based support, to identify areas for change and develop actions. Shropshire Council are using Making it Real to assist in building on the progress made with the transformation of adults' social care through their Live Life Your Way initiative. The Making it Real outcomes will be the focus of Shropshire Council's approach for improving adult social care in the coming years and are also relevant to improving health outcomes

First Draft

- Patient and Public Engagement – developing awareness and opportunities to comment on and mould the development of the Fund will be built into existing arrangements for engagement across the Clinical Commissioning Group and Council, with plans for any specific early events agreed by the end of this financial year. Two workshop events have already been health for health and Wellbeing Board members including representatives from Healthwatch and the Voluntary and Community Sector Assembly (VCSA). The Better Care Fund will be a specific item on the next VCSA Board meeting agenda.

e) 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**
BCF Joint Strategic Position paper	Joint Strategic Position paper V6.doc
BCF H&WBB workshop 1 slides	ITF workshop slides V2.ppt
BCF H&WBB workshop 2 slides	BCF workshop slides V3 STC Updated.ppt
BCF Governance	BCF Governance_final.ppt
BCF Plan on a Page	Better Care Fund plan on a page final.p
Job Description BCF	Job Description BCF.doc
Draft ToR Service Transformation Group	Draft ToR Service Transformation Grouן
Final Draft ToR Finance Contracts and Performance Sub Group	Final Draft ToR Finance Contracts ar
Final Draft ToR HWB Delivery Group	Final Draft ToR HWB Delivery Group.doc
Provider workshop slides	BCF workshop slides - Provider consultatio

First Draft

H&WBB workshop 2 minutes	Workshop Number 2 Jan 2014.doc
Future Fit – Project Executive Plan	140120 Shrop CSR PEP V1 0_excl Appen
Dementia Strategy	DELIVERY_PLAN_Dec _2013_Revised[1][2]
LTC Strategy	Long Term Conditions Strategy F
JSNA	http://shropshire.gov.uk/joint-strategic-needs-assessment/
H&WB Strategy	http://www.shropshiretogether.org.uk/wp-content/uploads/2013/03/HWB_Strategy_210x210mm_FINAL-Hyperlink.pdf
Details of on going engagement and consultation on the JSNA and H&W priorities	http://www.shropshiretogether.org.uk/consultation/

First Draft

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our joint vision and aspirations for the BCF

As politicians, executives, clinicians and local residents of Shropshire we 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 two challenges:
How do we ensure improved services and outcomes for the people of Shropshire?
How do we make the current health and social care system financially sustainable into the future?
Both of these challenges 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 main resources.
What we agree on is that we can't keep doing the same things in the same way and expect to meet either of these challenges. We need to radically change how we deliver services and where we place our largest resources.

The Better Care Fund provides us with this opportunity.
By applying our joint aspirations set out in the Health and Wellbeing priority areas, alongside our individual organisational priority areas for investment and disinvestment we can start to make the changes that are required to make the health and social care economy sustainable.
What our service users will experience is more flexibility of provision, increased choice and more appropriate care settings being provided locally in their localities. They will also experience improved outcomes with better provision for long-term conditions and an agenda focused on prevention and ensuring higher quality of life years for our younger generations.
Outlined in the document below is how we will embark on the first two years which will lead to closer commissioning of services, integrated teams and a new focus on service provision at the correct level of care.

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 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. The context of other transformational activities locally around hospital provision and other developmental work around primary care and community services provides a suitable backdrop for this work to take shape. Workshops were held with Health and Wellbeing Board members and key stakeholder in November 2013 and January 2014 to discuss in detail and agree the local position in relation to implementation of the Fund. These workshops considered the guidance, financial analysis, current priorities and local context.

The outcome of these workshops was agreement that the focus of the Fund would be broadly around the themes of:

- Prevention
- Living Independently for Longer
- Long Term Conditions
- Managing and Supporting People in Crisis.

First Draft

It is important that the development of the Better Care Fund fundamentally supports the key priorities set out in the JSNA, the Health and Wellbeing Strategy (both of which can be found in Appendix 1) and other key commissioning and business plans. In addition developments must be mindful of the particular current health and social care context in Shropshire relating to the Clinical Services Review and complement its development as set out below. In addition to this, for the final iteration of this plan further detail will be provided regarding the role of prevention services and the inclusion of services for children and young people.

Within the local health economies throughout the West Midlands, East Midlands and East of England, the set of circumstances faced by the populations of Shropshire, Telford & Wrekin and Powys in relation to service reconfiguration are exceptional. It is in this context that the current need to realise major benefits from further integration of hospitals services takes place. The case for change is based on the patient benefits of new models of service which overcome some of the safety, quality and clinical sustainability concerns of current fragmented and duplicated services. A recent economic analysis of financial projections for the health economy, show that the severe financial constraints within which we have to operate compound the unique set of challenges we face.

In order to address these challenges and the need to develop a service strategy for the next 20 years, a large scale Clinical Services Review is underway – FutureFit. The outcome of this will be one of the most significant factors influencing the pattern and configuration of services over the next 5 years and beyond in Shropshire. The work on the Better Care Fund does not attempt to pre-empt this work but to compliment the direction of travel to develop high quality, sustainable health and social care service for the future. Furthermore , Shropshire Council and Shropshire CCG are both committed to a number of overarching principles and streams of work that will support the development of the Better Care Fund. These include developing community resilience through our Compassionate Communities and Community and Care Co-ordinator developments, implementing7 day services and identifying our most complex service users and wrapping services around them. We are also working closely with Public Health to develop the impact of our prevention services.

As a council Shropshire has stated its strategic aim is to ensure everything is as efficient as it can be, focusing on the customer, prevention and partnership. Arrangements which will ensure that the best possible outcomes for the local people of Shropshire

The council wants to deliver value for money for Shropshire people by commissioning outcomes, based on demand, working with our Elected Members. We want Shropshire's communities to be resilient, to take ownership of issues important to them and, with our support to develop their own resources to be able to flourish during this time of change and into the future.

We recognise that there are many communities, people and organisations who are as well, or better, placed to deliver the solutions and services which will help us to deliver on our vision. We also recognise that other organisations are sometimes better placed than the council to attract external funding and to deliver inward investment to Shropshire. That is why we see the council's role as that of a **commissioner** as opposed to a direct deliverer of services. This means that the council's relationship with our customers and communities will be to engage, listen and understand needs and demand whilst securing the best possible solution from those organisations who will be delivering services in future.

Demand for Adult Social Care rises each year, people are living longer and there are more people living with long term conditions, particularly dementia. There are also increasing numbers of young adults in transition to adult services with complex needs.

This increased demand for services occurs at the same time that the local Authority is under unprecedented financial pressure with an overall reduction in the finance settlement for Shropshire. At the same time there is increased public expectation of Adult Social Care and rightly an expectation of personalised and flexible support for those who are eligible for Adult Social Care.

In order to respond to the monumental challenges described whilst continuing to deliver high quality support to those in need, we will **need to radically change our approach** to the provision of ASC in Shropshire. If we want to maintain the level of access that we currently have for ASC we need to signal a more focused offer to everyone. Social care is often a vital part of enabling people to live independent lives

First Draft

but it is far from being the only component to enable people to live fulfilled lives. We must build and harness the contributions that communities can make to support themselves and the people living in them.

We need to build a more sustainable ASC system that promotes and maintains greater independence for most people which maximises the support available within local communities. We need to enable local communities to respond to the needs within them to enable them to support each other for longer so that higher level of statutory provision is available for those who need it. We need to change the relationship that adult social care has with the public and that fosters and promotes independence and self-management at every level. We need to ensure that we have different conversations with the public from the moment we first engage with them so that these expectations are understood, promoted and acted upon.

We will do this by

- Reducing dependence upon paid support and enabling and maximising individual independence.
- That the service will be responsive with quick decision making at the closest possible point to the person.
- Maximise the use of community resources and natural support and developing resilient communities.
- The local service will be determined by what that local community needs in relation to advice and information and direct intervention from adult social care.
- Facilitating key partnerships within local communities that maximise the use of natural support and universal services as well as developing services that meet the needs of local communities
- There is a focus on the use of volunteers and particularly those that have lived experience of using services.
- The service will focus upon supporting and enabling carers to continue with this vital role whilst establishing and maximising the use of peer support.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Early themes emerging from the FutureFit programme have identified the following areas where tangible differences will be evident for local people. The Better Care Fund will be instrumental in aiding in their delivery :

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home

First Draft

- 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)
- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

Moreover the aim locally is for the Better Care Fund to support the Health & Wellbeing priorities (below) as well as the JSNA priorities
1. Health inequalities are reduced
2. People are empowered to make better lifestyle and health choices for their own, and their family's health and wellbeing
3. Better emotional and mental health and wellbeing for all
4. Older people and those with long term conditions remain independent for longer
5. Health, social care and wellbeing services are accessible, good quality and 'seamless'.

It is also anticipated that the Fund will support improvements in the areas of the 5 key outcomes measures
- Reducing permanent admissions to residential and care homes;
- Improving Quality of Life indicators for service users and carers.
- Reducing non-elective hospital admissions, re-admissions and length of stay.
- Reducing delayed transfers of care
- Improving the effectiveness of reablement/rehabilitation services

Shropshire CCG's Outcome Ambitions for the coming year and associated 5 year trajectories (a summary of which are included as an embedded document in section e) are the first step in moving towards our overarching vision for local health and social care services outlined above and along with the monitoring of the key metrics submitted relating to the Better Care Fund itself, will provide an additional layer of monitoring data. The Local Authority will monitor performance against both national and local measures through the Adult Social Care Outcomes Framework and these together with the metrics submitted for the Better Care Fund will be reported on a regular basis by the contracts and performance group to the health and wellbeing delivery group

The Health and Wellbeing Board has agreed the following key themes for the Better Care Fund in Shropshire:
- Prevention
- Living Independently for Longer
- Long Term Conditions
- Managing and Supporting People in Crisis.

Further aims will look at increased reablement, sustainability measures and affordability, focused on reduced dependence of the population on social care and the urgent care element of health.

It is also anticipated that the Fund will deliver financial efficiencies by reducing duplication, economies of scale and having the right services in the right places meeting the right needs

In order to ensure Parity of Esteem for the local residents of Shropshire The CCG and Council are committed to improving outcomes and addressing health inequalities for people with mental health needs and mental and emotional wellbeing has been identified as a priority for Shropshire's Health and Wellbeing Board, with a particular emphasis on supporting people with dementia and the mental and emotional health and wellbeing of young people. In particular within the scope of the Better Care Fund plan 2014-2016 there is a commitment to Improving access to Pyshological Therapies (IAPT), improving diagnosis and support for people with Dementia, improving awareness and focus on the duties with the Mental Capacity Act and reviewing Crisis service provision.

The complexities and breadth of the work involved in fully developing and implementing the better Care Fund are significant and as an aide we have developed a Better Care Fund "Plan on a Page" which

First Draft

demonstrates the work that will sit under the Better Care Fund banner and its interdependencies and correlation.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The initial phase of work will establish those programmes of development that are already in train and where joint arrangements are already in place or are already being developed that can be supported to achieve impact in year 1. These will consider the geography and rurality of Shropshire, recognising that some work will need to be adapted to reflect variations in local need, as well as the performance requirements of the National Conditions, National Metrics set out above and locally agreed targets. Work will be in line with the strategic direction set out in the JSNA and Health and Wellbeing Strategy as well as the local Long Term Conditions Strategy and Dementia Strategy. This will include work around Reablement, Locality Commissioning priorities to meet the differing needs of communities, the Integrated Community Service and Long Term Conditions work streams

Those services identified for inclusion in the Fund in 2014/15 are identified as follows:

Prevention:

- Carers Support and Liaison
- Think Local Act Personal and citizen engagement
- Access to employment and leisure activities for people with Learning Disabilities
- Locality Commissioning
- Improved care service monitoring (safeguarding)
- Falls prevention

Living Independently for Longer

- Maximising Independence – Hospital discharge/ admission avoidance
- Handyman Scheme
- Telecare
- Support for Adults with learning Disabilities
- Supported Living for people with learning Disabilities/ Mental Health
- PATH House supported living
- Jointly funded staff to support learning disabilities services
- Community and Care Co-ordinators
- Continuing Care respite
- Crossroads care attendants scheme
- Children and families – short breaks/ Summer play schemes/ Hope House
  Mental Health Carers Network and Carers Support
- End of Life Care – Hospice at Home service
- Carers Link Workers
- Primary Care carers support worker
- Substance Misuse carers support
- Age UK
- Compassionate Communities

Long term Conditions (including Dementia)

First Draft

- Enhancing preventions services (LTC)
- Services for people with Dementia
- Supported Housing (The Willows, Oak Paddock, 64 Abbey Foregate)

Managing Patients in Crisis
- Crisis Resolution
- Integrated health and social care pathway
- Mental health and Learning Disabilities Respite
- Escalation beds
- Independent Living Partnership
- PATH House

Supporting People After Crisis
- Increased social work capacity
- Rehabilitation beds
- START (Short Term Assessment and Reablement Team)
- Home from Hospital
- Stroke Association
- Social work input to support early discharge
- Step down START beds
- Headway (Acquired Brain Injury Support)
- Integrated Care Service

Central to our local developments is out Integrated Community Service. 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. The first phase of this service development began in Shrewsbury & Atcham in November 2013 focussing on early supported discharge but the next phases with include roll out to North and South localities and expansion of the scope of the service to include admissions avoidance.

The service aim is to provide a rapid response to care delivery in the right place at the right time to maximise a patient's independence deploying the optimum skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs with the default position being for the patient to remain at, or return to, their home. The service will achieve and demonstrate integration through a new shared culture, mind-set, values, objectives, working processes and practice.

Phase two of our implementation of the Better Care Fund will look at longer term more fundamental transformation work. Detailed plans for this work and consideration of the full National Conditions, National Metrics and local indicator will be carried out during 2014/15 and recommendations for 2015/16 will be presented to the Health & Wellbeing Board in September 2014 for agreement. This will include a focus on prevention, assistive technology and information and advice supporting people to be more self reliant and resilient within their local communities

Shropshire Clinical Commissioning Group is working with partners including Shropshire Council and the Parents and Carers Council (PACC) to ensure that the SEND Reforms are implemented successfully in Shropshire and that there are improved outcomes for children and young people with SEN.
We are working in partnership to deliver the following by September 2014:

- A single assessment process for education, health and care which includes parents of children and young people with SEN in the assessment process
- Replacement of SEN statements and learning difficulty assessments with an education, health and care (EHC) plan for children and young people with SEN aged 0 to 25 years
- Introduction of the option of personal budgets for young people and parents of children with SEN
- A local offer which provides information about support that is available
- Joint commissioning arrangements to deliver integrated support for children and young people with SEN aged 0 – 25 years

First Draft

Post-September 2014, we will regularly review the success of the reforms locally including the local offer, commissioning arrangements and service budgets in order to offer increased personal budgets and ensure that services meet identified need.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

There are a number of future pressures that threaten to overwhelm health and social care services and Shropshire is no exception in this. Whilst more people are living longer, many people are spending more years in declining health. This places significant demand on health and social care services and highlights the importance of healthy lifestyles. Many of the causes of poor health and early death are largely preventable. Furthermore the population is ageing and we are a seeing significant increase in the number of people with long term conditions, coupled with rising public expectations. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of current health and social care provision.

Preserving the values that underpin a universal health service which is free at the point of use will mean fundamental changes to how we deliver and use health and care services in the future. In addition the social care services available from the Local Authority will require a fundamental redesign and new operating model to ensure that resources are available to meet the needs of those with most need. The new operating model currently being developed by Shropshire Council will see a greater focus on prevention and reablement as required by the Care Bill as well as developing individual and community capacity and resilience to ensure that scarce resources are allocated to those in greatest need

The Fund presents some financial challenges particularly in a context of diminishing budgets across the local health and social care economy in Shropshire. The final target allocations review for CCG's has been published and identifies Shropshire as currently being funded at 4.6% (£16m) above its fair share target. This has led to the CCG receiving the lowest amount of uplift available for 2014-15 and 2015-16 (along with 64% of other CCGs). Both the Clinical Commissioning group and the Council are exploring avenues for lobbying the Government regarding rural issues and the relevance of this in making funding decisions.

In particular it is anticipated that the Better Care Fund will support maximising the acute phase and the movement of the post acute phase into the community. As already highlighted the development of the Better Care Fund for 2015/16 will need to compliment the Clinical Service Review taking place locally and support a reduction in dependency level within the acute sector. This is based on the assumption that we will still achieve all the NHS targets

The recent Kings Fund paper, "Making the Best Use of the Better Care Fund" (January 2014) sets out a number of areas of focus in implementing the Better Care Fund, these are:
Primary Prevention
Self Care
Managing ambulatory care sensitive conditions
Risk stratification or predictive modelling
Falls prevention
Care co-ordination
Case management
Intermediate care, reablement and rehabilitation

Work is already underway in relation to all these areas, in particular the Long Term Conditions Strategy sets out the local commitment and plans around these areas of work. The implementation of the Better

First Draft

Care Fund will further assist this and there has been broad agreement via the Health and Wellbeing Board workshops with this. Further work will be undertaken to develop joined up plans with our neighbouring CCG in Telford & Wrekin between now and September 2014

Furthermore, the CCG and Council have been considering the implication of the Commissioning for Prevention Guidance and how this can be applied in Shropshire to have the most impact. The outcome of this work will be a key factor in our development of the workstreams associated with the Better Care Fund over the coming months.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Overall Strategic Governance will be provided via Shropshire Health and Wellbeing Board. Workshops have taken place with members of the Health and Wellbeing Board to agree governance principles. The details of the operational governance arrangements that sit beneath this have now been agreed by the Health and Wellbeing Board and can be found as an embedded document in section e along with their associated Terms of Reference

The day to day responsibility for the implementation of the plan, financial and performance monitoring will be the responsibility of the Health and Wellbeing Delivery Group and a joint appointment will be made to a Better Care Fund Manager post to support this. The Job Description for this post can also be found as an embedded document in section e.

First Draft

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

The Local authority estimates, from working with local care providers, that around 40% of the care beds in Shropshire are occupied by people who fund their own care as their capital is above £23k. What is unknown is how many of these people are below or close to the new capital threshold being proposed by the care bill. A proportion of the BCF will have to be used to meet this increase in statutory responsibility. The number of people who self fund their own care from domicillary care providers is unknown and again the BCF may have to be used to meet this financial gap

In Shropshire the fund will protect expenditure on statutory services for people who are eligible for council funded support and who have needs assessed under the Fair Access to Care Criteria (FACS) as being either critical or substantial. The fund will also be used to protect services that support carers following the completion of a carers assessment. The level at which the eligibility criteria will be set through the Care Bill is as yet unknown and there could be an additional financial impact.

The CCG and the LA are committed to integrated care services that facilitate hospital discharge, prevent hospital admissions and reduce reliance on long term social care services and support people through targeted reablement and intensive short term support to remain living independently in their own homes and local communities. Both the CCG and LA are 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 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 of circa £25million.
The council is committed to delivering on its statutory responsibilities, which will change and grow as the Care and Support Bill is implemented and this may require changes to local policy, guidance and operating models. It has recognised the importance of a range of prevention and early intervention approaches including telecare, community equipment and reablement in keeping people independent.

The longer term demand management and enabling people to live independently has also been recognised by the council and 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.

Please explain how local social care services will be protected within your plans

In order to meet the demands of current and future social care support, the operating model defines the Adult Social Care approach in working with the individual, their family, the wider population to develop sustainable support, engagement with universal services, through to meeting complex levels of need and vulnerability through a personal budget.

The approach is based upon varied and localised interventions that are designed to promote independence. A person contacting the Council for support will be supported to develop personal resilience, guided through the differing interventions until a maximum state of independence has been reached. At this point a support plan, documenting how such independence will be maintained, will be completed.

In supporting people to reach a maximum state of independence the model aims to provide the most person centred and efficient experience possible.

As such the model asserts the following standards:

- People will only provide their personal details and circumstances once.
- A named point of contact will co-ordinate and be in place throughout any intervention.

First Draft

• Personal choice, assets and skills will be the starting point of any support.
• Assessment and support plans are not duplicated or completed in isolation.
• A culture of resolution and customer satisfaction is at the centre of all we do.
• Support to Carers will be accessible and tailored to the needs of the carer.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

7 day working is a requirement across the whole system and brings additional workforce challenges. As part of the FutureFit programme of work a full workforce review and plan will be a key part of the process and already there have been clinical engagement in these discussions.

The CCG have included in contracts with providers the requirement to include plans for 7 day services via the requirement for specific Service Development and Improvement Plans. The Health and Wellbeing Board recognises that access to services is a key issue for Shropshire and a priority within the Health & Wellbeing Strategy is improving access to services.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The local authority is currently entering on care records the NHS number where this is known. From April 2014 all new users will be allocated the NHS number on the council Care First system.

The NHS number field will become mandatory in May 2014 once the NHS number matching service has been installed and tested.

The appropriate software applications have been purchased to enable access to the NHS number matching service.

By the end of October 2014 all processes will be in place, tested and live and the NHS number matching service will be used for all open clients. ("Open clients" are defined as those clients being in receipt of a service from adult social care).

Benchmarking with other local authorities is indicating > 80% match and use within 12 months. Subject to resources and the identification of any manual data tidy up required we will aim for this to be achieved in Shropshire by the end of December 2014.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Not yet established but there is a clear commitment to do so by October 2014 as described above

First Draft

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Yes

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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 a care coordinators (each aligned to a practice) was allocated to support these at risk individuals with their ongoing health & care needs.

Also in 2013/14 a Care Home Advanced Scheme has been 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 is 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 key 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 work is being further developed and will be part of the plan for 14/15 outlined below.

In 2014/15 the Local Authority and CCG intend to build upon this foundation through implementation of the Admission Avoidance DES. Practices will work with their MDT to case manage 2% of the population most at risk of admission. Initially the focus will be 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)

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To date MDTs have been identifying individuals at risk of admission through computer searches, PARR data, local intelligence and opportunistically. The CSU is intending to provide a Risk Stratification tool in the coming months which will further support this process.

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 a specialist nurse in COPD, Heart Failure or Diabetes, a community and care coordinator, a social worker, care homes staff, clinical nurse specialist in palliative care, community matron, district nurse or 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 is supporting the CCG and LA in the development of a series of interdependent, self-populating templates which will support and guide the practices in delivering the 2% case management. Local and national guidance will be linked to the templates and an integral care plan will be printed off for patients and their carers. Further development includes moving toward a shared electronic care plan or 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. The Health Economy is developing a one stop shop for assessment in line with the NSF for older people Single Assessment Process. This assessment process will be delivered in locality bases or in the patient's own home. The process will be coordinated and supported by the voluntary sector.

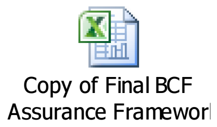
Work is in train with the Commissioning Support Service to develop an IT solution to support this single assessment process.

Work is also in development in relation to a single integrated assessment for children which will be in place by September 2014

First Draft

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers



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