Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

Cheshire East Health and Wellbeing Board
Better Care Fund planning template

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Cheshire East Council
Clinical Commissioning Groups	NHS South Cheshire Clinical Commissioning Group
	NHS Eastern Cheshire Clinical Commissioning Group
Boundary Differences	Cheshire East Health and Wellbeing Board (HWB) has a population of approximately 370,000 residents. This area is coterminous with the geographic boundaries of the Local Authority, and the area contains two Clinical Commissioning Groups; NHS Eastern Cheshire CCG and NHS South Cheshire CCG. Our two CCGs whilst established from the same Primary Care Trust come with some quite different population needs and requirements, high numbers of the frail elderly in parts of the area and differences in the levels of affluence, both of which affect the care needs and the drivers for change. The health needs of Eastern Cheshire patients are provided mainly by a small District General Hospital in Macclesfield, however the patient flow for additional acute and the majority of specialist services is into the Greater Manchester configuration. South Cheshire CCG was formed in close collaboration with Vale Royal CCG (within Cheshire West and Chester) – the close working relationship and shared management arrangements are due to the patient flows of patients around Leighton, a small District general hospital (Mid Cheshire Hospital Foundation Trust).Over 90% of patients from both CCGS use MCHFT as their acute provider of services. We are working closely with our neighbouring Cheshire West and Chester Health and Wellbeing Board to help improve the patient flows across the broader Cheshire geography as well as into neighbouring areas beyond the Cheshire boundary, in line with our joint and collective involvement in the Cheshire area Pioneer Programme.
Date agreed at Health and Well-	Draft version approved: 14.02.2014

Being Board:	Final version approved: 25.03.2014
Date submitted:	Draft version approved: 14.02.2014 Final version submitted: 05.04.2014
Minimum required value of BCF pooled budget: 2014/15	£1.209m
2015/16	£23.891m
Total agreed value of pooled budget: 2014/15	£9.221m
2015/16	£23.891m The above £23.891m includes the S256 funding from the Council and two CCGs for Reablement and Carers Breaks.

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS South Cheshire CCG
By	Simon Whitehouse
Position	Chief Operating Officer
Date	Informally approved 14/2/14 Formal approval for April.

Signed on behalf of the Clinical Commissioning Group	NHS Eastern Cheshire CCG
By	Jerry Hawker
Position	Chief Operating Officer
Date	Informally approved 14/2/14 Formal approval for April.

Signed on behalf of the Council	Cheshire East Council
By	Lorraine Butcher
Position	Executive Director of Strategic Commissioning
Date	Informally approved 14/2/14 Formal approval for April.
Signed on behalf of the Health and Wellbeing Board	Cheshire East Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Janet Clowes
Date	Informally approved 14/2/14 Formal approval for April.

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

The Cheshire East Health and Wellbeing Board's Better Care Plan builds upon the work already underway as part of our successful Integrated Care Pioneer submission.

The Cheshire Integrated Care Pioneer involves providers from across the health and social care economies within the geographies of the two authorities (Cheshire East and Cheshire West and Chester). The vision and ambition of the Pioneer submission has been endorsed by both commissioners and providers who worked together to secure Pioneer status.

The Better Care Plan supports and integrates the change programmes from Cheshire East Council (CEC) and our two CCGs; 'Caring Together' in Eastern Cheshire and 'Connecting Care' in South Cheshire.

In the development of the Plan a number of engagement events have been undertaken, seeking the views and engagement of our various providers. This engagement builds upon the local engagement activity underway within the CCG integration programmes. Both are proactively involving providers in their planning. For example the four work-streams developing the caring Together future care model all include provider representatives, from the hospital and mental health trusts, GPs and the community and voluntary sector. Additionally there are a number of ongoing multi-agency programmes of work involving a range of partners – namely Cheshire East Council, East Cheshire Trust (as the main provider of community health services), housing and voluntary, community and faith sector providers. These are all contributory activities towards the broader integration agenda.

Further work will be required to continue the dialogue with Providers, particularly in relation to the outcomes of the Plan and the risks and impacts of the changes that will be taking place. A meeting of Hospital and Mental Health Trust Chief Executives with the Health and Wellbeing Board took place recently and further telephone conference calls are booked in with the BCF steering group. This is in addition to the ongoing provider engagement in the two CCG localities in relation to the detailed work already underway.

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

Health Watch Cheshire East are engaged with the Better Care Fund planning through their representation on the Health and Wellbeing Board and the integration programmes of the two CCGs. They are also assisting with aspects of the Adult Social Services improvement initiative which links into the integration agenda (for example in relation to developing the Carer Strategy).

Within the Eastern Cheshire part of the HWB area the **Caring Together** Programme has undertaken detailed engagement with the community with the support of 'Participate' who, working in partnership with the CCG and partner's communications teams, have

captured insight from patient/carer groups through previous work undertaken and new engagement events and street surveys. This has been analysed and coded for common themes.

Participate have undertaken a series of interviews with individuals from three different stakeholder groups to capture their insight on the barriers to achieving integrated care and how they can be overcome within Eastern Cheshire. The three stakeholder groups were GPs, representatives from NHS and social services workforce and leadership (Other Professionals), and representatives of voluntary, community, and faith sector organisations (VCFS).

In addition the four work-streams that are developing the new care model all include patient representatives.

A full breakdown of all events is included in the embedded document below:


engagement log.docx

The outcomes and relevance of the engagement to the whole community is currently being assessed, aiming to identify where additional engagement might be beneficial, taking into account the different aspects of the community in the south of our area. The early assessment suggests that the engagement will be sufficiently representative at this stage, ahead of more detailed engagement around the Better Care Fund.

Connecting Care for Vale Royal and South Cheshire CCG footprints is to undertake engagement with patients and public alongside key stakeholders to ensure, at an early stage of planning, that the valuable engagement with our population is embedded. Initial engagement has taken place through a workshop based on the SCCCG operational plan which highlighted the strategic direction of travel for Connecting Care.

e) Related documentation

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

Document or information title	Outline
Pioneer Programme Expression of Interest  Integrated Care and Support - ... http://caringtogether.info/videos/8?project_id=1&client_id=1	This Pioneer programme outlines the commitment and plans of the Cheshire West and Chester and Cheshire East Health and Wellbeing Boards to integrate care and support services across the County area of Cheshire. The Pioneer programme sets out the common framework for integration; Communities, Case Management, Commissioning and Enablers as reflected in our BCF submission.
Caring Together (Eastern Cheshire CCG)	This programme outlines NHS Eastern Cheshire CCGs and partners proposals to redesign services

The Case for Change document will be supplied once signed off by all parties. **Need to Insert**	across the Eastern Cheshire area, including the integration of activity across health and social care functions. This is the pre consultation document which describes the rationale behind the Caring Together Programme. Key headlines are the imperative to change to enable the population of Eastern Cheshire to be empowered to manage their own health, and the delivery of a sustainable health and social care system both in terms of cost and capacity
Connecting Care (South CCG)  Connecting Care vision statement 9De	This programme outlines NHS South Cheshire CCGs and partners proposals to redesign services across the South Cheshire area, including the integration of activity across health and social care functions.
Joint Strategic Needs Assessment **http://www.cheshireeast.gov.uk/social_care_and_health/jsna.aspx**	This is a joint CCG and local authority assessment of the needs of residents across Cheshire East Council. This provides a common evidence base for the design and delivery of services.
Additional documentation/links to documentation  Health and Wellbeing Strategy 2014 - 16 v  The Provision of Early Help in Cheshire  Briefing Paper The Strategic Direction of **Need to Insert** **Need to Insert**	Cheshire East Health and Wellbeing Draft Strategy 2014 - 2016 Early Help Strategy – Cheshire East Council Promoting Open Choice – Strategic Direction of Travel for CE Adults Social Care – Cheshire East Council Adult Social Care – Informal Support to Address Prevention and Early Intervention – Cheshire East Council Draft 2 Year Operational Plans - EC CCG and SC CCG Draft Vulnerable People Housing Strategy – Cheshire East Council

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National Conditions	Any documentation specific to these to insert??
Plans to be jointly agreed	
Protection for social care services (not spending)	
7 day services in health and social care…	
Better data sharing between health and social care, based on the NHS number	
Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care, there will be an accountable professional.	
Agreement on the consequential impact of changes in the acute sector	

VISION AND SCHEMES

a) Vision for health and care services

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

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

Our submission under the Better Care Fund is designed to deliver our collective vision that within three-years the individual's residing within Cheshire East will enjoy improving standards of health and well-being through the implementation of our joint and collective plans. This will be delivered through our framework of integration, which incorporates that of the Pioneer Programme that is built around:

- **Integrated Communities**: residents will be supported within their communities by employing a mind-set that builds on the principle of community capabilities rather than deficits.
- **Integrated Case Management:** residents will receive a more coordinated experience of care and support services through the use of a single point of access and our support of seven-day working.
- **Integrated Commissioning:** services commissioned for local residents will be based upon strong evidence and proven effectiveness and commissioned as part of a whole system approach to commissioning.
- **Integrated Enablers:** on a pan-Cheshire geography we will use this work-stream to support the issues that will enable long-term integration, addressing issues such as; data-sharing, funding and contracting, and workforce development.

Over the next five years, and starting with those individuals with complex needs, our models of care will focus on:

- empowering people to live full and healthy lives, self-manage and where required supporting people and their families with improved information and technology
- strengthening primary care and its role in proactive long term condition management
- increasing the investment and portfolio of services in the community to support care closer to home where safe and effective to do so
- providing access to specialised services to optimise the safe care and clinical outcomes for patients
- people knowing where to get the right help at the right time
- people feeling safe in their communities
- people being active members of their communities and reducing social isolation
- carers supported to continue caring in partnership with other support services

Partners are committed to the following statements, to ensure that our future model of care and support services deliver the practical outcomes to local stakeholders/

People will agree that the following statements reflect their experience of local care and support:

- I am in control and treated with dignity and respect
- I feel part of a tight-knit team that works with me and tackles any obstacles to getting the help I need
- I only have to tell my story once
- I don't have to wait for a crisis to get the help I need
- I know that I, my family and carers have the support and information to help me
- I only need to go to hospital when I need to and have access to quality support in my local community
- I am in control of what happens to me

With improved outcomes that seek:

- Improved (better compared to current baseline) experiences of care
- Improved (exceed national best practice benchmarks) clinical and care outcomes
- Reduced health inequalities (better access to hard to reach groups)
- Increased range of low level support services

And building on the work from each of our areas we want our public to be able to simply say, *'I am supported to live well and stay well because I can access joined up care and support when I need it'*

Commissioners will agree that the following objectives have been achieved:

- We don't let organisational boundaries get in our way of what is right for our communities
- We jointly invest in the things that our residents need and the things that work
- We work as a team and rarely plan or commission as separate organisations
- We work to a shared plan that will help us secure good outcomes even as demand for services rise and budgets reduce.

Providers will tell us that the new system displays the following features:

- We work in an environment that helps us put people first
- We are given the permission to imagine, experiment and learn
- We work like a single organisation with joint systems, staff and ways of working.

With improved outcomes that seek:

- Improved utilisation of services (including reduced use of acute and residential care and increased use of primary and community services)
- Better use of financial resources through improved productivity because of the reduction of duplication, waste and variation and opportunity to draw on resources from other sources
- Achievement of the national outcome for integration to support sustained health and social care organisations and services
- Collaborative working across organisations

Our plans highlight the activity and approach to the implementation of projects contained within our BCF submission, which will result in continued improvement in the health and well being out comes for the individual's with our area.

b) Aims and objectives

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

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

The primary aim of our proposals is to provide quality care more efficiently and effectively to local residents. As outlined above we are committed to delivering improvements outlined against the payment by result elements agreed within our BCF against the five national outcomes attached to the BCF.

Caring Together

Within the Eastern Cheshire CCG area of the HWB geography the **Caring Together** programme, a whole health and care economy initiative, aims to transform the way all care is delivered. A case for change has been developed which is based on intelligence and analysis from all partners and is cognisant of challenges to be met, organisational accountabilities and joint outcomes to be achieved across health and social care and the wider communities sector.

Caring Together (CT) brings together professionals, patients, stakeholders, providers, community groups and the public to help shape the future of health and social care services in Eastern Cheshire. The aim is to deliver a new person centred model of care, with a seamless approach to be co-designed and tested in Eastern Cheshire, shaping integrated community focused models of care in conjunction with the other areas within the Cheshire Pioneer area.

There are specific work streams that include providers from the NHS, Social Care and the Community and Voluntary Sector. They are informing the Case for Change, the Quality Standards and the design of the new Care Model.

Given the flow of patients within Eastern Cheshire, the Caring Together Programme links into the Greater Manchester acute service reconfiguration programme to ensure that specialist services can be accessed within agreed pathways.

Connecting Care

Within the South Cheshire area of the HWB area the **Connecting Care** in communities programme, a whole health and care economy initiative has been established to ensure quality, personal, seamless support in a timely, efficient way to improve health and wellbeing'.

The overall aim of the programme links closely with the Caring Together programme, where the commitment is that the Cheshire partners will transform the health and social care system by:

- Working much more closely together and in smarter ways to provide reliably and without error, the care that will help people and ONLY the care that will help
    - Putting the individual at the centre of all care – 'no decision about me, without me', improving their experience of care
    - Assure quality by employing high quality, well trained staff with strong leadership and development skills
    - Focusing on the multiple determinants of both physical and mental ill-health and creating innovative solutions across partners
    - Creating more opportunities for and embedding cross organisational working that reduces duplication and achieves the best use of available resources
    - Adding value to the lives of individuals and their families/carers and decommissioning care that does not add value
    - Exploiting the use of new technologies to support independence, self-care and information sharing across partner organisations

- Building and strengthening community based services and support
    - More care will be organised and delivered outside of traditional hospital settings, in local communities with the development of integrated teams and closer collaboration across teams
    - People will access services differently:
        - with GP practices/neighbourhood focused teams and community services delivering care and support 'closer to home'
        - with a smaller, more flexible community facing hospital delivering emergency and specialist care and
        - regional specialist hospitals continuing to deliver specialist care, some of which will be in the community setting
    - Traditional 5 day per week community services will be extended to offer support when needed, 7 days per week
    - Care and support will be personalised, timely, responsive and seamless

- Developing our workforce and community assets to deliver new ways of working
    - Empowering individuals at a local level to lead change and problem solve with

full support from their colleagues
- Supporting people, their families/carers to take responsibility for their own wellbeing and make choices about their care based on their personal goals
- Offering education, training and development programmes to support the implementation of new ways of working, self-care, local leadership, change management and improvement approaches.

The HWB will through the BCF, align and integrate the two distinct programmes, so that the specific flavours and requirements unique to the two CCGs areas can be supported and delivered, within the overall co-ordination and oversight of the HWB and the wider Pioneer submission.

Remove below in yellow and add into Metrics Technical Template??

Below we set out our current benchmarks against these outcomes, and highlight the improvements we hope to deliver through the BCF. It is important to note that in examining the local performance against the nationally recorded data there are a number of concerns about the quality of the data. There is continued work in progress on our performance, which will receive further scrutiny and refinement through 2014/15, with the current analysis of our performance being detailed below:

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population:

The English average is currently 690.3 admissions per 100,000 population, whilst across the Cheshire East area we are currently reporting achievement at 561.1. We know that current performance reported is distorted by the treatment and categorisation of our respite care, which we believe is incorrect, resulting in an increased baseline. We will review our baseline during the early part of 2014/15 and following this review we will determine our collective ambition around the level of improvement we wish to achieve.

Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services:

The English average is currently 82.6% of older people remaining in their own homes after 91 days from discharge from hospital, whilst across Cheshire East 79.3% were still at home. It is important to note that across the Cheshire East area whilst our % performance is lower than the national average our delivery is to a larger % of the population, which will have a greater impact as we improve the proportion of older people still at home after 91 days. Our aim is to improve performance by continuing to expand the number of older people who have received reablement services whilst also seeking to increase those staying at home more than 91 days by 1% each year, until we reach our ambition of being upper quartile.

Delayed transfers of care from hospital per 100,000 population:

The English average is currently not known so it is not possible to compare the local performance against the national delivery. Locally across the Cheshire East area we are currently achieving 302.75 and will aim to reduce this by 5% from our baseline by 31 March 2015, continuing to improve on that performance year on year until we are recording high quartile performance. Detailed below is a graph showing the average

monthly delays from April 2011, which is one of the indicators being monitored locally:

Avoidable emergency admissions:

We have detailed our performance below for our two CCGs. We will add our collective ambition within the final submission, which will seek to improve performance and reflect the differing age profiles of the two CCGs.

Await the information provided by NHS England.

CCG	English Avg	Baseline (2012/13)	March '15
South	-	2,093.3	Tbc
East	-	2,211.0	Tbc

At Mid Cheshire Hospital Foundation Trust (MCHFT), South Cheshire CCG and Vale Royal CCG we have invested in additional services within the hospital setting (A&E) in particular to increase levels of staffing to treat patients quickly. There has been detailed analysis of the flow of patients both in A&E, but also across the wider hospital services to target those areas needing improvement to ensure the "front door" is not in crisis. Eastern Cheshire has invested in a 'primary urgent care' service linked to the NWAS pathfinder scheme providing an acute GP visiting services to optimise care outside of hospital and prevent avoidable admissions.

The CCGs have also invested in alternatives to acute care beds – these are multi agency services outside of the hospital setting ensuring patients can be discharged quickly, either from A&E or from hospital wards. The combination of investment and new services in place have meant that both MDGH and MCHFT has managed to deliver the four hour A&E target, and non elective admissions have remained on or slightly under plan for 2013/14.

The experience of patients and service users:

Proportion of people who feel supported to manage their long-term condition:

Across the Cheshire East area we are currently achieving % of 74.1 in the South Cheshire CCG area and 77.5 in the Eastern Cheshire CCG area, with an aim to increase this to upper quartile levels by 31 March 2015.

The table below is the Eastern Cheshire CCG submission in the operating plan to cover "what is your ambition for improving the health related quality of life for people with long term conditions":

	Average EQ-5D score for people reporting having one or more long-term condition
Baseline	77.50
2014/15	78.60

2015/16	79.70
2016/17	80.80
2017/18	81.90
2018/19	83.00

Equivalent information is currently being sought for the south area.

Locally important indicators:

Whilst these national indicators will provide an important measure of success in creating a more integrated model of care and support services, it is also important that partners monitor local outcomes that are tailored to the pressures that we know exist within local services. Therefore, alongside these national outcomes, we have focussed on the area where we know we need to make significant improvements

Direct admissions from hospital to long-term care settings:

We know that across the HWB we have challenges with direct admissions from hospital to long term care settings. We have regularly reviewed the information provided by the North West AQUA survey and will seek to develop strong robust indicators that will stand ongoing measurement.

Our local performance is x against our regional comparator performance of y. We will seek to improve this performance to upper quartile levels within a three year period.

We are currently considering the impact of additional local indicators such as falls and dementia.

It is also important to note that like all HWB areas there will be a need to take into account the recent Zero Based Review of the coding and classification by CIPFA and the Department of Health of Adult Social Care. This will require a full rebaslining of activity and the selection of appropriate indicators during 2014/15. It is suggested that a quick assessment of the situation be undertaken by CIPFA and DH.

c) Description of planned changes

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

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

Three key schemes underpin our BCF proposals in the immediacy with recognition that further work programmes will be added as joint commissioning activity progresses and indentified synergies emerge. As these schemes progress, other funding sources for those activities will be added to the BCF as appropriate.

Transition planning during 2014 – 2015 will be facilitated by early changes to current working practices, and learning from changes already introduced (for example the extension of GP urgent care in the Eastern Cheshire CCG area using winter pressures monies which has demonstrated significant impacts upon A and E admissions). We will move towards full implementation in 2015-2016. Section 256 monies will be used to help achieve these quick wins.

PLANNED SERVICE AREA 1	**SELF CARE AND SELF MANAGEMENT INITIATIVES**
SERVICE DESCRIPTION	Within the Connecting Care and Caring Together whole system major change programmes it is recognised that to achieve transformational change which provides lasting benefits to local residents we need to ensure that the individual is empowered to take responsibility for their own care and health. The aim is therefore to continue to develop our voluntary, community and faith sectors to provide vital services to support individuals, families and local communities to support themselves and thereby reducing reliance on statutory services. As individuals, we want to be given the right advice, information and support to be independent. Families want to be enabled to continue to care and share care. Communities want to be self-reliant (with support) to provide for themselves. Statutory commissioners can enable this to happen locally by stimulating and where necessary contracting with the sector to ensure low level advice, information and support services are available at all levels (individual, family, community). The BCF will be utilised to ensure an enhanced range of advice, information, care navigation and community development services are available in a range of settings and where possible to have these work as part of integrated teams and services. The Fund will be further used as investment in the community infrastructure to develop a range of services and initiatives with the aim of these becoming self sustaining over time. The focus on changing the dependency on statutory services to a culture of self help and self management will

	require a range of interventions from public health promotional initiatives through to community development interventions.
Intended Target Group	All Residents of East Cheshire
Impact Assessment on Patient Groups	All patient groups will be positively impacted by the range of information, advice and community support to be made available. The intention will be to have a generic level of support available and fully accessible within local neighbourhoods and communities. Additional targeted support and information for specific high risk groups will be prioritised e.g. mental health, frail elderly.
Impact on Acute Care Sector	The impact on the Acute Care Sector will be to divert people from resorting to attending A&E directly or via NWAS by providing the public with the necessary support and information to ensure that people know how to access appropriate community based support. The initiatives will target prevention measures and early intervention by providing access to early support to prevent a situation escalating. By diverting from A&E attendance and requests for ambulance call outs there will be a reduced likelihood of inpatient admissions. Demand on A&E will also be reduced.
Support for Seven Day Services	Service and support initiatives will ensure consideration of seven day support and selected advice and information sources being available 24/7.
Use of NHS Number as basis for Information Sharing	There will be limited use of NHS number with the lower level support initiatives and advice / information sources. Where this is possible this will be linked into public sector provision.
Protection of Social Care Services	The shift of focus to prevention and early intervention initiatives is critical for the needs of individuals to be appropriately met at an early stage. Utilisation of the BCF pooled budget to deliver low level response services will prevent deterioration and facilitate early access to the appropriate care pathways and will be an essential element of the prioritisation of spend. Services being considered for further investment include care navigators and care brokers for people who are not eligible for social care services or those who choose not to access services via a formal route. The offer of support and care navigation is an essential part of the advice and

	information services which takes account of the need to provide this in a way that is supportive and responsive to an individual who may struggle to make sense of what is available on their own. The development of the personalisation agenda required the support of the whole system to support the principle of the empowered person having access to the range of information and advice and support to ensure they accessed the right help at the right time. The focus of support to enable self help and self management inevitably supports the social care agenda and the wider whole system support for independence and self reliance.
Joint Assessment and Accountable Lead Professional	The initiatives within this planned area of enhanced service development is dependent on linkage with statutory services to ensure those who need a more formal assessment of their health and social care needs are able to access this quickly and appropriately. Once the access is determined the joint assessment and lead professional principles within statutory provision will become effective. There is however the development of the care navigator role which is intrinsic to more specialist types of voluntary sector and community provision which mirrors the principles of a lead professional maintaining oversight of the person and their family to ensure they get to the right help when they need it.
PLANNED SERVICE AREA 2	**INTEGRATED COMMUNITY SERVICES**
SERVICE DESCRIPTION	Integrated health & social care services will be needed for those people likely to be identified through risk profiling with increasing frailty and multiple health and social care needs (largely but not exclusively people over 70 years old). The core teams will be focused around groups of GP practices and will have the team as the single point of access. An appropriate professional will take on the co-ordination of care for each individual within the team – this could be the GP or another professional depending on the needs of the person. We are considering new models for contracting where a lead provider could co-ordinate services from one or more provider and is held accountable for the overall service model of delivery. The Better Care Fund is the opportunity to expand the capacity within social care beyond the

	current levels determined by critical and substantial needs (current Cheshire East Council Fair Access to Care criteria) in order to support those people whose care needs are complex and without such support would be at risk of hospital admission. The integrated teams will be the basis of transformation of services and will extend to wider integrated teams including community based geriatricians, mental health services, alternative beds to the acute hospital and new services to focus the long term care of these patients outside hospital or long term care settings in a co-ordinated, responsive manner. This will include provision currently referred to as Intermediate Care. The voluntary, community, faith and private care sectors will play a key role in supporting the integrated team model by providing additional wrap around services to keep people at home and help co-ordinate services. The range of community care support services will be expanded to increase the range of services which provide short term interventions with a recovery focus which will target specific patient groups e.g. stroke care. Lower level support services which provide a monitoring and oversight role will be included in the service model. This service response aims to provide short term and flexible care and support which may prevent the need for more costly service provision. We believe short periods of monitoring and assessment over time will ensure that the person gets the right care and treatment following a robust and thorough assessment. The plan will be to use the integrated community service model to assess, treat and provide the required interventions to people within the community to prevent the need for people to need to access hospital based services apart from those with the most urgent and/or critical conditions. Further exploration of assistive technology solutions for care and telehealth options will be part of this service development in addition to seeking new and innovative care and support solutions not currently available. The early work completed in designing the new community model of service has included the development of new job roles, which have a multi functional purpose. The aim being to be proactive in engaging people deemed to be in the high risk groups to develop coping strategies linked to their condition/situation and make available to them information and advice regarding a range of issues eg financial support, forward planning, contingency risk planning, local community support etc.

	The early work within the major change programme has seen the emergence of multi disciplinary teams of staff working together around specific GP practices/clusters of practices. The model described above will take this early step change to the next level of incorporating a more structural change to the multi disciplinary working and move to a robust model of care coordination for those within the agreed target group. Single assessments, care plans, care record systems will be key deliverables in addition to single contact number to access the new integrated community service. People having to tell their story once and being central to shaping the care they receive and how it is delivered will be key design criteria of the service model. This model of service is heavily dependent on having a range of skilled and highly trained assessing professionals with the skills to provide treatments and interventions in the community. To support this it is essential that there is a broad and accessible range of wrap around care and support services which will largely be commissioned within the voluntary and private care sector. The intention would be to develop a menu of services which will be flexible and responsive 24/7. This will include domiciliary care support, intermediate care services, bed based community assessment options, home based nursing, allied health professionals.
Intended Target Group	The priority target group will be those individuals who are deemed to be experiencing complex and multiple long term conditions. This will include a significant proportion of the over 70 population. This will for some areas of high deprivation include more people under the age of 70
Impact Assessment on Patient Groups	There will need to be a full equality impact assessment as the service model is further developed. It is however intended that people with dementia and other mental illness diagnoses will be included as part of the target group. The research and evidence available identifies the significance of the co morbidity of dementia and mental illness alongside other long terms conditions. The integrated community service model has a clear interface with specialist mental health services for adults and older adults. The plan is to have link professionals to ensure this interface is a dynamic and effective one to benefit the individuals using the service and the focus will

	be to maintain the concept of care coordinator across the generic and specialist care sector.
Impact on Acute Care Sector	It is intended that the impact will be to reduce the need for A&E attendance and inpatient admission. This impact will be effected by a more proactive and coordinated approach to patient care and the use of risk profiling which will ensure the coordination of care will be aligned with the timely and appropriate response to an exacerbation of condition(s). It is also intended to facilitate early and safe discharge from inpatient stays by developing the seven day service for all relevant service areas. It is intended that the risk profiling will be utilised to identify potential candidates who may become high risk in the future and thereby offer preventative measures linked to self help and self management techniques which will reduce the risk of condition exacerbation becoming critical. Ultimate impact will be to reduce attendance at A&E, admissions to hospital and to facilitate early discharge and reduce lengths of stay. Intention will be to ultimately reduce beds within inpatient units and increase alternatives outside of the hospital setting. Linkage between the integrated community teams and hospital discharge services will ensure a coordinated approach to ensuring the patient profile and wide support network is known at the point of admission which will reduce the need for duplication of assessment whilst an inpatient. The model of service will be dependent on strong team linkages between the secondary care specialists and diagnostics i.e. community physician and mobile diagnostics.
Support for Seven Day Services	Integrated Community services will provide a seven day service according to the needs of the local population. There will be the need to utilise the BCF to review the contract arrangements for all wrap around services which will need to be available and accessible seven days a week. This will include access to packages of care support from a range of services which will need to have staff available and on standby in the same way they are within Monday to Friday service provision. This will include statutory and private and voluntary care support services.

Use of NHS Number as basis for Information Sharing	This will be required to be in place as part of the new service model.
Protection of Social Care Services	The protection of social care services will include further expansion of reablement and recovery based services for older people and people with dementia; extension of services to provide respite for carers within the community setting as a real alternative to residential care options (both short and long term); development of social care focussed assistive technology solutions within an overall health and social care range of assistive technology solutions. The BCF is an opportunity to ensure that the social care sector is fit for purpose in terms of scale and range of social care support and care services. It is necessary to reflect that the focus on the development of integrated community assessment and intervention services will be dependent on a wide range of wrap around care and support services to support the initiatives needed to deliver viable alternatives to residential care provision. These services will be required to be skilled in a range of interventions in a crisis and be able to work as part of a multi professional approach. They will also need to be accessible 24/7 and be sufficiently resourced to work alongside NWAS and OOH medical services.
Joint Assessment and Accountable Lead Professional	The service model will incorporate a single assessment process involving the most appropriate members of the multidisciplinary team. Following assessment the person will be provided with a coordinated plan of care which will be overseen by a named lead professional who will take on the role of Care Coordinator.
PLANNED SERVICE AREA 3	**INTEGRATED URGENT CARE/ RAPID RESPONSE SERVICE**
SERVICE DESCRIPTION	We intend to commission and provide integrated urgent care and rapid response services spanning primary, community and secondary care (, Urgent Care Centre)The range of provision will include elements currently provided by A&E, out of hours social care services, NWAS, GPs, social care, mental health, learning disability and community health services. This will mean patients' urgent care needs will be met in a rapid and responsive way, avoiding duplication of work and unnecessary visits to A&E or hospital admission. Urgent care services will be able to respond to patients in their own home, in a residential care setting or at A&E, OOH, Urgent Care Centres in a co-ordinated system, rather than fragmentation of service

	providers. The model being developed involves the coordination of key services including GPs, NWAS, assessment specialists from health and social care professionals, all of whom will work together to ensure the prompt assessment of people who need a more urgent care and/or treatment response but one which need not be hospital based. The service will develop further the shared contingency crisis plan established by the NWAS pathfinder project and to develop this to a full health and social care plan for an agreed target group identified by an agreed risk profiling tool. The model will be implemented as an early step change in a phased transformation of the whole system within the two major change programmes. The intention is for the urgent care/rapid response service to have access to a range of wrap around services which will facilitate home assessments of both health and social care needs including where appropriate diagnostic services. In addition the range of wrap around provision will include ongoing assessment and treatment over a period of time to stabilise the condition and this will include domiciliary care to provide both personal care, low level health interventions and where appropriate carer support. The use of assistive technology solutions for both health and social care support will be a key element of this service. The intention would be to develop a menu of services which will be flexible and responsive 24/7. This will include domiciliary care support, intermediate care services, bed based community assessment options, home based nursing, allied health professionals. The service will ensure that urgent care where possible is delivered in a community setting. The service will be further developed to provide an effective service response to facilitate early discharge from hospital where a level of health and social care oversight is required for a short period following discharge. This will reduce the length of stay in hospital and avoid residential placements straight from an inpatient stay with the inherent risk of this becoming a longer stay or permanent residential placement. We are considering new methods of contracting for services which will support providers to "own" or be held accountable for the patient journey from urgent need/rapid response to a more stable situation within the home setting. The scheme will include the NWAS pathway pilot, nursing care home discharge initiative, 24/7 working to include increased medical and nursing cover, additional pharmacy access, increased social worker and access to social care services. This will also involve a redesign of urgent care, OOH services and A&E together in order to support patients

	with an urgent need requiring rapid responses to avoid an unnecessary admission to hospital or residential care. The intention is that access to the rapid response/urgent care service can be made from any of the patient contact points.
Intended Target Group	The priority target group will be those individuals who are deemed to be experiencing complex and multiple long term conditions.
Impact Assessment on Patient Groups	All patient groups within the target group will benefit from the ability to access an urgent care and raid response service. The need to access hospital based services for assessment, diagnostics, monitoring and treatment will be reduced. For patients with dementia related illnesses or for those with caring responsibilities there will be a service response appropriate to meet their needs within their own homes wherever this is practicable.
Impact on Acute Care Sector	The impact on the Acute Care Sector will be to divert people from resorting to attending A&E directly or via NWAS by providing the public with a contact point for urgent access to a community based assessment in cases where there is a need for an urgent medical, health and /or social care assessment. By providing a viable and robust urgent care response within the community, there will be a reduction in demand for assessments within A&E departments resulting in a subsequent reduction in admissions. There will be a need to consider how the current arrangement for accessing A&E departments for certain diagnostic tests can be relocated to alternate community settings to ensure that the access to an community based urgent care response can be safe and effective.
Support for Seven Day Services	This service model will deliver 24/7. There will be the need to utilise the BCF to review the contract arrangements for all wrap around services which will need to be available and accessible seven days a week. This will include access to packages of care support from a range of services which will need to have staff available and on standby in the same way they are within Monday to Friday service provision. This will include statutory and private and voluntary care support services. Commissioning of these services will need to reflect the flexible and responsive nature of the service model and will require a focus on service responses having the flexibility of multi tasking. The workforce development plans will reflect

	the need for new types of professional and support staff roles.
Use of NHS Number as basis for Information Sharing	This will be required to be in place as part of the new service model.
Protection of Social Care Services	The BCF is an opportunity to ensure that the social care sector is fit for purpose in terms of scale and range of social care support and care services at times of crisis. It is necessary to reflect that the focus on the development of integrated community assessment and intervention services will be dependent on a wide range of wrap around care and support services to support the initiatives needed to deliver viable alternatives to residential care provision. These services will be required to be skilled in a range of interventions in a crisis and be able to work as part of a multi professional approach. They will also need to be accessible 24/7 and be sufficiently resourced to work alongside NWAS and OOH medical services. The commissioning of care services will require a variety of care and support responses which will be required in an emergency. The risk of providing alternatives to hospital is that there is a default to residential based services. The urgent care/rapid response model of service will ensure an enhanced range of social care provision is available to provide a real alternative to a buildings based service response whenever that can be safely achieved.
Joint Assessment and Accountable Lead Professional (Care Coordinator)	The joint and coordinated assessment of people in a crisis situation will be a critical element of this service. It will draw on the crisis and contingency planning which will be in place for those people deemed to be at risk of crisis or relapse of their condition(s). The accountable lead professional will be nominated according to the individual situation and will ensure that the crisis plan of care is effective and is attending to the medical, social care and health needs of the person. The accountable professionals will be highly trained skilled professionals who are suitably qualified in the assessments of people within crisis situations and who are able to mobilise and coordinate the range of professionals and support staff needed in any given situation.

Other Initiatives/Tasks

We are developing a range of tasks and activity to ensure the outcomes are delivered, for

example developing the governance surrounding the pooled budget, regular risk management, contingency planning etc.


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All of the planned changes detailed above are part of the two transformational change programmes – Connecting Care and Caring Together. The broader context of the Pan Cheshire Pioneer programme is a critical element to our programme of change and planning. The pioneer programme takes account of the strategic ambition of the partner agencies involved and the opportunity to look at the whole system change on a far greater footprint. Inevitably this means that the planning at this stage for the Better Care Fund process is not totally aligned with the final proposal and planning stages of these three key programme areas. The plan therefore reflects a combination of the current position in terms of agreed plans and stated intentions of the whole system redesign.

Alignment of Activity

Across Cheshire East and Cheshire West and Chester a 'Pioneer Panel' has been established to lead and co-ordinate the integration work across the two areas. This will be particularly focussed upon the areas of activity that are better undertaken on a pan-Cheshire footprint, including for example workforce development, ICT infrastructure integration and data sharing.

The alignment of all the health and care economy strategic planning and priority activity is overseen through the Cheshire East Health and Wellbeing Board. The Board meets every other month. Over the last 12 months the Board has received reports on the ongoing refresh of the JSNA, the work to update the Health and Wellbeing Strategy, the CCG commissioning plans and integration programmes and ongoing improvement activity within Adults Social Care. A sub-group of the Board is the Joint Commissioning Board with senior representatives from all commissioners (including NHS England, the Police and Crime Commissioner, the CCGs, Public Health and the local authority). This group is prioritising and co-ordinating the re-commissioning activity across the health and care economy and ensuring joint commissioning where appropriate.

d) Implications for the acute sector

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

It is recognised that the Better Care funding is money that is already committed to health and social care services. Savings will be required across our health economies.

The impact of the transformation of services across South Cheshire and Vale Royal CCG collectively, will significantly impact on MCHFT as the local acute provider. The shared

plan – 'Connecting Care', is building the case for fewer beds and services within the hospital setting. Financial resources released from reduction in number of wards will move to community investment.

Locally we have already demonstrated the closure of a winter ward through increased resourcing in community beds/services as alternative provision. Currently 193 beds are available outside the hospital setting, reducing pressure on both A and E and flow through the hospital over winter. We intend to widen the extended practice teams to include community geriatricians (based on the work in Torbay where the inclusion of community geriatricians demonstrated the reduction in acute beds when alternatives are available).

The reshaping of current service providers (community health, social care, mental health and the Third sector)and additional investment from South Cheshire and Vale Royal CCGs into extended practice teams, should ensure community based services are able to support older people for longer at home, react quickly to a deterioration in the person's health or well being and avoid unnecessary admissions to hospital or residential settings.

MCHFT is an outlier in relation to the high number of reported delays to discharges. We also need to identify the potential cohort of patients who could avoid a hospital admission through risk profiling. A full business case is being developed that will clearly identify the potential cost reductions/movements and reductions in hospital activity necessary to achieve this transformation. is being driven by the Connecting Care Board where our main providers are full members.
The risks associated with not delivering the transformation is that the MCHFT will no longer be financially sustainable as a small DGH, and will not be able to deliver the current requirements of the NHS Constitution targets, for example the four hour A and E waiting times; be unable to deliver the required quality improvements and the seven day working requirements across services.

Similarly the Eastern Cheshire health economy is currently mapping services to be delivered across four pillars of care ranging from empowering people to self care and by transforming traditional primary, community acute and specialist care settings. Pillar four of the Caring Together Programme looks specifically at acute and specialist reconfiguration working with commissioning and provider partners in Greater Manchester and the North West of England 'south sector'. The aim of the change programme is to ensure services deliver quality outcomes against recognised best practice standards. The pre consultation business case is scheduled for completion in Summer 2014, which will include a detailed service and economic model.

What is agreed however is that there will be a requirement to close hospital beds and take existing investment out of this part of the care sector to support the health contribution to the BCF. Early estimates are that two 25 bedded wards need to be closed and removed from the system alongside the workforce plans for redeployment etc, to release the level of investment required.

Detailed investment and benefit management plans will be designed throughout 2014 – 2015 in line with CCG and Social Care Commissioning Plans.

Need to add additional info about risks of not realising savings. Also must clearly

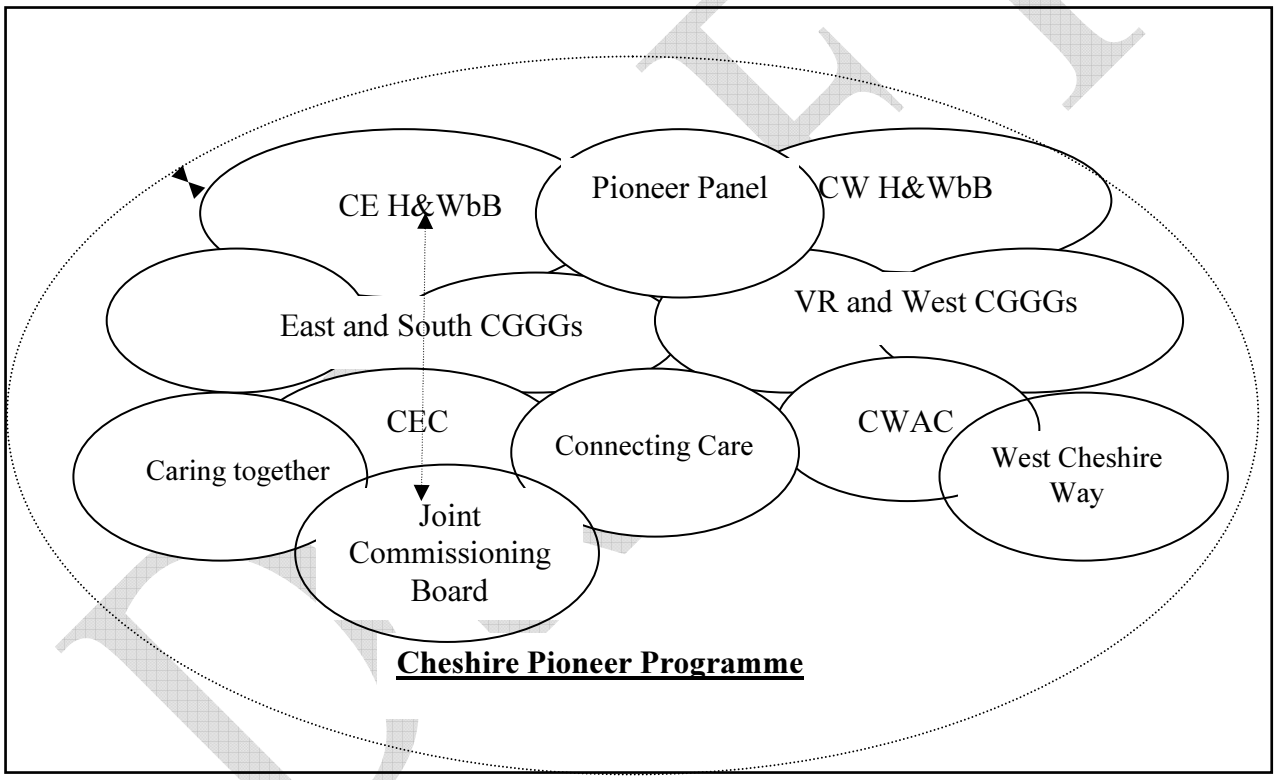
quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising.

e) Governance

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

The governance of the BCF will form an integral part of the overall plan of integration across the two CCGs, and inform the wider Pioneer Programme. The diagram below, indicates how the separate programmes of activity across the Councils and CCGs link and combine to form the overall five year Joint Strategy and Plan.

Locally across Cheshire East we will place the HWB at the centre of the management of our BCF programme, representing the shared interests of all partners in an open and established forum. This model of governance is illustrated below:



Our HWB will engage with the following bodies to ensure that we create a collaborative, effective and transparent model of governance:

- **Pioneer Panel:** Made up of representatives from across both Health and Wellbeing Boards to address integration issues on a pan-Cheshire geography.
- **Organisational Governance:** We will continue to use the existing structures and mechanisms that have been established to make sure that the BCF is aligned to mainstream governance and business as usual.
- **Scrutiny and Health-watch**: We will use the existing mechanisms to monitor our progress and champion the views of local residents, patients and service users to ensure there is appropriate accountability for this programme.

Governance will be clearly defined through the following roles:

(i) Health and Wellbeing Board
(ii) The two programmes – Connecting Care and Caring Together
(iii) Pan Cheshire Pioneer Panel
(iv) HWB Joint Commissioning Board

We will continue to align our varying workstreams to ensure that the overall governance framework remains sufficiently robust as we refine our draft plan, seeking to explore the best governance arrangements in place across the HWB area, including reviewing the items below:

Joint commissioning

Joint Commissioning MOU Final Jan 2013jv

This is an undated version can anyone advise on date agreement was finalised?

Health, social care and a wide range of other community partner organisations across Cheshire have made a commitment to working more closely together in new innovative ways to ensure that within the next five years, the people within our communities will enjoy a better standard of health & wellbeing & will have positive experiences of seamless care and support.

We are committed to delivering the National Voices narrative below:

For the individual:

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

National Voices & Making it Real

Our plans are ambitious and we will lead a programme of work to ensure that people within our local communities are empowered and supported to take responsibility for their own health and wellbeing. They will place less demand on more costly public services through the implementation of ground-breaking models of care and support based on:

- integrated communities
- integrated case management
- integrated commissioning and
- integrated enablers to support these new ways of working.

The two Health and Wellbeing Boards within Cheshire are leading this transformational change through a large-scale change programme with support from

the national Pioneer team. The Cheshire wide Pioneer plan encompasses a range of shared integration commitments and is structured as three core components based on local populations:

- Central Cheshire 'Connecting Care' programme
- East Cheshire 'Caring Together' programme
- West Cheshire 'The West Cheshire Way'/'Altogether Better'.

The **Connecting Care** programme board has been established to provide strategic leadership to the underpinning work-streams, to stimulate transformation of the local health and social care economy, to ensure close working between all partners, to ensure robust monitoring and risk management. The Board comprises representatives from our key partner organisations across health and social care and meets monthly, supporting a cohesive approach to service delivery for the population of South Cheshire/Vale Royal. Membership is currently being expanded to include representation from Healthwatch.

Within Eastern Cheshire the **Caring Together** Transformation programme is well underway having established a robust framework for governance engagement and programme delivery. The case for change as part of the pre consultation phase is being finalised and consultation scheduled for June 2014. Care model development groups are currently developing ambitious standards for new services across the four pillars of care to ensure improved health and social care outcomes are achieved

Caring Together governance structure

2) NATIONAL CONDITIONS

a) Protecting social care services

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

Partners recognise the budget challenges that exist across the health and social care economy. We know that social care services have delivered £30m (30%) of efficiencies over the last five years to 31 March 2014, whilst investing £20m in new services over the same period; health services have similarly delivered significant efficiencies. During this time the Council has struggled to maintain the delivery of services, whilst maintaining the consistent Fair Access to Care Service Eligibility Criteria at Critical and Substantial. The protection of social care services does not merely relate to budgetary issues, it more importantly focuses on the outcomes for people who have social care and support needs to maintain and promote independence wherever possible. It also requires the development of an increased range of services to promote the Prevention, Early Intervention and Well Being agenda in line with the Personalisation agenda and the new Care Bill. It is the Health and Wellbeing Board's intention to maintain services at the critical and substantial level (followed by the national eligibility criteria as determined by the Care Bill) with a commitment to developing targeted services for people with moderate needs.

The Council is committed to protecting and enhancing services required by the frail and

vulnerable individuals of our communities and through combining services provided by both Adult Social Care and Public Health has and continues to enhance services. Protecting services does not necessarily require the protection of funding. The Council, the two CCGs and prior to that the PCT have consistently reduced costs as shown above whilst enhancing service delivery over the first five years of the Council's existence. This work continues with the delivery of improved outcomes within reduced budget targets over the forthcoming years, which will be enhanced by the BCF.

We will not use the BCF to meet the budgetary challenges that are facing social care services over the coming three years. We believe that the BCF represents an exciting opportunity to invest in a wide and varied range of community services and assistive technology with the result of improved outcomes for our population. The changes to the investment pattern will contribute to the development of an integrated and balanced model of care and support that delivers on the ambitions in this plan and complements the range of health care provision.

We will use the BCF to promote the principles of integration and prevention to make sure that we have the appropriate funding for social care provision to extend effective services at scale and pace, and deliver wider benefits across the care and support services of Cheshire East. As the structure of health services change, social care services will also be reshaped to compliment and create coherence across the whole system.

One of the most notable changes that demonstrate this concept in action across the Council has been the development and change in domiciliary services. The Council has developed the external market for domiciliary services, whilst developing internal specialist services for re-ablement, adding improved outcomes at an overall lower cost to the public purse.

Social Care Reform

It is recognised that the BCF needs to incorporate statutory responsibilities as part of the Social Care Reform, Care Bill. Whilst there is a national allocation of £135m to cover carer's assessments and maintaining social care eligibility included within BCF there is no clear allocation to local areas. It is estimated that the funding available to Cheshire East is £1m and work is currently underway to determine the demand for carer's assessments and the impact of maintaining eligibility. The pathway between people requiring services and the assessment of their carer support network will be reviewed and developed as part of the review of health and social care services.

Alongside the Better Care Funding, it has been announced that there is National funding of £335m to support the funding of social care reform in 2015/16. Of this funding, £50m relates to capital which is incorporated within the BCF allocation. The Cheshire East allocation is £0.8m and this is being used to invest in the development of IT systems which incorporate the Social Care Reform policy changes. The allocation to Cheshire East of the £285m revenue allocation to cover increased social care assessments; deferred debt scheme; financial assessments is £1.7m in 2015/16. A recruitment request of 16 social workers is being progressed in February 2014 by the Council to ensure that there are sufficient resources in place to fulfil these additional requirements.

The Department of Communities and Local Government (DCLG) have not announced 2016/17 funding for further changes to eligibility criteria and the introduction of the care cost cap. The Council are working with ADASS to complete modelling information in

relation to the impacts of Social Car Reform changes.

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

Key areas of protection:

- Manage and reduce demand on Residential hospital care

- Maintain and enhance current level of provision for domiciliary care and support at home to provide real alternatives to people to stay at home and especially in a crisis
- Increase reablement resource to increase access and benefits to people especially on discharge from hospital
- Introduce dementia reablement service to focus on this client group at early stage of diagnosis to prevent/slow down deterioration in condition and introduce coping strategies/self management for the individual and carers
- Increase flexibility and response to requests for support from care providers over 24/7. Increased funding required for providers to home services available and accessible 24/7 for both routine and crisis responses
- Lower level short-term Social Care support on discharge to people without need for FACs eligibility assessment.

- Maintain Current Levels of Eligibility

- As LA budgets reduce and demand increases the need to maintain a safe and effective service response for people eligible for Social Care becomes more pressured and will need protecting.
- Future national eligibility may include greater numbers of people deemed eligible and resources to meet need need to be protected.
  Care fund criteria includes use of BCF to offset services at risk and the LA response to the Care Bill

- Meeting Responsibilities under Care Bill

  Additional Responsibilities include:
- Increased numbers of people requesting assessments to have their contribution for care counted towards their individual care account to be considered for the 'cap'.
- Increased eligibility for assessments and care and support for carers
- Possibly increased eligibility threshold
- Additional responsibilities for Social Care needs or prisoners in local prisons – ie Styal
- Focus on 'wellbeing and prevention' and support services to deliver/support this

- Integrated with health commissioning and provision
- Commitment to integration of service provision and commissioning activity will require a focus on the Social Care agenda and its contribution to the overall health and wellbeing agenda both in commissioning activity and provision
- Focus on wider determinants of health and the need to invest in whole system developments

Therefore, we will use the BCF to invest into areas of integration, prevention and support rather than using these funds to address budget gaps. We are committed to using this fund as the necessary investment to extend evidenced and proven areas of Social Care spending that support the aims of the plan with three main initiatives, which are; developing our Rapid Response/Urgent Care Services, enhancing our Community Services, including neighbourhood teams and introducing more Self-care, self-management and help to live independently at home.

Further detail is included within the attached document:

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b) 7 day services to support discharge

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

The Health and Well-being Strategy contains a commitment to enabling seven-day health and care services.

We will use the BCF to support residents seven days a week, as a lever to support proposals contained within the CCG operational plans.

Partners are committed to developing timely and effective services that provide timely discharge and prevent unnecessary admissions amongst high-risk cohorts. This will involve a process of risk stratification so that all local organisations have common information when working with common cohorts.

The CCGs and partners have utilised the urgent care board planning process to identify the need for seven day service provision within both hospital and community settings. The BCF will be utilised to ensure that all relevant service areas have appropriate staffing levels, contingency planning to provide rapid response services and also commissioning arrangements for flexible and accessible seven day wrap around care services. Learning from work already underway (for example using the winter pressures monies in Eastern Cheshire CCG) will inform planning.

We will continue to work up the plans utilising the newly formed Provider Board 'innovation fund' as a mechanism to develop appropriate 7 day services tpo meet local need.

c) Data sharing

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

We are currently using the NHS number as the primary identifier on a high proportion of our shared cases, capturing the NHS number within the Social Care Case Management system whenever possible. This builds on the earlier work completed across the Cheshire East area with the Common Assessment Framework Demonstrator, where the NHS number was a key element of that project. We continue to improve on the capture of the NHS number and to verify that with the NHS systems.

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

We are committed to having the NHS Number as the primary identifier for all local cases by April 2015.

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

We are committed to adopting market leading case management systems that utilise open APIs and Open Standards.

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

The Council and its partners are committed to being able to satisfy the IG Toolkit level 2 by March 2014 and Level 3 by March 2015..

d) Joint assessment and accountable lead professional

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

The model of service for rapid/urgent care response and the community service model is built around the principal of a single assessment process by the most appropriate professional(s) with a single care plan incorporating all elements of the persons care and treatment. The person with complex care needs involving multi professional/service input will be allocated a lead professional who could be any professional within the service area.

The lead professional will have a coordinating role and be accountable for ensuring the plan of care reflects the range of support and treatment to appropriately meet the assessed care needs and manage any identified risks appropriately. The lead professional will be identified as the most appropriate professional involved in the persons care. This will depend on the frequency of contact, knowledge of the person and the skill and/or expertise needed in any given situation. The individual may wish to influence who the lead professional will be and will have their wishes taken into account wherever possible.

The single assessment process will be supported by documentation and a single record system which allows for the professionals involved in the assessment to contribute to the process and record in one place and for a point in time. This assessment will be regularly reviewed and updates in keeping with the needs of the individual.

The crisis contingency care plan for the high risk group will be developed to reflect the intended responses across health and social care including NWAS. The crisis contingency plan will be developed in conjunction with the person and their carers.

Multi disciplinary groups in Eastern Cheshire currently meet regularly around groups of GP practices. This will be extended as a first step to enhancing the communication and coordination of those patients deemed to be in high risk groups. This is a precursor to the ambition to establish the lead professional role as detailed above.

In South Cheshire we are looking to explore a number initiatives, for example in one area, we plan to have three early implementers for extended practice teams by summer 2014 based on town geography clustered around groups of GP practices. There will follow a roll out of four other teams (which are seen as single point of access) through late autumn 2014/early 2015. Coverage of the teams is around 20,000-25,000 patients. The learning will be considered across the HWB area and across the wider Pioneer area to ensure the best practice emerges between the different areas in line with the Pioneer ambition.

Patients will be identified through risk stratification within each team and is likely to be 0.5 - 5% of a practice population, expanding over time. We are currently evaluating the use of various risk stratification tools (such as EMIS and ACG) across the HWB area and may pilot a couple of different approaches to assess the benefits and the potential alignment with the LA systems. MDTs are currently indentifying patients known to services already at high risk.

3) RISKS

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

Risk	Risk rating	Mitigating Actions
Improvement in the quality of preventative services may not achieve outcome improvements by the end of the BCF (2015/15) and would therefore lead to the double-running of costs. This could potentially impact on the funds that are available for preventative services prior to escalation.	High	We have modelled our BCF submission on the best available data, and have applied optimism bias to reduce risk. We will monitor these issues throughout 2014/15 and refine assumptions as far as possible.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	High	The BCF will be reported to governance and operational groups on a regular basis to ensure this relationship is monitored, and to stress the importance of this work.
The lack of local data provided and available may result in the targets included in our outcomes and metrics section may not be achieved, and therefore we would be left with a shortfall.	Medium	The payment by results targets have been based on the best available local data, including the forecasting for future years. Contingency plans have been developed to highlight potential alternatives should a shortfall occur. Under the Pioneer Programme a wider process of performance benchmarking is being conducted across the County.
The movement of resources may potentially destabilise services and providers, most critically the acute trusts.	Medium	We have engaged with the Acute Trusts and other providers throughout the development of these proposals. These plans have been developed over the past three years, and appropriate time has passed for a meaningful dialogue to take place on these issues.
Lack of investment to adequately resource delivery or integration programmes	Medium	Seek to review all exiting funding across the S256 programme Additional resources to “pump prime” setting up new alternatives before movement of monies as recurrent funding streams are embedded
Cultural change will not be delivered over the short and medium term and thus impact on the identified	Medium	Programme of workforce development to be established to ensure culture issues addressed

metrics		Development of Leadership Academy programme based on quality improvement systems.
Public/citizen engagement will be weak and not facilitate robust involvement/transformation redesign of health and social care	Medium	Engagement throughout the plan being considered.
Interdependency between programmes and activity, willingness to allow a collective HWB/Pioneer programme to evolve and flourish	Medium	Governance arrangements, providers and commissioners to ensure that activity reductions or increases can be tracked against the shared plan.
Interdependency with other areas of whole system change (for example Mental Health)	Medium	Governance has main providers, including mental health, ensuring the shared plan delivers whole system ownership and changes across health and social care.
Acute and the ability to lever change, the potential for double running costs.	Medium	There is potential for double running costs as the early implementer sites are embedded before resources can be released from the acute sector.

Caring Together Risks:

Programme Risk and Issue Log 8th Jan 20:

Contingency: **To be added**

Draft Metrics and Finance Template **(Needs replacing with updated template)**

To be added