Wolverhampton Health & Care Economy

Better Care Fund Planning Template – Part 1

April 2014

Black Country Partnership
NHS Foundation Trust

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Wolverhampton City Council**
Clinical Commissioning Groups	**Wolverhampton CCG**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**31/03/2014**
Date submitted:	**04/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£6,309,000**
2015/16	**£20,024,000**
Total agreed value of pooled budget: 2014/15	**£20,496,174**
2015/16	**£24,621,362**

b) Authorisation and signoff

Signed on behalf of Wolverhampton Clinical Commissioning Group	
By	Dr Helen Hibbs
Position	Accountable Officer
Date	4th April 2014

Signed on behalf of Wolverhampton City Council	
By	Sarah Norman
Position	Strategic Director of Community Services
Date	4th April 2014

Signed on behalf of the Wolverhampton Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr S Samuels
Date	4th April 2014

c) Service provider engagement

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

In June 2013, the four major statutory agencies and stakeholders in the local health &social care economy agreed to come together to find opportunities for better integrated working between the agencies. This initially culminated in an 'Integrated Pioneer' project based around dementia services. Whilst this bid for funding was unsuccessful, all partners resolved to continue the work. This partnership has evolved into the basis of the Integration Transformation Fund / Better Care Fund.

This work has produced a whole series of events across the health and social care economy and also across the widest range of participants and staff. These events have included front line staff and all four CEO's from the major agencies. All of this work has been underpinned by a core planning group comprised of the operational, planning and finance directors from each organisation with support from a small team of programme support management.

In the Autumn of 2013, the Chief Executives of the Provider Trusts (The Royal Wolverhampton NHS Trust and The Black Country Partnership Foundation Trust), the Accountable Officer of Wolverhampton Clinical Commissioning Group (CCG) and the Strategic Director of the Community Directorate of Wolverhampton City Council set up a structure to develop the response to the requirements of the Better Care Fund, implement the plan and deliver the wider transformational agenda.

Below this leadership level, an Interim Development Board (IDB) has been established.

This is a group of executive directors from each of the key stakeholder organisations including the Directors of Finance (or equivalent) and Directors of Planning / Chief Operating Officers (or equivalents) plus the Director of Public Health.

The IDB has hosted and facilitated a number of whole system events designed to co-produce the BCF programme vision, priority workstreams and projects.

The key events and outputs are set out below:

- Workshop - 20.06.13 – Identification of workstreams

- Leadership Alignment Event - 28.11.13
    - Senior representatives from all four organisations (RWT / BCPFT / WCCG / WCC)
    - Revision of the BCF workstreams

- Front Line Staff Event – 17.12.13 :
    - 60 plus staff representing : patients, carers, voluntary sector, health & social care (commissioners & provider) staff
    - Work & successes to date
    - Opportunities from what we have now
    - Opportunities in what we do
    - Under what circumstances – present assets & new opportunities
    - Opportunities in what we have lost
    - Immediate, practical, actions
    - Opportunities for transformation

- Whole System Event – 28.01.14
    - 70 delegates representing patients, carers, voluntary sector, health & social care (commissioner & provider – acute, mental health & primary care)
    - Develop vision for BCF and Sign off of Better Care Fund Plan workstreams & project ambitions.

- Leadership Alignment Event – 18.02.14
    - Review of the outputs of the Whole System Event
    - Sign off of the Wolverhampton Story
    - Wolverhampton Change Model & Pathway going forward.

A series of further events is planned over the first half of 2014 to establish and bed-in the vehicles for the whole system transformational change required.

d) Patient, service user and public engagement

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

As set out in 1c) above, the Wolverhampton Health &Social Care economy has used an inclusive approach to planning the BCF programme. Some of the above events had a specific focus to identify and develop patient, carer and public aspirations for the BCF Plan and the wider transformational agenda.

The key events have included:

- Front Line Staff Event – 17.12.13
- Whole System Event – 28.01.14
- Health & Well-Being Board – 05.02.14
- Adult Delivery Board – 11.02.14
- Wolverhampton Health Summit – 12.03.14
- Health & Well-Being Board – 31.03.14
- Patient Engagement Event –1.04.14

All of these events had patient, patient representative, carer and voluntary sector representation.

Planned future events and opportunities for engagement include:

- CCG Patient Engagement Groups / locality sessions: various.
- WCC Over 50's Forum
- WCC Learning Disability Parliament
- WCC SEN/D Reform Board

The Wolverhampton Adult Social Care Annual Report has a clear outcome on ensuring that people have a positive experience of care. To this end there is a hierarchy of engagement with service users ranging from information giving to co-production. The personalisation agenda puts service users at the centre of service provision and increasingly dominates future planning.

In terms of the mechanics of the plan construction, Wolverhampton Healthwatch have been significantly involved in developing the programme and its "story" or vision, in particular, Wolverhampton Healthwatch have requested to be included in the regular updates and development sessions via the local Health & Well-Being Board sub-structures / delivery boards. (Healthwatch declined an offer be to part of the IDB).

e) Related documentation

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

Document or information title	Synopsis and links
Initial Workshop	Outputs of the initial whole system workshop in June 2013 that identified transformational workstreams. June Workshop Action Notes.pptx
Leadership Alignment Event 28.11.13	Initial Leadership Alignment Event with Chief Executives/Accountable Officers and Directors from Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, The Black Country Partnership NHS Foundation Trust, The Royal Wolverhampton NHS Trust. Confirmed the transformational workstreams, commenced work on leadership alignment. Outputs of 281113.pptx
Front Line Event 17.12.13	Delegates made up of frontline staff from health & social care, carers, users and voluntary/3rd Sector. Using the 4 workstreams as the subjects, identifying opportunities from current practices, what could be changed. Practical, work that could start immediately. Front Line Staff Event Feedback.pptx Workstream 1.pptx Workstream 2.pptx Workstream 3.pptx Workstream 4.pptx
Whole System Event 28.01.14	Developing the Wolverhampton 'Story' and identifying what needs to happen to ensure transformational project success. Setting Up for Success Summaries.p BCF one wolverhampton.pptx

Better Care Fund Plan on a Page	This document provides an overview in graphical representation of the Better Care Fund Projects within each workstream and the strategic fit. BCF on a page V7 1.pptx
Better Care Fund Timeline	Graphical overview of the timeline for workstreams& projects. BCF Timelines v5.2 310314.pptx
Better Care Fund Project Summary	This document provides summary details from the individual Project Initiation Documents, the strategic objective and which metric the project contributes to. Project Summary v1.1 240314.docx
Better Care Fund Target Setting	The document provides the detailed calculation of the National and Local Metrics – part of Template 2 - a summary of which project contributes to which metric and metric targets in graphical form. Better Care Fund Target Setting.pptx
Wolverhampton Interim Development Board Terms of Reference (draft)	Terms of reference for the Interim Development Board, which will provide strategic direction for and monitoring of the Better Care Fund until such time as the governance arrangements have been agreed. Interim Development Board TOR v2 19031

Wolverhampton Transformational Change Programme Roadmap	Graphical representation of the Wolverhampton Transformation Change Programme of which the Better Care Fund is a significant part. Wolves LSI Pathway v2Feb14.doc
BCF Risk Register	Better Care Fund Risk Register, complied from high level and initial project risks. Risk Log 040414.xls

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

Wolverhampton Local Health & Care Economy is wholly committed to improving the health and wellbeing of our population. We will achieve this by placing patients at the centre of our decision making and deliver care through the newly established model of integrated commissioning and provision. This clinically-led model of care will bring about real integration of services delivering measurable benefits for the health of our population and their experience of services.

We have to deliver transformational change in order to realise an efficient and effective health and social care system in Wolverhampton, which is both affordable and provides the highest service standards, which our population rightly expects and deserves. Our programme of change will be led by clinicians and social care experts at the front-line; will operate in collaboration across all stakeholders (including people, practices and voluntary / third sector organisations) and is deliberately flexible in order respond to emerging circumstances.

At the Whole System Event in January 2014, representatives from key stakeholders, partners and our local community agreed a vision statement. The vision for our local Health & Care Economy vision for 2014-19 is:

Wolverhampton:

One Ambition, Working as One, for EveryOne.

This statement not only captured the will to change and transform - so energetically expressed by all participants on the day - but also has a high degree of synergy with the CCG vision (as expressed in its authorisation documents) for the ***Right Care*** in the ***Right Place*** at the ***Right Time*** for all of our population. A sentiment strongly echoed in the BCF guidance. The following will be yardsticks by which we will judge the results of our plan:

- Patients will feel confident that the **right care** is provided to the standard that they expect;
- Local health and care services will co-ordinate, collaborate and communicate in order to ensure that care is delivered in the **right place;**
- Care delivery and advice will be proactively planned and provided in order to ensure care is provided at the **right time.**

As a result of the Better Care Fund and it's workstreams and projects - over the next five years - we will see:

- Patients and service users receiving services that are wrapped around them, that are seamless and with no duplication.
- Less people living, permanently, in Nursing & Residential care with more people receiving services in their own homes.
- Those that remain in Nursing & Residential Care will have a named GP (1 GP per Home), with have agreed care plans for their Long Term Conditions and services designed to wrap around them, including access to Specialist Services historically provided in an acute hospital setting.
- A planned reduction in the number of acute medical beds, equivalent to 2 medical wards.
- A shift of workforce numbers from acute settings into community services.
- Patients living with Long Term Conditions managing their own conditions – with the appropriate support, taking control through personalised health and social care budgets and enjoying a better quality of life.
- Patients and service users with mental health problems identified early - in the primary care setting - and early intervention commenced.

b) Aims and objectives

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

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

We believe that this vision statement will be central in how the local partnership continues to develop the BCF programme. It has meaning on a number of levels and, as the table below sets out, the vision statement illustrates the ambition of a single plan for all partners – instead of the multiple (and sometimes conflicting) plans of the key stakeholders.

Strategic Objective	One Ambition	Working as One	For Everyone
What Are We Trying To Do?	Single Plan Sharing everything Prevention & Recovery	Integrated Pathways All Partners Working Together Shared Sustainable Outcomes	Each Individual Keeping People Well Self-caring Communities
	Right Care	Right Place	Right Time

We will share information (within the appropriate imperatives of safeguarding and good governance), facilities and resources. We will focus on preventing ill health rather than treating illness, but, when people are ill, we will strive to enable the best recovery to as full and high quality life as possible.

We will work together, implementing new integrated pathways and deconstructing the silos. We will find new solutions for our city and its community that provide effective and efficient use of resources – optimising the skills and strengths of our combined workforce.

This will deliver the outcomes required to deliver financial sustainability and improve the lives of our patients and citizens.

This programme will have meaning for everyone: staff, patients, public and organisations. We will put the person at the heart of our thinking, planning and delivery. It will support the personalisation agenda and focus on to services tailored to individual need. Our main focus will be to keep people well thereby reducing demand and improving lives. Part of our ambition will be to create cultures where people are able, and incentivised, to take responsibility for their own care wherever practical and optimise self-care for many conditions.

Within 5 years, the BCF programme will have:

- A single plan or a single over-arching framework covering the necessary suite of strategic plans from each partner which will be collaborative, complementary and assist partners in the delivery of agreed common goals.
- Routinely shared information, resources and facilities.
- Delivered a re-configured series of integrated services with single providers where appropriate.
- Embedded new ways of working ensuring that service users interact with fewer professionals, with fewer hand-offs between services, creating more seamless care and continuity of care.
- Shifted the focus on care planning from treatment to prevention.
- Moved the focus of Clinical Pathways and care services to be patient / service user centred – not organisationally orientated.
- Achieved clinical, financial and social outcomes which are sustainable.
- Made personalisation available to all.
- Kept more people well – maximising individual quality of life / independence and reduced need for unplanned care.
- Many more people taking increased responsibility for their own care and managing their own health & well-being.

In particular, the Wolverhampton BCF plan will:

- Reduce emergency admissions
- Improve patient experience of services
- Reduce permanent admissions to residential & care homes
- Increase effectiveness of re-ablement services
- Reduced delayed transfers of care
- Optimise independent living post-discharge
- Maximising independence
- Avoid preventable hospital admissions
- Maintain /improve personal well-being
- Optimise GP managed care
- Ensure improved, more co-ordinated services across the health and social care pathway, including patients with mental health problems

- Support the management of Long Term Conditions in the community
- Maximise self-care
- Dramatically improve the dementia diagnosis rate

The over-arching measure of health gain will be fewer hospital bed-based interventions.

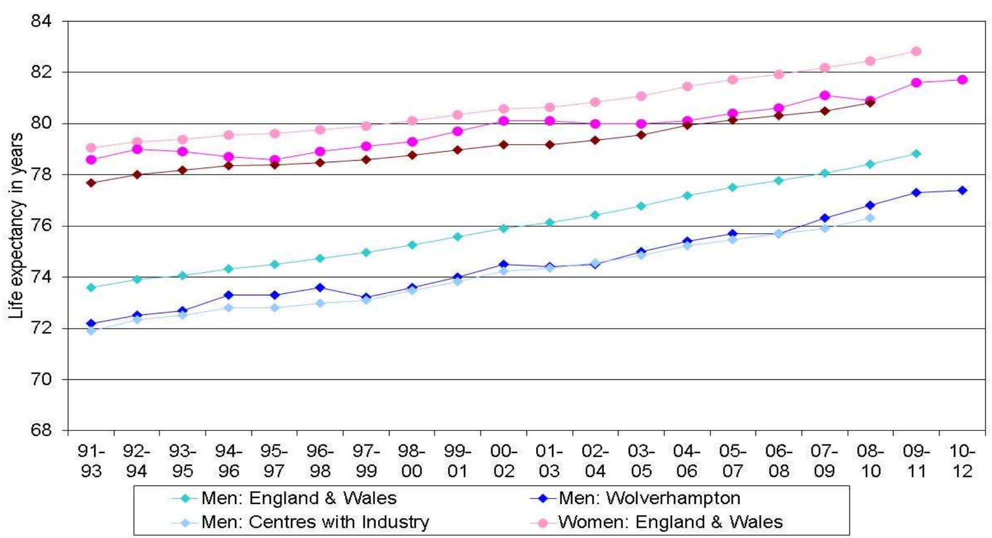
c) Description of planned changes

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

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

The JSNA for Wolverhampton shows people in Wolverhampton are living longer than ever before, however, the gap between life expectancy in the city and the national figure is not closing. Nevertheless, both males and females in Wolverhampton experienced lower overall life expectancy in 2010-12; 77.4 years for males and 81.7 years for females. This is almost two years less than the national average for both males and females. In addition, a male in Wolverhampton can expect to live just over 58 years free of any disability which is almost three years less that the national average. Women can expect to live almost 61 years free of any disability which is two years less than the national average. Therefore, not only do Wolverhampton residents live shorter lives but they also spend more of their lives experiencing ill health and disability.

Trend in male and female life expectancy in Wolverhampton



The analysis of key health problems has been shared across the local health and social care economy.

Social Care Dimension

What does the data tells about services for older people

- 80+ population will increase by 63% over the next 20 years
- 50% of Wolverhampton wards are amongst the most deprived nationally
- Too many resources are tied up in long term care
- We need to shift the balance towards community based intervention
- The spend per person is high
- There is a high unit cost, specifically relating to in-house services

What does the data tell us for younger adults?

- Reduced bed capacity within the Health provision for people with mental health needs
- Increased demand for Mental Health Act assessments
- We have too many young adults in residential and nursing care
- We pay too much for these services especially for disabled adults
- We like to look after people and can take away individual and family responsibility which doesn't support personalised support

The Plan for Older People

- To take an outcomes based approach to domically care
- To review external day care contracts
- Put re-ablement before assessment
- Have a focus on independence
- Review the Very Sheltered Housing Model

The Plan for younger adults

- Enablement and reablement before assessment
- Refresh the Mental Health reablement forward plan
- Work with the special schools to get the independence message across
- No one goes into residential care and everyone is given a ‘care in your own home’ option
- Everyone currently living in residential care is supported to move into their own homes
- Minimise the use of residential care for disabled children and adults for short breaks

The prioritised workstreams& projects have been developed through the series of whole system events and are based upon JSNA, the Health & Well-Being Strategy, CCG ICP and Local Authority strategic plan.

These workstreams are:

- Mental Health De-escalation
- Nursing & Residential Care
- Intermediate Care (Reablement/Rehabilitation)
- Dementia.

Mental Health De-escalation Workstream

Outcomes:

- To Maximise Recovery And The Support Of People With Mental Health Problems Within The Community
  - To improve patient experience and outcomes, supporting care as close to home as possible to reduce unplanned admissions

Project(s) :

- Urgent Mental Health Care Pathway including Liaison Psychiatry
  - Finalise Service Specification; Identify resources & funding; develop and implement action plan
  - Ensure patients are identified in Primary Care, with early referral to mental health services.
- Reablement Pathway
  - Agree the pathway; Finalise Service Specification; Review & align Service Specifications
- Co-production Recovery College
  - Adopt as a good process and sign up; Info & education re : 'What it is'; Review existing services

Success Factors :

- More people in recovery
- More people with mental health problems being managed within the community
- Less use of residential & hospital care

Nursing & Residential Care Workstream

Outcomes:

- To keep people well and prevent avoidable hospital admissions
  - To support Nursing & Residential Homes by providing in-reach support and education to reduce unplanned admissions

Project(s) :

- 1 GP Practice per Home
- Implement Single Commissioning & Contracting Arrangements
  - reflect analytical work; based on need; outcome focused specifications; monitoring & performance measurement
- Quality Standards
- Training & Education for Nursing & Residential Home Staff
- In-reach Services
  - covers training, chronic disease management & acute deterioration

Success factors:

- Less admissions to acute hospital from nursing & residential care
- Enhance capacity to look after people where they live
- Living life to the end of life

Intermediate Care (Reablement/Rehabilitation) Workstream

Outcomes:

- To maximise reablement after a period of ill health and provide alternatives to residential, nursing and hospital admissions
    - To deliver a single Intermediate Care Service that is easily accessible to all

Project(s) :

- 7 day therapy services
    - CICT proposal for OT/PT Sat/Sun; Rapid Response Services; To develop access to ILS; Explore therapy resources centres & West Park
- Single Intermediate Care Service including single point of referral
    - Develop work on clarifying boundaries/ease transitions; Clarity of referral process to external agencies; flagging CICT involvement on to Local Authority; Care First – review of assessment process (HARP)
- Single Assessment Process
    - Develop the process and act as the pilot for the Single Assessment Process prior to roll-out across Wolverhampton
- Community re-enablement network & directory
    - Earlier intervention – partnership

Success factors :

- Less A&E attendances
- Less emergency hospital admissions
- Speedier discharge (reduction in Length of Stay)
- Maximise re-ablement/rehabilitation
- Increase in the numbers returning to independent living

There is a significant challenge with the metric target of 89.5% for the 'Proportion of Older People who have undergone reablement or rehabilitation who are still at home 91 days post discharge'. Wolverhampton is already performing well in this area with our 2012/13 performance in the upper mid-quartile nationally and within our comparator group and significantly higher than both national and comparator averages.

Wolverhampton also offers reablement and rehabilitation to a much higher percentage of older people upon discharge from hospital due to the success of our current CICT and HARP services, with 2012/13 performance metrics showing that we offer reablement to 5.8% of people compared with a 3.7% average nationally and a 4.9% average amongst comparators. This puts us in the top quartile nationally and amongst our comparators.

Additionally, the project plans outlined in the submission aim to widen the criteria for people who are offered reablement or rehabilitation services post discharge and there is a risk that as the emphasis on offering these types of services to those who will benefit the most is reduced in favour of offering the services to more people in general, the success rate will naturally and not unexpectedly decline.

The current restrictions on the people who can be counted within this indicator based on the requirement that they must have undergone a social care or multi-disciplinary or social care assessment, excluding those that have received a health assessment only, may also prove a challenge with the relevant project streams needing to ensure that appropriate processes for multi-disciplinary assessments are implemented as part of the development of services. It is understood that the Department of Health are considering changes to this indicator so that health based reablement can be included, however this will not be in place for 2014/15.

Dementia Care Workstream

Outcomes:

- To provide holistic services that keep people with dementia well and independent
    - To deliver a dementia friendly city through agreed and implemented Dementia pathway across Health & Social Care

Project(s):

- Improve diagnosis rate and recording in Primary Care
- Single assessment process
- Increased Access to Resource Centres for patients with Dementia
- Dementia Hub
    - range of services; communication base; sign posting, etc..

Success factors:

- Improve the way care & support to people with dementia is provided
- Development of single assessments
- Use of named Lead Professionals
- Reduce crisis events
- Maintain independence
- Improve patient/user & carer satisfaction
- Learning to inform work on other Long Term Conditions

Initial Project Initiation Documents (PIDs) have been produced, these will be further developed as part of the next phase of the project, and will include:

- Service Vision – defining what the transformed service will look like, what this will mean for patients and users,
- Evaluation of existing services – value for money and quality,
- Implications for workforce,
- Quantification of contribution to metrics, targets and savings,
- Identification of any transitional (investment/pump-priming/double-running) costs for year 2014/15 – this will be funded from the transitional funding set-aside in the 2014/15 Operating Plan.

Further detail on each of the projects - from the initial PIDs - is included as related documents, together with the Better Care Plan on a Page and BCF Timeline summary documents.

d) Implications for the acute sector

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

This Integrated Better Care Fund Plan (the Plan) clearly displays the programmes and tactics for achieving our vision of meeting the health needs of the residents of Wolverhampton. Whilst acknowledging that we are yet to fully develop our approach and that we are working with a number of challenges, the Local Health & Care Economy has recognised that the integration of key services centred around the patient and citizen will deliver quality services; reduce or eliminate duplication and service gaps; and deliver efficiencies and financial savings.

As a result, we have split the creation and development of the BCF plan into two distinct phases:

- Establishment phase (Years 1 & 2):
    - To undertake the initial scoping work, develop governance structures, establish pooled budget arrangements and the scope of those arrangements.
    - Agree and embed the vision for the emergent partnership and set out detailed plans for the first two years of the programme.
    - During this phase, the scoping and detailed planning of the following stage will be undertaken to enable the significant expansion of the programme (and pooled fund).
    - This BCF Plan is largely concerned with this phase.
- Development phase: (Years 2 – 5)
    - Having created the foundations and infrastructure required for the ambition of the plan, The intention of the Wolverhampton Health & Care Economy is to further develop the programme.
    - Potentially including significant elements of spending and services currently locked into NHS contracts to enable transformational change across traditional health & social care boundaries.

This means that in Years 1-2, the focus will be on a review of existing services (including ensuring value for money & achievement of quality standards), establishing alternative services, testing the market for new or radically re-configured services and integrating care pathways. Together with other demand management initiatives in primary and secondary care, this will reduce demand for hospital based services, producing cash savings that can be transferred into other support and early intervention services via the BCF.

Both of the secondary care service providers – The Royal Wolverhampton Hospital Trust and The Black Country Partnership NHS Foundation Trust – have been actively involved in the development of the Better Care Fund Plan and the vision for service transformation.

Analysis has been undertaken to quantify the potential benefits associated with the Metric targets. At this stage the assumptions made are still to be finalised but the BCF is anticipating benefits accruing in the first year of c£4,807m. The gross benefits accruing have been identified as follows:

Permanent admissions of older people to nursing & residential care £'000	Delayed Transfers of Care £'000	Avoidable Emergency Admissions £'000	Total £'000
2,467	1,875	465	4,807

The figures pertaining to a reduction in permanent admissions of older people to nursing & residential care are based on the full savings – this level of savings will be realised however, there will be a need to re-invest a significant proportion to fund increased domiciliary services to support people in the community and their own homes. These monies would therefore not be invested in the BCF Pool they would instead be retained by the Local Authority in their capacity as commissioner for these services.

The impact on the acute sector primarily relates to the reduction in preventable admissions to be achieved from within the projects in order to hit and surpass the metric targets. Specifically we expect to reduce the number of unplanned admissions to the equivalent of £500k to be taken out of acute contracts (mostly RWT).

Reductions in avoidable emergency admissions have been discussed with the Royal Wolverhampton NHS Trust with consideration being given to 2014/15 and 2015/16 in particular. These assumptions are incorporated within the CCG's LTFM.

In addition, the work around developing intermediate care and reducing / maintaining DTOCS at a low level will drive system efficiencies, through reducing excess bed-day spend in the acute sector.

As stated in Section 2a – Vision for health & care services – in 5 years there will be a reduction in acute medical beds equivalent in numbers to 2 wards and a transfer of workforce numbers from acute to community services.

In developing the schedules of metrics and associated costs and benefits we have identified a number of queries and concerns relating to the data used. For the purpose of this return metrics have been articulated as provided via NHS England, however, data validation and subsequent costings will form a key task for the Information and Finance Workstream to focus on. These refinements to our figures will be reported and reviewed over the coming months.

The table below illustrates the value of the proposed transfer of CCG commissioning budgets into the BCF Pooled Budget by sector/organisation for 2015/16. For 2014/15 these budgets will remain with their originating organisation but will be operated in shadow form.

Organisation		
BCP		3,287,489
RWT		4,801,887
CCG/Reablement		2,266,000
3rd Sector		2,395,798
		12,751,174

Sources of funding – CCG Allocations

It should be noted that the CCG governance for the delivery of both the BCF and the Mental Health Strategy falls under the remit of the Integration Delivery Board. The Board will be responsible for ensuring that BCF and mental health plans are co-ordinated and complementary in order to avoid any duplication of activity, minimise any negative impact on the level and quality of services and achieve maximum integration of service delivery.

e) Governance

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

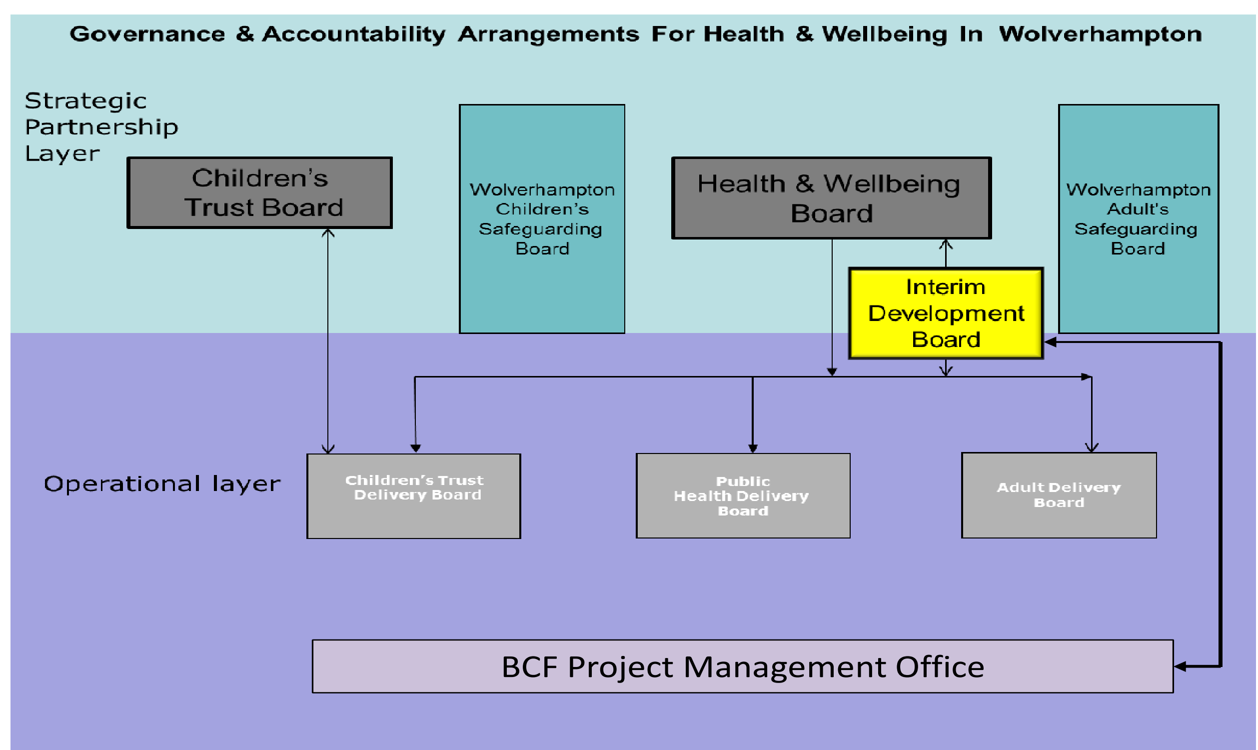
The Chief Executives / Accountable Officers of the key stakeholder organisations - The Royal Wolverhampton NHS Trust, The Black Country Partnership Foundation Trust, Wolverhampton Clinical Commissioning Group and the Local Authority [Community Directorate of Wolverhampton City Council] - have set up a structure to develop the response to the requirements of the Better Care Fund and implement the plan.

An Interim Development Board (Terms of Reference attached) has been established as a short term multi-agency governance body comprised of a group of senior executive directors from each key stakeholder organisation including the Directors of Finance (or equivalent) and Directors of Planning / Chief Operating Officers (or equivalents) plus the Director of Public Health.

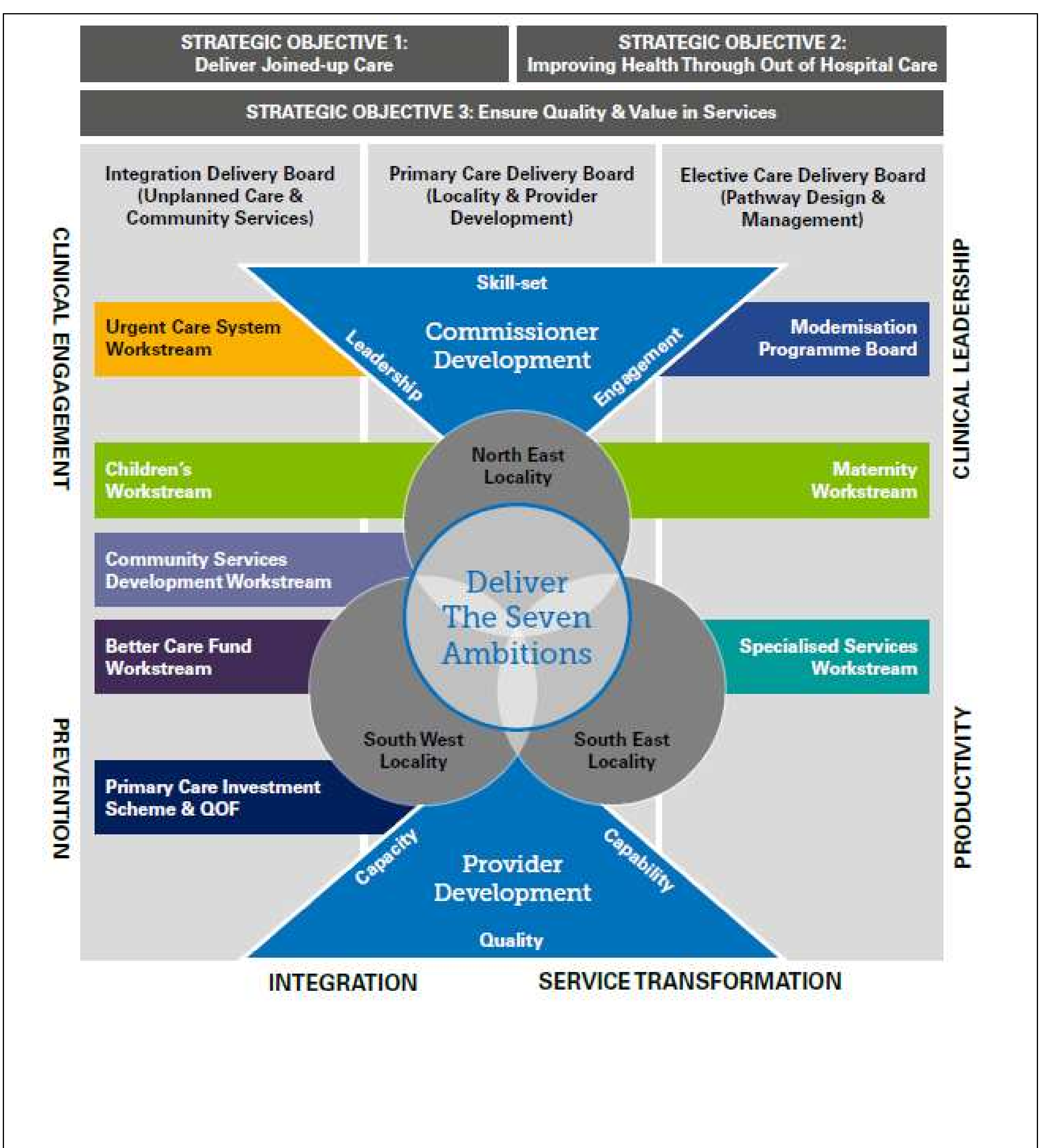
This Interim Development Board will report directly to the Health & Well-Being Board until such time as the existing structures of the Health & Well-Being Board have been constitutionally altered to provide overall governance and management of the proposed pooled budget and the work programme associated with the Better Care Fund Plan – planned for Quarter 1: 2014/15. In due course, operational and executive layers within the Health & Well-Being Board structures will assume the routine management and

accountability for the workstreams. The Health & Well-Being Board itself will remain the sovereign body accountable for the newly stabled pooled budget arrangement.

The graphic below illustrates the current Health & Well-Being Board governance arrangements.



Whilst the Health & Well-being Board will remain the sovereign body accountable for the Better Care Fund. The programme will also form a key part of the CCG Governance structure – shown below – and as such the individual projects will report into QIPP Portfolio Board via the relevant Delivery Board – this will ensure operational oversight of the individual projects and allow early identification of emerging risks and challenges.


STRATEGIC OBJECTIVE 1:
Deliver Joined-up Care
STRATEGIC OBJECTIVE 2:
Improving Health Through Out of Hospital Care
STRATEGIC OBJECTIVE 3: Ensure Quality & Value in Services
Integration Delivery Board (Unplanned Care & Community Services)
Primary Care Delivery Board (Locality & Provider Development)
Elective Care Delivery Board (Pathway Design & Management)
CLINICAL ENGAGEMENT
CLINICAL LEADERSHIP
Skill-set
Leadership
Commissioner Development
Engagement
Urgent Care System Workstream
Modernisation Programme Board
North East Locality
Children's Workstream
Maternity Workstream
Community Services Development Workstream
Deliver The Seven Ambitions
Better Care Fund Workstream
Specialised Services Workstream
South West Locality
South East Locality
PREVENTION
PRODUCTIVITY
Primary Care Investment Scheme & QOF
Capacity
Provider Development
Capability
Quality
INTEGRATION
SERVICE TRANSFORMATION

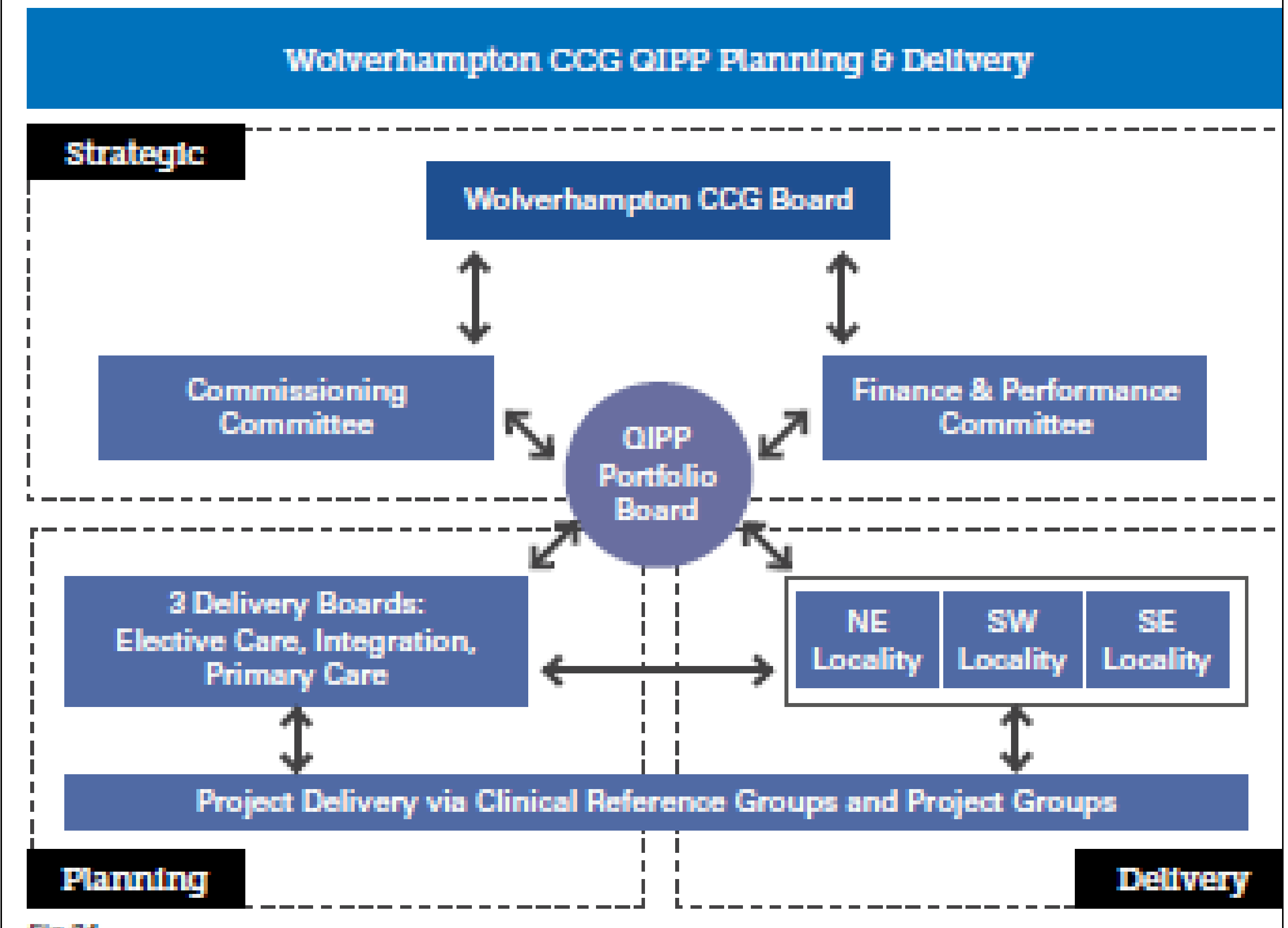
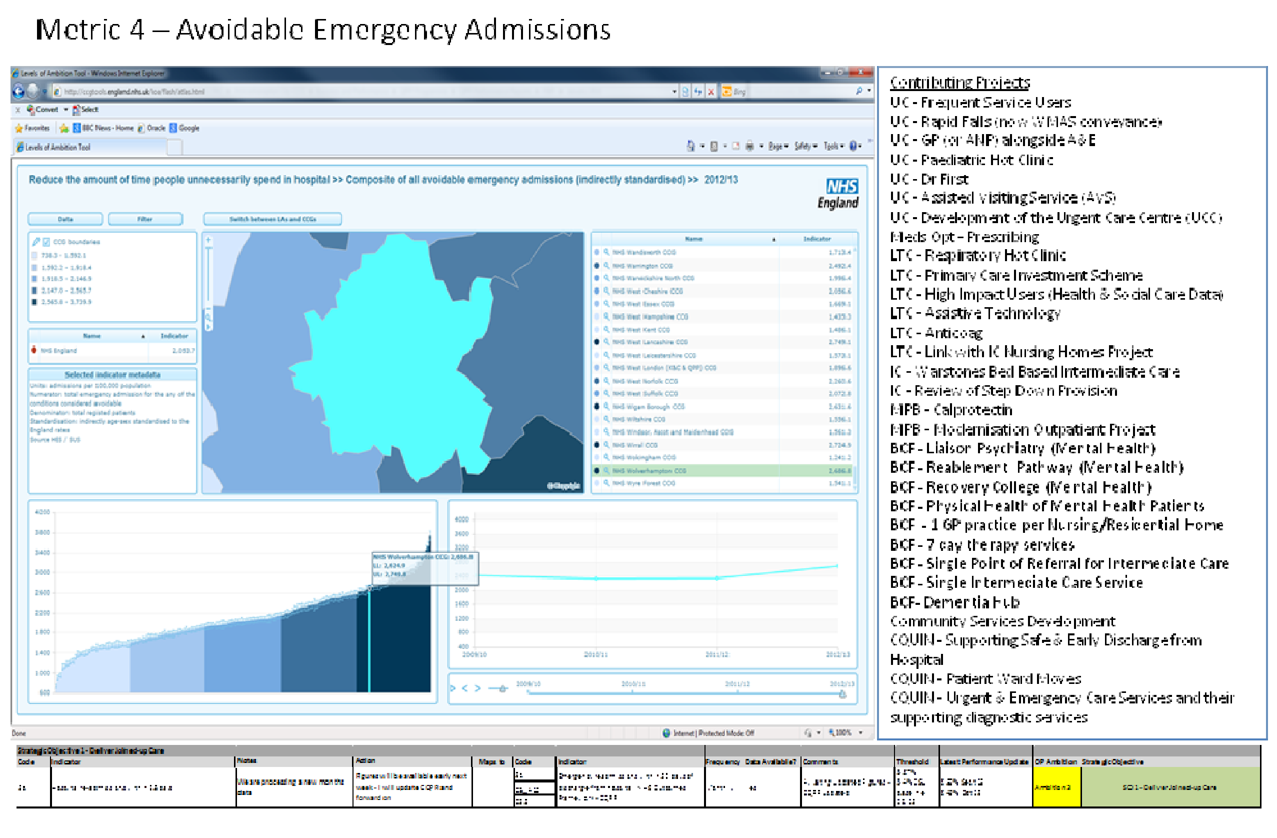
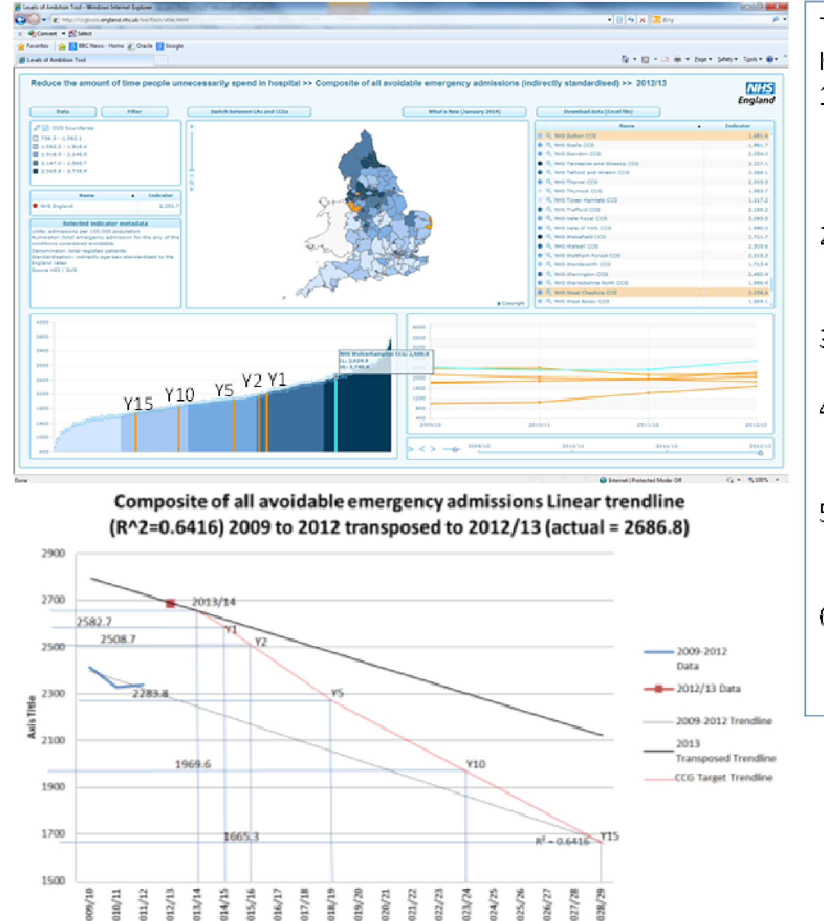


Fig 34

The following dashboard will be used in conjunction with the metric target graphs (see related documentation) will be used to monitor performance.

Metric 4 – Avoidable Emergency Admissions





The process for setting this target has been:

1) The CCG has taken into account previous performance to set a trendline for the long term target;
2) This was transposed to current baseline (from ATLAS) to set a start point;
3) QIPP intentions were added for Y1 target;
4) 15% ambition for reducing emergency ambitions added for Y5 target;
5) Series extended to meet long term 15Y target based on 2009-2012 trendline data.
6) Triangulation with BCF Statistical Significance Calculator and CSU data.

Financial Governance – relates to Part 2 completion

Presentation of Contribution to the Pool
The finance template (part 2) has been populated with information collated from both CCG and Local Authority budgets and the NHS related figures exceed the minimum values required by national guidance. Budgets for those services currently jointly commissioned by the CCG and Local Authority have been included within the template. In addition, the Local Authority's HARP service has been included due to the interdependency between this and the CCG-commissioned intermediate care services included in the figures.

There are a further series of Local Authority funded services - related to the Better Care Fund workstreams - which it would appear reasonable to include within the pooled budget, again, due to their interdependence with CCG-commissioned services. These have been included in the template position and presented as forming part of the pooled budget however this position will need to be reviewed subject to the appropriate governance and constitution changes being made within the Local Authority.

14/15 Figures
In 2014/15 the CCG and Local Authority will not operate a formal pool. Instead we will function with shadow arrangements; working jointly to prepare for and support services into transition. The figures included in the 14/15 columns of the finance template reflect the totality of budgets to be managed under the shadow arrangements.

15/16 Figures
Where benefits are captured in 2015/16 figures it should be noted that the figures presented represent the total benefits captured. This is not fully reflective of the value of monies to be reinvested into the BCF Pool. In most cases there will be a direct investment of the benefit numbers into the Pool however there may also be agreement between the CCG and Local Authority to retain monies within the commissioning organisation where they are realised.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

The Wolverhampton BCF (and its partner organisations) recognises the challenges for social care – and its need to protect statutory and essential preventative services – and will protect funding for the Care Bill and demographic growth in its financial planning.

The BCF partners are taking the following steps to protect short term expenditure.

I. DFGs/Carers Grant and Community Capacity Grant are automatically passported through to Local Authority social care;
II. Demographic growth of £2m a year is built into the budget.
III. Allocation of £989,000 to fund the Care Bill is built into the Better Care Fund.
IV. NHS transfer (section 256 / NHS support for social care) is seen as a key component of social care's contribution to the Better Care Fund and the protection of social care services.

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

The Wolverhampton Better Care Fund journey will build upon the strong existing work on integration of services. Our research and forecasting/commissioning has identified demand management, maximising people' independence and limiting the impact of any unpredicted decline to be the key components of this work and we already know a considerable amount about what can work in this area.

Our existing strong, collaborative, working in the field of intermediate care/ resource centres and joint Learning Disability and Mental Health provision form a firm foundation for future action.

The BCF action plan seeks to take each of these key theses to the next phase of operation by developing models which are predicated on one emphasis on outcomes, one process and one journey for the individual through the system.

This aspiration will cross All Adult Social Care groups and include all elements of service commissioning and provision.

Two key issues that are currently being picked up are the use of one identified lead professional between the services and 7 day a week working.

Protection for Social Care and Reducing Hospital Admissions - achieving both at the same time

The Council in Wolverhampton had made a commitment to maintain the current level of eligibility at critical and substantial. The opportunity to redesign services in ways that have a proven impact on reducing demand is a critical part of the approach. We know that if our reablement and intermediate care services were better aligned we would meet peoples' needs at a lower level, so improving outcomes for the person as well as reducing the reliance on beds and using resources more efficiently. We have already identified that a discontinuous system allows us to increase peoples' dependencies and we need to set up systems that stop this happening. This is inherent in each workstream.

The evidence from recent research undertaken by the Council is that demand reduction by both reablement and prevention offers the only sustainable service options for the future and the synergy and waste avoidance that can be captured by integrating this across the whole health and social care community offers the only solution for resource viability across the public sector.

In addition, we will :

- work together to ensure services are joined up and not duplicated or working in silos
- find alternative models of care to reduce the need for long term residential care and to support people to stay in their own homes where possible
- reduce the reliance on acute hospital care which will release funding to provide more low intensity interventions.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy).

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

A significant number of the schemes and projects contained within this BCF programme will introduce or (more frequently) extend 7-day services in health & social care to support patients being discharged or provided with alternative and clinically appropriate care. Intermediate care workstream plans will further develop a range of social care and therapy based services to augment existing 7 day services.

Within The Royal Wolverhampton Hospital Trust, staffing levels and skill mix are reviewed each year as part of the annual planning round. Where professional bodies provide guidance on staffing this is used to inform plans. Over the last year there were increases in consultant staffing to ensure provision of onsite presence of senior consultants' 7-days a week. Nurse staffing is reviewed using the AUKUH (Association of UK University Hospitals) model, most recent changes include making Band 7 Ward Managers supervisory and approval to recruit c.150 ward nurses in recognition of the rapidly changing dependency of our patients in acute wards and the need to increase the

number of weekend discharges.

Corporate services and back office functions will be market tested against industry levels over the next few months to ensure they are competitive on value and quality.

7-day working is already established in many aspects of the Wolverhampton LHE – within the next six months there will be a social work presence in the acute hospital seven days per week and the Integrated Discharge Team will be an integral part of 7 day discharge processes.

Within Primary Care the CCG is piloting weekend working and additional hours working for GP Practices, this will be evaluated and form part of the trajectory to achieving 7 day services in Primary Care. The CCG 5 year Strategic Plan clearly sets out an ambition to work towards practices in Wolverhampton opening 7 days per week for 12 hours per day.

The development of these services will be co-ordinated with the identified workstreams within the current BCF Programme.

Intermediate care workstream plans will further develop a range of social care and therapy based services to augment existing 7 day services and prevent un-necessary admissions at weekends.

Within the CCG SDIP with its main providers, the CCG has specific actions relating to 7-day working. This has been developed by the CSU and is the same in all contracts across Black Country. (see below).

Each provider of acute services must agree with local commissioners, and detail within an SDIP, action that it will take during 2014/15 to implement the clinical standards set out in the *NHS Services, Seven Days a Week Forum* review into seven-day services	Subject to General Condition 9 (Contract Management)	Provider to work up plans for the adoption of ten clinical standards that describe the standard of urgent and emergency care that patients should expect to receive, seven days a week. The standards include: 1. Patient Experience 2. Time to consultant review 3. MDT review 4. Shift handover 5. Diagnostics 6. Intervention/ key services 7. Mental Health 8. On-going review 9. Transfer to community. Primary and/ or social care 10. Quality improvement Implementation of the clinical standards as per the action plan agreed for full rollout by end of Q4	Plans to be made available to and agreed with the CCG by end of Q1 Q2-Q4

c) Data sharing

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

Better data sharing is a key component of the vision for BCF in Wolverhampton and work is progressing well on this – going forward the NHS Number will become the core identifier across all workstreams and services.

The NHS services are achieving the standards required for the use of the NHS number.

The city council have 70-75% of NHS numbers in CareFirst for current service users, people who have received a service in the past 2 years or people who have received an assessment in the past 12 months and continue to undertake regular batch matching exercises with the Acute Trust.

The next phase of work will be to embed the collection of the NHS number in social care assessment, review processes and systems over the coming months, alongside system and process changes to support the implementation of the Zero Based Review of Adult Social Care returns.

There is some initial work being undertaken with the CCG and CSU to link health and social care data via the CSU to understand the health and social care 'footprint' across the city – based on work undertaken in Birmingham and which Walsall, Solihull and Sandwell are commencing. This is currently with Information Governance Teams for sign off.

At its April meeting the Wolverhampton Health and Wellbeing Board approved the formation of a Health and Social Care Indicator and Information Group - made up of information and performance experts from across the partner organisations - in order to consolidate and improve the levels of sharing of information and data (using NHS number).

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

N/A

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

Robust information sharing is recognised by Wolverhampton as being key to successfully delivering the aims and plans of the Better Care Fund. Social Care have already begun to collect and record NHS number in the primary Social Care System (with over 70% of clients now having NHS number recorded) and work is being undertaken to embed the collection of NHS number within the assessment and care management process.

The Local Authority will lead on implementing processes for more robust information sharing and will work with the shared IT project stream to begin to look options for developing interfaces and API's between health and social care systems. This work is currently in its infancy, however, the development of a cross-partnership Health and Social Care Metric and Information Group has recently been approved by the Health and Wellbeing Board to take this work forward in line with embedded IG principles and agreements.

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

See above.

The work of the Health and Social Care Metric and Information group will ensure that any data sharing that takes place will fall within IG frameworks incorporating the IG Toolkit and Caldicott 2 :

- Staff receive training related to information security, the use of information and their personal responsibilities.
- Adequate security and working procedures are put in place.
- Systems are in place to monitor all aspects of information security.

d) Joint assessment and accountable lead professional

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

Care Planning for Disease and Risk Modification

Currently, all practices in Wolverhampton are engaged with the 2013/14 Primary Care Investment scheme which was initiated at the beginning of December 2013. The scheme uses a technical solution built on GP data that identifies and risk stratifies diabetic patients. GP practices, supported by the CCG and other providers (in acute and community care), develop and deliver proactive care plans for individual patients which places the emphasis on patient as well clinician management of the condition.

In 3 months - 7000 care plans have been produced for diabetic patients, using a process of patient targeting, risk stratification and care planning. Positive feedback has been received from clinicians (both primary and secondary care) and patients. The system has been designed in order to deliver improved health outcome, better co-ordination of care, improved patient self-management and reduced emergency admissions through the proactive modification of disease.

Short – Medium Term Objectives for Disease and Risk Modification for the elderly and /or those with a Long term Condition

In accordance with national guidance, our local priorities and the key messages from the Wolverhampton JSNA, we recognise that the proactive care management for the elderly and those with a long term condition is key to delivering our strategic objectives over the next 5 years.

Through disease and risk modification we intend to:

- Improve health outcome
- Reduce the burden of demand on healthcare services, particularly in terms of emergency admissions
- Address health inequality
- Focus on delivering care outside of hospital
- Focus on delivering proactive, co-ordinated and integrated care
- Engage and enable people to become involved in the management of their condition and the care that they receive

Target patient population

The CCG commissions significant levels of service and activity for patients with a long term condition and the elderly. With better planning and co-ordination, we predict that greater levels of service and quality can be provided with the resource that we have

available.

There are 193888 people over 75 registered with a Wolverhampton GP.

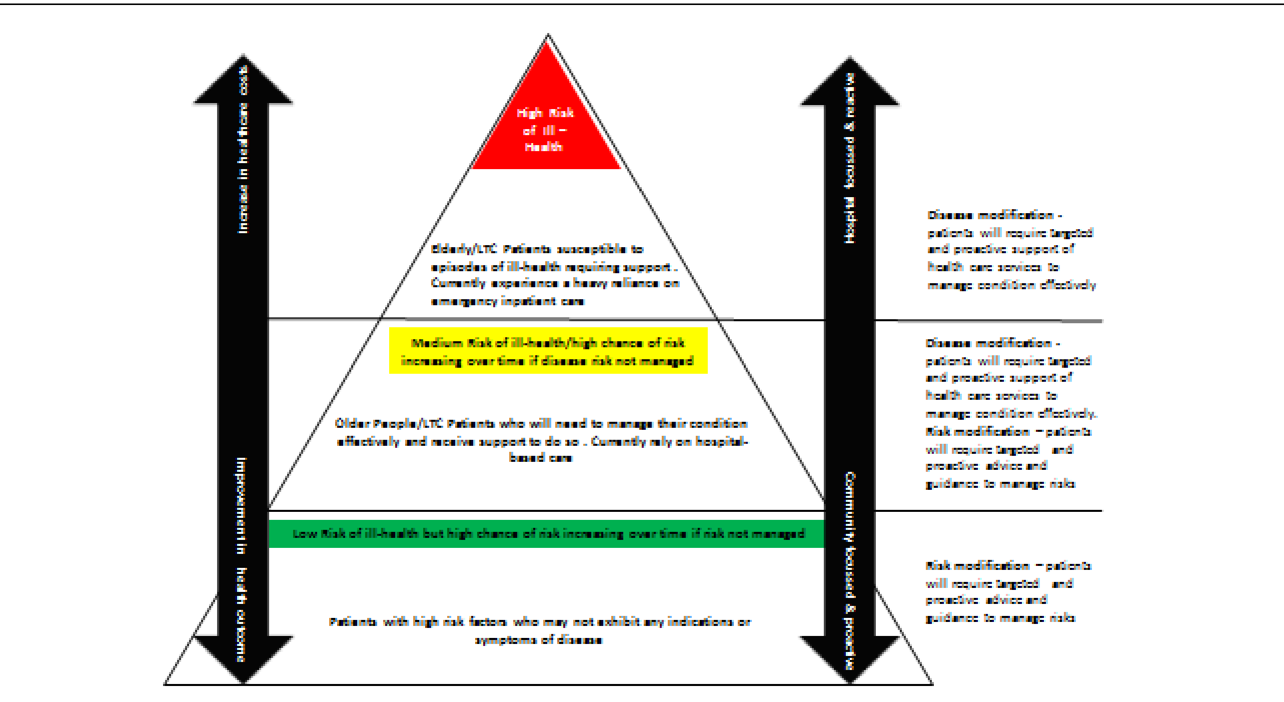
Sample LTC Prevalence in Wolverhampton, based on QoF registers (figures do not account for multiple LTCs)

- 20473 with respiratory disease
- 16340 with diabetes
- 9462 with CHD
- 4663 with stroke
- 39885 with hypertension
- 5057 with cancer

Strategic Intention

Our approach to developing disease and risk modification is built upon the systems and processes that we have developed as part of the Diabetic Optimal Management Index, Integrated Care Pathway and the implementation of care planning via the Primary Care Investment Scheme.

We intend to use the Optimal Management Index technical infrastructure, combined with clinical and managerial support, and the Primary Care Investment Scheme in order to target specific patient cohorts for, initially, disease modification, graduating to risk modification intervention over the course of this 5 year plan. In this way we will target those within the care system currently at greatest immediate health risk in order to proactively plan their care in order to improve their health outcome and reduce the need for emergency services. We will modify their disease risks so that they can live healthier and more fulfilling lives. As we do so, we will also start to shift our attention to those patient cohorts who are either at early, maybe undetected stages of disease or those who exhibit high risk factors. Using the same approach as our disease modification plans, and working in partnership with the Local Authority Commissioning and Public Health teams we will target patients and invite them to become involved in risk modification interventions using a proactive care planning approach, co-ordinated in primary care.



High Level Development Milestones

Our initial focus of activity in the next 2 years is to implement disease modification using care planning as the cornerstone in order to improve the health outcome and reduce emergency admissions for those at highest risk of ill-health. We will do this by targeting, risk stratifying and developing care plans for all long term condition patients and those over 75. This will be enabled using the Primary Care Investment Scheme and the national GP Contract for Enhanced Service for LTCs. In the longer term, years 3-5 of our Strategic Plan, we will target patient groups for risk modification interventions working in partnership and alongside the Public Health team from Wolverhampton City Council.

Key Delivery Vehicles

As part of the development of the Optimal Management Index and the Primary Care Investment Scheme, the CCG has developed the technical architecture, tools, support processes, supporting teams and care plans in order to support the delivery of care planning in primary care for risk stratified target patient cohorts. The CCG has made significant progress in delivering this for the care of Diabetic patients in 2013/14. We intend to use these processes for care planning in order to deliver disease modification in the short term graduating to proactive risk modification in the medium to long term.

Lead Professional

There are specific projects in two workstreams – Intermediate Care and Dementia – that focus on single, multi-disciplinary, assessment and allocation of lead professional, by their very nature these projects will include plans for the integration of community based multi-disciplinary health, mental health and social care teams.

Rather than re-inventing the wheel, work on single assessment and lead professional will utilise research on existing models and piloting to determine the best ‘fit’ for Wolverhampton.

The lessons learnt in these workstreams will allow single assessment and lead

professional allocation to be rolled out to all long-term conditions.

Models used in other parts of the country accept referrals into the named service – either as admission prevention or supported discharge; identify which professional – from the content of the referral – would be the most appropriate to undertake the assessment on behalf of the service. Once the assessment is complete the service then discusses which professional will take the lead and which elements of the service will be applicable to the patient.

In the interim, people at high risk of hospital admission will have an agreed accountable lead professional.

In addition to the single assessment process - as an enabler project - the CCG is working collaboratively with the CSU and the Local Authority to map social care data across health services to inform BCF projects moving forward. There is a requirement to agree a true health and social care virtual ward model focussing on emerging risk groups for the future.

One of the aims for the BCF is joined up care planning. Scoping work is underway to explore existing or new systems that extract data from GP systems and creating programmes around those moderate to high risk groups. This risk stratification approach would be replicated with social care data (using NHS numbers and single assessment process) to identify vulnerable people across the broadest range of factors that cross traditional silos.

4) RISKS

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

A risk register has been compiled from the initial Project Initiation Documents and is attached to this template, this register will be updated as work on the individual projects commences and proceeds. An up to date copy of the risk register will be reviewed by the Interim Development Board at its monthly meetings.

Set out below are the systems risks.

	ID No.	Risk	Possible Outcome	Consequence (Initial)	Likelihood (initial)	Rating (initial)	Mitigation	Owner	Residual risk score
System Risks	1	Failure to reduce Avoidable Emergency Admissions	Avoidable Emergency Admissions continue current trends	Possible	Major	12	BCF Projects : MH Urgent Care Pathway, MH Reablement Pathway, MH Recovery College, Single Intermediate Care Service, 7 Day Therapy Servies, Training for Care Home Staff, 1 GP per Care Home, In-reach Specialist Services, Single Commissioning (NH/RH) Arrangements, Dementia Hub	All workstreams	9
	2	Financial risk of failure to reduce Avoidable Emergency Admissions	Finaicial risk to CCG under PbR/Tarriff	Likely	Major	16	CCG Contingency Funds	CCG	16
	3	Increase in resources (financial and staffing) required to facilitate 7 day therapy working	Unable to implement	Likely	Major	16	Use BCF Transitional funding until such time as other projects delivery savings. If necessary recruit via agency.	Intermediate Care Workstream/Pooled budget holder	6
	4	Financial regime of the Local Authority in light of the reduction in budget & spend	Savings identified as accruing to BCF may be required to contribute to WCC plans. This would threaten the financial viability of the BCF.	Likely	Major	16	Finance and Information workstream to monitor and work together for early identification and mitigation of risks arising.	WCC	12
	5	Destabilistation of health care providers	Commissioning of services to deliver financial viability of BCF may require radical changes to services and potentially have a detrimental impact on provider income streams.	Possible	Major	12	Full engagement in BCF by provider units with early sharing of commissioning plans to identify risks and mitigations.	All workstreams	6