Appendix 'C'

Lancashire Health and Wellbeing Board
28th January 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lancashire County Council**
Clinical Commissioning Groups	**<CCG West Lancashire**
	<CCG
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>** Both West Lancashire Clinical Commissioning Group (CCG) and Lancashire County Council support individuals who have experienced an acute episode in Southport and Ormskirk NHS Acute Hospital Trust. The Trust forms part of an Integrated Care Organisation (ICO). Both Southport and Formby and South Sefton CCGs and Sefton Council are partners, along with West Lancashire Borough Council. There is an ambitious vision in place around the integration agenda which is being delivered via a key programme of work, entitled; 'Care Closer to Home' This involves a cross boundary partnership and the programme aligns both commissioner and provider priorities for whole system transformation across the urgent care system. At its heart is bringing care closer to people's homes and it has been developed in partnership with a broad range of agencies, in addition to those organisations identified above.

	There are sound Governance arrangements in place, through a formal Strategic Partnership Board, which includes cross boundary partners to maintain the integrity of the programme of work. The BCF will be an accelerator to this important programme of work which has true integration at its core – that being; providing person centred co-ordinated care.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£**
2015/16	**£7.4million**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Lancashire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

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.

We have been developing our existing work plans with our partners for some time now, co–producing our approach to implementing the Care Closer to Home (CCtH) agenda, with both our community, mental health and acute providers. Along this development journey and as part of this process we have also engaged with various providers and agencies, including the local VCFS. This engagement has been undertaken by various means, including workshops and events and underpinned by robust methods of communication.

'Care Closer to Home' is a clinically led programme of work which is being implemented across the local health economy. System integration is a philosophy and a key priority for our health economy. This philosophy is firmly demonstrated by our commitment to the established integrated care organisation and integration through neighbourhood working across health and social care. This shared philosophy also formed the basis of our Pioneer bid in the summer of 2013 which was a collaborative submission between Southport and Ormskirk NHS Acute Hospital Trust and Southport & Formby CCG and involved wider stakeholders including Lancashire County Council (LCC), Lancashire Care Foundation Trust (LCFT) and West Lancashire Borough Council (WLBC), amongst others. The work from this has subsequently been taken forwarded as part of the NHSIQ transformation programme where again, we are working closely with our neighbouring colleagues and the voluntary sector, amongst others.

The ambition is for 'Care Closer to Home' to be the mechanism by which partners across all sectors will work together collaboratively to deliver system wide transformation and true integration which is at the heart of the Better Care Fund (BCF). A journey, which in conjunction with our partners and the local population, has already commenced. The objectives of the programme are to provide quality services that are safe, efficient and effective and truly bring care closer to people's homes.

Underpinning the Care Closer to Home programme of work are a number of specific work streams with key enablers which cut across the whole programme (refer to section 2: vision and schemes). The Better Care Fund (BCF) will be the vehicle to accelerate the delivery of not only the Care Closer to Home vision, but also the underpinning work streams.

Not only have we been engaging with health and social care providers as part of the process, but part of the governance framework in place which supports this work involves organisations working collaboratively on a day to day basis. The programme is supported by the Programme Management Office (PMO) functions which exist within the Trust and the respective CCGs – with the PMOs working together to ensure delivery of the work streams mentioned above.

Care Closer to Home and the BCF are aligned in terms of both vision and their ultimate destination. The outputs from recent engagement aligning the two have been incorporated into this plan.

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.

This plan should be viewed as a development journey and we have engaged with citizens, carers and expert patients along this important journey and will continue to do so as we move forward. We have held a series of workshops and engagement events for Care Closer to Home which were well attended and from which extremely positive feedback was received. An example includes:

It certainly was very thought-provoking and gave me, as a patient representative, a broader knowledge of what is out there to avoid hospital admissions, where possible, and have more care at home'

There is a comprehensive communications and engagement strategy in place for Care Closer to Home which will underpin our engagement as we move forward and assist in achieving the Care Closer to Home / BCF vision of whole system integration.

Care Closer to Home follows the principle of co-production. It is working towards the delivery of what *National Voices* tells us patients and the public want; that being person centred co-ordinated care.

Additionally, as public organisations, we also have a duty to involve through legislation and guidance. The most important of these is the Health and Social Care Act, which puts into law the involvement of service users in the planning, development and decision making process of service change, design or redesign.
NHS organisations also have a duty to consult Overview and Scrutiny Committees in the substantial development of health services in the area of the local authority, or a substantial variation in the provision of services. The CCtH communication and engagement strategy therefore aims to both encourage and enforce this level of transparency and consultation with relevant service users. All the programme work streams are advised to consider this carefully.

<u>Worth specifically noting is the Department of Health Guidance Real Involvement (page 22), which states:</u>

"Users must be involved not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided or the range of services offered. For example, users must be involved in the development of a range of options for the way community services could be provided within a PCT area, not just asked for their opinion on a model that has been developed behind closed doors by health professionals and managers".

This, in conjunction with the 'Working together for Change' approach will ensure that citizens continue to not only have their voice heard, but that it remains integral to any redesign / service improvement.

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.

Document or information title	
Programme Management toolkit Project Plan - report	
West Lancashire, Southport & Formby and South Sefton Integrated Pioneer bid	
Care Closer to Home communications and engagement strategy	
NHSIQ Transformation programme - storyboard	
Lancashire JSNA – Health Inequalities (2013)	

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?

The vision for health and social care services for the West Lancashire local community is allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, **Citizen** / patient centred, accessible and seamless services. This will be delivered by a skilled, committed, satisfied and integrated workforce, who together with the public and colleagues across the health, social care and voluntary sectors, take pride in providing quality care **and support, including local community assets**. We will achieve this by being innovative and having the vision and courage to do the right thing, building trust and co-ownership with care providers, partners and patients through effective two way communication and listening to experiences of care.

The over-arching goals we are all collaboratively working towards for 2018/19 in West Lancashire are:

- Empower patients to take control and responsibility for their own health and well-being through self-care and management programmes
- Ensure that primary care services are accessible and of high quality in order to reduce demand on hospital services
- Improve the co-ordination of care for patients living with long term conditions in order to reduce their need to urgent care services

- Ensure that health and social care services are commissioned and delivered in a collaborative way in order that as many people as possible can be cared for out of hospital and to facilitate peoples' discharge from secondary care more effectively than it is currently
- Establish services to deliver as much as possible of peoples' urgent care needs our of hospital if they do not need the expertise of hospital clinicians

All the above will be supported by mature partnership agreements and risk share arrangements that will support the delivery of high quality, safe and timely services. The Better Care Fund will serve to be an accelerator for this local ambition and vision.

These goals are consistent with the approach in a report by The Kings fund and Nuffield Trust (2012) which states that the ageing population and increase in prevalence of chronic diseases requires a whole system re-orientation towards the prevention and self-care agenda, reducing variation in primary care, co-ordinating care for those with long terms conditions and away from the emphasis on acute care provision.

In terms of outcomes, the aforementioned goals will assist in achieving the following for our local community:

- Improved access to community services
- Reduced number of admissions to secondary care for patients with Ambulatory Case Sensitive Conditions (ACSCs)
- Reduced number of patients with long terms conditions presenting to urgent care settings
- Improved response rate for community services
- Increased productivity of community services
- Reduced number of admissions to secondary care
- Improved performance against A&E targets
- Reduced length of stay and improved bed utilisation
- Reduced number of delayed transfers of care
- Reduced number of short term placements
- Reduced number of readmissions

At the centre of all of this work is the citizen experience and story, creating a compelling case for change. We know from the *National Voices* work, which aligns with TLAP's 'Making it Real' that what is important to patients and the public is person centred co-ordinated care. Our ambition as a health economy is to achieve what citizens have told us is important to them:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

The vision will be realised through effective and sustainable shifts in activity and spend across the strategic partners, with a reduction in episodes of care in acute settings through effective pro-active Primary and Community care. This will be facilitated by local neighbourhood teams that also harnesses people as their best assets through effective self-care and management. We will also see improved wellbeing and Primary prevention with an increase in life expectancy.

Through continuous and effective co-production of services and supports across the community, through the whole spectrum of needs, we will see;

- **People first, partners will have joint ownership and accountability for enabling people, families and communities to have a good life of their choice, within the resources they have.** Strategic planning and delivery will be an inclusive process, utilising the commissioning process, for a whole population, with effective utilisation of all the resources, across the community, to shift culture, behaviour, practice, spend and activity, that is sustainable now and for the future, to address the demographic needs going forward. Local Health and Wellbeing Partnerships will be the host to strategic planning forums with robust governance and risk share agreements, focussing on whole population, pre-birth to end of life.

- **Everyone has a bed – it is in their own home, People expect to receive care and support close to their home.** We will shift culture, behaviour, practice, activity and spend to ensure sustained reduction in acute admissions, length of stay, readmissions within 30 days, readmissions within 6 months and reduced episodes of end of life in acute settings, which will result in a reduction in acute hospital beds by 2018. We will see effective utilisation of community assets and universal services delivered by the VCFS as part of a wider offer to keep people stable, safe and well.

- **No person will need to make a decision about long term care and support in a hospital bed.** We will reduce admissions to residential care by 2018, by offering time and opportunity to people, post acute phase, to recover, recuperate and maximise their life opportunities through person centred reablement, planning and support, away from the acute hospital bed.

- **Discharge to Assess not Assess to Discharge** We will have fully integrated seven day services and support, across acute and community services, with flexible capacity to support people outside the acute hospital setting who need further specialist assessment and or assessment for continuing health care. People with very complex needs including Dementia will have an equal consideration of their interests and the same offer of recuperation, reablement and person centred planning in the best and least restrictive environment.

- **People will receive seamless care and support, regardless of the number of clinicians or practitioners involved in their life** Every person who requires on-going support post an acute admission or crisis in their life, will have a core personal profile that will be visible and accessible to acute and community clinicians, that will be a nucleus live document that keeps people safe and well, informs safe and effective clinical decision making and informs further specialist assessment and joint health and social care support planning.

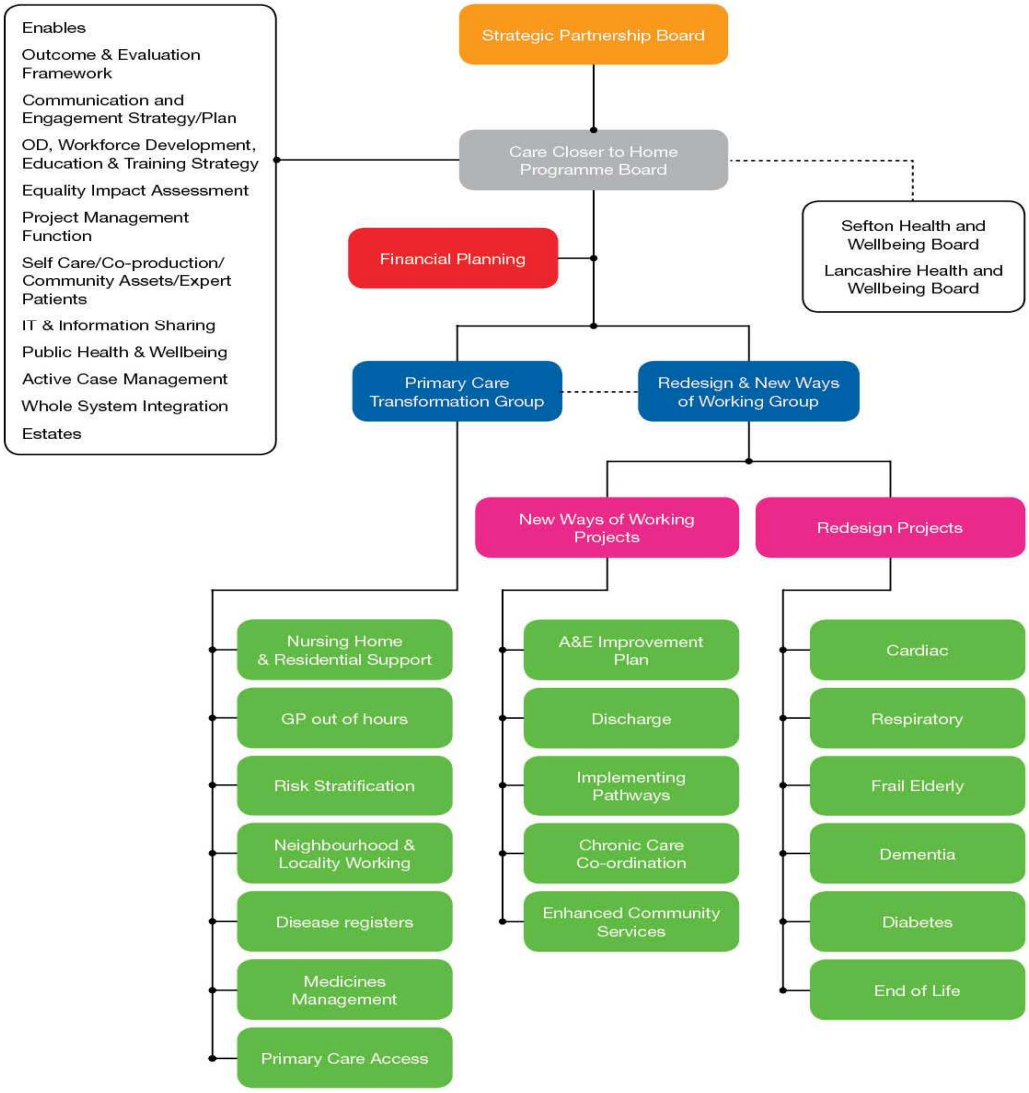
- **People will be supported to stay connected with local family and community networks and resources that keep them safe and well** Through effective local area coordination as an integral part of our neighbourhood teams model, local community assets and VCFS capacity will have a focus on keeping people safe and well, through linking and connecting people what they need, as part of their support plan. There will be an increased focus on people who are at 'tipping points' in their life, so not yet needing statutory offers, but at risk in the near future. There will be an increase in

using the core personal profile for those people identified, this will prevent and delay the demand on statutory services for both health and social care.

- **Resources, including voluntary community faith sector and community assets will be wrapped round local GP surgeries and coordinated through integrated neighbourhood team arrangements.** There will be 5 geographical cluster neighbourhood teams, fully established, wrapped round local clusters of GP surgeries, using risk stratification, integrated case management, self-care and local area coordination. The neighbourhood teams will include a wider social care offer including the VCFS and a model of local area coordination, which will support those most at risk of hospital admission and those at tipping points, with a wider focus on whole population and wellbeing. There will be effective IT infrastructure supporting the core personal profile, specialist assessment and care and support planning, across the acute and community services. There will be live and accessible capacity and demand management, with both acute and community resource capacity and utilisation live and accessible to all acute and community clinicians, 7 days 365 days a week. Here will be a multiple access point to coordinate access to the wide range of resources, with delegated authority to an agreed range of acute and community clinicians and practitioners, to avoid unnecessary hand offs. West Lancashire CCG is engaging with its membership currently, amongst others, to further develop the vision around neighbourhood teams.

- **We will pro-actively manage capacity and demand as one community of partners, utilising combined resources to ensure right support in the right place at the right time, 7 days a week, 365 days a year.** . Resources will be deployed flexibly to meet existing and predicted future demand, maintaining safe and effective levels of capacity across the community and acute services, which maintain the ambition and vision of partners. As part of our self-care work which is one of the key enablers for the CCtH programme, citizens will be enabled to manage their own health condition, as partners in care planning, to maximise independence and health outcomes

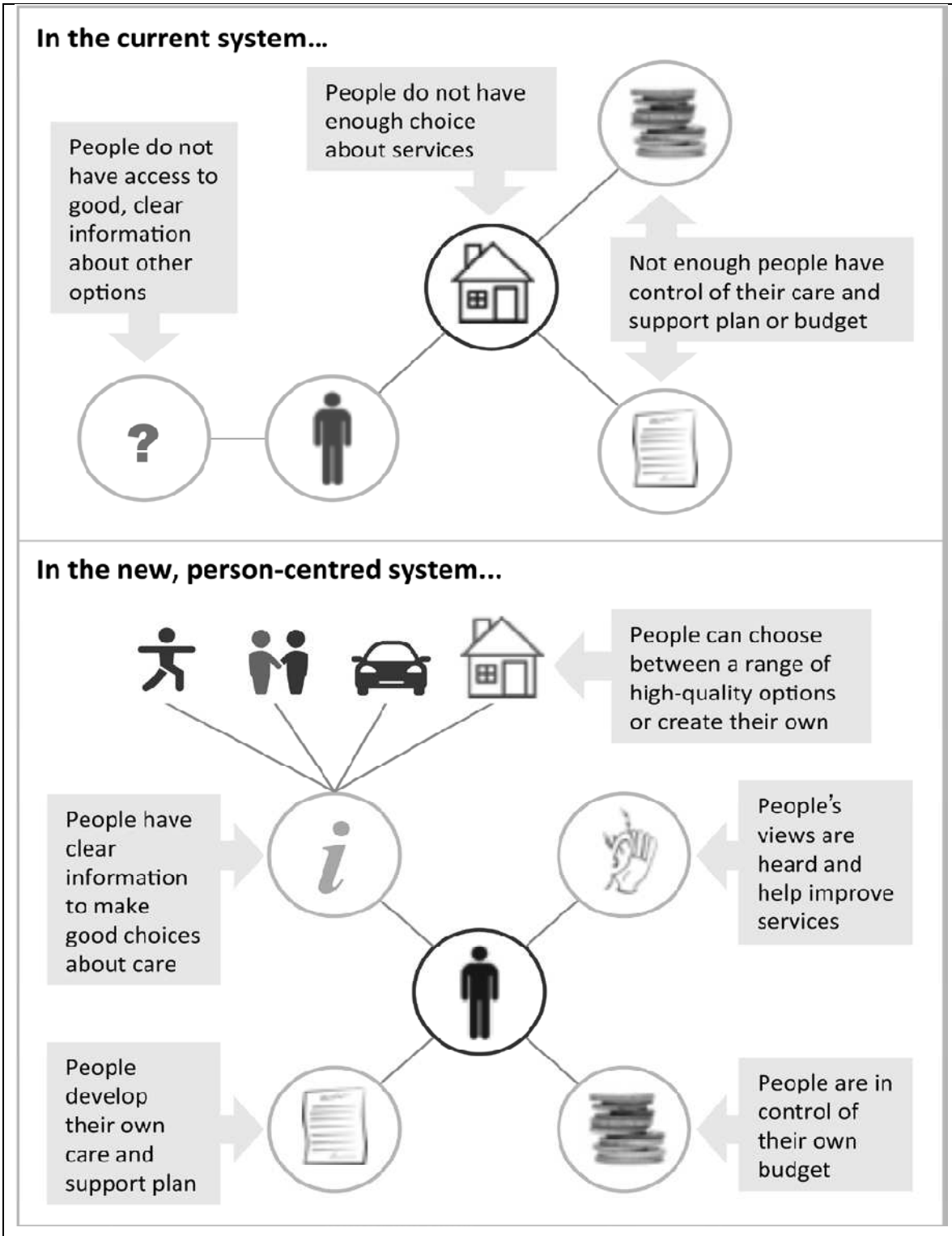
Care Closer to Home, will enable partners to achieve the transformational change required to deliver true integration via the BCF. The following outlines the work streams currently in place and key enablers, such as self-care, that will help deliver our aim and objectives and improve both patient and service user outcomes:



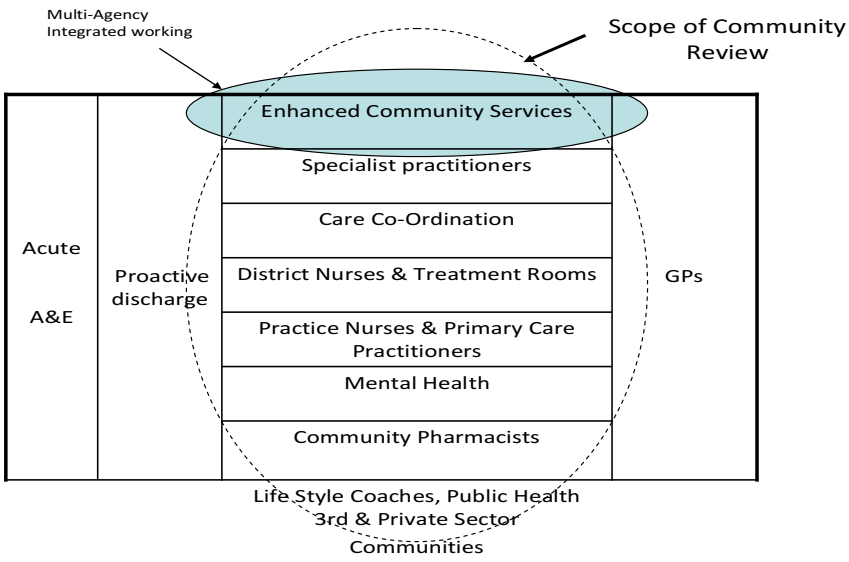
Although there is still some way to go in our collaborative journey, these work streams are already making progress towards delivery of the goals previously outlined.

The redesign projects, highlighted above, have now reached the end of phase 1 of their work. This includes the development and sign off of clinical pathways, pathways which were co-produced in conjunction with patients and the public. These pathways include heart failure, atrial fibrillation and frail elderly, to name but a few. These projects are now embarking on phase 2 of the process which is the implementation stage. This is one example of how we will work towards ensuring that the local system is transformed from its current system to one that is truly patient-centred and reflects the voice of the patient. An ambition that is reflected in the following:

Source: Dept. of Health (July 2012) 'Caring for our future: reforming care and support' (p9)



Similarly, as part of the Primary Care Transformation work stream, the Care Closer to Home Programme Board supports the development of a whole-system approach to the review of community services, recognising the need to optimise opportunities for integration. This piece of work will be a key focus from 2014/15 onwards:



Primarily this review will focus how we transform the delivery of health and care to a more person-centred system and optimise the integration of community services – services need to work in a more joined up way, eliminating duplication and fragmented delivery to provide co-ordinated responsive care, co-produced with patients.
This review, will achieve a number of objectives which are at the heart of integration and the aim of the BCF:

1. Change to a 'person-centred system' (as highlighted in the diagram on the previous page) which promotes independence, wellbeing and self-care.
2. Identify opportunities for integration and the most appropriate level of integration, recognising 'one size does not fit all' and supporting the Health and Wellbeing Board to deliver the Better Care Fund agenda. .
3. Streamline and integrate processes where appropriate, particularly referral, assessment and care planning processes.
4. Clarify the functions and purpose of each of the community elements shown above.
5. Address workforce planning issues, identifying current and future gaps in workforce capacity and skills.
6. Develop the infrastructure to support integration, particularly IT, information sharing and community facilities/estate.
7. Deliver neighbourhood working, building on the initial work undertaken, linked to GP practices and the 5 neighbourhood teams across West Lancashire
8. Align the community review to Health & Wellbeing Board integration plans and other relevant plans.

The Community Nursing Review is another example of work which is already underway to progress not only neighborhood team working, but wider integration which includes

prevention. It is envisaged that delivery of the objectives above and the work of the redesign work stream previous mentioned, will make a significant difference to patient and service user outcomes.

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?

Our aim is to create the circumstances and environment for people, families and communities, to have the best life they can within the resources they have and to truly delivery patient centred co-ordinated care.

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.

Considering the overarching vision and goals previously highlighted, we have unpacked this vision into a series of more specific aims and objectives which cross the breadth of health and social care. These are 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 West Lancashire?

- 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.

- 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**.**

- 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.

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 CCG and local authority commissioners who make up West Lancashire are committed to working together to create a marketplace and maximise all the assets including community assets, and effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

Across West Lancashire**, through our Care Closer to Home programme,** our process for achieving our vision, as set out in our 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.

- **Local health and care providers**, and associated public, private and voluntary and community sector groups, working together and 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.

Citizens will be enabled to manage their own health condition, as partners in care planning, to maximise independence and health outcomes

We will use the BCF to:

Help people self-manage, linking and connecting people to local assets and promote themselves as assets working in partnership with voluntary, community and long-term conditions groups which is consistent with the ‘Connect 4 Life’ approach

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.

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 r**educing 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:

Further progress the West Lancashire Neighbourhood Team model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary teams, including **Local Area Coordination**

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:

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**

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 Southport and Ormskirk Hospital Trust, 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 sets out the scope of commissioners' plans for integrated care, including target population, desired outcomes and budgets available, as well as providers' responses.

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

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 our neighbouring CCGs in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries.

Cross-cutting enablers: communications & engagement, workforce, Equality Analysis etc…

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.

By 2018, the following is proposed:

Reduction Hospital Emergency Activity by at least 15%

This will be achieved by delivering the aims and objectives of Care Closer to Home and re-investing acute savings (i.e. via bed reductions in emergency care) into integrated models of care in the community. The health economy will use transitional funding over two years to facilitate this and build on the current collaborative work programme.

The risk of not achieving savings is that we may not have sustainable solutions to match forecast demand, particularly in relation Frail Elderly services.

It is acknowledged that to achieve such system-wide transformation will have wider implications and these are currently being considered and potentially include:

- Workforce planning and development
- IT and estates infrastructure
- Information governance
- Rebalance of investment
- Public expectation and perceptions of change

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

As demonstrated in the CCtH governance framework (refer to section 2: vision and schemes) we have an established Strategic Partnership Board and Care Closer to Home Programme Board which oversee the delivery of the Care Closer to Home programme and is aligned to the Integration agenda. The latter includes representatives from West Lancashire Clinical Commissioning Group, Southport & Ormksirk Integrated Care Organisation (ICO), Lancashire County Council, Sefton Council and Southport & Formby Clinical Commissioning Group, amongst others. The arrangement is a maturing partnership, committed to collaborative working and risk sharing, through effective partnership arrangements.

To achieve the objectives of the care closer to home programme, the Programme Board ensures the following as it delivers its business:

- Working across boundaries to improve patient experience
- Establishing partnerships and better working relationships between all health and social care organisations in a geographical area and health community
- Agreeing and sharing goals, objectives and responsibility throughout the health and social care community
- Making sure any developments produce system-wide improvements
- Making sure delays are not caused by organisational boundaries or other non-clinical reasons

The partnership own the vision and oversee key work streams to ensure delivery of the programme's objectives.

Underpinning the monitoring of progress and outcomes is an electronic programme management tool which crosses organisational boundaries and is accessible by all organisations involved in Care Closer to Home, be them health, Local Authority or other. This tool allows users to oversee the delivery of key work streams and will provide alerts to identified persons when a task or scheme may be veering off track. It also permits users to record risks to delivery, assign owners and to record any mitigating actions. This is an innovative tool which assists with the collaborative approach to joint working which the Care Closer to Home programme and Integration agenda advocates.

There is also a strong link between the Partnership and the Lancashire wide Health and Wellbeing Board, as demonstrated in the aforementioned CCtH governance framework.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Within the West 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**,** which is consistent with the approach advocated in Call to Action: commissioning for prevention.

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

Within the 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, make 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, which is consistent with Call to Action: commissioning for prevention.

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.

West Lancashire CCG is 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.

We have used the Joint Health and Wellbeing Strategy (JHWS) to identify the main areas where integration and joint working will improve outcomes.

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.

Going forward the reshaping of step up / down will potentially require a different deployment in terms of workforce, still 7 days, but working in the new pathway, supporting a post-acute phase.

In essence we are fully committed to 7 day working and will reshape our workforce accordingly, based on the vision and ambition put forth as part of this work.

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 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 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, 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 anonmised

- 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.

Across all our GP practices they have been risk stratifying using a predictive risk tool (Aristotle) and producing associated care plans All 23 GP practices are participating in the risk stratification and case management Direct Enhanced Service Scheme (DES) in 2013/14.The practices have been working to identify patients to refer to the community matrons for a comprehensive assessment, care coordination and care planning.
. However, new limitations on the sharing of patient identifiable information have impacted on the risk prediction tool. Therefore the amount of patients identified this year has been lower than expected.

3) 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
Maintaining the integrity of the partnership, with competing financial pressures and performance indictors amongst the key partners, and a political agenda and context to change.	TBC	TBC
Existing funding tied up in a variety of contractual arrangements that may reduce the ability to recommission in a timely and effective manner	TBC	TBC
The scale of change and interdependency of work streams could be overwhelming at a time of reducing workforce capacity within the County Council	TBC	TBC
Operational capacity to maintain day to day integrity of the business, safely, whilst delivering change and new models of working	TBC	TBC
Workforce culture and development, processional boundaries and identities will be challenged	TBC	TBC
Shift in emphasis to community care, wellness and prevention will not sufficiently impact on acute hospital activity	TBC	TBC

Lack of integrated IT infrastructure to underpin the changes in culture practice and shifts in activity will drastically reduce impact.		
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