BIRMINGHAM BETTER CARE

Birmingham Integration and Better Care

Narrative Plan - 2017/19

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1. Approval and Sign Off

- The 2017-19 Birmingham Better Care Plan has been approved by the Birmingham BCF Commissioning Executive following engagement with the BSol STP Board and SWB (Sandwell and West Birmingham) Strategic Commissioning and Redesign Committee prior to receiving final sign off by Birmingham Health and Wellbeing Board.

- To support assurance, the Plan has also provides evidence that the **Key Lines of Enquiry (KLOE)** have been met in a way that makes sense to assurers as well as partners and the public. The KLOE's are outlined in Appendix 1.

1.1. Summary of plan

- This is the third Better Care Fund (BCF) Plan for Birmingham and builds upon previous ones. We have reframed our approach to delivering the vision, learning from and applying, local and national evidence. There are two key differences between this and our previous plans. Firstly, we are further developing the focus on preventing and delaying the need for care – *keeping people well where they live*. Secondly, our approach will embed the BCF across current city wide Health & Social Care transformation programmes, all of which are led by key Birmingham 'system' leaders.

- This is in contrast to creating a separate plan, with separate, standalone governance with limited ownership. The plan shows our four key priorities are:

    1. **Integrated urgent and emergency care**
    2. **Stabilisation and transformation of social care Birmingham**
    3. **Integrated care & support for people who want to remain independent**
    4. **Commissioning reform**

- The Plan has a particular focus on;
'***keeping people well at home for longer and when they are in need of health and social care provision ensuring our services are integrated enough to provide seamless provision***'

- To support assurance, we have referenced and provided direct links to planning documents that are currently in the public domain - either 'signed off' through NHS or Birmingham City Council processes. We will continue to 'sense check' with all our partners throughout the life of this plan.

1.2 Budget/Pooled funds

- Delivery of the BCF Plan is supported by a pooled budget of £132.7m for 2017/18 and £147.6m for 2018/19. Included in this allocation is the iBCF grant allocation of £33.792m for 2017/18 and £47.327m for 2018/19. Pooled funding amounts are outlined in Table 1.

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Table 1 Planned Funding Analysis for 2017/18 & 2018/19

	2016/17 (£)	2017/18 (£)	2018/19 (£)
Local Authority Contribution	**14,103,000**	**11,392,294**	**12,019,620**
iBCF Contribution	**0**	**33,792,214**	**47,327,714**
Minimum CCG Contributions	**75,939,917**	**77,299,241**	**78,767,927**
Additional CCG Contributions	**11,559,327**	**10,178,754**	**9,479,955**
Total BCF Pool	**101,602,244**	**132,662,503**	**147,595,216**

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iBCF Contribution	**0**	**33,792,214**	**47,327,714**
Minimum CCG Contributions			
Birmingham Cross City CCG	*47,735,704*	*48,590,174*	*49,513,387*
Birmingham South & Central CCG	*16,411,906*	*16,705,679*	*17,023,087*
Birmingham South & Central CCG Practice Transfer Adjustment	*0*	*468,694*	*468,694*
Sandwell & West Birmingham CCG	*11,792,306*	*12,003,388*	*12,231,453*
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1.3. Approval and Signatures

Birmingham City Council Interim Corporate Director for Adult Social Care and Health	Name: Graeme Betts Signature Date 11th September 2017
Birmingham City Council Section 151 Officer	Name: Mike O'Donnell Signature Date 11th September 2017
Signed on behalf of Birmingham CCGs Interim Chief Executive	Name: Paul Jennings Signature Date: 11th September 2017

Signed on behalf of Health & Wellbeing Board Cabinet Member for Health and Social Care	Name: Cllr Paulette Hamilton Signature  Date 11th September 2017
Signed on behalf of Sandwell & West Birmingham CCG Accountable Officer	Name: Andy Williams Signature  Date: 11th September 2017
Better Care Fund Lead Officer & Service Director for Commissioning	Name Louise Collett Signature  Date: 11th September 2017

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2. Our vision

- The BCF will support the Birmingham Vision for Integration. By 2020:

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Birmingham will have an integrated health and social care system that will ensure:

- The most vulnerable people are supported to improve their health and wellbeing
- People are enabled to stay independent as long as possible
- We support people to effectively manage their conditions themselves but easily get help when they need it
- We support people to remain active members of their communities for as long as possible
- We support communities to be healthy and well for as long as possible
- Crises are managed better, only utilising hospitals and long term residential care when needed
- We improve the resilience of our health and care system

- The vision was built on the Birmingham Health and Wellbeing Strategy[1] and the national Think Local, Act Personal - Making it Real framework[2] developed locally through engagement with Birmingham City Councillors, Health partners, members of the public, experts by experience, providers, commissioners and other practitioners.

- The Vision has been revised for 2017-19 to reflect interdependencies across the current system, including, the Birmingham City Council Vision and Plan[3], Birmingham and Solihull Sustainability and Transformation Plan[4] and the Birmingham improved Better Care Fund (iBCF) plan[5].

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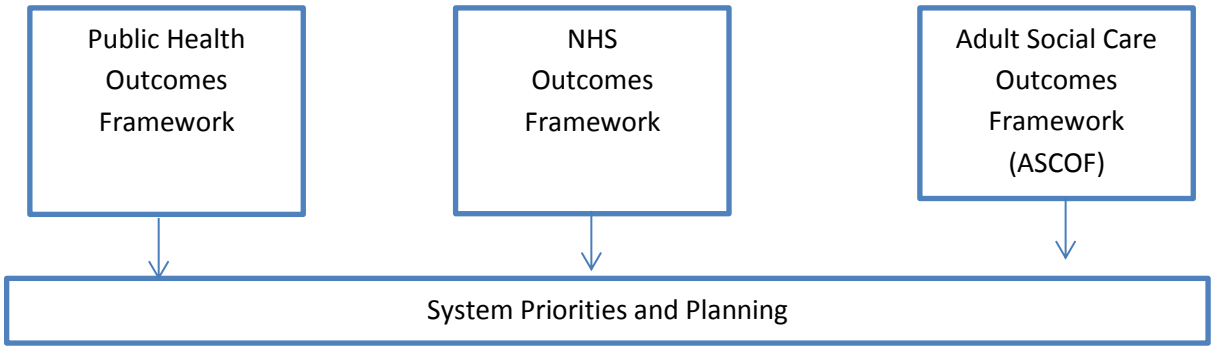
- It remains underpinned by the Birmingham JSNA function which provides a useful oversight and comparison of how the Birmingham health and social care 'system' is performing now, utilising nationally set indicators. The indicators are brought together in the form of three key national frameworks which are:



[1] Birmingham Health & Wellbeing Strategy http://hwb.birmingham.gov.uk/health-and-wellbeing-strategy/
[2] New guide for person-centred support https://www.thinklocalactpersonal.org.uk/News/New-guide-for-person-centred-support-for-people-with-experience-of-supported-housing/
[3] https://www.birmingham.gov.uk/downloads/file/1543/strat1_sustainable_community_strategy_birmingham_2026_2008pdf
[4] Birmingham and Solihull Sustainability and Transformation Plan https://www.birmingham.gov.uk/downloads/download/1008/birmingham_and_solihull_sustainability_and_transformation_plan
[5] Birmingham Improved Better Care Fund Proposals <<link>>

3. Background factors and context to the plan

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• There were a number of key challenges in Birmingham during 2016/2017 that have helped to form a view for future planning. Acknowledging these challenges helps support the rationale for our future approach, which is outlined in this plan.	17
• From a policy perspective, 2016/17 saw the introduction of the Sustainability and Transformation Planning (STP) processes by NHS England. Despite commitments to integrate the BCF into this process locally, it has proved challenging to do so in reality in 16/17 for the reasons outlined below.	14
• Firstly, there have been significant changes in organisational form and system leadership in Birmingham:	17
a. Practically this means that only one member of the original BCF Commissioning Executive remains in post. This has provided both an opportunity to develop new relationships and go 'back to basics' whilst ensuring current momentum is not lost.	
b. The Chief Executive of the University Hospitals Birmingham Foundation Trust and interim Chief Executive of the Heart of England FT, Dame Julie Moore, has been confirmed as the BSol System Leader and has made the improvement of services and experience for older people across the system a clear priority.	
c. Under interim senior officer leadership at Birmingham City Council proposals are advanced for the stabilisation and modernisation of adult social care as part of the journey to integration. This will link directly with the STP - and the BCF will support this work from both social work and commissioner perspectives.	
d. There are also significant changes taking place within CCGs as part of the proposed creation of a new health commissioning organisation to cover the Birmingham and Solihull CCG's/ current Birmingham Solihull STP footprint. A single interim Accountable Officer came into post in August 2017.	
e. In addition, the introduction of A&E Delivery Boards to oversee emergency and urgent care system resilience in recent months also brings an interest in some elements of the BCF programme and we are currently rationalising plans to avoid the issues of duplication and multiple priorities which the BCF plan delivery has previously faced. This is reflected in the proposed governance framework.	17
f. System leaders firmly believe that working together in a different way – around an approach to accountable care, will help improve the health and wellbeing of and services offered to our populations. In order to do this new relationships and levels of trust continue to develop and this remains work in progress. With the STP is starting to gather momentum and offering an opportunity in a way that has not happened before.	17

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• The implementation of iBCF will be critical to the current issues of winter planning and medium to longer term transformation of place/primary care to meet need (iBCF area 1), urgent and emergency care systems (iBCF area 2) and sustaining the social care provider market (iBCF area 3).	17 27
• There will be a focus in 17/19 on building on the learning from the previous BCF pilots and developing sustainable funding models. This is being done in collaboration with the Local authority and the third sector as part of a review of currently commissioned third sector services (including 'out of hospital' pathways), and exploring new sources of funding, including charitable funding, or the use of social impact bonds, which are being explored in neighbouring economies as part of the development of a clear asset based 'offer' that supports diversion from and avoidance of social care.	2
• It is planned that the implementation of the Clinical Utilization Review tool and the work with Newton, as part of the Crisis and Recovery Strategy, will create the infrastructure for the system wide change needed to support the development of the 'High Impact change' approach in Birmingham. This is fundamental to the BCF plan and to iBCF as well as to STP and A&E Delivery Board planning, in terms of supporting system change. They will support better patient flows (including in hospital social care), acute 'front door' services, timely discharge and 'out of hospital' support, and will contribute to the implementation of 7 day working as well as taking account of more 'at risk' cohorts such as those with dementia or frailty.	
• The work around informal carers and the ongoing implementation of the local Dementia Strategy will also add to the infrastructure for the development of 'preventative' capacity in communities & the building of community resilience.	24
• This plan continues to deliver the initial aspirations of the 15/16 BCF, namely: o Keeping people well where they live o Looking after people better when crises occur o Making the right decisions when people can no longer cope	

4. Health and Social care integration

• The changes to key leaders within the system and their coming together has enabled us to define what health and social care integration means for Birmingham.	
• Nationally, Health and Social Care integration has been attempted by successive Governments since the mid 1990's, organisational and cultural differences as well as financial challenges have limited progress on this front, so much so that the Better Care programme remains the only national policy with a primary mandate for integration. At a local level, integration in Birmingham has been influenced by a number of factors that are not uncommon in other areas of the country. Acknowledgment of these challenges has helped Birmingham form a fresh view on our approach to integration: o *Organisational sovereignty and financial balance:* Birmingham has a single Council responsible for a population of 1.3 million people. Its social care provision operates	17

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within a clearly defined geographical boundary. This is complimented by three acute NHS Providers, one Community Healthcare Trust, one Mental Health Trust, and three NHS commissioning organisations. Each organisation has its own culture, governance and financial accountability arrangements. Birmingham's system faces a huge future funding gap, that gap is not collectively owned, but is owned at individual organisational level.

- *Different financial incentives:* NHS healthcare providers in Birmingham are currently paid for each patient seen or treated which, it has been highlighted nationally encourages increased hospital activity, whilst integration attempts to reduce hospital activity. As well as this the misalignment of financial incentives is a barrier to integration.

- *Different funding models:* NHS treatment is free at the point of use, whilst local authority social care is means-tested. This is a well acknowledged conflict over funding and funding eligibility for patients between the two services.

- *Information sharing:* Ideally, a patient's care record would move with them through the Health and Social Care system, but frequently, there are differences between organisations regarding the interpretation of information sharing frameworks. Whilst there are some good examples in Birmingham, interpretation has affectively complicated consistency.

- *Competing policy priorities:* Recent national reforms have focussed on promoting citizen choice and control. This, in turn, has promoted competition within the NHS, making coordination of care across multiple providers more difficult. Also, concerns have been raised nationally regarding how the Better Care Programme and the Sustainability and Transformation Plans (STPs) interrelate.

- *Geographical Boundaries:* Around 20% of Birmingham residents live within the Sandwell and West Birmingham CCG (SWBCCG) footprint and this CCG currently sits within the Black Country STP meaning this BCF sits within 2 STPs. This is currently managed through SWBCCG having associate membership of the Birmingham and Solihull STP.

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- Given the challenges outlined, the 2017/19 Better Care Fund Plan for Birmingham has been reframed. System leaders across Birmingham have agreed that at present Birmingham will ***not aim to change organisational form as the key delivery vehicle for integrated services*****.** Our reframed approach will focus on promoting the principles of integration and integrated planning to ensure that the services provided:

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  - Are integrated from the point of view of citizens and service users
  - Improve the quality of life of Birmingham citizens
  - Promote the independence of adults
  - Focus on maintaining the participation of the citizen in the community in which they live
  - Protects and improves the safety of vulnerable people

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- Improves the quality of services
- Best anticipates needs and prevents them arising
- Makes the best use of the available resources, including people and other resources

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- The BCF programme and plan will be repositioned to facilitate integrated working, complimenting existing key local programmes and priorities.

5. Understanding Birmingham

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- A gap analysis, undertaken during 2016/17 as part of the STP process, has further enhanced the understanding of the challenges outlined in our previous BCF plans. The work was supported by the Birmingham JSNA and focussed on three key areas of; Health and Wellbeing, Care Quality and Financial Sustainability:

5.1. Health and Wellbeing

- Birmingham is a very diverse city, with 22% (238,313) of residents born outside the UK and 103,682 of these arrived in the UK since 2001. This diversity is reflected throughout our communities, for example, almost 40% of Bordesley Green, (38.3%), Sparkbrook (38.1%) and Washwood Heath (36%) ward residents report a main language other than English, compared with the Birmingham average of 15%. Overall, over 130 different languages are spoken in Birmingham schools. We have significant levels of educational and economic migration with 65,000 university students in the city. This diversity can present particular challenges in matching provision to need.

- In addition, the city is ranked the 9th deprived Local Authority in the UK. Over three quarters of the city is in the most deprived 40% of areas nationally, 430,000 people live in the most deprived 10% of areas nationally. The level of child poverty in Birmingham is worse than the national average; with 29.9% of children under 16 years in the city living in poverty. This is equivalent to 144,000 children living in the bottom decile. Almost one in five households in Birmingham suffers fuel poverty compared to an England average of around 10%.

- Birmingham men have a life expectancy of 77.6 years compared to 82.2 years for women. This compares to national figures of 79.4 and 83.1 years respectively.

- Life expectancy also varies greatly for males and females depending where in Birmingham people live. For example, men in Shard End (an area of high deprivation) live ten years less than men living in the mostly affluent area of Sutton Four Oaks (72.8 vs 83.4 years) demonstrating the stark inequalities that exist across the city.

- In addition, healthy life expectancy is lower than the national average at 58.8 years for men and 60.5 years for women compared to 63.3 and 63.9 years. The main causes of excess years of life lost in Birmingham, when compared to England have been identified as: Infant Mortality, Coronary heart disease; Lung cancer; Alcoholic liver disease; Stroke; COPD and Pneumonia.

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- Looking to the future, Birmingham's population is also projected to increase by 146,000 (13%) over the next 20 years. By 2035, the proportion of people aged 65-84 will increase by 35% and people aged 85+ by 75%.

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- The diversity, poor health, stark inequalities and projected population growth in Birmingham are all key influences on demand for health and social care services. This means that the key critical challenges are to improve population health and the way in which support is configured. Unless this is achieved, pressure and demand for services will continue to increase.

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- Improving the 'average' of population health of Birmingham will obviously be beneficial, but the key focus needs to be 'reducing the gap'. Birmingham has nearly half its population (c440, 000) living in the lowest decile of deprivation within the country. Within this population there are significant and shocking issues relating to health outcomes. Our 'life at the bottom' presentation below outlines this:

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- In summary, the key challenges facing Birmingham in terms of health and wellbeing are finding ways to support and embrace the diversity of our population alongside the issues of deprivation and inequalities and changes in demography.

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5.2 Quality Gaps

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- The additional quality challenges faced within our system are emphasised when key interfaces within the system are considered:

PRIMARY CARE – ACUTE CARE – POST ACUTE CARE INTERFACES

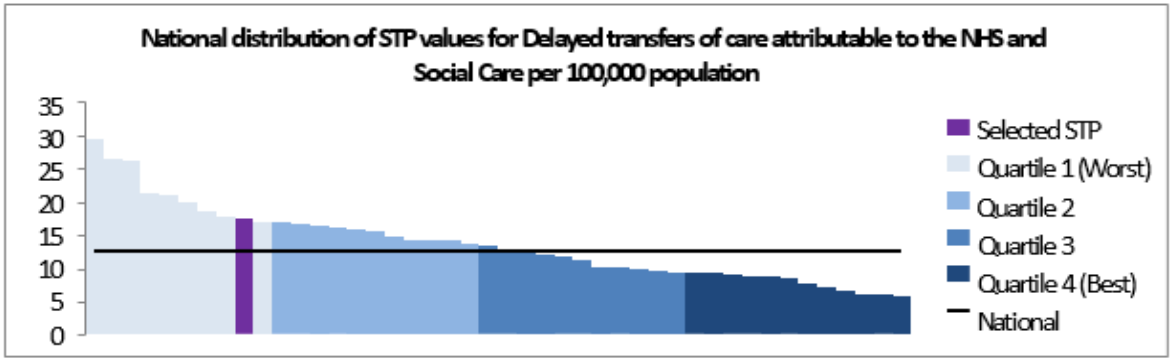
This relates to key 'touchpoints' or hand-off's between the sectors e.g. primary care to the acute sector or from the acute sector to community or social care. Analysis on total spend shows that 8% of the over 65s account for 62% of total spend - which reflects the significance of these touch points.

A & E ADMISSIONS

- There is a growth in emergency admissions for ambulatory care sensitive conditions (currently 940.8 per 100,000 population).

DELAYED TRANSFERS OF CARE (DTOC)

- Delayed transfers of care attributable to the NHS and Social Care across the LDP is 17.39 per 100,000 population (worst performing quartile nationally)



A AND E ATTENDANCES

- In 2015/16 Local analysis identified Birmingham Cross City and Birmingham South and Central CCG as above for average emergency admissions – further analysis indicated many of these admissions were unnecessary.

CHC AND DOMICILIARY SERVICES

- There are significant challenges with available capacity as well as variability in quality of care in nursing homes and domiciliary care
- There is also a need to improve quality assurance in relation to personal budgets

PRIMARY CARE

- The Birmingham and Solihull CCG's combined have the second lowest ratio of GPs and Practice Nurses per 100,000 population (0.53). The respective figures are Birmingham CrossCity CCG 0.48, Birmingham South and Central CCG 0.65 and Solihull CCG 0.56

- The quality and outcomes of Birmingham's Adult Social Care system (which reflects how health, social care and wider support is joined up) is poor. Using ASCOF as the key indicator, Birmingham is ranked in the bottom 3% in the country and has been for over 5 years.

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- We acknowledge that the improvements made against national metrics in year 1 of the BCF, except avoidable emergency admissions, have not been sustained against an increase in demand and this is why we are changing our approach.

- We are also working to further understand what is driving our local position around delayed transfers of care in both health and social care settings. Whilst these can affect inpatients of any age, there is evidence that the majority of patients experiencing delayed discharges are elderly. Utilising the business intelligence functions of both the NHS and Local Authority, analysis has shown that 70% of the patients experiencing delayed discharges were aged 70 years or more, and 51% were aged 80 or more. Whilst we have made some progress with this age group the cohorts are still seen as a significant factor in DToC's. Further analysis is outlined in section 14.

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5.3 Financial Gap

- The overall financial gap identified for the system by 2020 within the BSol STP, which included adult social care, was c £730 million. Much of this is driven by rising demand linked to the challenges of health and wellbeing of Birmingham citizens and the variation in quality of services. The financial gap is the equivalent of opening a new hospital with over 400 beds. Birmingham City Council had overall cost pressures of c.£60m in 2016/17, resulting from externally driven cost pressures; significant challenges in delivering annual agreed savings; and additional growth in care packages and prices. Extrapolating the savings gap to 2020/21, Birmingham City Council faces an overall gap of £123m within the BSol STP footprint for Adults, Children's, and Public Health services.

- When we consider how we spend our resource, indicative patient segmentation[6] shows that Birmingham spends most money on the healthy adult (16 – 69) patient group. That said, there are groups where both the volumes and the average spend per capita are high, these are; adults with 1 Long term condition (LTC), adults with 2 or more LTC and people >70 years of age with 2 or more LTC. These groups are most likely to benefit from integrated care.

- There is evidence that in Birmingham there is ongoing growth in emergency admissions for conditions which would not usually need a hospital stay. For example, for conditions such as dementia where issues arise, the default often is an acute admission - when evidence suggests there could be more suitable alternatives[7].

- Although there are increasing pressures on social care 'disability free life expectancy' at age 65 has been falling from its peak in 2010-12. It increased significantly between 2005-07 and 2009-11, however, since then men have lost 66% of the gains made earlier in the decade and women have lost 60%. In addition, there are huge socio-economic differences in disability free life expectancy at age 65 – a fivefold difference between people in the poorest and most affluent areas – e.g. a woman aged 65 has an expected 3.3 years of healthy living in the most deprived areas of the city compared to 16.7 years in the most affluent.

[6] Birmingham JSNA
[7] https://www.kingsfund.org.uk/sites/default/files/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf

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- Social Isolation is likely to become a significant issue, with more people are living alone - by 2032 11.3 million people in the UK are expected to be living on their own, more than 40 per cent of all households, (with the number of people over 85 is expected to grow from 573, 000 to 1.4 million[8]).

- In summary, the most pressing challenges for Birmingham relate to poor quality outcomes, variable service quality and financial pressure. From a system and population view this has amplified by;

  I. A fragmented urgent health and care system which drives people to default to A&E departments,
  II. A poor offer for frail individuals, particularly in an urgent situation which drives hospital care and, for too many, subsequent long term care
  III. The need to improving the capacity and quality of primary care
  IV. The need to modernise and transform adult social care and Continuing Health Care approach

- The STP has helped act as an additional support for delivering greater service integration and integrated commissioning at a faster pace across the health and social care system. Commissioning reform is taking place in response to challenges faced by local health and care systems reflecting the changes locally with the decision of the CCGs to establish a single commissioning voice in Birmingham and Solihull.

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- In the past year progress made against key contributory indicators such as the reducing rates of emergency admissions and reducing Delayed Transfers of Care (DTOC) have not matched expectations; too many citizens still lose their independence and live in residential/nursing settings and the quality of care provided in those settings varies; the quality & availability of care and support in the community again varies too much; and those families, friends and communities that care for those who need support often need better support themselves.

- Our most significant medium to long term challenge collectively is to better promote health and wellbeing and better support for individuals within the communities that they live, in the context of current health inequalities and deprivation.

- Our most significant immediate challenge is to reform our urgent care system and stabilise and transform adult social care & primary care.

[8] https://www.kingsfund.org.uk/projects/time-think-differently/trends-demography

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6 Our approach

- The second BCF plan identified a range of challenges in delivering the agreed programmes to achieve the integration of health and social care in Birmingham. Since then, in addition to the STP, significant changes have taken place within the Birmingham organisations which have provided an opportunity for a new approach. Whilst building on the approved Better Care Fund plan for 2016/17 this plan builds upon the benefits of the changes in organisational form and changes in key system leadership. These changes have enabled us to refocus and set a different, positive tone for collective change; creating a firmer platform for the progressive integration of health and social care services.

- The key challenges facing us have already been outlined in Section 4, which have helped inform our priorities:

    - *Our most significant medium to long term challenge collectively is to better promote health and wellbeing and better support for individuals within the communities that they live, in the context of current health inequalities and deprivation.* This will be delivered through our integrated care and support for people who want to remain independent STP programme. The development of sustainable high quality general practice health services are a key interdependency in this programme.

    - *Our most significant immediate challenges is to reform our urgent care system and stabilise and transform adult social care*. These will be delivered through delivering integrated care and support for people who need urgent and emergency care programme and a BCC Social Care programme identifying interdependencies were they occur.

6.1. The Contribution of the BCF

- The BCF will contribute to these changes through these programmes:

- Through a joint commissioning approach within the *'Integrated care and support for people who want to remain independent'* STP programme, developing a single approach to community assets and the voluntary and independent sectors, including housing. In addition, to develop clear pathways for people with dementia, at end of life and for informal carers across the area. This will help support people to remain at home and reduce pressures in secondary care as well as enhancing the quality of life and care for citizens. It will also contribute to improving the quality of care in care homes through evaluation of existing pilots.

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- The development of integrated community services together general practice, community nursing and social care (this list is not definitive) through the Integrated care and support for people who want to remain independent STP programme.

- The reconfiguration of services to an integrated out of hospital recovery, rehabilitation and re-ablement (RRR) care system and offer for frail individuals; and the joint commissioning actions required to support this, through the Integrated care and support for people who need urgent and emergency care STP programme. This programme will include the joint assessment of long term needs – continuing healthcare and social care.

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- The Improved Better Care Plan (iBCF), for which additional Local Authority funding which was announced in the Spring Budget 2017). This was provided for the purposes of:
    - Meeting adult social care needs;
    - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
    - Ensuring that the local social care provider market is supported.
- The iBCF programme will contribute to all programmes.

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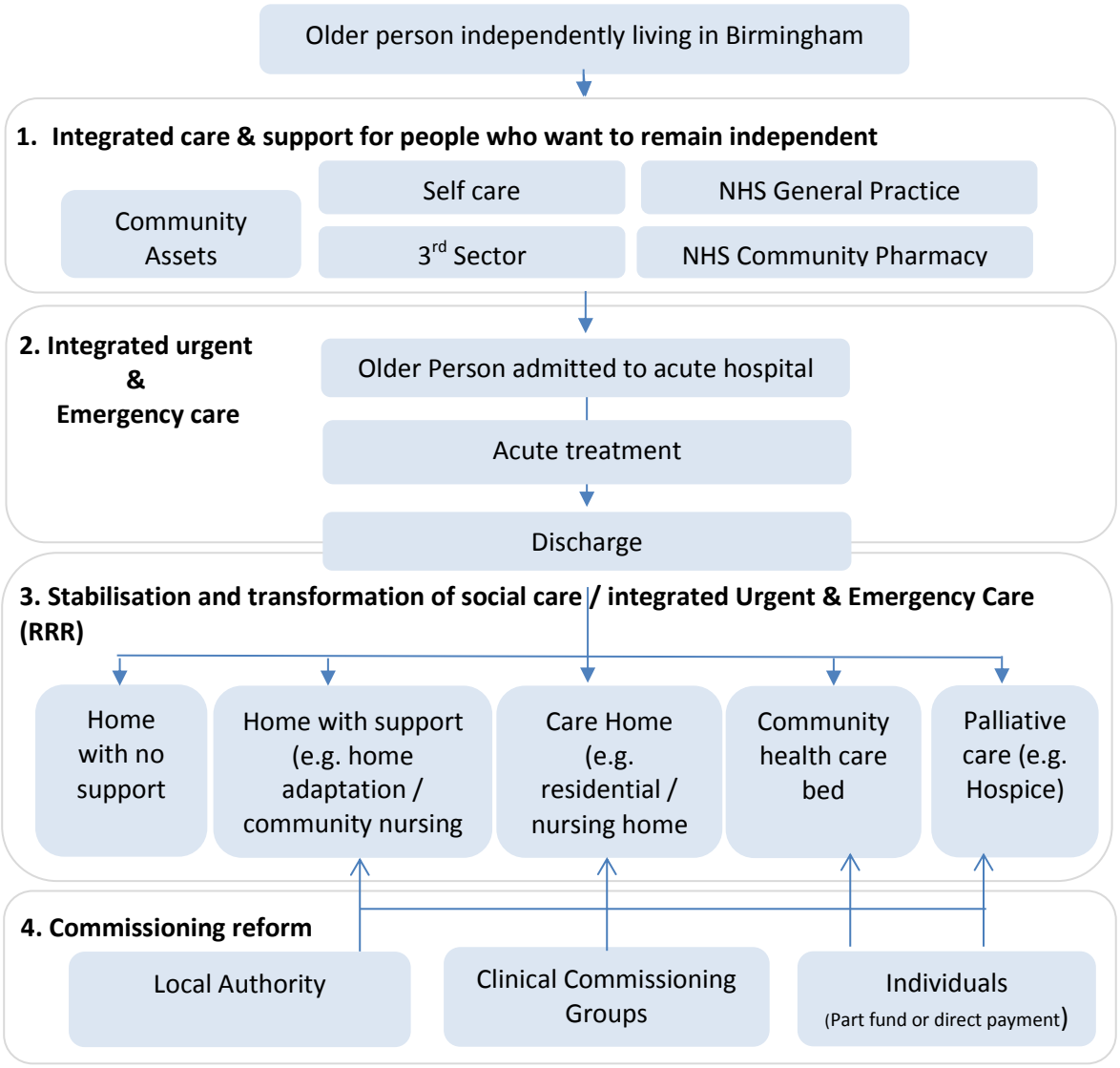
- Our approach will focus on the Birmingham citizen, keeping them as independent for as long as possible. If citizens require support to retain or regain independence, they will be able to find this support in their own community. If further support is required from our health and social care system it will be provided promptly, and it will be of good quality. This is why we have chosen our 4 key priorities. Our 4 priorities will impact on both the Birmingham citizen and the health and social care system:



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- Our Plan will also ensure continuous progress is made across Birmingham through:
    - The development of seven day services across health and social care;
    - Improved data sharing between health and social care; and
    - A joint approach to assessments and care planning.

- This plan also acknowledges that a key requirement for the development of integrated care is a strong primary care system.

- One of the key indicators of health & social care system integration is demonstrated by how, when treatment and support is provided to citizens, they are supported through the 'system'. This is why this Plan has a particular focus on managing transfers of care, and the related performance indicator Delayed Transfer of Care.

7 What will success look like?

- In previous plans we have outlined the benefits for Birmingham people linked to the **'I statements'** that have been developed. We believe our approach will deliver the following successes:

Integrated care & support for people who want to remain independent	• People will tell their story only once and having a single person to contact for support • Increased independence, health and wellbeing, and reduced loneliness and isolation • Improved accessibility to co-ordinated health and social care help, support and advice in people's local communities. • Practical support and 'quick fixes' in the local community for those in need. • People have more options for support as their needs start to change • People will be able to retain some levels of independence for longer • Support for Carers
Integrated urgent & Emergency care	• Hospital admissions are prevented where possible • Mental health needs are addressed as well as and alongside physical health needs. • People get back on their feet as soon as possible. • People with needs of specialist support will receive it
Stabilisation and transformation of social care / integrated Urgent & Emergency Care (RRR)	• People leave hospital earlier and are supported quickly at home and in their community • More people get back home after hospital rather than entering long-term care. • Money is spent more effectively, within communities, to support people's needs. • Better support for people with dementia to live well at home. • People are better informed and less anxious about the process and choices

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8. Local Area Performance Metrics

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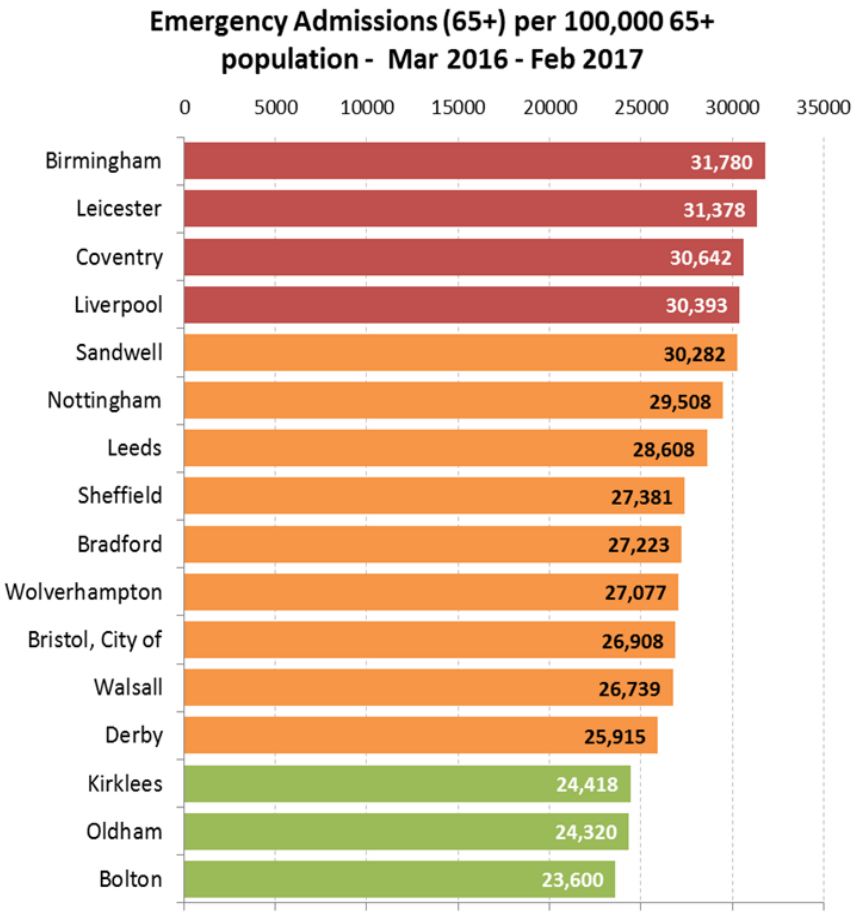
- The BCF policy framework establishes that the national metrics for measuring the progress of integration through the BCF will continue as they were set out for 2016-17. With the exception of measuring Patient satisfaction.

- The Department of Health and Department for Communities and Local Government have worked with stakeholders to develop a performance dashboard. The dashboard provides a set of measures indicating how health and social care partners in every Local Authority area in England are performing at the interface between health and social care.

- The summary below outlines comparison and progress made towards improving the key national metrics to date.

8.1. Emergency Admissions



Why is this important? Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions; and promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for emergency admissions.

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Overall Rank **143rd** out of 152 LA
46,304 Admissions
31,780 per 100,000

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- **Birmingham Performance:** Birmingham has very high emergency admissions - there are almost 25% more emergency admissions for people in this age group (65+ population) in Birmingham than the West Midlands and all England averages.

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- The introduction of the A&E Delivery Board and the national NHSE priority Urgent and Emergency Care programme has allowed a new focus on admissions and work to ensure that developments are

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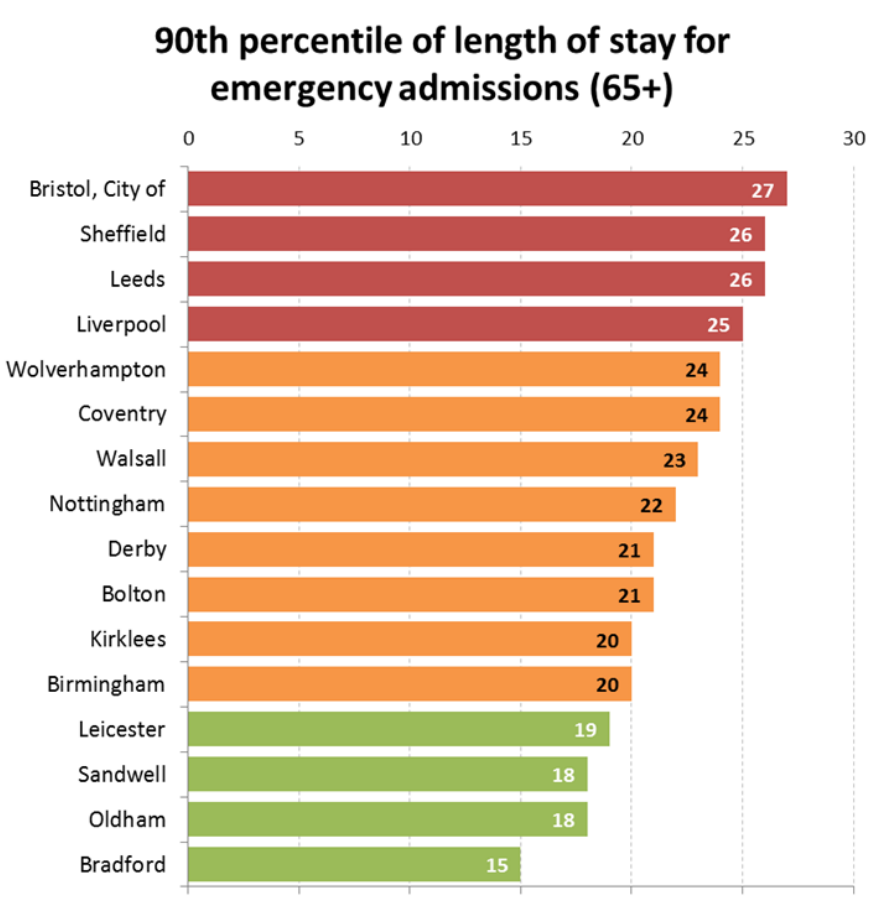
integrated across the system. The *'Hospital to Home'* element of this programme is one of the foundations of the 17/19 BCF and there will be links into the work being undertaken with Newton.

- No further 'Non Elective admissions' targets have been set for BCF, over and above those proposed in CCG operational plans.

8.2. Length of stay



Why is this important? - Longer lengths of stay can act as a powerful proxy indicator of poor patient flow.

Patient flow indicators have been trialled with systems taking part in the Emergency Care Improvement Programme (ECIP), and have supported reductions in length of stay and improvements in patient flow.

Overall Rank **55th**
20 days

- **Birmingham Performance:** Birmingham has a slightly shorter average length of stay compared to average and our statistical neighbours, with 10% of patients having a length of stay longer than 20 days (regionally and nationally the length of stay at the 90th percentile is 21 days).

- The data for March 2017 shows the end of year position to be a maximum length of stay of 33 days compared to the target of 29.This was mainly due to delays at one site whilst at other sites delays ranged from 18 days to 27 days.

- Work in 17/18 that will support improved performance includes the Newton System Diagnostic (Newton) work, the development of specialist care home capacity and the improvement of social care discharge pathways from NHS Acutes as well as the development of primary care enhanced, multi-disciplinary and Hub arrangements, providing alternatives to bed stays and to facilitate early discharge.

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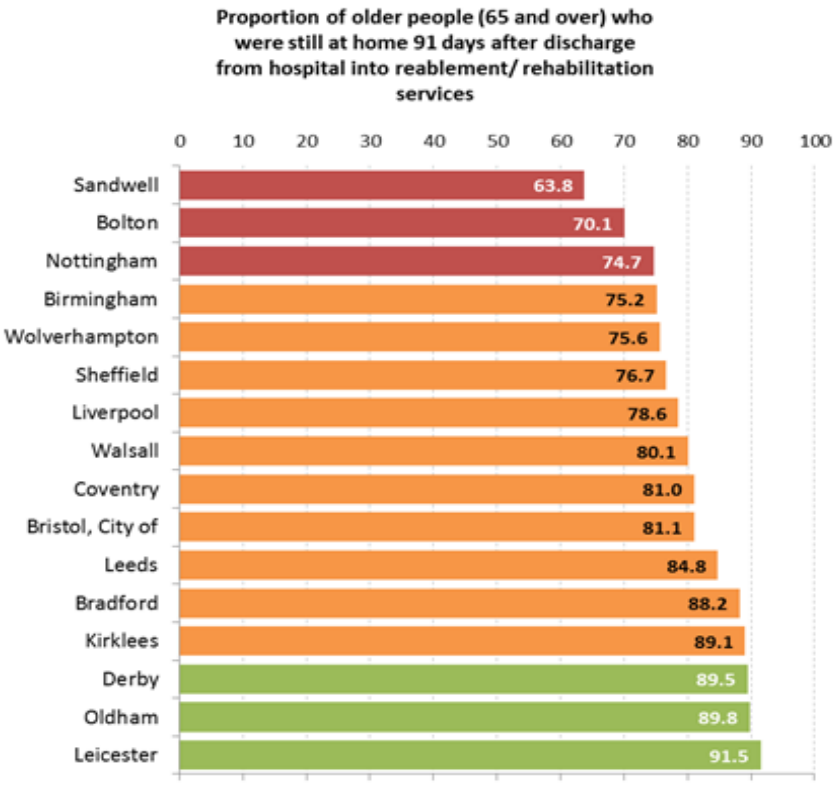
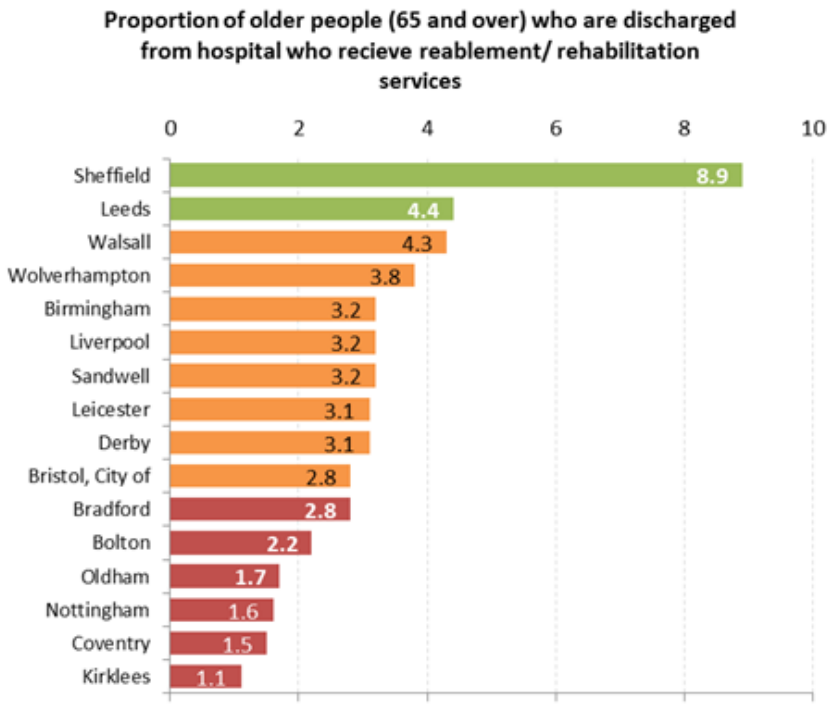
8.3. Reablement



Why is this important? - There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.

This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services



Birmingham Performance: Whilst the proportion of older adults discharged from hospital into reablement and rehabilitation services is better than the regional average (2.8%) and in line with the national average (3.2%), reablement effectiveness as measured by the proportion of people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services has worsened, with 24.8% of patients being readmitted within 3 months of discharge (compared to just 21.5% in the West Midlands and 16.6% nationally).

- Amongst the work in 2017/18 that will support performance to this metric will include development of recovery pathways, primary care enhanced delivery/ multi-disciplinary teams and HUBs, integrated services for frailty and respiratory, enhanced social care capacity and pathways, EAB capacity, and the development of community capacity driven by iBCF review of third sector services

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and the implementation of the Dementia and Carers Strategies. The expansion to include STP allows us to do this in a more coherent way than was previously possible.

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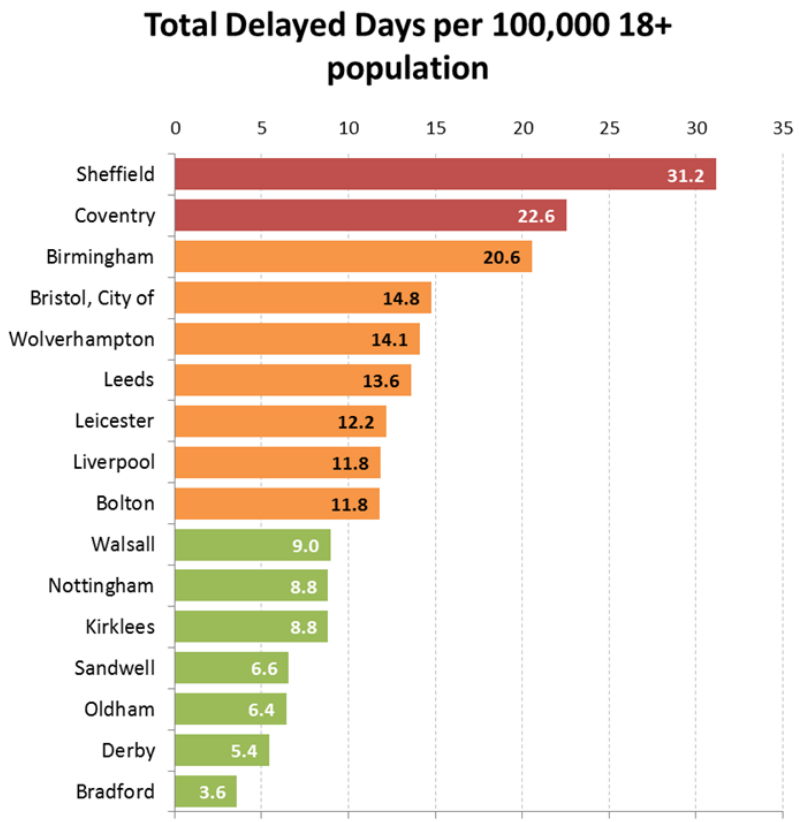
8.4. Admissions to residential and care homes

- BCF has contributed positively to managing the rate of residential and nursing care home admissions for older people and has achieved well against a challenging target - with a continuing downward trend. However, it should be noted that this decreasing number is offset by an increasing number of community and home care clients. There is further work planned, building on the 2 BCF pilots, to improve the quality of care home services and develop specialist capacity to accommodate more complex needs.

8.5. Delayed Transfer of Care



Why is this important? - This indicates the ability of the system to ensure appropriate transfer from hospital to social care services for the entire adult population.

It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services.

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- **Birmingham Performance:** In 2016/17, Birmingham residents experienced a total of 58,379 delayed days. The majority of these delays occurred in five Trusts: UHBFT, BSMHT, HEFT, BCHFT, and SWBFT. The charts below show performance split between Social Care and NHS Delays. Birmingham is a considerably poorer performer, regarding social Care delays, when compared to its statistical neighbour.

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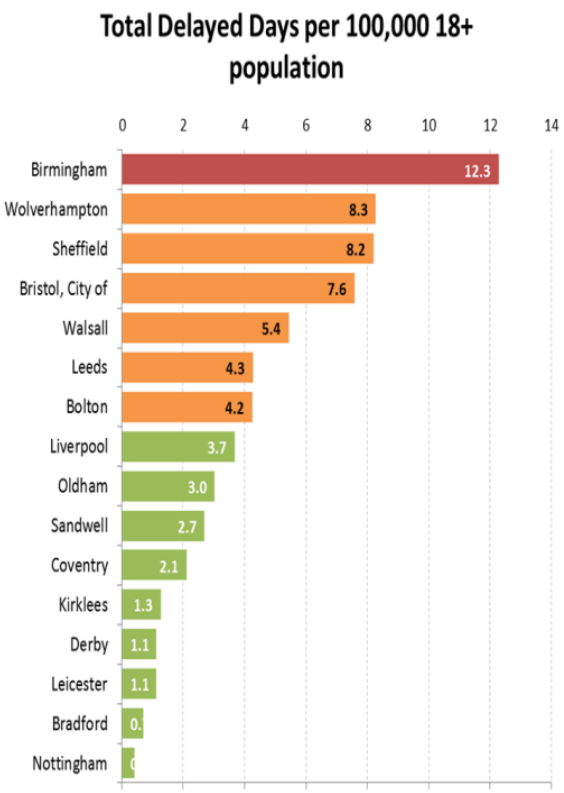
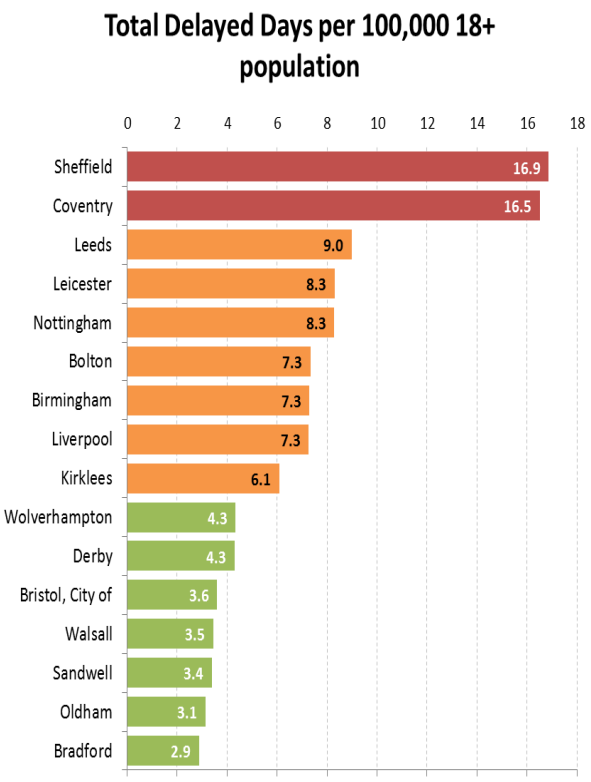
Social Care Delayed Transfer of Care



NHS Delayed Transfer of Care



- Overall, DTOC end of year outturn (March 2017) was 4% against a year end target of 3%. The BCF has played a key role in working with partners to achieve reductions however, this has occurred against a backdrop of rising demand and worsening performance across the health economy.

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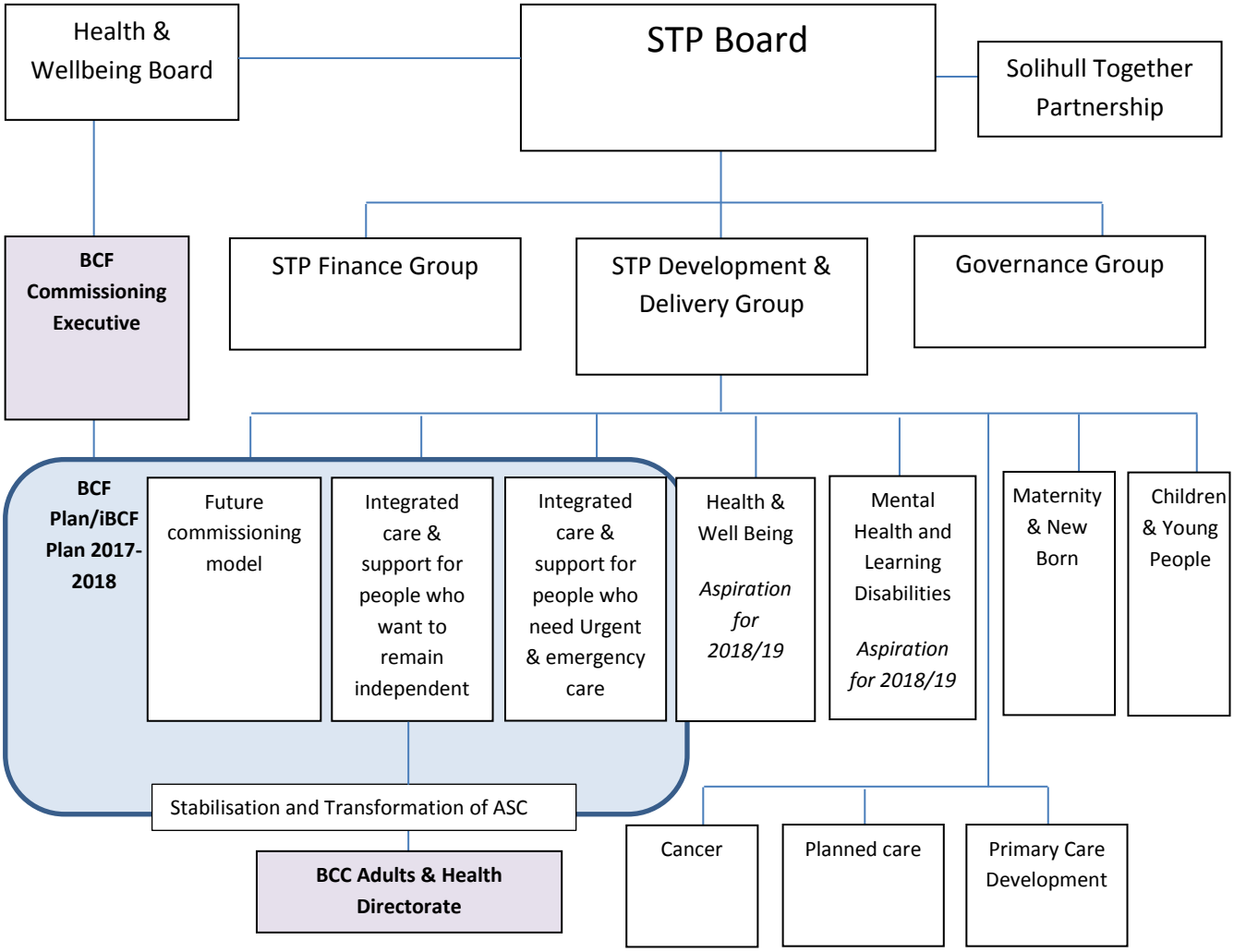
9. Governance

- As outlined previously, Birmingham needed to recognise the influences in the system and learn lessons from BCF implementation issues encountered both locally and nationally. For 2017/19 Birmingham has reframed its approach to the BCF ensuring that it is not separate to the delivery of other policy initiatives or plans. Instead, the BCF is firmly embedded and complimentary to wider system priorities. 18

- For this reason, the BCF will complement the refreshed approach to the BSol STP and its governance (September 2017). This is a significant move from the previous BCF programme and governance arrangements, which was set separately to the other system programmes. This is described below. 17



- The governance arrangements link firmly with the BSol STP plan, Adult Social Care Transformation and NHS Commissioning reform. The BCF Executive has reviewed its terms of reference given the changes in organisational configuration and closer alignment with the STP. 18

10. Better Care Fund plan 17/19

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- New interim officer leadership at Chief Executive and DAS levels at BCC, has provided the starting point of a new and positive approach to considering a system wide approach to improvement.

- The BCF (incorporating the iBCF) is now viewed as integral to the stabilisation and transformation of adult social care and the bridge between the City Council and the STP within Birmingham and Solihull. Work is in place to ensure delivery of integrated BCF and STP planning.

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- The BCF now forms one of a number of foundation blocks for the STP. Our experience over the last two years is that this alignment of plans and effort is critical to success and the Birmingham Health and Wellbeing Board welcomes the direction of travel as a positive thing. Oversight of a number of issues is intended to make this possible:
    - That social care and health are considered together equally, including the pressures faced by both
    - That west Birmingham is part of Birmingham
    - That appropriate and effective engagement takes place with the public

- As we move forwards with engagement around the STPs we will further develop the detail of changes with our public and people who use our services, building upon the work of the BCF and other programmes to date.

- The 'System' is considering how to apply the principles of integrated commissioning from a service user perspective which will also help form a view in considering an accountable care approach for service provision in Birmingham. The STP is focussing on what integrated commissioning and integrated provision could look like. The Birmingham and Solihull STP is in the process of agreeing a Memorandum of Understanding between partners which will form a formal foundation for this. The BCF will complement this work.

- As already outlined the BCF programmes 17/19 four key programme areas.

BCF Programme areas

Programme Area 1: Integrated Urgent and Emergency Care
(Governance through the STP Programme)

Programme Area 2: Stabilisation & Transformation of Adult Social Care
(Governance through BCC Adults and Health Directorate)

Programme Area 3: Integrated care and support for people who want to remain independent
(Governance through the STP programme)

Programme Area 4: Birmingham Commissioning reform
(Governance through STP Programme)

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Key system leaders across the Birmingham area are leading each of the programme areas. The tables below outline the programme areas, prioritised work areas. The governance links back to the structure outlined in Section 8.

Programme Area 1: **Integrated Urgent and Emergency Care**	**System Lead: Dame J Moore, CEO UHB**	20
Better Care Programme	**Work stream & Governance**	
System diagnostic (Newton Europe) to assess required systems capacity and develop a recognised and described model for post hospital recovery, rehabilitation and re-ablement.	BCF/ STP Urgent & Emergency care	
Rapid Response (front and back door)	BCF Urgent & Emergency care	
'Roll out ' of Clinical Utilisation Tool- The roll out of the Clinical Utilisation Review tool (CUR) began across two of the acute trusts and community trust in January 2016 and is continuing.	BCF Urgent & Emergency care	
Review of hospital social worker capacity and development of a structure which places social workers and OTs at the acute 'front door'	iBCF Priority 2 To provide support to the NHS	27
Review effectiveness, impact & scalability of Hospital to Home Commissioned Services	iBCF Priority 2 To provide support to the NHS	27
Develop a model of 'trusted assessors' with providers	iBCF Priority 2 To provide support to the NHS	27
Implementation of 7 day services – continuous progress and implementation of a permanent 7- day social work, brokerage & emergency duty team	iBCF Priority 2 To provide support to the NHS	27
Fund existing EAB beds funding gap	iBCF Priority 2 To provide support to the NHS	27
Other related programmes		
• Single Point of Access	STP/ Urgent and Emergency care	
• MDT Geriatric front door/ clinical hub	STP/ Urgent and Emergency care	
• Recovery, rehabilitation and reablement model	STP/Community Care First	
• Social care & CHC long term assessment	STP/ Planned care	
• Support to Care Homes	STP/ Planned care	
• Community IV/Pain Control services	STP/ Primary Care Development	
• Urgent End of Life Care	STP/Community Care First	

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• Integrated services for Frailty and Respiratory	STP/ Primary Care Development	
Likely impact on National Metrics • Non-elective admissions • Delayed Transfers of Care		15,7
Evidence of plans being in place FINAL BCF Newton proposal 0617.ppt Hospital to Home Plan 0817 v2.docx Copy of Item 5a - iBCF High Level Proje		

Programme Area 2: **Stabilisation & Transformation of Social Care**	**System Lead: Graeme Betts, Corporate Director, BCC**	20
Better Care Programme	**Work stream & Governance**	
Implementation of joint Carers Strategy	BCF 10 Carers Strategy	
Support communities & community based organisations to develop offers that support diversion and avoidance from SC services	iBCF Priority 1 To meet Adult Social Care need BCF 10 Carers Strategy BCF 09 Dementia Strategy	24 27
"Channel shift" carers assessments to Carers Hub, with associated support embedded in communities	iBCF Priority 1 To meet Adult Social Care need BCF 10 Carers Strategy	24
Citizen centred approach to social work which develops the community model	iBCF 1 Priority To meet Adult Social Care need	27
Reconfiguration of enablement services to optimise potential and align with health service	iBCF 1 Priority To meet Adult Social Care need STP/ Urgent & Emergency care	27
Bring forward the implementation of the new adult social care market framework	iBCF 3 To sustain the social care provider market	27
Care Homes - Incentivisation of gold standard providers	iBCF 3 To sustain the social care provider market STP Planned Services	27
Accelerate the uptake of Integrated Personal Commissioning	iBCF 3 To sustain the social care provider market	27
Commission an 'experts by experience' peer review function	iBCF 3 To sustain the social care provider market	27
Keeping people independent at home through Disabled Facilities Grant	BCF	
Likely impact on National Metrics		

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• Delayed Transfers of Care	
Evidence of plans being in place • See section 14	15,7

Programme Area 3: **Integrated care and support for people who want to remain independent**	**System Lead: Graeme Betts, Corporate Director, BCC**	20
Better Care Programme	**Work stream & Governance**	
Support communities & community based organisations to develop offers that support diversion and avoidance from SC services	iBCF Priority 1 To meet Adult social care need BCF 09 Dementia Strategy BCF 10 Carers Strategy	27
Review pilots of : Well Being Co-ordinators & Street Associations	BCF 03 Place based integration and the accountable community professional	
Carers – implementation of integrated Carers Strategy and Channel shift carers assessments to VCS	BCF Priority 1 to meet Adult Social Care need BCF 10 Carers Strategy	24
Social care – develop asset based integrated assessment	iBCF Priority 2 To provide support to the NHS	
Dementia – implementation of refreshed Dementia Strategy	BCF 09 Dementia Strategy	
Citizen centred approach to social work which develops the community model	iBCF Priority 1 To meet Adult social care need	
Reconfiguration of enablement services to optimise potential and align with health services	iBCF Priority 1 To meet Adult social care need STP/ BCF Urgent & Emergency care	
Purchase additional capacity in the care market, including for dementia	iBCF Priority 3 To sustain the social care provider market BCF 09 Dementia Strategy	
Other related programmes		
• Care homes- quality improvement framework	STP/ Community Care First	
• Falls prevention- develop and implement local strategy	STP/ Community Care First	
• Development of Primary care hubs/ multi-disciplinary teams	STP/ Community Care First/ Primary Care Development	
• End of Life Care Implementation of End of Life Strategy	STP/ Community Care First	
Likely impact on National Metrics		

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• Carer Satisfaction (SALT) • Dementia Diagnosis rate • Non Elective Admissions • Delayed transfer of care	15,7
Evidence of plans being in place • https://dementiaroadmap.info/birmingham/wp-content/uploads/sites/13/Birmingham-and-Solihull-Dementia_Strategy-2014-17.pdf	
Programme Area 4: **NHS Commissioning Reform** **System Lead: Paul Jennings, CEO Birmingham & Solihull CCGs**	20
• Support development of shared strategic direction	
Related Programme	
• Change the way NHS commissioning is arranged in Birmingham and Solihull • Set a clear direction for planning and partnership working • Develop a single commissioning vision and voice that is 'strong, consistent and credible' • Oversee transformation of health commissioning through shifting resources into prevention, early intervention, communities and primary care. To ensure: Effective system management underpinned by comprehensive information system • More effective and efficient commissioning processes – fewer gaps and less duplication • Greater focus on outcomes based commissioning • Better value through improved efficiency and reduced costs of commissioning function • Simpler and more effective governance of commissioning and decision making • Stronger service transformation approaches, decommissioning and re-commissioning • Aligned budgets (as a minimum) and agreed risk share arrangements	22
Likely impact on National Metrics • Non-elective admissions • Delayed Transfers of Care	
Evidence of plans being in place Supporting document 4 http://bhamcrosscityccg.nhs.uk/about-us/publication/get-involved/consultations/3440-final-report-on-2017-consultation-on-the-future-of-birmingham-and-solihull-ccgs/file	

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11. Key Programme initiatives

- The following section outlines additional narrative relating to key initiatives referenced in this BCF plan. The section also provides additional narrative relating to ongoing BCF supported initiatives that will contribute to the delivery of better outcomes.

11.1. System Diagnostic (Newton) Crisis and Recovery Strategy

- This builds on previous 2016/17 BCF 05 'step up and step down care' workstream which was merged with the Urgent care planning group to develop 'Crisis and recovery teams'.

- The impetus for this work was evidence that the system requires a better and more coherent front-line response for people who do not need to be treated in Emergency Departments (ED) in hospital or who present, in a crisis, with problems that do not require acute hospital care.

- There has been a measurable increase in the numbers of attendances at EDs and admissions of people who have conditions that could be treated more effectively in settings other than an acute hospital bed. Specifically, there are people who can be managed in the community effectively, without requiring the collective weight of diagnostic, specialist support and treatment capability that comes from a traditional hospital setting.

- The proposal developed outlines for three pilots of a new co-ordinated approach within ED involving other hospital and community health staff and adult social care working in parallel with ED clinicians to make the most appropriate decisions for individuals prior to entering the hospital system. The 'crisis team' is the current title for this approach and there will be a pilot in each hospital, namely, Heartlands, Good Hope and Queen Elizabeth Hospitals.

- Currently, each hospital has a different approach to admission avoidance and access to different services with only a limited level of consistency across the system in Birmingham. In addition, there are a number of services and their associated staff who we believe could have a more positive impact across the system if they were deployed in different ways within a 'crisis team' model.

- Once a patient can be safely discharged into the community the aim is to transfer the care from the crisis team to the recovery team where required. The development of this work will be led in conjunction with our partners Newton to create a Recovery Team that fully integrates both health and social care services and teams and has the systems, management, governance, capacity and resource to keep patients away from acute care and maintain care in settings close to, or at home.

- The 8 High Impact Changes are also be at the focus of this work and it will provide the following products to support the BCF programme, and future decision making:
    - A recognised and described model for post hospital recovery, rehabilitation and re-ablement.
    - Recognised and agreed models for integrated discharge teams and in hospital processes.

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- An assessment of the required capacity in each part of the model over 7 days informed by an assessment of opportunities for admission avoidance at the front door through improved front door decision making and in services which interface with the pathways.
- Agreement on how to fund the required capacity.
- Clarity of underpinning systems and processes to optimise flow, with accountability agreements.
- Single trusted assessments at the appropriate points within pathways.
- An agreed delivery plan that starts with the greatest identified opportunities taking into consideration the requirements on the system as a whole and individual organisations within it.

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11.2. Clinical Utilization Tool Implementation

- The roll out of the Clinical Utilisation Review tool (CUR) began across two of the Birmingham acute trusts and the community trust in January 2016. Leading up to this there was a preparation phase to action a procurement requirement to secure the most appropriate provider, put in place staff training and ensure technical readiness at an organisational level.

- The tool has now been implemented on relevant wards and each ward round considers whether the patient is appropriately placed in the bed they are occupying. The Trusts involved have produced some interesting data regarding the ratio of 'appropriate patients' and recent data has indicated that internal delays are a higher percentage of all delays than external delays.

- The commonest reasons for internal delays are shown to be:
  - Requiring on going physiotherapy,
  - Awaiting pathology
  - Continued stay determined by Consultant decision.

- The commonest top reason for external delays are shown to be:
  - Awaiting a social care assessment;
  - Waiting for an EAB bed
  - Waiting a social care package

- In 2017-18 work will focus on identifying internal blockages and set an improvement plan to rectify these. Birmingham will also be implementing the first CUR nationally in the mental health Trust. Work is underway currently to ensure that the algorithms used are fit for purpose and local implementation can be applied.

11.3. Carers

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- Work began in 2016 through the BCF to develop and implement a Birmingham Carers Strategy and has progressed well during the year. A strategic steering group is in place reporting to the BCF Executive.

- A key priority was to review and revise the local strategy in the context of national guidance. However, the continued delay in the issue of national guidance has meant that this will now be

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finalised later in 2017. The strategy, and the development of a commissioning infrastructure, has been supported by needs assessment, including a focus on the needs of BAME carers and the development of BAME specific support.	
• BCF funding enabled the establishment of Grant Awards. Providing community level, support to third sector and community groups. In total, 16 proposals were approved (out of 27 submitted) and commenced implementation from January 2017 onwards. The success of this work will be evaluated.	
• In addition, work in partnership with the Third Sector consortium provider, Birmingham Carers Hub 'Forward Carers', has helped to develop additional capacity in some existing services such as the 'sitting service' that forms part Carer's Emergency Response Service (CERs).	2
• We were also able to support 'Forward Carers' to work with (and in) GP Surgeries and Acute Trusts to promote carer self- recognition, and awareness, offering a health and wellbeing check with advice and signposting and access to a 'Carers MOT' as well as 'Social prescribing'.	
• In addition, we were able to develop a pilot with the same provider aimed at developing capacity in the organisation to undertake 'Carers Assessments'. This was very successful with over 170 completed as part of a pilot in 2016/17. In addition other projects looking variously at Safeguarding and carers and support for working carers were commenced in-year.	
• Work with Community Pharmacies included the production of information for carers and the offer of Carers MOT's and 'Carers Corners'.	
• In terms of training for carers the BCF has supported work with Birmingham City University to offer 'Carers Knowledge Information and Skills Sharing' (C-KISS). This aims to facilitate the delivery of skills information sessions to informal carers focusing on basic care strategies. These include manual handling, nutrition, skin care and stress management. As well as this we were able to offer training to carers of people with dementia around the early identification and management of UTI's and other common infections through Dementia Information and Support for Carers (DISC). This was intended to reduce the number of unplanned admissions that so often arise from common infections or conditions such as constipation that could be managed at home if identified early enough.	
• We were also able to fund a number of other projects including a 'Street Associations' project in the north of the city which has been very successful in identifying carers as it works to empower local communities to develop a more supportive local environment.	
• In 2017/18/19, as part of a joint plan between Birmingham CCGs, BCC and the third sector, funded through the iBCF, the 'Carers Hub' will be supported to complete all Carers Assessments. The Carers Hub will also be able to support the development of local networks for Carers.	2
• We will also be looking to increase the numbers of carers who are able to access direct payment and personal budgets (where applicable). We will also build on work to date to increase the links with	

primary care, acute and community services and domiciliary care, mental health and respite services, care homes to ensure there is earlier identification of potential carer breakdown and increased support and access to pathways.

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11.4. Dementia Strategy

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- The Birmingham and Solihull Dementia Strategy *'Give me something to believe in'* was adopted by Birmingham City Council and the local CCG's and other partners in 2014. Its overarching purpose was to understand the experiences of people with dementia, to identify what was already in place across Birmingham, and what we still needed to do to improve the outcomes for people with dementia and their carers. Following that Dementia moved into the Better Care Fund in 2015 and has worked closely with other workstreams to realise the potential of integrated working for people with dementia and their carers.

- In 2016/17 the Dementia Adviser and Dementia Support Worker services across the city were increased through CCG and BCF investment with a focus on developing links to primary care, supporting the work around increasing early diagnosis and ensuring patients are able to access support both during and after a diagnosis, and reducing unnecessary acute admissions.

- In addition, through the BCF, the carer support service across Birmingham has been increased as well as increasing numbers of dementia and activity cafes. Also training for carers in the early identification and management of UTIs and other infections (in order to prevent hospital admissions where possible) has been funded through the Carers workstream.

- Through the BCF, a 'pooled budget' for dementia has been developed for inclusion in the overall Better Care 'Section 75' agreement for 2017/18 that will help to align and protect budgets for services and ensure a more integrated approach to pathway development for people with dementia and their families and carers.

- Work has also been ongoing with Birmingham and Solihull Mental Health Foundation Trust to streamline diagnostic and post-diagnostic pathways for people with dementia, including piloting the prescribing of anti-dementia drugs in primary care and primary care models for assessment and diagnosis, whilst at the same time ensuring that secondary care assessment pathways provide a diagnosis in a timely manner.

- The CCG has continued to work towards the dementia diagnosis rate target - that 67% of people with dementia have access to a diagnosis and post-diagnostic support. Progress has continued throughout the year and February 2017 data shows CCG diagnosis rate varying from 63.4 to 97.8% at 63.4% against national achievement of 67.3%. This represents an increase of 18.5% since the work has been coordinated support through the BCF.

- The BCF team has worked closely with the BCC Health Overview and Scrutiny Committee inquiry "*Living life to the full with dementia*" to implement the recommendations of a previous review including the development of a Dementia Ambassador role among elected members. We have also

produced local guides to services and access to information about services online through the Dementia Roadmap.

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11.5. Supporting Communities

- Through the BCF two pilot projects have been introduced to support prevention activities within local communities across Birmingham, these are;
  - **Well Being Co-ordinators:** focussing on six pilot sites across Birmingham, delivered by four third sector organisations. The project aims to help vulnerable people, including frail elderly and/or those with long-term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups in Birmingham. The model is based on several social prescribing services across the country, which helps patients to access community services that promote good health and wellbeing, for example finance advice, physical activity sessions and social groups. There is a focus for the project on improving service users' health and wellbeing, and reducing unplanned admissions, A&E attendances and GP appointments.
  - **Street Associations:** Entering the second year of a two year project, the aim of Street Associations is to create resilient communities that support people to enjoy happy, healthy lives for longer. Street Associations are resident-led frameworks aimed at bringing people together, overcoming barriers and rekindling community spirit in streets where supportive community is most lacking. This is combined with a Connected Communities research-to-action project and we have included a clear focus on identifying carers and linking them to support.

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11.6. Multi Disciplinary Teams (MDTs)

- Multi-Disciplinary Teams (MDT) are a recognised discipline that improve the efficiency and effectiveness of patient care and are promoted in all national policy guidance. These are now being developed as part of the CCF programme as part of STP. The BCF will continue to support this programme and provide all the relevant products and experience that has been gathered to date, BCF will also support as part of A & E delivery Board remit.

11.7. Care Homes

- Two Care Home projects were previously included in BCF. These were a Digital Nursing Project and a Residential Care Home Support Service model and BCF will work with the STP to support further work as part of STP Enhanced Primary Care Models and Urgent care workstreams.

11.8. Virtual beds

- The "Community Virtual Beds" (CVB) admission avoidance service was developed by BCF as a pilot in 2016/17. The service focused on avoiding 'unnecessary' or 'inappropriate' admissions to acute settings and was based on evidence that a significant proportion of admissions could be avoided if appropriate alternative forms of care were available or if care had been managed better in the period leading up to the admission. It also focused on the need for high-quality expert decision-making as early in the process as possible (particularly for elderly patients), and that decision-makers have easy and rapid access to alternative services and diagnostics. An external evaluation of

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the pilot provided evidence of successful outcomes for the project that are being fed through the STP and A & E Delivery Board.

11.9. Disabled Facilities Grant (DFG)

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- Mandatory Disabled Facilities Grants (DFGs) are available from local authorities in England and Wales and the Housing Executive in Northern Ireland. They are issued subject to a means test and are available for essential adaptations. In order to qualify for adaptations in the home:
  - The person for whom the adaptations are being considered must be someone who is substantially and permanently disabled by illness, injury or from birth.
  - The person must also be 'ordinarily resident' in the area i.e. Birmingham
  - The adaptations must be 'required for meeting the needs' of that person, as defined in the Housing Grants Construction & Regeneration Act 1996. That is, essential or of major importance to the person because of the nature of their disabilities.

- To access DFG service users are advised to make a referral to the Occupational Therapy Service through Adult Social Care & Health Directorate access teams: Adults and Communities Access Point (adults) and Multi Agency Safeguarding Hub (children). The recommendation for provision of major adaptations for housing is made following the completion of an occupational therapy assessment. The assessment for this provision is a statutory requirement and conducted by the Occupational Therapy Service. Birmingham Occupational Therapy Service receives approximately 12,000 referrals per year requesting an assessment for major adaptation through DFG funding.

- DFG budget (Capital) is released as a Section 31 grant allocation from central government. The DFG is only used for owner occupier or privately rented properties.

- The Disabled Facilities Grant (DFG) was transferred to the Better Care Programme in 2016 and DFG Service was transferred from the Place Directorate to Adult Social Care and Health in April 2016.

- A service review was recommended by audit and commissioned by Senior leadership in BCC. The review is in the final stages of completion, and one of the identified priorities is to consider and review how efficiently this service works. It has been also highlighted that delays in provision of adaptation such as access to community and essential facilities (internally) have a negative impact on citizen's health and well-being and also increases the risk of hospital admissions and care.

11.10. iBCF priorities

- 1. To meet adult social care need
- 2. To provide support to the NHS
- 3. To sustain social care provider market

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- A traditional response to meeting adult social care need is to create more capacity or provision. We have shown in previous sections, through the JSNA, business intelligence and evidence that this is not a viable approach for the future. Therefore, our Birmingham approach will be to focus on prevention and building capacity within communities, in partnership with the third sector, to support an asset based approach to care. This will be matched by how both the social work offer is

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configured and our approach to commissioned social care. This is articulated in the section 11 of this narrative plan.	
• A key part of the iBCF plan is to work closely with the A&E Delivery Board and STP workstreams. This will provide support to the NHS especially in the application of the 8 High Impact Changes – included in section 14 of this plan. The work being undertaken in partnership with Newton (section 11.1) will provide the basis for redesign at a health and social care system level. It will be supported by a review of the effectiveness of out of hospital support (linked to the review of third sector support described above); development of a model of trusted assessors; development and implementation of a 7 day social work model; and a clear structure for adult social care support at the front door of acute hospitals and supporting diversion.	
• For the third element of the iBCF sustaining the social care provider market, we will ensure the implementation of the new adult social care framework together with an increase in provider capacity (particularly for nursing/ dementia). We will also ensure better quality of provision by incorporating customer experience/ experts by experience to inform this view. We will also be further encouraging uptake of Integrated Personal Commissioning.	27
• This work forms part of a broader strategic approach which is outlined in section 12 below.	

12. Stabilisation and Transformation of Adult Social Care– Strategic approach

• The goals that Birmingham City Council and its partners are seeking to achieve for adults and older people are that they should be resilient, living independently whenever possible and exercising choice and control so that they can live good quality lives and enjoy good health and wellbeing. These goals are reflected in our reframed approach to the Birmingham Better Care Programme.	
• Most adults and older people can achieve these goals independently or with help and support from their families, friends and social groups. However, for the most vulnerable people in Birmingham, this is only possible with support from Adult Social Care services and from other public sector agencies.	
• We have highlighted in previous sections of this plan how our current approach to providing Adult Social Care services and NHS services are not having the desired impact on improving outcomes, particularly for our most vulnerable. We have also highlighted that the way we currently deliver services will not be able to meet demand. This is why BCC, and the wider health and social care system needs to change	
• Birmingham system leaders recognise that these goals cannot be achieved simply through the provision of care services, it has to utilise its broader responsibilities across a range of areas to support achievement as well as working in partnership with communities. For example, the Council has a key role in ensuring there is appropriate housing which offers choice to people with a wide diversity of needs. This is why Birmingham Homelessness Prevention Strategy is also aligned to the Better Care Plan and forms part of our approach to improving health, wellbeing and independence.	2

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- BCC & its partners have recognised that they need to change the type of services they provide and that in order to deliver the desired goals for adults and older people, it is necessary to put in place a strategy that addresses potential barriers and obstacles and puts in place a framework to make the outcomes achievable.

- The narrative behind this strategy is that on the whole, people want to lead happy, fulfilled lives in touch with their families, friends and communities. They cherish their independence and prefer to live at home or in the community with support if necessary.

- The vast majority of people do not want to be dependent on others but will accept one-off support or ongoing support if it helps them to maintain their independence. For most people, this is achievable and it is only those people with disabilities or who lose their abilities with age that require long term interventions from adult social care services. And of course, for some people, because of disability, placements in residential and nursing settings are the best way in which these people can lead good quality lives.

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- Therefore, the iBCF plan which will enable these outcomes to be delivered contains these key elements outlined below.

12.1. Information, advice and guidance

- People need easy access to high quality information, advice and guidance and whenever possible and appropriate, they need to be able to self-serve or their carers and families need to be able to do so on their behalf. This approach allows people to maintain control and to exercise choice at whatever point they are at in their lives. Further, it helps the Health and Social Care system to use its resources more effectively.

- Building on this, it is essential that when people contact adult social care, they are given a positive response and support to help resolve the issues they face but by emphasising what people can do for themselves, what support is available from other organisations and what support is available in the community. The aim is to divert people to appropriate support other than formal care which fosters dependency.

- In order to deliver this element of the strategy, adult social care will continue to promote its services and how people can contact them. The first point of contact which can be through the internet or through a telephone contact centre will be continuously improved. The number of calls that are abandoned because of long waits will be reduced and more experienced workers will be based in the centres. The range of services that people can access directly will be increased (by building capacity in communities and supporting the third sector) and it will be made easier for carers to have their needs assessed.

12.2. Personalised support

- People require and respond better to personalised services. The approach that works most effectively always puts users and carers at the centre and builds support round them rather than fitting people into services. Essentially, there needs to be a strength-based approach to assessing

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people's needs – building on the assets people, their families, friends and communities can offer to support them. Further, Direct Payments are the preferred option for delivering support because they maximise the opportunity for people to exercise choice and control.

- In order to deliver this element of the strategy, there will be a reorganisation of the social work and care management services. This will be an ongoing journey as it is not desirable to throw all the pieces of the jigsaw up in the air at once. It is essential that the approach moves from assessing people for services to assessing them for the outcomes they desire and the assets they have to achieve them.

- There will be improvements to the systems that support this area of service. Further, the service will be delivered on a locality basis to strengthen workers' affinity to a local place, to strengthen joint working with workers from other services and to increase knowledge about the assets available in a local area.

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12.3. Community assets

- People need to be able to access a wide range of community assets which are local, flexible and responsive. Through being able to access these resources people can continue to enjoy good quality lives while maximising their independence.

- While the use of community assets is part of a broader approach to prevention, these assets are important for people to enjoy good quality of life whatever period of life they are in. Some may use them once in a while but still see them as a key part of being part of a wider community and others will make good use of them.

- Community assets are the wide network of services which range from very small, very local services provided by volunteers through to faith groups and community groups, national charities and private companies and businesses. They are all part of the wide network of community assets which provide choice and enable people to engage with others in activities they enjoy and which add meaning to their lives.

- In order to deliver this element of the strategy, we will be investing in local services. Resources need to be made available for local groups to provide the wide range of support that enables people to remain in the community. This will include support for volunteers to run activities and for micro-enterprises to run services such as personal assistants and day opportunities. There will need to be workers to undertake this work and they too will be based in the community. Essentially, they will be link workers or network workers and their role will be to make the links between formal services and the community assets.

- This approach needs to be supported by a broad corporate, and system wide, approach which ensures there is an emphasis on locality working. Similarly, GP practices need to be engaged as do community based health services and mental health services. Learning from the Vanguard pilots can be brought into this approach to locality working, ensuring that there is a partnership of integrated provision across formal care and health services and a diverse range of community assets.

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12.4. Prevention and early intervention	
• People need to be able to access prevention and early intervention services quickly and at any time in their lives. Services such as assistive technology can be beneficial at different times as can reablement and rehabilitation services. These services can help people to maximise their independence throughout their lives and as people's needs change, their needs for these services change as well.	
• It is important to have a comprehensive strategy for prevention to ensure that organisations in the public sector and in the third sector are 'joined up' in their approaches and maximise the available resources. Much can be done through 'Making Every Contact Count' principle and there are a wide range of partners who are keen to work in this area such as the Fire Service.	2
• One of the weaknesses of the public sector has been that it can be poor at anticipating demand. Too often, organisations wait until there is a crisis for services to click into gear but by then the only options may be high cost, acute services. That is why we will have a strategic approach to prevention which anticipates potential needs and intervenes early before they become a crisis. For example, people often fall several times before they break a hip. Investing early in low cost solutions and preventive actions can help avoid falls.	27
• In response to this a comprehensive approach to prevention will be developed and implemented. A key element of it will be the link to community assets and the link workers. These will play a key role in ensuring that people with lower level needs aren't left until they develop acute needs. A multi-organisation group needs to be established or an existing one such as the Health and Wellbeing Board needs to take the lead on prevention to ensure the strategic approach is implemented.	
• Other preventive services need to be developed and invested in. This will include assistive technology, aids and equipment, support for carers & people with dementia and easy access to reablement programmes.	
12.5. Partnership working	
• People's needs are often complex and require support and interventions from a range of organisations. Therefore, services need to be integrated and built on partnership working utilising multi-disciplinary teams and where feasible single points of access. This approach needs to be developed at all levels – quite simply, care and health services are a whole system and if one part of the system is not working then the system as a whole isn't and the people that suffer are the residents of Birmingham.	
• For commissioners, working in partnership can deliver better quality services that are more integrated and better value. At locality level, trust needs to be developed between professionals such as district nurses and social workers so that packages of care and support can be flexed without reassessment from social care staff and there need to be more joint visits and assessments.	

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- In order to deliver this element of the strategy, the City Council & its partners recognises the need to work as a whole system and need to support each other to achieve their separate and joint goals, and the BCF provides a vehicle for this.

12.6. Making safeguarding personal

- While recognising that for some people there is a need to protect them, it is essential that we ensure we "make safeguarding personal". It is essential that we understand what outcomes people want from safeguarding enquiries and actions. In this area, there is a balance to be achieved. It is essential that there is an effective Safeguarding Adults Board, that strategies are in place, that there is an effective team, that enquiries are robust, that there is excellent partnership working and there is high quality intelligence about safeguarding issues and performance. Further, it is essential that safeguarding is seen as everybody's business and that staff across the care and health sector are aware of the issues and know how to deal effectively with safeguarding concerns. Also, it is essential that this issue is kept in the public eye.

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- In order to deliver this element of the strategy, the strategy for safeguarding needs to be implemented and the service and its performance regularly reviewed. This area needs to be resourced at a level proportionate to the risks that exist in the system.

12.7. Co-production

- All services should be co-produced with users and carers as they are directly impacted by services and have first-hand experience of what works well and what doesn't. While this is important for all services, it is essential that commissioning demonstrates excellence in this area. Far too often, people feel they are being paid lip service when consulted on service developments. Approaches based on ongoing engagement need to be at the heart of commissioning and service delivery.

- In order to deliver this element of the strategy, an approach to co-production needs to be implemented across all services. For most services, this will serve as a reminder of best practice but for others it may provide the opportunity to refresh or develop their approach.

- In addition, a review of the use of resources will provide a framework for moving resources from areas where best value is not being delivered to areas where it can. So, for example, areas of service will receive investment such as the development of community assets and Shared Lives while other poorly performing services will have their resources reduced. This is not a one-off exercise and there will be on-going monitoring and review of spend to ensure resources are maximised.

- This paper will be discussed with managers and staff, partners and Members. It will be finalised over the next few months and it will provide a framework for the actions required to modernise services in Birmingham, ensure a corporate and partnership approach to delivering high quality outcomes and provide the framework within which resource decisions can be made.

13. Stabilisation and Transformation of Adult Social Care– Turning Strategy into action

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Delivery of the strategy is beginning to take shape with three core areas of work being undertaken

1. Social work offer (Assessment and support planning services)
2. Commissioned social care
3. Prevention First: An integrated Approach

13.1. Birmingham City Council Social Care offer (Assessment and Support Planning services)

- As recognised 'business as usual' cannot continue given the increase in demand for services and growing financial pressures. Therefore, in line with the strategy, a service delivery model is being introduced which adopts an asset based approach to social care assessments, alongside a community development model.

- Key areas that we need to improve on our journey to an asset based approach and community development model are the development of closer links to communities and the ability to identify family and other support networks for the citizens we assess, that share in the support of the citizen. 27

- As part of this model we need to empower decision making as much as possible at the point of contact with citizens to minimise the delays and any unnecessary bureaucracy in decisions being taken.

- The asset based approach and community development forms part of wider changes, that are key to addressing the shift from institutional care to promoting wellbeing. They will also form the basis of how demand for service is managed in future.

- For the service delivery model to be successful a major change in how BCC's current social care workforce is configured needs to be implemented. The BCC Social care workforce will be a vital 'connector' to other public services and community resources, especially the NHS and also local housing. Teams will work in partnership with community groups, voluntary and private providers and organisations that represent people who use services. To achieve this BCC are moving to formalise a constituency based model where social work teams serve a defined local constituency, also moving to work more closely with health colleagues particularly within primary care settings. The changes that are being proposed are:

    - Merging the workforce and delivery roles
    - Aligning teams to constituencies

- Ensuring that teams are aligned to constituencies is the first step in building local knowledge and working with partners and other local groups. Moving to a constituency model will also allow us to provide further opportunities to engage in community development.

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- The merging the workforce and delivery roles will allow us to be more efficient by removing the current overlap between the existing roles and also simplifying the assessment process in keeping with an asset based approach.

- This will streamline the process of recording by frontline staff while reducing the time and effort of management in terms of oversight. This approach has been developed in conjunction with Research. In Practice for Adults and Social Care Institute for Excellence underpinned by national research.[9]

- The model has been consulted on and is being implemented from November 2017.

13.2. Commissioned social care

- In conjunction with a change in the social care workforce model BCC is also introducing a significant changes in how we commission social care from third sector and private providers, utilising and aligning with the BCF, our commissioning approach will aim to; 27
    - Improve outcomes for those with health, care and support needs
    - Improve the quality of commissioned health and care services
    - Improve the resilience and sustainability of our health and care system
- These align closely to the eight key outcomes of an emerging BCF Vision and Strategy for Adult Social Care and Health:

    - **Information, advice and guidance** – by providing easy to use information about the quality of services and support informed choice.
    - **Personalised support** – by having specifications and a quality framework that focus on delivery of personalised care and support.
    - **Community Assets** – commissioning of services at a local level and working with care providers to develop their services to add social value.
    - **Prevention and early intervention** – a quality rating system that rewards those services that are working hard to support the independence of service users and those that are adding social value to the wider community to offer prevention and early intervention service.
    - **Partnership working** – working closely with NHS colleagues on the joint quality rating of providers and sharing market intelligence with regional commissioners, regulators and partners.
    - **Making safeguarding personal** – working to support the development of high quality services that reduce the risks of neglect to service users and sharing of intelligence with partners to safeguard vulnerable citizens.
    - **Co-production** – use of customer feedback in the ongoing monitoring and quality rating of providers.
    - **Use of resource** – transparent approach to pricing, including open book accounting to ensure value for money.

[9] https://www.scie.org.uk/prevention/research-practice/

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- To implement these aims and the vision, the following key proposals were consulted upon with service users, potential service users, members of the public, providers, staff, Elected Members, partners and stakeholders:
  - Implementing a geographic model for the commissioning of home support, closer to communities.
  - No longer doing business with poor or 'Inadequate' care providers and ensuring citizens who requires care and support can be assured that the support will be of good quality
  - Having clear quality standards, and allocating work based on quality
  - Having an annual inspection for each service to identify the quality of that service
  - Having a twice-yearly self-assessment of quality by providers
  - Moving to a fixed-fee approach linked to quality
  - Ensuring an annual review of prices
  - Increasing the scope of the new framework to include Supported Living and residential services for under 65's with and without nursing
- The approach has been consulted on with implementation from April 2018.

13.3. Prevention First: An integrated Approach

- Work with third sector providers, citizens representatives and partner agencies is currently underway to co design a new approach to commissioning/ prevention services that supports the delivery of the vision for Adult Social Care and Health: 27

  'Citizens lead healthy, happy, resilient and independent lives within their own homes and communities'.

- The preventative focus therefore needs to be firmly placed in the first instance within the universal offer whereby citizens are able to support themselves deploying community based responses wherever possible.

- There are four commonly identified barriers to this vision: the need to reduce isolation, maximise income, improved health and wellbeing and good quality housing and housing support. 2
  - The Prevention First model therefore has two integrated component parts:
  - Community assets and local networks are the natural first point of contact when citizens or carers need support
  - Where appropriate effective integrated pathways are available into targeted or more structured prevention activity

- Third sector expertise, resource, knowledge of localities and their place based assets are crucial to the delivery of this model. The co design work to date with third sector providers and BVSC[10] (as a gateway to Birmingham's Third sector) includes work to identify best practice locally and nationally, co/ design of local network models for commissioning; establish an evidence base to support investment decisions and associated methodology to evaluate the impact of the proposed commissioned activity. Running alongside this are the considerations to capacity build 2 21

[10] Birmingham Voluntary Services Council https://www.bvsc.org/

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third sector organisations to diversify their business models to reduce risk and dependency on one funding stream alone.

- A report is being prepared for the BCF Executive and BCC Cabinet for November which will set out the need to invest in prevention services and the proposed new commissioning activity. This includes the associated commissioning of housing support services using the pathway approach set out in Appendix 2.(Homelessness Prevention Positive Pathway)

14.Focus on Delayed Transfers of Care (DTOC)

14.1. Background

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- Reducing delayed discharges in the city is a central focus of this Better Care Fund plan. For too long the DTOC rate in the city has been far too high. While there have been improvements in recent years (in particular in 2015) recent benchmarking clearly positions Birmingham as one of the worst performing areas nationally.

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- Making improvements around delays has always been difficult when taking place against a backdrop of rising demand and worsening performance across the health economy. However performance has also been hampered by distinct factors associated with Birmingham. For example there has been a lack of a consistent approach to monitoring and measuring DTOCs across the different parts of the Birmingham system, punctuated by lack of shared vision for what we are trying to achieve. Often there are significant concerns about data accuracy both in respect of the designation of patients as delayed, and the attribution of responsibility for delays.

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- This plan will address these issues. The key outcomes of our plans around DToC are to:
  - Improve and strengthen relationships between the hospital trusts and the Local Authority ensuring there is one consistent well-understood approach to addressing delays in the acute sector
  - Take a preventative approach by working together across the health and social care system to deliver a range of services that prevent delays occurring
  - Improve services for patients by avoiding situations where, particularly older people, are put at risk by remaining in the acute sector when they no longer need acute care.

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14.2. Current Position

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- Benchmarking information provided in Section 8 of this report shows that Birmingham is one of the worst performing systems nationally, in particular around delays associated with Social Care. The recently agreed Better Care Fund DTOC targets agreed with LGA/NHS England are extremely challenging.

- As the chart below indicates – our current trajectories alone put us some way off meeting those targets so a step change in approach is needed. In addition the inclusion of sub-targets for NHS and Adult social care delays is intended to encourage a shared contribution to a planned bed day reduction. Targets place a disproportionate burden on the council and fail to recognise the improvement required to allow individual NHS Trusts to meet their targets.

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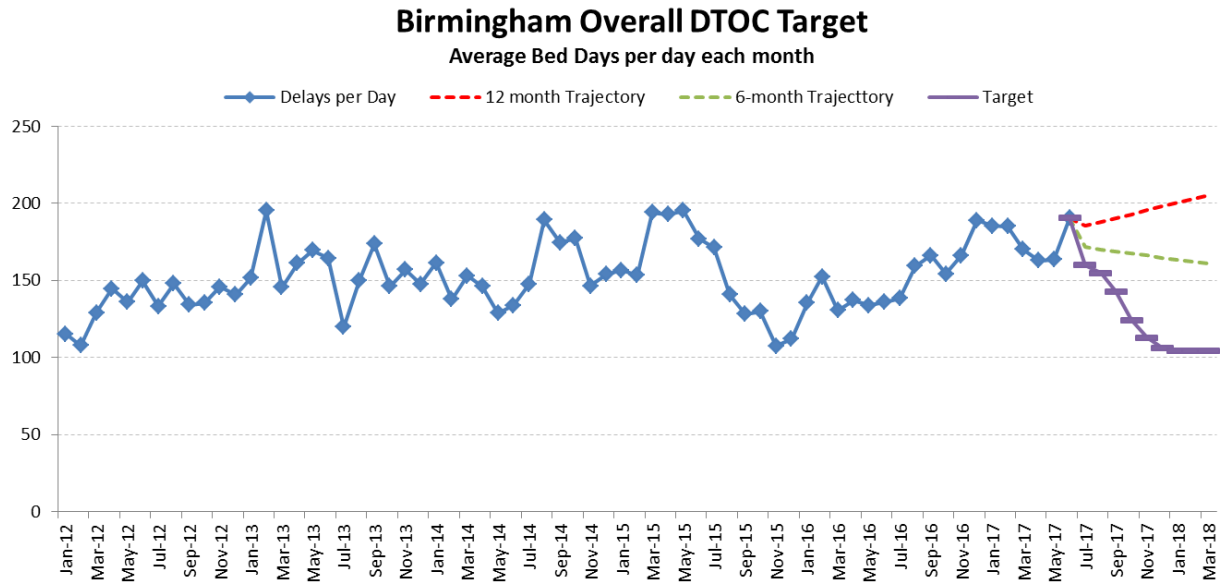
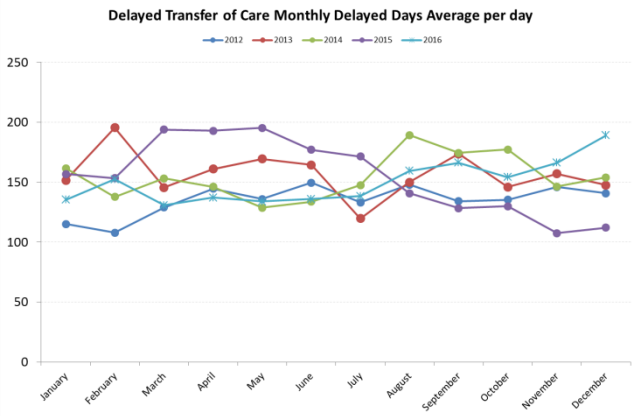
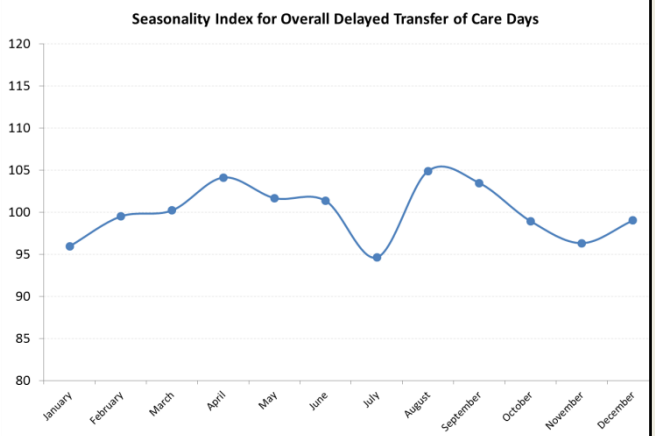
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS attributed delayed days	1956	1840	1673	1508	1393	1440	1440	1300	1440
Social Care attributed delayed days	2675	2644	2317	2078	1737	1587	1526	1378	1526
Jointly attributed delayed days	329	316	290	269	253	262	262	236	262
Total Delayed Days	**4960**	**4800**	**4280**	**3855**	**3383**	**3289**	**3228**	**2914**	**3228**



- One of the key issues around DToC traditionally has been around seasonality – for example greater demand due to winter pressures. However an analysis of seasonal delays indicates little correlation with health related seasonal differences, indicating that when needed, the system can cope to an extent with increased demand. This needs greater analysis.





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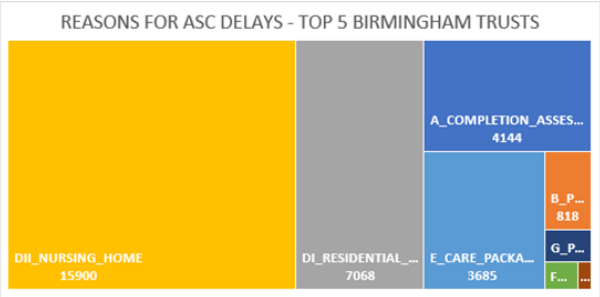

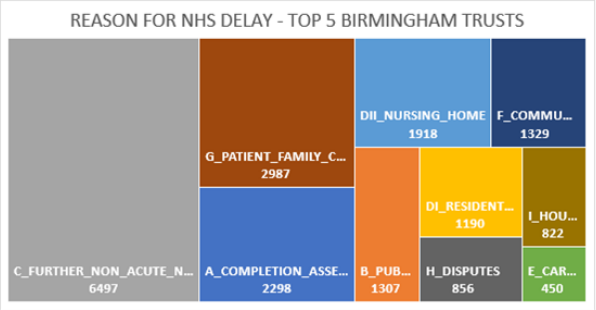

Monthly Delayed Transfers of Care 'SitRep' returns provide further information about the reasons Birmingham residents have been delayed in hospital and provide some insight into the improvement effort and capacity requirements in the Birmingham system. NHS delays are most frequently recorded for patients awaiting further non-acute NHS treatment (33.1%), followed by Patient & Family Choice (15.2%), Completion of Assessment (11.7%) and Nursing Home placements (9.8%). Delays attributed to Adult Social Care are primarily due to Nursing Home placements (49.3%), Residential Home placements (21.9%), Completion of Assessment (12.9%) and Home Care Package (11.4%)[11].

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14.3. National Condition 4: Managing Transfers of Care–Utilising the 8 High Impact Changes

- The High Impact Change Model aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters.

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- It offers a practical approach to supporting local health and care systems to manage patient flow and discharge and can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year.

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- The 'High Impact Model' establishes the principles and best practice which underpin the single plan that will be the DTOC, Hospital to Home and elements of the BCF plan for the Birmingham system. This will fulfil the requirements within the iBCF, BCF, and the STP national Urgent and Emergency Care Plan. Steps have already been taken to develop the work programme which has been previously described. In summary:

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  - Change 1– Early Discharge Planning: This model is under review currently considering the impact of social care involvement to assist with early discharge assessment particularly at the Heart of England Foundation Trust.
  - Change 2– Systems to monitor Flow: All acute Trusts currently monitor patient flow but it is not joined up with the 'out of hospital' system and does not have the same processes.
  - Change 3- Multi disciplinary and Multi agency Discharge: MDTs via discharge hubs are in place in all hospital sites but not community hospitals. Their refinement if necessary will be a focus of the Newton work outlined below
  - Change 4- Discharge 2 Assess: Our current model, which is not operating effectively for the system will be reviewed as a part of the wider system work discussed below. The principle of 'Home First' is not established.
  - Change 5- There is a 7 Day collaborative plan to be implemented which supports clinical Standard 9 describing the actions required from providers to respond to a whole system

[11] NHS – Adult Social Care Interface Dashboard - Further Analysis, Paul Johnson Impact Change Solutions

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approach to deliver a continuum of a 7 day pathway for appropriate services to improve patient flow. ○ Change 6- Trusted assessment: Currently modelling the trusted assessor approach based on work already completed at one acute trust and pilot at another. Consideration to be given as to how this can be rolled out across all providers ○ Change 7- Focus on Choice. There is universally agreed policy in place, further work required on full implementation. ○ Change 8- Enhancing health in Care homes: Pilots in 16/17 for digital nursing and support to residential care homes are currently being evaluated.	
• The 8 High Impact Changes are also at the centre of work, previously described, with our partners Newton. The aim is to provide an evaluation of current practice and identify and prioritise opportunities to achieve a collaborative system wide plan for improvement. This work is due to start in July 2017 with a preliminary report of opportunities in November 2017. In the longer term we hope to deliver on the aims described below, however timescales will be dependent upon the Newton initial findings. The aims are:	13 11
○ A recognised and described model for post hospital recovery, rehabilitation and re-ablement. ○ Recognised and agreed models for integrated discharge teams and in- hospital processes. ○ An assessment of the required capacity in each part of the model over 7 days informed by an assessment of opportunities for admission avoidance at the front door through improved front door decision making and in services which interface with the pathways. ○ Agreement on how to fund the required capacity. ○ Clarity of underpinning systems and processes to optimise flow, with accountability agreements. ○ Single trusted assessments at the appropriate points within pathways. ○ An agreed delivery plan that starts with the greatest identified opportunities taking into consideration the requirements on the system as a whole and individual organisations within it.	12
14.4. Short term Activity - To support meeting the November 17 DTOC trajectory	
• As outlined the trajectory target report for November 2017 (which will report September DTOC position, requires some immediate, short term work. This includes;	
○ **Implementation of consistent process for counting and validating DToCs:** This involves working closely across organisations to embed national guidance around counting and validating individuals.	12
○ **Implementation of weekly DToC review:** Ensuring senior leadership and ownership across all organisations	11
○ **Implementation of Escalation Process** – Introducing a consistent system of appropriate escalation. Communication to be sent to relevant managers at all hospitals setting out how issues should be properly escalated	11
○ **Shared understanding of organisation at work –** e.g. Educating health colleagues on the elements of good social work practice and providing an overview of social work practice for the benefit of clinical staff especially at discharge hubs	

- **Implementation of Patient/Family Choice Policy -** Incentivisation of providers to assess before offering choice
- **Better Utilisation of Bed Based Enablement capacity –** To better use the 70 bed enhanced assessment bed resource which currently is considered to be used inappropriately at times

14.5. Longer term Activity

- The Home to Hospital Plan constitutes a single plan Birmingham and Solihull footprint which covers the areas of:
    - DTOC planning,
    - Urgent and Emergency Care Hospital to Home Planning and
    - Parts of the Birmingham and Solihull Better Care Fund Plans.

- A key part of this plan has been the agreement for all partners within the Birmingham system to a joint piece of work with consultants called Newton to undertake a definitive review of the out of hospital system particularly linked to hospital discharge but also considering admission avoidance opportunities at the front door. This will inform the medium to long term planning actions required and is expected to report to the A&E Delivery Board in early November.

- In summary the Hospital to Home Plan has the following key milestones and deliverables:

National Milestones	Local Deliverables	KLOE
Early Discharge Planning: In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge and to allow an expected date of discharge to be set within 48 hours	**HEFT:** LOS reduction programme - supported by relevant task and finish groups	12
	UHB: Unscheduled Care Board	12
Systems to monitor patient flows: Robust patient flow models for health and social care, including electronic flow system, enable teams to identify and manage problems and to plan services around the individual	Newton Review	
	Developing an integrated service which appropriately supports ED and short stay units – capacity and flow modelling, systems and processes	12
	Data sharing agreement, integrated IT systems and processes tested at UHB as part of trusted assessor project	
Multidisciplinary/ multi agency Discharge Teams including the voluntary and independent sectors: Co-ordinated discharge planning based upon joint assessment processes and protocols, and on shared agreed responsibilities, promotes effective	Newton Review	
	Developing an integrated service (including CHC) which appropriately supports ED and short stay units - this will be a consistent service over 7 days and will include BCHC rapid response and mental health requirements to support those in crisis	12

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discharge and good outcomes for patients	Developing an integrated service (including CHC)which appropriately supports base wards, BCHC and EAB - this is likely to be a core five day service with a defined specification for cover over weekends and response at bank holidays and other key holiday periods.	
	Joint BCC/CCG Commissioning strategy for home care and residential/nursing care home providers	13
	Continuation of (until March 2017) and review of voluntary sector Hospital to Home service to develop long term strategy for recovery	
Home First / Discharge to Assess: Providing short term care and enablement in people's homes or using 'step down' beds to bridge the gap between hospital and home means that people no longer need to wait unnecessarily for assessments in hospital. In turn this reduces delayed discharges and improves patient flow.	Newton Review	
	Existing **EAB funding gap closed** in Birmingham - to be covered by iBCF	12 27
	Reconfiguration of enablement services in Birmingham	
	Additional long term nursing dementia capacity in Birmingham	12
	Joint BCC/CCG Commissioning strategy for home care and residential/nursing care home providers	
	Continuation of and review of voluntary sector **Hospital to Home** service to develop long term strategy	13 11
Seven Day Services: Successful joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	**Newton Review** (see above)	
	Developing an **integrated service** (including CHC) which appropriately supports **ED and short stay units** - this will be a consistent service over 7 days and will include BCHC rapid response and mental health requirements to support those in crisis	13
	Developing an **integrated service** (including CHC) which appropriately supports **base wards, BCHC and EAB -** this is likely to be a core five day service with a defined specification for cover other periods**.**	12
	Continuation of (until March 2017) and review of voluntary sector **Hospital to Home** service to develop long term strategy for recovery	12
Trusted Assessors: Using trusted assessors to carry out an holistic assessment of needs avoids duplication and speeds up response times so that	**Newton Review** (see above)	
	Continuation of **SIDs model** at HEFT over winter.	12
	Extension of **OT /ASC pilot** at UHB both numbers of wards	12

		KLOE
people can be discharged in a safe and timely way	covered and levels of packages commissioned on basis of 'trust'. Integrated IT developments.	
	Incorporate trusted assessor developments into **'short stay'** and **'base ward'** projects	12
Focus on Choice: Early engagement with patients, families and carers is vital. A robust protocol underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their options and reaching decisions about their future care	**Joint post implementation review of policy to improve from experience informed by Newton review**	
	Improvement plan for delivery at organisational level	
Enhancing Health in Care Homes: Offering people joined up and co-ordinated health and care services can help reduce admissions to hospital as well as improve hospital discharge	**Newton Review**	
	Joint BCC/CCG Commissioning strategy for home care and residential/nursing care home providers	11
	Hospital to Home Plan 0817 v2.docx	12 13 20 37

15.Review of National Conditions

- The four BCF National conditions (reduced from 8 in 2016/ 17) are:

National Condition One	A jointly agreed plan
National Condition Two	NHS contribution to social care is maintained in line with inflation
National Condition Three:	Agreement to invest in NHS-commissioned out-of- hospital services
National Condition Four	Implementation of the High Impact Change Model for Managing Transfers of Care

- The following section outlines how these conditions have been met

15.1. National Condition One: A jointly agreed plan

- The Plan has been approved by the Birmingham BCF Commissioning Executive following engagement with the BSol STP Board and SWB Strategic Commissioning and Redesign Committee prior to receiving final sign off by and Birmingham Health and Wellbeing Board. 1

	KLOE
• The Birmingham STP Board is chaired by the Leader of Solihull Metropolitan Borough Council and has CEO and Chair members from all provider and commissioner organisations with Birmingham. Its membership also includes the Chairs of the Health and Wellbeing Boards of Birmingham and Solihull. The BSol STP Board will be underpinned by a Memorandum of Understanding, prior to more formal arrangements being established. Plans are underway to ensure that this includes appropriate representation from voluntary and community services.	1
• The iBCF plan was approved by the Birmingham Health and Well Being Board on 4th July 2017 following a consultation with stakeholders.	27
• The BCF Plan was approved by the Birmingham Health and Well Being Board on 4th October 2017.	1

15.2. National Condition 2: Social Care maintenance

- The overall strategic approach to adult social care being taken by Birmingham City Council, in common with other local authorities is outlined below:
    - Reshaping care in terms of driving a fundamental personalisation and market reshaping agenda.
    - Strengthening, in terms of quality, price and volume, independent sector residential care and other market capacity.
    - Income maximization for service users and carers.
    - A range of prevention activity including assisted technology (helped by both capital and recurring expenditure investment), falls prevention, and low level dementia support.
    - Home care enablement.
    - Informed choice/signposting through fundamental systems support such as the My Care in Birmingham website and its associated arrangements.
    - Support for carers.
    - Transformation of social work services to make them more productive and effective, including a significant diversion of demand from the "back door."
    - Other efficiencies and rationalisation around, for example, common management and administrative savings.

- In this context the approach to the Birmingham BCF to 'maintaining' social care services has been as follows: 7
    - Supporting the transformation of Social Care through the iBCF (see section 11.10) considering a change in social care model, focus on prevention and a new approach to commissioning social care
    - Continuing to fund areas identified for 256 resources: re-ablement, carers, Implementation of Care Act
    - Providing financial support for additional capacity to manage DTOC (see section 12) – beds, social work staff
    - Supporting alternatives to admission which include social care – virtual beds
    - Directly supporting social care bottom lines to retain current capacity as far as possible - Enablement, Social work staff

KLOE

- Supporting prevention services and instigating pilots – route to wellbeing, wellbeing co-ordination

- Whilst BCF was able to afford a certain level of support to social care in 2016/17 (as described above), it was not able to avert some of the planned reductions of service. This is one reason why Social care maintenance and transformation is a key priority for the iBCF and a clear focus in priority areas 1 and 3 of the iBCF plan (see section 11). The significant management changes within Birmingham City Council have provided the opportunity to 'go back to basics' and ensure that we can learn from other areas that are doing things differently and more effectively with the same strategic aim. It also allows us to learn from each other- where expertise exists among partners e.g. implementing systems and processes to manage demand and capacity.

- In line with this, we have demonstrated that in 17-19 the Better Care Fund will focus upon the stabilisation and modernisation of adult social care and the development of joined- up services and approaches which are as efficient and effective as possible, both through statutory and non-statutory service developments. This will be done alongside the development and implementation of plans for out of hospital health and care services, and enhanced primary care services particularly supporting improvements and reducing pressures in urgent and emergency care through both the STP's and the iBCF plan.

- In the longer term, the BCF vision, as described in this report is to proactively intervene to support people at the earliest opportunity ensuring that they remain well, are engaged in the management of their own health and wellbeing, and wherever possible enabled to stay in their own homes. We have demonstrated that we will do this through taking the decisions and actions in managing markets and our own assessment functions which improve quality and place a focus on enablement and support rather than service.

- The expected contributions from CCG's for 2017/18 and 2018/19 are included in the planning template and meet the requirement of these National Conditions

15.3. National Condition 3: NHS commissioned out-of-hospital services

- Pool investment is summarised in the submitted template Expenditure Plan – our programme areas and governance demonstrate National Conditions have been met

8

- No contingency fund has been allocated against BCF

10

15.4. National Condition 4: Managing Transfers of Care

- Section 14 provided an in depth overview of how the Birmingham Health and Social Care System is tackling Delayed Transfers of Care. There is a clear understanding of the influences and the need for immediate short term actions to meet the challenging agreed trajectories.

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12
13

16. Finance

	KLOE
• This plan is intended to support work to address the financial challenges facing the Birmingham Public Sector organisations namely Birmingham City Council have made savings of almost £600 million since 2010 and expect to make a further £170 million savings by 2021. Also, based on current demand and activity Birmingham NHS face a £582million 'do nothing' deficit by 2021.	
• Over the two year period of 2017-19, the Better Care Fund will focus on supporting the stabilisation and modernisation of adult social care and the development of joined- up services and approaches in health and social care, which are as efficient and effective as possible, both through statutory and non-statutory service developments.	
• This will be undertaken alongside the development and implementation of plans for out of hospital health and care services, particularly supporting improvements and reducing pressures in urgent and emergency care through both the STP's and the iBCF plan. In the longer term, the BCF vision is to proactively intervene to support people at the earliest opportunity ensuring that they remain well, are engaged in the management of their own health and wellbeing, and wherever possible enabled to stay within their own homes.	7
• It can be confirmed that the CCG contribution to Social Care exceeds the minimum requirements for 18/19. In 17/18 from the template, it appears an inflationary amount of 1.2% has been achieved rather than the prescribed 1.7%. This is relating to an adjustment that was required on the 16/17 plan and budget. The plan for 16/17 was overstated by £528k, when this adjustment is taken into account the 17/18 to contribution to Social Care from the CCG minimum contribution does meet the inflationary requirement of 1.7%. The detail is included in the finance template contributions from CCG's for 2017/18 and 2018/19 are included in the planning template.	4
• The contributions to Social Care from the CCG minimum finance plan meets but does not exceed the prescribed contribution. Therefore the issue of affordability does not affect the BCF plan overall.	5
• The contribution to Social Care from the CCG's is in line with the previous years on going plans and in developing projects therefore there are no issues of destabilisation to the local Health and care system. We continue to work jointly to improve the DToC position and implement the High Impact changes to benefit the health and social care of the citizens of Birmingham.	6 11
• The contribution to Social Care from the CCG's minimum is being used to support and maintain social care services, but also to; further develop joint working on out of hospital services; refocus on prevention and reducing inequalities; develop community services in a multi- disciplinary setting; protect and sustain the provider market and invest in alternative provisions of care.	7

17.Assessment of Risk and Risk Management

	KLOE
• The Better Care Fund was established in Birmingham building on a local track record of integration around Learning Disabilities and Mental Health and has been able to model robust dialogue through the strategic partnership created by the Commissioning Executive as risk owner and accountable body.	
• The commencement of the STP has taken this further and brokered commitment to shared planning and a trust based approach to financial risk and BCF programme level risks are included in CCG and Local Authority risk monitoring and reporting. This recognised the system wide savings challenges early on and built into its deliver modelling of savings based on both fixed and variable costs.	
• A clear financial and programme management infrastructure has supported decision making through an established Commissioning Executive with membership at Accountable Officer level and governance has been revised this year in the light of changes external to BCF to support interaction with the revised strategic environment. Therefore the main delivery risks in taking BCF forward include:	18
○ **Level of cross organisational commitment to transformation:** The approach of this current plan is intended to ensure collaboration between organisations, to be built upon through STP, by being clearly based on existing plans in place across the health and social care system.	
○ **Financial Risk:** There is a risk that the overall financial position is so severe and challenging that it impacts on 17/19 onwards in terms of available budgets, making plan delivery impossible	21
○ **Level of Workforce change required:** The level of change required is unprecedented across; clinical and professional practice, terms and conditions, organisations, culture, engagement with people and each other	
○ **Challenges in implementing change across diverse STP's and H&WB Boards:** Due to the unique nature of Sandwell and West Birmingham CCG's footprint we may have more than one approach within Birmingham. This increases the complexity of delivery, performance management and outcomes across the Birmingham HWB area.	
• Mitigating actions have been taken to address all the risks identified – these include:	
○ Ensuring there is clear and shared financial planning in place supported by defined process for decision making with appropriate schemes of delegation.	21
○ Ensuring clear organisation commitment to work together through clear partnership arrangements and inclusion of strategic planning to ensure progress	
○ Ensuring there is robust financial governance and scrutiny in place supported by agreed risk-sharing agreement that sets out interdependencies and how pooled budget arrangements will work across health and social care	22
○ Ensuring clear accountability as part of Terms of Reference	
○ Ensuring robust programme management is in place and schemes are implemented on time and to budget supported by a clear performance framework with close monitoring of KPI's including activity, performance and associated spends.	

The risks and Risk assessment is described below

Risk Log for Better Care Fund plan 2017/18/19						**KLOE**
There is a risk that:	**How likely is the risk to materialise?**	**Potential impact**	**Overall unmitigated risk factor**	**Mitigating Actions**	**Mitigated risk factor**	
BCC financial position remains challenging impacts on 17/19 onwards available budgets, making plan delivery impossible	4	5	20	Clear and shared financial planning Financial governance and scrutiny in place Clear accountability as part of Terms of reference	8	21 22 23
Better Care Fund Schemes will not succeed in reducing non-elective admissions, leading to higher costs for the CCGs	4	4	12	Ensure implementation of schemes on time and to budget through robust programme management. Better Care Board to review performance against plan and take corrective action. Risk share	7	29
Better Care Fund schemes will not succeed in reducing permanent admissions to residential care	2	2 Risk falls on LA	4	Performance in 2015/16 has achieved target trajectory	2	
Schemes fail to have impact on desired priority outcomes, acute activity and savings not achieved or whole system spend increases.	4	5 Risk falls on CCG commissioners	20	Commitment of organisations to work together through the new partnership board – indicative letter of intent Developing schemes that can evidence impact on target population. Programme management of schemes overseen by Programme lead supported by a team of project managers. Implementation of a clear performance framework with close monitoring of KPI's including activity, performance and associated spends. Remedial actions taken if off target. Exploring options around commissioning and provider delivery models to incentivise whole system performance.	12	
Governance arrangements are insufficient to make investment decisions, ratify the vision and ensure ongoing alignment of the programme with whole	2	4	8	Programme has clearly defined purpose Commissioning Executive established - Members AO and CFOs	4	18

						KLOE
system strategic direction.				Defined process for decision making with appropriate schemes of delegation. Clear method for disagreement resolution. Rules on data and performance management agreed.		21, 22, 23
Failure to separate the business of making partnership work from internal priorities of each organisation.	4	4	16	Agreed risk-sharing agreement that sets out interdependencies and how pooled budget arrangements will work across health and social care to be developed New strategic partnership between BCC and health partners will enable this	7	
Failure to understand and agree appropriate funding flows throughout the system particularly in relation to savings (perception of double counting), benefits and risk.	2	3	6	Track record of integration around LD and MH. Already recognise system wide savings challenge Modelling savings based on both fixed and variable costs. Dialogue commenced through strategic partnership.	3	
Unprecedented level of Workforce change required across; clinical and professional practice, terms and conditions, organisations, culture, engagement with people and each other	4	4	16	Workforce will form part of the Sustainability and Transformation Plans but experience of 15/16 suggests achieving change will be challenging. Strategic partnership gives opportunity for collaboration and change	7	
Community capacity not in place in sufficient scale to meet demand pattern changes	3	4	12	Modelling of requirement to ensure accuracy and building clarity on current capacity. Pump priming investment achieved in 2015/16 and continued into 16/17 Strategic partnership gives opportunity for support	6	
Due to the unique nature of Sandwell and West Birmingham CCG's footprint we may have more than one approach within Birmingham. This increases the complexity of delivery, performance management and outcomes across the Birmingham HWB area.	4	3	12	Commitment of organisations to work together through the programme board to develop detail on the economy level governance, risk, measures, equity of delivery and finance for 16/17 BCC have signed MOU of support for 'Right Care/ Right Here' programme.	6	
Patients and the public do not adequately engage with	3	4	12	Continue to engage with patients, public and local communities	6	

the BCF schemes resulting in dissatisfaction and associated reputational risk.				through existing forums and involvement of Health Watch in BCF programme, via BCF02.	

Appendix 1

Birmingham Better Care Plan - Key Lines Of Enquiry

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Is KLOE evidenced in Birmingham Plan? (Page)
National condition 1: jointly agreed plan (Policy Framework)	**1.Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and well-being board?** **2.In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?**	1. Are all parties (Local Authority and CCGs) and the HWB signed up to the plan? 2. Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan? 3. Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach?	4 35
National condition 2: Social Care Maintenance (Policy Framework)	**3.Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19** **1.79% for 2017/18 and a further 1.90% for 2018/19*	4. Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template? 5. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution? 6. In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole? 7. Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision	53 53 53 51,53
National condition 3: NHS commissioned Out of Hospital Services (Policy	**4.Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	8. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? 9. If an additional target has been set for Non	52 52

Framework)		Elective Admissions; have the partners set out clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid? 10. If a contingency fund is established; Is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?	52
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	**5.Is there a plan for implementing the high impact change model for managing transfers of care?**	11. Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken, including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? 12. Is there evidence that a joint plan for delivering and funding these actions has been agreed? 13. If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information?	53 43-49
Local vision for health and social care	**6.A clear articulation of the local vision for integration of health and social care services?**	14. Does the narrative plan articulate the local vision for integrating health and social care services, including changes to patient and service user experience and outcomes, and a strategic approach to housing, social care and health, cross-referenced and aligned to other plans impacting on integration of health and social care such as STPs or devolution deals? 15. Is there an articulation of the contribution to the commitment to integrate health and social care services by 2020 in line with the intent set out in the 2015 spending review and the BCF policy Framework? 16. Is there a description of how progress will continue to be made against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework?	18,24 10
Plan of action to contribute to delivering the vision for social and health integration	**7.Does the BCF plan provide an evidence-based plan of action that delivers against the local needs identified and the vision for integrating health and social care?**	17. Is there a robust action plan that addresses the challenges of delivering the vision, including: •Quantified understanding of the current issues that the BCF plan aims to resolve •Evidence based assessment of the proposed impact on the local vision for integrating health and social care services through the planned schemes and joint working arrangements	8-10,12,24

Approach to programme delivery and control	**8.Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when needed?**	18. A description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF plan? 19. A description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? 20. Does the narrative plan have a clear approach for the management and control of the schemes? including as a minimum: •Benefit realisation (how will outcomes be measured and attributed?) •Capturing and sharing learning regionally and nationally •An approach to identifying and addressing underperforming schemes	24,54,55 12 29,28,27,26, 50
Management of risk (financial and delivery)	**9.Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?**	21. Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description of how these risks will be proportionally mitigated or managed operationally? 22. If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care or IBCF grant at risk? 23. Is there sufficient mitigation of any financial risks created by the plan if a risk share has not been included?	43,54 29,53,54 53
Funding contributions: **1.Care Act,** **2.Carers' breaks,** **3.Reablement** **4.DFG** **5.iBCF**	**10.Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose and this is appropriately agreed with the relevant stakeholders and in line with the National Conditions?**	24. For each of the funding contributions, does the BCF evidence: •That the minimum contributions set out in the requirements have been included? •How the funding will be used for the purposes as set out in the guidance? •That all relevant stakeholders support the allocation of funding? •The funding contributions are the mandated local contributions for: •Implementation of Care Act duties •Funding dedicated to carer-specific support •Funding for Reablement •Disabled Facilities Grant? 25. Does the planning template confirm how the minimum contribution to Adult Social Care and the funding for NHS Commissioned Out of Hospital Services will be spent? 26. Does the BCF plan set out what proportion of each funding stream is made available to social care and that the improved Better Care Fund has	22,27,31,35 See template 4,7,9,17,25, 26,27,49,51

		not been offset against the contribution from the CCG minimum? 27. Is there agreement on plans for use of IBCF money that meets some or all of the purposes set out in the grant determination?	
Metrics – Non Elective Admissions	**11.Has a metric been set for reducing Non Elective Admissions?**	28. Does the narrative plan include an explanation for how this metric has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? 29. Has a further reduction in Non Elective Admissions, additional to those in the CCG operating plan, been considered?	See Planning template 55
Metrics – Non Elective Admissions (additional)	**12.If a metric has been set for a further reduction in Non Elective Admissions, beyond the CCG operating plan target, has a financial contingency been considered?**	30. Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target?	19,20
Metrics Admissions to residential care homes	**13.Has a metric been set to reduce permanent admissions to residential care?**	31. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?	See Planning template
Metrics – Effectiveness of Reablement	**14.Has a metric been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?**	32. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of the reablement funding allocation for health and social care and other BCF schemes on performance in 2017-19?	See Planning template
Metrics Delayed Transfers of Care	**15.Have the metrics been set for Delayed Transfers of Care?**	33. Have all partners agreed a metric for planned reductions in delayed transfers of care across the HWB that is at least as ambitious as the overall HWB target for reductions of DToC by November 2017? 34. Is the metric in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area set out in the DTOC template? 35. If the local area has agreed changes in attribution from those set out in the template is there a clear evidence base and rationale for those changes? 36. Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance	44 44 44

		and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan? 37. Have NHS and social care providers been involved in developing this narrative?	50
Integrity and completeness of BCF planning documents	**16.Has all the information requested in the DTOC and planning templates been provided and are all the minimum sections required in the narrative plan elaborated?**	38. Have the DTOC template, Planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? (Better Care Support Team will carry out central data validation)	See planning template

Appendix 2

Homelessness Prevention Positive Pathway