Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Hampshire County Council**
Clinical Commissioning Groups	**NHS North East Hampshire and Farnham CCG**
	NHS North Hampshire CCG
	NHS South Eastern Hampshire CCG
	NHS Fareham and Gosport CCG
	NHS West Hampshire CCG
Boundary Differences	Commissioning across all five CCGs in Hampshire has taken account of boundary differences. • The population of North East Hampshire & Farnham CCG straddles the counties of Surrey and Hampshire. To deliver the requirements of the BCF the CCG has worked in collaboration with both Surrey and Hampshire County Council and is included in both Local Authority Joint BCF Plans. The CCGs financial allocation has been appropriately split across the two LA BCFs based on population. The CCG has aligned both BCF Plans to ensure the risk of inequality is minimised. The small proportion of the population residing in Bracknell and Ascot CCG area have been taken into account in planning arrangements • North Hampshire has a small proportion of the population registered with GPs in Hampshire residing in Berkshire County Council area • In South Eastern Hampshire there are people registered with GPs in Hampshire residing in West Sussex County Council and Portsmouth Unitary Authority areas

	• In West Hampshire people registered with GPs in Hampshire either reside or use services in Wiltshire and Dorset areas • For the County Council a proportion of the population are registered with GPs in out of county CCGs. Ensuring people are able to access services regardless of boundary differences has been a long standing feature of commissioning arrangements, such that people do not suffer disadvantage as a result of our administrative arrangements.
Date agreed at Health and Well-Being Board:	**11 February 2014**
Date submitted:	**12 February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£ TBC**
2015/16	**£80,757,000**
Total agreed value of pooled budget: 2014/15	**TBC**
2015/16	**TBC**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	North East Hampshire and Farnham CCG
By	Maggie MacIsaac
Position	Chief Officer
Date	TBC

Signed on behalf of the Clinical Commissioning Group	North Hampshire CCG
By	Lisa Briggs
Position	Chief Officer
Date	TBC

Signed on behalf of the Clinical Commissioning Group	South Eastern Hampshire CCG
By	Richard Samuel
Position	Chief Officer
Date	TBC

Signed on behalf of the Clinical Commissioning Group	Fareham and Gosport CCG
By	Richard Samuel
Position	Chief Officer
Date	TBC

Signed on behalf of the Clinical Commissioning Group	West Hampshire CCG
By	Heather Hauschild
Position	Chief Officer
Date	TBC

Signed on behalf of the Council	Hampshire County Council
By	Andrew Smith
Position	Chief Executive
Date	TBC

Signed on behalf of the Health and Wellbeing Board	Hampshire Health and Well Being Board
By Chair of Health and Wellbeing Board	Cllr Keith Mans
Date	TBC

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

All Clinical Commissioning Groups (CCGs) and Hampshire County Council are working together on established transformation programmes to deliver integrated care and support for local people.

Integral to this work is a programme of consultation events across all Clinical Commissioning Group (CCG) areas. All events have involved partners, practitioners, stakeholders and members of the public. Examples of consultation events are listed in the documentary evidence below.

In each of our four systems within Hampshire (South West Hampshire, South Eastern Hampshire, North and Mid Hampshire and North East Hampshire) we have strategic joint commissioner and provider fora that are key components of all four system sustainability programmes. The work is aligned with the approach of Southampton and Portsmouth, the neighbouring Unitary Authorities in West Hampshire and South Eastern.

Across Hampshire at this locality level many of the transformation programmes are managed within the Health and Care 'system groups that are already established. Through these health care providers are active participants in the planning and pathway implementation work to change the model of service, together with a range of other providers including the voluntary and community sector. Providers have been actively involved in working through the implications. CCG clinical leaders are our local champions.

Individual General Practitioners and a wide range of health and social care practitioners are directly involved at locality level through the development of integrated care teams and wider clinical pathway redesign and through the clinical engagement and leadership infrastructure within each CCG.

Integral to the plan is the County Council's transformation programme and social care providers are engaged in key work programmes. Examples already underway include the Hampshire Extra Care Housing Strategy, the transformation and re-commissioning of a new model of reablement and "care at home" that incorporates personal care and support is engaging and involving more than 70 domiciliary care agencies.
To lever the change required new contractual models are being considered and reward and incentive schemes are being designed to accelerate progress alongside the required cultural and behavioural change at a local level.

Our commitment is to continue to work with providers on the further development and implementation of plans. One-size-fits-all solutions will not work as not every area of Hampshire is moving at the same pace and the needs of our communities differ. We have agreed that our journey towards integrated commissioning and delivery requires the development of shared plans amongst partners, appropriate mechanisms to share risks and benefits and to jointly specify services which we commission and deliver together.

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 Joint Health and Wellbeing Strategy 2013 "Working Together for a Healthier Hampshire" reflects our vision for whole system integrated care and is informed by what people have told us is important to them. Our engagement and consultation with local people has given us a strong mandate for change. Through a large number of public, patient and service user workshops, interviews and events, local people have told us integration of health and social care services in Hampshire cannot happen in isolation, it has to bring together people, communities and the public, private and voluntary sector.

At a local CCG level people who use services, their carers and other members of the public are involved in developing person centred care and the Hampshire Health and Well Being Board has adopted the National Voices approach.

The link below provides an examples of feedback and progress made in North Hampshire CCG http://www.northhampshireccg.com/info.aspx?p=9

Insight has been gathered from our learning from complaints and experience feedback as well as the Hampshire Personalisation Expert Panel (PEP), the Learning Disability Partnership Board and Mental Health Well-Being Innovation Networks. Our future plans will build on a continuous 'listen , learn and redesign principle' looking at the potential to further explore the benefits of technology to support individuals in giving direct customer/patient experience feedback

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

Document or information title	Synopsis and links
Better Care Fund	

Project Initiation Document and Communication Strategy	Sets out the approach to developing the plan for the Better Care fund along with our plans for information sharing, communication and engagement
Mapping of schemes and projects	Maps out all the schemes in plan for delivering national and local metrics
Hampshire Wide Documentation	
Joint Health and Wellbeing Strategy 2013	Hampshire's Health and Well Being Strategy which is based around four priorities
Joint Strategic Needs Assessment 2013	Assessment of need in our population developed jointly with CCGs to inform strategic commissioning priorities
Health and Well Being Board Seminar 10 September 2013	Summary of event involving membership charged with overseeing strategic development across Hampshire systems
Health and Well being Board Seminar 10 December 2013	Summary of event involving membership to scrutinise proposed benefits realisation and planning approach
Working together for a Healthier Hampshire – Hampshire Integration Pioneer application	Submission for Integration Pioneer status describing the vision for the Hampshire health and care system.
Delivering Integrated Commissioning across Hampshire	Report approved by all Hampshire CCGs and Adult Services on proposals for leading the integrated commissioning agenda for Hampshire November 2012
Report on the Hampshire Integrated Commissioning Development Event	Summary of commissioning event 13 March 2013, identifying priorities for Hampshire commissioners
Hampshire Integrated Commissioning Framework	Framework developed and sponsored by the Hampshire Integrated Commissioning Group
CCG Transformation Programmes	Summary of all CCG transformation programmes and local projects
Adult Services Documentation	
Hampshire Adult Social Care Vision 2012-2015	The strategy for Adult Social Care
Hampshire Integrated Commissioning Strategy/Framework (Adults)	The Framework for integration developed by the Integrated Commissioning Group in consultation with a wide range of commissioning leads across Hampshire.
County wide commissioning – The development of ICTs - Adult Services offer	Description of the Adult Services "offer" to support development of Integrated Care Teams.
Older Person's Voice – outcome of research with high intensity service users	Exemplar of engagement with service users with complex needs to inform wider system commissioning development.
North East Hampshire & Farnham Documentation	
North East Hampshire &Farnham - System Transformation Programme	Exemplar strategic statement confirming system intent to work together to deliver a system response.
Developing a Sustainable Health and Care System in North East Hampshire & Farnham – a five year vision	Exemplar strategic statement confirming system five year vision.
North East Hampshire &Farnham – Report on North East Hampshire &	Exemplar strategic statement confirming system intent to work together to deliver a system

Farnham CCG Stakeholder Event	response.
NE Hampshire & Farnham, Surrey Heath and Bracknell & Ascot health and social care system Transformation Programme	Strategic vision for the area.
Frimley System Dementia Strategy	Exemplar joint strategic plan for Dementia Services development.
Frimley System DLIG Pathway	Exemplar dementia services pathway.
North East Hampshire & Farnham CCG Vision for Primary Care	Exemplar strategic plan fro primary care.
North Hampshire Documentation	
North Hampshire CCG, Joint Strategic Needs Assessment	An exemplar of an assessment of need in a local CCG population to inform local strategic commissioning priorities
Commissioning Integrated Care Teams (ICTs) evaluation report in North Hampshire – social care	Exemplar of the evaluation of Integrated Care Teams to inform wider system development.
North Hampshire CCG evaluation of integrated care development	Exemplar of the evaluation of Integrated Care Teams to inform wider system development.
North Hampshire CCG and HCC commissioning integrated care strategic statement	Exemplar of a strategic statement to demonstrate commitment to an integrated approach
North Hampshire CCG value case	Description of the value case based on current experience.
West Hampshire Documentation	
Older persons partnership service model for Southampton and South West Hampshire	Exemplar of the blueprint for a local service model developed by providers proposing adoption of an integrated approach.
Working Together – Southampton and South West Hampshire – System Chiefs Agreement	Exemplar strategic statement confirming system intent to work together to deliver a system response.
West Hampshire CCG Out of Hospital Care Strategy 2014 - 2016	Exemplar of the strategic model for local commissioning.
West Hampshire principles for selecting and rolling out ICT cluster teams	Exemplar plan to co-produce and deliver transformation to integrated delivery.
South Eastern & Fareham and Gosport Documentation	
Portsmouth & South East Hampshire System Sustainability Strategy	Exemplar strategic statement confirming system intent to work together to deliver a system response.
Future Health Services for the Population of Whitehill and Bordon	Exemplar plans for local health and care services
Wessex LAT / CCG / LA event for Providers 25 November 2013	Commissioner and provider event co-ordinated by Wessex Local Area Team to inform and engage in development of the BCF plans

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?

Traditional models of care are no longer managing the increasing care gap between generalist community based health and social care services as acute services become more specialised and where necessary centralised. This care gap, in terms of both activity and complexity is neither appropriate nor affordable. Closer working between health, and local government and the wider community and voluntary sectors has been vital to ensure the longer term sustainability of services and outcomes for people.

The importance of prevention and earlier intervention are well evidenced to help people stay well, living independently and enjoying a quality of life for longer. Helping people to improve their health and well being and self manage their longer term conditions into later life is ultimately fundamental to tackling the inexorable growth in demand.

Even with a substantial transformation programme in place, significant demand pressures continue to affect our system for health and social care. This is driven by a number of factors including the increase in success of health interventions to support longer life expectancy, albeit with greater likelihood that an individual will need to manage complex co-morbidities.

In *Working Together for a Healthier Hampshire*, our application for pioneer status, we set out our agreed strategy for developing vibrant, resilient communities where people have access to services and equality of opportunities, and where all our 1.32 million residents across the county, 11 districts, 5 CCGs and 1,400 square miles, especially older people and those with long term conditions, are able to live healthier and more fulfilled lives. The Joint Health and Well Being Strategy identifies four key objectives:

- Starting Well: so every child can achieve its potential and will thrive through transition to adulthood;
- Living well: empowering people of all ages to live healthier lives;
- Ageing well: supporting people to remain independent, in control with timely access to high quality services; and
- Healthier communities: helping communities to be resilient, strong and support those who may need extra help.

Our vision is for a simple, *"joined-up"* health and care journey through the system for people and communities. This approach aims to address three key challenges:

- Avoiding unnecessary cost in the system, moving to lower cost solutions
- Preventing dependency and demand for longer term publically funded services
- Delaying people's dependency on long term health and social care interventions.

We have adopted the National Voices definition of integrated care as meaning person-

centred, coordinated care reflected in the statement: ***"I can plan my care with people who work together to understand me and my carer (s), allow me control, and bring together services to achieve the outcomes important to me".*** We are working together to ensure the services that we commission meet our strategic aims and programme objectives

Our strategic framework is sufficiently flexible to enable local progress towards common goals. Key priorities have been drawn together from partner organisations, building on our understanding of evidence from the JSNA. Table 1 below sets out these priorities which are translated into the high level aims and objectives in our integrated system.

Aim	Program Objectives
Provide the right care in the right place at the right time	To increase the proportion of people benefitting from evidence based prevention and early intervention
	To increase the proportion of people with complex and long-term health and social care needs receiving planned and coordinated care in, or close to home
	To ensure people have their health and care needs met seamlessly in the most appropriate setting
Maximise health, wellbeing and quality of life	To improve the health related quality of life and wellbeing of people with long-term conditions
	To maintain or improve independence and recovery for people with long-term health and care needs
	To reduce the difference between those with the best and worst health
Place the person at the centre of care	To empower key population groups to maximise their capabilities and to manage their health and wellbeing
	To increase the proportion of people with health and social care needs that have choice and control of their care
	To improve satisfaction with health and social care services

Table 1: Key priorities

Our plan is to approach integration in a phased but interdependent way to avoid destabilising the system of care we are transforming and to simultaneously "listen, learn and redesign principle". The following phases have been identified:

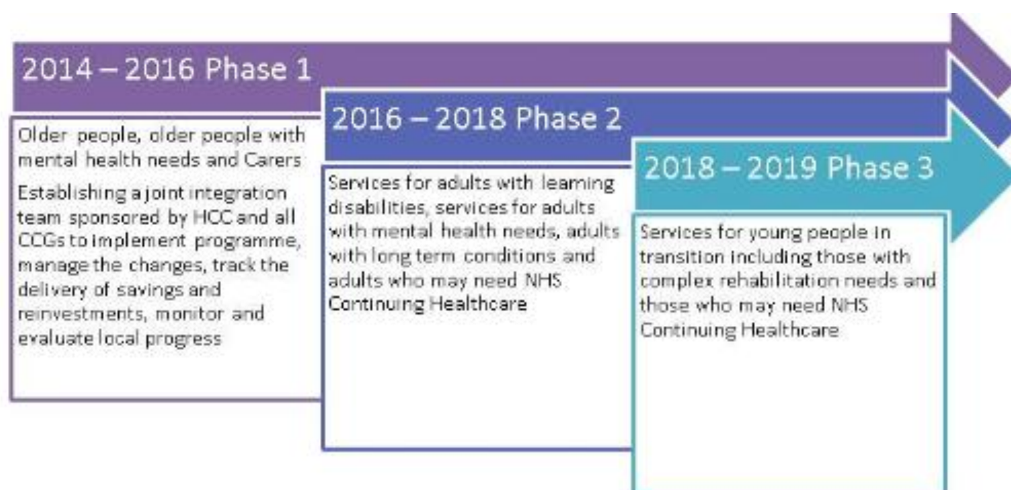

Figure 1: Phased approach

The Better Care Fund for Hampshire is £80,757,000. The phasing of the plan reflects the value of the 2014/15 Social Care to Benefit Health grant transferred through a Section 256 and associated activity totalling £ 20million.

In addition, in 2014 as part of the joint programme it has been agreed that prior to the submission of the final Better Care Fund plan in April, a review of integrated external spend commissioning opportunities will be undertaken. This will include a desk top review of CCG Quality Innovation Productivity and Prevention plans with a strong focus on Continuing Health Care, Care at home and Residential and Nursing home placements (including FNC). These areas have been agreed as they link to the Local Authority transformation and category management plans and have the greatest opportunity to deliver bottom line revenue saving .

In the context of the CCG financial position and the Local Authority medium term financial strategy this work is critical as the achievement of an identified cash releasing plan of a further £20million in 2015/16 needs to be in place to ensure we can meet the national requirements of protecting social care services and through this continue to meet the increasing pressures associated with demographic pressures and complexity of social care needs.

Delivering this vision at scale and pace requires substantial change management across all our health and care systems. In order to ensure coherence we have an overarching infrastructure and governance framework that runs across all the phases and links to both County Council and CCG's transformation and efficiency plans, ensuring that these changes are integral to individual organisations wider transformation programmes. As part of this we are working jointly to deliver the programmes that will translate our strategic vision into operational reality. This will not happen if we do not invest and support the individual staff responsible for the front line activities. Workforce development is therefore an essential part of our approach in terms of competency and capability. Specific programmes and funding have been agreed **to facilitate the right behaviours.**

This approach will re-shape and develop the health and social care market and to achieve this we are engaging local health and care providers and local communities to "co-produce" models of care so that:

- **Independence is the expectation** with support at home in the community empowering people to manage their own health and well being

- **Care is co-ordinated** around individuals and targeted to their specific needs and they will know about and be able to access information, care and support in their local community to keep them at home

- **Proactive and "joined-up" case management** reduces the likelihood that people will have to rely on more specialist services and rapidly regain their independence when they do

- **Experience of care is positive** with the appropriate services available where and when they are needed

- **Outcomes improve** reducing premature mortality and reducing morbidity

As commissioners in phase 1 we will ensure we address the three key challenges:

- Avoiding unnecessary cost in the system, moving to lower cost solutions
- Preventing dependency and demand for longer term publically funded services
- Delaying people's dependency on long term health and social care interventions.

The plans will delivery the following changes to ensure high quality, sustainable health and care system for Hampshire.

- **Our CCG and Social Care Commissioners** will commission and procure jointly
- **Investment** and procurement will support **integrated care delivery**
- **Our Community Providers** will implement new models of service delivery that they have co-produced, drawing on assistive technologies where this is appropriate to do so
- **Our General Practitioners** will be collaborating in wider networks focused on populations of 20 – 50,000 within agreed geographical area to deliver primary care at scale.
- **Investment in Integrated Care Teams** will deliver 7 day working with care co-ordinated around individuals
- **Access to high quality emergency care** with services delivered locally where possible, central where necessary will be sustained
- **The volume of emergency and planned care activity** in hospitals, nursing and residential care homes will be reduced.

Alongside these developments across the health and social care market we will build voluntary and community sector capacity in local communities. People will be supported to remain independent and able to 'live well ' with health related problems and remain active and engaged in their community, reducing the impact of social isolation

Our high level plan for **phase 1 2014 – 2016** will deliver the national requirements. We will embed a Joint Integration Team sponsored by Hampshire County Council and all the Clinical Commissioning Groups to programme manage the changes, track delivery of savings and re-investments, monitor and hold the system to account for delivery on local areas evaluate local progress to:

We will:

- **Keep people well, supported by effective care co-ordination**
    - Implement a sustainable model of primary care and integrated care teams embedding key characteristics of risk stratification and proactive case management; shared decision making; lead professional; standard operating procedures; strong partnerships at a local community level; strong clinical leadership
    - Moving to 7 day services operating a round the clock "pull model" where the community resources take the lead in helping people navigate the system
    - Individuals will be supported to participate in their care including using personal health budgets
    - Care pathways e.g. dementia, wound care, falls will be reviewed
    - Commissioning a robust approach within teams to ensure programmed

review and right-sizing care and support packages is routine
    - Enhanced psychological support will be available for people with long term conditions

- **Manage proactive intervention**
    - Through primary care based urgent care access; Rapid Advice and Assessment Units; Integrated Geriatrician; Targeted therapies and End of Life Care
    - Developing approaches to share data in real time so that people can make the best choices

- **Support recovery**
    - Redesigning the intermediate care model including reablement and personal care
    - Developing and supporting the care market so that skilled carers work in synergy with clinical teams and enable people to retain their independence

- **Respond to the Care Bill -** early joint priorities to meet the Care Bill's ambitions for integration will include:
    - Developing a joint strategy to meeting the needs of carers who will gain new rights to receive a service under the Care Bill
    - Ensuring that early intervention and prevention services operate effectively to reduce or delay the demand for more expensive social care
    - Developing an effective knowledge base and more accessible information/advice resources to support individuals to navigate through the social care and health system in a more seamless way

From **2016 – 2019** our programme will work to deliver a fully integrated commissioning system, creating flexibility of roles such that the cultural and behaviour change is apparent

- **NHS Continuing Healthcare**
    - Our approach will be supported through Integrated Teams, a pooled budget and individual participation through a greater number of personal health budgets, increasing choice and competition in our local markets
- **People with Learning Disabilities and Adult Mental Health problems, young people in transition**
    - Will benefit from fully integrated commissioning approaches that will also improve the experience of transition to adult services.

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?

Hampshire health, public health and social care commissioners continue to learn and develop a stronger understanding and evidence base of how to support people to maximise their independence, supporting people to remain in their communities.

We recognise that many factors influence mortality and morbidity; however our plans for integration can make a crucial contribution to improving health and have developed a benefits realisation model as set out in table 1. We will also use proxy indicators where required. For 2014/15 – 2015/16 we would expect integration to contribute, in the longer term to:

- Reducing premature and total mortality from the major causes of death
- Reducing the difference in life-expectancy between people living in the least and most deprived areas

We expect integration to have a direct impact on:

- Improving health related quality of life for people with long-term conditions
- Helping older people to recover their independence after illness or injury

We are developing a patient / service user focussed outcomes framework which enables us to measure the success of the Better Care Fund across the full range of the services we propose to integrate in the next five years. This has allowed us to develop indicators that relate directly to the developments we are proposing. To measure success of the programmes at a local level we are developing a suite of process and outcomes indicators for each objective; these will be based on evidence from other integrated care pilots and be clearly linked to the service interventions we are proposing.

We will use both the national metrics and locally relevant metrics to assure ourselves that the desired outcomes are being realised. The metrics are being aligned to the strategic priorities of all partners. As our priority population group in phase one is older people including those with long-term conditions, specific metrics will be developed for this population for the years 2014/15-2015/16. We will measure health gain using locally relevant health outcome measures that align with the NHS, Public Health and Social Care Outcomes Frameworks[1] as well as our joint health and wellbeing strategy. We will include metrics that explicitly measure inequalities in health. Our benefits realisation is set out in Table 2 below.

Table 2 Benefits realisation

1	**Maintain a constant focus on long term quality of care and the achievement of outcomes for users**	To achieve outcomes for service users, commissioners will focus on long-term quality focused on reducing dependency. Providers will need to be incentivised differently so that they focus on outcomes rather than provision. This is a radical shift given current payment mechanisms on the basis of the care provided.	**Achieve long-term quality outcomes**

[1] https://www.gov.uk/government/collections/health-and-social-care-outcomes-frameworks

2	**Ensure that fairness and equality in the broader context underpins every decision that we make**	There is no doubt that fairness and equality underpin decision-making, but in order to meet rising demand, decisions will need to be based on fairness and equality in the broader context of our communities, rather than just on a case-by-case basis.	
3	**Give service users and their families choice and control over their outcomes**	National policy on choice and control has shaped significant changes in service delivery. To meet longer term demand, choice and control needs to be framed within the context of outcomes rather than services.	
4	**Increase self-sufficiency and independence reducing reliance on services where possible and appropriate**	We intend to increase self-sufficiency and potential, and therefore quality of life. This will require a major shift in the way in which commissioners works with providers and incentivises them.	**Reduce demand**
5	**Protect the sustainability of services to meet current and future demographic, financial and statutory constraints**	We know that current service delivery models are not sustainable in the long-term. Commissioners need to focus on more affordable delivery models that take account of future demand and resource availability. This will require commissioners to think differently about their service users and planning services in a more sophisticated way, taking account of age, gender and other factors, and not just service user type as is traditionally the case.	**Reduce cost**

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

Hampshire is home to 1.32 million people and is the third most populous shire county in England. It has an increasingly diverse and ageing population and is growing all the time. 18.5% of the population is aged 65 years and above. This will grow to 29% of the population aged 65 years or older by 2021. This is higher than the regional and national average. Hampshire has a diverse and varied population with both rural and urban areas and the largest proportion of armed forces personnel in the country. At the same time, a significant proportion of the population will remain under 20 years. As with adults, there are pockets of deprivation and a significant number of our children growing up in poverty which lead to some achieving poorer outcomes than others. The Hampshire Children and Young People's plan focuses on narrowing this gap to ensure our children and young people have access to a wide range of educational opportunities, excellent academic institutions and varied employment opportunities. Hampshire offers the dual benefit of being able to model change at a local level as well as at scale.

Hampshire is bordered by a number of other local authorities including Berkshire, Dorset, Portsmouth, Southampton, Surrey and Wiltshire with links to the Isle of Wight. This creates a diverse and challenging demography for the health and care system which will benefit hugely from more integrated and person-centred services. As our work has evolved, increasingly we have been able to identify common themes and challenges for people in greatest need, which if addressed would make a real difference to the individual, the people who deliver services and the system of care partners seek to deliver.

We are already working together on system wide change programmes in each CCG area and have strong foundations to build on. Through mapping the current experiences, capabilities and need of local people, including those identified as part of the Year of Care demonstrator site activities in West Hampshire and patient journey mapping in other CCGs, we have aligned our priorities.

Our early workforce discussions have concluded the following elements of a joint workforce plan:

1) Implementing the Hampshire Dementia strategy
2) Workforce development to enable integrated care teams to operate in new ways (including qualified and unqualified staff in health and social care)
3) Developing enhanced clinical skills and new roles within community services
4) Workforce change capability to support the transformation at scale i.e. across all sectors

This will support our work to commission a model that transforms the current arrangements to a new model for better care in Hampshire encompassing:

- Primary prevention and early intervention
- Supported self care
- Risk stratification and predictive monitoring
- Managing ambulatory care-sensitive conditions
- Care co-ordination and case management
- Proactive management of admission avoidance, rapid response and effective discharge planning,
- Specialist input for mental health, end of life care etc.
- Intermediate care, rehabilitation recovery and reablement support

Figure 2: below summarises the components of the model

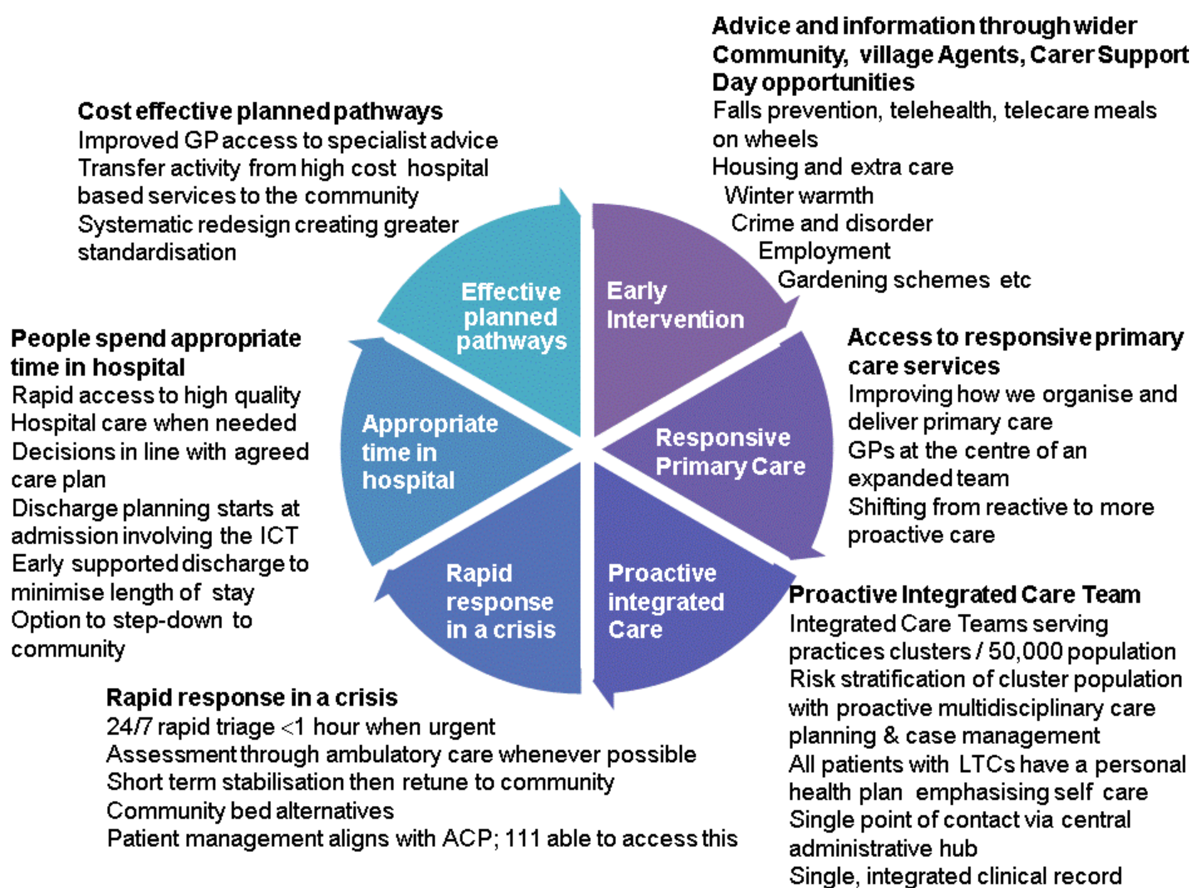

Figure 2: Components of our model of care and support

There are a range of improvement projects in progress that will **deliver in 2014/15**. These are summarised in the Mapping of Schemes and Projects document reference in the evidence section. Examples include:

- A total of 35 Integrated Care Teams established by June 2014
- 6 Enhanced Integrated Care Teams across NHS North Hampshire CCG
- Re-commissioning personal care and support
- Re-commissioning a new model of Reablement and Assessment Care Team Service (REACT)
- Community Geriatrician in West and Mid Hampshire
- Embedding primary care in acute “front door”
- Review of day services contracts
- Embedding “pull model” in hospital discharge teams by ensuring they are embedded within Integrated Care Teams
- Rapid response service development in NHS South Eastern and NHS Fareham and Gosport CCGs
- Collaborative arrangements for Personal Health Budgets and NHS Continuing Healthcare eligibility in NHS North Hampshire

These schemes and others will be delivered at sufficient scale and pace to achieve the transformation required for

- Protecting social care services
- 7 day services to support discharge
- Data sharing and the use of the NHS number
- Joint assessments and accountable lead professional

The wider community will provide access to the resources and support that will compliment the health and care activities enabling prevention and early intervention and described in Figure 3 below:

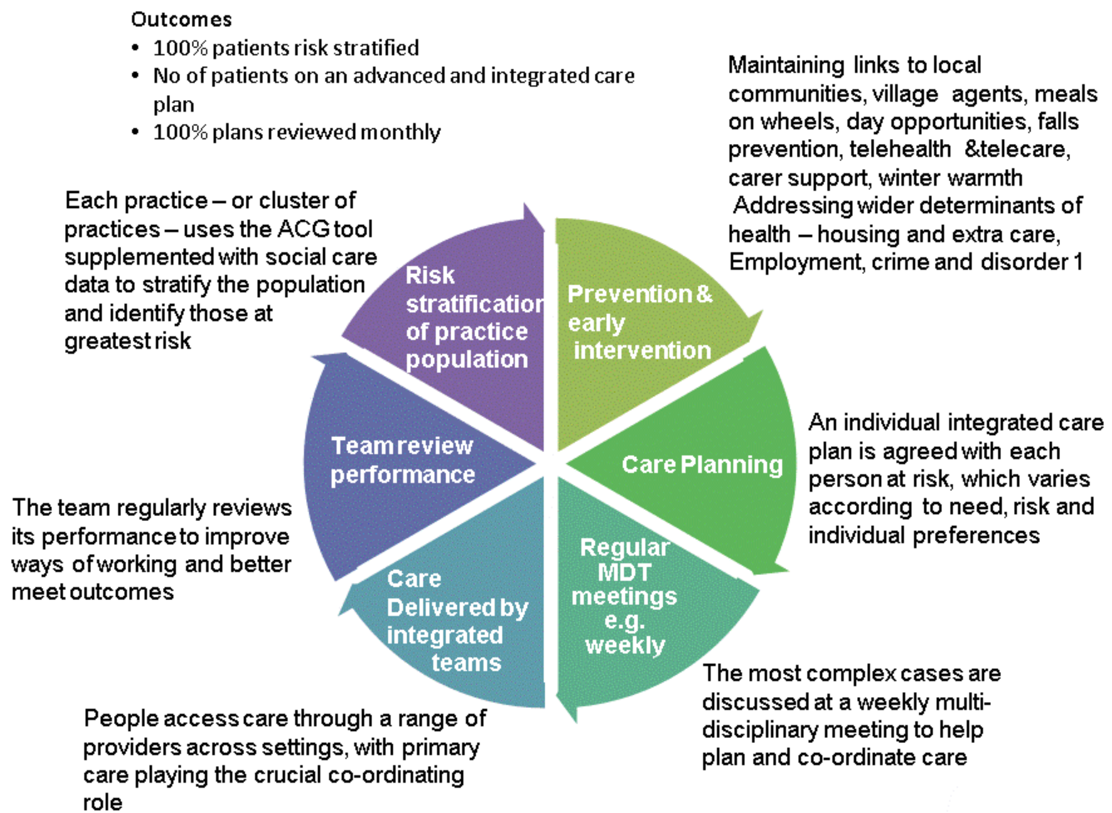

Figure 3: Approaches to Prevention and Early Intervention

We are working to support GPs to become fully engaged as lead professionals in proactive multi-agency teams in local systems to deliver a new model of primary care at scale as outlined in Figure 4 below:

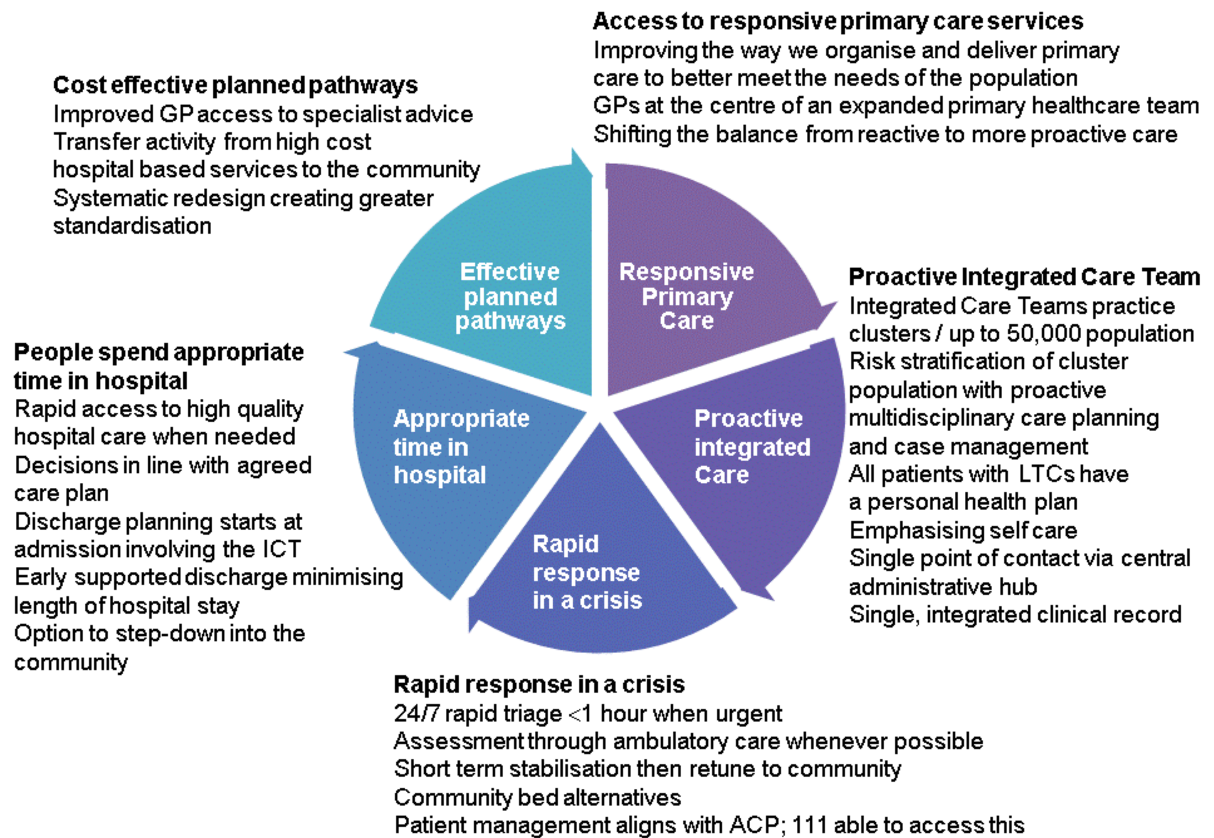

Figure 4: Delivery at the level of a General Practice / Integrated Care Teams

Our plans will create a completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that people are fully empowered in their own care with access the relevant specialist input to meet their need and individuals have strong community support in the manner described in Figure 5 below:

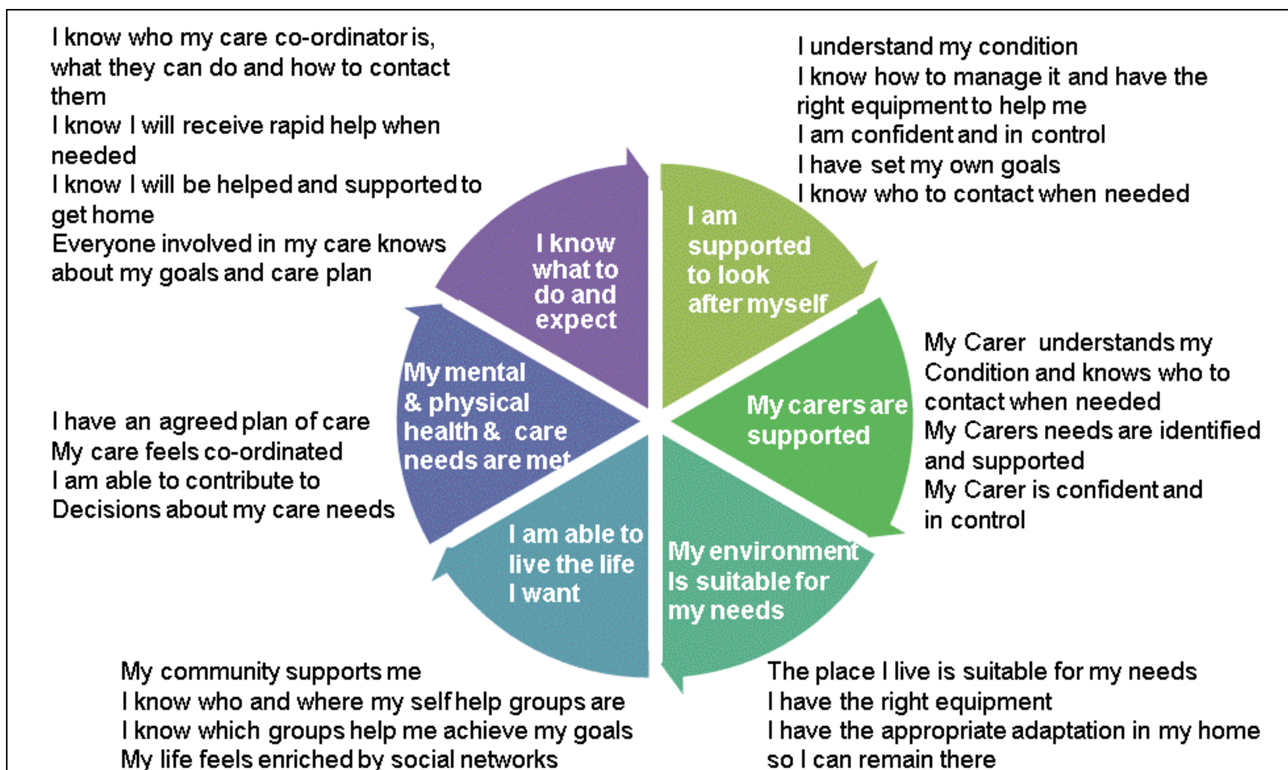

Figure 5: Self Care and Support for Individuals

These changes will result in:

Giving people a bigger say:

- Co-produced delivery with people, patients and communities
- Sharing decisions with those who enter the care and support system and an even more personalised service.
- More involvement in the way services are run, leading to reductions in health inequalities.

Meeting need and managing demand:

- More appropriate and responsive service models and professional roles to get the best out of integrated working for people using services and staff delivering services
- Improving access to services so that more people can have longer term care and support delivered closer to home by transformed care and support services that are part of their community.
- Using technology to add value to care and support packages
- Promote diversity and quality in the care and support market, to meet the market shaping requirements in the Care Bill, and to respond to the increasing demand for services from older people, particularly from self-funders and from carers

Reducing inequalities:

- Through a stronger focus on preventative measures to keep people healthy so that fewer people will die from conditions that could have been prevented.
- Improved outcomes for people.

Maintaining a flexible workforce:

- A robust workforce development plan developed in partnership with Health

Education England will support the sector

- Staff will own the changes
- Our staff will be working in an environment where they are encouraged to be innovative and exchange ideas and good practice
- More opportunities for professional development and will work in a more collaborative environment.
- Greater job satisfaction from feeling a "job well done" rather than the current frustration where boundaries are not seamless.

Establishing system sustainability:

- Managing demand, increasing productivity, driving up service quality in multidisciplinary teams working together to transform their services.
- Improved communication across the system, identifying ways to remove waste.
- Increased opportunities, working in financially viable yet dynamic organisations
- Public sector partners commissioning the most appropriate services especially where there are known challenges without adding to the cost of commissioning.
- Clarity about the resources committed and for what period of time.

The scope of integration needs to build and move significantly beyond the historic domains of joint commissioning of health and social care into a more comprehensive spectrum of Health and Wellbeing services. Some elements will need to be locally agreed to ensure they address local CCG and Hampshire County Council priorities to achieve the savings and efficiencies required from the integrated plans. Areas initially out of scope may be included at a later date as the models are fully implemented to ensure flexibility, cross learning and optimisation of benefits.

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.

Currently the services that people need and / or want do not align and we need to see a fundamental shift in the way urgent care is provided. This means services will need to change both what and where they are available, so that interventions and support will be co-ordinated around individual needs and delivered as close to people's homes as possible, minimising disruption and inconvenience. People with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities to maximise their chance of survival and good recovery.

To be successful we will require a level of investment in primary, community and social care services to meet the challenge, shifting some acute hospital based planned activities to safe, alternative community based services. Through transforming and integrating delivery of services we are:

- Re-commissioning the "front door" of acute hospitals to have a primary care led integrated team linked to wider primary care provided at scale
- Vertical integration with specialist outreach to enhance the capability of Integrated Care Teams

- Integrated discharge arrangements moving to a “pull” model connected to a modern model of integrated care
- Alternative use of existing capacity to enable a step change in the productivity of elective care
- Shifting some services e.g. chemotherapy to community settings

[Drafting note: Need to add in the impact on admission rates to reflect operating plan assumptions]

Commissioning models will clearly define access criteria to evolve to meet changing population needs, moving away from episodic care to pathway / outcome based. Some of these changes require pump priming and should lead to increased efficiency and productivity between health and social care. Our analysis to date indicates that as integrated community services change and develop, we expect the number of general and acute beds needed in Hampshire will reduce. However, we expect the number of beds will reach a plateau with future growth reflecting the ageing population and long term conditions prevalence. We are planning for a reduction in non elective admissions over the next three to five years. This will have an impact on the acute service capacity.

There are greater financial pressures in some parts of the NHS in Hampshire than others. If we do not deliver these activity reductions we expect most parts of our system to move into deficit of up to £40 million overall

At this stage we are working with all the Acute and Community Providers to assess the impact of changes. Initial estimates will be revised to reflect emerging evidence of local system change. In essence we aim to commission a system of care that will operate as outlined in Figure 6 below:

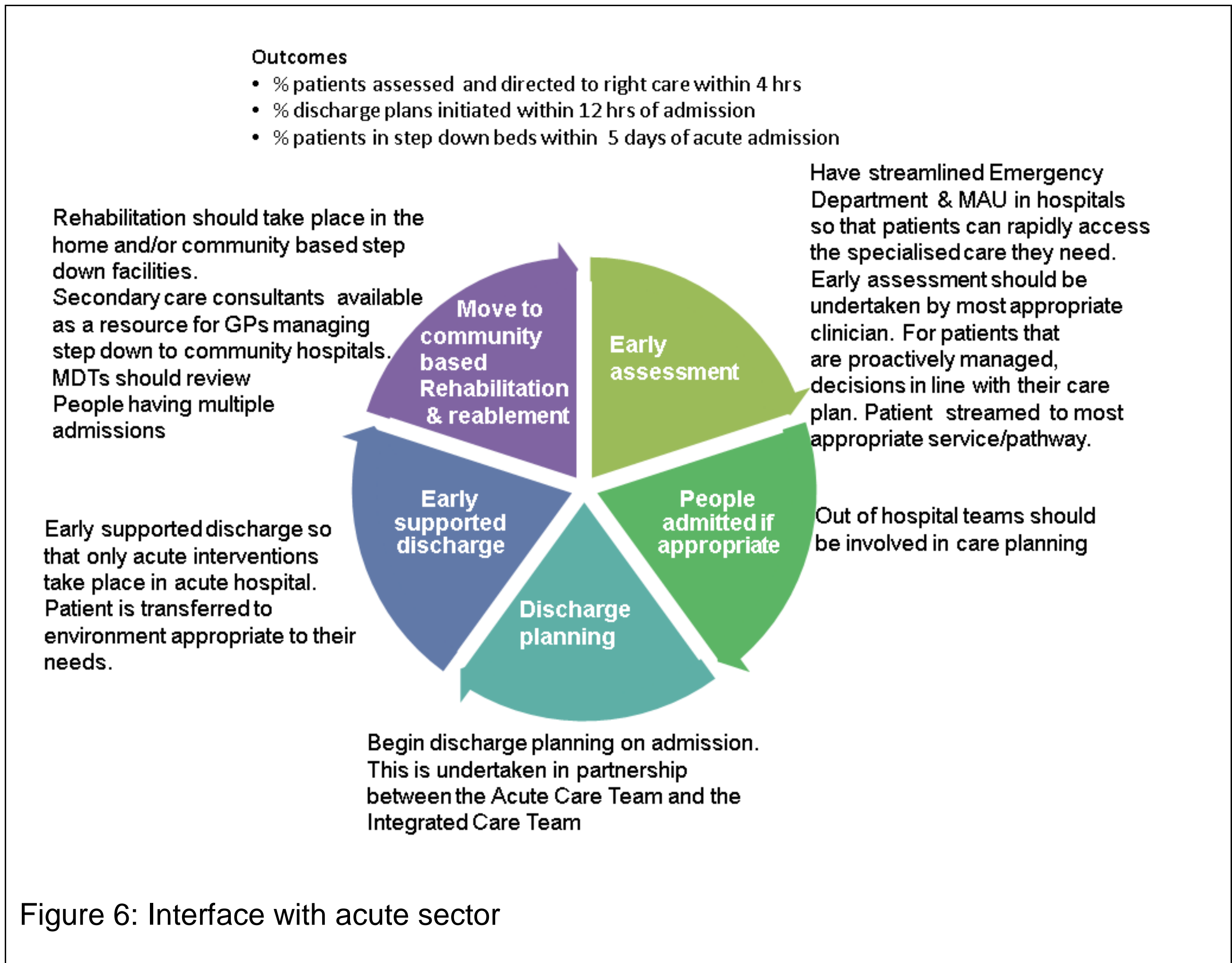

Figure 6: Interface with acute sector

e) Governance

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

We are determined to use every opportunity to engage staff and users of health and care services, to create and plan these changes together.

We will be open and honest about the challenges and opportunities ahead and we will keep people regularly updated and informed about developments. We will seek support for BCF the programme by sharing ideas, encouraging others to get involved and being open to the opportunities of a more joined-up approach so that we:

- Make the best use of resources
- Target the right groups of people, at the right time and place e.g. prevention and earlier intervention
- Involve and engage people
- Strengthen leadership and collective “effort” towards more inventive ways of “joined up” commissioning processes that incentivise more coordinated integrated delivery
- Improve strength and depth of information sharing in all areas and managed expectation
- Adopt a collaborative culture and mutual respect
- Influence - plurality of market supply
- Aligning OD and workforce development plans

At a county level we have made good progress in building governance, transcending individual

organisational boundaries and supports our delivery of the BCF. However we recognise there are opportunities to deepen these relationships in the context of the scale and ambition of the BCF.

We therefore propose as part of this process to explore how we bring together management and accountability across the care and health services for the benefit of local people.

The Hampshire Health and Well Being Board chaired by a Council Cabinet Member with Deputy Chair being the Clinical Chair of North Hampshire CCG, which includes our Districts and Boroughs, will provide strategic leadership and political oversight. Reviewing the Terms of Reference of our current Health and Well Being Board and ensuring it is positioned to robustly govern our joint approach will be a priority for the final submission in April.

In parallel we will establish a joint leadership model with the Local authority and CCG's and ensure robust governance and legal agreements support our joint working have clear and shared arrangements for the joint fund.

Part of the strategic delivery mechanism is the Hampshire Integrated Commissioning Group which is sponsored by Adult Services all five Clinical Commissioning Groups and Public Health with , participation of the voluntary and third sector partners , This will become integral to the strengthened governance and delivery mechanisms across Hampshire with strong links to the Hampshire 5 Commissioning Group and the Hampshire County Council Transformation of the Council 2015.

There is also significant potential for us to have a strengthened approach to working with some of the key providers in Hampshire where there is mutual benefit in improving outcomes and reducing costs through joint approaches. Robust Programme Governance will be applied to the arrangements

Governance structures in place balance the requirements of Hampshire wide solutions delivered at a local level. The following diagram provides a representation of how the strategic (whole population) locality (200,000 plus population) and local (individual at OCT level) outcomes will be delivered through robust governance arrangements that operate at every level: strategically, in localities and at a local level for individuals. Figure 7 illustrates the governance across the system.

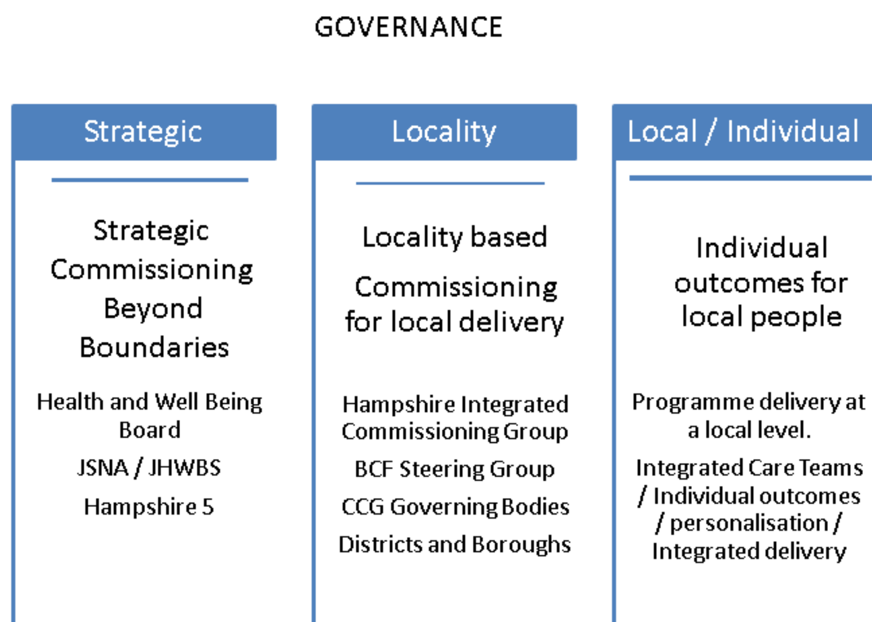

Figure 7: Governance at every level

At a local operational level CCG transformational plans and programmes are formally discussed with the wider clinical stakeholder participation.

These projects and programmes are summarised by area in the reference documents.

To deliver the ambition of the BCF plan, we recognise the need to expand our strategic and operational governance arrangements, bringing together accountability arrangements across care and health services for our residents and patients as a whole. This will begin in the North Hampshire area and lessons learned transferred to other CCG areas.

Drawing on the Local Authority's category management plan and the CCGs Out of Hospital Care Strategies, initial areas for consideration include the personal care and support in people's own homes from both NHS community services and the personal care market. We envisage the joint arrangements would enable us to deliver the full benefits of reablement and intermediate care services provided in people's own homes and to remove waste and known gaps.

We envisage these joint arrangements will enable us to deliver the full benefits of care and support services we commission removing current gaps and duplication overall.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Protecting social care services means ensuring local people in need continue to receive the care and support services they need in the context of increasing demand and growing financial constraint. Developing new approaches that join up care so that individual retain their independence and continue to enjoy a quality of life and well as maintaining current eligibility criteria will benefit our population, their communities and the whole health and care economy. By intervening earlier to enable people to engage in the management of any health conditions as well as supporting them to remain in their own home, we will protect and enhance the quality of care as well as protecting services

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

Funding currently allocated under the Social Care to Benefit Health Grant (£17.1m) has been used to deliver strategic priorities and enable the Local Authority to sustain the current level of eligibility criteria and to provide a range of services (including reablement, information and signposting) to people who are not FACS eligible.

We anticipate this will need to be increased and within the funding allocation for 2014/15 and beyond to maintain and extend to deliver 7 day services and the requirements of the Social Care Bill for people who did not previously access services

It is proposed to build the additional resources identified in the BCF and existing pooled resources to commission services jointly to deliver enhanced personal care and reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

This will include:

- A new style of personal care support service
- Access to a wide range of telehealth and telecare
- Increased roll out of Direct Payments and Personalised Health Budgets
- Ensure carers feel supported
- Wider community development and voluntary sector support in local communities

At the heart of the Better Care Fund is the ambition that by health and social care jointly commissioning integrated health and care provision, significantly improved outcomes and client experiences can be achieved within the same or even reduced amount of resource. This will require a dramatic transformation of existing provider models, most notably in the workforce and role definitions; information technology; and in the way in which care is paid for.

b) 7 day services to support discharge

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

The Integrated Care Team development and current work supporting the Acute Care 4 hour Access Target has informed the development of seven day health and care

services, facilitating discharge and preventing unnecessary admissions at weekends by identifying higher risk groups and introducing rapid response services.

7 day working is a key principle of our integrated model. Many of our services are already available 7 days a week.

Our commitments will be overseen by the Hampshire Integrated Commissioning Group, supported by the Health and Well Being Board to ensure

- We have identified where additional 7 day working capacity is required
- We will match capacity to demand,
- 7 day working will become “business as usual” with access to 24/7 support where appropriate.
- We will prioritise whole system urgent care pathways including local care providers,
- Services must be person-led with individuals accessing and receiving the same service 7 days a week
- Primary care access
- 7 day access to specialist clinical advice and support

A mode detailed plan will be available as part of the strategic plan being developed in 2014/15

c) Data sharing

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

All health services use the NHS number as the primary identifier in correspondence

82.5% of current Social Services cases have the NHS number identified. By using the NHS number we are linking the health and social care information through the Hampshire Health record Data Repository. We are committed to the universal adoption of the NHS number as part of our information governance work.

Compliance with Information Governance standards can be confirmed.

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

NHS number to be the primary identifier by April 2015

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

We are committed to adopting systems based upon Open APIs and Open Standards

To enable cross boundary working we will improve interfaces between systems. Further we will use the Hampshire Health Record data warehouse to aggregate data from different sources into a consistent format. This will provide one view over the whole system of health and social care and allow queries and analyses across multiple systems to occur.

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

Hampshire has an information sharing protocol amongst commissioners and providers of health and care services.

All activities will comply with the Information Governance Framework and we are committed to maintaining the five rules in health and social care to ensure that patient and service user confidentiality is maintained. i.e.

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

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. 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.

Our integrated team development assumes GPs taking the lead in coordinating care as the agreed lead accountable professional for people at high risk of hospital admission.

We can track the number of people with a care plan [Drafting note: need to add in numbers]

The John Hopkins Adjusted Clinical Groups (ACG) algorithms tool is being rolled out to predict high intensity users and stratify risk in relation to Long Term Conditions at risk of hospital admission.

Each GP Practice currently reviews the top 1% of their most at risk population each Quarter and implements an agreed care plan for 10% of identified patients, coordinated through an accountable GP lead. These reviews are conducted in an MDT environment utilising the expertise of both health and social care professionals. Based on the output of modelling and stratification we will monitor the impact on hospital admission within the next year.

Joint assessment MH LD integrated teams
Based on the output of modelling and stratification we will monitor the impact on hospital admission within the next year

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 No.	Risk Description	Risk Rating	Mitigation
1	Failure to create a strong integration ethos due to financial constraints or risk of destabilising providers that restrict cross-boundary working	15	Sharing governance and transparent approach with clear decision making and accountability Developing plans that take account of whole system impact and co-design at the heart of change processes
2	Failure to establish "back office" integration such as sharing client and baseline information preventing seamless planning and care services delivery	15	National guidance is awaited which may act as a lever for the acceleration of change Detailed mapping and consolidation of opportunities and costs to be used in validation
3	Failure to incentivise providers to overcome professional boundaries in direct provision	10	Regional and National ADASS, HWBB Use of BCF "start up" resource to avoid risk in capacity to support overall organisational development
4	Failure to influence front line professionals and embed a culture of integration	15	Deliver local and county wide workforce events. Present evidence of successful integrated working models Produce robust Communications and Engagement Strategy and Implementation Plan
5	Delays and adjustments in national guidance that results in the partners adopting an approach that does not subsequently align with requirements	15	Regional and National ADASS, HWBB, advice
6	Failure to release and reinvest funds to deliver the outcomes of the BCF	15	Robust programme management, strong governance and assurance
7	Failure to communicate the opportunity of the BCF in a manner that achieves clear understanding and buy in from CCG members and politician partners, staff and workforce that causes delays to implementation	15	Robust programme management, effective stakeholder communication strategy and plan, strong governance and assurance
8	Timescales of current and planned procurement approaches do not align with BCF requirements and approach has an adverse impact on NHS QIPP programme or fail to translate into reductions in acute and nursing home care costs	15	Robust programme management, strong governance and assurance Modelling assumptions using a range of data Using 2014/15 to test and refine assumptions to support development of detailed service specifications and business case proposals
9	Failure to accurately assess the financial impact of the introduction of the Care Bill in 2016	15	This risk cannot be entirely mitigated. Initial impact assessment underway. We will continue to refine assumptions in parallel with our BCF response.