Updated July 2014 – 3rd Draft (H&WB Board – 1)

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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 CCG**
Boundary Differences	**The Council and CCG share the same boundaries. However all of our provider organisations are not co-terminus and work across Shropshire and Telford & Wrekin boundaries**
Date agreed at Health and Well-Being Board:	
Date submitted:	
Minimum required value of BCF pooled budget: 2014/15	**£12,128,000**
2015/16	**£21,451,000**
Total agreed value of pooled budget: 2014/15	**£12,128,000**
2015/16	**£21,750,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Caron Morton
Position	Accountable Officer
Date	16/09/2014

Signed on behalf of the Council	
By	Stephen Chandler
Position	Director of Adult Services
Date	16/09/2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Karen Calder
Date	16/09/2014

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

Document or information title	Synopsis and links
Visuals Pack	BCF Visuals v11 10092014.pdf
Scheme Overview	Scheme Overview v6 10092014.pdf
Programme Overview	Programme Overview v6 100920:
Terms of Reference – Service Transformation Group	Draft ToR Service Transformation Grou

Terms of Reference – Performance, Finance and Contracts Group	Final Draft ToR Finance Contracts ar
Terms of Reference – Health & Wellbeing Delivery Group	Final Draft ToR HWB Delivery Group.doc
Terms of Reference – System Resilience Group	OCRP App 2 - SRG ToR draft.doc
Terms of Reference – Health & Wellbeing Board, Healthwatch & Scrutiny Memorandum of Understanding	2014 Memorandum of Understanding OS(
Terms of Reference – Care Act Programme Board	Terms of Reference Care Bill Programme E
Engagement Summary	Health Economy Engagement Summar

Key to coloured text in draft:

RED – Text still to be inserted or considered

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

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 challenges and this document sets the context of how these challenges manifest themselves locally, our resolve to address them and our vision for achieving sustainable change.

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

We envisage a system where, through working together, we have created a pattern of services that offer excellence in meeting the distinctive and particular needs of the rural and urban populations of Shropshire. We propose to tackle the challenges we face responsibly, creatively and with a passion for what matters most.

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

How we will work towards our Vision

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

It is the aspiration of Shropshire Council and Shropshire CCG to 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, as well as work already undertaken to modernise mental health services provide a suitable backdrop for this work to take shape.

Shropshire is well served by the strategic intent of both its Council and CCG. The Council's Business and Financial Strategy and Adult Social Care Strategy clearly set out the Council's

strategic aspirations for Shropshire. Similarly, the CCG's Strategic and Operational (two and five year) Plans and its Operational Capacity and Resilience Plan detail a comprehensive approach to local challenges in health and care. The Health and Wellbeing Strategy sets out a partnership approach to these challenges highlighting areas of common challenge, priority areas of focus and cross agency commitment to make a difference. This Better Care Fund Plan takes this a step further building on this common set of objectives, applying defined schemes of work, combining resources, committing to achieve challenging targets and allocating financial resource specifically to these tasks.

In practical terms, as a result of stakeholder consultation and engagement (for which detailed documentation is set out later in this document) four strategic themes have been adopted under which our Better Care Fund work will be focused:

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

This document will set out how our Better Care Fund plans will address the challenges we face, deliver our vision and what differences this will make to the residents of Shropshire.

b) What difference will this make to patient and service user outcomes?

Read as a whole this Better Care Fund Plan sets out the context of the health and social care challenges faced by the population of Shropshire, the evidence to demonstrate this, the vision for transforming the health and care landscape and gives details of the evidenced based schemes that will deliver these changes. These schemes are anchored to wider strategic transformation programmes that have been undertaken, (mental health modernisation) are underway (FutureFit, and the ASC New Operating Model) or are just beginning (Primary Care transformation – FutureFit2) each of which is being undertaken with a partnership approach across the county.

Simply put, the difference made through the Better Care Fund (in the context of a system wide transformation programme) is that outcomes for patients/service users will improve.

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

- A far more coordinated and integrated pattern of care, across the NHS, social care and the voluntary sector, with reduced duplication and better placing of the patient/service user at the centre of care
- A pattern of services that by better meeting population needs, more hours of the day and more days of the week through bringing teams together.
- 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
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making
- Empowerment of the patient to make choices in their health and care needs supported by a system that is responsive and supportive of this
- Reducing dependence upon paid support and enabling and maximising individual independence.
- Services that is responsive with quick decision making at the closest possible point to the person.
- Developing resilient communities that are better able to help themselves via the development of local resources, support networks, embedded specialist facilitated by the CCG, Council and Voluntary sector in partnership
- A focus on the use of volunteers and particularly those that have lived experience of using services.
- Better supporting and enabling carers to continue with their vital role whilst establishing and maximising the use of peer support.
- Less people requiring treatment in hospital and for those who do need treatment more of them receiving it whilst continuing to function at home
- An increased focus on prevention leading to a general improvement in population health and a reduction in health inequalities for our population

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded works contribute to this?

The Better Care Fund sits within a unique whole system transformation plan for Shropshire in which there will be fundamental redesign of the health and care landscape over the next five years and beyond. Whilst the Better Care Fund itself will focus on developing services in the community there is an underlying interdependence of all the local transformation schemes (Reconfiguration of hospital services, transformation of community services, transformation of primary care and mental health modernisation) to achieving success. The Health and Wellbeing Board is the vehicle through which the local health and care economy ensures alignment of these transformation schemes across the local footprint as the underperformance of one will directly impact on the success of the others and vice versa.

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

Delivery of Change

The following gives a summary of the anticipated changes in the configuration of services over the next 5 years. Details of the particular schemes cited can be found in Annex 1 of this document.

Prevention

Prevention services will be configured to empower people to make better lifestyle and health choices for their own and their families health and wellbeing, preventing the prevalence of ill health and the need for intervention

The impact of falls and the increasing number of people living with dementia has been identified as a significant challenge within our economy the following schemes will assist in the delivery of the outcomes of this strategic theme:

- The **Integrated Falls Prevention** model will reform existing falls and fracture pathways, increasing the number of falls assessments, increase the number of people receiving falls risk reduction interventions and deliver a reduction against our baseline of falls related admissions
- The **Dementia Strategy** aimed at integrating memory services into GP practices. This will see an increase the numbers of referrals to the memory service, supporting more timely diagnosed and onward referral for treatment and support. This in turn will promote a

continued focus on early intervention ensuring intervention before patients and their carers reach crisis.

- The Prevention Group of the Better Care Fund is keen to incorporate a response to the level of falls due to Urinary Tract Infection as part of a wider piece of work. Also the group is keen to consider AF/Stroke Prevention and Cardiac Rehab as key areas of work.

Early Intervention (Case Management)

This strategic theme will focus on the transformation of Primary Care services to deliver the identification of 'at risk' groups of people and the approach to support those people through a process of joint assessment, allocation of a 'key-worker' joint care planning and active case management

All of our GP practices have, or will have by 2015, direct or indirect support from the following schemes to assist in the delivery of this strategic theme:

- **Proactive Care Programme** requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access. In addition, the practice also provides timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or accident and emergency (A&E) attendances
- **Community and Care Co-ordinators** will be available in all GP practices in Shropshire. Providing a focal point within each community based within primary care this service will build on community resources and networks to support people living independently for longer, ensure individuals receive the correct level of care rather than placing patients in care settings that are of a higher dependency than their needs require and have direct impact on reducing hospital admissions
- **CHAS** – care homes advanced scheme covering all care homes with personalised care plans (individually agreed and developed with the patient and their relatives alongside the GP) to support ongoing care provision within the care home, admission avoidance and improved clinical and social outcomes for the resident
- **Team around the practice project** – through the utilisation of local resources and partners (general practice, local pharmacies, voluntary groups, community groups, community services, mental health, out of hours and social services) a model of "rural primary care at scale" will be produced enabling the integration of all care provision locally and avoiding unnecessary admissions.

Also a range of transformation activity, not delivered through the Better Care Fund will assist in the delivery of the outcomes of this strategic theme:

- **Information flow** – telehealth and IT projects to include shared care records with providers, telehealth solutions and an integrated urgent care dashboard is in use and being developed across the health and social care economy

- Co-location of primary care led **Urgent Care Centre** with current Trauma unit – allowing admission avoidance through access to primary care consultation and expertise working alongside AE colleagues eventually in an integrated team
- Specific admission avoidance schemes based on Commissioning for Value data for SCCG – projects underway to avoid intervention and deterioration (including acute admission) for Osteoarthritis (through Keele University across all practices in our South locality) and Diabetes advanced care (in our North locality).

Supporting People in Crisis

In the event that an individual finds themselves in crisis, rapid, focused intervention with a view to helping a person remain in their own home or return there as quickly as possible. The following schemes will assist in the delivery of this strategic theme:

- **Integrated Community Service** – integrated community and social services team focusing on admission avoidance, early discharge, maintaining care at home and avoiding re-admission through reablement and enablement.

- **Mental Health Crisis Care Services -** To support people who are experiencing mental health crisis's so that they can access support as soon as possible when they are in crisis with the anticipation that it will either prevent admission or lead to early discharge whilst reducing the impact on the crisis on their long term mental health.

Also a range of transformation activity, not delivered through the Better Care Fund will assist in the delivery of the outcomes of this strategic theme:

- **Mental Health Modernisation** – Within mental health services locally significant work has been undertaken around a scheme of mental health modernisation. This work commenced in 2011 to realise improvements to the provision of Community services throughout the county which led, in turn, to a requirement for fewer inpatient beds. The Redwoods Centre, which was the subsidiary building element of service change, was opened in September 2012 under budget and ahead of schedule. A review of this work has been completed and has found that:
    - Community services have been successfully implemented with the crisis resolution and home treatment teams meeting with particular success in reducing reliance on hospital admission.
    - The service is operating within a substantially reduced bed capacity without difficulty.
    - Length of stay has been reduced through more therapeutic staffing levels and the successful delivery of revised community models of care.
    - The project to design, construct and operationally commission The Redwoods Centre was highly successful and has delivered an award winning inpatient facility that is recognised as best in class.

The benefits of this work will continue to be felt by patients/service users accessing these services in years to come. However, importantly the review has also identified areas for further review, improvement and action:

- Higher levels of bed usage in Shropshire linked to differences in community services.
- An increasing trend in use of Psychiatric Intensive Care, which requires focused exploration
- Opportunities for the re-designation of beds at The Redwoods Centre, which would support a pilot for mental health rehabilitation involving a third sector partner.
- A length of stay for inpatient services that is higher than targeted within the Full Business Case with a particular issue for older adults in Shropshire.
- Bed occupancy levels that are higher than the local target and significantly above national expectations.

Work will now be undertaken to explore these issues and development and implement plans. Although the outcomes of this work cannot be quantified explicitly at this time is anticipated that the benefits of this work would be realised within the next 5 years.

- **FutureFit -** Focusing particularly on the reconfiguration of local hospital services. Future Fit is an ambitious programme already underway. Whilst the outcome of this work is yet to be determined and the detailed and sensitive work needed to bring this work to a conclusion is still some way away it is anticipated that the benefits and opportunities, some of which will be realised in the next 5 years, will be along the lines outlined below: They see the opportunity for:

  - 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
  - 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

Supporting People to Live Independently for Longer

- Local carer support charities have joined forces to deliver an **Integrated Carer Support** service to support vulnerable carers with respite care. This will increase service capacity by delivering support to an additional 200 local carers
- The delivery of a prototype scheme around **End of Life Co-ordination** will have been completed. If this is successful in the way that is anticipated support will be available within GP practices for patients identified as being in their last year of life, there will be an increase in the numbers dying at home rather than in hospital and an associated reduction in hospital episodes
- Investing in and developing **Resilient Communities** – including the roll-out of the established Compassionate Communities project across the county already operating in key localities with the aim is to develop a sustainable community based approach that supports families and people to have the best chances in life, to live independently, and to have active, prosperous and healthy lives.

Also a range of transformation activity, not delivered through the Better Care Fund will assist in the delivery of the outcomes of this strategic theme:

- **Adult Social Care Operating Model -** To respond to the challenges of increasing demand and significant reductions to public spend, and to continue to deliver high quality support to those in need, it is recognised that the approach to the provision of Adult Social Care (ASC) in Shropshire needs to change.

  The specific purpose of Social Care is to enable people to live independently and well for as long as possible, by maximising people's individual resilience and ability to meet their own needs, and to continue to support and develop contributions that communities can make to support the people living within them.

  Following a fundamental review of Adult Social Care, a system wide transformation plan has been created; designed to reduce costs, improve outcomes and create a sustainable, locality based solution to support Shropshire's most vulnerable residents.

  The new operating model creates a pathway that essentially allows the service user/family carer to receive information and advice upfront so that they can make informed decisions without having to go through the entire customer pathway to achieve the same goals. This means that resources can be applied to those that require more in-depth support, more effectively. It is built on the following principles:

- Reducing dependence upon paid support and enabling and maximising individual independence.
- The service will be responsive with quick decision making at the closest possible point to the person.
- Maximising 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.
- 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.
- Members of staff will play a key role alongside individuals who use the service in making decisions about how the service is delivered.
- The service will work from a presumption of a mobile and flexible operating approach within local areas.
- Increasing the focus on professional standards and profile of social work to enable improved outcomes for individuals and give a sense of pride and ownership for the staff group.

Collectively implementation of the schemes and plans outlined above will, we believe, directly deliver our vision for the Better Care Fund in Shropshire as set out in section 2. It will also enable us to deliver the Better Care Fund Metrics. We therefore anticipate that in the next 5 years:

- Avoidable emergency admissions to hospital will be reduced by a minimum of 3.5%
- Delayed transfers of care will be reduced
- Permanent admissions of older people to residential and nursing homes will be reduced
- The proportion of older people still at home 91 days after discharge from hospital into reablement/ rehabilitation services will have increased.

3) CASE FOR CHANGE

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

The Strategic Context in Shropshire

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

- Community health services.
- GP out of hour's services.
- Ambulance services.
- Mental health services.
- Specialist health services for people with learning disabilities.
- Acute hospital services.

Shropshire has a population of approximately 306,000. Shropshire is a large rural county. The county town of Shrewsbury is central to the county with a number of market towns geographically spread across the area. Shropshire Clinical Commissioning Group has co-terminus boundaries with Shropshire Council and the two agencies work closely together.

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

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

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

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

The Health and Wellbeing strategy describes a vision for Shropshire of "*Ensuring everyone living in Shropshire is able to flourish and enjoy a sense of wellbeing; reach their potential; and be part of a supportive community.*" and is guided by the following principles:

- Keeping people well rather than simply treating them when they are ill.
- Recognising the impact of the wider determinants of ill health.
- Greater trust and responsibility to skilled professionals at the frontline to better support the people they serve.
- Basing decisions about interventions on robust evidence.
- Supporting innovation in order to increase our understanding of what works.
- Choice and control for patients and service users.

- Managing our resources wisely.
- Maintaining quality.

The Strategy sets out how resources will be targeted to areas of greatest need and outlines how they will be delivered in partnership by a whole range of organisations across the private, public and voluntary and community sectors, with the Better Care Fund acting as an enabler and driver for the majority part of this strategy.

Provider Landscape

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

- **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 819.

- **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, 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 113 beds.

- There are **44 GP practices** in Shropshire and Local practices have recently formed a GP Federation. The single Walk in Centre is currently located in the outskirts of Shrewsbury, with consultation underway to bring this onto the Royal Shrewsbury Hospital site.

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

Powys. Shropdoc also provides home visits and the flagging of high risk end of life and COPD patients.

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

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

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

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

- **The Voluntary and Community Sector Assembly (VCSA)** works to facilitate partnership between the VCSE sector and public sector. Representation work ensures that the VCS is represented on the groups led by the CCG, Shropshire Council and other partners listed within this table. 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.

The Case For Change

National Picture

- **Policy Change.** The NHS belongs to the People - A call to Action (NHS England 2013) set out a number of future challenges for the NHS: Ageing society, Long Term Conditions and rising expectations. Similarly key local government documents such as A Vision for Adult Social Care: Capable Communities and Active Citizen, (Department of Health, 16 November 2010), Making a Strategic Shift to Prevention and Early Intervention 2008 (Putting People First) and Think Local, Act Personal, January 2011 note a similar context. Shropshire is not exceptional in these trends and challenges and the JSNA supports this.

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

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

- **Reducing budgets.** Both Shropshire CCG and Shropshire Council face unprecedented financial pressures which are exacerbated by the increasing costs associated with an ageing population and the impact of increasing demand for complex, high cost care.

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

Local Picture

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

- **Changes in our population profile** - The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. The general population is anticipated to grow by at least 15,000 over the next 10 years according to ONS data. However, further to this the Shropshire Core Strategy Policy (CS10) suggests that 21,799 new homes will be built by 2016. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

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

public sees as a high priority. There is a network of provision across Community Hospitals that is part of the redesign of services to increase local care.

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

- **Two Site working** - In Shropshire the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service. Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites, although stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

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

- **Workforce** - Shropshire is not exceptional in relation to the health and care related workforce challenges it faces including issues of recruitment and retention in relation to health and care posts, particularly specialist posts, an aging workforce and Shropshire's rural profile and the issues of access and travel distances this brings are also a consideration. A core workforce issue for local health is the need to address a shift from an acute centred workforce to a more community centred workforce with Shropshire Council similarly moving towards its practitioners working in a flexible and mobile way with reduced reliance upon office-based working. Shropshire Council is also increasing the focus on professional standards and profile of social work to enable improved outcomes for individuals and give a sense of pride and ownership for the staff group

- **Technology** - The case that technology is changing the way that we live our lives is irrefutable. The need to promote this technology to support the health and social care sector in the future has been made, but to date there is less impact than would have been expected in the way people are cared for. The need to improve the understanding of what technology can do and its limitations is something that needs collaborative working across commissioners and providers. It may also need significant changes in systems and working patterns for some areas.

Factors in Shropshire's population that impact on health

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

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

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

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

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

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

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

The following table highlights the top 10 emergency admissions diagnoses in Shropshire (2013/14). Many of these admissions are more prevalent in frail elderly people and many are preventable. They also reflect many of the health issues highlighted in the JSNA as priorities. For example urinary tract infection is often a precursor for falls and fractured neck of femur is often a consequence of falls. Collectively they contribute to a high number of admissions and also cost almost £4 million, this is excluding the costs of care once discharged. Similarly older people with

chronic conditions are more susceptible to pneumonia and respiratory illness than those without chronic conditions. Lifestyle risk factors also have an impact on susceptibility to respiratory illness. Alcoholism, smoking, diabetes, heart failure and COPD all increase the susceptibility of pneumonia.

Diagnosis	Emergency Admissions	Cost
Urinary tract infection, site not specified	890	£2,273,893
Chest pain, unspecified	663	£435,069
Unspecified acute lower respiratory infection	556	£1,063,606
Lobar pneumonia, unspecified	513	£1,470,430
Pain localized to other parts of lower abdomen	429	£391,898
Other and unspecified abdominal pain	395	£361,665
Atrial fibrillation and flutter	377	£412,943
Syncope and collapse	376	£366,223
Pneumonia, unspecified	318	£796,434
Fracture of neck of femur	317	£1,695,876

Source: Hospital Episode Statistics, Shropshire and Staffordshire Commissioning Support Unit, 2013-14

Modelling work for the Future Fit programme has highlighted that if there is no change in the health status of the population and demographics there will be an increase in admissions to hospital by 2018/19. Although this increase will largely be due to elective admissions, however many of these could also be prevented by improvements in lifestyles and management of long term conditions.

Some of the precise issues that the Better Care Fund will be used to address is detailed in the descriptions of each scheme which can be found in Annex 1 of this document, in summary:

- **Integrated Falls Prevention**

This programme focuses on optimising three main areas. Firstly through primary prevention by screening for falls and bone health and developing pathways to primary prevention intervention. Secondly through falls and bone health screening and access to secondary prevention through fracture pathway development within fracture services. Finally through the development of a robust measurement framework to assess impact of falls prevention activities across the whole health economy. There is much evidence to suggest that falls are costly to both health and social care services, with the cost of fragility fractures to the NHS estimated to be around £2 billion a year. There is also evidence around physical activity, bone density scanning and osteoporosis that are cost-effective interventions in reducing falls. Although fragility fractures as a result of falls can be costly they are not inevitable. Around half of people with a hip fracture will have had previous fragility fractures which provide an opportunity for prevention.

- **Proactive Care Programme**

This enhanced service is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs who are at risk of hospital admission or re-admission. This enhanced service will be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions. The CCG is committed to the principle of care planning and is exploring application of the Care Programme Approach beyond the 2% requirement

- **Community and Care Co-ordinators**

This scheme has a particular focus on individuals that are frail and vulnerable, at risk of hospital admission or coming to the end of their life. The role of the co-ordinator is to work in the practice to identify vulnerable people and sign post them to resources that are available to them in the community. Initial findings from this scheme show that there has been a reduction in GP appointments and also a reduction across several factors including A&E attendance and hospital admission in individual patients in the three months after involvement with the scheme.

- **Care Home Advanced Scheme**

Shropshire has one of the highest numbers of care home beds per head of population in the region; this is growing rapidly. Emergency admissions to hospital are dominated by frail and complex patients and residents of care homes form a disproportionate number of these. Once admitted, they have poorer outcomes than the general population. During the six month period from 1st Feb- 31st July 2013, there were 486 admissions from Care Homes, at a cost of £1.4 million. Based on these figures, the admission rate from care homes is >1:4 residents per year. The project reduces unnecessary hospital admissions, A&E attendances and realise improvements in quality of care and outcomes. This is achieved by adopting pro-active care through active case management, care planning and multidisciplinary review for patients in care homes by identifying nursing home residents that are most at risk of being admitted to hospital. Care plans to support the patients are developed using a multi-disciplinary team approach. Evidence from similar schemes to suggest that such an approach can have an impact on reducing admissions to hospital.

- **Team Around the Practice**

A clear vision is emerging within the local health economy that to provide the best possible co-ordinated care for our population the patient and their GP practice should be at the centre of the support services they might need. The team describes several layers of care from in-house care provided by the practice nurse, through the district nurses to the support of specialist nursing services, consultant advice, voluntary sector input, allied health professionals and Local Authority input to optimise the care given and to avoid unplanned hospital admissions

- **Integrated Community Services**

This scheme supports discharge from hospital back home or into appropriate community settings or to prevent an avoidable hospital admission by ensuring that people get the right level of support in order to maintain independence. A team of professionals from different disciplines will work together to support the patients and ensure that they gain a seamless service. Local evidence highlights that there has been difficulties reducing delayed transfers of care from hospital due to the complexity of discharges. An additional MCAP audit highlighted that there were in patients in both acute and community hospitals that are in non-elective beds that could be supported in a community setting. The ICS should address some of these issues. This audit also found that the top reason for people that could have been treated at a lower level remained in hospital was due to them awaiting multi-disciplinary assessment. The next most likely cause was due to there being no bed available in alternative care.

- **Mental Health Crisis Care Service**

This project to develop a “Home Resolution Service” aims to support people who are experiencing mental health crises so that they can access support as soon as possible when they find themselves in crisis with the anticipation that it will either prevent admission or lead to early discharge whilst reducing the impact on the crisis on their long term mental health. In January 2014 the Department of Health launched “Closing the Gap: Priorities for essential change in mental health.” The central theme of this document reinforces the Principles of ensuring *Parity of*

Esteem between Mental Health and other types of health provision. As well as ensuring there is: Access to support before crisis point, Urgent and emergency access to crisis care, The right quality of treatment and care when in crisis, Recovery and staying well, and preventing future crises. When in place this service will offer a more flexible response to those in crisis, further alternatives to hospital care, better coordination of services, opportunities to receive extended support whilst in crisis.

- **Resilient Communities**

This scheme aims to maximise community assets and supports the development of resilient communities. It aims to ensure that people remain independent in their own homes as long as possible, ensuring that people get the right support early on to prevent future need and to strengthen local networks and relationships to prevent isolation. The delivery of care to patients as close as possible to their communities and home environment is integral to their speed of recovery and ability to return to their previous level of functioning. The approach focuses on a holistic approach to support via partnership, multiagency intervention wrapped around a community using established local resources and community networks.

- **Dementia Strategy**

This scheme aims to increase diagnosis of dementia, support and increase self-management of dementia, raise awareness of dementia in communities and to work towards preventing dementia by preventing the lifestyle risk factors associated with it. Evidence is increasingly suggesting that poor lifestyle choices can lead to not only vascular dementia, but also Alzheimer's Disease. Physical activity has been shown to protect against developing Alzheimer's disease and obesity in middle age increases the risk of Alzheimer's Disease. There is also some evidence to suggest that early diagnosis and effective management of dementia can have an impact on the intensity and need for support services. With research from the Geriatric Research Education and Clinic Centre at the Minneapolis Veterans Medical Centre suggesting outpatient costs can be reduced by almost 30% if dementia is diagnosed early and followed up by appropriate information and support.

- **Integrated Carer Support**

This project has been designed to reduce the risk of carer breakdown, in order to prevent the person being cared for being admitted to hospital. Evidence from the census shows that there are many carers in Shropshire experiencing poor health and there are also many providing more than 50 hours a week of care. Recent work around residential care has also highlighted that it is often due to carers needs not being met that the people being cared for end up in residential care. The project aims to integrate the work of several voluntary agencies to support carers identified as vulnerable.

- **End of life co-ordinator**

This prototype scheme will deliver a support service to patients approaching the end of their life, (from all causes) led by a Clinical Nurse Specialist in end of life care. This will enable people to die in a place of their choosing, which for many people will be in their own home. The 2012 VOICES national survey found that the overall quality of care across all services in the last three months of life was rated by only 44% of respondents as outstanding or excellent. For those who expressed a preference, the majority preferred to die at home (81%), although only half of these actually died at home (49%). The most commonly reported place of death was a hospital (52%).

<u>Summary</u>

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

4) PLAN OF ACTION

a) Map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The Better Care Fund (BCF) is an enabler to the delivery of the CCG 5yr Strategic & 2 Yr. Operational Plans, the Local Authority Business and Finance Strategy and the Health & Wellbeing Strategy. Our BCF Plan is built upon existing integrated programmes of work and enhanced by newly developed schemes that will help to deliver our long-term vision for health and social care in Shropshire.

The Better Care Fund programme that will deliver the transformation of integrated care and support is organised into four 'Strategic Themes'. Each of the 'Strategic Themes' has a number of 'Transformation Schemes' which should contribute to the delivery of the 'Theme Objective'. The 11 Transformation Schemes are:

Strategic Theme - Prevention

- Integrated Falls Prevention
- Dementia Strategy

Strategic Theme - Early Intervention (Case Management)

- Proactive Care Programme
- Community & Care Coordinators
- Care Home Advance Scheme
- Team Around the Practice

Strategic Theme - Supporting People in Crisis

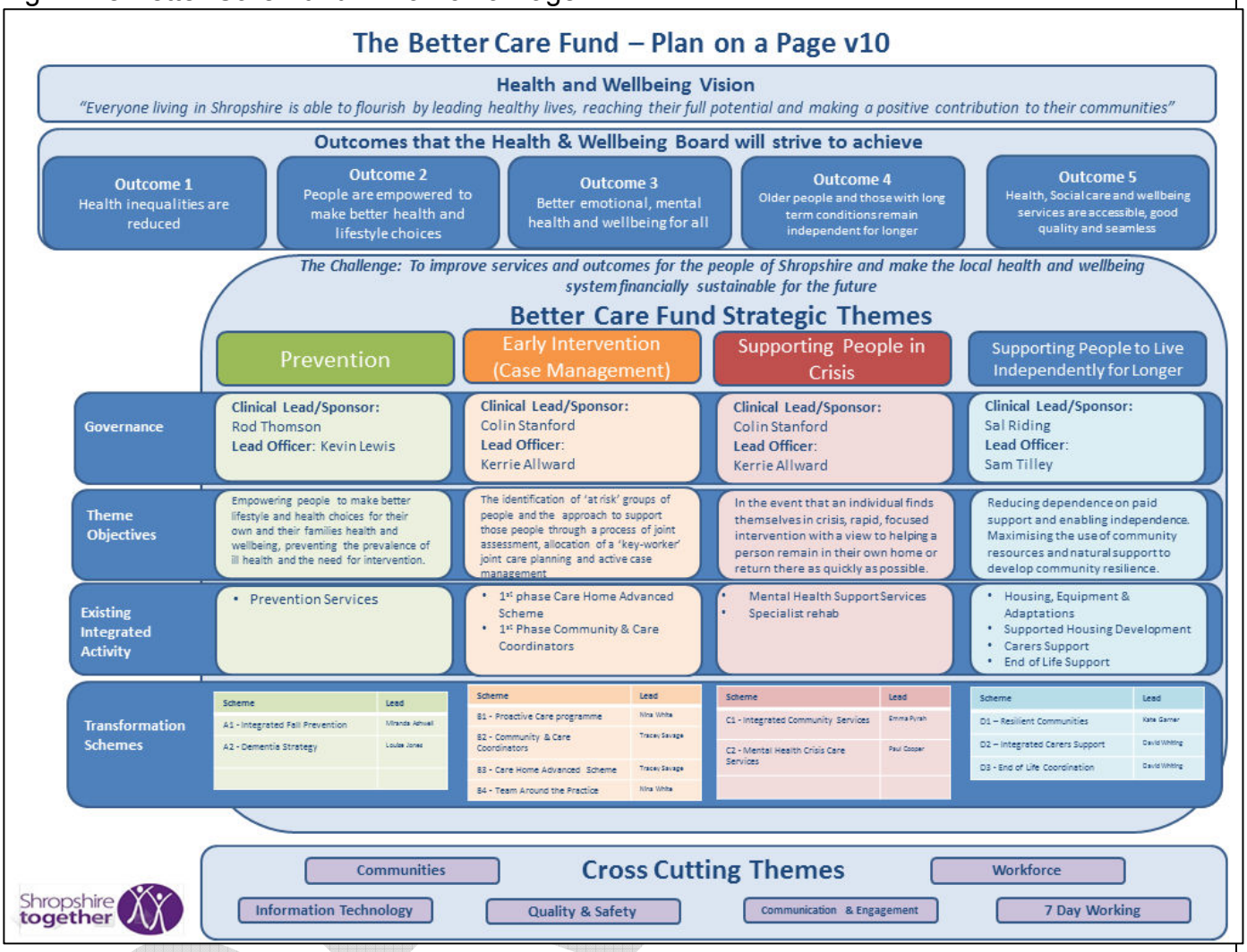
- Integrated Community Services
- Mental Health Crisis Care

Strategic Theme - Supporting People to Live Independently for Longer

- Resilient Communities
- Integrated Carers Support
- End of Life Coordination

Each of the strategic themes has an allocated 'Clinical Lead/Sponsor' and a 'Lead Officer'. It is their responsibility to ensure that the 'Transformation Schemes' aligned to their 'Strategic Theme' will deliver the overall 'Theme Objective'. This is detailed in the illustration below of the Better Care Fund Plan on a Page and is attached as an appendix to this document. Fig 1

Fig.1 The Better Care Fund – Plan on a Page



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

- **Prevention** - Empowering people to make better lifestyle and health choices for their own and their families health and wellbeing, preventing the prevalence of ill health and the need for intervention

- **Early Intervention (Case Management)** - The identification of 'at risk' groups of people and the approach to support those people through a process of joint assessment, allocation of a 'key-worker' joint care planning and active case management

- **Supporting People in Crisis -** In the event that an individual finds themselves in crisis, rapid, focused intervention with a view to helping a person remain in their own home or return there as quickly as possible.

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

The Transformation Schemes are at varying levels of development, with some already delivering good outcomes and others that are still at the early stages of development. The Scheme Descriptors in Annexe 1 of this document and the Programme Overview, which is attached as an appendix, details the stages of development and when schemes are expected to deliver outcomes. A summary of the key milestones in the first year are listed below:

September – December 2014

Dementia Strategy
- Memory Clinics introduced into some GP Practices
- Referrals for Home Treatment to be introduced

Proactive Care Programme
- Telephone access/by-pass numbers in place
- Personalised Care Plans in place for all patients added to the register

Integrated Community Services
- Prototype expanded to include hospital discharge service in North and South Shropshire
- Prototype expanded to include admission avoidance service in Central Shropshire

Integrated Carers Support
- Carer Strain Index assessments introduced
- Enhanced Carers Support available

End of Life Coordination
- Clinical Nurse Specialist for End of Life Care appointed
- Pathways and processes developed

January – March 2015

Integrated Falls Prevention
- Falls Action Plan implemented into Care Homes

Dementia Strategy
- Expand Memory Clinics to other GP Practices
- Patient education and peer support programmes developed and introduced

End of Life Coordination
- Prototype started and working with GP practices to identify patients

April – June 2015

Integrated Falls Prevention
- New pathways introduced to prevent falls

Dementia Strategy

- Public awareness campaign launched
- Training programme for care home workforce introduced
- Dementia Friendly Shropshire Action Plan implemented

Proactive Care Programme

- Programme evaluated and expanded

Team Around the Practice

- Virtual Team prototype started in some practices

Integrated Community Service

- Prototype expanded to include admission avoidance service in North and South Shropshire

Resilient Communities

- Build Community Capacity, Family Approach to Early Help and Health & Social Care Working Together in Communities prototypes started

July – September 2015

Integrated Falls Prevention

- Expanding scope of prototype to include 'Postural Stability Exercise'

Mental Health Crisis Care

- New service commissioned to support people in their own homes following a Mental health Crisis

Resilient Communities

- Build Community Capacity, Family Approach to Early Help and Health & Social Care Working Together in Communities prototypes expanded

The individual scheme delivery is also supported by programme milestones that ensure that programmes are continuously reviewed and new transformation activity is identified to replace schemes that are reaching closure.

Phase 1 April '14 - September '14

Phase 1 of the Better Care Fund (BCF) Plan will establish those work streams that are already in train and where joint arrangements are in place or are being developed that can be supported/accelerated to achieve impact in Year 1 (Q4 14/15 – Q3 15/16). Work streams have been developed in line with Shropshire Joint Strategic Needs Assessment (JSNA), alongside local evidence of where our current systems do not work well and have been prioritised through CCG/Local Authority commissioning plans.

The BCF will coordinate those work streams into a single programme of activity, working towards an agreed set of outcomes, under a single governance structure. Work streams will be reviewed and may need to be adapted to reflect the requirements of the BCF National Conditions and the BCF Metrics. Work streams will be developed into BCF Transformation Schemes.

The Schemes developed will offer the opportunity to address immediate pressures on services but will also become the foundation of a more integrated system of health and social care in Shropshire.

Phase 2 October '14 – March '15

Phase 2 of the BCF Plan will focus on reviewing the Transformation Schemes and the expected impact on the BCF National Conditions and BCF Metrics – the Schemes and expected impact will be triangulated with evidence of local need to identify any areas for where outcomes can be improved.

Phase 3 Schemes will be generated in consultation with Stakeholders, including Patient/Service User groups and shortlisted for progression to 'Scoping' stage.

Monitor interdependencies with System Resilience Planning (SRP) over the winter period to ensure that the impact and outcomes of any aligned Schemes is not obscured or augmented by SRP activity.

Phase 3 April '15 – September '15

Phase 3 of the BCF Plan will manage the implementation and benefits tracking of the Transformation Schemes. Schemes will be at varying stages of development and implementation. The programme will be managed by the Better Care Fund Manager and overseen by the Health & Wellbeing Delivery Group, Finance, Contracts & Performance and Service Transformation sub-groups.

Phase 4 October '15 – March '16

Phase 4 of the BCF Plan will review the Transformation Schemes and the impact on the BCF National Conditions and BCF Metrics – the learning from the Schemes and the impact on the BCF National Conditions and Metrics will be triangulated with evidence of local need to identify areas for where outcomes can be improved.

2016/17 Schemes will be generated in consultation with Stakeholders, including Patient/Service User groups and shortlisted for progression to 'Scoping' stage.

b) Articulate the overarching governance arrangements for integrated care locally

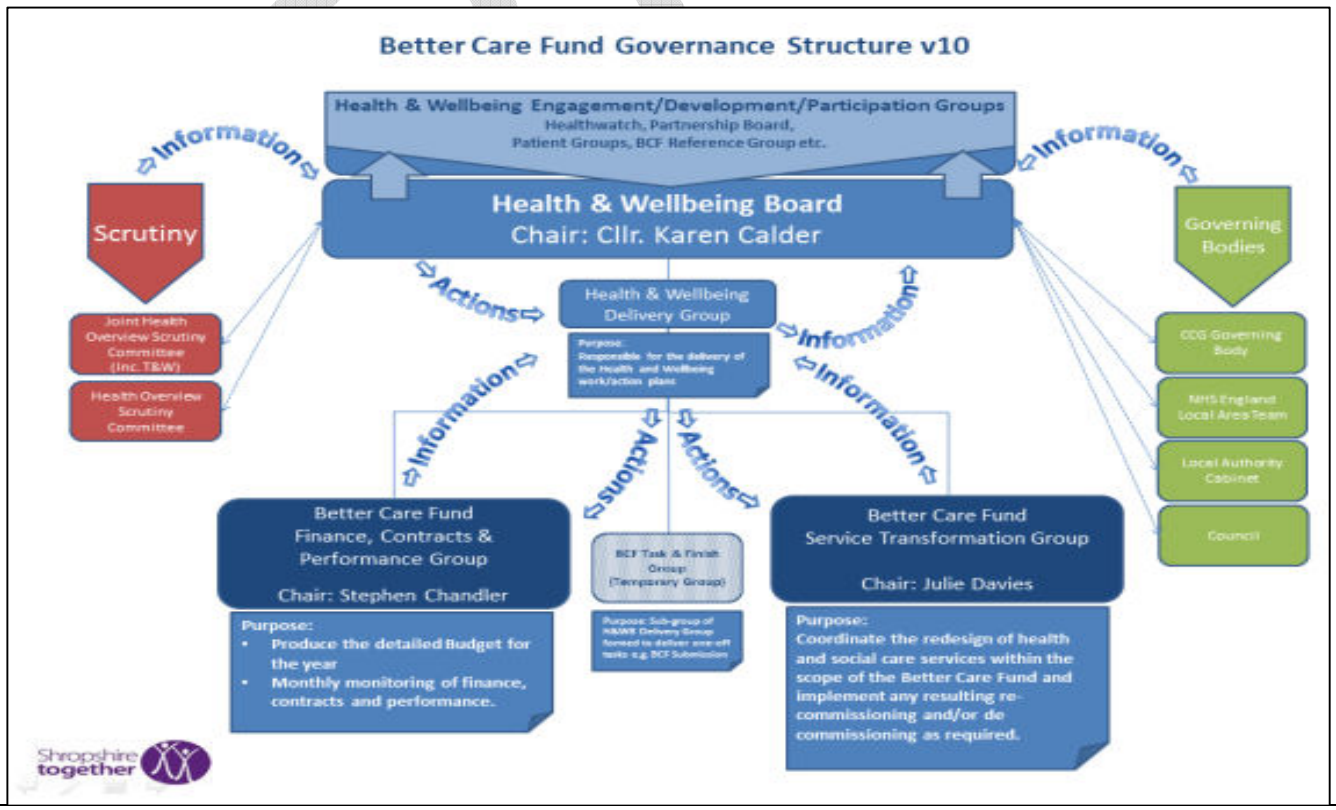
CCG, Local Authority and providers have a very good working relationship – based on past work an open dialogue and trust. We believe that this is the most important ingredient to good governance.

Overall Strategic Governance will be provided by the Shropshire Health and Wellbeing Board. Workshops have taken place with members of the Health and Wellbeing Board to agree governance principles. The Health and Wellbeing Board, Healthwatch and the Overview and Scrutiny Committees have signed a memorandum of understanding to ensure good lines of communication and a collective understanding of each other's roles.

Implementation of the plan, financial and performance monitoring will be the responsibility of the Health and Wellbeing Delivery Group. The Health & Wellbeing Delivery Group is made up of the relevant Directors and Senior Representatives of Shropshire Council and Shropshire CCG and whose purpose is to drive the development and delivery of the Health and Wellbeing work/action plans including the Better Care Fund Plan. The Terms of Reference for this group can be found as an appendix to this document.

The programme management and coordination of the Better Care Fund will be performed by the Better Care Fund Manager, who is a joint appointment across Shropshire Council and Shropshire CCG.

It is the responsibility of the Health & Wellbeing Delivery Group to ensure that strategic objectives across Health & the Local Authority are aligned. Strategic issues are resolved through this forum. An illustration of the governance arrangements is detailed below and can also be found as an appendix to this document. (Fig 2). Fig. 2 Better Care Fund Governance Structure

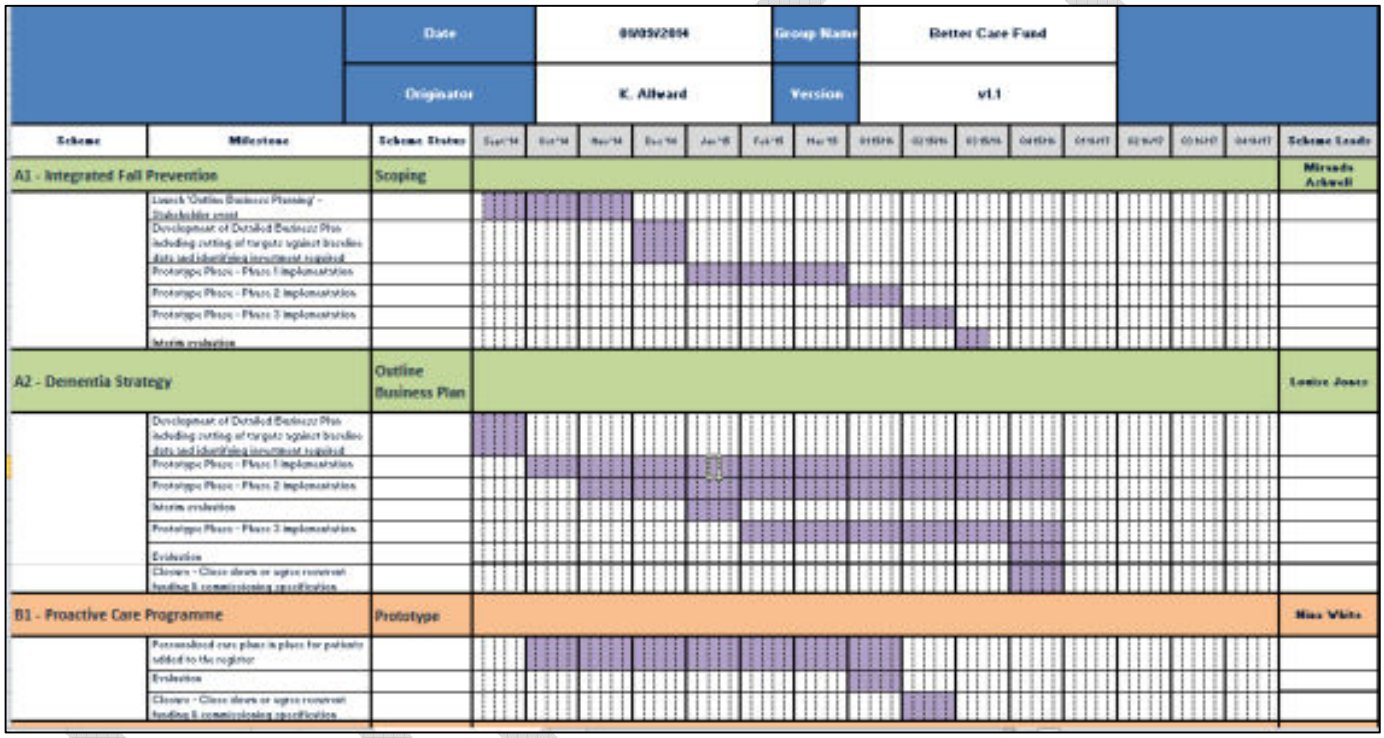


c) Provide details of the management and oversight of the delivery of the Better care Fund plan; including management of any remedial actions should plans go off track

Operational delivery of the BCF is managed through two sub-groups of the Health & Wellbeing Delivery Group; the 'Finance, Contracts and Performance Group' and the 'Service Transformation Group'. The groups are chaired by the Director of Adult Services, Shropshire Council and the Director of Strategy & Service Redesign, Shropshire CCG respectively. The terms of reference for these groups can be found as an appendix to this document.

Progress of the Transformation Schemes is monitored by the Service Transformation Group using the 'Programme Overview'. See extract below Fig 3, this is also attached as an appendix to this document.

Fig 3 Better Care Fund Programme Overview



Operation issues will be escalated by Scheme Leads to the Lead Officer of the Strategic Theme to which the scheme is aligned. The Lead Officer will seek to resolve but will escalate issues to the Health & wellbeing Delivery Group if a resolution cannot be reached.

Risks and poor performance will be raised at the Health & Wellbeing Delivery Group and to the Health & Wellbeing Board, where appropriate.
Scrutiny, Healthwatch and Patient Group Representatives – We will use existing mechanisms to monitor our progress and champion the views of local residents, patients and service users to ensure that there is appropriate accountability for this programme.

The BCF Reference Group was developed to secure alignment with Stakeholder Organisational Plans and to create consistency in the way that we consult and engage with cross-economy stakeholders regarding the BCF Plan.

The BCF Reference Group comprises of senior representatives from:

- Acute Trust – Shrewsbury & Telford Hospital NHS Trust (SaTH)
- Community Health Trust – Shropshire Community Health Trust (SCHT)
- Mental Health Trust – South Staffs and Shropshire Foundation Trust (SSSFT)
- Orthopaedic Hospital – Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)
- Primary Care – GP Federation
- Adult Social Care – Shropshire Council, Adult Services (ASC)
- Housing – Shropshire Council, Housing Support
- Independent Sector Consortium – Shropshire Partners in Care (SPIC)
- Voluntary Sector – Shropshire Voluntary & Community Sector Assembly (VCSA)
- Health Watch
- Patient Representation – Shropshire Patients Group

The BCF Reference Group is currently meeting weekly, whilst the plan is in the development stage but will move to monthly once this is complete.

d) List of planned BCF schemes

List below the individual projects or changes which you are planning as part of the Better Care Fund. Complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
A1	Integrated Fall Prevention
A2	Dementia Strategy
B1	Proactive Care Programme
B2	Community & Care Coordinators
B3	Care Home Advanced Scheme
B4	Team Around the Practice
C1	Integrated Community Services
C2	Mental Health Crisis Care Services
D1	Resilient Communities
D2	Integrated Carers Support
D3	End of Life Coordination

Whilst this plan focuses primarily on the four Strategic Themes and the eleven Transformation Schemes, there are other important cross-cutting themes which need to be integrated into the process. Although scheme descriptors have not been produced for these areas as they serve as 'enablers' for the Transformation Schemes rather than schemes in their own right, each 'Cross-Cutting Theme' has a programme of work that supports the implementation of the Better care Fund.

Cross-cutting themes are represented at the Service Transformation Group by the strategic lead for each area.

The cross-cutting themes are:

E1	Workforce
E2	Information Technology
E3	7 Day Working
E4	Quality and Safety
E5	Communication and Engagement
E6	Communities

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Impact on local system in particular DTOC of neighbouring Welsh Health Board policy	4	3	12	Limited as this point to individual relationships with Welsh commissioners and escalation via accountable officers if required AO attends regular board meetings with Montgomeryshire/Powys Health Board.
Shared providers with Telford & Wrekin CCG and differences in commissioning policy could cause operational issues for providers	4	3	12	Joint collaborative commissioner meetings in place and planned joint meetings with providers as their individual impact of BCF is more clearly defined. Joint commissioning plans and risk mitigation have been built into contractual mechanisms between Shropshire and Telford & Wrekin CCGs – in particular around non-elective activity as part of the CCG 2 year operational plans and QIPP.

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

workforce required to deliver them				Workforce constraints will be considered as part of all BCF scheme design, prototyping to ensure that we can train, develop and hire appropriate clinicians and practitioners to deliver the schemes. Vice chair of H&WB Board is also the quality lead across CCG also has direct involvement with workforce planning and contingency plans at acute trust
Plan doesn't address health inequalities across all client groups	3	3	9	Equality Impact Assessment to be completed on each service change Equality & diversity key value in all organisations
Developing different plans across Shropshire & Telford & Wrekin	3	3	9	Collaborative Commissioning Forum, Executive Discussion Group are forums where such plans can be discussed System Resilience Group is a cross-border, cross economy group and will have oversight of much of the plan developments. TOR for SRG attached for reference.
Implications of the Care Bill has several risks linked to BCF:- metric associated with admission rates to care homes will be impacted by the change in the eligible population, financial pressures of the care bill may impact on the council's ability to contribute to further integration	5	3	15	Risk to this indicator and metric that admissions will increase not because of new admissions but because the financial threshold in the Care Bill will increase and make more people eligible for funded care

Unintended consequences of service change that affects quality	3	3	9	Complete a full quality impact assessment on every proposed service change The HWBB and the BCF reference group will have the responsibility to assure that no decisions on service changes will negatively affect current provision and quality of care or negatively impact on any partner organisation.
BCF deliverables may not provide sufficient support to the costs of introducing the Care Bill.	4	4	16	Mitigations to be confirmed following receipt of further guidance in order to address the following risks • Increased financial pressure for LA as more people are eligible for LA funded support • Additional social work assessments required and the cost of providing these • Increased number of deferred payments with potential impact on cash flow • Costs associated with providing additional information and advice • Increase in number of people in residential and nursing care homes as existing residents who fund their own care become eligible for LA funded care due to change in capital threshold. This will impact on the performance metric • The requirement to provide support and direct payments for carers and the financial impact of this • The financial impact and resources required in changing IT systems in order to manage an individual's care account • Resources and costs of staff training

Service transformation does not deliver efficiencies to support Health & Social Care delivery plans (Risk to delivery of QIPP	4	4	16	Monthly Supporting Delivery meetings of the CCG review the progress of QIPP. The delivery of QIPP is directly related to the availability of the full BCF fund in 15/16. Draft QIPP Plan fully identified and signed off by CCG Governing Body for 14/15 and a high level plan for 15/16. Provider engagement at an operational and strategic level on QIPP ambitions. Majority of QIPP signed off in provider contracts Our robust BCF programme setup will allow us to adjust and revise schemes, timelines, resources accordingly based on evaluation and delivery of benefits.
Voluntary and Community Sector ability to provide increased expectation (through a number of schemes), particularly given recent disinvestment in the voluntary and community sector	4	3	12	Make expectations of VCSE providers clear through the commissioning and contracting processes Ensure the VCSE are included in scheme development

b) Contingency plan and risk sharing

Outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

There are a number of specific financial risks associated with the BCF, in summary, these are:

Risk	Who does it impact?	Potential value of Risk	Probability of Risk	Risk Management actions
That the schemes do not succeed in reducing non-elective admissions	CCG, Providers	£2m-£3m	50%	Schemes are already implemented before the start of the year to which the savings relate. Schemes are regularly monitored and externally evaluated to ensure they are performing appropriately. Further schemes are identified in strategies for rolling implementation to support the existing schemes.
That the schemes do not succeed in reducing admissions to residential care	LA	£2m-£3m	50%	Schemes are already implemented before the start of the year to which the savings relate. Schemes are regularly monitored and externally evaluated to ensure they are performing appropriately. Further schemes are identified in strategies for rolling implementation to support the existing schemes.
That the schemes do not reduce delayed transfers of care	CCG, Providers	C£1m	25%	See risk register re working with Powys. System Resilience group will be monitoring impact of DTOC and potential additional actions to resolve.
That schemes are successful and the contingency is not required and remains unspent at the year end	CCG and LA	£2.8m	10%	Rolling programme of scheme development and implementation will provide for any available contingency.
That there is slippage in implementation of new schemes leading to unspent budget at the year end.	CCG and LA	£3m	10%	Slippage on new schemes likely to be held back as a contingency against potential cost pressures. Once cost pressures are managed the rolling programme of scheme development and implementation will be reviewed for opportunities.
That there are cost pressures or overspends on individual schemes within	CCG and LA	£0.5m	10%	Rolling review of existing schemes and contracts should identify opportunities for efficiencies to offset against cost pressures. In year slippage on new developments will also be held back to

the pool not accounted for at budget setting				offset against cost pressures. Financial agreement will include risk share for overspends/ over performances not managed within the fund.

Dealing with risks once they have occurred

The contingencies identified within the Better Care Fund for 2015-16 are:

- **Pay for Performance contingency** £2.8m – In order to manage the risk around the reduction in emergency admissions not taking place the pay for performance element of the fund will not be committed. This will allow for the funding to be available to pay for the excess admissions if required.
- There are a number of schemes currently commissioned separately by the LA and CCG that have been identified as part of the fund from 2014-15 with the potential to be reviewed for **integration efficiencies.**
- There are a number of contracts/schemes due for **review and renewal** during 2014-15 and 2015-16. Where schemes are not deemed to be achieving the required outcomes or are not identified as contributing towards the BCF objectives the schemes may not be renewed.
- For 2015-16 the **additional funding being invested** in the fund has been committed to achievement of specific strategic goals but is not currently committed against individual schemes and there is likely to be a phased implementation period for this funding which will allow for in year slippage to occur.

The BCF Finance Contracts and Performance Group will be the forum for where the performance of the fund will be monitored in detail. Any significant changes in performance that potentially increase risk to a stakeholder will be highlighted to the group; actions will be agreed to address and monitored to address the immediate impact and move the ensure performance moves to target levels. This will include:

- Identify the risk and impact
- Develop a plan to address the immediate affect and address the underlying cause
- Agree the plan of action
- Put plan in place

This group will make recommendations to the Health and Wellbeing Board on how the contingencies should be applied and where risk sharing agreements may need to be actioned. The group has membership from both the CCG and LA and this will allow the implications of the financial risks for the accountable bodies to be considered and understood.

The following risk sharing principles will be applied to the pool:

- All stakeholders have a collective responsibility for the delivery of the BCF Programme outcomes and efficient use of the monies identified within the Programme.

- That financial risks should be managed within the pool in the first instance using the contingencies and slippage detailed above
- 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.
- The CCG and LA share the financial risk of maintaining other services if activity levels continue to grow at historical trends.
- That the Health and Wellbeing Board will make recommendations to the statutory organisations where there is a need to trigger risk sharing agreements.

Commissioning and Contracting - Responsibility for commissioning services will remain with the accountable body. Monies within the pool are set out within the H&WB expenditure plan submission. These must be spent on the schemes documented. If resources are re-aligned they need to be agreed through the governance structures.

Contracts held by one organisation where the CCG and LA both contribute financially needs to be considered to share the financial risk.

Overspends - Where an area of spend is over budget there needs to be an action plan developed, agreed and in place. Responsibility for the overspend is the commissioners, who carries the financial risk. If commissioners believe other stakeholders should carry some of the financial responsibility for the overspend this will be highlighted and considered.

Underspends - Where underspends occur the balance will be ring-fenced to fund related services within the pooled budget e.g. increased community capacity; increased acute activity; increased social care costs related to the BCF programme.

Unused monies at the year-end will remain within the pool for use the following year.

Shropshire Council and Shropshire CCG are developing an overarching Partnership Agreement which will pull together existing agreements. This will be signed off by respective boards in October 2014.

6) ALIGNMENT

a) Describe how these plans align with other initiatives related to care and support underway in your area

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

The Transformation Schemes have been determined in order to address the challenges that face both Shropshire Council (SC) and Shropshire CCG (SCCG) and therefore they naturally align with SC and SCCG priorities.

Some of the initiatives that are currently underway that are not delivered through the Better Care Fund but where there is a clear interdependency or alignment include:

System Resilience Plans
This is a whole system plan that identifies our current position, the continuing risks and how the CCGs as system leaders will work in partnership with wider system partners to plan for known variations in demand in Q3 and Q4. It also addresses how we will as a system respond to changes in capacity through surge planning and commits at the level of chief officers through the System Resilience Group (SRG) Describe how the whole system will work collectively to deliver against the constitutional targets of 18 weeks and 95%.

Plans aim to address the significant local system resource and transformational challenges required to deliver effective, high quality elective and non-elective care. These are being led through the FutureFit and **Better Care Fund programmes**.

Urgent Care - SMART plan

A SMART Plan has been developed to deliver quick win sustainable system, process and capacity improvements by the end of September. The aim is to deliver 74 less breaches per week which it is calculated will enable achievement of the 95% target. The Plan has been signed off by the Urgent Care Working Group. Each scheme within the plan has an identified lead and defined metrics. Oversight of delivery of the SMART plan will be through the SRG.

Short term plans centre on scaling up developments already started on integration of health and social care services such as **Integrated Community Services** (ICS).

Single Referral and Trusted Assessor prototype

This prototype aims to develop a single referral document, replacing the existing systems (including the notification 2 and notification 5 system) in order to improve the quality of referral information, reduce confusion and inappropriate referral and avoid duplication.

This development will support the progression towards 'Trusted Assessor' status for the acute hospital trust; (initially developing ward coordinators into Transfer of Care Coordinators) aid the development of Single Point of Access and the roll-out of **Integrated Community Services** by ensuring the hand-off between the acute trust and this community service is a smooth transition.
Strategic Housing Authority

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

Strategic housing objectives translated to higher level commitments would be:

- Commitment by the Strategic Housing Authority to the provision of extra-care housing
- Commitment by the Strategic Housing Authority to address the health and care impacts of excess cold and by extension poor property condition, for example through the provision of the multi-agency one-stop Heatsavers service, located within the Housing Service
- Delivery of the statutory DFG programme in the context of and complementary to the BCF agenda.
- Commitment to 'resilience at home' (linked to 'home is normal') through continuing financial/ core funding support via Housing for the Countywide Home Improvement Agency and Handyperson Service, both of which are able to assist with and facilitate transfer home from hospital or residential care, undertake and/or facilitate adaptations and install equipment, carry out falls risk assessments and associated remedial works, and deliver emergency heating solutions etc
- Strategic Countywide commissioning of targeted housing support services which meet diverse needs/ deliver sustainable outcomes at locality level ('home is normal')

Community Hubs

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

Let's Talk Local – Provided by People2People

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

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

- Social work advice,
- Key partners advice e.g. Housing support e.g. Sustain, benefits advice,
- Carers assessments,
- Peer support sessions,
- Occupational therapy advice
- Assistive technology demo's
- Public health advice and workshops

- Financial advice for self-funders
- Keeping independent for longer workshops delivered by peer supporters alongside OT.

This new approach supports the **Resilient Communities** transformation scheme and the development of Team Around the Practice.

The Community Hub and Lets Talk Local approach will also consider the transition of children with disabilities from children's' to adult services, as part of the scoping exercise of the Resilient Communities project, it will consider how the Better Care Fund can support/enable this piece of work. This piece of work will also link closely with both the Children's Services Early Help Strategy and the Targeted Mental Health Programme for Schools.

Targeted Mental Health Programme for Schools TaMHS

The Chief Medical Officer Dame Sally Davies published her annual report in September 2014 highlighting the need for Young people in particular to have better access to Mental Health Support, as half of adults with mental health problems develop them before the age of 15 and three-quarters by 18.

Shropshire is currently in a good position in relation to this as Shropshire was one of 25 sites across the country that ran a government funded targeted mental health programme for schools (TaMHS). The highly regarded pilot captured significant learning from participating schools. The overall aim of the programme is: 'to improve mental health outcomes for children and young people via interventions delivered through schools'

The evidence base for mental health is strong and over the past decade there have been numerous strategies, studies and programmes that can demonstrate the impact of intervening early especially in the crucial childhood and teenage years that will help to prevent the future development of mental health illness.

Children's Services Early Help Strategy

The vision for children and families sits within the wider council and CCG approach to offer advice support and assistance to the people of Shropshire to "help them help themselves" promoting engagement of the community and the voluntary sector to identify and meet the needs of their local community. The Early Help approach focusses on a child-centred and coordinated approach to prevention and early assistance where the voice of the child is heard and their experience of life is understood by all professionals working with them.

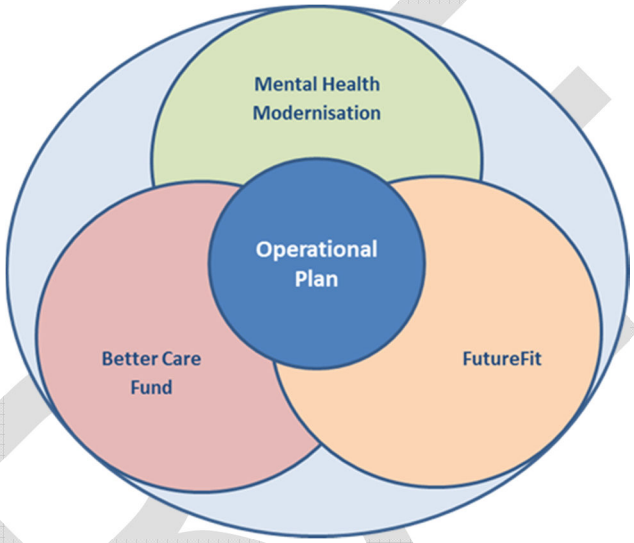
Where there are specific additional needs of a child or issues impacting on parental capacity that are relatively low level universal services may be able to take swift and helpful action within the community or home setting to meet these. If the child or young person's situation is not fully understood or if there are indicators that a child and family would benefit from coordinated support from more than one agency (e.g. education, health, housing, police) there should be an inter-agency Early Help assessment completed..

b) Describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Alignment to CCG 2 year operating and 5 year Strategic Plans

Five year Strategic Plan

Shropshire CCG's Strategic Plan sets out the three key component parts of delivering its vision: Future Fit, Better Care Fund and Mental Health Modernisation. Contained within these key components are a multitude of strands of work which contribute to achieving the strategic vision. These component parts work together to perform overlapping, but also distinct, roles in the achievement of the vision, with this Better Care Fund Plan addressing the detail of what sits within the Better Care Fund component.



Key Improvement Interventions

The key schemes which will be implemented over the next 5 years to deliver real change in Shropshire are set out within the CCG's Strategic Plan as:

- **Future Fit**
- **Mental Health Modernisation**
- **(Better Care Fund)**

Similarly these key areas of work are also cited within this Better Care Fund Plan as the strategic backdrop to a whole system transformation plan which is underway.

- **FutureFit**

FutureFit is a major programme of work through which the significant challenges in acute and community hospitals will be addressed. This is supported by the creation of a clinical vision to take

forward the development and implementation of the preferred option for the configuration of acute and community hospital provision locally.

Through the FutureFit Programme, bespoke analytical work has been used to identify expected changes in demand and opportunities for improvement. This modelling of future demand is fundamental in the identification of our Better Care Fund schemes to ensure they support the necessary shift of activity from the hospital setting into the community, whilst protecting Adult Social Care and delivering against the BCF metrics, of which reducing hospital admissions if a key target.

- **Better Care Fund**

For those improvement interventions that require investment in integrated health and social care services, Health and Wellbeing Boards will take lead responsibility for commissioning service transformation through the Better Care Fund. It is also anticipated that the Urgent and Planned Care Working Groups and the Long Term Conditions Steering Groups will also have a key role to play.

- **Mental Health Modernisation**

It is now 18 months since the new inpatient mental health provision, the Redwoods Centre, was opened. Progress delivering the Modernisation Plan has been closely monitored by commissioners and a review of the modernisation recently completed sets out the successes of this process and identifies further areas for improvement moving forwards.

Two Year Operational Plan
The CCG's Operational Plan sets out in detail the improvement interventions which will take place over the first 2 years of the 5 year strategy sets in motion the first stages of reaching the strategic vision. The two year Operational Plan is structured around the 5 Domains and the 21 planning fundamentals set out in NHS England's "Everyone Counts: Planning for Patients 2014/15 to 2018/19" Planning Guidance.

- **Domain 1 – Preventing people from dying prematurely**

Shropshire CCG will be working closely with Public Health colleagues to develop a local response to the Commissioning for Prevention guidance in order to identify the local high impact prevention measures and to develop implementation plans to support this. In particular to understand how best to improve life expectancy for men in our most deprived areas and to enhance work on reducing smoking in pregnancy. A full review of cancer services will also be undertaken. The CCG will be developing its response to the 'Closing the Gap: Priorities for essential change in Mental Health' including implementing the recommendations from the RAID review, developing health checks for mental health service users and improved out of hours mental health provision. There will also be continued work on implementing health checks for adults with learning disabilities.

- **Domain 2 – Enhancing the quality of life for people with Long Term Conditions**

There will be a focus on enhancing the diabetes and Pulmonary Rehabilitation services along with admission avoidance and reducing time spent in hospital for people with LTC. There will be an expansion of the Integrated Community Service (ICS) and the Care Home Advanced Scheme (CHAS) along with the introduction of competency based education and training for care home staff linked to admission avoidance. Further to this three new paediatric pathways will be introduced along with carers' champions in GP practices.

- **Domain 3 – Helping people recover from episodes of ill health or following injury**

As highlighted above the ICS and CHAS schemes will be further developed with the focus on reducing re-admissions and maintaining independence. A new wheezing pathway will also be introduced. There will be clinical reviews of follow up ratios of those specialities above the WM average. In addition there are plans to appoint a joint Rehabilitation and Reablement post with Shropshire Council which will focus on commissioning more integrated rehabilitation to improve recovery. Work will also continue to consolidate stroke services on one hospital site. There will be a review of current Enable services supporting people with mental health issues into employment

- **Domain 4 – Ensuring that people have a positive experience of care**

The CCG will continue to develop and embed robust systems and processes to engage, empower and support patients in matters relating to their own experiences. This will be achieved by building on current CCG strategic developments including the implementation and evaluation of the Local Health Economy End of Life strategy, engaging with forums such as our Young Health Champions and improving provision and access for people with mental illness. Following a review of local maternity services a programme of improving women and their families' experience of maternity settings will continue. In addition the local health economy is part of a national pilot for improving patient feedback and experience across a Long Term Condition (LTC) pathway for Diabetes using the Friends and Family Test (FTT). The evaluation from the pilot will be used to inform further innovative approaches to improving positive engagement with challenging to reach minority groups. A variety of systems and processes ensure that we capture, question and act on relevant contemporaneous feedback and data to improve patient safety, experience and outcomes across all services and the improvements and learning are implemented.

- **Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm**

Robust systems and processes will be implemented to ensure that relevant contemporaneous feedback is captured, questioned and acted upon and data is used to improve patient safety, experience and outcomes. A programme of the skills and expertise across key roles within CCG to interrogate and act on data to improve transparency will be developed and implemented during 2014/15. The CCG remains committed to reducing the incidence of avoidable harms via the National and Local Health Economy strategy and working groups. Measurable improvements in the prevention and control of Health Care Associated Infections are supporting significant progress towards eliminating avoidable deaths in hospital caused by problems in care and this work will continue. The CCG will continue to Deliver safe care to children in acute settings by ensuring effective implementation of the acute paediatric reconfiguration, with services moving from RSH site to PRH site which will see a reduction in bed provision and ensuring successful implementation of 3 revised pathways for wheeze/diarrhoea and vomiting/constipation

Through the structure of the 21 fundamentals the plan also highlights further areas of focus, in particular 7 day services, financial resilience, safeguarding and parity of esteem.

Alignment across plans is evidenced with the Better Care Fund standing as one of the key delivery components for the whole system transformation work set out on the five year Strategic Plan. The two year operational plan as the first phase delivery model for this strategy shows a clear link to our four key Better Care Fund Themes: Prevention, Early Intervention, Supporting People in Crisis and Supporting People to live independently.

Our 11 key planned Better Care Fund Schemes, can be found either specifically cited in the two year operational plan as work areas under the domain headings or can be seen to support to the overall aims of the plan.

Alignment with Provider Vision

Provider organisations have been involved in the development of the 5 year strategic plan and the triangulation between system vision and individual provider plans. This includes not only agreement across the strategic vision and models for delivering that, but also agreement in relation to the financial and activity modelling that supports the Five year Strategic Plan. A series of provider engagement workshops were held during the development stages for both the CCG and provider 5 year plans to ensure there was agreement on the sentiments of the plan. This provider engagement has been continued throughout the development of this Better Care Fund Plan via a Better Care Fund reference Group and Non-Executive briefing sessions.

Alignment with Local Government planning Documents

Shropshire Council's Business and Financial Strategy sets the scene of building a profoundly different relationship between public services and customers and details how the council is responding to a once in a lifetime, irreversible shift in funding by embarking on its own transformation programme. The context for this need for change cites the same demographic and financial pressures highlighted in the Better Care Fund Plan

The Adult Social Care (ASC) Strategy outlines a commitment to base future services on the following set of principles, which have been used to develop the four themes of Prevention, Early Intervention, Supporting People in Crisis and Supporting People to live independently adopted for the Better Care Fund itself

- working together
- prevention
- enabling
- maximising independence and choice
- being innovative
- providing targeted, personalised support where it is needed.

The Adult Social Care Transformational Operational Model highlights that in order to respond to the monumental challenges faced by the social care economy of Shropshire whilst continuing to deliver high quality support to those in need, there is a need to radically change the approach to the provision of ASC in Shropshire. To maintain the current level of access for ASC there is a need to signal a different and smaller offer to everyone. The Model goes on to highlight that Social Care is often a vital part of enabling people to live independent lives but it is far from being the only component to enable people to live fulfilled lives. Therefore the contributions that communities can make to support themselves and the people living in them must be harnessed.

The Model focuses on:

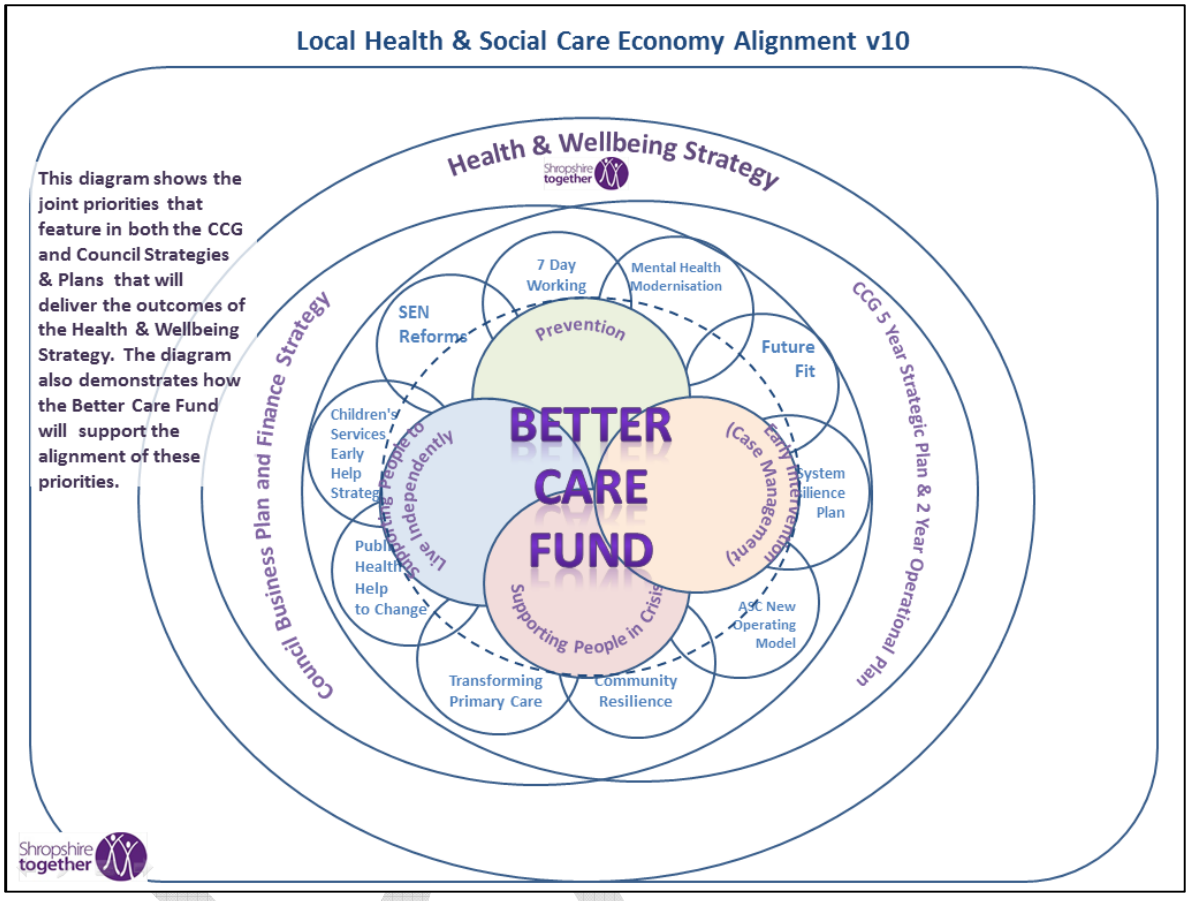
- The need to build a more sustainable ASC system that promotes and maintains greater independence for most people which maximises the support available within local communities.

- The 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.
- The 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.
- The need to ensure that the Council have different conversations with the public from the moment they first engage so that these expectations are understood promoted and acted upon.

The Model sets out that this will be achieved 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.
- 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.
- Members of staff will play a key role alongside individuals who use the service in making decisions about how the service is delivered.
- The service will work from a presumption of a mobile and flexibility operating within local areas.
- Increasing the focus on professional standards and profile of social work to enable improved outcomes for individuals and give a sense of pride and ownership for the staff group.

The sentiments and principles of the Council's Strategic aims show clear alignment with the Strategic aims of the Better Care Fund and they have been fundamental in the development of the vision for the Better Care Fund and its associated schemes of work. The diagram below gives a flavour of the breadth of work we are taking forward in partnership



The acknowledgement that we are in simple terms, attempting to address a common set of issues with the same resource challenges has strengthened the resolve and commitment across the Council and CCG, supported by the Health & Wellbeing Board, to work together to address these issues and make a tangible difference to the lives of our local population.

Shropshire together

c) Describe how your BCF plans align with your plans for primary co-commissioning

For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Describe the arrangements in place for primary co-commissioning in your local area – how can these support the delivery of the BCF schemes?

Summary response: The CCG has signed up to Co-commissioning with the local area team of NHS England. The core principle underpinning the decision was recognition that fundamentally both the CCG (its membership) and NHS England are aspiring to deliver the same outcome of holistic, personalised, responsive primary care provision for local people. The approach adopted in reaching this decision was to consult across our membership of 44 practices ensuring an inclusive and collaborative approach can be adopted. The focus for the next 18 months will be in the following co-commissioned project areas-

(i) Developing a clear understanding of the longer-term **vision** for general practice in a rural county, workforce challenges and solutions, access to services and seven day provision which collectively will allow the wider health economy through the BCF work a complete strategic vision for health and social provision which has been lacking due to a paucity of knowledge linked to primary care (in particular collective general practice) future plans. Delivered through FutureFit phase 2 project (FF2)

(ii) Developing **integrated service provision** across primary care – initially starting with integrated health and social care provision (Integrated Community service project) and quickly expanding across primary care based providers to include voluntary sector. Delivered through FutureFit phase 2, ICS project, Community resilience projects and Team around the practice project.

(iii) **Prevention agenda**, initially focusing on admission avoidance and enhanced recovery and reablement, will become a key component of the outcomes across the projects outlined above and in the document below. Close working with all partners through the Health and Wellbeing Board, BCF delivery groups and at a 1:1 level with public health colleagues will shape a cohesive response to attaining the outcomes set in the BCF linking to the HWB priorities, JSNA evidence base and FutureFit vision and delivery.

(iv) Alongside NHS England initially mapping of all primary care **facilities and estate** to enable a cohesive and structured plan to create both equity of provision across our 3 localities, utilise our estate appropriately whilst maximising potential, and align estate planning with future vision for health and social care provision locally. Delivered through FF phase 2, FF phase 1, and direct work with NHS England and Local Authority.

(v) Improving job opportunities, **recruitment and sustainability of local workforce** and service provision. Supporting the ongoing work as a key partner alongside Shropshire Council and public health with the development of a university campus in Shrewsbury to include health and social care related courses. Potential joint delivery with NHS England in the future.

Assurance – does the plan link with the enhanced GP service to be delivered through Transforming Primary Care?

Summary response: Shropshire CCG has just over 31 000 over 75 patients registered with our 44 practices. Over the past 2 years the CCG has invested in projects that have been based on the principles of delivering integrated, personalised care through proactive clinical care and intervention, where the concept of "home is normal" and providing local people with continuity of care provision through the delivery of family general practice and accessible local primary care is central. This work to date has formed the foundation for the development of the larger scale system change described in the BCF and enables delivery of the national Enhanced GP service.

All our GP practices have in place, or will by 2015 have in place, access to the following schemes to support the delivery of the Enhanced service:

(i) **Integrated Community Service** – integrated community and social services team focusing on admission avoidance, early discharge, maintaining care at home and avoiding re-admission through reablement and enablement.

(ii) **CHAS** – care homes scheme covering all care homes with personalised care plans (individually agreed and developed with the patient and their relatives alongside the GP) to support ongoing care provision within the care home, admission avoidance and improved clinical and social outcomes for the resident

(iii) **Team around the practice project** – through the utilisation of local resources and partners (general practice, local pharmacies, voluntary groups, community groups, community services, mental health, out of hours and social services) a model of "rural primary care at scale" will be produced enabling the integration of all care provision locally and avoiding unnecessary admissions.

(iv) **Information flow** – telehealth and IT projects to include shared care records with providers, telehealth solutions and an integrated urgent care dashboard is in use and being developed across the health and social care economy

(v) Investing in and developing **community resilience** – investment in the development of Care Co-ordinator schemes run by local volunteers who have been formally trained to support vulnerable residents at risk of admission – available to all practices. Roll out of established Compassionate Communities project across the county already operating in key localities alongside aspiration for every local community to sign up to Dementia Friendly project championed and supported by the Health and Wellbeing board.

(vi) **Specific admission avoidance schemes** based on Commissioning for Value data for SCCG – projects underway to avoid intervention and deterioration (including acute admission) for Osteoarthritis (through Keele University across all practices in our South locality) and Diabetes advanced care (in our North locality).

Detailed outline of Primary Care role and inclusion in the Better Care Fund

The Shropshire Landscape

Shropshire CCG comprises of 44 general practices across a large, mainly rural county (see attached map of practices). The majority of our practices are General Medical Services (GMS) commissioned and all practices provide enhanced services.

The county is naturally divided into three localities, with approximately 15 practices in each. The whole time equivalent GP to patient ratio is 1,948.

The **South Locality** is the most sparsely populated and has the longest travel distance to acute service provision. It is strongly reliant on community services to support local care provision and has three community hospitals operating in the area, two of which have MIUs that are currently open for 12 hours per day and staffed by community nursing staff.

The **North Locality** utilises both acute sites (PRH and RSH) as well as services north of our border. It is mainly rural and struggles with pockets of high social deprivation and substance abuse. Located within its boundary is a single community hospital with a MIU facility and a specialist orthopaedic trust (RJAH) with casualty facilities and a small number of geriatric care beds

Shrewsbury and Atcham Locality serves the centre of the county and, although this comprises a more urban population, it still covers rural sectors. No community hospital facility is available and access to any rehabilitation service outside of patients' homes has been offered traditionally from the acute site facility at RSH or through a number of commissioned 'rehab beds' within Isle Court and The Uplands at Oxon Care Homes.

The patient profile within the county is largely an elderly population that has increased by 21% for those aged over 65 in the past three years compared to the national average of 17%. Many of these residents live in both rural isolation and deprivation, with poor access to public services and on low household incomes. Fuel poverty is an active concern for commissioners and public health. In our younger generation we have an increasing problem with obesity and physical inactivity despite the rural nature of the county. Additionally, there is recognition by all sectors that recruitment and retention of young professionals is difficult in Shropshire.

Strategic Partnership around Primary Care

Primary Care has a central role to play in helping people to manage their conditions better in the community. In particular, improving outcomes and personal experience of health and care services through more a joined up and personalised approach are as relevant in primary care as in other key areas of focus within the Better Care Fund. The contribution that primary care will be asked to make to the transformation of health and care services is central to the clinical vision and models of care that are being developed locally.

Understanding and co-creating the future vision for primary care, how it integrates into local secondary and community based services, how it is made sustainable and adequately resourced is essential for the delivery of Health and Wellbeing priorities. The concept of co-commissioning with NHS England through joint decision making, joint system re-design and joint planning is therefore essential to meet the challenge set to us, as local commissioners, by our patient population.

In taking forward developments in Primary Care the Area Team have established a group to develop a collaborative approach to the commissioning of primary care services and following Simon Steven's letter earlier this year, the CCG's proposal to the Area Team is to co-commission elements of Primary Care services based on the parameters outlined below.

1. "Working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities"
2. "Supporting the design and negotiation of local contracts"
3. "Jointly approving discretionary payments"
4. "Jointly deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice merger applications"

Principles
The principles that underpin the local development of Primary Care are set out below, these four key principles can be seen as a common thread throughout the CCG's strategic, operational, resilience and Better Care Fund (BCF) plans:

- "Home is normal"
- "Sustainability of services"
- "Empowerment of patients, clinicians and communities"
- "Future proofing our future through new ways of working"

"Home is Normal"

The delivery of care to patients as close as possible to their communities and home environment is integral to their speed of recovery and ability to return to their previous level of functioning. Achieving this outline will be strongly predicated on our ability to help shape service provision in the community and, in particular, within primary care. Currently primary care is functioning at capacity and any additional transfer of activity is unlikely to be possible without a restructuring of how we deliver these care pathways. It will therefore be essential to align the vision of local family general practice with caring for more patients in the community and the priorities set by the Health and Wellbeing through the joint strategic needs assessment findings and work. We will need to do this in conjunction with our GP colleagues and local patients ensuring that primary care is strengthened through adequate resourcing (both financially and workforce) to provide this care and, in cases where this isn't feasible, that appropriate other providers are established locally that integrate and support primary care delivery without adding additional activity.

"Sustainability of Service"

This encompasses not only workforce sustainability but also appropriate premises and equipment for patient care. Our strategy outlines how we need to recruit and retain adequate clinical staff, reconfigure service provision to ensure sustainability and continuity of delivery, and upgrade local facilities with investment in equipment, IT and buildings within which to treat our patients. The same challenges face primary care and, if they are to be in receipt of a cohort of patients that transfer into the community, the facilities, equipment and workforce available to them needs to be tailored to meet these demands. Sustainable service will also be dependent on the resilience of local communities to support elderly, frail residents, through the expansion of the fledging services within compassionate communities and care co-ordinators already in place (details can be found in Annex 1). Primary care is integral to the strengthening of their local communities and local GPs play a central role in community support beyond clinical care

"Empowerment of Patients, Clinicians and Communities"

Ensuring that patients are provided with adequate advice and support to manage their health and wellbeing independently for as long as possible, and that communities can be supported to address the wider determinants of health are both strongly reliant on the continuity of relationship that local people have with their GP today. Ensuring that this is integrated into the whole system solution is essential to provide the change in health and social outcomes that our strategy outlines. Local GPs provide the majority of preventative care currently and, unless we place primary care centrally within our commissioning strategy, the risk of fragmentation of prevention delivery is inevitable.

Our consultant colleagues have highlighted the need to be able to access expert advice and support from their peers in different specialities through co-location of services on acute sites. Through these discussions it has also become apparent how strong the interdependence between the primary care and secondary care clinician is. Ensuring that local GPs are able to access support and advice from consultant colleagues enabling them to treat patients at home, and consultant colleagues are able to access support and advice from GPs to enable safer, sooner discharge of patients out of acute hospital settings is required. Joining up services not only at this level but also with social care, voluntary sector and eventually tertiary centre care will result in better patient outcomes and experience

"*Future proofing* our future through new ways of working"

Our strategy outlines integrated team working. This is already established through the Integrated Community Service (ICS) (Details can be found in Annex 1) and is being expanded across the county, but must eventually include elements such as mental health and voluntary sector support as priority areas. Use of telemedicine to allow increased access to consultant/expert advice in a large geographical county where travel cost is an important factor, improved IT systems to enable improved information sharing and better outcomes for our local population, and rebuilding the links between secondary and primary care to enable shared learning and smoother patient transitions between providers is essential.

All of these elements will greatly improve the patient experience, quality of care provided and range of services available to rural communities. However the ability to implement any of these changes is dependent on primary care and the central role the GP plays in the patient journey over their lifetime.

Vision

Our local vision is built around three key elements:

- Primary care at Scale – the Shropshire way
- Community Resilience
- Using Local Resources

Whilst primary care delivered at scale may have merit in some of the more urban areas across the geography of Shropshire, Primary Care through integrated models may also have merit where at scale isn't feasible due to geography or rurality. This model will enable individual GP practices to offer the same services as the "at scale" model within a rural footprint. The impact of the rurality of Shropshire on the planning and delivery of care is explored in section 2 of this document. However, Importantly the rural nature of the county means that it still retains a strong community focus with extremely good uptake of voluntary services, compassionate communities and care coordinators, (set out in Annex 1) all of which support social and healthcare service provision in our towns, villages and hamlets. The strong sense of place also means that we have been able to establish patient participation groups in each of our 44 practices. There is also an active central committee co-

ordinating the work locally and, centrally within the CCG, focussing on service reconfiguration and provision.

Shropshire Council and Shropshire CCG believe that building community capacity, maximising the use of local resources and natural support and developing resilient communities is a cornerstone of future models for health and care provision and GP practices are at the heart of this.

- People living in communities want to help themselves and each other. Neighbourliness, volunteering, philanthropy and community spirit are still present in abundance, but require organising and enabling to be truly effective.
- Communities should be enabled to influence the wider determinants of health at a local level, as part of the wellbeing agenda. Tackling exercise, diet, smoking, alcohol, isolation, inequality and parity of esteem requires co-ordinated local action across all sectors of society and cannot be left to statutory health and social services alone to address.
- Statutory health and social services need to establish more strategic partnerships with voluntary and charitable organisations. The "Compassionate Communities" project and "Community and Care Co-ordinators" promote such partnerships and connect local people in need of support with their local community and statutory services in a more effective way.
- The development of community hubs using the local GP practice either physically or virtually will provide a focus for community mobilisation. They will be experienced as a 'cared for', non-institutional environment, welcoming to everyone, whether there by appointment or 'walk in'. It will provide consistent services and activities which not only promote patient and community empowerment, but also enhance the quality and sustainability of local NHS acute, planned and long term condition services. The community hub will be 'the place I go when I have a question or a problem'

Implementation of Transformation in Primary Care

In line with the Government's document "Transforming Primary Care", as well as addressing some of the strategic issues surrounding the development of Primary Care outlined above, practical steps have been taken to meet the challenges set out in this document. These include implementation of the GP enhanced service across all practices in Shropshire (Proactive Care Programme), Community and Care Co-ordinators, Team around the Practice, Building Community Resilience (including Compassionate Communities) the Care Home Advanced Scheme and the Integrated Community Service. Details of all these schemes are included in the "Scheme Descriptors" section in Annex 1 of this document and due to their integral nature to the wider transformation work underway across the county associated with the Better Care Fund, this work will be referenced on several occasions throughout this paper.

In addition to this, the Area Team and Shropshire CCG will co-commission FutureFit 2. This will build a clinical model for work transferring to Primary Care as a result of the FutureFit work to reconfigure local hospital services, build a financial model to support this, and model the workforce required to deliver it. It will also include building a vision and strategy for general practice across our 44 practices and addressing the contractual implications of implementing the Team around the Practice. Further to this we continue to move towards the procurement and subsequent implementation of an Integrated Electronic Patient Record across the Shropshire and Staffordshire footprint. With the support of our CSU we anticipate this to be in place by June 2015.

Whilst we move towards a phase of increased activity in transforming local Primary Care considerable work is already in process to improve and co-ordinate primary care provision across agencies. This includes linking to Public Health's work with local pharmacies to develop the services they offer in their communities and work with our providers on projects around better access to rural primary care under the umbrella of our system resilience planning. This builds on the steps already taken to co-locate our Shrewsbury based walk in clinic with A&E at Royal Shrewsbury Hospital and the GP telephone access and triage services implemented some time ago.

In summary Primary Care, supported by our plans for co-commissioning, our vision and our principles, is at the heart of our whole system transformation plan in Shropshire. The success of which, and therefore our commitment to it, forms a key part of our Better Care Fund vision and plans.

7) NATIONAL CONDITIONS

Give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

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

Shropshire Council is maintaining eligibility criteria under Fair Access to Care Services (FACS) at 'Substantial' and 'Critical' needs for 2014/15. The implementation of the Care Act in 2015 is expected to see National eligibility set at 'Substantial', however early guidance indicates that there may be a wider scope in the definition of 'Substantial' meaning that needs that we would currently categorise as 'Moderate' may well be considered as 'Substantial'.

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

- Continued investment into supported living schemes for adults with learning disabilities and adults with mental health needs and a corresponding reduction in residential care placements for younger adults
- The provision of good quality nursing care and nursing care for people with dementia in a care home setting
- A focus on developing and supported employment opportunities for younger adults with mental health needs recognising how employment contributes to improving self-esteem and reducing isolation.
- Increasing the use of personal budgets for those people that are eligible for local authority funded support including supporting the CCG in the implementation of personal health budgets
- Supporting young people and their family carers through transition ensuring that young disabled adults are supported in their local communities closer to family friends and family

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

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

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

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

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

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

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

Older People

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

Existing and predicted demand on Adult Social Care services

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

the oldest age band are the population most likely to be in receipt of some form of social care provision due to the associated rise in long-term conditions.

Current and predicted population of Shropshire, by age bands

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

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

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

Dementia

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

Adults with a Physical Disability

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

- **Existing and predicted demand on Adult Social Care services**

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

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

Adults with Learning Disabilities

In comparison to the England and Wales average, Shropshire has a greater percentage of the adult population with a learning disability. There are approximately 1,000 [FR1]people with a learning disability living in Shropshire and around 850 are supported by adult social care.

- **Existing and predicted demand on Adult Social Care services**

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

Adults with Autism

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

- **Existing and predicted demand on Adult Social Care services**

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

Adults with Mental Health problems

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

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

- **Existing and predicted demand on Adult Social Care services**

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

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

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

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

Demand management and enabling people to live independently is a priority area for the local authority, the council is also focused on enabling communities and volunteers, and the social capital within communities to reduce demand on the public sector and developing a range of wider environmental place shaping schemes to enable people to live as independently as possible for as

long as possible. The Resilient Communities Transformation Scheme supports these priorities by focussing on developing a sustainable community based approach with an emphasis on early help and prevention, developing and maximising the use of local assets, enabling voluntary activity and supporting the development and growth of community based iniatives and challenging peoples negative attitudes towards their circumstances and the capacity of their community.

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

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

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

iii) Indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

Care Act Funding

For 2015/16 the BCF is expected to meet £758,060 of Care Act implementation costs.

Care Bill implementation funding in the Better Care Fund (£135.9m nationally)		Shropshire £000s
Carers	Put carers on a par with users for assessment.	122.691
	Introduce a new duty to provide support for carers	264.344
Information advice and support	Advice and support to access and plan care, including rights to advocacy	80.865
Safe-guarding	Implement statutory Safeguarding Adults Boards	30.115
Assessment & eligibility	Set a national minimum eligibility threshold at substantial	157.826
	Ensure councils provide continuity of care for people moving into their areas until reassessment	24.538
Veterans	Disregard of armed forces GIPs from financial assessment	9.642
Law reform	Training social care staff in the new legal framework	26.211
	Savings from staff time and reduced complaints and litigation	-75.846
Advocacy	Independent Mental Health Advocacy	51.865

Impact of DWP policies on councils/providers	Pressures relating to pensions auto-enrolment (provider cost) and the announced 1% increase of working age benefits in 15/16 (reduced client contributions)	65.807
Total		**758.060**

The BCF detailed funding tables shows an allocation of £859k which exceeds the minimal amount expected to support the Care Act Implementation costs.

Capital:
For 15/16 the BCF is expected to contribute £50m of capital funding to Care Act Requirements. This amounts to £279,000 locally and has been earmarked from the Social Care Capital Grant in the detailed funding tables.

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

Below we set out some of the new duties resulting from the introduction of the Care Act 2014 and what this means for Shropshire.

The new duties include:

1. Adults' well-being, and outcomes, is at the centre of every decision;
2. Focus on preventing and delaying needs, and integration and partnership working is reinforced;
3. Carers placed on same footing as those they care for;
4. Embedding the right to choice through care plans and personal budgets;
5. New national eligibility criteria;
6. From April 2016, a ceiling on care costs incurred by adults;
7. Deferred payments scheme with wider range of opportunities;
8. Self-funders entitled to ask the local authority to procure services to meet their needs;
9. Places adult safeguarding on a statutory footing;
10. Extends the opportunity for independent advocacy

What this means for Shropshire

New duty from Care Act	What this means for Shropshire	How this will be met through the Better Care Fund
Increase in the number of assessments for both service users and carers	The Local Authority estimates, from working with local care providers that around 1100 care beds in Shropshire are occupied by people who fund their own care as their capital is above the current threshold of £23k, these people will require an assessment. There are an estimated 10,000 carers in Shropshire, (Census data) the Local Authority	Integration, rationalisation and streamlining of existing carers support

	currently supports 3000, the difference of 7000 may request an a assessment Additionally we are expecting an increase in the number of people living in the community and funding their own care requesting an assessment	services commissioned across health & social care to ensure demand can be met within existing budgets. Care Act increased assessment costs met through BCF allocation
Introduction of a Universal deferred payment scheme	Shropshire currently offers a deferred payment scheme, however with national publicity the demand for this may increase. This will require additional financial assessment and legal resources and there may be an impact on cash flow	
Support for People in Prison	Shropshire has one prison - Stoke Heath	
The impact of the funding reforms in 2016	The Local Authority estimates, from working with local care providers that around 1100 care beds in Shropshire are occupied by people who fund their own care as their capital is above the current threshold of £23k, in addition to requiring an assessment as noted above if eligible for funded care there is a potential financial impact with the change to the capital threshold which is still being modelled using the Lincolnshire model. Early indicative data from Providers is that, in their view, around 30% of these people will meet the eligibility threshold.	Reducing demand on care homes by providing an integrated approach to hospital discharge and admission avoidance which focusses on meeting needs at home, rather than a bed based setting
Adult Safeguarding	Shropshire currently has an adult safeguarding board which will have a statutory status and may require an independent chair and paid service and support functions	
Transitional amounts and implementation costs		Costs to support implementation are partly met through the BCF

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

v) Specify the level of resource that will be dedicated to carer-specific support

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

Table 2: Provision of Unpaid Care

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

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

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

Better Care Fund budgets aligned to services that support carers equates to £759k and delivers a wide range of services supporting carers. There are also a number of local initiatives which includes the identification and support of carers for example, Resilient Communities, Community and Care Coordination, End of Life[R2] Coordination, Integrated Community services, Dementia Strategy, the detail of which is described in the scheme descriptors.

The Care Act has prompted a review of these services so that through the Better Care Fund the Integrated Carers Support scheme will identify the gaps and duplication in meeting the needs of

carers, and a local carer's pathway will be developed. The pathway will integrate these new initiatives and existing services to enable a clear process of identification, assessment of need, signposting and delivery of a menu of support. The Integrated Support for Vulnerable Carers initiative will enable the element of the pathway around assessment of need to be explored and improved as part of the wider work. A budget has been allocated to support this scheme.

As previously indicated there are an estimated 10,000 carers in Shropshire, and the Local Authority currently supports 3000, the difference of 7000, with the introduction of the Care Act are entitled to an assessment and may require support services as a result of identifying a need.

It is anticipated that the Integrated Carers Support scheme will seek to integrate, rationalise and streamline the services provided to carers to ensure Value for Money, so that increased demand can be met within existing resources.

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

The Adult Social Care **known** financial pressures remain unchanged from the original BCF Plan. However, there remains a risk that the implications of the Care Act are largely unknown and may still require the CCG and the Local Authority to consider a changed position once further information is received.

b) 7 day services to support discharge

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

NHS organisations across Shropshire are reviewing their organisational plans against the Clinical Standards for NHS Services and planned developments in 2014/15 and 2015/16 reflect this.

- **Evidence engagement with the Action Plan to deliver clinical standards for 7 day services (7DS) contained in the Service Development and Improvement Plan section of NHS local contracts between CCG and providers**
  - Shropshire CCG have held monthly planning meetings to engage providers and work collaboratively to ensure the 7 day clinical standards have been incorporated into the contracts where appropriate.
  - Shropshire CCG has identified Executive and clinical leads for 7D and these leads are working with the 7D leads in the provider organisations.
  - Shropshire CCG held a workshop on 26th August 2014 to map out the current position on the 7D services and to identify the gaps and challenges in delivering the 7D agenda.
  - CRB and CQRM meeting are held monthly between CCG and providers. Also consider workforce/clinical challenges which may impact on 7D working.
  - CQUINS for 7D services is monitored at the CQRM on a monthly basis; these are twice daily wards rounds in AMU, SAU and critical care, daily wards rounds, access to diagnostics and discharge.

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

  - SATH – An action plan to deliver the clinical standards is included in the local contract to be completed by March 2015 and implementation timescales will be identified in the completed action plan.
  - SSSFT –A review is currently being undertaken of the 2014/5 contract to consider the requirement for the specific standards.
  - SCHT – The Service Development and Implementation Plan is included in the local contract to agree with local Commissioners action that it will take during 2014/15 to implement the clinical standards set out in the NHS Services. The action plan incorporates equal access to care and increased integration of services and local solutions.
  - RJAH - Contractual indicators have not being applicable. The organisation is an elective provider.

The output from the Cross Economy Workshop on the 26th August is summarised below.

Existing 7 Day Services	Planned Developments	Opportunities

• RAID
• Crisis Resolution/HT Inpatients
• Emergency Duty Team
• START
• Reaching Outs Service – CAMHS
  o Consultant Psychiatrist On-Call
  o Additional support to avoid hospital admission or facilitate discharge (8-8, 6 days p/w)
• Children's Nursing Team
  o On call system for EOL Care 24/7
• Prison Nursing Services -24/7
• Community Hospitals
  o Nursing Care Hospital Beds 24/7
  o MIU (except Whitchurch& BCH)
• Community Nursing Services 8-6pm 7/7
• Integrated Community Services (Shrewsbury Only)
• Homelessness Services – 24/7
• RJAH – Theatres and Day Case Unit 6/7
• RJAH - Out-patient Clinics 6/7
• RJAH – Radiology
  o On-call radiologist
  o Routine post-op service
  o Radiographer in theatre & out-patients
• RJAH – Physiotherapy for surgical patients 7 emergency on-call 7/7
• RJAH – Pharmacy 6/7
• Age Uk
  o Volunteer Befriending Service
  o Home from Hospital Service
  o Help at home activity
	• Community MH Teams
	• Dementia Teams
	• ICS
	• Transfer of Care Document & Training to support care home assessments over 7 days
	• Workforce development to support providers to manage needs in the community
	• Reaching Outs Service – CAMHS
	  o Additional support to avoid hospital admission or facilitate discharge - expand to 24hrs, 7 days PW
	• Children's Nursing Team
	  o Expand to 7 day service to cover all aspects of acute and chronic care for children
	• Integrated Community Services – Roll Out North & South Shropshire
	• RJAH - MRI Scanner at weekends
	• RJAH – Expansion of CT Service
		• Community Hospitals
		  o Ward clerking
		  o Therapists
		  o Diagnostics
		• Community Nursing Services Expansion of hours to 10pm
		• Age Uk -
		  o Extention of admission avoidance services
		  o Extention of volunteer services, such as befriending

Change visual when SaTH plan received

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

Furthermore the Mental Health Crisis Care Service will support people who are experiencing mental health crisis's so that they can access support as soon as possible when they are in crisis with the anticipation that it will either prevent admission or lead to early discharge whilst reducing the impact on the crisis on their long term mental health. This service will operate 24hrs a day over 7 days a week.

c) Data sharing

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

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

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

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

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

Currently the percentage of current and recent clients on CareFirst with an NHS number is **69%.**

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

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

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

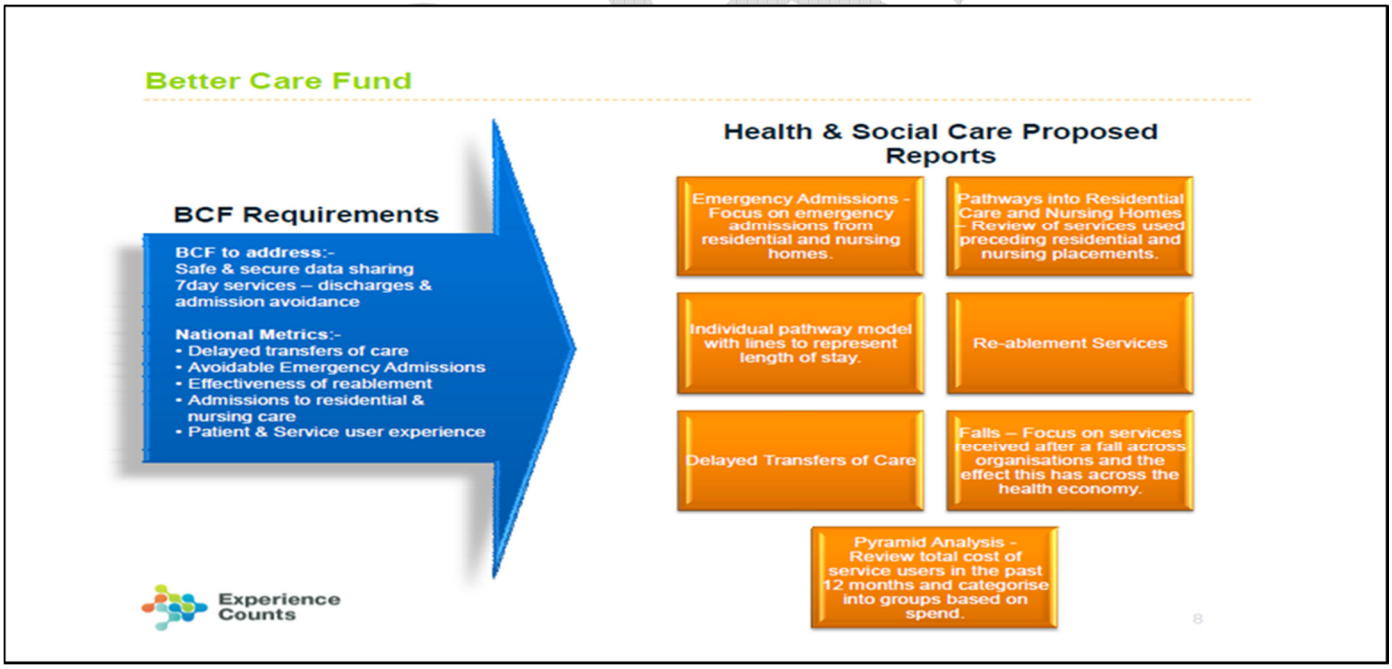
The initial objectives being to:

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

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

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

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



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

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

Information Governance Leads from the Local Authority and the CCG are involved in the development of the Better Care Fund plan through involvement in individual Transformation Schemes and through representation at governance boards and groups.

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

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

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

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

d) Joint assessment and accountable lead professional for high risk populations

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

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

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

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

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

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/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.

In 2014/15 the BCF Plan will build upon this foundation through implementation of the Proactive Care Programme. Practices will work with their MDT to case manage at least 2% of the population most at risk of admission (although it is acknowledged that this percentage is likely to be much higher when fully implemented). Initially the focus 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)

Plans will be developed further through the scaling up of the Integrated Community Service Team and the introduction of the Team Around the Practice scheme. Some of the barriers that have previously restricted the success of Integrated Assessment, Planning and Lead Professional have been challenged through the development of these schemes and the cross-cutting themes, for example the move towards integrated teams and the use of the NHS number as the primary identifier.

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

Unfortunately, this information is not readily available, however we are working together to develop a view of this.

8) ENGAGEMENT

a) Patient, service user and public engagement

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

A key function of the Health and Wellbeing Boards is to ensure that we work with our communities to design health and wellbeing services in Shropshire. Working with Shropshire residents and service users ensures that their views are woven into the DNA of our Board decision making. More than this, engaging in this way enables everyone to understand their roles and responsibilities in keeping our population healthy; it encourages our communities to better understand how they can take charge of their own health and how they can support each other in their own homes and communities.

The Health and Wellbeing Board set its Health and Wellbeing Strategy Based on the Joint Strategic Needs Assessment (JSNA) alongside strong service user engagement. The Board responded to the public with a 'You Said, We Did' approach to feedback on strategic priorities and the Board continues to publish feedback from all public consultation on our website (www.shropshiretogether.co.uk). Healthwatch Shropshire is a key partner for the Health and Wellbeing Board and is a key partner for developing the Better Care Fund Engagement as it works to help make sure everyone gets the best from their health and social care services.

The HWB Board has continued to work with service users on service design via Healthwatch, the Health and Wellbeing Stakeholder Alliance, workshops, face to face discussions and surveys, and in 2013 the outcomes of the HWB strategy were tested by groups of service users via HWB focus groups and the CCG led Call to Action. The Call to Action saw Telford and Wrekin (T&W) CCG and Shropshire CCG ask their local populations during autumn 2013 to have their say on the NHS by asking people to get involved in feeding back their personal opinions, experiences and stories.

The Call to Action has given rise to a comprehensive programme of service user, carer and clinical engagement across the CCG and has been developed as part of the Future Fit (Clinical Services Review) work across Shropshire and T&W. The details of this work will provide Shropshire and T&W a sound base for decision making and a springboard for further engagement activity for all health and social care. The Health and Wellbeing Board provides the CCG and Shropshire Council a robust mechanism for ensuring that the user voice is a key element of decision making.

The Patient Participation Groups and the Young Health Champions are both supported by the Shropshire CCG; and the Voluntary and Community Sector Assembly and Members of Youth Parliament, both supported by Shropshire Council, also have robust mechanisms for supporting work streams via participation on operational and strategic groups, workshop development and the like.

With the breadth of service transformation Shropshire Council has undertaken numerous consultation and engagement exercises to inform strategic decision making, this includes, Adult Social Care (People 2 People), Locality Commissioning, and Making it Real. The Engagement Summary which can be found as an appendix to this document details much of this engagement across the commissioning functions for Shropshire.

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

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 Further, as Healthwatch embeds its position within Shropshire, the Health and Wellbeing Board and the Better Care Fund will work closely with Healthwatch, the Voluntary and Community Sector Assembly, service providers, and all our partners to ensure that service users are fully engaged in the conception, design and implementation of service transformation.

While Shropshire has done well by involving service users in the development of plans, more can be done to ensure the coproduction of services as part of the Better Care Fund. Building on our work over the last two years, the development of a Health and Wellbeing Communication and Engagement Strategy will detail how we work with our population as a key priority for delivering transformation. We will work closely with Healthwatch, our provider organisations, and the Voluntary and Community Sector to ensure that we are making the most of the resources available to us. As such, consultation and Engagement will take place within available resources and will be carried out via a range of methods/ media.

Key principles around our communication and engagement include:

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

Key areas for further development include:

- Embedding service user feedback and all consultation and engagement responses within the JSNA, including evidence of the reaching a wide ranging group of people;
- Refocussing on 'You Said, We Did' approach to ensure that the public understand how their views aid, impact, and mould decision making;
- Embedding engagement requirements in all contracts, including appropriate reporting and linkages to the JSNA;
- Embedding Service User Satisfaction in the BCF Metrics

Work on consultation and engagement will be on going and will include building on existing work in areas related to the Fund. Better Care Fund Schemes will be required to demonstrate how they have and will engage with service users and the community going forward. They will do this by providing evidence in the following format:

Better Care Fund Scheme	User led working groups/ workshops	Stakeholder led workshops/ focus groups	Communication Methods Newsletters/ Press Releases	Scheme working groups – to include user representation	Reporting mechanism/ governance	'You Said, We Did' Feedback

b) Service provider engagement

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

1. NHS Foundation Trusts and NHS Trusts

In Shropshire we have a number of NHS provider services; the key providers in Shropshire include Shrewsbury and Telford Hospitals (SaTH), the Shropshire Community Health Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital, South Staffordshire and Shropshire Foundation Trust, Shropdoc, the West Midlands Ambulance Service, and the Shropshire Local Pharmaceutical Committee.

Our providers have been extensively involved with the development of some of the services as described in the scheme descriptors. However, in relation to the Better Care Fund specific provider workshops have been held to set the scene and share plans for 14/15 highlighting key priority areas and more detailed planning for 15/16. In addition to the health providers, the independent care home and domiciliary care sector were represented as well as the Voluntary and Community sector.

It has also been recognised that regular discussions must take place across a group of provider agencies and hence the Provider Reference Group has been developed. This group is not exclusively NHS providers and has explored the Better Care Fund schemes, the potential impact on provider services, the inclusion of the Better Care Fund in provider's operational plans, and importantly the risks associated.

Importantly both the risks of successfully delivering the Better Care Fund and associated reduction in A&E admissions and the risks of not delivering the reduction have been explored with this group.

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

The Health and Wellbeing Board was keen to ensure that while the operational discussions and planning were taking place, the Board members of our provider organisations were also provided an opportunity to engage with the BCF planning process. As such a Health Economy Board Chairs and Non – Executive Group has been established. This group will meet four times to discuss the Better Care Fund submission.

This group is Chaired by the HWBB Chair and membership includes SaTH, SCHT, RJAH, SSSFT, Healthwatch, Shropshire Partners in Care (SPIC), and Shropshire Council Cabinet. The group has pledged to continue to meet on a regular basis to ensure that integration is discussed and understood at every level. As the Shropshire Health and Wellbeing Board membership does not include providers, it is delighted to have resurrected this engagement across health and social care.

2. Primary care providers

Primary care providers are key stakeholders in the transformation of services. The 2013 Shropshire Call to Action confirmed that the general population in Shropshire trusts and relies on GPs and other primary care providers (including nurses, midwives and Pharmacies) to support their health needs. As such primary care is at the heart of most of our transformation schemes, as is demonstrated in the scheme descriptors. The Community Care Coordinators, the Compassionate Communities project, and the Care Home Advanced Scheme are excellent examples of the role GPs and GP surgeries play in the health economy of Shropshire, and GPs have been at the centre of decision making around these schemes.

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

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

The Locality Boards of the CCG in the North, Central and South of the county provide an excellent opportunity for CCG members to be engaged. As demonstrated in the Health Economy Engagement Summary, these groups have been and are an important part of the engagement plan.

3. Social care and providers from the voluntary and community sector

Our providers, including social care, independent care homes, domiciliary care, and VCS providers have been involved with the development of the services as described in the scheme descriptors.

In relation to the Better Care Fund overarching plan, specific provider workshops have been held to set the scene and share plans for 14/15 highlighting key priority areas and more detailed planning for 15/16.

Membership on all scheme working groups ensures that the appropriate stakeholders and partners are involved.

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

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

c) Implications for acute providers

Clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Acute providers have been fully engaged in both modelling the impact of the non-elective reduction on their organisation through the QIPP plans and in development of the individual transformation schemes.

By continuing to implement better care for patients closer to home, the demand for NHS Acute, hospital based services has changed and will continue to change.

The CCG and Local Authority are moving ahead with plans for transformational change to support better care for patients in 14-15 and 15-16. The impact of this on the acute providers differs between SATH and RJAH. This is due to the CCG being an outlier in terms of Orthopaedic activity and plans to correct this. For SATH the impact on activity is forecast to be approximately 1.3% of the overall commissioned activity (or the equivalent of demographic growth i.e. commissioned activity levels for 15-16 are planned to be at the same level as 14-15). This equates to approximately 309 avoided emergency admissions. For RJAH there will be a planned cut in activity between 14-15 and 15-16 of approximately 4.5% of inpatients and day cases. This will bring the CCG back into line with other commissioners and represents £1m reductions in orthopaedics spend.

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 workstream associated with the Better Care Fund over the coming months.

In order to ensure Parity of Esteem for the local residents of Shropshire The CCG and the LA are committed to improving outcomes and addressing health inequalities for people with mental health needs and mental and emotional wellbeing. This 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.

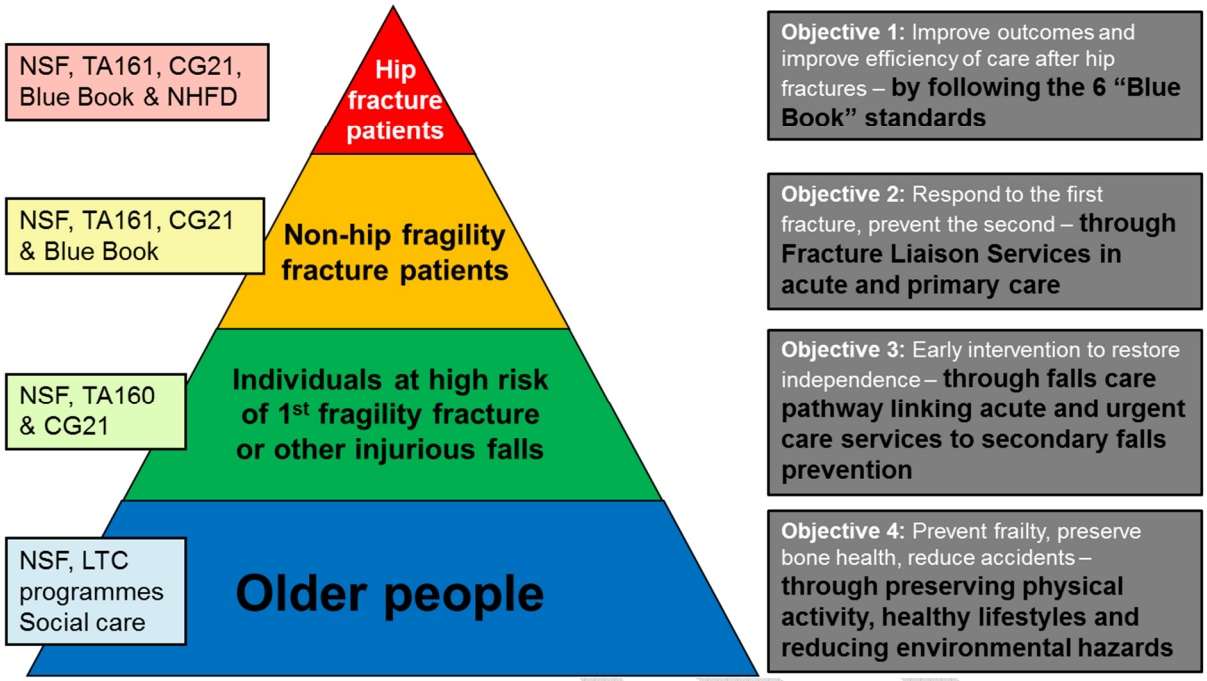
In particular within the scope of the Better Care Fund plan 2014-2016 there is a commitment to Improve access to Psychological Therapies (IAPT), improving diagnosis and support for people with Dementia, improving awareness and focus on the duties with the Mental Capacity Act and reviewing Crisis service provision.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
A1
Scheme name
Integrated Falls Prevention
What is the strategic objective of this scheme?
These works will radically re-shape falls prevention in Shropshire through realistic and achievable changes that optimise both current and new opportunities to identify and manage risk of falls. The scheme will develop a whole system approach to falls prevention to: 1. Proactively identify and reduce risk of falls through risk stratification across all services, e.g. risk stratification through GP records, walk- in centre at A&E 2. Improve patient outcomes and improve efficiency of care after fractures through compliance with core standards. 3. Respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings 4. Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries 5. Prevent frailty, promote bone health and reduce accidents – through pathways into evidence-based postural stability exercise, encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There is huge potential to reduce falls and their impact in our older population. Shropshire currently has a range of services, but these are fragmented and not currently maximising their potential; opportunities to reduce falls are currently being lost. The ambition of this scheme is to embed a proactive approach to identifying risk across services and ensure pathways are in place to ensure people are able to access the right preventive service at the right time. The scheme will undertake a Public Health-led whole system review throughout the local health and social care economy and implement a coordinated 'whole system' falls prevention approach based on Department of Health falls and fractures framework (commissioning toolkit 2009). This will widen the scope and reach of existing falls services and pathways to systematically address the four pillars of falls and fragility fracture care for secondary and primary prevention. The scale and ambition of this scheme is achievable through the collaborative engagement of all stakeholders in achieving this as part of the Health and Wellbeing strategic priorities.

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



The target group for this scheme is people over 65.

Scheme focus will be on optimising:

- Primary prevention through falls and bone health screening (e.g. NHS Health Checks) and pathways to primary prevention intervention (e.g. evidence based exercise programmes)
- Falls and bone health screening and access to secondary prevention through fracture pathway development within fracture services.
- Development of a robust measurement framework to assess impact of falls prevention activities across the whole health & social care economy.

As falls risk is multifactorial, with a fall often being the result of an underlying health condition, the collection of falls data is notoriously complex. The local impact of injurious and non –injurious falls on services is therefore difficult to measure with accuracy. This work will address this by implementing a robust mechanism to measure A& E activity related to falls.

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

Strategic lead; Health and Wellbeing Board Prevention Group (responsible to the Service Transformation Group of the Better Care Fund - HWBB)

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

Providers: Acute A& E, West Midlands Ambulance Service, Shropshire Community Health Trust , GP practices, SCHT falls prevention Service, Voluntary and community sector, Leisure Services, care home sector

The evidence base

Reference the evidence base which you have drawn on

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

As highlighted in the JSNA and the Health and Wellbeing Strategy, Shropshire's population has a higher than average number of older people and our population is ageing. This poses significant challenges for our health and care services and is a significant factor when considering Prevention and Access to Services. Meeting the needs of older people is therefore a local imperative. The Health and Wellbeing Strategy has significant focus on keeping people independent for longer whilst ensuring access to services. As a major cause of loss of independence in older people, preventing both primary and secondary falls through pathways into the right service at the right time will make a significant contribution to achieving this element of the Health and Wellbeing Strategy vision.

Falls represent a significant public health challenge, with incidence increasing at about 2% per annum. Increased rates of falling, and the severity of the consequences, are associated with growing older and the rising rate of falls is expected to continue as the population ages.
Based on NICE guidelines and population modelling, amongst a population of 300,000 around 10,000 people per year who fall should receive a falls assessment, with a further 5,000 potentially requiring a brief screening of gait and balance. In a CCG population such of 300,000 such as Shropshire:

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

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

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

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

There is an economic cost too. Fragility fractures currently cost the NHS more than £2 billion per year. A Kings Fund report from Torbay has demonstrated just how extensive the costs associated

with falls are[1]. For a cohort of 421 patients, representing about 1% of the over-65 population, the sums spent on care within the first year after the fall accounted for 4% of the hospital inpatient budget and 4% of the entire adult social care budget. Yet falls are not an inevitable consequence of ageing, they can often be predicted and prevented (For example, half of all people with a hip fracture will have had a previous fragility fracture which provided an opportunity for prevention.

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

There are a range of interventions available that have been shown to be effective and cost-effective in reducing falls and fracture risk, from balance and physical activity programmes to bone density scanning and osteoporosis treatment. Systematic identification of patients at risk can readily be achieved through risk stratification of the GP record and through addition of a screening tool to the NHS Health Check. Given the ageing of the Shropshire population, the prevention of falls and fragility fractures will become an ever more pressing priority.

The Better Care Fund has provided us the opportunity to ensure greater joint working and to undertake a whole system review and subsequent health economy approach to falls and falls prevention. This work will keep older people (and those with long term conditions) well and physically active for longer, reduce pressure on emergency services, primary care and social care and ultimately reduce admissions to hospital.

The review will focus on service re-design requirements to optimise effectiveness and to widen the scope of existing falls service across the whole health economy.

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References:

NICE guidance: Falls
Assessment and prevention of falls in older people
Issued: June 2013

Investment requirements

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

Impact of scheme

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

Shropshire's current position of having a range of disparate services means that there is no true visibility of falls occurrence or information on impact of falls. A coordinated whole system review will address this. It is anticipated that a coordinated, integrated approached to falls prevention will result in:

- Increase number of falls risk assessments
- Increase in number of people receiving falls risk reduction interventions
- Reduction against baseline in falls admissions (acute) by at least 50 per annum
- Reduction against baseline of admissions from care homes

Feedback loop

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

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

Metrics will be determined in the 'Detailed Business Plan Phase. The metrics are likely to include:

- Impact on local health economy including screening rates for primary and secondary falls prevention,
- Pathways,
- A&E attendances
- Ambulance services,
- Care homes,
- Participation in evidence based exercise for falls prevention programmes.

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

Progress of the project will be monitored by the Transformation sub-group of the H&WB Delivery Group

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

- Secondment of dedicated project officer
- Stakeholder involvement in review processes
- Consultation with over 65's, service users and carers.
- Development and delivery of review
- Development and delivery of transformation plan to include;
    - Significant change within all services to systematically optimise opportunities to identify and reduce falls risk through shared pathways.
    - Training across whole local health economy;
    - Inclusion of falls prevention in Making Every Contact Count approach locally;
    - Stakeholder implementation of transformation approach
    - Data sharing agreements and mechanisms to be implemented to measure impact.
    - Single data set to measure impact of falls prevention activity throughout the whole health economy

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
A2
Scheme name
Dementia Strategy
What is the strategic objective of this scheme?
1. To increase diagnosis rates, increase post diagnosis support, develop shared care plan, further improve partnership working between GP practices and the memory service. 2. To enable patients with dementia and their carers to live well with dementia and live as independently within their own homes for as long as possible. Help to prevent avoidable admissions through increased knowledge and support groups. 3. Building a dementia friendly Shropshire – Raising local awareness of dementia through developing dementia friendly communities and development of the local dementia action alliance; helping to better identify those with dementia and support people with dementia in their own communities. 4. Primary prevention work with public health to raise public awareness of reducing lifestyle risks which may increase the risk of dementia. Helping to better identify those at risk of developing dementia. 5. To ensure people with dementia and their carers receive support and care from staff appropriately trained in dementia care. Aiming to help reduce avoidable admissions.
Overview of the scheme **Provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** **To support and implement the Shropshire dementia strategy 2014-16 which encompasses the above work streams** - **Which patient cohorts are being targeted?** **People with dementia and their carers within Shropshire.**
1. Integration of the memory service with primary care: The project is to be delivered across six GP practices within Shropshire and will integrate South Staffordshire and Shropshire Mental Health Foundation Trust Memory Services within primary care. Initially the memory service will operate clinics within each of the six GP practices providing assessment and diagnosis and some follow up review appointments. This will be reviewed after three months and it is anticipated that this will be rolled out to include other practices. 2. Patient education and peer support for dementia: To develop education and information materials for patients and carers to access to help increase knowledge and help patients and carers to self-manage their condition more effectively. To develop peer support groups within local communities for patients and carers. Shropshire CCG currently has a Project Manager assigned to take forward this work.

3. Building a dementia friendly Shropshire: the local Dementia Action Alliance (DAA) has been established with the aim to encourage local businesses to become members and agree an action plan outlining how they intend to make their business dementia friendly. Currently Shropshire CCG and Shropshire Council have a representative on the steering group and Shropshire Council is a member of the local DAA.
4. Primary prevention work with public health – collaborative working between Shropshire CCG and Shropshire Council's Public Health team to identify information relating to "Brain Health" which can be displayed on the public facing local "Healthy Lifestyles" website to raise public awareness and improve knowledge. Creating dementia friendly leisure centres ensuring staff are dementia friends and undertake facilitated discussions around ensuring local leisure centres and activity groups are inclusive of people with dementia and their carers.
5. Development of a training programme for care home workforce: Shropshire CCG & Shropshire Council are currently working in collaboration with Shropshire Partners in Care to develop a modular training programme for care home staff which is based on a model delivered throughout Telford and Wrekin and commissioned by Telford and Wrekin CCG. The training programme is targeted at Care home Managers and Senior front line staff from all care homes across Shropshire.

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

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

Delivery Partners:
- Telford & Wrekin CCG
- Dementia Action Alliance

Providers:
- GP Practices,
- South Staffordshire and Shropshire Mental Health Foundation Trust
- Shropshire Partners in Care
- Shropshire Community Health Trust
- Voluntary and community sector,
- Local Businesses

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

The work streams included in this scheme are outlined within the Shropshire Dementia Strategy and supporting action plan, identified as priority areas of work, agreed by the Health and Wellbeing board to deliver outcome 3 - to make Shropshire a dementia friendly county to enable earlier diagnosis and

improved outlook for people with dementia. The strategy also outlines future action required in relation to understanding the support people with dementia need, raising awareness and providing the right information at the right time.

These local priorities also support the national strategic direction for dementia, outlined in the National dementia strategy 2009 and subsequent document Prime Minister's Dementia Challenge 2012.

Local evidence is provided by the Joint Strategic Needs Assessment which identifies the ageing population within Shropshire as one of the key challenges facing health and social care provision across the county and it emphasises the need for people to be supported to age well.

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

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

Outcome measures are being further developed, however it is anticipated that the following outcomes will be achieved from the work streams:

1. Communities across Shropshire will have awareness and understanding of dementia. Measured by numbers of "dementia friends" (data obtained from Alzheimer's Society)
2. Early access to support and intervention following an early diagnosis. Measured by increased diagnosis rates from 43.7% and numbers of referrals into the memory service for assessment and diagnosis and follow up support.
3. People with dementia receive care from staff appropriately trained in dementia care: Measured by patient and carer feedback and numbers of care home staff undertaking training programme.
4. People with dementia and their carers feel supported to live well. Measured by patient and carer feedback obtained from dementia café's/peer support groups.
5. Ensure people have the right information at the right time: Measured by patient and carer feedback obtained from dementia café's/peer support groups and patient stories collected by voluntary sector including Rural Community Council. Also measured by numbers of carers attending and completing the Alzheimer's Society CrISP education course commissioned by Shropshire CCG.

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

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

Progress of the project will be monitored by the Transformation sub-group of the H&WB Delivery Group

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

There is an opportunity for health, social care, voluntary and private sector partners to work together to support the work streams with the aim to deliver improved quality of care and health outcomes for people with dementia and their carer's.
For the scheme to be successful all partners need to take a proactive approach to the delivery and implementation of the work streams.

ANNEX 1 – Detailed Scheme Description

Scheme ref no:
B1
Scheme name:
Proactive Care Programme
What is the strategic objective of this scheme?
The Scheme is as identified by NHS England Enhanced Service (ES): 'Avoiding unplanned admissions :proactive case finding and patient review for vulnerable people', now referred to as the 'Proactive Care Programme' The aims of this ES in 2014/15 are to encourage GP practices to: • Increase practice availability via timely telephone access; • Identify patients who are at high risk of avoidable unplanned admissions, establish a minimum two per cent case management register and proactively manage these patients; • Review and improve the hospital discharge process for patients on the register and coordinate delivery of care; and • Undertake internal practice reviews of emergency admissions and A&E attendances. • For CCGs it provides new opportunities to shift funding into primary care services and community health services – and is designed to bring about a step change in the quality of care for frail older people and other patients with complex needs. The local health and social care economy is committed to the principle of 'active case management' and supportive of application beyond the 2% requirement of the ES, as a mechanism for improved patient care, reduction in A&E attendances and admission avoidance.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Unplanned admissions to hospital are distressing and disruptive for patients, carers and families. Many unplanned admissions are for patients who are elderly, infirm or have complex physical or mental health and care needs which put them at high risk of unplanned admission or re-admission to hospital. This enhanced service (ES) is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or readmission. The ES will be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions. The ES commenced on 1 April 2014 and requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a

case management register, personalised care plans and improved same day telephone access. In addition, the practice also provides timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or accident and emergency (A&E) attendances.

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

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

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

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

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

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

Commissioners:

- Shropshire CCG ,

Providers:

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

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

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

Guidance and audit requirements, NHS England Gateway reference 01307

NHS England specification, Gateway reference 01933

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

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

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

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

Implementation & evaluation is supported by:

- Nina White, Programme Lead, SCCG
- Dr Steve James Clinical Lead for Primary Care, SCCG
- Dr Colin Stanford Clinical Lead for Early Intervention (Case Management), SCCG

Monitoring:

- Baseline data and target outcomes will be agreed and monitored by the Finance, Contract and Performance sub-group of the H&WB Delivery group.
- Ruth Bolderstone (Area Team)
- Alison Callingham (SCCG)

Reporting to**:**

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

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

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

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

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

ANNEX 1 – Detailed Scheme Description

Scheme ref no
B2
Scheme name
Community and Care Coordinators
What is the strategic objective of this scheme?
The strategic objective of the Community and Care Coordinator prototype is: • To demonstrate the potential of non-clinical individuals, working as part of the practice team, to proactively case manage individuals at risk of loss of independence and hospital admission as a result of more pastoral or social unmet need. • To explore the potential of such an individual supporting collaborative working between the practice, the voluntary sector, community groups and volunteers, in effect, both recognising and creating links with existing resource in the community and supporting its growth and further development. Detailed objectives include: • Increase the practice team's awareness of the services and skills provided by the voluntary sector and by volunteers in the community. • Improve communication between the Local Authority, voluntary sector, community groups and the practice. • Support the practice to identify frail and vulnerable patients at risk of inappropriate admission, opportunistically and proactively, through computer searches, risk stratification and communication with the wider community. These will often include patients toward the end of life, patients with dementia, patients who are lonely, isolated or who have minimal or no family or social support. • Where considered appropriate by the MDT or lead clinician to sign post individuals to statutory, non-statutory and voluntary services and to care coordinate those individuals who continue to struggle to navigate the system. • Introduce an assessment process for frail and vulnerable patients that will begin to record and code clinical and non-clinical information relevant to their holistic care. • Support the community in the development of peer groups, carers groups and volunteers. • Make links between these developments and those who might benefit from what they offer.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

The practices are funded to enable them to either second or employ a Community and Care Coordinator (C&CC). The C&CC is employed for 1 session a week per registered population of 2000 patients (nearly two days per week for an average practice).

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

The C&CCs have two main functions:

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

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

In particular the co-ordinators focus on people who are:

- Identified as frail and vulnerable
- At risk of admission to hospital and/or loss of independence
- Coming toward the end of their lives

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

Commissioners:

- Shropshire CCG ,

Providers:

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

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

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

There is considerable evidence that case management including care coordination of the frail and vulnerable members of society improves outcomes. This innovation looks at a non-clinical member of the practice team supporting and sign posting those individuals where it is appropriate to do so as

part of a multidisciplinary team. It is in line with NICE End of Life, National End of life and LTC Strategy, Kings Fund and Health Foundation research.

This workstream was introduced to explore how practices might become better able to manage the demand created by the growing older population and equally how as a health and social care economy we might pool effort and resources and work in a more integrated way to better support this very vulnerable part of our community. This within a context of increasing prevalence of older people, increasing demand on primary care, increasing hospital admissions and a growing awareness of the impact unmet health and social care need, isolation and loneliness can have on individuals and the health economy.

An initial prototype has been in place since Winter 12/13 and it's impact and effectiveness has been evaluated. In summary Community and Care Coordinators are clearly valued by GPs, practice managers, patients and carers. They have increased activity within the voluntary sector and begun to support the development of peer groups and Compassionate Community volunteers in the communities.

Trend data has shown a positive change in GP appointment activity. A&E attendance, and hospital admissions fell over the year however the admissions also fell in the practices without a C and CC. Shropdoc activity rose in all practices similarly.

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

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

The impact on social costs such as care packages and care home placements is positive but the evidence is not yet robust. Chester University has offered their support in the closer evaluation of this element as the project moves forward.

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

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

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

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

Feedback loop

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

Implementation & evaluation is supported by:

- Tracey Savage, Programme Lead, SCCG
- Dr Colin Stanford, Clinical Lead for Early Intervention (Case Management), SCCG

Monitoring:

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

Reporting to**:**

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

See table below

Summary of evidence from the evaluation of phase 1 of the C&CC prototype				
Outcome	**Evidence**	**So did it?**	**Strength of evidence**	**Comments**
Reduce GP Apt's	Testimonials Pre and post data Questionnaires Pt. stories	Yes Yes Yes Yes	Green	Pre and post data show a reduction of 48%
Reduce A&E/999	Pre and post data Trends	Yes No to prof ref Yes to self ref	Orange	Pre and post data show a reduction of 33% Trends show a reduction in self-referrals of - 660 in C&CC Practices with a population size of 44130 (6 month period)
Reduce hospital admissions	Pre and Post data Trends Pt. stories Testimonials	Yes Yes Yes Yes	Orange	Pre and post data show a reduction of 58% Trends show a reduction by 3% for a population size of 44130. However, there is also a reduction in non-practicing practices 4% in a population size of 24148
Reduce Shrop doc calls	Pre and post data Trends	Yes No	Red	All Shropdoc data has increased seasonal, bank holidays, 111 etc. Pre and post data show a reduction of 78% in 80 patients
Reduce the cost associated with dependency	Pre and post data Trends of self refs Testimonials Questionnaires Pt. stories	Yes Yes Yes Yes Yes	Green	Evidence from pre and post data show a reduction of all services used, self referrals to A&E have reduced, voluntary services being used to support rather than statutory services

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

ANNEX 1 – Detailed Scheme Description

Scheme ref no:
B3
Scheme name: Care Home Advanced Scheme
Care Home Advanced Scheme (CHAS)
What is the strategic objective of this scheme?
Shropshire has one of the highest numbers of care home beds per head of population in the region; this is growing rapidly. Emergency admissions to hospital are dominated by frail and complex patients and residents of care homes form a disproportionate number of these. Once admitted, they have poorer outcomes than the general population. During the six month period from 1st Feb- 31st July 2013, there were 486 admissions from Care Homes, at a cost of £1.4 million. Based on these figures, the admission rate from care homes is >1:4 residents per year. The aim of the project is: • To reduce unnecessary hospital admissions, A&E attendances and make improvements in quality of care and outcomes. This will be achieved by adopting pro-active care through active case management, care planning and multidisciplinary review for patients in care homes
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Overview of model of care and support and patient cohorts targeted: • 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 • 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 **Detail of scheme** • A list of residents for each general practice of their patients who are residents of care homes and deemed at high risk who would therefore benefit from pro-active care through active case management. • An assessment by the GP of each patient on this list and the development of a care plan jointly agreed by the GP, family members, care home staff and other community professionals as appropriate.

- The care plan which employs agreed and consistent documentation and the same as that used in other groups who are providing active case management. This will include an avoiding admission plan and, where appropriate, an End of Life / DNAR form.
- Pro-active care delivered as agreed in the care plan
- Review of the care plan when clinically appropriate (minimum 6 monthly)
- A significant event analysis for any patient who is admitted into an acute hospital bed from a nursing/care home setting to determine cause and avoidable factors
- Cross referencing those patients with mental health needs or learning disabilities who are in receipt of other services and on other practice registers.

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

Commissioners:
- Shropshire Clinical Commissioning Group
- Local authority

Providers:
- Care Home providers
- Shropshire GPs

Delivery Partners:
- Shropshire Partners in Care – umbrella organisation for care home providers
- Shropshire and South Staffordshire Foundation Trust – mental health provider
- Shropdoc (Shropshire out of hours service)
- Shropshire Community Health Trust – community provider

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

Evidence from similar initiatives has demonstrated significant positive impacts on the costs associated with hospitalisation. For example Birmingham East and North implemented this type of extended service and saw net savings of £1.1 million, which was approximately a reduction by one third of the costs associated with hospitalisation.[1]

A study to investigate the impact of local extended services to care homes in London found that there was:[2]
- Improved life for care home residents
- Improved continuity of care
- Reduced hospitalisation
- Improved health monitoring
- Improved prescribing systems
- Positive working relationship between care home and GP – fixed regular visits allowed communication and consistency
- Patients have appreciated the impact of a 'familiar face'

NICE suggests that between a third and a half of all medicines prescribed for long-term conditions are not taken as recommended. If the prescription is appropriate, then this may represent a loss to patients (in terms of health gains associated with medicine taking), the healthcare system and society. This proposal aims to ensure patients in care homes receive regular medication reviews and are supported in their medicine taking.[3]

References

1. Anon. 'Birmingham East and North GP Locally Enhanced Scheme'. Clinical Support to Care Homes and Nursing Homes.
2. Briggs D et al. Reducing hospital admissions from care homes: considering the role of local enhanced service from GPs. Working with older people. 10.5042/wwop.2011.0114.15:1:
3. National Institute for Health and Clinical Excellence. 'Medicines adherence Involving patients in decisions about prescribed medicines and supporting adherence' http://www.nice.org.uk/nicemedia/live/11766/43042/43042.pdf

Investment requirements

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

Impact of scheme

Enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

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

Residents in care homes have complex and changeable medical needs – their needs will be met more effectively through this advanced scheme and there will be:[1]

- Reduction by 20% in emergency admissions from care homes
- Reduction by 10% in A&E attendances
- Decrease in resident LoS by 10%
- Improved life for care home residents and enhances the quality of life people with long-term conditions (NHS Outcomes Framework domain -2)
- Improved continuity of care
- Improved health monitoring
- Improved prescribing systems

Positive working relationships between care home and GP – regular visits allowed communication and consistency

Secondary Outcomes:

- Reduce Shropdoc call outs
- Improve communications between care homes and practices
- Improve health and well-being for patients and carers
- Improved access for health professionals/carers to GP advice to care options and decisions
- Discussions around End of Life/DNAR with family and carers
- Improved education and competence of care home staff
- Reduction in ambulance call outs

The CHAS will deliver against the following domains of the NHS outcomes framework.

Domain 2	Enhancing quality of life for people with long-term conditions	☑

Domain 3	Helping people to recover from episodes of ill-health or following injury	☑
Domain 4	Ensuring people have a positive experience of care	☑
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	☑

Feedback loop

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

- Emergency admissions for patients aged 65 years and over from care homes – monthly data to be provided in order to check against progress
- Against all emergency admissions for patients aged 65 years and over (taking into account other projects to reduce overall admissions) – monthly data to be provided
- Project includes feedback via 'Significant Event Analysis' (SEAs) to the CHAS team of any patients admitted to hospital as emergencies

Implementation & evaluation is supported by:

- Tracey Savage, Programme Lead, SCCG
- Dr Colin Stanford, Clinical Lead for Early Intervention (Case Management), SCCG

Monitoring:

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

Reporting to**:**

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

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

- A clear link between primary care, the local authority, the voluntary sector and the community enabling integrated care and improved communication.
- Facilitation and community leadership for the development of carer and peer networks.
- Resilient communities

ANNEX 1 – Detailed Scheme Description

Scheme ref no:
B4
Scheme name:
Team Around the Practice
What is the strategic objective of this scheme?
At the Shropshire Community Trust and Shropshire CCG Board to Board on May 15th 2014, it was agreed that the two organisations would work together to understand the role of the Community Trust clinicians as key members of a practice support network or "Team around the Practice", in particular community nurses, case managers and therapists that form the Community Inter-disciplinary Teams (IDT). Over the last decade services have been configured in a way that fails to recognise the central role of the practice. Rather than supporting practice activities services increasingly appear to work at best separately from practices and at worst in competition with practices. This has led to fragmentation, duplication, gaps in services and deterioration in relationships between practices and other community delivered services. There is a lack of clarity within all contracts around what practices can expect from services. The practices and the CCG Board have signalled an intention to more effectively define these services as elements of a virtual "Team around the Practice" with clarity around what can be expected of them by the practice, how they work together and communicate together, how they can be supported in using a shared system of electronic record keeping and their role in the care coordination of the patients identified through the Proactive Care Programme.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The CCG and Local Authority supports a model in which the practices retain overall responsibility for assessing need and coordinating care for their patients and are supported in this by a range of community services closely linked to the practice. This model underpins the new GMS contract which clearly defines the practices overall responsibility for patients on its list and in particular the identification of and care coordination of individuals more at risk. Currently these community services or "Team around the Practice " are not considered sufficiently robust or integrated to provide the quality and capacity of support required to meet the need generated by both the demographic change and the trend to care for people closer to home and outside of a hospital setting.

The proposal is that we look at the commissioning of community services, that is services delivered in the community but not as part of the current national primary care contract, as a number of modules of care. These modules of care will be instigated as required as the needs of an individual change. The modules would support the primary care team who provide "normal care" but who remain responsible for the overall patient journey and responsible for medical care whilst the patient is managed in the community.

The Better Care Fund and the expectation of closer working with the Local Authority offer an opportunity to explore the potential benefit of virtual integration of adult social services alongside community care and primary care. 'People to People' currently deliver care management services for Older people and People with a Physical or Learning Disability on behalf of the Local Authority in Shropshire.

The target patient group is likely to be those identified under the admission avoidance scheme. This equates to 4954 of Shropshire's population (over the age of 18), with a large proportion of these anticipated to be over 65 years of age.

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

Commissioners:
Shropshire CCG
Shropshire Council

Providers:
GP Practices
Shropshire Community NHS Trust
People to People
SATH - Therapies
SATH - Diabetes Specialist Team
Shropshire Community NHS Trust - COPD Specialist Team
Shropshire Community NHS Trust – Falls Prevention Team
SATH - Heart Failure Specialist Team
Severn Hospice - Palliative Care Specialist Team
Mixed - CBT/Counselling
Shropshire Council- Substance Misuse
South Staffordshire & Shropshire Foundation Trust (SSSFT) - CPN in practice
Shropshire CCG - Community Pharmacist
Shropshire Community NHS Trust - Paediatric support/ Health Visiting
SATH - Midwifery

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

The proposal is aligned to national and local drivers including:
- The GMS Contract

- The Better Care Fund
- Future Fit

And by the findings of a recently completed Community Nurse Review

Investment requirements

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

Impact of scheme

Enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

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

Impact of this scheme will be identified through the Outline Business Planning phase of development. Anticipated outcomes include:

- Reduction in A&E attendances for those patients identified through the admission avoidance scheme.
- Reduction in delayed transfer of care, through improved care planning
- Reduction in admissions to residential and nursing home care
- Benefits to patient and carer satisfaction to be defined

Feedback loop

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

The scheme is in the scoping phase and therefore more detail will be available in the Outline Business Planning phase.

Implementation & evaluation is supported by:

- Nina White, Programme Lead, SCCG
- Dr Colin Stanford, Clinical Lead for Early Intervention (Case Management), SCCG

Monitoring:

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

Reporting to**:**

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

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

- Developing clear methods of communication and accountability between practices and the teams that support them in the community
- Clear specifications that clarify the nature of the support these organisations provide to the practice
- Shared records and care plans.

- Assessment process spanning social and health need.
- Understanding co dependencies and supporting integration in the community.
- Developing the community network to support care closer to home and the right shift
- Engagement with relevant partners
- The implementation of the community services commissioning modules
- Success of concurrent work streams including the Integrated Community Service and Future Fit
- Shared systems of record keeping supported by data sharing agreements

Further success factors to be defined as the scheme progresses to an Outline Business Plan

ANNEX 1 – Detailed Scheme Description

Scheme ref no:
C1
Scheme name:
Integrated Community Services (ICS)
What is the strategic objective of this scheme?
The strategic objectives for ICS can be described in terms of patient focusses objectives and performance and process focussed objectives: Patient focussed • More people with urgent care needs are supported in the community • People get the help they need when they need it • More people benefit from intermediate care • People only spend the time in hospital needed • People are enabled to recover and regain their independence Performance and process focussed • Reduction in Length of Stay (LOS) and excess bed days • Reduction in Delayed Transfers of Care (DTOC) • Reduction in admissions to bed based rehabilitation and long term care home placements from hospital • Reduction in domiciliary care packages • Increase in uptake of carer assessments and support services • Reduction in readmissions within 28 days of discharge • Reduction in level of need on completion of reablement (minimum 60% require no ongoing social care support)
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service aims to ensure that people over 18 years of age who are ready for discharge from a hospital setting and require support to gain/ regain independence are supported to discharge home or to the most appropriate community setting with the correct level of support in a timely manner. Once in the community they will receive a comprehensive assessment of their needs and be supported to develop a time limited independence plan enabling individuals and their carers to remain as independent as possible, for as long as possible. The pathway for the individual will be integrated

across health and social care, delivered by a single team with all professionals involved working together to deliver seamless support to the individual to enable them to maximise their independence.

The vision of what success looks like for an Integrated out of hospital service to Optimise Capacity to Support Discharge:

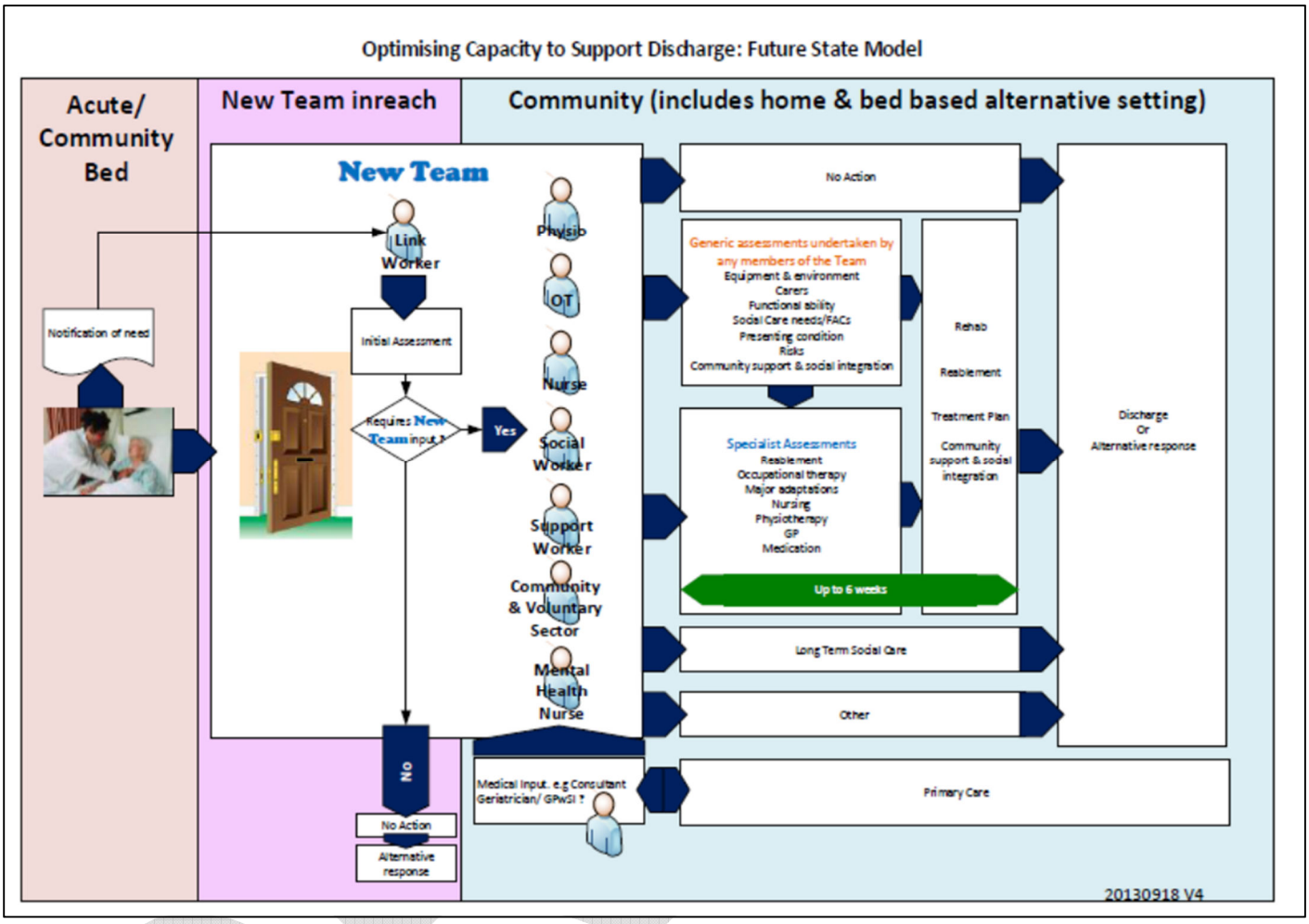
- A locality based health and social care, community and voluntary sector integrated team with responsibility for complex patients requiring discharge from an inpatient bed.
- The service will receive referrals through a single point of access.
- 'Discharge Home to Assess' or 'home is normal' will be the default position, home being the patients' usual place of residence.
- The service will undertake shared generic assessments, to be completed by any member of the team, so that patients do not have to re-tell their story.
- People will be provided with the necessary support in a community setting to maximise their independence and recover from a period of ill-health before they are assessed for their longer term health and social care needs.
- The integrated community provision will ensure people have access to appropriate care in the right place at the right time closer to their home.
- The service will use shared chronological notes to document the patients' journey.
- The service will enable people to regain confidence and be able to contribute and be part of their local community.
- The service will increase the identification of, and support to informal family carers to ensure that their needs are also met.
- The service will ensure effective interfaces with the wider system and change programmes to ensure seamless and coordinated care.
- The service will operate over seven days per week.

The service will support:

- People who are 18 and over and a registered patient with Shropshire or Telford and Wrekin CCG's or resident in the Shropshire and Telford and Wrekin areas.
- Patients who are fit for transfer from acute or community hospital, or are at risk of admission but require additional support and care to regain their independence

An illustration of the model of care is featured below.

Intergrated Community Services – Model of Care



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

Commissioners:
Shropshire CCG
Shropshire Council

Providers:
Shropshire Community NHS Trust
Shropshire Council
British Red Cross

The evidence base
Reference the evidence base which you have drawn on
- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

This section describes the key findings from the project team's analysis of its mapping of the current state in terms of:

- National and local context
- Key performance challenges/ pressures in the system
- Current availability of relevant services in the local economy (Capacity).
- Findings from the August 2013 Non-Elective In-Patient audit survey (undertaken by Oak Group) (Demand).

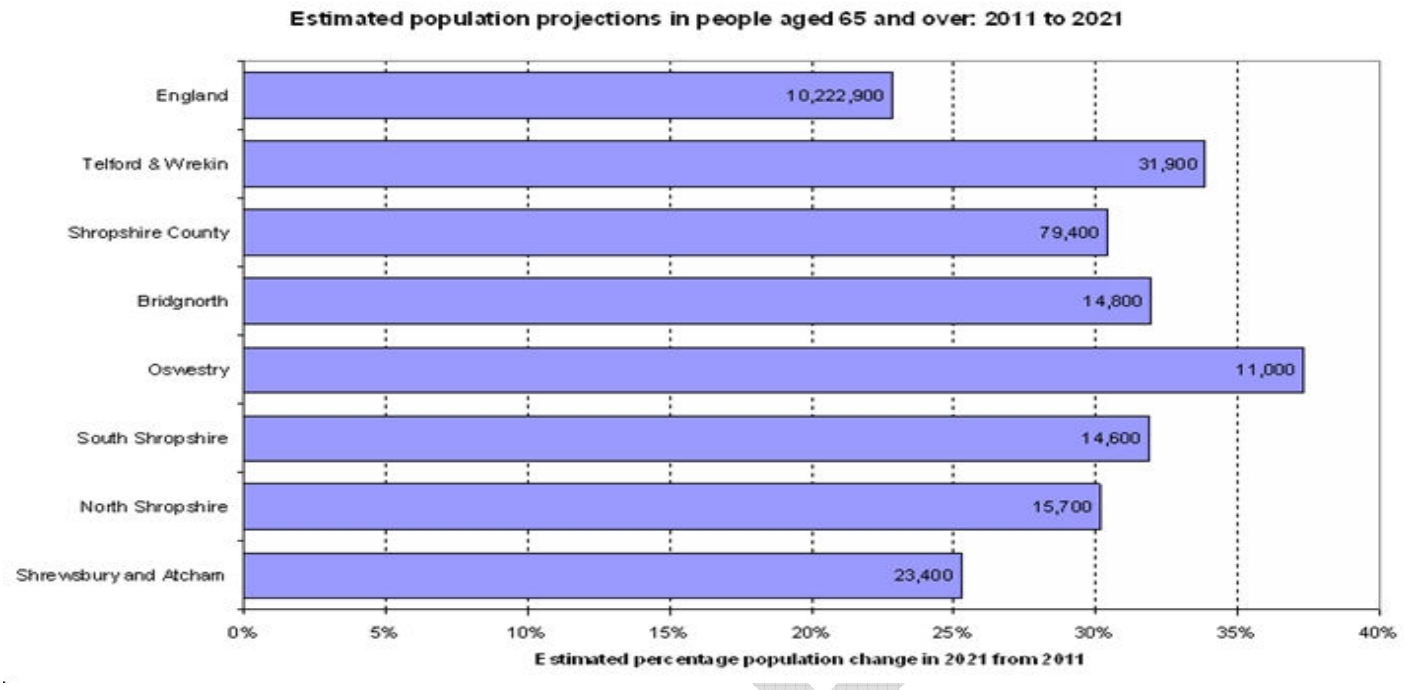
Changing demographics

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

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

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

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



Implications of this include increased pressure on acute hospital services, and increased need for a shift to care in community settings.

The key issues for Shropshire are the numbers of those who are frail elderly with complex care needs who are already within health and social services and the increased numbers that will continue to need services this winter and beyond. This is an immediate pressure. The key issue for Telford and Wrekin is to plan for the gradually increasing numbers that will emerge over the next 10 years that will accelerate exponentially.

Financial challenges

There are a number of financial challenges within the local economy as well as nationally. Council funding has reduced by 20% over the last two years. Furthermore, a report by Finnamore Consulting has, after detailed analysis, identified a potential financial gap of £74-82m by 2015 within the local Shropshire (Shropshire and Telford and Wrekin CCG/ Council) economy.

Local strategic context - Unscheduled Care Strategy

A cross economy, three year Unscheduled Care Strategy was developed in 2011 with wide stakeholder involvement including patients and clinicians. One of the key principles of the strategy is that patient journeys need to be simpler, shorter, safer and more effective.

The strategy was built on the following patient statements:

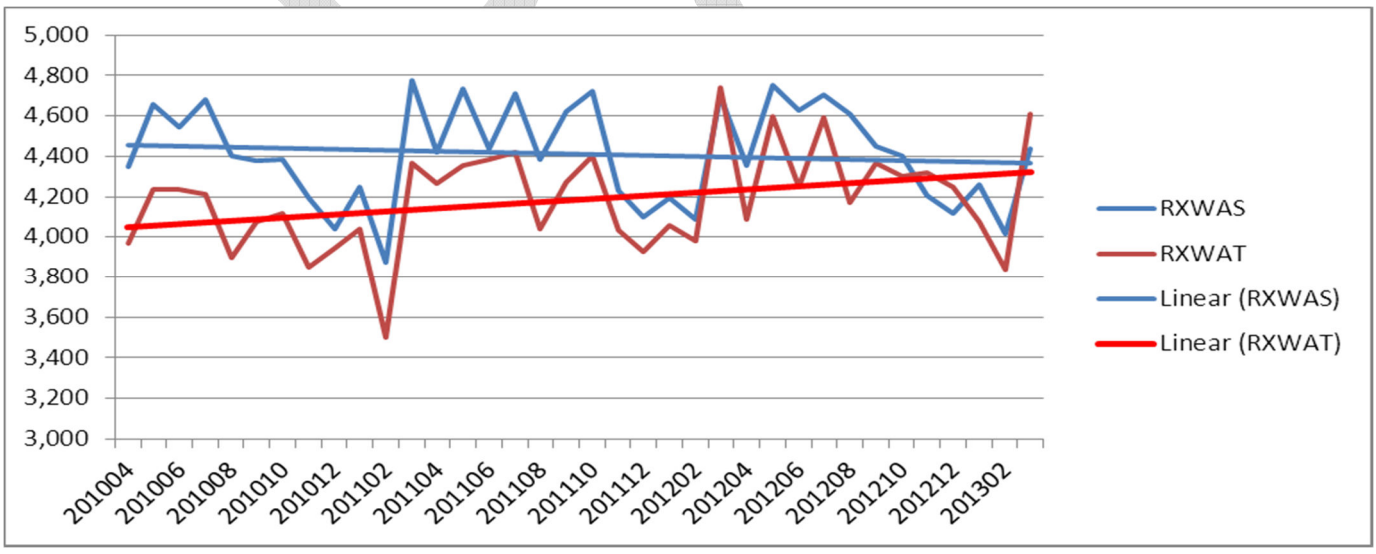
- Be 'joined up' and responsible for my care
- Help me understand my (urgent care) needs
- Assess and treat me promptly and in the right place
- Admit me to hospital only when necessary
- Try to care for me at home, even when I am ill

The strategy delivery was divided into a number of work streams, one of which is 'Frail and Complex'. During winter 2012-13 the economy piloted an integrated multi-disciplinary health and social care acute frailty team in A&E/ AMU in both Princess Royal Hospital (PRH) and Royal Shrewsbury Hospital (RSH). The team included specialist medical input, acute and community nursing and therapy and social care members. The aim of the pilot was to test if by using this approach an admission could be avoided or where admission was necessary to facilitate early supported discharge within 72 hours. The key learning from the team of professionals involved in the pilot is listed below:

- Some lack of confidence and knowledge by acute professionals of availability of community provision and their responsiveness leading to unnecessary admissions and delayed discharges.
- Lack of standardised referral and assessment processes.
- Significant variation in capacity and provision between localities
- Examples of poor communication between organisations
- Duplication of work, in particular, assessments
- Reablement used inconsistently across the economy and limited home based rehabilitation/ reablement options in Shropshire
- Lack of timely response by external partners to facilitate early supported discharge
- Lack of capacity compounded by not making the most of what we have got.
- Risk averse behaviour by staff regarding discharge
- Inconsistent integration of health and social care
- Lack of clear roles and responsibilities for discharge planning

Key Performance Challenges/ Pressures

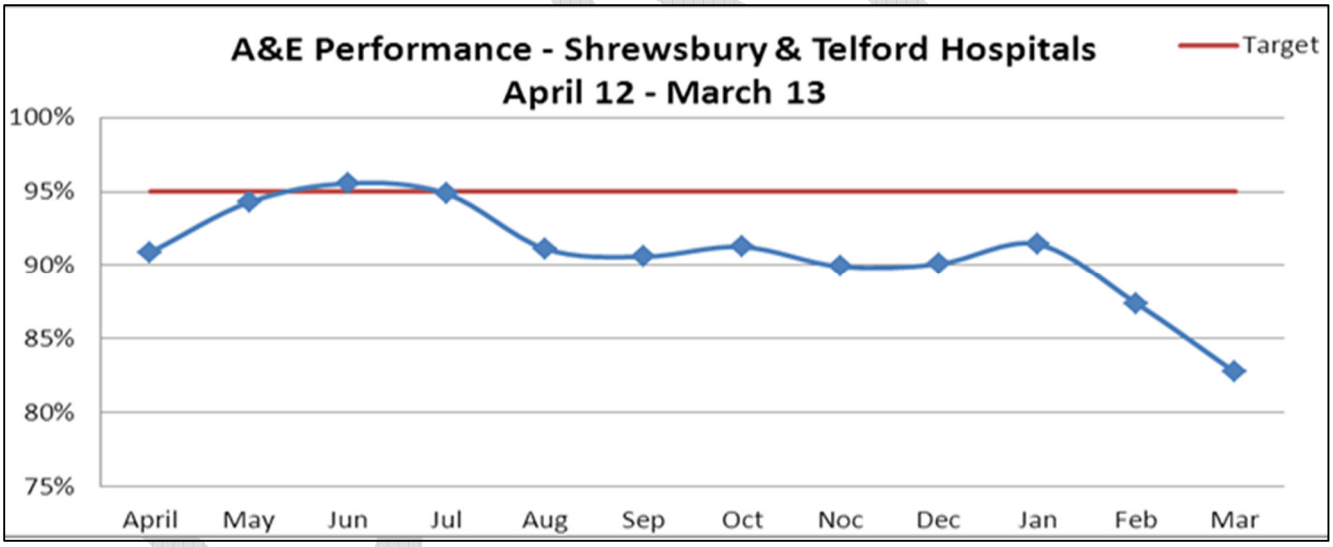
4 Hour A&E Target Performance (Data source: A&E Recovery Plan)
ED Activity April 2010- Feb 2013



Key:
RXWAS – RSH
RXWAT – PRH

Locally Shropshire and Telford CCGs have not seen the dramatic rises in A&E attendances seen nationally over the last three years. However, despite this SaTH failed to achieve the 95% 4 hour target during the majority of 2012-13. Although the graph details performance across both sites collectively, there are differences in the level of achievement at each site with PRH performing consistently better than RSH. The predominant reason given at each site for the escalation and subsequent breaches was the non-availability of beds to transfer patients who required admission (RSH 70.1%/ PRH 61.7%). RSH site was the location for the majority of the 12 hour trolley breaches and delays in excess of one hour hand over for ambulance services.

SaTH A&E performance



Delayed Transfers of Care (DTOC)

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

Winter pressures

For both PRH and RSH sites', taking all admission types together, activity was significantly lower in winter 2012-13 compared to the same period the previous year. However, a reduction in SaTH bed capacity in the summer of 2012 as part of service reconfiguration compounded by spells of prolonged cold weather meant that despite no significant increase in demand, the pressure on acute services was significant. More Escalation Level 3s, indicating increased pressure in the system, were called during the period compared to the previous year. The situation culminated in SaTH declaring a Level 4 Major Incident in April 2013.

On 10 September 2013, the Secretary of State for Health announced additional winter funding totalling £250 million to be allocated across 53 Acute Hospital Trusts in England identified as being at the highest risk for non-achievement of the A&E 4 hour 95% target this winter. SaTH was identified as one of the Acute Trusts to receive additional financial support and as such the economy has been allocated £4 million. The Winter Plan to invest this money includes a combination of increased bed capacity through the purchase of additional community beds alongside support for additional clinical and non-clinical hours both in acute and community and increased social services capacity.

Mapping Current State Availability of Services

The project team conducted a mapping exercise of relevant current services (external to SaTH) across Shropshire and Telford & Wrekin (T&W). Whilst it is clear that a wider variety of health and social care services exist there is wide variability in models of care, service capacity and capabilities within teams across Shropshire and Telford &Wrekin (T&W).

Key observations and findings from the mapping exercise include:-

- Existence of an integrated health and social care Enablement Team and Home from Hospital team in T&W whilst not in Shropshire.
- Fundamental differences between the structures of community service teams – Community Inter-disciplinary teams (IDTs) operate in Shropshire (nurses and therapists integrated into one team) whilst the structure of nursing teams in T&W is more traditional

- Inconsistency in working hours of different teams and therefore wide variation in service availability and access.
- Large number of discrete teams, ranging from general to specialist. The number of discrete teams in Shropshire CCG being significantly higher than T&W.
- Inequity of service capacity and skill mix between the 3 Shropshire localities.
- Variation in access to community hospitals for example there are three located in South Shropshire, one in North Shropshire, none in Shrewsbury & Atcham or T&W (although it should be noted that these last two areas have access to a small number of NHS commissioned rehab beds in nursing homes).

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

Background to the Audit

Early on in the project, the project team determined that accurate, reliable, objective information to measure demand post discharge must be gathered for the project outcomes to be achieved. In reaching this consensus, the following factors were considered:

- The need for a credible picture of demand to develop a strategy for the future.
- The need for rapid mobilisation, given the very short project timescale.
- Previous internal studies have been undertaken but tended to focus on resource based assessment rather than needs based.

For these reasons, an external organisation Oak Group was commissioned (via support of the Chief Officer's Group in July) to conduct a point prevalence audit of non-elective patients, across acute and community hospital settings.

Patient Cohort

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

Audit Methodology

Oak Group undertook this audit over a six day period in early August. This involved a team of nurses (and a seconded social worker from the project team) reviewing medical and nursing notes for the patient cohort described. Additional information was obtained by talking to the clinical team where this was necessary.

Each patient was reviewed between 1 and 3 times during the audit dependent on their length of stay:-

1. Current day (ie. the day of the review),
2. Day of admission
3. Intermediate day of care (retrospective)

Each review was completed using Oak Group's Managed Care Appropriateness Programme (MCAP) System - an evidence-based, structured tool to determine medical necessity of patient placement. The audit collected the following data:-:

- Was the patient at the correct level of care?
- If not, what level of care was needed?

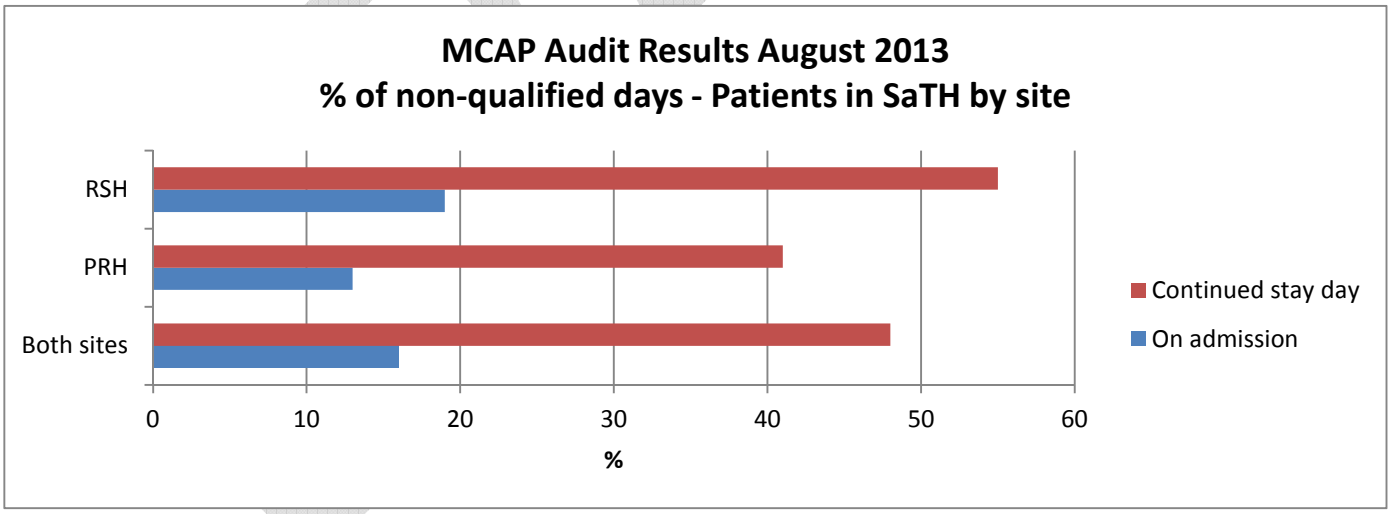
- What was the reason the patient was not at the correct level of care?
- The audit designated patients as either '**qualified**' or **'non-qualified'** using the following definitions:
- **Qualified** - The patient is at the correct level of care to meet his/her medical needs. The intensity of clinical services required to treat the patient, as defined by their care plan, cannot be provided at a lower level of care.
- **Non-qualified** - The patient could be treated at a lower (or higher) level of care to meet medical needs (includes existing and potential levels of care).

Key Findings from the Audit

SaTH

- 299 patients audited in total. 53% were on a ward in PRH and 47% in RSH. The clinical specialties targeted were medicine, rehabilitation, respiratory, orthopaedics and stroke (as areas likely to have the highest percentage of complex discharges).
- 70% of these patients were over 70 years of age.
- 88% had significant risk factors, the most prevalent being co-occurring conditions and poor mobility.
- 16% of patients were non-qualified on admission (13% PRH, 19% RSH) and 48% of continued stay days (41% PRH, 55% RSH) (Figure 4)
- 68% of the reasons for non-qualified days were recorded in the audit as being within the control of SaTH. Only 28% of PRH patients and 43% of RSH patients had a discharge plan, almost all were completed after admission and most of these were poorly documented. An estimated date of discharge was noted in only 28% of PRH patient records and 22% of RSH patient records.

MCAP Audit Results - % non-qualified days in SaTH

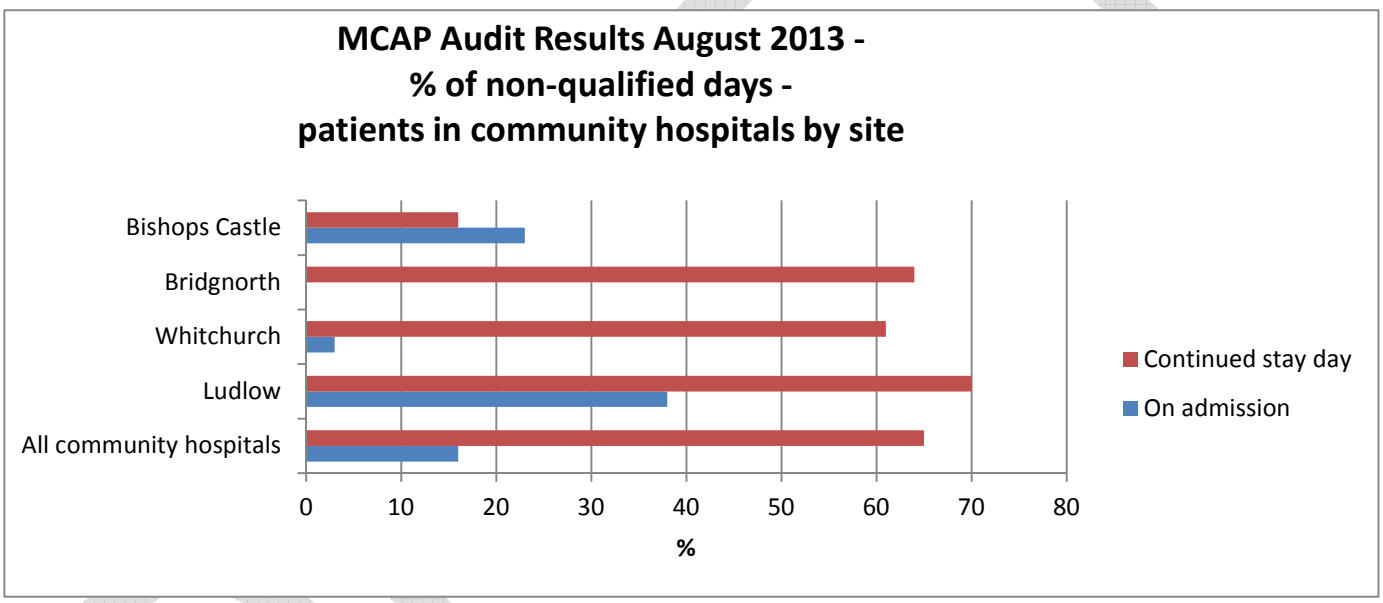


Community Hospitals (Ludlow, Whitchurch, Bridgnorth, Bishops Castle)

- 93 patients audited in total (this represents 82% of the total 113 community hospital beds, with the shortfall attributable to vacant beds on the audit capture days). Figure 5 below shows proportional split of patients audited by community hospital.

- Over 95% of patients audited were over 70 years of age. This is typical for community hospital care in the UK.
- Over 95% of patients had significant risk factors, the most prevalent being multiple drug therapy and patient living alone.
- 16% of patients were non-qualified on admission (range 0-38%) and 65% of continuing stay days (range 61-70%) (Figure 6)
- 56% of all reasons recorded for non-qualified days were within the control of the community hospitals. Discharge planning occurred in about 41% of rehabilitation intermediate patients and 63% of medical intermediate patients.

MCAP Audit Results - % non-qualified days in SCHT Community Hospitals



The key findings of the audit highlight that:-

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

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

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

An in depth analysis of the current state and supporting evidence from the studies completed by SaTH, Atos and the Oak Group led the Optimising Capacity to Support Discharge group project team ('the team') to consider the case for change in detail and how services and functions could be better aligned to address some of the challenges that the analysis highlighted. Using local and national research of what works well, the team developed a vision of what success should look like and produced a draft model. The key elements of this relate to addressing the fragmentation, duplication and gaps that exists in our local health and social care systems to deliver better outcomes and experiences for our populations.

The draft vision and model were tested with key stakeholders who were invited to the team to review this and at a stakeholder workshop that was held in early August. The workshop was well attended by stakeholders from all key organisations across the Health and Social Care economy, including representation from the independent sector.

There was strong support for changes to the health and social care system and for the draft vision and model, with considerable frustration expressed as to why the proposed changes had not been implemented earlier.

The research, analysis and feedback from stakeholders led the group to develop a proposed vision and model for an integrated service within Shropshire and Telford & Wrekin.

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

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

Performance will be organised into 4 high level themes,

Feedback loop

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

ICS will collect and report the data required to monitor and report against these metrics in a single IT solution

- ICS intends to commission a single platform that supports the collection of the data required to monitor and report against the key outputs and outcomes in phase 2.
- Our aspiration is to work towards an IT platform that supports an integrated health and social care record.

The Team Dash-board will help the team to work collaboratively by having accessible patient level information to track patients through the system and flag patient flow issues.

Implementation & evaluation is supported by:

- Emma Pyrah, Programme Lead, SCCG
- Dr Colin Stanford, Clinical Lead for Early Intervention (Case Management), SCCG

Monitoring:

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

Reporting to:

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

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

- Simplify the pattern of services to reduce complexity and fragmentation of services.
- Co-design and develop the best, outcome-based, efficient, integrated health and social care pathways based on the needs of patients and carers for intermediate care services.
- Develop the capability to harness the power of the wider community to support people in their own homes.
- Create the workforce and services that offer a robust, effective alternative to bed based rehabilitation and reablement and recovery.
- Work collaboratively across the whole system to achieve real transformation with all key components in place and working consistently; partial implementation will not be sufficient to create significant change.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
C2
Scheme name
Mental Health Crisis Care Service
What is the strategic objective of this scheme?
To support people who are experiencing mental health crisis's so that they can access support as soon as possible when they are in crisis with the anticipation that it will either prevent admission or lead to early discharge whilst reducing the impact on the crisis on their long term mental health.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A working group including Psychiatry, GP, mental health practitioners, LA and SSSFT managers, voluntary sector, service users and carers met to consider proposals and to identify a model of support. The model has been cross referenced with the Mental health Crisis Care Concordat that places a duty upon local agencies to produce a Mental Health Crisis Care declaration regarding the development and operation of all mental health crisis services. The new service will seek to: • To offer a service that provides intensive to support to individuals in their own home environment whilst experiencing crisis • This service to include peer recovery workers within its establishment • This team to work in tandem with the CR/HT who will lead on their deployment and collaborate extensively • The team to be available over a 24 hour period • The role of the team will need to see the full utilisation of Crisis Plans i.e. service users to have a detailed plan detailing the supports to be offered when they are in crisis • Links to other crisis services such as Shropdoc to be developed • Collaboration with and support to carers to be fundamental to the role This will be for all service users who need an immediate response, coordinated through the Crisis Resolution and Home Treatment Team owing to a mental health crisis
The delivery chain Provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners**:**
Shropshire CCG
Shropshire Council

Providers:
South Staffs and Shropshire Foundation Trust
Shropshire Council

The evidence base

Please reference the evidence base which you have drawn on

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

In January 2014 the Department of Health launched "Closing the Gap: Priorities for essential change in mental health." The central theme of this document reinforces the Principles of ensuring *Parity of Esteem* between Mental Health and other types of health provision. It sets out 25 areas in which they evidenced change was required in order to see improvements in mental health provision. Priority Area 15 states that, "no-one experiencing a mental health crisis should ever be turned away from services."

It then goes on to explain that not all services are available 7 days a week and there are particular difficulties in arranging for health places of safety for those detained under section 136 of the Mental Health Act. [The CCG and Shropshire Council, West Midlands Ambulance Service, West Mercia Police and the SSSFT on a separate but related piece of work about this area].

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

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

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

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

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

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

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

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

More detail about the potential impact of the scheme will be developed in the 'Detailed Business Plan' phase, however it is anticipated that the following, high level outcomes should be achieved:

- More flexible response to those in crisis,
- Alternatives to hospital care,
- Better coordination of services,
- Opportunities to receive extended support whilst in crisis.

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

The scheme is in the Outline Business Planning phase and therefore more detail will be available in the Outline Business Planning phase.

Implementation & evaluation is supported by:

- Paul Cooper, Programme Lead, SCCG
- Dr Colin Stanford, Clinical Lead for Supporting People in Crisis, SCCG

Monitoring:

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

Reporting to**:**

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

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

- The service needs to further strengthen relationships with Shropdoc
- Staff need to accept family member referrals and act on them

- Crisis Plans need to be more fully developed – if we get this right everyone on CPA would have a detailed crisis contingency plan that is accessible to CR/HT, community teams, GP/Shropdoc, AMHP/EDT, service user and family. This would include who should be contacted at the earliest stage possible when a crisis is emerging, how to be contacted and response to expect.
- GETTING HELP IN A CRISIS SHOULD ONLY TAKE ONE CALL
- Further training needs to focus upon creating and using Crisis Plans including listening to family
- A telephone response line needs to be created that is available out of hours and is staffed by qualified staff who can give advice/support or mobilise other resources as require

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
D1
Scheme name
Resilient Communities
What is the strategic objective of this scheme?
Our aim is to develop a sustainable community based approach that supports families and people to have the best chances in life, to live independently, and to have active, prosperous and healthy lives by: • Placing the emphasis on “early help” and "prevention" within the community • Working in a way which adopts a whole family and person approach that best understands and supports people's needs • Supporting "hard to reach" and socially isolated groups • Developing and maximising the use of local "assets" - buildings, organisations, individuals, and resources • Providing people with a "gateway" for advice and guidance support services • Co-ordinating voluntary activity and supporting the growth of community based initiatives • Challenging people's negative attitudes towards their circumstances (and their community) • Ensuring easier access for families and individuals to early help services to prevent escalation to social care
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Our approach to developing Resilient Communities is based on a collective understanding that people are our most important resource and that working together is the best way to address the challenge of supporting vulnerable residents. This can be best summarised as: • Independence and living at home is normal, invest in the things that increase people’s independence • Starting well, an emphasis on providing the right support to people at the right time within their communities • Asset based community development, recognises the existing capacity of the community and is underpinned by strong local networks, relationships and a commitment to a common cause We want to develop activities within three themes.

1. **Family approach to early help**
   - Let's Talk Local provision for all ages
   - Work with young people in transition between Children and Young People Services (CYPS) and Adult Social Care (ASC) to see how they can achieve better outcomes
   - Identify the opportunities to bring together similar roles in ASC early help and CYPS early help and implement these opportunities
   - Redesign Children Centre services and activities to enable them to be delivered from other places that maximise the family approach.

2. **Health care and social care maximise the opportunities to work together in communities**
   - Work together to develop the team around the practice and team around the community concept, including the Building Community
   - Capacity work
   - Reducing residential placements

3. **Building community capacity**
   - Work together to develop the community co-ordinator concept
   - Work together to develop the community hub concept
   - Work alongside people living in the towns and villages to identify where we can support and enable community activity that compliments the Resilient Communities purpose and outcomes

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

The local health and social care economy wants to work together with partners to develop a place-based approach that maximises the use of local community assets and positively encourages and supports the development of community capacity and resilience.

Within this approach the local health and social care economy will use its resources to support the better development and integration of local community capacity within a Resilient Communities approach. Our focus in the future will be on understanding the impact of all of ours and partner services on local people and on how all of the local assets and resources that work alongside these can be best used to provide better outcomes (at a cheaper long terms cost).

Commissioners:
Shropshire CCG
Shropshire Council
Town & Parish Councils
Citizens

Providers:
All local providers
Communities

Citizens

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

We have taken the local learning from 'locality commissioning' prototyping activities and will be applying this to our Resilient Communities approach.

We want to develop our approach in the context of the Compassionate Communities initiative being led by the Severn Hospice. Using local volunteers this approach is supporting social connectedness within Shropshire's communities with early evidence showing that this approach is making a real difference to social isolation, a major determinant of poor health.

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

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

We will know when we have got our Resilient Communities approach right when:
- The residents of Shropshire, particularly those with a need for early help and for support with complex and multiple needs, will get a service that is better, faster, cheaper, delivered together and with a focus on prevention
- Communities respond to the challenge maximising all the assets at their disposal to achieve the greatest benefit to local residents
- Shropshire PLC is able to make its funding stretch further and to achieve its objectives by working together
- Investment in local services and infrastructure maximises the long term business sustainability of local organisations and supports on-going growth and innovation
- Town and Parish Councils and Shropshire's voluntary sector have the opportunity to manage local assets and to deliver services that are shaped locally

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

The scheme is in the Outline Business Planning phase and therefore more detail will be available in the Outline Business Planning phase.

Implementation & evaluation is supported by:
- Kate Garner, Scheme Lead, Shropshire Council
- Dr Sal Riding, Clinical Lead for Supporting People to remain Independently for Longer, SCCG

Monitoring:

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

Reporting to**:**

- Progress of the project will be monitored by the Transformation sub-group of the H&WB Delivery Group.

Our approach will be based on the rigorous application of Cost Benefit Analysis and we will apply best practise developed within the New Manchester Economy model in order to demonstrate fiscal, financial and social benefits.

Targets will be determined in the 'Detailed Business Plan' Phase for following high level outcomes:

- Improve the health and well-being of all Shropshire residents of all ages, by reducing loneliness and increasing social connectedness through the activity of local communities.
- Increase employment levels by supporting people to find suitable and sustainable employment and supporting them to move closer to employment through volunteering and training or increased life skills.
- Increase the number of people living at home independently by supporting people to find the resources in their communities that will support them to do this.

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

If we are to successfully implement this scheme there are a number of important underlying principles that will be critical to its success including:

- Trust
- Local leadership
- Resource to support change
- Partner and community involvement

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
D2
Scheme name
Integrated Carers Support
What is the strategic objective of this scheme?
A new integrated approach to supporting vulnerable carers. The aim of this support is to: • Reduce the risk of carer breakdown, • Promote carer health and well-being and • Prevent unplanned admission of the person they care for into long term care or hospital.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are a number of local initiatives to identify and support carers which are described in separate scheme descriptors. Resilient Communities, Community and Care Coordination, Care Coordination at the End of life[R3]. There are also historical services delivered by the Local Authority and voluntary sector. The Care Act has prompted a review of these services so that through the Better Care Fund Integrated Carers Support scheme the needs of carers can be identified, gaps and duplication of provision clarified and a local carer's pathway developed. The pathway will integrate these new initiatives and existing services to enable a clear process of identification, assessment of need, signposting and delivery of a menu of support. The Integrated Support for Vulnerable Carers initiative will enable that element of the pathway around assessment of need to be explored and improved as part of the wider work. Shropshire Rural and Community Council (RCC) Carers Support, British Red Cross and Crossroads Care - Carers Trust 4aLL will work together to improve and integrate our support to vulnerable carers and link this support into other key initiatives such as Compassionate Communities, Shield workers, People2People, the Peer Support and Education Project, Care and Community Co-ordinators in GP Practices and existing carers work in individual practices. Shropshire RCC Carers Support Service will screen all carers referred to its services routinely using the Carers Strain Index (CSI). The CSI is a 13 item validated tool for measuring caregiver stress developed in the USA but has been adapted for our use in conjunction with Wolverhampton University. This tool will help Carers Support Workers to identify carers experiencing high levels of carers strain/stress and allow them to identify the sources of strain/stress.

Shropshire RCC staff team will screen up to 200* carers using the CSI and for those scoring highly (indicating significant levels of stress) they will work with the carer in developing a mutually agreed personal support plan. We anticipate that in our prototype phase up to 80* carers will have scored high on the CSI and require a support plan.

In developing the plan our staff and the carer will be encouraged to be creative and resourceful in finding ways of reducing/preventing carer stress or building carers resilience/coping strategies. This will include being able to provide the additional package of practical support offered by our partners the British Red Cross and Crossroads Care - Carers Trust 4all. This short term practical help and/or flexible respite breaks will be critical in creating the 'space' needed by the 'overwhelmed' carer to learn new patterns of behaviour, create stronger links with their family, friends and local community support and time to explore longer term solutions to the carers identified stressors.

The target group for this scheme will be 'Vulnerable Carers'. We define vulnerable carers as those who have two or more of the following characteristics[R4]:

- Are caring for 50 hours per week or more,
- Are isolated and have limited family or community support,
- Have health problems, permanent or temporary
- Are over 75,
- Have significant money worries,
- Have multiple caring responsibilities
- Are struggling to juggle work/family and caring responsibilities

**The number of carers being screened and needing a support plan have been based on our current referral rates and the numbers of carers identified as being overwhelmed, stressed and experiencing poor health by Cambridgeshire's Family Carers Prescription Service 6 months pilot project.*

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

Commissioners:
Shropshire CCG
Shropshire Council

Providers:
Shropshire RCC Carers Support
British Red Cross
Crossroads Care - Carers Trust 4aLL

This project will also be monitored by the Shropshire Carer Partnership Board.

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

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

The 2011 census shows us that among the 34,000 people currently caring for relatives, friends and neighbours there are over a third who spend 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 and of these 901 carers who are providing over 50 hours per week. A recent survey by Carers UK (2014) has also indicated that carers often neglect their own physical and/or mental health. All of the above may be a contributory factors leading to carer breakdown.

Being a large rural county, a proportion of Shropshire's carers will also be living in isolated areas. We know that living in remote rural areas can contribute to feelings of carer isolation and depression. Likewise caring can also lead carers to feel cut off from family support and loss of contact with friends and neighbours (Carers UK, 2014).

A recent survey showed that many such carers are also unknown to health and care services and not in receipt of any formal support.

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

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

If successful in delivering expected outcomes the initiative will be a key element of the local carer's pathway. The scheme will deliver:

- Targeted[R5] carers strain/stress assessment and personalised support plans for vulnerable carers who are most at risk of carer breakdown
- Targeted, flexible and time limited respite and practical support to vulnerable carers aimed at reducing the level of carer stress and creating the opportunities for building stronger links with local support network

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

The table below describes how this particular piece of work will be monitored and measured:

Outcome	Intervention / Activity	Measures
Up to 200 carers recognise the stresses and strains in their caring role	CSI Assessments	Number of CSI's completed Report on CSI scores and the common stressors for carers
Up to 80 vulnerable carers are assessed as needing additional support to reduce the impact of stressors	CSI Score baseline measures In-depth assessment of stressors Joint Support planning	Number of in-depth assessments Number of signed support plans

Up to 50 vulnerable carers report feeling less overwhelmed and better equipped to cope with their caring responsibilities.	50 carers receive flexible respite provision for up to 15hrs per carer 50 carers receive practical help around the home by volunteers for up to 6 weeks 30 carers perceive greater involvement from family. friends and community in supporting them	Number of carers receiving flexible respite Number of carers receiving practical support Comparison of baseline CSI scores and CSI scores post intervention Case studies and Diary entries Number of links to community support
Up to 50 vulnerable carers experience a reduction in baseline measures of the Carer Strain Index post interventions	80 carers involved in developing their own support plan Interventions for 80 carers are more focused on the identified stressors.	Sample support plans Case studies demonstrating impact of support plan interventions Comparison of baseline CSI scores and CSI scores post intervention
Up to 50 vulnerable carers self-report an improved sense of health and well-being	12 carers receive training for carers on stress management 50 carers supported to engage in activities which will promote their health and well-being and reduce stress including more exercise, healthier eating, meditation, mindfulness, 50 Carers receive booklet on reducing stress with self-help tools	Results of measurement tool for well-being Diary entries Case studies Level of CSI scoring reduction
Up to 50 vulnerable carers report benefits from a more co-ordinated approach to their support	Sharing of information Reduction in unnecessary duplication	Diary entries Case studies

Implementation & evaluation is supported by:

- David Whiting, Scheme Lead, SCCG
- Dr Sal Riding, Clinical Lead for Supporting People to remain Independently for Longer, SCCG

Monitoring:

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

Reporting to**:**

- Progress of the project will be monitored by the Transformation sub-group of the H&WB Delivery Group.

What are the key success factors for implementation of this scheme?
There is an opportunity for health and social care commissioner and voluntary sector providers to work together to support the scheme with the aim to deliver improved outcomes for people and their carer's. For the scheme to be successful all partners need to take a proactive approach to the delivery and implementation of the scheme.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
D3
Scheme name
End of Life Coordination
What is the strategic objective of this scheme?
Our service needs to give enough support to allow patients to stay out of hospital wherever clinically possible, this is best for patients and will free up funding to pay for the coordination and the health and social care support needed. This prototype uses additional resourcing to (i) provide better care co-ordination for patients and (ii) in doing so, reducing the number of hospital admissions with the consequent positive impact on quality and costs of care provided. To deliver a high quality service for people to allow them to die in their place of choosing, this is likely to be outside of the acute hospital setting. This prototype scheme supports patients approaching the end of life, from all causes, by a Clinical Nurse Specialist in End of Life Care who will coordinate the health and social care support required to enable the patient to die in the place of their choosing.
Overview of the scheme Provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The CCG, in partnership with Severn Hospice, will deliver a scheme in which all individuals are supported, as they approach the end of life, by a Clinical Nurse Specialist and team. The CNS and team will work closely with the practice to support the early identification of patients as they approach the last year of life. They will attend and support the Gold Standards Meetings held in Shropshire practices and support practices in identifying patients in the last year of life at risk of admission as part of the Proactive Care Programme. They will be responsible ultimately for ensuring that all patients identified as being in the last year of life have an end of life or advanced care plan. They will be responsible for care coordinating patients in the last year of life who are identified to be at risk of admission and will be responsible for coordinating care, supported by their team, as the patient approaches the last weeks of life. As is currently provided to individuals with a cancer diagnosis they will become involved with the patient initially about one year before end of life. At this stage they will open conversations with the individual, the family and other involved care professionals about preferences for end of life care. They will develop an end of life or advanced care plan including preferred priorities for care. They will advise about benefits, funding streams and opportunities for support in the community. They will hold discussions about the benefits of establishing lasting power of attorney, resuscitation decisions

and escalation of care. If needed and in partnership with specialist nurses and community nurses they will begin to put in place support services needed.

As the needs of the individual become more complex the CNS and team will support the coordination of services to meet the needs of the individual so that the care plan can be delivered. They will bring expertise in palliative care, a comprehensive understanding of services available and funding mechanisms and sensitive sign posting and support for carers and families. Although the focus of their work would be in last few weeks of life when coordination becomes more essential they would begin their relationship with the individual early through the development and review of the care plan over the twelve month period prior to the end of life.

They will provide this service regardless of whether the individual is in a care home in their own home. If the patient is in a community hospital they will work in partnership with the community hospital discharge team to facilitate delivery of the end of life plan and the preferred priorities of care. If the patient is in an acute ward they would support the hospital based CNS, the Integrated Community Service and the discharge planning team in facilitating discharge into the community enabling always the delivery of the end of life plan and preferred priorities of care where possible.

The services in place locally to support patients in the last year of life are currently poorly integrated. Services are traditionally commissioned separately by the CCG and Local Authority. There are multiple providers with lack of clarity around responsibilities leaving gaps and duplication. There are also new initiatives described in other project descriptors such as Compassionate Communities, Community and Care Coordinators, Team Around the Practice, Single Assessment, Carers Support, Case Management, CHAS, Integrated Community Service, which add further levels of complexity.

Establishing a care coordination system for those whose needs are increasingly complex toward the end of life is a first step in a broader programme of clarifying gaps and duplication and simplifying provision of care around an end of life pathway.

The Clinical Nurse Specialists will have a key function in mapping current services and identifying gaps duplication and blocks in the system, including those related to funding, and carers needs. This information will be used to inform the commissioning of more integrated effective care going forward.

For each patient, comprehensive records will be kept, primarily by the hospice team[R6]. These will include details of care provided, all EOL tools used (such as PPC, power of attorney, advance decisions, DNaR), outcomes of funding and care assessments, and details of whenever hospital admissions have been avoided due to the coordination work. The information can be shared with the wider team looking after the patient, utilising an Electronic Health and Care Record when in place.

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

Commissioner:
Shropshire CCG

Provider:
Severn Hospice

Delivery Partners:
GP Practices
Shropshire Community NHS Trust
People to People
SATH - Therapies
SATH - Diabetes Specialist Team
Shropshire Community NHS Trust - COPD Specialist Team
Shropshire Community NHS Trust – Falls Prevention Team
SATH - Heart Failure Specialist Team
Severn Hospice - Palliative Care Specialist Team
Shropshire Council- Substance Misuse
South Staffordshire & Shropshire Foundation Trust (SSSFT) - CPN in practice
Shropshire CCG - Community Pharmacist

The evidence base

Reference the evidence base which you have drawn on

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

The 2012 VOICES national survey[2] found that the overall quality of care across all services in the last three months of life was rated by only 44% of respondents as outstanding or excellent. For those who expressed a preference, the majority preferred to die at home (81%), although only half of these actually died at home (49%). The most commonly reported place of death was a hospital (52%).

The Nuffield Trust produced a report looking at the impact of Marie Curie Nursing Service (MCNS) hospice at home services ('The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life' 2012)
The MCNS service provides care and emotional support for people in their own homes at the end of life, including discharge support from all settings to help manage patients' symptoms at home and prevent unnecessary hospital admissions. It found that;

- 76.7% of those who received MCNS care died at home, while only 7.7% died in hospital. In contrast, 35.0% of the controls died at home, while 41.6% died in hospital.
- People who received MCNS care were less likely to use all forms of hospital care than controls. 11.7% of MCNS patients had an emergency admission at the end of life, compared to 35% of controls; while 7.9% of MCNS patients had an A&E attendance, compared to 28.7% of controls. Across most types of care, MCNS patients used between a third and half of the level of hospital care of controls.
- Significant differences were found in the costs of both planned and unplanned hospital care between MCNS patients and controls. Total hospital costs for MCNS patients were £1,140 per person less than for controls from the first contact with MCNS until death (however, this figure should be considered alongside other costs, including the cost of the MCNS itself and possible impacts on other services).

This evidence indicates that a coordinated end of life service can deliver quality care and also the funds to pay for the community services, plus further savings. The established Hospice at Home

[2] National Statistics 'Statistical Bulletin - National Bereavement Survey (VOICES), 2012' 2013

service in Shropshire (which incorporates the Marie Curie Nursing Service) has delivered the same service since 2003 and provides a foundation for further development in reducing hospital admissions/deaths

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

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

Targets will be determined in 'Detailed Business Plan' Phase for following high level outcomes:

- People are supported to die in the place that they choose
- People are not admitted to hospital during the weeks prior to death
- Improved coordination of support for people in their last year of life
- Carers supported
- Quality of life in the last year of life improved.

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

Implementation & evaluation is supported by:

- David Whiting, Scheme Lead, SCCG
- Dr Sal Riding, Clinical Lead for Supporting People to remain Independently for Longer, SCCG

Monitoring:

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

Reporting to**:**

- Progress of the project will be monitored by the Transformation sub-group of the H&WB Delivery Group.

The outcomes can be measured by monitoring the uptake and input from the care coordination service (including the already in place specialist palliative care outreach team and hospice at home services).

A baseline for the practices involved will be used to compare the impact of the care coordination, such as numbers on the practice GSF list, numbers who died, place of death, whether they had a care plan.

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

- Developing clear methods of communication and accountability between practices and the teams that support them in the community

- Shared records and care plans.
- Commissioning services in partnership with the local authority
- Assessment process spanning social and health need.
- Engagement with relevant partners
- Shared systems of record keeping supported by data sharing agreements

Further success factors to be defined as the scheme progresses to the Detailed Business Plan phase

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	