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Adult Care and Health Overview and Scrutiny Committee

Date:	**Wednesday, 13 September 2017**
Time:	**6.00 pm**
Venue:	Committee Room 1 - Wallasey Town Hall

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AGENDA – supplementary papers

4. DYNAMIC PURCHASING SCHEME FOR CHC (NHS CONTINUING HEALTHCARE) BEDS

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8. BETTER CARE FUND - PLAN AND PRIORITIES FOR 2017/18

(Pages 7 - 22)

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Midlands and Lancashire Commissioning Support Unit

Wirral Clinical Commissioning Group

Report for Wirral Health Overview and Scrutiny Committee
Dynamic Purchasing System (DPS) for Continuing Healthcare (CHC)
in Cheshire and Wirral

Introduction

1. The 5 CCGs in Cheshire and Wirral have entered into an agreement with Midlands and Lancashire Commissioning Support Unit (MLCSU) to use a Dynamic Purchasing System (DPS) provided by a company called Adam HTT Limited. The Adam DPS is an automated procurement system to modernise the way in which Nursing Care placements for both Nursing Home and Care at Home, are procured for patients who have continuing healthcare (CHC) needs and have qualified for CHC funding.

2. NHS England have established a programme to look at how Continuing Healthcare services can be improved. One of the goals of the programme is to make best use of resources. One of the recommendations is for more innovative procurement, one method being Dynamic Purchasing Systems like the one offered by Adam.

3. The aim of the Adam system is to drive up quality, give consistency of choice across a further area, expand the market, increase quality of care and provide contractual levers and incentives to providers. The current market is inequitable with some providers receiving packages of care while others are never considered. The system ensures compliance with EU law and introduces the prospect of value for money through competition.

4. The DPS went live for the procurement of Care Home placements for CHC eligible patients of NHS Western Cheshire CCG on 1 June. Mid-June, this extended to Eastern Cheshire, Wirral, South Cheshire and Vale Royal CCGs, with Eastern Cheshire CCG also piloting its use for Care at Home packages. The system is now being used by all CCGs with Wirral CCG using the system for Care Home placements from mid-June and Care at Home packages from early July.

5. The Adam system is used successfully for Care at Home by other clients, however MLCSU were the first to use the system for NHS care. The system was first used by health in February 2016 when MLCSU introduced it to its Staffordshire CCGs for Care Homes only. Due to its success Staffordshire are currently undertaking a feasibility study for the use of the system for Care at Home. Two Merseyside CCGs have been using the system for Care at Home as well as Care Homes since 1 May 2017.

6. The implementation period in Cheshire and Wirral followed a set project plan used previously, covering system configuration, securing key decisions to underpin the operation of the system, communication and engagement with CHC staff, referring clinicians, hospital discharge teams and providers (Care Homes and Care at Home providers), and onboarding of providers and training on the system.

7. Following Go Live of the system, the project manager, CHC Clinical Leads and Assistant Contracts Manager have been revisiting discharge teams, providers and local hospices as required to support understanding and improve communication so that we ensure patients and families are given the correct information and feel confident in the new arrangements for securing the package of care to meet theirs or their loved one's clinical needs.

Context

8. Wirral CCG spend approximately £40m a year on Continuing Health Care and Complex Services. This represents a considerable proportion of the CCGs budget. The Care Home and Care at Home market varies with providers of varying size, quality and stability. The CCGs were engaged with a set number of providers that had joined the Framework at a point in time, making it difficult for new providers to be considered.

9. In the past is has proved challenging to commission packages of care and time-consuming negotiating prices. T There was no way of identifying capacity amongst providers with brokering placements becoming a lengthy- administrative burden, often consuming considerable clinical time. In the past, providers have been favoured by clinicians and discharge teams due to their location onsite or personal preferences leaving commissioning of packages open to challenge and presenting an unfair provider market. As there is a need to improve hospital discharge times, improve the patient and family/carer experience, manage rising demand and commissioning services in a fair and transparent way.

10. The CHC service are committed to a vision to provide high quality services for patients eligible for NHS funded Continuing Healthcare. They wish to promote value for money by engaging with a wider number of providers that allows providers to better engage with the commissioning process which is fair and transparent for both providers and patients.

Benefits of the DPS

11. The DPS allows the CHC service to engage with all available providers to best meet patient needs -subject to providers meeting CCG set criteria i.e. CQC registration and proving financial stability, it allows providers to join at any point and encourages market development.

12. The clinician is able to put the care requirements out once for all providers to see and respond to, avoiding the need for multiple telephone calls or emails to try and identify a suitable provider.

13. Providers submit their most competitive price- 'in real time' if they can meet the patients' needs and have capacity. The system can help the CCGs control the gradient of increasing costs of care. Contracts are monitored continuously during the contract lifetime to increase quality. The system provides the CCGs with access to unprecedented management information reports, covering all aspects of the process from market appetite, capacity, speed of placement, costs and quality of providers awarded contracts. Individual care requirements are commissioned via the system to encourage a high-quality, value for money approach. Commissioning of care packages is fair and transparent.

14. As invoicing and payment is also managed through the system, it reduces time spent by finance and CHC teams in processing invoices and dealing with invoice queries. The service agreement is generated by the system based on the package details entered and price provided by the provider. Any changes are logged and a full contract audit trail sits on the system.

Choice and distance

15. Patients and their carers are able to choose whether they would like their care needs met in a care home setting or within their own home. This choice is always met, unless a patients needs are so complex, or substantial equipment is required, that the needs cannot be safely met in their own home. We encourage referring clinicians to discuss any preferences with the patient and their family, this includes a preferred postcode area or home and capture this on the fast track or discharge support tool documentation before submission to the CHC team.

16. The postcode provided may be for a next of kin or friends where it makes sense for the patient to be placed closest to. This postcode is then used as the centre for the radius in which the Care Requirement goes out to providers. Where a preference is made by a patient/carer for one or more homes or providers, the team encourage the provider to respond to the Requirement on the system, there is no guarantee they will be the selected provider as they may not be able to meet the patients clinical needs, or capacity at that time, or the quoted cost may be more than other providers are offering for the same or better quality of care.

17. If a family request that their loved one is not placed in a particular home due to genuine reasons the team always meet this request. Each care package is considered individually with clinical oversight, the local CHC team have the ability to override the system in exceptional circumstances.

18. The local CHC nurse responsible for putting the care package onto the system as a new Requirement is able to set the mile radius in which it goes out to the provider market. 10 miles is often used as standard to ensure adequate market coverage to be able to secure a provider quickly and arrange for the care package to start as quickly as possible. This can be reduced with justification. We are looking into ways of helping the

system understand the geography in Wirral and prevent offers going out across the River Mersey into Liverpool where this may fall within the radius as the crow flies.

19. The local CHC nurses take all information made available to them into account when placing the Care Requirement onto the system, whilst we cannot guarantee to meet specific choices that do not relate to care needs we will always do our best to encourage any homes of choice to respond to the requirement and will use the postcode provided by the family as the centre of the radius for responses from the market.

20. It is a statuary requirement that The NHS is responsible for providing a package of care to meet patients assessed continuing healthcare needs. Providers registered on the system must be CQC registered with no red ratings, to assure quality of care provided. The system uses an algorithm to score responses to Requirements by providers. This takes account of quality and value for money ensure that quality providers quality providers are selected that can meet the patients clinical needs and are value for money.

21. If a patient or family decline the offers) selected from those that have responded to say they can meet the clinical needs and have availability, the individual or their family would need to find and fund a placement themselves. This happens very rarely and usually once the hub have spoken with the patient and their family and assured them of the care provided by the selected provider(s) they accept the offer. Patients still have the right to complain to the CCG if they remain unhappy and each case will be reviewed.

22. Hospital is not the best setting for patients with CHC needs when they are medically stable. There is evidence that patients have had delayed discharges from hospital due to difficulties sourcing nursing home or care at home placements. The aim of this system is to speed up the discharge process safely and in a timely manner.

The role of the MLCSU Adam Hub

23. The staff within the Adam Hub at MLCSU have responsibility for the following tasks: -

- Administration of the ‘Adam’ system
- Monitor Requirements distribution for;
  - Number of providers in range
  - Providers response rate
  - Providers offers
- Re-issue Requirements if needed (roll back)
- Chase providers for response
- Motivate providers to offer
- Select winning offer, subject to any approval criteria specified by CCG’s
- Offer contract to winning provider
- Establish Contract
- Communicate with Referral /Discharge Point
- Handling queries from Patients and their Families

- Applying suspensions and lifting suspensions of providers
- Ending Service Agreements (with authorisation from CCGs)
- Managing changes to Service Agreements (with authorisation from CCGs)
- Creation and sign-off for Service Agreements
- Handling payment queries from providers
- Working with the Adam onboarding team to manage and maximise market engagement

24. The staff in the Hub need to establish strong working relationships with the local discharge teams and CHC staff to ensure the process runs smoothly and patients and their families are kept informed of progress each step of the way. We are working hard to improve communication and relationships as the new system beds in.

Monitoring and Lessons Learnt

25. Monthly Management Information Review meetings are held with Adam and the CSU to review the performance of the system and any targeted actions agreed to ensure continuous improvement. An issues log has been in place since Go Live and is reviewed regularly to ensure resolution of issues. Prior to Go Live full system configuration testing was undertaken by Adam and the project team set key actions that had to be achieved before Go Live, including adequate providers registered and circulation and communication of a new patient leaflet. The implementation in Cheshire and Wirral used learning from Staffordshire and continues to take advantage of the hubs growing experience. A full lessons learnt has been undertaken by MLCSU and Adam, with learning continuing to be logged. Cheshire and Wirral chose a phased approach to implementation to monitor issues, this was a movement from previous implementations. Communication and engagement is a key theme, particularly reflecting feedback from care providers that communication about the new system could have commenced prior to the engagement events and we will take this on board for future implementations. Having the most appropriate contact details for providers, to ensure we communicate with the most appropriate people within those organisations is also key. We have also reviewed the approach to engaging with referral points and discharge teams.

Current Status and Next Steps

26. We are currently re-visiting hospital discharge teams to review feedback and experience to ensure continued improvements. There is targeted ongoing provider engagement underway to ensure all previously used providers are registered on the system and supported to fully engage with the system (new packages plus payment). We will continue to engage with stakeholders to confirm and discuss process, communication responsibilities, improve relationships and place priority focus on continued improvement for speed of placement and patient/family satisfaction.

27. Concerns have been raised in some cases regarding suitability of providers selected through the system. Initially, we were not seeing adequate responses from providers,

and many of the providers used by the CCGs, whilst they had registered on the system, were not engaging and responding to new care requirements. This meant new providers not known to discharge teams, or providers not previously favoured, were being offered to families. We have undertaken targeted work to support all previously used providers to come on board and engage with the system. We are confident this activity will have a positive impact. We are however aware of instances where families are receiving unhelpful information on the process and about the system, we are therefore working closely with Commissioners within the CCG and Acute Trust senior staff to ensure families are given the right information in the right way to support them through the process feeling confident and assured of best intentions.

28. Work continues to ensure all existing packages to be paid through the system are loaded and showing correct for providers to service receipt against to receive payment. Further training sessions have been provided to ensure providers are able to fully engage with the system.

Conclusion

29. Dynamic Purchasing Systems are one of the options for innovative procurement recommended part of the new NHS England programme for CHC. The Adam DPS has been a success in Staffordshire. All new systems can expect some teething issues and take time to bed in. Resource and onsite support remains in place to ensure early resolution of issues and the success of the system for Cheshire and Wirral. Feedback from providers and clinicians has been very helpful and concerns are taken very seriously. We are confident that we understand the outstanding issues and activities to address these are progressing well.

WIRRAL

ADULT CARE AND HEALTH OPVERVIEW AND SCRUNITY COMMITTEE

13 SEPTEMBER 2017

REPORT TITLE	*Better Care Fund (BCF) Narrative* *Two Year Plan 2017/18 and 2018/19*
REPORT OF	*Director of Health and Care*

REPORT SUMMARY

1. Local Vision for Health and Social Care Services in Wirral

1.1. Wirral continues to move towards an increasingly integrated model of care, building upon developments, achievements and learning from the past couple of years. As a system, we are committed to driving integration forward to ensure we work collaboratively to achieve the best outcomes for Wirral residents, maximise the use of resources and ensure VFM for the Wirral.

In June 2017, social care delivery teams transferred to Wirral Community Trust, the first clear step in our journey. Our focus is to now refine and develop delivery approaches to ensure the principles of BCF, such as single lead professional shared systems and effective 7 day community services, are embedded. An outcome focussed commissioning approach with contract monitoring arrangements is in place with close monitoring for year 1, utilising an open book accounting approach.

It is our intention to now move to an integrated commissioning entity by April 2018. Work is well underway to consider a new operating model, alongside a due diligence exercise for pooling of resources, with recommendations due to Cabinet and Governing Body in November 2017. Discussions and developments are also underway to move to Accountable Care System by April 2019. Aqua are supporting providers with these challenges, with commissioners developing prospectus in the later part of 17/18 to shape the integrated commissioning intentions for Wirral, advising providers of key priorities and outcomes.

1.2. The focus of this Health and Wellbeing model is person centred and considers self-care and independence as a foundation to wellbeing, enabling timely access to information, advice and guidance as appropriate, maximising community assets and access to public sector services only when necessary. The model promotes a care navigation approach to accessing layers of provision as appropriate to individual need, which supports people to live healthier for longer with more emphasis on empowered self, familial and community based models. Wirral is currently committed to a programme of transformational change, supported by ECIP. As a system we are committed to the following vision and principles.

Our Health and Social Care System will be:

VISION	
"RESPONSIVE"	Quick access for the very best advice and care delivered as close to their home as possible
"RELIABLE"	Right care, first time with consistent delivery across service providers
"EFFICIENT"	Improved quality and effectiveness whilst reducing cost

Vision Principles:

- A new relationship between public services and people
- An asset based approach, building upon strengths of individuals, families and communities
- Integrated services
- An engaged workforce with shared values;
    - Be positive
    - Be courageous
    - Be accountable

- Building self-reliance and independence resulting in behaviour change and reduced demand for services
- Avoid deconditioning of older people by avoiding admissions wherever possible and discharging at the earliest opportunity (eventually optimised)

Everyone has a bed and that's at home.

H – Home, everyone has a bed and that's at home
O – Ongoing assessment
M – Managing expectations
E – Every time

- Assessing for ongoing need outside of hospital setting (transfer to assess)
- Minimising the number of stranded patients (those in 7 days or more)
- Developing a sustainable 7 day offer to avoid admissions wherever possible and ensure 7 day discharge

Supported by the following behaviour and cultural change, focusing on I do not I don't:

- Be positive
- Be accountable
- Be courageous

See Appendix 1

2. Local Context

2.1. Wirral's overall population is projected to increase by 2.7% between 2014 and 2030, from 320,800 in 2014 to 329,600 in 2030. The older population (aged 65 years and above) are projected to increase at the fastest rate. By 2030 this population is projected to total 86,400, compared to 66,100 in 2014, an increase of 20,300 (31%). The population over 85 is projected to increase from 9,100 in 2014 to 15,100 in 2030, an increase of 6,000 (66.0%) increase.

2.2. More than 100,000 people in Wirral – 30 per cent of the population – have one or more long-term condition (Department of Health 2011). This includes people with a range of conditions that can be managed but often not cured, such as diabetes,

arthritis and asthma or a number of cardiovascular diseases and mental disorders. Current projections by the Public Health Observatory in England suggest that the prevalence of diabetes, cardiovascular diseases, COPD and hypertension will increase by 10% by 2020 (Public Health Observatory, 2009).

2.3. There are currently 3,195 people aged 65+ who have a recorded diagnosis of dementia in Wirral. Projections estimate that the number of people with dementia in Wirral will increase from 4,798 in 2015 to 7,019 in 2030. Dementia rates are expected to increase in Wirral by 46% between 2015 and 2030. This is lower than the projected England increase of 59% over the same period.

2.4. Therefore the aim is to deliver meaningful outcomes with better experience for what matters to people and their families closer to home.

3. Transformational Priorities going forward for 17/19

3.1. The system has agreed the following priorities:

I. Implementation of clinical streaming at the front door
II. Consistent and complete implementation of safer throughout the hospital and community beds
III. Implementation, expansion and embedding of Transfer to Assess (T2A) – own home and bed base including Trusted Assessor, joint assessment and care planning.
IV. Expansion of admission avoidance schemes including Rapid Community Service, Green Car ensuring resilience
V. Investment in domiciliary care and commissioning of alternate models, to ensure responsive and flexible capacity, supporting flow across the system
VI. Support to care homes including tele triage, care home connector training, upscaling of staff with increased access to specialist support
VII. Demand divergence from hospitals: ambulances reducing ambulance conveyances

VIII. Whole system therapy redesign, developing a generic offer and supporting a shift left.

IX. Whole system approach to Business Intelligence, monitoring evaluation, evidencing ROI, VFM and trajectories to achieve KPI's – overarching dashboard with tight oversight and evaluation

3.2. BCF scheme focus to support whole system priorities. The system agrees the above priorities will enable Wirral to achieve the required national metrics:

- Non elective admissions
- Admissions to residential and nursing homes
- Effectiveness of Reablement
- Delayed transfers of care

See the following appendices:

- 9 Point Plan – Appendix 4
- 5 Priorities Plan – Appendix 5

3.3. **Transformational Support (IBCF)**

We have identified priorities to support delivery and mobilisation of our plans, reflecting upon learning for the challenges experienced in 16/17.

Therefore, as a system we have prioritised the following support, from funding available

I. Whole system capacity and demand modelling capacity (external commission) to ensure enhanced understanding of required level of services across acute and community modelling will inform commissioning priorities and facilitate more robust approach and preparation for winter planning.

II. Additional implementation capacity to focus on delivering/embedding 4 priorities: (12 month full time post)
   - Clinical streaming
   - Safer
   - T2A
   - Therapy redesign

III. Additional 6 month implementation support to embed change of behaviours/cultures with the new T2A model and approach.

IV. Additional BI post – 12 months to support whole system data/KPI tracking and analysis

V. Additional 6 month BCF scheme contract post to evaluate ROI/scheme outcomes

VI. Transformational project management support (12 months)

VII. Communications support (6 months)

We have also agreed as a system an element of funding for a more structured approach to winter capacity requirements and contingency to allow for short term double running costs, associated with the change programme.
Plans for winter capacity are being jointly developed and will be submitted to A&E Board and NHSE.

4. How does the BCF support the bigger picture

4.1. Alignment with Sustainable Transformation Plan (STP)

The Cheshire and Merseyside footprint is the second largest in England, covering a population of 2.5million people and bringing together over 30 NHS organisation and nine local authorities.

This is a diverse footprint, bringing together areas of deprivation where populations have higher levels of poor health, alongside more affluent areas that have a different set of challenged, including an increasing proportion of older people with high health needs.

Due to the size and diversity of Cheshire and Merseyside it has been divided further into 3 local delivery systems (LDS) – North Mersey; the alliance (Mid-Mersey) and unified Cheshire and Wirral. Each of the three local delivery systems has established its own ideas and proposals, guided by a common set of strategic priorities which are:

- Improving the health of the Cheshire and Merseyside population;
- Improving the quality of care and addressing the sustainability of services in community settings and in the regions hospitals.
- Maximising the efficiency of clinical and administrative support services.

High Impact Community Based Integrated Care Schemes: • Integrated Community Teams • New Models of Primary Care • Long Term Conditions Management • Intermediate Care • Care Homes Support • Intermediate Care Development • Integrated Discharge Processes • Community Services Multispecialty Community Provider	Delivery of four Transformation Programmes across Cheshire and Wirral will see the expansion of out of hospital care services	• Reductions in non elective admissions. • Reductions in length of stay • Reduction in delayed transfers of care from hospital • Shift in activity from acute to community sector.
Primary and Community Demand Avoided through investment	• Delivery of a range of physical and mental health initiatives designed to deliver care closer to home and reduce demand on acute services. • Introduction of new models of primary care and community care.	• Reductions in non elective admissions. • Reductions in length of stay • Reduction in delayed transfers of care from hospital Shift in activity from acute to community sector.

4.2. The BCF priorities and direction of travel is woven into and supports the delivery of local commissioning and delivery plans for the Wirral economy;
- CCG Operational plan
- Healthy Wirral 2020 vision
- A&E action plans –Appendices 4 and 5
- GP Forward View
- Accountable Care developments
- Carers strategy – Appendix 12

4.3. All partners have agreed to maintain and protect social care for 17/18 and 18/19, providing a level of protection that does not destabilise the local social and health care system and which is:
- Consistent with 2012 DH guidance to NHSE on the funding transfer from the NHS to social care in 2013-14
- DFGs – (S16)
- Care Act 2014 monies (S17)
- Former Carers Break Funding (See below Appendix 12) (S18)
- Reablement Funding (S19)
- Local provision extends to 72 hour care packages, mobile nights, IMC with wrap around MDT.

4.4. Wirral has held a number of value stream analysis (VSA) workshops and emergency care improvement programme (ECIP) events over the past year with representatives from Health and Social Care Organisations and members of the BCF steering group. The workshops have focussed on Urgent Care, frail elderly and ECIP principles of home first, assess to admit, todays work today, transfer to assess and reducing DToC. As such schemes prioritised for the next 2 years and their impact on the national requirements of reducing non-elective admissions are considered priorities for 17/18 and 18/19.

5. Key challenges and risks for the BCF.

The following table identifies risk and mitigations and is reviewed monthly at BCF board and steering group.

Challenge	Risk	Mitigation
1. Complexity of people requiring health and social care	○ Bed pressure at acute hospitals (insufficient capacity) ○ Pressure on community services (lack of capacity and inability to respond) ○ Reduced flow in hospital ○ Pressure on budget ○ Bottle necks across the system	○ Increased focus on performance analysis and intelligence to understand the full picture ○ Implement 'shift left' models asap to reduce deconditioning ○ Increasing investment in priority areas. Decommissioning offers (e.g. community offer) ○ Implement safer ○ Implement national best practise ○ Work as whole system

2. Step up/down capacity – beds and MDT. (Reduction of community bed BCF funding from 15/16 to 16/17)	○ As above	○ Review/evaluation of IMC ○ Implement safer in the community ○ Focus on T2A model ○ Investment in bed capacity from all services ○ Identify winter pressure contingency
3. Responsiveness and capacity of Social Care Market	○ As above plus ○ Pressure on social care market – capacity inability to respond e.g. domiciliary care	○ Work with providers to increase capacity and flow ○ Re-tender services ○ Future outcome based model ○ Fee base increase to attract providers and support retention of staff ○ Maximise community assets
4. Quality of provision in social care market	○ As above plus: ○ Deconditioning of older people ○ Stranded patients increase	○ Same as above, plus ○ Work with CQC and quality assurance to stabilize market, give assurance and minimise suspensions ○ Ensure work summits include senior representative from all organisations, including acute ○ Ensure line of sight with BCF Board
5. Achieving transformational change for D2A / home first at scale for pace and shifting to discharge medically optimised people	○ As above plus: ○ Deconditioning of older people ○ Stranded patients increase	○ Consider transformational capacity ○ Maximise support for ECIP ○ Streamline and simplify pathways and paperwork ○ Maximise use of single gateway, using transfer of care forms ○ Invest time in culture shift ○ Invest in future model of D2A / home first ○ Explore opportunities for trusted assessor
6. Modelling and capacity planning for winter pressure	○ As above	○ Allocate deducted winter pressure contingency in BCF ○ Continue to plan and work as whole system ○ Ensure transformational changes implemented during summer 16/17 ○ Robust whole system performance data and analysis

7. Recruitment and retention of workforce across health and social care and independent sector	○ Insufficient staff to deliver safe care and standards ○ High recruitment costs for providers ○ Competition between providers	○ Providers work collaboratively to recruit ○ Providers move to Accountable care partnership ○ Increasing use of generic models / workers
8. Communicating effectively across all organisations the changing offer	○ Inconsistent offer ○ Lack of knowledge regarding potential pathways and outcomes ○ Inconsistent outcomes for patients	○ Dedicated communications funding in BCF ○ Single integrated gateway key to navigation, advice and support ○ Line of sight in UCRG

6. Governance and meeting national conditions

6.1. BCF plan jointly agreed and approved by Health and Wellbeing Board(s) (HWB), supported by involvement of other stakeholders – providers, housing authorities, voluntary groups VCS which includes joint approach to performance and risk management.

6.2. Risk sharing is approached via monthly BCF Board review of section 75 timescale of November.

6.3. All minimum funding requirements have been met including NHS contribution to social care in line with inflation and agreement to invest in NHS commissioned out of hospital services strengthening the 7 day community offer.

6.4. Clinical Commissioning Group (CCG) minimum contribution has increased in line with CCG overall budgets.

6.5. Agreement has been reached on use of IBCF money to ensure that the local social care provider market is supported with clear focus to reduce DToC.

6.6. Agreement has been reached on use of DFG funding .

6.7. Whole system assessment of high impact change model was completed and used to inform our immediate priorities. It is our intension to review progress early 2018.

6.8. The integrated commissioning board has agreed governance arrangements, including oversight of pooled budget arrangements on the back of 17/18. A due diligence exercise has been commissioned as part of the CCG and Council considerations regarding the risk share and future pooling of resources. The BCF agreement of 17/18 exceeds the minimum requirements as indicated in section 5.

6.9. Quarterly Monitoring of Schemes -17/19 Dashboard to monitor

- NEL admissions
- Admissions to residential homes
- Effectiveness of reablement
- DTOC

6.10. BCF board continues to oversee commissioning and delivery arrangements and progress on a monthly basis.

6.11. Monthly whole system ‘steering group’ oversees progress of schemes with a newly formed BCF scheme leads meeting on a monthly basis.

RECOMMENDATION/S

N/A

SUPPORTING INFORMATION

1.0 REASON/S FOR RECOMMENDATION/S

N/A

2.0 OTHER OPTIONS CONSIDERED

N/A

3.0 BACKGROUND INFORMATION

Celebrating Success 2016/17

3.1 Building upon two years of developments and Learning

Wirral's BCF invested in a number of key community services, as a real alternative to hospital admission and where admission was deemed appropriate, ensuring timely discharge. Throughout the last two years admission prevention schemes have reduced non-elective admissions, supporting people to be independent at home. Over the last 2 years the budget has protected and extended social care. This now includes a 7 day response for rapid community service, intermediate care and integrated discharge team. We wish to build upon our successes and continue to invest in a robust community offer, as that alternative to acute care including:

- 7 day rapid community service, with immediate access to domiciliary, reablement and mobile night support.
- Effective intermediate care and reablement service
- Community Care hubs, which effectively support people with complex needs to remain at home wherever possible
- 7 Day equipment and falls prevention/pick up service
- Range of carers services
- Mental Health support services
- 3rd sector community offer
- 7 day care arranging, access to domiciliary care, mobile nights and reablement

The focus for 2017/19 is therefore to build on local success and evidence from national best practice which includes ECIP principles of shift left, home first and transfer to assess.

Some schemes have now transferred to business as usual within the acute and community contracts; this includes community older people's services. This demonstrates the success of admission avoidance, embedding reliable and consistent pathways within the health and social care economy and releasing resource to tackle other issues that have arisen as our population ages.

3.2 The 7 day offer has been reviewed (see Appendix 2). This highlights that priority weekend services are not yet fully utilised. We are committed to reviewing this with providers to understand the reasons and agree on action plan.

3.3 The BCF will continue to support and drive integrated transformational change, adhering to national best practice, working in collaboration with ECIP and aligning with A and E delivery board targets. A summary of our achievements, successes and learning is embedded in Appendix 3 (BCF headlines)

4.0 System Challenges

Wirral has faced a challenging period during the winter of 2016, continuing to date. The acute hospital and A&E saw unprecedented pressure during winter. There has been little let up on that pressure into the summer months.

Key challenges have included:

- Domiciliary care market, experiencing key providers leaving the market at a time of increased demand for services
- Achieving DTOC target of 3.5% as agreed with NHS England
- Recruitment and retention of key professionals, especially therapists
- Capacity and ability to lead the 'hearts and minds' changes required to achieve the necessary behaviour and culture shift
- Financially challenging position across the system
- Changes in system leaders resulting in loss of traction
- Continued expectations and behaviours of the public

As such the acute remains in the bottom quartile nationally for performance. This is a situation owned and recognised as a whole system challenge, requiring collaborate solutions.

The urgent care challenges for Wirral are therefore a priority, acknowledging all organisations have a part to play and that there are opportunities to make better connections between planned and unplanned care, recognising if we can improve planned care, the impact will be felt in urgent care too.

5.0 FINANCIAL IMPLICATIONS

N/A

5.1 Funding priorities

Funding priorities have been discussed and approved with all organisations at BCF Steering Groups, Urgent Care Operational Groups, A&E board as well as BCF board, prior to Health and Wellbeing board final agreement.

The plan for BCF has been a collaborative one with the chair of A&E board agreeing with the BCF board allocating an element of funding for innovation, continuing to drive and enable whole system transformational change.

The BCF will continue to support and drive integrated transformational change, adhering to national best practice, working in collaboration with ECIP and aligning with A and E delivery board targets.

In summary, BCF is targeting additional funding into the following areas to ensure delivery of our priorities and national metrics.

5.2.1 **Summary of Investments for 17/19**

5.2.2 Maintained investment for 16/17;

- Rapid Community Service
- Wirral independence Services
- Carers Services
- Intermediate Services
- Maintenance of Social Care
- Care Act Priorities
- Mental Health Services
- 3rd Sector Offer
- Dementia Services

5.2.3 Newly commissioned services - core funding:

- T2A (bed base, home first, independent sector leads, therapists, health care assistants/Reablement/clinical cover nurses)
- Tele-triage/Telehealth
- Dementia crisis nurses
- 3rd sector offer:
    - Discharge lounge
    - Home of choice
    - Presence at single gateway
    - Falls army
- Growth in Dom care
- Green Car
- Trusted assessor – care homes / domiciliary care.
- Winter planning and contingency

5.2.4 Newly commissioned services – innovation funding:

Implementation capacity -

- Streaming
- T2A
- Performance
- Communications
- Project support

- Whole system capacity demand and modelling
- Discharge coordinator
- Clinical streaming at the front door
- Falls prevention/pick up
- Street triage – NWAS

5.3 Our 17/19 BCF has committed funding above the minimum requirements. A significant change has been the transfer of Public Health funding for Drug and Alcohol services.

We have taken the approach in Wirral to allocate the additional £8.3m as follows

- £5m supporting protection and maintenance of Adult Social Care in line with minimum contribution set for 18-19
- £1.3m managing transfers of care. Supporting reduction in DToC by funding additional community resources in T2A models and domiciliary care capacity fees.
- £2m innovation fund.

Commissioners are ensuring the funding is meeting Adult Social Care need, whilst reducing pressure on the NHS by supporting people medically optimised to be assessed out of hospital setting, to determine ongoing care needs.
Additional funding has been put directly into the Adult Social Care market to uplift fees and ensure responsive capacity.

Description	Min. Allocation 18/19 (£m)	Total Allocation 18/19
CCG	25.85	25.85
Social Care*	15.44	22.75
DFG	3.59	3.59
	44.88	52.20

**£22.75m is made up of 5.14m Supplementary Funding, £8.3m iBCF, £2m ASC contribution and £7.31m Public Health*

Out of Hospital Schemes	17/18 (£m)	18/19
Tele-triage role out across Care Homes	0.11	0.23
Tele-triage - Single Gateway/7 Day Response	0.10	0.10
Home First Capacity - supporting growth in dom care, reablement, mobile nights	0.07	0.07
Home First – MDT	0.40	0.40
Home First - Clinical Support/Discharge Capacity	0.54	0.54
10 x T2A Residential Beds - core funding	0.26	0.27
86 x T2A Nursing Beds - core funding	3.36	3.53
Growth in T2A Beds (Nursing)	0.18	0.16
T2A - 10 beds - Cover for Pressure periods (Nursing)	0.23	0.24
Additional MDT support, including clinical cover for extra beds (10)	0.11	0.11
Primary Care and Therapies for T2A Beds	0.97	0.97
	6.32	6.62

5.4 Full scheme breakdown is attached in Appendix 7, illustrating financial details and priorities.

Indicative figures are within the financial summary for 18/19 (see Appendix 7 – includes overview of schemes), as a system we have commissioned work to

support a whole system capacity and demand model. The first draft is expected October 2017, we will be referencing this work to review and refine investments, to ensure we have funding in the right places.

Our further review of BCF schemes with regard to outcomes and ROI will further refine our final decision making in year 2.

Both A&E delivery board and BCF Board will have a line of sight on these considerations and recommendations.

6 LEGAL IMPLICATIONS

N/A

7 RESOURCE IMPLICATIONS: ICT, STAFFING AND ASSETS

N/A

8 RELEVANT RISKS

N/A

9 ENGAGEMENT/CONSULTATION

N/A

10 EQUALITY IMPLICATIONS

No because there is no relevance to equality.

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APPENDICES

Appendix 1	Behaviours and Cultural Change	Appendix 1 Behaviours 300817.d
Appendix 2	Review of 7 Day offer	Appendix 2 - Review of 7 day services.doc
Appendix 3	BCF Headlines	Appendix 3 - HWBB paper 110717.pub

Appendix 4	Wirral 9 Point Action Plan	Appendix 4 - 9-Point Action Plan - v5 Augu
Appendix 5	Wirral Urgent Care 5 Priorities Plan	Appendix 5 - Wirral Urgent Care Priorities
Appendix 7	BCF Plan – including scheme overview and finances	Appendix 7 - Scheme Profile 18-19 Prepara
Appendix 12	Wirral Carers Strategy	Appendix 12 - Carers Strategy.docx

REFERENCE MATERIAL

N/A

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
N/A	

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