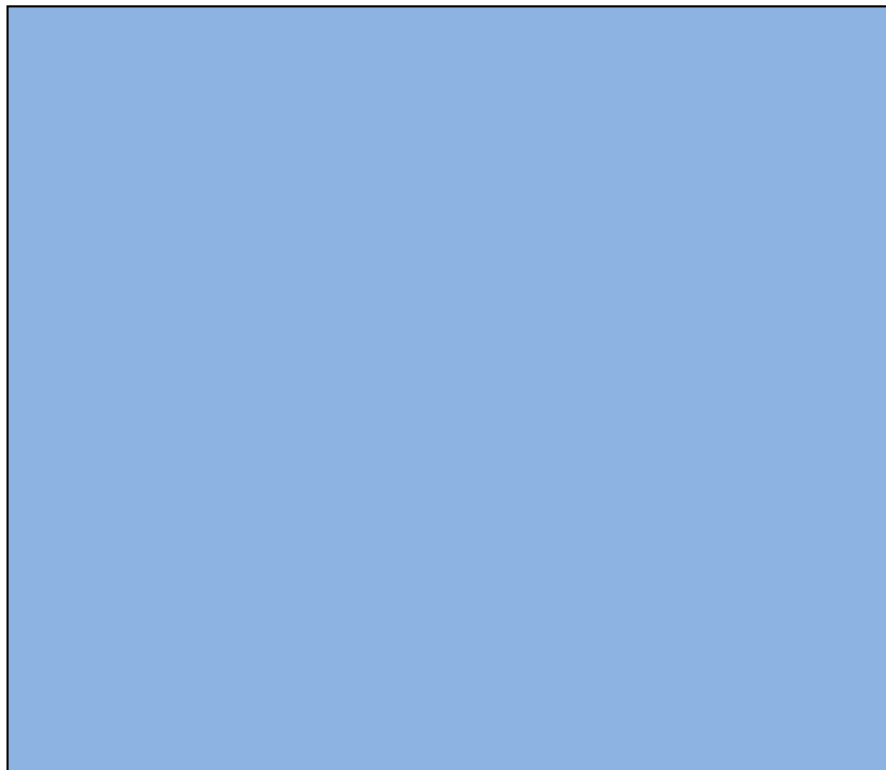
Lancashire County Council

Greater Preston Clinical Commissioning Group

Chorley and South Ribble Clinical Commissioning Group

Appendix 'A'

Lancashire Health and Wellbeing Board
28th January 2014



1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lancashire County Council**
Clinical Commissioning Groups	**CCG Greater Preston**
	CCG Chorley & South Ribble
Boundary Differences	**Identify any differences between LA and CCG boundaries and how these have been addressed in the plan**
Date agreed at Health and Well-Being Board:	**28/01/2014**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£24.555m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£24.555m**

DRAFT

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	
Position	
Date	

Signed on behalf of the Clinical Commissioning Group	
By	
Position	
Date	

Signed on behalf of the Council	
By	
Position	
Date	

Signed on behalf of the Health and Wellbeing Board	Lancashire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	
Date	

DRAFT

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This draft reflects a number of existing programmes which have included health providers as active participants; together with a range of local social care providers, and our voluntary and community sector as a whole, providers are now also being engaged in developing future plans

We have been developing our existing work plans for the past 4 years, co –producing our approach to implementing Integrated Case management, neighbourhood teams and self care with our Community and Acute providers. We have also fully included local VCFS and independent providers, through a series of workshops and planning events that have been well attended.

The implementation plan for neighbourhood teams is being led by the Community Provider Trust.

We have engaged District Council partners in the implementation groups and steering groups of our key work streams.

We have utilised local Health and wellbeing Partnerships to inform on progress and to hold us to account at a local level and will continue with that arrangement.

Over the past 9 months there has been a review of urgent care and several high impact changes have been co-produced through a series of inclusive workshops and subsequent joint work streams, with each partner taking a lead on one of the high impact work streams.

We have now joined up the urgent Care work stream with the work on neighbourhood teams and formed a collaborative programme office, with each partner taking a lead on at least one of the high impact changes.

The BCF has been at the heart of recent discussion and planning, with a small BCF steering group, with all providers represented, ensuring the BCF is linked directly to the current work streams.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

We have held a series of workshops and engagement events, 6 in the last 12 months, including citizens, carers and expert patients. We have used the principles of 'Working Together for Change' to co-produce our vision and develop the 'I' statements.

We have used local partnership and patient forums to seek continuing feedback on elements of our plan.

DRAFT

We will use 'working Together for Change' going forward to review our progress and to understand the actual experience and impact for local people and communities.

We will continue to review the 'I' statements to ensure the integrity of our vision, as experienced by local people, is maintained.

Working Together for Change is a simple engaging process that informs what is working, what is not working and what we need to do different, across our work streams. It is part of our citizen engagement plan and supports our commitment to co-production.

We will engage 'Health Watch', to support the monitoring of outcomes and the experience of citizens and patients across the broad range of services and supports, in Acute, Community and Primary care settings.

e) Related documentation

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

Reference	Document or information title	Synopsis and links
E1	JSNA	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and wellbeing of our population for both CCGs.
E2	Delivering seven day services – attach critical bid from KPMG	Central Lancashire vision to be an early adopter for seven day working
E3	Urgent Care transformational programme	The vision for an integrated care system and demonstrates the work programme across the health economy. This includes people their carers and families being empowered to exercise choice and control.
E4	Commissioning for Value Packs	
E5	Patient stories	

DRAFT

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

Greater Preston CCG and Chorley & South Ribble CCG serve a population of just under half a million, covering three District Council boundaries of Preston, Chorley, South Ribble and within the Lancashire County Council boundary. As key partners together with our excellent Community Health and Acute Provider Trusts, we have agreed to re-focus services on the needs of residents, not the convenience of providers or commissioners, reflecting the principles of the Better Care Fund.

Our vision is to provide health and social care which is:

- **Seamless** – boundaries between commissioning and providing organisations should be, as far as possible, invisible to patients, services users and members of the public.
- **Patient-centred** – the needs, interests and views of patients and local people should be the key determinant of service design.
- **High quality** – all citizens should have access to the best services we can afford, regardless of age, gender, ethnicity or disability.
- **Efficient** – we will manage our resources wisely, eliminate waste and ensure that every pound is well spent.

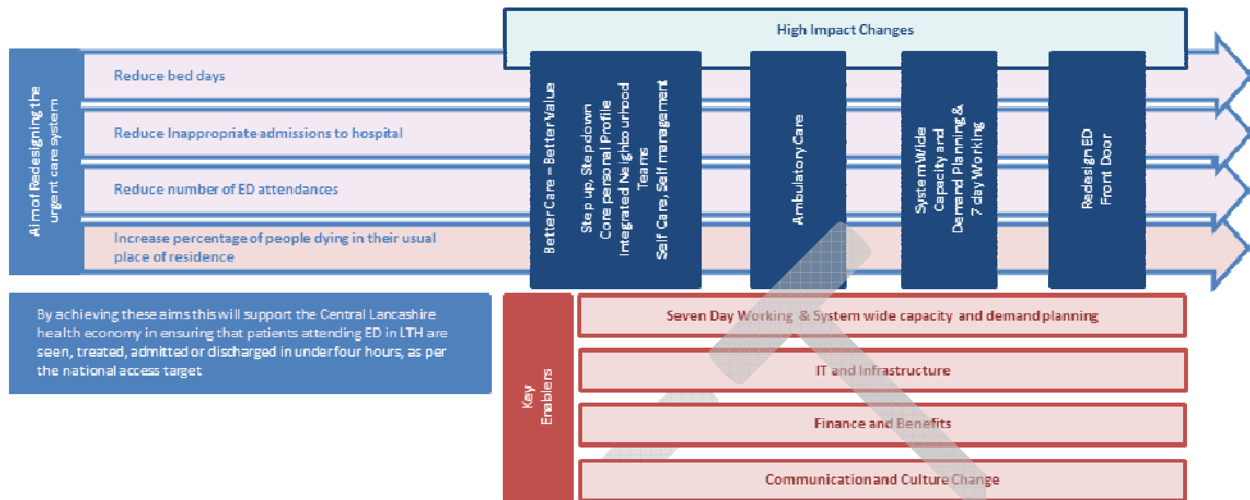
We will translate this vision into more specific aims, ambitions and plans for specific areas of service delivery.

For example:

It has been clear for a while that there is a pressing need to improve the quality and cost-effectiveness of urgent care provision across the central Lancashire health economy. Our urgent care transformation programme is doing just that and is currently at the heart of our day to day business across all public sector health organisations. The diagram below shows the vision, aims, the four high impact projects and the supporting enabler workstreams:

We will focus BCF activity for 2014/15 and 2015/16 specifically on 'Better care Better value' work stream, identified below, however the context is within our wider transformational work, with all elements being interdependent, so it is important to capture the wider ambition below, even though the initial focus is on No2. Below;

DRAFT



1. **Ambulatory Care Strategy**
   Developing system-wide pathways for ambulatory care-sensitive condition
2. **Better Care, Better Value**
   - ***Step Up, Step Down Care*** - Increasing access to step and step down intermediate care services by extending the referral criteria
   - ***Core Personal Profile and Shared Care Plans*** - Agreeing a single form and process for assessing patients' needs for community health and social care to support multi-disciplinary working
   - ***Integrated Neighbourhood Teams*** **-** To plan and oversee the development and implementation of local integrated health and social care teams in Central Lancashire
   - ***Self Care, Self Management*** **–** A whole system adoption of activities to enable patients to develop the knowledge, skills and confidence to manage their own health
3. **System-wide capacity planning & *Seven Day Working***
   - Planning system-wide capacity in response to variable demand on a daily, weekly and seasonal basis and in response to exceptional circumstances
   - Evaluating how demand and capacity should be aligned throughout a week; system-wide escalation describes how demand and capacity should be aligned during rare and unpredictable events
4. **Redesign ED Front Door**
   - Improving streaming of patients at the front door of ED to ensure that patients have prompt access to the most relevant care for their condition

The diagram below highlights the ambition for each of the projects. In year one and two the Health Economy will be focusing on the Better Care, Better Value workstream to complement the planned changes

DRAFT

All the projects are supported by enabler workstreams to ensure delivery such as seven day working and IT. Collectively they comprise a complex, whole-system transformation to the urgent care pathway in Central Lancashire. The programme is currently in the detailed design phased to ensure implementation will start in April/May. Implementing these changes will require new ways of working across the local health economy including:

- New forms of organisational governance and robust operating procedures between all stakeholder organisations
- Complex pathway redesign across multiple organisations
- New ways of working within existing teams and through new team structures across multiple organisations
- IT initiatives that will enable changes across more than one organisation
- Changes to contracts, incentives – both personal and corporate

The programme objectives and outcomes align with the Better Care programme and will make a major difference to the lives of local people by providing co-ordinated, transparent, streamlined services for the community. For example patients will progressively see a single care manager and co-produce a personal care plan over which they feel a real sense of ownership. This process will start with our older patients, who often have the most complex needs. They will be served by integrated teams focused on maintaining them in their homes safely and for as long as is possible. This will have a form of local Area Coordination, utilising local community assets and the VCFS as part of the wider neighbourhood team, supporting those with the most complex needs and those people at tipping points and supporting future community capacity and resilience.

Although we aim to maximise the independence of our older citizens, thereby dealing the need for long-term care, we will continue to require a strong supply of housing and support options, ranging from extra care housing units to high-quality nursing homes, to provide the best possible care towards end of life.

DRAFT

We will need to make investments in skills, capacity and infrastructure to support a more coordinated, integrated and person-centred approach to the delivery of health and social care. This will allow us to develop health and social care professionals who are confident about working outside their precise professional boundaries. This will mean that **people** are served and supported in a more targeted way by a smaller number of professional staff.

We will achieve more effective co-ordination of delivery by providers through the implementation of a whole-system **inclusive** approach to commissioning, made possible by the pooling of budgets. This will require a clear focus on outcomes and quality, with organisational boundaries becoming less and less relevant and visible. The result of this collaboration over the next five years will be a substantial shift of resources from emergency, bed-based, secondary health care into community-based health and care services.

GPs will be at the centre of organising and coordinating people's care.

Through investing in primary care, we will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services and a closer relationship with pharmacy services. Our GP practices will collaborate in networks focused on populations over at least 20,000 within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined up support for those individuals with long-term conditions and complex health needs.

By 2018-19 we will:

- maximise both public and wider community resources in a way that achieves the best possible outcomes for communities, families and individuals, reducing health and social inequalities and improving life opportunities and experience.
- jointly plan and deliver integrated services and support across partner organisations to achieve the right support, in the right place, at the right time, with the right outcome, at the right cost.
- be mature partnership agreements and risk-sharing arrangements that will support the delivery of safe and timely services that are high quality, offer best value, within the least restrictive environment, that promote wellness, recovery and seek to maximise the resilience and capacity of individuals, families and communities.
- be focussing on reducing the impact of ageing, long term conditions, disability and health inequalities in a proactive manner, as opposed to reactive systemic management

DRAFT

The Better Care Fund (BCF) will be an accelerator of local ambition and vision that is based on four years of work to date, listening to the experience of people living in the local communities, understanding local population needs and developing key collaborative work streams for long term conditions and urgent care.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

The strategic vision is articulated in the previous section: we aim to provide health and social care which is seamless, person-centred, high-quality and efficient. We have unpacked this vision into a series of more specific aims and objectives, as follows:

- Promote independence and help people and their carers better manage their own health and social care needs.
- Identify people's health and social care needs at an early stage and involve them in shaping a personalised care plan to meet those needs.
- Improve team working and co-ordination between professionals and voluntary agencies to deliver seamless care.
- Deliver care in, or close to, home where possible.
- Develop actions that reduce urgent interventions and improve value for money.

What will this mean for the people of Greater Preston and Chorley & South Ribble?

- They will feel reassured, because their needs and the needs of their carers have been taken fully into account and shared with the professionals involved in supporting them.
- They will know that decisions about their care will be made in consultation with them and will be made more quickly.
- They will know that their personal goals will inform clinical and care decisions and they will have more control over their health, enabling them to live as full and independent a life as possible.
- They will only make trips to the GP and hospital when necessary.

What will success look like?

We will focus single-mindedly on outputs and, wherever possible, on outcomes rather than on inputs. Success will be measured in the following key areas:

- There will be a significant and measurable reduction in pressure on acute settings. This will be achieved by shifting resources from bed-based care to primary and community-based care.

DRAFT

- There will be a demonstrable shift to whole-system joint commissioning across health and social care.
- People will feel empowered to direct their care and support and to receive the care they need in their homes or local community.
- Carers will feel better supported and that their own needs are better met, thus enabling them to continue their value contribution to the community.
- There will be a demonstrable shift from block contracting to personalisation through co-production of care plans.
- We will have the services in place that will allow **people** to spend longer in their family homes and less time in secondary care and care homes (including end of life care provision).
- GPs will be at the centre of organising and co-ordinating people's care. At the heart of this will be a form of Local Area Coordination, maximising community assets and universal supports as part of a wider inclusive offer.
- We will have a strong and self-confident group of health and social care providers, working together collaboratively and competing, as appropriate, and meeting the needs of local people. The local market will include strong community provision, delivering a joined-up set of low-level interventions which prevent patients from entering into unnecessary high-cost care packages.

We will set targets and measure our performance in the following areas:

- Level of acute admissions and number of beds and bed days.
- Level of emergency admissions.
- Level of admissions to residential and nursing care and number of beds and bed days.
- Number of whole-system commissioning decisions (i.e. fewer contracts that apply only within a single provider organisation).
- Number of block contracts (i.e. fewer block contracts and an increase in commissioning of personalised care plans).
- Percentage of patients with LTCs who have a personalised care plan
- Percentage of patients who have a joint health and social care personal budget with a single support plan.
- Feedback from patients and carers about their experience, their involvement in decisions and the extent to which their needs and wishes are met.
- Feedback from GPs about their role in organising and co-ordinating patient care.
- Strength of local providers, as assessed by relevant health and social care regulators.
- Deaths in hospital as a percentage of all deaths

The changes we are planning will be comprehensive and transformational in their impact. We will therefore expect to see major shifts in culture, behaviour, activity and spend as well as improved patient experience and health outcomes.

To measure our performance we will need to access a wide range of information, from multiple sources.

DRAFT

We will need to cross-reference key performance and activity data with actual impact on individual experience and with key health, wellbeing and organisational indicators.

This will require significant investment in IT infrastructure to support the recording, collation, analysis and reporting of performance information.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

We recognise that achieving our vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with citizens, patients and each other. The CCGs and local authority commissioners who make up Central Lancashire are committed to working together to create a marketplace and maximise all the assets including community assets and seeing people and families as assets, and effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

Across Central Lancashire , our process for achieving our vision, as set out in our joint commissioning intentions means:

- Local health and social care commissioners, in partnership with NHS England where necessary, identifying what populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; the performance management and governance arrangements to ensure effective delivery of this care. We will include a form of Local Area Coordination to ensure community assets and the VCFS is an integral part of the wider offer of care and support.

- Local health and care providers, and associated public, private and voluntary and community sector groups, co-designing the care models that will deliver these outcomes; transitioning resources into these models to deliver the outcomes required; ensuring governance and organisational arrangements are in place to manage these resources; agreeing the process for managing risks and savings achieved through improving outcomes; establishing information flows to support delivery; and ensuring effective alignment of responsibilities and accountability across all the organisations concerned.

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

DRAFT

We will use the BCF to:

Help people self-manage and Develop our Local Area Coordination offer, linking and connecting people to local assets and promote themselves as assets working in partnership with voluntary, community and long-term conditions groups.

Invest in developing personalised health and care budgets working with patients and service users and frontline professionals to empower people to make informed decisions around their care.

Implement routine patient satisfaction surveying from GP Practices to enable the capture and tracking of the experience of care.

Use Working together for change to check out the experience of citizens, patients, clinicians and practitioners across the whole system, with reference to the citizen 'I' statements

Invest in Reablement through a new joint approach to Community Independence, reducing hospital admissions and nursing and residential care costs.

Reduce Delayed Discharges through investment in services and strengthen 7 day social care provision in hospitals and reducing admissions to residential care directly from Acute settings

Integrate NHS and social care systems around the NHS Number to ensure those frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need.

Undertake a full review of the use of technology to support primary and secondary prevention, enable self-management, improve customer experience and access, and free up professional resources to focus on individuals in greatest need.

GPs will be at the centre of organising and coordinating people's care.
We will use the BCF to:

Roll out the Whole Systems Integrated Neighbour Teams Care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary team, including local Area Coordination – community connecting.

Invest in 7 day GP access in each locality and deliver on the new provision of the GMS.

Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

We will use the BCF to:

Establish a Joint Integration Team working across the local authorities and CCGs to support the implementation of integrated commissioning of health and social care.

DRAFT

Review all existing services, including services commissioned under existing section 256 agreements, to ensure they represent VFM and re-procure services where necessary to enable integrated working. This will include our current investment in VFS and low level / universal services to continue our commitment to Local Area Coordination and community connecting

Create a joint Nursing and Care Home Commissioning Team focussed on improving outcomes through transforming the quality, consistency and co-ordination of care across the nursing and care homes.

Review and support our commitment to Safeguarding – supporting changes in Care and Support Bill for the Adult Safeguarding Board to be on a statutory footing

Review Psychiatric Core 24 services to cover Lancashire Teaching Hospitals, providing holistic support for physical and mental health needs and input into the Neighbour teams.

An overview of the overall timeline is provided below:

January – March 2014:
Develop locality integration plans, which set out the scope of commissioners' plans for integrated care, including target population, desired outcomes and budgets available, as well as providers' responses.

Across the two CCGS, prepare the detailed specifications and plans for joint commissioning and provision in 2014/15 as per the priority areas outlined above.

April 2014 – March 2015
Central Lancashire-wide basis, complete detailed planning to implement concepts developed during co-design phase to achieve our objectives.

Monitor financial flows in shadow budgets to evaluate financial impact of possible models on different providers and on total cost to commissioners.

Manage the implementation and benefits tracking for the newly integrated services that are "live" and developing our next tranche of joint commissioning plans in line with local needs and the Transformation work programme.

Introduce regular customer satisfaction surveying to develop our baseline for user experience.

From April 2015
Use preparation from planning using co-designed materials and learning from implementation local schemes to implement new models of care at scale with actual budgets attached.

We are ensuring related activity will align by working in close collaboration with the other CCGs in Lancashire in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners,

DRAFT

and that we are proactively sharing learning across borough boundaries.

Our plans are aggregated into the Health Economy whole Systems Plan in order to accelerate learning and joint planning. On a Central Lancashire basis the Board provides oversight to this process, as described in the governance section below; with each locality Health & Wellbeing Board taking the lead in approving local joint commissioning plans

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The CCG objective set out how we plan to rebalance the Health Economy across both CCGS to focus on the needs of our patients. These plans need to be further developed and consultation with local authority, hospitals and other local stakeholders.
Achieving our targets will require significant investment in primary and community care and reduced acute activity, as described in our CCG plan, we will be setting out major changes in how services will be configured in our health economy over the next 3-5 years, including:

- Integrated Urgent Care system
- Integrated Primary and Community Care
- Development of local services
- Seven day services

The CCG is developing its commissioning intentions for its main NHS providers, which it will be sharing in the context of the 2014/15 commissioning round, during the final quarter of 2013/14.

The activity plans and associated contract value will be finalised in discussion with the NHS providers direct, if the CCG holds the contract locally, or through the relevant Commissioning Support Unit, i.e. for acute services. The case for any adjustments to the 2013/14 outturn position will be supported by clear and credible plans that demonstrate for providers the basis upon which activity is expected to change.

The CCG will be looking to establish contractual terms with NHS providers affected by the BCF and its other QIPP plans that help mitigate against the risk of any planned savings not materialising whilst maintaining quality and standards and the achievement of key delivery targets, for example by utilising the CQUIN component of the contract.

Thereafter, through regular and close monitoring of activity and cost in year, any material variation to the plans will be managed through the relevant and appropriate contractual terms.

DRAFT

There is a significant need to increase capacity in community and Primary care to sustain the required shifts in activity, with at least 25% further investment in reablement and rehabilitation services

We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce mortality through better access to senior doctors; improve access to GPs and other services so patients can be seen more quickly and at a time convenient to them; reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community; and ensure less time is spent in hospital by providing services in a broader range of settings.

There will need to be further investment in Primary care, as more complex and vulnerable people are supported in the community.

There will be a need to invest in a new evolving workforce, based on the cultural and practice shifts required over the next 5 – 10 years, it is too early to indicate what that may look like.

The whole system must transform and shift at the same time, which will require quick cash releases from acute contracts and re-investment in Primary and community care. However there is a risk that if the demand on acute hospital beds does not reduce as anticipated, the system will not cope and there will be significant funding and capacity gaps in the system.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

To deliver the ambition contained in our BCF, we recognise the need to develop further our strategic and operational governance arrangements. We therefore propose to look at, as part of this process, how we start to bring together management responsibilities and accountability across care and health services, for our residents and patients and as whole. We would see our future management team accountable for the commissioning of integrated care, through the Health and Wellbeing Board, to the Local Authorities and the CCGs. In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

Our current proposal is to delegate specific functions between Local Authority and CCGs in areas that facilitate delivery of the BCF. The initial areas that we wish to consider are the commissioning of step up step down care, and the commissioning of care delivered in people's homes.

Our business case for the step up step down care demonstrates that, if this were done as one team across our agencies, we would save money and improve quality. LCC have a strong track record in this area, and we are therefore looking at options for our CCGs to delegate this responsibility to the local authorities. We envisage that these joint arrangements would enable us to deliver the full benefits of reablement and intermediate

DRAFT

care services provided in people's homes, and to remove current gaps and duplication in provision.

The first step in doing this will be to pool our funding for these services, and to commission one team who will be responsible for this budget, the health and social care needs (including assessment, brokerage and in-house provision). We envisage that both the local authority teams and the CCG teams would be held to account for the delivery of these services by clinical senate and the Health and Wellbeing Board. Reviewing the Terms of Reference of our senate and Health and Wellbeing Boards, and ensuring they are in a position to provide effective governance for the new joint funding, will be a priority for the coming months.

We have an established Clinical Senate, with representatives from the Chorley & South Ribble Clinical Commissioning Group, Preston Clinical Commissioning Group, Lancashire Teaching Hospital Foundation Trust, Lancashire Care Foundation Trust and Lancashire County Council. The clinical senate is a maturing partnership, committed to collaborative working and risk sharing, through effective partnership arrangements.

Regular briefings to the Clinical Senate Cabinet and the CCG Governing body are designed to help to ensure effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities.

Throughout this process, we will ensure that the local Health and Wellbeing Boards for each CCG remain central to the development and oversight of the proposed schemes making up our Better Care Fund, with a principle of pooling as much health and care funding as is sensible to do so, and with a focus on developing our joint commissioning and outcomes frameworks to drive quality and value.

Across Central Lancashire the Clinical Senate, combining health and local authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography.

DRAFT

3. NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Within the Central Lancashire area, the County Council commissions and provides a range of adult social care services which, alongside a range of community health services in the area, making a major contribution to the high impact changes, necessary for transforming the whole system. These services have been included within the BCF and partners have agreed that they will be protected, in line with their effectiveness in delivering the agreed vision, aim and objectives of the plan.

Protecting social care services means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures.

Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole.

Where local services, health or social care, are effectively supporting the delivery of the BCF, enabling sustained shifts in the activity required, they will continue to be protected. However, where they are not, work to transform and redesign services will be undertaken jointly in light of the evidence from reviews of the services themselves, feedback from individuals and their carers, national research and best practice, alongside the JSNA and the existing commissioning plans of the partners.

By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

This is in the context of our wider ambition to shift the emphasis on wellbeing and prevention, rather than just service delivery.

Please explain how local social care services will be protected within your plans.

Local Social Care Services will be protected to be able to fully deliver the new duties and responsibilities as set out in the new Care Bill. The services being proposed for the BCF will help Social Care deliver the new duties including; Preventing needs for care and support and promoting integration of care and support with health services.

A commitment from the CCG not to see resources for social care reduced as a result of the BCF and the top slicing of Social Services spend required to create the fund. Any reduction in social care services would need to be reported back through the governance structure set out and agreed by the Local Authority before being implemented.

DRAFT

Recent transfer of funding from Health to social Care, through section 256 agreements has been utilised to maintain the existing eligibility criteria at substantial, maintain investment in crisis and rehabilitation services and increase capacity in reablement This has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation / reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Both organisations are committed to providing 7 day services to support discharge. Care management support at the hospital will be put in place to allow for 7 day discharge into intermediate care or reablement and rehabilitation services. The CCG are investigating how to provide 7 day services right across primary and community based health provision and will be utilising the extra funding available through the BCF to achieve this national condition.

The Integrated Neighbour Team Pilot has helped us to further our commitment to providing seven-day health and social care services, supporting patients being discharged and prevent unnecessary admissions at weekends by identifying high-risk patient groups and introducing rapid response services.

We have used the Joint Health and Wellbeing Strategy (JHWS) to identify the main areas where integration and joint working will improve outcomes. Our commitments will be overseen by the senate and we have the full support of our local partners as recognised in our successful seven day pioneer site application

We have committed to a principle that all services will be 7 day, unless there is an exceptional reason why they should not be included.

We are committed to developing integrated 7-day services that will be integral to delivering our high impact changes.

DRAFT

We already commission a range of services that support admission avoidance and discharge that are 7 day services. The total spend on these services will be included in one of our outlined proposals, supporting a new step up / down model and fully integrated admission avoidance and discharge team linked to wider community neighbourhood teams.

We have improved 7 day working practice by widening the referral rights to the crisis and rehabilitation services for acute case managers and community clinicians, reducing hand offs and enabling timely and safe access to services over 7 days.

Across the Health Economy as part of our joint plans we are developing a system wide capacity plan and a costed plan for 7 day services will be developed in 2014 for implementation in advance of the 2014/15 Winter period.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Yes all health and care systems will use the NHS Number

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Number to be the primary identifier across the two CCGS by April 2015.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open APIs and Open Standards. We already use Emis Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record;

To enable cross-boundary working, we will improve interfaces between systems. Further, we are exploring a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records.
By Autumn 2014 our GP practices will all be using the same IT system, providing the opportunity for our care providers to all use the same patient record; the BCF will help ensure this happens by joining up Health and Social Care data across the 2 CCGS, linked as above via the NHS number

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldicott 2.

All of this will take place within our Information Governance framework, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users or patients should be treated confidentially and respectfully
- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual
- Information that is shared for the benefit of the community should be anonymised
- An individual's right to object to the sharing of confidential information about them should be respected
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Across all our GP practices they have been risk stratifying using a predictive risk tool and producing associated care plans All 66 GP practices are participating in the risk stratification and case management Direct Enhanced Service Scheme (DES) in 2013/14. The CCG has set the participating practices a target to identify and produce care plans for 2% of their registered patients, approximately 4,000 care plans CCG-wide. However, new limitations on the sharing of patient identifiable information have impacted on the risk prediction tool and since April 2013 participating GP practices have been relying solely on clinical judgement to identify patients at risk of deterioration and requiring proactive intervention. We have a number of pilot practices within the (integrated neighbourhood care) programme pilot, whereby patients identified are referred to a community matron for a comprehensive, home-based assessment, care coordination and care planning.

Changes to the GP contract and associated DES in 2014/15 are expected to set GP practices targets for care planning. The CCG will be setting GP practices its own target of 4.15% (or 2,400) of all over 65s to be referred for community matron assessment and care planning in 14/15 and is planning to invest further in community matron capacity to support this. The CCG focus on over 65s is informed by the risk stratification work in 2013/14, where almost 500 patients have been referred for assessment, case management and care planning by the practices participating in the pilot programme

DRAFT

The community provider is reorganising its teams to operate as twelve, co-located locality teams comprising a dedicated team leader and team coordinator, community matron, district nurses, physiotherapists, occupational therapists, nurse rehabilitation assistants, healthcare assistants and physiotherapy assistants. In some localities the team will be joined by a co-located social care manager and community psychiatric nurse to support joint assessment via a single point of entry, the allocation of a lead professional based upon need and the improved coordination of care and care planning. The evaluation of the pilot is expected to lead to integrated teams across each of the 12 community localities during 2013/14.

DRAFT

4. RISKS

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

Risk	Risk rating	Mitigating Actions
Reliability of the funding year-on-year to be able to build a sustainable delivery model while both organisations have to make savings and fund not identified beyond 2015/16	Medium	A risk from NHS England that the funding is not sustained making is difficult to forward plan and putting intervention services at risk. Continue to make this position/ risk know to government
CCG/LA working relations tested in debates over which part of the system funds what part of the service – e.g. when is it a health cost, when is it a care cost etc.	Medium	Strengthening relations through regular meetings, workshops and 1:1 numbers to establish positive working relationships Move to a more mature funding position that evaluates whole system spend and moves funds flexibly according to need and where the money can achieve the best outcomes
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	Medium	An initial impact assessment of the effects of the Care Bill is being undertaken and we will continue to refine our assumptions around this as we develop our final BCF response.
That the success of the services in the BCF will not have the desired effect of moving resources out into the community and spend is not be freed up from acute care and nursing care	High	The Whole Systems transformation programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes	High	We have modelled our assumptions using a range of available data, including metrics from other. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications

DRAFT