Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

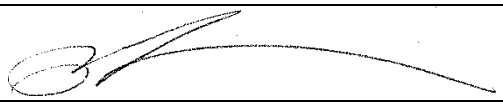
a) Summary of Plan

Local Authority	**Wirral Borough Council**
Clinical Commissioning Groups	**NHS Wirral CCG**
Boundary Differences	**Coterminous**
Date agreed at Health and Well-Being Board:	**25/03/2014**
Date submitted:	**04/04/2014**
Minimum required value of BCF pooled budget: 2014/15	**£10,759,824**
2015/16	**£28,009,000**
Total agreed value of pooled budget: 2014/15	**£15,635,780**
2015/16	**£33,368,039**

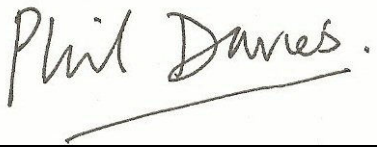
b) Authorisation and signoff

Signed on behalf of the Wirral Clinical Commissioning Group	
By	Jon Develing
Position	Interim Accountable Officer
Date	17th September 2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Graham Hodkinson, Wirral Borough Council
Position	Director of Adult Social Services
Date	17th September 2014

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr Phil Davies, Chair, Wirral Health and Wellbeing Board and Leader of Wirral Council
Date	17th September 2014

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) 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. http://info.wirral.nhs.uk/ourjsna/wirral2009-10/
Wirral Health and Wellbeing Strategy	This document sets out the overarching Health and Wellbeing Strategy for Wirral.

Vision 2018 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.
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.
Wirral Homelessness Strategy 2013-18	This document set out Wirral Councils strategy to responding to and preventing homelessness
Thematic Analysis of Engagement Data for Vision 2018	This document sets out of the thematic analysis of data from the public engagement session and stakeholder workshop data: collected 12th and 13th February 2014, undertaken by the Centre for Public Health at John Moores University.
Wirral Better Care Fund Public and Partner September version (Exec Summary)	This document is our executive summary of our Better Care Fund Programme
Scheme impact admissions bed days final	Summary of modelling work supporting delivery of schemes detailed in Annex 1
Vision 2018 Narrative for BCF	Wirral's 5 year Vision
Vision 2018 BCF years 1 and 2 scheme status	Project plan and timelines for BCF years 1 and 2

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

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. It is crucial that all organisations, both commissioners and providers work collaboratively to meet the challenges ahead to achieve the ambitious outcomes required.

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 2.7% between 2014 and 2030, from 320,800 in 2014 to 329,600 in 2030.

Table 1 – Percentage change in population by age group, 2014 to 2030

	Age group	Projected Population					% Change 2014 to 2030
		2014	2015	2020	2025	2030	
Children	0-18	67,600	67,500	69,100	70,100	68,900	1.9%
Working Age Adults	18-24	24,500	24,200	21,400	20,700	22,600	-7.8%
	25-44	74,700	74,400	74,400	75,200	73,700	-1.3%
	45-64	87,900	88,100	87,200	82,900	78,000	-11.3%
	Total 18-64	**187,100**	**186,700**	**183,000**	**178,800**	**174,300**	**-6.8%**
Older People	65-74	35,300	35,800	37,700	37,600	41,100	16.4%
	75-84	21,700	21,900	23,800	28,300	30,200	39.2%

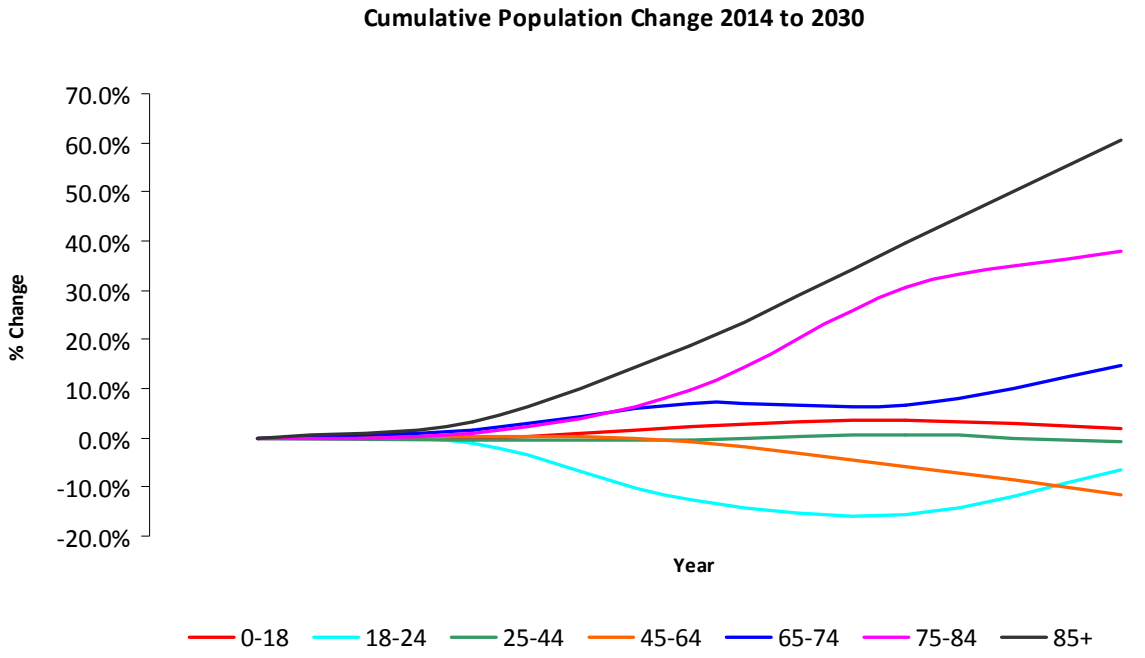
	85+	9,100	9,400	10,800	12,700	15,100	65.9%
	Total 65+	**66,100**	**67,100**	**72,300**	**78,600**	**86,400**	**30.7%**
Total		**320,800**	**321,300**	**324,400**	**327,500**	**329,600**	**2.7%**

Source: ONS 2012 based population projections, 2014

The older population (aged 65 years and above) are projected to increase at the fastest rate. By 2030 this population is projected to total 86,400, compared to 66,100 in 2014, an increase of 20,300 (31%).

The population over 85 is projected to increase from 9,100 in 2014 to 15,100 in 2030, an increase of 6,000 (66.0%) increase.

Figure 1 – Percentage change in population by age group, 2014 to 2030



Source: ONS 2012 based population projections, 2014

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, 2014

	Age group	Projected Population					% Change 2014 to 2030
		2014	2015	2020	2025	2030	
Older People - Limited a little	65-74	7,736	7,845	8,262	8,240	9,007	16.4%
	75-84	6,212	6,269	6,813	8,101	8,645	39.2%
	85+	2,200	2,273	2,611	3,046	3,626	64.8%
Older People - Limited a lot	65-74	7,615	7,723	8,133	8,111	8,866	16.4%
	75-84	6,919	6,982	7,588	9,023	9,629	39.2%
	85+	3,953	4,083	4,691	5,473	6,515	64.8%
	Total 65+	**16,148**	**16,387**	**17,686**	**19,387**	**21,278**	**31.8%**

Source: www.poppi.org.uk / www.pansi.org.uk

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.

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, and the objectives of the homelessness review of reducing admissions for complex homeless clients with dual diagnosis.

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.

Bearing in mind 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".

To achieve this we commit to the following principles:

- Our strategy will promote good health and seek to reduce health inequalities.
- Everything we do is aimed at improving outcomes and the experiences of the population of Wirral, and of the people who use our services, their families and carers.
- 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 promote early intervention and prevention, supporting people to self-help and supporting the development of strong communities.
- We will provide person centred care that considers an individual's physical and mental health and well-being needs, and that supports them to be the best they can.
- We will provide care and services focused around the individual, ensuring access to appropriate services at the first point of contact.
- We will ensure that the way health and care is provided delivers high quality services which are safe, accessible and sustainable for our future patients and communities.
- 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 whose needs cannot be met in a community setting.
- We will ensure our workforce is fully engaged and contributes to the development of this vision and the services that are part of it, and changes appropriately to reflect these developments.
- We will maximise the opportunities to make an even greater difference to peoples lives through working with other sectors e.g. housing, voluntary sector.

Vision 2018 is being led by Wirral Clinical Commissioning Group, in partnership with Wirral Council, Wirral Community NHS Trust, Wirral University Teaching Hospital and Cheshire and Wirral Partnership NHS Foundation Trust, with the help of many other third sector and voluntary organisations including patient and public representation. A Vision 2018 Strategic Leadership Group meets monthly to set the high level aims and objectives. 12 workstreams (whose members are from all the partner organisations) along with an 'Engagement of people' group have been established to further develop and carry out the plans.

Vision 2018 will transform GP, primary care, community health, hospital and social care services, so that:

- Community based health services will be available 7 days a week including access to GPs, community nurses, social workers and other community health and social care professionals
- More hospital services will be available in the community, with consultant led teams,

meaning fewer trips to outpatients and shorter stays in hospital

- For people with ongoing needs –both children and adults - health and social care professionals will work together to ensure joined up services, involving people in planning their own care and looking after their own wellbeing: one assessment, one care plan, one key coordinator
- Specialist in-patient hospital care will be available for those that need it both in an emergency and, for planned treatment, with waiting times and admission dates increasingly tailored to individuals needs
- People will be supported to look after themselves and stay healthy. They will know how best to access care - using the right service, at the right time, in the right place.

The following strategic outcomes have been agreed for Vision 2018:

1. We deliver the right care in the right place at the right time. First time & every time.
2. We deliver an improved health & wellbeing experience to all patients, service users and carers, in all health, community and social care settings
3. We reduce the frequency and necessity for emergency admissions and for care in hospital, residential and nursing home settings
4. We enable more people to access effective services closer to home
5. We improve health & social care outcomes in early years to improve school readiness
6. We enable more people to live independently at home for longer
7. We improve the health and social care related quality of life for people with more than one long term condition, physiological and/or psychological
8. We increase collaboration and effective joint working between health and social care partners
9. We improve the satisfaction levels for our workforce colleagues across all health, community and social care settings
10. We improve the end of life experience for individuals and their carers.
11. We are better able to prevent ill health and diagnose conditions quickly thereby reducing the burden on treatment facilities
12. We enable people to live longer, healthier lives
13. We reduce the unit cost of health & social care while maintaining balance of quality and value
14. We ensure equal and equitable access to clinically appropriate services for everyone on the Wirral

b) What difference will this make to patient and service user outcomes?

Over the next 5 years the BCF 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 4 priority areas:

- Early intervention and prevention
- Keeping people in their local communities

- Step Up Step Down Services
- Mental Health including drug and alcohol services

Each of these areas are part of the Vision 2018 Programme areas (Unplanned Care, Long Term Conditions, Planned Care) and will also contribute to delivering the Vision 2018 Strategic Outcomes.

The **key success factors** for delivery are:

- Improved visibility and availability of self care and self management support
- Quick and practical access to the technology and the adaptations that people need.
- Improve independence and wellbeing so that people can live in their own homes and communities for longer.
- Crises prevented and need for long-term support reduced.
- Increased reassurance for carers
- Improved access to health and social care providing a positive and integrated experience of care
- Increased independence, health and wellbeing and coordinated planning of care
- More people get back home after hospital rather than entering long-term care
- Better support for people with dementia to live well at home
- Improved accessibility to help, support and advice in people's local communities

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

Diagram 1

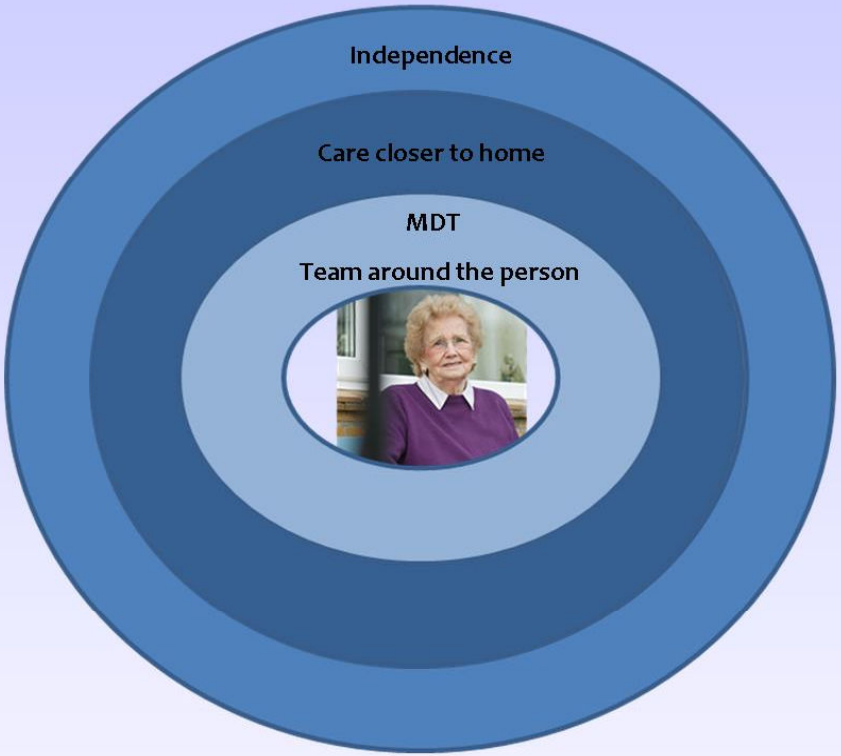
Wirral Caring together for Mrs Smith

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

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

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

We believe this transformation will also require the input of a range of health, social care and housing 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.

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)
- Investing in health and social care services accessible 7 days a week, with a focus on hospital admission avoidance
- 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 to effectively target resources to deliver key outcomes, re-commissioning where appropriate
- 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 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, many of which are being developed to offer a 7 day response:

- Self help, information advice and support
- Self care
- Early intervention and prevention (falls, community equipment, early assessment)
- Assistive technology / telehealth
- Integrated discharge team redesign
- Integrated care coordination teams
- Step up / step down provision
- Care of the elderly services in the community
- Whole system model of care for adults with Learning Disabilities
- Mental health outreach and an integrated approach to dementia 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 2015/16 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 in 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.

Significant service redesign is taking place in year 2014/15 in order to scale up in readiness for 2015/16.

Vision 2018 will continue to develop programmes of work up to 2018/19 to achieve the transformational changes required to meet the strategic outcomes.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Focusing on the case for change for integrated teams, there is significant local, national and international evidence that integrated working delivers improved outcomes, patient/carer

experience and the best value for the total invested resource.

National and international evidence is set out in the BCF toolkit and highlights three key areas where integration delivers the biggest impact:

- Multidisciplinary Teams (evidence suggests hospitalisation reduced by 15-30%)
- Care coordination (evidence suggests hospitalisation reduced by 37%)
- Individualised care plans (evidence suggests hospitalisation reduced by 23%)

Local evidence from the implementation of integrated mental health teams has shown that inpatient bed base can be significantly reduced through integration and a focus on keeping people in their own homes.

Further work will be ongoing to utilise population level risk stratification analysis and segmentation (available from October 2014) in order to underpin the case for targeting the BCF resources in the more effective areas.

Engagement with staff across organisations, patients and the public has told us that they would like services to work in an integrated way, for example:

- Patient Engagement Officers from the Hospital, Community, LD & MH Trusts and the Council spoke to people who use services / patients about their experience of joined up working across health and social care between September and October 2013. The central message from patients was that they placed a high value on their Social Workers, Nurses and Therapists but were frustrated by the lack of integration, demonstrated by gaps in handover between professions and between the hospital and the community.

- Between October 2013 and March 2014 Community Nurses, Therapists and Social Work staff were engaged in a roll out of integrated teams and their views were collected on the level of integration, and how integration can improve care for patients in practice. The central message from professionals was that they wanted to work more closely together and could see the benefits to their patients of doing so, but that the systems, organisational and funding boundaries prevented them from integrating as much as they would like to.

- There have been several independent reports examining whether patients in Arrowe Park Hospital require admission there. The most recent, in July 2014 was commissioned by Wirral CCG asking Utilisation Management to undertake a Point Prevalence Review of non-elective (NEL) Medical and Trauma and Orthopaedic (T&O) specialty inpatients at Arrowe Park Hospital. The primary purpose was to identify people who do not require 'acute' hospital level care. This concluded that 54% were deemed not to require an acute hospital bed at the point of review.

- From October 2013 MDT Co-ordinators have been convening care planning meetings for community nurses, social workers and therapists to develop care plans with the aim of preventing unplanned admissions to hospital.

- The model being adopted is one of a single care co-ordinator, and a single care plan, supported by risk stratified data to ensure the patients most at risk of unplanned admission

are prioritised.

- In April 2014 health and social care organisations agreed on a shared local footprint of four areas shaped around the local constituencies so that services could be co-ordinated and delivered as close to people's homes as possible, and local teams of health and social care professionals were developed to implement this model.

- The Voluntary, Community and Faith sector in Wirral was engaged between April and July 2014 in contributing to a new, integrated way of working, and they began to attend the Integrated Care Co-ordination meetings.

- From April 2014 reablement and domiciliary care contracts were implemented on the same local footprint as the integrated teams, supporting a model of providing care in people's homes. The co-ordinators of these services are part of the integrated team.

- The Cheshire and Merseyside CSU developed a risk stratification model which collected secondary care data to establish the level of risk of unplanned admission, but accessing the data for providers of care was problematic, and the model did not allow the layering of primary health, social care, mental health and learning disabilities data to give the full picture professionals need to develop effective alternative plans to avoid admission.

- The risk stratification model the CCG had proposed was re-started in July 2014 and will be in place by the end of September 2014. This will support all of the above requirements and ensure not only that the right patients are prioritised, but that clinicians and professionals have the information they require to intervene more effectively.

- Information Sharing agreements have been developed between the Hospital and Community services to support the regular sharing of information about patients who are frequently being admitted to hospital, and patients receive information about the integrated teams, and with their permission are referred to the teams so that care plans are co-ordinated, in partnership with the patient to prevent further unplanned re-admissions.

- System changes that are being made but have not yet been fully implemented include:
    - A Single Integrated Community Gateway / number for people to call with their health and social care needs
    - A single, accountable manager for each of the Integrated teams to have oversight of the performance of the integrated teams, systems and services in the community, to be appointed
    - Alignment of community nursing and adult social care structures to support integrated teams
    - Pooling resources for the Integrated Teams to access to commission support to support people in their own homes.

- Integrated care plans and delivering the lead professional role is a key priority. We are developing a performance framework which examines the number and length of unplanned admissions in the year before the care plans were created and compares this with their experience after the care plan was created. Early indicators demonstrate an increased involvement by community and primary care clinicians in taking cases to the integrated

teams, and earlier decision making on agreeing interventions, reflecting a more joined up and less protracted customer journey for our patients.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

A project plan is being finalised which sets out the milestones for delivery of schemes for Better Care Fund, other urgent care initiatives and detailed milestones for the incremental delivery of integrated care coordination teams. This outline plan covers the next 6 months, with further programme plans being delivered beyond this through the Vision 2018 Programme Management Office. These projects are a combination of review of current service provision, targeted investment in new services and focusing resource on projects and programmes that deliver the required outcomes.

b) Please articulate the overarching governance arrangements for integrated care locally

The integrated care governance structures are within the Vision 2018 model detailed in following section 4 (c)

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track.

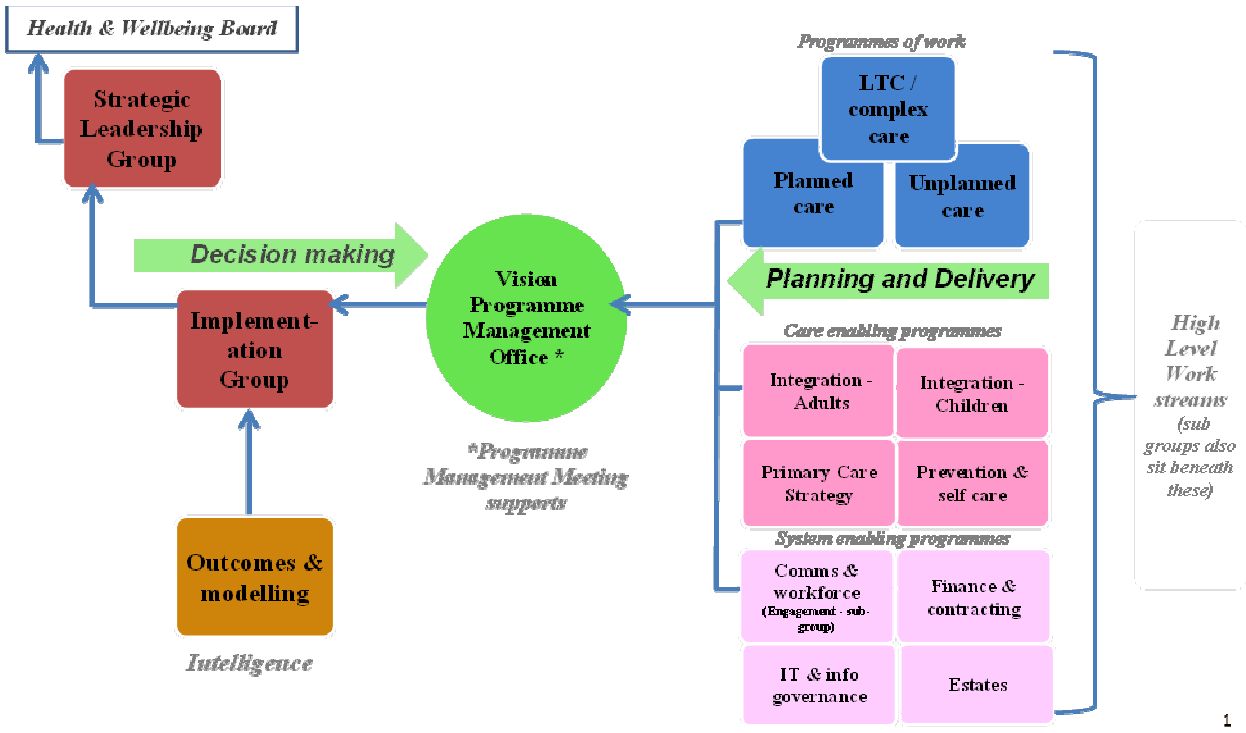
The primary body to oversee the governance of this process will be the Wirral Health and Wellbeing Board, however this is supported by a Joint Strategic Commissioning Group where monthly finance, performance and outcome reports will be discussed. In addition there are specific governance arrangements 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.

A section 75 agreement will be in place for 2015/16 with a section 256 in place for 2014/15. A joint finance / contracting post will be appointed in 2014/15 to support the development of this agreement.

An operational delivery group is being established to oversee the implementation of schemes and delivery of required outcomes. There will be senor representation from all partners on this group. This will report to the Joint Strategic Commissioning Group and provide monthly updates with performance oversight at the Health and Wellbeing Board.

A key priority will be to progress opportunities for joint commissioning arrangements which drive

efficiencies and make best use of commissioning capacity across the CCG and Adult Social Services / Public Health.



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

d) List of planned BCF schemes.

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	See modelling summary and Appendix 1 for details attached below Scheme Impact Admissions Bed Days

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
The reduction in funding from the CCG budget will not be offset by the redesign work / possible efficiencies	3	5	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	3	5	High	Prioritisation of initiatives to offset loss of budget; robust monthly performance monitoring and management with appropriate escalation and governance.
If the reduction in non-elective 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	4	5	High	A stepped approach to the redesign over 3 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.
The acute hospital activity (and associated cost reductions to commissioners) do not materialise because non-elective admissions continue to rise due to demography and acuity of patient need	3	5	15	Modelling of the predicted rise due to demographic and acuity of patient need to quantify the impact these factors could have on non-elective admissions Create workstreams within the Vision 2018 strategy to provide alternative pathways of care
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers particularly in the acute sector	4	5	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 Act currently in consultation 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.	4	5	High	Wirral Council to undertaking a detailed impact assessment of the effects of the Care Act once requirements are fully known.
The required cultural change in the workforce to enable greater integrated working does not take place due to an unwillingness or inability to work across organisations	4	5	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.	4	3	Medium	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	4	4	High	2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.

home activity by 2015/16 impacting the overall funding available to support core services and future schemes.				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 (including recruitment and retention issues) will restrict the ability of our workforce to deliver	5	5	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	3	3	Medium	Monitoring of key additional outcomes for quality of care to be integral to performance reporting to allow mitigation of any issues highlighted.
There is a risk that other service redesign initiatives (Vision 2018/unplanned care) create confusion for staff groups	3	3	Medium	Map all service redesign intiatives across the health and social care economy and ensure Vision 2018 communications strategy takes this into account
If we do not manage the communication carefully there is a risk stakeholders do not know what is happening, when it is happening and how it will work.	3	3	Medium	Refresh stakeholder analysis and include in communications strategy
The BCF programme is ambitious and contains 25 projects. There is a risk that this represents too many initiatives for the CCG/Council/providers to focus on at once,	3	3	Medium	Undertake an assessment of capacity and capability across all schemes, considering whether this is sufficient for delivery

hampering delivery				Create a realistic resourcing plan to deliver each project and be prepared to flex as appropriate

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place.

i) Between commissioners across health and social care and ii) between providers and commissioners.

Risk share principles

The Joint Strategic Commissioning Group has discussed and agreed the following principles in relation to financial contingency and risk share:

- Wirral Council and Wirral CCG agree that the plan needs to take into account the performance related element of the £35 million
- Wirral Council and Wirral CCG have agreed a financial contingency (risk share) in the event that outcomes are not met
- Wirral Council and Wirral CCG will take financial responsibility for any under performance against agreed outcomes on an 18% - 82% basis (2014/15 and 2015/16). This spilt is based on the proportion of total committed resource from each party
- Wirral Council and Wirral CCG agree to take responsibility for any over performance on PBR expenditure in 2015/16 on an 18% - 82% basis (2014/15 and 2015/16).
- Wirral Council and Wirral CCG agree to take responsibility for any over performance on the community care budget in 2015/16 on an 18% - 82% basis (2014/15 and 2015/16).
- Wirral Council and Wirral CCG agree that any surplus from an under performance is shared equally on an 18% - 82% basis (2014/15 and 2015/16) and reinvested on priority areas based on outcomes required.
- Wirral Council and Wirral CCG agree that some existing expenditure for both organisations will be badged against the BCF
- Wirral Council and Wirral CCG need to demonstrate agreement of the BCF plan with major providers

- Wirral Council and Wirral CCG agree that the preparatory contractual and financial work for agreement of a pooled budget in 2015/16 needs to take place throughout 2014/15, although this may now be covered by a national section 75 agreement (awaiting further guidance)

- Wirral Council and Wirral CCG agree that continued performance and financial modelling, service redesign, cultural shift and progress towards goals in 2015/16 is required throughout 2014/15

- Wirral Council and Wirral CCG agree that the BCF work programme should be overseen by the Vision 2018 Programme Management Office and report through the Programme Managers Group and the Joint Strategic Commissioning Group

- Wirral Council and Wirral CCG need to decide which organisation holds the pooled budget and an integrated finance / contracting post will be appointed to support this work in early 2014/15

- Wirral Council and Wirral CCG have agreed outcomes and proposed baselines for 2015/16 – 2017/18 with a stretch ambition for non-elective admission reduction.

- Wirral Council and Wirral CCG need to assess the likelihood of meeting financial and outcome targets in 2015/16 and plan accordingly

- Wirral Council and Wirral CCG are will continue to model the impact of the loss of resource to acute, community and social care services in conjunction with providers

Contingency Arrangements

The Joint Strategic Commissioning Group has agreed a contingency of 5% in 2015/16 to mitigate risk, support transition and double running, which equates to £1,781,900 from the total pool in 2015/16.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The BCF plans include the implementation of integrated teams across health and social care and

additional initiatives are designed to be complimentary and supportive of the overarching vision to integrate services.

In addition the BCF plans also reflect and are supportive of the operational and capacity plans of the Wirral System Resilience Group for winter 2014/15; and also on Wirral the urgent care action plan which has been put in place as a result of a period of challenge in relation to the A&E 4 hour wait target. This action plan reflects the findings of the "perfect day" initiative, the Greater Manchester Commissioning Support Unit Utilisation Management and Point Prevalence Reviews.

The BCF plan also aligns closely with priorities of the Wirral Health and Wellbeing Strategy, the Wirral Council Transformation Programme, the Department of Adult Social Services Departmental Plan and the Families and Wellbeing Directorates Improvement Plan.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The Vision 2018 Programme Managers group has met to consider plan alignment across 2 year operational and 5 year strategic plans, particularly in the context of CCG and Wirral University Teaching Hospital NHS FT. It was acknowledged that in the April submissions there was some misalignment across plans.

A potential solution going forward was for the Vision 2018 Senior Leaders Group to agree a "level of ambition" for non-elective admission reduction over 2-5 years and therefore not amend plans for 2014/15. It was also agreed that a recommendation would be made that all organisations make a commitment to agree a single plan across individual organisations plans for 2015/16 onwards although further work is required for this to be agreed.

As part of the Vision 2018 discussions it has now been agreed with senior representatives of key partners a level of ambition which would achieve a minimum 15% reduction in non-elective admissions over a 3 year period from 2015/16- 2017/18.

In addition to our formally stated target of 15%, we would also want to set an overall stretch ambition of 23% by 31st March 2018, recognising recent increases in non-elective admissions. This will be achieved by developing transformational programmes of work through Vision 2018. This will be an iterative process following clinical and public engagement, building on the work that has been done to date.

We are jointly considering the impact of the implementation of the Care Act and how this may impact on providers and service demand across health and social care.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

NHS Wirral CCG is currently not expressing an interest in primary care co-commissioning due to the current assurance status of “assured with support” from NHS England. The BCF plan has been discussed with primary care leads in the CCG.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending).

In Wirral, all partners recognise the increasing pressure on Adult Social care budgets, as a result of the demographic pressures and increasing complexity of conditions people are living with. The continued reduction in Council funding impacts upon Health and Social care budgets, the gap between available money and spending pressure threatens the future viability of a range of Council 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). 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. We expect to see the numbers of people being supported with a range of lower level interventions to increase, if we are successful in diverting people from Acute and complex care services. As such we will need to invest in these services.

Key outcomes for customers include:

- Reduction in the number of people moving to long term residential care
- Increase in the number of people in receipt of assistive technology
- Increase in successful reablement
- Increase in the numbers of people supported at home with domiciliary support.
- Carers feeling less isolated and better informed
- Increase in the number of people with a Personal Budget
- Better access to advice, information and support
- Increase in the number of people supported to self manage.

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.

Our intention is to ensure we have an integrated approach to commissioning; CCG, Adult and Children's Social Care, Public health & housing.
Our partnership approach to develop and deliver services in Wirral determines that protecting social care services also means protection of our partners provision.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care.

Current funding has been used to enable the LA to sustain the current level of eligibility and to provide timely assessments and care management capacity. Redesign of our pathways and capability and capacity focuses upon earlier interventions, to avoid crisis and ongoing high levels of support. We will utilise funding to support people to improve their health and wellbeing. Our aim is to promote and maintain independence. Our schemes focus upon a range of community provision, which can be accessed 7 days a week and has a rapid response element to avoid people being admitted unnecessarily.

We will ensure that we maintain services to those with critical or substantial unmet needs, signposting those who are non FACS eligible. The Council has funded demographic growth for both older people and learning disability services and invested in community capacity 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 Act.

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.

A significant proportion of the total pooled investment in 2014/15 is allocated to protecting and extending social care to 7 day a week provision. This includes additional social work capacity, care arranging team, domiciliary care, reablement, mobile nights, assistive technology, services for carers (including short stay respite services), community equipment and extra care housing. This continues and is enhanced with additional investments in 2015/16 (for example in the step up step down service).

The Care Act will bring new duties for Adult Services in regard to the provision of assessments, advice and information. Part of the BCF will be utilised to meet the requirements of these new duties, including:

a. Setting national eligibility criteria
b. Implementing statutory Safeguarding Adults boards
c. New duties for Self funders
d. Duties to assess carers.

Local schemes support investment in domiciliary services, reablement, mobile night services, carer services, respite provision and Intermediate care. They also support investment to expand to provide a 7 day service.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties)

Wirral's proportion of the £135m for the implementation of the new Care Act duties in 2015/16 is £976k, this is the amount identified. The amount against protection of social care is £4.396 million (this does not include new investment in jointly commissioned services or social care elements of existing jointly commissioned services).

In addition, we can confirm that the Wirral Council element of £976K for the implementation of the Care Act is allocated and ring fenced within the BCF proposal.

The table below provides a breakdown of funding for the protection of adult social care services

Area of Funding	Total Funding 2014/15	Total Funding 2015/16
Short Term beds	£2,750,000	£2,330,000
Community Based Services	£1,443,000	£1,254,000
Protection of Front Line Staff	£203,000	£812,000
Total Funding Requirement	**£4,396,000**	**£4,396,000**

Whilst permanent admissions to residential and nursing care beds are on a downward trend there remains a need for short term beds to enable further assessment to take place in non-acute settings. Forecast activity indicates a total of 45,600 bed nights will be commissioned during 2014/15 costing a total of £2.75m, with an anticipated 15% reduction for 2015/16.

Approximately 47% of all commissioned short term beds support hospital discharges; activity over the past 12 months and forecast activity indicates that 60% of these people will require an ongoing commissioned package of care costing a total of £ 1.44m, with an anticipated 15% reduction for 2015/16.

During these times of austerity the ability to maintain the current volume of front line staff proves a challenge. Total budget saving during 2014/15 for Wirral Council are £36.3m of which £11.8m are attributable to Adult Social Care. Of the overall savings the Council has to save £9.4m from employee costs. To achieve this Adult Social Services has to reduce its staffing costs by £1.4m and £812k of this is attributable to front line staff. This is a full year saving and the part year effect (3 months) is £203k.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Whilst the reforms set out in the Act are welcomed, the new responsibilities present significant challenges and risks as well as opportunities for the Council. They consist of financial risks, the scale and pace of the implementation and additional demand through new carers and assessment responsibilities. This means that that the implementation will be highly sensitive and dynamic. In order for the Council to successfully implement these reforms to the timescale set by the Government, health and social care partners will need to be closely involved in planning and delivery of the new statutory duties.

Key Priority Areas include:

Workforce

There will be significant workforce implications resulting from the reforms. Staff within adult social care services will need to be provided with training and advice once the required changes in working practices are more clearly understood. The reforms may require staff to adopt new models of care delivery to help manage the demand of increased activity levels but also deliver preventative and personalised approaches to care arrangements. As a result, the workforce planning and in particular, the wider development of a joint workforce such as integrated health and social care teams will need to be adapted to ensure partners are cognisant and compliant with the Act's requirements. This will require Human Resources support in relation to Terms and Conditions, retraining (culture and capability) and restructuring.

Advice and Information

The Care Act confirms that wellbeing is now the unifying purpose around which adult social care is organised. In the immediate term, a communication strategy will be required for the wider public, service users and their Carers, key health and social care stakeholders to understand the reforms and what it means for them. The Council will have a duty to provide advice and information to help people navigate the care system regardless of whether people meet the eligibility criteria including those people who have means to fund their own care. Advice and Information is considered to be a priority area and Corporate Directorates will need to be actively involved with Adult Social Care in planning for this change.

Consultation and Communication

An initial Consultation, Engagement and Communication Plan will need to be developed. Key stakeholders identified and meetings arranged as a preliminary consultation to a full impact assessment plan. The full impact assessment plan will need to be finalised following publication of detailed secondary guidance and regulations in October 2014.

Legal

There are significant legal implications for the Council resulting from the consolidation of adult social care law which dates back to the National Assistance Act (1948). Legal Services officers will need to work closely with Adult Social Care staff. In particular, they will be closely involved in a legal impact assessment of the final secondary guidance and regulations published in October

Implementation Planning

There is a National Programme in place, co-led between the DCLG and the LGA with ADASS involvement. There is also a regional programme, led by ADASS North West Branch, with a lead officer and sub groups. The Council is working with and contributing to these work groups and is utilising financial modelling tools developed by Surrey and Lincolnshire County Councils.

In order to gain a detailed understanding of the changes and the implications for the Council, a programme of work is being developed to consider in detail the implications of the Act and to scope and plan the implementation of the required changes. A 'Care Act Programme Board' is being established with work streams identified against key areas of work. This work will also enable the Council to identify future resource requirements arising from implementation of the new responsibilities.

The key issues in relation to underpinning the changes required by the Care Act will be:

- Maintenance of day to day services
- Maximising opportunities for integration with Health Partners wherever this delivers better outcomes for service users/carers and value for money
- Working closely with relevant Council Directorates to understand and manage wider implications of the Care Act across the Council
- Ongoing implementation of the Council's budget strategy 2014 to 2017 and the requirement to deliver further savings
- A need in all areas to update policies, procedures and practice in order to ensure that resources are maximised and work as efficiently as possible, reducing duplication and confusion.

Substantive work streams are to be set up, each with Terms of Reference, an action plan and risk register. The work streams are:

- Information Advice and Guidance
- Finance, Deferred Payments and Charging
- Assessment, Eligibility and Transitions
- Commissioning
- Safeguarding.

The Enabling sub-groups underpinning each of the work streams are:

- Communication and Customer Engagement
- Policy Group
- Carers
- Workforce Development
- ICT Change
- Legal Perspectives.

There are also a number of other actions to determine the implications of the Act that will need to be addressed through Task and Finish Groups. These include:

- The development of a guidance document or care management manual which sets out clearly the way in which the Council is implementing the Care Act. This will include specific guidance which will be developed by each of the work streams. This manual should be reviewed by Legal Services, once complete, to ensure the Council is compliant with the Care Act. It will need to be reviewed, following any legal challenge to the Act and at least annually to ensure ongoing compliance
- Provider Services/Quality of Services – while not a focus of the Act, there are implications for both in-house provider services, Contract Compliance Officers, Contracts Team and Performance and Quality Services. The impact of the Duty of Candour, ratings, service quality profiles to be assessed and actions agreed
- Carers – this is the change with the potential to have the largest financial and resource implications. To ensure that the strands that relate to carers – assessment, eligibility, support planning, charging – are developed consistently across the work streams, a workshop or task and finish group will be established to scope the actions required and task out to the work streams for delivery.

The implementation process results in significant changes to Council Policy – both in terms of

amendment to existing and new policy. Consideration will need to be given to the way in which these changes can be managed efficiently in respect of the Council's decision making and approval processes, including consultation with Members, and Cabinet timetables.

Regular reports will be presented to the Executive Member for Childrens and Adults Services, Health and Wellbeing Board, Chief Executives Strategic Group, the Cabinet and the relevant Scrutiny Committees.

The Care Act and Better Care Fund are inextricably linked. Key outcomes across health and social care include:

Information and advice:

- Enhancing systems to ensure that a duty to secure the provision of information and advice on care and support for adults and support for carers, and increased involvement from third and independent sector
    - Wirral intends to work in partnership with the current organisations that provide information services. Significant investment and focus will be necessary to scale up to the requirements of the Care Act.

Eligibility and Assessment:

- A review and consultation of Wirral criteria to ensure that they are at a national standard
    - The act gives local authorities a duty to carry out a needs assessment and must be provided to all people who appear to need care and support. This includes carers. The assessment must focus upon needs and the outcomes they want to achieve. The person must be supported to fully participate, which may involve an advocate. When not deemed eligible for support, the person must be informed in detail and in writing why this is the case in a format appropriate. Our plans include a robust workforce development plan and additional social worker, occupational therapists and non qualified assessors will be needed. Additional advocacy and carers support will also be required.

Carers Support:

- Implementing the extension of responsibilities towards carers ensuring that carers will have a right to an assessment and maintaining their health and wellbeing
    - As above additional capacity is currently being modelled to support the increased need for carers assessments. Carers support is a key consideration in our prioritisation of schemes.

Personalised Care and Support Planning:

- Implementing the responsibility to provide a care and support plan (or a support plan in the case of a carer)
    - Embedding the legal entitlement to a personal budget. The person can ask for this as a direct payment. Wirral has a commission in the third sector, aimed at providing advice and support to manage direct payments. Wirral is considering the additional capacity and investment required to support the envisaged uptake.

v) Please specify the level of resource that will be dedicated to carer-specific support

The amount of funded dedicated to carer-specific support is identified in the table below.

Targeted Support	Volume	Total £
Older People with Dementia – Day Care	42 places	£70,000
Early Onset Dementia – Day Activities	46 places	£70,000
Carers Practical Support		£90,000
Carers Grants	1,500 carers	£170,000
Sitting Service	500 carers	£300,000
Early Intervention & Prevention: • Advice & Information • Carers Emergency Scheme • Counselling • Training		£65,000
Total Investment through BCF		£765,000
Short Term Bed Capacity (Residential & Nursing including EMI)	24 beds	£560,000
Total Investment in Carer Services		£1,325,000

The Vision for Carers in Wirral:

"Carers in Wirral will feel supported in their caring role, feel valued within their communities and recognised by professionals for their valuable contribution"

The focus for Wirral Council, the Clinical Commissioning Groups and all our partner agencies will be to embrace the vision and build into planning processes the following:

- Developing information and services for Carers
- The Carers role and development
- Carer involvement and empowerment

The vision for Carers in Wirral will be achieved by an improvement in recognising and identifying Carers across all agencies; Staff and volunteers will have an awareness and understanding of people who provide unpaid care for others.

- Working towards Carers being able to access services within their communities
- Improving the support networks for Carers, signposting them to the available support services and encouraging the development of Carer support networks so that they can continue with their caring role
- Continuing to encourage GP's and other front line staff to identify Carers who can benefit from health checks and utilise preventative techniques such as the Carers Emergency Contact Card
- Building stronger links to education and training to support Carers, ensuring they feel supported to undertake training or education to develop new skills thereby enabling them to continue to work
- We will promote the rights of working Carers
- Supporting Carers to maintain a life outside their caring role

- ❖ Promoting community services that are accessible to all people.

Agencies recognising and valuing the Carers expertise in the care of the person; staff will have an appreciation of the expertise of the Carers and their understanding of the needs of the person they care for:

- ❖ Adopting the Joint Memorandum of Understanding: supporting agencies in the 'whole family approach', where the needs of the Carer, cared for and the wider family are considered when providing support
- ❖ Identify young people under the age of 18 years who are providing inappropriate care for an adult
- ❖ Ensuring that there is an improved diversity of Carers involved in the design and delivery of services
- ❖ Working closely with all agencies to ensure that services are open and accessible to all Carers. The Carers Partnership Board will review its membership to ensure that Carer representation reflects the diverse range of Carers from different ethnic communities, disability groups and to other Carers who are disadvantaged because of their caring role, in line with the Equality Act 2010.

The new Carers Health and Wellbeing Service is for all adult Carers providing care for another adult but with an emphasis on Targeted Support for Carers across the following groups:

- ❖ Older people with dementia
- ❖ People with early on-set dementia
- ❖ Older Carers of people with learning disabilities
- ❖ Working with organisations that support Carers of hard to reach groups e.g. people in BME communities & Drugs and alcohol
- ❖ Transitional Young Carers (Young Adult Carers) and Parent Carers.

Wirral has a Carers Strategy 2014-2017:
http://www.wirral.gov.uk/search/Carers%20strategy

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Wirral Council continues to face major budget cuts at a time of increasing demand for services and increased complexity.

By the end of 2017 the Council's grant funding will have been reduced by around 57%. Despite already agreeing savings of more than £100 million since 2013 the Council has to reduce its spending by a further £70 million before 2018. On top of this, there are £57 million of cuts which have already been agreed and are in the process of being implemented during the next two years.

Adult Social Services is required to achieve savings in excess of £11 million in the current financial year. The allocation of savings across the Council for 2015/16 has not, at this stage, been determined and the Council has recently launched a public consultation to enable staff, residents, community groups and partner organisations to have a say on a number of budget

saving options.

As part of the budget savings already agreed for the current year the Council has to save £9.4m from employee costs. To achieve this every Council Department has been asked to deliver a 10% reduction in staffing costs. The financial impact of a 10% reduction in staffing for Adult Social Services is £1.4m. Of the £1.4m, £812k is attributable to front line staff. In addition to the 10% reduction there is a further Council saving of £1.5m from a reduction of posts at Senior Management level. The Department is trying to protect front line staff in order to maintain existing service levels and support the implementation of new duties set out in the Care Act.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends.

Currently a number of key services operate on a Monday to Friday, 9am to 5pm basis, This proposal would aim to achieve the national requirements for 24/7 admission avoidance and discharge as a priority. Through investment from the Better Care Fund, key services will move towards a 7 day a week model.

It has been agreed that 7 day working (8am to 8pm) developments in 2014/15 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.

- Full access to community services 7 days (e.g. domiciliary care/reablement/ intermediate care/community equipment)

In 2015/16 the following areas will be the priority, with plans for full implementation being worked up during 2014/15, focusing on ensuring sufficient capacity is available across the range of community interventions.

- Working towards full primary care 7 day working

- Improved access and response times across community health services

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. This will run in parallel with a range of interventions to avoid admissions and promote early intervention and prevention.

c) Data sharing

i) Please set out the plans you have in place for 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.

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.

In accordance with the NHS Standard Contract the parties agree and acknowledge that the submission of complete and accurate data in accordance with the Service Condition 28 Information Requirements is necessary to support the commissioning of all health and social care services in England.

The Provider must provide the information specified in Service Condition 28 and in Schedule 6 Part B Reporting Requirements with the frequency, in the format, by the method and within the time period set out or referred to in Schedule 6 Part B (Reporting Requirements); and as detailed in relevant Guidance; and if there is no applicable time period identified, in a timely manner.

Where applicable the provider should conform to any information standards published by the Secretary of State or NHS England; conform to the requirements set out in NHS England or HSCIC publications regarding the implementation of collection or extraction; and conform to requirements in relation to the depreciation and/or retirement of any information standard or collection as published by the Secretary of State, NHS England or HSCIC.

ii) Please explain your approach for 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 explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

Yes, all relevant organisations are level 2 IG compliant. Data sharing and Information Governance, agreed between Caldicott officers are in place. 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.

In accordance with the NHS Standard Contract the parties agree and acknowledge that the submission of complete and accurate data in accordance with the Service Condition 28 Information Requirements is necessary to support the commissioning of all health and social care services in England. The following is included in all major providers DH standard contracts:

The Provider must provide the information specified in Service Condition 28 and in Schedule 6 Part B Reporting Requirements with the frequency, in the format, by the method and within the time period set out or referred to in Schedule 6 Part B (Reporting Requirements); and as detailed in relevant Guidance; and if there is no applicable time period identified, in a timely manner.

Where applicable the provider should conform to any information standards published by the Secretary of State or NHS England; conform to the requirements set out in NHS England or HSCIC publications regarding the implementation of collection or extraction; and conform to requirements in relation to the depreciation and/or retirement of any information standard or collection as published by the Secretary of State, NHS England or HSCIC.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them.

The risk stratification tool that will give us this information is currently being developed and will be in place for the end of October 2014. The following is a summary of the proposed approach which will be taken to analysis and implementation.

We are proposing, with support from the CCG / Vision 2018 Programme to focus on cohorts of patients with our integrated teams to ensure that the people identified have reduced levels of unplanned admissions. We will commence adopting a model of rapid cycle testing, that is pdsa (plan, do, study, act) with tight timescales with a defined cohort of patients working with a specific team, to identify what is the most effective at producing change.

We are applying risk stratification in the South Wirral team, focussing on readmissions data with the Wallasey team and focussing on care homes referring to ambulances with the Birkenhead team. From this we will have a clear picture of which interventions produce the greatest effect in reducing unplanned admissions.

For the risk stratification cohort (South Wirral) this is a population of 70,265, based on 12 GP practices within the political constituency of Wirral South. The risk stratification tool will be produced on 6th October 2014 and we will be identifying, through joint work with these practices, the patients at highest risk of admission to hospital, and those at 70% risk of admission or higher will be referred by the GP via the Community Matron to the Integrated team who will be responsible for identifying the care co-ordinator and the care plan with the aim of preventing further admissions to hospital. Where appropriate to the patient, the GP will be the care co-ordinator and will present the case to the Integrated teams.

We are not able to be absolutely specific as to the number of patients that will be more than 70% at risk of admission from hospital until 6th October (when the tool will be available for testing). Our aim is to work down from those that are at the highest risk of admission down to lower levels of risk, evaluating the impact of this work using the pdsa methodology.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population.

Once the risk stratification tool has been developed the patients at high risk of admission will be contacted by their GP to seek permission to refer them to the ICCT (Integrated Care Co-ordination Team). Once consent has been obtained a referral will be made by the GP to the MDT Co-ordinator who will check on the health and social carer systems to identify who is involved with the patient and the relevant professionals will be invited to the ICCT meeting where the care plan will be developed and the care co-ordinator identified who will take the lead on working with the patient on developing the care plan with the aim of preventing any further unplanned admissions to hospital.

Wirral has developed 4 ICCT's to support care around the person. They provide multidisciplinary care to provide a rapid response inclusive to all adults in Wirral. The core team is composed of community nurses, community matrons, allied health professionals, social workers and mental health practitioners. Each patient will have a care coordinator responsible to coordinating their care. GPs work closely with the ICCT's to support joined up care. The ICCT will decide for each patient case who will be the most appropriate professional for that particular patient case, so this could be a community matron, therapist, CPN, social worker or a GP.

GP Practices have been aligned to the 4 ICCTs and through the over 75s and investment in primary care initiatives that the CCG has put in place practices are required to:

- Identify a named integration lead– this person will be the point of contact for ICCT core members
- Put in place a clear communication channel will be created for ICCT's to share and request information and have a clinician to clinician discussion
- Demonstrate GP/Practice Nurse attendance or video conference in to ICCT meeting for discussion of practice's very complex patients
- Undertake joint assessments for very complex patients identified by ICCT e.g. alongside social workers/community nurses
- Refer patients to ICCT's as appropriate

Each participating practice must submit a short delivery plan to Wirral CCG including the following:

- How capacity will be managed within practice to accommodate patients requiring urgent access
- Telephone consultation
- Face to Face consultation
- Please provide direct telephone line that A&E/SPA staff can use to refer
- Please provide details of your integration lead and the preferred route for ICCT members to contact the practice

Wirral's mental health services provider has played an integral role in the development of ICCTs and has aligned appropriate staff to ICCTs. They are also playing a leading in workforce development and long term conditions programme. The CCG has supported funding for additional mental health practitioner posts to work within the integrated teams to provide mental health support for patients, particularly those with drug and alcohol problems and other mental health conditions e.g. dementia, coordinating care plans to include physical health and social care needs.

Dementia support is through early referral to memory clinic for diagnosis and referral to ICCT for coordinated health and social care plan with management escalation as condition changes.

Where patients are hospitalised dementia nurses support patient management and carers and refer to the ICCTs for community care post discharge and/or in reach as appropriate
risk stratification will include searches on practice registers for patients with diagnosis of dementia who are at risk of admission and whom the GP can refer to the ICCTs for assessment and management to coordinate health and social care needs

iii) Please state what proportion of individuals at high risk already have a joint care plan in place.

ICCTs (Integrated Care Co-ordination Teams) are implemented and in the process of incrementally developing between now and April 2015. Each of these patients have an

integrated care plan which aims to prevent unplanned admissions to hospital. Referrals into the team come from health and social care, GPs, hospital and a range of sources, based on individual assessments of risk, and are therefore all assessed as being at high risk of unplanned admission. Each patient referred to the team has followed the same joint process as above.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future.

Following the announcement of the Better Care Fund, initial discussions and considerations were held with representatives of the local authority, Wirral CCG, GP's, Public Health and the Health and Wellbeing board.

An initial draft plan was made public at the Council's Cabinet and the CCG Governing body in March. The draft plan has also been available on the Council's and CCG's web sites from this time.

The joint strategic commissioning group and Vision 2018 has overseen the development of the Better Care Fund plan and considered priorities for Wirral. The first draft was discussed with key stakeholders at the HWBB in February.

Discussions have continued between all key stakeholders to develop the plan and ensure agreement prior to its endorsement by HWBB in March. A special meeting was called to ensure full consideration and priority.

The plan builds upon and strengthens existing foundations of integration in Wirral, including:

- Joint work outlined in the existing Section 256
- Additional Integrated projects under development
- Identified priorities for jointly commissioned services
- Work to oversee and deliver against the requirements of the Care Bill
- Demographic Pressures which will impact
- Plans to invest and develop community based responses to the reduction in unplanned admissions

A Provider engagement event with social care providers (care home, reablement, IMC and domiciliary care and 3rd sector) was held in March to share and develop the plan. Throughout 2013/14, providers have helped shape the co-production of integrated services. 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. Specific provider engagement meetings have now taken place. Constructive comments and feedback have been incorporated into the plan (with some specific comments on programme areas), including:

- Acknowledgement from all organisations f of the size of the challenge and timescales that have been set by NHS England, but also endorsement of the overarching plans as focusing on the right priorities

- Acknowledgement from organisations of the need to work collaboratively to achieve the targets and address common workforce and culture issues across all organisations

- Active commitment from all organisations to be part of the BCF steering group and joint commissioning reviews and commitment to support joint modelling and delivery of schemes

- Emphasis on the need to deliver schemes at pace in order for challenging targets to be met in 2015/16 and also to contribute to reducing operational pressures, against a realistic planned trajectory

- Agreement on the scale of ambition to reduce emergency admissions by 15%

- Acknowledgement that the scale of redesign will impact over a 5 year period

- Support for the establishment of contingency funding.

- Agreement that close performance management will provide reassurance of deliverability, as we will be able to decommission quickly, if schemes do not deliver as anticipated.

- Emphasis of the importance of appropriate capacity in service redesign functions across all partner organisations

- All Chief Executives of major NHS providers including the Acute Trust, are members of the Vision 2018 project, along with appropriate level leaders from Wirral Borough Council.

- Engagement has taken place with Wirral's Housing Authority in January/February 2014 to determine how housing functions can contribute to the overall vision for health and care services. This will be on-going in 14/15

Wirral is committed to stakeholder engagement and involving key partners in co-production and co-design of plans and future services.

The North West Ambulance Service (NWAS) are a key partner and regular attendee at the Health and Wellbeing Board, the Wirral System Resilience Group and project groups for specific initiatives. The CCG has worked in partnership with NWAS to recently undertake a "deep dive" to analyse all ambulance activity to understand the reasons why Wirral people use the ambulance service and assess how alternative services can divert activity in the future.

It should be noted that Healthwatch are core member of the Wirral Health and Wellbeing Board and as such have contributed to the development and sign off of the submission over the last 6

months. They are also a key partner in scheme 5 (care homes schemes).

As part of the Vision 2018 strategy, the CCG and the Council worked together to host an engagement event on 12th February 2014 with the public and professionals. This event explained why we need to transform the way we provide care, and how it will improve services for Wirral residents. Attendees then had the opportunity to contribute to the initial stages of the vision and better care fund plans, followed by a question and answer session. This event was successful with more than 100 Wirral residents attending and providing feedback on what matters to them.

Following this an online survey was launched to broaden the reach to Wirral residents, to date there have been 246 responses.

Communications and engagement will be split into the following phases:

- Phase 1(October 2013-March 2014): Initial Vision public & key stakeholder events
- Phase 2(March 2014-May 2014): Focus groups, co-design approach including staff and public
- Phase 3 (June 2014): Locality events (engaging public and MPs)
- Phase 4 (July – October 2014): Formal public engagement
- Phase 5 (October 2014 onwards): continuing communications and engagement
- To inform and engage in the progress of the Vision.

The feedback from this engagement process is being analysed at the end of each phase and will directly feed into the planning and priorities for 15/16 and beyond.

From the initial thematic analysis, over the topics of primary care, secondary care and integration arose three main themes that were salient to the overall implementation of Vision 2018. There were:

1) Increased GP availability
2) Better communication and information sharing across and between services, and between services and patients
3) Educate patients on appropriate use of services and promote and share information of local services (health, community, voluntary etc).

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.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts.

Wirral University Teaching Hospital NHS FT, Wirral Community NHS Trust and Cheshire and Wirral Partnership NHS FT have been consulted as part of the development of this Better Care Fund Plan.

A regular BCF steering group and performance/outcomes group has taken place since May 2014 with senior leads from each organisation.

Partners have been actively engaged in identifying the challenges, gaps and priorities for investment over this period. They have worked together to share data to evidence the challenges that exist. The BCF schemes have been significantly amended since the submission in April 2014 due to engagement with management leads and lead clinicians. This has resulted targeted focus on reducing occupied bed days (for example through the early supported discharge scheme) and greater emphasis on admission avoidance for example NWAS diversion schemes (including rapid response) and significant investment in alcohol services in the community. This work has been recognised as the beginning of an ongoing planning exercise which will inform the iterative development of the BCF.

In addition there has been a significant amount of joint work on assessing the impact of BCF schemes both from a commissioning and provider point of view, which is highlighted by the schemes templates in part and also has been fed into wider CCG and Vision 2018 work.

Further there has also now been significant discussion with the Vision 2018 Programme regarding how the BCF contributes to and facilitates the delivery of the level of transformational change that has been agreed by the Senior Leaders Group.

The process has identified that the current operational plans of the CCG and the providers are not aligned for 2014/15, however there is a commitment to the level of ambition of non-elective admission reduction and further a commitment (agreed by the Vision 2018 programme managers) to align plans for 2015/16 onwards.

ii) Primary care providers

The primary care providers have particularly been engaged in the development of integrated care coordination teams, as they play a crucial role in the delivery of care in the community. There is GP representation on both the Vision 2018 Implementation Group and the Integration Board.

iii) Social care and providers from the voluntary and community sector

Social care services have been actively engaged in both Vision 2018 and associated programme groups. Wirral Council chairs the Vision 2018 Implementation Group, the Integration Board and the Joint Strategic Commissioning Group.

Social care services have actively contributed to scheme development and prioritisation from both a commissioning and provision perspective and are committed to supporting the challenging transformation agenda. For example, there is investment in community capacity to deliver 7 day working in social services.

As part of the joint commissioning reviews and redesign, third sector have been actively involved in shaping discussions and supporting changes in the market place to help achieve the key outcomes of the BCF. For example the Wirral Independence Service which covers telecare, assistive technology, falls and community equipment; and also the carers support services.

The independent sector has played a pivotal role in delivering a responsive domiciliary, reablement and intermediate care service and continues to work with commissioners to develop the services further in line with the BCF outcomes.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The Vision 2018 Senior Leaders Group have agreed both a level of ambition and also a "shape changing analysis", see attached below, which sets out over 5 years the scale and impact of the financial challenge for the acute trust and the whole economy.

Shape change slides SLG Sep 9 v3 edit.ppt

As previously stated, there has also now been significant discussion with the Vision 2018 Programme regarding how the BCF contributes to and facilitates the delivery of the level of transformational change that has been agreed by the Senior Leaders Group.

As part of the Vision 2018 discussions it has been agreed with senior representatives of key partners a level of ambition which would achieve a minimum 15% reduction in non-elective admissions over a 3 year period from 2015/16- 2017/18.

In addition to our formally stated target of 15%, we would also want to set an overall stretch ambition of 23% by 31st March 2018, recognising recent increases in non-elective admissions. This will be achieved by developing transformational programmes of work through Vision 2018. This will be an iterative process following clinical and public engagement, building on the work

that has been done to date.

Success, even for the 15% target, is dependent on all partners working collaboratively and at pace, including addressing the cultural and behaviour change required.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
What is the strategic objective of this scheme?
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	