NHS
Wolverhampton
Clinical Commissioning Group

Better Care Fund

Health & Well-Being Board 7th May 2014

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Update

- BCF Plan submitted on 4th April
- Clarification required on 1 point
- Plan resubmitted on 16th April
- Initial feedback :
  - No 'Red' rated sections on the template
  - Overall Financial Assessment – Amber
  - Plan is not deemed High Risk
  - Local Area Team recommend plan to be approved
- Next phase is to :
  - Move into more detailed project planning to ensure desired outcomes are achieved
  - Review programme support & project team development
  - Finalise infrastructure & support for operational workstreams
  - Identify team members , & set up meetings, for core function workstreams

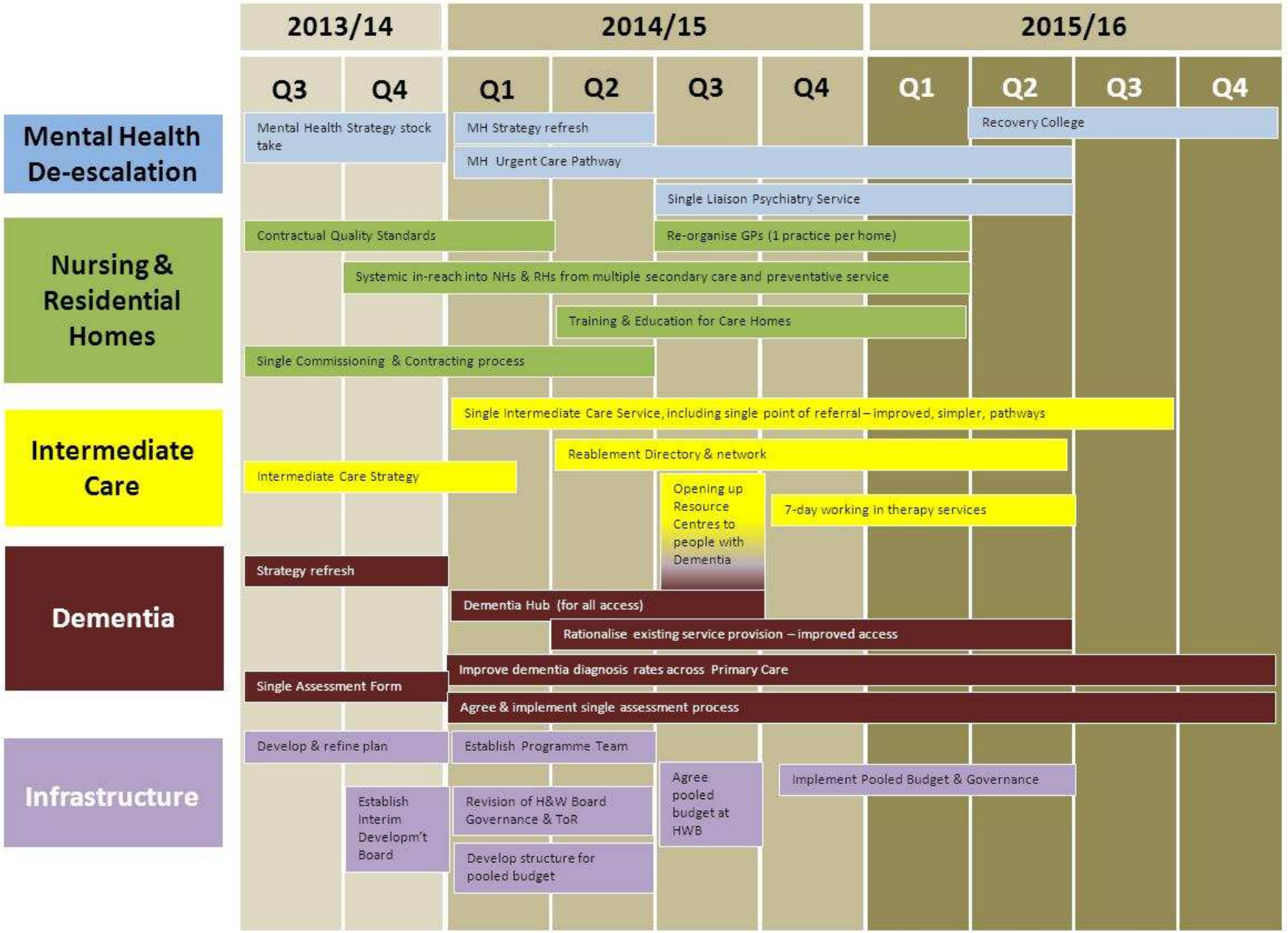
Better Care Fund: Plan on a Page

V7.1

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	• MH Urgent Care Pathway • MH Reablement Pathway • Single 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 & RH 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



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Recommendations to Health & Well-Being Board

1. Note the feedback and recommendation of the Local Area Team – for the plan to be approved.
2. Note the next phase of work to ensure delivery of the plan.