DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 7**

REPORT SUMMARY SHEET

DATE	28th June 2017
TITLE OF REPORT	**Progress Update- Dudley Health and Wellbeing Strategy 2017-2022**
Organisation and Author	Julia Simmonds, Service Manager- Strategic Partnerships; Karen Jackson -Head of Healthy Communities and Place Dudley Council
Purpose of the report	To update the Board on the development of Dudley's health and wellbeing strategy 2017-2022
Key points to note	• At the development session in March the board agreed o a new vision , o 3 goals o a commitment to working differently based on alliances between agencies and communities, with people at the centre. • The results of these discussions, along with feedback from the people's network and the age alliance have informed the development of the draft Health and Wellbeing Strategy 2017-2022 • It was recognised that a key element of working differently would be changing the narrative between organisations and communities, and a commitment to agreeing a common language that everyone understands, and we all use. • The draft strategy emphasises this new relationship with communities which is reflected in the style of the strategy and in the strategic objective which describe: o what we as organisations will do, o what we can do together with communities o what individuals and communities can do for themselves and each other
Recommendations for the Board	That the Board • Note the progress made • Agree the branding for the strategy, design and format • Agree the strategic objectives set out on page • Agree the next steps -consultation and launch
Item type	Strategic
H&WB strategy priority area	All

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 8**

REPORT SUMMARY SHEET

DATE	28th June 2017
TITLE OF REPORT	Launch of HWB Strategy final consultation and development of HWBB website & community of practice
Organisation and Author	Shelley Brooks, Communications, Dudley Council
Purpose of the report	• To recommend an approach to launching the HWBB draft strategy and seek final views before formal launch • an approach to communicating the work of the HWBB to the public and partners (communities of practice)
Key points to note	• The draft DHWB strategy needs to go out to final consultation before formal launch. • The proposed consultation is to be carried out over the summer through above the line promotion and via an online survey taking into account existing consultation mechanisms across partners • A final launch event will be organised in the autumn alongside the launch of a HWBB website and community of practice. • The HWBB proposed website will help to communicate the work of the Board to the public and partners (communities of practice) • It is proposed that the Board's Collective Commissioning Group will oversee the work of the launch and the website
Recommendations for the Board	1. To note the contents of the report. 2. Approve the approach for the launch and the website. 3. Agree the defer the overseeing of this activity to the Collective Commissioning Group
Item type	Strategy
H&WB strategy priority area	All

DUDLEY HEALTH AND WELLBEING BOARD

DATE 28 June 2017

TITLE: Launch of HWB Strategy final consultation and development of HWBB website & community of practice

1. PURPOSE OF REPORT

- To recommend an approach to launching the HWBB draft strategy and seek final views before formal launch
- an approach to communicating the work of the HWBB to the public and partners (communities of practice)

2. BACKGROUND

- The Dudley Health and Wellbeing Board has over, several months, reviewed its overall vision and strategy and is now in a position to go out to consultation one final time with a view to launch the strategy in the Autumn.

3. MAIN ITEMS OF THE REPORT

2.1 Draft Strategy Launch

2.1.2 Launch objectives

- To ensure all partners and stakeholders are aware of the vision and commitment within the strategy and have an opportunity to comment before formal launch
- To raise awareness of the HWBB vision and strategy to the general public during final consultation and launch

2.1.3 Messages

Primary

Dudley Health and Wellbeing Board is made up of all those agencies who play a part in making improving the health and wellbeing outcomes for all people in the borough.

Our health and wellbeing strategy is about how we can make Dudley a place where people live

“longer, safer, healthier lives’

A key component of achieving this is through how we can improve people’s wellbeing. This is about:

- Us as individuals and our connections with families, friends and community
- The way we look after ourselves and others
- How we will make Dudley a great place to live

As a borough we face a number of challenges:

- Only the richest in the borough can expect to get to 70 years old in good health. Some people in the borough can only expect to reach 55 years before having health problems
- People’s expectation and demand for services is growing, but the money we have to spend is reducing - so we need to do more with less money

Information about people’s lives in Dudley is telling us that we could make the biggest difference to people’s health and wellbeing by focussing our resources and energies on 3 goals:

1. Promoting healthy weight
2. Reducing the impact of poverty
3. Reducing loneliness and isolation

We all have a role to play in helping to achieve these goals – individuals, families, communities, organisations and local politicians. We are inviting everyone to play an active part in making Dudley borough a place where everyone can live longer, safer and healthier lives.

Call to action

We want as many people as possible to tell us their views on our draft vision of how we can improve the health and wellbeing of people in the borough by completing a short questionnaire or via twitter using #dudleyhwb before 8 September 2017.

Secondary

We have identified 4 principles that will inform the way we work together to achieve our vision. These are about how we will:

- support individuals help them to take an active role in looking after themselves, and make healthy choices

- support communities to use their valuable sills to do more from themselves
- continue join up health and care services
- know whether the strategy has changed people's lives for the better.

2.1.4 Publics

- Public
- Partners – all staff
- Voluntary sector
- Members
- Press

2.1.5 Marketing options/tools

News release(s)
Social media #DudleyHWB
Dudley iZone
Community Council E-bulletin - circulation 80,000 borough residents
Partner mailing lists
Early Help Mailing lists
Article for partner bulletins/newsletters
Keep it Brief (Council bulletin)
Carers Alliance
Safe and Sound
http://www.dudley.gov.uk/community/initiatives/health-wellbeing/

2.1.6 Timescales

To commence July to 8 September 2017

2.1.7 Next steps

To devolve coordination of the launch to the HWBB Collective Commissioning Group

2.2 Health and Wellbeing website and community of practice

With the launch of the HWB strategy and vision there is a pressing need for an online presence (social media and website) and community of practice to promote and support the Health and Wellbeing Board and its constituent alliances..

Currently there are some text pages on the council website

The benefits of this would:

- Be a one stop shop for all information regarding the HWBB

- Be a site that individuals can subscribe and receive information on a request basis and at an information category specific level
- Be a partnership site for members (protected/extranet) to include partnership meeting details, papers, discussion forums etc.
- Provide an engagement platform so that partners, local stakeholders, staff and the wider public can have their say about future improvements to health and wellbeing in Dudley
- Have direct links to social media, twitter, facebook

2.2.1 Next steps

A web design brief together with a potential landing page has been drafted (*see Appendices A,B).*

It is proposed (subject to Health and Wellbeing Board approval) to test the feasibility of the design with web developers, (including Psiams which may give additional functionality) during June & July.

It is also recommended to devolve coordination of this activity to the HWBB collective commissioning group.

4. FINANCE

It is estimated that the cost of the platform will range from £5-20k (to be approved by the Health and Wellbeing Board)

5. LAW

No legal issues identified by this report.

6. EQUALITY IMPACT

The website will be developed in an inclusive manner with information being made available electronically for all and will comply with accepted web accessibility standards

7. RECOMMENDATIONS

1. To note the contents of the report.
2. Approve the approach for the launch and the website.
3. Agree the defer the overseeing of this activity to the Collective Commissioning Group

Contact officer details:

Shelley Brooks, Senior Account Manager, Communications and Public Affairs

Design brief for Health and Wellbeing Board website

Suggested web address:

- **www.DudleyHealthandwellbeing.org.uk**

We require design options for a new partnership website to promote the work of the HWBB and the constituent alliances priorities/projects.

The site's purpose is to:

- Be a one stop shop for all information regarding the HWBB
- Be a site that individuals can subscribe and receive information on a request basis and at an information category specific level
- Be a partnership site for members (protected/extranet) to include partnership meeting details, papers, discussion forums etc.
- Provide an engagement platform so that partners, local stakeholders, staff and the wider public can have their say about future improvements to health and wellbeing in Dudley
- Have direct links to social media, twitter, facebook

Key features

The site will be built on an appropriate platform, eg Sharepoint, Wordpress CMS, and will have the following requirements:

- **Home Page** with:
    - **Rolling banners** – page wide images with overlaid headlines.
    - '**Latest posts'** – this will bring together blog posts from various sections of the site.
    - **Top level horizontal navigation (see below)** with drop down sub-menus.
    - **Featured documents** –PDFs available for public download.
    - **Branding area –** probably a full width footer to feature partner logos.

    - **RSS feeds – from key sites**
- **Sub Page with:**
    - **Vertical side menu for subpages**
- **Blog Page with: (aggregated dependent on permissions)**
    - **Support for post filtering side bars** (latest posts, categories, author, theme etc)

Typography

It would be interesting to try more modern serif based typography for body text, H1,H2 etc (see www.typekit.com)

Suggested home page design

See attached

General notes

The site will pull together information from the various work programmes of the HWBB. Some information will be more relevant to particular sets of users than others, and as such it would be good to try and cater for this in the design.

This could be done using slightly different colour tones for each of the areas, and for small icons to denote what area a blog post is related to.

Members of the programmes, along with members of the public will be invited to contribute to blogs relating their experiences, hence the desire to keep things quite ordered and identifiable.

This site will need to be able seamlessly interface with social media, twitter and facebook to allow simultaneous posts.

Essential is the inclusion of a secure document exchange to allow authorised users to collaborate on various files.

5 June 2017

Shelley Brooks, Senior Account Manager, Communications and Public Affairs

Site landing Page – what it might look like from a layout pov

Health and Wellbeing Board identity

What this site is about –
For public and practitioners
Partnership approach etc

Dudley Health and Wellbeing Board

Children and Young People Alliance

Adult's Alliance

Safe and Sound

Dudley Children Safeguarding Board

Adult Safeguarding Board

Feedback , Getting Involved and Networks

Dudley Children & Young People's and families network

Chatterbox for professional and volunteers

Dudley Parent Carer Forum

Carers Alliance

People's Network

Older People's Alliance

News

Partner's logos

Subscribe to this site
To receive real time updates via email

Events calendar

Explanations of landing pages headers:

All pages to follow the same template essentially all pages will include 'report it safeguarding' link (wording) useful links and documents.

The landing page headers (Blue boxes) will have their own area on and subsequent pages on the site. Each area will have specific sections for practitioners. I have used the HWBB and the CYPA (and early help) as an example

Dudley Health and Wellbeing Board

to include links information on...

- General description of the aims of the Board
- Membership
- Health and Wellbeing Strategy
    - Information for practitioners
        - Minutes and agendas (protected)
        - Procedures

Children and Young People's Alliance

to include links/information on...

- Vision
    - Strategy
    - alliance
- Transformational programmes
    - Voice of the child/young person
    - Community resilience
    - Emotional health and wellbeing
    - Early help
    - Employment and training
    - Disabilities and special needs
    - Healthy weight

Example

Early Help

- What is Early Help
- How the public can access EH
    - Family centres
- Practitioner information
    - Minutes and agenda of Early Help Steering Group(protected)
    - Procedures
    - Discussion area

Feedback , Getting Involved and Networks

The orange boxes will provide links and information to the individual engagement networks

News

This box will provide news form all the constituent projects including a regular health and wellbeing newsletter for practitioners which will include updates on Adults and Children's activities/priorities.

It will also include a twitter feed

Subscribe

People/practitioners will be able to subscribe to all or elements of the areas to recive news in real time.

Events calendar

To provide calendar of events of all programme activity and public events

Shelley Brooks
5 June 2017

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 9**

REPORT SUMMARY SHEET

DATE	**28th June, 2017**
TITLE OF REPORT	**Dudley End of Life Palliative Care Strategy Report**
Organisation and Author	**Dudley CCG** **Andrew Hindle - Commissioning Manager for Integration**
Purpose of the report	To inform the Dudley Health and Wellbeing Board of the Dudley End of Life and Palliative Care Strategy Plan on a Page and the processes for implementation.
Key points to note	• The Dudley End of Life and Palliative Care Document was jointly developed to ensure collective ownership by the organisations and written by the three organisations taking part (Dudley Group of Hospitals NHS Foundation Trust, Dudley Clinical Commissioning Group and Mary Stevens Hospice). • The long term aim of the strategy is to achieve a number of outcomes which are in line with the National Palliative and End of Life Care Partnership Ambitions: Identification, Care Planning, Coordinated Care, Equitable Access 24/7, Positive Experience of Care, Education and Training. • The strategy group will continue to meet on a quarterly basis and ensuring the delivery of the key priorities.
Recommendations for the Board	That the Board notes and approves the Dudley End of Life and Palliative Care Document and supports the self-assessment and implementation process.
Item type	*Information, strategy*
H&WB strategy priority area	*Services, children, mental wellbeing, lifestyles, neighbourhoods,* ***integration, health inequalities, quality assurance,*** *community engagement,*

DUDLEY HEALTH AND WELLBEING BOARD

DATE 28th June, 2017

REPORT OF: The Dudley End of Life and Palliative Care Strategy Group (representatives from DG NHS FT, Dudley CCG, Mary Stevens Hospice and Dudley MBC)

TITLE OF REPORT Dudley End of Life Palliative Care Strategy Report

HEALTH AND WELLBEING STRATEGY PRIORITY

1. The strategy supports one of the health and wellbeing board's functions to promote integration across partners to maximise health and wellbeing outcomes.

PURPOSE OF REPORT

2. To inform the Dudley Health and Wellbeing Board of the Dudley End of Life and Palliative Care Strategy Plan on a Page and the processes for implementation.

BACKGROUND

3.1 The Dudley End of Life and Palliative Care Document was jointly developed to ensure collective ownership by the organisations and written by the three organisations taking part (Dudley Group of Hospitals NHS Foundation Trust, Dudley Clinical Commissioning Group and Mary Stevens Hospice) to help support all organisations delivering care to patients with end of life and palliative care needs and guide them with their own strategy implementation.

3.2 The strategy and implementation process was presented and approved by the Dudley Clinical Strategy Board on March 8th 2017.

THE MAIN ITEM/S OF THE REPORT

3. The main information or discussion items and options

4.1 The National Palliative and End of Life Care Partnership in the UK has produced a national framework for local action for the years 2015-2020. This contains the six ambitions for all palliative care services to aim for:-

- Ambition One: Each person is seen as an individual
- Ambition Two: Each person gets fair access to care
- Ambition Three: Maximising comfort and wellbeing
- Ambition Four: Care is coordinated
- Ambition Five: All staff are prepared to care
- Ambition Six: Each community is prepared to help

4.2 **Strategy Aims and Desired Outcomes**

The long term aim of this strategy is to achieve a number of outcomes which are in line with the National Palliative and End of Life Care Partnership Ambitions as outlined above. These outcomes are listed below and need implementation across

the whole of the Dudley to achieve the level of quality palliative and end of life care that is needed by all patients and their families.

Identification
To ensure all patients and families with palliative care needs regardless of diagnosis or setting are identified in a timely manner.
Care planning
To ensure patients and families with palliative care needs are offered the chance to create a personalised care plan.
Coordinated care
To ensure the individual plans and care needs of patients & families are fully understood and coordinated effectively by and amongst all supporting agencies. This will involve provision of an effective system to enable shared records.
Equitable access 24/7
To ensure all patients and families with palliative care needs regardless of diagnosis or setting can access the right help at the right time.
Positive rated experience
To ensure effective data collection including person centred outcome measurement, patient and families experiences. Data collection to support team learning and reflection and policy improvement initiatives.
Education and training
To develop and implement a framework for education, training, competency and Continuing Professional Development to ensure all staff have the necessary skills, knowledge and attitude to care for palliative patients.

3.3 **End of Life and Palliative Care Strategy Implementation Self Assessment**
Following the self-assessment process each organisation will be expected to complete the implementation process (appendix 1).

FINANCE

5. No financial implications identified at this stage.

LAW

6. No legal issues identified by this report.

EQUALITY IMPACT

7.1 The services to support people with End of Life and Palliative Care needs and their families/carers are provided regardless of age and are non-discriminatory.

7.2 Services provided by health and social care will ensure that the guidance on equality, diversity and language needs are embedded into the service ethos through appropriate induction, on-going staff training, and quality testing.

RECOMMENDATIONS

7. That the Board notes and approves the Dudley End of Life and Palliative Care Document and supports the self-assessment and implementation process.

Signature of author/s

Andrew Hindle - Commissioning Manager for Integration
Dudley CCG

Dudley End of Life and Palliative Care Strategy

Implementation Plan 2017

Contents

End of Life and Palliative Care Strategy Implementation Plan 2017

This document is to be used in conjunction with Dudley's cross health economy document 'End of Life and Palliative Care Strategy on a Page' (attached as appendix 2).

What is a strategy implementation plan?
Having a collaborative End of Life and Palliative Care Strategy is a good step for our collective organisations to take, and the goals and outcomes in that strategy are important for our health economy to own. However, many strategies fail due to a lack of a robust approach to implementation.

This document has been written by the three organisations taking part (Dudley Group of Hospitals NHS Foundation Trust, Dudley Clinical Commissioning Group and Mary Stevens Hospice) to help support all organisations delivering care to patients with end of life and palliative care needs and guide them with their own strategy implementation. The document will support this process by providing an approach to self-assessment of implementation.

Following the self-assessment process each organisation will be expected to complete the implementation process (appendix 1).

Strategy implementation often fails so by explaining this at the start of the process we hope to avoid it. The common mistakes are:

- The organisation ignores the plan and managers make decisions at odds with it, which is confusing for stakeholders
- There is poor communication of the strategy to stakeholders, or confusing terminology and language is used
- Operations day to day cause the organisation to lose sight of the strategy
- The strategy is an add-on rather than seen as core business of the organisation
- Once the strategy is written, the organisation goes back to business as usual and ignores the strategy
- The organisation avoids the sometimes tough decisions that implementation of the strategy calls for
- Measuring the wrong things - choosing what's easy rather than what's important
- No benchmarking against other organisations
- Stakeholders see the strategy as an end in itself

Each of the organisations in Dudley should look at ways of ensuring that these common mistakes do not happen as part of their implementation.

Terminology
To provide clarity, for the purposes of this document, the more common term of 'Specialist Palliative Care' is referred to as 'Specialist Level Palliative Care'. Similarly 'Generalist Palliative Care' is referred to as 'Core Level Palliative Care' to highlight the universal need for a basic or core level of palliative and end of life care for all those facing progressive life-limiting illnesses.

Demographics
In England, approximately half a million people die each year. The number is expected to rise by 17% from 2012 to 2030[1]. The percentage of deaths occurring in the group of people aged 85 years or more is expected to rise from 32% in 2003 to 44% in 2030.

Approximately three quarters of deaths are expected, so there is potential to improve the experience of care in the last year and months of life for at least 355,000 new people and those close to them each year[2]. High quality end of life care is required for all these people, and can largely be delivered by non-specialist health and care staff as part of their core work, provided they have adequate time, education, training and support to do so.

A proportion of these people will have complex needs requiring access to advice and/or direct care from professionals trained in specialist palliative care. Currently up to 170,000 people receive specialist palliative care each year[2] but this is likely to be an underestimate as there is growing recognition of unmet need, especially for those with conditions other than cancer and harder to reach population groups.

Currently there are 15 million people in England with a long term condition (LTC)[3]. By 2025, the number of people with at least one LTC will rise to 18 million. The number with two or more LTCs is projected to increase from 5 million to about 6.5 million. Most of these people will need end of life care as they approach their last years, months and days of life. An estimated 10-11% of people over 65 years, and 25-50% of those over 85 years, are frail. Frailty is strongly linked to adverse outcomes including increased mortality.

Around half a million carers provide support to people dying at home of a terminal illness. The cost to informal carers may include lost earnings, caring around the clock and physical or mental health consequences, some of which may be permanent[4]. Between 2001 and 2011, the number of unpaid carers has grown by 600,000[5], with almost 4 million of the population care for 1-19 hours each week with the biggest increase in those providing 50 or more hours per week[6].

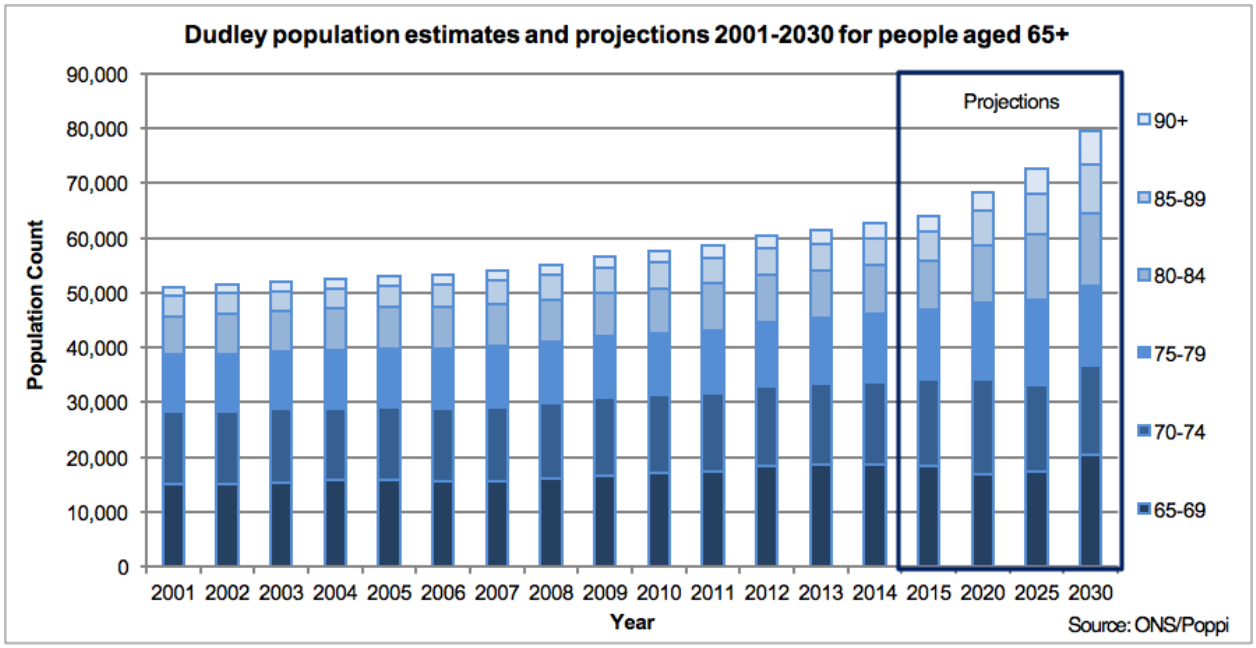


Figure 1

Figure 1 demonstrates the increase in the 65 and over population from 2001 to 2014 and the projected increase to 2030. Between 2001 and 2014 there has been a 23% increase in the number of people aged 65 and over in Dudley. This increase is weighted more heavily towards the older age groups; a 58% increase has been observed in the 90+ age band. This is expected to continue to increase with the over 64 year old population expanding by an additional 27% between 2014 and 2030, with a 134% increase projected for the 90+ age band. Overall an additional 16,825 people are expected to be aged 65 and over in 2030 compared to the 2014 population estimates. As a proportion of the total Dudley population the number of people aged 65 and over is expected to rise from 20% in 2014 to 24.2% in 2030. The increase is even higher in people aged 85 and over, currently this age group accounts for 2.5% of the population, it is expected that they will account for 4.5% of the population by 2030.

The implications from these population projections will be a rise in the numbers of people requiring additional palliative care support for a range of conditions including cancer, respiratory, cardiac, neurological and renal causes, dementia and general frailty. This will also correspond with an increasing need for support in the community particularly where patients identify their preferred place of care as their own home.

Definitions
Many terms are used regularly and interchangeably so it was felt appropriate to define each concept and term used to clarify what is meant when used in this document.

Palliative care
The World Health Organisation has defined palliative care as follows: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient's illness and in their own bereavement; uses a team approach to address the needs of patients and their families; enhances quality of life and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, and includes those investigations needed to better understand and manage clinical complications. Palliative care can be provided by a range of health and social care staff and may be done alongside treatment intended to reverse particular conditions[7].

End of life care
Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days) and those with: a) advanced, progressive, incurable conditions; b) general frailty and co-existing conditions that mean they are expected to die within 12 months; c) existing conditions if they are at risk of dying from a sudden acute crisis in their condition; d) life-threatening acute conditions caused by sudden catastrophic events. In General Medical Council guidance the term 'approaching the end of life' also applies to those extremely premature neonates whose prospects for survival are known to be very poor, and to patients who are diagnosed as being in a persistent vegetative state (PVS) for whom a decision to withdraw treatment may lead to their death[7].

Specialist level palliative care
Specialist level palliative care is required by people with progressive life-limiting illness, with or without co-morbidities, where the focus of care is on quality of life and who have unresolved complex needs that cannot be met by the capability of their current care team. These needs may be physical, psychological, social and/or spiritual. Examples include complex symptom, rehabilitation or family situations and ethical dilemmas regarding treatment and other decisions[8].

Core level palliative care
Palliative care that can be provided by a person's usual care team, either in a primary or secondary care setting.

Ambitions for Palliative and End of Life Care
The National Palliative and End of Life Care Partnership in the UK has produced a national framework for local action for the years 2015-2020. This contains the six ambitions for all palliative care services to aim for.

Ambition One: Each person is seen as an individual
Ambition Two: Each person gets fair access to care
Ambition Three: Maximising comfort and wellbeing
Ambition Four: Care is coordinated
Ambition Five: All staff are prepared to care
Ambition Six: Each community is prepared to help[7]

Strategy Aims and Desired Outcomes
The long term aim of this strategy is to achieve a number of outcomes which are in line with the National Palliative and End of Life Care Partnership Ambitions as outlined above. These outcomes are listed below and need implementation across the whole of the Dudley to achieve the level of quality palliative and end of life care that is needed by all patients and their families.

Identification
To ensure all patients and families with palliative care needs regardless of diagnosis or setting are identified in a timely manner.

Care planning
To ensure patients and families with palliative care needs are offered the chance to create a personalised care plan.

Coordinated care
To ensure the individual plans and care needs of patients & families are fully understood and coordinated effectively by and amongst all supporting agencies. This will involve provision of an effective system to enable shared records.

Equitable access 24/7
To ensure all patients and families with palliative care needs regardless of diagnosis or setting can access the right help at the right time.

Positive rated experience
To ensure effective data collection including person centred outcome measurement, patient and families experiences. Data collection to support team learning and reflection and policy improvement initiatives.

Education and training
To develop and implement a framework for education, training, competency and Continuing Professional Development to ensure all staff have the necessary skills, knowledge and attitude to care for palliative patients.

Appendix 1

End of Life and Palliative Care Strategy Implementation Self Assessment

In order to achieve the outcomes listed above, the starting point must be to take stock and consider what is already being done in line with the outcomes. To do this, each organisation should use the six self-assessment tables below to identify where they already are in the process of implementing the strategy. The results of this will help guide the next steps of the work that each organisation needs to do in order to achieve the outcomes.

Outcome 1 (Ambition 1 & 2)

Identification: To ensure all patients and families with Palliative Care needs regardless of diagnosis or setting are identified in a timely manner

	No plan in place – no implementation	Plan in place – no implementation	Plan in place – partially implemented	Plan in place – fully implemented	Evidence to support rating
Systems / processes in place to identify the palliative care needs of patients and families					
Proactive communication about patient identification including use of Information Technology (IT)					
Education and training of staff in identification of palliative care needs					

Outcome 2 (Ambition 1 & 4)

Care Planning: To ensure patients and families with palliative care needs are offered the chance to create a personalised care plan

	No plan in place – no implementation	Plan in place – no implementation	Plan in place – partially implemented	Plan in place – fully implemented	Evidence to support rating
Agreed personalised care plan document in place					
Clear process agreement with who holds the document, how it is updated and communicated amongst professionals					
Education ensures professionals have the competencies to support patient and family to develop the care plan					

Outcome 3 (Ambition 3 & 4)

Co-ordinated care: To ensure the individual plans and care needs of patients & families are fully understood and coordinated effectively by and amongst all supporting agencies. This will involve provision of an effective system to enable shared records

	No plan in place – no implementation	Plan in place – no implementation	Plan in place – partially implemented	Plan in place – fully implemented	Evidence to support rating
Clear defined roles and responsibilities exist within organisation regarding the provision of specialist and core level palliative care for patients and families					
Shared electronic clinical record with robust consent procedure and data sharing agreements					

Outcome 4 (Ambition 2,3,4,5 & 6)

Equitable access 24/7: to ensure all patients and families with palliative care needs regardless of diagnosis or setting can access the right help at the right time

	No plan in place – no implementation	Plan in place – no implementation	Plan in place – partially implemented	Plan in place – fully implemented	Evidence to support rating
24/7 access to core palliative care					
24/7 access to specialist level palliative care					
Equitable access for all; including children, people transitioning from children's to adult services, people from all cultural backgrounds					

Outcome 5 (Ambition 3, 5 & 6)

Positive rated experience: To ensure effective data collection including person centred outcome measurement, patient and families experiences

	No plan in place – no implementation	Plan in place – no implementation	Plan in place – partially implemented	Plan in place – fully implemented	Evidence to support rating
Collection of person centred outcomes					
Reporting process of person centred outcomes					

Outcome 6 (Ambition 5 & 6)

Education and Training: To develop and implement a framework for education, training, competency and CPD to ensure all staff have necessary skills, knowledge and attitude to care for palliative patients

	No plan in place – no implementation	Plan in place – no implementation	Plan in place – partially implemented	Plan in place – fully implemented	Evidence to support rating
Training needs analysis exists in your organisation					
Current training and education programme and process of implementation					
Assessment and reporting of competences					

REFERENCES

1 Gomes B and Higginson IJ. Where people die (1974-2030): past trends, future projections and implications for care. Palliative Medicine 2008; 22: 33-41

2 Commissioning guidance for specialist palliative care: helping to deliver commissioning objectives. Developed in collaboration with Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care and Palliative Care Section of the Royal Society of Medicine 2012 http://www.ncpc.org.uk/sites/default/files/CommissioningGuidanceforSpecialistPalliativeCare.pdf

3 Long Term Conditions Compendium of Information: Third Edition. Department of Health 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

4 Social Care Institute for Excellence. Dying well at home: the case for integrated working: SCIE Guide 48 March 2013 http://www.scie.org.uk/publications/guides/guide48/files/guide48.pdf

5 Office for National Statistics: 2011 Census Analysis: Unpaid Care in England and Wales, 2011 and comparison with 2001 (2013) http://www.ons.gov.uk/ons/dcp171766_300039.pdf

6 Carers UK Policy Briefing 2014 http://www.carersuk.org/for-professionals/policy/policy-library/facts-about-carers-2014

7 Ambitions for Palliative and End of Life Care, National Palliative and End of Life Care Partnership 2016 http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

8 NHS England Specialist Level Palliative Care: Information for commissioners April 2016 https://www.england.nhs.uk/wp-content/uploads/2016/04/speclst-palliatv-care-comms-guid.pdf

Appendix 2

Our vision for Dudley

All people with palliative and end of life care (EOLC) needs, irrespective of their diagnosis, together with those closest to them, are able to express their needs and wishes; and that as far as clinically appropriate and practically possible, these needs and wishes are met.

Ambition 1	Ambition 2	Ambition 3	Ambition 4	Ambition 5	Ambition 6
Each person is seen as individual	Each person gets fair access to care	Maximising comfort and wellbeing	Care is coordinated	All staff are prepared to care	Each community is prepared to help

Outcomes

Identification:
To ensure all patients and families with palliative care needs regardless of diagnosis or setting are identified in a timely manner.

Care planning:
To ensure patients and families with palliative care needs are offered the chance to create a personalised care plan.

Coordinated care:
To ensure the individual plans and care needs of patients & families are fully understood and coordinated effectively by and amongst all supporting agencies. This will involve provision of an effective system to enable shared records.

Equitable access 24/7:
To ensure all patients and families with palliative care needs regardless of diagnosis or setting can access the right help at the right time.

Positive rated experience:
To ensure effective data collection including person centred outcome measurement, patient and families expenences. Data collection to support team learning and reflection and policy improvement initiatives.

Education and training:
To develop and implement a framework for education, training, competency and Continuing Professional Development to ensure all staff have the necessary skills, knowledge and attitude to care for palliative patients.

Partnership working between The Dudley Group NHS Foundation Trust, Dudley Clinical Commissioning Group, Dudley Council and Mary Stevens Hospice.

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 10**

REPORT SUMMARY SHEET

DATE	28th June 2017
TITLE OF REPORT	Development and Commissioning of Dudley's New Care Model – the Multi-Specialty Community Provider (MCP)
Organisation and Author	Neill Bucktin – Director of Commissioning – Dudley CCG
Purpose of the report	To advise the Board of progress to date with the development and procurement of a MCP
Key points to note	1. Dudley was established as a "Vanguard" site in 2015 and has been working to establish a new care model – the MCP as part of the national new care models programme. 2. Some initial evaluation has taken place, the early findings of which demonstrate some benefits to the system 3. To establish a MCP contractually, the CCG and the Council need to conduct a procurement exercise which commenced properly on 9 June 2017. 4. It is anticipated that a contract will be in place by 1 April 2018.
Recommendations for the Board	That the position in relation to the development of Dudley's new care model be noted
Item type	Strategy
H&WB strategy priority area	Integration of services

DUDLEY HEALTH AND WELLBEING BOARD

DATE **28th June 2017**

REPORT OF: **Neill Bucktin – Director of Commissioning – Dudley CCG**

TITLE: Development and Commissioning of Dudley's New Care Model – the Multi-Specialty Community Provider

1. PURPOSE OF REPORT

To advise the Board of progress to date with the development and procurement of a MCP

2. BACKGROUND

The Board will recall that in 2015 Dudley submitted a successful bid to become a Vanguard area as part of NHS England's new care models programme, the intention being to develop a MCP. This report describes the original proposed care model, some early evaluation findings and progress with the procurement process necessary to establish a contract for a MCP

THE CARE MODEL

Dudley's population is characterised by people who are living longer with more complex health and care needs. These needs can require input from a range of services – general practice, pharmacy, community physical and mental health services, social care and the voluntary sector. People present in the first instance to their GP with whom they are registered. Demand on primary care and other services is increasing. This means that as a system:-

- we need to join up services better to provide an effective response to complex need that does not fit neatly into existing organisational models;
- we need a more resilient GP service that can manage its registered patient population and cope with increased workload, whilst recruiting and retaining a modern workforce.

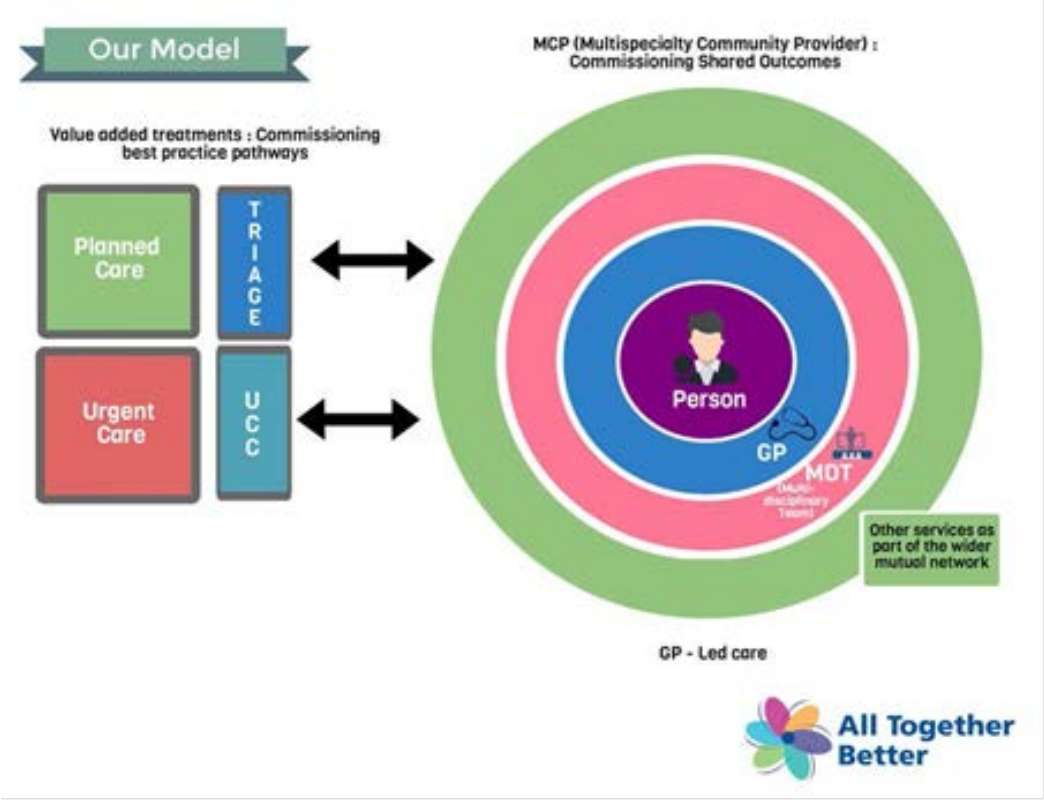
The MCP is seen as the most appropriate model for dealing with these challenges.

The MCP is based upon the registered GP list and as such the registration of a patient with a practice is the starting point for the MCP. From this the basic care

model centres upon a series of practice based multi-disciplinary teams (MDTs)which bring together the key community based services required to provide an effective response to people with increasing levels of complexity.

These teams are connected to more specialist community based services within a community and ultimately have access to the most effective care pathways for access into those elements of care that are not the responsibility of the MCP – planned and urgent care services delivered by hospital (secondary) care.

The teams have a shared responsibility for providing a set of interventions to a shared population and delivering a shared set of outcomes (see below). They must manage that population effectively to prevent inappropriate use of both hospital and care home services, as well as facilitating access back into the community for people being discharged from more intensive forms of care to support their independence.



The CCG has accessed additional resources made available by NHS England to support the development of the model and put in place those services that are required to meet the national prescribed model for an MCP. There are 4 key “care elements” that contribute to this:-

- whole population – prevention and population health management;
- urgent care needs – integrated access and rapid response service;

- ongoing care needs – enhanced primary and community care;
- highest care needs – coordinated community based inpatient care.

Additional resources have been committed to support:-

- increased practice based pharmacist capacity;
- centralised repeat prescribing service (Prescription Ordering Direct);
- support to care homes including a telemedicine service;
- new forms of workforce to support the MDTs;
- a new "social prescribing" service – "Integrated Plus";
- an organisational development programme to support MDT working.

The CCG has also carried out further work to rationalise the outcomes framework which forms part of the GP contract and this is further supported by all local practices using the same clinical IT system.

EVALUATION – EARLY FINDINGS

The evaluation of the new care model is being undertaken by the Strategy Unit and its partners ICF and University of Birmingham. The work has been organised into two main strands. They are set out below, alongside headline findings from each strand.

Overall system level

a) A programme of interviews with strategic stakeholders from across the system (in summer 2016) showed:-

- a shared, clear definition of difficulties facing Dudley's system ('Do Nothing' was not seen as an option);
- a broadly shared / logically described sense that an MCP could address these difficulties;
- tensions and challenges putting this model into practice;
- the need to focus on primary care entering into procurement.

b) Headlines from the latest quarterly performance report (to the end of Jan 2017) showed:-

- recent stabilisation in the otherwise upward trend in emergency admissions;
- a fall in delayed transfers of care and emergency bed days;
- a fall in unplanned hospitalisations for ambulatory care sensitive conditions.

This requires further analysis to establish a clear “cause and effect”

Specific schemes within the new care model

a) An evaluation of the Multi-Disciplinary Teams (MDTs) in primary care (reported May 2017) found:-

- consensus that MDTs are the right way to coordinate care for some patients;
- evidence of expected benefits for staff (in particular) and patients;
- evidence of reductions in primary care use – voluntary sector element vital;
- an apparent impact on length of stay but not admissions.

It recommended: operational tweaks – including methods of targeting patients; and better use of data – especially patient reported measures.

b) An evaluation of the Long Term Conditions (LTC) Framework for primary care (reported April 2017) found:-

- variation in implementation by practices and consequential results;
- some evidence of efficiency gains in practices;
- improvements in care planning / shared decision making.

It recommended: further work on care planning and shared decision making; positive use of variation (find and replicate good practice); and more research on practice costs / likely system benefits**.**

Plans for this year’s evaluation include a repeat of the overall strategic level stakeholder reviews; ongoing monitoring of system-wide measures; follow-on work from the MDT and LTC framework evaluations; and a focused evaluation of specific schemes funded using NHSE’s ‘transformation fund’.

THE PROCUREMENT PROCESS

The national framework for MCPs describes 3 models that can be developed:-

- a virtual MCP using existing contracts and bringing providers together using an “Alliance Agreement”;
- a “partially integrated” MCP – where GPs retain their existing contracts whilst entering into an “integration” agreement with the MCP;

- a “fully integrated” MCP – where GPs relinquish their existing contracts for a salaried or other option.

The local proposal is likely to be a hybrid of the latter two options. The scale of change involved requires a procurement.

The framework further describes the arrangements that should underpin a MCP contract:-

- the MCP receives a “whole population budget” covering the cost of the services it is responsible for;
- the contract is long term – in our case 15 years – in order to create a less adversarial and more developmental relationship and the space to develop preventative approaches that are capable of containing demand;
- the MCP has the “right to decide” how the whole population budget is used;
- the MCP is commissioned to deliver a set of outcomes designed to improve population and individual health status in the widest sense, including the wider determinants of health such as employment, rather than the “event based” (attendances, admissions, contacts) commissioned at present;
- the MCP must have a registered list making the involvement of general practice a pre-requisite.

In July 2016, the CCG Board approved three key documents to support a procurement:-

- the prospectus – describing the characteristics and style of the organisation we wish to commission services from;
- the service scope – the range of services to be delivered including general practice; community physical health services for adults and children; mental health services; learning disability services; some out-patient services; public health commissioned services; voluntary sector services;
- the outcomes to be delivered – building on the GP Outcomes Framework referred to above.

These documents were the subject of a consultation exercise last summer and were approved by the CCG Board as the basis for the procurement in September 2017.

DUDLEY HEALTH AND WELLBEING BOARD **Agenda Item No. 11**

REPORT SUMMARY SHEET

DATE	**28th June 2017**
TITLE OF REPORT	**Integration & Better Care Fund**
Organisation and Author	**Joint report of the Chief Officer, Adult Social Care, DMBC and the Director of Commissioning, Dudley CCG**
Purpose of the report	**Updating report** • Year-end performance report for the Better Care plan for 2016/17 • Planning for Integration & Better Care Fund 2017-2019
Key points to note	**BCF Plan for 2016/17** • **National conditions** – there was some slippage in the plan for 7 day services to prevent non-elective admissions and/or delayed discharges; otherwise, all national conditions have been met. • **Budget** - £334k overspend (Council £205k; CCG £129k), equivalent to <0.6% of the pooled budget. The overspend is mainly attributable to increased assessment capacity and dom care and step-down provision needed to meet increased demand from hospital. • **Supporting metrics** – performance has worsened since 2015/16 in 3 out of 6 metrics (non-elective admissions; DToCs; admissions to residential & nursing care) whilst for 2 metrics performance has improved but has fallen short of target (reablement; dementia diagnosis). **Integration & Better Care Fund Plan 2017 – 19** • Drafting of the plan for the next 2 years is progressing, subject to receipt of the final guidance. • The Integration & Better Care Fund Plan supports the Dudley model of care by developing those MCP capabilities that are dependent on integrated health and social care provision, and supporting the mobilisation of the MCP in 2018/19. • Planning assumptions include an £8m increase in the pooled budget to £70m in 2017/18 – largely as a result of the Improved Better Care Fund grant to the council. • Discussions to agree the BCF spending plan, including the use of the IBCF grant, are ongoing.

Recommendations for the Board	1. Note the Better Care Plan 2016/17 performance report; 2. Note the position regarding the development of the Dudley Integration & Better Care Fund Plan for 2017-19; 3. Confirm the planning assumptions developed by the Integrated Commissioning Executive as the agreed basis for plan development; 4. Note the arrangements for plan development, sign-off and assurance
Item type	Information, discussion , strategy
H&WB strategy priority area	Integration

DUDLEY HEALTH AND WELLBEING BOARD

DATE 28th June 2017

REPORT OF: The Chief Officer, Adult Social Care, DMBC and the Director of Commissioning, Dudley CCG

TITLE OF REPORT Integration & Better Care Fund - Progress Update

HEALTH AND WELLBEING STRATEGY PRIORITY

1. The Better Care Fund (BCF) was introduced to facilitate the integration of health and social care provision. Integrated health and social care provision is a local HWB priority and a requirement of governing legislation.
2. The new model of care being developed in Dudley relies on integrated health and social care provision and will be a feature of the operation of the Dudley Multispecialty Community Provider.

PURPOSE OF REPORT

3. This report summarises the performance of the Better Care Plan 2016/17 and outlines progress towards the development of the Integration & Better Care Fund Plan for 2017-19.
4. The report seeks Health & Wellbeing Board support for the principles and assumptions underpinning IBCF planning in Dudley and for the proposed sign-off arrangements.

BACKGROUND

5. Announced in June 2013, the Better Care Fund (BCF) brings together health and social care budgets to support more person-centred, coordinated care. HWB areas have been required to produce BCF plans since 2015/16.
6. The BCF policy framework sets out the Government's vision that by 2020 health and social care should be integrated across the country in order to reduce health inequalities, support sustainable systems and better co-ordinated care. The BCF supports this objective by providing a framework for joint health and social care planning and commissioning.
7. The Better Care Fund is the only mandatory policy to facilitate integration. It pools Clinical Commissioning Group (CCG) allocations with local government Disabled Facilities Grant (DFG) and, for 2017-19, the major injection of social care money announced at Spring Budget 2017 (Improved Better Care Fund Grant). The current iteration of the policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically.
8. There is a requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s).

9. The Integrated Commissioning Executive (ICE) has been set up under the direction of the Health & Wellbeing Board to develop and manage the operation of the Better Care Plan. ICE receives monthly progress reports on scheme delivery, performance, finances and risks, and uses this information to direct resources accordingly.

10. Health & Wellbeing Board receives quarterly progress reports to enable it to monitor the delivery of the Better Care Plan and to give strategic direction, where necessary, to the Integrated Commissioning Executive.

DUDLEY BETTER CARE PLAN 2016/17

11. The Dudley Better Care Plan for 2016/17 created a pooled fund of £62.0m for integrated provision. The money was allocated across a range of contracted and demand-led services in accordance with local priorities and nationally set conditions.

12. In-year expenditure monitoring by the Integrated Commissioning Executive identified a number of budget pressures arising primarily from increased acute hospital activity. Adjustments in budget allocations within the pooled fund were made throughout the year to largely mitigate these pressures, although by the year-end an overspend of £344k (0.6% of the budget) was reported. This reflects a significant shift from the forecast presented in March, due primarily to an acceleration of the Disabled Facilities Grant programme in the final quarter and the additional costs associated with increased provision to meet demand associated with maintaining patient flow through hospital. A summary of the budget outturn report is shown below.

FINAL ISSUED FOR ICE AT 29/5/2017			**Year-end variance**	**Comments**
Summary Expenditure Plan	**16/17 Revised Budget Feb**	**Outturn**	**Over / Under spend**	
Crisis & Emergency Services	5,328,749	**5,337,640**	**8,891**	
Promoting Independence Services	31,088,191	**31,349,220**	**261,029**	Overspend on staffing and additional buildings costs
Stabilisation & Maintenance Services	23,827,263	**24,035,036**	**207,773**	Domiciliary Care service pressures offset in part by an underspend against DFG.
Support for People with Dementia	1,767,422	**1,634,131**	**-133,291**	Closure of one dementia gateway mid-year
Total	**62,011,625**	**62,356,027**	**344,402**	

13. The basis of the section 75 agreement between the CCG and the Council is that each party bears the burden of over-expenditure from within its own Lead Commissioner budget. On this basis the Council has contributed an additional £215k in 2016/17 and the CCG has provided a further £129k.

14. The BCF plan included a focus on four schemes that had been identified as offering potential to mitigate or reduce demand for high-cost services across the system. By

the end of 2016/17 three of the four schemes (Care Home Support, Carer Support and Falls Service Redesign) had been implemented. The fourth scheme (Integrated Discharge Pathway) moved away somewhat from the planned actions, under the direction of the Accident & Emergency Delivery Board, as system resources needed to be diverted towards crisis management in order to improve patient flow through the acute hospital. Notwithstanding this change in emphasis, a number of improvements in flow management (as reported to HWB in March) have been seen.

15. Notwithstanding the largely positive budget management and plan delivery seen in 2016/17, BCF performance targets have not been met. However, this must be seen in the context of the significant demand pressures experienced in the acute sector and the consequential impact this has had across the system. The Health and Adult Social Care Scrutiny Committee has received significant detail about the performance of the urgent care system across the winter period and will focus on system performance as part of it's work programme in 2017/18. A copy of the year-end performance scorecard, with supporting narrative, is shown below.

Target Area	End of Year Result	Performance Summary
Non-Elective Admissions	**No improvement in performance**	Year-end performance was 1.7% above 15/16 baseline and 2.1% above 16/17 target. Dudley is 23% above the West Midlands Standardised Admission Ratio (SAR) having 7,856 more admission than the expected rate. The data reveals some practice variation and an emergency admissions age profile that shows the biggest number of admissions amongst children aged 0 – 4 years, where there is an average length of stay of just under 1 day and a readmission rate of 0.7%. The growth in emergency admissions is mainly attributable to the 0 – 4 and 20 – 35 age bands. A range of actions is underway and has contributed to an improvement, with performance in Q4 being better than both baseline and target. Analysis by the CCG of Admissions data shows 90% of patients admitted to CDU/AEC being discharged after an average of 6 hours on two assessment units (CDU and AEC). The CCG has commissioned a coding & counting review of emergency admissions at Russell's Hall Hospital, to include benchmarking to consider variance from the expected rate by sub-chapter / HRG (Cardiac disorders, Thoracic, Digestive System, Pediatric medicine and Musculoskeletal, which collectively account for 5,163 admissions. The second stage of the audit, to be carried out in June, will include a full coding review of 350 patients across six 'short stay' wards (AEC, CDU, EAU, GAU, SAU and PAU). This will be followed up by a clinical coding audit on patients that meet the definition of an admission (up to 150 patients) to ensure they are coded accurately in line with national guidance.
Delayed Transfers of Care	**No improvement in performance**	Delays experienced per 100,000 Dudley residents increased by 28.8% in 2016/17. Social Care accounted for 54% of delayed days, with the main reasons given as Awaiting Completion of Assessment (40%) and Awaiting Care Package in own home (14%). NHS delays were mainly attributable to Patient & Family Choice (29% of delayed days), with delayed days up by 78% for this reason since 2015/16.
Dementia Diagnosis Rate	**On track for improved performance, but not to meet full target**	Performance in 2016/17 showed an improvement from 58.3% in 2015/16 to 60.5% in 2016/17. A Local Improvement Scheme in Q4 helped push performance beyond baseline in Q4 but not sufficiently to reach the 66.7% target - a shortfall of 254 registered people with Dementia required to meet the national standard. Dudley is in the process of refreshing its Dementia Improvement Plan and recovery trajectory.
Patient Experience - Quality of Life	**Data not available**	This is measured from the annual ASCOF measure 1A, which will not be available until Q2 17/18.
Admissions to residential care	**No improvement in performance**	Rate of admissions to R&N care 11.9% higher than in 2015/16, and 23.4% above 2016/17 target. Performance reflects the additional demand for care home placements to meet hospital discharge pressures
Reablement effectiveness	**On track for improved performance,**	Performance at the year end was 6.7% above (better than) that achieved in 2015/16 but fell 2.9% short of the target.

16. All but one of the National Conditions defined in the BCF planning requirements for 2016/17 were met; some recruitment delays and challenges around service design meant that some of the seven day services planned for Q4 have been delayed until 2017/18.

17. Progress on IT Interoperability remains dependent on Local Digital Roadmap and STP plans which are beyond the scope of the BCF. Delivery against these plans should ensure that we have interoperable systems and integrated care records in line with national deadlines. Monitoring of the Local Digital Roadmap plan is established at Partnership Board and STP levels.

18. It should be noted excellent performance has been achieved in reducing the waiting time for Disabled Facilities Grants (DFG) from 13 months down to 5 months across the calendar year.

19. Overall this has been a difficult year characterised by rising and often unprecedented levels of demand across the system. It is the view of the Integrated Commissioning Executive that the BCF Plan in 2016/17 has strengthened integrated working and has made a positive contribution to performance.

BCF PLANNING 2017-19

20. The requirement to develop two-year Integration & Better Care Fund Plans covering the period from April 2017 to March 2019 was included in CCG Planning Guidance in the autumn of 2016. However, the detailed BCF Planning Guidance expected in November 2016 has still not been released by DH. In its absence we have been advised to plan on the basis of draft guidance provided by the LGA, in the expectation that we will have a maximum of six weeks in which to finalise the plan once the definitive guidance is produced.

21. The draft guidance highlights a number of changes, summarised as follows:

- A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year; and
- The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four:
    i. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
    ii. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
    iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement;
    iv. All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

22. The reduction in national conditions is intended to focus the conditionality of the BCF, but does not diminish the importance of the issues that were previously subject to conditions. These remain key enablers of integration and narrative plans should describe how partners will continue to build on improvements locally against these formal conditions.

23. The Improved Better Care Fund (IBCF) Grant allocation to councils, announced in the Spring 2017 budget, must be included within the BCF pooled budget and is subject to the following grant conditions:

- Can only be used 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
- "Providing stability & extra capacity in local care systems"
- Spending Plan must be agreed by partners
- Subject to monitoring by (but not approval of) NHSE

24. The Dudley health and wellbeing system is rapidly progressing towards a model of care that will see a new Multispecialty Community Provider (MCP) take over responsibility for a wide range of community health and care services. The MCP Development Programme is helping system partners to align current provision to the MCP model in anticipation of service transition to the new provider in 2018, while our Procurement Project is engaging with potential providers over a service specification that includes integrated provision. Our Integration and Better Care Fund Plan for 2017-19 describes how health and social care integration will support this transition and is fully aligned to the mobilisation of the MCP from 2018 onwards.

25. Drafting of the plan is progressing in accordance with the draft guidance and on the basis of the following planning assumptions:

- Alignment to the New Care Models national requirements as described in the MCP implementation Matrix
  - Developing MCP capabilities that require H&SC integration (year 1)
  - Services aligned to MCP mobilisation (year 2)
- Four Schemes – comprising services and improvement initiatives
  - Whole Population – prevention & population health management
  - Urgent & Emergency care needs – access & rapid response
  - Ongoing care needs – enhanced primary & community care
  - Complex needs – coordinated in-patient & community care (inc. hospital discharge)
- Contribution to local health & wellbeing priorities and in particular:
  - Alignment to population health priorities / JSA analysis
  - Potential to impact on key system performance priorities through integrated provision
  - Financial benefit as demonstrated by scheme-level business case
- Plan for Managing Transfers of Care
  - Reduction in Delayed Days for Dudley Residents, wherever delayed (i.e. not just RHH)
  - Fair & proportionate contribution towards RHH 3.5% Occupied Bed Days target
  - Eight High Impact Interventions
- Baseline investment consistent with 2016/17 plan (£62.0m plus inflationary increase to maintain spending on ASC services in real terms)
- Protected spending on NHS commissioned out of hospital services in line with 2016/17 plan
- IBCF Grant is in addition to baseline and meets specific grant conditions

26. The Health & Wellbeing Board is asked to agree these assumptions and to identify any additional requirements that it has for the Integration & Better Care Fund Plan 2017 – 19.

27. It is expected that the deadline for submission of the first draft Integration & Better Care Fund Plan will be within six weeks of the date of publication of the planning guidance. Based on past experience and owing to the compressed timescales for submission it is expected that work on the preliminary draft Better Care Plan for 2017 – 19 will need to take place up to and including the date of submission. To meet the requirement for Health & Wellbeing Board support for the Better Care Plan the Board agreed in March that the Chair of the Health & Wellbeing Board, in conjunction with the Chief Officer, Adult Social Care, DMBC and the Director of Commissioning, Dudley CCG, are authorised to approve the preliminary submission as directed in BCF Planning Guidance.

28. Arrangements for plan assurance remain as described in March; moderation by regional panel followed by any required modifications and final submission. Our preferred plan is for presentation of the final draft to the next scheduled HWB Board meeting for formal approval remains our preferred plan although delegation as described above may be necessary dependent on timings.

FINANCE

29. The Better Care Fund operates as a pooled budget established under section 75 of the NHS Act 2006.

30. The financial position of the BCF Plan for 2016/17 is as described in paragraphs 12 and 13 above.

31. The tables below summarise the Dudley Better Care Plan for 2017 – 2019 based on the planning assumptions set out above, the known conditions applying to DFG and IBCF Grants and the expectations described in the draft planning guidance released by the LGA.

	2016/17 (baseline)	**2017/18**	**2018-19 (indicative)**
Minimum NHS ring-fenced from CCG allocation	21,029,253	21,405,677	21,812,384
Additional CCG Allocation *****	17,181,570	17,181,570	17,181,570
Disabled Facilities Grant	4,373,000	4,818,360	5,232,000
Additional funding paid to local authorities for adult social care (IBCF)	-	7,218,226	4,461,449
Additional local authority allocation **	19,427,801	18,723,747	18,723,747
Total	**62,011,624**	**69,347,580**	**67,411,150**

***** Assumes no change in 'additional contributions' from CCG.

** Reflects known adjustments for 2017/18, including closure of Russell's Court

Commissioning Plan 2017/18	**Contribution to the Pool**	**Lead Commissioner for**
CCG	£38,587,247	£25,107,824
Council	£30,760,333	£44,239,756***
Total	**£69,347,580**	**£69,347,580**

******* Includes £13.479m transfer from the NHS to maintain spending on social care services in real terms (as required in the Policy Framework)

32. Work to develop the investment plan associated with the IBCF Grant is ongoing. The council has identified the following priorities:

Investment Priority		Recurrent Investment beyond 19/20	2017/18	2018/19	2019/20
		Y/N	£m	£m	£m
Increase the weekly rate of discharges	Temp increase from 40 to 50	No	1.500	1.500	0.000
New models of domiciliary care/reablement	Accelerated inflation and outcomes based model for hospital discharge	No	2.753	2.200	1.563
3rd Party Top-Ups	Adopt LGO s recommendation	Yes	0.250	0.046	0.046
Integrated Discharge Pathway	Model needs to be sustainable after 2017/18 investment. Increase care for complex dementia	No	1.000	0.000	0.000
Transitions Capacity to enable the Transitions Pathway	Enable transforming care agenda. Fixed term posts.	No	0.115	0.115	0.000
Invest in innovation/prevention schemes	Outcomes based investment	No	0.500	0.500	0.500
Telecare/Telehealth	Equipment. Linked to Airedale/MDT schemes	No	1.000	0.000	0.000
Protection from Financial Abuse	Work with Trading Standards in respect of people at risk of financial abuse	No	0.100	0.100	0.100
TOTAL ALLOCATED			7.218	4.461	2.209
FUNDS AVAILABLE IBCF			-7.218	-4.461	-2.209
GAP Funds Available			0	0	0

33. Financial plans will be finalised during the drafting process and are therefore subject to change. In particular the service budgets are subject to confirmation by the commissioning partners in light of savings requirements over the period of the plan.

LAW

34. The legal framework for the Better Care Fund derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area the CCG(s) transfer minimum allocations (as set out in the NHS Mandate) into one or more pooled budgets, established under Section 75 of that Act. Approval of plans for the use of that funding is subject to conditions set by NHS England. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.

35. The Disabled Facilities Grant and Improved Better Care Fund Grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003. LAs are legally obliged to comply with grant conditions, and assurance will check compliance with these conditions.

36. The NHS Act 2006 also gives NHS England powers to attach additional conditions to the payment of the CCG minimum contribution to the Better Care Fund to ensure that the policy framework is delivered through local plans. These powers do not apply to the DFG and IBCF.

EQUALITY IMPACT

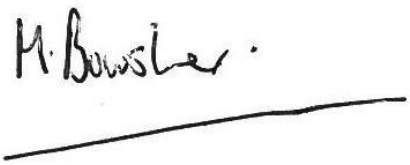
37. The impact on different demographic groups is a factor in determining the scope of the BCF and when planning in-scope services. The ICE considers that there are no discernible equalities impacts.

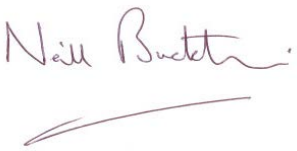
RECOMMENDATIONS

38. Health & Wellbeing Board is asked to:

1. Note the Better Care Plan 2016/17 performance report;
2. Note the position regarding the development of the Dudley Integration & Better Care Fund Plan for 2017-19;
3. Confirm the planning assumptions developed by the Integrated Commissioning Executive as the agreed basis for plan development;
4. Note the arrangements for plan development, sign-off and assurance

Signature of author/s
Contact officer details





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Appendices

Appendix 1 – Integration & Better Care Fund 2017 – 19 Policy Framework – Available on the Committee Management Information System (CMIS)
http://cmis.dudley.gov.uk/cmis5/Meetings/tabid/116/ctl/ViewMeetingPublic/mid/543/Meeting/5414/Committee/484/Default.aspx