Final Submission

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

• PLAN DETAILS

a) Summary of Plan

Local Authority	**Dudley MBC**
Clinical Commissioning Groups	**Dudley CCG**
Boundary Differences	**Coterminous boundaries. No significant differences**
Date agreed at Health and Well-Being Board:	**Approved by Chair, 17th September 2014. Submitted to HWB 30th September 2014**
Date submitted:	**19/9/14**
Minimum required value of BCF pooled budget: 2014/15	**£6.890m**
2015/16	**£23.84m**
Total agreed value of pooled budget: 2014/15	**£8.212m**
2015/16	**£69.548m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Dudley CCG
By	Paul Maubach
Position	Chief Accountable Officer
Date	17/9/14

Signed on behalf of the Council	Dudley MBC
By	Andrea Pope-Smith
Position	Director of Adult, Community and Housing Services
Date	17/9/14

Signed on behalf of the Health and Wellbeing Board	Dudley Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr. R. Harris
Date	17/9/14

c) Related documentation

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

Document or information title	**Synopsis and links**
Integration Pioneer Bid	Sets out basis for our integrated service model in context of JSNA and JHWS. Attached.
Activity Graphs	Shows how we anticipate activity will change across the system. Attached.
Organisational Development Programme	Our programme for organisational development across all partners. Attached.
Schedule of services	Full breakdown of services to be included in the BCF. Attached.
Dudley Local Account for Adult Social Care 2012/13	Attached.
Dudley Making it Real Action Plan	Attached.
Living Well Feeling Safe Approach	Attached.
Dudley Information Governance Strategy	Attached.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Population-based Health and Wellbeing Services - What it Means for Health and Social Care in Dudley

Our JHWS identifies as one of its 5 priorities:-

"making our services healthy by integrating health and care services to meet the changing Dudley borough demography, starting with urgent care".

This priority pre-dates the advent of the Better Care Fund and is derived from the recognition that integrating services at a local level is required to deliver benefits to our population.

Our Joint Health and Wellbeing Strategy's vision is **to improve the health and wellbeing of people in Dudley borough and to reduce health inequalities**.

Dudley Metropolitan Borough Council (MBC), Dudley Clinical Commissioning Group (CCG), Healthwatch Dudley, and Dudley Council for Voluntary Services (CVS) are all signatories to this strategy.

The strategy goes on to say that to accomplish this we need to aim for the provision of **innovative, integrated, localised and personalised services that give excellent value for money – giving the best possible service within the resources available**.

We need a step change in how our public services work together to sustainably support our population to live long and healthy lives. Achieving this involves all aspects of health and social care coming together to support people's health and wellbeing.

Integration of services

In Dudley we are bringing together all population-based care into one set of integrated services based upon the registered populations with general practice. The public register with their GP and look to them as the first point of contact for many health and wellbeing services. So GPs are at the heart of this model, as the key co-ordinators of care. They are also a central part of a much broader network of health, social care and voluntary sector services which make up the full integrated model.

This integration of health and social care services will be the catalyst in Dudley for major improvements in the way those services are planned, developed, organised and delivered. This includes projects being developed locally in response to the budgetary challenges created by the national Better Care Fund (BCF) but it is important to understand that it is much wider in scope than the BCF work.

Effective integration requires the active participation of involved organisations, staff, service users and local communities. Securing and maintaining that participation in turn requires effective communications: starting with a shared understanding of, and agreement to, key principles about why we are doing this and what we are trying to achieve; followed by a clear agreement on how we organise services to most effectively enable our frontline staff to be able to follow those principles.

Key Principles

The integration model in Dudley has, at its heart, three principles:-

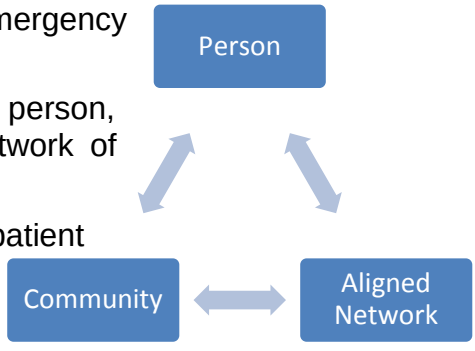
- **shared ownership** – the NHS is owned by UK citizens and each person is a registered member of their GP practice, and by inference is therefore a member of Dudley CCG. All public services are similarly owned by UK citizens and those services are therefore accountable to the public for what they do;
- **shared responsibility** – all services and all staff have a shared responsibility to work together in the best interests of the public. Also we want to shift responsibility from 'the system' providing care to dependant individuals, to instead achieve mutual responsibility whereby health, social care and wellbeing are co-produced with people (which in reality is what happens);
- **shared benefits** - the benefits of the Council, NHS and other public services are shared mutually between all stakeholders. We aim to achieve defined outcomes – both for the whole community in improving overall health and wellbeing; and for individuals in their personalised care and wellbeing.

The Organisation of Care

Health and wellbeing has to be personalised to the individual so that they can fully engage in co-producing their care and in taking responsibility for their own health. So the design of our model is based on how we work with the individual **person**.

The public register with their GP as their main connection to health and wellbeing services. So the overall organisation of care starts with the GP and their practice. However, to make it as easy as possible for other services to take shared responsibility for working in the best interests of patients and their carers; we will align other services to work with the same practice populations – so creating an **aligned network** of services or teams around each practice. This is the core level of integrated working.

These teams are based in the **community**; and once working together, they can develop a shared understanding, together with their population, of the shared benefits and outcomes that they are trying to achieve. These shared outcomes will change over time – but they will include measures that reflect people's health (such as improving life expectancy); wellbeing (such as social or mental wellbeing); and measures that demonstrate how we maintain people's autonomy and independence (such as reducing the need for emergency admissions to hospital).



So the organisation of care starts with the individual person, registered with their GP, supported by an aligned network of care that is working locally in their community.

The networks of care provide a model which enables a patient or carer to access a joined up package of services and support which may come from any or all of the NHS, council, voluntary, community or private sector organisations involved in providing those services and support.

More than that, though, there is an expectation of a change of culture within all these partner organisations – not just a willingness to work together but an expectation that all partners in delivering integration will take a shared responsibility in achieving shared

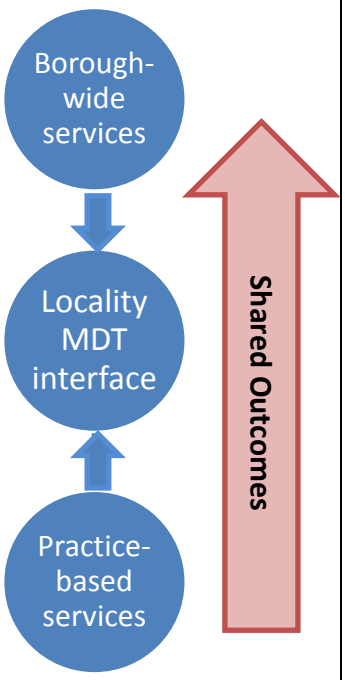
outcomes. This will be followed through by increasingly commissioning for the achievement of these outcomes.

Resilience and Co-ordination

Practically, in order to ensure resilience and provide cover, whilst some services can work at the practice level, those services will also need to be grouped across a wider geography. So some services will operate at practice level but be grouped into five localities – in effect creating a locality-based community team.

We will organise, locality-based multi-disciplinary teams (MDTs) to enable these services, together with practices, to share learning across the locality. These groups will be able to share their understanding of how the outcome benefits being delivered at practice level, come together across the locality. These locality-based MDTs will also enable other organisations and teams, too small to participate completely at practice level, to link in to the integrated working.

Similarly there are other services which will only be resilient if they operate at a borough-wide level. For those services we will expect them to connect into these locality-based MDTs. So the locality MDT becomes the interface between borough-wide groups and practice-level working.



We expect borough-wide groups to operate on a population basis working for the collective benefit of all of the population. In this way, these groups can also participate in taking their shared responsibility for the shared benefits for the population. This similarly creates an aligned network of providers, working to the same objectives across the borough.

In the future this will also be followed through by increasingly shifting these borough-wide services out in to the community – placing them in community centres in each locality; and by commissioning these services on how they support the achievement of these shared outcomes.

Some Practicalities

The core team for integrated practice-level working

The basic integrated team will consist of:-

- GP
- community nurse
- mental health link worker
- practice based pharmacist
- social care link worker.

They will be led by the GP. There will be a "congruence of responsibility" for each member of the team - they will each have responsibility for serving the same group of patients. Some team members may additionally serve patients of other practices and be members of other teams (in which case there will be a similar congruency with workers serving those patients from other services).

At any time the team members will all serve the same patients so that they can take a shared responsibility for achieving shared outcomes with those patients. They will also allocate lead care-co-ordinators from within the group for those patients who require detailed care planning.

The organisation at locality level

The locality team will consist of:-

- GP
- lead community nurse
- lead social care link worker
- lead mental health link worker

All the above are drawn from those working at practice/community of practices level. In addition, this team will consist of:-

- Community Rapid Response Team representative
- Virtual ward representative
- CVS Locality Link Development Officer
- Other services working borough-wide as part of the integration model, where necessary

They will be led by a GP Clinical Leader. The locality teams will be sharing learning and reviewing the collective performance of all the teams in their locality through an aggregated performance report; reporting on progress and developing ideas for improvement; and ensuring that pathways from practice to locality to borough wide services function effectively.

This will include working with named nurses, social care workers and mental health workers at a practice MDT meeting to look at the top 2% complex patients identified from our risk stratification tools. They will look at newly referred patients and agree who is the lead care coordinator for each complex case.

We are working with five GP practices (one in each locality) as early Implementers of the model. They are developing a standard care plan format and assessing the requirements for IT to support integrated working. The learning from these practices will shape the future roll out of the model across all practices.

An Infrastructure for Integration

Our approach will be underpinned by some key enablers including:-

- a comprehensive organisational development programme, with a focus on changing practice and culture;
- a common I.T. platform;
- a common approach to care planning;
- an agreed performance framework linked to our BCF metrics;
- the deployment of the required resource of £5 per head to support the over 75s in general practice.

The components below are designed to support our integration model

Community Rapid Response Team

A key feature of our model will be a scaled up rapid response service, working in conjunction with the West Midlands Ambulance Service, acting as the first response to patients who may have historically been admitted to hospital.

Community and Voluntary Sector Services

We will seek to create more resilient community and voluntary services in conjunction with our partners. This will include the development of a social prescribing service and an integrated range of services to support the frail elderly and patients with long term conditions, as well as 5 locality link workers working with and developing preventative voluntary and community sector services.

Urgent Care Centre (UCC)

A new urgent care centre will be developed on the Russell Hall Hospital site adjacent to the existing emergency department (ED). This will result in the reconfiguration and movement of the existing Dudley Walk-in Centre and Out of Hours Service.

This will provide a single point of access for all urgent care patients 24 hours a day, 7 days per week and 365 days per year. It is anticipated that the redirection of patients through the UCC will result in reduced attendances at ED and reduced emergency admissions.

Systematic Management of Long Term Conditions

The systematic management of patients with long term conditions will be a key element of this model and will include:-

- the Dudley Respiratory Assessment Service (DRAS), redesigned and aligned to our 5 localities, providing a step down service to the Community Rapid Response Team. This will be part of a comprehensive approach to managing COPD including a re-launch of our LES;
- the implementation of a revision to our diabetes LES and a more community focussed community diabetes team, including appropriate psychological input;
- a more community based approach to anticoagulation services;
- utilising technology following a joint scoping exercise with social care;
- provision of IV antibiotics and IV diuretics;
- management of familial hyperlipidaemia;
- a systematic approach to self-care programmes.

End of Life care

A specialist community palliative care team will provide further community capacity to intervene early, prevent unnecessary admissions and facilitate preferred place of care for patients.

b) What difference will this make to patient and service user outcomes?

Our model of integrated health and social care is designed to ensure that:-

- every Dudley person has a high quality experience of health and care throughout their life journey;
- the health and care system promotes independence;
- prevention and wellbeing are integrated and privileged;
- every unplanned hospital admission is treated as a system failure;
- risk stratification and other tools enable an intelligent approach to service intervention.

Our approach is based upon integrating primary, community, mental health, social care and public health activities to support older people. In addition, our model supports integration with voluntary and community sector services at a neighbourhood level. Integration will take place at three levels – practice level, locality level within our 5 CCG localities and at Borough wide level. Integrated teams will integrate services from practice to Borough wide level and connect local services more effectively with their local communities

These services will provide:-

- proactive, preventative support to a common population using risk stratification and other data tools;
- an enhanced community rapid response service as a real alternative to ED/hospital admission;
- step down for supported discharges from secondary care;
- a consistent response, 7 days per week, to agreed clinical standards.

Service delivery will be enabled by a single IT solution.

Measuring Success

Success will be measured by:-

- a reduction in total emergency admissions from 31,722 in 2013/14 to 29,222 by 2015/16 and 30,148 by 2018/19;
- a reduction in residential home admissions from 748/100,000 in 2012/13 to 706/100,000 in 2014/15;
- reduced levels of dependency as measured through the number of older people still at home 91 days after discharge, with an increase from 86% in 2012/13 to 88% in 2014/15;
- a reduction in the number of delayed days per 100,000 from 242 delayed days per 100,000 in 2012/13 to 198/100,000 in 2014/15;
- reduced clinical risk as measured by the risk stratification tool;
- an increase in the rate of dementia diagnosis from 45.6% in 2013/14 to 67.2 % in 2014/15.

The teams described above will be performance managed through a series of performance indicators at an individual team level that relate to the population they hold a shared responsibility for.

As well as the above quantative performance metrics, a suite of more outcome focused measures are included in the proposed BCF performance framework that include:-

- enhanced service experience for patients and users as measured by an indicator to be developed with Healthwatch;
- reduced social isolation as measured through the evaluation of our social prescribing schemes using our PSIAMs tool;
- better quality of life for patients with long term conditions through efficient management as reported through their EQ -5D score;
- reduced level of social care need, post reablement.

Patient and Public Engagement

Our plans have been informed following discussion in a number of settings including our patient participation groups, our Healthcare Forum and our Health and Wellbeing Board "Spotlight" events. The use of "patient stories" is a consistent feature of our implementation process and engagement with patients and the public.

Health Gain

The CCG's Operational Plan sets out those areas, based on JSNA analysis and other tools, where intervention is required to reduce health inequality and deliver health gain.

Those areas where we would wish to see health gain are:-

- specific health inequalities for the male population both in terms of mortality rates in the 60 – 74 year age band and alcohol specific problems for the 40-59 year age band;

- reducing the life expectancy gap between the most and least deprived parts of our population, specifically in relation to cancer, heart disease, stroke and liver disease;

- better and systematic management of patients with long term conditions through primary care and community health services, leading to greater diagnosis and avoidance of exacerbation;

- mental health and the relationship between mental health, physical health and the management of long term conditions.

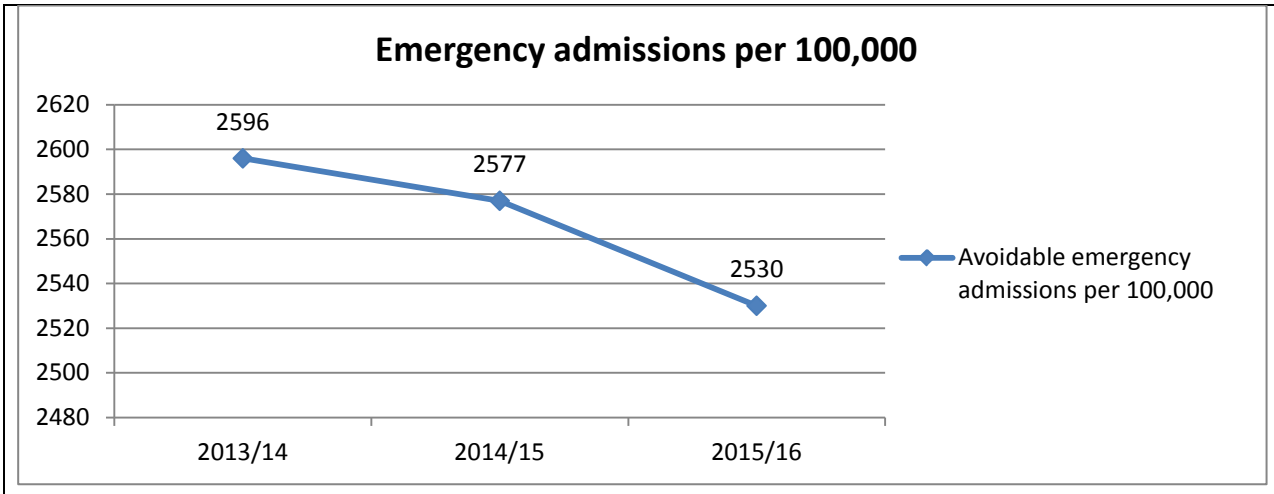
Our locality based service delivery model will provide an appropriate, differential intervention at neighbourhood level to respond to local health inequalities.

These issues will also be addressed in our "Memorandum of Understanding" with the Office of Public Health which sets out our joint work programme.

Specific Performance Targets

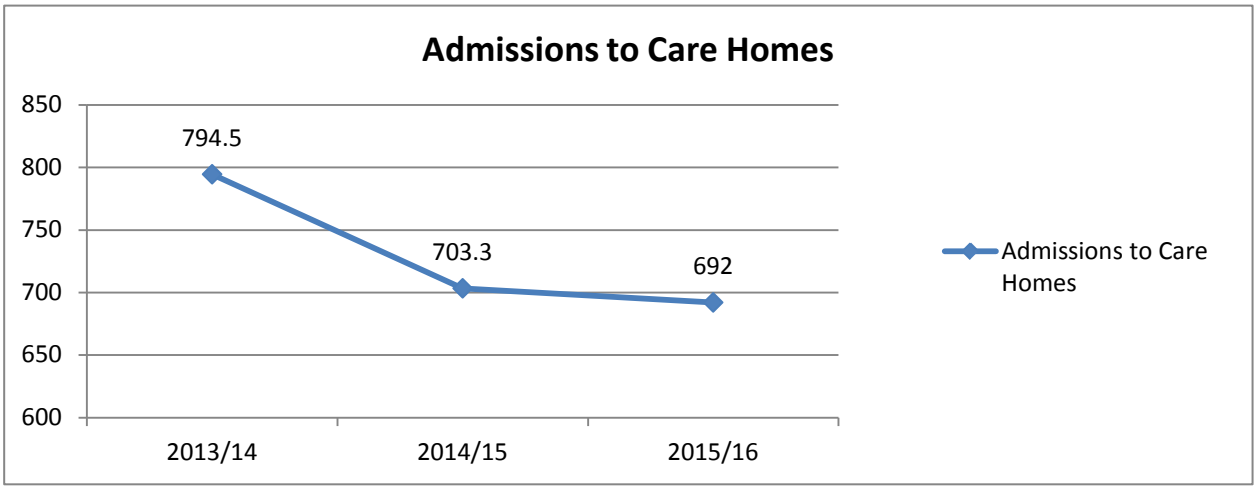
(a) Emergency Admissions

- total emergency admissions to reduce from 31,722 in 2013/14 to 29,222 by 2015/16 and 30,148 by 2018/19, allowing for demographic change;
- avoidable emergency admissions to reduce from 2448/100,000 in 2013/14 to 2322/100,000 by 2015/16 and 2322/100,000 in 2018/19 (Operational Plan indicator);
- avoidable emergency admissions to reduce from 2596/100,000 in 2013/14 to 2530/100,000 in 2015/16 and 2018/19 (BCF resident based indicator).



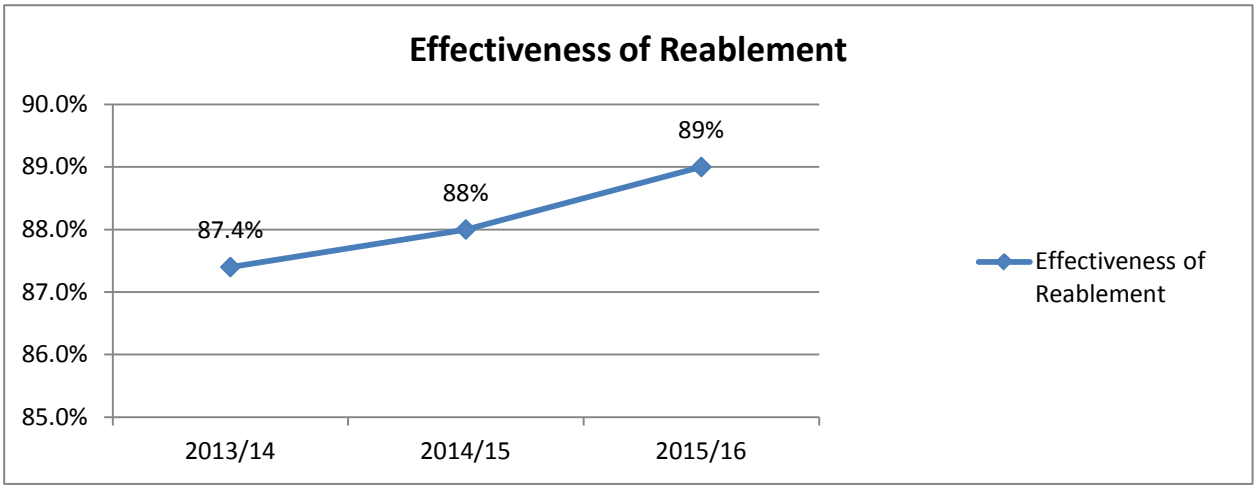
(b) Admissions to Care Homes

To reduce from 794.5/100,000 in 2013/14 to 703.3/100,000 in 2014/15 and 692/100,000 in 2015/16



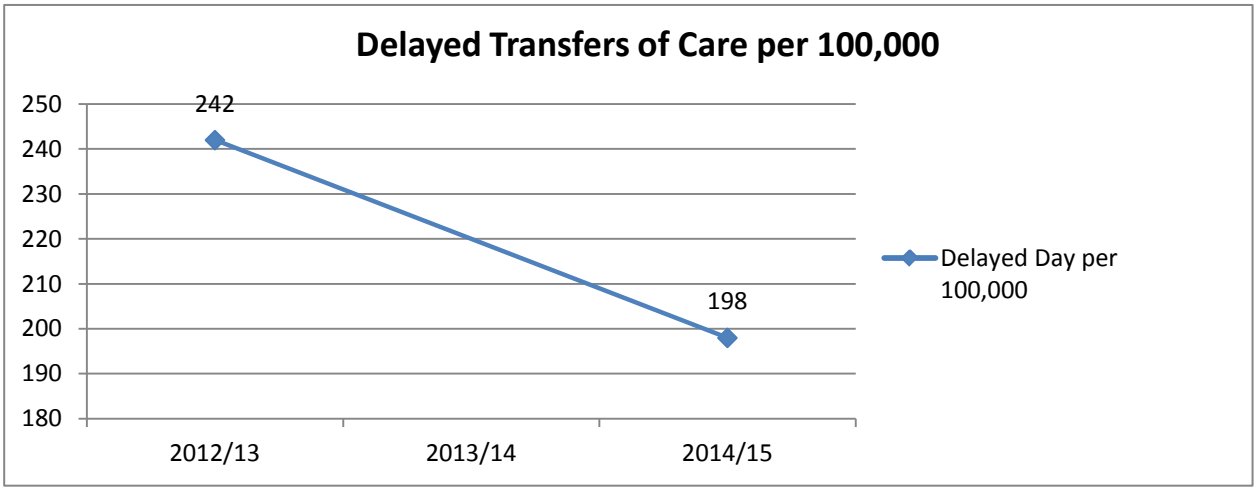
(c) Effectiveness of Reablement

Proportion of older people still at home 91 days after discharge to increase from 87.4% in 2013/14 to 88% in 2014/15 and 89% in 2015/16



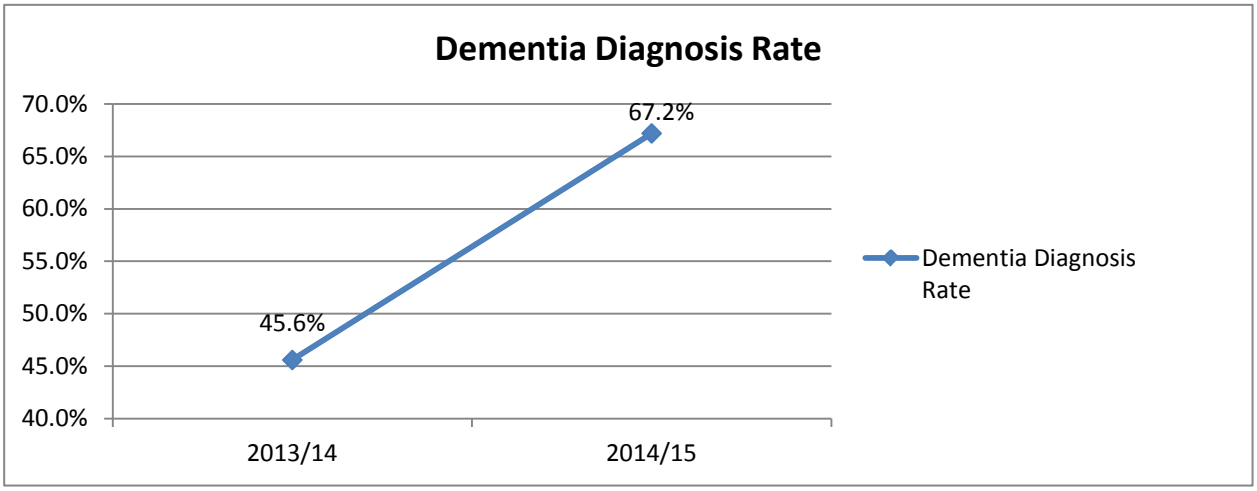
(d) Delayed Transfers of Care

To reduce from 242 delayed days /100,000 in 2012/13 to 198/100,000 in 2014/15



(e) Dementia Diagnosis Rate

Rate to increase from 45.6% in 2013/14 to 67.2 % in 2014/15



c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The Better Care Fund enables us to take forward key elements of our integrated services model and prioritises those interventions that will help embed our vision and deliver a sustainable system through:-

(a) crisis and emergency intervention - a community based team of advanced nurse practitioners and associated services including the practice integrated teams, designed to manage frail elderly patients who traditionally would have been admitted to secondary care;

(b) promoting independence – reconfiguring the access to and commissioning, coordination and provision of support and services that enable people to regain and retain their independence in their communities;

(c) stabilisation and maintenance - enabling people to continue to stay at home within their communities rather than moving into residential/nursing care or hospital at the point at which their health and social care needs become more complex or palliative;

(d) support for people with dementia - improving services and outcomes for the increasing numbers of people with and affected by dementia.

By April 2016 Patients/service users will:-

- know the one person in charge of their care – a single point of contact who knows them and their condition;
- be involved in discussions with the professionals about their care;
- be provided with appropriate information and supported to make decisions;
- have access to their care records;

- always be informed about what happens next;
- be able to stay at home wherever possible because services will work together to achieve this;
- be supported to help them not become socially isolated;
- have a say in who will provide care and how it will be provided;
- know that services will be put in place whenever there is a risk of an emergency situation developing.

It is our intention to deliver the most significant of these changes within two years.

In five years our vision is of a system where:-

- community health, mental health and social care **services are integrated around the patient** led by general practice;
- **all unnecessary admissions** to hospital, nursing and residential care **are treated as system failures;**
- greater **choice and control will exist for service users**, managing their own budgets;
- the **market entry** of new providers **will facilitate choice and responsiveness**;
- the **movement of** more **services** from traditional settings **to community settings will be the norm**;
- **greater connection exists between service users and their communities** as part of a mutualist system.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The Joint Health and Wellbeing Strategy's priority of service integration is informed by both our Joint Strategic Needs Assessment and the use of our risk stratification tool.

Joint Strategic Needs Assessment (JSNA)

The CCG has set out in its Operational Plan (pp12-13) and Strategic Plan (pp7-8), the key facts from the JSNA and their implications:-

- we have specific health inequalities for the male population both in terms of mortality rates in the 60 – 74 year age band and alcohol specific problems for the 40-59 year age band;
- this is contributing to a widening of the life expectancy gap between the most and least deprived parts of our population;
- we need to ensure our locality based service delivery model provides an appropriate, differential intervention at neighbourhood level to respond to local health inequalities;
- interventions in relation to cancer, heart disease, liver disease and stroke are required. We must ensure that our practices perform well in delivering smoking cessation services;
- the systematic management of patients with long term conditions in primary care and community health services will be a major contributor to our success, including the management of diabetes;
- we have a growing frail elderly population, we need to improve the care pathway to prevent unnecessary admissions and create the conditions to enable people to be re-abled and retain their independence in their communities;
- we have a higher than average rate of delayed transfers of care attributable to social care reasons;
- we require a continued focus on mental health and the relationship between mental health, physical health and the management of long term conditions;
- we need to ensure that our approach to prescribing and the input of our practice based pharmacists continues to improve our performance in relation to the use of drugs to reduce cholesterol, reduce blood pressure and manage atrial fibrillation;
- we need to ensure that our work on the systematic management of long term conditions, redesigning urgent and planned care pathways and integrating services in our localities is sensitive to the needs of our child population;
- as part of our approach to the Equality Delivery Scheme, we need to facilitate work with those groups protected by legislation where the difference in health outcome and need is greatest, as well as analyse the barriers to improved patient access and experience for these groups;
- we need to use an asset based approach to our work with partners in addressing the wider determinants of health.

This suggests that:-

- **needs are complex** and cannot be solved by the intervention of health and social care, either alone or isolation;
- these **needs are compounded by high levels of co-morbidity** (see stratification analysis below);
- **we need to manage long term conditions systematically** with both health and social care interventions;
- we have **a growing frail elderly population**. We **need to improve the care pathway** to prevent unnecessary admissions, create the conditions to re able people and maintain their independence in their communities;
- **"one size fits all" solutions will not be sufficient** to respond to the identified layers of complexity. We need to respond in a manner that reflects the individual need of the patient with co-ordinated input from relevant services.

Risk Stratification

Dudley CCG uses the ACG risk stratification tool, developed by Johns Hopkins University.

Our high level analysis shows that:-

- 90% of the population are very low risk and prime candidates for a primary prevention strategy;
- low risk patients predominantly use out-patient services;
- emerging risk patients require secondary prevention through the systematic management of their long term conditions;
- established risk patients are at higher risk of inpatient spells and need to be targeted by admission avoidance schemes;
- high risk patients are in poor health with multiple morbidities, they are prime candidates for management by an integrated health and social care team;
- risk for high cost patients increases substantially over time driven by age and complexity of morbidity;
- risk increases significantly around retirement age for men and women;
- renal disease and heart disease are the most costly and patients with these conditions tend to have the greatest volume of co-morbidities;
- over the next 12 months, cost and utilisation is predicted to increase for people with hypertension (£3.3m), metabolic disorders (£2.4m), renal failure (£2.2m) and diabetes (£1.6m);

- levels of emergency inpatient care for the elderly in Dudley are increasing.

Emerging risk population (n = 6273)

- 50% have 5 or more co-morbidities;
- majority are CVD, MSK and endocrine diagnoses;
- they represent 2.2% of the population but 11% of the costs.

Established risk (n = 4278)

- most have several established chronic conditions;
- majority are as for emerging risk population but renal failure is now also prevalent.

High risk (n = 3136)

- frail and elderly, more women than men;
- 2/3 have 5 or more chronic conditions;
- as well as those conditions identified above, cancer is more prevalent;
- 1 in 50 may be candidates for palliative care.

Impact of Co-Morbidity

- 40% of patients have 1 or more morbidities. Patients with co-morbidities draw more upon both health and social care with each additional condition, depending upon the mix of conditions;
- in Dudley patients with hypertension display the highest level of other co-morbidities**.**

In effect, **our stratified population is characterised** by:-

- prevalence of **long term conditions**;
- high levels of **co-morbidity**;
- growth in the **frail elderly**.

All these factors can result in unnecessary admission to hospital, residential and nursing home care.

This analysis, coupled with the evidence from the JSNA informs our intentions in relation to:-

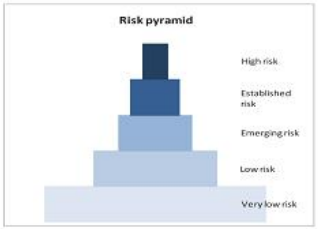
- the systematic **management of long term conditions** in primary care;
- the use of a **community based virtual ward**;
- a focus on **patients in care homes** through a **care home CPN** and **care home nurse practitioners**;
- a community based **rapid response team** to **avoid unnecessary admissions,** particularly **for those patients with co-morbidities;**
- community services to **support people at the end of life** enabling them to die in their location of choice;
- the use of **risk stratification and other data tools** at practice level to support practice based integrated teams.

The diagrams below illustrate:-

- the shape of our stratified population in terms of high, established, emerging and low risk populations;
- the relationship between these segments and our planned interventions.

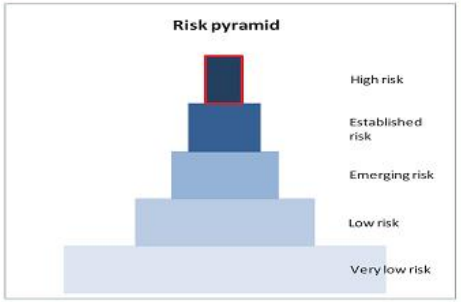
Nominal grouping of risk scores based on previous local ACG evaluation (Dr. Khesh Sidhu, 2012):

Risk group	Probability of future high cost	Dudley CCG patients	
		n	%
High risk	50%+	3,136	1.1
Established risk	30% to 49%	4,278	1.5
Emerging risk	20% to 29%	6,273	2.2
Low risk	10% to 19%	19,392	6.8
Very low risk	< 10%	251,835	88.4



NHS Dudley Clinical Commissioning Group

Dudley Metropolitan Borough Council

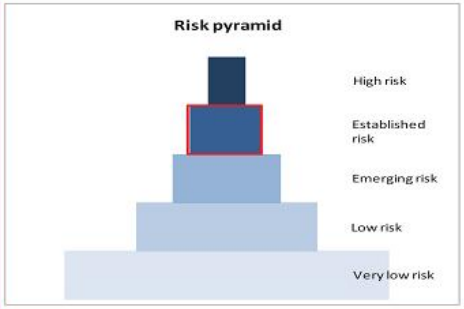


Key population characteristics:

- Generally frail and elderly, with more women then men.
- 2 in 3 now have 5+ chronic conditions
- Most common diagnoses are CV, MSK and Renal. Cancer now more prevalent
- 1.1% of population but 11% of healthcare costs utilised
- Very high average cost per head (£6,588)
- Average IP spells = 7, OP appts = 12 and >1 A&E attendance.
- Nearly 1 in 6 predicted to have ICU spell in next 12 months.
- 1 in 50 may be candidates for palliative care in next 12 months

Possible intervention approaches:

- Case management (may be palliative)
- Flu uptake and cancer screening
- Pre-dialysis or non-dialysis pathways

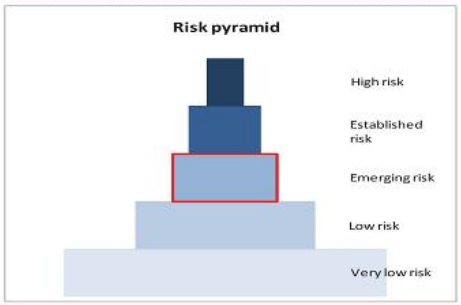


Key population characteristics:

- More even age distribution but most with several established chronic conditions
- 4 in 10 have at least one frailty marker
- Of those with morbidities majority are CV, MSK & endocrine although renal now prev.
- 1.5% of the total population, but 9% of healthcare costs utilised
- High avg. costs per head (£3,656), predicted to rise by 20% in next 12 months
- OP and IP spells now fairly regular, A&E usage approx 1 per patient during year.
- 1 in 3 likely to have IP spell < 6 mths and over half likely to have high pharma costs in next 12 months

Possible intervention approaches:

- Case management
- Falls prevention
- Closer integration with social care teams / ESD

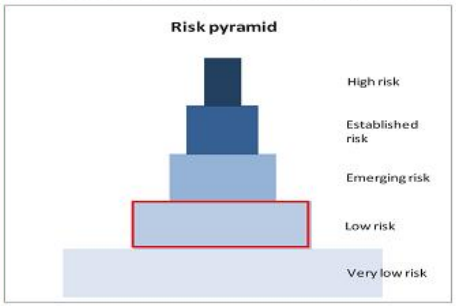


Key population characteristics:

- Vast majority 65+ years, more females
- 1 in 3 now have 1 or more frailties at this stage
- 50% now have 5+ morbidities
- Of those with morbidities majority are CVD, MSK and endocrine diagnoses
- 2.2% of the population but 11% of healthcare costs
- Costs per head £2,854, although predicted to rise by £195 in next 12 months
- Average 7 OP encounters per patient and 1+ IP spells. 1 in 2 will have A&E 'episode'
- Still relatively small probabilities of acute activity in next 12 months.

Possible intervention approaches:

- Health checks across whole risk band
- OP clinics in community (Diabetes, CHD)
- Post IP follow-up / care planning

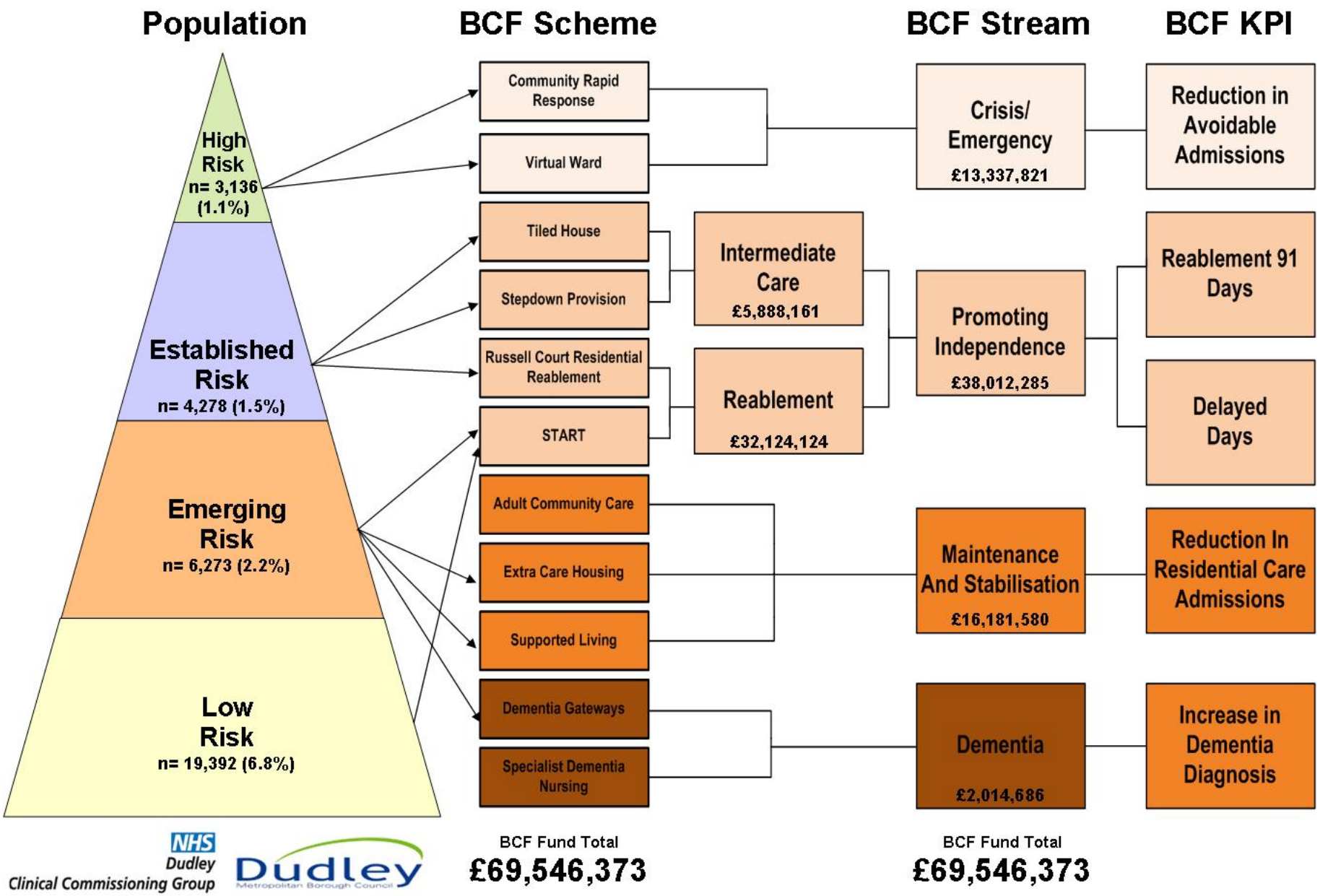


Key population characteristics:

- Predominantly middle-aged (55-74), slightly more females than males
- Around 15% with some level of frailty
- Chronic conditions common although few with many (5+) co-morbidities
- Majority of conditions detected are CVD or MSK
- 6.8% of the total population but generates 19% of the total resource utilised
- Average cost / head £1,672, predicted to rise by £281 over next year
- Utilisation mainly in OP setting
- Low probabilities of most utilisation, although pharma may increase suddenly

Possible intervention approaches:

- Assessment of those with increasing risk (Health checks)
- Medicines usage review for those with early stage LTC / antibiotics awareness campaign
- Brief interventions for lifestyles


Population
BCF Scheme
BCF Stream
BCF KPI
High Risk
n= 3,136 (1.1%)
Established Risk
n= 4,278 (1.5%)
Emerging Risk
n= 6,273 (2.2%)
Low Risk
n= 19,392 (6.8%)
Community Rapid Response
Virtual Ward
Tiled House
Stepdown Provision
Russell Court Residential Reablement
START
Adult Community Care
Extra Care Housing
Supported Living
Dementia Gateways
Specialist Dementia Nursing
Intermediate Care
£5,888,161
Reablement
£32,124,124
Crisis/ Emergency
£13,337,821
Promoting Independence
£38,012,285
Maintenance And Stabilisation
£16,181,580
Dementia
£2,014,686
Reablement 91 Days
Delayed Days
Reduction in Avoidable Admissions
Reduction In Residential Care Admissions
Increase in Dementia Diagnosis
BCF Fund Total
£69,546,373
BCF Fund Total
£69,546,373
NHS Dudley Clinical Commissioning Group
Dudley Metropolitan Borough Council

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Delivery of the Better Care Fund plan sits within a broader plan for integration, underpinned by robust programme and project management arrangements that are overseen by the Integrated Services Working Group.

The Dudley Integrated Health & Social Care (DIHSC) Programme is structured around three core competencies:-

- an infrastructure for integration – covering the governance, systems, culture and practice in Dudley, including the submission and assurance of the BCF plan;
- an integrated service model – as described in our vision for integrated service provision (Section 2 above) and including delivery of our BCF schemes;
- efficiency through integration – our approach to mitigating the financial risks associated with BCF performance and sustaining investment in integration.

Our Milestone Plan (see below) reflects the high level schemes, activities and timescales for delivery of the DIHSC Programme over the period March 2014 to March 2019 and allows for iterative approaches to the identification, approval, delivery and oversight of integrated service and efficiency opportunities.

BCF schemes have been scheduled according to their impact / contribution to performance and efficiency objectives, with those having the greatest impact scheduled to deliver first. This approach should optimise our ability to realise the benefits required.

Dudley Integrated Health & Social Care Programme – Milestone Plan

Programme Components Schemes	Activity Milestone	Lead Organisation	Due Date	2014										2015												2016				2017				2018			
				March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August	September	October	November	December	Jan - March	April - June	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec
Infrastructure																																					
- Governance	Establish arrangements	HWBB	Complete																																		
- BCF Bid Submission	Agree & submit bid	DCCG	19-Sep-14																																		
- Organisational Development	Design Programme	ISWG	Complete																																		
	Deliver interventions	DCCG	June 2014 - March 2015																																		
- Performance Management	Agree requirements	ISWG	Complete																																		
	Agree data sharing arrangements	DCCG, DMBC	Sep-14																																		
	Implement new arrangements	DCCG, DMBC	Nov-14																																		
	Report / manage performance	ISWG	Nov-14																																		
- Communications	Agree communications strategy	ISWG	Oct-14																																		
	Schedule communications	ISWG	Nov 2014 – March 2016																																		
	Deliver & evaluate communications	ISWG	Nov 2014 – March 2016																																		
Integrated Service Model																																					
- Service Design																																					
Seven Day services	Agree service specification	DCCG	Nov-14																																		
	Service Launch	DCCG	Dec-14																																		
Locality Link w orkers	Agree service specification	ISWG	Complete																																		
	Recruit & train	DCVS	June - Sept 2014																																		
	Launch	ISWG	30/09/2014																																		
Practice / Locality focused multi-disciplinary teams	Agree service design	DCCG	Jun-14																																		
	Early Implementation Pilot	DCCG	Sep-14																																		
	Contract agreement / sign-off	DCCG	Nov-14																																		
	Service Launch	DCCG	Dec-14																																		
- BCF Scheme Delivery																																					
1 - Crisis / emergency services																																					
Community Rapid Response	Agree service specification	DCCG	Mar-14																																		
	Agree clinical governance	DCCG	Jun-14																																		
	Recruit & train	DCCG	June - Sept 2014																																		
	IT/Telephony set up	DCCG	Aug - Sept 2014																																		
	Service Launch	DCCG	29/09/2014																																		
Virtual Ward Expansion	Agree PID / Business Case	DCCG																																			
	Agree service specification	DCCG																																			
	Recruit & train	DCCG																																			
	Service Launch	DCCG																																			
Other crisis & emergency services	Agree PID / Business Case	DCCG / DMBC																																			
	Agree service specification	DCCG / DMBC																																			
	Recruit & train	DCCG																																			
	Service Launch	DCCG																																			
2 - Promoting Independence																																					
Locality Prevention Hubs	Agree PID / Business Case	ISWG	Apr-15																																		
	Agree service specification	ISWG	April - June 2015																																		
	Tender & Procure	DMBC	June - Aug 2015																																		
	Service Launch	DMBC	Sep-15																																		
Single Point of Contact	Agree PID / Business Case	ISWG	Sep-14																																		
	Agree service specification	ISWG	Jan-15																																		
	Partnership agreement / SLA	DCCG. DMBC	Mar-15																																		
	Recruit & train	DCCG. DMBC	June - Oct 2015																																		
	IT/Telephony set up	DCCG. DMBC	Sep-15																																		
	Service Launch	DCCG. DMBC	Nov-15																																		

Programme Components Schemes	Activity Milestone	Lead Organisation	Due Date	2014										2015												2016				2017				2018			
				March	April	May	June	July	August	September	October	November	December	January	February	March	April	May	June	July	August	September	October	November	December	Jan - March	April - June	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec	Jan - March	April - June	July - Sept	Oct - Dec
Reablement / Intermediate care	Agree PID / Business Case	ISWG	Oct-14																																		
	Agree service specification	ISWG	Dec-14																																		
	Tender & Procure	DCCG. DMBC	Jan - March 2015																																		
	Recruit & Train	DCCG. DMBC	Jan - March 2015																																		
	Service Launch	DCCG. DMBC	Mar-15																																		
Integrated Community Teams	Agree PID / Business Case	ISWG	Dec-14																																		
	Agree service specification	ISWG	Mar-15																																		
	Recruit & Train	DCCG. DMBC	March - May 2015																																		
	Service Launch	DCCG. DMBC	May-15																																		
3 - Stabilisation & self-management																																					
Advanced Planning	Agree PID / Business Case	ISWG	Dec-14																																		
	Agree service specification	ISWG	Mar-15																																		
	Recruit & Train	DCCG	March - May 2015																																		
	Service Launch	DCCG	May-15																																		
Extra Care Housing	Agree PID / Business Case	ISWG	Jan-15																																		
	Agree service specification	ISWG	Apr-15																																		
	Recruit & Train	DMBC	April - June 2015																																		
	Service Launch	DMBC	Jun-15																																		
Personal Budgets / PHBs	Agree PID / Business Case	ISWG	Feb-15																																		
	Agree service specification	ISWG	May-15																																		
	Recruit & Train	DCCG. DMBC	May - July 2015																																		
	Service Launch	DCCG. DMBC	Jul-15																																		
Disabled Facilities Grants	Agree PID / Business Case	ISWG	Feb-15																																		
	Agree service specification	ISWG	May-15																																		
	Recruit & Train	DMBC	May - July 2015																																		
	Service Launch	DMBC	Jul-15																																		
4 - Support for people w ith Dementia	Agree PID / Business Case	ISWG																																			
	Agree service specification	ISWG																																			
	Recruit & Train	DCCG																																			
	Service Launch	DCCG																																			
Future Service Integration Planning																																					
Phase 1	Identify efficiency opportunities	ISWG	Oct 2014 - March 2016																																		
	Business case approval	ISWG	Oct 2014 - March 2016																																		
	Delivery	ISWG	Oct 2014 - March 2016																																		
	Benefits realisation	ISWG	Oct 2014 - March 2016																																		
Phase 2		ISWG	April 2016 - March 2017																																		
Phase 3		ISWG	April 2017 - March 2018																																		
			April 2018 - March 2019																																		
Efficiency & Sustainability																																					
Management Arrangements	Establish processes	DMBC	Oct-14																																		
Phase 1																																					
(a) Programme Design	Prioritise & Plan phase 1 efficiency opportunities	ISWG	Dec-14																																		
	Deliver phase 1 efficiency schemes	ISWG	Jan 2015 - March 2016																																		
(b) Programme Delivery	Achieve savings for reinvestment	ISWG	Jan 2015 - March 2016																																		
(c) Benefits realisation		ISWG	By March 2016																																		
Phase 2		ISWG	Jan-16																																		
Design			Dec-15																																		
Delivery			Jan 2016 - March 2017																																		
Benefits realisation			Jan 2016 - March 2017																																		
Phase 3			Dec 2016 - March 2018																																		

b) Please articulate the overarching governance arrangements for integrated care locally

This plan has been agreed by all partners. The CCG's 2 year operational plan, our initial Better Care Fund Plan, the associated metrics and outcome targets were approved by the Health and Wellbeing Board in the context of Dudley's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) on 26th March 2014. The CCG's strategic plan was subsequently approved by the Health and Wellbeing Board on 17th June 2014.

From a system perspective there are two key issues which partners face across the NHS and local government – delivering an effective urgent care system and integrating services in such a way as to deliver the objectives of the Better Care Fund. Our system wide governance arrangements reflect this.

Our Urgent Care Working Group and our Integrated Services Working Group both report to the Health and Social Care Leadership Group which consists of chief executive/director representatives from the NHS, local government and the voluntary sector. This has now also been designated as the "System Resilience Group" in the context of national guidance on operational resilience and capacity planning.

This Group reports to the Health and Wellbeing Board on key aspects of system wide performance including:-

- delivery of Joint Health and Wellbeing Strategy priorities;
- delivery of the BCF Plan as a work stream of our integrated services programme;
- reviewing system performance metrics.

The multi-agency Integrated Services Working Group is responsible for the continued development and implementation of the Dudley Integrated Health & Social Care Programme, including delivery of the Better Care Fund plan, and acts as the Programme Board for our Integration / BCF Programme. A sub-group of the Integrated Services Working Group has a specific focus on the performance metrics associated with the BCF and the wider integration programme, with oversight of performance, risks and issues maintained at all levels across our governance arrangements.

Management and delivery of operational aspects of the Programme are dealt with by task groups who report to the the Integrated Services and Urgent Care Working Groups. Escalation procedures ensure management of operational and strategic issues and decision making at the most appropriate levels. Programme Office support arrangements ensure good information flows and transparency of progress whilst supporting delivery

capacity across the programme.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

There is strong ownership of the Better Care Fund at a strategic level. The performance dashboard (see below) will be scrutinised by the Health and Social Care Leadership Group as described above. The performance dashboard will be considered alongside our risk log (see below).

Performance Data and progress reports will be tabled for scrutiny and debate at the Dudley Health and Wellbeing Board as a standing agenda item.

The Integrated Services Working Group (ISWG) is responsible for delivery of key performance indicators and consists of senior representation from all of the organisations listed above alongside Dudley Healthwatch and Dudley CVS. Exceptional performance (either positive or negative) will be flagged and mitigated at this level.

A specialist Performance Management Sub-Group will be established to validate and monitor the performance dashboard and escalate emerging trends and issues to the Integrated Services Working Group.

Each of our integrated teams at practice and locality level will receive a report on a sub-set of metrics relating to the population for which they have responsibility for delivery.

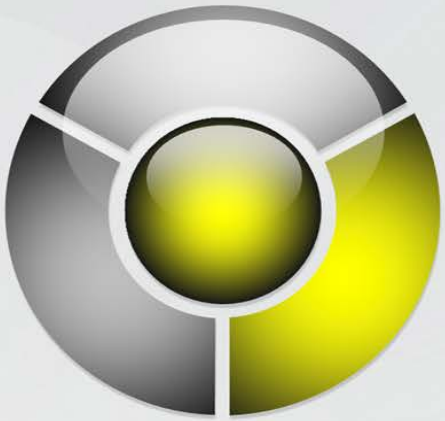
Our organisational development programme is designed to create a system of distributed leadership, where individual practice teams will review their performance against a suite of metrics. This performance will in turn be reviewed by the locality teams and reported to CCG Locality meetings. Remedial action will be executed at as local a level as possible with assurance being given to the Performance Management Sub-Group. This will enable a clear grip of performance from strategic to operational levels and a consistent set of expectations and clearly articulated targets at these levels.

Better Care Fund

CRISIS/ EMERGENCY

AVOID UNECESSARY ACUTE ACTIVITY

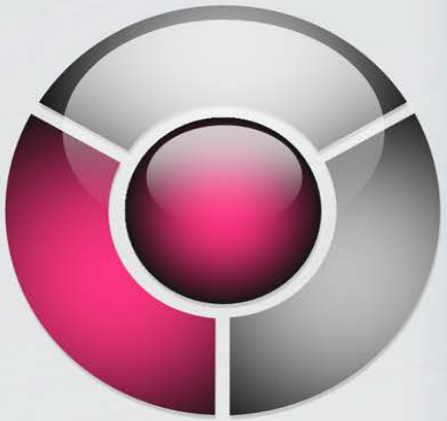
- COMMUNITY RAPID RESPONSE
- VIRTUAL WARD
- CARE HOME PRACTIONERS
- DIABETES & HYPO RAPID RESPONSE
- FALLS SERVICE
- OUT OF HOURS/PERIPETETIC CARE
- CRISIS RESOLUTION/HOME TREATMENT
- EARLY ACCESS/INTERVENTION



PROMOTING INDEPENDENCE

RECOVERY/REABLEMENT IN RIGHT ENVIRONMENT

- RESIDENTIAL INTERMEDIATE CARE
- STEPDOWN CARE
- ACUTE REHABILITATION
- START
- RESIDENTIAL REABLEMENT
- DISCHARGE 2 ASSESS
- CES
- OT
- SUBSTANCE MISUSE



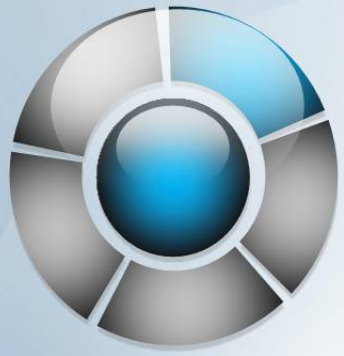
MAINTENANCE & STABILISATION

REDUCE/DELAY DEPENDENCE

- PERSONAL BUDGETS
- SUPPORTED LIVING
- EXTRA CARE HOUSING
- DISABLITY FACILITIES GRANTS
- COMMUNITY MENTAL HEALTH TEAMS
- PALLIATIVE CARE

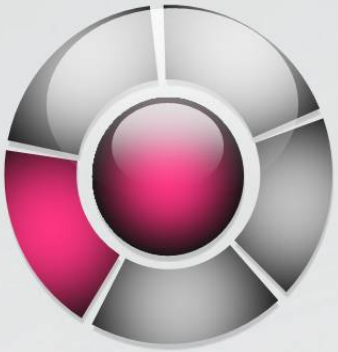
MIT

Better Care Fund – Performance Metrics



Admissions to Residential care

Reduction in Permanent Admissions to Residential Care.
Source – ASCOF 2a (Social Care)

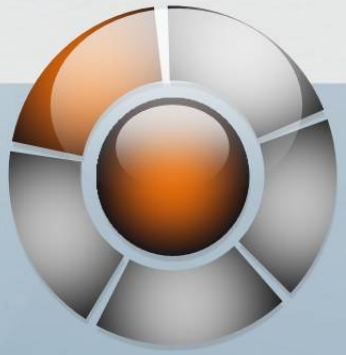


Avoidable Admissions

Reduction in Avoidable Admissions to Hospital.
Source – (CCG)

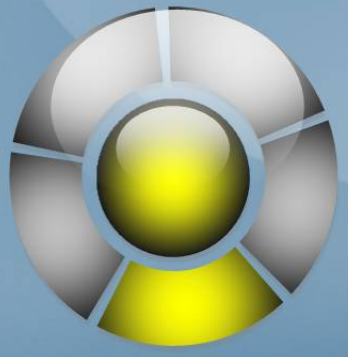
Delayed Days

Reduction in Average number of Delayed Days in Hospital.
Source – UNIFY (DGoH)



Dementia Diagnosis

Increase in Dementia Diagnosis.
Source – (CCG)



Re-ablement – 91 Days

Increase in re-abled clients, still at home after 91 days. Source - ASCOF 2b (Social Care)

- Detail at the lower level includes the agreed performance metrics for schemes that have been included within the greater BCF, against the primary agreed metric, that relates to each team/schemes activity.

Dudley Metropolitan Borough Council

NHS Dudley Clinical Commissioning Group

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

-	Scheme
1	Crisis and Emergency Intervention
2	Promoting Independence
3	Stabilisation and Maintenance
4	Support for People With Dementia

5) RISKS AND CONTINGENCY

a) Risk log

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

Risk Rank	**There is a risk that:**	**How likely is the risk to materialise?**	**Potential impact** *(if financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Mitigating Actions**
High	Admissions to nursing/residential care static or increased	High	High £20k per person per annum to Dudley MBC	Active role of rapid response service and associated community services. Management of public expectations, provision of alternatives to institutional care. Improved operational effectiveness of preventative services
High	Dudley Group NHS FT fail to reduce non-elective bed capacity.	Medium	High £7.5m based on cost of non-elective activity to CCG and	Contracted level of activity. Agreed bed reduction plan.

	Dudley Group NHS FT back fill non-elective capacity with elective work, where commissioning responsibility resides with Dudley CCG		Dudley MBC	Agreed plan for supported and unsupported discharges. Contract management process in relation to planned levels of activity and waiting time performance.
High	Performance fund not delivered	Low	High - £5.98m	Performance management arrangements and ongoing focus on performance at all levels of the structure Ongoing focus on identifying efficiency opportunities to mitigate any shortfall in performance receipt.
Medium	Integration model not fully implemented and expected efficiencies not realised	Low	High At least £2.89m to Dudley CCG and Dudley MBC	Large scale od programme to support development of model. Joint assessment process. Use of risk stratification at practice level to focus work on those patients most at risk of admission. Clear performance framework for each team as a sub-set of BCF measures. Agreed plan for utilisation of mobile technology to increase time spent with service users.
Medium	Emergency admissions increase	Low	High At least £7.5m to	Active role of rapid response service in reducing admissions,

			Dudley CCG	provision of alternatives to institutional care and improved operational effectiveness of preventative services
Low	Failure to fully engage all partners	Low	Low	Effective governance arrangements. Contractual requirement for 2014/15 and 2015/16. Also reflected in Section 75 Agreement
Low	GPs fail to embrace leadership role	Low	Low	NHS England contractual arrangements. Od programme.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Emergency admissions need to **reduce** by a financial value of **£7.5m** to enable the fund to balance and the performance element to be available in full.

The **total value** of the performance element is **£5.98m**. The first call on this total performance fund will be **£2.893m** to be spent by the CCG on **out of hospital NHS services** (the Community Rapid Response Team and GP care for over 75s). This means that **the balance of £3.087m will be allocated to social care** services in the pool on achievement of the total reduction in emergency admissions (£7.5m). As such, **total non-achievement** represents a potential **risk to Dudley MBC equivalent to £3.087m.**

The **CCG's risk** is equivalent to 50% of the value of emergency admission activity (£7.5m) - **£3.75m**. **Dudley MBC** will have the **residual risk of £0.683m** (£3.75m - £3.087m).

Thus the **total risk of non-delivery** of the performance target for each partner is **£3.75m based on a risk sharing agreement of 50% : 50%.**

There is a further requirement to deliver cash releasing efficiency savings from the total fund of £2.893m. Again this will be shared on a 50%:50% basis.

Thus the combined level of **risk for each partner is £5.197m.**

It is our intention to have a level of pooled funding in excess of the minimum requirements. The precise arrangements for the management of any risk with under or

over spends associated with the wider pool will be the subject of further agreement as the governance arrangements for the pooled budget are established through our Section 75 Agreement..

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Dudley is regarded as a “high risk” system in terms of operational and capacity planning requirements for 2014/15.

Our submitted plan contains a number of initiatives that are being commissioned, initially on a non-recurrent basis, designed to deal with issues that have a bearing on service integration and the need to reduce emergency admissions and speed up the discharge process. These include:-

- the testing of a “discharge to assess” model to improve patient flow and enhance reablement;

- the use of a dedicated vehicle supported by a paramedic, community psychiatric nurse and police officer to intercept and prevent unnecessary ED/Section 136 suite attendances for people with mental health problems.

As part of the process for developing its commissioning intentions for 2015/16 and reviewing the impact of winter 2014/15, these schemes will be considered for funding on a recurrent basis.

The CCG is in the process of implementing personal health budgets for people meeting the NHS continuing healthcare criteria. The CCG will look to develop this process further for people with long term conditions, given the significance of promoting the systematic management of patients with long term conditions, as identified above.

A number of initiatives are underway to reduce duplicated assessments, improve the timeliness of interventions and offer increased control and choice over care services in a community based setting. The Council’s Customer Journey programme has streamlined access to care and support. The Council has a long established commitment to delivering choice and control via Making It Real (see www.makingitrealindudley.org), with personal budgets embedded across adult social care. The requirement to integrate care and support also aligns with preparations to implement the Care Act which sees preventative support (amongst other areas) becoming a statutory duty of care. Dudley MBC operates a programme management office to co-ordinate delivery across its change portfolio and to manage interdependencies, including with BCF delivery, and is sharing resources with Dudley CCG to extend programme management arrangements across the integration agenda.

The principle underpinning the formation of BCF delivery task groups is one of partnership and shared resources.

The Performance Management Sub- Group is a joint group involving performance expertise from the CCG and the Council, supported by resources commissioned from NHS Central Midlands Commissioning Support Unit.

A joint Communications Task Group of CCG and Council communications specialists is developing a communication & engagement strategy for the Dudley Integrated Health & Social Care programme, under the direction of the Integrated Services Working Group.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our approach to service integration is set out in the CCG's 2 year operational plan, in terms of how this is designed to respond to the needs identified in the JSNA and in response to the 6 system characteristics.

All schemes identified in this plan feature in the operational plan and the CCG's financial plan. Activity changes are reflected in agreed contracts with the CCG's providers.

Our future vision is reflected in the CCG's strategic plan.

Integration is a component of the Council's target operating model for adult social care and a recurring theme throughout the Council's Efficiency Strategy.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG has expressed a strong expression of interest in co-commissioning and this identifies the achievement of service integration as an intended benefit.

All services which form part of our integrated service are commissioned either by the CCG or the Council. However, contracts for primary medical services, which lie at the heart of the model, are commissioned by NHS England.

Having the ability to commission primary medical services, alongside our existing commissioning responsibilities, will enable us to pilot new commissioning models so that we commission all health and care providers serving a common population on the basis of a common set of outcome measures.

As a result of this we consider that we will be better able to:-

- enhance quality standards;
- enhance patient and public involvement;
- reduce variation in services;
- tackle health inequalities;
- improve system effectiveness.

contributing to the overall BCF programme.

7) NATIONAL CONDITIONS

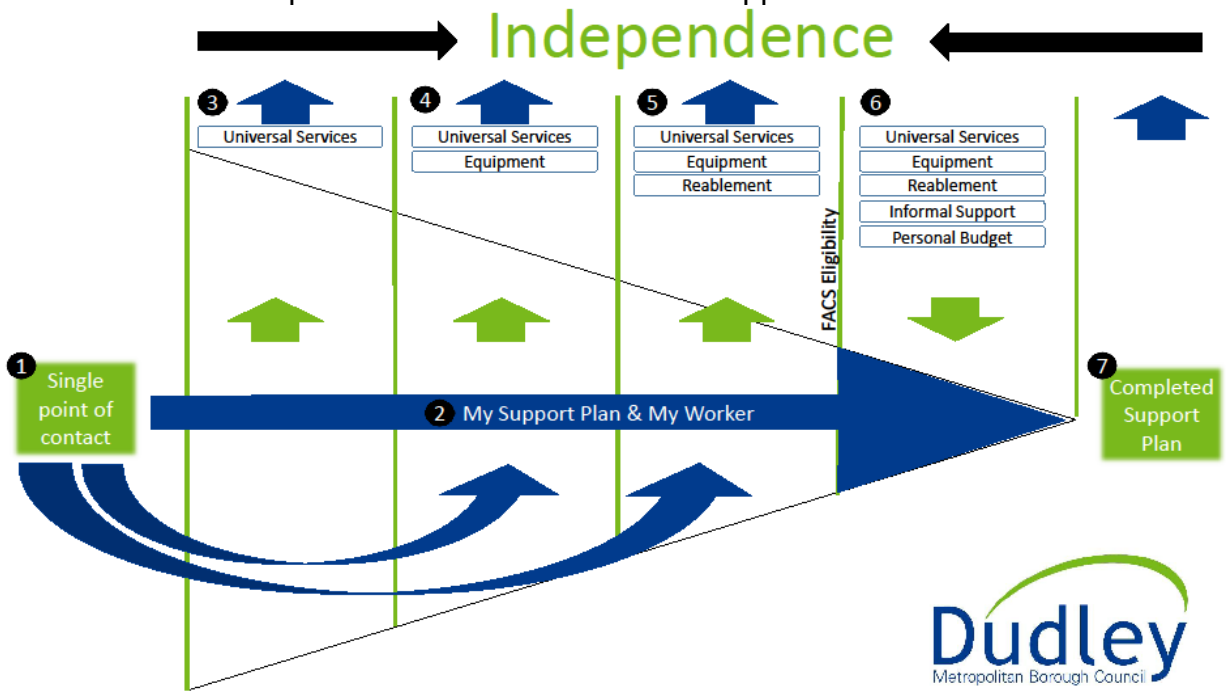
Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Protecting adult social care services (not spending) in Dudley means establishing and maintaining a new operating model in order to meet the demand for current and future social care and support within a sustainable system.
The target operating model defines the adult social care approach in working with the wider population to engage universal services, through to meeting complex levels of need and vulnerability through a personal budget. The model is a response to the changing financial context up to 31st March 2017 and focuses on:-

- integration;
- prevention;
- implementation of the Care Act 2014;
- a core offer of personalised care and health support.



The model identifies a single point of contact for all access to care and support. The model is underpinned by the need to promote and maximise independence irrespective of age or disability and avoid the need for complex and intensive social care.
The approach is based upon a number of tiers of interventions that are designed to promote independence. A person contacting the Council for support will be guided through the differing interventions until a maximum state of independence has been reached. At this point a support plan, documenting how such independence will be maintained, will be completed. In supporting people to reach a maximum state of independence the model aims to provide the most person centred and efficient experience possible.

As such the model asserts the following standards:-

- people will only provide their personal details and circumstances once;
- a named point of contact will co-ordinate and be in place throughout any intervention;
- personal choice, assets and skills will be the starting point of any support;
- assessment and support plans are not duplicated or completed in isolation;
- a culture of resolution and customer satisfaction is at the centre of all we do;
- support to carers will be accessible and tailored to their needs.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

The following preventative aspects of this model will be protected through our plans:-

- the Emergency Response Team;
- intermediate care;
- access service;
- reablement (both community and residential based);
- dementia gateways;
- personalised care and support;
- Disabled Facilities Grants and implementation of the new statutory duties in the Care Act.

Adult social care funding in Dudley will decrease by up to £25m over the next four years - a significant decrease in our operating budget of £80m. Our plan will offse**t £8.3m** of the savings pressures and will enable further efficiencies to both the health and social care economy by avoiding the need for hospital, residential and nursing care admissions. The Section 75 Agreement to govern usage of the Better Care Fund will explicitly articulate the statutory duties associated with the Care Act and will commit investment accordingly.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total amount allocated for adult social care services **is £32.994m**, which incorporates sums included in the adult social care base budget, transfers of funding from NHS England, monies allocated from the delivery of the performance metrics and transfers of funding from the CCG.

The amount from the Better Care Fund that has been allocated for the protection of Adult Social Care Services **is £6.854m** and this represents the Council's share of the national allocation of £1.9bn. Of this sum, £1.1m has been earmarked to cover some of the costs of implementation of the Care Act.

Some £3.07m of the monies identified for the protection of adult social care services is expected to be generated through the delivery of the performance metrics in relation to admission avoidance. This amount is at risk if the performance metrics around admission avoidance are not met and could lead to increased costs for the Council and this may in turn affect our ability to protect some key services. This has been identified as a key risk for both BCF and the Council.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Care Act 2014 is built around people. Compliance with the Act will:-

- ensure that people's well-being, and the outcomes which matter to them, will be at the heart of every decision that is made;
- put carers on the same footing as those they care for;
- create a new focus on preventing and delaying needs for care and support, rather than only intervening at crisis point, and building on the strengths in the community;
- embed rights to choice, through care plans and personal budgets, and ensuring a range of high quality services are available locally.

The Act makes care and support clearer and fairer, by:-

- extending financial support to those who need it most, and protects everyone from catastrophic care costs though a cap on the care costs that people will incur.
- ensuring that people do not have to sell their homes in their lifetime to pay for residential care, by providing for a new deferred payments scheme;
- providing for a single national threshold for eligibility to care and support;
- supporting people with information, advice and advocacy to understand their rights and responsibilities, access care when they need it, and plan for their future needs;
- giving new guarantees to ensure continuity of care when people move between areas, to remove the fear that people will be left without the care they need;
- including new protections to ensure that no one goes without care if their provider fails, regardless of who pays for their care.

The target operating model for adult social care has been designed with the Act's duties and principles in mind. The new customer journey has a clear focus on wellbeing and independence, through measures that will prevent, delay, reduce and, where necessary, meet ongoing care and support needs. Information systems are being enhanced whilst operating structures, capacity, systems and workforce development plans are all being designed in light of the change in demand that is expected to arise. Assessment and care planning processes have been remodelled, whilst engagement with providers has focused on achieving better outcomes through a diverse, high quality and sustainable care and support market. Collectively these measures are required to mitigate the inevitable increase in costs that will arise from the Act's provisions.

The schemes developed under the Better Care Fund in Dudley enable us to fulfil our statutory duties. For example, our five locality based hubs will be commissioned from the community and voluntary sector to facilitate prevention type services in each local area. The hubs will build upon our current “living well feeling safe” partnership to provide information and advice alongside supporting people to develop personal resilience and reduced dependence upon public services. The access service will include the provision of signposting, low level equipment, initial assessment and screening, and will also serve as a single point of contact for crisis response and safeguarding. Practice and locality based multi-disciplinary teams will adopt person centred practice and perform joint assessments, reducing duplication and handoffs in the system and helping people to receive a swifter and more appropriate intervention.

v) Please specify the level of resource that will be dedicated to carer-specific support

Dudley CCG and Dudley MBC have commitment to carers with both a Carers Strategy and an Integrated Carers Investment Plan. This outlines the current resources and how support for carers will be provided to improve carer well-being, provide practical support and information to carers, promote choice to enable carers and service users to have more power and control over their lives and recognition of the carers and cared for as valued people within the community.

The current joint investment in carers services is around £1.6m, this is spent on a range of services including information and advice, specific carers services, respite care and carers grants. These are provided by a cross section of staff commissioned by the CCG and the Council together with commissioned services from the third and private sectors. The Care Act places additional demands on the Council to provide assessments and advice to carers. An additional sum of around £300k (£99k assessment costs and 198k additional support for carers) has been identified within the Better Care Fund to support the additional demand for services that we believe the Care Act will bring.

vi) Please explain to what extent has the local authority’s budget been affected against what was originally forecast with the original BCF plan?

Renegotiation of the financial arrangements underpinning the BCF plan has been considered in order to better reflect the performance delivery risk arising from changes in the BCF guidance.

Whilst the revised arrangements have been concluded at a net nil cost to the Council’s budget, there is an increased risk arising from changes in the Pay for Performance arrangements. As a result, the Council is developing contingency plans aimed at mitigating its share of the performance risk.

b) 7 day services to support discharge

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

The health and social care economy has demonstrated its commitment to 7 day working by becoming a national pilot site for 7 day service transformation.

Our locality model is constructed on the basis of providing a response on a 7 day basis and we are actively realigning our services to achieve this as part of our overall plan. The following services operate on a 7 day basis:-

- community nursing;
- dementia gateways;
- mental health crisis resolution;
- respiratory assessment;
- telecare;
- virtual ward;
- community rapid response team.

A range of other services will be reviewed in terms of their potential to move to 7 day working in 2014.

In order to ensure that the discharge process is managed effectively, 7 days per week, we have agreed a system wide plan for supported and unsupported discharges across health and social care. This defines the level of discharges expected for a planned level of admissions. This plan will be overseen by the Urgent Care Working Group, reporting to the Health and Social Care Leadership Group (see above) and will act as the key means of holding the system to account.

The service specification for the Rapid Response Service sets out clear clinical standards. As part of our involvement in the 7 day service transformation programme, we will seek to develop and implement clinical standards for all our community services. These will be embedded in our contracts with providers.

We have an agreed programme of work to develop local standards in relation to:-

- patient experience – capturing post care and advanced care planning;
- speed of access and assessment in the community;
- follow up – within 24 hours;
- handover and communications;
- diagnostics – access to scans, blood tests etc.;
- mental health – access and for health and social care community teams to be educated in early signs of illness;
- communication with relatives and carers;
- reablement;
- appraisal of care – MDT approach;
- information access;
- workforce satisfaction.

This will build on the Council's long established track record of delivering 24/7 preventative support such as the reablement and telecare service.
We have already articulated our vision for 7 day services in primary care, not least through our new urgent care model and this will be developed through our co - commissioning arrangements with NHS England.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The use of the NHS number is embedded in NHS contracts for 2014/15.
In addition 85% of social care records now include the NHS number with an expected increase to 100% by the end of 2014/15. At this point the NHS Number will become the primary identifier across health and social care services.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Open APIs

We have established a multi-agency working group to develop an IT infrastructure that:-

- allows information to be exchanged between systems through open standard interfaces (supported by open APIs where appropriate);
- meets national standards and services used wherever possible will streamline, coordinate and standardise IT systems wherever possible.

Open Standards

In Dudley there are a number of specific arrangements which have been put in place through which Email can be sent externally via a more secure environment:-

- a private link to NHS.Net has been established using stringent security at a N3 network level;
- a secure email service product called Sophos SPX Encryption;
- GCSX Secure email for mail transmission between any Central Government department, other local authorities and the NHS (where the Health users is a nhs.net account holder).

We also utilise the facilities of the Council's Content Management System (CMS). This can be used to create secure portals that can enable sensitive information to be obtained and shared through a secure website.

We are working with our Commissioning Support Unit to develop a combined data base of health and social care information to inform our commissioning process. In addition, we are reviewing how we ensure that integrated information systems are in place which are based upon our integrated service delivery model, rather than being organised around traditional organisational boundaries.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The approach to information governance is long established in Dudley with robust IG controls in place. All requirements will be met.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Our model is based upon having a lead accountable professional at both practice and locality level. We have described above how we expect this to function. Our OD programme will embed this in the culture of our teams.

1.1% of our population are at risk of hospitalisation as identified by the Johns Hopkins University All Care Groups (ACG) risk stratification tool (for analysis see above). The use of this risk stratification tool, extended to social care, is a pre-requisite for how we expect integrated teams to function, using this data to inform decision-making and monitor performance.

Engagement with ACG risk stratification data will be a key item of business at MDT meetings. We will use risk scores for patients as a means of measuring the impact of interventions on reducing levels of dependency.

Our integrated service model will mean adopting the principles of common assessment and a care co-ordination approach led by GPs in multi-disciplinary teams. In practice this will mean:-

- people will only provide their personal details and circumstances once;
- a named point of contact will coordinate and be in place throughout any intervention;
- personal choice, assets and skills will be the starting point of any support;
- assessment and support plans are not duplicated or completed in isolation;
- a culture of resolution and customer satisfaction are at the centre of all we do;
- support to carers will be accessible and tailored to the needs of the carer;
- the model will evolve and be responsive to the needs and feedback of local people;
- consent is obtained by the person or relevant person to provide care and treatment.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The ACG risk stratification tool is used to risk stratify the population at GP practice level. This also supports the National Enhanced Service for Proactive Care.

The top 2% are assessed, a care plan developed and lead responsibility allocated by the practice team to the lead GP or a named care co-ordinator.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

By 30th September 2014, all patients falling into the top 2% will have a joint care plan in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

These plans were developed through our established patient and public engagement mechanisms including health and social care provider fora, the CCG's Healthcare Forum and our network of patient participation groups.

In addition, we undertook a range of engagement events entitled "Your Care, Your Support, Your Way"; a set of consultation events in relation to the CCG's proposals for the development of urgent care and the Health and Wellbeing Board's "Spotlight" event on urgent care.

The consistent feedback from these processes highlighted the need for better coordination across community based care and health services and this is reflected in our proposal.

The Integrated Services Working Group are utilising patient stories to inform the design process for our integration model.

Voluntary and community sector organisations are a key component of our model. Ensuring effective access to community support, maintaining independence and enhancing social capital will be measures of our success. Obtaining continuous feedback from these groups, with their roots in our local communities, will add to other engagement processes.

We will commission Dudley Healthwatch to manage a future evaluation of the plan as it is implemented, making appropriate adjustments. Healthwatch will engage with the community to define patient based measures of success for the BCF.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

This plan is a further development of work carried out to develop the Dudley Health and Wellbeing Board's proposal for "integration pioneer" status originally made in July 2013.

Our original bid was jointly agreed by Dudley CCG, Dudley Group NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust, Dudley MBC (adult services and public health), NHS England and Dudley Council for Voluntary Services. Our plan continues to reflect the main principles of integrated locality working across health and social care and engagement with providers has been at the heart of our work. Specific negotiations have taken place in relation to the operation of the BCF involving all partners listed above.

The Health and Social Care Leadership Group (see above) is the main vehicle of engagement between the bodies involved, including the voluntary sector. This Group will act as the "governing body" for our Section 75 Agreement.

The multi-agency Integrated Services Working Group is responsible for the continued development and implementation of the plan.

The proposals in this plan have been informed by Dudley's Joint Strategic Needs Assessment, the priorities in our Joint Health and Wellbeing Strategy, the CCG's Operational Plan, the Dudley Local Account for 2012/13 and the Making it Real Action Plan.

The contracts agreed between the CCG, Dudley Group NHS FT and the West Midlands Ambulance Service NHS Trust for 2014/15 reflect our joint work on activity modelling that relates to the implementation of our plan.

ii) primary care providers

There has been full engagement with general practices in Dudley given the key role they play in our model of integrated service delivery.

Over the past 12 months, our plans have been a consistent feature of our monthly CCG Locality meetings (attended by representatives of all practices within a given locality) and at our borough wide membership meetings (attended by representatives of every practice in Dudley).

Primary care colleagues are fully engaged in our organisational development programme which underpins our plan. Since August, 5 of our larger practices have acted as early implementers of our integrated model, prior to wider roll out across all practices.

iii) social care and providers from the voluntary and community sector

Engagement has taken place with the West Midlands Care Home Association, 120 care provider organisations through Black Country Partners for Care, the Domiciliary Care Provider Forum and the Micro Provider Network.

Dudley Council for Voluntary Service was a co-signatory of our original "Integration Pioneer" proposal. This body, represented on the Health and Social Care Leadership Group and the Integrated Services Working Group, has been fully engaged in the process of developing local plans.

Events have taken place with local voluntary and community sector organisations as part of the development process. The CCG has commissioned a specific social prescribing scheme from Age UK to support the model. In addition, following discussions with the voluntary and community services sector, the CCG has commissioned 5 locality link workers with responsibility for ensuring effective links and pathways from practice and locality based integrated teams into voluntary and community sector services, as well as facilitating the creation of additional capacity in response to identified need.

Engagement has also taken place with Dudley Healthwatch.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

NHS savings will be realised in the following ways:-

- integrated working at practice level (see above) delivering operational efficiencies, supported by the application of information technology, ensuring that patient contact time is maximised;
- unnecessary admissions being avoided through the use of the Community Rapid Response Team;
- the implementation of a new pathway for urgent care and the operation of the new urgent care centre.

The implication of these elements has formed part of the negotiations with NHS providers for 2014/15 and beyond. Our activity and financial assumptions are set out in the attached graphs.

They will primarily impact upon Dudley Group NHS Foundation Trust (reduced admissions, increased community contacts) and West Midlands Ambulance Service NHS Trust (reduced conveyances).

The CCG's contract for 2014/15-2015/16 with Dudley Group NHS Foundation Trust has been agreed on the basis of these activity assumptions and the need to reduce emergency activity by 15%.

Specific negotiations have taken place with Dudley Group NHS FT regarding capacity reductions. This will equate to reducing capacity by the equivalent of 4 acute wards. This is being factored into our future joint planning assumptions and forms part of the Foundation Trust's Integrated Business Plan.

Assurance was given to NHS England on this element of the plan via an email exchange between The FT's Director of Finance and the LAT's Director of Operations and Delivery dated 17/4/14.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

Scheme 1

Scheme ref no.
1
Scheme name
Crisis and Emergency Intervention
What is the strategic objective of this scheme?
A community based team of advanced nurse practitioners and associated services including the practice integrated teams has been designed to manage frail elderly patients who traditionally would have been admitted to secondary care and nursing/residential care. Key objectives are to:- • reduce emergency admissions to secondary care; • reduce admissions to care home; • reduce mortality rates; • reduce care home admissions; • increase end of life care choice; • improve management of long term conditions; • reduce levels of dependency; • reduced levels of social isolation; • to have a consistent response 7 days per week.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The schemes will operate 7 days per week and consist of:- **Community Rapid Response Team** • The Community Rapid Response Team (CRRT) is a team of nine advanced nurse practitioners (ANPs). • The team provide a proactive approach to supporting older people with frailty to remain at home, as an alternative to admission, using a shared care approach between health and social care including West Midlands Ambulance Service (WMAS). • The ANPs in the CRRT will either take calls from WMAS, GPs, Out Of Hours GP service, ambulatory ward and the community nursing teams or co-respond/intercept green code 2 calls via the Computer Aided Despatch system of WMAS. Their role is to assess, initiate treatment, and instigate a care package to step down to the integrated nursing teams. • The CRRT is integrated with a dedicated team of social care assistants to ensure that urgent social care packages are initiated as part of the immediate care

management to avoid admission.
- The CRRT are further integrated with the care home nurse practitioners to ensure robust, well-resourced and effective management of patients in care homes (see below).

Care Home Nurse Practitioners

- The current care home nurse practitioner team will be integrated with the CRRT. This team currently consists of three nurse practitioners and a community nurse to undertake proactive work.
- In order for the team to become a 7 day service and maintain the commissioned proactive service (educating care home staff on managing and preventing conditions) there is a new investment of 3 nurse practitioners to provide a 7 day service from 08.00-22.00.
- This team will accept referrals via the CRRT as part of a step down process. They are commissioned specifically to support care homes given the complexity of conditions that residents can present with. There are 2,200 Dudley CCG registered patients in nursing and residential care homes with the level of co-morbidity identified as a result of the risk stratification process.
- As part of this approach, there will be a dedicated educational programme and revised contract arrangements to ensure that care home staff follow protocols to refer to the CRRT for certain conditions rather than 999.

Virtual ward

- The nursing staff on the Virtual Ward provide case management which is fundamental to both the step down from the CRRT and the delivery of integrated working at practice level.
- Case management includes self-care and a proactive approach to identify the most vulnerable people with highly complex multiple long term conditions and use a multi-disciplinary approach to anticipate, assess and co-ordinate their care in conjunction with the practice based team.

Heart Failure Service

- A redesigned heart failure service will work 7 days per week to support the step-down from the CRRT at weekends for both acute management and increased provision of intravenous diuretics in a community setting to prevent unnecessary admission.
- This supports the creation of an integrated seamless pathway for heart failure management and enables increased opportunities for earlier supported discharge and the utilisation of remote monitoring

Community Respiratory Service

- In order to reduce respiratory urgent care admissions the service will be redesigned to have a permanent community respiratory team.
- The new community team will accept referrals direct from the CRRT as well as attending practice integrated team meetings to review the case management of complex respiratory patients as part of the case management approach.

- The new service will also enable more people to have a choice at the end of life, dying in their preferred place of care.

Palliative care and end of life

The CCG in partnership with the Dudley Group NHS FT and Mary Stevens Hospice were successful in a bid to Macmillan Cancer Care to become an "Innovative Centre for Community Specialist Palliative Care". This includes a new palliative care consultant to develop a collaborative community specialist palliative care service in Dudley.

The new service will operate in the community as follows:-

- integrating hospice and community specialist services via a single point of access for patients;
- provide earlier referral to services to prevent unplanned hospital admissions provide early crisis intervention;
- facilitation of preferred place of care;
- working with the other community teams to provide an integrated response;
- facilitating a greater level of advance care planning;
- preventing duplication of services, reducing over-processing of patients, improve
- care planning and minimise the burden placed on patients and carers by repeated assessment;
- accessing and navigating the health care system;
- supporting the development of an integrated IT infrastructure across palliative care services which supports collaborative working and Electronic Palliative Care Communication systems.

  A new Gold Standard Framework local improvement scheme has been developed to help practices recognise the numbers of people in the last year of their life and increase the recognition of numbers of patients with palliative care needs requiring enhanced care in the community - the 'Find Your 1%' campaign.

There is particular emphasis on supporting people who do not have a cancer diagnosis, but who are at the end of their life due to other conditions, or general frailty.

Requirements to participate in the GSF ES stipulated in the service specification include:-

- a nominated end of life care lead in the practice;
- having a structured format to the GSF meetings, linked to our integrated model;
- providing an up to date register of patients at the end of life / in receipt of palliative care;
- ensuring that people identified and on the GSF register are offered advance care planning and ensure that appropriate documentation is initiated.

Diabetes

- Delivery of Local improvement scheme to ensure more activity and diabetes care is undertaken in the community.
- To deliver a community based model of care building on existing community based nurse led clinics and developing consultant out-reach.

- Review of current Diabetes patient and clinical education programmes and commission outcome based structured education programmes in the future.

Over 75s and Care Planning

- The CCG have identified their top 2% high risk of emergency admission patients via a new risk stratification tool and received training in care planning to support these patients.
- Following the guidance to CCGs to provide further funding to commission additional services the practices have identified areas to improve the quality of care for older people. This includes a new long term conditions framework and additional care planning with a proactive review of patients who have been identified as having an emergent risk through the risk stratification tool. Importantly this will include identifying and reaching out to those who have disengaged with their practices

Falls Service

- Dudley CCG and MBC have worked in partnership to develop an integrated falls pathway with a single point of access. This enables all referrals for falls to be triaged via the Dudley community falls service.
- This includes referrals from primary care, ED and hospital wards, community services and MBC services including sheltered and extra care housing.
- The triage service includes a registered nurse who completes initial screening of cases for access to falls/syncope clinic. This enables the ortho-geriatrician to assess those patients that meet appropriate criteria i.e. Syncope, blackouts, loss of consciousness.

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

Service	Lead Commissioner	Providers involved
Community Rapid Response Team	Dudley CCG and Dudley MBC	Dudley Group FT and Dudley MBC
Care Home Nurse Practitioners	Dudley CCG	Dudley Group FT
Virtual Ward	Dudley CCG	Dudley Group FT
Heart Failure Team	Dudley CCG	Dudley Group FT
Respiratory Team	Dudley CCG	Dudley Group FT
Palliative Care Team	Dudley CCG	Dudley Group FT
Falls team	Dudley CCG and Dudley MBC	DG FT and Dudley MBC

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

Evidence to support the change:-

- Lack of resources in the community has been identified as a reason by GPs and WMAS as to why patients cannot be managed in their own homes and are forced to admit to secondary care.
- Where community resources are available they do not provide 7 day services resulting in an inconsistent response.
- Admissions for general medicine account for 50% of all admissions for the over 64s.
- 83.7% of admissions for this cohort are by ambulance.
- A third of all total admissions are for the over 75s.
- 60% of the cost of all admissions is attributable to the over 64s (£32.5 million).
- A significant proportion of admissions are for 2 days or less.
- Infection is the dominant reason for admission (chest, UTI and cellulitis).
- Potential benefit of this intervention given the stratification of the population as described above.

This supports the provision of a service for the frail elderly based upon:-

- Highest cost of admissions.
- Longest length of stay.
- Admissions taking place for conditions that could be managed by an intervention by an advanced nurse practitioner.
- Admissions for 2 days or less support the need for intervention and management in the community.
- A consistent response 7 days per week.

References

- Emergency Care Intensive Support Team Report

- Intercollegiate Document ‘Quality Care for Older People with Urgent & Emergency Care Needs ‘’Silver Book’’(2012) - supports the recommendation for community based services with a rapid response

Investment requirements

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

The investment of £13 million in the schemes to deliver emergency and crisis are as follows

Service	**Investment**
Community Rapid Response Team	£1.78m
Care Home Nurse Practitioners	£0.16m
Virtual Ward	£1.62m
Heart Failure Service	£0.59m
Community Respiratory Service	£0.43m
Palliative Care and End of Life	£0.92m
Crisis Resolution & Home Treatment	£3.05m
Emergency Response Team	£0.51m
Community IV Therapy	£0.55m

Early Access and Intervention	£1.22m
Out of Hours – Social Services	£0.28m
Diabetes	£0.46m
Over 75s and Care Planning	£1.57m
Falls Service	£0.20m
Total	**£13.34m**

Impact of scheme

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

Service	BCF Metric	Level of impact	Evidence to support assumption
Community Rapid Response Team	Non elective admissions	High	Significant number of admissions could be avoided if appropriate community service was available (see above).
	Delayed Discharges	High	Service will be available 7 days per week
	Care home admissions	Medium	Significant number of admissions could be avoided if appropriate community service was available (see above).
	Patient experience	High	Patient and public consultation (Healthcare Forum and HWB Spotlight Events) indicates a preference for community based services to enable people to stay in their own home.
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Care Home Nurse Practitioners	Non elective admissions	High	Significant number of admissions could be avoided if appropriate community service was available (see above).
	Delayed Discharges	High	Availability of care home nurse practitioners to support care homes will facilitate discharge process
	Care home admissions	Low	Significant number of admissions could be avoided if appropriate community service was available (see above).

	Dementia diagnosis	High	Ability to identify and diagnose enhanced by availability of specialist staff.
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Virtual Ward	Non elective admissions	High	Availability of virtual ward provides an alternative to hospital admission.
	Delayed Discharges	High	Availability of virtual ward staff enables stepping down of patients from acute care
	Care Home Admissions	Medium	Significant number of admissions could be avoided if appropriate community service was available (see above)
	Patient experience	High	Patient and public consultation (Healthcare Forum and HWB Spotlight events) indicates a preference for community based services to enable people to stay in their own home.
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Heart Failure Service	Non elective admissions	High	Availability of community based service enables step down from CRRT, 7 days per week to prevent admission.
	Care home admissions	Medium	Availability of community based service enables step down from CRRT, 7 days per week to prevent admission.
	Patient experience	High	Patient and public consultation (Healthcare Forum and HWB Spotlight events), indicates a preference for community based services to enable people to stay in their own home.
Service	**BCF Metric**	**Level of**	**Evidence to support**

		Impact	assumption
Community Respiratory Service	Non elective admissions	High	Service can provide step down from CRRT, 7 days per week, to prevent admission.
	Delayed Discharges	High	Service can facilitate early supported discharge, 7 days per week.
	Reablement	High	Availability of a community based service facilitates a community reablement approach.
	Care home admissions	Medium	Availability of a community based service provides an alternative to admission.
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Palliative Care and End of Life	Non elective admissions	High	Availability of community based service enables step down from CRRT, 7 days per week to prevent admission. Numbers of patients dying in acute settings is high.
	Delayed Discharges	High	Service can facilitate supported discharge and enable patients to die in the place of their choice.
	Residential care	High	Availability of community based service enables step down from CRRT, 7 days per week, to prevent admission.
	Patient experience	High	Patient and public consultation via Healthcare Forum has indicated a preference for people to be able to choose to die at home.
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Diabetes	Non elective admissions	High	Level of co-morbidity and prevalence of diabetes indicates a need for more community based care. Community intervention can prevent admission and provide

			step down from CRRT.
	Delayed Discharges	High	Availability of a community based service facilitates effective discharge following admission.
	Reablement	High	
	Care home admissions	Medium	Availability of a community based service provides an alternative to hospital admission.
	Patient experience	High	Consultation with service users indicates a preference for amore community based service
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Over 75s and Care Planning	Non elective admissions	High	Effective care planning in conjunction with integrated practice teams, virtual ward, palliative care team and community teams for diabetes and respiratory services provides an alternative to admission. Evidence shows a significant number of admissions for this group, many of which are for infections.
	Delayed Discharges	High	Effective care planning, linked to integrated practice team and support of associated community based services, enables effective discharge.
	Reablement	High	Effective care planning, linked to integrated practice team and support of associated community based services.
	Care home admissions	High	Effective care planning in conjunction with integrated practice teams, virtual ward, palliative care team and

			community teams for diabetes and respiratory services provides an alternative to admission. Evidence shows a significant number of admissions for this group, many of which are for infections.
	Dementia diagnosis	High	Effective care planning enables earlier diagnosis and access to dementia gateways (see scheme 4 below)
	Patient experience	High	Consultation with Healthcare Forum and Patient Opportunity Panels demonstrates a strong preference for A more personalised approach to care planning for over 75s.
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Falls service	Non elective admissions	High	Risk stratification (see above) shows that there are patients in the established risk group who would benefit from this intervention.
	Delayed Discharges	Medium	Availability of a community service facilitates effective discharge.
	Reablement	High	Availability of a community service facilitates effective discharge.
	Care home admissions.	High	Risk stratification (see above) shows that there are patients in the established risk group who would benefit from this intervention.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?
The key measure of success for this scheme will be in term of preventing admission to hospital and residential/nursing home care. We will monitor the performance of these services over 7 days per week in relation to:- • number of referrals; • number of interceptions; • number of packages of care initiated; • step down to practice based teams/virtual ward ED/EAU/intermediate care; • WMAS green code 2 and 4 calls for patients over 65. Performance reports on these key indicators will be generated at a number of levels for :- • the Rapid Response Team itself; • the integrated practice teams; • the locality teams; • the Integrated Services Working Group/Health and Social Care Leadership Group. on a monthly basis providing a rapid feedback loop.
What are the key success factors for implementation of this scheme?
• Build on strong history of partnership working. • Investment and participation in organisational development programme as agreed. • Full engagement of general practice as achieved through our locality structures. • Full support of West Midlands Ambulance Service. • Investment in skills of ANPs and social care support staff. • Ensuring associated services are invested in at appropriate scale to provide adequate response.

ANNEX 1 – Detailed Scheme Description

Scheme 2

Scheme ref no.
2.
Scheme name
Promoting Independence
What is the strategic objective of this scheme?
This scheme will reconfigure the access, coordination and provision of support and services to enable people to regain and retain their independence in their

communities. This is a key priority identified within the Dudley Joint Strategic Needs Assessment.

Promoting independence services exist to support people following a period of ill health, so that they can return to an optimal position of independence. As such, they help facilitate prompt and safe discharge from hospital, whilst serving to reduce the need for long-term and intensive forms of support.

Effective services in this scheme depend on integrated access and commissioning arrangements and on the existence of a diverse, high quality, affordable and sustainable provider market.

Whilst these services currently exist within Dudley, they operate in parallel, rather than as an integrated, health and social care response. Our case for change is based upon the following issues within the health and social care system:-

- a lack of visibility of health and social care for the public ,particularly around pre crisis response to enable self-service;
- multiple points of contact that create duplication and frustration for the public;
- our intermediate care and reablement services are provided and commissioned by multiple organisations leading to under utilisation and delay;
- multiple teams travelling across the borough working with the same people, asking the same questions. This reduces our capacity and results in a slow journey for the customer.

This scheme will address these issues through:-

- **locality prevention hubs** - commissioning 5 community and voluntary sector locality based prevention hubs which raise awareness of health and social care enabling people to self-care/manage;
- s**ingle point of contact** - for all health and social care enquiries that provides a consistent response and enable people to access the right service, first time;
- **reablement/intermediate care** – redesign services to have an integrated approach to intermediate reablement/intermediate and therapeutic intervention to reduce duplication and handoffs, making better use of our physical resources and workforce;
- **integrated practice and locality teams** - bringing together health and social care staff to serve a common population.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme will be delivered in Dudley through partnership commissioning arrangements in relation to community and voluntary sector provision; a single point of contact; a single reablement/intermediate care system; and practice integrated community teams

This scheme has four elements:-

1. **locality prevention hubs –** we will commission 5 community and voluntary sector organisations to provide a prevention hub in each of our localities. These hubs will be designed to provide information and advice to enable people to self-care/manage. A newly defined pathway will support people from a point of crisis to a point of resolution including helping people develop a level of resilience to manage future problems.

   Support will be brokered for people in relation to more specialist services. The early provision of support will reduce the number of occasions when support is triggered at point of crisis. Access to equipment that enables people to stay mobile/independent and prevent falls is an example of the type of support that will be provided alongside information around healthy lifestyle choices.

   These services will target the 33,800 people in Dudley aged 65 – 75 and will aim to change public perception so that accessing low level support becomes an accepted component of getting older, rather than being attached to negative connotations around being old;

2. **single point of contact** – this will be designed to provide people with consistent and effective information and advice directing them to the right support, first time. The service will include both health and social care staff under joint management arrangements with access to a single client record system**.** At present, there are multiple points of contact with many community teams. A single point of contact will remove this duplication giving, for example, GPs a single point to initiate crisis care and support;

3. **reablement/intermediate care –** across health and social care we currently spend around £15.6m for the provision of support services that are designed to promote people's independence, keep them well and remain in the community. We will look to re-commission this array of services to make the

most effective use of both our bed based resources and our workforce and enable support to be provided that reduces hospital admission and ensures discharge is safe and timely.

The intervention received will be person-centred and based around therapeutic need. Multidisciplinary team of nurses, therapists and social workers will coordinate every intervention with a lead practitioner identified in every case.

This service will be provided by a mixture of health, social care and private sector staff under a joint management structure.

The scheme will be designed to work with adults who have been assessed as having a need for health and social care support and have potential to regain/improve their level of independence;

4. **integrated practice and locality teams** – a series of teams will be established for integrated **practice-level** working. The basic integrated team will consist of:-
    - GP
    - community nurse
    - mental health link worker
    - practice based pharmacist
    - social care link worker.

    They will be led by the GP. There will be a "congruence of responsibility" for each member of the team - they will each have responsibility for serving the same group of patients. Some team members may additionally serve patients of other practices and be members of other teams (in which case there will be a similar congruency with workers serving those patients from other services).

    At any time the team members will all serve the same patients so that they can take a shared responsibility for achieving shared outcomes with those patients. They will also allocate lead care-co-ordinators from within the group for those patients who require detailed care planning.

    At **locality level** teams will consist of:-

    - GP
    - lead community nurse
    - lead social care link worker
    - lead mental health link worker

All the above are drawn from those working at practice level. In addition, this team will consist of:-

- Community Rapid Response Team representative
- virtual ward representative
- voluntary sector locality link development worker
- Other services working borough-wide as necessary

They will be led by a GP Clinical Leader. The locality teams will be sharing learning and reviewing the collective performance of all the teams in their locality through an aggregated performance report; reporting on progress and developing ideas for improvement; and ensuring that pathways from practice to locality to borough wide services function effectively. They will report on the collective performance of the locality to the CCG's locality meetings as part of the performance framework. Each level – practice and locality will be responsible for its share of the BCF performance metrics for the population it serves.

We are working with five GP practices (one in each locality) as early Implementers of the model, who will develop a standard care plan format and assess the requirements for IT to support the integrated working. The learning from these practices will shape the future roll out of the model across all practices.

The delivery chain

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

Service	**Lead Commissioner**	**Providers involved**
Locality prevention hubs	DMBC/CCG	Community and voluntary sector
Single point of contact	DMBC/CCG	DMBC/Dudley Group NHS FT
Integrated community teams	DMBC/CCG	DMBC/Dudley Group/Dudley and Walsall Mental Health Partnership NHS Trust
Reablement/intermediate care	DMBC/CCG	DMBC/Dudley Group NHS FT/Dudley and Walsall Mental Health Partnership NHS Trust

The evidence base

Please reference the evidence base which you have drawn on

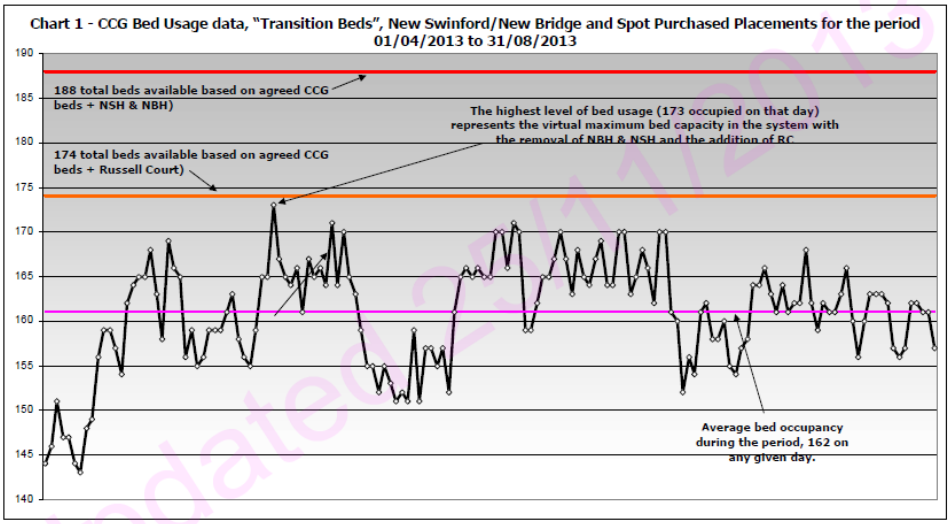
3. to support the selection and design of this scheme
4. to drive assumptions about impact and outcomes

1. **Locality prevention hubs –** we commissioned a feasibility study of this model alongside "popshops" and a department store approach in June 2014. The study showed that bringing together organisations and support services into a single service was one which local people would welcome. We also visited Shropshire to investigate their "people 2 people" model. This model provides similar informal information and advice. This found a 50% reduction in formal contacts going through to the Council's points of access. Similar performance was also identified in an investigation of Bromsgrove District Council's approach to rent arrears.

2. **Single point of contact –** in June 2013 the Council commissioned an external evaluation of its access services. This review highlighted the need for redesign and streamlining and made a series of recommendations.

3. **Integrated practice and community teams –** we have looked to the King's Fund publication "Evidence Base for Integrated Care" to inform the benefits of bringing together integrated teams.

4. **Reablement/intermediate care** – in November 2013 the Council commissioned an external evaluation of its reablement service. This made a number of recommendations that have informed our approach. In December 2013 an analysis of bed utilisation was commissioned. The Council, CCG and Dudley Group NHS FT all currently commission bed based services that are designed to enable timely and safe discharge from hospital and prevent inappropriate admissions. The Graph below illustrates that during a defined period across all organisations there were 188 beds available to the health and social care economy, yet at no point did utilisation exceed 173 beds, with the average occupancy being 162 beds. This evidence is supportive of the defined change.



Investment requirements

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

Currently 34 services are commissioned to provide support within the scope of the Promoting Independence Scheme to the value of £38m. This level of investment will be initially redefined as follows

Service	Investment
Locality prevention hubs	£1.99m
Single point of access	£2.67m
Reablement/intermediate care	£13.26m
Integrated community teams	£20m

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Service	BCF Metric	Level of impact	Evidence to support assumption
Locality Prevention Hubs	Non elective admissions	Low	DMBC analysis in 12/13 established that 68% of the people who received a Telecare service, were not in receipt of any other social care service. The majority of people
	Delayed Discharges	Low	
	Reablement	Low	
	Care home admissions	Low	

	Dementia diagnosis	Medium	accessing preventative services would not meet current FACs criteria.
	Patient experience	High	
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Single Point of Access	Non elective admissions	Low	DMBC analysis established that 41% of the calls received from Access Centre in 2013/14,that required further non call handler input, were signposted.
	Delayed discharges	Low	
	Reablement	Low	
	Care home admissions	Low	
	Dementia diagnosis	Medium	
	Patient experience	High	
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Reablement/Intermediate care	Non elective admissions	Medium	In 2013/14, 46% of all new clients from the community or hospital, received an assessment from the Living Independently Team. 50% of the clients who received a reablement service went on to longer term social care support.
	Delayed discharges	High	
	Reablement	high	
	Care home admissions	high	
	Dementia diagnosis	low	
	Patient experience	medium	
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Integrated Community Teams	Non elective admissions	Medium	CSU analysis in 12/13 established a large overlap between social care clients and community health contacts, that 50% of
	Delayed discharges	High	
	Reablement	Medium	

	Care home admissions	Medium	nursing home residents had an emergency inpatient admission in the year and that 73% of social care service users had one outpatient appointment.
	Dementia diagnosis	Low	
	Patient experience	Medium	

Feedback loop

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

The scheme and its associated performance will form part of our integrated performance dashboard. This approach will aggregate performance up from each service line of schemes to establish the impact upon the defined better care fund measures. As per our submission this performance dashboard will have visibility at leadership level within the health and social care economy to enable progress to be monitored, mitigated and challenged.

Service	Mechanism for measurement	Indicators of success
Locality Prevention Hubs	Providers are required to submit an electronic self assessment to or commissioning Gateway and PSIAMS	Number of people supported
		Improved outcomes
		Improved independence
Service	Mechanism for measurement	Indicators of success
Single Point of Contact	Data from call management system and client index system	Call rate
		Client data quality
		Effectiveness of screening
Service	Mechanism for measurement	Indicators of success
Intermediate care/Reablement	All data derived from client index system	Effectiveness of reablement
		DTOC
		Bed utilisation
Service	Mechanism for measurement	Indicators of success
Integrated Community	All data derived from	Number of handoffs

Teams	client index system and annual survey	Timeliness of assessment
		Customer satisfaction

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

- Establishing a culture of resolution and shared ownership across our teams
- An experienced and suitably trained workforce
- Improved customer experience
- Reduced duplication
- Single systems and approaches

The programme plan included in our submission alongside details of our organisational development programme provides evidence of our planned approach to integration.

ANNEX 1 – Detailed Scheme Description

Scheme 3

Scheme ref no.
3
Scheme name
Stabilisation and Maintenance
What is the strategic objective of this scheme?

This scheme specifically looks to enable people to continue to stay at home within their communities rather than moving into residential/nursing care or hospital, at the point at which their health and social care needs become more complex or palliative. Our vision for health and care services identifies this as one of our key priorities.

People with continuing care and support needs often have no option other than moving into residential/nursing care because of the time delay associated with adapting their home to meet their accessibility needs.

Residential and nursing placements can often be perceived as an easier option than enabling someone to return home with support arranged through a personal budget.

Currently many people are admitted to hospital at the end of life, despite clearly articulating a wish to remain at home

This scheme will address these issues by:-

- implementing person centred plans that enable people to choose where they end their life;
- enabling access to Disabled Facilities Grants more timely and efficiently;
- enabling access to personal budgets/direct payments more timely and efficiently;
- building contingency planning into support plans;
- providing real alternatives to residential care through the redesign of extra care housing.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme will be delivered in Dudley through integrated commissioning arrangements in relation to private sector community based care provision, coordination of palliative care by a community based team and the facilitation of disabled facilities grants through multi agency teams including occupational therapists

This scheme has four elements:-

1. **embedding advanced planning in palliative care** – our palliative care teams and social care teams will deliver services that are based upon person centred plans which following a robust mental capacity/best interest approach, enable people to articulate advanced plans with regard to where they wish to end their life. The investment in additional community support and the commissioning of enhanced services from primary care is described above. These plans will include any clinical implications and risk associated with the person's choice and the role of any commissioned service supporting the person. Engagement across our private sector providers alongside our ambulance service will agree a consistent approach to supporting a person in line with their advanced plan. We will develop our client record systems across health and social care to enable multi agency access to advanced plans to ensure consistency.

   Around 4500 people are supported by adult social care at any one time. This means that at some point in the future we will be supporting the vast majority of these people to develop advanced plans.

The new approach will ensure that any person with a terminal diagnosis will be given the opportunity with their families to develop an advanced plan as part of the support they receive from health and social care teams. Any adult over the age of 95 will also be given the opportunity to develop an advanced plan. Currently adult social care support around 500 people who are 95 and over.

2. **redesigning extra care housing to be a real alternative to residential care** – the Council currently commissions 286 units of extra care housing in partnership with two community and voluntary sector providers. A further 120 units are planned for 2015/16 and a further scheme is scheduled for development in 2017/18. The schemes are available to local residents over the age of 55. The redesign will see the funding arrangements of the service move from block purchase to individual purchasing arrangements that will result in there being no restrictions to the level of support that can be provided within extra care, thus reducing the number people being placed in residential care or having to transfer from extra care to residential care because their needs have increased. The redesign will also see the referral process improved to enable appropriate admissions to extra care from hospital for new and existing tenants to be more timely. The CCG will also continue to commission an extra care liaison nurse to manage people's health needs.

In Dudley there are currently around 1700 residential and nursing beds available with utilisation at around 93%. The redevelopment of extra care housing will provide increased capacity in this area and prevent admission to residential and nursing home care.

3. **developing an integrated approach to personal health budgets that is timely, effective and sustainable; with an external market that is shaped to meet current and future demand**

In Dudley there are currently around 2200 people with a personal budget. Personal budgets are provided to people continuing to live in the community who have been assessed as having substantial or critical needs in relation to FACS. Personal health budgets enable people to continue to live in the community who have NHS continuing health care needs.

Currently personal budgets/personal health budgets are completed separately developed by the Council and CCG, with distinct professions attached to the respective processes. Often a therapist or health professional has to pass a person for allocation to a social worker so that a personal budget can be progressed. This causes delay and duplication in the customer's journey.

Personal budgets, in particular direct payments, are considerably slower to set up than a residential or nursing home service which means that people are inappropriately placed in care homes.

Private sector providers can often be inflexible around supporting discharges from hospital and managing fluctuations in a person's needs, causing delays and inappropriate admissions to hospital.

The scheme will look to address these issues through the following mechanisms:-

- development of an integrated pathway for personal health and social care budgets based around a trusted assessor model;
- commission our domiciliary care services to provide greater capacity and increased requirement to support hospital admission/avoidance. To also include the development of external reablement capacity;
- streamline our direct payments process to increase take up;
- develop integrated support plans that focus upon resilience and contingency planning.

4. **redesign the Disabled Facilities Grant (DFG) process to be more timely and efficient –** the current process for DFGs is fragmented across a range of organisations and professionals who each contribute a component part of the process. No single individual co-ordinates each DFG and the current waiting time is around 6 months. During this period people are regularly admitted to residential and nursing care as their needs can no longer be met at home.

A DFG is only available to people who are disabled within the meaning of the **National Assistance Act 1948**. Each year we support around 360 people to apply for DFG's

To improve the timeliness of DFGs we will:-

- bring architects and occupational therapists together into a single team responsible for all DFG applications across all tenures. This will enable a key worker to be identified for all applications;
- develop more robust agreements with housing associations so that they fulfil their responsibilities for adaptation rather than a default being a DGF application;
- enable small variations to plans, as a result of changes in need to be completed much more easily;

- introduce self- assessment at the start of the DFG application process;
- review the need for financial assessment for low value items such as level access showers and stair lifts as this can be the cause of significant delays;
- assess the use of relocation grants as an alternative to costly and significant property adaptations.

The delivery chain

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

Service	Lead Commissioner	Providers involved
Advanced planning	CCG	Community & Voluntary sector
Extra care Housing	DMBC	Midland Heart/Beacon
Personal Budgets & Health Budgets	DMBC/CCG	DMBC/Dudley Group/DWMHPT/CCG
DFG	DMBC	DMBC/Housing associations

The evidence base

Please reference the evidence base which you have drawn on

5. to support the selection and design of this scheme
6. to drive assumptions about impact and outcomes

1. **Embedding and enforcing advanced planning in palliative care** –

   Research and evidence –

   Our approach to this development has been based upon:-

   - Advance Care Planning: A Guide for Health and Social Care Staff (University of Nottingham, 2008)
   - Advance Care planning (University of York, 2013)

   These documents outline that a saving of around £390 per person can be achieved in relation to advanced planning implementation rather than hospital admission

2. **Redesigning extra care Housing to be a real alternative to residential care**

   Research and evidence –

Our approach to this development has been based upon;

- Establishing the extra in Extra Care Perspectives from three Extra Care Housing Providers (The International Longevity Centre, 201)

In this data, we find evidence that residence in extra care housing is associated with a reduced level of expected nights spent in hospital than may be expected in an equivalent population living in the community, matched on demographic and selected socioeconomic characteristics.

3. **Developing an integrated approach to Personal/Health budgets that is timely, effective and sustainable with an external market that is shaped to meet current and future demographics**

Our approach to this development has been based upon:-

- Personal Budgets Outcome Evaluation tool (2014)
- Evaluation of Personal Health Budget Pilot Programme (2012)

The use of personal health budgets was associated with a significant improvement in the care related quality of life (ASCOT) and psychological well-being (GHQ-12) of patients (at 90% confidence).

The cost of inpatient care (an 'indirect' cost) was significantly lower for the personal health budget group compared to the control group after accounting for baseline differences.

4. **Redesign of the Disabled Facilities Grant process to be more timely and efficient**

Our approach to this development has been based upon:-

- Home Adaptations for Disabled People – a detailed guide to related legislation, guidance and good practice (2013).

Investment requirements

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

Our baseline investment in this scheme in Dudley through the Better Care Fund will be £16,181580

In 2014/15. The current make up of this spend is as follows;

Personal Budgets	**£ 12,241,580**
Disabled Facilities Grants	**£ 2,867,000**
Extra care housing	**£ 865,000**
Advanced planning	**£ 208,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Service	BCF Metric	Level of impact	Evidence to support assumption
Advanced Planning	Non elective admissions	Medium	Availability of advance plans provides a basis to ensure people are able to die in the place of their choice, thus preventing admission and supporting patient views.
	Delayed Discharges	Low	
	Reablement	Low	
	Care home admissions	Low	
	Dementia diagnosis	low	
	Patient experience	Medium	
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Extra care Housing	Non elective admissions	Low	In The International Longevity Centre 2011, there is evidence that residence in extra care housing is associated with a reduced level of expected nights spent in hospital than may be expected in an equivalent population living in the community.
	Delayed discharges	Low	
	Reablement	Low	
	Care home admissions	Medium	
	Dementia diagnosis	Low	
	Patient experience	Low	
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Personal budgets & Personal health budgets	Non elective admissions	Low	2283 people received a personal budget from DMBC in 2013/14. All of these clients would meet substantial or critical FACs criteria and as such have significant
	Delayed discharges	Medium	
	Reablement	Low	
	Care home admissions	Medium	

	Dementia diagnosis	low	levels of need. Personal budgets allow people to remain in their own home as long as possible and allow them the choice and control in how their care is delivered.
	Patient experience	High	

Service	BCF Metric	Level of impact	Evidence to support assumption
DFG	Non elective admissions	Low	Office for Disability Issues (ODI) research states that Home modifications can prevent or delay residential care for disabled older people. The right adaptations can reduce high levels of home care and delay the need to move into residential.
	Delayed discharges	Low	
	Reablement	Low	
	Care home admissions	Medium	
	Dementia diagnosis	Low	
	Patient experience	Low	

Feedback loop

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

The scheme and its associated performance will form part of our integrated performance dashboard. This approach will aggregate performance up from each service line of schemes to establish the impact upon the defined better care fund measures. As per our submission this performance dashboard will have visibility at leadership level within the health and social care economy to enable progress or issue to be monitored, mitigated and challenged.

Service	Mechanism for measurement	Indicators of success
Advanced planning	Client index systems	Number of people supported
		Number of people admitted
		Implemented Advanced plans

Service	Mechanism for measurement	Indicators of success
Extra Care Housing	Client index systems and commissioning gateway	Bed utilisation
		Reducing Residential placements
		Admissions to Hospital
Service	Mechanism for measurement	Indicators of success
Personal Budgets & Health Budgets	All data derived from client index system and through 1-1 interviews for POET	ASCOF 1C
		Reduced residential care
		Outcome achievement
Service	Mechanism for measurement	Indicators of success
DFG	All data derived from client index system and annual survey	Timeliness of completion
		No waiting lists
		Reduced residential care

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

The key success factors across this scheme pertain to;

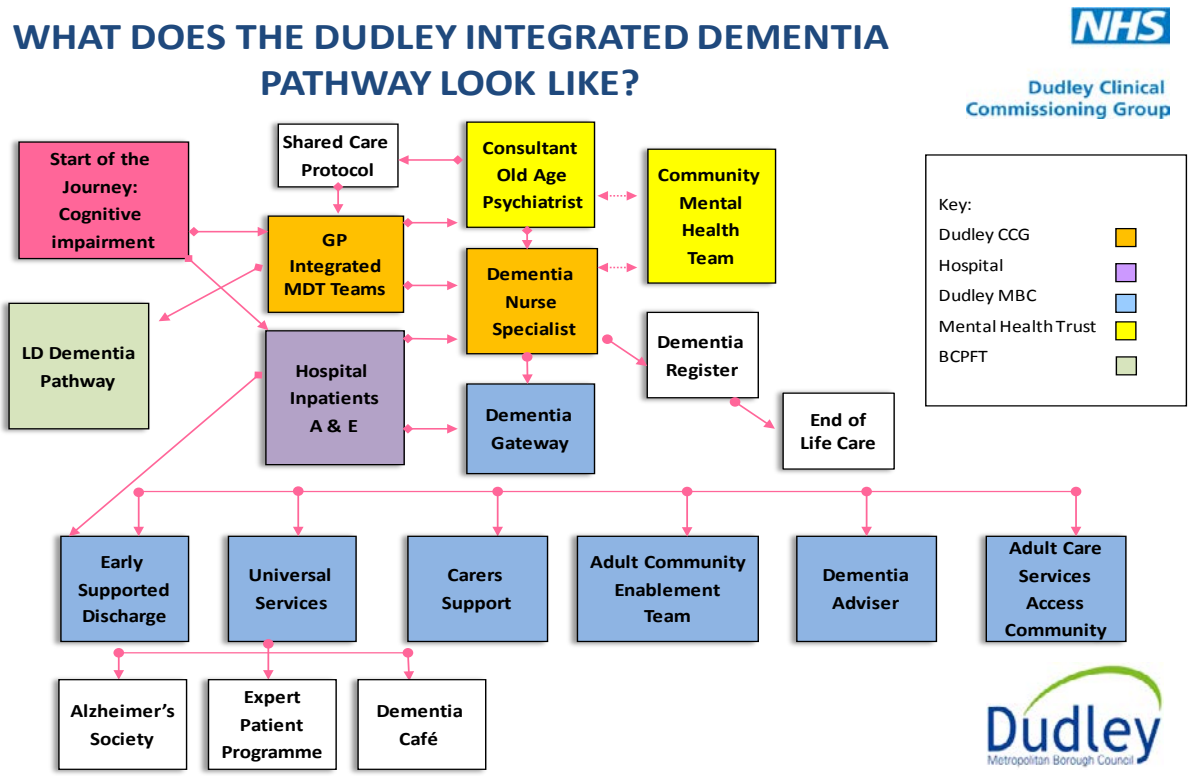
- Establishing a culture of resolution and shared ownership across our teams
- An experienced and suitably trained workforce
- Improved customer experience
- Reduced duplication
- Single systems and approaches

The programme plan included in our submission alongside details of our OD programme provides evidence of our planned approach to integration.

ANNEX 1 – Detailed Scheme Description

Scheme 4

Scheme ref no.
4
Scheme name
Support for people with dementia
What is the strategic objective of this scheme?
Dudley has a nationally recognised dementia pathway and gateways that support over 1,800 people. However, there is still a considerable amount of work required to improve services for the increasing numbers of people with dementia and their carers. The key objectives of this scheme are to:- • enhance and develop the current dementia pathway; • improve services via a more integrated approach; • ensure earlier diagnosis; • secure on-going support. The above schemes will be coordinated by the three Dudley Dementia Gateways that provide a one stop shop of information and support, timely and appropriate intervention & review, working closely with voluntary sector partners including the Alzheimer's Society and carers' organisations.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The schemes will enhance the dementia pathway (captured in the flowchart below)



Specific initiatives to support the scheme

Dementia diagnosis

- Supporting GPs to identify more people to be referred and assessed for dementia, to achieve the national target of 67% against the prevalence rate for Dudley.

Palliative care

- Ensuring every patient with dementia is offered the opportunity to have an advanced care plan. This work is also linked into and monitored via the Dudley Gold Standard Framework Enhanced Service described in scheme 1 above.

Improved awareness of dementia and the importance of good diagnosis

- A new communications strategy will be launched on dementia to ensure more people are correctly diagnosed and to raise awareness of dementia amongst both the public and health/social care workers to ensure greater access and utilisation of services.
- To deliver training to the wider MDT integrated teams on caring and managing people affected by dementia. This work will also link in and be evaluated by the GP locality leads.

Practice integrated care teams

- Coordination of care for people with dementia will be enhanced via the practice integrated teams. For example, a patient who has a physical illness which is exacerbating their dementia can have their care dealt with more efficiently and effectively through an integrated case management approach.

Care Homes

- To recruit a CPN for care homes to work alongside the care home nurse practitioners with a remit of training staff in care homes to manage people with challenging behaviour, take referrals from the Community Rapid Response Team (CRRT) where there are complex mental health issues and facilitate discharge from hospital. The number of admissions to hospital for people with dementia will be monitored against baselines from the previous year.

Increasing the scope of the Dementia Gateways

- The Gateways are a successful example of integration with three NHS specialist dementia nurses based in the gateways and working alongside seven dementia advisors. To assess opportunities for occupational therapy/physiotherapy in the dementia gateways for supporting patients to return home post injury; provide balance and stability control to reduce risk of falls; improve sleep patterns..

Supporting people as an alternative to hospital or care home admission

- To reduce unplanned admissions and re-admissions by improving access to support in the community including the practice integrated teams and the Community Rapid Response Team.

Young onset dementia

- To provide specialist support for young onset dementia/working age dementia, improve the quality of care and provide more tailored services for this smaller cohort of people affected by dementia.

Hospital in-patient care

- Implement an acute care pathway for patients in hospital. This work is scheduled to be completed in autumn 2014.

Service redesign

- To commission a dedicated dementia specialist team by redesigning existing services for older adults with mental health problems.

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

Service	Lead Commissioner	Providers involved
Dudley Dementia Gateways	Dudley MBC	DMBC/South Staffordshire and Shropshire NHS FT
NHS Mental Health Services	Dudley CCG	Dudley and Walsall Mental Health Partnership NHS Trust/ South Staffordshire and Shropshire NHS FT
General Hospital Services	Dudley CCG	Dudley Group NHS FT

The evidence base

Please reference the evidence base which you have drawn on

5. to support the selection and design of this scheme
6. to drive assumptions about impact and outcomes

All the above schemes are aligned to the objectives in the National Dementia Strategy (DH 2009), NICE Quality Standards for Dementia (2010), Joint Commissioning Panel for Mental Health (2012), Prime Minister's Dementia Challenge (2012).

Investment requirements

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

The investment in dementia services are as follows

Service	Investment
Dementia Gateways	£1.83m
Specialist Dementia Nurses	£0.19m
Total	**£2.02m**

Impact of scheme

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

Service	BCF Metric	Level of impact	Evidence to support assumption
Dementia Services	Dementia diagnosis rate	High	Direct support with practices will increase diagnosis rate
	Patient experience	High	Enhanced diagnosis enables more effective support to patients and carers
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Palliative care	Non elective admissions	High	Provision of advanced care plans reduces the need for admission
	Delayed	High	Provision of advanced

	Discharges		care plans facilitates effective discharge.
	Care home admissions	Medium	Provision of advanced care plans reduces the need for admission
	Patient experience	High	Strong preference expressed by patients and public to be able to die in the place of their choice.
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Improved awareness of dementia and the importance of good diagnosis	Dementia diagnosis	High	Diagnosis rate enhanced due to availability of appropriate services.
	Patient experience	High	Enhanced diagnosis enables more effective support to patients and carers.
Service	**BCF Metric**	**Level of impact**	**Evidence to support assumption**
Practice integrated teams	Non elective admissions	High	Better co-ordination of dementia and physical health needs prevents admission.
	Delayed Discharges	High	Better co-ordination of services at practice level facilitates effective discharge
	Reablement	High	Better co-ordination of services at practice level facilitates effective reablement.
	Care home admissions	Medium	Better co-ordination of dementia and physical health needs prevents admission.
	Dementia diagnosis	High	Better co-ordination facilitates diagnosis.
	Patient experience	High	Enhanced diagnosis enables more effective support to patients and carers.
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Care Homes	Non elective admissions	High	Consultation with care homes indicates that availability of a CPN would prevent admission and facilitate earlier discharge

	Delayed Discharges	High	As above
	Reablement	High	As above
	Care home admissions	Low	As above
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Increasing the scope of the Dementia Gateways	Non elective admissions	High	Consultation with dementia gateway staff indicates that the provision of more therapy support will better enable people to remain in their own homes and return home after a fall.
	Delayed Discharges	High	As above
	Reablement	High	As above
	Care home admissions	High	As above
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Supporting people as an alternative to hospital or care home admission	Non elective admissions	High	Consultation with GPs indicates that ability to access CRRT, 7 days per week, facilitates step-down to services to prevent admission.
	Care home admissions	High	As above
Young onset dementia	Patient experience	High	Consultation with carers indicates a need to provide more support for this group.
Service	**BCF Metric**	**Level of Impact**	**Evidence to support assumption**
Hospital in-patient care	Delayed Discharges	High	ECIST report indicates that appropriate care pathway for this group would enable more effective discharge/reablement and prevent need for discharge to care homes
	Reablement	Medium	As above
	Residential care	High	As above
Service	**BCF Metric**	**Level of Impact**	
Service redesign	Non elective admissions	High	Consultation with GPs indicates that the

			availability of a specialist dementia team would better able the integrated practice teams to diagnose and manage patients in the community
	Delayed Discharges	High	As above
	Reablement	High	As above
	Residential care	High	As above
	Dementia diagnosis	High	As above
	Patient experience	High	As above

Feedback loop

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

Research demonstrates that appropriately supported carers have the capacity to prevent the institutionalisation of patients.

The key performance indicator for this scheme is its ability to support people in their own homes and communities and prevent crisis situations that can result in an urgent care admission or an early admission to nursing/residential care.

Early diagnosis enables patients and carers to be supported and prepare for the progression of illness.

As a result of these schemes the numbers of admissions to hospital with a primary/secondary diagnosis of dementia will be reduced. In addition the number of admissions to residential/nursing home care for people with early stage dementia will be reduced.

Baseline information on dementia diagnosis rates and secondary care activity is established and updated on a monthly basis. Feedback will consist of:-

- increasing the number of people newly diagnosed;
- increasing the numbers of people affected by dementia accessing services through the Dudley Dementia Gateways;
- increasing, via the Dementia Gateways, the number of support packages as an alternative to admission;
- decreasing the numbers of emergency admissions for people with either a primary or secondary diagnosis of dementia;
- decreasing the number of admissions to residential/ nursing home care for patients with early stage dementia;
- decreasing the number of readmissions of patients with a diagnosis of dementia.

Performance reports will be submitted to the multi-disciplinary teams relating to the Dementia Gateways and the Integrated Services Working Group

What are the key success factors for implementation of this scheme?
This is part of and builds upon a nationally recognised best practice scheme for integrated dementia care. Investment in a range of specialist dementia staff has taken place. Educational programmes have been implemented for GPs, social care and acute hospital staff. Further work required to ensure appropriate recording of diagnoses and early referral to the specialist dementia nurses and the Dementia Gateways is taking place.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Dudley CCG
Name of Provider organisation	Dudley Group NHS FT
Name of Provider CEO	Paula Clark
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	29,847
	2014/15 Plan	28,585
	2015/16 Plan	27,010
	14/15 Change compared to 13/14 outturn	(1,262)
	15/16 Change compared to planned 14/15 outturn	(1,575)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	(1,231)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	(1,891)

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Not Applicable
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes confirmed by email between Dudley Group NHS FT's Director of Finance and the LAT's Director of Operations and Delivery on 17/4/14