Gloucestershire's Better Care Fund Plan 2016/17

Health and Wellbeing Board	Gloucestershire
Date of Submission (Draft)	21st March 2016
Date signed off by HWB	Virtual sign off 18th March 2016. The next HWB meeting is 22nd March, draft paper to be presented at the meeting

Signed on behalf of the Clinical Commissioning Group	Gloucestershire CCG
By *(signature: Mary Hutton)*	Mary Hutton
Position	Accountable Officer
Date	21st March 2016

Signed on behalf of the Council	Gloucestershire County Council
By *(signature)*	Mark Branton
Position	Deputy Director of Adult Social Services
Date	18th March 2016
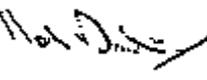
Signed on behalf of the Health and Wellbeing Board	Health and Wellbeing Board
By *(signature)*	Dr Helen Miller
Position	Vice Chair
Date	18th March 2016

Contents

Appendices:

1. 'We are Gloucestershire' devolution plan
2. Gloucestershire Strategic Forum Terms of Reference
3. Joint Commissioning Partnership Executive Terms of Reference
4. BCF Risk Register

Introduction

Gloucestershire has a long and well established history of joint and collaborative commissioning as a health and social care community. There is a joined up vision for all partners working with individuals, carers and local communities to transform the quality of care provided and improve levels of health and wellbeing as set out in our 15/16 BCF plan.

We are, therefore, pleased to set out our ambitions for the Better Care Fund into 2016/17. In order to ensure we cover all areas required in the Key Lines of Enquiry the paper is divided into sections to provide confirmation of funding contributions, our narrative overview and address the eight national conditions.

Section 1 – Confirmation of funding contributions

Gloucestershire CCG and Gloucestershire County Council plan to meet the minimum contribution requirements to the Better Care Fund in 2016/17:

CCG minimum contributions	£36.631m
Disabled Facilities Grant	£4.682m
	£41.313m

Included within the CCG minimum contributions are schemes to support carers representing funds previously identified as Carers' Break Funding. £3.075m is planned to provide grant funding to Carers Gloucestershire.

£2.911m of re-ablement funding is planned to maintain current re-ablement capacity across the county. This comprises Hospital Rapid Discharge, multi-disciplinary integrated community teams and funding for re-ablement beds with private providers

£2.982m is planned to support implementation of the Care Act 2014 and other policies. An additional £7.3m supports on-going social care demand.

There will be no further contributions above the minimum level of funding from either the CCG or local authority.

A full overview of funding contributions for 2016/17 and any changes from 2015/16 are shown below:

Scheme type	2016/17 £m	2015/16 £m	Change £m
GP Delivered	**2.125**	**2.125**	**-**
Hospital based	**3.589**	**3.589**	**-**
Mental health liaison	**0.715**	**0.715**	**-**
Out of hospital	**19.919**	**19.359**	**0.560**
(of which reablement)	2.911	2.911	
(of which support for carers)	3.075	3.075	
Social care	**14.964**	**14.159**	**0.805**
(of which Disabled Facilitied Grant & 15/16 social care capital)	4.682	3.959	
(of which Care Act & other policies	2.982	2.900	
(of which social care demand)	7.300	7.300	
TOTAL Better Care Fund	**41.313**	**39.947**	**1.366**

Section 2 – Narrative overview

In our 15/16 plan we set out our vision for integration through the adoption of our strategy Joining Up Your Care (JUYC). This strategy was developed through working in partnership to undertake a comprehensive public, staff and partner engagement exercise to develop our vision and strategy for health and care services for 2019. As a result of this exercise, our citizens have told us that we need to focus on the following in order to improve health and wellbeing:

- Encourage and support people to adopt healthy lifestyles to help prevent both physical and mental health problems from developing
- Support people to take more responsibility for their own health and take early action to tackle symptoms and risks
- Support communities to take an active role in improving health and wellbeing
- Support people to live independently in their own homes wherever possible, with the right care and community help
- Ensure independent care providers are supported so that they can play their role in providing high quality care
- Ensure greater access to a range of Wellbeing services supporting people maintain good mental health
- Provide timely assessment and high quality, safe services when people need care outside the home
- Join up services (integration) to improve care, reduce duplication and save money
- Improve information sharing across health and social care to ensure patient records are available to the right professionals at the right time with appropriate safeguards
- Ensure we make the most of the limited money available.

We have taken into account these wishes in adopting our agreed shared vision across the NHS, Local Authority and voluntary sector partners:

"To improve health and wellbeing, we believe that by all working better together – in a more joined up way – and using the strengths of individuals, carers and local communities we will transform the quality of care and support we provide to local people"

In order to deliver this vision we need to ensure that:

- People are provided with support to enable them to take more control of their health and wellbeing, recognising that those who live in vulnerable circumstances will benefit from additional support
- People are provided with more support in their own homes and local communities where safe and appropriate to do so, moving away from the traditional focus on hospital-based care; and
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way

By working together across traditional organisational boundaries, keeping people well, and supporting their recovery after periods of illness, we can improve people's quality of life while also reducing demands on local services.

Partner engagement events were held between October and December 2015 facilitated by the Gloucestershire Voluntary Care Sector (VCS) Alliance and Healthwatch Gloucestershire to support the update of JUYC and the development of the CCG Five Year Forward View.

The scale of change required in the Five Year Forward View will be a challenge if we fail to understand the scale that is required. We believe integration can support us to address the following challenges

The health and wellbeing gap; the need to focus on prevention and early intervention as highlighted in the Care Act are essential if we are to prevent spending on avoidable illnesses

The care and quality gap: the need to reshape care delivery, harness technology and drive down variations in quality and safety of care is essential in order to meet need, reduce harm and avoidable variation in outcomes

The funding and efficiency gap: the need to match reasonable funding levels with wide-ranging system efficiencies is essential to ensure we maintain a skilled workforce, effective services and reduce restrictions on new treatments

Implementing our BCF plan has provided an effective platform on which to develop conversations regarding how we move to full integration by 2020. Over the last year ambitions have increased locally to move to full devolution and our plan 'We are Gloucestershire' setting out our aspirations is attached (Appendix 1).

Gloucestershire's 2016/17 BCF plan will continue to support local integration through ongoing investment in integrated services such as our locality based Integrated Care teams. The importance of an effective and integrated workforce remains a key element of delivering our BCF aspirations in 2016/17. A supporting framework to this is our intention, as set out in our Operational Plan, to develop the principle of **One Place, One Budget, One System** to progress a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda and delivery of ongoing integration of our health and care system, facilitated by the work on Gloucestershire Devolution
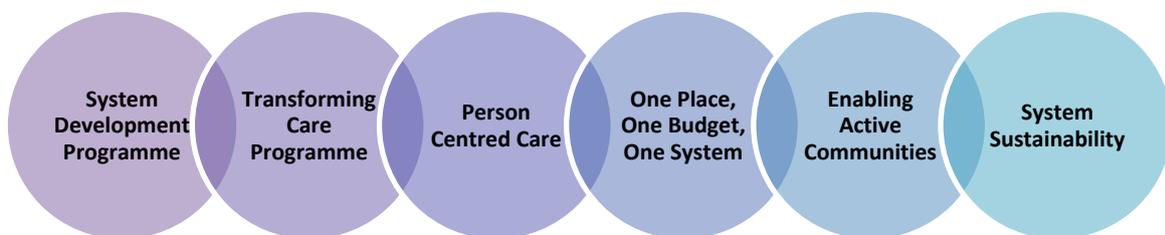
Taking account of our shared system objectives, our five year strategy Joining Up Your Care and the five year forward view priorities, our **organisational objectives for 2016/17** are as follows:

- Work with system partners to deliver the **Enabling Active Communities** strategy, and improve **Health and Well-Being** for people in Gloucestershire, further building on the work we have developed through the prevention and self-care agenda. We will ensure there is a focus on prevention and self-care through all our key programmes of work
- Focus on **Primary Care and Locality Development** to ensure the future sustainability of this critical part of our system
- Work with system partners on **Transforming Care** for people in Gloucestershire using the Clinical Programmes Approach, particularly looking to create more joined up pathways moving from models of episodic based care to pro-active care and case management, particularly for those with long term conditions
- Ensure a continued focus on achieving **Parity for Mental Health and Learning Disabilities** for our population.

- Work through the principle of **One Place, One Budget, One System** to develop a place based approach to service delivery, using this to develop our system response to the New Models of Care agenda and delivery of ongoing integration of our health and care system, facilitated by the work on Gloucestershire Devolution
- Further develop our approach to delivering **Person Centered Care**, rolling out personal budgets in partnership with social care and being an active member of the South WEst Integrated Personal commissioning pilot
- Work with health and social care partners on our shared **System Development Programme,** to develop and deliver a system wide sustainability and transformation plan for Gloucestershire
- Have a continuous focus on **System Sustainability,** ensuring constitution compliant, high quality and cost effective services, reducing avoidable variations in outcomes, aligning delivery incentives and use ways of working such as case reviews to bring a clinical and evidence based focus to service redesign and improvement

-
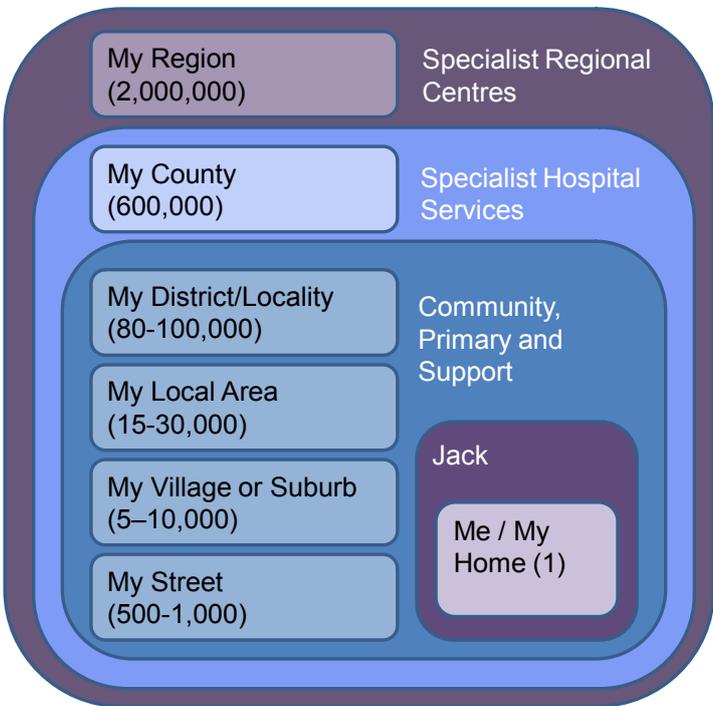
The Gloucestershire community has adopted a People and Place approach to developing our service plans. This combines both a population based approach to planning and developing health and care locally, with a place based focus building on natural geographies and communities. The November 2015 Kings Fund report, "Place-based systems of care, a way forward for the NHS in England" (Chris Ham and Hugh Alderwick) advocates a greater focus on population system planning. It recommends 10 key principles to guide the development of systems of care. Our shared Gloucestershire vision, the People and Place model and our principle of One Place, One Budget, One System follow the key principles set out in the report.

The People and Place model has been developed with and supported by the Gloucestershire Strategic Forum (Appendix 2) and underpins the Gloucestershire devolution proposals which have at their heart developing vibrant communities and places to live. We have used this model to consult and engage with our partners and stakeholders on the shape of future health and care services for Gloucestershire. In the CCG our Clinical Programme groups have also used this model to test and to develop their service transformation plans. The outputs of this engagement and work from our clinical programmes are critical to developing the shape of our future provision and therefore our proposals for New Care Models. They are also key to how we build and strengthen our locality planning and our joint work with the Council, Districts and the voluntary sector on Enabling Active Communities.

The Enabling Active Communities work is aimed at supporting local communities to become stronger and more sustainable and in turn improve health and wellbeing building on the principles in JUYC to

☐ **Reduce social isolation** and the associated negative impacts on health and wellbeing;
☐ **Improve outcomes for vulnerable people and families,** and reduce the risks they face.

Although these are the primary drivers, further areas include:
 – Reduce demand for services by enabling more people to receive help within their communities
 – Enable people to live in their own homes safely as long as they are able/wish to;
 – Encourage people to take more control of their own health and wellbeing, including self care/management;
 – Be local centres for community activity, and connecting local people;
 – Be a gateway into accessing other public services;
 – Reduce the need for people requiring extra care;
 – Enable protection of, and support for, vulnerable people in their communities;
 – Strengthen local communities in an inclusive way.

BCF METRICS – UPATE ON PROGRESS

Reductions in numbers of people over 65 years old in residential care

Gloucestershire plans to continue the trend in the reduction of service users entering residential and nursing care. The CCG forecast for 2015/16 is a 2% reduction on the 2014/15 baseline, which equates to a 17% reduction on the BCF baseline period.
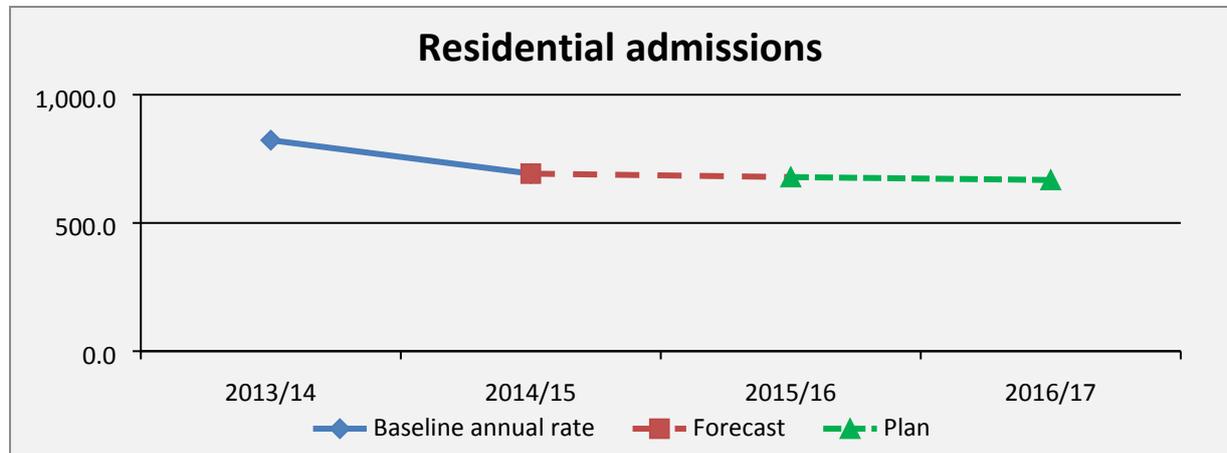

Plans for 2016/17 are for a further reduction which would move Gloucestershire to the England average.
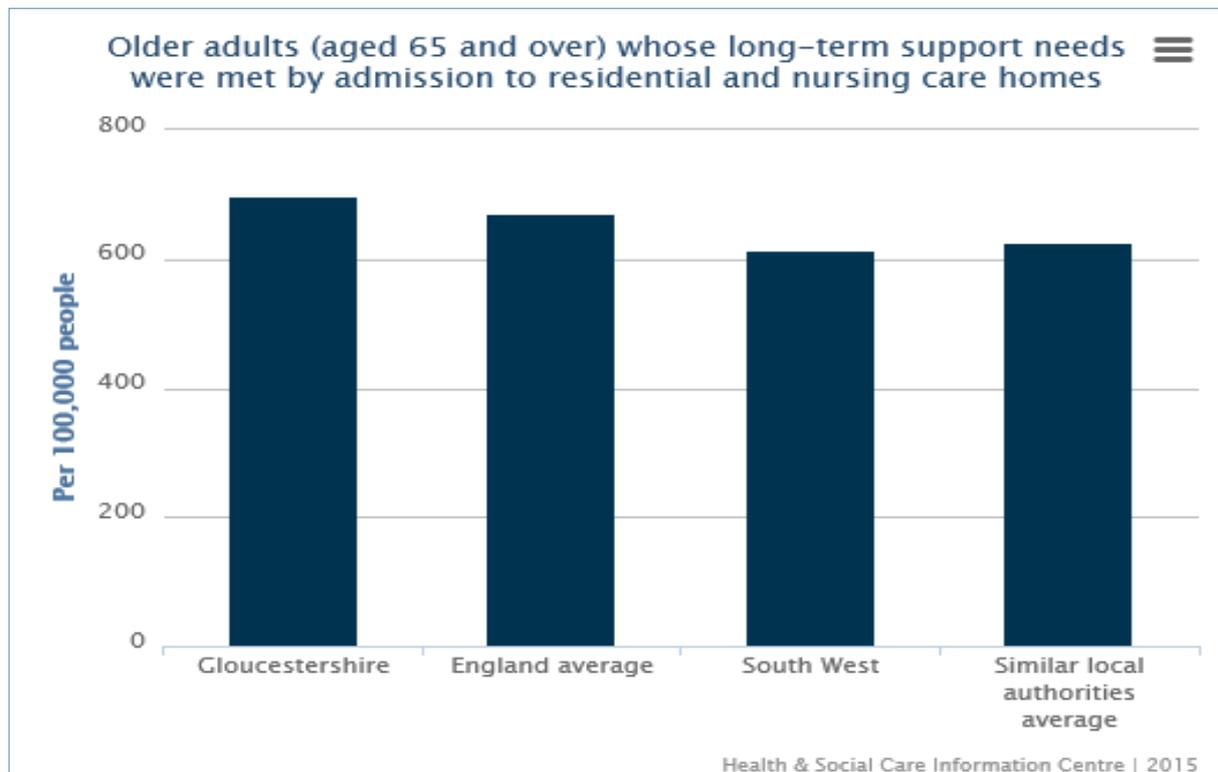
Reduction in emergency admissions

Within Gloucestershire we have seen 2.5% growth in non-elective admissions over the period January 2014 to December 2015. The 2.5% has been calculated using the defined BCF metrics (based on providers monthly activity returns MAR).

BCF non-elective admissions
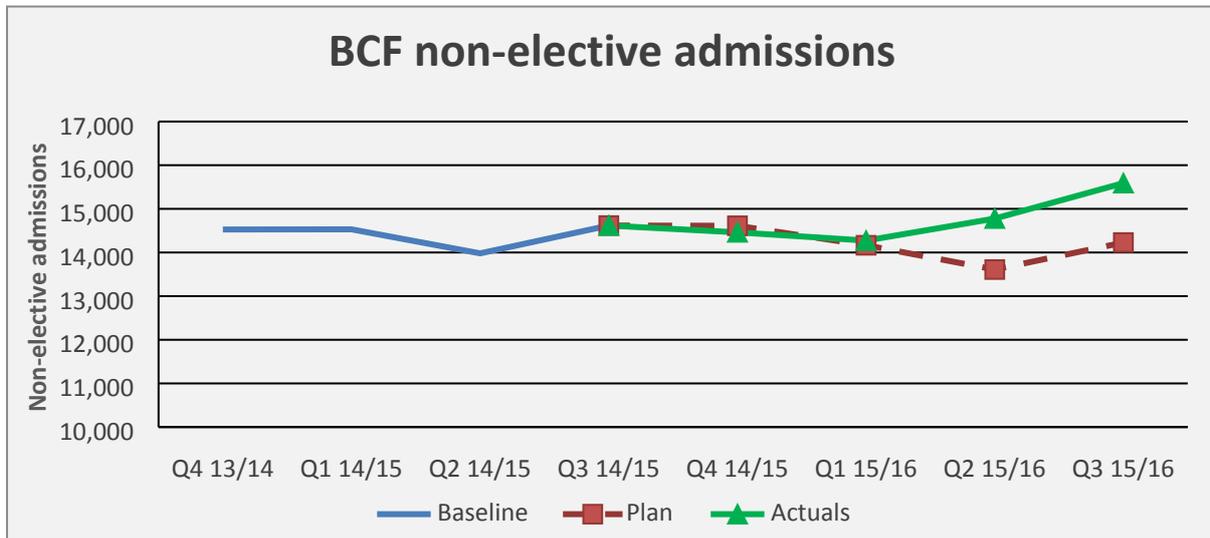
The Gloucestershire BCF plans for reducing non-elective admissions are aligned with the Gloucestershire CCG and Gloucestershire Hospitals NHSFT plans for 2016/17.

Gloucestershire CCG's plan is for a 1.6% reduction in non-elective admissions. Within this assumption growth is 2.5%, while revised contract baseline and admission avoidance schemes are estimated to make a 4% reduction.

Gloucestershire CCG
Total Non Elective activity Plan 2016/17
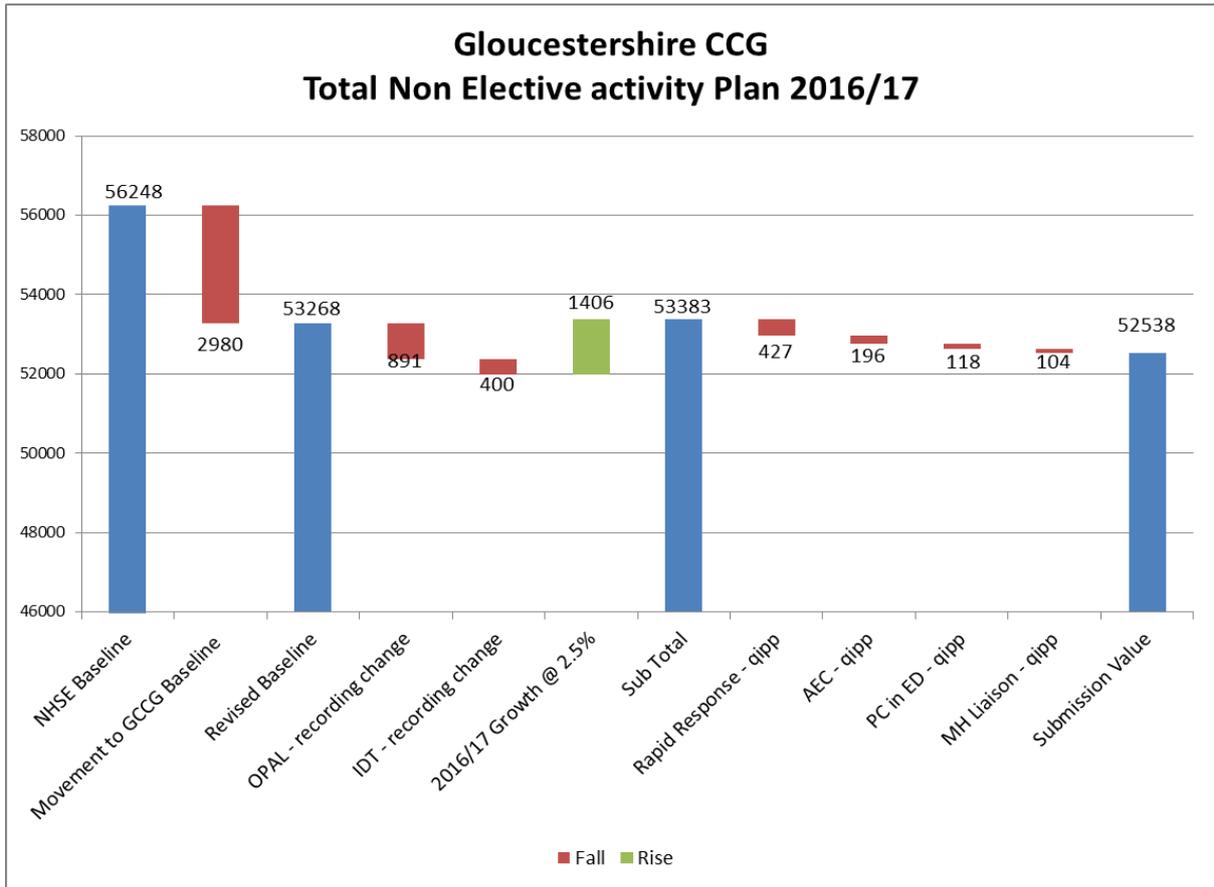
The overall plan for emergency admissions and schemes to reduce/redirect people to appropriate services has been approved by the Strategic Resilience Group; all major providers in Gloucestershire are members of this group.

In support of the 2016/17 plan we will work in partnership to further develop the following:

Frail older people work, integrated workforce including Rapid Response, _ASAP (campaign launched to provide information about alternatives to A&E, reducing unnecessary waiting for patients in A&E), support services in A&E to reduce admissions currently provided by the British Red Cross.

People are at home 91 days post discharge

The proportion of people who were still at home 91 days after discharge increased by 4.6% during 2014/15, the plan is to improve to meet the south west average which represents a 4.1% increase by the end of 2016/17.
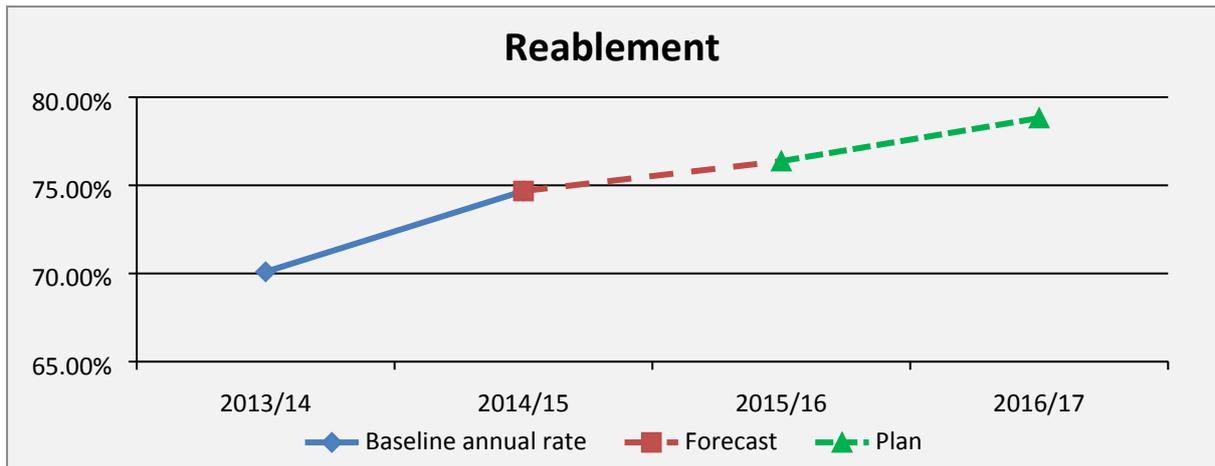
Reablement

Focus and prioritisation continue in this area to ensure we have robust preventative and crisis management services in the community, in particular effective re-ablement services that support people post-discharge and help them to achieve their full potential recovery.

Reduction in Delayed Transfers of Care

Gloucestershire performance on delayed transfers compares favourably to the England average. The figures reported at the end of the BCF period (Q3 2015/16) show an increase in the number of delayed transfers, the forecast for quarter 4 has been factored through an additional increase due to the pressures within the healthcare system.

Across 2016/17 we have shown a 5% reduction from the Quarter 4 positon across the year as this is an area of focus for our system. Please see section on local DToC plans on page 26 under Section 3, National Conditions.
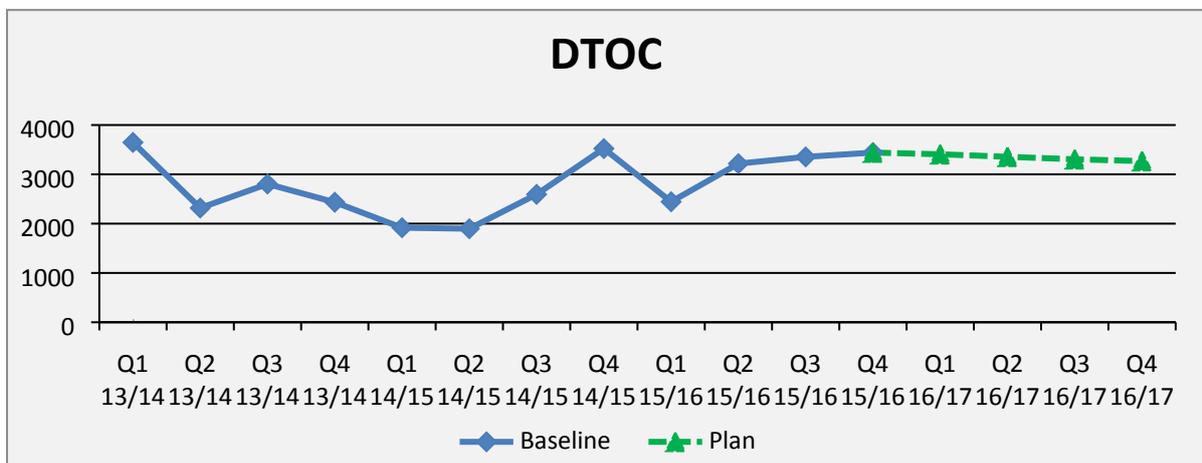
Patient Experience

It was agreed that patient experience reporting would be aligned with evidence gained through the surveys related to patient reported outcomes of ICT services.

A baseline was recorded during quarter 4 of 2014/15, with the following question asked of ICT rapid response clients, 'How likely are you to recommend our service to friends and family if they needed similar care or treatment':

2014/15 baseline results: 131/133 clients (98.5%) provided a positive response (95 extremely likely and 36 likely)
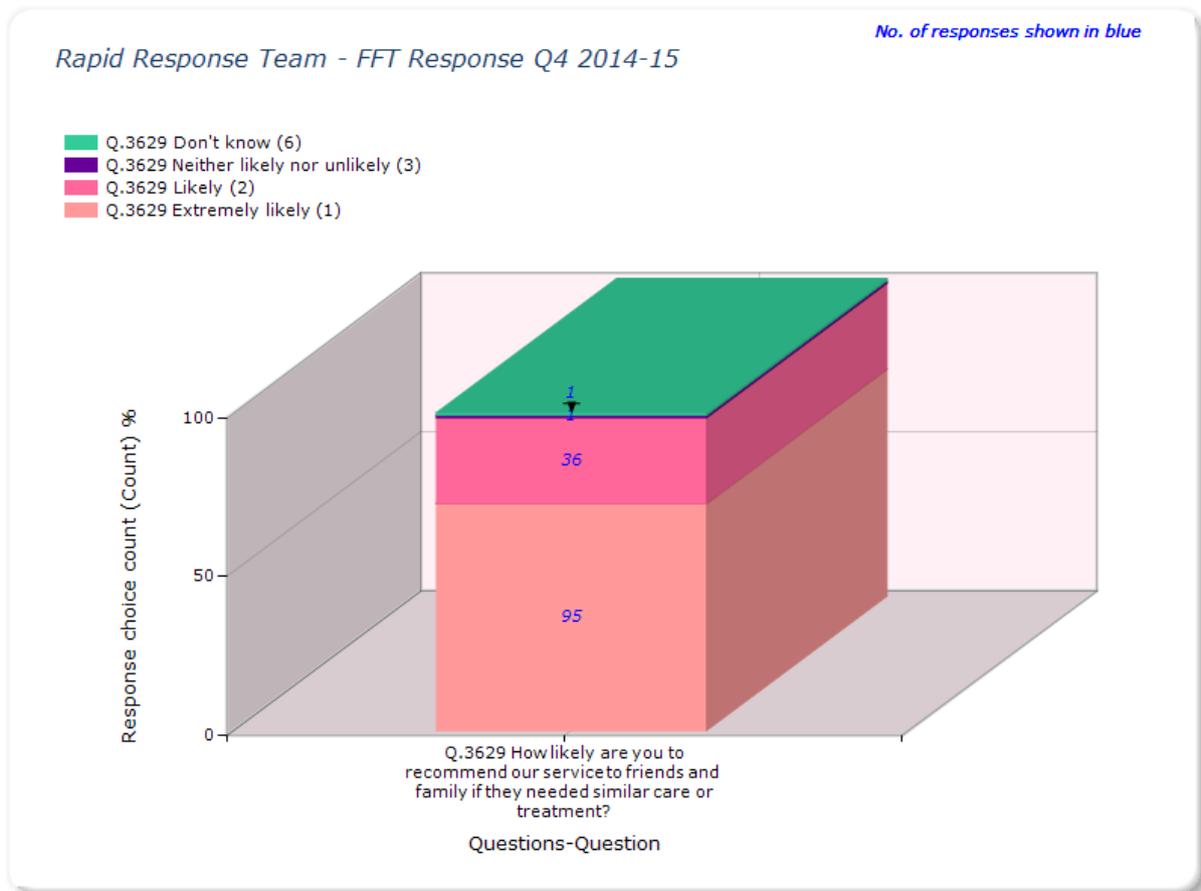
The latest results collated at the end of December 2015 indicate that from the 1st of April 98.93% of respondents have provided a positive response.

The main question is supported by 6 further questions based on NHS voices:

1. I always knew who the main person in charge of my care was
2. I didn't need to keep repeating how I was feeling and explain what I needed to different people
3. I was involved in discussions and decisions about my care as much as I wanted to be
4. Information was given to me when I wanted it
5. The information given to me was appropriate to my condition and circumstances
6. I feel the people I met were kind to me

The plan for 2016/17 is to increase the response rate from 14.6% during 2015/16 to 15% in 2016/17; this is in line with the national guidance on the Friends and Family test.

Improving Quality of Life for Carers

Results for the 2014/15 survey showed a 3.8% reduction in quality of life from the 2012/13 baseline. The plan for 2016/17 is to reach the England average by meeting the original BCF target of 7.9 (6.4% increase on 2014/15).

Carer-reported quality of life
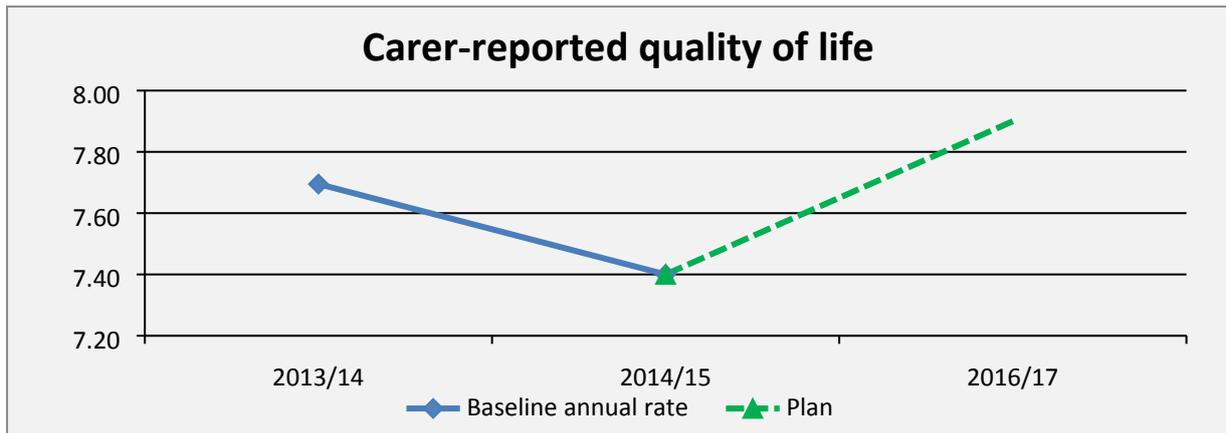
Carers Gloucestershire hosts the Gloucestershire Carers Alliance whose mission is to provide a strong, independent, diverse and inclusive carer-led and carer-centred group influencing policy and services to improve outcomes for all carers. Plans are in place to further develop relationships with the Alliance/Carers Gloucestershire to provide a route through which providers and commissioners of services can engage and hear views and feedback from carers.

All of the 'carers' services' contracts include satisfaction surveys and are showing a strong positive response, with an increase in the number of carer's assessments undertaken and evidence of meeting the 6 week target from referral to assessment. In addition, each contract in turn will be subject to a carer peer group evaluation, which includes monitoring of contracts and interviews with carers.

BCF SYSTEM ENABLERS – UPDATE ON PROGRESS

System Enabler: Developing Integrated Commissioning for Health and Social Care

Our BCF schemes and investment in them will remain unchanged for 16/17 as embedding an integrated workforce is at the heart of our ambitions. However, we have identified the need to build on our joint commissioning arrangements to manage and drive change across a number of complex systems. The drivers for this are broadly the same challenges that the BCF seeks to address, such as

- Rising demand/need and expectation
- Central policy – Care Act, BCF, 7 day working
- Reducing or limited central government funding
- Inefficiencies, overlap and duplication
- Mutual interdependencies – savings in one area can impact on another eg. hospital admissions and discharges
- Inflexible systems and processes that do not support a focus on patients/service users
- Need to fully integrate our professional workforce

Commissioning in a more joined up way is crucial to improving life for Gloucestershire residents – seeing health, public health, social care, and other local authority functions such as housing, education and leisure as a whole system rather than lots of individual services can only benefit residents. It is anticipated that greater integrated commissioning will support improved health and wellbeing, ensure services are focussed on what is needed and make better use of our resources.

The commissioning process is resource intensive and there are efficiencies in doing this jointly. In many instances, the needs of patients and service users are indivisible to agency boundaries but the responses to meet that need are often diverse and sometimes disjointed across organisations. We know that transformation will not happen overnight, but by further integrating our commissioning functions together GCC and the CCG want to encourage providers to work together and create more seamless services for our customers. The benefits to be delivered include:

- Improved outcomes for residents;

- Alignment of intentions and spend between GCC and the CCG;

- Facilitating the development of new market opportunities in the County;

- Improvements in core services;

- Reduced duplication of effort and spend;

- Increased focus on quality standards;

- The alignment and improvement of business processes for commissioning

There has been extensive staff engagement across the CCG and Council on a new model for commissioning, in particular a 'hub' concept which has been viewed with some enthusiasm by staff. A workshop has taken place to look at the scope of the hubs and plans for implementation are in the process of being agreed.

System Enabler: Front Line Culture Change

Since creating the ICT/IDTs we have learned the importance of culture and the need to support staff to develop their practice. As part of Phase 2 of the ICT implementation programme we have 3 work-streams

- Positive Risk Taking/Coaching and Mentoring/People Power
- Team formation
- Giving staff permission to get to know someone

The Positive Risk Taking work-stream has proved popular with all our providers. The aim of the work-stream is to empower staff to treat people in a way that puts their happiness and wellbeing at the heart of all our interventions and care planning. Part of this work included myth busting - one example that relates well to our BCF aspirations is the myth that people will be safer in a care home or hospital setting when evidence would suggest key to safety is familiar surroundings. In order to spread these messages we commissioned a theatre company to produce a play to illustrate the importance of how we engage with people and the unintended consequences these interactions can lead to if we don't use a person led approach. We are also hoping to spread these messages to the wider public through a variety of mediums to include posters, information leaflets and a short film of the play (YouTube https://www.youtube.com/watch?v=xFJR7hoib-E&feature=youtu.be). The intention is to build on the JUYC strategy and incorporate the essence of our strategy in this wider culture based work.

The 'Giving staff permission to get to know someone' work-stream was established to support and enable staff to only act when doing so adds value to the person. This includes active listening, using a strengths-based approach, joint visits with other professionals and verbal referrals between agencies. It is about ensuring we have the right balance of expertise between the professional and the patient.

The Team Formation work-stream was established to ensure our health and social care staff in ICTs are working in an integrated way and then expanding this to include mental health colleagues as well as colleagues in the voluntary and community sector. An example of this is that some voluntary and community sector staff now base themselves with the ICTs one day a week and we have staff induction agreements between GCS and 2gether, whereby new staff work shadow colleagues in their respective agencies.

One of the main focuses on ICT Phase 2 is a better relationship between staff in ICTs and 2gether. We want staff to be thinking about a whole person, rather than be task orientated, and by better working relationships with mental health colleagues, we are hoping that ICT staff will be more aware of a person's mental health as well as their physical health and feel confident in who they can contact for support.

System Enabler: Developing a cultural commissioning programme

To build on our work on social prescribing, Gloucestershire has also been working alongside the New Economics Foundation, National Voluntary of Community Council's and Arts Council England to understand how arts and culture can be used to improve the health and wellbeing of our local population.

During the summer, Arts and Cultural organisations from the VCSE were invited to apply for funding via the cultural commissioning grant programme. The aim of the grant programme is to test out opportunities for arts and culture interventions to support health and wellbeing outcomes for participants. We received a total of 24 applications and awarded grants to six

of the nine projects. Examples of successful applicants include singing for respiratory disease, mindfulness based art approach for chronic pain in men and a multi-art programme for young people exploring themes of social media; bullying; self-harm & violence in relationships.

Clinical Programme Groups will be working alongside clinicians, lay members and the VCSE to co-develop appropriate and effective service models. This will provide the opportunity for commissioners and the public to ensure that the pilots are designed in a way that provides meaningful and measurable outcomes.

The grant programme has been support by a number of partners including the VCS Alliance, Forest of Dean District Council, Gloucester City Council and Tewkesbury Borough Council. Create Gloucestershire (the county umbrella organisation for art and culture) have also supported the grant programme by developing capacity within the VCSE sector. This included supporting organisations with their applications and acting as a bridge between the sectors

System Enabler: Social prescribing

As a part of our prevention and self-care agenda, we have worked with G.Doc and a range of voluntary and statutory partners to develop an innovative social prescribing model. Social prescribing is a structured way of linking patients with non-medical needs to sources of support within a community and of providing one to one support where this is needed. These opportunities may include: arts; creativity; physical activity; learning new skills; volunteering; mutual aid; befriending; and self-help, as well as support for a wide range of problems including: employment; benefits; housing; debt; legal advice; and parenting problems.

By the end of February 2016 the scheme had been extended with social prescribing available to all GP practices in the county. Roll out to staff in ICTs and Community Hospitals continues and will be completed by the end of March 2016.

The external evaluation by the University of the West of England (UWE) to conduct an independent evaluation to inform the future of the service has commended with a final report due in August 2016.

System Enabler: Gloucestershire Wheelchair Review

We have worked collaboratively with all stakeholders, including wide public engagement, to progress the provision of Wheelchair Services within Gloucestershire towards an integrated model, encompassing a whole needs approach.

The joint commissioning team has strengthened links with key partners across health, social care, education, employment and voluntary sector organisations to improve and add value to wheelchair provision with the aim of optimising independence, health and wellbeing for Gloucestershire residents with Physical Disabilities.

The service is aligned to and actively participating in Gloucestershire County Council's Building Better Lives Policy, which is an 'all age all disability' 10 year Strategy to shape how the council works with people with disabilities, with the additional intention of leading the way in making changes in our whole community across Gloucestershire and the way in which it treats people with disabilities.

We continue to engage and co-produce with service users, carers and parents within this work stream to continually improve the service provision and ensure it is delivering a service with service user voice at its centre.

System Enabler: Equipment and Telecare

Work to reduce dependency on packages and increase use of assistive technology has exceeded targets set in 2015/16. Plans are being developed to embed telecare within our locality referral centres, the reablement service and supported self-service.

Over the coming months we will be working in partnership with our integrated community equipment provider, Gloucestershire Industrial Service (GIS) and telecare provider Stay Safe and Independent at Home, to develop a one service model to deliver service improvements, efficiencies and manage demand by maximising combined logistical ability and responsiveness. We will also be working alongside the other equipment services to develop combined Gloucestershire Equipment Service to improve the user experience and improve efficiencies with multi skilled staff (such as sensory).

We have upgraded the equipment ordering system which will support greater functionality and gatekeeping under the authorisation and competency framework and ability to better manage existing stock for recycling. Further work to improve recycling includes a collection poster campaign, creating drop off locations, review of the service user leaflet and development of a public facing service website.

Responder Service

Following a short pilot in North Cotswolds between July and September 2015, Gloucestershire Fire and Rescue (GFRS) have become the first responders to all telecare across the county using retained fire fighters.

Previously, people who were unable to offer a number of responders were declined from the service and to mitigate risk would have been placed either short or long term in a residential care home setting. Additionally if responders were unavailable other emergency services such as ambulance or police were called out, usually resulting in an admission to hospital and longer than necessary length of stay, all avoidable costs to the public purse.

The pilot provides significant social return on investment with care home placements, ambulance, emergency admissions and hospital stays, police and fire brigade call outs avoided.

The most important aspect to this joint working are the vulnerable individuals in our communities that can return and remain in their own homes within existing GCC infrastructure.

GFRS are responding to all calls, including dementia wandering, faulty telecare and other equipment, supported self-assessment and are working alongside the voluntary sector in supported hospital discharge. All contacts also result in Safe and Well visits, encompassing the top 2% risk stratification of vulnerable people.

The initiative was shortlisted for Innovation in the national Excellence in Fire and Emergency Services Awards 2015 in London.

GFRS are also one of three pilots with PHE working on reducing social isolation, falls prevention, falls and flu vaccinations – this is a common agenda – with significant collaborative working meaning that the most vulnerable people are being identified and supported in their communities.

In 2016 plans are to implement multi-agency Community Risk Intervention Teams, e.g. utilising fire station facilities for mobile clinics, community equipment pick up and drop off facilities and enabling supported self-service capabilities in people's own homes.

System Enabler: Risk Stratification

Within Gloucestershire we divided the population into groups to show the split by age and then secondly by condition (using long term condition QOF data). These groupings have been helpful to understand the characteristics of the population needs and to help to understand the types of schemes and services which need to be developed to address current and futures issues along with areas of unmet need. We have started to use these groupings to look at the direct impact on the service/schemes which have been put in place.

We are also exploring with GP colleagues how we can use the groupings to target the most vulnerable patients who are most at risk of admission to ensure the appropriate services are provided. This in turn will impact on the delivery of the BCF outcome indicators in particular supporting service users to remain within their own home, delayed transfer of care, reduction in emergency admissions and fewer permanent admissions to residential homes.

During 2016/17 we are planning on further developing population segmentation to include deprivation factors combined with prevalence of long term conditions and age in line with the Risk Stratification methodology. This approach has been developed in discussion with stakeholders from across the health and social care system and will be a focus of the Gloucestershire Systems Resilience Group.

The population has been dived into the following groups, these were then split by age bands; younger people (0-19years), people of working age (20-64 years), people of retirement age (65-79 years) and older people (80+ years). The segments were then reviewed to look at the demand for services.

Segment Code	Segment	People	Emergency Admissions Actual	Rate p. 1,000	A&E Attendances Actual	Rate p. 1,000	GP Practice Activity Actual	Rate p. 1,000
0A	0 QoF LTCs, aged 0-19	122727	8107	66	37312	304	923284	7523
0B	0 QoF LTCs, aged 20-64	254440	8500	33	56235	221	2955650	11616
0C	0 QoF LTCs, aged 65-79	30671	823	27	4257	139	554965	18094
0D	0 QoF LTCs, aged 80+	5390	352	65	923	171	133434	24756
1A	1 QoF LTC, aged 0-19	15329	2524	165	7740	505	202741	13226
1B	1 QoF LTC, aged 20-64	75029	6251	83	24416	325	1582575	21093
1C	1 QoF LTC, aged 65-79	26424	1845	70	5270	199	777197	29413
1D	1 QoF LTC, aged 80+	8042	1087	135	1988	247	273877	34056
2A	2+ QoF LTCs, aged 0-19	637	565	887	698	1096	18610	29215
2B	2 QoF LTCs, aged 20-64	16653	3395	204	7553	454	592712	35592
2C	2 QoF LTCs, aged 65-79	16499	2324	141	4592	278	656523	39792
2D	2 QoF LTCs, aged 80+	8159	1949	239	2921	358	359244	44030
3B	3 QoF LTCs, aged 20-64	4726	1783	377	3029	641	225741	47766
3C	3 QoF LTCs, aged 65-79	8329	2260	271	3398	408	424062	50914
3D	3 QoF LTCs, aged 80+	6059	2355	389	3052	504	327598	54068
4B	4 QoF LTCs, aged 20-64	1318	846	642	1207	916	80859	61350
4C	4 QoF LTCs, aged 65-79	3686	1592	432	2070	562	230820	62621
4D	4 QoF LTCs, aged 80+	3571	2165	606	2590	725	232543	65120
5B	5+ QoF LTCs, aged 20-64	548	731	1334	979	1786	45782	83544
5C	5+ QoF LTCs, aged 65-79	2391	2206	923	2374	993	188232	78725
5D	5+ QoF LTCs, aged 80+	2875	3206	1115	3371	1173	231837	80639
Grand Total		613503	54866	89	175975	287	11018286	17960

The segment groups which showed the largest area of demand were; patients aged 0-19 years with 2 or more LTCs, patients aged 20-65 years with 3 or more LTC conditions, patients aged 65-79 with 3 or more conditions and 80+ with 5 or more conditions.

The above population segmentation was then applied to risk stratification data (applying the Johns Hopkins University Adjusted Clinical Group methodology) to establish those population groups who were most at risk of admission. The analysis demonstrated that those patients aged 80+ had a higher chance of admission than other age groups from 0 LTC to 5. Those patients aged 65-70 had approximately the same chance of admission as those aged 20-64.

The cost profile of the admissions are consistent across all aged bands (excluding 0-19) for those with 2 or more LTC but at a higher cost where patients are aged over 65 with 0 to 1 LTC.

The table below shows the estimated cost change for emergency admissions over the next 20 years if no changes are made to services.

	Emergency admissions 2014/15 £	Emergency admissions- Forecast 2034 £	Change £	Cost Change %	Population change over the period %
0 - 19	11,118,954	11,929,227	810,273	7%	8%
20 - 64	33,643,564	32,936,381	-707,183	-2%	-1%
65 - 79	24,963,106	36,128,549	11,165,443	45%	35%
80 +	26,816,969	59,524,550	32,707,581	122%	96%
Total	**96,542,593**	**140,518,707**	**43,976,114**		
Total Increase in cost over the period			46%		
Total population increase over the period			12%		

From the population segmentation and risk stratification analysis those population groups identified as focus groups were people aged 65-79 and 80+ with 2-5 long term conditions.

It was acknowledged in the previous submission that there needed to be some focus on the younger age groups for those with multiple long term conditions and although not the complete focus of the BCF plan health related schemes these have been worked up and are included within the CCG's 5 year plan.

System Enabler: Governance and Accountability

Governance arrangements are well established in Gloucestershire with joint commissioning processes in place over a number of years. In addition to a number of joint commissioner posts across health and social care the integration programme and BCF progress are regularly monitored by the Joint Commissioning Partnership Executive (JCPE), Joint Commissioning Partnership Board (JCPB) and ultimately the Health and Wellbeing Board (HWB) on which there is representation from Healthwatch Gloucestershire. These arrangements support joint working and Terms of Reference for JCPE and the current BCF risk log are attached (Appendix 3,4).

Section 3 – National conditions

<u>Plan Jointly Agreed</u>

The Better Care Fund plan of £41.313m covers the minimum of pooled funds specified in Comprehensive Spending Review.

<u>Joint Agreement</u>

There is joint agreement across commissioners and providers of the role of the Better Care Fund within our shared strategic context. Since its approval in January 2015 regular updates on BCF progress have been provided to the HWB (Appendix 5). In addition regular updates are tabled at the bi-monthly BCF Provider Forum. There is wide representation across all statutory and voluntary sector providers at the Forum. The aspirations of the BCF and our local strategy JUYC are embedded across our system with both providers and commissioners signed up to deliver the required outcomes. Engagement regarding implications to providers is ongoing due in part to the emerging nature of this programme and the system redesign we are undertaking together.

<u>Workforce Development</u>

There is a project in place to join up our approach to workforce planning across the county in order to deliver the local community's health and wellbeing ambitions for the future as set out in the Gloucestershire Health and Wellbeing Strategy and Joining Up Your Care. The project will involve the following key stages:

- Agreeing key principles for how we want to work together
- Collectively understanding our current and predicted workforce
- Developing our understanding of future workforce needs to meet changing service models and care delivery contexts
- Learning from each other and from best practice elsewhere
- Developing a strategy to guide our collective approach going forwards
- Identifying key gaps or areas where collective action is needed to ensure that we are able to deliver quality care now and in the future
- Developing a work programme to support these key areas

The Gloucestershire Strategic Forum has developed a programme of work to underpin the delivery of our shared goals across the county. Central to the ability to deliver joined up care and models of care which will be fit for the future is our workforce. The GSF has therefore recognised and endorsed the need for the development of a cross-community focus on developing and planning for our workforce. This project has been set up to respond to this.

The key drivers for establishing this project are:

- Workforce is key to delivery of strategic change
- There are workforce pressures felt now and predicted for the future
- The need for coherence of approaches to workforce across the community – e.g. avoiding out pricing for the same staff
- Assurance - there is a national requirement to plan locally
- 5 Year Forward View new models of care will require changes in workforce skills
- The changing context of care delivery

- The need to better predict the skills and staffing levels needed for the future

DFGs and changing the 'offer' into Peoples' own homes

In working together we have begun to understand the pivotal role of effective housing in any health and social care system, both in supporting our aspirations and on the wider determinants of health and wellbeing. The BCF Provider Forum has a sub group focused on housing with representation from local housing authorities and District Council officers. The aim of this group is to review our current ways of working in order to improve health and social care outcomes for those living in poor housing conditions. Two main areas have been identified as priorities; sharing information and improving access to advice to both the public and front line staff and agreeing a set of principles as to how we will support people in their own homes through use of small adaptations and DFGs.

The national organisation Foundations has been involved with this group and will be supporting us to agree a set of principles all parties can sign up to. We will review current pathways, embed innovative best practice and integrate the services as far as is possible. A workshop is planned to engage with District Officers, Occupational Therapists, Citizens Advice Bureau and Older Peoples Groups to ensure we use the DFG monies to best effect with increased levels of preventative strategies and early intervention. In addition we are currently undertaking a review of Occupational Therapy service across the county and have a work programme with the County Council to reduce barriers to accessing equipment and assessment.

Maintaining Provision of Social Care

The total amount allocated to supporting Adult Social Care in 2016/17 is £10.282m of which £2.989 is planned to support implementation of the Care Act 2014 and other policies. This represents an increase of £82k on the current year. An additional £7.3m continues to support on-going social care demand.

In our submission last year we identified our commitment as a health and social care community to protecting social care. We stated our recognition

 "that without changes to the current health and social care system, the increasing demands placed on our services as a result of financial pressure and demographic change will make those services unsustainable. Although individually we may be able to address some of these pressures through tactical re-design and continuous improvement initiatives, reducing the inefficiency and duplication that exists across organisations requires a transformational approach across the whole system. Our approach therefore to protecting social services is to utilise integration and early intervention to reshape activity and funding levels across the sector."

One year on we have made significant progress with our plans outlined within the Better Care Fund and are driven by the vision and activity already signed up to across the Community and in Joining Up Your Care. We continue to focus on the use of early intervention and re-abling approaches to reduce on-going demand across the health and social care system either through service models such as the Rapid Response and High Intensity Service element of Integrated Community Teams or by enhancing the contribution of existing provision such as the refocusing of pathways into the re-ablement service.

We have as a whole community, both as part of the development of our JSNA and our Better Care Fund plans and building on national predictive tools (POPPI and PANSI), undertaken detailed demographic analysis and more importantly calculated the impact of these changes to our population on the provision of social care services. Funding has been specifically set

aside for protecting social care as we recognise the challenges social services will face over the coming years; we need to safeguard core social care services in order to deliver our joint aspirations within the Better Care Fund outcomes.

In support of this recognition the BCF has been used to make an additional agreed contribution for 16/17 of £0.082 million to the estimated impact of demographic and other demand pressures across Adult Social Care Services in order to maintain:

- National Eligibility Criteria (Care Act 2014)
- Access to preventative services such as telecare and re-ablement where there is an assessed risk of an individual deteriorating to substantial and critical without such investment;
- Existing (enhanced Level) Hospital social work services.

This is in addition to the investments in a number of other key schemes such as carers, rapid response, integrated community teams and the integrated discharge team. Each of these schemes also contribute to managing the overall impact on adult social care as an integral part of their governance arrangements.

A comparison to 2015/16 plans is shown on page 28 under 'Scheme Level Spending Plan'. The approach is consistent with DH guidance 2012 on funding transfers in 2013/14.

7 Day Services

Further to the development of ten clinical standards and following discussions with the Academy of Medical Royal Colleges, the following four standards have been identified as having the most impact on reducing weekend mortality and will therefore become our immediate focus. These are:

The Clinical Commissioning Group has agreed within the contract with the acute and community provider to implement the four areas determined as having the greatest impact.

These are:
- Standard 2 : Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review

Within Gloucestershire we have a 7 day services Board, chaired by the Chief Executive of the Acute Trust which supports the delivery of this agenda.

A robust baseline has been established within the acute sector showing the extent to which these standards are being met nationally and will be used to track progress against the standards. These standards support timely discharge (acute and mental health) over 7 days avoiding Delayed Transfers of Care.

In February 2016, providers and commissioners agreed to increase the frequency of Working Group Meetings to quarterly to ensure:

- Providers progress the "must dos" set out in the recent NHS Planning Guidance, "Delivering the Forward View" for 2016/17 – 2020/2021
- Each provider is able to complete a gap analysis for 7DS and develop a delivery plan

- Providers are able to share their delivery plans and help each other where there are co-dependencies. Joint working will be encouraged to help identify gaps where services overlap and to understand the impact on services of any changes to the health and social care system.
- Delivery plans are aligned to the Urgent and Emergency Care Network and Sustainability and Transformation Plans

These meetings will be led by commissioners and will help with the provision of assurance to NHS England on 7DS delivery to prevent unnecessary non-electives through Out of Hospital services across 7 days and support timely discharge (acute and mental health) over 7 days avoiding delayed discharges

During the first week in April 2016, each trust will be completing a 6 monthly survey to measure the progress against the standard for Consultant assessment, access to diagnosis, consultant directed interventions and Consultant on-going review. The methodology is via a prospective case note review of 280 patients admitted as an emergency across both sites.

Data Sharing

NHS number is used consistently within the main 2Gether NHS Foundation Trust, Gloucestershire Care Services and Gloucestershire Hospitals NHS Foundation Trust who all obtain a level of 91% - 100% however there is some further work to be done with South West Ambulance service NHS Trust and the County Council to improve current rates. A plan is in development as part of the Digital Roadmap to improve the proportion of patients with a verified NHS number and this will be developed in further detail during April and May 2016.

The results of the Digital Maturity Assessment for 2016 for Gloucestershire are outlined below:

Question		National (Dataset)		Acute (Subset)	Mental Health (Subset)	Community Health (Subset)	Ambulance (Subset)	Social Care (Subset)		2Gether NHS Foundation Trust	Gloucestershire Care Services NHS Trust	Gloucestershire Hospitals NHS Foundation Trust	South Western Ambulance Service NHS Trust
Standards		41%		41%	41%	41%	41%	42%		96% - 100%	96% - 100%	91% - 95%	51% - 75%
For what proportion of patients is a verified NHS number included on all information shared with any other care provider or organisation directly involved in a patient's care and treatment?		88		88	90	91	77	89		100	100	87	17

- Pursuing interoperable APIs with required security and controls

  – The Joining Up Your Information (JUYI) project is working with the suppliers of the provider systems in Gloucestershire (e.g. RiO, Liquidlogic, TrakCare) to obtain secure data feeds into the JUYI solution.
  – What data is then shared with whom will be strictly controlled by the Data Sharing and Control Group, comprising a range of clinicians and lay members.
  – The JUYI solution will have role-based access and proactive auditing, to actively seek out any inappropriate access

- Appropriate IG controls in place in line with revised Caldicott principles and IGA guidance

  – A "Gloucestershire Information Governance Group" (GIGG) has been convened, comprising the information governance leads from the providers in the county
  – A Gloucestershire Information Sharing Partnership Agreement has been agreed by this group an overarching information sharing framework. It also specifies the template for Specific Information Sharing Agreements, to be used for each dataset that is shared
  – Dedicated expert information governance resource supports the GIGG and the JUYI project
  – A Privacy Impact Assessment will be completed for the data that is to be shared.

- Local people are clear about how data is used, who has access and how they can exercise legal rights (National Data Guardian review)

  – Joining Up Your Information (JUYI) – Gloucestershire's Shared Care Records Project - has supported development of a range of materials including newsletters, posters and leaflets.
  – All materials have been reviewed by Healthwatch Gloucestershire's Reader Panel and a selection of GP Practice Patient Participation Groups.
  – A countywide mail-out to all patients of Gloucestershire GP practices (over the age of 15 ¾) is imminent, and arrangements are in place to establish a freephone Advice Line at the CCG to support public enquiries.
  – The website: (http://www.gloucestershireccg.nhs.uk/joiningupyourinformation/index.php) has a wealth of information about how patient data will be shared with professionals caring for them, including case studies, an animation and an FAQ section.

- Impact on Integration

  – The JUYI project has the following vision:
  "To support the delivery of safe, effective and collaborative care, centred around the service user, by ensuring that any professionals and the service user have access, and can contribute to, all relevant and up-to-date clinical and administrative information which relates to their care, from all sources whichever organisation they are working for and whenever and wherever they are working. This includes the service user, enabling them to collaborate in the planning and provision of their care."

JUYI Vision and
Principles v1.4.docx

  – In addition, Principle 11 of the Vision and Principles document states:

> "JUYI will help minimise the duplication of data acquisition, data entry, investigations, treatments and other interventions during the care and support pathway."

– Thus, a care professional will have full sight of the care being provided to the care recipient they are treating, avoiding fragmented or duplicate care. By bringing the disparate information together, a virtual care team is formed that can work together in a coordinated manner. In the case of teams formed from professionals in different organisations (e.g. the Turnaround Children's Service), data is entered onto their own systems and access to the whole picture is problematic. JUYI will bring data together and facilitate collaborative working, e.g. having a plan that all members can contribute to and view.

Joint Approach to Assessment

Risk Stratification in primary care supports identification of those who will benefit from case management. In addition there are a variety of projects in place to support identification of those who would benefit from case management such as frailty indicators and we are now working to link the groups across community and acute sector to share intelligence and learning and enable us to provide pro-active case management. We recognise this work requires more co-ordination across the county but are encouraged by initial progress.

A key element of our strategy to improve patient outcomes and experience of care is to improve our ability to target health and social care resources for those individuals who are at greatest risk of admission to hospital or residential care/nursing care homes. This involves improving patient data flow e.g. triangulating patient data relating to individuals who are known to ICT who have been recently admitted to hospital. Adopting this approach has enabled frontline teams to review on a multi- professional basis a patient's needs following discharge from hospital. Those individual patients who continue to be deemed at high risk of losing their independence are allocated a case manager who is best placed to meet their primary need. It is anticipated that this approach will be strengthened and refined throughout the year in order to strengthen a preventative person centred approach.

Another key element underpinning our current strategy is to create virtual wards and community matrons that will mean case management and care coordination functionality within ICTs is mainstreamed. This work will be aligned with improvements taking place regarding the quality of Social Worker assessments and care planning processes in line with the requirements of the Care Act. For instance in locality referral centres health and social care professionals are jointly triaging patients who are contacting ICTs in order to identify proportional and person centred approaches to meet their needs. In one locality we are piloting a model which involves mental health practitioners participating in MDT meetings, Locality referral centre processes so that the needs of patients with the onset of dementia can be addressed on a multi professional at the earliest opportunity. Also further links are being planned for embedding an integrated approach for case management between ICTs and primary care. The production of a holistic self-care management plan for a patient is a key outcome of this approach as are joint assessments.

Gloucestershire Primary Care Dementia Pathway includes a county wide Dementia Advisor (DA) service, jointly commissioned since 2010 and provided by the local Alzheimer's Society. The pathway is supported by close collaboration between 2gether NHSFT and the Alzheimer's Society; 2gether provide specialist clinical support around diagnosis and complex care, working closely with primary care teams as the focus for diagnosis shifts from secondary care to GPs. 2gether dementia consultants and nurses also offer specialist advice to ICT and care homes. The DA service provides peer support, advice and signposting. Since 2014, both pathway partners have actively engaged with the development of Integrated Community Teams and the Social Prescribing project to ensure that ICTs particularly are aware of the range of dementia services accessible.

Gloucestershire also jointly funds a county Dementia Training & Education Strategy which provides training to both health and social care workforces, as well as VCS and ensures that a consistent message is given that endorses strengths-based, person centred care with skills and competencies to assess and address issues such as challenging behaviour. The Dementia Training & Education Strategy is also enabling and coordinating the development of community dementia networks that complement the national Dementia Friendly Community/ Dementia Friends campaigns.

During 2016/16, the Primary Care Dementia Pathway will be reviewed. The national target of achieving two thirds dementia diagnosis has been met, with a local target agreed for 2017 of

70%. The Prime Minister's 2020 Dementia Challenge identifies a number of priorities, one of which is to ensure a good standard of post diagnostic support. Given the continued improvement in diagnosing dementia locally, there is a need to ensure that the pathway introduced in 2010 is able to meet the needs of people living with dementia, and reflects the change in community services.

Agreement on the Consequential Impact of Change

As demonstrated by our devolution bid we approach any changes in Gloucestershire as one whole system. We undertook an extensive programme of engagement that led to our joined up vision. Our shared vision has been signed off by all parties across the whole system. Our provider organisations are signed up to the principles in JUYC and have contracts that reflect our direction of travel. Further to this the CCG's Operational Plan aligns with the principles of the Better Care Fund.

Parity of Esteem is when mental health is valued equally with physical health and is a really important Government ambition that we as a Health and Social Care system must take significant action to achieve. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses.

Gloucestershire has in place a Mental Health & Wellbeing Strategy with detailed implementation plans that include a range of local objectives that respond and align with the No Health Without Mental Health 6 high level objectives and the 25 priorities for essential change in mental health as set out in Closing the Gap (DH 2014).

The CCG has led a multi-agency response to the national Crisis Care Concordat and has in place a local declaration and continuous improvement action plan.

The CCG also aims to ensure parity through contract arrangements with the Mental Health provider 2gNHSFT, including CQUIN arrangements for physical health checks for SMI patients, inclusion of parity of esteem within service specifications, supporting service developments within IAPT relating to MUS/LTC and continuing to enhance access to MH Liaison services.

Agreement to invest in NHS commissioned Out of Hospital services

Agreement has been reached to invest in NHS commissioned out of hospital services within the BCF; further schemes have been developed and in some cases piloted, in 2015/16 for full implementation in 2016/17. These schemes have been referenced elsewhere within the document and also include out of hospital schemes. The Council and CCG have agreed that there will not be a formal risk sharing agreement for non-elective admissions or other targets within the BCF.

For 16/17 these services will remain in place, however, we are currently writing a specification to tender for an all-encompassing supportive discharge service that will work across 7 days of the week to ensure we provide our citizens with ongoing support and ensure effective patient flow.

We are piloting a scheme called Discharge to Assess (D2A) which aims to ensure that as soon as a patient in an acute or community hospital is medically stable for discharge they are discharged to their usual place of residence. Where this is not possible, the patient is discharged to an appropriate setting for further assessment or rehabilitation to ensure that hospital beds are available for those with acute or sub-acute needs. These patients may require extensive or exceptional assessment over a period of weeks. D2A assessment beds allow assessments to be carried out over a longer period of time to ensure the right decision

about a patient's ongoing and long term care needs is made. Care Home Selection, an independent organisation commissioned by the CCG, oversees these beds until a decision can be made with the patient/service user in relation to their long term goals.

Agreement on local DToC plan

Within 2015/16 a review of Gloucestershire Delayed Transfers of Care (DToC) was undertaken to ensure alignment with the NHS England guidance. The review's purpose was to ensure that the Gloucestershire plan supported improved patient flow and a good patient experience. The system has an agreed target for medically stable patients, which it works together on a daily basis to support. The target is reported on a daily basis (and a weekly return provided to NHS England), the system has awareness of the target and works towards support for the identified patients. Additionally, the target of medically fit for the community is also reported daily, so there is a high level of system awareness in relation to these targets.

We have invested in supportive discharge by commissioning an Integrated Discharge Team (IDT); this team supports front door admission avoidance and back door discharge. The team comprises a mixed group of health and social care professionals. The team is accountable to both the community and the acute trust, for delivery and the governance for this initiative is through an IDT Board, chaired by the CCG Deputy Accountable Officer, with Director level colleagues from the Local Authority, Acute and Community Trust. This Board reports to the System Resilience Group with Gloucestershire and is also governed through our BCF arrangements through JCPE, JCPB and HWB.

Process maps are in place and Standard Operating Procedures (SOP) are in development (to be in place April 2016) to support the teams across the community and acute sector to deliver an effective level of care. The SOP for DTOCs in Gloucestershire will be based on our shared ambition for no more than 40 people to be on the medically stable list at any time. For 2016/17, the plans are to review the success of the IDT front and back door model. This will be undertaken alongside a light touch review in light of the National Guidance for DToCs to ensure that the local position can maintain exemplar performance and that any process changes do not result in unintended consequences. Both of these are underway and will be completed by the end of April 2016. Latterly, the acute trust has a focus on every patient over 14 days length of stay (which includes elective patients). Of this group, focused support will be offered to move these patients back to their place of residence (the majority being non-complex). A jointly produced discharge plan has been produced and is currently with Healthwatch for their feedback.

On a wider scale, work with the voluntary sector through the development of a Hospital at Home and Assisted Discharge scheme has commenced following a pilot project provided by the British Red Cross. We also have a service provided by AgeUK that supports older people on discharge from acute and community hospital beds. We plan to tender for a full comprehensive service to support discharges at both the front and back door in 2016/17.

NHS Gloucestershire CCG is piloting a scheme called Discharge to Assess (D2A) which aims to ensure that as soon as a patient in an acute or community hospital is medically stable for discharge they are discharged to their usual place of residence, with support and further assessment if required. Where this is not possible, the patient is discharged to an appropriate setting for further assessment or rehabilitation to ensure that hospital beds are available for those with acute or sub-acute needs. These patients may require extensive or exceptional assessment over a period of weeks. D2A assessment beds allow assessments to be carried out over a longer period of time to ensure the right decision about a patient's ongoing and long term care needs is made.

D2A is a collaborative initiative between Gloucestershire Commissioners across health and social care, providers of health and care services and the patients and carers of Gloucestershire. Healthwatch Gloucestershire are members of the project and a patient survey is in development.

Scheme Level Spending Plan

Scheme Name	Scheme Type	Provider	2016/17 Expenditure (£m)	2015/16 Expenditure (£m)	Change (£m)
GP delivered care	Improving healthcare services to care homes	Private Sector	0.854	0.854	-
	Personalised support/ care at home	Private Sector	1.271	1.271	-
Hospital based care	7 day working	NHS Acute Provider	0.500	0.500	-
	Intermediate care services	NHS Acute Provider	1.365	1.365	-
	Personalised support/ care at home	NHS Acute Provider	1.724	1.724	-
Mental health liaison	Intermediate care services	NHS Acute Provider	0.715	0.715	-
Out of hospital care	7 day working	NHS Acute Provider	0.300	-	0.300
	Assistive Technologies	Private Sector	1.100	1.100	-
	Improving healthcare services to care homes	Private Sector	0.350	0.350	-
	Integrated care teams	NHS Community Provider	4.612	4.612	-
	Intermediate care services	NHS Community Provider	1.263	1.263	-
	Other	Charity/Voluntary Sector	1.551	1.551	-
		Local Authority	0.090	0.090	-
		NHS Community Provider	0.750	0.750	-
	Personalised support/ care at home	Local Authority	0.025	0.025	-
		NHS Acute Provider	0.899	0.899	-
		NHS Community Provider	2.994	2.733	0.261
	Reablement services	Charity/Voluntary Sector	0.210	0.350	- 0.140
		NHS Community Provider	1.675	1.535	0.140
		Private Sector	1.026	1.026	-
	Support for carers	Charity/Voluntary Sector	3.075	3.075	-
Social Care	Personalised support/ care at home	Private Sector	4.682	3.959	0.723
			10.282	10.200	0.082
Grand Total			**41.313**	**39.947**	**1.366**