CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Wolverhampton Health and Care Economy BCF

Narrative Plan 2017-2019

(DRAFT)

Black Country Partnership NHS Foundation Trust

The Royal Wolverhampton NHS Trust

Contents

1. Approval and Sign-Off

KLOE Ref.

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1.1 Summary of Plan

Local Authority	City of Wolverhampton Council
CCG	Wolverhampton CCG
Boundary Differences	None
Date submitted first draft	
Date submitted final plan	
Minimum required value of Pooled Budget	
Total agreed value of Pooled Budget	

1.2 Approval and signatures

Signed on behalf of City of Wolverhampton Council	
by	Linda Sanders
Position	Strategic Director
Date	
Signed on behalf of Wolverhampton CCG	
by	Dr Helen Hibbs
Position	Accountable Officer
Date	
Signed on behalf of Royal Wolverhampton Trust	
By	David Laughton
Position	Chief Executive Officer
Date	
Signed on behalf of Black Country Partnership Trust	
By	Lesley Writtle
Position	Director of Operations
Date	
Signed on behalf of Health and Wellbeing Board	
By	Cllr R Lawrence
Position	Chair/Leader of the Council
Date	

1.3 Completeness and Accuracy Check

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2. Vision and Outcomes

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2.1 Vision Statement

- *'Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them live longer, healthier and more independent lives no matter where they live in the city. Health & Social Care colleagues will work better together, alongside local community organisations to deliver support closer to where individuals and families live and in line with their needs'.* **We have visualised this 'end-state' in** *Figure 1* below:-

Figure 1 – Wolverhampton's Vision/End State for 2020

- Our vision involves:-
  - **A fundamental transformation of health and social care in Wolverhampton** that will have a direct impact on reducing health inequalities and provide a better experience for the population of Wolverhampton.
  - **Care and support will be delivered closer to home and focus on promoting independence and prevention**, whilst providing a rapid health and social care response to persons where appropriate.
  - **Services being proactive in meeting population needs** and service developments that are evidenced based. Individuals will be empowered to take a more active role in managing their own care and support needs by making use of all assets available to them, not just those provided by statutory services.
- *Figure 15* in **Section 8 – Integration, p46** demonstrates our vision of what integration will look like in Wolverhampton with a number of examples described around how this is currently

taking shape

2.2 What will success look like?

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Landscape Change	Demonstrated Through
People in Wolverhampton receive **seamless wrap-around services**	Through the delivery of **integrated, multi-disciplinary neighbourhood teams across three localities.** **An increase in the number of people with identified care coordinators**, a care plan, and contingency plan
Less people living permanently in Nursing & Residential care, with **more people receiving services in their own homes**	**Uplift in the number of services and support offered across 7 days and 24 hours** within the community
Those that remain in **Nursing & Residential Care will have a named GP** (1 GP per Home unless patients choose otherwise), with agreed care plans for their Long Term Conditions and services designed to wrap around them, including access to Specialist Services historically provided in a hospital setting	**Number of patients who are resident in a nursing or residential home with a named GP** – 100% **Clear transition of activity from hospital to the community**
A planned reduction in the number of acute medical beds, equivalent to 2 medical wards - one of which has already closed	Benefits realised through a **reduction in Delayed Transfers of Care (DTOC) and non-elective admissions**
A shift of workforce numbers from acute settings into community services	**Demonstrable activity shifts from hospital to community** **Access to more services across 24 hrs., and 7 days** per week in communities **Increase in self-management** and asset based community services being delivered in each neighbourhood
People living with Long Term Conditions managing their own conditions – with the appropriate support, taking control through personalised health and social care budgets and enjoying a better quality of life	The **number of active personal budgets**
People with mental health problems identified early - in the primary care setting - and early intervention commenced	**Increase in dementia diagnosis** **Increase in self-help and early intervention** services for mental health

2.3 Outcomes and Expected Improvements to Person Experience

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- In line with the vision **Wolverhampton has signed up to set of co-produced outcomes** that the programme is working towards across the life-course of our population:-
    - People will **live healthier lives for longer** and health inequalities will be reduced
    - People will receive the **care and support they require closer to where they live**
    - People will be **supported to stay at home for longer**, reducing reliance on residential and nursing care
    - People will be **more in control of the care and support they receive** through the continued development of personal budgets and individual service funds
    - People will have **one point of contact with a professional who will co-design the care plan with them**. The care / support will subsequently be **coordinated by a single professional** on behalf of the health and social care community neighbourhood teams
    - People will have **self-care and self-management treatment plans** which focus on maximising the potential for good quality independence
    - **More people will access community assets** to address fundamental wellbeing issues e.g. social isolation and depression
- In terms of the person experience we have engaged and listened to what matters (*Appendix 1 and 2*) and these are at the heart of our plans. *Figure 2* below outlines some of the significant findings. In addition, City of Wolverhampton Council has commenced a consultation on the Commissioning Strategy.

Figure 2 – Engagement Feedback

Source: Wolverhampton CCG 'You Said – We did' and Commissioning Intentions 2017-18'

2.4 Challenges

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- **Wolverhampton's vision is rightly ambitious and brave, but both achievable and measurable**. The challenges we have to achieve success are significant, not least because some of the underlying root causes of demand across the current health, care and housing systems are influenced by current economic, social and demographic factors.
- What we do know and can accomplish **is a partnership approach across the city that crosses organisational and sector boundaries and goes directly into the heart of communities**. This presents us with the best opportunity to achieve success. We see the most significant challenges of achieving this to be:-
- **Significant financial pressures** and constraints across the public sector
- Clarity of understanding that the shifts outlined in the vision will be **long term and require patience to see the impact**
- **Effecting the changes in the culture, lifestyle and behaviour** of the population that can lead to more complex health and social care needs in later life. See **Section 3 – The Evidenced Based Case for Change, p13**)
- **Creating a partnership culture and model across the health and care system that builds in the capability to flex over time** with shifting types of demand, growing populations and increased diversity
- **Creating a genuine partnership environment** within the context of often conflicting priorities, culture, financial constraints, political context, shifting public sector landscape and contractual arrangements
- **Alignment with STP** (See **Section 9, p51** of the plan for mitigation strategy)
- **Alignment with the emerging new models of Primary care in Wolverhampton**. The challenge here is that GPs have formed their models across locality boundaries and we need to continue working in partnership to ensure synergies with BCF model. To mitigate the above we have ensured a robust engagement strategy to ensure alignment and equity for the population of Wolverhampton and the GPs have agreed to move into localities.
- **This plan represents how we are beginning to meet these challenges in Wolverhampton and our plans to continue to do so going forward into 2017-19 and beyond**

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2.5 Vision Narrative

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- In common with the rest of England, **Wolverhampton's health and social care economy is experiencing unprecedented demand and growth for services, with limited resources to meet those demands**. Despite progress in recent years, the resultant pressures are being reflected across the hospitals, GP surgeries, community healthcare teams and social services on a daily basis. **As the population grows and people live longer, the challenge to balance available resources and local needs will continue to grow**. Wolverhampton's starting point for responding to this challenge is to not regard it as simply a financial issue or view pressures in one part of its public services as being resolvable in isolation from others. **The vision for the next 3 years is therefore nothing less than a continuation of the fundamental transformation of the quality and experience of care**, across all elements of commissioning and provision on behalf of Wolverhampton's population.
- In line with the five year forward view, Wolverhampton CCG's Primary Health Care Strategy

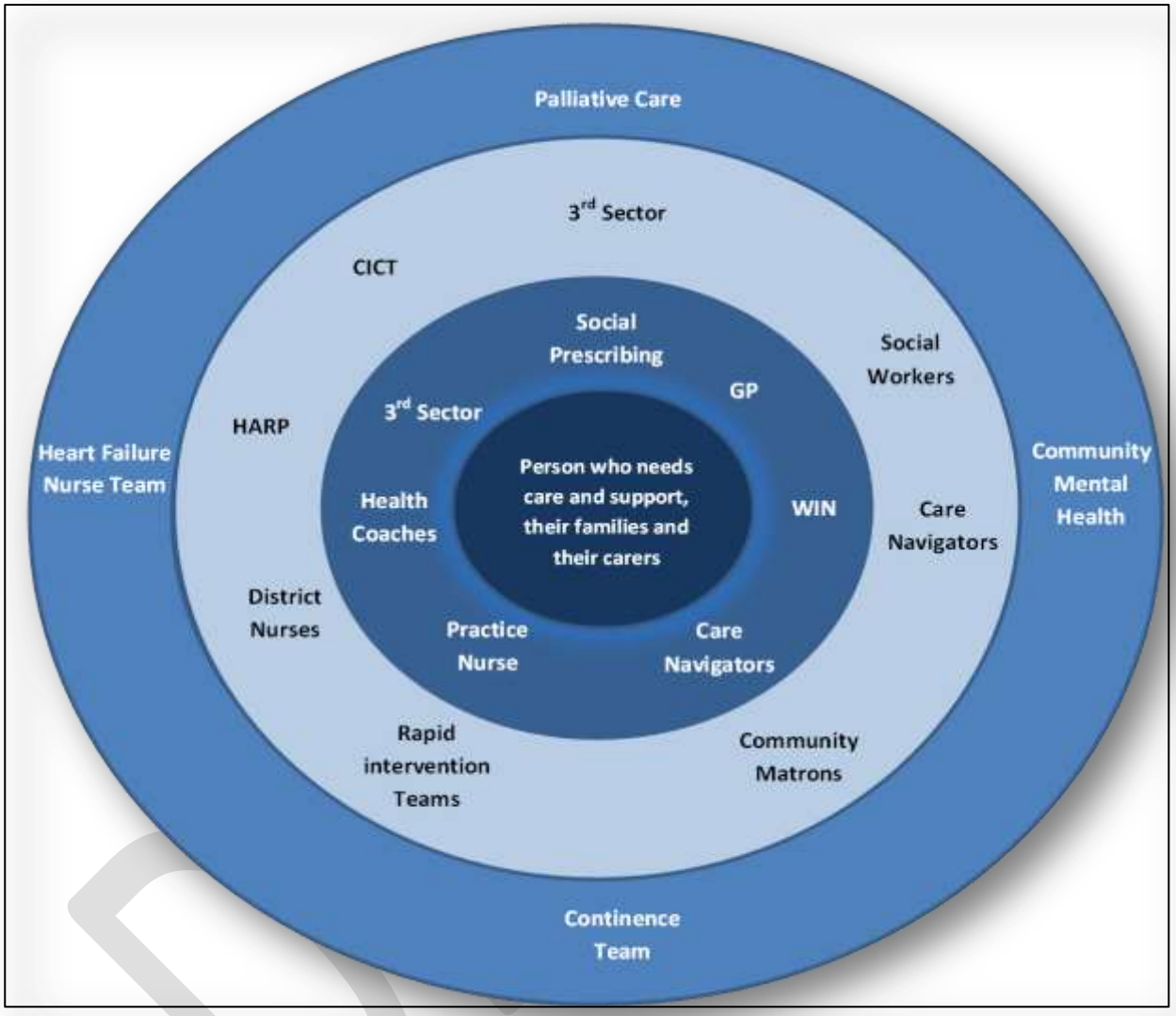
2016-20 (*Appendix 8*) describes a number of emerging new models of care in Wolverhampton that **BCF will proactively seek to ensure synergy** with. There are two groups of practices that are established as Primary Care Homes (PCH) that represent circa 60,000 of the population. A larger group of practices, currently representing circa 120,000 of the population function in line with a Medical Chamber model. The PCHs and the Medical Chamber group are all working towards MDT working. There are currently five GP practices representing a further 50,000 of the patient population who have subcontracted their General Medical Services (GMS) contract to the local acute and community provider. A further two practices are currently going through the due diligence process of aligning with the local acute and community provider. **From a person's perspective the Primary Care Home model describes that practices will offer "multi-speciality working through our 'Home', creating a 'one organisation' approach to delivering bespoke population health from a group of practices serving that community** – whilst ensuring we retain personalised care for individuals, and continue to identify at risk person groups."

- **Clearly the BCF programme will need to work closely with these models to ensure that care across the city is aligned**. It is the responsibility of current commissioners to ensure our services are developed and implemented in a way that makes them the preferred services for the new emerging organisations.

Within the programme we will:

- **Deliver holistic, person-centred care** *(Figure 3)* based on a population, place based approach. This ensures parity of esteem across physical, mental health and social care service.
- **Increase the diagnosis and management of people with Dementia** within a primary and community setting.
- **Deliver a range of services to support care closer to home**, promote confidence to enable **people to manage their own care** (this includes educating persons and carers of how to manage crisis situations) thus **enabling a reduction in A&E attendances and emergency admissions**. **See Section 5 – Delivery Model for details, p24**.
- **Actively promote a shared care approach with Primary Care professionals**, supporting Primary Care in the identification and case management of people identified at high/medium risk through MDTs and risk stratification
- **Be wrapped around Primary Care** based in our three localities supporting the emerging new models of care, to enable the delivery of a more localised approach to care closer to home.
- **Be multi-disciplinary across health and social care** in three localities to ensure equity of access and efficient use of wider community resources including the effective use of Information Technology
- **Work in collaboration with our Housing Partners to identify, scope out and develop any opportunities which would be enhanced by greater integration across Health, Social Care and Housing** that supports the outcomes and vision of the BCF Programme.

Figure 3: Person Centred Model of Care



2.6 Whole System Change

- **Wolverhampton's vision for the future will require whole system change** e.g. how work is commissioned from providers to how providers interact with people and with each other. Wolverhampton is committed to effecting behavioural and attitudinal change in all areas by working together in partnership as a joint health and social care economy, with a central role for the voluntary, community sectors, and not least its citizens.
- This document sets out the joint commissioning intentions and areas for development. **It explains how local authorities and CCGs, working with people and communities, will mobilise resources to target areas of need and deliver improved outcomes in 2017-2019 and beyond**. It captures why this is needed, what the expected outcomes are on both an individual and locality-wide basis and the current best estimates of the specific investments required to make this happen.
- In doing so Wolverhampton's plan is to go far beyond using BCF funding to back-fill existing

social care budgets, preferring instead **to work jointly to reduce long-term dependency across the health and social care systems, promote independence and drive improvement** in overall health and wellbeing for local people.

- **The volume of emergency activity in hospitals will be reduced as will the planned care activity in hospitals**. This will be achieved through the strengthening of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the Community Neighbourhood Teams (CNT's), will result in a minimisation of delays in transfers of care, reduced pressures in A&Es and wards, and ensure that after episodes of ill health, people are helped to regain their independence as quickly as possible.
- **Wolverhampton recognises that there is no such thing as integrated care without the inclusion of mental health services.** This in mind, the plans are designed to ensure that the work of community mental health teams is:-
  - Integrated with community health services and social care teams;
  - Organised around groups of practices;
  - Enables mental health specialists to support GPs and their persons in a similar way to physical health specialists.
- **In reviewing the Wolverhampton population demographics there are significant mental health needs for children and young people in the city**. On most indicators, the population of Wolverhampton scored significantly higher when compared to England averages. Measures include data on hospital admissions for self-harm, rate of children being looked after, first entrants into the youth justice system, and numbers of children living in poverty. Wolverhampton needs analysis data for CAMHS also describes under use of universal and targeted services at TIERS 1 and 2, causing over use of services at TIER 4. **Wolverhampton's vision is to re-balance activity across TIERS 1-4 by closing gaps, pump priming safe sound and supportive services whilst also increasing capacity and capability in early intervention and prevention services.** Future in Mind funding will be initially used to transform mental health services for children and young people by building capacity and capability mainly within specialist Child and Adolescent Mental Health Services at critical points, so that **by 2021 we can demonstrate measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people's mental health outcomes**
- **By improving ways of working with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care**. BCF will continue to be used to:
  - **Help people self-manage** and provide peer support working in partnership with voluntary, community and long- term conditions groups e.g. Dementia Cafes.
  - **Invest in developing personalised health and care budgets** working with persons and frontline professionals to empower people to make informed decisions around their care.
  - **Implement routine person satisfaction surveying** to enable the capture and tracking of the experience of care.
  - **Invest in reablement and the use of Telecare** reducing hospital admissions and the overall budget for nursing and residential care.
  - **Reduce delayed discharges**, through investment in neuro-rehabilitation services, strengthen 7 day social care provision in hospitals and implementation of the Discharge to Assess pathway.
  - **Integrate NHS and social care systems around the NHS Number** to ensure frontline professionals, and ultimately all persons have access to all of the records and information they need.
  - **Undertake a full review of the use of technology** to support primary and secondary

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prevention, enable self-management, improve access and service experience, and release professional resources to focus on those in greatest need. An example being the enhancement to the Wolverhampton Information Network (WIN) in the summer of 2017, which is a free web based signposting facility that enables the public and medical professionals to benefit from a comprehensive view of local services covering the entire spectrum from health, through social care, and community. This can be either via self-service or through sign-posting by health care professionals.

- **Developing a new model of joined-up care will require a physical and cultural shift with new ways of working and new ways of thinking**. Previously, Wolverhampton's health and social care system has taken a reactive approach to managing the care of people in crisis often leading to a hospital admission and a journey in to long term care. **Since the implementation of the BCF Programme this has begun to change to a more positive and joined-up experience of care and a more proactive approach. We are aware, however, that much more improvement can be made.** The CCG Strategic Plan sets out its intent to put the health and care economy on a sustainable footing, through developing community-based services and addressing the default of receiving care in acute settings. This is also in the context of City of Wolverhampton Council (CWC) needing to save in excess of £54.2 million over the next 3 years. **To address this, both organisations will be working in partnership, with a CCG focus on increasing capacity in primary care and council focus on strengthening the community reablement offer.**
- The **BCF programme aims to reduce the number of people treated in hospital who could be treated more effectively in, or closer to their own homes**. It also **aims to reduce the number of people attending hospital at the point of crisis** by focusing on how to prevent the crisis happening. Wolverhampton wants to **encourage people to take control and lead healthier lives**. The assets of local communities will also play a big role in helping people to access different types of support closer to where they live. The mapping of community assets to ensure they can become part of how we plan care with people has begun and will continue up until 2020

2.7 Underpinning Support for our Vision

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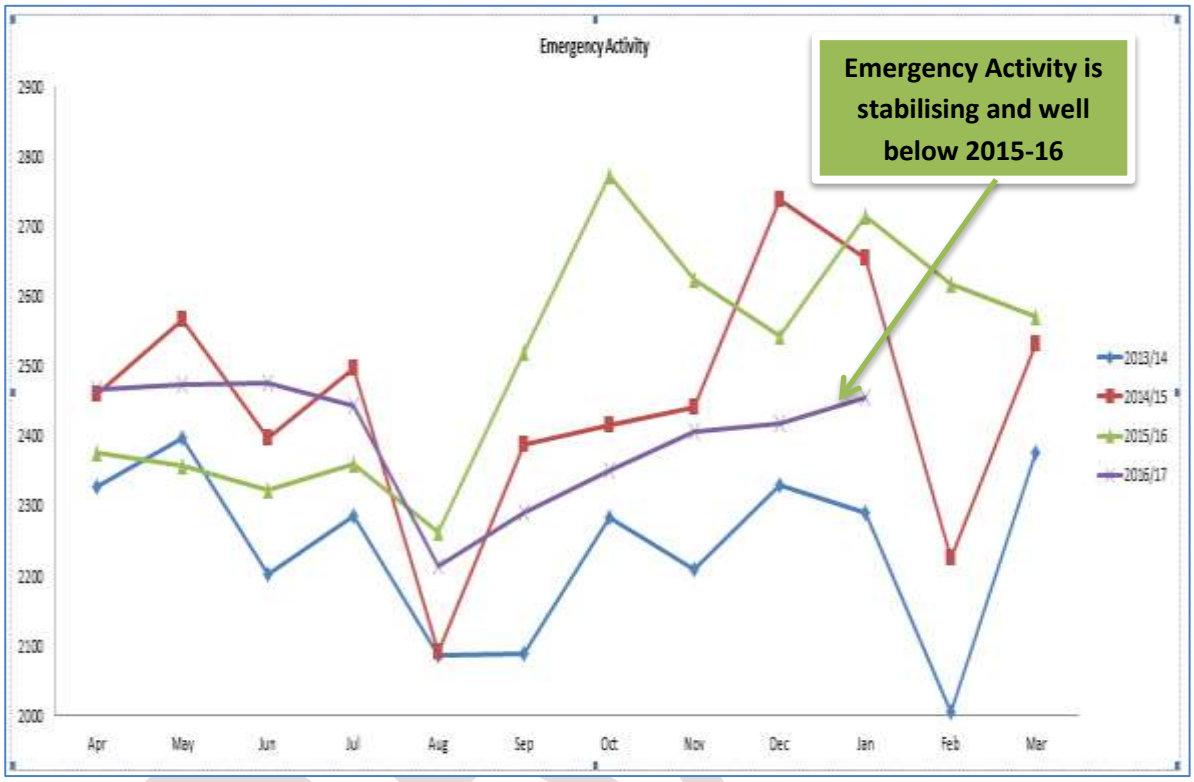
- Wolverhampton's vision for health and social care services for its community is **underpinned by**:
  - **The jointly agreed and developed Health and Wellbeing Strategy**. (Appendix 3)
  - **Effective engagement with the local community** and listening to what they have told us (Appendix 1 'Commissioning Intentions 2017-18' and Appendix 2 'You Said-We Did')
  - **Wolverhampton CCG Operating Plan 2015-2017** (Appendix 4)
  - **The Council's Corporate Plan and 'Our Vision Our City - Our Vision for the City of Wolverhampton in 2030'** (Appendix 5 and 6)
  - The evidence base regarding the future needs of the population of Wolverhampton through the **JSNA** (Appendix 7)
  - **Wolverhampton CCG** Primary Health Care Strategy 2016-2020 (Appendix 8)
  - **Neighbourhoods, Homes & People-Wolverhampton Housing Strategy** 2013-18 (Appendix 9)
  - **The Council also is consulting on a draft People Directorate Commissioning Strategy**. This brings together transformation activity across children and young people services, adult care services and public health. Commissioning intentions are proposed through which well-being, strengthening prevention, and ensuring care for all people are all promoted. Close partnership working is needed to deliver the commissioning intentions and the BCF has given us an environment in which to integrate further and align Council and CCG commissioning intentions.
  - **The Black Country Sustainability and Transformation Plan** 2016 (Appendix 10)

2.8 Progress and achievements over past 12 Months

- As outlined in the challenges to achieving the vision it will be take patience to see the full impact of the transformation, however **it is vital that we do measure, demonstrate and celebrate the progress** that Wolverhampton has made on the journey so far. Whilst more detail on this can be found in **Section 6 – Reflection on 2016-17, p31** significant aspects of our progress are:-
- **Reduction in emergency activity** and significantly less variation in the system **indicating greater system stability and control** has been established (*see Figure 4 below*)

Figure 4 – Emergency Activity over Time



- **Rapid Intervention Team** (RITs) – This service has moved from pilot phase to business as usual and is now operating as a 7 day admission avoidance service and is now accepting referrals form West Midlands Ambulance Service
- **Risk Stratification** – Community Matrons working with GPs to identify persons of high risk of admission and proactively manage their care. The next phase will be to work with medium risk patients to stem the flow and dependency on acute care
- **Integrated Health and Social Care Multi-Disciplinary Team working** – 3 Locality based MDTs, meeting on a monthly basis to discuss an identified caseload of persons.
- **Wound Care Pathway** – development of a multiagency Wound Care Pathway
- **End of Life Pathway** – development of a multiagency End Of Life Care pathway
- **Mental Health –** development of Street Triage and a prevention focused service called 'Starfish'
- **Discharge to Assess** (D2A) – Establishment of a D2A project to develop and implement an Integrated D2A pathway
- **Memory Matters** – Establishment and rollout of Advice and Information clinics across the city for people who are concerned about memory issues and possible dementia delivered from non-health buildings
- **Dementia** - A business case was agreed by the A&E Board to 'pump prime' service

transformation by increasing the number of dedicated liaison and outreach dementia staff across RWT and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT

- **Social Prescribing** – Partnership working with Wolverhampton Voluntary Sector Council to deliver a 12 month Social Prescribing pilot
- **WIN – Enhancement of the Wolverhampton Information Network** to create a single information portal for health, social care, voluntary and community services
- **Data Sharing Agreement** – City wide data sharing agreement approve to enable Integrated teams to work more effectively
- **Fibonacci** – the implementation of an IT system allowing members of MDT to view health and social care data

3. Evidenced Based Case for Change

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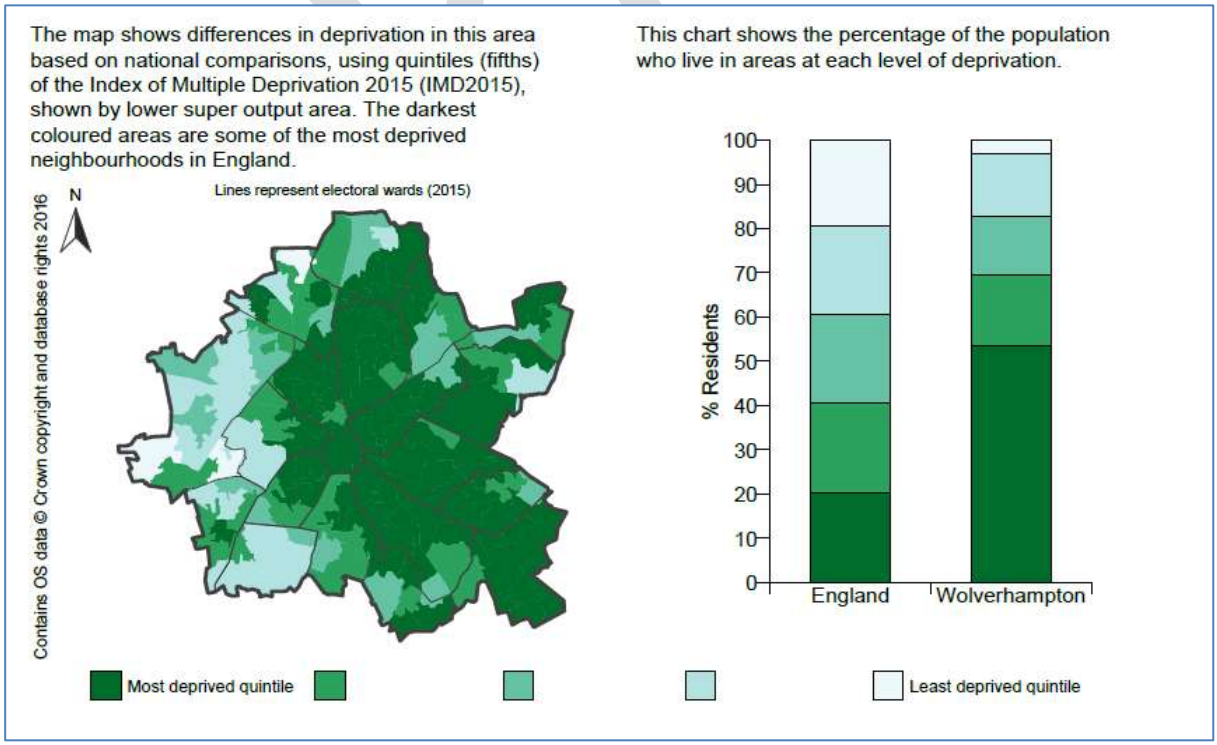
3.1 The Economic Challenge

- **The Wolverhampton economy as a whole is financially challenged**. All key partners are experiencing significant financial challenges now and in forthcoming years. In the CCG the Quality Innovation, Productivity and Prevention (QIPP) delivery programme has a current 4 year plan of £35-40million savings that need to be made alongside the savings target for CWC over the next 3 financial years of in excess of £54 million.
- **Wolverhampton as a city area experiences more than twice the level of most significant deprivation than the national average, and proportionately much lower areas of prosperity**. As demonstrated in the wider determinants of health, those deprived are more likely to have lower life expectancies and earlier disease manifestations. *Figure 5* below shows the deprivation level comparator between Wolverhampton and the rest of England, the darker the green the more deprived.

Figure 5 – Deprivation in Wolverhampton



- The entire health and social care community in Wolverhampton understands that **in order to gain the most value from its joint investment, the BCF is the opportunity**, particularly around

community based services, to pool its resources. For the CCG, this means enacting its strategic intentions to transfer appropriate elements of care from a hospital setting into the community as well as reviewing and transforming existing community based services to deliver the most significant demonstrable quality and value.

3.2 Drivers creating demand in Wolverhampton

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3.2.1 Executive Summary

- The evidence from Public Health, JSNA and clinical data sources indicate a **likely increase in demand for health and social care services in Wolverhampton** as a result of a forecast increase in the numbers of older adults with comorbid health problems of a complex nature alongside challenging social care needs. The information depicts a current Wolverhampton population:-
  - **Projected to increase,** including a **forecast 95% growth rate in the 85+ age range** rising from 6,000 in 2014 to 11,700 in 2039.
  - With **over half falling amongst the most deprived** in the country. Wolverhampton remains the 21st most deprived Local Authority district in the country (*DCLG The English Indices of Depravation 2015)*
  - With a greater than ever life expectancy **but no corresponding increase in healthy life expectancy** *(JSNA)***.** As they grow older, the longer people remain healthy, the less growth in demand for health and social care services there will be. **The pressure of an aging population is not in itself the key factor but rather how healthy people are.**
  - That can **expect to live on average 2 years less** than the England average *(JSNA)*
  - With a **Health Summary that is statistically amongst England's worst** *(Health Profile 2016, Public Health England)* where **31% are currently registered on a chronic condition register** and, **27.7% have one or more long term conditions** *(Moving care closer to home, Business Case)* and **over 64% of adults over 60 are living with frailty** *(Wolverhampton Frail Elderly Workshop, March 2017)*
  - That has **significant health inequalities** across the city and ethnicities *(Health Profile 2016, Public Health England).*
  - Where other than cancers of all types, **Cardiovascular Disease (CVD) remains the single greatest cause of lost life years** and although this is improving over time, mortality from CVD remains considerably higher than the national and west midlands average *(JSNA).*
  - As of September 2016, the **recorded prevalence of Dementia in those aged 65 and over in Wolverhampton (4.94%) was significantly higher compared to England** (4.31%) and the West Midlands (4.14%) (JSNA).
  - The **Dementia diagnosis rate in October 2016 was higher in Wolverhampton compared to the England average**. (JSNA) what is the dementia diagnosis rate? Andrew Woods
  - The **rate of emergency admissions with a mention of Dementia in Wolverhampton were significantly higher compared to England and the West Midlands**, at the most recent data point (2015-16).(JSNA).
- Addressing these issues within the context of financial constraints and the local economic climate represents a significant challenge where **doing nothing is not an option**

3.2.2 Population Forecast

- The Sub-National population projections to 2020 suggest an increase in the resident population with growth set to continue even further ahead to a projected estimate of Wolverhampton's population in 2039 as 288,000 with growth being most rapid in the child and older populations. These estimates show:
  - **The number of people aged 65 years or older is projected to grow** from 42,400 in 2014 to

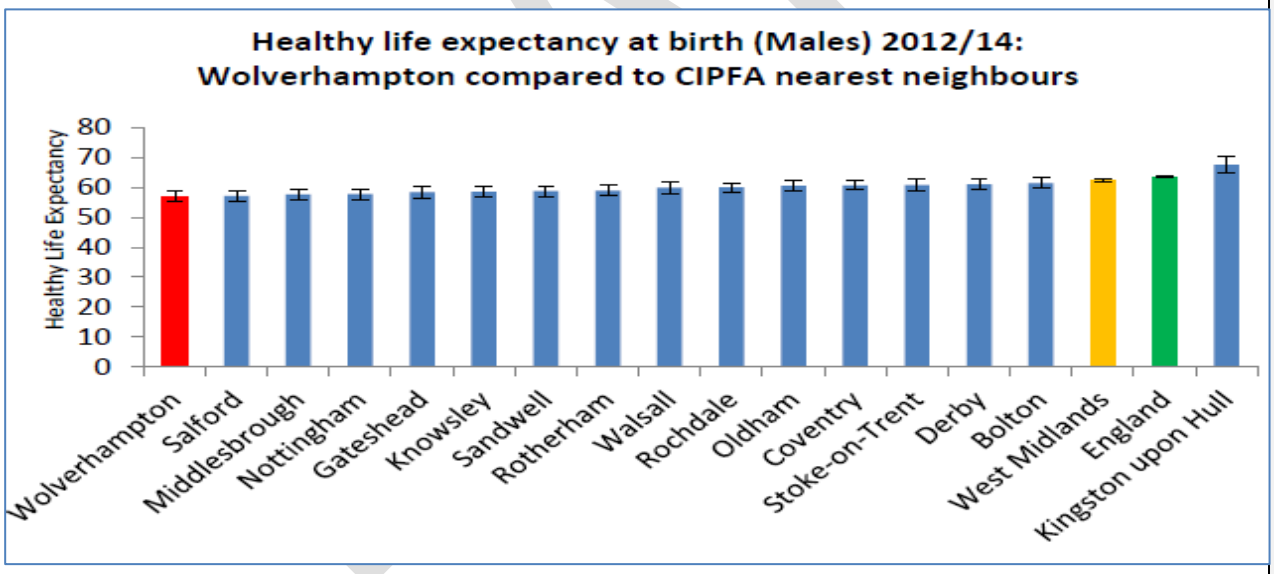
60,500 in 2039: a gain of 18,100 (42.7% growth).

- **The number aged 85 years or older is shown to grow by 5,700 (95.0% growth)**, from 6,000 in 2014 to 11,700 in 2039.
- The number of children (aged 0 to 15 years) is projected to increase from 51,300 in 2014 to 59,000 in 2039. This is a net gain of about 7,700 (15.0% growth)
- The number of people aged 16 to 64 years is projected to rise slightly from 159,400 in 2014 to 168,500 in 2039. This is a net gain of about 9,100 (5.7% growth).

3.2.3 Life Expectancy and Health Inequality

- The Joint Strategic Needs Assessment (JSNA) (Appendix 7) for Wolverhampton shows that although overall life expectancy in the city has improved over the last 12 years, **it is still some way below the national averages for both sexes with a significant health inequality gap** remaining in the city.
- Life expectancy in Wolverhampton is currently 77.6 years for males and 81.8 years for females, **which is almost two years less than the national average for both**.
- Healthy life expectancy in Wolverhampton **is almost six years less than the national average** for both sexes. Males can expect a healthy life expectancy of just over 56.9 years which i**s currently the worst of all our statistical comparators** *(See Figure 6)***.** Females have a healthy life expectancy of 58.3, which is also amongst the worst of all our statistical comparators.

Figure 6 – Healthy Life Expectancy for Males



- **The gap in life expectancy between the most and least deprived areas in the city is increasing.** The latest statistical information can be found below in (*see Figure 7)*

- **The Black Minority population is over represented in relation to emergency hospital admissions Ethnic (BME - using the definition of BME as non-White residents),** *see figure 8*. This suggests that some people are not accessing or receiving the care most suited to managing their condition, and are therefore further disadvantaged. 32% of Wolverhampton's residents are classified as being from BME backgrounds; the largest is Asian at 18%, followed by black and mixed race at 6.9% and 5.1% respectively. This diversity is higher than the national distribution where 14.6% of the population is classified from a BME community. In addition, Wolverhampton has an increasing growth population from Eastern Europe. Equality Lead – Juliet Herbert

- **The BCF plans to reduce health inequalities in the city by the implementation of the person centred model of *care*** *(Figure 3).* In addition each workstream is required to complete Equality Impact Assessments for any project work undertaken as an integral part of the governance processes

Figure 7 - Health In-equality – Life Expectancy Gap across the City

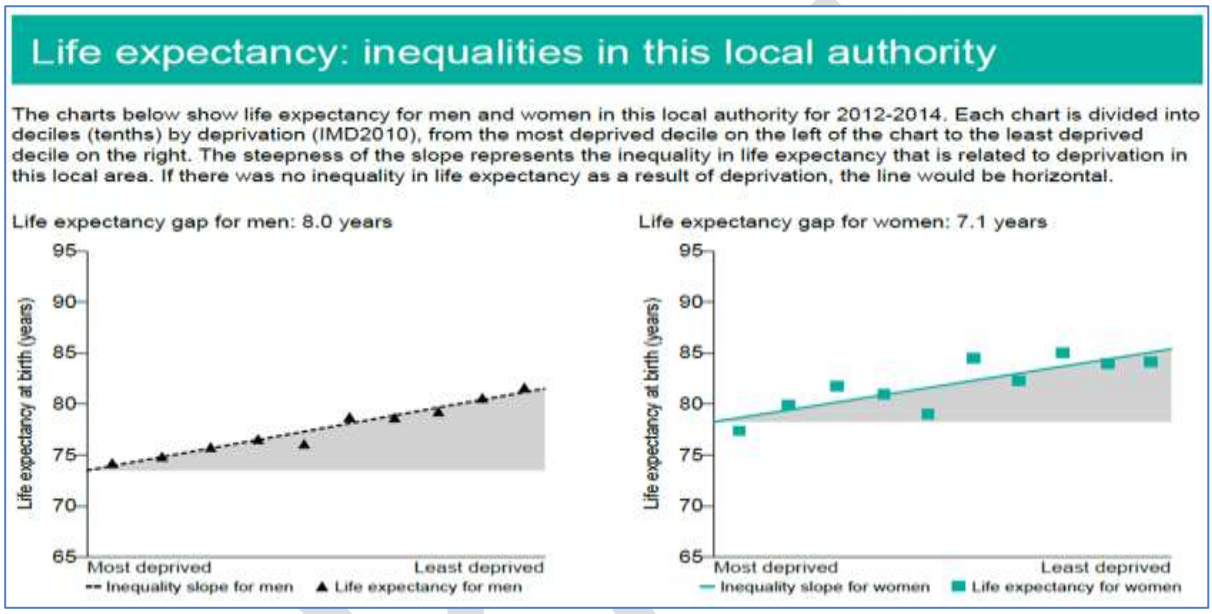
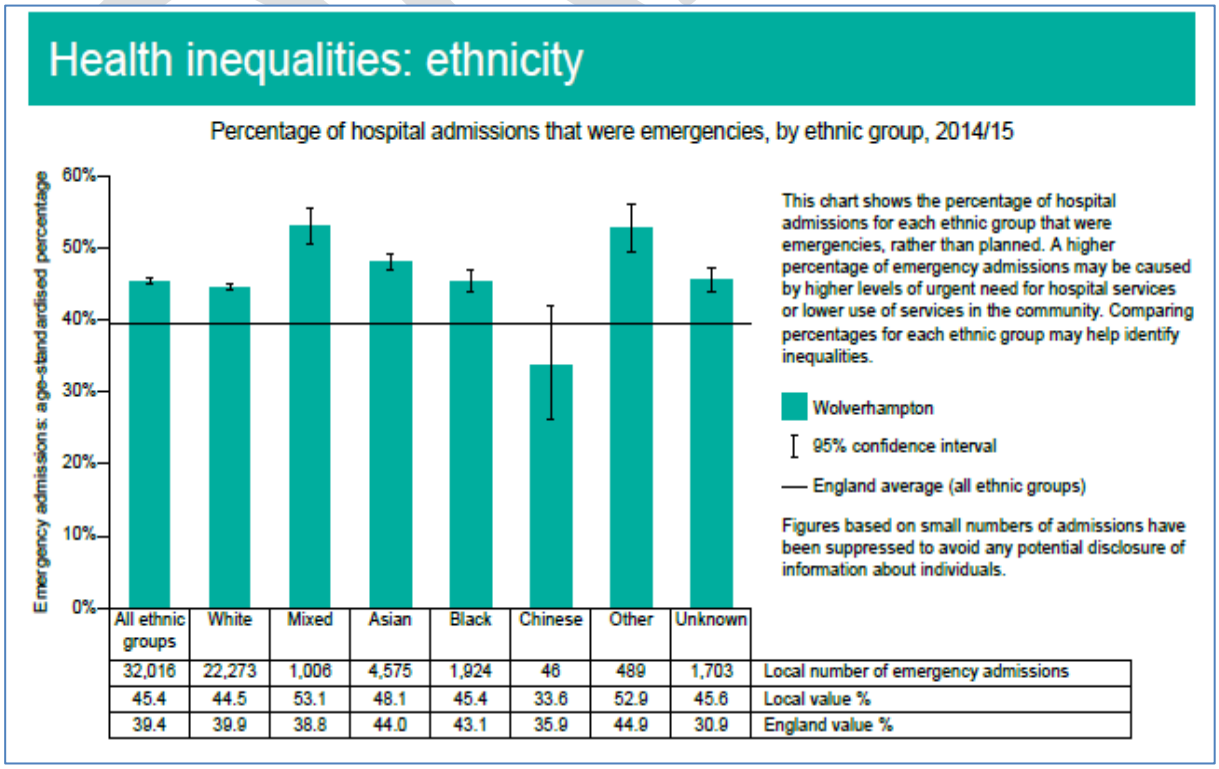


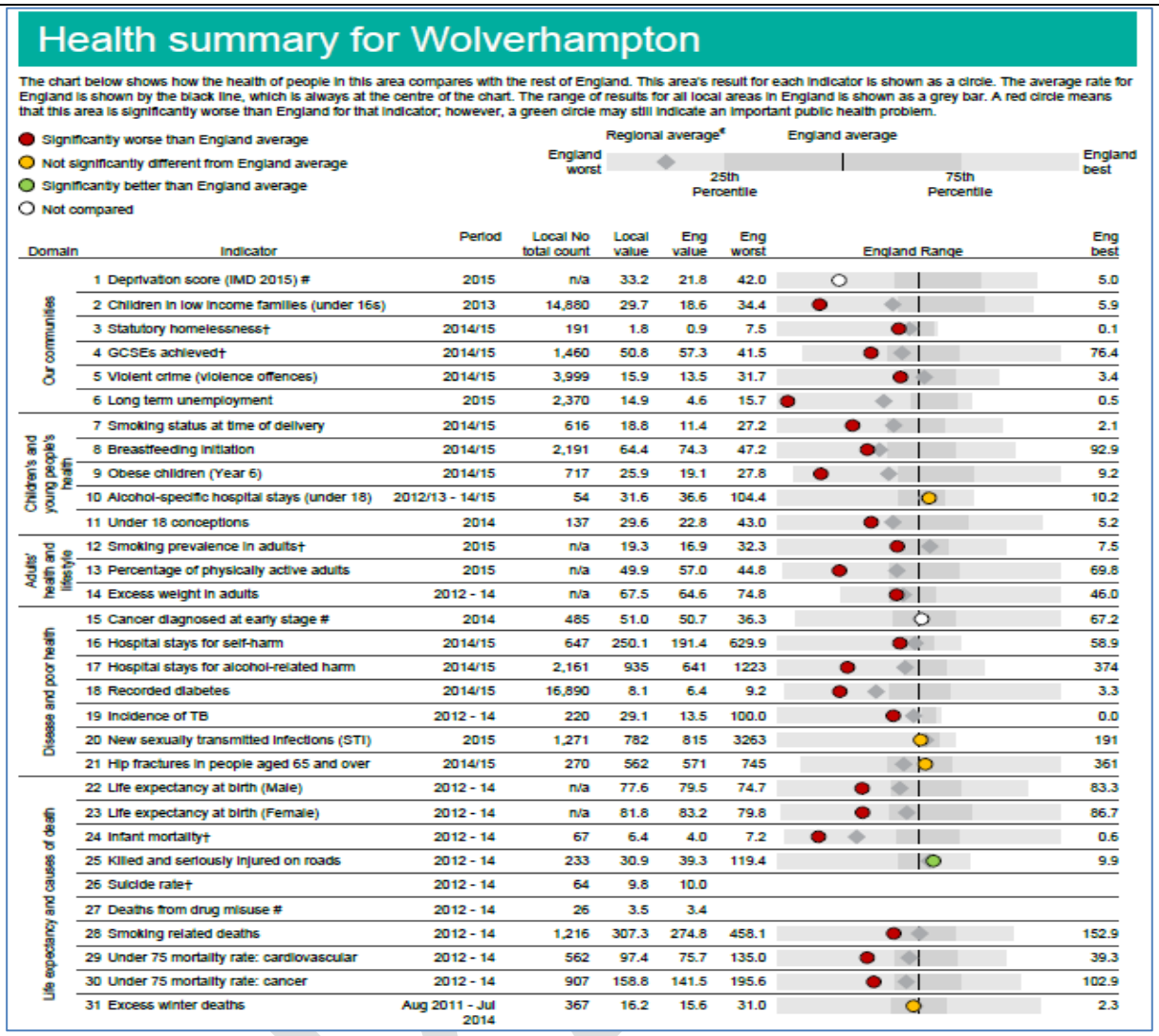
Figure 8 - Health In-equality – Ethnicity



3.2.4 Health Summary and Long Term Conditions

- **Wolverhampton benchmarks very poorly against a number of significant health factors and the wider determinants of health** (See *Figure 9* below) that typically contribute to a life limiting illness, frailty and/or long term medical condition later in life e.g. smoking, obesity and alcohol consumption
- Highlighted areas of demand suggest **that a significant proportion of the Wolverhampton population – 16.1% - have a long term condition** *(See Figure 10, p18)*, with 11.6% having more than one long term condition; in total 27.7%, with 79% of those people with a single long term condition being within the 16-69 age range, and 53% of those with more than on long term condition are represented in this age range. Whilst this sits within the national average range, the growth expectations regarding the over 85 population suggest that Wolverhampton will experience a potential increase in the numbers of older adults with comorbid health problems of a complex nature, and with challenging social care needs.
- A further indication of a likely increase in demand is suggested from information extracted from primary care clinical systems that currently indicates approximately **82,000 adults aged 18 and over (approximately 31% of total population) that are currently registered on a chronic condition register** which equate to nationally derived QOF cohort counts (including diabetes, asthma, heart disease, lung disease, dementia, stroke and arthritis) and an increasing number will develop these conditions as they grow older.
- Primary care data using the Electronic Frailty Index (eFI) indicates **over 64% (37,880 individuals) of the over 60 population in Wolverhampton are living with frailty** with a further 26.6% (18,437 individuals) aged between 49 and 60 (*Wolverhampton Frail Elderly Workshop, March 2017).*
- In reviewing the Wolverhampton population demographics **there are significant mental health needs for children and young people in the city.** On most indicators, **the population of Wolverhampton scored significantly higher when compared to England averages.** Measures include data on hospital admissions for self-harm, rate of children being looked after, first entrants into the youth justice system, and numbers of children living in poverty. **Wolverhampton needs analysis data for CAMHS also describes under use of universal and targeted services at TIERS 1 and 2, causing over use of services at TIER 4**.

  Figure 9 – Health Summary



Health summary for Wolverhampton

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

Regional average[¶] England average

England worst — 25th Percentile — 75th Percentile — England best

Domain		Indicator	Period	Local No total count	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation score (IMD 2015) #	2015	n/a	33.2	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2013	14,880	29.7	18.6	34.4		5.9
	3	Statutory homelessness†	2014/15	191	1.8	0.9	7.5		0.1
	4	GCSEs achieved†	2014/15	1,460	50.8	57.3	41.5		76.4
	5	Violent crime (violence offences)	2014/15	3,999	15.9	13.5	31.7		3.4
	6	Long term unemployment	2015	2,370	14.9	4.6	15.7		0.5
Children's and young people's health	7	Smoking status at time of delivery	2014/15	616	18.8	11.4	27.2		2.1
	8	Breastfeeding initiation	2014/15	2,191	64.4	74.3	47.2		92.9
	9	Obese children (Year 6)	2014/15	717	25.9	19.1	27.8		9.2
	10	Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	54	31.6	36.6	104.4		10.2
	11	Under 18 conceptions	2014	137	29.6	22.8	43.0		5.2
Adults' health and lifestyle	12	Smoking prevalence in adults†	2015	n/a	19.3	16.9	32.3		7.5
	13	Percentage of physically active adults	2015	n/a	49.9	57.0	44.8		69.8
	14	Excess weight in adults	2012 - 14	n/a	67.5	64.6	74.8		46.0
Disease and poor health	15	Cancer diagnosed at early stage #	2014	485	51.0	50.7	36.3		67.2
	16	Hospital stays for self-harm	2014/15	647	250.1	191.4	629.9		58.9
	17	Hospital stays for alcohol-related harm	2014/15	2,161	935	641	1223		374
	18	Recorded diabetes	2014/15	16,890	8.1	6.4	9.2		3.3
	19	Incidence of TB	2012 - 14	220	29.1	13.5	100.0		0.0
	20	New sexually transmitted infections (STI)	2015	1,271	782	815	3263		191
	21	Hip fractures in people aged 65 and over	2014/15	270	562	571	745		361
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2012 - 14	n/a	77.6	79.5	74.7		83.3
	23	Life expectancy at birth (Female)	2012 - 14	n/a	81.8	83.2	79.8		86.7
	24	Infant mortality†	2012 - 14	67	6.4	4.0	7.2		0.6
	25	Killed and seriously injured on roads	2012 - 14	233	30.9	39.3	119.4		9.9
	26	Suicide rate†	2012 - 14	64	9.8	10.0			
	27	Deaths from drug misuse #	2012 - 14	26	3.5	3.4			
	28	Smoking related deaths	2012 - 14	1,216	307.3	274.8	458.1		152.9
	29	Under 75 mortality rate: cardiovascular	2012 - 14	562	97.4	75.7	135.0		39.3
	30	Under 75 mortality rate: cancer	2012 - 14	907	158.8	141.5	195.6		102.9
	31	Excess winter deaths	Aug 2011 - Jul 2014	367	16.2	15.6	31.0		2.3

Figure 10 – Long Term Conditions

Estimated Wolverhampton population breakdown based local data

	Mostly healthy	1 LTC	Multiple LTCs	SEMI	Dementia	Cancer	Learning Disability	Physical Disability	Grand Total
Child	48,616	2,411	13	8	-	34	-	108	51,190
16-69	121,308	33,630	16,380	2,200	142	2,897	968	1,791	179,316
70+	5,234	6,169	14,070	361	1,725	3,257	45	413	31,274
Grand Total	175,158	42,210	30,463	2,569	1,867	6,188	1,013	2,312	261,780

- The assumption from this data and the current data analysis regarding emergency admission activity is **that there is a need to plan for an increasingly health challenged aging population with complexity and co morbid conditions**. Alongside this is an **absolute need to adopt an early intervention, self-care management and prevention approach to support this population** over the coming years positively to live well and with general good health.
- As described in the CCG operating plan **our overriding aim is to enable people to live longer and more healthily.** Although life expectancy is increasing we need to ensure that people enjoy disability free years of live as well as having increasing longevity. **The increasing problem of the**

frail elderly population means that we have to look at specific services to support people to remain in their own homes and to receive care closer to home where appropriate. We are working together as a health and social care economy to try to address these issues.

- In line with the seven NHS ambitions detailed in the NHS outcomes framework we **aim to improve the quality of life of people with one or more long term condition, including mental health conditions.**

3.2.5 Conclusion

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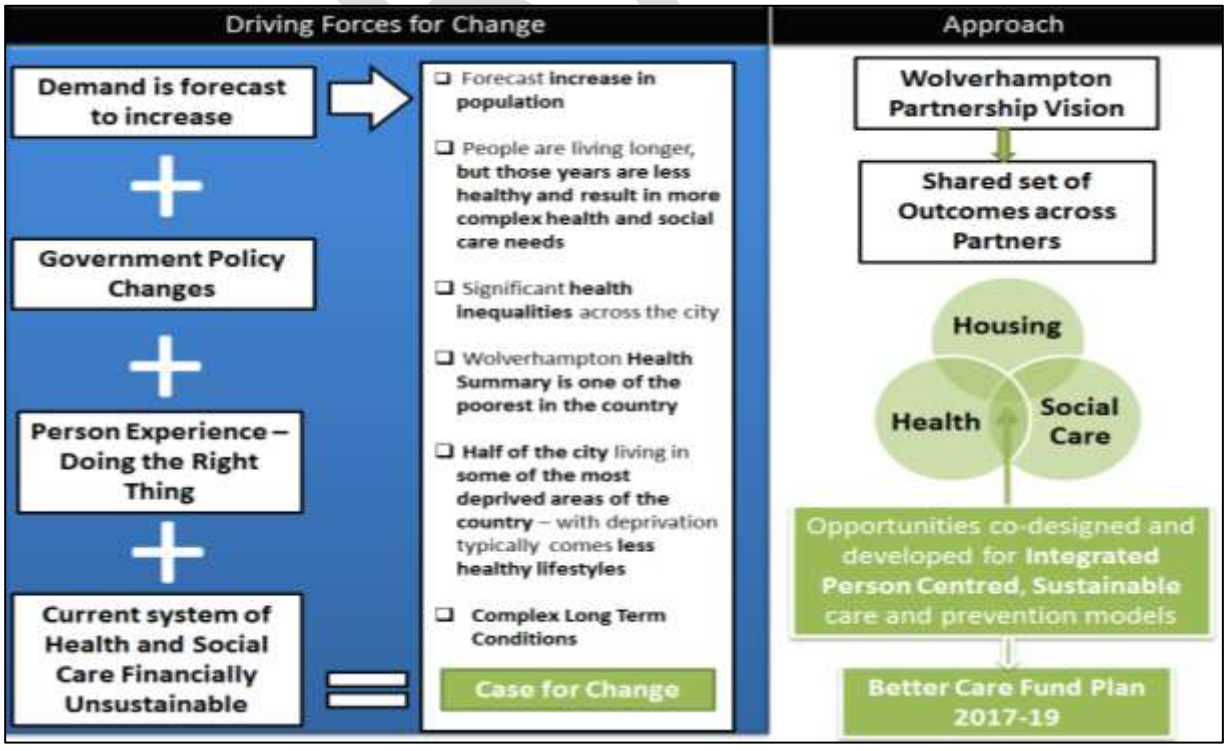
- The insight that is available on the demographics, JSNA and Health Summary for Wolverhampton all provide a strong indication of the likely increase in demand for Health and Social Care services in the future. When reconciled with the economic challenges that are presenting both regionally and nationally this rise in demand will be unaffordable and unsustainable without significant transformation of the health and social care landscape *(see Figure 11 below*).
- As a component part of the wider public and voluntary sector system (and acting within those constraints) our BCF plan aims to redesign the model of health and social care delivery in Wolverhampton where our insight tells us that we can make the most difference in terms of person experience, preventing demand in the first place (where appropriate and right for the person) and where we can make the best use of our scarce resources once people need more complex health and social care needs. **It is on these principles that our plan to address the challenges are built and measured.**

Figure 11 – The Case for Change



4. Programme Delivery Method and Control

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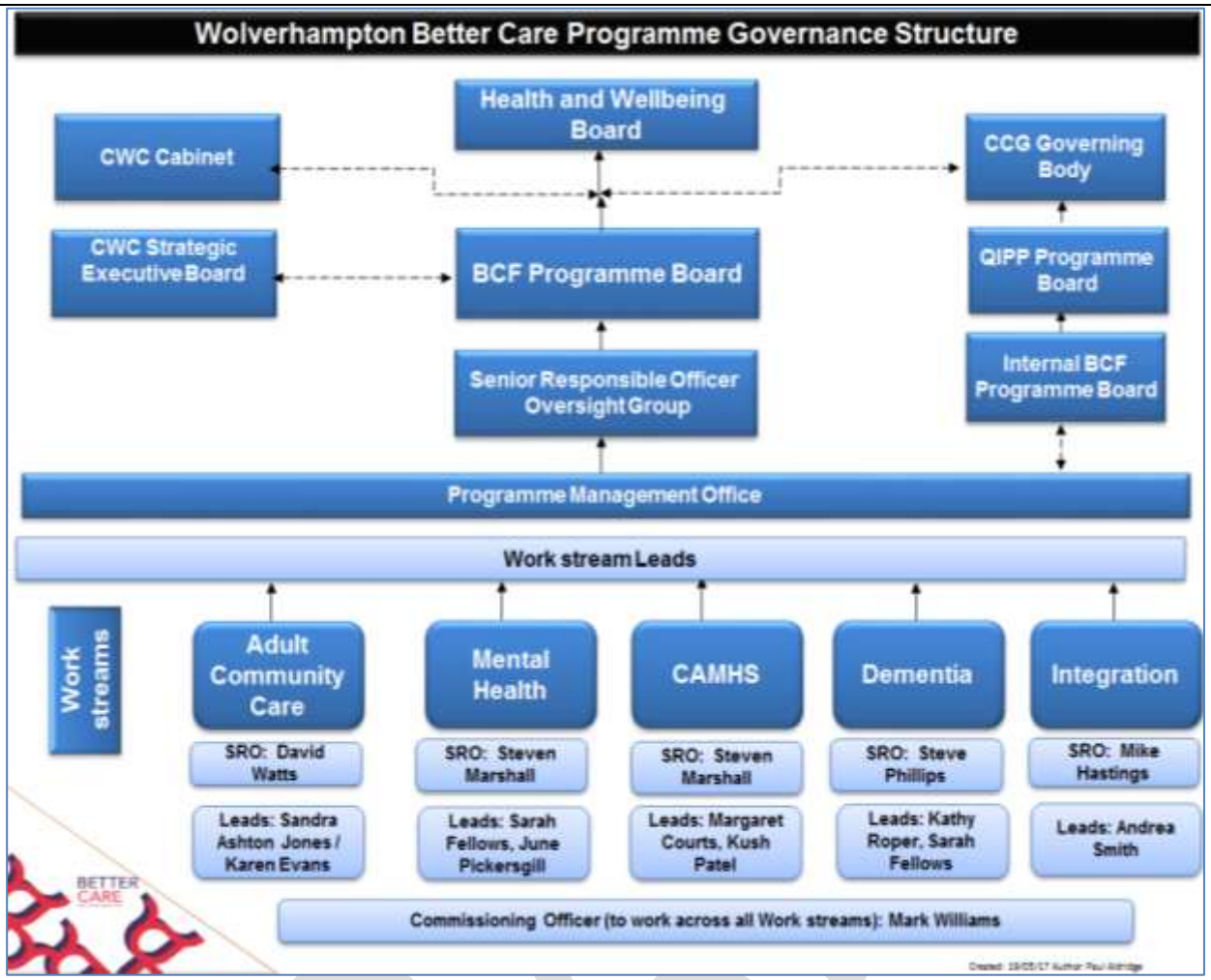
4.1 Overarching Governance Arrangements

- Wolverhampton's BCF is overseen by the HWB. The specific BCF programme of is managed through the BCF Programme Board which is co-chaired by the Accountable Officer at the Wolverhampton CCG and the Strategic Director (People Directorate) for CWC.
- The programme is underpinned by a refreshed formal Section 75 agreement between CWC and Wolverhampton CCG. Membership of the HWB will be reviewed in order to reflect the requirements of the Section 75 agreement and the robustness of approach it will need to take.
- The governance arrangements for the BCF are as streamlined as possible, bearing in mind the scale of the financial commitment involved and the scope of the overall project. Day to day operational management and oversight of the fund will be the responsibility of the BCF Programme Board. Each workstream within the Programme has an allocated Senior Responsible Officer and workstream leads from the key organisations involved in that work stream. Members of BCF Programme Board have delegated responsibility from both partner organisations to hold the Senior Responsible Owners to account and make necessary decisions from a planning and performance management perspective.
- The Senior Responsible Officers provide oversight and monitoring of the Pooled budget, supported by their respective organisation Finance leads.
- *Figure 12* below demonstrates the structure that provides the delivery mechanism and Governance to the Programme. CCG, LA and Provider organisations are represented at each of the levels of the structure except for the PMO which is a joint CCG and LA function. Both organisations resource a Programme and Project Manager and there is a jointly funded Project Support post.

Figure 12 – Wolverhampton BCF Governance Structure



4.2 Wolverhampton's Governance Flow Management and Oversight

- Wolverhampton CCG and CWC have co-terminus boundaries, and as such, have an element of already established oversight and management arrangements. Nevertheless, in relation to the BCF Programme, and in order to support the wide transformation agenda and current joint commissioning arrangements across the City, the two commissioning organisations have recognised the need to establish a clear and explicit governance framework which adds value to the existing partnership mechanisms.
- At the heart of the arrangements is the HWB, which, as mandated by the BCF Framework, has overarching accountability and oversight of the BCF Plan. Both CWC's Cabinet, and Wolverhampton CCG, have issued initial delegated authority to the Board for this oversight on behalf of the 2 organisations, with the HWB now being enhanced by additional elected membership.

4.3 Section 75

- Underpinning the management and oversight of the BCF Programme is the development of a Section 75 agreement. Wolverhampton currently has established joint commissioning arrangements in relation to mental health, learning disability, and all age disability. The Specific Section 75 agreement for BCF will cover:-
  - The complexity of the role of the HWB in relation to Section 75 oversight (i.e. the requirement for a change to Council constitution, and the Boards broader remit)
  - Risk sharing
  - Specific inclusion requirements
- These governance arrangements will ensure that there is sufficient authority to take

appropriate decisions and scrutiny of those decisions and the operation of the arrangements generally. The governance arrangements have been developed over the last 12 months, and clearly articulate the reporting requirements. They will be set out in full in Schedule 2 of the Section 75 agreement. Existing contracts between the CCG and providers and the Council and their respective providers will not be affected by the continuation of a single host for the pooled fund.

4.4 Pooled Fund Management

- Each individual work stream where there is a pooled fund has designated pooled fund management from both a health and social care perspective (commissioner). This role is undertaken by existing commissioners within each of the statutory partners, with the following duties and responsibilities:
  - The day to day operation and management of the pooled fund
  - Ensuring that all expenditure from the pooled fund is in accordance with the provisions of the Section 75 agreement and the relevant scheme specification
  - Maintaining an overview of all joint financial issues affecting the Council and the CCG in relation to the services and the pooled fund
  - Ensuring that full and proper records for accounting purposes are kept in respect of the pooled fund
- Reporting to the Commissioning Executive Group (CEG) as required (this would be through SROs)
- Ensuring action is taken to manage any projected under or overspends relating to the pooled fund in accordance with the Section 75 agreement
- In conjunction with the overall pooled fund manager preparing and submitting to the HWB/Integrated Commissioning and Partnership Board quarterly reports (or more frequent reports if required) and an annual return about the income and expenditure from the pooled fund together with such other information as may be required by the HWB to monitor the effectiveness of the BCF and to enable the CCG and the Council to complete their own financial accounts and returns
- In conjunction with the overall pooled fund manager, preparing and submitting performance reports to the HWB on a quarterly basis (per Section 75 paragraph above)

4.5 Metrics and Performance Tools

- Wolverhampton's health and social care community acknowledges the need to respond to the scale and pace of the BCF Programme with a governance and management oversight infrastructure that is robust and has clear lines of accountability. Supporting the roles of the management and oversight infrastructure is a portfolio of metrics in a developing dashboard. This will provide 'at a glance' oversight of work stream delivery against programme objectives, risks, mitigations and benefits realisation on a programme wide basis. These are outlined in the table below:

KLOE Ref.

Management Oversight Tool	Reporting To	When
Workstream Dashboard – Metric Impact	BCF Programme Board	Monthly
Programme Plan Highlight Report, Risks and Escalations	Programme Office	Monthly
Aggregated Performance Dashboard	BCF Programme Board and Health and Wellbeing Board	Monthly
Risk and Mitigations Exception Reports	Senior Responsible Owners	Monthly
Engagement and Communication Report	BCF Programme Board	Monthly
Performance report	Workstream	Monthly

4.6 Risks, Risk Share and Management of Risk

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- Risks are identified (via risk log), analysed (typically using likelihood/impact matrix) and managed across the programme from individual project level through to workstreams and ultimately up to Programme level where significant risks are reported to and managed by the BCF Programme Board. Key stakeholders are represented at each of the levels.
- Alleviation of risk for providers relies heavily on understanding the commissioning intentions of the commissioning bodies. Wolverhampton commissioning intentions for both the council and the CCG are published in line with national timeframes and organisational requirements. Detailed discussions between commissioner and provider are undertaken during contract negotiations which fully address risk for providers.
- A comprehensive risk review has been undertaken across the 2017/19 programme. In each case where a risk was identified, thought was given to potential mitigations that would alleviate, assist or resolve the risk should it develop into an issue for any given provider. For the two NHS Trusts, much of this work has been addressed via contract negotiations, Commissioning for Quality and Innovation Payments Framework (CQUINS) and negotiated solutions using internal processes.
- The financial risk identified by the programme risk review are summarised below and can be confirmed as not putting any element of the minimum contribution to social care or iBCF grant at risk:- 23, 24

	CCG Risk%	Council Risk %
Adults Community Service	53	47
Dementia	90	10
Mental Health and CAMHS	65	35
Demographic Growth	56	44

- The 2017/19 pooled fund agreement has been achieved through a transparent process of sharing detailed projections, outturn information, and data and looking carefully at those areas of the whole Health and Social Care system that when pooled could create “cause and effect”. This approach has allowed both Wolverhampton CCG and the CWC to develop a shared incentive for overall agreement. As referred to earlier in the document the pooled fund for Wolverhampton during 2017/19 will be £70.934m. This is broken down across the following

work streams:

Work streams	CCG Funded services (£000)	Council Funded services (£000	Total Services (£000)
Adult Community Services **(Note: includes iBCF Funding within Council Funded services)**	29,086	25,644	54,730
Dementia	2,627	282	2,909
Mental Health	5,313	2,809	8,122
CAMHS	839	470	1,309
Ring Fenced Capital Grants – DFG	0	2,678	2,678
Care Act Funding **(TBC)**	964	0	964
Total	**38,829**	**31,883**	**70,712**

4.7 Risk Share – Underperformance

- The proposed revenue value of the pooled fund to be managed via the Section 75 agreement is £67.070m and consists of £37.865m of CCG funded services alongside £29.205m council funded services. The council contribution includes £6.513m for 17/18 and £6.637m for 18/19 representing the NHS transfer to social care (Section 256 funding). The pooled budget also includes a capital grant amounting to £2.678 m which is managed by the council.

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4.8 Risk Share – Overspend

- The host organisation (CWC) will produce monthly financial reports and share these with the other party. The first reconciliation to recoup any overspend shall take place at quarter two (month six), and quarter three (month nine). Month 11 reporting will incorporate year end estimates on the pool fund.
- The BCF Programme Board shall consider what action to take in respect of any actual or potential overspends. The Board will take into consideration all relevant factors including, where appropriate the BCF Plan and any agreed outcomes and any other budgetary constraints and agree appropriate action in relation to overspends which may include the following:
  - Whether there is any action that can be taken in order to contain expenditure;
  - Whether there are any underspends that can be vired from any other fund maintained under this Agreement;
  - How any overspend shall be apportioned between the partners, such apportionment to be determined on the basis of the individual partner's contribution to the individual work stream as detailed in the table above.

4.9 Non-financial Risks

- The major areas of non-financial risk sharing specifically within the BCF largely relate to performance against targets, information governance and equalities. Each of these key areas were identified at the very start of the BCF journey.
- **Performance against targets.** The programme is well structured and managed. Work streams meet on a face-to-face basis fortnightly and management of activity and progress is documented and shared via the maintenance of comprehensive project management toolkits (critical paths, implementation plans, action, risk, issue and escalation logs) supplemented by highlight reports to programme board. Performance is measured against targets through

routine collections of data by each organisation's Business Intelligence team and reported to the programme board monthly. This allows for early identification of issues which enables proactive management at appropriate levels of the governance arrangements.

- **Information Governance and Equalities.** An overarching Information Sharing Agreement has been created to support the shared care approach we are working towards here in Wolverhampton. An agreement has been reached for the four main partners to install, gain access and utilise a software platform that allows frontline workers to comprehensively 'view' client data across all available systems for identified purposes. Given that this is a 'view only' solution that does not allow any changes to already stored data, this is a real step forward in the professional health and social care world. Existing information and data cannot be compromised and therefore the four BCF partners have each agreed a 25% financial cost and associated risk share arrangement. This ability for professionals to instantly access a person's health and social care information irrespective of their employing organisation will profoundly affect the timeliness of treatment and support available to those people in need, reducing the risk of duplication and gaps in service
- **With regard to equalities**, impact assessments are undertaken for each project and are continually reviewed and refreshed as required.
- **Other non-financial risk** sharing agreements sit largely across the BCF organisational partners as service level agreements rather within the Programme itself. These service level agreements relate to a variety of processes and practices across the health and social care economy the key ones relating to timeframes for:
  - Hospital discharge
  - Service response
  - Service quality

5. Delivery Model

5.1 Summary

- We have a number of programmes of work which are designing and developing services across Wolverhampton as part of our BCF approach (*see Figure 13 - Strategic High Level Roadmap*). These have been established over two years and have engaged health and social care provider organisations, commissioners, the voluntary sector, GPs, local forums and front line staff to contribute towards a review and redesign of services enabling us to deliver on the national performance metrics:-
  - **Reducing emergency admissions** to hospital
  - **Reducing the number of delayed transfers of care** from hospital
  - **Improving the effectiveness of reablement**
  - **Reducing the number of people permanently placed in nursing and residential care**
- **Our aim is to have integrated health and social care teams, supported by Voluntary Sector and community groups, wrapped around GP practices and their individuals to provide place based co-ordinated proactive and reactive case management for people with medium to high level of need, long term conditions and who live with frailty.** They will be co-located in community hubs which will be developed to underpin this vision. The hubs will contain integrated health and social care teams working together to develop person centred interventions within the community they serve. The plan is for there to be one hub in each of the three localities across the city, however we are increasingly mindful of the emerging New Models of Primary Care and are working closely with the GP groups to ensure that development of the teams is also reflective of the Primary Care landscape.

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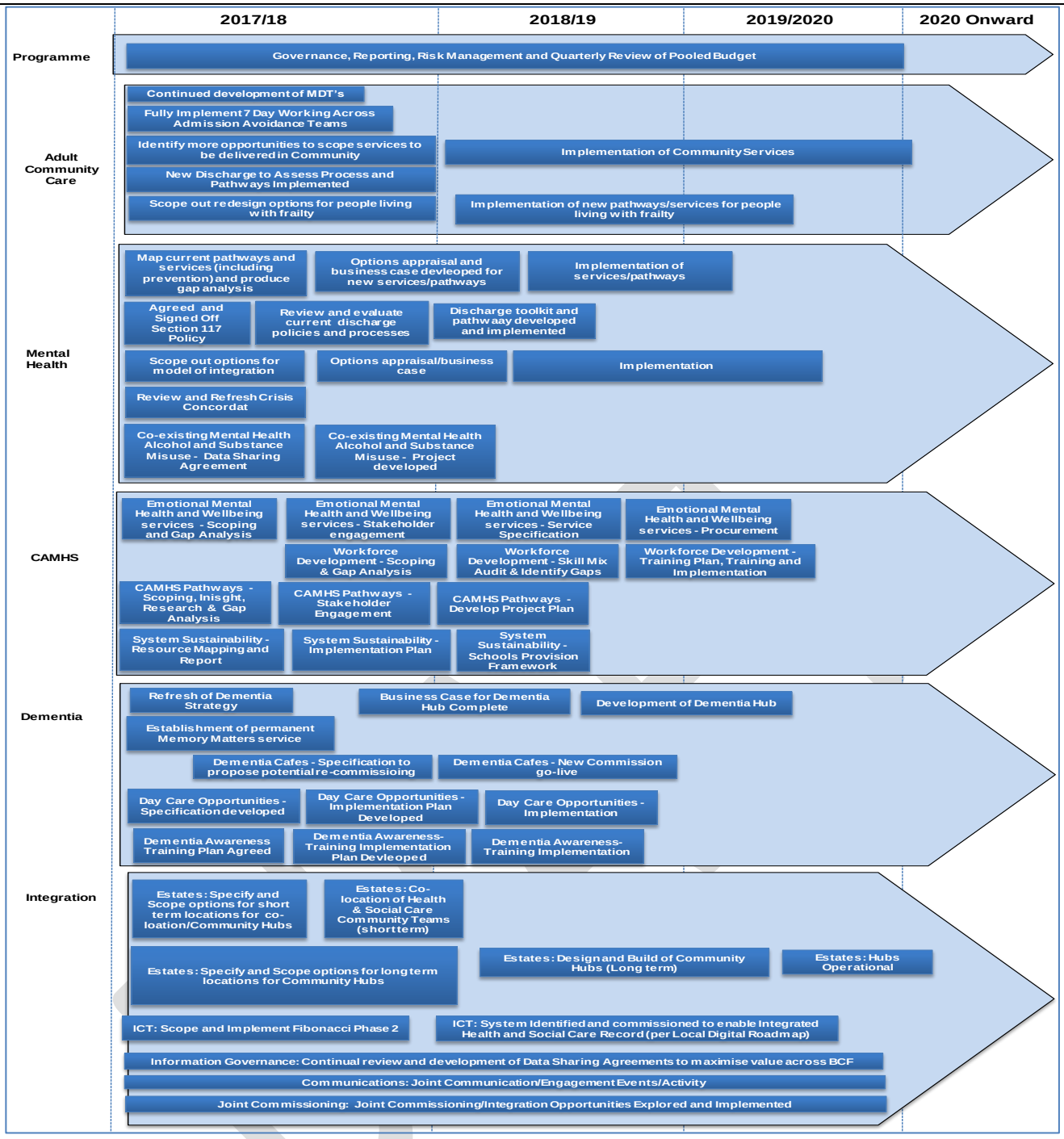
- **These teams are currently working virtually and hold Multi-Disciplinary Team meetings on a monthly basis in all three localities** whereby the health and social care teams discuss in detail their caseload of people with complex and interdependent needs, ensuring that appropriate care is being co-ordinated and delivered.
- **The teams will work alongside the numerous stakeholders such as the individual's GP, Voluntary Sector, specialist teams, the Police, West Midlands Ambulance Service, West Midlands Fire Service and local pharmacies** delivering both proactive and reactive models of care depending upon the person's needs.
- **We aim to build a neighbourhood approach which generates self-care, early identification and screening, integration and resilience of communities**. Delivering a person centred focus to support for those who are living with frailty and/or complex health and care needs which maximises their independence and enables people to remain in the home they are ordinarily resident for as long as possible.

Figure 13 – High Level Strategic Roadmap 2017-2019



5.2 Proactive approach

- The proactive approach aims to identify those individuals presenting with high demand for services and at risk of attendance at A&E and emergency admission. **By identifying these people early we aim to provide support that educates and empowers them to understand and manage their condition more effectively** with the support of our community neighbourhood teams, Primary Care and Social Prescribing teams.

- **For Social Prescribing, Wolverhampton CCG in partnership with Wolverhampton Voluntary Sector Council, have launched a twelve month Social Prescribing Pilot** to provide an alternative to and compliment Primary Care. The service will work closely with other agencies in order to maximise the options available to individuals (i.e. voluntary sector organisations, Local Authority, and the local NHS provider Trusts). Each practice will have a named Social Prescribing Link Worker. The Social Prescribing Pilot will work very closely with Primary Care and aims to be anticipatory, preventive and proactive in its approach:-

- To reduce demand on GP Primary Care (and potentially A&E attendances, admissions and readmissions to hospital for persons referred into the service) by improving their health and wellbeing.
- To improve the health and wellbeing of individuals
- To help improve the quality of life of individuals through education and low level support
- To enable individuals to develop friendships and networks
- To raise individuals awareness of available services

- **We utilise our Business Intelligence and analytical expertise to identify areas of need**, whether that is people with high numbers of A&E attendances and emergency admissions, areas of the city with specific condition prevalence, or to identify trends in activity.

- Persons are **identified through a number of routes but primarily between the GP and Community Matron utilising a Risk Stratification tool**. **Once identified the person is contacted to obtain consent for the Multi-Disciplinary team to case manage them**. (Multi-Disciplinary teams are made up of Community Matrons, District Nurses, Social Workers, Specialist nurses and link with the Persons GP, community mental health teams and voluntary sector when appropriate). **The person is then referred onto the MDT caseload where a joint (health and social care) plan is agreed and implemented**.

- **GPs will now also be identifying and monitoring the persons Frailty index** and these persons will also be case managed to reduce the risks associated with frailty.

- Now the **Fibonacci system (electronic shared record) has been successfully implemented across health and social care, it is used within the MDT environment to look at the person record** and can also be utilised by members of the team when they are with the person to ensure that they have the most up to date person information.

- **A robust Telecare offer has been created to support users to remain in their own homes and communities,** through the provision of technology based on individual needs and, where appropriate, provision of mobile response to a non-injury fall or instance of no response from the user, as provided by West Midlands Fire Service (WMFS). In 16/17 there were 2,219 response callouts, 57% relating to a fall, and only 14% of all callouts resulting in an ambulance intervention. Telecare is currently provided to over 5,000 people across the city, with a growth objective of 3,000 new users over a 3 year period through to end of 18/19. 2016/17 saw 1,150 new users supported. The development of the Telecare offer aims to support:
  - Reducing admissions due to falls
  - Rapid Hospital Discharges/Delayed Transfer of Care
  - Reduce, defer and delay the need for more intensive support
  - Reduced spend on delivery of care services both in care homes and at home
  - Meeting needs of an ageing population with reducing budgets
  - Promoting independence and self-management in the citizens of Wolverhampton

  An example of the partnership with WMFS and the approach across Health and Social Care can be seen at: https://www.theguardian.com/healthcare-network/2017/apr/27/firefighter-falls-callout-service-easing-pressure-ambulances

- **For Dementia:-**
  - Using the pathway in the Joint Dementia Strategy the Memory Matters project has been developed to respond to a need for information advice and guidance to support early diagnosis.
  - Multi agency dementia awareness training is now being rolled out
  - The care market is being incentivised to support people with dementia

- A revised commissioning model for clinical services has been commissioned that responds to the NICE guidelines

5.3 Reactive Approach

- Whilst much resource is aligned to managing people's conditions and preventing an acute crisis, some people will, at some time experience an exacerbation of their condition, either with their physical or mental health. We have implemented and continue to enhance a number of rapid response elements to the programme to further avoid emergency admissions to those persons in crisis

5.3.1 Mental Health Street Triage

- The mental health street triage care is a service jointly provided by CWC, BCPFT, WMAS and West Midlands Police. It is imperative that people with mental health problems get the right assessment, care and treatment they need as quickly as possible especially in emergency situations. This arrangement sees mental health nurses accompany officers to incidents where police believe people need immediate mental health support. The aim is to ensure that people get the medical attention they need as quickly as possible, thus preventing inappropriate use of police custody cells & and s136 suites
- Please see below link for media coverage of the Street Triage work and evidence of the Social Value of this way of working

  https://www.expressandstar.com/news/2017/05/19/black-country-triage-team-save-west-midlands-police-18m/#9AkYSmbseulSb5Sg.03

5.3.2 Community Rapid Intervention Team

- The purpose of the team is to **primarily prevent unnecessary hospital admission by providing a multi-disciplinary team approach for those experiencing an acute episode of illness or injury who are in a health and/or social care crisis.** *See Figure 14, p28 – Example of the co-designed integrated pathway for the Rapid intervention Teams (RiTs)*
- Once the acute episode of care has been managed, **the service will then work with a wide range of health, social care and voluntary sector professionals to identify and agree the on-going management of the persons** and the requirements of the person and carer, to be able to confidently manage their condition (where clinically appropriate) within their usual place of residence.
- The service will have the **following locally defined outcomes:**
  - A progressive reduction in attendances at A&E and all urgent care portals
  - A progressive reduction in emergency admissions to acute based care
  - A progressive reduction in preventable admissions
  - A progressive reduction in readmissions for persons within a 90 day period
  - Incremental increases in improvement in person experience
  - All referrals will be responded to within the agreed timescales
  - Delivery of care in the persons home or usual place of residence
  - A comprehensive assessment of the health and social care needs of each person
  - A progressive reduction in the delayed transfers of care for persons fulfilling the criteria for this service
  - Support timely discharge from hospital
  - Improvement in recovery from the acute episode of their illness
  - Maximise independent, healthy living and build confidence to enable persons to self-care
  - Utilise equipment including Telecare and telemedicine to enhance and support independence

- Working with Social care partners, prevent admissions to permanent nursing or residential care
- Working with Social care partners, prevent the need for high intensity social care packages of care
- Provide step up care to persons to avoid admissions to hospital
- Work in partnership with other agencies to provide a seamless service to all persons

Figure 14 – Co-designed integrated pathway for the Rapid intervention Teams (RiTs)

5.3.3 Reablement

- **The Bradley Reablement service** provides a short term residential reablement programme to enable a person's timely discharge from hospital, assessment of needs in a community environment, enable further recovery, encourage independence and facilitate a return to independent living at home as early as possible. The service has access to on site therapists and social care staff and referrals are made to equipment, Telecare and community based services where required to ensure a coordinated approach to returning home. Referrals are also received from the community for short term work to aid a person's return to on-going independence at home.
- **The Home Assisted Reablement Programme (HARP) Reablement service** provides a short term reablement programme in an individual's home, working together with the person and

appropriate partners to maximise skills, independence and confidence to ensure on-going independent living at home. The programme supports people to be as independent as possible ensuring individuals continue with activities associated with daily living skills, personal care, kitchen skills, mobility skills and social inclusion. The HARP service will promote awareness and use of assistive equipment and technology to maintain a person's independence, reduce dependency on support services and promote safety within their home environment. The service receives people by way of hospital discharge or community referrals.

5.3.4 Evidence Based Approach

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- **Integration is the key to delivering demonstrable improvements in quality, value and outcomes for the people of Wolverhampton**. There are a significant number of emerging case studies and papers which support the case for integrating services.
- **The case for developing integrated, person-centred services and the benefits to be derived from this is clearly articulated in the Kings Funds 'Making Best Use of the BCF" and "Making Our Health and Care Systems Fit for an Aging Population"**, the 9 components of which have been absorbed into Wolverhampton's planning.
- Evidence suggests implementing integrated care has shown that integrated health and social care services can support older people to maintain their independence longer. **This helps to prevent emergency admissions, reduces length of stay in hospital and as a result reduces demand on full social care, all core areas of focus in Wolverhampton.**
- **There is a strong emerging evidence base for the BCF plans and Wolverhampton is confident that by building on current and previous experiences, it can embed and deliver sustainable, resilient and responsive integrated services that are person-centred**. A recent example of this is the delivery of integrated discharge planning services, and the mutual benefits derived from them. There are also a number of case studies available from the schemes that are now up and running with a sample included at **Section 6.1, p37** that evidence the impact on the individuals and their families.
- Articulating what is meant by integration is equally important in supporting the case for change. **Wolverhampton has undertaken significant consultation, local evidence review and engagement prior to selecting the 5 work stream programmes that it proposes to take forward between now and 2020.** A summary of these is included at **Section 2.4, p6**, *Figure 1* with more detail in *Appendices 1 and 2*
- **Workshops have been held across the health and social care economy** with stakeholders across all areas, professions, providers and **communities. There have been public events for people and their carer's to talk about their experience of local community** as well as through GP locality events with our primary care providers.
- Themes have emerged that have become golden threads in the description of the **need to deliver integrated, person-centred services** , in short Wolverhampton' services:-
    - **Must be more explicit and coordinated across health and social care** in the targeting of resources, thereby removing the traditional boundaries in existence. **People only want to tell their story once.**
    - **Must be sustainable, resilient and able to deliver better outcomes**, quality and value through behavioural and organisational change.
    - **Must strengthen the way community and primary care facing services are constructed and delivered** in order to reduce the growing pressures on the local emergency and urgent care systems
    - **Must maximise the value of return on investment** through activity shifts from hospital to community facing services as a means of successfully realising benefits

- **Must 'upstream' the focus toward asset based local community developments** for a redesigned model of integrated delivery of community facing services
- **Must encourage through design, living well, self-care, self-management and maximisation of choice**

- **The outcome of this process has been the identification of core work streams whose focus will be on transformational service redesign** that works towards the vision, outcomes and 'end state' as described and visualised in **Section 2, p4**. In doing so Wolverhampton has laid down the marker for its level of ambition and commitment to deriving maximum benefit from the BCF Programme.

- The core work streams are outlined in the table below, alongside the national and local evidence base for their inclusion in the programme;

Workstream	Evidence Base
Adult Community Care	Stepping up to the Place – NHS Confederation The Evidence Base for Integrated care – The Kings fund Delivering better services for people with long-term conditions - Building the house of care. The Kings Fund The Torbay Model – "Mrs Smith" Building bridges, breaking barriers, Care Quality Commission Making our Health & Care systems fir for an ageing population, The Kings Fund Efficiency opportunities through health & social care integration, Local Government assc Supporting integration through new roles working across boundaries, The Kings Fund Integrated care for older people with frailty – Royal College of General practitioners
Mental Health	The Five Year Forward View for Mental Health (NHS England) Bringing together physical and mental health" (March 2016), The Kings Fund No Health Without Mental Health Case Study: Sandwell Nurse Led Psychiatric Liaison
Dementia	JCPMH: Practical Mental health Commissioning - Dementia LGA Integrated Care Value Toolkit Dementia Map NICE Dementia Care Pathway – Dementia Interventions NICE Dementia Care Pathway - Diagram and Assessment NICE Dementia Care pathway - Overview
CAMHS	Future in Mind: Children and Young People's Mental Wellbeing (Department of Health/NHS England) Transforming Care Plan (The Black Country) Wolverhampton CCG CAMHS Transformation Plan What good could look like in integrated psychological services for children, young people and their families What really matters in children and young people's mental health Implementing the five year forward view for mental health

6. Reflection on 2016-17

The workstreams and projects within them were outlined in our plan for 2016/17. The table below demonstrates our progress and achievements against those projects.

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions
Adult Community Care	**The Continuing development of three locality based Integrated Health and Social Care Community**	Working with partners to develop a Wolverhampton City Strategy to deliver the vision of the BCF ACC workstream. To ensure that our planning of services takes account of the opportunities to provide truly	Reduction of A&E attendances Reduction of emergency admissions	Jointly agreed plans Supporting 7 day services Better data sharing Joint approach to care planning and

Neighbourhood Teams, wrapped around Primary Care and supported by specialist teams and Voluntary Sector	integrated care to our local population by wrapping services around our persons to deliver person centred, holistic care. To ensure we are commissioning services based on evidence of need including the complexity of conditions our population is presenting with. To continue to build good working relationships with our providers, co-producing services based on the holistic needs of the population working towards commissioning for outcomes. Providing both proactive and rapid response to our person's needs. Development of extensive Community Offer reducing demand on health and social care services and supporting citizens to become more independent	Reduce DToC Improve person experience Co-location of the H&S care teams Reduction in high cost demand by 5%	assessments Agreement on the consequential impact on providers Investing in out of hospital services Supporting plans for reducing delayed transfers of care

Achievements / Current Situation

Joint working:
The Community nursing teams and Social care colleagues now meet in each locality on a monthly basis for an integrated MDT supported by a newly developed electronic IT solution to capture individual care plans. This year has seen the introduction of mental health into the MDT and the work stream.

Admission Avoidance:
The admission avoidance team have commenced seven day working and continue to work in partnership with Primary Care, WMAS, Voluntary sector and the Local Authority reablement services avoiding admissions and conveyances to accident and emergency.

Step up beds:
The CCG has commissioned a small number of step up beds to pilot the impact on avoidable admissions. This pilot will be fully evaluated to measure the impact in terms of quality of person care and impact on emergency admissions.

Discharge to Assess (D2A):
This year has seen the introduction of a major programme of work on delayed discharges. Senior responsible officer for the programme is the Lead for Adult Social Care supported by the CCG Head of individual care. The programme has representatives from health and social care including our main acute care provider to ensure a whole system approach and the scope focuses on pathway redesign to promote and embed a 'home first' approach to hospital discharge.

The main objectives of the programme are:
- support admission avoidance where appropriate
- support timely discharge from hospital
- maintain independence wherever possible
- reduce the level of long term packages of care
- have a net neutral impact on the health and social care economy
- provide a 7 day service

Fibonacci:
This year saw the successful implementation of an electronic shared care record. This initiative supports the monthly integrated MDT's. Phase 2 will commence in May and this will bring online Mental Health and Primary Care.

Reablement:
Telecare - is offered by the City of Wolverhampton Council and supports people to live independently in their own homes by giving them a range of assistive technology, from emergency alarms and fall detectors to smoke and flood sensors. It aims to give peace of mind and reassurance 24 hours a day to people who are either living on their own or caring for someone else by providing support in crisis situations.

The Development of a Wound Care pathway	To provide a seamless 7 day service for persons who will receive treatment at the right time, in the right place by an appropriate health	New Wound Care pathway Improved person experience	Jointly agreed plans Supporting 7 day services Better data sharing

	professional		Efficiencies in reducing variance Standardisation of assessment for non-healing wounds	Agreement on the consequential impact on providers Investing in out of hospital services

Achievements / Current Situation

A multi stakeholder steering group has fully reviewed the current ambulatory wound care provision across Wolverhampton. This has included Primary Care, Community Care and domiciliary care. Some pathways within the acute hospital have also been reviewed to provide a more whole system approach. A new model of care has been developed to include a robust whole pathway approach including prevention and education that will deliver an optimal service for our population. The new model is a community based model with a clinical streaming element to ensure persons are treated by staff with appropriate capacity and capability. The model has a number of outcomes including quality of life outcomes for this person cohort.

We need to agree for community services the 7 day services e.g. weekend increase for DN to provide a 7 day service as only essential needs are met. Community Matron now 5 days how do we build this model and consider 7 day service around self-activation of PMP and support

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions
Dementia	**The development of a Dementia Hub for Wolverhampton**	The aim is to promote greater independence and choice for people with dementia, increasing their self- esteem and encouraging people to maintain good social and personal relationships. Amongst other things the hub model would host an Integrated dementia team, a Dementia Café, the Education and Awareness programme and the Dementia Pathfinders	A detailed specification for the hub and what it will provide.	Jointly agreed plans Supporting 7 day services Investing in out of hospital services Agreement on the consequential impact on providers
	Raising Awareness, information advice and guidance	The aim of this project is to ensure that all citizens and professionals have a relevant understand of dementia and can find information easily when required	Increase the number of people who are Dementia Friends Wolverhampton maintains its 'working towards being a dementia friendly community	Jointly agreed plans
	Memory Matters clinics	This is a community based 'pop up' information and advice service run by health and social care professionals (CPN/SW/CDWO) offered in a non-health and social care venue on the first Tuesday of every month across a twelve month period. The aim is to provide information and to signpost people towards support and early diagnostic services where appropriate The project received funds from The Big Lottery to co-produce information for the public. Co=production was undertaken with young people and people form BME groups	Reduced anxiety around memory concerns Family carers re more confident about supporting a relative to seek diagnosis Increasing awareness of dementia and how to support someone with dementia	Jointly agreed plans
	Dementia Care pathway	• To 'pump prime' service transformation by increasing the	Analyse of HRG data and cluster	Jointly agreed plans Better data sharing

		number of dedicated liaison and outreach dementia staff across RWT and by increasing the remit of their role to pro-actively assess and navigate the required next steps for patients with dementia or suspected dementia presenting in RWT. • To align dementia care pathways across the 'whole system' across primary, secondary and tertiary care including residential and nursing care to improve care, clinical outcomes and quality of life from diagnosis to end of life and where possible, reduce unplanned admissions to RWT and BCPFT. All of the above provide an opportunity to develop and deliver a transformational plan	data within BCPFT to identify admission causes for those with primary or secondary diagnosis dementia to inform service redesign. Dedicated PMO support will scope and describe current care pathways against best practice including NICE Guidance Reduce relapse, hospital admissions to RWT, numbers of people placed out of Wolverhampton in acute overspill and / or longer stay beds by keeping people well and responding pro-actively to periods of relapse / crisis.	Agreement on the consequential impact on providers Investing in out of hospital services	

Achievements / Current Situation

Joint Working
The group has established a strong ethos of joint working across CWC, CCG RWT BCPFT, carer services and the Dementia Action Alliance. The DAA is the local partnership board where representative form voluntary, community, and retail organisations work collaboratively to make Wolverhampton a dementia friendly community. The involvement of the DAA in the BCF programme ensures that the pathway re-design is co-produced at a number of levels.

Dementia Awareness
- BCPFT have trained all staff in dementia awareness at a level that is appropriate for the job they have
- Dementia is mandatory training at CWC
- The Dementia Action Alliance has been re-launched
- Alzheimer's Society did a dementia awareness session at the Team W event for GP's

Memory Matters
The first six sessions were centrally located and well attended but the service now moves around the city and pops up at relevant locations to rotate the sessions Dates and venue are being published on WIN Feedback to date indicates that the local people place a high value on receiving quality, informed and accurate information about concerns for their own or someone else's memory functions. The service is being formally evaluated with a view to moving from its current 'pilot' status into a permanent service

Dementia Hub
The new model and the business case are still in development. The BCF group have agreed to review the business case and undertake some research into other models of dementia hubs. The alternative models will include satellite surgeries in existing community resources. Professionals and members of the Dementia Action Alliance (DAA) are involved in developing the specification through feedback at the DAA. The dementia hub and alternative model will be included in the consultation plan and the final model will be developed following consultation in December 2017.

Dementia Care Pathway
Pathway agreed as specified in the Joint Dementia Strategy which improved access to specialist services, improved early diagnosis and more staff appropriately trained in dementia. Next steps are to develop the pathway to include all services available in each element of the pathway and to publish information in a single portal – probably utilising WIN

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions

	Mental Health	**Street Triage**	The MH Rapid Response Triage care is a dedicated "blue light" ambulance vehicle deployed under guidance of Police / AMBO control rooms. It delivers a 7 day multi-agency response (Police, Ambulance and CPN) to appropriate 999 and 111 calls across the Black Country population of 1.2million. Planning is underway to further develop the service through the inclusion of AMHP expertise Expanded as per 15/16 service redesign and in 16/17 to include focus on dementia.	Options appraisal for inclusion of AMHP into rapid response car developed.	Jointly agreed plans Support of 7 day services Better data sharing Investing in out of hospital services.		
		Hospital Discharge Pilot	Hospital Discharge pilot to include re-focus in 16/17 on Penn and RWT delays Dedicated social care mental health support to urgent care pathway to increase the number of AMHPs and provide dedicated support to Penn Hospital to reduce delayed discharges and facilitate mental health in patient flows with RWT and BCPFT.	Achievement of 7 day access to urgent health and social care services	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC.		
		Mental Health Liaison Psychiatry	Service expanded as per 15/16 service re-design and in 16/17 to include re-focus on dementia	Achievement of 7 day access to urgent health and social care services	Jointly agreed plans Support of 7 day services Better data sharing		
		Reablement and 1st Avenue	This will involve the implementation of a redesigned recovery and outreach service that includes:- Provision of a 2 bed crisis unit Integrated reablement / outreach recovery pathway An assertive outreach service Community recovery service – provides assertive outreach approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and / or relapse and readmission delivered from a range of bio-medico – psycho interventions, fully utilising NICE guidance	Operational 2 bed crisis unit in the community Operational social care assertive outreach service	Jointly agreed plans Support of 7 day services		
		Resettlement	A two tier approach that will include:- The timely identification of individual needs through health and social care assessment and case review activity The development and implementation of additional supported living (50 units over a 3 year period) The development and implementation of a single floating support service	Operational access to 26 additional supported living units Integrated reablement / outreach recovery pathway	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC.		
		Prevention	This will involve the recommissioning via a tender	Commissioned single joint	Jointly agreed plans Investing in out of		

	process of a single joint prevention service across health and social care	prevention service	hospital services
Urgent Care Pathway	Delivers Wolverhampton Crisis Concordat for adults of all ages with a focus on compassionate and practice and responsive services and interventions, including starter schemes initiated in 2015/16 described above and also including single Point of Access and crisis resolution and Home treatment fully utilising NICE guidance	Redesign, develop implementation of interoperational implementation plan across AMHS and dementia Achievement of 7 day access to urgent health and social care services.	Jointly agreed plans Support of 7 day services Better data sharing Investing in out of hospital services
Community Recovery Service	Provides Assertive outreach approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and /or relapse and readmission delivered from a range of bio-medico – psycho interventions, fully utilising NICE guidance	Redesign, develop implementation of interoperational implementation plan across AMHS and dementia	Jointly agreed plans Support of 7 day services Better data sharing Supporting plans for reducing DTOC. Investing in out of hospital services

Achievements / Current Situation

Street Triage: Discussions were held with Street Triage about the possibility of an AMHP being included into the car, however this was not considered necessary by stakeholders who believed this was an unnecessary use of resource.

Hospital Discharge Pilot: This pilot began in June 2016 and information was provided to the A&E board in February 2017 to evidence that the aims and outcomes were met. This resulted in an extension to this pilot for another 12 months. This is currently being fulfilled by an Experienced Social Worker/ AMHP who is seconded from the MH Social Work Team (Mon-Fri).

Reablement and First Avenue: Provision of 2 bed crisis unit achieved through a contract with P3. Social care 'assertive outreach' type service in place to support prevent crisis and promote independence and community inclusion for service users.

Resettlement: Social care case review completed and assessments on-going to support service users in moving to less restrictive environments, and therefore promoting independent living and community inclusion. 14 flat scheme (Woodhayes) projected to be completed in July 2017.

Prevention: Service with a prevention focus commissioned by LA called 'Starfish' and commenced April 2017. Further work is required to map and review all preventative services and to redesign, respecifiy and potentially re-procure on a city wide basis. This is reflected in our 2017/19 plan. Our mental wellbeing needs assessment has been completed and this will inform service development.

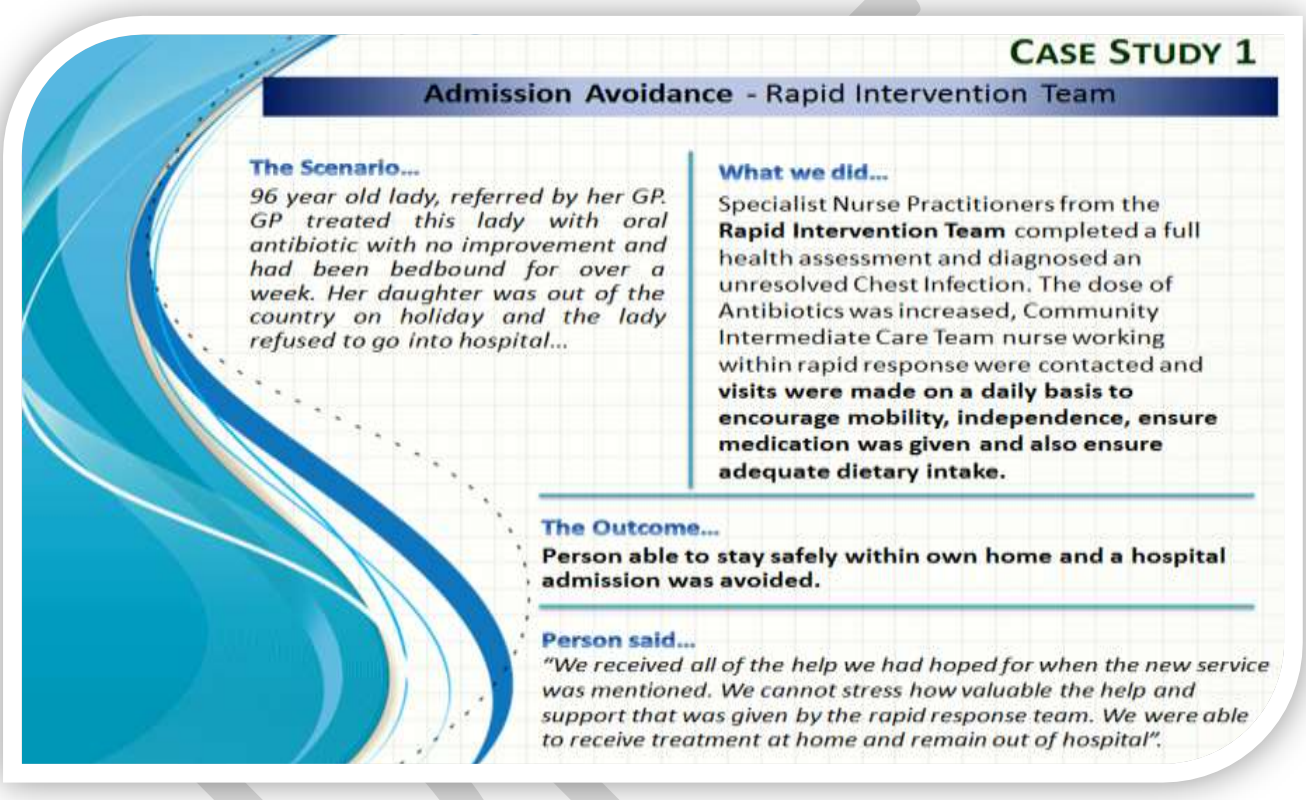
Mental health colleagues are now invited to the Community MDT that takes place in each locality when mental health input is required.

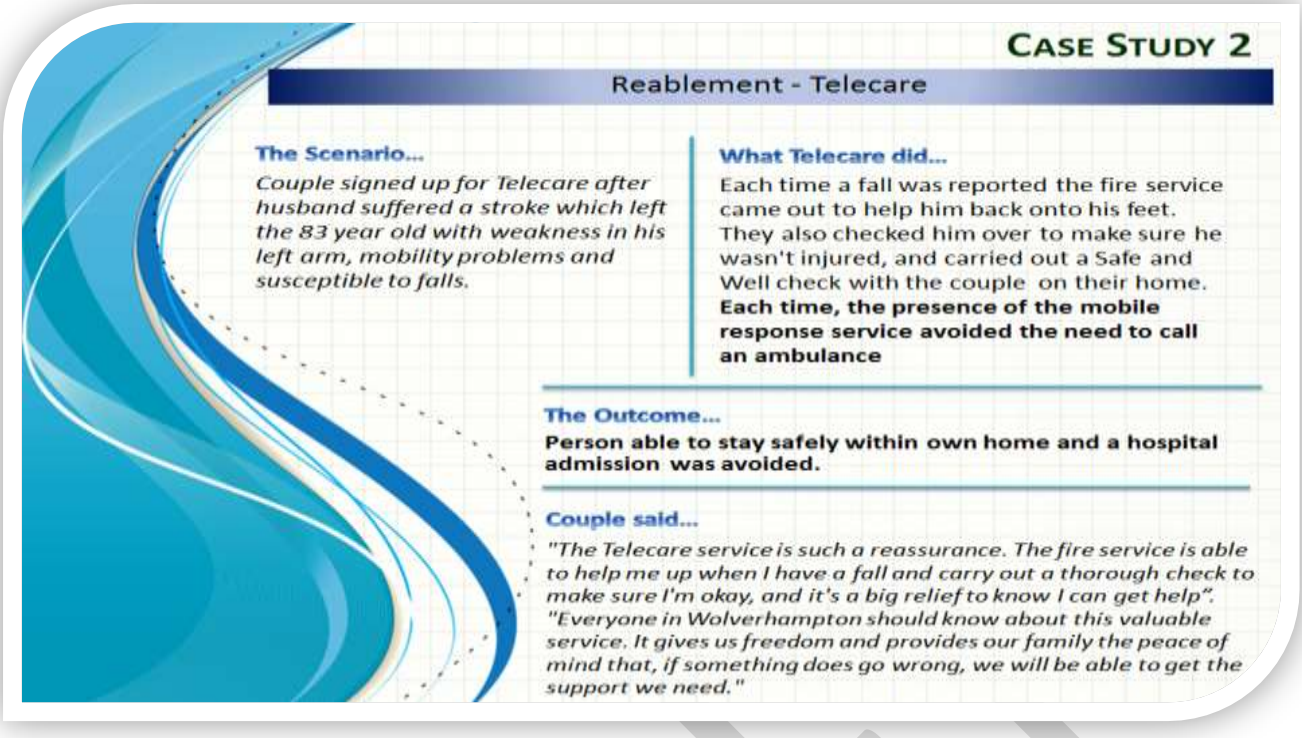
Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions

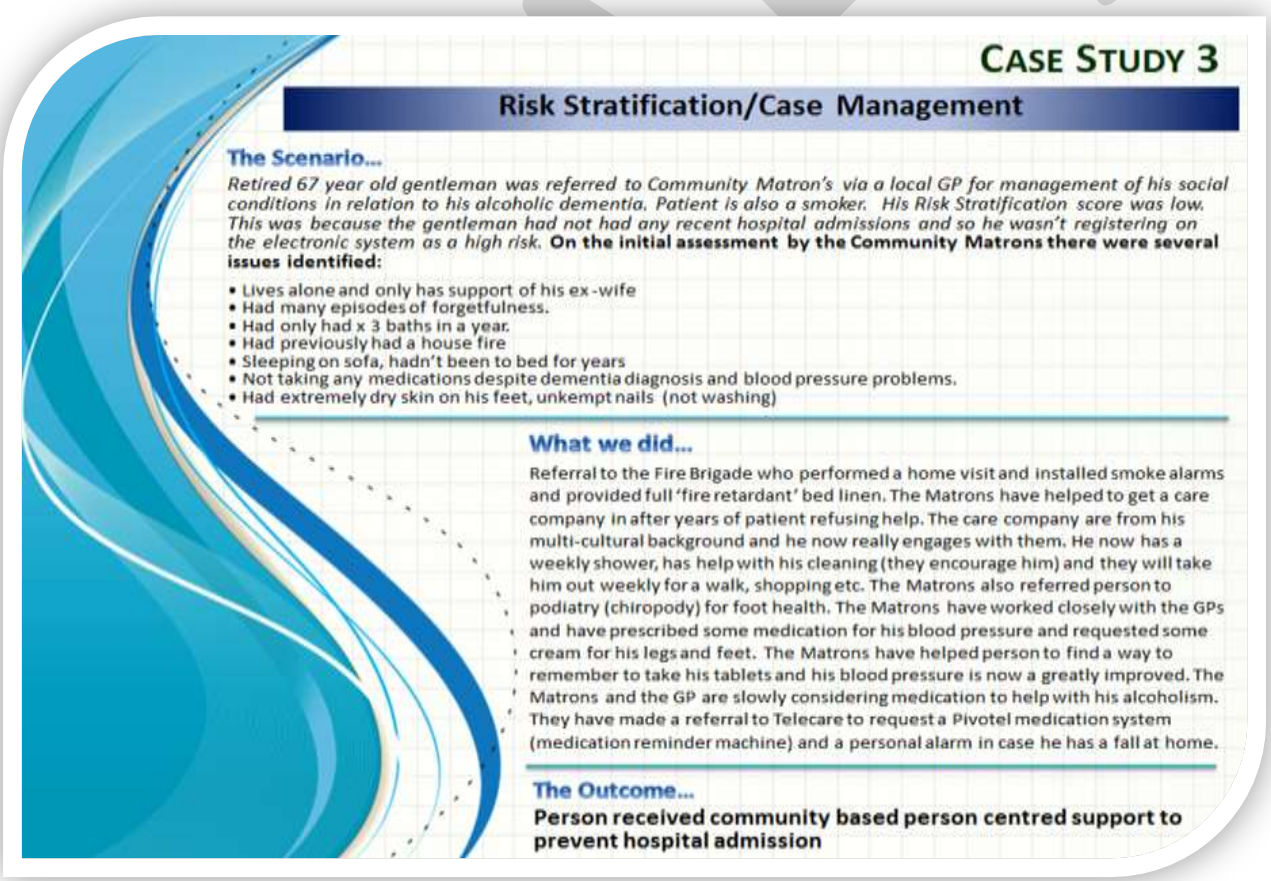
CAMHS	**Transformation of CAMHS services**	This work stream is to be included in the Programme for 16/17 in "shadow form". It will utilise the governance and joint working approach of the programme to deliver a review and transformational change of CAMHS services across Wolverhampton. The programme manager leading on this piece of work is a joint appointment between the CCG and Local Authority	An assessment and review of current CAMHS services. A transition plan of redesign of CAMHS services	Jointly agreed plans
	Achievements / Current Situation Following a review of the CAMHS services it has been identified that the main gap is the tier 2 services. Funding has been identified from WCCG and CWC to procure a service to meet these needs. These services to be managed under the BCF with a section 75 completed for a pooled budget to be agreed.			
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions**
Integration	**Estates**	To identify estates requirements for the programme as a whole and for individual projects. For example to support the co-location of Community neighbourhood teams, the moving of outpatient clinics from an acute to community setting, the development of a dementia hub and of developing dementia services in the community. To work with Estates colleagues to scope appropriate premises and to work towards the move to integrated health and social care teams	Estates specification produced Premises identified	Jointly agreed plans Supporting 7 day services Joint approach to care planning and assessments Agreement on the consequential impact on providers Investing in out of hospital services Supporting plans for reducing delayed transfers of care
	IT	To implement the Fibonacci system to enable health and social care staff to share information on a role-based access view only basis. To continue the exploration of open APIs for the economy with a long term view of developing integrated health and social care systems	Fibonacci implemented Integrated Health and Social Care record	Jointly agreed plans Better data sharing Joint approach to care planning and assessments Supporting plans for reducing delayed transfers of care
	IG	To ensure that pathways, processes and systems have robust and appropriate information sharing agreements at all stages and comply with Caldicott 2	Signed Data Sharing Agreement	Jointly agreed plans Better data sharing Joint approach to care planning and assessments Supporting plans for reducing delayed transfers of care
	HR	To ensure that in the move toward integration and the changes in person and service user pathways that change management processes are undertaken appropriately and fairly and all relevant policies and legislation is adhered to		Jointly agreed plans Supporting 7 day services Joint approach to care planning and assessments Investing in out of hospital services
	Achievements / Current Situation **Estates -** Work continues to progress in finding suitable accommodation for the co-location of Integrated Health and Social care teams and for the provision of services in the community. Whilst it has proved difficult to find suitable premises all key stakeholders are still committed to driving this forward. The Local Authority and CCG are jointly funding a Consultant to undertake a Service Strategy and Feasibility studies on potential estate across the City. This strategy will take into consideration the direction of travel in Primary Care and also work being undertaken within the STP.			

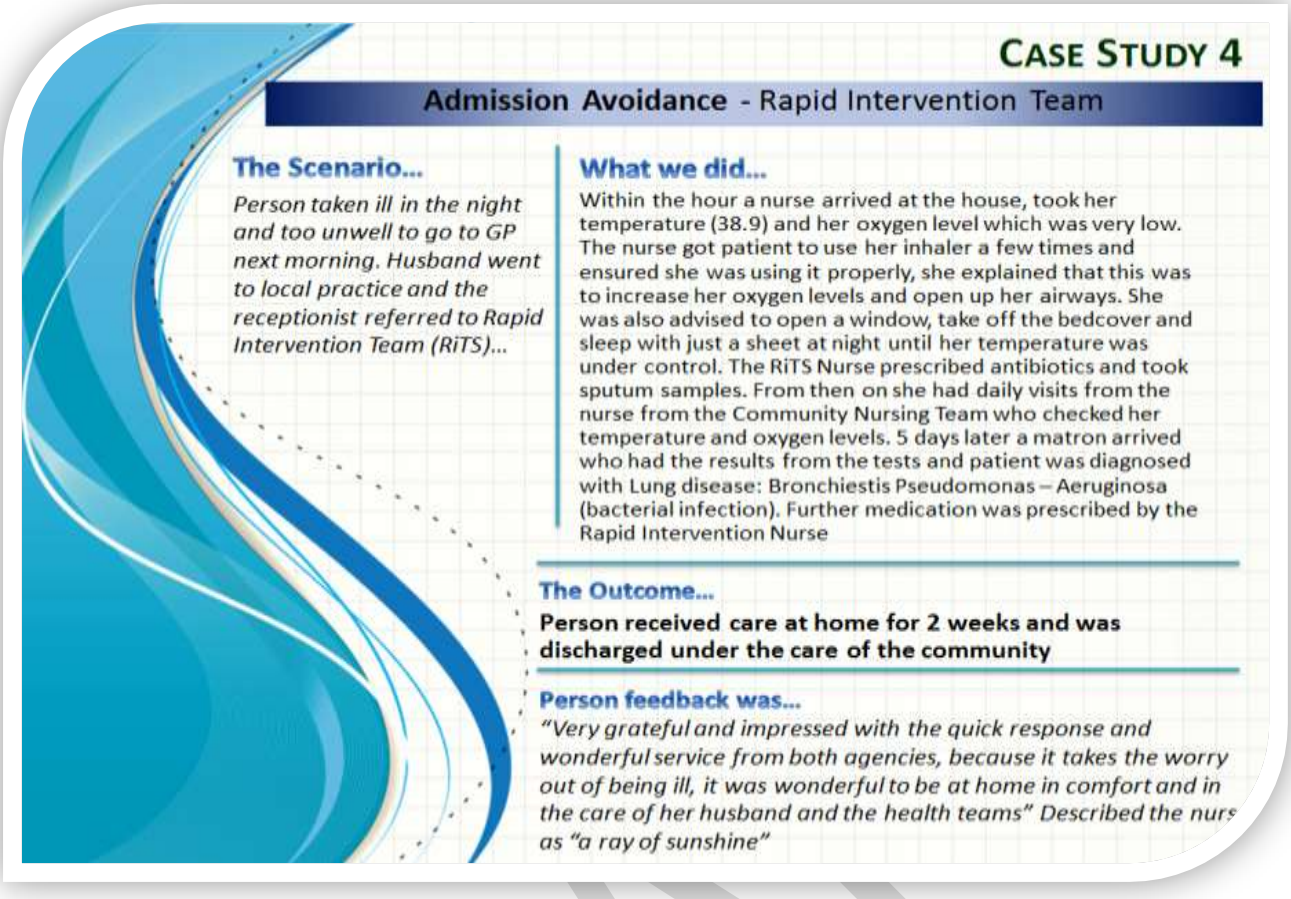
	IT – We have successfully implemented an IT system "Fibonacci" that pulls health and social care data into one view for members of the Community multi-disciplinary team. This enables front line staff to manage persons more effectively understanding all of the contacts and interventions that the person has undergone, relevant to their care management. The system is co-commissioned by CCG/LA/RWT/BCPFT. We continue, through the Local Digital Roadmap Group to explore options for an Integrated H&SC record and for systems to provide H&S care data to holistically inform our commissioning decisions. **IG –** we have a Data Sharing Agreement in place covering the functions of the BCF programme which is signed by CCG/LA/RWT/BCPFT ensuring our compliance with Caldicott 2. **HR –** HR is a standing agenda item at the Integration Workstream. This enables us to identify any HR issues that may arise in relation to the integration of teams or Co-location etc.	

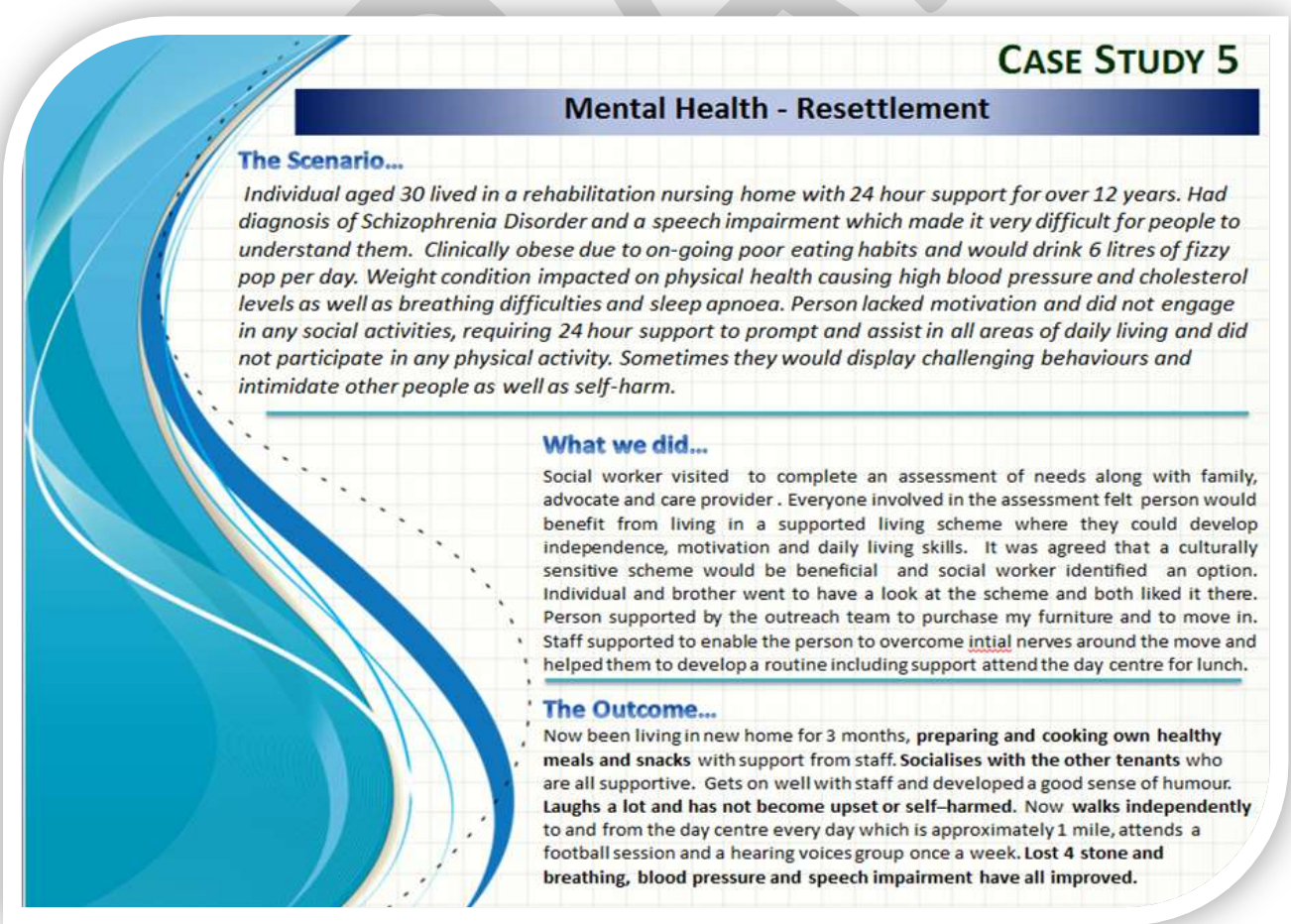
6.1 Case Studies

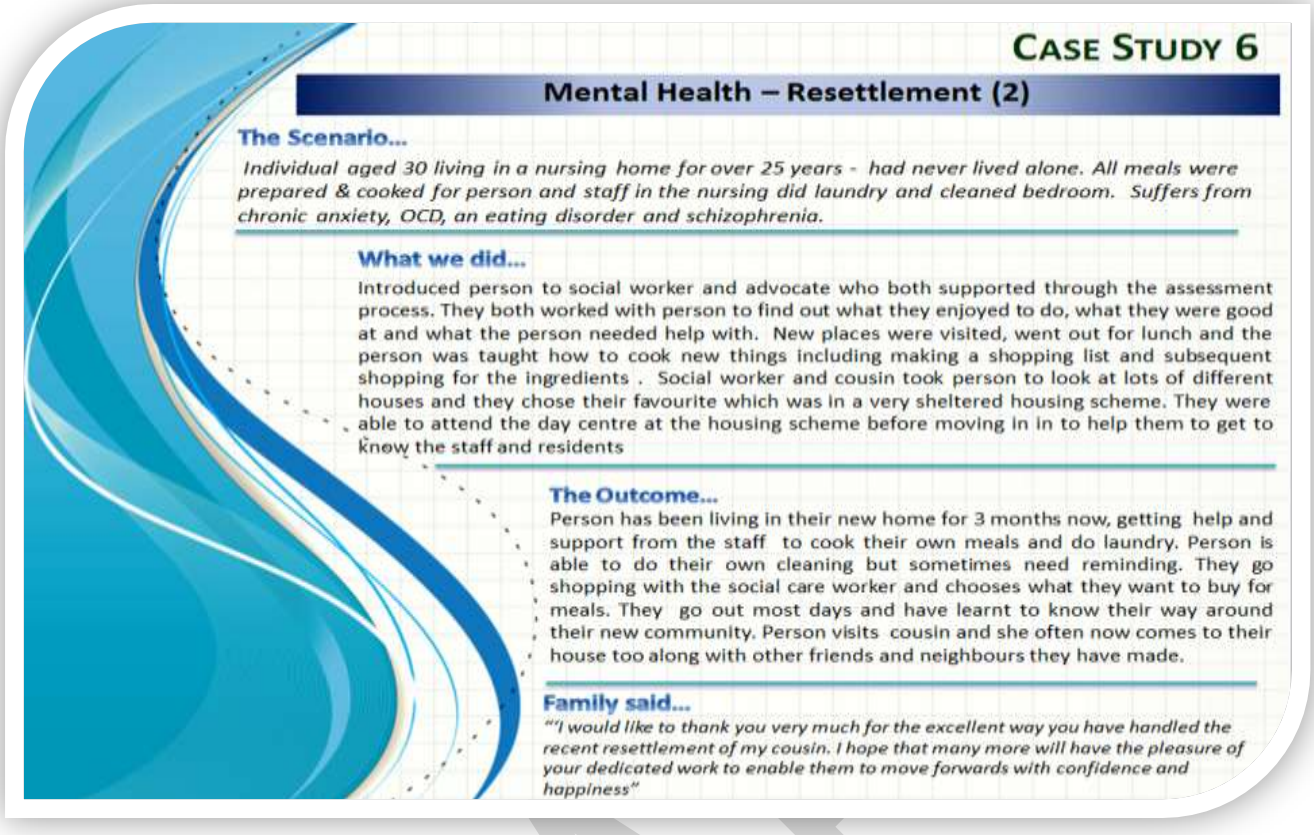


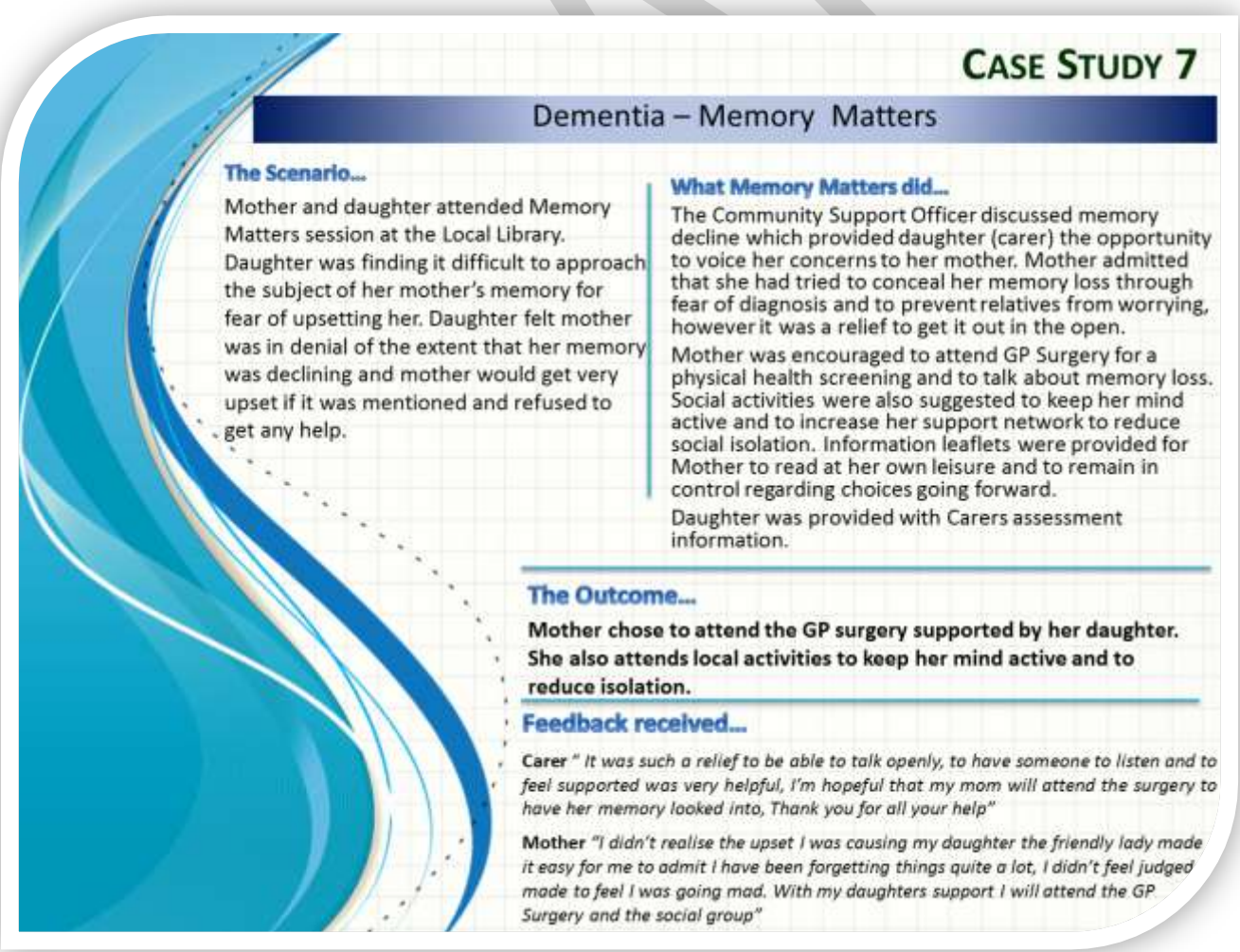

CASE STUDY 2
Reablement - Telecare
The Scenario...
Couple signed up for Telecare after husband suffered a stroke which left the 83 year old with weakness in his left arm, mobility problems and susceptible to falls.
What Telecare did...
Each time a fall was reported the fire service came out to help him back onto his feet. They also checked him over to make sure he wasn't injured, and carried out a Safe and Well check with the couple on their home. Each time, the presence of the mobile response service avoided the need to call an ambulance
The Outcome...
Person able to stay safely within own home and a hospital admission was avoided.
Couple said...
"The Telecare service is such a reassurance. The fire service is able to help me up when I have a fall and carry out a thorough check to make sure I'm okay, and it's a big relief to know I can get help". "Everyone in Wolverhampton should know about this valuable service. It gives us freedom and provides our family the peace of mind that, if something does go wrong, we will be able to get the support we need."


CASE STUDY 3
Risk Stratification/Case Management
The Scenario...
Retired 67 year old gentleman was referred to Community Matron's via a local GP for management of his social conditions in relation to his alcoholic dementia. Patient is also a smoker. His Risk Stratification score was low. This was because the gentleman had not had any recent hospital admissions and so he wasn't registering on the electronic system as a high risk. On the initial assessment by the Community Matrons there were several issues identified:
• Lives alone and only has support of his ex-wife
• Had many episodes of forgetfulness.
• Had only had x 3 baths in a year.
• Had previously had a house fire
• Sleeping on sofa, hadn't been to bed for years
• Not taking any medications despite dementia diagnosis and blood pressure problems.
• Had extremely dry skin on his feet, unkempt nails (not washing)
What we did...
Referral to the Fire Brigade who performed a home visit and installed smoke alarms and provided full 'fire retardant' bed linen. The Matrons have helped to get a care company in after years of patient refusing help. The care company are from his multi-cultural background and he now really engages with them. He now has a weekly shower, has help with his cleaning (they encourage him) and they will take him out weekly for a walk, shopping etc. The Matrons also referred person to podiatry (chiropody) for foot health. The Matrons have worked closely with the GPs and have prescribed some medication for his blood pressure and requested some cream for his legs and feet. The Matrons have helped person to find a way to remember to take his tablets and his blood pressure is now a greatly improved. The Matrons and the GP are slowly considering medication to help with his alcoholism. They have made a referral to Telecare to request a Pivotel medication system (medication reminder machine) and a personal alarm in case he has a fall at home.
The Outcome...
Person received community based person centred support to prevent hospital admission


CASE STUDY 4
Admission Avoidance - Rapid Intervention Team
The Scenario...
Person taken ill in the night and too unwell to go to GP next morning. Husband went to local practice and the receptionist referred to Rapid Intervention Team (RiTS)...
What we did...
Within the hour a nurse arrived at the house, took her temperature (38.9) and her oxygen level which was very low. The nurse got patient to use her inhaler a few times and ensured she was using it properly, she explained that this was to increase her oxygen levels and open up her airways. She was also advised to open a window, take off the bedcover and sleep with just a sheet at night until her temperature was under control. The RiTS Nurse prescribed antibiotics and took sputum samples. From then on she had daily visits from the nurse from the Community Nursing Team who checked her temperature and oxygen levels. 5 days later a matron arrived who had the results from the tests and patient was diagnosed with Lung disease: Bronchiestis Pseudomonas – Aeruginosa (bacterial infection). Further medication was prescribed by the Rapid Intervention Nurse
The Outcome...
Person received care at home for 2 weeks and was discharged under the care of the community
Person feedback was...
"Very grateful and impressed with the quick response and wonderful service from both agencies, because it takes the worry out of being ill, it was wonderful to be at home in comfort and in the care of her husband and the health teams" Described the nurs as "a ray of sunshine"


CASE STUDY 5
Mental Health - Resettlement
The Scenario...
Individual aged 30 lived in a rehabilitation nursing home with 24 hour support for over 12 years. Had diagnosis of Schizophrenia Disorder and a speech impairment which made it very difficult for people to understand them. Clinically obese due to on-going poor eating habits and would drink 6 litres of fizzy pop per day. Weight condition impacted on physical health causing high blood pressure and cholesterol levels as well as breathing difficulties and sleep apnoea. Person lacked motivation and did not engage in any social activities, requiring 24 hour support to prompt and assist in all areas of daily living and did not participate in any physical activity. Sometimes they would display challenging behaviours and intimidate other people as well as self-harm.
What we did...
Social worker visited to complete an assessment of needs along with family, advocate and care provider . Everyone involved in the assessment felt person would benefit from living in a supported living scheme where they could develop independence, motivation and daily living skills. It was agreed that a culturally sensitive scheme would be beneficial and social worker identified an option. Individual and brother went to have a look at the scheme and both liked it there. Person supported by the outreach team to purchase my furniture and to move in. Staff supported to enable the person to overcome intial nerves around the move and helped them to develop a routine including support attend the day centre for lunch.
The Outcome...
Now been living in new home for 3 months, preparing and cooking own healthy meals and snacks with support from staff. Socialises with the other tenants who are all supportive. Gets on well with staff and developed a good sense of humour. Laughs a lot and has not become upset or self–harmed. Now walks independently to and from the day centre every day which is approximately 1 mile, attends a football session and a hearing voices group once a week. Lost 4 stone and breathing, blood pressure and speech impairment have all improved.


CASE STUDY 6
Mental Health – Resettlement (2)
The Scenario...
Individual aged 30 living in a nursing home for over 25 years - had never lived alone. All meals were prepared & cooked for person and staff in the nursing did laundry and cleaned bedroom. Suffers from chronic anxiety, OCD, an eating disorder and schizophrenia.
What we did...
Introduced person to social worker and advocate who both supported through the assessment process. They both worked with person to find out what they enjoyed to do, what they were good at and what the person needed help with. New places were visited, went out for lunch and the person was taught how to cook new things including making a shopping list and subsequent shopping for the ingredients . Social worker and cousin took person to look at lots of different houses and they chose their favourite which was in a very sheltered housing scheme. They were able to attend the day centre at the housing scheme before moving in in to help them to get to know the staff and residents
The Outcome...
Person has been living in their new home for 3 months now, getting help and support from the staff to cook their own meals and do laundry. Person is able to do their own cleaning but sometimes need reminding. They go shopping with the social care worker and chooses what they want to buy for meals. They go out most days and have learnt to know their way around their new community. Person visits cousin and she often now comes to their house too along with other friends and neighbours they have made.
Family said...
"I would like to thank you very much for the excellent way you have handled the recent resettlement of my cousin. I hope that many more will have the pleasure of your dedicated work to enable them to move forwards with confidence and happiness"


CASE STUDY 7
Dementia – Memory Matters
The Scenario...
Mother and daughter attended Memory Matters session at the Local Library. Daughter was finding it difficult to approach the subject of her mother's memory for fear of upsetting her. Daughter felt mother was in denial of the extent that her memory was declining and mother would get very upset if it was mentioned and refused to get any help.
What Memory Matters did...
The Community Support Officer discussed memory decline which provided daughter (carer) the opportunity to voice her concerns to her mother. Mother admitted that she had tried to conceal her memory loss through fear of diagnosis and to prevent relatives from worrying, however it was a relief to get it out in the open.
Mother was encouraged to attend GP Surgery for a physical health screening and to talk about memory loss. Social activities were also suggested to keep her mind active and to increase her support network to reduce social isolation. Information leaflets were provided for Mother to read at her own leisure and to remain in control regarding choices going forward.
Daughter was provided with Carers assessment information.
The Outcome...
Mother chose to attend the GP surgery supported by her daughter. She also attends local activities to keep her mind active and to reduce isolation.
Feedback received...
Carer " It was such a relief to be able to talk openly, to have someone to listen and to feel supported was very helpful, I'm hopeful that my mom will attend the surgery to have her memory looked into, Thank you for all your help"
Mother "I didn't realise the upset I was causing my daughter the friendly lady made it easy for me to admit I have been forgetting things quite a lot, I didn't feel judged made to feel I was going mad. With my daughters support I will attend the GP Surgery and the social group"

7. 2017-19 Plan

Workstream	Project	Aims and Objectives	Measurable Outcomes	BCF Policy Framework National Conditions (New and Maintaining Progress)	15, 16, 11
Adult Community Care	**People living with Frailty Programme**	Review and redesign of current pathways to ensure services are meeting the needs of our aging population. A revised model of care will place a stronger focus on prevention, aging well with the delivery of proactive care aiming to keep people living independently for longer.	• Gap Analysis working with NHS Right Care to inform direction • Define scope and plan for redesign based on gap analysis and best practice • Pilot Frailty Clinic in Primary Care (developed through Primary Care Home Model aligning to the new GP contract requirements) • Delivery of Prevention services, aging well agenda and proactive care	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	
	Review and Redesign of community services programme	In depth review of current Community Based services to establish effectiveness, efficiency and improve quality. To adopt a place based approach to the delivery of community based services ensuring where possible, persons are activated and encouraged to self-manage and remain in their usual place of residence where appropriate. Undertake a scoping exercise to identify acute based services that could safely be delivered within a community setting to achieve care closer to home Co-production of detailed plan and the development of a robust business case based on opportunities identified	• Full review of current services with recommendations and or options for redesign and or improvement • Implement new model of Ambulatory Wound care across the city • Analysis of acute based services that could potentially transfer • Options Appraisal and Business Case • Plan for implementation • Governance documents – Quality impact assessment, equality impact assessment, privacy impact assessment		
	Discharge to Assess Programme	This important programme of work is underway and working at pace to redesign pathways out of hospital to ensure a 'home first' culture is adopted and embedded when discharging persons from acute care. Workstreams have been identified, with named leads and project plans developed.	• Pilot and roll out across agencies of trusted assessor model • Pilot and roll out of D2A Hub • Redesign/Commission/ Procure new services to facilitate new pathways • Reduction in DTOC monitored and delivered		11
	Admission Avoidance Programme	Review and development of established Admission Avoidance capability to identify opportunities to improve current performance and further promote services to partners and stakeholders.	• Fully implement 7 day working across admission avoidance teams • Continue to work in partnership with Primary Care and other		

			Undertake modelling with Primary Care to ensure alignment with new models of care emerging across the City	professionals delivering proactive care to persons identified through risk stratification • Embed and further develop MDT across localities utilising electronic shared care record • Develop plan for further partnership working with West Midlands Ambulance Service (WMAS) • Evaluate Step up bed pilot and seek approval to roll out. • Development of robust business case for step up beds based on outcome of evaluation • Further roll out of redesigned CICT service			
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)			
Dementia	**Refresh of the Joint Dementia Strategy**	Clear direction of travel. Vision for dementia services in Wolverhampton	Dementia strategy signed by all key stakeholders with implementation plan – integrated approach (including an Integrated Care Pathway) involving Primary Care, Mental Health and Acute and Community Services A stakeholder mapping event with CCG, RWHT and social care professionals took place in April. A revised model with commissioning intentions is being developed. The revised model will be consulted on and take to health scrutiny – consultation to be completed by Dec 17.	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans			
	Establishment of permanent Memory Matters service	The service has been extended and is now a roaming clinic to ensure the service is reaching a wider audience Public health are completing an evaluation to support the establishment of permanent service.	Permanent service established, dementia awareness increased, increase in early diagnosis of people with dementia. Outreach Dementia Tool development to continue				
	Explore the potential Re-commissioning of Dementia Cafes	The aim of this project is to establish a well-functioning dementia café service that supports people with dementia and their family	Review of current service to be completed in June 17, this will include focus groups New specification developed by August 17 Tender timeline to				

				commence in September with a new provider in place for April 1st 18			
		Dementia Awareness Training	To develop a city wide multi agency training and awareness plan to increase awareness of dementia and support Wolverhampton becoming a dementia friendly community where all staff have appropriate dementia awareness training	Training Plan agreed by all key stakeholders with implementation plan			
		Dementia Hub to remain within the scope of work stream	Clear Vision and model for Dementia Hub is developed, consulted on and agreed	Service Specification signed by all key stakeholders with implementation plan			
		Dementia – Mental Health Liaison to become part of Core 24	As per CCG Operational Plan / NHS E Planning Guidance collaborative model across Acute and Mental Health Trust (pilot currently in place – focus on reduced non-elective admissions, greater support to nursing / residential care and reductions in hospital lengths of stay)	Service Specification signed by all key stakeholders with implementation plan			
		Day Care Opportunities	As per CCG / BCPFT SDIP and Operational Plan / NHS E Planning focus on NICE Evidence based care pathways for patients clusters 18-21 and also a focus on reduced non-elective admissions, greater support to nursing / residential care and reductions in hospital lengths of stay	Service Specification signed by all key stakeholders with implementation plan A review of Blakenhall has commenced.			
	Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)		
	Mental Health	**Review of Preventative Services**	Identify and develop joint commissioning/integration opportunities that exist that may prevent escalation into more complex/acute services	• Cohort analysis • Map of current as is preventative services in Wolverhampton (including community and voluntary sector) • Gap Analysis • Produce business case for joint commissioning Intentions • Awareness of available services and how to access them	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes		
		Mapping of Current Services and Pathways	To map out all current pathways and services for Mental Health in Wolverhampton	• Cohort analysis • Map of current as is Pathways in Wolverhampton • Gap Analysis • Produce business case for joint commissioning Intentions/Options for new Pathways if appropriate • Awareness of available services and how to access them			
		Review and	To review current Discharge	• Review / evaluation of			

		Development of Discharge Planning and Pathways	policies / pathways and to produce an agreed Discharge pathway for patients with mental health needs	current discharge policies to include review of assessment and discharge planning under care planning approach (CPA) • Policy (Section 117) agreed and Procedure developed and signed off • Toolkit and Pathway developed and implemented • Alignment with the D2A Project • Evaluate Penn Hospital Discharge Pilot • KPIs developed	on the providers that are predicted to be substantially affected by the plans		
		Develop New Model of Integrated Mental Health Services/Offer in Wolverhampton	To identify and co-design opportunities for greater integration across partners	• Workshop to develop ideas and document what good integration would look like and benefits • Options appraisal and business case • Implementation Plan			
		Co-existing Mental Health, Alcohol and Substance Misuse	Development of a project to identify and manage high service users of Acute hospital services, a significant number of which have dependencies upon alcohol and substance misuse.	• Data Sharing Agreement finalised and approved • Project developed / Business case development • Implementation plan			
		Urgent Mental Health Care Pathway	Refresh CRISIS CONCORDAT. Continued focus on reduction of non-elective admissions to RWT for high volume service users.	• Review current Concordat • Refresh as appropriate			
		Mental Health Assertive Outreach Service	Review the requirement /gaps for a MH Assertive outreach service	• Gaps in service identified. • Options paper for Mental Health Assertive Outreach Service produced			
	Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)		
	CAMHS	**Transformation of CAMHS Service**	Following a review of the CAMHS services it has been identified that the main gap is the tier 2 services. Funding has been identified from WCCG and CWC to procure a service to meet these needs. These services to be managed under the BCF with a section 75 completed for a pooled budget to be agreed.	Procurement of a suitable tier 2 service which reduces the number of referrals being sent through to specialist CAMHS. • **Emotional Health & Wellbeing** project scoping, gap analysis, service specification and procurement • **Workforce Development** project scoping, gap analysis, skill mix audit, training and implementation plan • **CAMHS pathways**	**Plans jointly agreed**		

			project scoping, insight/research, gap analysis, stakeholder engagement and development of project plan • **System sustainability** resource mapping/report, implementation plan and schools provision framework		
Workstream	**Project**	**Aims and Objectives**	**Measurable Outcomes**	**BCF Policy Framework National Conditions (New** and Maintaining Progress)	
Integration	**Estates**	Identify and commission premises for integrated health and social care teams (Community Neighbourhood Teams) in the short term to allow more effective integrated working. 3 locality based teams Develop a service strategy to determine which services will be delivered in the community in which areas. This will influence the estates requirements Identify and undertake feasibility studies for premises for Community Neighbourhood hubs based on the needs identified in the Service Strategy. Identify Funding and commission Community Neighbourhood Hubs	Teams co-located in each of the 3 localities Wolverhampton wide Service Strategy produced Locations/premises identified Feasibility Studies produced Hubs operational	**Plans to be jointly agreed, Agreement to invest in NHS commissioned out of hospital services which may include 7 day services and adult social care, Managing Transfers of Care,** Supporting 7-day services, Better data sharing between health and social care, based on NHS number, Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional, Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	
	IT	Expand use of Fibonacci to Mental Health data and explore option of including Primary Care data Identification of a system to enable Integrated Health and Social Care record Agreement on a common system/s to provide secondary data to inform commissioning decisions	Mental Health data available in the system. Primary Care data available in the system System identified System/s commissioned		
	IG	Ensure the Data sharing Agreement is fit for purpose during the evolvement of the BCF Programme	Regular reviews and updates to DSA are undertaken		
	Communications and Engagement	Co-production events, jointly presented LA and CCG to work with public, persons and carers Development of a Communication and Engagement Plan for 2017-19 Internet/Intranet, Newsletters, GP Briefings updated regularly	Events planned and undertaken Revised Communication and Engagement plan in place Regular Updates		
	Developing joint	Develop a plan to further	Options appraisal		

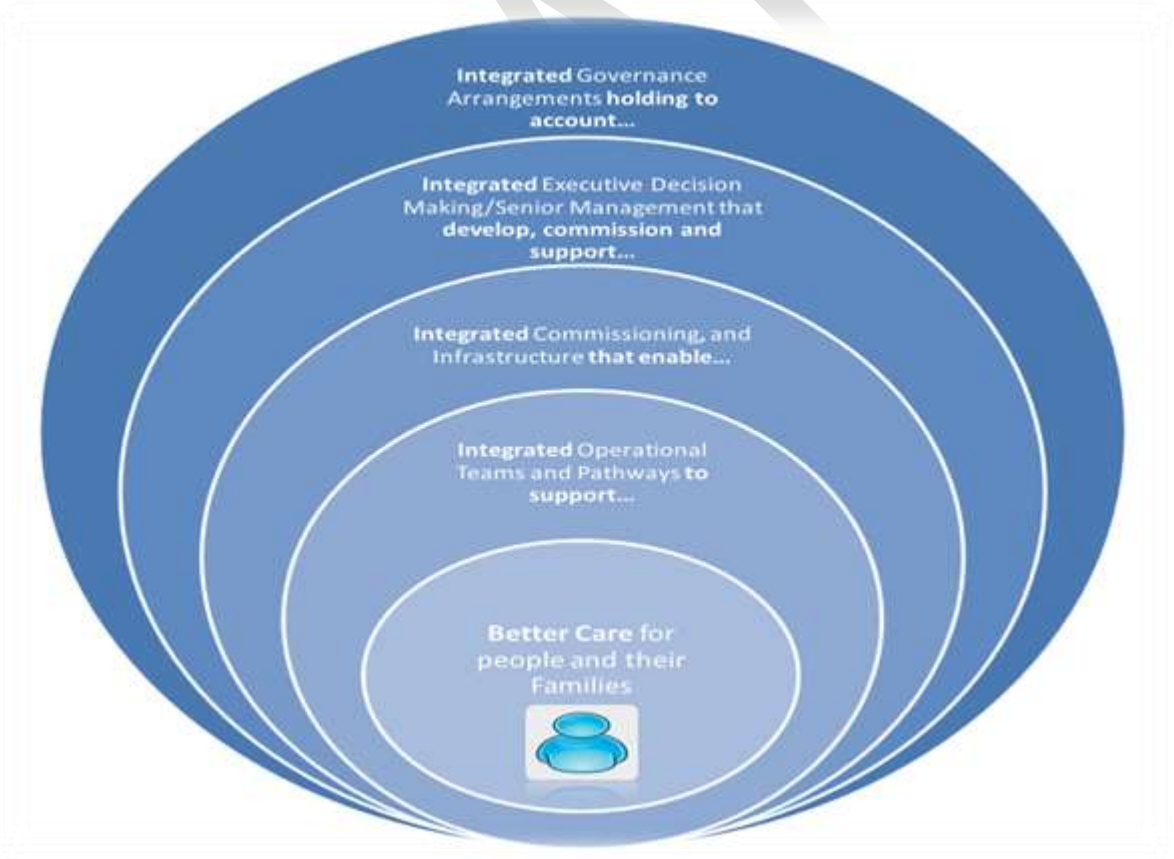
	commissioning	integrate staff across health and social care, either virtually or co located.	produced for collaborative commissioning/joint commissioning posts in the future		
	HR	As the programme moves towards further integration and co-location of health and social care staff, and the moving of clinics from and acute setting into the community, ensure that HR issues are identified and addressed in a timely manner	HR involvement in Integration and Co-location plans		

8. Integration

8.1 Our Vision and Model for Integration

- Wolverhampton's model of integration is based on the principle where individuals and organisations in the city work together, creating joined up care around individuals and their family's needs. This model of working is underpinned by the development of strong partnership governance arrangements that holds executive management across our organisational boundaries to account, as well as the continual building of integrated functions such as data sharing, information technology (e.g. Fibonacci), commissioning and the genuine co-design of new pathways and services. A summary of this model is included in *Figure 15* below

Figure 15 – Wolverhampton's Summary Model of Integration



- This model is being brought to life across health and care in Wolverhampton and some specific examples follow:-

8.2 Integrated Governance Arrangements

8.2.1 Section 75

- The Better Care Fund has been established by the Government to provide funds to local areas

to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

- Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.
- The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will be able to pool funds and align budgets as agreed between the Partners.

8.2.2 Integrated Programme Structure

- The Better Care Fund Programme Structure demonstrates an integrated programme structure both in the PMO *(see figure 12, p20)* and in the Workstream structure. Each Workstream within the programme has a lead nominated form CCG, CWC and Provider organisation. These leads work together, to deliver the objectives of the work stream, redesigning pathways and in an integrated way. One example of a new integrated pathway co-designed by the Adult Community Care Workstream can be demonstrated in *Figure 14, p28.*
- Each workstream meets on a fortnightly basis and consists of members from the three key organisations (CCG, CWC, Provider) and other key stakeholders. *See Appendix 10* for an example of a Terms of Reference.

8.3 Integrated Executive Decision Making and Senior Management

8.3.1 Wolverhampton Transition Board

- Recognising the continued pace of change across the local health and social care economy, Wolverhampton CCG, The Royal Wolverhampton Trust, Black Country Partnership NHS Foundation Trust and the City of Wolverhampton Council have established a Transition Board. The Transition Board is made up of Executive leaders from across each organisation and acts as a joint forum to support system transformation across Wolverhampton to ensure that it delivers better health outcomes for residents across the city. Their vision statement is: '*To promote health and wellbeing for the Wolverhampton community, enabling them to live longer and healthier lives.'*
- The Transition Board will be responsible for setting the strategic direction for system transformation across the City and for making recommendations to the constituent organisations about actions to be taken to ensure transformation work helps to achieve the overall vision in the City's Joint Health and Wellbeing Strategy, Ensuring good health and a longer life for all in Wolverhampton.
- The board is working towards the following principles:-
    - Ensure the health and care needs of the people of Wolverhampton are at the heart of everything we do
    - See the whole person, recognising and respecting their life experience and views
    - Support people to receive care closer to home, improving the system so that hospital is the last resort
    - Be open and honest with the community and each other, about what we can achieve and what we cannot, and ensure we deliver what we promise
    - Work together locally and nationally, removing barriers to make people's use of services

simpler and a more positive experience
- Make Wolverhampton a great place to work in and maintain a quality sustainable workforce, fit for the future

8.3.2 Senior Responsible Officers (SROs)

- Each work stream within the programme is allocated an SRO as lead for the workstream. The SRO provides strategic direction and guidance for the work stream and reports highlights, risks and escalations to the Programme Board for their workstream. SROs are Executive level within their organisations and as such have the authority to make decisions and unblock issues at the most senior level.

8.4 Integrated Commissioning and Infrastructure

8.4.1 Joint Quality Assurance of Care Homes – Quality Nurse Advisor Team

- The Joint Quality assurance of care homes is undertaken by the Quality Nurse Advisors (CCG) and the Quality Assurance and Compliance Officers (CWC). **This integrated way of working aims to provide assurance that the care delivered in Care Homes is safe, high quality, effective and responsive to the needs of the individual.** The Quality Nurse Advisors assess care delivery by carrying out quality monitoring visits and analysing data received from care homes on the national safety thermometer and the monthly quality indicator submissions and involvement in conducting pressure ulcer root cause analysis investigations and supporting homes with implementing quality improvements and training. Information sharing is fundamental to promoting harm free care and best practice in Care Homes, and there are close working relationships with Regulatory Bodies, Partner Organisations and Statutory Agencies with the aim to reduce unnecessary hospital admissions by preventing avoidable serious incidents and enabling effective management of chronic conditions. **The integrated work programme includes:-**

Objective	Benefits/Outcomes
Revision of quality assurance visit tool for care homes	Collaboratively standardise the approach to quality assurance and compliance and develop a suite of reporting documents/best practice tools
Development of an on-line self-assessment tool for care homes and providers	Collaboratively standardise the approach to quality assurance and compliance and develop a suite of reporting documents/best practice tools
Development of a Risk Matrix for care homes	Standardise approach to quality assurance &compliance
Joint quality and sustained improvement visits	Standardise approach to quality assurance & compliance Universal approach to Quality Assurance and Compliance processes for the provider/care home and good customer experience for the service user/patient
Provide Health and Social Care support to facilitate management of failing Providers under LA Large-Scale Strategy	Collaborative approach to managing failing providers
3 Yearly Care Home/Domiciliary Registered Care Managers Development Events	Collaborative approach to developing care home managers Build good intelligence and rapport with Providers/care Homes Deliver three - six workshops in 2017/18 to improve quality of care
Provide health advice and investigations to MASH (Multiagency Adult Safeguarding Hub)	Collaborative approach to adult safeguarding providing daily clinical expert advice.
Co-chair CQC information sharing	Collaborative approach to adult safeguarding
Joint working for Pressure injury and falls prevention	Citywide approach to prevention of major harms The aim of the Scaling Up Improvement project is to introduce a tool that improves the prevention &

	management of pressure injuries and skin related conditions.

8.4.2 Communication, Engagement and Marketing

- Within the BCF Programme there is a dedicated Communications and Engagement lead that represents the four key partner organisations. Wolverhampton CCG's Communications, Engagement and Marketing team undertakes this role and regularly works with both commissioning and provider communications teams on a variety of both long and short term projects.
- Communication leads from Wolverhampton CCG, City of Wolverhampton Council, The Royal Wolverhampton NHS Trust and Black Country Partnership NHS Foundation Trust meet face to face at 6-8 week intervals, with a standing agenda item of Better Care Wolverhampton. As the agenda includes other areas such as STP, safeguarding, and city wide campaigns there is assurance that the communication around BCF is aligned with other Wolverhampton priorities.
- Both telephone and email contact is regular between these meetings and covers any joint press releases, such as the launch of the Fibonacci software. See link below for example of our integrated approach to press releases:-

  https://wolverhamptonccg.nhs.uk/news/320-wolverhampton-patients-benefit-from-pioneering-technology
- Not just targeting the general public and persons, all leads for communications share communications for use within existing internal channels and membership groups, to share information about integrated working and innovation within both their own organisations and those that they work closely with. Working jointly through sharing of local knowledge allows us greater flexibility within our limited resources.

8.4.3 Estates

- Estates are managed within the BCF via the Integration work stream which also includes Finance, Performance and IT. There are existing forums with their own terms of reference where collaborative estates strategic (Local Estates Forum (LEF)) and operational (CCG Capital Review Group (CRG)) work is carried out. There is representation from the Local Authority, the CCG, RWT and BCPFT at the LEF, supported by Community Health Partnerships (CHP) who also support the One Public Estate (OPE) work streams. At the CRG the lead is taken from the LEF and operational plans are discussed and actioned by operational managers from all organisations, including the BCF Programme leads.

8.4.4 Integrated Commissioning

- With the support of the BCF and the pooled budget we aim to jointly commission services where we can jointly influence service provision and make efficiencies both financially and in relation to service improvement and user experience. Examples of these are:-

  #### Community Equipment Service

  - The CWC and the CCG are commissioning an **integrated community equipment service** to meet health and social care needs across the City. One of the key strategic objectives is that care is delivered closer to home and that services are designed and commissioned in recognition of people's desire to remain at home.
  - The overarching intention is to help all people maintain as much control over their lives as possible and to promote their independence, health and wellbeing. Equipment can make a

fundamental contribution to this agenda and can bring significant benefits to both social care and health partners, by:

- Enabling all people to live in the community for longer
- Reducing the need for and the level of domiciliary care packages
- Reducing care home and avoidable hospital admissions
- Facilitating early discharge from acute care
- Reducing the amount of time people, including children and young people spend avoidably in hospital through better and more integrated care in the community
- Supporting persons approaching end of life to die in their preferred place of death

CAMHS

- The transformation of the emotional mental health and wellbeing service system involved the establishment of the CAMHS Transformation Partnership Board (CTPB). A place based care model has been co-designed with partners, and aligns with the establishment of Strengthening Family Hubs and HeadStart satellite sites. These co-located, multidisciplinary teams will be able to deliver care closer to home, as well as devise specific proactive interventions targeted to meet the needs of the neighbourhoods in which they work.
- The budgets for children and young people's Emotional Mental Health and Wellbeing service were managed in shadow form by the Better Care Programme Board during 2016/17. Some of the Mental health services for children and young people which are funded both by Wolverhampton CCG and City of Wolverhampton Council are proposed to be governed through joint arrangements with Wolverhampton Clinical Commissioning Group (WCCG) and City of Wolverhampton Council (CWC), and in a similar manner to adult mental health services. This will result in a joint approach to commissioning, contract management, and activity monitoring for this service. Further, by joining budgets for services that are funded by both CWC and WCCG, Emotional Mental Health and Wellbeing services can be more effectively aligned.

8.4.5 Local Digital Roadmap

- **The Wolverhampton Local digital roadmap was developed via a cooperative process between Health and Social Care organisations** that provide services within Wolverhampton. This plan is now incorporated within the Black Country Local Digital Roadmap. The key areas of development within Wolverhampton are:
- **Sharing information across sectors of care**: The development of a shared care record across the whole Health and Social Care economy, which will include primary, secondary, community, acute, mental health and Social Care. The CCG are deploying EMIS Remote consultation and mobile access to Clinical systems, enabling GP practices to utilise mobile working and access to patient records across primary care.
- **Empowerment:** The rollout of patient online services, allowing patients to access their own records, book appointments, view test results, letters and order repeat prescriptions. The expansion of e-referrals to social care and inclusion of child protection information within unscheduled care settings.

8.4.6 Joint Approach to Provider Failure

- There is a diverse market for care and support services in Wolverhampton including public, private and voluntary sector organisations. As in any market, some providers leave whilst new providers come in. Providers may leave the market for a number of reasons; examples include a provider selling on its property for residential use or a provider's business being taken over by a competitor. Most exits from the market are handled responsibly by providers who ensure that those receiving care services continue to do so in line with contractual obligations. This process is

normally managed in an orderly way that does not cause disruption of services for the people receiving care. Occasionally, when care providers do exit the market in a way that adversely impacts on their ability to manage the closure of the service in a planned way, the agreed Provider Failure Policy is initiated. These procedures give clear guidelines on how any failures can be mitigated and managed to minimise the risk to people who use our services. In all circumstances a coordinated response between the Local Authority, Wolverhampton CCG, and the care provider will be required. The CCG are a key stakeholder, their critical role is to work as part of the strategy group, review any clients who are funded by the CCG, take any relevant actions and respond within the timescales agreed by the strategy group. The CCG are also invaluable partners when assessing risk to residents and advising on clinical responses to these risks. **A close collaborative relationship between the LA and CCG supports effective management of provider failure and supports a holistic approach to supporting the residents affected.**

8.5 Integrated Operational Teams and Pathways

8.5.1 Mental Health

- **Adult Mental Health are considering options for progressing an integrated service** as part of the Better Care fund recommendations for improved service delivery.
- **Street Triage** – The mental health street triage care is a service jointly provided by CWC, BCPFT, WMAS and West Midlands Police. The service aims to ensure people with mental health issues are kept out of police custody and receive the right treatment and care. The service is mental health nurses and paramedics accompanying police officers where it is believed people need immediate mental health support.
- **Physchiatric Liaison** – Integration in as much as the team (? Who are they?) are embedded within ED at RWT

8.5.2 Integrated Health and Social Care Team

- The team operates an integrated set of functions across health and social care, incorporating patient flow, social work and community care assessment with administrative and management support wrapped around. They operate in a collaborative way that promotes communication and maximises the opportunity for effective discharge planning with appropriate outcomes using the following philosophy:-
  - To provide support and advice across the range of specialties within the Acute Trust and Step Down facilities.
  - Ensure that the patient/family receive the appropriate outcomes, providing information and support on services that they can access and promote choice and inclusion in their planning for discharge.
  - Provide additional, expert support as Health and Social Care Practitioners, interfacing between agencies to ensure that client receives the right support at the right time and in the right place.
  - To begin planning for discharge as early as possible to identify complex issues and ensure effective discharge arrangements in line with the medical plan for discharge including starting from pre-admission clinics.

8.5.3 Multi-Disciplinary Teams

- There are three locality based multi-disciplinary teams across Wolverhampton. They include Community Matrons, District nursing, social workers and therapists. Specialist teams such as heart failure nurses, palliative care consultants, community mental health teams, Home

Improvement team or the patients GP are opted onto the MDT to discuss specific patients. The MDT is supported by a consultant geriatrician and the purpose of the meetings is to manage patients with complex needs in the community by care co-ordination and joint care planning.

9. Alignment with Sustainability and Transformation Plan (STP)

13

- We are fully aware of the interdependencies between BCF and the STP. Links across both programmes of work are maintained from SRO, Programme Management and Workstream lead level. In Wolverhampton, wherever possible we utilise the BCF Programme Structure as the vehicle for the Place Based STP delivery. For example the review of Community Services and determining of services to be delivered in primary and community care is managed though the BCF Adult Community Care workstream. This then informs the development of the Wolverhampton STP place based model. Our work stream lead for Mental Health is also the STP mental health lead for the Black Country and therefore the two programmes of work are aligned with any duplication or contradiction identified at the earliest stage. The current Black Country Sustainability and Transformation Plan, is included in *Appendix 10*.

10. National Conditions

10.1 National Condition 1 – Plans to be Jointly Agreed

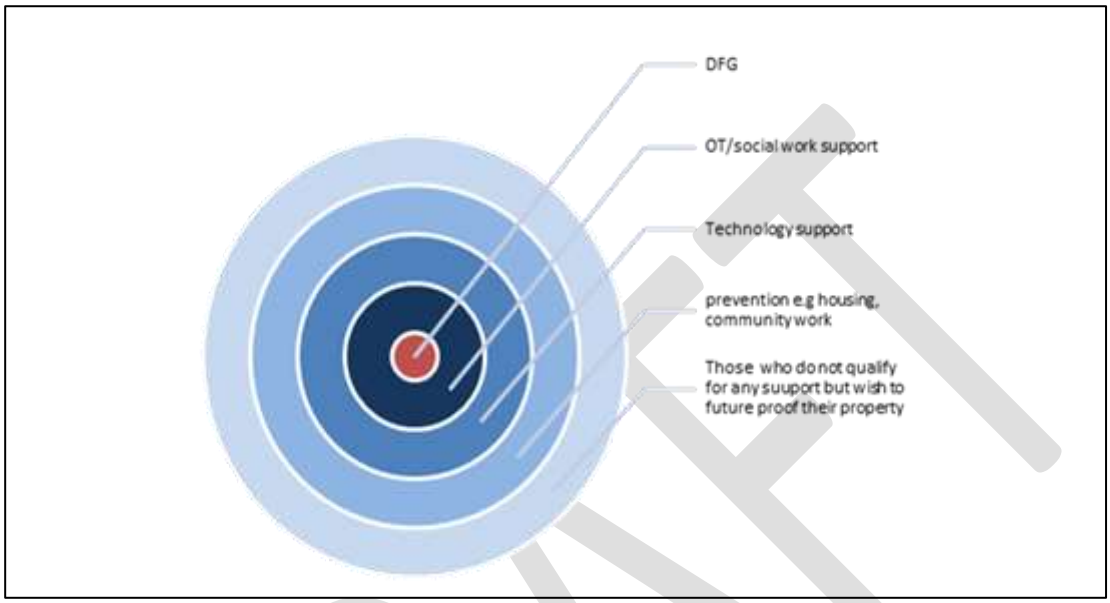
2

- Wolverhampton local health & social care economy is wholly committed to improving the health and wellbeing of its people. The principle of co-production is fully supported by the BCF partner organisations and is embedded in the overall governance structure of the programme. In 2016-17 partners agreed a set of principles about what the content of the pooled fund / BCF Programme should support and this agreement continues through to the 2017-19 plans. The principles are:-
    - Co-production
    - Better Health Outcomes
    - Improved Well- Being
    - Promoting Independence
    - Identifying and utilising inter-dependencies between organisations
    - Moving intervention downstream
    - Targeted interventions by integrated teams
    - Working with Voluntary Sector
    - Care Closer to home

2 & 3

- The DFG budget sits within the housing capital programme for CWC (which is a single tier authority) and is included in the Pooled Fund **(See Section 4.6, p23).** The plan for spending the DFG monies is currently as per mandatory requirements and the existing discretionary policies (these support fast track installation of ramps and stair lifts).
- Equipment and adaptations are a key enabler to maintaining independence and CWC will work in partnership with stakeholders to consider future actions required in delivering DFG's and adaptations. Colleagues from CW have been invited onto the BCF workstreams where appropriate and discussions are on-going around the shaping of further housing contribution to the current and future BCF plans including the potential for the co-design of a new DFG pathway. *Figure 16* below represents the current high level model for housing support in Wolverhampton through from prevention to the greatest of need (the DFG). BCF plans to explore opportunities that may exists across all of the tiers to enhance current and future plans

Figure 16 – CWC Model for Housing Support



- There is currently no official submission deadline for the 2017/19 plan but colleagues across partners are working proactively in line with the Policy Framework and latest Regional advice to produce a plan that will be a solid foundation upon which to amend quickly once official guidance is available.
- To mitigate against this 'delegated authority sign off' has been agreed by the CCG Governing Body on 11th April 17. The plan will then need to be presented to LA Senior Executive Board (SEB) on xxx for internal approval and will be presented to the Chair of the Health and Wellbeing Board *** and cabinet lead for Adult services on xxx, and the cabinet lead for children and young people on xx. Arrangements for formal acceptance and agreement of the BCF plan and content of the pooled budget are as follows:-
  - CCG Governing Body May 2017.
  - Health and Well Being Board 28th June 2017. Delegated Authority (Cllr Lawrence, Chair of Health and Well Being Board) for sign off prior to submission.

10.1.1 Involvement of stakeholders

- Through the CCG Clinical Reference Group, the plan has had oversight and input from Primary Care Colleagues. The Plan has also been shared with A&E Delivery Board, Health watch and Wolverhampton Voluntary Sector Council. Routine, regular, focused BCF meetings with the chair of the H&WB Board, other key elected members of the local council and the CCG Governing Body (made up of member elected GPs from each of the localities) have taken place throughout the duration of the programme and each body continues to approve and sign off planning at each stage of the implementation process.
- In the period prior to each submission phase, the development of the BCF plan (co-produced with work stream leads) is discussed with the Senior Responsible Officers and the BCF

Programme Board each month. Executive representation from Health and Social Care providers (RWT, BCPFT and CWC) are full members of this BCF Programme Board. In addition, the Programme is supported by work stream groups (led by commissioning leads) who are pro-active in the planning and development of transformation plans. These work stream groups include operational managers from across Wolverhampton's health and social care commissioner/provider services.

- This co-production of transformation planning and implementation from strategic to operational ensures that all partners are cognisant of what the re-designed service will look like in the future and as a result, what the predicted impacts of changes to service delivery will be. This approach is supported within health by discussions within the contract negotiation process which details the activity that will be impacted at HRG level and within social care through the established review monitoring and negotiation processes.
- In terms of wider stakeholders, Wolverhampton has always and continues to engage with stakeholders:-
- Design phase events included over 120 frontline Health and Social Care local professionals, individuals, users, carers, voluntary sector organisations and community groups.
- Engagement with the public has demonstrated that people want care closer to home.
- With regard to impacts for the voluntary sector, current grant recipients and other agencies are invited on a regular basis to the work streams to promote services, facilitate discussions and identify opportunities for closer working relationships. There is a Voluntary Sector forum that is held quarterly and is managed by the voluntary sector council. The LA and CCG attend the forum with a view to supporting VS organisations in capacity building (how to tender, financial stability, assistance with grant applications).
- The Local Authority is currently developing its community offer in conjunction with its stakeholders. Its aim is to provide an effective, targeted community offer, which helps citizens remain healthy, happy and independent for longer, and in so doing reduce, delay or prevent the social care needs of citizens. This is a key enabler of other projects looking to promote independence and reduce costs because it provides alternative support options. One element currently provided is the Social Prescribing pilot, which works a number of GP practices offering low level support regarding benefits, finance, housing etc. freeing up GP's time to deal with appropriate appointments. Wolverhampton Voluntary Sector Council (WVSC) are also running a 12 month pilot for Social Prescribing to support people with low level needs with the aim of improving people's wellbeing and reducing social isolation.

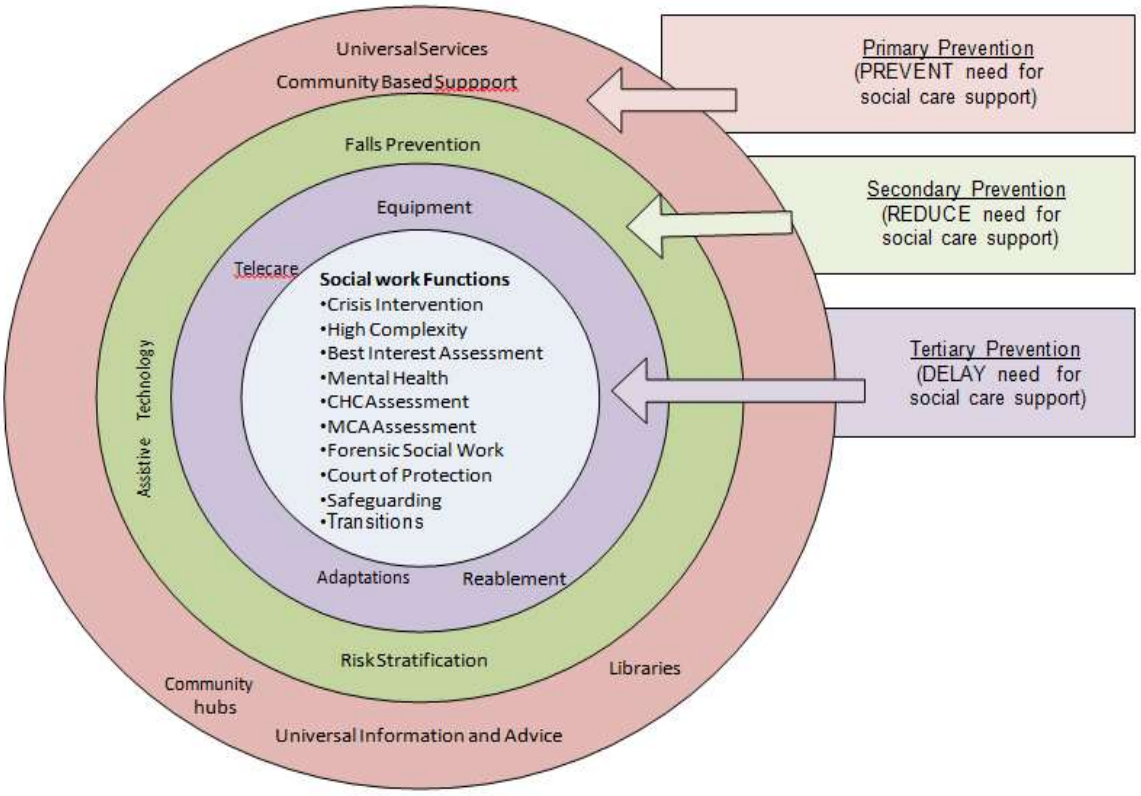
10.2 National Condition 2 – NHS contribution to Adult Social Care is maintained in line with inflation

- CWC Cabinet Report of 26/4/2017 *(see Appendix 11*) **4, 5, 6**
- The minimum CCG contribution for 2017/18 is £18.182m and £18.527m for 2018/19 which includes £964k **(note: still awaiting figure for 2017-18 £964 represents last years as a guide only)** Care Act monies and is in line with CCG overall budget inflation as notified by NHSE. The CCG can confirm that this minimum contribution is maintained and exceeded with the total CCG contribution being £37.865m. The development of integrated health and social care pathways and teams, including adult social care continues to be a priority within the programme, ensuring that there is no detrimental effect on the local health and social care system. *See Planning Template for detail.*
- Agreement on the high level plans for the allocation of IBCF money to ensure the local social care provider market has been attained.
- The Wolverhampton vision (see **Section 2, p4**) and delivery model (**Section 5, p24**) outline the **7**

plans for transforming and integrating the health and social care landscape in Wolverhampton and articulate the benefits, both and health and otherwise, to the population with the specific outcomes listed in **Section 2.4, p5**. The sample of case studies included at **Section 6.1, p37** outline how the BCF schemes are benefiting the people of Wolverhampton now.

- The following protection of social care model (*Figure 17*) continues to be adopted across the BCF work streams, recognising that protection of social care is a key BCF objective.

Figure 17 - Protection of Social Care Model



10.3 National Condition 3 – Agreement to Invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care

- **NOTE – awaiting planning guidance around the minimum allocation for NHS commissioned out of hospital services.** 8

- The projects within the BCF Programme all support the movement of activity from acute to community, primary, social care, voluntary and general preventative services. An example is the work between GP's and community matrons to risk stratify people who are then case managed by the integrated health and social care teams and the development of the Community Rapid Intervention Team (see **Delivery Model, Section 5, p24 for details**)

- Risk stratification tool is currently being used which enables Community Matrons to work with GPs to identify patients at high risk of emergency attendance/admission. Individualised care management plans are developed for these patients with a view to managing their condition more proactively and reduce their risk of future health deterioration, maintaining people in the community. We continue to work with partners to redesign these proactive pathways with the ambition to move activity from secondary care to out of hospital services. We have worked

closely with our local provider to agree the level of reduced emergency admission activity and to develop plans to further strengthen community working, investing further funding into the community contract this year.

- In line with the underlying principles of the BCF Programme the local area is committed to funding out of hospital commissioned services. This is demonstrated in the planning return expenditure plan. More detailed examples of these services are:-

- The CCG has negotiated with Providers a shift in funding streams from the funding of emergency admissions to the increased funding in community services. This has been possible as the demonstration of the impact of the schemes during 2016/17 has again instilled confidence in the future delivery of impact going forward. **There has been an overall reduction in emergency admissions in Wolverhampton of 1,655 when compared to the previous year of which 35% at least can be directly attributable to the BCF Programme schemes**. As a result of this we have agreed a BCF targets for 2017-18 of reduction in admissions of 1,677. Emergency admission performance data for 2016-17 is shown in the BCF dashboard extract *(Figure 18).*

Figure 18 – Current Performance – Emergency Admissions

BCF Monitoring	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Full year
Baseline (15/16 Activity)	1990	1960	1966	1992	1833	2100	2326	2228	2161	2187	2064	2035	**24842**
16/17 Actual Activity - Total Emergencies	1968	1954	1964	1953	1752	1855	1946	1996	1980	2072	1793	1954	**23187**
Variance	-22	-6	-2	-39	-81	-245	-380	-232	-181	-115	-271	-81	**-1655**
Variance (baseline v 16/17)	-1%	0%	0%	-2%	-4%	-12%	-16%	-10%	-8%	-5%	-13%	-4%	**-7%**
1617 Actual Activity - All Providers Total EM	2124	2139	2133	2163	1919	2035	2118	2160	2151	2243	1929	2102	

- The Programme is enhancing relationships with voluntary sector providers to support out of hospital services. Through a Grant Policy Framework a number of contracts have been awarded to voluntary sector organisations to support the teams in their delivery of support to the people of Wolverhampton. These schemes include a telephone befriending service with the aim of reducing social isolation, an advice and education Programme for persons with long term conditions, a support network for those at end of life and tailor made packages of support for targeted groups with aim of reducing subsequent need and dependency on NHS services and promote social inclusion.

- Two step up beds have been commissioned and are ring fenced for use by the Rapid Intervention teams for up to 7 days. These beds will increase the opportunity for avoiding emergency admission and retaining people in the community in a safe environment.

- The Street Triage/Mental Health crisis car is an example of collaborative working between organisations to provide care out of hospital.

- The Programme also commissions P3 a voluntary sector organisation that supports persons with mental health issues that are homeless so that when they hit emergency services help is given to identify suitable accommodation for the individual not in a hospital setting.

- Preventative mental health services – the council commissions Starfish to provide support to community groups outreach and one-one support for people with low level mental health provisions.

- For Social Prescribing, Wolverhampton CCG in partnership with Wolverhampton Voluntary Sector Council, have launched a twelve month Social Prescribing Pilot to provide an alternative to and compliment Primary Care (see **Delivery Model - Section 5, p24** for further detail).

- WCCG is working with colleagues in RWT and colleagues in Staffordshire in the delivery of a Research project around Health Coaching. Working with Health Navigator we are undertaking a project which sees persons with high Outpatient attendances, A&E attendances and emergency admissions being supported by Health Coached. These health coaches meet with

the person and set up an individualised care management plan looking at their holistic health and care needs. The project will run for two years.

- Work is progressing with housing colleagues across sectors to shape and co-design the integrated process to access DFGs and other housing support and adaptions, enabling people to be as independent as possible and remain out of hospital wherever appropriate.
- **No additional target has been set for Non Elective Admissions** and therefore no contingency funds have been necessary to establish. **9, 10**

10.4 National Condition 4 - Implementation of the High Impact Model for Managing Transfers of Care **11, 12**

- **Wolverhampton is in the process of a robust self-evaluation against the High Impact model with** the objective of ensuring that any gaps are identified and action plans are being developed to address. The self-evaluation is being jointly undertaken to ensure a Wolverhampton perspective and will be presented to both BCF Programme Board and A&E Delivery Board for assurance and approval of action plans.
- **There is a D2A programme that is working to develop and implement a Discharge to Assess model in Wolverhampton**. This is led by the Service Director for Adults at CWC with all key stakeholders being involved in the design and implementation. The focus of this work is to get people home from hospital as soon as it is clinically appropriate to do so. Where a person no longer needs acute care but does needs further assessment, rehabilitation and reablement this will happen in a community setting. Objectives are to:-
  - support admission avoidance where appropriate
  - support timely discharge from hospital
  - maintain independence wherever possible
  - reduce the level of long term packages of care
  - have a net neutral impact on the health and social care economy
  - provide a 7 day service
- **The D2A project will be achieved by two projects running concurrently to deliver the objectives. Project 1: Moving people out of acute care into a community health or social care setting.** Deliverables will include:
  - A Wolverhampton integrated discharge to assess offer
  - A trusted assessment screening tool for identifying on-going health and social care issues that will be assessed further in a community setting.
  - Simplified clear criteria for access to Pathway 1, 2 and 3 services
  - A single referral hub for all discharge to assess community health and social care services – this will involve a re-design of current services
  - Agreement and sign up from neighbouring authorities with regard to the implementation of the D2A pathways that all persons at RWT will follow
  - Clear pathways from ED into D2A services
  - New referral processes where necessary
  - Information for staff and persons about pathways and referral criteria
  - Engagement with mental health services to understand existing pathways into mental health and to identify gaps in provision
  - A reduction in delayed transfers due to medication or equipment not being available promptly.
  - Improved communication and information flows from acute care into community settings
  - An evaluation framework for the D2A programme
- **The Rationale for project 1 is-**

- At present numerous professionals may be asked to assess a person before he or she is deemed ready to move. This can cause delay. This project will develop a single trusted assessment to identify issues to be resolved once the acute episode is finished.
- Referrals for community services are made in a number of ways – through WUCTAS, through a social care referral point and between health and social care professionals. Ensuring the correct referral route to the most appropriate service relies on the individual knowledge of a range of services and professionals. This can slow down the process. The project will produce a business case for a single referral hub for D2A services which will describe the operating model. The project will also be responsible for the development and implementation of the hub.
- Many persons attend ED and then have their hospital admission diverted. Some will need on-going assessment and reablement in the community and should have access to D2A services. This project will develop the pathways from ED into these.
- The group is tasked with ensuring that persons receive the appropriate medication on discharge from hospital and that the provision of TTOs does not delay transfer and that the appropriate equipment and adaptations are available to persons in a timely manner on Pathway 1.
- This project will also be responsible for ensuring smooth information flows from hospital to the referral hub and out into community services. Wherever possible information should be collected once and shared with all relevant parties.
- It will be vital to demonstrate that the new D2A pathways are being used for the appropriate persons and that they are having a positive impact on outcomes and quality of life. This project will agree evaluation metrics, ensure that baseline information is available and that systems are in place for capturing data to support evaluation.

- **Project 2: Developing appropriate Discharge to Assess services utilising the pooled budget as per the section 75 agreement for the Better Care Fund.** *Deliverables will include:*
  - The development of jointly funded services in the community that facilitate the individual to return to his/her usual place of residence, as soon as possible, for people who do not require admission for acute care or have completed an acute episode.
  - Assessment(s) currently undertaken in an acute setting will now happen in the community.
  - All persons on the pathway receive a full assessment on arrival at the D2A service, have a care plan that identifies their rehabilitation and reablement potential with goals to achieve this and regular review
  - A reduction in the length of stay for persons across all D2A pathways
  - Services commissioned for each pathway with standard referral criteria and the same standard level of wrap around care.
  - Care homes commissioned that can demonstrate commitment to a cultural change to reablement and rehabilitation
  - All affected staff groups training needs identified and an on-going programme of workforce development is agreed and implemented.
  - A clear, co-produced communications plan to all stakeholders including a comprehensive information campaign to health and social care staff about the new pathways and how persons' are informed of and access them
- **The rationale for project 2 is:-**

- One of the reasons persons are admitted/ delayed in New Cross is because of the range of services available and a lack of understanding about which is the most appropriate. There are 3 levels of care for persons on the discharge to assess pathways and the services that support them should have clear referral criteria consistent with the pathway and assessed needs of persons and be grouped in fewer places offering an equitable geographic spread. The purpose of this project is to ensure future provision reflects this. It will involve reviewing capacity to ensure the service can meet demand, refining the referral criteria and reviewing provision in residential and nursing homes for pathway 2 and 3. This may result in a change of service provision.
- Persons on the D2A pathways will have a multi-disciplinary assessment of their needs undertaken in the community setting, an agreed care plan that identifies milestones and goals and a discharge date. There will be regular planned multi-disciplinary assessment of progress against these goals. The purpose of this project is to ensure that these principles and culture are adopted in all services on the pathway and that staff receive the training needed to achieve this. The project will also look at whether there are any additional clinical skills needed to manage persons (often with increased complexity) in the community and identify training needs. This work will also focus on developing clear messages, in the most appropriate form, to persons and staff about the D2A referral pathways and criteria. Clear agreed messages to persons will explain the purpose of D2A i.e. of further assessment and rehabilitation in the community and will ensure all staff involved in the delivery of care to the persons place emphasis on its' short term nature.
- A significant proportion of the people who are delayed in hospital do not live in Wolverhampton. A medium term aspiration is to get agreement that these people are moved into their local area for assessment by the relevant authority. Alternatively there would need to be agreed agreement that out of area persons are transferred into a Wolverhampton D2A service as soon as they have become medically ready and assessed promptly by staff from the local authority covering the area where they live. This would involve charging the authority concerned.

10.5 Maintaining Progress on the 2016-17 National Conditions

10.5.1 Seven day services

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- The Programme already has a number of services that support service delivery on a 7 day basis. The Community Intermediate Care Team (CICT), Home Access Reablement Programme (HARP), Bradley Reablement Service and Therapy Access Team services are available 7 days a week from 8.00am until 8.00pm. The Council's therapy led resource beds in the community and the nurse led rapid intervention beds at West Park Hospital can be accessed 7 days a week. These services all support the existing acute and emergency services and the developing community teams. We have commissioned 2 step-up beds that are accessible 7 days per week to support the admission avoidance agenda.
- Our Rapid Response pilot has now moved into an embedded 7 day admission avoidance service and is currently undergoing evaluation. The co-location of social care AMHPS in the Urgent Care Centre across weekends and bank holiday periods is now complete.
- As development of the programme progresses and in conjunction with provider colleagues, all new integrated services will have a phased approach to 7 day service delivery where appropriate in order to prevent avoidable admissions and support timely discharge.
- Wolverhampton is working with NHS England to be an early adopter of 7 day services and the BCF partners are working collaboratively to develop an implementation plan for delivery. A project group has been set up by RWT, which includes representation from: Wolverhampton

CCG, CWC and BCPFT to collaboratively implement the plan.

- The programme will also explore how 7 day services can be supported by other organisations such as Primary Care and Voluntary Sector.
- There are now step up and step down beds being piloted with both offering a 7 day service

10.5.2 Data Sharing

- We now have a signed DSA to cover BCF in Wolverhampton, which has been developed and approved by CCG, LA, RWT and BCFPT. This enables front line staff to deliver more effective care to the population of Wolverhampton.
- The progress on data sharing has underpinned and enabled the successfully implementation of the "Fibonacci" IT system that pulls health and social care data into one view for members of the Community multi-disciplinary team. This enables front line staff to manage persons more effectively understanding all of the contacts and interventions that the person has undergone, relevant to their care management. The system is co-commissioned by CCG/LA/RWT/BCPFT. We continue, through the Local Digital Roadmap Group to explore options for an Integrated H&SC record and for systems to provide H&S care data to holistically inform our commissioning decisions.
- Progress is also being made around enabling the use of the NHS number as the key data field. Social Care systems currently reporting a figure of 85% and plans in place to identify and resolve the issues connected to the unmatched 15%.

10.5.3 Joint Planning and Assessment

- Work is being undertaken by the emerging CNT's to identify a caseload for proactive case management. The proportion of the local population who receive case management and a named care coordinator will be the most vulnerable and this group will be identified via a risk stratification tool. This is being done by two methods:-
- A consolidated view of current health and social care caseload within each of the 3 localities to identify a cohort of persons that would benefit from a joint approach of care planning. This is undertaken during regular MDT meetings where health professionals and social care staff meet to agree a joint approach to assessments and care planning.
- Community matrons working with individual GP practices to identify a cohort of persons, based on risk stratification that would also benefit from a joint care planning approach from the integrated health and social care teams. People identified are either managed directly by the team of community matrons or referred into the MDT for a collaborative management plan to be developed.
- As we move forward we will be developing a more Primary Care MDT focus
- As the CNT's develop further and become more mature this approach will be embedded in their ways of working. This will be further enhanced when the teams become co-located. Work is underway with estates colleagues to identify available and suitable premises in each of the 3 localities and also to identify capital funding to enable this to happen. The opportunity to align to existing bids for new build premises within Primary Care is being explored as part of the longer term estate planning solution.
- The teams will develop an approach whereby each person is allocated a named accountable professional dependent upon their primary need.
- The CNT's are currently meeting on a monthly basis to discuss their caseload and a joint approach to care planning. The outcome of these meetings are recorded and updated accordingly into a care management plan. The next phase to have these available in a single

person record. This is the first phase of development and our plans describe how these teams will be enhanced in the future.

11. National Metrics

11.1 Non-Elective Admissions

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- **The non-elective admissions (NEL) target reduction for 2017/18 has been set at 1,677**. This figure has been reached through discussion with RWT community teams, contracts and clinicians (both primary and secondary care) who have reviewed the conditions that people are admitted with against the schemes that are in place through BCF and as an outcome have agreed on the potential impact (*see Figure 19 below*).

Figure 19 – Non Elective Admissions Plan 2017-18

BCF Monitoring - 2017-18 Plans	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Total NEL - BCF Related Plan	914	943	927	955	888	898	933	958	973	954	916	967	**11,226**
BCF Planned Reductions	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-140**	**-139**	**-139**	**-139**	**-1,677**
Total NEL - Non BCF Related Planned	984	1,022	1,006	1,043	935	959	1,005	1,057	1,071	1,044	1,010	1,064	**12,200**
Total NEL	**1,758**	**1,825**	**1,793**	**1,858**	**1,683**	**1,717**	**1,798**	**1,875**	**1,904**	**1,859**	**1,787**	**1,892**	**21,749**

- **This will be a challenge**, and to contextualise in 2016/17 Wolverhampton achieved an overall reduction in NEL of 1,655, with 575 of the typically most complex cases directly attributable to the BCF Programme.
- The target for 2017/18 was set based firstly on evidence of deliverability of last year and whilst the target was not achieved last year a number of reasons are known for this (staff recruitment, influx of pneumonia in the winter months). **By continuing to work with our provider partners and with continued investment into community services we are confident that the set target, whilst challenging, is achievable if all plans are delivered.**
- **Secondly, the determination of the target has been very much clinically led**. Our community nursing teams, GPs and Consultant geriatrician have reviewed the conditions that people are being admitted for, alongside the interventions that we have and are planning to put in place, and have estimated the impact that the programme can, in theory, make on reducing emergency admissions.
- **No other reductions have been set for NEL admissions** in the CCG Operating Plan.

11.2 Admissions to Residential Care

- **The 'Long-term support needs of older people (aged 65 and over) met by admission to**

32

residential and nursing care homes, per 100,000 population' target has been set at 260 admissions (an average of between 21 and 22 per month). The total number of admissions in 2016/17 was 385 – an average of 32 a month.

- In 2015/16, Wolverhampton was in the top quartile among comparators with admissions of 299 – an average of 25 a month, but was in the lower-mid quartile regionally and nationally. Based on 2015/16 data, to be in the top quartile regionally there would need to be fewer than 234 admissions (an average of 19-20 a month) and to be in the top quartile nationally there would need to be fewer than 219 admissions (an average of 18 a month).

Graph to go here with new targets

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	644.8	638.0	698.8	581.9
	Numerator	273	273	299	252
	Denominator	42,338	42,787	42,787	43,307

- Service redesign to promote independence and strengthen access to treatment and support in the community is well underway, as is work to support the development of mechanisms to track it.
- The CWC is in the process of procuring the Care and Health Track system and is currently working to agree the content and delivery timescales. This will provide access to much more detailed information about health and social care needs across the City.

11.3 Effectiveness of Reablement

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- **The proposed target for the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services is 80.3% - the same as 2016/17**. Although the target was not achieved, there will be additional reablement capacity with the introduction of the externalised service which it is proposed will be twin tracked with the internal HARP services as part of the IBCF monies. Further work will be done to understand the reasons why people do not remain at home following reablement to understand what else can be done to further maximise its effectiveness.
- The plans set out within this BCF submission to further increase the reablement offer to the citizens of Wolverhampton both within the community and on discharge from hospital further. Increasing the offer of reablement through a more widely encompassing selection and identification criteria for people who would benefit from the offer, often leads to a decline in overall reported effectiveness due a lessening of the 'cherry picking' effect that more stringent selection criteria can produce. It is therefore believed that maintenance of current performance against an increased reablement offer is realistic while providing a degree of ambition.
- The following metric has been selected:-

  'Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services'

  Need to update graph for targets

Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	80.5%	94.3%	75.6%	80.3%
	Numerator	330	330	195	490
	Denominator	410	350	258	610

11.4 Delayed Transfers of Care

- The requirement for measuring delayed transfers of care has changed for 2017-19. There is a national target that has been set that by September, the number of delayed transfers of care should be no more than 3.5% of occupied bed nights. Although the detailed methodology has not been released for this, it is understood that the measure most likely uses the snapshot DTOC figure (number of people who are delayed at midnight on the last Thursday of the month) and the average daily occupied consultant led bed nights as published in the quarterly reports. Occupied bed nights are only available by Trust. Using data for the Royal Wolverhampton Trust, the figures for 2016/17 are as follows:

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Need DTOC graphs – then some narrative (none to bring over from last submission)

12. Budgets

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TBC

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