Report to: Health and Wellbeing Board **Date of Meeting/Report:** 19th February 2014
Report to: Cabinet **Date of Meeting/Report:** 27th February 2014

Subject: Better Care Fund (Formerly the Integration Transformation Fund)

Report of: Deputy Chief Executive **Wards Affected:** All

Is this a Key Decision? No **Is it included in the Forward Plan?** No

Exempt/Confidential No

Purpose/Summary
This report provides members of the Health and Wellbeing Board and Cabinet with the background to the Better Care Fund (BCF) (formerly the Integration Transformation Fund) and outlines the approach being taken in developing Sefton's Better Care Plan. The first stage of which is that a BCF template has to be submitted by 14th February to NHS England (North), which will then be assured by that organisation, with support from the Local Government Association, to assess whether Seftons BCF, is sufficiently robust to deliver the governments vision for the integration of health and social care.

Recommendation(s)
That the Health and Well Being Board agree and recommend to the Cabinet and the two CCG Boards, the first iteration of the Better Care Plan, in the form of the attached template, as agreed by the Chair of the Health and Wellbeing Board, Councillor Moncur, in consultation with the Cabinet Member Older People and Health, Councillor Cummins, which was submitted to the government on the 14th February 2014, subject to agreement by the Health and Wellbeing Board and the Councils Cabinet.

That Cabinet endorse the recommendation from the Health and Wellbeing Board, that the Cabinet agree the first iteration of the Better Care Plan (template attached), and note that the Plan will be brought for approval by Cabinet as a key decision at its next meeting, in order to meet the governments deadline of April 4th 2014.

That the Health and Wellbeing Board and the Cabinet note that there is no new money attached to the Better Care Fund.

How does the decision contribute to the Council's Corporate Objectives?

	Corporate Objective	Positive Impact	Neutral Impact	Negative Impact
1	Creating a Learning Community			
2	Jobs and Prosperity			
3	Environmental Sustainability			
4	Health and Well-Being			
5	Children and Young People			
6	Creating Safe Communities			
7	Creating Inclusive Communities			

8	Improving the Quality of Council Services and Strengthening Local Democracy			

Reasons for the Recommendation:

The Governments is pooling resources within the Better Care Fund, and has nominally proposed the amount for each local area, subject to jointly developing with its CCG(s), a joint plan. The first stage of the process is to submit a planning template, which will be assured, to assess whether the plan is likely to deliver the governments vision for integration of health and social care. The deadline for the template to be submitted was 14th February, 2014, and the Cabinet Member for Older People and Health, in consultation with the Cabinet Member for Children, Schools, Families and Leisure, as Chair of the Health and Wellbeing Board, agreed to submit the template by the deadline, but subject to the approval of the Cabinet on formal recommendation of the Health and Wellbeing Board. It is not known what the impact would be of none compliance with the process, but it is possible that the resources nominally allocated to Sefton would not be available. Therefore to ensure the resource is secured, the process has been complied with.

What will it cost and how will it be financed?

(A) Revenue Costs

The Better Care Fund Pooled Budget for Sefton has a proposed value of £24.0 M in 2015/16. Of this, £2.8 M, is for disabled facilities grants and social care capital grant, and is currently resources which the council receives (see B below).

In 2014/15, the Council will receive, as previously reported, a further £9.3 M from the Southport and Formby CCG and South Sefton CCG, which will continue in 2015/16, and forms part of the aforementioned £24 M. This is currently spent on a range of S256 agreements which support social care but have a health benefit, carers break expenditure, and reablement services.

The balance of the £24M: £11.9 M, will be transferred to the Better Care Fund by the two local CCGs, and is resources which currently funds acute and community services. Of this, in 2015/16, £3 M is required to protect social care, and to off set some of the demographic pressures on social care services, resulting from Better Care Fund vision.

(B) Capital Costs

Of the £24.M resources referred to above, £2.8m relates to capital expenditure to cover the Disabled Facilities Grants and the Social Care Capital Grant. These items are currently included within the Council's single capital pot and will need to be ring fenced in future years to facilitate the transfer from the Council's single capital pot into the Better Care Fund.

Implications:

The following implications of this proposal have been considered and where there are specific implications, these are set out below:

Legal **NHS England Planning Guidance – Developing Plans for the Better Care Fund, December 2013, Health and Social Care Act 2012, The Care Bill.**	
Human Resources	
Equality	
1. No Equality Implication	√
2. Equality Implications identified and mitigated	
3. Equality Implication identified and risk remains	

Impact on Service Delivery:

What consultations have taken place on the proposals and when?

The Head of Corporate Finance and ICT has contributed to the preparation of this report and is aware of the future changes being proposed by introducing a pooled budget to support the social care and health needs. At this stage the financial risks cannot be evaluated as the proposals are not yet fully developed to identify risks arising from the changes in commissioned services and any resulting impacts this could have on the Council's responsibilities and budget choices. She supports the recommendations in order to maximise the resources available to meet the Sefton population needs and will review the risks as the plan matures. (FD 2802/14)

The Head of Corporate Legal Services (LD 2108/14)

Are there any other options available for consideration?

Implementation Date for the Decision

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Background Documents
Better Care Fund Guidance
Better Care Fund Template
Better Care Fund Finance Template

Background

In the autumn of 2013 the Government set out its intentions for the implementation of an Integration Transformation Fund (ITF), now known as the Better Care Fund. The Better Care Fund places requirements on local health and social care systems to plan for a higher level of integration as part of a five year strategy. The most recent detailed guidance on Better Care Fund outlines the following requirements:

- Plans are to be jointly agreed and signed off by the Health and Wellbeing Board
- Protection of social care services (not spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- 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 in the acute hospital sector

The guidance requires the first iteration of the completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans, to be submitted to the government by 14 February 2014 and for a revised version of the Better Care Plan to be submitted to NHS England (North) as an integral part of the constituent CCGs' Strategic and Operational Plans by 4 April 2014.

What is the Better Care Fund?

The Better Care Fund (formerly known as the Integrated Care Fund) requires Councils and Clinical Commissioning Groups (CCGs) to deliver five year local plans for integrating health and social care.

Whilst the Better Care Fund does not come into full effect until 2015/16, the intention is for CCGs and Local Authorities to build momentum during 2014/15, using the £200 million (nationally) due to be transferred to local government from the NHS to support transformation. Plans for use of the pooled budgets must be agreed by CCGs and local authorities, and endorsed by the local Health and Wellbeing Board. It is not yet clear how this will be released to local authorities.

It is important to clarify that this money is not new money, but a transfer of resources from the NHS to Local Authorities that is already committed to existing services. The funding is intended to be used to support adult social care services which also have a health benefit. The funding can be used to support existing or new services or transformation programmes where such programmes are of benefit to the wider health and social care system where positive outcomes for service users have been identified. The Sefton Better Care Plan is being developed in order to derive the maximum benefits for our residents, whilst seeking to protect adult social care services within the current climate of significant budget pressures and growing demand. The approach has been developed to assist the Council in delivering the proposals for modernising adult social

care as outlined in the report on the Adult Social Care Change Programme being presented to Cabinet on the 27th February 2013.

Payment linked to Performance

Nationally, £1bn of the £3.8bn included in the total Better Care Fund will be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for performance element of the Fund will operate. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and a single locally determined metric.

The national metrics/measures underpinning the Fund are:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

There is no single measure of patient / service user experience of integrated care currently available and a new national measure is currently in development. In addition to the above five national metrics/measures, local areas are required to choose one additional indicator that will contribute to the payment-for-performance element of the Fund. The following menu of nine metrics/measures selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks have been chosen by the government which local areas can choose from as their local metric/measure:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life
Public Health Outcomes Framework	
1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as "inactive"
2.24i	Injuries due to falls in people aged 65 and over

Local areas must either select one of the measures from the above menu, or agree a local alternative. Any alternative chosen must meet robust criteria as outlined in the guidance.

It is recommend to the Health and Wellbeing Board and Cabinet that the following metric from the NHS Outcomes Framework be adopted as the local metric for the Sefton Better Care Plan:

2.1: Proportion of people feeling supported to manage their (long term) condition.

The reasons for recommending this metric to the Health and Wellbeing Board and Cabinet is that it will be collected as part of the existing performance management processes for the NHS thereby not requiring the Council to invest in any new surveys or consultations processes. Additionally the model of integration described in the attached planning template, would be supported by this measure.

Each metric/measure will be of equal value for the payment for performance element of the Fund. The Better Care Fund Plans will go through an assurance process involving NHS England and the LGA in order to release performance related funds. The government will not withhold the performance-related funding and reallocate elsewhere in 2015/16. However, they are considering whether such an approach should be adopted in future years. In terms of failure to achieve the levels of ambition outlined in the plan the government may require areas to produce either a contingency plan or recovery plan, for which any the held-back portion of the performance payment from the Fund will be made available.

It is important to note that the BCF is only part of our overall plans to integrate health and social care, which is a core purpose of the Health and Wellbeing Board, and a duty under the Health and Social Care Act 2012 and will be a duty under the Care Bill when enacted.

Attached at Appendix One is the Better Care Fund Planning Template for Sefton which, with the approval of the Chair of the Health and Wellbeing Board, in consultation with the Cabinet Member for Older People and Health, was submitted to the Government on the 14th February. The submission was made subject to approval by the Health and Wellbeing Board on the 19th February 2014 and ratification by Cabinet on the 27th February 2014. South Sefton CCG and Southport and Formby CCG gave a delegation to their Chief Officer and Chairs of the two Boards, to sign the planning template for submission. Members should note that the Council and CCGs will not be bound by the draft planning template as there will be further iterations developed as the plan goes through the assurance process working towards a revised submission on the 4th April 2014.

Requirements in developing a Better Care Plan

- The Health and Wellbeing Board are required to sign off the plan on behalf of the Council and the CCG's
- The plan must be developed as an integral part of a CCG's wider strategic and operational plans, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan
- The plan should include an agreed shared risk register, an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and the steps that will be taken if, for example, emergency admissions or nursing home admissions increase

- Councils and CCGs must engage with all providers, both NHS and social care (and also providers of housing and other related services), to develop a shared and agreed view of what future services will look like, help manage the transition from current service delivery to the future proposed models, including an assessment of future capacity and workforce requirements across the system, and agreement to all the service change consequences.

Assurance Process

The Government issued further draft guidance on the assurance process for the Better Care Fund in early February 2014. NHS England and local government regional peers will have the primary role in the assurance process of the BCF Plans. The assurance process includes a testing timetable working towards a revised iteration of the plan being submitted by the 4th April 2014. Further funding has been made available in year 2013/14 and for 2014/15 to support a sector led support programme for the Better Care Fund and the Care Bill across the nine local government regions.

The Local Approach to Developing our Better Care Plan

The Health and Wellbeing Board held a number of workshops during November to January with a range of representatives from the Council and CCGs at which the framework for integration in Sefton was developed. Following this, under the direction of the Health and Wellbeing Board, the Programme Group established a task and finish group of officersfrom the Council, the Clinical Commissioning Groups for Southport and Formby and South Sefton and Clinicians to share ideas about how to develop the Plan for Sefton.

The Health and Wellbeing Board hosted a listening event on the 22nd January 2014 to engage wider partners from the hospitals, community health trusts, pharmaceutical and optical committees, housing providers, health and social care providers and the voluntary, community and faith sector, including those representing public voice, to share ideas and further shape the approach to integration within Sefton. From this a report has been developed which has informed the vision and outcomes expressed in the BCF planning template. Further work is planned to further develop this work within the Council, with CCGs and with those invited to the event, over the coming months.

A range of public engagement and consultation sessions have been held on the CCGs Strategic Plans for Southport and Formby and South Sefton which included taking feedback as it relates to the Better Care Fund. The first iteration of the Better Care template has been developed by also utilising the feedback from the public, service users, and stakeholders from the wide ranging consultation and engagement processes that underpinned the development of the Sefton Strategic Needs Assessment and the Sefton Health and Wellbeing Strategy. Further events with stakeholders, the public, service users and the voluntary sector will take place during the coming months to inform the final Better Care plan for Sefton.

The approach adopted to developing our Better Care Plan has been informed by the Council's significant budget pressures, which are compounded by our demographics and the dialogue that is taking place with the public around self care and self management. This approach will continue to underpin the development of the final Better Care Plan for Sefton, and will inform our approach to integration.

Conclusion

Preparations for the development of a Better Care Plan, as part of the CCG's Southport and Formby and South Sefton 5 year Strategic Plans are underway, in accordance with the national guidance. Once feedback, both from the assurance process referred to above, and from continued engagement on the first cut of the Better Care template and the CCG's draft 5 year strategic plans is received, a more detailed revised plan will be brought to the Health and Wellbeing Board and Cabinet. The guidance on the BCF has been changed during the process of development, and it is anticipated it will continue to be firmed up over coming months as the assurance process validates whether the BCF templates are robust enough in terms of vision, ambition and schemes, to draw down the funding. The risks associated with the plan are set out in the attached template, and the Health and Wellbeing Board and Cabinet is asked to consider the risks when it considers the attached BCF template.

Local Government Association

NHS England

Foreword

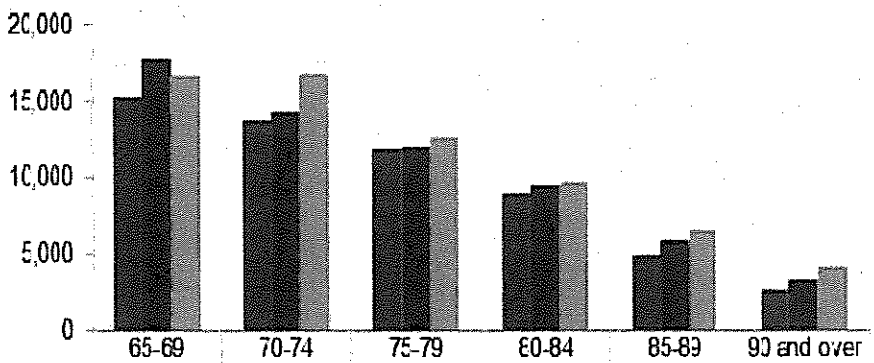
Who we are?

Sefton is a borough in Merseyside. Our population is approximately 275,000 and is centred around 5 townships. Sefton is served by two Clinical Commissioning Groups: Southport and Formby CCG and South Sefton CCG, which together, have co-terminus boundaries with Sefton Council. We have 54 GP practices: 20 in Southport & Formby and 34 in South Sefton and our population is served by a range of acute hospitals, including Southport and Ormskirk Hospital Trust: which is an Integrated Care Organisation, and Aintree University Hospital Foundation Trust. Our population is also served by Royal Liverpool and Broadgreen Hospital Trust. Community services in the south of the Borough are provided by Liverpool Community Health Trust and they also provide some specialist services and children's services for the whole of the borough. Mersey Care NHS Trust provides borough wide Mental Health Services. There are a range of specialist hospitals within Merseyside and beyond, which meet the specialist needs of our community, including Alder Hey Children's NHS Foundation Trust providing both secondary and tertiary care for children and the Walton Centre NHS Foundation Trust. We have a thriving domiciliary and residential care market and an active community, faith and voluntary sector.

What are the challenges?

The Borough faces particular challenges with regards to its significantly ageing population, with multiple long term conditions, compounded by unacceptably high health and wellbeing inequalities. Between 2011 and 2021, while the overall population of the Borough is expected to remain largely unchanged (an increase of 1%), it is predicted that there will be a 16% (57,366 to 66,545) increase in our population aged 65 and over, and a 40.5% (7,633 to 10,723) increase in the numbers of people aged 85 years and over in the same period, with those over the age of 90 expected to increase by more than 55%[1].

Projected Growth in over 65's Within Sefton 2011-2021



	65-69	70-74	75-79	80-84	85-89	90 and over
2011	15,262	13,630	11,902	8,939	4,953	2,675
2016	17,734	14,285	11,929	9,436	5,357	3,249
2021	16,661	16,715	12,705	9,740	6,556	4,157

The above charts shows a predicted increase across all quintile age groups age 65 and over by 2021.

[1] ONS Population Projections 2011-2021

Although the percentage increase in residents over the age of 65 is lower than percentage increases both nationally and regionally (23% and 20% respectively), the proportion of the area's population that is aged 65 or over is predicted to increase more rapidly. This is as a result of an increase of just 1% in Sefton's overall population, compared to 9% nationally and 4% across the North West. By 2021 over 65's are projected to represent 24% of the overall population, compared to 19% both regionally and nationally. Sefton's ageing population is further compounded by a falling working age population, expected to fall by 4%, compared to a national increase of 4% and a reduction of less than 1% across the North West. This demographic time bomb points to an increased demand for Council services during a time when resources and generated revenue to the authority are reducing.

The Council has significantly reduced resources as a result of the austerity measures; whilst at the same time is facing increased demand and expectation from within our communities. We are working within a context of dynamic national policy change, which is impacting on individuals and communities within the Borough. To put some of this in context, Council resources will have reduced by over £110m by 2014/15 and will see a further approximate reduction of £55m by 2017 This equates in real terms to a 40% reduction in resources since 2011/12. Around 60% of the Councils budget is currently spent on vulnerable adults and children. The core purpose of the Council is to protect the **most vulnerable** and to manage demand for support and services, and not just supply. We must pursue borough growth, as well as make savings, and empower communities and support independence by doing things differently in the context of reduced resources. We want to develop our commissioning approach and move from a contracting function where we have a small number of contracted services that have to be used to meet all assessed need, to one that starts from the position of identifying what people, families and communities can do for themselves augmented by a vibrant and responsive market place that has the flexibility to deliver support to fill the gaps.

There are also considerable pressures on the health system with the need to make on-going efficiencies, maintain quality, reduce secondary care activity, whilst working to further develop our approach to integration.

Local prosperity and community resilience go hand in hand, and as partners, we recognise that we must collaborate not just within the Borough, but also across geographical boundaries. An example of this is that Southport and Formby and South Sefton CCG collaborated with West Lancashire CCG around Southport and Ormskirk Hospital Trust which is an Integrated Care Organisation. Additionally, South Sefton CCG collaborates with Liverpool and Knowsley CCGs around the Aintree catchment, community and mental health services. We believe we need to align around the needs of people not organisations, to enable us to innovate and rise to the significant challenges which our communities face. By 2020, local government and public service will be unrecognisable, with people, families and communities having to do more things for themselves. Our challenge is to focus on people and place, not just the financial pressures on organisations, and more of the same will not be good enough if we are to achieve the aspirations of our community.

It is recognised that the Better Care Fund is important to the alignment and integration agendas, and we intend to use it for these purposes. However, the Fund alone is not enough to resource real and sustainable integration. This requires commitment from all partners, commissioners, providers, and the voluntary community and faith sector to effect the scale of change we need in our Borough, and through our engagement, we are creating the climate for this to happen. This work, together with work by individuals and communities, is part of the change, and an understanding that the Council will not be able to continue to provide services in the way it has to date. We believe that sustainable change at the scale required by the government is not achievable within five years, and that a more realistic planning horizon is five to ten years.

Due to the particular challenges in Sefton, the journey of integration has been on-going for some time. The Better Care Fund will help in focussing attention, by making it real. We have begun to align Social Care and Health Care Services in Sefton and tested new models of integrated care: known locally as 'Care Closer to Home' and 'Virtual Ward'. We made a Pioneer Integration Bid, with West Lancashire District Council and the Southport and Formby CCG, which regrettably was unsuccessful, but is evidence of our commitment to drive forward change.

The Council and the two local CCGs are aligned at strategic and operational levels, facilitated through the sub structure to the Health and Wellbeing Board. We have a strong foundation of integrated working with Public Health, with the Director of Public Health having been a shared post with the Council and NHS for a number of years, and we are currently mapping our community assets, as these are seen as key to community resilience.

We collectively want to make a real and positive difference to the most vulnerable people in our community. Our ambition is to integrate to support the achievement of the outcomes in our Health and Wellbeing Strategy, to mitigate the impact on the acute sector and the changes in commissioning

We will work together with our communities to do this as our ambition is to make Sefton a better place, despite the many challenges that we face. We are providing system leadership but we are in very difficult times, and the pressures on the system, whether from government austerity measures, welfare reform, demographic pressures, expectations of people around entitlements to services, means there must be a recognition of the challenges we collectively face, in seeking to effect real economically viable, sustainable, and holistic system change.

Timeline

This plan will be signed off by Sefton Councils Cabinet (at its meeting on 27th February 2014); South Sefton and Southport and Formby CCG Boards – as part of their 5 year strategic and operational plans, gave delegated authority at meetings held on 29th January 2014 and 30th January 2014 respectively, to the Chairs and Accountable Officer to sign on their behalf and Sefton's Health and Wellbeing Board (at its meeting on 19th February 2014). However, in so doing we note that it our considered view that if sustainable change is to be achieved, on the scale that the government is requiring, a ten year planning horizon is more realistic.

Better Care Fund planning template – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Sefton MBC
Clinical Commissioning Groups	Southport and Formby CCG
	South Sefton CCG
Boundary Differences	The geographic boundaries are co-terminous
Date agreed at Health and Well-Being Board:	19/02/2014
Date submitted:	14/02/2014*
*submitted subject to approval by the Board as above and the Councils Cabinet on 27th February.	
Minimum required value of ITF pooled budget: 2014/15	£
2015/16	£24.040M
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£24.040M

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Fiona Clark
Position	Chief Officer, South Sefton CCG and Southport and Formby CCG
Date	XX/XX/2014
Signed on behalf of the Clinical Commissioning Group	
By	Dr Niall Leonard
Position	Chair, Southport and Formby CCG
Date	XX/XX/2014
Signed on behalf of the Clinical Commissioning Group	
By	Dr Clive Shaw
Position	Chair, South Sefton CCG
Date	XX/XX/2014

Signed on behalf of the Council	
By	Margaret Carney
Position	Chief Executive, Sefton MBC
Date	XX/XX/2014
Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Ian Moncur
Date	XX/XX/2014

c) Service provider engagement

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

We have actively engaged our partners throughout the development of our Sefton Strategic Needs Assessment, the Health and Wellbeing Strategy, the CCGs Strategic Plans, and we are continuing to build on these existing engagement activities. The engagement approach has been focused on wellbeing as opposed to just Health and / or Social Care. To this end, joint engagement sessions (Sefton Council, South Sefton CCG and Southport & Formby CCG) remain programmed in prospectively to June 2014 as part of the CCG's Strategic Plan development. We have actively engaged with health providers as active participants; together with a range of local social care and housing providers, and our voluntary, community and faith sector as a whole. As a result, our providers have told us that they are keen to work with us to co-produce our future plans. We have through this engagement, gained a greater understanding and an appreciation that collectively we need to do things differently, to innovate, and to work together to find solutions to issues.

The Adult Social Care Strategic Plan and Priorities 2013 - 2020 set out the vision for Adult Social Care in Sefton. The Change Programme will deliver the transformation necessary to deliver the vision. The programme includes a full consultation and engagement plan with people and partners. The Market Position Statement sets out our current market place and how we will work with providers to develop the range of support necessary for our communities to make informed choices about their care and needs

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

Our vision for integration is based on what people have told us is most important to them and this is evidenced through the feedback on our Sefton Strategic Needs Assessment, the Health and Wellbeing Strategy, the CCG Strategic Plans for Southport and Formby and South Sefton and in developing this Plan. The Health and Wellbeing Board has also utilised the National Voices approach to ensure that the public, patients and service users (including carers) have directly influenced the priorities within our Health and Wellbeing Strategy and the content within this Plan. We have further enhanced our understanding of what patient and the public experience of services is through "Big Chat" and "Mini Chats" events and "Community Chats" within the Borough, which have brought partners together in engaging with our communities, on what matters to them. This has informed our plans, delivery and commissioning. Our Big Chat event in October 2013 highlighted the ambitions of the Health and Wellbeing Board and our emerging models of integrated working.

e) Related documentation – to be added to

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
JSNA – Sefton Strategic Needs Assessment	Joint Council, Southport and Formby and South Sefton CCGs and NHS England assessments of the health needs of the local population in order to improve the physical and mental health and wellbeing of the people of Sefton.
Sefton Strategic Needs Assessment Consultation Report	Report provides details of the consultation process and findings undertaken on the Sefton Strategic Needs Assessment
Borough Ward and Parliamentary Profiles	The profiles disaggregate the SSNA to a Ward and Parliamentary Constituency level
Joint Health and Wellbeing Strategy	This document sets out the overarching Health and Wellbeing Strategy for Sefton.
Joint Health and Wellbeing Strategy Consultation Report	Report provides details of the consultation process and findings undertaken on the Joint health and Wellbeing Strategy.
Pioneer Bid	Bid to become a pioneer in Integration Care and Support by West Lancashire, Southport and Formby, and South Sefton CCGs
Joint Commissioning Intentions	The Sefton Integrated Commissioning Group identified a range of areas and services on which it would focus its joint commissioning activity. These areas are now recognised within the Health and Wellbeing Board sub group structure.
Big Chat Reports	These documents provides details of the two CCG/HWBB Big Chat events held in October 2013
HWBB Stakeholder Event Report	This document provides details of the engagement event that took place in January 2014 on Integration in Sefton – the Better Care Fund
CCG Strategic Plan/BCF Engagement Schedule	This document outlines the engagement schedule planned to consult with the public and the voluntary, community and faith sector on the CCG Strategic Plan and Integrated Care
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
Individual CCG QIPP, Strategic and Operating plans	South Sefton CCG and Southport & Formby CCG have developed draft 2 year operational plans, in line with NHS England requirements. Draft will be submitted 14/02/14 and finalised by 4/4/14. The final 5 year strategic Plan will be in place by 20/6/14
LGA Peer Challenge Evaluation Report	This evaluation document provides details of the process and findings of the Peer Challenge

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

Our Vision for Sefton, as described in our Health and Wellbeing Strategy, is:-

"Together we are Sefton – a great place to be!
We will work as one Sefton for the benefit of local people, businesses and Visitors"

Our Health and Wellbeing Strategic Objectives are:

- Ensure all children have a positive start in life
- Support people early to prevent and treat avoidable illnesses and reduce inequalities in health
- Support older people and those with long term conditions and disabilities to remain independent and in their own homes
- Promote positive mental health and wellbeing
- Seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing
- Build capacity and resilience to empower and strengthen communities

Over the next 5 years, we will aim to deliver transformed services for the people of Sefton focusing on moving care from hospital to community based resources and supporting people in their own homes. Where care and other support is needed, we will look to make it available *in the right place, at the right time, at the right quality, whilst being cost effective.*

In seeking to deliver our 5 year ambition we will focus on:

- Early Intervention and Prevention
- Health promotion
- Self-care, self-help, self-management, with the longer term aim of reducing reliance on public sector services
- Encouraging self-determination and responsibility
- Information, advice, signposting and where necessary, redirection to appropriate services
- Developing integrated approaches across professional and organisational boundaries e.g. primary and secondary care clinicians working together in the community, assessment, meeting care needs, single gateway, seamless front door
- Facilitating a significant shift in culture and behaviours, across professions and organisations, but also in individuals in our community
- Innovation and whole system change

To achieve this we have committed to the following principles:

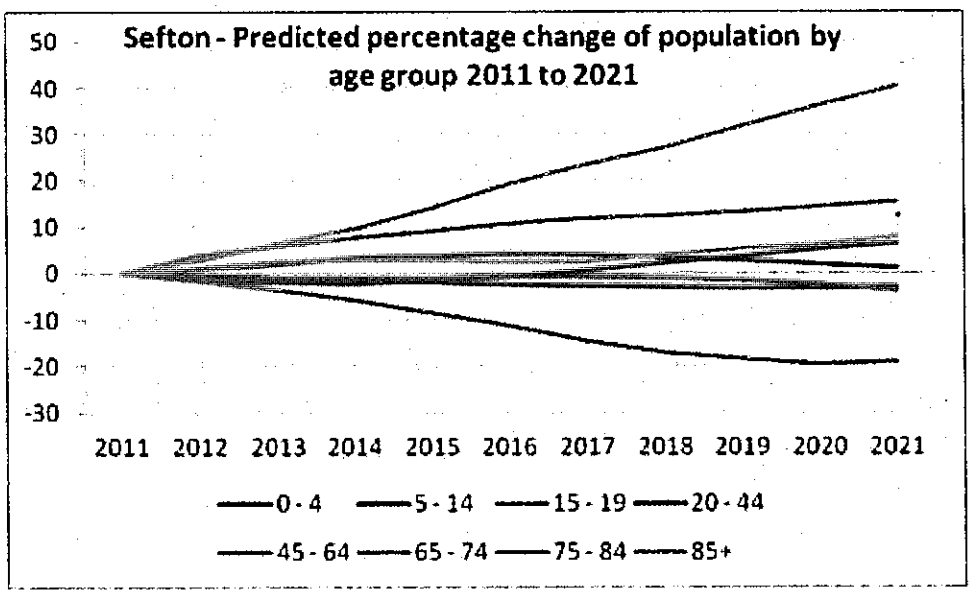
- Everything we do is to improve outcomes and the experiences of people
- We will engage with the people who use our services as partners, establishing a new and equal relationship with our professional staff in co-designing and continually improving services
- We will provide person centred care that considers an individual's physical and mental

health and well-being needs

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

Population & Demographics

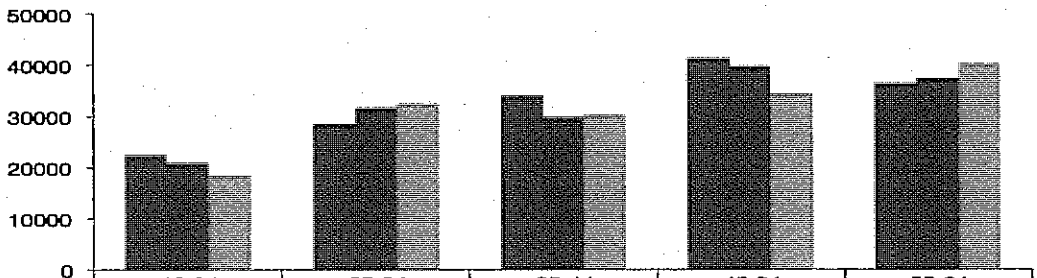
Sefton is a diverse borough with different challenges facing South Sefton and Southport & Formby. South Sefton has some of the most deprived areas in the country, with high levels of benefits reliance, social housing and deprivation. This has many health implications for families in these areas, with high levels of smoking and obesity. Whilst the North of the Borough (Southport and Formby) faces different challenges. Southport is a seaside town, which attracts an older retirement age population, which may be more dependent on care within the home to help them remain living independently.



Source: ONS 2011 base Population Projections – 2012

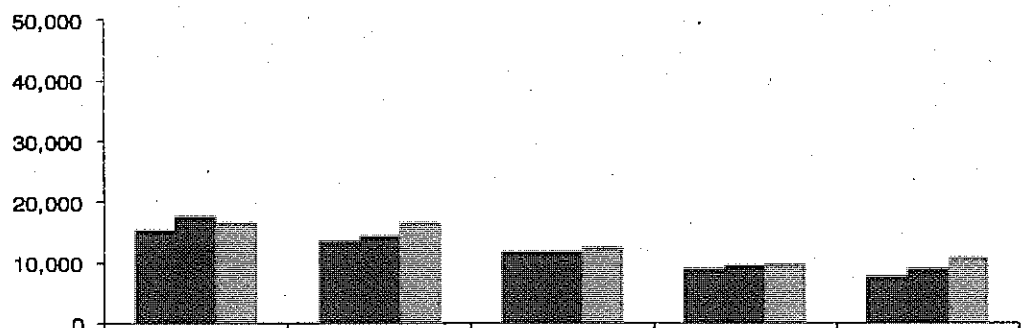
The line chart above shows a significant increase in older population whilst the age groups below 65 either remain consistent or are falling. This indicates the proportion of older people will grow significantly over the next ten years (see pie charts below)

Projected Change in 18-64 Year Olds within Sefton 2011-2021



	18-24	25-34	35-44	45-54	55-64
2011	22431	28435	33848	41409	36287
2016	20864	31598	29743	39786	37313
2021	18448	32304	30169	34578	40211

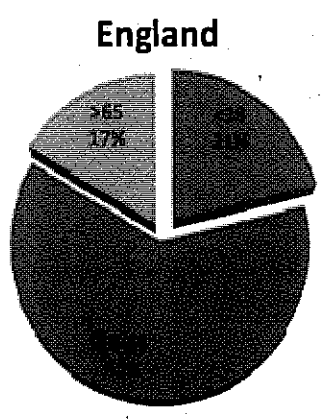
Projected Change in 65 and Over within Sefton 2011-2021

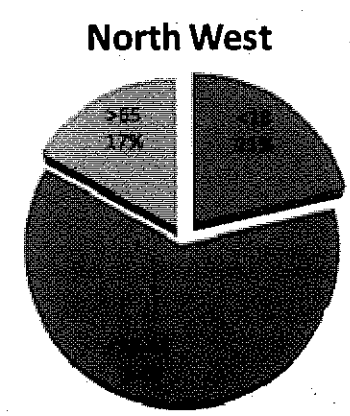


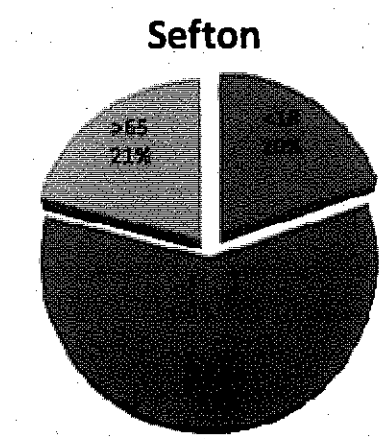
	65-69	70-74	75-79	80-84	>85
2011	15,262	13,630	11,902	8,939	7,633
2016	17,734	14,285	11,929	9,436	9,106
2021	16,661	16,715	12,705	9,740	10,723

Whilst Sefton's overall population is expected to remain largely unchanged overall in the next 10 years, the two charts above show that whilst overall the number of working age people within Sefton is likely to fall by around 4% over the next ten years, the population over 65 is expected to increase by some 16%. With those over 85 expected to increase by more than 40%

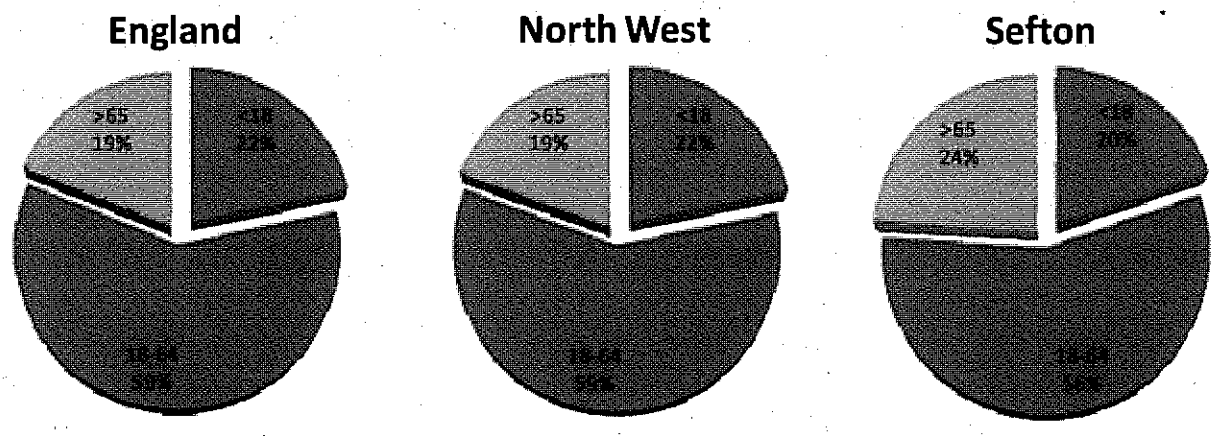
Population Proportion Breakdowns (2011)







Population Proportion Breakdowns (2021)



Population projections show that by 2021, almost one in four Sefton residents will be aged 65 or over compared to one in five both nationally and regionally. Whilst the percentage increases in older people across Sefton are not dissimilar to percentage increases both nationally and regionally, the proportion of over 65's in Sefton is compounded by a stagnating overall population (projected to increase by just 1%, compared to 9% nationally and 4% across the North West) and a reducing working age (18-64) population, which across Sefton is predicted to fall by 4%, compared to a national increase of 4% and a reduction of less than 1% across the North West.

This change in population will put further demands on services; whilst income to the Authority is likely to fall with the reduction in working age residents.

By 2020, over 3,500 people are currently forecast to be living in a care or nursing homes, an increase of more than 21% on current levels. Over the same period it is projected that 18% more people aged 65 and over will have dementia impacting on their wider health and their care needs.

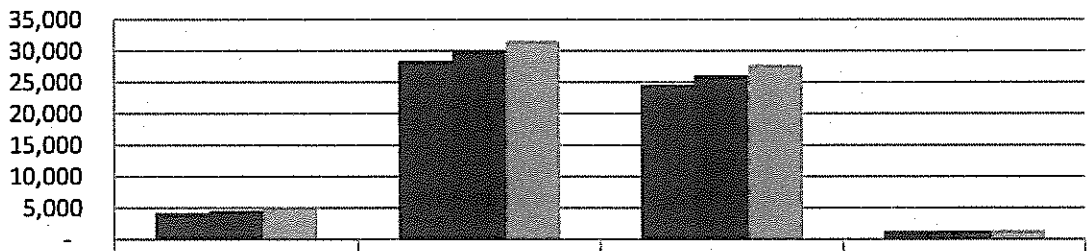
Source: modelled figures, www.poppi.org.uk

	Sefton Actual Change			Sefton Proportions		National Proportions	
Total population aged 65 and over forecast...	2012	2020	Increase 2012-20	% of Over 65 Population 2012	% of Over 65 Population 2020	% of Over 65 Population 2012	% of Over 65 Population 2020
to be admitted to hospital as a result of falls	1,274	1,438	12.80%	2.16	2.19%	2.08	2.15
to have a fall	15,837	17,866	12.80%	26.84	27.20%	26.67	26.98
to be unable to manage at least one self care activity on their own	20,155	22,752	12.80%	34.16	34.63%	33.44	34.02
to have a BMI above 30	15,253	18,763	8.20%	25.85	26.56%	26.11	25.87
to have dementia	4,249	5,013	18.00%	7.20	7.64%	7.02	7.41
to live alone	22,259	24,533	10.20%	37.73	37.40%	38.79	38.79
to be in local authority residential care	2,922	3,552	21.60%	4.95	5.41%	3.48	3.88
to be unable to manage at least one domestic task on their own	24,541	27,794	12.80%	41.76	42.37%	40.71	41.59

The chart above highlights the increased demand on Sefton services with predicted increases across all categories and also shows the proportion of the over 65 population compared to national proportions, which with the exception of obesity and those living alone, are all higher than the national proportions.

These demographic pressures, coupled with increasing social care demands as outlined above, will impact significantly on our ability to do things differently in Sefton. During the life of this plan, we will mitigate the impact on social care by moving to an integrated model. However given the scale and complexity of the challenge, sustainable change that improves outcomes, remains a significant risk when you couple this with the demographic pressures and the Government's austerity measures.

Key factors that may influence potential changes in demand for health & social care in people aged 65 and over



	People Predicted to be Living With Dementia	People With a Long Term Limiting Illness	Unable to Manage at Least One Domestic Care Task	Hospital Admissions as a Result of Falls
2012	4,249	28,405	24,641	1,274
2016 Projection	4,603	30,059	26,122	1,342
2020 Projection	5,013	31,642	27,794	1,438

The chart above highlights the increased demand on Sefton services with predicted increases across all categories

- People with dementia is expected to increase by 18%
- People with long term illness is expected to increase by 11%
- Those unable to manage at least one domestic task is expected to increase by 13%
- Hospital admissions as a result of falls is expected to increase by 13%

Coping with these demographic pressures, with significantly reduced resources available to the public sector is a current and on-going challenge. We have analysed the impact at a lower super output area, at a borough ward level and at a parliamentary constituency level, which demonstrates the diverse and difficult needs of our communities. We believe that a local solution, appropriately targeted, with our partners, and people, is the best way to try together to address our challenges. The challenge is such that we see no other way forward, than to do things differently.

The emergent Strategic Plans of South Sefton CCG and Southport and Formby CCG, together with work on transforming Adult Social Care by Sefton Council, describe a 'framework' for integrated care in Sefton, which this plan builds on. The strategic priorities of our CCGs and the Council priorities, underpin the achievement of the health and wellbeing strategic objectives. The needs of our communities in Sefton are very different, and are described in summary above.

Currently we have two models of integrated care in place: the Virtual Ward in South Sefton and the Care Closer to Home Programme in Southport and Formby. Both use risk stratification of people as a basis for implementing interventions and aim to:

"promote and maintain the independence of frail and older people and those with long term conditions who are at increase of risk of unplanned care."

These programmes help to shift the focus towards a more person-centred approach, reducing the need for urgent care, reducing hospital admissions, and focussing on a prevention, social care and wellbeing model of working, including, where appropriate, seven day working.

We intend to review Care Closer to Home and Virtual Ward programmes during 2014/15 to inform how we could 'scale these up' or "plus" the approaches. We want to integrate care so that it achieves the best possible outcomes for the people in Sefton. To achieve, this will require us to continue to build on our effective partnership approach with other public sector bodies, the voluntary, community and faith sector, with our diverse providers of health, care, social care, and wellbeing services, and importantly, will require even greater contributions from individuals and communities themselves, if we are to realise fully the benefits of prevention, self-care and self-management.

The following will form the basis of our approach in Sefton and we propose to use the fund most appropriately to support this approach, with the primary funding focus being protection of social care, and investment in social care to create improvements in the health of our population:

- Care Closer to Home Plus – Southport and Ormskirk/Virtual Ward Plus – South Sefton - integrated care coordination, including urgent care
- Transforming adult social care – including increasing the use of assistive technology, developing a new model of reablement and scaling this up, increasing personal and community resilience and commissioning services and support that 'do with' people rather than 'do for' people.
- Early intervention and prevention (reablement, falls, community equipment, early assessment, self-care)
- Long term conditions and mental health – An impact assessment will be undertaken in order to see if we have realised the desired outcomes and achieved value for money from services commissioned to support those people with poor mental health and wellbeing and long term conditions.
- Integrated Assessment and Integrated Discharge
- Integrated Commissioning
- Community and voluntary sector
- Carers
- Transitions from child to adulthood
- Dementia Friendly Communities, and dementia awareness
- Self-help, information and advice
- Public voice
- Integrated safeguarding and quality assurance
- Whole system model of care for adults with Learning Disabilities

We also intend to review and invest in a series of enabling schemes, which we will scope and implement a programme management approach to delivery in order to achieve our vision for integration in Sefton.

Priorities within the draft 5 year CCGs Strategic Plans and Budgets which will support our approach include:

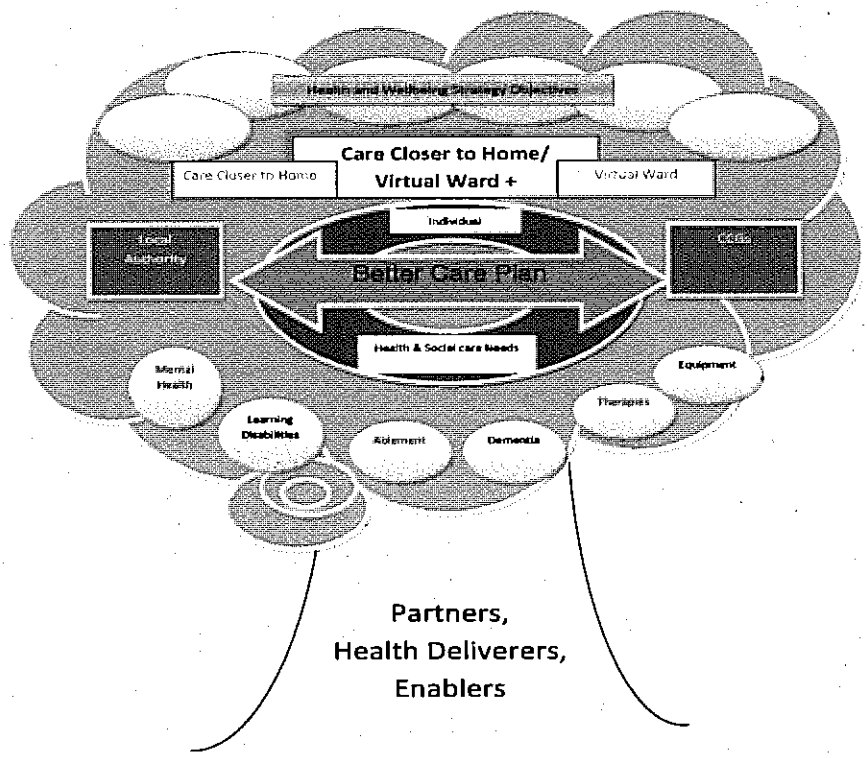
- Frail Elderly
- Unplanned Care
- Primary Care Transformation - enabling and supporting the development of a stronger role for primary care services at the heart of integrated care
- Cardiovascular Disease (including stroke)
- Respiratory Disease
- Cancer
- Children's
- Urgent Care
- End of Life
- Diabetes
- Mental Health

The CCG Strategic 5 year Plan focuses on delivering a shift in activity and resources over 5 years from a secondary care environment to a community environment. During 2014/15 the Health and Wellbeing Board, Cabinet Members, and the CCG Boards, will actively engage our partners, providers, the public, and anyone with a stake in Sefton, in developing a health, social care and wellbeing system which is fit for the future. From 2015, our focus will be on gearing up to transform the way we do things

To deliver on our ambition will require a significant culture change for people, families, our communities, organisations and the voluntary sector. We recognise the significant challenge this poses, and in 2014/15 we will develop a change programme to deliver, **in a 5 to 10 year period, changed patterns of services** which will see:

- An increase in the number of people living independently and receiving care at home when needed.
- Families, charities, volunteers and neighbours will increasingly be the providers of services playing a pivotal role in the prevention agenda and promoting dementia friendly communities.
- Decreases in unnecessary admission and readmissions to hospital.
- Social care focused on enabling people to live independently, rather than on assessing and meeting need: with staff focusing on assessing what people can do for themselves and only meet the needs of the most vulnerable.
- Increased use of appropriate home technology, tele-health and telecare
- Participation of people in applied research studies, particularly in primary care and related to the acceptability of technology.
- Appropriate use of joint Health and Social Care packages.
- Young people transitioning seamlessly from Children to Adult Services provision.
- Carers supported to continue in their unpaid caring roles.
- A reduction in social isolation.
- Effective and appropriate mental health provision.
- End of Life / Palliative Services, where people are treated with dignity and respect.
- Enhanced, targeted and focused reablement across community, intermediate and hospital based care.
- 7 day services, where appropriate
- Integrated access for all referrals using NHS number as the primary identifier.
- People, partners, providers, the two CCGs and Council working in an integrated way, to reduce the longer term reliance on public sector services.
- People and their families taking primary responsibility for looking after themselves early in order to remain fit and healthy whilst planning how they will personally financially

contribute towards any care that may be required.



Our joint vision, as highlighted in the above figure, has been developed from patient and public participation using a "Fruits" and "Roots" model to deliver better integrated care and improve outcomes.

The aims are to:

- **improve the health and wellbeing** of people in our community, with a focus on tackling inequality.
- co-ordinate care around individuals targeted to their specific needs with the ambition of **working towards a single assessment framework** to assess and meet the needs of individuals in their homes and communities, with seamless delivery of health and social care. This means ensuring there is a good quality care plan in place for all those at risk, backed by co-ordinated provision commissioned to deliver on the required support and outcomes envisaged in each and every plan.
- **improve the quality and experience of care**, with the right services available in the right place at the right time and use these experiences to evaluate and improve services.
- **maximise independence** by providing appropriate support at home to those who need it and in the community, and empower all people to self-care and self-manage their own health and wellbeing.
- provide **proactive and common case management**, which avoids unnecessary admissions and readmissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health and self-manage their long term conditions.
- facilitate integrated care through **Primary Care** across the Borough. Our ambition is that community, social care services, specialist mental and physical health services will be organised to work effectively through our model of integrated care, enabling Primary Care to ensure their patients are getting the very best person-centred care.
- collaborate with our **providers** to develop new models of service delivery, driven by clinical and professional staff on the ground.

- adopt national and international best practice and embrace innovation and ideas

Configuration of Services

We have a strong focus on shared distributive leadership within Sefton. We plan to use these relationships to maximise the use and value for money of all resources, to eliminate the necessity for people to have to negotiate complex systems and in particular, time consuming multiple assessments.

We will continue to explore opportunities to progress from alignment to integration which provides for:

- The continued development of the Lead Professional role.
- Co-location of services regardless of provider/employer
- Excellent links from primary care to secondary care.
- The ability of all services to bend and flex to meet need where that need is presenting. For example, an ability to immediately and responsively transfer resources from bed based to community services if this is required.
- Strong links and effective support, and where necessary, co-location with voluntary sector services, registered social landlords, housing services and independent private health and social care providers.

Monitoring our Outcomes

We aim, through these delivery models, to achieve a 15% reduction in non-elective care. This level of reduction requires whole system change. We intend to use the Better Care Fund to help social care services align better with health and wellbeing services, and to collectively work together to promote and facilitate prevention, self-care and self-management.

We will utilise existing outcome frameworks, which align with the Health and Wellbeing Outcomes Framework in our Health and Wellbeing Strategy (a fresh iteration of which is underway) with a particular focus on the Adult Social Care Outcome Framework (ASCOF), the overarching NHS Outcomes Framework and the Public Health Outcomes Framework. As monitoring frameworks develop, we will contribute and support developmental work to ensure these frameworks represent genuine outcomes for people and we will benchmark our performance.

Outcomes will be monitored through the existing performance arrangements for the Council, CCGs and the Health and Wellbeing Board, which will evaluate the value for money and effectiveness of our approach.

The performance management arrangements of the Health and Wellbeing Board have been reviewed and we will use the opportunity that this presents to ensure that the appropriate arrangements are in place through the sub structure to the Board, so that a wide range of partners, individuals and communities are engaged in ensuring achievement of the outcomes across the domains of the Health and Wellbeing Strategy and that the specific outcomes in the BCF Plan, are achieved.

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?

Aims and objectives of the integrated system

The aims of our approach are both qualitative and quantitative. We are determined that any changes we implement will have people at the heart of them and specifically will increase the quality and timeliness of service provision, where it is needed. Our integrated approach will seek to support more people via community based, prevention and early intervention initiatives to reduce demand on more intensive health and social care services. Where formal health and social care services are required, these will be focused on rehabilitation/reablement and regaining self-caring skills in the first instance to reduce the potential for a progression on to more specialist and nursing care services.

Through the risk stratification tool which underpins virtual ward/care closer to home, we will focus on those who will benefit most from early intervention, prevention, self-management and self-care. We will further develop this model, and build on our wider vulnerability work, to ensure we are targeting the most vulnerable, and those who will benefit most from our integrated approach.

In terms of monitoring outcomes and metrics, we will monitor key performance measures over time to ensure the system reforms are delivering the key aims and objectives of rescaling demand, reducing levels of dependency and supporting as many patients and services users within community settings as possible. The current 'Virtual Ward and 'Care Closer to Home' programmes are helping us to re-evaluate our overall approach to health, social care and wellbeing and to examine how we could do things differently to not only ensure value for money, but ensure that services are appropriate, affordable, sustainable and meet the needs of people in Sefton. We will also use this framework, to build individual and community resilience, and work with our communities, to maximise community assets.

The emphasis of our scaled up version of care closer to home and virtual ward, is around self-care, self-management and prevention. As demonstrated by our approach to developing our first Health and Wellbeing Strategy, we have a long tradition of working across organisational boundaries to achieve positive outcomes for local people. Our work was commended during our recent LGA Peer Review of our Health and Wellbeing arrangements, which highlighted strong and effective partnerships across the health, social care and wellbeing system. We are committed to doing things differently to achieve our vision for Sefton. However we believe our demographics present a huge challenge, and potentially will impact on our ability to transform at scale and pace.

Our Health and Wellbeing Strategy is focussed on prevention of ill health and poor emotional wellbeing, early detection of disease, support to people to remain independent at home, manage their long-term conditions, wherever possible avoid unnecessary hospital admissions and in situations where hospital stays are unavoidable, ensure that there are no delays to their discharge.

The specific quantitative aims of our integrated approach are:

- To reduce the number of people being admitted to care homes, from both acute and

community settings.
- To decrease the number of delayed discharges and lost bed days from acute settings for those patients medically fit for discharge.
- To reduce the requirement for emergency placements.
- To reduce the length of stay for people who do require an emergency placement where no other alternative is available.

To support these aims, we will also expect to see significant qualitative improvements through a more integrated model. Initial aims we expect to deliver are:

- Residents only having to tell their story once. This supports the principle of the shared care record and is one of the key messages from our public engagement processes.
- Faster response times and more integrated support to people where needed.
- Positive feedback and customer satisfaction reports.

How will you measure these aims and objectives?

We will **measure our success** against the aims and objectives of our plan by:

- Communicating regularly with people to receive and act on feedback about performance.
- Utilising feedback and learning from complaints and compliments about services and ensuring this is effectively implemented.
- Carefully monitoring performance across the whole system using key indicators related to the improvements referred to above and taking action to address deficiencies in performance where necessary.
- Robust financial management - monitoring financial information across the services to identify pressures and/or shifts in demand.

Health Gains

There are a number of potential measurable health gains from the service changes, which are nationally verified and published, (which we can also measure locally as required) which align to the national metrics that underpin the Better Care fund. These include better management of the following:

- **Unplanned admissions for chronic ambulatory care sensitive conditions**. These are chronic conditions such as congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. Latest data shows that Sefton's rate of unplanned admissions for chronic ambulatory care sensitive conditions for April-November 2013 was 551.4 per 100,000 populations. By supporting people with these conditions better we aim to reduce this measure managing patients appropriately and safely on the same day without the need to admit. To this end, the CCGs have been developing its strategic plan around key related programmes (CVD, Respiratory, Diabetes), with a particular focus on the Frail Elderly and Unplanned Care. Key outcomes around the following are being developed:
    - Patient Years of Life Lost.
    - Emergency Admissions.
    - Patient Experience of In-patient Care.
    - Patient Experience of GP / out of hours service.
- **Emergency admissions for acute conditions** that should not require hospital admissions (such as ear, nose and throat infections, kidney infections and heart failure). The Sefton value of 650.4 admissions per 100,000 population between April and November 2013. Therefore we would expect these changes to have the impact of a reduction on this measure as patients are helped to manage these conditions better outside the hospital setting.

- **Emergency readmissions to hospital** are also a key issue locally. Readmissions within 30 days of discharge in South Sefton CCG were 12.4 per 100,000 population between April and November 2013, and in Southport and Formby CCG were 13.7 per 100,000 population between April and November 2013. This indicator is a key NHS Outcomes Framework indicator, the CCG will target and support the practices and specialties that are over performing in this measure.
- **Admissions to residential and care homes** is an issue for us locally given our significant demographic pressures coupled with the reductions in Council revenue due to the government's austerity measures. Our commitment through the Councils Adult Social Care Change Programme, and the Better Care Plan, will see a shift of investment into **effective reablement services** resulting in admissions to residential and care homes remaining either static or reducing.
- **Patients who have to stay in hospital will be discharged rapidly** thereby reducing costs and freeing up scare resources for elective care procedures,
- **Patient and service user experience** will be one of the cornerstones of our integration programme, and through our local processes, Healthwatch Sefton and the new national metric we will see improvements in people's experiences of health and social care.

All of these issues were highlighted as important locally in the 2013 Sefton Joint Strategic Needs Assessment Update. Demand for adult emergency care services are increasing; however the capacity of hospitals to manage these numbers is not, therefore action is needed to reduce demand on emergency care services. In particular, there are pressures related to seasonal demand due to cold weather, and an ageing population with increased numbers of long term conditions. 22.7% of the local population have a limiting long term illness. This is higher than the overall rate for England at 17.6%.

In addition, there are approximately 29,800 over 65s (54%) in Sefton with a long term illness or disability that limits their daily activities. This is higher than the England average of 51.5%. This trend is likely to put an increased burden on health and social care services, again providing an impetus for better integration. Therefore, to support the key objectives of reducing demand in urgent care and cross organisational sustainability, strategic integration plans will focus on enhanced integrated community developments. This will promote care closer to home, resourced appropriately to meet the needs of the geographical population. Sefton has high morbidity and mortality in over 65's. Figures from the 2011 Census show that the Borough has numerically approximately 5% above the English average of over 65's and approximately 0.5% above the English average of over 85's. Our over 75's also have an average of 3 chronic diseases. As mentioned above, excess winter deaths are an important issue locally. The excess winter deaths index for 2008-11 was 24.9 in Sefton meaning about one in four extra deaths occurred between December and March compared to the rest of the year. This was the highest index of any local authority in the North West, and much higher than the England average (19.1%). Particularly, excess winter deaths due to respiratory conditions are higher in Sefton (35.2% in 2011/12) than in both the North West and England (26%% and 32% respectively).

By being better joined up (e.g. to increase vaccination rates) we would aim to reduce this figure and already improvements are being delivered. In 2013, Southport and Formby CCG hit the 75% target for vaccinating over 65s against flu and has the highest rate for vaccination of under 65's at risk in Merseyside. South Sefton CCG is close to reaching the 75% target with approximately 73% of over 65s being vaccinated in 2013. Locally the hospital Trust has also achieved its target for staff vaccinations.

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

Our model of integration described in this plan is based on a scaling up of our current programmes of integrated care provided through the framework of care closer to home and virtual ward. The CCGs in Sefton already invest heavily in these programmes, and the framework is described in their strategic plans. The BCF plan builds on that framework, in that it identifies what we need to invest in to support that framework to work, the schemes that underpin the model, and importantly protect social care. We recognise that there are some significant challenges in seeking to deliver integrated care successfully. From our learning and experience of delivering through our Care Closer to Home and Virtual Ward Programmes, we have identified the following enabling schemes that we will need to focus on to deliver our vision

- **ICT** – integrated electronic records linking primary, community, secondary and social care systems. Consideration of 7 day working also requires an appraisal of IT systems. A fully integrated system which includes multiple organisations in the health and social economies needs IMT. This is perhaps the greatest challenge of all. We have identified the need to develop an Informatics Strategy to enable sharing of information in the support of integrated care. We will seek to maximise technology within available resources and we would welcome a wider dialogue to help shape national direction of travel and to tap into any projects aimed at improving health and social care outcomes.
- **Workforce** – remodelling, new skills, multi-disciplinary approaches, including our CCG and Social Care commissioners, where possible, will be commissioning and procuring jointly, focussed on improving outcomes for individuals.
- **Data & Intelligence** – to enable appropriate identification of patients/people who would benefit most, and how to design services to support prevention. Coordinating business intelligence/evidence, and evaluating the impact of population/ needs/delivery models on the health and social care economy. We believe we need to develop evidence to support the scaling of our approach, and we will focus on this in 2014/15.
  Culture Change/Behaviour Change/Communications – across commissioners and providers, the community, health care system, and government. We are currently developing a communications timeline for engagement with staff, partners and the public to co-design the strategy.
- **7 day working** - in order that people receive the right care, in the right place; at the right time we will consider ways to facilitate 7 day working, where appropriate. A failure to facilitate this will lead to gaps in provision out of hours and not only disjointed but broken episodes of care. In particular we will work with acute providers to support discharge from hospital and reablement.
- **Performance Management/Outcomes** – we have work already underway to refresh our Health and Wellbeing Strategy and we will ensure the outcomes which underpin this plan align with our outcomes framework, and that we have robust performance management arrangements in place. We are developing integrated dashboards, and will build on this work.
- **Finance and Contracting** – we have identified the need for continued/iterative work on contracts, developing financial plans and modelling assumptions.

The planned changes build on what we have already achieved within these areas; however we recognise the challenge this poses. The Performance Group, and the sub structure to the

HWBB, will drive the changes needed to support the delivery of a fit for future, health, wellbeing and social care system. The Adults Social Care Transformation Board within the Council, will continue to drive the transformation already underway within this service, but will link through into the Health and Wellbeing Board Programme Group and wider sub structure. The Cabinet Member for Older People and Health has a key role to play in ensuring the Borough has an affordable, effective, social care system which is transformed to meet the needs of our communities, and his role on the Health and Wellbeing Board in overseeing integration within Sefton is key to sustainability.

The CCG Boards are responsible for delivering on their Strategic Plan outcomes, as well as being a key partner on the Health and Wellbeing Board, and its substructure. In 2014/15 these work streams, and the aforementioned schemes, will be scoped, so we have an effective integration strategy and plan, to achieve the delivery of a different model of integrated care across health, social care and wellbeing. Early intervention and prevention is a key theme across all these areas; however this will take time to achieve through a managed process of transition and change. In addition we have a commitment to joint commissioning and integrated delivery of services wherever this will improve outcomes for the people of Sefton.

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 referred to above.

The Health and Wellbeing Board, supported by its Programme Group will ensure that activities to deliver across all the priority areas are aligned, to deliver the ambition for integration of the Council, the CCG Boards, and our wider partners.

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

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

This includes a range of services, currently commissioned separately. We have an integrated commissioning plan and will build on this looking for opportunities to jointly commission further during 2014/15 and through this; the economy will ensure value for money. Our focus will be to ensure appropriate investment in a range of community services to see a reduction in demand on acute care and long term residential/nursing placements.

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

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.

All the plans and development included in the Better Care Fund Plan are in keeping with the development of a model of integration articulated in existing plans aimed at improving outcomes and thereby minimising pressure on the acute sector. In summary, the proposals in the plan are aimed to support the acute sector by:

- Decreasing demand pressures for non-elective admissions to hospital and attendance at Accident and Emergency through a range of preventative approaches including the expansion of ambulatory care pathways.
- Decreasing the number of unnecessary re-admissions to hospital.
- Proactive identification of patients in primary care through risk stratification and other means to offer a range of preventative interventions to improve the management of long term conditions and maintain independence.
- Maintaining capacity within the Acute and Sub-Acute settings to facilitate safe and timely discharge in accordance with national best practice and NHSE planning policy.
- Increasing the range of community resources available 7 days per week and at key hours to both divert pressure from the hospital and ensure a wide range of services to facilitate timely and personalised discharge following admission or transfer from Accident and Emergency.

The integration model remains focused on enabling the shift in activity and resources from the Acute to the Community setting by optimising Health & Social Care effort to support real value and improvement to health needs.

A number of other initiatives contained in the plan will have a positive impact on our Acute Trusts and will enable them to deliver safe and effective services. Initiatives include:

- Improvements in recording and the focus on moving to the utilisation of the NHS number as the key identifier for all patients.
- The clear identification of a lead professional for a key cohort of patients and more effective discharge processes without delay.
- Strengthening and maintaining safeguarding.
- Reviewing Mental Health Services.
- Freeing up capacity to enable the local acute providers to focus on maintaining elective performance and the repatriation of appropriate elective work and to seek any opportunities to provide services in community settings.

Through the development of the CCG's strategic and operational plan, work will continue to be carried out with key providers to quantify the impact of the planned outcomes from the BCF on each organisation. Where the impact can be measured in terms of reduced non elective activity for example reduced AED (Accident and Emergency Department) attendances, non-elective admissions and readmissions this will be quantified.. As existing schemes gather momentum and new schemes, via the BCF, are implemented, acute providers have an opportunity to reduce overall unplanned bed capacity and support the transition to enhanced community care and the avoidance of unnecessary unplanned activity.

We will work with our key providers to model scenarios and to reflect these in contract

arrangements for 2014-15, 2015-16 and beyond. It is important that all partners have an appreciation of the consequential impact of changes on the Acute Sector and that there is appropriate engagement with the public and service users. The actual impact of schemes should be measured both in terms of outcomes, most notably the outcomes set out and described as part of the "Everyone Counts" planning Guidance (Annexe D-G) and the BCF planning guidance. These include;

- NHS Constitution Measures
- NHS Constitution Support Measures
- Activity Measures
- Health & Justice Measures
- Public Health Service Measures
- Specialised Services Measures
- Primary Care Measures

The key driver for understanding the implications on the Acute Sector is that the funding to support BCF is already committed and the necessary shift of funding is most likely to come from spend with acute providers. We have not underestimated the impact this will have and are shaping our joint plans accordingly.

Our joint plan demonstrates our commitment that those individuals at high risk of health and social care interventions be proactively managed and supported to avoid the requirement for hospital based interventions. We recognise that in order to make both the BCF and our joint longer term sustainability a reality, we have to reduce the overall spend in the acute sector in order to properly fund our integrated model.

We are working with our main acute and community providers through the Virtual Ward and Care Closer to Home Programmes to turn this high level plan into real actions that allows all partners to reshape their model of service provision accordingly. We have developed a joint approach and a shared understanding of how we might deliver sustainable and transformational change-across the system, e.g. Care Closer to Home.

Specifically we will aim to target our efficiency savings around:

- Admissions avoidance
- Reduced length of stay
- Reduction in delayed discharges

Admissions Avoidance

The CCGs have a focus on Mental Health as part of their strategic 5 year plan. This emphasis is orientated at moving from a traditional medical model of mental health care to one based on recovery and outcomes. The overall aim of this strategy will be to facilitate optimum community provision to deliver the optimum outcome for individuals, based on needs.

The key areas where they will impact will be through advance care planning – making sure those at most risk of accessing acute services have the necessary support packages in place – and through rapid intervention when individuals do require acute interventions to return the individual to their normal place of residence a soon as possible.

Whilst the impact this will have on both acute sector admission numbers and subsequent levels of service provision are currently being worked up, we envisage enabling acute providers to make significant cost efficiencies through refreshed models of service delivery based around footfall and activity. In our discussions with providers, it is clear that they are committed to shaping their services to reflect the impact of the expected changes. Together we recognise the challenges this might create if we are to sustain high quality hospital care for our residents, and we will

continue to work in partnership to minimise this risk.

Length of Stay/Delayed Discharge

For those patients who are admitted, we want to ensure there is a clear discharge plan and the necessary support in place to speed rapid discharge. Whilst much of this is already in place, we believe our new model will allow a much greater synergy between organisations and will ensure any blocks to discharge are identified and removed as soon as practicably possible. The single contact point will have a key role to play in this scenario and the introduction of 7 day a week working across organisations will also facilitate this. We are under no doubt about the challenges this system change will bring but our joint commitment to making the necessary changes will help us to deliver the change we need. We recognise that what we are proposing carries an element of risk should the necessary reductions in admissions and length of stay not be achieved. We are confident that we have built a strong partnership across the health and social care system and coupled with our common vision of what the future should be, we will work together in 2014/15 to understand, and seek to manage this risk.

e) Governance

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

We have invested in building strong governance through our Health and Wellbeing Board, which transcends traditional organisational boundaries. The Board's Peer Challenge by the Local Government Association has confirmed its maturity and from this we have a robust action plan, which has informed our governance arrangements.

Our Health and Wellbeing Board is a tightly focused governance body, which comprises 3 Councillors (2 of whom are Cabinet Members), the Chairs of the two Clinical Commissioning Groups (which similarly ensures due accountability through the CCG Boards governance structures), the statutory officers for Children and Adult Services within Sefton Council, the Director of Public Health, the Chief Officer of the two CCGs, together with the Director of Finance for the NHS England (North) and the Chair of Sefton Healthwatch.

Included within the 3 Councillor representatives are two Cabinet Members whose portfolios of responsibility are Children, Schools, Families and Leisure and Older People and Health, which aligns the decision making through the Council's Cabinet. These are key Cabinet Portfolios and provide the links back to the Council's Cabinet. Another Elected Member on the board has a significant amount of experience of working and leading in the health economy. Cabinet is the constitutional forum for key decision making for the Council and a core part of the due process for the changes envisaged in this document.

The Health and Wellbeing Board provides wider system leadership and influence, through a sub structure which was put in place last year. The sub structure comprises a Programme Group, made up of representatives of the Health and Wellbeing Board, the Deputy Chief Executive of the Council and the Chief Executive of the Council for Voluntary Service (CVS), which oversees the delivery of the Health and Wellbeing Strategy, and through a series of Forums and Task Groups, integrated commissioning arrangements, amongst other things.

The Board maintains overall sovereignty of the achievement of the Strategy, for wider system leadership, and for promoting and championing integration. Its sub structure ensures that commissioning and delivery achieves outcomes and importantly that it has arrangements in place to enable our partners to work with us to innovate, to challenge, and to plan how to do things differently. These arrangements are maturing, and are sufficiently robust to provide oversight

and governance for this plan.

The Programme Group of the Health and Wellbeing Board is responsible for overseeing integrated commissioning, on behalf of the Health and Wellbeing Board, with accountability being vested in the individual Board Members of both the Local Authority and the CCGs. The Local Authority, the CCGs and Members of the Health and Wellbeing Board, have collectively led the development of this plan, demonstrating clear and shared visibility and accountability in relation to the management of all aspects of the fund.

From 2015-16, the BCF funding will be underpinned by a Section 75 pooled budget arrangement which will be jointly governed by the LA and CCG. It is not envisaged that separate governance arrangements will be established for the BCF but existing structures will be flexed to provide due accountability for the BCF Budget.

The Council's Health and Social Care Overview and Scrutiny Committee will play a key role in ensuring the effectiveness of the plans.

In support of delivery, key networking and collaborative arrangements will be utilised to underpin achievement of the plan across the borough, these include:

- Health & Social Care Forum.
- Contract Meetings with Acute Providers.
- Contract Quality Performance Groups.
- CCG Network.
- Collaborative Commissioning Forums.
- Strategic Partnership Boards with Providers.
- Tri-partite Board with West Lancashire CCG and Southport & Ormskirk Hospital Trust.
- Urgent Care Networks.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

As highlighted above, Sefton is facing significant challenges in terms of growing demands from an ageing population coupled with significant reductions in government funding. The Local Authority embarked upon an Adult Social Care Change Programme, the overall aim of which is to develop a model for Sefton Council's Adult Social Care (ASC) that is sustainable, modern and flexible, delivering the four strategic priorities as set out in the ASC Strategic plan 2013-20 :

- the Council's commitment to safeguarding;
- how the Council will focus resources on the most vulnerable;
- the need to work with our partners and the community; and
- and the development of the market to deliver the required change.

The change programme is structured around a number of inter-related projects and commissioning activity; the main projects are on awareness, eligibility and support.

The Council will continue to assess and review in accordance with the Department of Health Guidance: Prioritising need in the context of Putting People First, 2010 which replaces the previous Fair Access to Care (FACS) criteria. There are four bands associated with the guidance with Sefton's eligibility criteria set at Critical and/or Substantial. Maintaining eligibility criteria is one aspect; however this does not mean maintaining the same traditional services. Through the Adult Social Care Change Programme and the BCF Plan, we will focus upon developing new forms of joined up care and community services, which help ensure individuals remain healthy, well and self-sufficient and enabled to stay as independent as possible, for as long as possible. We will focus upon protecting and enhancing quality of life and working collaboratively to promote early interventions and self-management, wherever possible. We recognise that change can be difficult, challenging and sometimes uncomfortable, but we recognise that the service is at a point where doing more of the same - or trying to do more of the same with less - is going to fail people, carers, families and the communities. Managing expectation is the key in delivering this programme of change.

In February 2013, the Council approved a proposal to work with the two Sefton Clinical Commissioning Groups (CCGs) and agreed a model of reablement that will enable more users to go through a reablement process, thereby reducing levels of admission to short & long term care. The rationale for this change is based on national longitudinal studies that have demonstrated that timely intervention of home care reablement, focusing on activities for daily living, can enable people to live more independently and reduce their need for ongoing homecare support.

The aim is that the new ways of working will reduce the reliance on longer term packages of care, in turn reducing future pressure on the community care and nursing and residential care budgets. The outcomes required from this work include;

- increased numbers of people being offered reablement
- achievement of personal outcomes
- reduction in the requirement for Community Care assessments
- reduction in the need for ongoing homecare support
- achieving Value For Money

The BCF will help to 'protect' these services by:

- Enabling/maintaining continued health linked provision.
- supporting the development of preventative services.

- facilitating the development of integrated services which deliver better outcomes for individuals and improved efficiency for commissioners and providers.

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

The use of the fund, and stronger collaboration between CCGs, the Council and other parties and stakeholders, will seek to minimise the financial and delivery risk facing the provision of social care services. Present financial projections based on the Local Government Spending Settlement and the demographic forecasting, have, and will, continue to have significant impact on social care services, which help to improve health and wellbeing. Without the utilisation of the Better Care Fund to offset the impact of some of the proposed reductions, the Council would be in danger of failing to meet its statutory obligations, such as timely hospital discharge.

The Plan will ensure that a range of adult social care services continue to be maintained and developed in accordance with Sefton's Health and Wellbeing Strategy.

The new delivery will see roles and responsibilities change significantly in both the Council and the provider. The size of this change cannot be underestimated as it is dependent on whole system change including assessment and review and health processes, the use of assistive technology, telehealth, system development, plus significant cultural change. The Better Care Fund Plan will align the work of the local Health System, and the Adult Social Care Transformation Programme.

The Plan seeks to:

- Support improvements in quality and efficiency of existing services through the developments of integrated initiatives such as lead professional, data sharing, increased hours of operation;
- Develop preventative measures to help avoid pressure on acute services and social care provision;
- Develop 7 day services, where appropriate, around the needs of the citizen;
- Utilise investment to pump prime redesign of services and deliver new models of care; and
- Ensure we have the financial resource and capacity to meet the social care needs of the most vulnerable.

To support these aims, the Local Authority will:

- define priorities and identify who our "most vulnerable" are
- integrate with partners and the NHS to provide efficient, co-ordinated, consistent, effective, services
- design social care services and activities that are modern, flexible and sustainable with self care and self management at the core
- help people to understand how to get independent financial advice where this might be helpful in making decisions about funding their care
- continue to identify those services which the Council must continue to provide as an absolute minimum and assess their current efficiency
- continue to assess and manage risks based on new financial forecasts

Current NHS funding to social care to benefit health has been used to enable the Local Authority to provide timely assessment, appropriate care management, safeguarding and service provision, and where appropriate targeted prevention models. There will be pressures to see an increase in future allocations in order to reflect the demographic pressures and deliver the requirements under both the Care Bill and BCF.

Further, it is recognised that many of the anticipated changes will have a significant impact on the community, workforce, partners, providers, suppliers, pathways, processes and technology. Also the complexity of the Transformation agenda and the Better Care Fund Plan aims will mean that there are dependencies on other projects, and Local Authority and Partner works

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

Our experience of both the Virtual Ward and Care Closer to Home Programme has helped us to determine what we need in terms of 7 day services to reduce admissions at weekends. We are committed to providing seven-day health and social care services to support patient discharge. All partners are engaged in existing work streams through NHS IQ, and sub-regional groups. The Board and the programme group will oversee delivery against this commitment.

c) Data sharing

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

At present the Council and the CCGs do not currently use the NHS number as the primary identifier for correspondence, though it is already recorded and embedded in the core adult social care systems used by the Council and health systems used by the CCGs. The Council and the CCGs intend to use the NHS number as a primary identifier for correspondence and care planning by no later than April 2015.

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 using the NHS Number as primary identifier for social care records. This will help to provide co-ordinated health and social care for service users. The use of the NHS Number as primary identifier will support safer patient identification practices and help to access records more easily and accurately.

Integration will result in improved care for service users by ensuring coordination of their care pathway and that their current needs are met accurately and efficiently.

NHS Number is already being recorded in the Adult Social Care System and this is reviewed on a regular basis through the NHS Tracing Service to allow us to check and update records, where necessary. Further work is currently underway to identify NHS Numbers for child records via the NHS Tracing Service which will allow inclusion of NHS Number in our Integrated Children's Social Care System. This implementation will be completed no later than April 2015.

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

We are committed to adopting systems that are based upon Open API's and Open Standards, where appropriate, and linked to a suitably assessed business case. For example, we have

adopted secure GCSX email accounts for secure communication with our health practitioners.

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

We will comply with all current and future IG issues and will develop a specific IG work stream as part of our overall programme plan. This will also incorporate compliance with Caldecott2 and other national conditions. We already have connection to the NHS N3 spine / COIN and our compliance with the standard requirements for that connection is reviewed on an annual basis. The Council is putting in place internal information governance structures based around standard 'connecting for health' practice including Senior Information Risk Owner and Information Asset Owners embedded across Council departments and undertaking a review of its wider information governance structure and data sharing processes to be completed by November 2014.

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.

Within the virtual ward based in South Sefton CCG, the Multi-Disciplinary Team (MDT) work together to assess risk and allocate patients during their admission to the ward. This approach will be expanded as part of the scaling up of the Virtual Ward and Care Closer to Home models of care.

4) RISKS

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

Risk	Risk rating	Mitigating Actions
Shifting of resources to fund new joint interventions and schemes will **destabilise current service providers**, particularly in the acute sector.	High	Plans will be based on our Health and Wellbeing Strategy Vision linked to the 5 year strategic plans for our two CCG's. Over coming months, we plan to work with the health, wellbeing and social care economy to develop a collaborative approach to redesign, integrated working and risk sharing. Consideration will be given to transitional support to providers.
A **lack of detailed baseline data and** the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable.	High	A review of baseline data and the production of trajectories will be undertaken when performance outcomes are known in 2015/16.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision in our BCF submission a reality.	High	We are already seeing increasing demands for health and social care services which will impact on the ability for the workforce to adapt. This will be a specific work stream within our plan.
Improvements in the quality of care and in preventative services will **fail to translate into the required reductions in acute and nursing / care home activity** by 2015/16, impacting the overall funding available to support core services and future schemes.	High	Robust performance monitoring and management against agreed trajectories for improvement, including residential/nursing placements and acute demand. Integrated commissioning to improve value for money.
The introduction of the **Care Bill,** currently going through Parliament and expected to receive Royal Assent in 2014, will result in a **significant**	High	Sefton will undertake a detailed assessment of the impacts of the regulations when published.

increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.		
The demographics within Sefton are such that we are predicting a large increase in the number of frail elderly people, and in particular, a number with co-morbidy and complex needs. In addition, we have a significant number of people who have a learning disability and in particular, a large number with complex learning and physical disability coming through transitions. These two things together may put undue pressure on both our health services and our health and social care budgets. Therefore, we may be unable to meet the national targets, without national recognition of this significant risk.	High	We are seeking to mitigate some of the pressures, but the scale of the challenge is significant. We aim through the Adult Social Care Transformation Plan to mitigate where we can, within resources available
Governance processes in respective organisations will **stifle progress** and slow down developments	High	Robust governance arrangement will continue through the Health and Wellbeing Board, Cabinet Members, Cabinet and the CCG Boards
Differing organisation and **workforce cultures** inhibit progress at scale and pace, and the **HR element of 7 day working**	Medium	This will be a specific work stream within our plan
Proposed model does **not reduce emergency** admissions	High	We will adopt a stepped approach to the redesign over 5 years and a transitional approach via commissioning. An approach to demand reduction including self-management and raising public awareness of changes. Early identification of issues and escalation into the Health and Wellbeing board will be

		critical.
Impacts of the model do **not have sufficient benefits for the Adult Social Care** agenda and increase costs	High	Prioritisation of initiatives to offset loss of budget; monthly performance monitoring and management with appropriate escalation and governance.
Integrated assessments not delivered, leading to multiple assessments, duplication of services, loss of value for money, unnecessary admissions and delayed discharges	Medium	This will be a specific work stream within our plan, with a transitional approach, linked to workforce development and ICT infrastructure.
Non elective admissions and readmissions increase. Having invested growth funding in the BCF any growth in non-elective activity will place the **CCG** in **severe financial pressure** and undermine any investment in Primary, Community and Other Services	High	2014/15 will be used to test and refine our approach to reducing non elective admissions. We will work with the acute sectors to develop detailed business cases and service specifications that move from acute services to primary and community services.

A key theme we are working on is how the risks associated with this plan can be mitigated. Where they fall to the Council, the risk will be included in the Corporate Risk Register.

Risks identified within this plan attributable to CCG delivery mechanisms, will be included in the 5 year Strategic and Operational Plans for the South Sefton and Southport and Formby.