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	**Torbay Council**
Clinical Commissioning Groups	**South Devon and Torbay**
Boundary Differences	**The CCG boundary includes all of Torbay Local Authority**
Date agreed at Health and Well-Being Board:	**February 12th 2014**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£5.2m**
2015/16	**£11.7m**
Total agreed value of pooled budget: 2014/15	**£5.2m**
2015/16	**£11.7m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	South Devon and Torbay CCG
By	Simon Tapley
Position	Director of Commissioning
Date	<date>

Signed on behalf of the Council	Torbay Council

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By	Caroline Taylor
Position	Director of Adult Social Care
Date	<date>

Signed on behalf of the Health and Wellbeing Board	Torbay HWB
By Chair of Health and Wellbeing Board	Chris Lewis
Date	<date>

c) Service provider engagement

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

Our plan reflects a number of existing programmes, the development of which have included health and care providers as active participants, including our voluntary and community sector. Providers will also be engaged in the development of our ongoing and future plans.

A key strategic planning and design framework agreed between commissioners and providers has allowed a number of key groups to consider plans for the Better Care Fund. This has included an evaluation tool being developed and completed for existing services and pilot projects in order to inform decision for on going service provision and movement of allocation across the integrated health and social care system.

We have a long history of including our providers in service planning and reviews, and have a number of multi-disciplinary Clinical Pathway Groups, which in turn feed into senior level multi-disciplinary Service Redesign Boards. In addition to this, the Social Care Programme Board for Torbay provides the senior management forum for oversight of the Annual Strategic Agreement through which the Council delegates commissioning and delivery of Adult Social Care to the NHS.

The previous Integrated Transformation Fund has been discussed with the Health and Wellbeing Board and plans for it's further development in to the Better Care Fund and links with Pioneer and Integrated Care Organisation are proposed regular agenda items.

As the first cohort of Integration Pioneers, both commissioners and providers have formed a programme board - including the community provider (Torbay and Southern Devon Health and Care NHS Trust), the acute hospital (South Devon Healthcare Trust), our mental health provider (Devon Partnership Trust), Council-provided Children Services along with Virgin Healthcare, South West Ambulance Service, the voluntary sector (Torbay Community Development Trust) and Rowcroft hospice – which will oversee our programme of integration and pooled funds. Given the opportunities that the Better Care Fund presents this is seen as integral to the planning and implementation of our plans as integration Pioneers and the priorities for the Integrated Care Organisation which will increase our ability to deliver better care through pooled funding of almost £240M.

This plan recognises the importance of early help and prevention and the role of adult social care services in keeping people independent at home, as well as the vital contribution of local communities and the voluntary sector in reducing loneliness and

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isolation by providing both formal and informal support to frail and vulnerable people. These services make a positive difference by reducing reliance on bed based care and supporting reablement and recovery through outcomes based care and support

Torbay & South Devon Health and Care NHS Trust is an integrated health and adult social care provider and has been instrumental in the completion and submission of this template, although it is worth reinforcing that the Better Care Fund sits within the Pioneer governance and Health and Wellbeing Board arrangements.

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

We have undertaken an extensive public engagement process for our community services, taking three months and including 21 public events across the CCG footprint plus additional meetings with staff, district councils, the voluntary sector and local groups.

Now that there is a new commissioning organisation with clinical leadership, there is a great opportunity for taking a fresh look at how mental health and support services work in our area. The experience of people who use mental health services, their families and carers should directly influence the commissioning process, so our new team have embarked on a rolling programme of engagement events and individual engagement to collect feedback.

The events – held across our geography – have been attended by more than 200 people so far and are inclusive of patients, carers, GPs and provider staff. Areas of focus have included:

1. General focus on adult mental health (June 2013)
2. Urgent care, inpatients and community services (August 2014)
3. General focus on adult mental health (December 2014)
4. Time to talk, about reducing the stigma of mental health (February 2014)
5. Dementia (March 2014)

Further events aimed at reducing the stigma of mental health are being arranged to coincide with national Time to Talk Day in February as well as one in March for older people's mental health.

The core messages from all of these events have been instrumental in the development of this plan and our vision for integrated care and support, and we will continue to engage and consult with the public as we begin to implement it.

We recognise that a "one size fits all" approach will not work, and for this reason each of the CCG five localities has developed a steering group made up of local people. These groups initially helped to inform and run the full engagement process, but will continue to meet and act as expert reference groups as our plans are implemented and further developed.

Our local Healthwatch are represented on each of the steering groups and were wholly involved in the engagement process.

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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**
Pioneer application June 2013	The vision for whole system integrated care in South Devon and Torbay Sallie to expand synopsis
Better Care Fund Plan December 2013	Siobhan / Sallie?
CCG Strategic Commissioning Plan 2014-2019	This sets out the ambitions and intentions for the CCG which is consistent with identifying priorities which have a focus on integrated planning and delivery in order to deliver on the challenges faced by health and social care.
Torbay Council strategic plan	**Corporate plan**
South Devon and Torbay CCG Engagement report	The report analysing the feedback from our extensive community services engagement process
South Devon and Torbay Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.
Joint Health & Wellbeing Strategy 2012/3 – 2014/15 (JHWS)	Agreed set of priorities for Torbay covering the lifecourse with three underlying principles of 'First & Most'; 'Early intervention'; 'Integrated and Joined up approach'.
Living Well at Home	
An Overview of Dementia	Analysis of dementia prevalence and predictive modelling provided by Public Health.

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 whole system integrated care and support is articulated in our application for Pioneer status.

With our local communities, we are resolved to make a major difference to the quality of life of our population, to support people to be as well and independent as they can be,

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and to provide care with compassion when they cannot. To do this, we need to join up with each other to make our care seamless and put more power in the hands of those who need our care and support.

In the Torbay of the future, Mrs Smith or her daughter will make a single call for any health or care service. Her GP will be integrated into a community hub, where she can find not just health and social care but personalised support for her mental health and general wellbeing needs, too, all organised with her single named care coordinator. Thanks to information-sharing across all parts of the system, whenever Mrs Smith receives care for one condition it automatically and electronically triggers others that are needed, for support or prevention. Acute hospital interventions are included, but it's a long time since Mrs Smith has been to hospital; hand-held diagnostics come to her in her home, her GP can monitor her vital signs remotely and the last time she did need intravenous treatment she chose to have it in her own home. Together with her family and key health worker, Mrs Smith has planned her end of life care, and has chosen hospice care in her own home. For now, volunteers from the 'neighbourhood connector' scheme have made sure handrails are fitted in her home, and they help her with her garden.

Mrs Smith's 15 year-old grandson Robert won't lose his CAMHS support at his next birthday; his named key worker will be on hand and work closely with the community-hub-based GP and adult mental health services so that he can transfer smoothly. Robert will take control of planning his care, in a way that works for him. He now benefits from peer support, so he is learning ways to manage his emotions, complementing his psychological therapy from the all-age depression and anxiety service. Carer support for his mother is automatically triggered; this means help with her housing difficulties, too. Moreover, Robert is getting support to find a vocational course that will interest him.

As an Integrated Care Organisation from August 2014 with pooled resources overall pressures on our hospitals and health spend will have reduced, as we shift from high-cost reactive to lower-cost preventative services, supporting greater self-management and community based care. Our social care spend will be going further, as new joint commissioning arrangements deliver better value and improved care at home reducing the need for high-cost nursing and care home placements.

To increase independence at home we will have delivered further extra care housing units, re-commissioned community equipment services and community care and support will be focused on meeting individual outcomes to re-able people quickly and keep them independent and well at home.

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b) Aims and objectives

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

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

The core principles of our vision for integrated care and support are:

- People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.
- Key services will be available when and where they are needed, seven days a week
- Joined up IT and data sharing across the entire health and care system with a workforce
- Promoting self-care, prevention, early help and personalised care

The CCG strategic plan sets out the detail along with the key outcomes and indicators for each of its high level priorities in line with the vision for integrated care and support. This also demonstrates the number of workstreams in place to make it happen within the context of the challenge of a flat cash environment: prevention, primary care, community, urgent care, mental health, long-term conditions, learning disability, planned care, medicines, joint commissioning and children's services.

In conjunction with these ambitions and in alignment with the 'Everyone Counts: Planning for Patients 2014/14 to 2018/19' planning guidance we will be working towards achieving improvements in the following seven ambitions and three key measures:

- **Additional Years of Life**
- **Quality of Life for people with Long-term Conditions**
- **Eliminating avoidable deaths in hospital**
- **Positive experience of care outside hospital**
- **Positive experience of hospital care**
- **Avoiding hospital through Integrated Care**
- **Older people living independently**
- **Reducing health inequalities**
- **Improving health (via prevention)**
- **Parity of esteem**

At this stage of the BCF process our health, social care and public health teams have undertaken a baseline analysis of the suggested metrics. In considering the population demographics, priorities set out in the Pioneer and Integrated Care Organisation the proposed local indicator is '*Estimated diagnosis rate for people with dementia*.'

c) Description of planned changes

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

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

The refresh of the CCG strategic commissioning plan is currently being drafted, supported by information from the JSNA and the close link between CCG and public health specialists, who are seen as an integral part of the CCG commissioning and performance team. This ensures the alignment and focus of priorities between health and local authority plans including our developing children and young peoples plan, joint commissioning strategies for dementia, carers, learning disability, mental health and housing related support. The key priorities for each area, developed by multi-disciplinary

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redesign boards, and with timescales, are detailed in section 4.2 of the CCG integrated plan.

The Joint Strategic Needs Assessment has developed from one of a reference publication into an interactive tool, available to partners to manipulate and interrogate the data to service need. In addition there has been a number of segmented and condition specific in depth profiles at a geographical ward and neighbourhood level such as Learning Disability, Suicides and Alcohol. In recognising the value that sharing and interpretation of information across partner agencies brings in supporting the commissioning and planning of services there has been a joint information intelligence virtual team established ('iBay') with organisations signed up including health, council, education and police.

The BCF fits with the existing priorities set out in the Health and Wellbeing strategy which takes the life course approach and identifies priorities such as those supporting a system of self-care for people with long term conditions, promoting independence and mental health.

To set out opportunities and encourage a diverse market we are developing a market position statement for Torbay with the first phase focussing on adult social care. The statement provides an analysis of how well current service supply will meet future demand. It will provide clear messages to the market on the vision for integrated care services in Torbay over 7 days a week, reducing reliance on bed based care. It will outline how provision needs to change to stimulate a diverse and vibrant market in Torbay, increasing choice and innovation in services, supporting the vision of reablement and early help to support people manage their conditions through early help and a focus on personal outcomes and choice.

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.

Our local provider of community services, Torbay & Southern Devon Health and Care NHS will be acquired by South Devon Healthcare NHS Foundation Trust to form the Integrated Care Organisation, which will provide acute, community and social care services. Through the acquisition and by pooling almost £240m of funding, we expect to see a transfer of resources from inpatient beds to care provided in people's homes, which is of high quality and value for money for our population. To deliver this we expect to see a shift in the current workforce configuration to more community based teams, delivering seven day a week services.

Provider Landscape

Our vision is to have excellent, joined up care for all. We believe that services should be based on populations in local communities and centred on the individual's needs within those communities. We also believe that services should be built on the public's needs not organisational imperatives, which serves as a mantra for the formation of our

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Community Hubs. Community Hubs will be centres of well-being where our population can receive co-ordinated support in relation to prevention, self-care, social care and medical support from primary and community care.

We wish to promote well-being and independence and will require all providers to move away from an institutional bed based model of care to a delivery system that is flexible and responsive to the changing needs of our populations. We have been told, through our Locality Engagement events, that people want care closer to home with a single-point of access. Therefore, over the next five years we will expect to see a reduction in inpatient beds. This is also in line with the evidence we have already collected from three consecutive acuity audits that all clearly state that with additional personal care services 30 - 40% of patients cared for in a community hospital bed could be at home.

Our local provider of community services, Torbay & Southern Devon Health and Care NHS will be acquired by South Devon Healthcare NHS Foundation Trust to form the Integrated Care Organisation, which will provide acute, community and social care services. Through the acquisition we expect to see a transfer of resources from inpatient beds to care provided in people's homes, which is of high quality and value for money for our population. To deliver this we expect to see a shift in the current workforce configuration to more community based teams, delivering seven day a week services.

We are working with the Acute Trust on detailed infrastructure (hospital estate and IT but also the location of services) and workforce plans. A Joined up workforce and integrated IT, which enables multiple professionals to share patient records and treatment plans, are vital in achieving a better quality of service for our patients in the most cost effective way. We are also working with providers of mental health services in our CCG to ensure that mental health professionals, as well as other agencies, are an integral part of our community based teams, which will be co-ordinated through our Community Hubs.

We are also working with independent and voluntary sector providers to stimulate a vibrant and diverse market for services in Torbay.

Key Risks

The aim of our risk management process is to provide a systematic and consistent framework through which our priorities are pursued. This involves identifying risks, threats and opportunities for achieving these objectives and taking steps to mitigate the risks and threats. An integrated approach will be taken so that lessons learned in one area of risk can be quickly spread to another area of risk.

Some of the specific risks currently highlighted are as follows:

Overall our ambulance service provider delivers a high quality service with good response times. However, over the last year our provider has achieved 72% against the new Red 1 target, which requires 75% of ambulances to respond to presenting conditions that may be immediately life threatening, within 8 minutes. For our local area our provider has achieved 79.5% however, this is a particularly challenging target for the provider as a whole, who covers a very large geographically dispersed area from Cornwall & the Isles of Scilly to South Gloucestershire. To ensure this target is achieved in 2014/15 we have asked our provider to produce an action plan and recovery trajectory, which will show delivery of the target next year through a combination of advanced triage

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and additional defibrillators.

We have a very stretching target for reducing the incidence of Clostridium Difficile next year. We plan to tackle this by focusing on prevention and working closely with our local providers and local authority.

Referral to Treatment times are improving and we are currently on track to achieve the trajectory we set at the beginning of 2013/14. However, we are managing a complex set of interdependencies relating to market supply, demand and technological advances, which mean that this will need close monitoring into 2014/15. This will be undertaken through our contract review meetings with our providers.

The creation of the Better Care Fund (BCF) will create a pooled fund for joint use by NHS and Local Authority commissioners. The monies to create this pooled fund are already being spent on existing, joined up services in the community. The CCG commitment to considering the pooled fund as the total sum within the Integrated Care Organisation is supported by a risk share agreement and as such takes steps to mitigate against destabilisation of health and care services.

e) Governance

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

Governance structures for integration have a firm grounding in the existing health and social care pooled arrangements, and there is intent to strengthen this through the creation of the Integrated Care Organisation (ICO) in the future and it's part within delivering the Pioneer Programme. The Health and Wellbeing Board has a key role in integration and provides the strategic oversight with responsibility for sign off of relevant plans.

Existing structures such as the JoinedUp Health and Care Cabinet have provided a forum where agreements have been brokered around risk-sharing, changes to financial flows and other significant 'unblocking' changes to the way in which care is delivered in South Devon and Torbay. Along with the Joint Commissioning Partnership Group for Torbay which has helped to develop a shared set of commissioning strategies and intent for further service developments across the health and social care system including mental health and children services.

Governance arrangements will continue to be strengthened making sure that the ICO and Pioneer remain the focus of integration with a reporting line to the Health and Wellbeing board.

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NATIONAL CONDITIONS

a) Protecting social care services

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

We have been working closely with our partners, in particular the Health and Wellbeing Boards of Torbay and Devon providing local leadership to deliver a sustainable health and care system. The Health & Wellbeing Boards have been integral to developing this plan and bringing together the alignment of priorities, across partner organisations, for the benefit of our communities. Through our community being awarded Pioneer status, and the national support which comes with this, we will continue to build on this work to deliver the significant changes which are needed.

The National Voices narrative, built around the key 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'* has been adopted across organisations, and complements the success of the model of Mrs Smith as a representative user of adult social care and health services. Creation of an Integrated Care Organisation in South Devon and Torbay and implementation of the Pioneer Plan will extend this model to young people and families, with even closer working with communities through creating community hubs where services will be linked together with a single point of access, so that care takes a whole person approach to meeting need and promoting independence in the community outside hospital and closer to home.

There is a strong commitment of a wide range of partners and organisations to this programme of works and our success to date is now being built upon to drive integration to a new level, including further structural integration and extended organisational care pathways between social care services and the local acute trust. We will use the opportunities of the better care fund and pioneer status to pool budgets and increase joint commissioning across all our health and care providers and ensure there is diverse range of care and support services available.

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

Links within this document refer to our integrated plan which demonstrates our commitment to local services. Torbay already has an excellent track record of integrating health and social care services, as evidenced by the impact of local social care services on reduced lengths of stay and bed numbers.

Additionally, there has been an investment in excess of £300,000 in a Community Development Trust to support the development and coordination of the third sector in Torbay, and to access funding streams and grants through a collaborative approach across organisations and partners. This will leverage both skills and resources which is evidenced in one current initiative - Fulfilling Lives: Better Ageing.

We will continue to review the pooling arrangements for the BCF alongside the wider pooled budget for the Integrated Care Organisation, to consider whether additional resources will be invested within this pooled fund in order to work towards our shared vision.

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b) 7 day services to support discharge

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

We are committed to providing seven-day health and social care services, supporting patients being discharged and preventing unnecessary admissions at weekends. We have pilots underway which will ensure we will see a continued roll out of six/seven day services across key services, as informed by those pilots and through on-going evaluation, with fully joined-up services across the health and care system providing continuity of care and support seven days a week.

People with urgent but non-life threatening needs will be provided with highly responsive, effective and personalised services, outside of hospital wherever possible. These services will wherever possible be configured to deliver care on a consistent seven day a week basis as close to people's homes as possible, thereby minimising disruption and inconvenience for patients and their families.

As previously mentioned our local provider of community services, Torbay & Southern Devon Health and Care NHS will be acquired by South Devon Healthcare NHS Foundation Trust to form the Integrated Care Organisation, which will provide acute, community and social care services. Through the acquisition we expect to see a transfer of resources from inpatient beds to care provided in people's homes, which is of high quality and value for money for our population. To deliver this we will see a shift in the current workforce configuration to more community based teams, delivering seven day a week services.

Our integrated business plan includes working towards fully joined up 7 day provision of which Primary Care is identified as being a key element. Key to delivering this will be continuing the work which is underway to develop General Practice Federations so that care will be able to be provided to a population rather than to the registered Practice list. This will enable a federation of Practices to work together to provide different care models, including extension of existing services into periods of the week during which access to General Practice is currently restricted. As part of this collaborative approach we will be seeking to optimise the current workforce capacity by continuing our pursuit of technology based solutions that complement traditional face to face consultations, so that not only is access extended in terms of timings but also in terms of styles. To allow federated working and also improve quality of patient interactions with other health and social care providers we are working to extend the ability to share patient records (where consent to do so exists) across providers, thus delivering better informed consultations and improved outcomes.

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 our health and social care services use the NHS number as the primary identifier.

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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

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))

Our joint IT strategy is based on international interoperability standards.

All CCG staff use NHS Mail (nhs.net) which is recognised as secure.
In the event that an intended recipient in another organisation does not have a secure email address (e.g. gcsx.gsi.uk) the CCG use Secure Send.

CCG staff work with data held on a secure drive (hosted by the South Devon Health Informatics Service) with role-based access granted for each of the work area folders – e.g. staff working in Finance cannot see the Safeguarding data.

Further info required.

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

The CCG enters into service agreements using the NHS Standard Contract. In the event that this is found to be lacking in IG / Confidentiality requirements, an additional bespoke clause will be inserted for signature by the contracted party.
The CCG enters into data sharing agreements to ensure the secure and legal processing of personal data.
The CCG published its IG Toolkit (version 11) on 30 September 2013 at level 2 for all requirements. The supporting evidence has been audited by Audit South West and also by the HSCIC.
The CCG has been granted Accredited Safe Haven (ASH) status in order to process personal data for specified purposes; this has been authorised by the Secretary of State and agreed by the Confidentiality Advisory Group (CAG) who ensure that the Caldicott2 guidelines are adhered to.
The CCG delivers face-to-face Information Governance training for all staff, which includes the caldicott2 guidelines.

Further info required.

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

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risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

We use a risk stratification tool, the Devon Predictive Model, to identify patients at risk of hospital admission in the next 12 months. The top 0.5% of our population are then pro-actively case-managed on our monthly community virtual wards. Virtual ward meetings are held in every practice, every month. The virtual ward teams use the predictive tool to objectively identify patients who are then pro-actively and holistically case-managed by a multi-disciplinary team, including primary care, community and rehab teams, palliative care, mental health, social care and the voluntary sector. Each patient is allocated a named case-manager who then co-ordinates their care and support. Each of our 37 GP practices are signed up to the National Risk Stratification DES, and we have added some additional requirements to this locally – including monthly meetings (not quarterly as per the DES) and recording the case management details on the out of hours system.

We also have a Frequent User Panel, which looks at our top 10 frequent users of A&E every month. This panel includes representation similar to that of the virtual wards, but also includes the ambulance service, the fire service and the police.

Recognising the importance and value of risk stratification in terms of improving and personalising care to prevent avoidable hospital admissions we have agreed a local variation to the Quality Outcome Framework for quarter 4 of 13/14. Local Practices will be bringing forward planned 14/15 initiatives regarding named clinicians for their over 75 population, improving telephone access for vulnerable patients, and up-skilling in terms of managing frailty. By committing to planning and initiating change during 13/14 we are locally accelerating delivery of the changes planned nationally to take place during 14/15.

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3) RISKS

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

Risk	Risk rating	Mitigating Actions
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	High	Our plans have been developed in partnership with our providers as part of our integration programme, allowing for a holistic view of impact across the provider landscape We will continue to actively engage and involve providers in all key strategic decisions during this process to manage change effectively.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	Medium	Contingency planning is undertaken as part of the business plan and implementation phase.
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	We have modelled our assumptions using a range of available data, including that based on previous performance and national guidance. We will continue to test and refine these assumptions as part of our ongoing review and evaluation process
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	We will remain well-informed of policy and legislative developments and will continue to refine our assumptions around this as part of our planning process and as more of our plans begin to deliver. We believe there will be potential benefits that come out of this process, as well as potential risks.
Progress of implementation and ability to effect change is hampered by inability to reach agreement between organisations due to Geographical boundaries of local authorities and CCG	Medium	Joint commissioning forums in place between senior and director level managers . Early and continuing discussion of BCF, ICO and Pioneer is on agendas

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