Wolverhampton City Council

NHS Wolverhampton Clinical Commissioning Group
Black Country Partnership NHS Foundation Trust
The Royal Wolverhampton NHS Trust

NHS

Wolverhampton Health & Care Economy

Better Care Fund Plan

One Wolverhampton

One ambitition, working as one, for everyone

One Wolverhampton

One ambitition, working as one, for everyone

Contents

Background

1. Background

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

1.1. What is the Better Care Fund?

The Better Care Fund (BCF) provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care "pioneers" initiative, through Community Budgets, through work with the Public Service Transform

1.2. What is included in the Better Care Fund and what does it cover?

Nationally, The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

There is very little new money or uncommitted resources in the BCF process.

In Wolverhampton, it means that a joint fund of just over £20m will be created using a variety of existing budgets, in brief these are:

- CCG mainstream allocations
- NHS support for Social Care (section 256 monies)
- Disabled Facilities Grant (DFG)
- Some Social Care capital Grants

Some of these funds will still be subject to restrictions placed upon them and further guidance is expected on their usage as part of the BCF.

1.3. What will the Better Care Fund do differently?

The June 2013 Government Spending Round was extremely challenging for local government - handing councils reduced budgets at a time of significant demand pressures on services. Meanwhile, the NHS has increasing demand creating a significant affordability and sustainability challenge.

In this context the announcement of £3.8 billion worth of funding is to ensure closer integration between Health and Social Care. This has been viewed locally as a real positive. The money is an opportunity to improve the lives of some of the most vulnerable people in our society. The funding – which is drawn from existing budgets - is described, nationally, as 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities'.

One of the key tenets of the BCF is that we (the key agencies and stakeholders) must give people control, placing them at the centre of their own care and support, make their dignity paramount and, in doing so, provide them with a better service and better quality of life. In Wolverhampton we have the opportunity to do something radically different to improve services and quality of life.

It should also be noted that an element of the national funding will be 'held back' pending achievement of satisfactory performance against the national conditions and metrics (see section 3). Approximately 25% of the national budget will be initially retained and then distributed on a 'Payment-for-Performance' basis in year. Failure to achieve the target performance may require the local Health & Care economy to produce a recovery plan – to be approved by ministers – before the payment-for-performance element is released.

1.4. The Partners

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 have set up a structure to develop the response to the requirements of the Better Care Fund and implement the plan.

Below this leadership level, an Interim Development Board has been established. This is a group of 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. Below this Interim Development Board, four workstreams have been identified:

- Mental Health Recovery & Reablement
- Nursing & Residential Care
- Intermediate Care, Rehabilitation, Reablement
- Dementia Care Management.

Each of these workstreams will have a slightly different structure, but all will report through to the Health & Well-Being Board and its substructures.

The table below summarises the key Representation from the Partnership.

Table 1

	Named representative	Title	Organisation
Chief Executive & Accountable Officers	Dr Helen Hibbs	Accountable Officer	Wolverhampton CCG
	Ms Sarah Norman	Strategic Director Of Community	Wolverhampton City Council
	Mr David Loughton	Chief Executive	Royal Wolverhampton Trust
	Ms Karen Dowman	Chief Executive	Black Country Partnership Foundation Trust
Interim Development Board	Mr Richard Young	Director of Strategy & Solutions	Wolverhampton CCG
	Ms Claire Skidmore	Chief Finance & Operating Officer	
	Ms Viv Griffin	Assistant Director – Health, Wellbeing and Disability	Wolverhampton City Council
	Mr Anthony Ivko	Assistant Director for Older People and Personalisation	
	Mr David Kane	Head of Finance	
	Ms Ros Jervis	Director of Public Health	Public Health - Wolverhampton CC
	Ms Maxine Espley	Director of Planning & Contracts	Royal Wolverhampton Trust
	Ms Gwen Nuttall	Chief Operating Officer	
	Mr Kevin Stringer	Chief Finance Officer	
	Mr John Campbell	Chief Operating Officer	Black Country Partnership Foundation Trust
	Mr Paul Stefanoski	Director of Finance	


Vision

2. The Vision

As part of the Wolverhampton Better Care Fund Plan, all partners recognised that there is a need to agree a compelling narrative that can act as a springboard to action, to mobilise the system, ensuring a sense of community with a shared story, the ability to tell the story quickly, simply and memorably and clarity of ambition. To this end a 'Whole System Event' for the development of a shared vision and to assist this narrative on the 28th January with representatives from of key stakeholders, third sector partners, patient & public representatives, Members of the City Council and GP CCG Board members.

The vision was considered at a special meeting of the Health & Wellbeing Board on 5th February 2014. The Health & Well-Being Board approved & adopted the vision statements (together with the first-cut draft submission).

2.1. One Wolverhampton

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, 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, a vision statement was produced and we agreed our local Health & Care Economy vision would be:

One Wolverhampton

One ambitition, 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 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.**

2.2. Unpacking the Vision

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 key words helping to define the vision statement illustrate the ambition of a single plan for all partners instead of the multiple – and sometimes conflicting – plans of the key stakeholders. 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, agreeing new integrated pathways and deconstruct 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.

We have summarised this in the table below to standardise and promote our vision statement.

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

2.3. Commissioning for Outcomes

Whilst the ambition for transformational change seeks to go much further, The Interim Development Board has agreed four workstreams to initiate the BCF programme. These are:

- Mental Health – initially focused on De-escalation – now recovery & reablement
- Nursing & Residential Care – initially focused on Hospital admission avoidance
- Intermediate Care – maximising opportunities for prevention & reablement
- Long-term conditions – initially focused on Dementia Care Management.

The detail behind these workstreams is set out in section 3 of this document, however – guided by the vision statement and directed by the metrics contained within the BCF guidance – the outcomes from the programme seek to deliver:

- A clear ambition for prevention and early intervention focussed on keeping people well;
- Develop integrated care systems that ensure the delivery of co-ordinated and seamless care;
- Develop an outcome based focus that sets out clearly what the expected benefits from the plans.

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 patient 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
- 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 based interventions.

2.4. The Wolverhampton Challenge

The 'case for change' and the context for the socio-economic analysis for the City (and its residents) is set out in a number of documents utilising the Joint Strategic Needs Assessment (JSNA) produced by Public Health Wolverhampton. These are most recently revised and set out in the CCG Operating and Strategic Plans and will not be re-produced here.

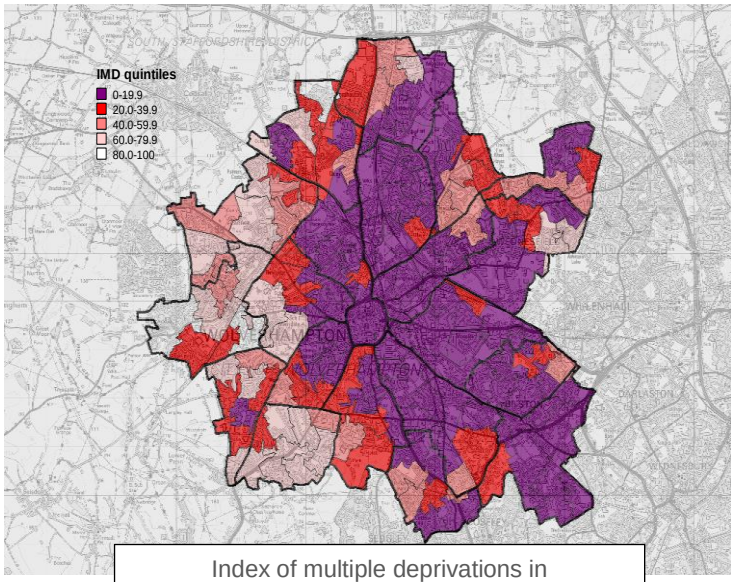
These challenges include the high level of socio-economic deprivation, the elevated incidence of long-term illness and the extent of health inequalities within the City. In addition, the plan acknowledges that services must be of the highest quality, sustainable and affordable in the context of increasing demand and in period of meagre financial growth.

2.5. Wolverhampton's Health Needs

The key messages and challenges can be summarised as:

1) Population

The 2011 census data shows the city's resident population is 249,470 but our registered population is 262,000. The average age of residents in Wolverhampton is 39, which is similar to the national average; however, broken down by specific age groups, Wolverhampton has a slightly higher proportion of children aged under 16. The older population (age 65 years and over) is predicted to increase over the next 10 years both locally and nationally. It should be noted that Wolverhampton's predicted population growth rate is below the national, regional and Black Country averages.



Index of multiple deprivations in Wolverhampton 2010

2) Diversity

The majority of residents in the city belong to the white ethnic group (68%), with the remaining 32% from black minority ethnic backgrounds (BME). The largest of the BME groups is Asian at 18.8%, followed by black and mixed face at 6.9% and 5.1% respectively. This is quite different to the national distribution with only 14.3% from a BME background. The south east of the city has the highest proportion of BME residents.

3) Deprivation

Deprivation is a fundamental determinant of poor health and dependence. There are significant levels of deprivation in the city. Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. This

indicates that over half of Wolverhampton's population live in the poorest areas in England, which impacts on life expectancy and premature mortality rates in the city. Deprivation is disproportionate across the city, with the least deprived wards in the west of the city and the most deprived located in the north east and south east of the city (see figure, above).

4) Life Expectancy

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 experience 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.

5) Joint Strategic Needs Assessment

Wolverhampton's Joint Strategic Needs Assessment has focussed on the outcomes contained in the three national outcome frameworks: Public Health (PHOF), NHS (NHSOF) and Adult Social Care (ASCOF), and an additional locally developed outcomes framework for children and young people. The key health needs identified from these frameworks highlight the priorities for commissioned services to improve health and reduce inequalities.

2.6. The Better Care Plan

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 recognising 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 fully 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:

I. Establishment Phase:

- 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 document is largely concerned with this phase.

II. Development Phase:

- 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
- Phase II will further develop the BCF strategy and expand the programme to shift further monies from the hospital sector (by avoiding 'unnecessary' unplanned care and better management of Chronic Conditions / LTCs reducing the need for hospital based care). These resources will be invested into community-based services to maintain and improve health in the community.
- Potentially, this phase could include significant elements of spending and services currently locked into NHS contracts which, when released, will enable transformational change across traditional health & social care boundaries.

Whilst commissioners within the Council and the CCG will exhibit robust contract management with its provider organisations, it is accepted that continuous improvement of the health and social care system can only be achieved by establishing effective partnerships with all key stakeholders and promoting the interaction between them. The BCF has catalysed a new generation of strategic alignment between the major agencies and our on-going and developing partnership with our patients and population.

Our commissioning decisions will be shaped by the views of our patients and the public and effective engagement will be a central factor within our new ways of working. The need for engagement is reflected in the status of the plan and the document will develop continuously to become the blueprint for our work.

2.7. Strategic Fit

This BCF Plan has been developed in light of the Wolverhampton Joint Strategic Needs Assessment, the CCG Operating Plan, the draft System Vision and five year Strategic Plan for health care in Wolverhampton.

The JSNA process has informed the development of the Wolverhampton Joint Health and Wellbeing Strategy, produced by the Health and Wellbeing Board. The health and wellbeing priorities listed below have been selected to provide a number of high, level evidenced-based priorities that are a challenge to resolve and span organisational responsibilities. The strategic outcomes for the strategy are aimed at increasing life expectancy, improving quality of life and reducing child poverty. Therefore, the top five priorities identified to achieve these outcomes are:

- Wider determinants of health
- Alcohol and drugs
- Dementia (early diagnosis)
- Mental Health (diagnosis and early intervention)
- Urgent Care (improving and simplifying)

We have three main strategic objectives:

I. Transforming and Integrating Services to Maximise the Quality of Care

To develop and deliver integrated services and joined-up care across health and social care in order to ensure care is focussed on the patient in a way that helps to improve provision and health outcome. This will be integrated care that:

- Reduces duplication and inefficiency
- Is focussed on patients' needs
- Facilitates care outside of hospital and in the patient's own home
- Avoids unnecessary and traumatic emergency admissions and reliance on the hospital's emergency department
- Targets specific groups that we know are reliant on healthcare support on a regular basis
- Maximises the capacity and capability of GP and community care services
- Maximises the potential of local authority, voluntary/third sector and private sector organisations.

II. Development of Services and Capacity Outside Of Hospital

To maximise the potential of services outside of hospital in order to provide a greater range and level of care that is proactive and seeks to avoid the need for emergency support. Services that contribute to health improvement:

- Focus on specific groups
- Accentuate self-management
- Are focussed on proactive and early intervention, based on care planning
- Promote avoidance of secondary care where appropriate
- Promote avoidance of ill-health and health lifestyle

III. Assurance, Monitoring and Development to Ensure Quality and Access to Services

To continuously assure the quality and value of services in order that the care provided meets the reasonable expectations of patients and professionals alike. This will include:

- Rigorous and robust quality monitoring and assurance processes
- Listening and acting on patient feedback and experience
- Pathways that are focussed on the patient

- Reducing duplication and improving access for patients
- Ensuring that patients' NHS constitution rights are delivered and upheld
- Ensuring patients do not have to wait unnecessarily for treatment
- Ensuring patients can expect the right treatment outcome each time they use healthcare services
- Developing and ensuring services can offer the right level of access, seven days a week

It can be clearly seen that when comparing these imperatives and priorities from the Health & Well-Being strategy and those of the CCG, there is a high degree of correlation with the vision and commissioning intentions set out in sections 2.1 – 2.4 above.

2.8. Protecting Social Care Services

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 and collaborative working in the field of intermediate care / resource centres and joint Learning Disability & 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.

There has been considerable collaborative work undertaken by the partners to increase the level of NHS number utilisation within Social Care, and within a 3 month period of work we have achieved 75% coverage, which has enabled us to participate in a regional data matching exercise to better correlate health and social carer data, again a key component of the BCF approach. However, this work has also allowed us to ensure that the degree of effective information sharing that we can achieve in our programmes going forward will be maximised and the use of the NHS number as the primary identifier will be a key component of all revised care pathways.

We have also got many services that currently have 7 day a week cover for services and our new contractual arrangements allow all of the agencies to specify 7 day working patterns as part of routine process and the requirement to consider these patterns will be built into each Better Care Fund Work stream.

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 to this absolute design commitment the partners are taking the following steps to protect short term expenditure.

1. 'DFGs/Carers Grant and Community Capacity Grant are automatically passported through to Local Authority social care;
2. That demographic growth of £2m a year is built into the budget.
3. 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.'

2.9. Longer-Term Whole System Change

The Better Care Fund Programme is regarded by the Local Health & Care Economy as a catalyst and microcosm of a much larger and fundamental long-term transformation strategy. To this end, key stakeholders have embarked upon an ambitious journey of whole system change. Whilst in its very early stages of development, the Better Care Fund initiative has arrived to give the emergent programme short term focus and impetus.

The Wolverhampton Whole System Change and Improvement Programme is focussed around enabling adults in Wolverhampton to live fulfilling lives by enhancing their independence, health and quality of life through seamless, efficient action that strives to improve experiences and outcomes.

This basic model describes large-scale change programmes as being based in three phases:

- Scoping – when connections among key people are made, clarity, purpose and commitment is developed and issues and possibilities identified.
- Work design – when ideas and options are researched, generated and evaluated; assumptions and interventions are tested and capability for delivery is developed; and a clear pathway agreed with plans and responsibilities for key recommendations
- Delivery, action and implementation – when new structures, processes and ways of working are embedded and lessons captured

Of course these are not clearly separate from each other and many projects cycle through all three phases more than once; intentional design often means working through elements of each within each of the phases. Running throughout the programme will be three core elements of Change Management, Work design and Programme Management. They are each required in all phases, but some elements may come to the foreground in particular activities or phases. All three are required for success. At the end of each main phase there is a 'gateway'. This is simply a checkpoint people can use to ensure that they have covered the work required and are ready to move on.

All large scale initiatives will be iterative and the content and focus of the plan will develop and shift as the work goes forward. The discipline of setting out the phases and committing to work overtime does:

- Provide a common framework and language to talk across activities, about what stage they are at and what they are doing
- Sets out the scale and scope of ambition, which makes explicit the time, commitment and capabilities required to make progress
- It allows teams to be very clear when they recruit new people as to what they have already done.
- Introduces some rigour to involvement, creativity, and whole system thinking

This transformation project will provide the basis of the longer term Health & care strategy for Wolverhampton and will be a key plank in the CCG 5-year Strategic Plan.

2.10. Plan on a page

We have attempted to set out our vision, outcomes and metric goals in a diagrammatic form (see overleaf). Whilst this Plan on a Page is still under construction and, at the point of writing this version of the document, it is anticipated that the format and some detail may change, this represents the ambition of the programme and this element is unlikely to alter substantially.

2.11. Better Care Fund – Timeline chart

The first phase of the BCF programme is mapped out in outline terms below.

Better Care Fund: Plan on a Page

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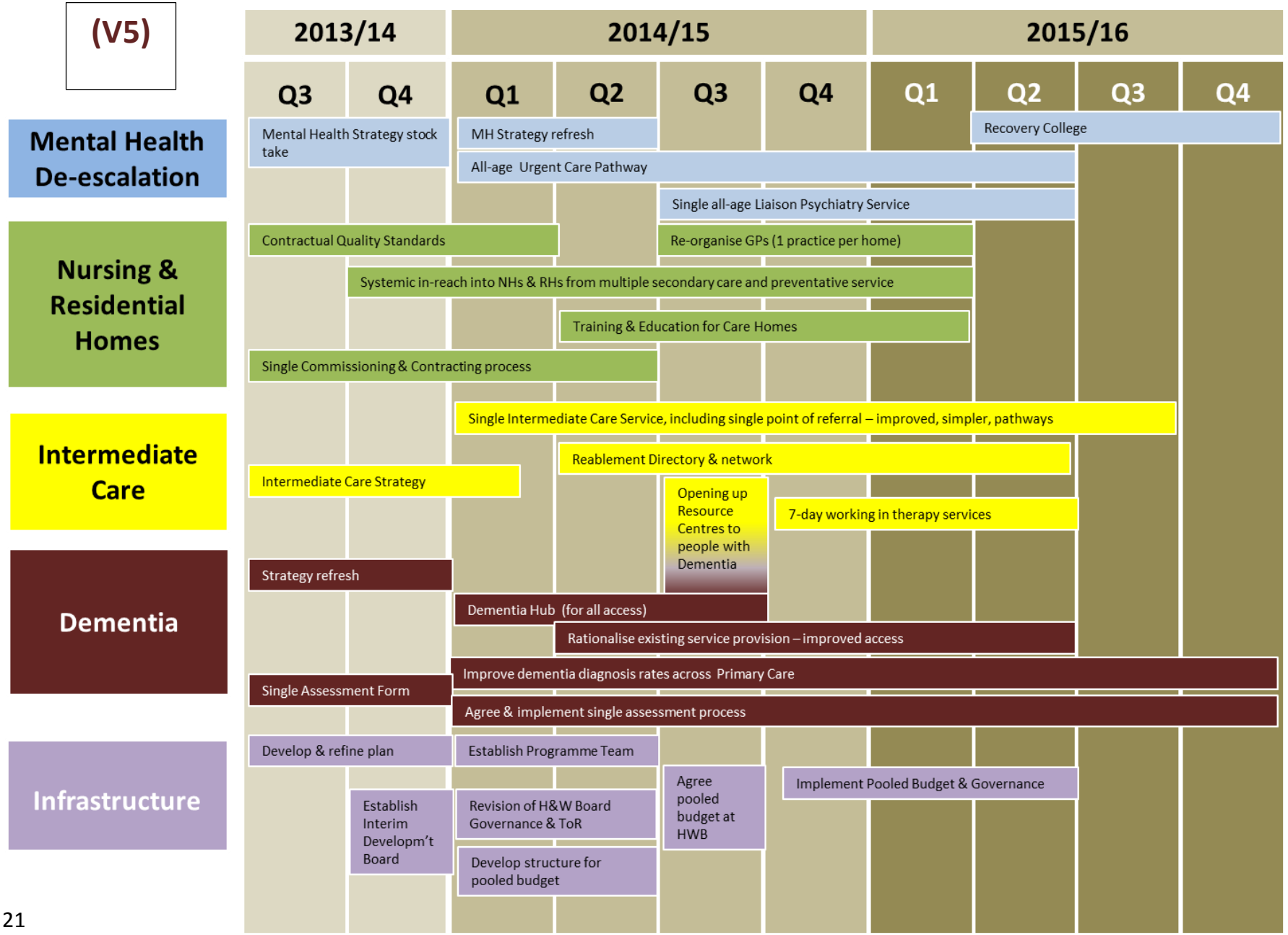
V7

Vision: **Wolverhampton One Ambition, Working as One for EveryOne.**

Strategic Objective	One Ambition	Working as One	For Everyone
What Are We Trying To Do?	Single Plan Sharing everything Keeping People Well	Integrated Pathways All Partners Working Together Shared Sustainable Outcomes	Each Individual Prevention & Recovery Self-caring Communities
Priority Areas			
Mental Health De-escalation	To Maximise Recovery And The Support Of People With Mental Health Problems Within The Community	• All-age Urgent Care Pathway • MH Reablement Pathway • Single All-age Liaison Psychiatry Service	• Recovery College
Intermediate Care	To Maximise Reablement After A Period Of Ill Health And Provide Alternatives To Residential, Nursing And Hospital Admissions	• Single Intermediate Care Service to include single point of referral • Single Assessment Process	• Reablement Directory & Network • 7-day Therapy Services
Nursing & Residential Care	Keep People Well & Prevent Avoidable Admissions	• Quality Standards • Single Commissioning Arrangements	• Training For NH & Community Staff • 1 GP Per Care Home • In-Reach Specialist Services
Dementia Services	To Provide Holistic Services That Keep People With Dementia Well And Independent	• Single Assessment Process • Increased access to Resource Centres	• Dementia Hub • Improved diagnosis & recording rate in Primary Care
Outcomes Sought	• Increase in effectiveness of these services whilst ensuring that those offered service does not decrease • Reduced Hospital Admissions	• Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.	• Older people (65+) continue to live in their own home. • Local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience.
	• Reduce Emergency Admissions Which Can Be Influenced By Effective Collaboration Across The Health And Care System.		
Outcome Targets (see Metrics table)	• Increase proportion of older people still at home 91 days after discharge from hospital into reablement services	• Reduce delayed transfers of care from hospital per 100,000 population • Increase diagnosis and recording rate of Dementia in Primary Care	• Reduce Permanent admissions of older people (65+) to residential and nursing care homes, per 100,000 population
	Reduce Emergency Admissions		

Better Care Fund – Timeline chart

(V5)



The Schemes

3. The Schemes

3.1. How we got started

In June 2013, the four major statutory agencies and stakeholders in the Local Health & Social Care Economy in the city agreed to come together to find opportunities for better integrated working between the agencies. This initially culminated in 'integrated Pioneer' project based around dementia services. Whilst this bid for pioneer status 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 core planning group comprised of the planning and finance directors from each organisation with support from a small team of programme support management.

A Front Line Staff event was held on the 17th December 2013, where in excess of 50 people representing carers, voluntary groups, health and social care staff - who have a role in one (or more) of the workstreams- met to discuss :

- 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'.

This event confirmed that the chosen workstreams were relevant and that not only was there an opportunity to effect some immediate, practical, actions but that there was scope for transformation of services.

The Wolverhampton BCF plan has four main workstreams, these are:

- Mental Health – initially focused on De-escalation, now Recovery and Reablement
- Nursing & Residential Care – initially focused on Hospital admission avoidance
- Intermediate Care – maximising opportunities for prevention & reablement
- Long-term conditions – initially focused on Dementia Care Management.

The prioritised workstreams (summarised below) have been developed through the series of whole system events (described in 1c &1d) and are (in part) based upon the Health & Well-Being strategy, CCG ICP / Operating Plan and Local Authority strategic plan.

The time scales for these projects are set out in the BCF timeline chart attached.

3.2. Mental Health – Recovery and Reablement

Need para explaining the 'vision' for the workstream
Need para linking the investment and the 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

Projects:

- Urgent Mental Health Care Pathway including Liaison Psychiatry
- Finalise Service Specification; Identify resources & funding; develop and implement action plan
- 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

Mental Health Reablement & Recovery

Project	Project Summary	Strategic Objective	BCF Metric
MH Urgent Care Pathway	The integrated Urgent Mental Health Care Pathway will provide emergency and urgent assessment – Liaison Psychiatry - treatment, intervention and care and support within an integrated health and social care model for individuals with acute and severe mental health difficulties who require high levels of care and support in urgent and/or emergency situations. The project will map existing services, develop new model – to include 7 day services, joint assessment and named accountable lead professional - and agree implementation plan and oversee its implementation.	Working as One	Metric 4 Reduce Avoidable Emergency Admissions Metric 5 Patient/User experience
MH Reablement Pathway	The integrated Mental Health Reablement and Recovery Care Pathway will provide specialist reablement and recovery focussed assessment, interventions and support for adults with severe and enduring mental illness (SMI). This will include nursing and residential care, step-down, specialist community support and intervention, specialist mental health supported accommodation and floating support and day services and also individualised packages of care for people with high levels of need. The project will develop and transform the mental health reablement and recovery service model/s within health and social care by pooling these into an integrated health and social care pathway with the required multi-disciplinary form, function, systems, processes, skills and expertise to deliver the range of psycho-social assessment and interventions – as a 7 day service - to deliver the outcomes described above. An integrated recovery and reablement health and social care team will provide single, holistic assessment and case management, with an accountable lead professional for each referral, transition across the care pathway, support for dedicated support for primary care regarding SMI registers and support for service providers to improve outcomes for patients and their families and carers. The project will adopt the same methodology as for the MH Urgent Care Pathway.	Working as One	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 4 Reduce Avoidable Emergency Admissions Metric 5 Patient/User experience
Recovery College	The Recovery College is an enabling project which, through co-production with service users and their carers, will provide an educational setting for which service users might want to explore as part of their recovery – and at the same time provide them the knowledge, support and network to live with a Mental Health condition with greater independence. This	For Everyone	Metric 4 Reduce Avoidable Emergency Admissions Metric 5

model will complement the clinical model of care currently being offered, and it is planned to expedite the transition back into the community without secondary support quicker and with less risk.

Patient/User experience

The Recovery College will provide a range of courses to help people to develop their skills and understanding, identify their goals and ambitions and give them the confidence and support to access opportunities.

The college will bring together two sets of expertise – professional and experience – in a non-stigmatising college environment with the same systems as other educational establishments. All of the courses provided at the college will be designed to contribute towards wellbeing and recovery. People who share experiences of mental health or physical health challenges will teach and support the teaching on the courses with the intention of inspiring hope and embodying principles of recovery.

The courses will be designed to put people back in control of their life, helping each person to identify goals and ambitions whilst giving the confidence, skills and support to access opportunities. They are open to adults who:

- Have personal experience of mental health challenges
- Care about people with mental health challenges
- Are a member of staff in mental health services

The project is delivered by a partnership of Trust professional and Service Users and Carers; the project is also receiving support from ImROC and in particular Mersey Care who have operated one of the first Recovery Colleges in the UK. The College is working to the principles defined by the NHS Confederation, the Centre for Mental Health (formerly the Sainsbury Centre for Mental Health) and the National Mental Health Development Unit, using methodology developed by the Centre for Mental Health based on structured self-assessment, goal setting, implementation and review in relation to ten challenges which organisations wishing to implement Recovery are advised to address.

There 10 objectives which this College will address:

1. Changing the nature of day-to-day interactions and the quality of experience.
2. Delivering comprehensive user-led education and training programmes
3. Establishing a ‘Recovery Education Centre’ to drive the programmes forward.
4. Ensuring organisational commitment, creating the ‘culture’; the importance of leadership.

5. Increasing personalisation and choice.
6. Changing processes for risk assessment and management.
7. Redefining service user involvement.
8. Transforming the workforce.
9. Supporting staff in their recovery journeys.
10. Increasing opportunities for building life 'beyond illness'.

Whole system/service change will incorporate:

- Development of an adult education model and setting for Wolverhampton, 18+.
- Delivery of a responsive, peer-led education and training curriculum.
- Recovery focused workshops and courses.
- Development of new skills for students.
- Move towards an increase in the understanding of Mental Health challenges
- Coproduced courses, and support by co-delivery.
- The bringing together of people to realise and inspire both individual and collective potential.
- The college will provide hope, empowerment, possibility and aspiration for its students, a collaboration of strengths and successes rather than highlighting deficits and problems.
- Study buddies, peer support, support with learning challenges and difficulties through to the provision of a library and resource centre.

Project	Service	Commissioner / Provider	Activity 13/14	£s 14/15
Recovery College	None provided			
MH Urgent Care	Referral & Assessment	BCP	595	1,261,860
	Crisis & Home Treatment	BCP	6	1,530,651
	CAMHS Home Treatment	BCP		335,792
	Key Team	B		177,325
	Mental Health Liaison			86,698
	Intake Team			904,250
	Emergency Duty Team (Part)			205,285
	Recovery House (Crisis Compone		TBA	224,540
	Total			**4,926,401**
MH Recovery & Reablement	Victoria Cour Heart)	Joint Commission	5840 OBDYs	567,980
	AC	Joint Commission	TBA	213,805
		Joint Commission	TBA	145,780
	eart)	WCC	N/A	TBA
	ale Lodge		TBA	69,050
	plex Cases	CCG care purchasing	25 care packages	2,372,000
	Community Hub	WCC	N/A	200,000
	WCC Care Purchasing	WCC	100 care packages	3,285,890
	Recovery House (reablement component)	WCC	TBA	224,540
	Total			**7,079,045**
Total				**12,005,446**

To be updated

3.3. Nursing & Residential Care – Hospital admission avoidance

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

Projects:

- 1 GP Practice per Home
- Implement Single Commissioning & Contracting Arrangements
    - reflect analytical work; based on need; outcome focused specifications; monitoring & performance measurement
- Single Assessment
    - lead GP signed up to information sharing; all professionals agree to completing a single, transferable, record (nursing & residential) per patient - paper initially, working towards electronic
- Training & Education
- 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

Nursing & Residential Care Homes

Project	Project Summary	Strategic Objective	BCF Metric
Quality Standards	The CCG has implemented a Nursing Home Improvement Plan, with the specific aim of improving the quality of care within Nursing Homes in Wolverhampton. This Improvement Plan includes an Escalation Framework to ensure the CCG has a systematic plan in place to enable it to take appropriate action when required. Nursing Home Quality Monitoring visits – announced and unannounced - are undertaken under the auspices of the Improvement Plan to ensure that high quality, evidence based, services are purchased and delivered. Now that the plan has been implemented within Nursing Homes this will be developed into an Improvement Plan for Residential Homes to ensure similar high quality, evidence based, services are purchased and delivered.	Working as One	Metric 4 Reduce Avoidable Emergency Admissions
Single Commissioning Arrangements	Purpose of the project is to create an overarching pre-placement residential and nursing home contract. **Initial Activity:** • To establish a Project Management Team to drive and oversee the development of the Pre-Placement Residential and Nursing Care Contract • To formally consult with all residential and nursing homes across the city • To engage with representatives of the Wolverhampton branch of the West Midlands Care Association to further the consultation process • To engaged with the Wolverhampton Clinical Commissioning Group to develop a set clinical practice guidelines to be incorporated within the new contract **Aim of the project** To introduce a single commissioning arrangement for residential and nursing homes placements across the city. Long term project objectives will be to develop a working group to explore the following: • To introduce a range of fee tariffs that reflect an individual persons care requirements. • To introduce a range of sanctions that could be applied to homes not meeting contractual requirements. • To ensure that on-going requirements of the CCG are fully incorporated in to the contract. • To work more closely with neighbouring local	Working as One	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 4 Reduce Avoidable Emergency Admissions

	authorities to achieve consistency in approach		
Training for Care Home staff – The Care Homes Programme	The project has developed a training programme for care homes for 2014/15 which covers topics identified via the Quality Nurse Advisors and the care homes programme workshop held in September 2013. The outcomes from the training programme will be monitored and evaluated in year. Where homes have been identified as having quality issues they will be actively encouraged to send team member onto the training as part of their recovery action plan.	For Everyone	Metric 4 Reduce Avoidable Emergency Admissions
1 GP per Care Home	The project will investigate the potential of linking a named GP to each of the care homes within Wolverhampton to streamline clinical support and enable GP ward rounds. There are a number of models that could be adopted including: • A number of local GPs each with named homes that they are responsible for • A separate service that provides GP support to care homes on behalf of the local GPs The following system changes will be required: • Development of a new service model for GP care for care homes residents • Changes to care home practice to allow ward rounds to occur	For Everyone	Metric 4 Reduce Avoidable Emergency Admissions
In-reach Specialist Services	The project is to provide additional clinical support to nursing homes to prevent A&E attendances, prevent acute admissions and improve the quality of care for residents. **Phase one:** The Home In reach Team (HIT) will be a rapid response unit consisting of a number of Advanced Nurse Practitioners who are able to prescribe medication and begin treatment. The team will provide a rapid response service to nursing homes for residents whose health has deteriorated. The patient will be assessed to identify if they are safe to remain in the home with additional support from this team. A pilot has been running since mid-January 2014 and is being evaluated on an on-going basis. The team will also undertake regular virtual ward rounds with the Community Geriatrician to identify potential issues with residents early and prevent, or delay, deterioration. The following system changes will be required:	For Everyone	Metric 4 Reduce Avoidable Emergency Admissions Metric 5 Patient/User experience

- Development of a team of advanced nurse practitioners with access to a community geriatrician
- Implementation of virtual ward rounds in nursing homes
- Development of new pathways to incorporate the new support option
- Changes to nursing home policies to enable them to contact team rather than call an ambulance

The Home In-reach Team will be a seven day service when implemented fully.

Phase two:

The project will investigate the possibility of having services in the current community contract in reach into residential and nursing homes e.g. district nursing, tissue viability, falls service.

The following system changes will be required:

- Development of new specifications for services
- Contract negotiations for changes to services
- Implementation of changes to services

Project	Service	Commissioner or Provider	Activity 13/14	Budget £s 14/15
Training for care homes	Training			40,000
	Tissue Viability training for Nursing Homes			25,000
	Total			**65,000**
In-reach - Phase 1	Home In-reach Team Pilot		S	280,000
In-reach Phase 2	District Nursing - General	CCG	191053	6,890,828
	District Nursing - End of Life	CCG	364	858,809
	Community Matrons	C	4260	563,206
	Continence Services		2075	1,380,451
	Phlebotomy		97037	288,750
	Falls Service Clinic		130	55,311
	Falls Service Com		3540	221,482
	Physiotherap		12256	1,474,779
	Occupat	G/BCF	9725	1,002,309
	OC	CCG/BCF	2903	358,455
		CCG/BCF	2307	231,678
	py	CCG	18814	1,087,069
		CCG	14022	1,163,868
		CCG	40000	1,162,728
	sessment	CCG	383	22,976
	otal - Phase 2			***16,762,699***
	Total BCF & CCG/BCF - Phase 2			**3,344,014**
1 GP per Practice	None provided			
Single Commissioner			800 individuals	20,000,000

To be updated

3.4. Intermediate Care – Prevention & Reablement

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

Projects:

- Adoption of NHS number
- 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 Point of Referral Signposting
- Engagement with review of WCTAS;
- Community re-enablement network & directory
- Earlier intervention - partnership
- Single Intermediate Care Service - CICT/HARP
- 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)

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

Intermediate Care

Project	Project Summary	Strategic Objective	BCF Metric
Single Intermediate Care Service	This project will encompass a Single Point of Referral for the new services. The project will evaluate existing Intermediate Care/Reablement/Rehabilitation Services, available as both community and in-patient bed services – to identify what works well and what could be improved by developing a single service. Alternative options for service models will be researched and evaluated to identify the most appropriate model for Wolverhampton A new service model will be developed - including 7 day working and achieving an increase in service capacity to reduced Delayed Transfers of Care - and consulted upon, prior to implementation. In order to ensure easy access, whilst reviewing existing services the project team will evaluate and identify how best to implement a single point of referral.	Working as One	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 2 Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services Metric 3 Delayed transfers of care from hospital Metric 4 Reduce Avoidable Emergency Admissions Metric 5 Patient/User experience
Single Assessment Process	This project will follow on from the Single Assessment Process developed within the Dementia Workstream.	Working as One	
7 Day Therapy Services – Intermediate Care	The project will be run in conjunction with the Single Intermediate Care Service project, but will address the requirements for the provision of 7 day working and where indicated lead on the consultation with staff prior to implementation. 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	For Everyone	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 2

	care workstream plans will further develop a range of social care and therapy based services to augment existing 7 day services.		Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services Metric 3 Delayed transfers of care from hospital Metric 4 Reduce Avoidable Emergency Admissions Metric 5 Patient/User experience
Reablement Directory	The project will develop a directory of existing, and new, services acting as a resource for professionals, patients and their carers.	For Everyone	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 2 Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services Metric 3 Delayed transfers of care from hospital Metric 4 Reduce Avoidable Emergency Admissions

Metric 5
Patient/User
experience

Project	Service	Commissioner or Provider	Activity 13/14	Budget £s 14/15

3.5. Long-term conditions – initially focused on Dementia Care Management.

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

Projects:

- Improve diagnosis rate and recording across organisations
- Agree multi-agency single assessment process – CAF approach
- Enhanced Acute and Community Services
- Dementia Hub
    - range of services; communication base; sign posting, etc
- Agree & implement Dementia pathway across health & social care, acute & community services – using Stroke & Birmingham Models as guidance

Success factors:

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

Dementia

Project	Project Summary	Strategic Objective	BCF Metric
Single Assessment Process	The project will build upon existing work – based on the CAF approach – and will ensure that all relevant health and social care professionals regardless of profession, or employer, utilise a single assessment process and associated documentation. This will also encompass the allocation of a lead professional. Models used in other parts of the country accept referrals into the named service, 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.	Working as One	
Rationalisation of existing services	The CCG currently commissions specialist dementia services from Heantun Care via block contract arrangements. This model of care needs to be updated and much more person-centred rather than investing in beds or institutions of care. The partnership needs to review existing commissioned care and reduce the gaps/overlaps in services. • Decommission existing arrangements • Develop new models of care – including new patient and family support services and peripatetic / in-reach services centred around supporting the patient in their own home • Develop new pathways of care • Re-specify and tender for new models of care	For Everyone	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 4 Reduce Avoidable Emergency Admissions Metric 5 Patient/User experience
Increased Access to Resource Centres	Currently Resource Centres do not accept patients with Dementia; this then leads to an extended length of stay in an acute unit whilst a suitable alternative place of care is identified. On occasions patients are transferred to nursing & residential care for a short period of time but this – due to the nature of the illness – then becomes a permanent placement.	Working as One	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 3

			Delayed transfers of care from hospital
Dementia Hub	The aim is to further integrate services for people with dementia, making services more efficient and effective, whilst at the same time improving quality, reducing duplication and delivering better value for money. To achieve the above the following action plan will be implemented: • Develop and receive endorsement for Home as the Hub vision and pathway • Ensure the inclusion of reablement and intermediate care as an option for people with dementia • Deliver more community based support • Provide support in a more personalised way • Increase knowledge and awareness across all sectors and communities • Identify current and future needs • Review existing procedures • Identify areas of service delivery where integration is a possibility	For Everyone	Metric 1 Permanent admissions of older people (aged 65 and over) to residential & nursing care homes Metric 4 Reduce Avoidable Emergency Admissions Metric 5 Patient/User experience
Improved diagnosis & recording rate in Primary Care	The project will focus on ensuring patients who come into contact with Primary Care practices, where appropriate, are investigated for dementia and any subsequent confirmed diagnosis is captured on the Primary Care Clinical Information System.	For Everyone	Metric 6 Number of patients diagnosed with dementia whose care has been reviewed in a face to face contact and coded on the GP Clinical System

Project	Service	Commissioner or Provider	Activ	Budget £s 14/15
Rationalise Existing Services	None given			
Dementia Hub	Dementia Cafes	WCC		80,000
	Blakenhall, Merry Hill House, Nelson Mandela			TBA
	Bradley & Woden		beds	TBA
	Blakenhall, Merry Hill House Mandela		24 long stay beds	TBA
	Blakenhall Resour		180 day care places/week	TBA
	Woden Rese		75 high dependency day care	TBA
	M	BCP	16 beds (older people acute functional/organic mental illness)	2,463,812
		RWT	20 beds, acute admissions with dementia	1,259,760
		BCP	TBA	2,054,761
		BCP	TBA	425,425
	Court	Heantun		TBA
	dry Court	Heantun		TBA
	Total			**6,283,758**

To be updated

3.6. Managing and Delivering the Programme

Until such time as the governance arrangements for the Better Care Fund have been reviewed and adopted the Interim Development Board will take responsibility for managing and delivering the Better Care Fund Programme, and as such :

- The Wolverhampton Interim Development Board is accountable to the respective organisations Management Teams/Boards and the Wolverhampton Health & Well-being Board.
- The Wolverhampton Interim Development Board is the Project Board for the Wolverhampton Better Care Fund programme development and implementation.
- The Wolverhampton Interim Development Board will oversee the work of the Better Care Fund Workstreams and escalate any issues to the Chief Executive Group, or the Wolverhampton Health & Well-being Board, which require executive involvement in their resolution.
- The Wolverhampton Interim Development Board will remain established until such time as a revised committee structure is established.
- To deliver the Wolverhampton Better Care Fund programme and a pooled Better Care Fund budget.

Key Tasks

- To develop the Better Care Fund Plan for Wolverhampton and its submission to NHS England / Local Government Assurance Processes in accordance with planning guidelines.
- To deliver the final draft of the Plan to the Health & Well-Being Board (and partner organisation boards, etc) for consideration prior to submission.
- To develop a programme management structure to assist creating the plan and to deliver the programme.
- To recommend governance structures to the Health & Well-Being Board (or its nominated officers) to ensure appropriate executive direction for the programme, assurance of delivery and good governance.
- To develop proposals and governance mechanisms for the establishment of a pooled budget for the BCF.
- To ensure joint working arrangements, to work with the BCF programme management function, to deliver the programme from existing resources and personnel.
- To ensure that BCF performance metrics and timelines are achieved.

Monitoring & Escalation

- Until such time as the governance arrangements for the Better Care Fund have been reviewed and adopted the Interim Development Board will monitor performance against the overarching BCF timeline and metrics on a monthly basis.
- Each Workstream will have an agreed timeline, which will support the overarching BCF timeline. If milestones are not achieved the Executive Workstream Lead will be required to provide an exception report and remedial action plan to the Interim Development Board or its successor.
- Each Workstream will have agreed - measureable - targets, contributing to the relevant BCF Metric. If performance against target(s) is not achieved the Executive Workstream Lead will be required to provide an exception report and remedial action plan to the Interim Development Board or its successor.

- The Interim Development Board will monitor remedial action plans until such time as performance is back on original plan.
- Should the Interim Development Board or its Executive Members be unable to address or resolve issues these will be referred to the Chief Executive Group for resolution or arbitration.

Wolverhampton Whole System Change and Improvement Programme

4. Whole System Change and Improvement Programme

Enabling adults in Wolverhampton to live fulfilling lives by enhancing their independence, health and quality of life through seamless, efficient action that strives to improve experiences and outcomes

4.1. The Transformation Model

This basic model describes large-scale change programmes as being based in three phases:

- **Scoping** – when connections among key people are made, clarity, purpose and commitment is developed and issues and possibilities identified.
- **Work design** – when ideas and options are researched, generated and evaluated; assumptions and interventions are tested and capability for delivery is developed; and a clear pathway agreed with plans and responsibilities for key recommendations
- **Delivery, action and implementation** – when new structures, processes and ways of working are embedded and lessons captured.

Of course these are not clearly separate from each other and many projects cycle through all three phases more than once; intentional design often means working through elements of each within each of the phases.

Running throughout the programme will be three core elements of Change management, Work design and Programme Management. They are each required in all phases, but some elements may come to the foreground in particular activities or phases. All three are required for success. At the end of each main phase there is a 'gateway'. This is simply a checkpoint people can use to ensure that they have covered the work required and are ready to move on.

All large scale initiatives will be iterative and the content and focus of the plan will develop and shift as the work goes forward. The discipline of setting out the phases and committing to work over time:

- Provides a common framework and language to talk across activities, about what stage they are at and what they are doing
- Sets out the scale and scope of ambition, which makes explicit the time, commitment and capabilities required to make progress
- Allows teams to be very clear when they recruit new people as to what they have already done.
- Introduces some rigour to involvement, creativity, and whole system thinking

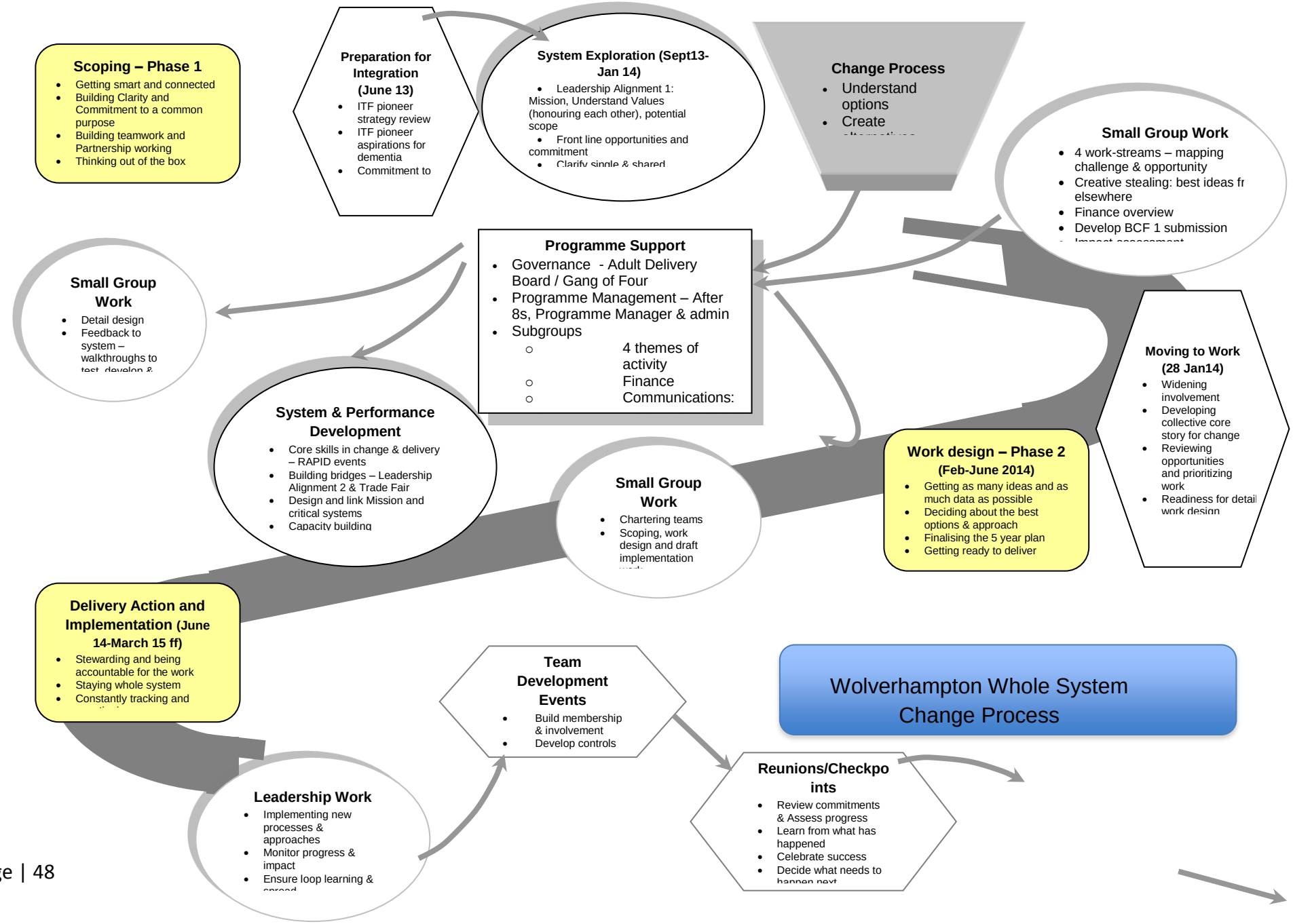
4.2. The Project Pathway

Phase	Elements	Activities	Events and Processes	Outputs
Scoping (June 13 – January 14)	Getting Smart and Connected	• Individual Interviews with key players in the system to understand the information we all hold • Sharing thoughts on issues and opportunities in the context of the ITF pioneer process – with a focus on dementia • Ensuring we have information from all relevant stakeholders – 4 Health and Care players and local people, service users and 3rd sector colleagues • Beginning to understand the way the system works (boundaries, relationships etc..) • Checking we have the 'right ' people involved • Learning about individual styles, motivations, backgrounds • Exploring ways in which we each add and create value	• Interviews June 13 • ITF Pioneer Workshop 20 June 13 • Adult Delivery Board Meeting • Gang of Four check in 3 October 13 • Director Team discussion (the After 8s) 22 October 13 • Leadership Alignment 1 28 November 13 • Front Line Event 17 December 13 • Whole System Event Design 16 January 14	**• Common ground amongst leadership re urgent need for change & ITF /BCF as useful vehicle** **• Commitment to invest time and other resources in working together differently** **• Initial involvement of some 100 people as a cross section of the system in identifying opportunities for improvement and ambition to change** **• Initial commitment to 4 work-streams of activity:** **○ Mental Health de-escalation** **○ Support to Nursing and Residential Homes** **○ Reinforcing intermediate care and rehabilitation** **○ Excellence in dementia care & intervention** **• Dementia to be a marker and test for applying learning across long term condition service delivery** **• Early identification of key players across the system to be involved in work design & delivery** **• Developing the large scale change map and investing in system development for delivery** **• Visible leadership and commitment from across the 4 public organisations** **• Populating BCF 1 plan as part of work design and programme management processes** **• New BCF requirement to initiate scoping phase for children's work**

Scoping (June 13 – January 14)	Building clarity and commitment to a common purpose	• Exploring potential and desirable organisational impact of a large scale change approach • Identifying potential outcomes in dementia and beyond: mental health, intermediate care, frailty • Having a dialogue about the overarching purpose of the work and what it will mean for leaders and their organisations • Reality checking with other information from the system – including aligning with the requirements of the Better Care Fund process • Gaining consensus on the mission and goals of the work	• ITF Pioneer Workshop 20 June 13 • Leadership Alignment 1 28 November 13 • Front Line Event 17 December 13 • DoF and DoC discussions re BCF 1 6 January 13 and ff • Gang of Four check in 20 January 14 • Whole System Event 28 January 14	• **Emerging collective vision for integrated care and support services for adults** • **Understanding that demand reduction & management must be central to plans in challenging financial context** • **Insight across leadership group of ways in which system drivers and regulation can pull the organisations in opposite directions and exacerbate tensions** • **Emerging priorities for process integration and change: information access and sharing, integrated care planning, home as the hub of care** • **Recognition of crucial role of unpaid and low paid carers in maintaining the system and need to invest and support** • **Shared understanding of a range of opportunities and ideas for improvement across 4 areas of activity** • **Initial focus of activity in the 4 work-streams, and early identification of players and leaders for work design** • **Better understanding of need to invest capability and time in the work design phase to be able to move to successful delivery** • **Emerging metrics and ambition to feed into work design phase**
	Building team	• Dialogue across the system and	• Leadership Alignment 1	• **Development of common ground on the need and**

	and partnership working	within organisations about accountabilities • Discussing philosophies, principles, norms and guidelines • Identifying resources needed and establishing access to them, including programme support • Establishing individual roles, accountabilities and norms • Building a basis for trust • Being ready to stay connected and track progress • Being ready to communicate purpose, goals and possibilities more widely • Knowing who we might need to involve in the future	28 November 13 • Interim programme director appointed 9 December 13 • ITF / BCF bi-weekly calls • DoF and DoC discussions 6 January 13 and ff • Gang of Four check in 20 January 14 • Whole System Event 28 January 14	**ambition for change** • **Development of a single story for the system change programme** • **Early testing and development of Trust within and between organisations** • **Initial enhancing relationships and insight across the system** • **Involvement of colleagues beyond the immediate system in early dialogue e.g. from specialized mental health services** • **Agreement and budget to secure design and development support and a shared programme management infrastructure** • **Adoption and re-design of the Adult delivery Board for governance, supported by Director's 'After 8s' group**
	Thinking out of the box	• Identifying and exploring possibilities • Understanding what breakthrough would look like • Surfacing the basic assumptions everyone takes for granted and how we can challenge them • What would be 'new' and different • Developing a shared ideal image of the future	• ITF Pioneer Workshop 20 June 13 • Front Line Event 17 December 13 • DoF and DoC discussions 6 January 13 and ff • Whole System Event 28 January 14	• **Use of de Bono techniques to find opportunities and generate options** • **Focus on priority areas of 'High Value' impact** • **Recognition that much of the savings will come through productivity released by new and enhanced processes and relationships, and is therefore difficult to measure up front** • **Insight that we need to tap into and accelerate the desire of clinical and other front line staff to 'do a good job' if we want to mobilise support and involvement in the change (and that a narrative of cuts or government imposition will just generate resistance)** • **Identified an initial map of interventions and activities and access to knowledge and skills in change design and capability** • **Insight that Wolverhampton public bodies will need to develop a new relationship with the public**

			based on different assumptions about the local role of the State; this will take time and dedicated work • Recognition of challenge and need to work both 'whole system' and 'individual organisation' if to deliver significant change • First cut Better Care Fund plan setting out enabling activity in 2014/5
Gateway (Feb 14)	• Clarity and commitment to the purpose of working together differently at leadership level and with important stakeholders from across the system • Shared sense of urgency and positive motivation to proceed • Clear understanding of current position including the different and common issues, needs and opportunities facing each of the 4 partner organisations • Emerging sense of team working with clear accountabilities at leadership level • Clear description of the scale and scope of the change programme, with evidence of new thinking and approaches • Strong shared sense of potential impact during and beyond the work, including hard and soft measures • Activity set out in first cut Better Care Fund plan and submitted to Local Area Team		


Scoping – Phase 1
Getting smart and connected
Building Clarity and Commitment to a common purpose
Building teamwork and Partnership working
Thinking out of the box
Preparation for Integration (June 13)
ITF pioneer strategy review
ITF pioneer aspirations for dementia
Commitment to
System Exploration (Sept13-Jan 14)
Leadership Alignment 1: Mission, Understand Values (honouring each other), potential scope
Front line opportunities and commitment
Clarify single & shared
Change Process
Understand options
Create
Small Group Work
4 work-streams – mapping challenge & opportunity
Creative stealing: best ideas fr elsewhere
Finance overview
Develop BCF 1 submission
Small Group Work
Detail design
Feedback to system – walkthroughs to test, develop &
Programme Support
Governance - Adult Delivery Board / Gang of Four
Programme Management – After 8s, Programme Manager & admin
Subgroups
4 themes of activity
Finance
Communications:
Moving to Work (28 Jan14)
Widening involvement
Developing collective core story for change
Reviewing opportunities and prioritizing work
Readiness for detail work design
System & Performance Development
Core skills in change & delivery – RAPID events
Building bridges – Leadership Alignment 2 & Trade Fair
Design and link Mission and critical systems
Capacity building
Small Group Work
Chartering teams
Scoping, work design and draft implementation
Work design – Phase 2 (Feb-June 2014)
Getting as many ideas and as much data as possible
Deciding about the best options & approach
Finalising the 5 year plan
Getting ready to deliver
Delivery Action and Implementation (June 14-March 15 ff)
Stewarding and being accountable for the work
Staying whole system
Constantly tracking and
Team Development Events
Build membership & involvement
Develop controls
Wolverhampton Whole System Change Process
Leadership Work
Implementing new processes & approaches
Monitor progress & impact
Ensure loop learning &
Reunions/Checkpoints
Review commitments & Assess progress
Learn from what has happened
Celebrate success
Decide what needs to

National Requirements

5. National Requirements

5.1. National Conditions

There are six national conditions which the Wolverhampton Better Care Fund plan is required to meet. These are summarised below together with a synopsis of the assurance with references to further detail in the main document.

5.2. The Plan Will Be Jointly Agreed

The Plan will be jointly agreed between the Council and the CCG – and signed off by the Health & Wellbeing Board at a special meeting on 5th February 2014 for the initial submission.

The Health & Well-Being Board will receive further updates and will consider the final draft prior to final submission (26th March 2014).

5.3. Protection for Social Care Services (Not Spending);

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 to this absolute design commitment the 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. That demographic growth of £2m a year is built into the budget.
III. 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.'

5.4. 7-day Services

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 health service providers, 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. 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.

Within our SDIP we have specific actions relating to 7 day working. This has been developed by the CSU and is the same in all contracts across Black Country.

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	Plans to be made available to and agreed with the CCG by end of Q1
		Implementation of the clinical standards as per the action plan agreed for full rollout by end of Q4	Q2-Q4

5.5. Prevent Unnecessary Admissions at Weekends

Intermediate Care and Nursing & Care Home workstreams plans will further develop a range of rapid response and alternative step up intermediate care / community based to avoid unnecessary admissions. (See sections 3.3, 3.4 and 3.5).

5.6. Better Data Sharing - Based On the NHS Number

Better data sharing is a key component of the vision for BCF in Wolverhampton and work is progressing well on this.

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.

A proposal is being presented to the April Health and Wellbeing Board asking them to consider 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). All Partners have signed up to this in principal and subject to approval by the Board; more detailed Terms of Reference will be developed.

5.7. Ensure a Joint Approach to Assessments and Care Planning

The project will build upon existing work – based on the CAF approach – and will ensure that all relevant health and social care professionals regardless of profession, or employer, utilise a single assessment process and associated documentation.

This will also encompass the allocation of a lead professional.

5.8. A Simple Single Assessment Document / Process

A commitment has been made to look at a simple single assessment document / process which all the major stakeholders could share for BCF in Wolverhampton and work is progressing well on this.
(See section 3.5)

The CCG has a dedicated IM&T service which is working alongside partner organisations in order to develop a shared electronic solution for the single assessment process. This will involve data sharing and integration across disparate IT systems to enable clinician's access to a shared record.

Project Resources have been committed to ensuring there is a multi-faceted approach to implementation and delivery.

5.9. An Accountable Professional for Integrated Packages of Care;

The single assessment process in Wolverhampton will ensure a named / accountable professional.
(See section 4.5)

5.10. Agreement on the Consequential Impact of Changes in the Acute Sector.

Whilst all schemes will require further development, key provider representatives (including CEO and DoFs) have been intrinsically involved in the creation and development of the construction of the fund from existing resources and all first cut schemes in the programme was signed off by the Interim Development Board at its meeting on 10th Feb.

RBY / JC to calculate impact on acute sector of:

- Achieving metric targets
- Known reductions / transfers of budgets into BCF.
- NB: cost analysis picked up in metrics section ?
- NB: risk picked up in risk management section ?

Outcomes and Metrics

6. Outcomes and Metrics

6.1. National Metrics

In addition to the conditions, national metrics will underpin the delivery of the fund. The metric baselines and performance targets are set out in appendix XX (BCF template part 2). The national metrics are set out below.

1. Permanent admissions of older people (aged 65 & over) to residential and nursing care homes, per 100,000 population – reducing inappropriate admissions of older people (65+) into residential care;
2. Proportion of older people (65 & over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services – increase in effectiveness of these services;
3. Delayed transfers of care from hospital per 100,000 population – effective joint working facilitating timely and appropriate transfer from all hospitals for all adults;
4. Avoidable emergency admissions – reduce emergency admissions which can be influenced by effective collaboration across the health and care system;
5. Patient/service user experience.

There is a requirement for an additional locally set indicator to be used as part of the outcomes reporting framework. Wolverhampton is developing a local indicator to measure access / diagnosis rates for dementia. (See section 5.4 below)

6.2. Local Metric – Improving Diagnosis Rates for Dementia

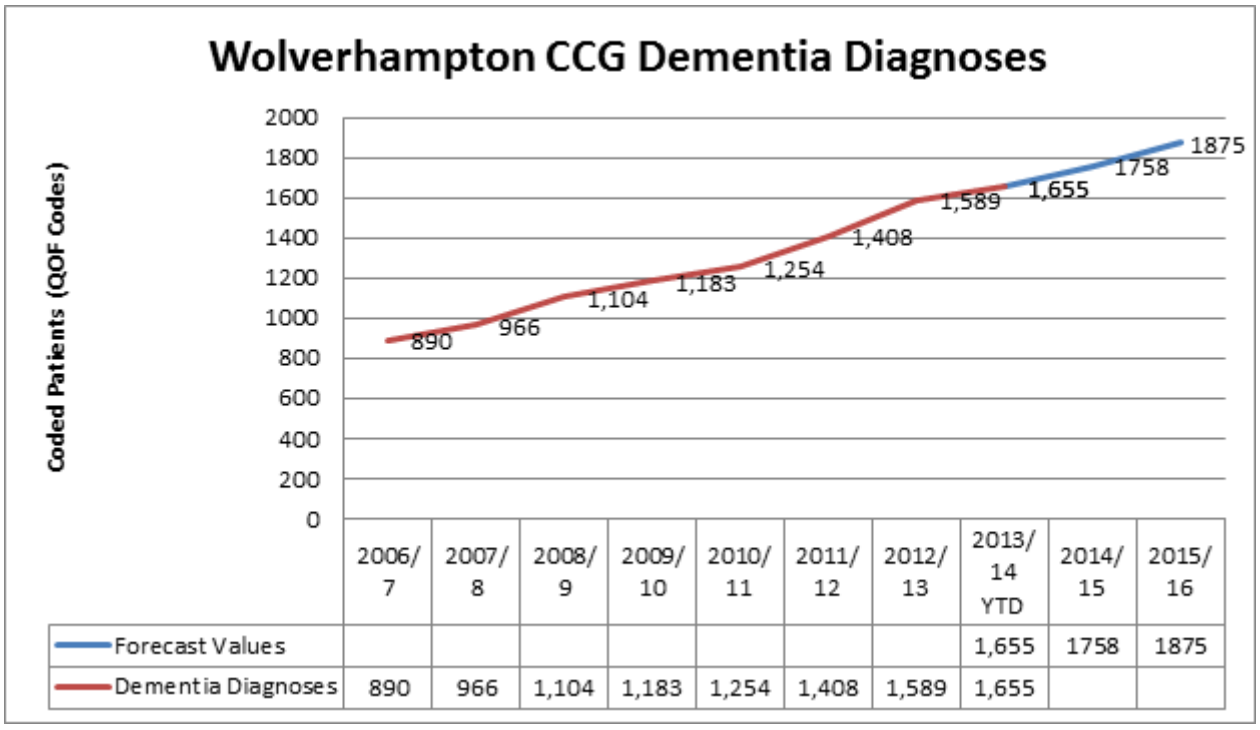
LTC and Dementia Care Planning.

The CCG and its partners have already begun work on LTC management, using an integrated care planning approach through the development of the CCG Primary Care Investment Scheme. The scheme focusses on care planning for patients with long-term conditions, practice quality assessment using the assurance tool employed by NHS England, and practice development activity directly related to the population management of patients with long-term conditions. Care planning activity focusses specifically upon patients with Long-Term Conditions – initially focussing on Diabetes and Dementia because these are the subject of CCG commissioning priorities in 2013/14. The scheme involves substantial joint working and is a leading example of the delivery of integrated care across primary, community and secondary care. We aim to roll this out to patients with other long-term conditions as a means of improving the quality of their life by avoiding unnecessary hospital visits, emergencies or otherwise.

GPs are responsible for ensuring that each patient in the higher risk categories on their practice lists has a care plan agreed. The care plan places emphasis on both the patient and their GP to manage the patient's condition. Advice, guidance, training and development is provided by the diabetes specialist team at RWT. The community matron nursing and pharmacy advisor teams provide support to practices in undertaking the necessary patient interventions in order to agree care plans.

The rationale for the development of care planning is to address the implementation of the five most cost effective, high impact interventions recommended by the NAO in regards to disease modification of people with long-term conditions management.

The CCG has chosen to use the recording of Dementia diagnosis within Primary Care as the BCF Local Measure. This is available on the NHSE Atlas tool online as an annually reported figure. The Baseline data puts Wolverhampton at 0.63 per 100 patients. In order to set the targets for the next 2 years, the past 8 years data has been collated from GP QOF submissions using HSCIC information. This has been forecast ahead for the next two years to give an achievable but stretched target, as shown below:



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14 YTD	2014/15	2015/16
Forecast Values								1,655	1758	1875
Dementia Diagnoses	890	966	1,104	1,183	1,254	1,408	1,589	1,655		

Applying this data to the Atlas data (i.e. applying the rate of increase to the 'per 100' rate) the targets are:

- Baseline: 0.63
- 2014/15: 0.70
- 2015/16: 0.75

The Unify submission has been set using numbers of diagnoses, as shown in the chart but both measures are inextricably linked and the CCG will use both sets of data to manage and monitor performance.

Wolverhampton CCG is in the position, thanks to innovative and progressive work in partnership with all GP practices, that anonymous (non-PCD) Read coded data from GP systems can be extracted and reported upon instantaneously. Work has been carried out to create a report on coding locally so that performance against targets can and will be reported and managed throughout the reporting period. Mitigation plans can then be put into place in case of any underperformance on a practice by practice basis.

The expected outcome for this metric is to improve the diagnosis rate for people with dementia. This requires effective collaboration across mental health services, local authority, social and intermediate care and primary and secondary care providers to facilitate timely diagnosis through the use of a robust memory assessment service. This collaborative working approach supports the approach detailed within the Joint Health and Wellbeing Strategy.

The setting of baseline data for this metric can be supported using 2012/13 data from the Health and Social Care Information Centre.

Appropriate modelling and planning discussions; including analysis of historic performance data and a review of other factors/assumptions which may affect future performance have been taken into account during discussions of the plan and baseline with services.

This local metric will be embedded within service contracts for 2014/15. This will ensure services are focussed on delivering the outcomes and will provide further assurance of delivery against targets through effective contract management.

Performance data will be supplied by the Central Midlands CSU and will be sourced from HSCIC. The data will be verified by the Commissioning Intelligence Support Unit (CISU) and provided to the CCG in a timely manner.

Services will be performance managed for this metric by the CCG, with updates on performance provided through annual reporting for this measure and through the appropriate committee board/contract review meetings.

6.3. Development of Local Targets

Underpinning the national metrics is a need to ensure that local, statistically significant, targets are applied to each of the Wolverhampton Better Care Fund Projects and alongside this a mechanism for monitoring project performance against these targets.

A Wolverhampton dashboard for each national metric is under development – Metric 4 is attached as an example. (See example dashboards on following pages).

On the first page, the dashboard uses the Health Atlas to show Wolverhampton CCGs current position on the metric and sets out the projects - QIPP/CQUIN/Public Health or Better Care Fund - that will contribute to the achievement of the target.

Page 2 of the dashboard uses the Health Atlas to show where Wolverhampton CCG will be in years 1, 2, 5, 10 and 15. An explanation of the process for setting the target is included in the text box. The graph at the bottom of the page shows the historic trend & trajectory based on that trend; in the case of Metric 4 an adjusted trajectory has been included - as activity significantly increased in 2013/14. The target trend line is shown in red.

In order to triangulate the targets, the BCF Statistical Significance Calculator and data provided by the Commissioning Support Unit have been used. The use of the BCF Statistical Significance Calculator ensures that the targets are sufficiently challenging.

These targets will be used to set individual project targets - for each of the projects that will contribute to the achievement – this in turn will lead to the development of a mechanism to monitor individual project performance.

The dashboard will be used at Executive Level to ensure delivery of the target at the required timescale.

6.4. Over-Arching Outcome: Reduce Preventable Hospital Care

It is clear that there are a number of factors combining to drive up unplanned admissions to hospital within Wolverhampton. An aging population living longer with a greater disease burden is part of that combination. Other factors also include an absence of a fully developed, risk stratification-based chronic disease management system and a very strong local culture to “go to A&E” when people feel ill. All of this is exacerbated by a current Wolverhampton urgent care system that has limited options and alternatives outside of hospitalisation and the lack of a fully joined up intermediate care system to provide those alternatives.

The newly developed Urgent Care strategy in Wolverhampton will go some way to addressing some of these issues. However, the BCF programme can play a crucial part in re-developing that intermediate care system to be fit for purpose and provide those alternatives to hospital where these are clinically appropriate. Further, the BCF will focus on Long Term Conditions management as the programme develops.

All of the initiatives in the prioritised workstreams will work together to create a level of service that aims to keep people well in the first instance and, when this is not possible / appropriate, ensure that people receive the right care in the right place at the right time to optimise individual outcomes and maximise the system benefits of reducing preventable acute admissions.

Finances

7. Finances

In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

National Guidance has set out that Councils will receive their detailed funding allocations in the normal way and NHS allocations will be two-year allocations for 2014/15 & 2015/16 to enable more effective planning.

The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.

I. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.

II. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

7.1. BCF Allocations for Wolverhampton

The table below sets out the known detail of the allocation for the City. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

7.2. Scope of services considered for inclusion with BCF

The following table details the existing commissioning budgets that could transfer over to the BCF programme. Note that the £18.5m is significantly in excess of the minimum requirement of £11.6 (see table below).

Better Care Fund - Sources and Applications of Funds

	Minimum £'000	Proposed £'000
Sources of Funding		
Disabilities Facilities Grant	1,319	1,319
Social Care Capital Grant	766	766
From within CCG Budgets	11,630	18,561
S256 NHS Monies	6,309	6,309
LA budgets	0	0
Total Source of Funding	**20,024**	**26,955**

Applications of Funding		
Disabilities Facilities Grant	1,319	
Social Care Capital Grant	766	
CCG Funded Schemes:		
Mental Health		
Dementia		,277
Int Care and Nursing Home Supp		6,572
LA Bed Based Intermediat	,200	1,200
Domiciliary Based I	1,100	1,100
Commissioni	250	250
T ment & Adaptations	900	900
ischarge Team	372	372
– Continuation of Dementia al Respite	500	500
arer Support – Continuation of external market block contract day services across the City	600	600
ILS, HARP etc	0	TBC
Demographic growth challenge	2,000	2,000
Care bill burden	1,100	1,100
Total Application of Funds	**21,737**	**28,668**
Surplus/(Deficit)	**-1,713**	**-1,713**

7.3. Funding for Care Act 2014 implementation

It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.

- £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.
- £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

Wolverhampton has now been advised on its 'allocation'. This is set out below:

Table 2: Care Bill implementation funding in the Better Care Fund.

Wolverhampton		
Care Bill implementation funding in the Better Care Fund (£135m nationally)		allocation, £000s
Personalisation	Create greater incentives for employment for disabled adults in residential care	16
Carers	Put carers on a par with users for assessment.	86
	Introduce a new duty to provide support for carers	172
Information advice and support	Link LA information portals to national portal	0
	Advice and support to access and plan care, including rights to advocacy	129
Quality	Provider quality profiles	26
Safe-guarding	Implement statutory Safeguarding Adults Boards	42
Assessment & eligibility	Set a national minimum eligibility threshold at substantial	208
	Ensure councils provide continuity of care for people moving into their areas until reassessment	23
	Clarify responsibility for assessment and provision of social care in prisons	34
Veterans	Disregard of armed forces GIPs from financial assessment	13
Law reform	Training social care staff in the new legal framework	24
	Savings from staff time and reduced complaints and litigation	-71
Sub-Total		702
IT	Capital investment funding including IT systems (£50m nationally)	287
Grand Total		**989**

In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and councils. A condition of

accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

7.4. Transition Year 2014/15

? Finance section

Table xx: Allocation of the Better Care Fund in 2014/15.

	Minimum £'000	Proposed £'000
Applications of Funding		
Disabilities Facilities Grant	1,319	1,319
Social Care Capital Grant	766	766
CCG Funded Schemes:	11,630	
Mental Health		6,712
Dementia		5,277
Int Care and Nursing Home Support		6,572
LA Bed Based Intermediate Care	1,200	1,200
Domiciliary Based Intermediate Care	1,100	1,100
Commissioning & Financial Support	250	250
Telecare/Community Equipment & Adaptations	900	900
Integrated Hospital Discharge Team	372	372
Carer Support – Continuation of Dementia Residential Respite	500	500
Carer Support – Continuation of external market block contract day services across the City	600	600
ILS, HARP etc		TBC
Demographic growth challenge	2,000	2,000
Care bill burden	1,000	1,000
Total Application of Funds	21,637	28,568
Surplus/(Deficit)	-1,613	-1,613

7.5. Establishing Funding Pool

? Finance section

Governance

8. Governance

The Health & Wellbeing Board submitted the first cut of the completed Better Care Fund template as an integral part of the CCG's Strategic & Operational Plan to NHS England on 14th February 2014. This revised version of the plan, if approved by the Wolverhampton Health & Well-Being Board, will be submitted to NHS England as part of the CCG's Strategic & Final Operational Plan on 4th April 2014.

8.1. Reports to the Health & Well-being Board

In November 2012, a general report was submitted to the Health & Well-Being Board to provide members with a general overview of the BCF process. A more detailed report covering the "first-cut" draft plan was submitted and approved on 5th February 2014 – prior to the CCG submission to NHSE Area team. The presentation will be given to members included the key elements of the Plan and provided members with the necessary detail and information in order to consider the Plan. It should be noted that, at that time, the Plan was an initial document and still under development.

At its meeting on 31st March 2014, the Health & Well-Being Board considered the final draft of the BCF plan entitled: "One Wolverhampton".

[Outcome of the meeting to be inserted here]

8.2. Governance Arrangements

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 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 times 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. 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 timetable for this revision of the Health & Well-Being Board is set out below:

Q3 2013/14	**Establish Interim Development Board to create BCF plan as part of wider**

	Health economy strategic alignment work
5th February 2014	H&WB agree to incorporate IDB into its sub-structures. H&WB agree to review & revise the terms of reference of the board and its substructures to: • enable H&WB to manage a future pooled budget arrangement, and • Remodel its sub committees to create appropriate delivery and programme management structures.
31st March 2014	H&WB consider final draft of programme – including principles for future reporting, accountabilities and programme management.
Q1 2014/15	Establish PMO Review Health & Well-Being Board Terms of Reference
Q1/Q2 2014/15 (7/5/14 & 9/7/14)	H&WB to consider / adopt new TOR. Structures for managing pooled budget drafted
Q2 2014/15	Health & Well-Being Board to formally adopt new ToR and committee structures.
Q3 2014/15	Implement pooled budget governance (in shadow form for remainder of 2014/15).

The Better Care Fund (BCF)forms part of Wolverhampton City Council's Medium Term Financial Plan and is an integral part of Wolverhampton Clinical Commissioning Group's 5 year Strategic Operating Plan.

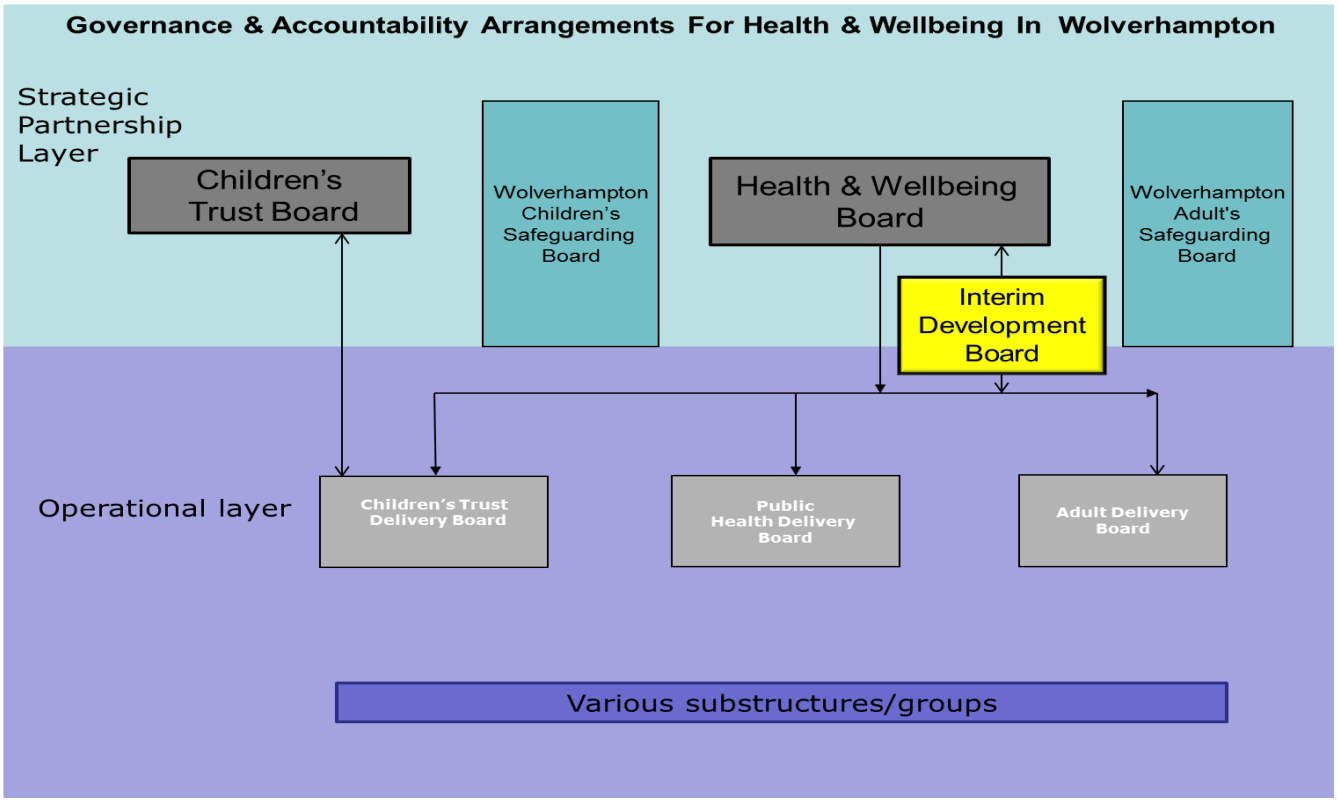
The outcomes contained within the Plan are therefore an integral part of existing planning and performance governance arrangements. We therefore would not want to establish separate governance arrangement for BCF but would want to strengthen existing governance arrangements to incorporate the BCF Programme.

Governance and Oversight for progress and outcomes is via:

- BCF Development Board (operational development and coordination of individual project work streams involving work stream leads / executive programme leads / finance from across the health and social care economy)
- Adults Delivery Board (bi monthly programme reporting against the project plan which monitors progress against key milestones, metrics, achievement of outcomes and assesses and mitigates risk. Involves commissioners, providers and other partners.)
- Health and Wellbeing Board (each Business Meeting oversees the programme, formally agrees plans for integration and joint working and monitors achievement of key national milestones. Involves all Members of the Health and Wellbeing Board.)
- Wolverhampton Clinical Commissioning Group – Governing Body (Executive oversight of the programme)
- Wolverhampton City Council - Cabinet(Executive oversight of the programme)
- RWT and BCPFT will provide executive oversight through their senior management arrangements and formal governance / reporting through the respective Trust Boards.

Figure XXX below illustrates the current Health & Well-Being Board governance arrangements.

8.3. Governance & Accountability Arrangements



Patient Public & Stakeholder Engagement

9. Patient Public & Stakeholder Engagement

9.1. Healthwatch Wolverhampton

Healthwatch Wolverhampton supports the Better Care Fund application and the strategy to bring together the key decision makers and service providers in developing and implementing a system wide change to the way local people experience services.

Working differently and greater partnership will be essential to the success of the plans and Healthwatch sees its role as being a critical partner in ensuring accountability to patients, carers, service users and the public and that patient and user experience underpins evaluation and improvement. This will be a good opportunity to acknowledge that people who use services should be considered a partner in the development and monitoring of services. Therefore opportunities for effective consultation and engagement with the public, patients by experience and individuals or groups who have expertise and knowledge should be a priority for the Better Care Fund Development and Implementation team.

It will be important to see an engagement and communications plan for the strategy and clarity in relation to structures to ensure accountability.

We look forward to supporting this new direction and approach.

Maxine Bygrave
Independent Chair, Healthwatch Wolverhampton

9.2. Systematic Engagement With Partners, Patients and Our Communities

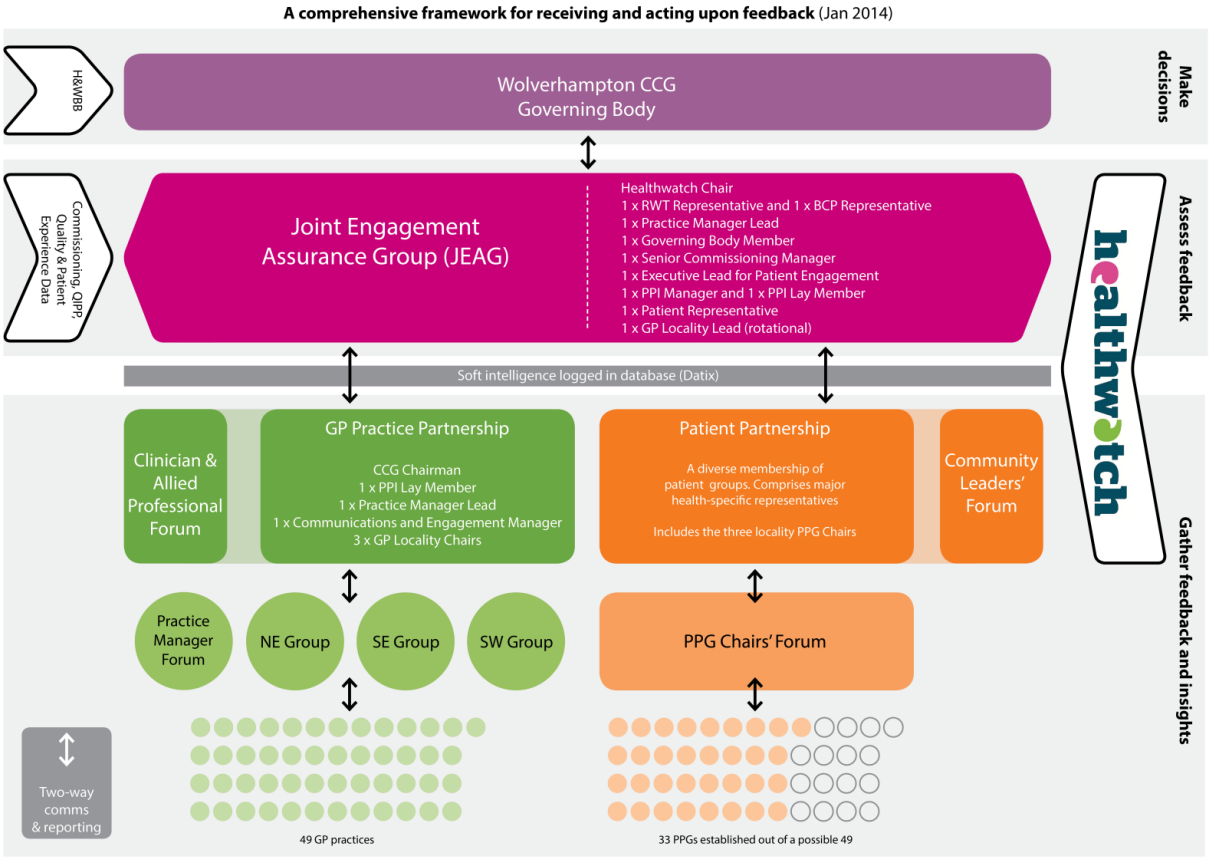
We have a comprehensive framework for engagement, the outcome from which is robust gathering, triangulation, reporting and responding to insights received from patient and community groups. Through this framework, which comprises a range of forums that meet quarterly, the CCG is able to collaborate with a diverse range of representative groups – residents, PPGs, patient/community groups, clinicians and allied health professionals, and Healthwatch. The groups are able to report their experiences, but also scrutinise and influence the CCG's plans and strategies, which are taken by CCG leaders to these groups.

Additionally, a formal meeting takes place between the Healthwatch Chair and the CCG's Lay Advisor for Patient and Public Involvement at which key intelligence themes are shared for action.

All reported insights are reviewed and discussed at the CCG's Joint Engagement Assurance Group which has multi-agency representation. An Assurance Framework comprising key risks around communications and engagement is overseen by the group ensuring both the performance of and confidence in our engagement framework is maintained.

We use a range of creative methods to engage with the wider community. We work with the city's Equality and Diversity Forum to reach the seldom heard and we evaluate our self-selecting Patient Partner membership against the city's demography statistics (Census 2011) to ensure they are representative. Our forthcoming communications and engagement strategy refresh will address any differential with a view to building strong engagement with under-represented members of our community.

Below: our structures for systematic engagement and how they link to CCG governance



9.3. One Wolverhampton: Involving Patients and the Public

It is important to involve stakeholders and the wider public in the development of Better Care Fund proposals in the city. All partners understand the importance of developing a consistent and coherent narrative on the Better Care Fund in order to achieve maximum co-production, ownership and legitimacy for the changes that will ensue.

We will communicate and engage widely through a campaign call-to-action called 'Your Future NHS'. This will be an umbrella for on-going stakeholder and public conversations that will shape the CCG's strategic plan and BCF proposals.

'Your Future NHS' will be a diverse campaign and will use a range of communications and engagement approaches and will incorporate the CCG's engagement framework, as above.

- We will use innovative digital and face-to-face engagement approaches to learn about people's hopes, concerns and expectations for the future NHS;

- We will use a range of communications approaches including the local press and an on-air radio campaign to create a big public debate;
- We will hold the following meetings and discussions (set out on section 9.3.1 below):

9.4. Special Events

- **Your Future NHS: Breaking Down the Boundaries to Better Care**
  1 April 2014
  Partners and the public are invited to learn about the Better Care Fund and how we are developing plans in Wolverhampton to share budgets and break down boundaries in care.

- **Your Future NHS – The Big Debate**
  15 May 2014
  A chance for partners and local people to hear and debate our proposals for how the local NHS will modernise to meet its challenges head on.

- **Your Future NHS – Passing the Baton**
  Late June 2014
  Following on from the big debate that has taken place across the city, this session will explain the vision for care created with local people and launch new opportunities for on-going involvement as plans are formed.

9.5. CCG Engagement Framework

The BCF will be presented and discussed at the following meetings within the CCG's engagement framework:

03/04/14	Practice Managers' Forum	13/05/14	Governing Body Meeting
03/04/14	NE GP Locality Meeting	14/05/14	WCCG Staff Meeting
08/04/14	Governing Body Meeting	21/05/14	Team W
09/04/14	WCCG Staff Meeting	27/05/14	C&E Team Meeting
10/04/14	C&E Team Meeting	27/05/14	Patient Participation Group
10/04/14	SW GP Locality Meeting	(PPG)	
16/04/14	Patient Partnership Meeting	05/06/14	Practice Managers' Forum
22/04/14	C&E Team Meeting	10/06/14	Governing Body Meeting
29/04/14	JEAG	11/06/14	WCCG Staff Meeting
30/04/14	SE GP Locality Meeting	12/06/14	C&E Team Meeting
08/05/14	CAPF	24/06/14	C&E Team Meeting
08/05/14	C&E Team Meeting	26/06/14	Team W

Risk Management

10. Risk Management

The Interim Development Board (IDB) has developed a local joint risk register for the programme. Wolverhampton BCF Partnership has utilised a Risk Register which is a record of all the current and potential risks identified by workstream and project leads that require close attention, continual monitoring and discussions. This risk register will be considered routinely at every scheduled meeting of the IDB. Exceptions will be reported to the Health & Well-Being Board.

The CCG currently uses a central system via the CCG intranet (Datix) which allows staff members to input Risks and score accordingly in line with the National Patient Safety scoring system. It is proposed to incorporate the BCF risk register as a sub-set of the CCG system.

10.1. Managing Risk

Once a Risk has been identified, it is inputted by the handler and must be updated on a monthly/bi monthly basis depending on the actual Risk Score. The risk will then become live on an internal Risk Register and is reviewed by the IDB on a monthly basis.

Each responsible director will always have sufficient permissions to over-ride any pre-existing risk score selected by staff members, thus ensuring that the scoring and severity of a Risk is accurate.

The risk template asks the inputter to define the risk by hazard, harm and requires all existing controls in place to be inserted. The register also allows the Risk handler to select a number of CCG board Assurance Domains provided by NHSE England to accompany each Risk which are critical to the accuracy of reporting to the CCG Governing Body and its sub committees.

The Risk Register's purpose is to ensure that all responsible staff members are aware of potential Risks, and to enable early interventional measures to be introduced, with regular updates ensuring the Risk score is always accurate, until eventually closed if necessary.

The Risk Register is hosted and maintained centrally by the Quality and Risk Team within the CCG but is accessible and available to all managers.

10.2. Risk Register

The Interim Development Board has developed a local joint risk register for the programme. The full register is attached as appendix 3.The following table is an extract from the risk register.

Risk	Risk rating	Mitigating Actions
Failure to reduce emergency attendances at A&E	16/25 Amber	Urgent care strategy sets out a number of alternatives to traditional A&E' Development of whole system intermediate care provision (including step-up beds and in-reach support into nursing homes) will provide alternatives to A&E.
Failure to reduce emergency admissions to Acute & Mental Health Services	12/25 Amber	Urgent care strategy sets out a number of alternatives to traditional A&E' Development of whole system intermediate care provision (including step-up beds and in-reach support into nursing homes) will provide alternatives to A&E.
Financial risk to CCG of funding BCF & no reduction in attendances/admissions	20/25 RED	Phase 1 of BCF programme is not reliant shifting resources in-year. Utilisation of transition funding will establish services (including clinical / professional credibility) before significant funds are shifted between sectors.
Inability to close acute beds as a result of no reduction in emergency admissions	16/25 Amber	Alternative financial mechanism will be required for urgent care Ineffective services will be curtailed.

Authorisation and Sign Off

11. Authorisation and Sign Off

Signed on behalf of the Wolverhampton Health & Well-Being Board	
Name	Cllr S Samuels
Position	Chair: Wolverhampton Health & Well-being Board
Date	31st March 2014

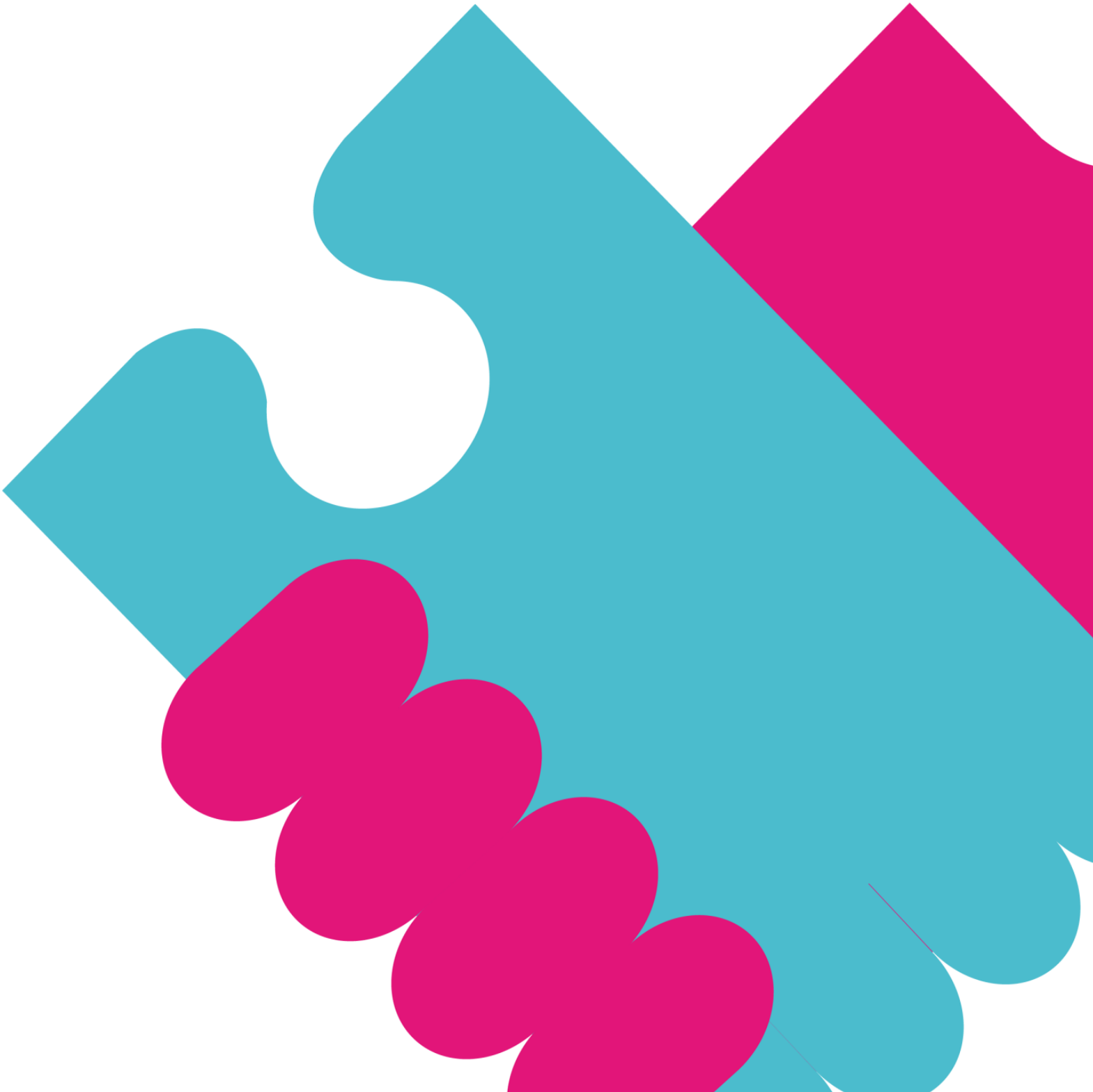
Signed on behalf of Wolverhampton Clinical Commissioning Group	
Name	Dr Helen Hibbs
Position	Accountable Officer
Date	31st March 2014

Signed on behalf of Wolverhampton City Council	
Name	Ms Sarah Norman
Position	Strategic Director of Community Services
Date	31st March 2014

Signed on behalf of the Royal Wolverhampton Trust	
Name	Mr David Loughton
Position	Chief Executive
Date	31st March 2014

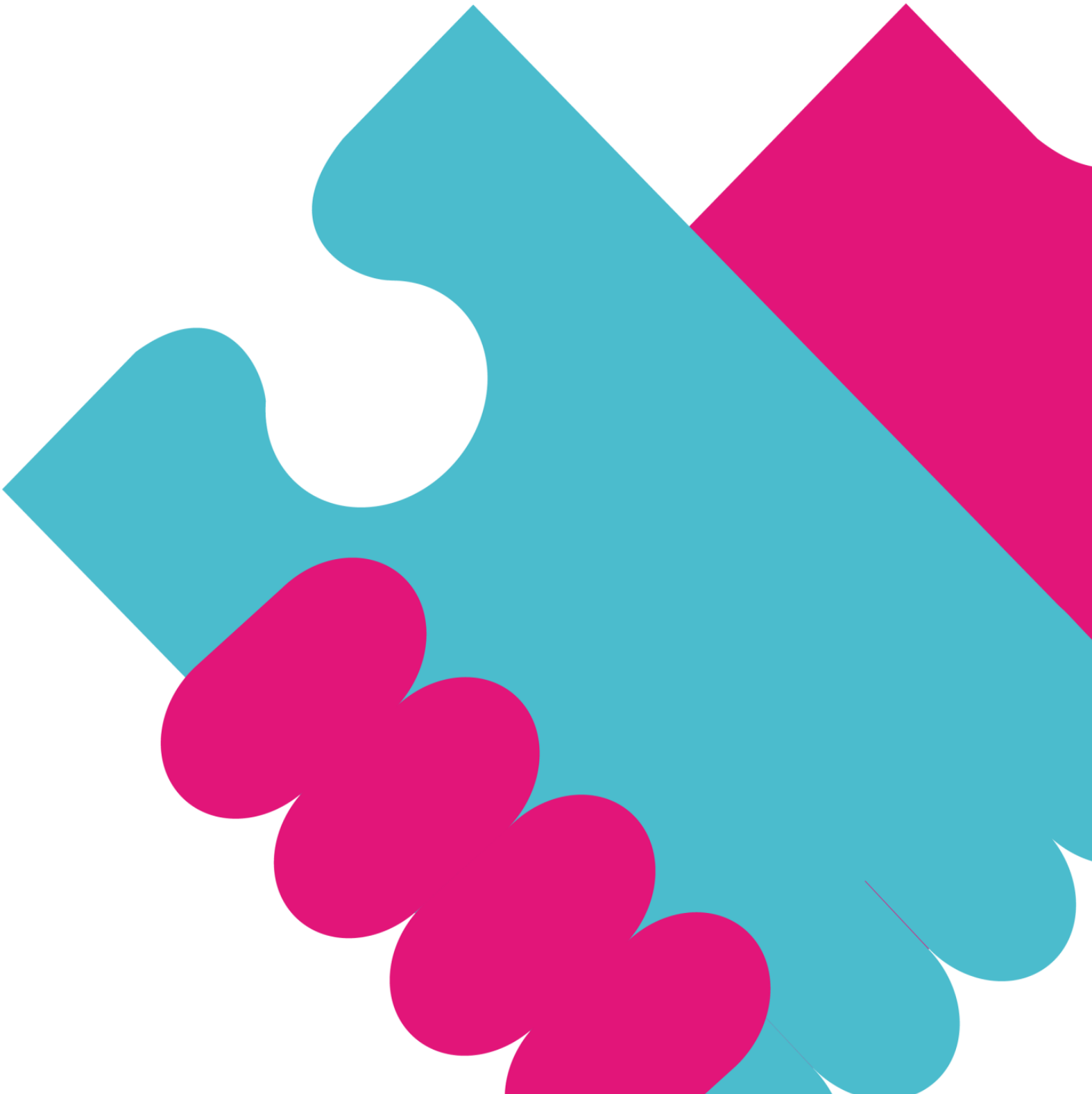
Signed on behalf of the Black Country Partnership Foundation Trust	
Name	Ms Karen Dowman
Position	Chief Executive
Date	31st March 2014

12. Appendices (not attached)



- APPENDIX 1: Summary detail of BCF Workstream Projects
- APPENDIX 2: Details of BCF Metrics and Targets
- APPENDIX 3: BCF Risk Register
- APPENDIX 4: BCF Interim Development Board Terms of Reference

13. References



Need to update

Better Care Fund Planning Guidance & support tools – Local Government Association
Better Care Fund Planning – NHS England
NHS Act 2006

One Wolverhampton

One ambitition, working as one, for everyone