Appendix 2

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	**Wirral Borough Council**
Clinical Commissioning Groups	**NHS Wirral CCG**
Boundary Differences	**Coterminous**
Date agreed at Health and Well-Being Board:	**22/01/2014**
Date submitted:	**15/02/2014**
Minimum required value of ITF pooled budget: 2014/15	**£TBC – 256+reablement+carers+additional transfer**
2015/16	**£TBC – as above+DFG+additional transfer**
Total agreed value of pooled budget: 2014/15	**£ 256 agreement for 2014/15**
2015/16	**£ TBC for 2015/16**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Wirral CCG
By	Dr Abhi Mantgani
Position	Accountable Officer
Date	<date>

Signed on behalf of the Council	Wirral Borough Council
By	Graham Hodkinson
Position	Director of Adult Social Services
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Wirral Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Phil Davies
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

- Provider engagement with social care providers (care home, reablement, IMC and domiciliary care) has taken place over the last 9 months as part of the development of a market position statement for Wirral. Ongoing provider engagement is planned throughout 14/15. For example:
    - Intermediate care providers have been an integral part of the service redesign of the step up step down system
    - Reablement and domiciliary care providers have assisted in shaping the new service specification as part of the re-procurement process in 2013/14
- Provider engagement has taken place with the major NHS providers as part of the Vision 2018 project and regular contracting meetings throughout the year.
    - All Chief Executives of major NHS providers are members of the Vision 2018 project, along with appropriate level leaders from Wirral Borough Council

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

It has been agreed as part of the Vision 2018 programme and the better care fund project on Wirral that patient, service user and public engagement will be undertaken.

The CCG and the Council are working together to develop an engagement event on 12 February 2014 and further engagement will happen throughout March and April including through websites, social media and a virtual public group.

It is acknowledged by all partners that this process will not be completed prior to the first submission date in February 2014 but that the engagement work will be an integral part of the Vision 2018 project going forward. The feedback from this engagement process will directly feed into the priorities for 15/16 and beyond.

The JSNA provides the evidence base for the BCF plans. As part of the annual development/assurance process for the JSNA residents & relevant stakeholders are engaged via questionnaire to a.) feedback on the quality of the evidence provided & to identify gaps that need to be addressed prospectively b.) identify the key issues for Wirral residents. This engagement process over the past 2 years has resulted in older people & long term conditions being identified as the 2 key issues for the population of Wirral.

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	**Synopsis and links**
Vision 2018 document	Executive summary of the programme
Joint Strategic Needs Assessment	Joint local authority and NHS HCCG assessments of the health needs of the local population in order to improve the physical and mental health and wellbeing of the people of Wirral.
Wirral Health and Wellbeing Strategy	This document sets out the overarching Health and Wellbeing Strategy for Wirral.
Caring Together – strategy for integration on Wirral	This document sets out the plan for operational integration of primary care, community and social care services.
Market position statement	Provides key information to the market, summarising intelligence and how the Local Authority intends to strategically commission and encourage the development of high quality provision.
Draft CCG Strategic Plan	This document sets out the 2 and 5 year strategy for the CCG across 11 key programme areas, linking in to the Vision 2018 strategy.

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?

Over the next 5 years we will deliver a transformed service for the people of Wirral focusing on moving care from hospital to community based resources and supporting people in their own homes. There will be a focus on:

- Early intervention and prevention
- Health promotion
- Self-care and self help
- Encouraging self-determination and responsibility for communities and neighbourhoods
- Information, advice, signposting and where necessary redirection to appropriate services
- Developing integrated approaches across professional and organisational boundaries e.g. primary and secondary care clinicians working together in the community, assessment, meeting care needs, single gateway, seamless front door
- Facilitating a significant shift in culture and behaviours across professions and organisations

We will ensure that we:

- Improve key outcomes
- Improve health and wellbeing of individuals in our community
- Support independence
- Manage complex care and provide care closer to home
- Integrate our approach to commissioning
- Improve quality of care
- Adopt national and international best practice

If we are successful, funding for unplanned admissions to hospital, particularly for people who are 75 and over, will be reduced because people will not need to go to hospital in the same numbers as they do at the moment, and lengths of stay will be shorter. In addition we would expect a significant reduction in long and short term nursing and residential care placements with an associated reduction in expenditure. The specific workstreams we will deliver to achieve this are highlighted in section b (aims and objectives).

An illustration of what this will mean for "Mrs Smith of Wirral" is shown in diagram 1 (overleaf).

Nationally, the health and social care system is under enormous pressure. The social care system faces a complex mix of changing demography, rising need and increased public expectations. We face unprecedented challenges at a time of severe economic constraint whilst retaining and improving service quality and safety.

Earlier this year, NHS England published a landmark document: 'The NHS belongs to the people-a call to action'. This sets out the challenges and makes a case for developing bold and ambitious plans for the future.

We will not achieve these goals if we just rely on the thinking that has got us where we are today. Without radical rethinking of the way we go about change, the pressure to contain costs will only be met by cutting services, increasing waiting times or forcing overstretched staff to work even harder. We need to develop a range of interventions and engage with health and social care colleagues, people who use our services and our entire workforce to get better, faster, more cost effective outcomes for the resources we invest.

In health the pressure is best demonstrated by an increase in emergency admissions to hospital, which rose by 27 per cent in England in the period 2000-01 to 2011-12.

Councils are having to make unprecedented savings from their budgets due to reductions in funding from central Government. The NHS is also facing an unprecedented challenge in its budget from 2015/16.

1. Wirral's Population

Wirral's overall population is projected to increase by 1.4% between 2011 and 2021, from 319,863 in 2011 to 324,226 in 2021 (Table 1).

Table 1 – Percentage change in population by age group, interim 2011 to mid-2021

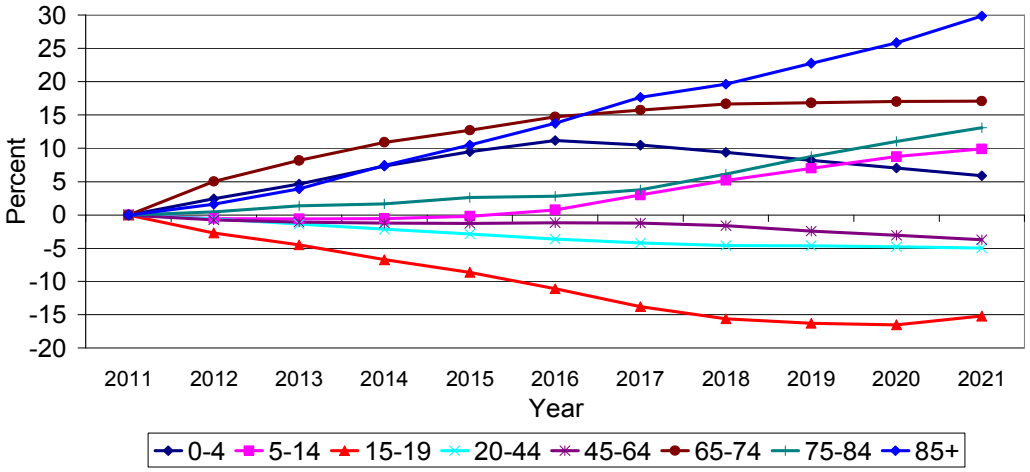
	Age group	Population				% change 2011 to 2021
		2011	2014	2018	2021	
Children	0-16	63324	64013	65797	67311	6.3
	0-4	18543	19899	20286	19628	5.9
	5-9	17772	18668	19856	21083	18.6
	10-14	18874	17776	18691	19192	1.7
	15-16	8135	7670	6964	7408	-8.9
Older People	65+	61427	65847	69655	72150	17.5
	65-74	31593	35033	36858	36993	17.1
	75-84	21374	21725	22677	24172	13.1
	85+	8460	9090	10120	10985	29.9

Source: ONS 2011 based population projections, 2012

- The older population (aged 65 years and above) are projected to increase at the fastest rate. By 2021 this population is projected to total 72,150, compared to 61,422 in 2011, an 11,000 (18%) increase.

- The population over 85 is projected to increase from 8,460 in 2011 to 10,985 in 2021, a 2,500 (29.9%) increase (Figure 1).

Figure 1 – Percentage change in population by age group, interim 2011 to mid-2021



Source: ONS 2011 based population projections, 2012

2. Long term conditions and disability

More than 100,000 people in Wirral – 30 per cent of the population – have one or more long-term condition (Department of Health 2011). This includes people with a range of conditions that can be managed but often not cured, such as diabetes, arthritis and asthma, or a number of cardiovascular diseases and mental disorders. Current projections by the Public Health Observatory in England suggest that the prevalence of diabetes, cardiovascular diseases, COPD and hypertension will increase by 10% by 2020 (Public Health Observatory, 2009). The majority of people will have more than one long term condition with 30% also experiencing a co-morbid mental health problem (Fortin et al., 2005). Currently the total cost of long term conditions is estimated to be 70% of the total NHS and social care budget and expected to increase in the near future.

The Census 2011 reported that about 36,000 (57%) people aged 65 years and over reported a long term condition or disability that limited their daily activities (Table 2). Evidence suggests that with aging of the population alone, with no alteration in the incidence or prevalence of disease or disability, there will be a 67 per cent increase in the numbers with disability over the next 20 years (Jagger et al., 2006). Numbers of the oldest old (those aged 85 years and over) with disability will have doubled and the numbers experiencing one of the key chronic diseases will have increased by over 40 per cent by 2025 (Jagger et al., 2006). The evidence about whether the aging population will live their extra years with better health is still being gathered in the UK but in other countries the evidence suggests there will be some reductions in disabilities for the 'older old' population (Crimmins, 2004).

Table 2: Long-term health problem or disability, Wirral, 2011

	Number	Per cent
Day-to-day activities limited a lot	19195	31%
Day-to-day activities limited a little	15639	26%
Day-to-day activities not limited	26132	43%
All categories	60966	100%

Source: Census 2011

Bearing in my these challenges, a Vision 2018 Group has been set up on Wirral to enable leaders from the Health and Social Care Economy to come together in partnership to address these challenges together, towards the following agreed vision:

"To ensure the residents of Wirral enjoy the best quality of life possible, being supported to make informed choices about their own care, and being assured of the highest quality services provided as close to their home as possible and providing them with a voice to effect change"

To achieve this we have committed to the following principles:

- Everything we do is to improve outcomes and the experiences of patients, service users, their carers and families.
- We will engage with the people who use our services as partners, establishing a new and equal relationship with our professional staff in co-designing and continually improving services

- We will provide person centred care that considers an individual's physical and mental health and well-being needs
- We will provide care and services focused around the individual - there is no wrong front door - promoting early intervention and prevention, encouraging people to self help where possible
- We will ensure the location of services is in or as close as possible to people's own homes, with hospital and residential care targeted at those who require that level of care
- We will ensure our workforce is fully engaged and contributes to the development of this vision and the services that are part of it
- We will maximise the opportunities to make an even greater difference to people's lives through working with other sectors e.g. housing, voluntary sector

Please see Appendix xx for the Executive Summary of the Vision 2018 Programme.

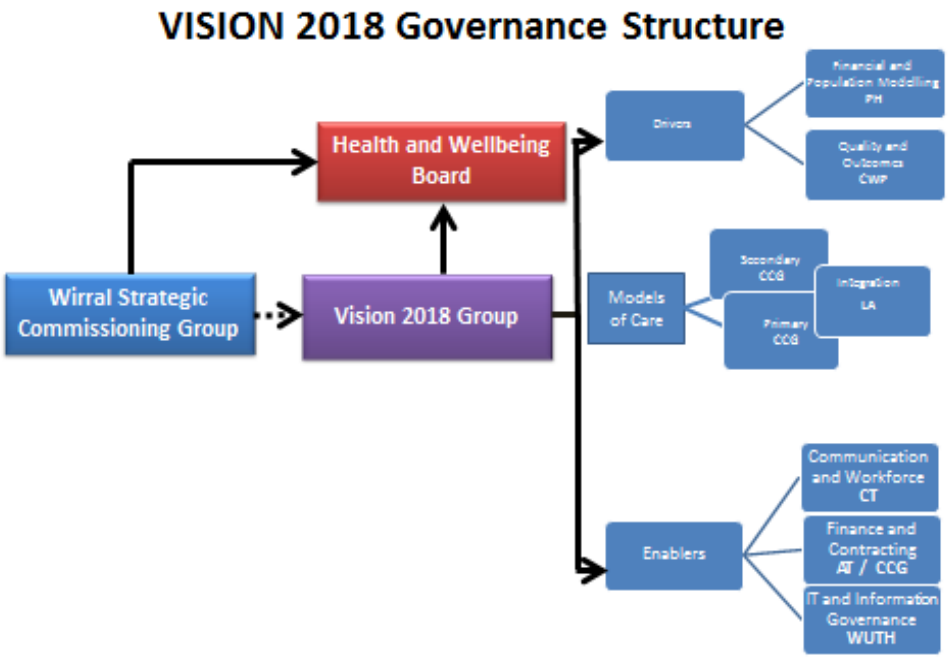
Enablers

There are 8 workstreams that have been set up under an overarching programme board to deliver against these principles:

- **Financial and population modelling**
  Coordinating business intelligence/evidence support for the Vision programme, and evaluating the impact of population/needs/delivery models on the health and social care economy
- **Outcomes and Quality**
  Agreed terms of reference and membership and the aim to ensure that any models of care which are developed encompass high level outcomes.
- **Primary Care**
  Currently developing a draft primary care strategy.
- **Secondary Care**
  Currently identifying the redesign of secondary care models of care
- **Integration**
  Currently overseeing the roll out of Integrated care coordination teams and developing proposals for the next steps for integrated systems approach.
- **Communications and Workforce**
  Currently developing a communications timeline for engagement with staff and public to co-design the strategy
- **Information Technology and Information Governance**
  Currently developing a health-economy wide Informatics Strategy to enable sharing of information in the support of integrated care.
- **Finance and Contracting**
  Currently informing contract negotiations, developing financial plans and modelling assumptions.

These workstreams will define and oversee delivery of a different model of integrated care across health and social care in terms of commissioning and front line services over the next 5 years.

Please see Appendix xx for NHS England Governance and Assurance Framework agreement outlining requirements for the Better Care Fund Submission.



In addition to this overarching Vision 2018 structure a Wirral Joint Strategic Commissioning Group is in place to oversee progress of the Better Care Fund Programme and will act as a bridge between the operational group and the Health and Wellbeing Board.

Diagram 1

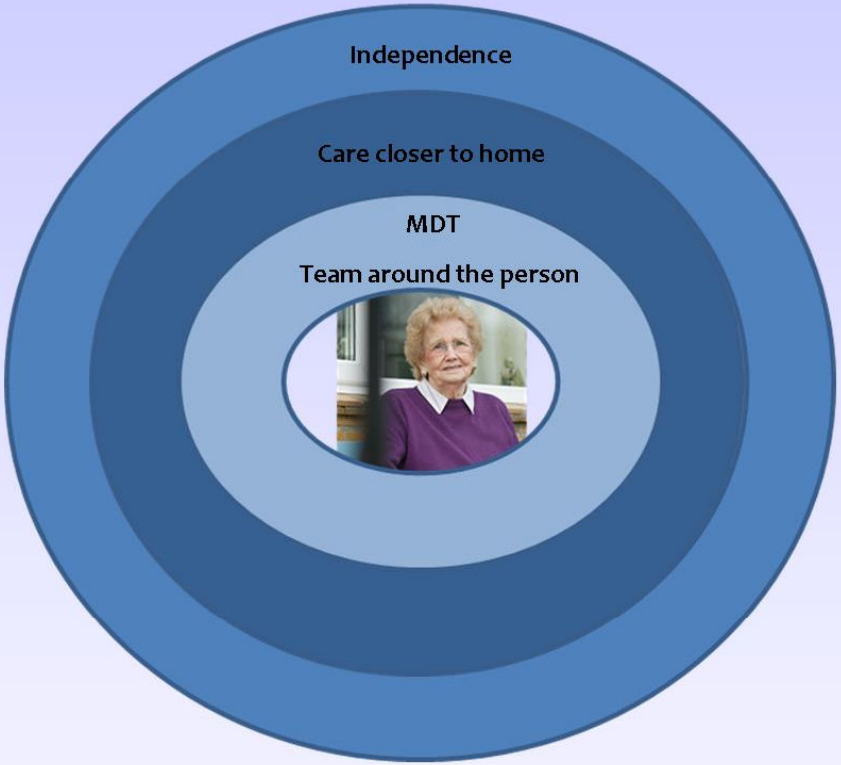
Wirral Caring together for Mrs Smith

Who is Mrs Smith

Mrs Smith is 80 years old. She lives on the Wirral, her family live down south. She is getting frailer and she has Diabetes and COPD; she is a lifelong smoker. Her neighbours help when they can, but she is fearful she will lose her independence.

Her Current Journey

- She falls and is taken to A&E.
- She is then admitted to AAU.
- She is transferred to DME ward; although medically fit OT assessment indicates package of care.
- Package not available for 1 and a half weeks.
- A rapid access bed is arranged.
- Mrs Smith's condition exacerbates-she is now on insulin, her COPD requires further treatment.
- She is at risk of falling again.
- Mrs Smith moves to short term residential care. Her family like the care home.
- Mrs Smith stays at the care home.



Future Journey

- Integrated teams available in the community
- Core team of health and social care professionals
- Single Assessment
- Key worker
- Responsive service
- Hospital admission avoided

Self Care

- Social networking
- Lifestyle choices
- Goal setting
- Online/community offline
- Connects to support services

Risk Stratification

- Identify those at risk of hospital or care home admission
- Identify complexity of need
- Care plan in place
- Stream to integrated teams where needed

NHS Wirral Clinical Commissioning Group
Wirral University Teaching Hospital NHS NHS Foundation Trust
cwp Cheshire and Wirral Partnership NHS NHS Foundation Trust
WIRRAL
Wirral Community NHS NHS Trust

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 aims and objectives for our integrated system are to bring together all of the public agencies that provide health and social care support, especially for older people, to better co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting. We will deliver this through developing "integrated care coordination teams".

Through movement of care to the community and supporting self care, signposting and early intervention we will reduce demand on downstream services such as acute care and long term social care. We will also use risk stratification to target integrated support for patients who are potential high users of health and social care services.

We believe this transformation will also require the input of a range of health and social care providers as well the greater involvement of the community and voluntary sectors. There are numerous opportunities to improve current service provision as part of this programme of work. To support the achievement of the outcomes we will need to focus effort on significant behavioural and cultural change across organisations. This will have a direct impact on demand management, for example by reducing duplication and improving customer outcomes.

This will require a different way of working from our service providers and will require us to develop an infrastructure that will allow both the voluntary and community sectors to play a greater role of supporting people more effectively in their communities. This will be through providing:

- Seamless and timely response from integrated teams and other appropriate services
- Single gateway to services
- Streamlined pathway
- Rapid assessment and support
- Coordinated care plans with lead professional
- Housing support
- Develop neighbourhood based support
- Encouraging self care and self help

We will measure the agreed outcomes (both BCF and locally agreed) through a jointly developed performance reporting system which feeds into a monthly strategic joint commissioning group. **See Appendix xx for details of Local Scorecard.**

In addition we will measure our success against the 7 national outcomes as set out in Everyone Counts:

- Securing additional years of life for the people of England with treatable mental and physical health conditions
- Improving the health related quality of life for 15+ million with one or more LTC including mental health Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people having a positive experience of hospital care
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

In terms of **health gain** to the population the interventions that we put in place will be supported by an overarching evaluation framework which will examine both qualitative and quantitative factors e.g. to determine cost benefit, QALY (quality adjusted life years) gain. This will facilitate the on-going &prospective prioritisation of initiatives to ensure we maximise improvements in outcomes, quality and value for money.

Fundamentally, we believe that the Better Care Fund should be used for genuine transformation of the health and social care system in Wirral, not to plug a gap in the social care or health budgets brought about by increasing demand and reducing budgets.

This transformation is not just about reducing admissions to hospital, but rather about changing the whole system so that it is focused on supporting people wherever possible with person-centred and professionally-led primary / community / social care, with the goal of living as independently as possible. A key part of this will be to ensure that access and response times of all services meet the needs of the population and that capacity meets demand across the range of services. This aligns with the principles set out by Government, NHS England and LGA, is consistent with the priorities set out in Wirral's Joint Strategic Needs Assessment, NHS Wirral CCG's Strategic Plan and the Council's Corporate Plan and Commissioning Intentions.

We already have a programme of work which is working towards:

- Development of Integrated Care Coordination Teams (ICCTs)
- Focusing on 7 day care provision across primary and social care
- 7 day admission prevention
- 7 day discharge facilitation across all services
- More effective joint commissioning of key services
- Developing more effective community interventions such as falls response and prevention services, assistive technology, community equipment, appropriate mental health and dementia interventions
- Redesign of existing services
- Supporting reduction of capacity in acute care

These will all require a much closer level of integration between primary health (GPs), community health (e.g. district nursing, physiotherapy) and social care (support to live independently), so that these services can identify, support and intervene much earlier to prevent a crisis occurring or someone feeling they are unable to access the support they need. Information technology will play a key role in facilitating new ways of working.

A prioritisation process is currently being developed jointly between Wirral Council and Wirral CCG. This will aim to use system dynamic modelling to evaluate the impact of initiatives (old & new) to determine which ones will have the biggest impact on the 6 national outcome priorities. This work will be supported by a comprehensive performance management framework which span operational (service managers) and strategic decision makers (e.g. Health & Wellbeing members).

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

The key success factors for delivery are:

- Improved outcomes for the people of Wirral, including positive experiences of care
- Implementation of integrated health and social care teams in the community
- Reduced demand on acute services
- 7 day access to a range of health and social care services
- Demand management through self care, signposting and utilisation of the third sector
- Information and IT systems shared across professionals and organisations

Our Health and Wellbeing Strategy outlines 3 key priority areas:

- Mental Health
- Older People
- Alcohol

Early intervention and prevention is a key theme across all these areas. In addition there is a commitment to joint commissioning and integrated delivery of services wherever this will improve outcomes for the people of Wirral.

These priorities directly align with the Better Care Fund priority areas in both 2014/15 and 2015/16. In addition they also align with the CCG strategic priorities in Unplanned Care (including Older People and Alcohol), Adult Mental Health Services and Dementia.

The Health and Wellbeing Board, supported by the Joint Strategic Commissioning Group will ensure that activities to deliver across all the priority areas are aligned.

The planned changes across health and social care commissioning have been developed based on the 5 national priority areas (excluding the joint sign off):

- Protection of social care services
- 7 day working
- Data sharing and IT
- Joint assessment and care planning (including accountable professional)
- Acute sector impact

A number of schemes within each category are already underway, some planned for 2014/15 and significant redesign will occur in 2014/15 to prepare for schemes in 2015/16. We will continue to develop and improve the following schemes as examples:

- Self help, information advice and support
- Self care
- Early intervention and prevention (falls, community equipment, early assessment)
- Integrated discharge team redesign
- Integrated care coordination teams
- Step up / step down provision
- Care of the elderly services in the community
- Assistive technology / telehealth
- Whole system model of care for adults with Learning Disabilities
- Mental health outreach and an integrated approach to dementia care
- Enabling and supporting the development of a stronger role for primary care services at the heart of integrated care
- Integrated safeguarding and quality assurance
- Integrated commissioning, shared vision, plans and budget across key areas

This includes a range of services, currently commissioned separately, which will be jointly commissioned during 2014/15 and through this the economy will ensure value for money. Our priority focus will be to ensure appropriate investment in a range of community services and to see a reduction in demand on acute care and long term residential/nursing placements.

In addition we will aim to invest new schemes, particularly to support 7 day working across health and social care and information technology.

We are working with public health colleagues to retain a focus on early intervention and prevention and to ensure that a range of requirements are delivered through existing investments, for example supporting self care, alcohol services and falls prevention.

This plan has been supported by the evidence base from the JSNA and will link in with both CCG and Council commissioning plans for 2014/15 and 2015/16.

On Wirral it has been agreed that in addition to the national outcomes, there will be one additional locally agreed outcome, plus a range of other metrics that will be monitored to ensure delivery across all schemes. Success will be measured on the basis of reduction in activity in acute care, reduction in long stay residential and nursing care home placements and the delivery of a responsive range of quality community services across health and social care.

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 overall impact on the acute sector is described in the CCG 5 year Strategic Plan (2014-19) in **Appendix xx.** This outlines how acute care is intended to change over this period and includes significant movement of care from a hospital setting to a community setting and a concurrent reduction in the size and the cost of the acute hospital.

The economy will need to reduce demand on secondary care in order to make this possible, with a specific target of a reduction of 15% in emergency admissions over 2 years. This equates to a £9.3 million efficiency and a total reduction in emergency admissions of 8200 per year (22 per day). This target is extremely challenging to achieve. It should also be noted that a 20% reduction in planned care demand is required over the same period.

As part of the BCF plan for 14/15 and 15/16 there will be investment in community 7 day provision across health and social care which will deliver some of the system efficiencies required in 15/16. In addition there are a number of schemes proposed for joint commissioning (particularly where services are commissioned separately at present) which will deliver system efficiencies in 15/16. There will also need to be areas where health and social care have agreed continuing funding from previous years agreements. Some of the efficiencies required in 15/16 and beyond will need to be delivered through a direct reduction in the value of the provider contracts (acute trust, community, mental health, GPs and social care providers). This will need to be discussed as part of the 14/15 and 15/16 contract negotiations.

In addition the Better Care Fund should also supporting the achievement of:

- Reduction in A&E attendances
- Reduction in need for emergency bed days
- Reduction in length of stay
- Reduction in readmissions
- Reduction in the conversion rate from A&E attendance to non-elective admission

Given the challenge that the 15% target represents it is vital that the development of risk management and governance is agreed between Wirral CCG and Wirral Council.

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

The primary body to oversee the governance of this process will be the Wirral Health and Wellbeing Board, however this is supported by a joint commissioning group where monthly finance, performance and outcome reports will be discussed. In addition there

are specific governance arrangements being agreed between all partners to support the Vision 2018 programme. Budget implications and performance actions will reported to the CCG Governing Body and Council Cabinet.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

We will ensure that any service user whose support needs are currently met by social care will continue to be met under the current arrangements (provided they are eligible), in a time of growing demand and budgetary pressures. Maintaining eligibility criteria is one aspect, however, we will also focus upon developing new forms of joined up care and community services which help ensure individuals remain healthy, well and independent, wherever possible enabled to stay within their own homes. We will focus upon protecting and enhancing the quality of care and working collaboratively to promote early interventions and self management wherever possible. A key focus of the services that we commission will be to ensure quality of care and with an associated reduction in safeguarding referrals, alerts and concerns.

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

Current funding has been used to enable the LA to sustain the current level of eligibility and to provide timely assessments, care management and review and commissioned services to those with critical or substantial unmet needs and signposting those who are non FACS eligible. The Council has funded demographic growth for both older people and learning disability services and delivered contractual increases where appropriate. This will need to be sustained, if not increased, in order to deliver 7 day services and meet the additional requirements of the care bill.

This does not mean that services will remain the same, for example, a short term intensive recovery programme (reablement) may mean that someone learns to live more independently and as a result their needs for formal support would be reduced and any social care package might be reduced appropriately.

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

This would aim to achieve the national requirements for 24/7 day admission avoidance and discharge as a priority, where appropriate.

It has been agreed that 7 day working (8am to 8pm) developments will focus on the following:

- Social care 7 day working with a priority focus on Integrated Discharge Team, care arranging team & step up step down multi-disciplinary team.

- Primary care 7 day working

- Full access to community services 7 days (e.g. dom care/reablement/IMC/community equipment etc)

It is clear that while 7 day working is also currently being addressed in secondary care services (acute, mental health), the focus of national guidance is to prioritise any investment in primary, community and social care outside the hospital to drive transformation and redesign across all settings. The key outcome will be to reduce demand in acute services.

Work is underway to redesign pathways to ensure timely assessments and safe transfers. Assessment of additional capacity is underway. A costed plan for the 7 day services will be developed in 2014 for implementation in advance of the 14/15 winter pressure period, running in parallel with a range of interventions to avoid admissions and promote early intervention and prevention.

c) Data sharing

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

The NHS number is not currently being used as the primary identifier for correspondence across all health and social care services. The Information Technology workstream of the Integration Programme in Wirral will ensure that the NHS number will be used for all health and social care correspondence and integrated working through the implementation of new systems which ensure a single view of key information on patients and service users for health and social care professionals to support integrated working.

The IT workstream of integration board is working to link systems together across providers (System One, Liquid Logic, Cerner, including primary care systems). The aim is to link all provider systems (including social care). This could be done using existing capital funding in addition to any BCF investment.

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

We are committed to ensuring that the NHS number is the primary identifier for correspondence and will ensure that this is in place 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)

There is a significant commitment and a Privacy Impact assessment has been completed and signed off by Governance lead. All of our clinical systems are NHS Interoperability Toolkit compliant. The adoption of open standards, including API's is central to the ambition to create a single data warehouse that underpins the Wirral vision of Integration.

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 Caldicott2.

Yes, all organisations are required to be level 2 IG toolkit compliant. Data sharing and Information Governance, agreed between Caldecott officers is well advanced. There are compliance IG meetings held regularly.
We are committed to ensuring:

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

Wirral Council is currently tendering for additional/specialist Information Governance support to focus on the IG Toolkit and data sharing agreements.

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.

The Wirral Economy has an integration board which was being directed by a Chief Executive Steering Group chaired by the CCG Chief Officer and is now part of the Vision 2018 governance structure. The board was originally established to support the Department of Health's Long Term Conditions Programme on Wirral which aimed to implement the 3 core areas of the programme, integrated teams, risk stratification and self care support. The board membership has included both the CCG and Social Services and engaged all major providers (acute trust, community trust and the mental health trust). As a result of this work the Wirral Economy is advanced in implementing integrated teams and risk stratification and has also commissioned an online self care support service (Puffell).

Integrated Care Coordination teams will be active across Wirral by end of March 2014. People identified as high risk of admission (risk stratification or other) will be allocated a coordinator of care who will be their lead professional. Joint documentation has been developed as part of referral process, assessment and plan of care to include review. The appropriate accountable professional may be different according to needs for example social worker, community nurse, CPN, therapist.

The Risk Stratification process has been developed in Wirral. This is a risk stratification algorithms model that predicts the risk of emergency admission for all registered patients that will allow Wirral patients to be risk stratified to show likelihood of admission. The data extraction to identify the proportion of the adult population at high risk will be completed by the end of February 2014, and once permission has been gained from those patients in accordance with the information sharing protocols that we have put in place, the relevant information will be shared with the Integrated teams who will identify a care co-ordinator, and jointly develop an integrated care plan for each of these patients.

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**
As the reduction in funding from the CCG budget will not be offset by the redesign work / possible efficiencies	High	Prioritisation of initiatives to offset loss of budget; robust monthly performance monitoring and management with appropriate escalation and governance.
As there are cuts to the DASS budget the BCF transfer will not offset the impact	High	Prioritisation of initiatives to offset loss of budget; robust monthly performance monitoring and management with appropriate escalation and governance.
If the reduction in demand on the acute trust is not delivered and if the internal pathways in the acute trust are not adequately redesigned the cost will need to be met by an economy wide risk share	High	A stepped approach to the redesign over 5 years (no dramatic reduction in capacity) and a transitional approach via contracting. Ensuring that a whole system performance management process (both operational and strategic) is in place. An approach to demand reduction including self management and raising public awareness of changes. Early identification of issues and escalation into the Vision 2018 board will be critical. Monthly exception reporting will be developed.

Shifting of resources to fund new joint interventions and schemes will destabilise current service providers particularly in the acute sector	High	Plans will be based on the Vision 2018 strategy currently under discussion, linking with the 5 year strategic plan There is a commitment across the health and social care economy to work together on a collaborative approach to redesign, integrated working and risk sharing. Consideration will be given to transitional support to providers.
The impact 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 in 15/16 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	Wirral Council to undertake a detailed impact assessment of the effects of the care bill once requirements are fully known.
There is a risk that a change in the cultures and behaviours of front line staff and organisations (across all partner organisations) is not delivered (which is required to support the whole system redesign required).	High	Vision 2018 programme will address this via one of the workstreams
Failing to achieve BCF outcomes and additional locally agreed outcomes will impact significantly on system flow and financial balance.	High	Robust performance monitoring and management against agreed trajectories for improvement, including residential/nursing placements and acute demand. Commitment to joint commissioning in all appropriate areas.

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	2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. We have undertaken a capacity and demand analysis for key parts of the system (e.g. step up step down care) and will continue to build on this throughout 2014/15.
Operational pressures and capacity will restrict the ability of our workforce to deliver.	High	Consideration of the need for double running / transitional capacity while service redesigns are implemented.
Failure to deliver the BCF outcomes could impact upon quality of patient care and service provision.	High	Monitoring of key additional outcomes for quality of care to be integral to performance reporting to allow mitigation of any issues highlighted.