Agenda Item No: **6**

Scrutiny Board

9 December 2014

Report title	Better Care Fund update	
Cabinet member with lead responsibility	Councillor Sandra Samuels Cabinet Member for Health and Wellbeing	
Wards affected	All	
Accountable director	Sarah Norman, Community	
Originating service	Wolverhampton Clinical Commissioning Group	
Accountable employee(s)	Sarah Carter Tel Email	Programme Director, BCF 01902 445941 sarah.carter21@nhs.net
	Viv Griffin Tel Email	Assistant Director - Health, Wellbeing and Disability 01902 555370 vivienne.griffin@wolverhampton.gov.uk
Report to be/has been considered by	n/a	

Recommendations for noting:
The Scrutiny Board is asked to note and comment on:

1. The progress that has been made in relation to the Better Care Fund programme.
2. The planned activity for the next three months.
3. The governance and assurance structure.

1.0 Purpose

1.1 The purpose of this report is to update the Scrutiny Board on progress regarding the development of the Better Care Fund programme (BCF). It also aims to ensure that the requirements of the programme are fully known and understood, and that the Board is fully sighted on the current position and next steps.

2.0 Background

The Better Care Fund programme, previously referred to as the Integration Transformation Fund, was announced in June as part of the 2013 spending round. The fund encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. It is also an important enabler to take forward the agenda of integration (both service delivery and commissioning) at scale and pace. The programme will build on existing work the Council and Clinical Commissioning Group have already undertaken in relation to joint development of programmes, and support the sustainable delivery of services to the people of Wolverhampton.

3.0 Progress and work going forward

Submission outline

3.1 The initial submission of the Better Care Fund programme was made to NHS England in April 2014. A further announcement was made on 1 August 2014 which recommended an extension to final plan submission nationally to allow for more robust testing and development.

3.2 The plan, submitted on 19 September 2014, is a single plan jointly agreed across health and social care, which focusses on incorporating public engagement. Governance arrangements have been established which include a Transformation Delivery Board; a Transformational Commissioning Board; and direct reporting into the Health and Wellbeing Board for formal agreement. Please see Appendix 1.

National Conditions and Metrics

3.3 There are national conditions and national metrics associated with the development of the BCF programme. They are articulated below, alongside the current collaborative BCF response to them.

National Conditions	**BCF Programme Update**
Jointly agreed plans between health and social care	Agreed and submitted to NHS England, in April, a final submission occurred on 19 September 2014. The Health and Wellbeing Board has operated as the approval group for this submission, and this is nationally mandated.
Protection of social care services (to be locally agreed)	The Disabled Facilities Grant/Carers Grant and Community Capacity Grant which form part of the scope of the programme are passported automatically into the local

	authority. In addition, demographic growth has been factored into the financial commitment to the value of £2million, alongside a £989,000 commitment to support the Care Bill implementation and section 256 monies. These measures contribute towards the mandate of protecting social care services.
7 day services in health and social care to support discharge and prevent unnecessary admissions	There are currently four workstreams operating in support of the transformational change programmes required from the implementation of the programme, they are; mental health, dementia, primary and community care, and intermediate and re-ablement care. Seven day services is a core component of these workstream programmes
Data sharing should be developed across the health and social care agencies	This is an enabling strategy to support the improved integrated health and care services delivery, and a shared understanding of the current profile of Wolverhampton. As such, a business case is under development for the development of a shared IT system in collaboration with local providers.
Joint approach to assessment and care planning	There are currently four work streams operating in support of the transformational change programmes as outlined above. Further developing integrated approaches to assessment and care planning is a core component of the workstream programmes. Each workstream has an executive sponsor from both commissioning organisations, and named workstream project leads. Health and social care provision is represented on the workstream programmes, and the voluntary sector is engaged as are core workstream members.
Agreement of the impact on the acute sector(provider by provider breakdown and analysis) + public, patient and service user engagement in planning	This analysis has been undertaken and submitted as part of the BCF programme. We are forecasting a 3.5% reduction in emergency admissions to the Acute Hospital through the implementation of a variety of starter schemes and transformational change programmes.

National and Local Metrics	**BCF Programme Update**
DTOCs	These are being measured between April and December 2015 for reduction achievement.
Avoidable emergency admissions	These are being measured from January 2015.
Admissions to residential and nursing care homes	These are measured within the 2015/16 programme.
Effectiveness of reablement	This metric is measured within the 2015/16 programme .

Patient/service user experience	This is being measured via existing social care data set collections.
Dementia diagnosis (local)	A focus on improving diagnosis rates for dementia in primary care is aligned to both the PCIS and the national planning guidance. Underpinning this is the alignment of the development of the dementia care pathway to provide earlier community focussed support to those diagnosed with dementia.

3.4 During July each workstream will participate in a facilitated all day workshop to develop and consolidate the programme, and ensure a consistent approach to programme discipline and delivery. Membership of the workstream project groups includes representation across health, voluntary sector and social care provision, and commissioning.

3.5 Workstreams continued to work at scale and pace across August, September, October and into November, and progressed the following areas;

- Full integrated care pathway development
- Joint outcomes based commissioning approaches
- Development of joint approaches to the delivery of efficiency
- Neighbourhood approaches and person centred modelling

Plan Submission

3.6 On 19 September 2014, our final submission was made for the Health and Wellbeing Board's Better Care Fund programme. Plans have been reviewed at a national level and received ministerial oversight.

3.7 At the end of October 2014, following this comprehensive review and triangulation exercise, the Wolverhampton plan was the only plan in the Birmingham and Black Country area which was approved with support – all others received conditions. This means that overall the review team and moderation panel have confidence in our plan. The team identified some items of evidence and information that were needed to be submitted to provide full assurance. These are in the process of being reviewed before our plan can be fully approved. This is a straightforward and light-touch process and the aim is for all HWBs in this category to be fully approved before December.

Next Steps

3.8 Workstream programmes will continue the development of plans, case for changes and service design proposals for submission by December 2014.

3.9 Approval of proposals via Health and Wellbeing Board will be sought in January 2015 for implementation development in the last quarter of the year.

3.10 Reporting to the Health and Wellbeing Board will develop to include progress against plan. This will include highlight and exception reporting, and will support the Board in

demonstrating outcomes and impact, considering strategic direction and synergies, and the whole system view against priorities.

4.0 Financial implications

4.1 The Scrutiny Board is requested to note the following potential implications:

(1) The plan is delivered within 100% currently committed resources, and is dependent upon the ability of the system to transform in order to reduce activity in acute care (unplanned emergency admissions, length of stay, and reduced readmissions), reduce spend into long term care placements, and deliver earlier intervention and prevention.

(2) Both commissioning organisations are operating within austere economic conditions with challenging efficiency programmes. The CCG's financial position has worsened, and the local authority faces significant budgetary challenges. The programme needs to ensure that benefit delivered is only counted once, and that joint approaches are developed for strategic commissioning and service development transformation that support achieving sustainable delivery models and the requirements of each organisation's financial challenge.

(3) In mitigation, the governance structure which has been implemented will continue to ask core questions of the programme which include;

- Does the proposal deliver against the metrics?
- How will benefit be extracted?
- Where will the benefit be deployed?
- What are the timeframes for benefit delivery?
- Is the transformation iterative over a number of years?
- Are there any hidden financial risks?
- Is the transformation sustainable?

(4) Core to the effective delivery of the programme is ensuring that proposals do not destabilise the health and social care system, as this could have significant financial impact. Workstreams continue to develop individual sensitivity analysis with regard to financial impact, and a systematic approach to ensuring financial impact and future commissioning and contracting is managed.

(5) As mentioned earlier in this report, protection of social care services has been incorporated into plans and jointly agreed.

5.0 Legal implications

5.1 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. The Section 75 agreement is currently in draft form and is being developed across the partnership.

6.0 Equalities implications

6.1 Each work programme and proposal for transformational change will have an equality impact assessment in order to demonstrate that the changes have no adverse impact on the protected characteristics.

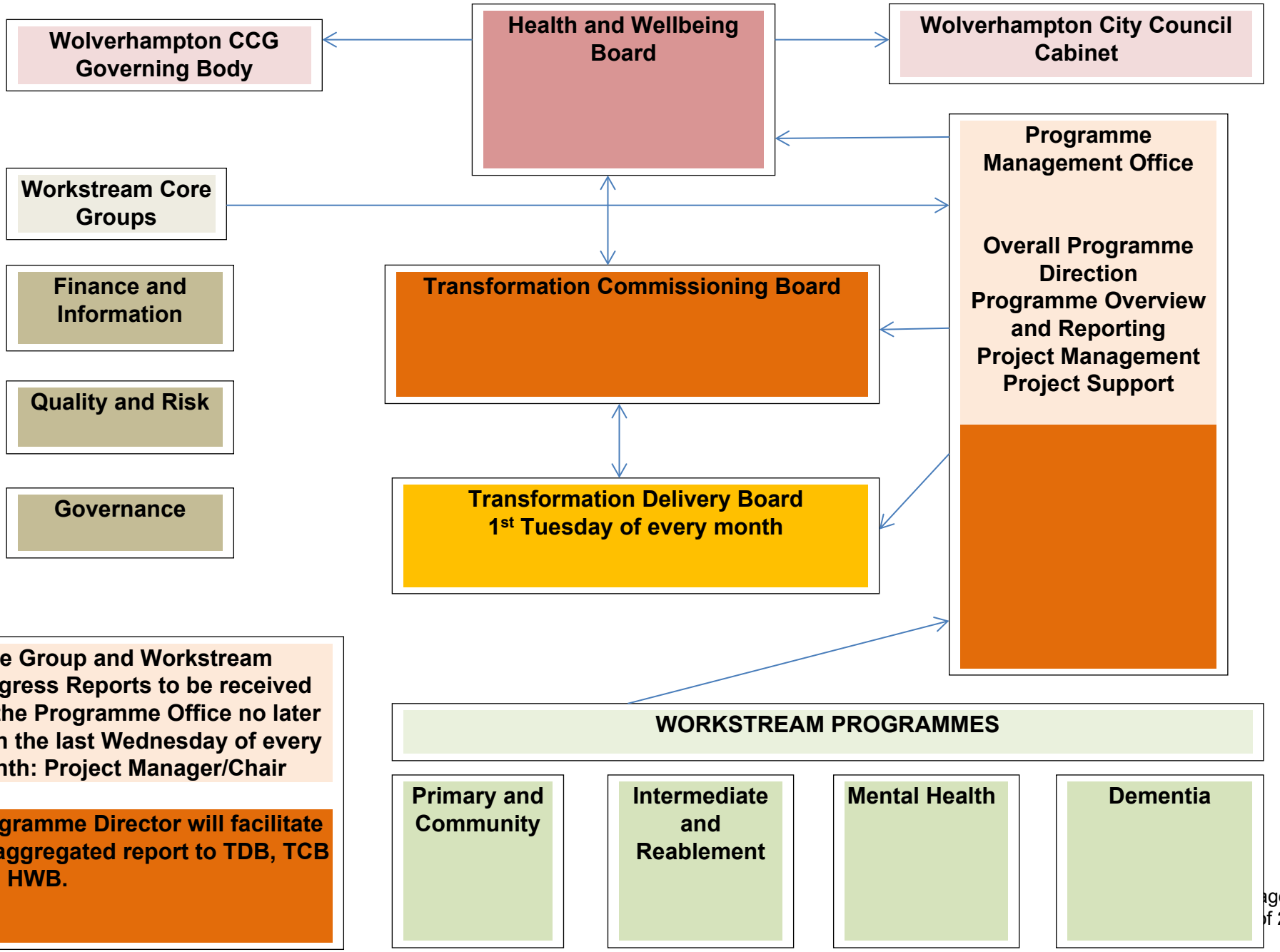
7.0 Environmental implications

7.1 No direct implications at this stage.

8.0 Human resources implications

8.1 Transfer of Undertakings for the Protection of Employment (TUPE) will apply for those staff currently working on existing contracts where services are affected by procurement approaches.

Appendix 1: Governance and Reporting Structure – Better Care Fund Programme



Appendix 2:

Detailed BCF Workstream Scheme Descriptions

Appendix 2a – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
PC1
Scheme name
Primary and Community Care Workstream Redesign Programme
What is the strategic objective of this scheme?
Primary and Community Care Workstream – building a neighbourhood approach which generates self-care, early identification and screening, integration and resilience of communities. Developing and delivering Wolverhampton's transformational approach to fully integrated neighbourhood teams which deliver primary health, community health, social care, and voluntary support and interventions across a functional and service level of integration**.**
Overview of the scheme **Please provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
The scope for this workstream is the full redesign of the way in which community and primary care is delivered in Wolverhampton. Operating on the principle of fully integrated neighbourhood teams across 3 neighbourhoods The new neighbourhood teams will focus upon developing innovative approaches to person centred support, living well with 1 or more long term condition, single point of access and single assessment, wraparound care coordination, the role of primary care, and delivering reduced social isolation alongside building enhanced community assets which support staying well and living well. The work stream will undertake a specific piece of work in relation to the development of developing person centred integrated approaches for older people with complex health and care needs. The scope includes developing innovative approaches to support those people living with frailty and/or complex health and care needs, enhancing the opportunities for 'high touch' approaches, developing effective coordination approaches, and improving integrated responses to developing crisis The co-design of community and primary care services will be enhanced by delivering primary care development and the utilisation of enhanced service opportunities to deliver improved outcomes. The Community and Primary Care Core workstream will oversee a number of schemes which include early adoptions and development in 2014/15 of; targeted nursing home and residential care support and care coordination, alongside adoption of Eclipse risk stratification and pharmacology alert systems. Other specific elements include;

Complex Older Adult Plan – Redesigning the Wolverhampton approach to supporting those people living with frailty and/or complex health and care needs, enhancing the opportunities for 'high touch' approaches, developing effective coordination approaches, and improving integrated responses to developing crisis.

GP Care Home Targeted Input- Care Home Visiting Scheme to improve primary care within residential homes across Wolverhampton covering the top 15 Care Homes (based on emergency attendances/admissions). The scheme will operate seven days per week with pro-active weekly ward rounds and rapid response to requests for visits by the care home or by WMAS if they deem the patient clinically suitable.

Eclipse implementation - Roll out access to the Eclipse Live web based system to Wolverhampton GP practices. Patients at risk of emergency hospital admissions through medicines related events.

Homes In reach –Delivering targeted in-reach to nursing homes, to support admission avoidance in the over 75s age range. Care home training and education in relation to specific care and treatment of conditions (particularly wounds and pressure sores).

Additional Social Workers to support seven day working and winter pressure including brokerage- seven day working for Social Care staff will require staff to work any five out of seven days. The consultation with staff that will be affected by the changes in working patterns was launched on the 1 July 2014. This will last 16 weeks, ending on 27 Oct 2014. This also covers the key staff involved in brokering packages of care. Initially the cover will focus on extending to Saturday with close monitoring to determine the demand for the full level of weekend and Bank Holiday cover. Homes can come in and do assessments quicker. Senior sign off of all Delayed Transfers of Care is already in place. DToCs are agreed daily and distributed to senior social care staff. Data on a daily basis is seen and agreed. This data forms the basis of the monthly submission

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

Wolverhampton CCG and Wolverhampton City Council are the commissioners for the services in scope for redesign within this programme. The Royal Wolverhampton NHS Trust is the provider of both acute and community care health services with Wolverhampton, which operate across discreet Divisions. The local authority provides social care services (social work, carers and social care support) at present).

All providers (including GPs and prescribing and dispensing services) in scope for this redesign programme are actively engaged in the process of design, alongside representatives from the voluntary sector, and patient/carer involvement.

The evidence base
Please reference the evidence base which you have drawn on

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

The evidence base

The Kings Fund report-Older people and Emergency Bed Use – concludes that community-based resources (including primary, community and local authority services) can help to avoid admissions or facilitate early discharge, and that relationships between services and the extent to which they co-ordinate and work collaboratively are also important. These relationships between services are critical to changing and improving our system and its outcomes.

The Kings Fund: Making Our Health and Care Systems Fit for and Aging Population describes the need for whole system transformation in order to make our services fit for the developing challenge of an aging population. "Transforming services for older people requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time."

Locally, over 75s are significantly over represented in our emergency admission data, and in terms of population proportion and cost, have a very significant impact.

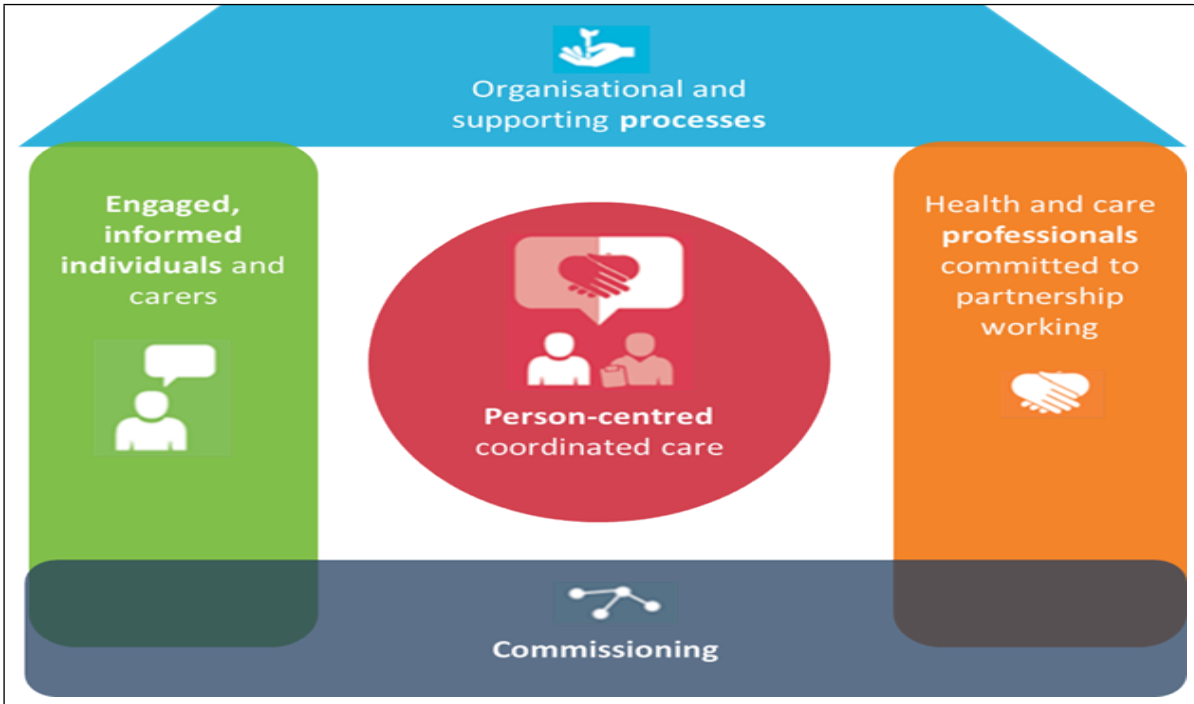
Highlight emergency admission report 2013/14

Results for Wolverhampton CCG	74 and under	75 and over	Total
Activity per 1000 population	81.43	324.65	101.19
Cost per 1000 population	£115,774	£887,954	£178,516
XBD Activity per 1000 population	18.11	224.01	34.84
XBD Cost per 1000 population	£4,074	£48,343	£7,671

% of Actual Activity	73.93%	26.07%	100.00%
% of Actual Cost	59.58%	40.42%	100.00%
% of Actual XBD Activity	47.76%	52.24%	100.00%
% of XBD Actual Cost	48.79%	51.21%	100.00%

% of Population	91.87%	8.13%	100.00%

In the table below, NHS England: The House of Care, demonstrates the pillars which support effective care delivery.



LGA Integrated Care Value Toolkit describes the case of the importance of whole system integrated care because only by delivering change at scale can we ensure that:
• people consistently experience the best possible care
• necessary investment occurs in a timely and effective way
• the improvements that result are sustained and built upon

NHS services that were set up to provide tradition and episodic care, are now struggling to meet the changing nature of demand, including increasing numbers of people requiring long-term care. In many cases those individuals are the very same people requiring support from local authority social services to help them stay independent and well.

Prescribing Services Ltd – Eclipse scheme evidence recent study reports that of an audit of 370 practices, eclipse live use was associated with:
10% reduction in emergency admissions
8% reduction in all admissions
17% reduction in total referrals
10% reduction in A&E attendances
The association was amplified with increasing eclipse live logins.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£46,170,000

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

Scheme Impact

The primary and community care redesign work programme is expected to deliver the following impacts:

National Metric Impact	Measure 2014/15 & 2015/16
Reduction in non-elective admissions	743
Reduction in permanent residential admissions	8
Reduction in delayed transfers of care	4
Increased effectiveness of reablement:	15
Additional Outcomes	
Improvement in the health of Care and Rest Home Residents	No of emergency admissions
Care plans in place	90% +
All patients in the designated care/nursing homes will have access to a GP on a Saturday or Sunday	GP availability over 7 days
Pro-actively manage the patient in their usual place of residence, avoiding the need to convey and admit the patient where clinically appropriate.	Patient experience
Regular good communication and relationship with GP & Staff	Staff feedback
Initial system objectives have been proposed enabling patient safety to improve by reducing emergency admissions through medicines related events and assessment of current practice against NICE guidance in the following areas: • GI Bleeding; • Diabetes; • Anti-psychotic drugs.	Workstream dashboard
Care coordination for all patients with 1 or more long term condition and all those over 75.	8.13% population 75 + with care coordinator
Fully integrated services which are benchmarked against the evidence base	LGA toolkit audit
Shorter length of stay	Pathway measure through reablement
Social care assessments at the weekend will be available	No of social work assessments over 7 days

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

The outcomes for the scheme will be measured through the approach articulated in the planning template part 1. This involves a dashboard approach which will not only articulate performance in relation to national and local metrics but allow for a review of the anticipated outcomes performance**.**

Management Oversight Tool	Reporting To	When
Workstream Dashboard – Metric Impact	Transformation Delivery Board	Monthly
Programme Plan Report	Programme Office	Weekly
Benefit Realisation Delivery report	Programme Director Transformation Delivery Board	Weekly Monthly
Aggregated Performance Dashboard – **Risk and Mitigations Exception Reports NAD (Notice, Action Decision) Reports**	Transformation Commissioning Board Health and Wellbeing Board	Monthly Bi Monthly
Engagement and Communication Report	Transformation Delivery Board	Monthly

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

Success factors for the implementation of the Primary and Community Workstream redesign programme are;

- Clinical system extracts to be taken weekly
- Time/ backfill for GP's to review the medicines related alerts
- Leadership and engagement of core providers
- Effective core data and analysis
- Effective activity and patient pathway modelling
- A shared and agreed understanding of the integrated delivery model, roles, responsibilities, and approach to the management of the service by all partners – change management planning

Appendix 2b – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
IC2
Scheme name
Intermediate Care
What is the strategic objective of this scheme?
Intermediate and Reablement Workstream- Developing and delivering Wolverhampton's approach to effective alternatives to admission, effective discharge, and early discharge programmes.
Overview of the scheme **Please provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
The model of intermediate care and reablement is in the process of being redesigned. The design principles which underpin the modelling include; • Building on the current approach to discharge planning and delivery, enhanced community facing discharge liaison function, risk stratification and planning approaches • An integrated approach to asset based community development, and building community capacity to improve health and reduce social isolation around the person as part of the whole person approach to reablement and intermediate care • A material shift from care and support being delivered on an episodic basis to support, and interventions being wrapped around the individual to maximise the potential for independence • Fully integrated approach to intermediate and reablement care which is community facing and supports person centred care, providing both alternatives to admission that are community facing and accelerated discharge with intensive, needs based support. This support will be delivered and coordinated on an integrated basis in the community • Effective support in a crisis • Robust support to residential and nursing care, Elements of the programme already modelled and established include; Tissue Viability Nursing Home Training-provide tissue viability training for nursing homes Winter reablement/ homes medication review – Increase in capacity of CICT to facilitate early discharge from hospital Early Supported Discharge- Current target is 3%. A CQuIN is in place to support safe and early discharge with milestones set across the 4 quarters of 2014/15. Each quarter, there is an audit of 20 patients from the 3% to ensure patients are using the discharge checklist. This identifies gaps, resulting in an action plan. The following quarter an additional 20 patients are monitored with the view that this should show evidence of improvement. Home In Reach Team- A rapid response team service supporting care homes within Wolverhampton. It is anticipated that the rapid response team will reduce the number of A&E attendances and acute admissions from care homes. This will be achieved by having advance nurse prescribers and geriatrician targeting nursing homes across the

city, 7 days per week.

Diabetes Education- Diabetes education to newly diagnosed - X-PERT Diabetes Education programme is a self-management programme that aims to help people with type 2 diabetes control many of the risk factors associated with these outcomes and to improve their well-being and reduce the incidence of complications primarily through self-management techniques. The programme consists of six weekly sessions, each session lasting up to 3 hours in duration, focusing upon a different aspect of managing diabetes: The programme will be delivered to 414 patients. This will deliver the course to 23 cohorts, each with 18 delegates.

OT West Park- Additional Occupational Therapy to support the effective reablement and discharge planning.

Senior Medic for Discharge Planning at weekends- Ward rounds not covered by routine 7 day review are now being reviewed by a senior medic at weekend.

Cardiology in Reach- Provides a move from 5 to 7 day review of cardiology patients to our AMU.

Homeless Patient Service- Homeless patients are at higher risk of re attendance due to their social circumstances. Without a fixed abode they are more likely to not be registered with a GP. This service allows the Acute Trust to refer patients to a charity based in the city who will work with them to find suitable accommodation. This scheme has previously delivered improved outcomes and reduced delays supporting pro-active supportive plans for people with mental health difficulties and other vulnerabilities such as substance misuse especially.

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

Intermediate and reablement care is commissioned via Wolverhampton Clinical Commissioning Group and Wolverhampton City Council.

Current services in scope for redesign include the intermediate care beds provided by the Royal Wolverhampton NHS Trust (RWT). The Integrated Discharge Team is currently provided across both Social services and the RWT.

Various community facing voluntary sector organisations, whilst not currently commissioned, potentially will develop support services as part of the redesign of the integrated intermediate care pathway.

The evidence base
Please reference the evidence base which you have drawn on

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

In the next 20 years, the number of people with some diseases is expected to double. Currently, 58 per cent of people aged over 60 have a long-term condition and people in the poorest social class have a 60 per cent higher prevalence than those in the most affluent social class (Department of Health 2012). Wolverhampton is the 20th most

deprived area in England, and has significant over representation of older people in the acute care pathway and in nursing and residential homes (See Wolverhampton LA Pack).

The Kings Fund: Making Best Use of the Better Care Fund report in relation to support into nursing and residential care advises that successful intervention programmes include:

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review with modification/withdrawal

These strategies underpin our intervention relating to falls.

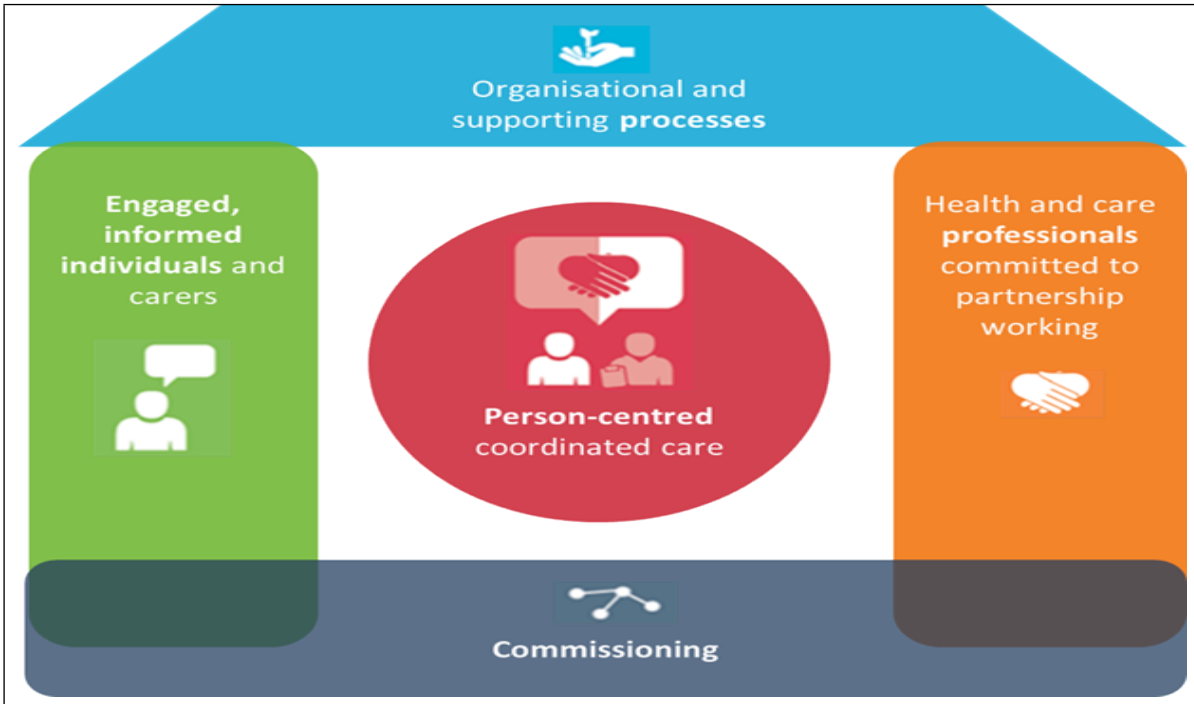
The report also advises that Intermediate care services, including rehabilitation and re-ablement, have the potential to reduce length of stay by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up).

Key areas from the evidence include:

- ✓ Shared and comprehensive assessment of needs and personalised plans, based on shared information and protocols between health and social care partners to address physical, social and psychological needs of service users
- ✓ Commissioning for outcomes, not time periods and tasks, for example, with lump sum payments, to ensure people move on as soon as they are ready or are able to spend longer than six weeks if necessary
- ✓ Workforce led by a senior clinician, with an appropriate skill-mix and with specific re-ablement training and skills that are distinct from broader home care services and focus on supporting people to do things for themselves
- ✓ Adequate provision for rehabilitation and re-ablement outside acute hospitals, based on demographic characteristics of the local population
- ✓ Spot purchasing nursing home beds or new forms of sheltered or retirement housing known as ‘extra care housing’ to provide rehabilitation and re-ablement and prevent hospital admission or discharge from hospital to long-term care
- ✓ Where a person needs ongoing support at the end of rehabilitation and re-ablement, planning care to provide those services and maintain the progress.

Social Care Institute for Excellence (2013). Maximising the potential of re-ablement. London: SCIE evidence also supports this approach

In the table below, NHS England: The House of Care demonstrates the pillars which support effective care delivery.



LGA Integrated Care Value Toolkit describes the case of the importance of whole system integrated care because only by delivering change at scale can we ensure that:
• people consistently experience the best possible care
• necessary investment occurs in a timely and effective way
• the improvements that result are sustained and built upon

Locally, we have piloted the input of our enhanced service into nursing homes, and have modelled our expected impact based upon those findings.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£67,628,000

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

We expect the impact of the schemes to include;

National Metric Impact	Measure
Reduction in non-elective admissions:	180
Reduction in permanent residential admissions:	8
Reduction in delayed transfers of care:	46
Increased effectiveness of reablement:	9
Additional Outcomes	

Accountable actions to prevent pressure ulceration.	A reduction in pressure ulcers
Promote best practice in wound care.	Wound care delivered in or close to home
Staff networked with acute and community staff at training sessions	Improved staff experience
Increased number of patients who can be placed in the resource centre for rehab who would have otherwise been displaced to alternative provision due to a lack of GP support	Amount of patients placed in resource centres
The Joint Integrated team work involves both nurse and social care. This improves communication resulting in speedy decisions - improving flow.	Monitored via CCG - Quarterly submission by Acute Trust with action plans as required
The implementation of 'Safe Hands' Expected Date of Discharge element will be used as a planning tool.	Tool implementation audit
Robust communication to patients takes place from the point of admission. Patients are given a leaflet explaining process and expectations. This is reported via the CQUN	CQUIN
When under pressure - two nursing homes will step down patients at times pressure but at present this is for selected homes only	No of step down patients at times of pressure
Rapid Response, assessment and diagnosis	No of rapid response assessments
Palliative advice and support delivered DNACPR completed in a timely manner, preventing future admission	No of emergency admissions
Ordering appropriate blood tests investigations Oxygen / HOOF	
It is expected that the principles of self-management will empower patients to have a greater understanding of their condition, and better control of risk factors thus preventing emergency admissions to hospital	No of emergency admissions
More access/home visits undertaken prior to discharge	No of home visits prior to discharge
Patients contacts/assessments undertaken in a more timely manner in order to facilitate an earlier discharge	Length of stay in hospital
Increase in weekend discharges.	Weekend Pharmacy 7 day working
Reduction in Length of stay	Length of stay in intermediate care
Additional TTO's, prescribed on Sat/ Sun to align with additional weekend discharge plans.	Weekend Pharmacy 7 day working
Senior Medic for Discharge Planning at	

weekends-	
Increase in weekend discharges	Senior medic 7 day working
Reduction in length of stay	Length of stay in hospital
Increase the number of patients who have no fixed abode when discharged from RWT, to find accommodation	Amount of patients to find accommodation when discharged from RWT

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

The outcomes for the scheme will be measured through the approach articulated in the planning template part 1. This involves a dashboard approach which will not only articulate performance in relation to national and local metrics but allow for a review of the anticipated outcomes performance.

Management Oversight Tool	Reporting To	When
Workstream Dashboard – Metric Impact	Transformation Delivery Board	Monthly
Programme Plan Report	Programme Office	Weekly
Benefit Realisation Delivery report	Programme Director Transformation Delivery Board	Weekly Monthly
Aggregated Performance Dashboard – **Risk and Mitigations Exception Reports NAD (Notice, Action Decision) Reports**	Transformation Commissioning Board Health and Wellbeing Board	Monthly Bi Monthly
Engagement and Communication Report	Transformation Delivery Board	Monthly

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

Success factors for the implementation of the Primary and Community Workstream redesign programme are;

- Leadership and engagement of core providers
- Effective core data and analysis
- Effective activity and patient pathway modelling
- A shared and agreed understanding of the integrated delivery model, roles, responsibilities, and approach to the management of the service by all partners –

change management planning • Effective realisation of benefits through longer term redeployment of resources away from beds to community facing in home services

Appendix 2c – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
DE03
Scheme name
Mental Health
What is the strategic objective of this scheme?
Developing and delivering Wolverhampton's approach to fully integrated functional mental health community services, and the development of community facing pathways.
Overview of the scheme **Please provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
The scope for the workstream includes, enhancing the development of fully integrated care pathways for mental health, including where crisis and urgent care needs occur, establishing a recovery pathway for OOA placements which ensures care is delivered as close to home as possible, achieving parity of esteem for those with mental health needs, approaches to supporting those who no longer have enhanced needs and mental health awareness, anti-stigma and self-help development. Core elements of the model include; Mental Health Rapid Response Scheme – Mental Health community based rapid response scheme - Service will operate from 2pm - 2am Monday - Friday and 10am - 2am at weekends and bank holidays. Staffing will be 4 x Band 6 Mental Health Nurses (on secondment), 4 x Police Officers (on secondment) and 4 x Paramedics. Service will be able to deal with physical and mental health issues. The service will be operational from 1st November 2014. The service will deal with people who have mental health issues and treat at the scene, transport to an appropriate setting or detain under a section 136 The principle will be to provide street/doorstep intervention for this defined cohort of patients which in turn will reduce the need to convey as an emergency by WMAS Mental Health Concordat- The development of the local Mental Health Concordat is being taken forward by the Mental Health Partnership Group. We will align this with our plans to re-model urgent mental health care into an integrated care pathway with health and social care. A pilot Liaison Psychiatry Service (LPS) will deliver improved waiting times, reduce delays and improve patient experience, utilising MBT

expertise. This will include a dedicated and embedded function at RWT within the urgent and planned care pathway and increased capacity within the local mental health urgent care pathway including CAMHS. The embedded liaison psychiatry function and increased capacity with Crisis CAMHS will support compliance with NICE self-harm guidance, improve patient experience and increase connectivity with local care pathways and services and support the patient's referral and discharge to the next stage.

Urgent and Planned Care Pathway Redesign and Delivery- the development and transformation of the mental health urgent care service model/s within health and social care by pooling these into a co-located 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 to deliver the outcomes described below. This will include all in scope health and social care services.

The integrated Mental Health 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 objectives are as follows:

•Provide pro-active multi-disciplinary psycho-social assessment, intervention, treatment and support within the home and community environment. All referrals will have a named lead accountable professional.
•Deliver an integrated health and social care reablement care pathway that provides a delivery agent to facilitate transition of patients through reablement services via a pro-active, recovery focussed and personalised model of care.
•Reduce delayed discharges and increase step down from hospital based care, including specialised services.
•Increase access to alternatives to and step-down from hospital admissions and nursing and residential care such as supported accommodation and floating support.
•Improve the physical, psychological and social assessment and treatment of adults with SMI, promoting independence at all stages of the care pathway.
•Improve access to specialised community support for people with mental health difficulties who misuse substances, and so reduce clinical risk.
•Deliver WRAP / crisis plans (Wellness Recovery Action Plans) for people with SMI (Severe Mental Illness) and therefore improve outcomes and support people to self-manage.
•Improve access and egress into and out of secondary and specialised mental health services.
•Increase access to integrated dedicated resettlement and reablement staff support for patients, families and carers and provider organisations, delivered via a case management system.
•Reduced hospital re-admissions relapse rates for people with SMI.
•Increase access to individualised community care packages for people with SMI who require high levels of care and support usually met within hospital and or nursing home environments.

•Increase numbers of people with SMI accessing day support, leisure and educational opportunities.
•Increase numbers of people with SMI receiving regular physical health checks within primary care.

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

The current lead provider for mental health services in Wolverhampton is the Black Country Partnership NHS Foundation Trust (BCPFT). Services are predominantly commissioned via Wolverhampton Clinical Commissioning Group, however Wolverhampton City Council commission mental health social work and access to AMHP/Out of Hours AMHPs. Services are not currently integrated on a service and functional basis; however a joint commissioner is responsible for the commissioning of all services, and operates across the 2 commissioning organisations through a Joint Commissioning Unit.

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

No Health Without Mental Health articulates that;

- At least one in four people will experience a mental health problem at some point in their life and one in six adults has a mental health problem at any one time.
- One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood. Half of those with lifetime mental health problems first experience symptoms by the age of 14, 7 and three-quarters before their mid-20s. Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression. About one in 100 people has a severe mental health problem.
- Some 60% of adults living in hostels have a personality disorder. Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.

In Wolverhampton 0.98% of adults are described as having a severed and enduring mental health problem; however we are lower than national average in the number of people admitted to hospital for self-harm behaviour. This suggests that we are getting some things right, and have the opportunity to build upon our current work delivered both in the community and along the urgent care pathway.

Case Study: Our local provider BCPFT undertook a pilot project in Sandwell relating to Psychiatric Liaison. The Sandwell Nurse Led Psychiatric Liaison evaluation supports the following outcomes;

- Reduced risk of harm to the patient and/or others within A&E/Acute setting
- Reduced waiting time spent in A&E and the Acute setting
- Reduced rate of re-admissions for all adult populations
- Improved care pathways for patients with dementia
- Improved experience and treatment of people who frequently re-attend at A & E
- Reduced risk of adverse events
- Improved compliance regarding the legal requirements of the MHA 1983 / 2007 and MCA 2005 and associated good practice guidance
- Improved support for staff within A&E and the wards at RWT

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

£20,240,000

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

Focussing on parity of esteem, delivering integration and seamlessness, and supporting the approach to ensure the people of Wolverhampton can live well with mental health needs is a strategic priority for Wolverhampton. Developing a focus on the entire care pathway for those experiencing mental health needs, including mental health promotion and prevention, intervening early when people experience mental health needs, and establishing longer term, high impact changes are priorities. Measures and outcomes include;

National Metric Impact	Measures
Reduction in non-elective admissions:	101
Reduction in permanent residential admissions:	3
Reduction in delayed transfers of care:	30
Increased effectiveness of reablement:	3
029-Mental Health Rapid Response Scheme –	
Reduced mental health patients attending hospital	No of admissions
Assist in better managing Frequent Service Users (need to agree baseline/measure),	Effectiveness of care plans audit
Alternative disposition for 111 calls with mental health issues (need to agree measure/baseline),	111 output audit
Improved outcome for patients	Patient experience survey
Timeliness improved of response by AMP (Approved Mental Health Practitioner)	Mental Health Act assessment audit

Reduce presentations and admissions to RWT	No of admissions
Improve patient waiting times within the Acute Trust for mental health assessment, intervention and support	Time taken for assessment and intervention
Improve patient flow through the urgent and planned acute care pathway.	Audit

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

The outcomes for the scheme will be measured through the approach articulated in the planning template part 1. This involves a dashboard approach which will not only articulate performance in relation to national and local metrics but allow for a review of the anticipated outcomes performance.

Management Oversight Tool	Reporting To	When
Workstream Dashboard – Metric Impact	Transformation Delivery Board	Monthly
Programme Plan Report	Programme Office	Weekly
Benefit Realisation Delivery report	Programme Director Transformation Delivery Board	Weekly Monthly
Aggregated Performance Dashboard – **Risk and Mitigations Exception Reports NAD (Notice, Action Decision) Reports**	Transformation Commissioning Board Health and Wellbeing Board	Monthly Bi Monthly
Engagement and Communication Report	Transformation Delivery Board	Monthly

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

RWHT are in the process of developing an Urgent Care Centre which is due to be operational by November 2015 and rooms / facilities to enable psychiatric assessment are being incorporated into the design of this facility. This will provide further opportunities to enhance the service model and collaborative working in the interest of patient care. This will form a second phase to this development and will aim to be integrated into urgent and emergency care pathways.
Additionally success factors for the implementation of the Mental Health Workstream redesign programme are;

- Leadership and engagement of core providers

- Effective core data and analysis
- Effective activity and patient pathway modelling
- A shared and agreed understanding of the integrated delivery model, roles, responsibilities, and approach to the management of the service by all partners – change management planning

Appendix 2d – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
DE4
Scheme name
Dementia
What is the strategic objective of this scheme?
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 • Adopt an integration approach to the service delivery model Creating a fundamental shift from episodic, step change care and support to deliver support across the entire integrated care pathway that is effectively coordinated around the full range of an individual's and their carers needs. This workstream will deliver a pathway that prioritises early identification, intervention, and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time across neighbourhoods, and embracing of community and the voluntary sector synergies and skills
Overview of the scheme **Please provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
The model of care and support includes; Development and delivery of Wolverhampton's approach to the challenge of increasing

numbers of those diagnosed and undiagnosed with dementia.
The scope for this workstream includes developing a fully integrated dementia care pathway which responds effectively to changing levels of need including; developing an enhanced awareness raising and neighbourhood engagement approach, establishing integrated health, care and voluntary sector approaches which complement and enhance community care services, developing fully integrated enhanced care pathways, advanced planning, and systems of crisis management which supports a home as hub approach for people with dementia.
Other elements of the planned delivery of this integrated system include;
Establishing an integrated Palliative care design programme-
Delivering the overarching shared Dementia Strategy

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

The primary provider of dementia service is the Black Country NHS Foundation Trust (BCPFT), with social care services provided by Wolverhampton City Council Social services department. Services are commissioned via Wolverhampton CCG and Wolverhampton City Council.

Critical also to the delivery chain is the role of primary care and GPs within the system.

The evidence base
Please reference the evidence base which you have drawn on

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

Dementia Map – the dementia map for Wolverhampton suggests that we are below average in terms of checking for dementia.

NICE Quality Standards and National Dementia Strategy outliens these core statements as being critical to the delivery of a fully supportive integrated care pathway for adults with dementia.

I get the treatment and support that are best for my dementia and my life.
Links to NICE quality standards 1, 4, 5, 7, 8;
National Dementia Strategy objectives
2, 6, 8, 9, 10, 11, 13, 18.

I am treated with dignity and respect.
Links to NICE quality standard 1;
National Dementia Strategy objectives 1,13.

I know what I can do to help myself and who else can help me.
Links to NICE quality standards 1, 3, 4, 5;
National Dementia Strategy objectives
3, 4, 5, 6, 13.

Those around me and looking after me are well supported.
Links to NICE quality standards 3, 4, 6, 10;
National Dementia Strategy objectives 3, 4, 5, 7.

I can enjoy life.
Links to NICE quality standards 3, 4; National
Dementia Strategy objectives 1, 4, 5, 6.

I feel part of a community and I'm inspired to give something back.
Links to National Dementia Strategy
objectives 1, 5, 16.

I am confident my end of life wishes will be respected. I can expect a good death.
Links to NICE quality standards 5, 9;
National Dementia Strategy objectives 12,13.

Dementia UK (2007). Dementia UK: a report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society. This articulates the need for redefined integrated services which support the whole person, from pre diagnosis through to end of life care.

Making Best Use of the Better Care Fund advises, based upon the evidence that, identification of people who are at the end of life and co-ordination of care can improve the quality of care, and there may be some scope for cost savings through reduction of unnecessary admissions into the acute setting.

JCPMH:Practical Mental Health Commissioning – Dementia has produced the good commissioning guide which, based upon best practice, outlines the key priority areas for dementia design to be ;

- People want seamless services between health, social care, housing and other providers.
- Services should be commissioned and provided on the basis of need, not chronological age.
- Different services are needed at different times – from diagnosis, as the disease progresses, through to end of life care.
- Dementia should be seen as everybody's business. Most people with dementia live at home, supported by neighbours, communities and mainstream services. Mainstream health and social care services should be 'dementia friendly' and all staff should have a basic awareness of dementia and what it means.
- Care should be delivered in partnership – organisations and individuals should work together to ensure that people with dementia and their carers/families are fully involved in their health care,
- Care should be personalised – services and support should be tailored to the needs of the individual with dementia; people should have choice and control about their health care and support.

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

£19,754,000

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

National Metric Impact	Measures
Reduction in non-elective admissions:	23
Reduction in permanent residential admissions:	13
Reduction in delayed transfers of care:	30
Increased effectiveness of reablement:	3

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

The outcomes for the scheme will be measured through the approach articulated in the planning template part 1. This involves a dashboard approach which will not only articulate performance in relation to national and local metrics but allow for a review of the anticipated outcomes performance.

Management Oversight Tool	Reporting To	When
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Aggregrated Performance Dashboard – **Risk and Mitigations Exception Reports NAD (Notice, Action Decision) Reports**	Transformation Commissioning Board Health and Wellbeing Board	Monthly Bi Monthly
Engagement and Communication Report	Transformation Delivery Board	Monthly

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

Success factors for the implementation of the Dementia Workstream redesign programme are;

•Leadership and engagement of core providers
•Effective core data and analysis
•Effective activity and patient pathway modelling
•A shared and agreed understanding of the integrated delivery model, roles, responsibilities, and approach to the management of the service by all partners – change management planning. This is supported by the experience of the The Worcester Well Connected Pioneer Programme.
•Effective realisation of benefits through longer term redeployment of resources into early identification and neighbourhood/community based support**.**