Health and Wellbeing
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A Vision for Health and Social Care Services in Suffolk

Better Care Fund Plan 2016/17

Approved: August 2016

Health and Wellbeing
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Working together to improve people's health and wellbeing in Suffolk

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Section 1 – Confirmation of funding contributions

1.1 Local agreement on funding arrangements

The total amount of the Suffolk Better Care Fund is £51,438,000. The individual funding contributions are set out in the Planning Template. The contributions are in line with national planning guidance on the Better Care Fund and reflect changes to the guidance since 2015-16.

The Better Care Fund will be used in the following areas:

- Funding front line health and care services in the community which aims to keep people living independently in their own homes and help them to return to independence after a health or care crisis
- Disabled Facilities Grants provided by the District and Borough Councils
- To cover a small amount of non-elective activity in the three acute hospitals
- To enhance health and social care system integration

The full break down of spending against the BCF schemes and other areas of spend is in the Planning Template.

Our transformation plans, and therefore the BCF, are based on evidence of best practice. We have tracked the progress of the BCF metrics throughout 2015/16, and have decided to keep these as our headline metrics for 2016/17 as they represent a good picture of the success of our health and care system. To date it has been hard to demonstrate the cause and effect of our plans, however our ability to assess the impact of changes on services is developing and this will be a core element of the local Sustainability and Transformation Plans.

Section 2 – Local vision and the case for change

2.1 Local Vision for health and care services

2.1.1 Suffolk's vision

Suffolk's Joint Health and Wellbeing Strategy 2012–2022 sets the long term strategic framework for improving health and wellbeing in Suffolk[1]. It guides the direction of an enormous range of statutory, voluntary, community and private sector agencies that impact on health and wellbeing in Suffolk. It sets a number of outcomes designed to deliver the vision: "*People in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent through greater improvements in more disadvantaged communities*."

[1] Suffolk Health and Wellbeing Strategy - http://content.govdelivery.com/attachments/topic_files/UKSCCTSSTAFF/UKSCCTSSTAFF_31/2016/02/21/file_attachments/503255/JHWS%2BREfresh__503255.pdf

The Health and Wellbeing Strategy sets the outcomes for the next three years to achieve the vision. The State of Suffolk 2015[2] (a key part of the Joint Strategic Needs Assessment) has informed the refresh of the Joint Health and Wellbeing Board Strategy ensuring that the strategy is evidence-based and focused on the relevant key issues including: inequalities, demographic pressures and re-designing services to meet need and enhance opportunities for prevention.

The Suffolk Health and Wellbeing Board is committed to delivering the 'Forward View' locally and its vision - that people in Suffolk live healthier, happier lives - supports the national direction.

Since the launch of the Joint Health and Wellbeing Strategy for Suffolk in 2012 the financial pressure on all public sector organisations has been significant. The challenge to support those in need whilst radically reducing spend has provided an increased incentive for collaborative, integrated and transformative change in the way public services are delivered. Alongside a shift to prevention, community support and early help so that people can live as independently as possible. For health and care, for example, this means having more of a focus on prevention and self-care.

The Health and Wellbeing Board is an important system leader in identifying opportunities to help make these shifts. This has included, under the devolution agenda, influencing national and regional agencies to secure more local system wide control over longer term resources to enable more effective use of resources to ensure the best outcomes for local people.

Our aim is to create strong resilient communities so that individuals have less need for interventions from public services. When communities and individuals do need services, we want these to be delivered at a local level so that people will receive seamless, coordinated care and integrated services, which are not duplicated or leave gaps. This means that resources are used more effectively, and by taking early action will prevent or delay the need for long term care. Through working jointly across health, local government, other public sector partners, the voluntary sector and wider communities we can make a real difference in improving health and wellbeing opportunities for people in Suffolk.

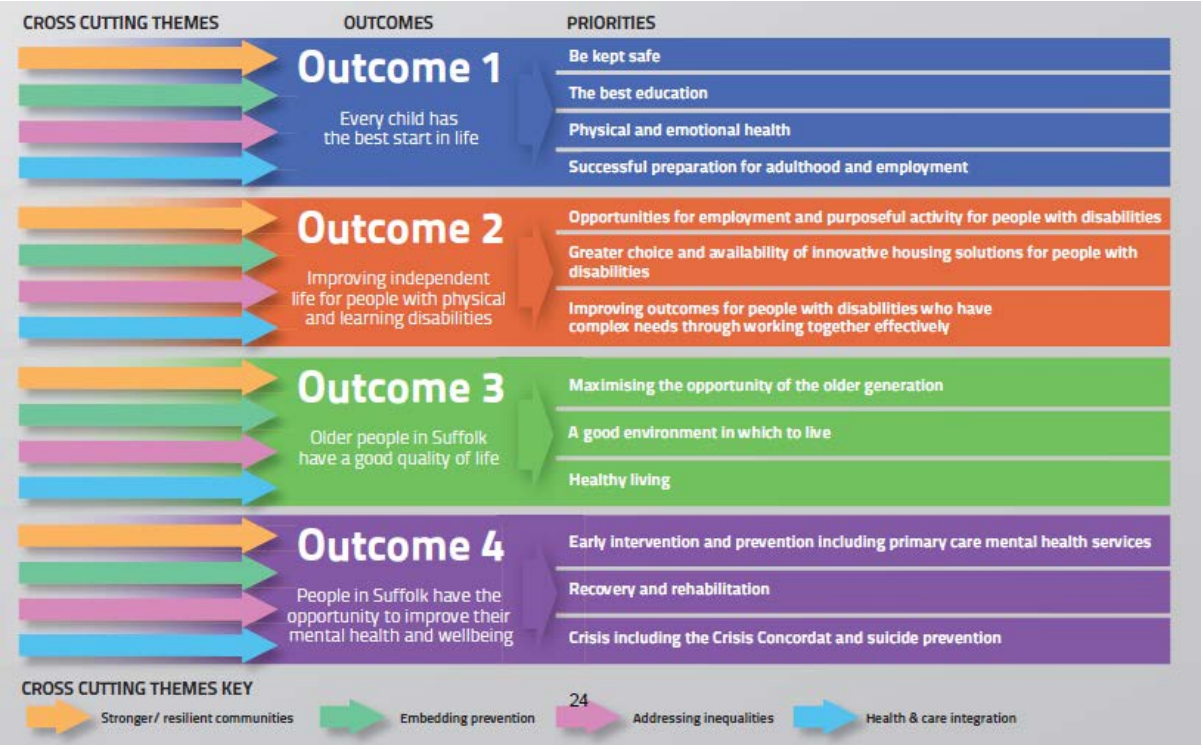
To achieve the Board's overarching aims of increasing healthy life expectancy and decreasing health inequalities we need to put in place wide ranging actions across Suffolk to prevent ill health where this is possible and ensure that all we do reaches those most likely to suffer the effects of health inequalities. By focusing prevention on decreasing the gap between healthy life expectancy and life expectancy we can both improve the health and wellbeing of people in Suffolk and also decrease demand within the health and care sector.

However we know that if we do not specifically focus on how we deliver our services those most in need sometimes do not take advantage of what is offered. We therefore need to monitor our services to ensure that as well as improving health they are accessible to all and support our aim to decrease health inequalities.

The themes from the State of Suffolk Report have been embedded across the four Health and Wellbeing Board priorities, and have been refreshed within the "Joint Health and Wellbeing Strategy

[2] State of Suffolk Report 2015 - http://www.healthysuffolk.org.uk/joint-strategic-needs-assessment-jsna/reports/reports/state-of-suffolk/

(refresh 2016-2019)." The refreshed Strategy reflects the changing environment for public services in Suffolk and sets out four key outcome and associated priorities:



The Health and Wellbeing Board and partner organisations are aligning the activity within each of the four outcomes above to the System and Transformation Plans, so that there is a clear read through from ambition to activity in Suffolk.

2.1.2 Better Care Fund contribution to the implementation of the vision of the Five Year Forward View and the move towards fully integrated health and social care services by 2020

The Better Care Fund Plan is wholly consistent with local plans for implanting the Five Year Forward View. The delivery of the schemes and national conditions are elements of the developing programmes within those plans.

In **Ipswich and East Suffolk and West Suffolk (IEWS)** system leaders have agreed the following joint statement.

It is accepted that Suffolk cannot meet the challenges it faces and deliver this vision over the next five years through continued incremental change. In addition, no single partner or locality can deliver the scale of transformation proposed on its own. Our transformation must be comprehensive through covering all aspects of health and care to our local population.

There are three interlinked programmes of transformation in the Sustainability and Transformation Plan (STP):

1. A step change in health prevention and the building of safer, stronger, resilient communities
2. Transforming locality based care and support through health, care and other services integration

3. Creating sustainable acute and specialist care for our population

And a fourth programme which underpins the delivery of the other three programmes:

4. Enabling better health and care through the development of innovative new models of care and ways of working

The Better Care Fund will contribute to these transformation programmes. In particular Scheme 1 – proactive care – developing integrated neighbourhood working will support programmes 1 and 2, whilst Scheme 2 – reactive care – developing responsive urgent care will support programmes 2 and 3. In all of our schemes we are looking to develop innovative new models of care and ways of working, e.g. in our work with care homes, and our work with the voluntary and community sector in the Connect sites.

Across the **Great Yarmouth and Waveney (GYW**) system there is a clear commitment towards integration. The CCG vision described in the BCF Plan 2015/16 remains valid and relevant today and so we will build on it rather than replace it.

By 2018/19 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/ borough services, from a cohesive integrated care system (ICS) acting as a single provider of services. The ICS will be user focused, delivering high quality and safe services with an orientation to innovate and develop new methods delivering better care based on the ideas and ambitions of professionals and the feedback of users. Because it is operating in a coordinated way, eliminating inefficiency and waste, and striving for more effective delivery methods it will be using resources optimally and constituent member organisations will be in financial balance and able to invest in further improvements. The ICS is a radical, ambitious and transformational approach towards integration, working across two county councils and two district councils.

The Better Care Fund is seen by key partners and stakeholders as a key enabler towards greater health and social care integration across the Great Yarmouth and Waveney system. Plans for 2016/17 will build on the success of 2015/16 and ensure that we learn from our experiences to overcome barriers to change.

Key elements of the BCF include the work towards a more integrated commissioning structure, demonstrated through the Most Capable Provider (MCP) process and the investment in the Out of Hospital model using integrated teams as outlined in the Shape of the System consultation.

The schemes identified clearly link to the strategic approaches within Suffolk County Council for the delivery of adult social care - Supporting Lives, Connecting Communities.

The activity to be delivered within NHS Great Yarmouth and Waveney CCG Operational Plan 2016/17 is inter-linked with the Better Care Fund plan, as they share a common purpose, as outlined in the vision statement above.

2.1.3 Which aspects of the change will be delivered using the Better Care Fund?

Change on the ground will be delivered through our whole system transformation plans. The Better Care Fund plans describe and support this change through our schemes and the delivery of the national conditions. In particular our move to integrated locality working, delivering a more preventative, person centred service along with an integrated approach to reactive care, which will prevent emergency admissions and facilitate people successfully returning home after a stay in hospital. Delivery of the national conditions will take forward some of the practical aspects of this work, in particular through better data sharing and the development of integrated systems, and the shared planning around 7 day services and delayed transfers of care.

Our whole system transformation plans are:

- Ipswich and East Suffolk and West Suffolk (IEWS) – Health and Care model
- Great Yarmouth and Waveney – Integrated Care System

IEWS - Health and Care model

In 2014/15, system partners worked together to develop a shared vision and delivery model for integrated health and care, with improved access to high quality urgent and emergency care.[3]

Partners agreed four overarching transformational outcomes:

1. *People manage their own health and social care with the right support when needed*: When people have the tools, information and advice to self-manage their health and social care, the whole system will support people and their family carers at every stage to be more independent for longer. This will include information about local Neighbourhood Networks (NNs) and the groups, societies, clubs and other services within the community including help for people to link up with them.

2. *Communities are easy and supportive places to live with a health or care need:* Integrated care in Suffolk will mean people can get many of their needs met within their own community. Integrated Neighbourhood Teams (INTs) will work in a coordinated, collaborative and flexible way. They will work closely with Urgent Care and Specialist Services where needed ensuring that people are treated swiftly and discharged safely to their own homes and will draw support from their NNs made up of voluntary and community organisations.

3. *The health and care system is co-ordinated and effective*: Integrating care in Suffolk will create a single system with common processes and procedures to ensure resources are used in the right place, information is shared and there is good communication around the system. This will blur the lines between hospital and community when more specialist interventions are needed for a person's plan. The vision is for integrated, person-centred care and support achieved through greater integration and co-operation between health, care and support and the wider determinants of health.

4. *Higher cost interventions are replaced with lower cost interventions*: Integrating care in Suffolk will improve care by keeping people as well as possible and helping them to avoid crisis and

[3] Health and Care Model - http://www.healthysuffolk.org.uk/assets/Useful-Documents/2014-11-20-Integrated-Health-and-Care-in-IES-and-WS-Service-Model-Version-1-0-Clean.pdf

emergency care, and reduce the demand for hospital based emergency services. When people do need interventions they will focus on helping people regain the independence they want and value, with swift and appropriate support. Family carers who are key to helping their relatives regain independence will also be supported.

This work is now being progressed in 2016/17 through the 'Connect' programme and the re-procurement for delivery of NHS '111', Primary care Out of Hours (OOH) and Community Services (by 1st October 2017). A series of workshops with our local stakeholders is planned throughout early 2016 to finalise the detail within the three emerging specifications for proactive care, reactive care and specialist children's services.

The core features of the design work undertaken so far include:

- Integrated 24/7 single access and care coordination – this functionality will support both reactive and proactive care
- Clinical triage and decision making – building on the concept of clinical hubs
- Integrated community response to support people in crises building on our successful Early Intervention Team and bringing in a range of clinical, social and care responses to support a wider range of care needs
- Case management and clinical coordination through Integrated Neighbourhood Teams supported by risk stratification
- Building resilience of communities through third sector and borough council partnerships

Delivery

During 2015/16 progress was made on delivering integrated care in a number of key areas;

- Two Connect early adopter sites established with Integrated Neighbourhood Teams
- Connect roll out plan agreed with timescale and identified resources
- Joint workforce programmes established
- Bi-weekly system leadership group established, with Transformation Academy training commissioned
- Insight and intelligence manager appointed providing regular monitoring of progress
- Two Local Area Co-ordinators appointed in Connect sites
- Integrated working developed through multi-disciplinary team meetings and trialling of shared care plans.

For 2016/17 we have broadened out the joint planning to ensure a joint approach to the delivery of both reactive and proactive care.

Great Yarmouth and Waveney - Integrated Care System

Changes in service delivery that will bring about our vision for the future are:

- Removal of the boundaries between acute and community providers with shared teams, in reach and out-reach services between the organisations.

- Larger, stronger, better resourced teams of GPs, nurses and other professionals working from multi-disciplinary healthy living centres in close concert with non-health partners such as benefits officers, community police staff and social care professionals.
- A move away from traditional bed-based models within acute and community care, to a model that supports people remaining safely at home wherever possible. This will be delivered through Out of Hospital Teams (two already up and running with a team of health and social care workers, using shared facilities, increasingly sharing data and with streamlined management). Two additional Out of Hospital Teams will be introduced during 2016/17 within Waveney.
- An increase in preventative activity which includes Integrated Rehabilitation and Reablement and developing community resources; working with communities and families, rather than just providing formal services
- A change in the way in which we use capacity and provide community based care. We will work with our acute provider to reduce length of stay and reduce the need for inpatient care. Our proposed change in community bed capacity involves commissioning care home bed days based close to local communities, together with providing higher acuity community beds as necessary. The direct impact of the increase in community activity and improvements in the quality of care will see the demand for acute capacity fall and the consequential reduction in demand for acute beds in our area
- Pathway design around one stop services, and providing interventions in reduced activity settings e.g. increased day case activity and moving some day case activity to outpatient settings
- Non-elective admissions - The continued roll out of the Out of Hospital Team model across Great Yarmouth and Waveney has had an impact on the level of non-elective admission volumes during 15/16 (possibly above OOHT cost benefit analysis)
- Dementia diagnosis - Throughout 15/16, the CCG improved its dementia diagnosis rate from 55.3% to 64.1%

These changes will be experienced by everyone who accesses care and health services. However they will be most felt by those with complex (often multiple) long term conditions, the frail elderly and people with disabilities. Their experience will be of a single system providing support 7 days a week, regardless of the provider or which organisation has commissioned the service. All partners are signed up to the vision of integrated care. The Better Care Fund will be an enabler for delivery of the change, and specific elements of the funding will be spent on our Better Care Fund schemes as detailed in the BCF Planning Template. Through pooling funding and developing a joint plan at this level of detail the Better Care Fund deepens and extends our understanding of how the mechanisms to deliver integrated care, particularly the funding, might work. It is likely that without the Better Care Fund progress in these areas would be limited and would shift at a slower pace.

Since the 2015/2016 Operation Plan, Great Yarmouth and Waveney CCG has continued the work towards greater integration and concluded our third and fourth public consultations in 2015 entitled Shape of the System. This set out an ambitious vision to extend the out of hospital model using integrated teams and beds with care across Great Yarmouth and Waveney. This will enable the closure of inpatient beds in both the acute and community hospitals and the enhancement of both

the environment and staffing at Beccles Hospital to provide enhanced Intermediate Care and specialist palliative care.

In August 2015 we launched a 'Most Capable Provider' process to support the provider integration agenda. Six provider organisations across the local health and social care system (including a private provider) have committed to work together across service bundles to ensure efficiencies by streamlining management, avoiding duplication and maximising our skills and available resources. This contract is scheduled to be awarded for the first bundle in July 2016 following a comprehensive assurance process, with additional service bundles being rolled out beyond January 2017.

Delivery

During 2015/16 progress was made on delivering integrated care in a number of key areas;

- Development of combined service specification for Gt Yarmouth and Waveney Adults Social Care and NHS Continuing Health Care universal domiciliary care provision
- Launch of Ageing Well community based support intervention including establishment of community navigators
- Cost benefit analysis that enables system providers to see impact of Out of Hospital Team model
- Development of Great Yarmouth and Waveney Integrated System Resilience Plan
- Enhanced Crisis Resolution Team and Acute Psychiatric Liaison service in place

The following details key elements of the work plan in Waveney for 2016/ 17.

We will continue to improve the quality and accessibility of services for our local population and in doing so we are confident we can meet the national must do. As well as the continuing performance and improvement work undertaken within programme areas we have key transformation projects to deliver system integration. Some of this work will begin in year one and develop over the period of the STP (System Transformational Plan). The agreement for this radical transformational change has been brought about through consultation with partners and the public.

Implement the Shape of the System public consultation recommendations[4]

- This will mean that by the autumn the entire population of Great Yarmouth and Waveney has access to an Out of Hospital team supported by beds with care
- Develop and implement the plans for community hubs in conjunction with system partners

Implement the GP practice premises public consultation recommendations

- Work with colleagues across the public and voluntary sector to deliver an integrated campus style approach to ensure, better facilities for health and social care

Deliver the Most Capable Provider initiative

[4] http://www.greatyarmouthandwaveneyccg.nhs.uk/shapeofthesystem

In addition to this we are planning a more integrated approach to commissioning with our commissioning partners. Budget planning, commissioning and strategic alignment with our County and District colleagues is a major short term aim.

The following activity was also approved by the BCF Partnership Board in 2015/16 and will continue into 2016/17.

- Development of a Market Position statement for Care Homes – this work is focused on bringing together the commissioning intentions/ delivery of the key partners into one place and to give a clear indication of future activity to providers
- Development of an Integrated Reablement and Rehabilitation pathway – Workshops have been set up for May and are focused on work across organisations, using a whole system approach, to design what the most effective and integrated reablement and rehabilitation model could look like at all stages of a person's journey in the future.

2.2 The case for change

2.2.1 Suffolk's case for change

The case for change in Suffolk has not altered since the Better Care Plan was produced in 2015/16 and our plans are still based on our assessment of need and opportunity.

Most importantly we know that people in Suffolk value the services that they receive but that there are aspects of care that they would wish to see improved.

Alongside this we know that in Suffolk, life expectancy is good and better than the rest of England. In 2011-2013, life expectancy at birth was 84.1 years for women and 80.7 years for men. However;

- A boy born in the most deprived areas of Suffolk will on average live 6.4 years less than a boy born in the least deprived areas
- A girl born in the most deprived areas will on average live 4.2 years less than a girl born in the least deprived areas. This life expectancy gap does not appear to be decreasing and may even be increasing
- Healthy life expectancy is falling, meaning that more people are living fewer years in good health and instead more years with ill health or disability
- 7.4% of Suffolk's population lives in the 20% most deprived areas in England
- The population of Suffolk is generally older than that of the East of England and England as a whole
- The prevalence of most long term conditions is higher than average for England
- Emergency admission rates are slightly lower than the national average. However, as a consequence of the projected growth in older residents there is a high risk that emergency admissions will increase if no change is made. There is also variation in admission rates across CCG areas in Suffolk
- The relative rurality of Suffolk is an important factor which has been taken into account in the system redesign
- The health and care system in Suffolk will experience increasing financial pressure as a result of these challenges

2.2.2 What are the precise issues that the BCF will be used to address in the local area

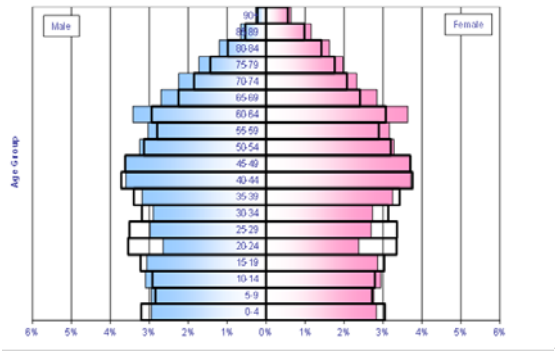
Changing demography

Suffolk's population is estimated to be over 732,000 (Office for National Statistics (ONS), 2013). This represents a growth of 10.3% since 1998, slightly higher than that in England (9.6%) over the same period. The age profile is also changing, with the number of older people increasing rapidly. In 2012, 21% of the population was aged 65 or over. By 2037, it is anticipated that this will rise to 31%, with those aged 85 and over increasing by almost threefold over the same period.

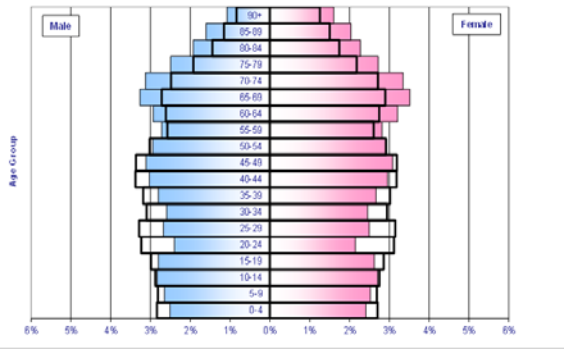
The population pyramids below illustrate the impact of the demographic changes anticipated in Suffolk (coloured bars) compared to England (dark lines) between 2010 and 2037. It shows that we will have fewer people in the working-age groups and a lot more people in the older age groups over the next two decades. This will have implications for our workforce. It also suggests that we will also have fewer people available to provide care in the face of rising demand.

Suffolk Population Pyramids

2010



2037



Deprivation and rurality

The table below shows that although life expectancy in Suffolk has increased since 2009-11, it has been accompanied by a decrease in healthy life expectancy. Men in Suffolk can expect to live only 64 years in good health while women can expect to live 66 years in good health. If this trend continues, it will lead to increased pressure on health and care services in Suffolk.

Male and female life expectancy summary, Suffolk 2009-2013

	Males			Females		
	Life expectancy	Healthy life expectancy	Years of disability	Life expectancy	Healthy life expectancy	Years of disability
2009-11	80.3	65.6	14.7	84.0	68.3	15.7
2010-12	80.6	66.1	14.5	84.1	68.2	15.9
2011-13	80.7	64.8	15.9	84.1	66.1	18.0
	Healthy life expectancy difference could be chance			Healthy life expectancy significant difference		

Source: Public Health Outcomes Framework (PHOF) (2015)

*Life expectancy, **Healthy life expectancy

We know that life expectancy, healthy life expectancy and living in an area of relative deprivation are closely associated. The 2010 Marmot Review on health inequalities (Institute of Health Equity 2010) showed that when compared to those living in the most affluent areas people living in poorer areas on average lived shorter lives and spent more of that time living in disability. The same is true of Suffolk. As pointed out earlier, there is a life expectancy gap between people living in our most deprived and least deprived areas. Over the past decade, males in Suffolk have shown a consistently larger gap in life expectancy when compared to females.

According to the Indices of Deprivation 2010, Suffolk is a relatively affluent county with pockets of deprivation. Income deprivation mainly affects the urban areas in the county: parts of Ipswich and Lowestoft and parts of the market towns. About 7.4% of Suffolk's population lives in the 20% most deprived areas in England, equating to about 53,000 people. Ipswich remains the most deprived local authority (LA) in Suffolk, being ranked 87th out of 326 LAs in England. Ipswich has risen in the rankings from 109 in 2007, but remains outside the top 20% of worst deprived LAs in England.

Individual lifestyles or behaviours (e.g. unhealthy diet, smoking, harmful alcohol consumption, physical inactivity) and exposures in the environment in earlier life all have an impact on how healthy we are in later life. These behaviours are more prevalent in populations living in more deprived areas, putting them at greater risk of developing ill health, disability and frailty in later life. However, modifying behaviour or lifestyle choices and exposures even at an older age can have a positive impact by slowing the decline in functional capacity and the onset of premature disability. Opportunities for prevention therefore exist, and action is required right across the life-course to address these inequalities.

Rural deprivation is also an issue in Suffolk, where pockets of deprivation are masked by areas of relative affluence. In 2011, The Suffolk Foundation commissioned a report 'Hidden Needs: hidden

deprivation and community need in Suffolk' [5] which identified ten pockets of rural deprivation which were amongst the 10% most deprived in the East of England (Fenton et al. 2011).

Addressing these health inequalities will be crucial in helping achieve our vision for Suffolk and in creating a more sustainable health and care system.

Long term conditions

As highlighted earlier, the number of years we spend living in ill health or with disability in Suffolk is increasing. As we age, about that half of us will develop at least two or more long term conditions and live with these in the last 15 years of our lives. However, how soon this happens will vary across different population groups and deprivation, for example, has been shown to accelerate this process.

Dementia

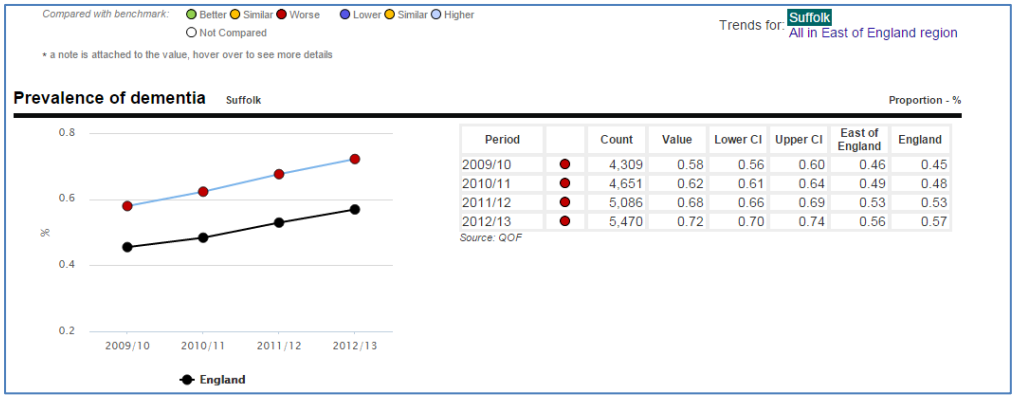
In 2012/13, the estimated prevalence of dementia in Suffolk was approximately 11,000 people (Dementia UK population projections). By 2024, it is anticipated that this will rise to about 16,000 and by 2037 the prevalence of dementia will have more than doubled to just over 24,000. If we apply national estimates of incidence to the local population, we would expect to see approximately 435 new cases of dementia per year.

According to 2013/14 Quality Outcomes Framework (QOF) data, the number of registered patients in Suffolk with a dementia diagnosis is 5,470, giving Suffolk a detection rate of around 50% (PHE 2015d). It is therefore estimated that there are around 6,000 people with dementia in Suffolk who remain undiagnosed.

As can be seen in the graph below, between 2009/2010 and 2012/13 Suffolk's detected prevalence gradually increased and was higher than the England and East of England average. Although this is presented in the chart as being 'worse' the national and regional averages, the identification and diagnosis of dementia in more people is a good thing, as early diagnosis of dementia enables the person with dementia and their family carers to make choices about their care. It also allows access to specialist dementia services which provide care and support to the family, thereby reducing the likelihood of crises, admission to hospital and residential care.

[5] Hidden Needs: Hidden Deprivation and Community Need in Suffolk - published by the Suffolk Foundation http://suffolkcf.org.uk/publications/hidden-needs-in-suffolk/

Trend in dementia prevalence in Suffolk

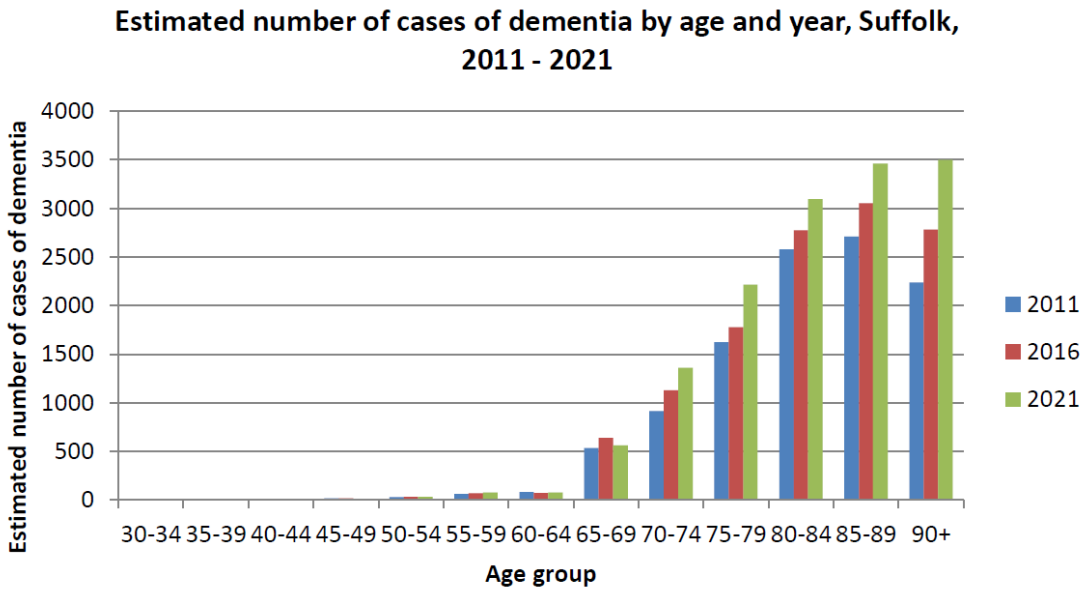


Period		Count	Value	Lower CI	Upper CI	East of England	England
2009/10		4,309	0.58	0.56	0.60	0.46	0.45
2010/11		4,651	0.62	0.61	0.64	0.49	0.48
2011/12		5,086	0.68	0.66	0.69	0.53	0.53
2012/13		5,470	0.72	0.70	0.74	0.56	0.57

Source: PHE (2015d)

The risk of developing dementia increases with age - 85% of people with dementia in Suffolk are over the age of 75 years. The number of people living with dementia in Suffolk is therefore expected to rise as the population ages. If these projections remain true, there will be a rise in demand for services which is likely to place a significant strain on existing services.

Dementia cases by age and year in Suffolk



Source: Suffolk County Council (2015a)

It is also worth noting that an estimated 70% of people in Suffolk with dementia live in the community and 30% live in residential care.

We know that at present many people with dementia only get a diagnosis of dementia at a late stage. An early diagnosis of dementia is vital as it will allow a people living with dementia and their carers to access services and make choices about their care and their future. CCGs in Suffolk therefore continue to focus on improving dementia diagnosis rates.

A wide range of services to support people with dementia and their carers are available across Suffolk. However, a recent dementia needs assessment found that these were fragmented and access to the services was variable. In response, partners from both the statutory and voluntary sector in Suffolk are currently working together to provide a more integrated service for people living with dementia and their carers – through from diagnosis to more advanced stages of the illness. An example of this is ongoing work to commission an integrated post-diagnosis dementia service which will transform the quality and experience of dementia care by 'joining up' health and social care support and pool existing resources together to deliver better outcomes for people.

Suffolk has endorsed the national dementia friendly communities' programme, and we are working with a wide range of partners to develop local resources within our communities and encourage more Suffolk communities to become 'dementia friendly'. Examples of these in Suffolk include the Debenham Project and local projects in Halesworth and Wickham Market.

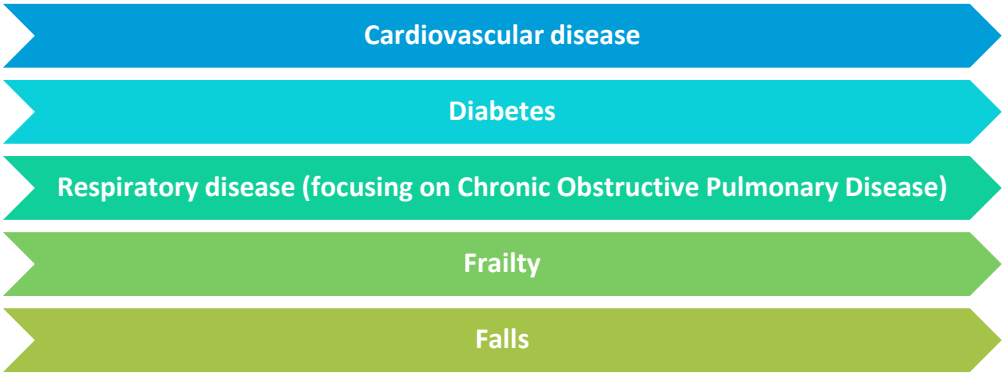
Work is also ongoing to raise dementia awareness by supporting national and local awareness campaigns and providing "dementia friends" training e.g. for staff within the council, Health and Wellbeing Board members, etc.

There has also been investment in infrastructure improvements to make the environment more dementia friendly. These include enhancements to people's own homes, care homes, garden development and also the deployment of a range of assistive technologies.

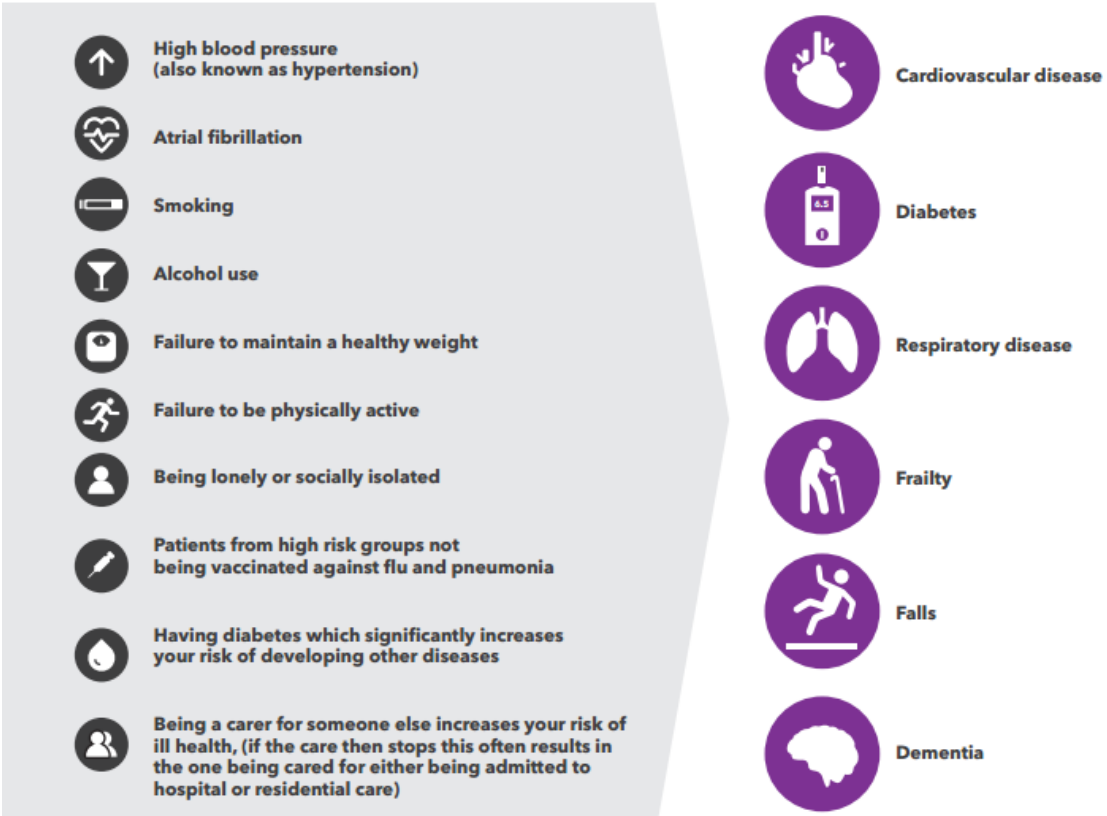
2.2.3 Identification of the opportunity to improve quality and reduce costs, based on segmented risk stratification

We have identified a number of key conditions amenable to prevention in the short to medium term (3-5 years) and underlying risk factors which contribute to the development of these conditions and subsequently leading to high cost demand in Suffolk.

These conditions include:



A number of risk factors which contribute to the development of these diseases, and hence to high cost demand. These are summarised below and include:



It is evident from this that many risk factors have an impact on more than one preventable disease.

This segmentation and analysis is further explored in the 2015 Annual Public Health Report.[6]

2.2.4 How integration will be used to improve the issues identified

Our models of care are designed to address the issues that we face in Suffolk. We believe that by having more services locally based, integrated and delivered around the needs of the person themselves we will be able to deliver a more preventative and holistic service. We are increasing the information available to people to help them manage their conditions better, as well as developing urgent care responses that help people get back to independent living as quickly as possible, whilst avoiding the need for longer term acute care.

In addition the ambition to connect more closely with community assets and networks will help to support people's wider needs, which have an impact on their health, such as isolation and primary health needs.

We recognise that establishing sustainable year-round delivery requires demand and capacity analysis to be both ongoing and robust, which then informs the planning and delivery of services based on evidence. The rigorous and ongoing analytical review of the drivers of system pressures has been agreed by all partners. This will help us develop plans to mitigate these pressures using a

[6] http://www.healthysuffolk.org.uk/assets/JSNA/Annual-Report/19673-APHR-2015-LR-20151209.pdf

collaborative approach. This will enable the whole system to move away from a reactive approach to managing operational problems, and towards a proactive system of year round operational resilience, by calculating the amount and type of capacity that will be required in the future.

2.3 A co-ordinated and integrated plan of action for delivering change

2.3.1 The wider context

Suffolk's Health and Wellbeing Board has agreed ambitious plans to deliver better outcomes for people in Suffolk through transformed health and care services. The Health and Wellbeing Board holds the overview for the delivery of integrated care in Suffolk as a key enabler for meeting these outcomes which are articulated in the Health and Wellbeing Strategy.

These plans need to be seen as part of the wider public sector transformation agenda. This is led by the Suffolk Public Sector Leaders group (SPSL) which is the strategic leadership group for Suffolk with membership consisting of the Leaders and Chief Executives of all the Suffolk Councils, the Chair of the Health and Wellbeing Board, the Police and Crime Commissioner and the Chief Constable. The Board focuses on issues affecting government, with a particular focus on community safety, policing, health and wellbeing issues, ensuring a strong Suffolk political voice in regional and national policy matters. The transformation agenda will be further strengthened by the Devolution Deal agreed in March 2016 which states "*This Devolution Deal signals a commitment to take forward the goal of improving local services and building resilience for future generations*."[7]

2.3.2 Governance and accountability for the delivery of integrated care and arrangements for joint working

In Suffolk we have a good track history of joint working through collaborative governance arrangements and joint posts. We are working towards a position where all our transformation programmes will have joint working arrangements in place.

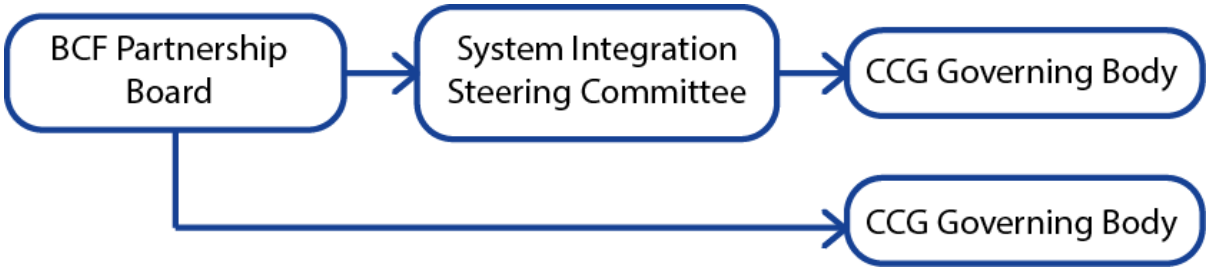
Better Care Fund Planning is carried out by a group of officers from the three Clinical Commissioning Groups (CCGs) and the County Council. They co-ordinate the quarterly returns as well as the development of this plan.

Other programmes such as the **Transformation Challenge Award** Systems Working Group and the **Devolution Working Group** are cross county and bring together officers from the CCGs, SCC, District and Borough Councils with others to deliver integrated and aligned working in the public sector.

[7] The East Anglia Devolution Agreement - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/508115/The_East_Anglia_Devolution_Agreement_FINAL_with_signatures_and_logos.pdf

Within our two planning areas there are different governance arrangements for the delivery of integrated care.

The governance arrangements in **Waveney** are as follows:



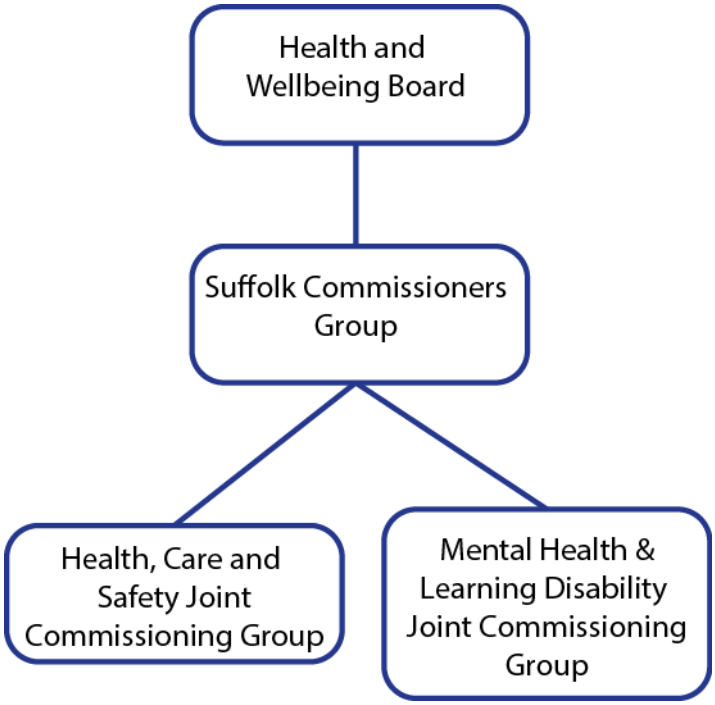
The Great Yarmouth and Waveney Better Care Fund Partnership Board includes representatives from each of the partners. The purpose of the board is to provide strategic oversight in achieving the aims and objectives of the Better Care Fund in Great Yarmouth & Waveney and monitor the progress of the Programme Management Office (PMO). Building on the learning from 2015/16, membership of the board will be extended to including representation from local District Councils.

A System Integration Steering Committee will be established to include all commissioners across the system to take forward the local integration agenda. In addition to this, Integrated Care Principles have been developed through the System Leaders Partnership in recognition that integration is a key strategy across Norfolk and Suffolk. With this in mind a set of core behavioural principles for the workforce, which have integration at their heart have been developed. These can be defined as an approach that seeks to improve the quality of care for individuals and carers by ensuring that everyone understands the needs of the local population and services are well co-ordinated around those needs.

Jointly funded with Norfolk County Council, the BCF PMO was established in February 2015 to coordinate and monitor projects that would deliver and release savings linked to risk share arrangements. Additional responsibilities now include developing and supporting transformational projects across the system, monitoring schemes within the BCF plans and reporting progress of BCF planning to NHS England.

Each work stream will have clearly defined objectives, agreed milestones and an associated risk log.

The governance arrangements in **Ipswich and East and West Suffolk** are as follows:



Groups have the following remit:

The Suffolk Commissioners Group exists to deliver a joined up approach to commissioning Suffolk services for delivery of elements of the joint Health and Wellbeing Strategy and other areas of agreed joint working as appropriate. The SCG has representation from the CCGs, Suffolk County Council and the District and Borough Councils. The Group is for all ages.

The key functions of the group are to:

- Identify and agree on areas of beneficial joint commissioning for priorities identified through the Health and Wellbeing Board (HWBB)
- Agree plans to deliver the joint strategic aims where cross organisational commissioning is required
- Scrutinise progress of the joint commissioning workstreams and remove blockages to progress
- Deliver system leadership in the optimum use of resources to deliver the best overall outcomes for Suffolk residents

Health Care and Safety Joint Commissioning Group is responsible for developing and delivering transformation plans, making sure that progress is being made on the ground, sorting out blockages and delays and that our plans are innovative and take account of evidence and good practice. The group is shortly to be widened out to include provider organisations as core members. District and Borough Councils and the Police are already members and the group is for all ages.

The Mental Health and Learning Disability Joint Commissioning Group covers the following conditions - Mental Health, Learning Disability, Dementia, Autism, Substance misuse (Drugs and Alcohol).

The group is responsible for overall co-ordination of strategic commissioning of the services for customers with those conditions in Suffolk, reflecting joint commissioning principles of shared multi-agency working to develop a fully integrated care system. Specific responsibilities are to:

- Be an advisory body to the HWBB, CEWG and Suffolk Commissioners Group
- Oversight of the delivery of the Joint Mental Health (MH) and Learning Disability Strategies and of agreed improvements to Dementia and Autism services
- Work in conjunction with the Transforming Care (TC) Board to ensure delivery the TC plan
- Oversee delivery of the HWB Outcomes for Mental Health and for Learning and Physical Disabilities
- Oversee the strategic development of substance misuse services and the links with mental health service
- Take a strategic view on performance of commissioned services, provider market and community resilience
- Agreeing commissioning intentions
- Scope the opportunity for integrated provision, aligned and / or joint budgets

Membership includes - CCG and SCC commissioners, Public Health, the police, Department of Work and Pensions. Other commissioner representatives and providers are invited as required.

In IEWS the health and care organisations of primary care, acute hospital, mental health trust, social care, public health and Clinical Commissioning Group have come together and agreed to work together towards an **Integrated Care System** (ICS). It is likely that the governance structures for the delivery of the Better Care Fund will adapt and change as the ICS develops.

The key elements of the Ipswich and East Suffolk and West Suffolk Integrated Care Systems are:

- A health and care model where:
    - People manage their own health and social care with the right support when needed
    - Communities are easy and supportive places to live with a health or care needed
    - The health and care system is coordinated and effective
    - Higher cost interventions are replaced where possible with lower cost interventions
- A set of agreed principles and behaviours for joint working as a board
- The need for an agreed joint system transformation plan
- The need for financial and governance arrangements that align organisations and front line staff to deliver the health and care model for the benefit of the population. This should support a greater focus on locality working and co-location of provider teams
- Joint working to be progressed further on enablers to the system, including IT, recruitment, engagement & communication, training and development

Connect Co-ordinating Team – this is a group of three officers (a lead from the SCC and both CCGs) who co-ordinate and drive the delivery of the Connect project which is rolling out Integrated Neighbourhood Teams across the IEWS area. The team have a joint work plan, share tasks and have a weekly telephone call to discuss work and agree priorities.

2.3.3 Management and oversight to support the delivery of the BCF Plan

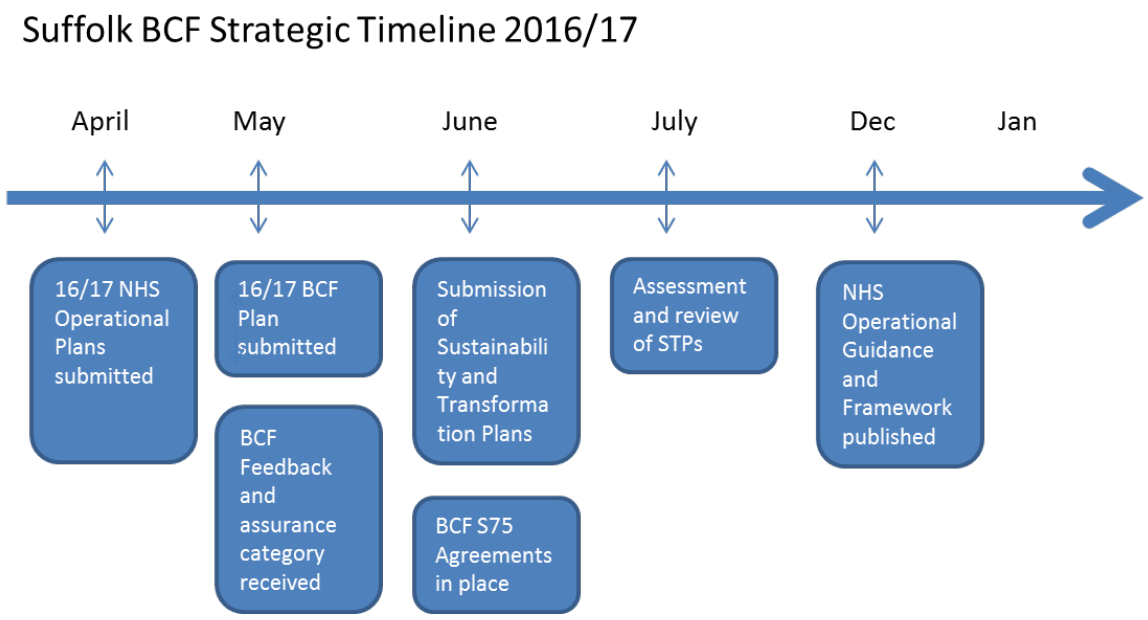
The following arrangements have been put in place to provide oversight of the Better Care Fund Plan.

Quarterly reports are made to the Health and Wellbeing Board, also reviewed by the Suffolk Commissioners Group (for IEWS) and the Better Care Fund Partnership Board (for Waveney).

Reports provide information on:

- BCF metrics
- Progress on delivery of
    - Transformation plans (and therefore our schemes)
    - National Conditions
    - Workforce development
    - Informatics
- BCF spend
- Outstanding risks

2.3.4 Key milestones associated with the delivery of the action plan in 2016/17



2.3.5 Scheme level and national condition milestones

March 2016	• **IEWS** - CCG Community and Urgent Care Contracts - First draft of 'Reactive' service specification complete (ref IEWS Scheme 1)
April 2016	• **IEWS –** Integrated Neighbourhood Teams launched and implemented in Forest Heath and Bury Rural, with initial meetings held in Eye and North West • **Waveney –** Social prescribing – stakeholder buy in for business case and model of delivery • **Waveney –** appointment of Local Area Coordinator

May 2016	• **IES -** Review of risk stratification arrangements and use of RAIDr tool in Ipswich and East Suffolk (in support of National Condition 5) • **IEWS –** Integrated Neighbourhood Teams launched and implemented in Felixstowe and Saxmundham/Leiston • **Waveney -** Most Capable Provider – Completion of Dialogue Negotiation phase • **Waveney –** Home Support - Completion of Phase 1 – understanding market and service need
June 2016	
July 2016	• **Waveney** - Social prescribing – funding identified and successfully obtained • **Waveney –** Out of Hospital Team – Sole Bay • **Waveney –** Home Support – Completion of phase 2 – service redesign
August 2016	• **IEWS -** Integrated Neighbourhood Teams launched and implemented in Haverhill and Bury Central • **Waveney –** Out of Hospital Teams – Beccles, Bungay and Kessingland • **Waveney –** Most Capable Provider – Governing Body approval to continue with commissioning model
September 2016	• **IEWS -** CCG Community and Urgent Care Contracts – Service specifications finalised • **IEWS -** Phased integration of existing admission avoidance schemes • **IEWS –** Integrated Neighbourhood Team launched and implemented in Woodbridge/Wickham Market • **Waveney** – Mental Health – Evaluation of IAPT service across the system

October 2016	• **IEWS -** CCG Community and Urgent Care Contracts – Specifications complete and procurement of services commences (new contract start date: 1st Oct 2017) • **IES** - New agreements around risk stratification and use of RAIDr tool in place in Ipswich and East Suffolk (ref National Condition 5) • **Waveney** – Social Prescribing – pilot phase starts
November 2016	• **IEWS -** Connect East Ipswich IP3/4 – Site for co-location at Sidegate Lane up and running (Health, Wellbeing and Reablement Centre) (ref IEWS Scheme 1)
December 2016	
January 2017	• **Waveney –** Most Capable Provider – Bundle 1 go live
February 2017	
March 2017	• **Waveney –** Social Prescribing – Evaluation of pilot and recommendations for sustaining service • **Waveney –** 7 day services Clinical Standards o Patient experience o Time to first consult review o Intervention/key services care o Emergency General Surgery – on going consultant review
April 2017	• **IEWS** – INT roll out completed • **Waveney –** Home Support – Completion of phase 3 – operational roll out • **Waveney** – Mental Health – Post diagnostic pathway for those with dementia in place

2.3.6 Risk log and risk management

The risk log and risk management for the BCF 16/17 has been updated from the BCF 15/16. The table below shows the risks and mitigations, with an indication as to whether the risk is considered high, medium or low.

	There is a risk that:	**Mitigating Actions**
1.	There is a system wide risk that resources available to us are unable to reduce forecast demand growth	We recognise that this is a risk that we need to manage together across the health and care system. All partners are involved, as the impact of this risk affects all our organisations. We have committed to managing this risk together as system

	There is a risk that:	Mitigating Actions
	and manage the impact of reductions in central government resources for health and care.	leaders, dynamically and collaboratively. We will ensure effective joint working to implement the schemes, timely monitoring and evaluation of the impact when schemes are implemented and joint governance, risk sharing and financial monitoring/planning. The development of Integrated Care Systems will help to address and manage this risk. Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
		Risk factor - high
2.	This plan is not rigorously or coherently delivered due to an organisational inability to co-ordinate, manage and deliver change leading to inefficient service models.	Senior leadership directly involved, with strong programme governance arrangements and robust delivery plans, including a collaborative workforce development plan. CCG and County Council design leads are working closely together and with key partners (e.g. VCS, providers, service users/patients). Plans are being tested against the best available evidence and jointly modelled to assess local impact. Plans implemented through a "learning through doing" approach, with a performance dashboard that allows development to flex to build on what works and stop what is not working. Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
		Risk factor - moderate
3.	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 in 2016/17, impacting on the overall funding available to support core services and future schemes.	We will monitor delivery of our action plans against anticipated outcomes. This information will be embedded in the governance system and monitored regularly. This will enable the right part of the local system to take appropriate remedial action Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
		Risk factor - high
4.	Full sharing of data at a system level is not possible due to information governance restrictions on organisational use of local	Plans to implement the NHS number are well advanced however the statutory restrictions on data sharing reduce the ability to plan in an integrated way. It also undermines the local system's ability to fully understand an individual's journey through the system.

	There is a risk that:	Mitigating Actions
	patient information.	Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
		Risk factor - high
5.	Public confidence is not maintained during the development and implementation of our plans.	We have clear communication, consultation and coproduction strategies and aligned messages so that people in Suffolk have a coherent story of change, know what we are doing and why. Where appropriate we will carry out formal consultation exercises. We have a strong ethos of co-production in our transformation programmes which will involve people in changes to the health and care system. The Health and Wellbeing Board takes an active role in overseeing the Suffolk wide shift to integrated working. Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
		Risk factor - high
6.	7 day services are not effective due to affordability with some parts of the system not able to deliver 7 day services or there is a delay in implementation	Integrated Care governance arrangements and the Workforce Development and Planning Forum will be asked to develop mitigating actions to manage this risk. Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
		Risk factor - high
7.	The anticipated impact of closer working with the Voluntary and Community Sector is not realised.	Our plans build on the Supporting Lives Connecting Communities approach which has delivered significant demand reduction in adult social care. Early engagement has taken place through established joint forums such as the Working Together Forum and Suffolk Congress. VCS are key partners in the work we are doing to deliver early adopter sites and initiatives. Connect sites have specific VCS workstreams. Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
		Risk factor - moderate
8.	Moving to new models of care and contracting arrangements slow down the development of our integrated system.	Integrated Care System governance will move to having a core role in the transformation programmes and therefore the delivery of the BCF in Suffolk, including the BCF schemes. A shared vision for change, coupled with a compelling case for change will keep the ICS Boards focused on timely delivery.

	There is a risk that:	Mitigating Actions
		Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports
Risk factor - moderate		
9.	Delayed transfers of care lead to additional costs for health, care and other organisations in the system.	Joint plans are developed and owned by the system leadership groups, with a focus on reducing DTOC while ensuring safe and timely return to independence. Owner – Health and Wellbeing Board Timeline – Quarterly HWB reports

2.4 An agreed approach to financial risk sharing and contingency

2.4.1 The quantified pooled funding amount that is 'at risk'?

The amount in the Suffolk pooled fund that is "*at risk*" is £1,811,263. This has been calculated in line with guidance, and the methodology is set out in the text for National Condition 7.

2.4.2 An articulation of any other risks associated with not meeting BCF targets in 2016-17?

The other key financial risk in not meeting BCF targets is around the costs of delayed transfers of care which are carried across the health and care system. As detailed in the text for National Condition 8 joint plans have been developed to reduce and manage Delayed Transfers of Care (DTOC) within our system, recognising that that the costs of DTOCs fall on health (community and acute) and care services.

The financial impacts of the agreed funding for the BCF are embedded in the CCG Operational Plans and the developing Sustainability and Transformation Plans. Financial balance for the CCGs is predicated on challenging QIPP targets (including reductions in emergency admissions) and savings plans which are tightly monitored through the appropriate governance arrangements.

We are developing comprehensive risk logs for BCF activity. Where there are existing risk logs for schemes they are attached at the end of this Plan. For other elements of the Plan the risk logs are held within our organisations and we are working towards comprehensive shared risk logs as part of the Sustainability and Transformation Plan development.

Section 3 – National Conditions

3.1 National condition 1 - Plans to be jointly agreed

3.1.1 Engagement with health and social care providers likely to be affect by the use of the fund

Our transformation plans have been developed in collaboration with providers and partners in the Suffolk system. Health and care providers, along with District and Borough councils have been, and continue to be round the table during both the design and implementation phases of our plans. Our governance arrangements include provider organisations.

Some of the engagement activities that we have undertaken with providers likely to be affected by our transformation plans are:

Ipswich and East Suffolk and West Suffolk:

- The development of Integrated Care System Boards has brought together primary care, acute hospital, mental health trust, social care, public health and Clinical Commissioning Groups, with an agreement to work together towards two Integrated Care Systems (ICS).
- Workshops to develop the 'reactive' and 'proactive' care models (which are integral elements of the health and care model) included provider organisations.
- The Support to Live at Home programme which has transformed the delivery of home care in Suffolk has been shaped by providers and commissioners with the aim of having a more person centred, responsive and reabling home care service.

Great Yarmouth and Waveney system:

- In Dec 2015, a workshop was held in Great Yarmouth and Waveney which focused on a review of the 2015/16 BCF plans and progress with integration in Great Yarmouth and Waveney. This was well attended by representatives from Mental Health, Social Care, Palliative Care and Children's Services from across the local authorities and CCG. In addition and in recognition of system wide integration the workshop was also attended by the borough/ district councils.
- In recognition of the wider system and role of Housing Authorities, for 2016/ 17 they will be a standing member of the GYW BCF Partnership Board to continue to develop this partnership and ensure they have a continued role in the development and delivery of activity detailed within the BCF plans. There will be a particular focus on the usage of the Capital Grant funding allocated through the Better Care Fund and how this supports people to live independently, and reduce non-elective admissions and admissions into Care Homes.
- As activity is identified, or delivered, appropriate consultation is held with providers and stakeholders in accordance with best practice. This can be best evidenced through the innovative work being done through the Most Capable Provider (MCP) process which forms part of the Better Care Fund activity for 16/17, which has the strategic aim of developing and delivering a cohesive integrated care system (ICS). This process currently includes the following providers;
    - James Paget University Hospital (JPUH),
    - East Coast Community Healthcare
    - Norfolk and Suffolk NHS Foundation Trust

    - All Hallows HealthCare
- The Shape of the System Public Consultation in Great Yarmouth and **Waveney** set out an ambitious vision to extend the out of hospital model using integrated teams and beds with care across Great Yarmouth and Waveney. This model was supported by the local public and by May 2016 all areas will have access to an out of hospital team. This will enable the closure of inpatient beds in both the acute and community hospitals and the enhancement of both the environment and staffing at Beccles Hospital to provide enhanced Intermediate Care and specialist palliative care.
- The Health and Wellbeing Board approved the Health and Housing Charter in 2015, which was developed by housing authorities and providers along with other partners and which is aligned to our transformation programmes.
- Suffolk County Council produces an annual Market Position Statement[8] which contains spending and strategies for different adult social care service types, information on the state of specific markets in Suffolk and analysis that will be of benefit to providers of services. By setting out priorities and intentions in this way market intelligence is presented so providers can plan their businesses with confidence and meet customer expectations.

3.1.2 Assessment of future capacity and workforce requirements across the system

We are undertaking a new workforce planning process entitled "Place Based Planning" which is intended to be all encompassing and will cover health and social care and primary care. This will be brought together in the Sustainability and Transformation Plans. The plan will build on existing workforce profiling carried out across Norfolk and Suffolk which will deliver the following:

- A single cross sector health and social care workforce profile by locality area
- A process for identifying workforce capacity implications of new service models
- A tool to assist predicting and planning future demand and workforce requirements
- A workforce in post in the optimum geographical location with the right skill mix and competencies to meet the needs of the population
- Colleagues from across Health and Social Care working together to maximise the efficiency of the community based workforce
- Improved awareness of the workforce profile across the system

Some of the practical actions that have improved workforce collaboration across health and care are:

- Rotational multi-agency apprenticeships
- Joint apprenticeship co-ordinator appointed
- Workforce shadowing for Integrated Neighbourhood Team members
- Lunch and Learn events for INT members
- Joint leadership training commissioned (to be delivered in summer/autumn 2016)

[8] Suffolk County Council Market Position Statement - https://www.google.co.uk/search?q=suffolk+county+council+market+position+statement&gws_rd=ssl

3.1.3 Implications for local providers

In Suffolk, provider organisations are key partners in our transformation programmes, both in the programme governance and in the delivery of change on the ground. They have been part of developing and agreeing the future customer outcomes and models of care and are working with commissioners on plans to implement the changes needed to achieve these. They also sit on the Health and Wellbeing Board and therefore have been involved in the development of the BCF Plan.

From an acute provider perspective, it is unlikely that the BCF presents a risk to them as they tell us that they make a loss on non-elective activity. At two of our acute providers, activity above the 2008/09 threshold (or adjusted) is paid at 30% as per National Tariff arrangements. Acute providers will continue to be paid as per the contractual agreement on activity performance. In the event that the Better Care Fund is successful in reducing emergency admissions, there is a risk to that there will be some 'stranded costs', primarily fixed costs that the trusts may not be able to take out of the system immediately. However, our providers advise us that reductions will ease the considerable pressure on clinical resources and that they are planning to reduce capacity in line with reductions as they materialise.

The implications for community providers are set out in our future commissioning plans, which are currently under development in Great Yarmouth and Waveney and in Ipswich and East Suffolk and West Suffolk CCG areas. However, it should be noted that current providers of community services are sited on the vision and future models of care that the BCF describes and are fully signed up to their delivery.

3.2 National Condition 2 - Maintain provision of social care services

3.2.1 Explanation of how adult social care services will continue to be supported

Adult social care will continue to be supported through the Section 75 agreement for the transfer of resources between the NHS and Local Authority and through our transformation and commissioning plans. The Section 75 transfer will only provide resources to fund social care aspects of the BCF schemes. The longer term transformation plans will deliver a different model of health and care delivery that prioritises prevention, a joint approach to care management and an integrated system for crisis care. All these elements will help to manage demand and to reduce the need for more intensive longer term care. The adult social care programme Supporting Lives Connecting Communities has shown that the pattern of costs can be changed by taking this approach.

3.2.2 Definition of support agreed locally

Our definition of protecting social care in Suffolk has not changed since the BCF 2015/16. It states that the criteria for adult social care will remain at substantial and critical and that the provisions of the Care Act will be fully implemented. This means that people in need of care and support will continue to receive the appropriate services they need in an integrated and preventative health and social care system. Our approach is founded on a whole system approach to health and care services.

The Health and Wellbeing Board understands the vital importance of robust social care provision in Suffolk as part of a whole system approach to health and social care.

We recognise that the way we allocate financial resources within health and adult social care may change because of our shared transformation programmes, but what we are interested in is delivering better outcomes for individuals.

In Suffolk we know that the social care demands from our population are increasing year on year in part because of the rising numbers of older people in our communities. At present approximately 10% of Suffolk's population is aged over 75 and this is set to rise by 72% by 2031. Between 2012 and 2017 there is a predicted 15% increase in people with high and very high care needs and the number of people with dementia will double between 2013 and 2030. The cumulative effect of demographic changes will place additional demands on adult social care, which translates into ongoing financial pressures of around £5 million each year.

Meeting these challenges requires transformation of the health and social care system and we recognise that the best way of protecting adult social services provision is to do this together. This means developing integrated services together, commissioning jointly and differently and working to ensure that different elements of the health and care system interact in an effective, efficient way in the interests of the service user. We have committed as a system to finding additional financial savings through the System Transformation Pans in order to deliver on a fully sustainable system including fully protecting adult social care.

3.2.3 Ensure any change in the level of protection does not destabilise the local social and health care system.

Due to the financial constraints in the health sector there has been a reduction in the level of guaranteed protection to social care but both sides are committed to working together to release further transformational savings so as to ensure that the local social and health care system is not destabilised.

3.2.4 Total amount from the BCF allocated

The total amount from the BCF that has been allocated for the protection of social care is £17,081,579. It includes £1,875,305 for the implementation of Care Act duties. This transfer of funding is consistent with the 2012 DH guidance and maintains in real terms the level of protection as provided through the mandated minimum element of the BCF agreement in 2015/16.

In 15/16 the minimum amount was enhanced by £1m through a risk sharing agreement associated with health and care savings projects. The risk sharing agreement ceased at the end of 15/16 and therefore the additional funding is not available in 16/17. This means that the amount of funding from the BCF pool that has been allocated for the maintenance of social care services in 16/17 is a 3.7% reduction from 15/16. However as stated above both sides are committed to working together to release further transformational savings.

3.2.5 Include a comparison to the approach and figures set out in the 15/16 plans

The totality of the agreement around the protection of social care services in 15/16 included an agreement to work on a number of projects where joint working would accrue savings to the NHS, with an agreement that a proportion of these savings would be transferred to SCC for the further protection of adult social care.

Our approach to this additional activity has changed, as the identification and delivery of the planned savings did not achieve the planned outcomes. This year system leaders have agreed to find additional savings through the System Transformation Pans in order to deliver on a fully sustainable system including fully protecting adult social care.

3.2.6 How informal family carers will be supported by local authorities and the NHS

It is estimated that there are over 77,000 unpaid carers in Suffolk, making up just over 10% of the population.[9] The partnership approach to support for carers was agreed by the Health and Wellbeing Board in May 2015:

- Driven by Evidence– Carers JSNA and the Carers Partnership Strategy
- Meeting the requirements of the Care Act to put Carers needs on a par with the Cared for
- Establishing Joint Commissioning with CCGs
- Focusing on breaks as a key issue

The new approach has been implemented through a strengthened partnership with Suffolk Family Carers, with Trusted Assessors trained to complete carer assessments in order to increase the number and quality of carer assessments carried out in Suffolk. Other commissioned projects have included:

- Open Door Carers Support
- BSEVC I'm Special Too Project
- Sunset Barn Care Farm
- Bangladeshi Support Centre (Rural Suffolk) Project.
- Respite on prescription: to help carers look after their own health, providing them with time-out to attend their own health appointments
- A Health Education project for family carers in Suffolk project, in conjunction with Sue Ryder and Suffolk Family Carers

3.3 National Condition 3 - Agreement for the delivery of 7 day services across health and social care

3.3.1 Plans in place to provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care

[99] Suffolk Joint Strategic Needs Analysis (source 2011 census)

Our plans for 7 day services are designed to reduce and prevent unnecessary non-elective admissions - both physical and mental health, as well as to support the timely discharge of patients on every day of the week. They have been developed with all system partners including community and acute providers.

In **IEWS** 7-day services put in place (and milestones where appropriate) are as follows:

- Mental Health – Access and Assessment and Crisis Resolution and Emergency Response – from March 2014 onwards. Psychiatric liaison services will help to discharge mental health patients.
- Primary Care – In addition to Extended Hours DES and the out of hours general practice provider Care UK, routine appointments, diverts from A&E and diverts from the ambulance are accepted by Suffolk Federation until 9pm and funding for this continuing into 2016/17 was announced at an NHS England teleconference on 8th March 2016.
- Community Health and social care – A Crisis Action Team (Ipswich and East Suffolk) and Early Intervention Team (West Suffolk) including community health and social has been in place since October 2015 through system resilience monies and operates 7 days per week. Continuation into 2015/6 is subject to approval by the CCG Governing Body in March 2016 with a first draft of a service specification for this as business as usual being developed by March 2016. This will build on a joint workshop which was hosted by Ipswich and East Suffolk CCG, Suffolk County Council, West Suffolk CCG and which included the acute hospitals, mental health provider, community health provider, GPs, and Out of hours general practice provider.

NHS Great Yarmouth and **Waveney** CCG together with key partners is an early adopter of seven day services. An Integrated Steering Committee has led a whole system approach to the delivery of 7 day services since June 2014 with representatives from all the NHS and Social Care providers across Great Yarmouth and Waveney. This commitment is now lead by the Acute Trust.

Progress in achieving 7 day service delivery and the removal of variation in access and outcome across the week will be expected from all providers. This will require cooperative working and innovation in delivering services within the current funding framework.

In September 2015, Monitor and NHS England outlined priority focus to four of the ten clinical standards. Trusts are expected to deliver these standards by 2016.

These are:

- Standard 2 – Time to first Consultant Review
- Standard 5 - Diagnostics
- Standard 6 – Intervention/Key Services
- Standard 8 – On going consultant review

NHS Improving Quality published compliance on their website and the James Paget University Hospital is fully compliant with one of the four priority clinical standards (6) with progress being made against the other three standards. The other six standards will be expected to be delivered by 2017.

Additional funding has been provided to introduce a weekend social work presence at the James Paget University Hospital. This is supported by further funding for a weekend social care, Care Arranging Service (CAS) to support the hospital teams.

The recent 5 Year Forward View for Mental Health report stipulates that people facing crisis should have access to mental health care 7 days a week. In response to this requirement the following services are delivered; Crisis Resolution and Home Treatment (CRHT), acute in-patient beds and a Section 136 suite.

3.4 National Condition 4 - Better data sharing between health and social care based on the NHS number

3.4.1 The right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care

We have formed the Suffolk Informatics Partnership Board (SIP) with representation from digital, clinical/operational leaders from all partners across the Suffolk system. The SIP reports to the Health & Wellbeing Board to progress this and associated agendas. This (and its sub-groups) complements our existing pan-Suffolk Information Governance groups & network, and interfaces where appropriate with each organisation's Caldicott Guardian. In place is a pan-Suffolk Information Sharing agreement and the Clinical Information Assurance Group (CIAG), a subgroup of the SIP, is working collaboratively to refine agreements, policy and process to ensure consistency.

Plans are in place to develop the local Digital Roadmaps (in line with the National Information Boards Personalised Health & Care 2020, underpinning NHS England Five Year Forward View). The first iteration of these plans will be published in July 2016.The Digital Roadmaps will set out the plans and milestones for delivery of the National Condition across Suffolk.

NHS Great Yarmouth and **Waveney** CCG is strengthening links to county transformation programmes with a view to determining how a local working group can support the Norfolk and Waveney footprint in developing local digital roadmaps for June 2016. The coordination of this is being led by Norwich CCG and supported by North and East London Commissioning Support Unit and local governance processes have been agreed with all relevant parties engaged.

A cross Suffolk workshop was held on the 25th April which brought together the three CCGs, the County Council and experts from NHS England and the Health and Social Care Information Centre. The workshop was exploring the development of a shared care record. The next step will be a proposal to the SIP to develop an options paper, building on models of good practice from elsewhere in the country.

3.4.2 The NHS Number is the consistent identifier for health and care services, and if not there are plans to do so

The NHS number is used throughout health services as the consistent identifier, and has been for a number of years. Care services have continued their activities around use of validated NHS numbers within care records; this is operationally in place, and is planned to become more streamlined with

the procurement of their care records application, ideally with connection to the NHS Summary Care Record.

3.4.3 Interoperable Application Programming Interfaces (APIs) are being pursued (i.e. systems that speak to each other) with the necessary security and controls

All contracting authorities in the Suffolk system that have existing applications with the technical capability to develop APIs are working closely with their vendors to progress this agenda. Where suppliers do not have this capability organisations are seeking alternate options (such as system replacement or middleware in the short term). This is a key programme within the Local Digital Roadmap.

3.4.4 Appropriate Information Governance controls are in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, there are plans for it to be in place

The NHS number is used for direct care purposes with controls operated to secure the Caldicott Principles are adhered to in delivering direct care to service users.

For invoice validation CEfF controls are in place (Controlled Environment for Finance) ensuring that where NHS numbers are used to validate invoiced care this information is not retained beyond the time required to carry out the purpose for which it was collated. For secondary care purposes data is pseudonymised and anonymised to ensure information risk is managed effectively.

Information sharing is being taken forward by the Clinical Information Assurance Group, who are holding a workshop on 18th May 2016 to finalise the Information Sharing agreement. This will supersede and rationalise the existing agreements and be for the whole system.

3.4.5 Local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review)

All patients & service users are informed (at the point of need) how their data is used for the provision of their care, who may have access (organisations involved in care pathway) and how to exercise their legal rights. Obviously not all local people are current (or recent) service users – so not all local people will have clarity at this time. However those people will not be having data shared beyond the organisational boundaries of the data controller at this time.

3.4.6 How these changes will impact upon the integration of services

The Local Digital Roadmap (LDR) for Suffolk is being aligned to the Sustainability & Transformation Plans, as each has a critical and perpetual dependency on the other. The vision of complete, accurate, timely, relevant and attributable data shared across services is a key enabler of integrated services that must progress in parallel with wider integration. The LDR and SIP plans will identify milestones focussed on local integration aims; where this cannot realistically be achieved digitally business processes will be implemented that support shared information.
Practical applications of better data sharing include:

- shared health and care records
- more effective coordinated care
- greater ability to identify at risk customers at Multi-Disciplinary Team (MDT) meetings

3.5 National Condition 5 - A joint approach to assessments and care planning

3.5.1 Which proportion of the local population will be receiving case management and named care coordinator

In **IEWS** the CCGs have adopted the QIPP Right Care approach to identification of patients, based on the 2% of highest cost. Within these 2%, patients have been prioritized according to their A&E attendances and clinical judgement in relation to the avoidability of their admissions. Since March 2016 all practices have been given a list of high priority patients for discussion at MDT and a review is currently underway to assess the effectiveness of the algorithm and those discussions. MDTs are led by the Interface Geriatrician and community case managers and supported by a shared care and support plan and care coordination.

In **Great Yarmouth and Waveney** the Out of Hospital teams are fully functional across Lowestoft with further plans to extend the service to South Waveney. Out of Hospital services provide a rapid response function in the system supporting 'at risk' individuals by coordinating timely assessment and joint care planning between health and social care. All individuals have access to Consultants in acute settings or named GP's and/or Community Matrons once care packages are in place. This model has had a significant impact on reducing non-elective emergency admissions.

The 'Shape of the System' public consultation has been used to inform development of a Waveney Out of Hospital model. In addition to this Primary Care makes good use of Multi-Disciplinary meetings within GP settings and involving social workers to ensure appropriate provision is made for 'at risk' individuals. Each GP practice within the CCG currently runs a form of risk stratification each month to identify 2% of their registered population as being at Risk. In general these patients are identified based upon admission activity and primary care coding of long term conditions but the exact process used by each practice varies. It is not possible for the CCG to perform a standardised approach for each practice because the CCG does not have access to primary care data. However, the CCG does monitor the practice at Risk lists to ensure each practice has identified the required 2%. The Better Care Fund plans for 2016/ 17 evidences that Dementia and Mental Health remain a priority for commissioners.

3.5.2 Dementia services as a particularly important priority for better integrated health and social care services, supported by care coordinators (for example dementia advisors)

The Suffolk Annual Public Health Report "Is prevention better than the cure?"[1] sets outs a number of priorities to address dementia, and to improve the quality of post-diagnosis treatment and support for people with dementia and their carers. These recommendations are in line with our new

[1] Is prevention better than the cure – 5 – 10 year options for prevention in Suffolk
http://www.healthysuffolk.org.uk/assets/JSNA/Annual-Report/19673-APHR-2015-LR-20151209.pdf

dementia strategy currently under development which will mirror the expectations of the National Dementia Strategy and the Prime Minister's Challenge on Dementia 2020.

The Better Care Fund Plan supports the national ambition for two-thirds of the estimated number of people with dementia in England to have a diagnosis and appropriate post-diagnosis support.

Specific actions include working with our local Dementia Alliance and the voluntary and community sector to promote and support the development of Dementia Friendly Communities across Suffolk and grant making through the Dementia Fund. In addition, all 'Connect' site activity commissioned by the Neighbourhood Networks workstream will have a focus of addressing social isolation and loneliness as a key theme (evidence suggests 39% of people with dementia are lonely which directly impacts on poorer outcomes).

There is joint work across IEWS to develop an integrated dementia pathway, with an agreement to migrate investment to have a greater proactive emphasis thus reducing the reliance on current expensive reactive services. This will include developing a comprehensive post diagnostic service model for people with dementia and their carers to eliminate gaps, duplication, fragmentation and short term funding. The intention is for the new pathway to go live in April 2017.

This will be supported by work to review the current services for people with dementia and their carers.

In **Waveney**, BCF Scheme 4 – Support for people with dementia and mental health problems is aimed at addressing the needs of people with dementia.

3.5.3 A description of plans for health and social care teams to use a joint process to assess and plan care

In **IEWS** Joint processes have been developed with health and social care teams and agreement has been reached on a shared care plan template which is being trialled in our Connect sites. Progress has been significant in 15/16 and has included the following milestones which were achieved between June 2015 and December 2015 for the Connect Group:

- Access to information on other services to support joint working
- Agreement of single assessment process/protocols
- Development of shared care planning arrangements
- Review of existing MDT meetings and tools used to identify and case manage patients/customers with high dependency needs
- Development of shared operational processes for INT (virtual and co-location)

Out of Hospital services in Great Yarmouth and Waveney provide a rapid response function in the system supporting 'at risk' individuals by coordinating timely assessment and joint care planning between health and social care workers co-located and managed within one team. In addition to this, Primary Care makes good use of Multi-Disciplinary meetings within GP settings and involving social workers to ensure appropriate provision is made for 'at risk' individuals.

Milestones for this work are the same as for our Integrated Neighbourhood Team (Connect) roll out and the development of Out of Hospital Teams.

3.6 National Condition 6 - Agreement on consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

3.6.1 Public and patient and service user engagement in planning, as well as plans for political buy-in

The Suffolk Health and Wellbeing Board has been involved in the production of this plan through their involvement in the transformation plans in Suffolk, as well as specifically consulted on the contents of the BCF Plan 2016/17.

In **IEWS** there has been considerable public and patient engagement, including:

- Engagement with grassroots clinicians
- Public sector and voluntary sector leaders, for example at Health and Wellbeing Board dedicated session
- Large events at Ickworth House, Trinity Park and the Indian Mela
- Over a dozen outreach events in supermarkets, churches, street stalls and sports centres, for example through Town Talk, Village Voices
- The use of 25 patient stories, 15 from health and 10 from social care, has been particularly helpful in defining the model

The findings of these events were independently analysed by Healthwatch Suffolk which produced a report which showed public support for our plans[10].

3.6.2 Alignment to provider plans and the longer term vision for sustainable services

In **IEWS** the transformation plans have been developed through a joint review commissioned by the Health and Wellbeing Board which applied to the geographical area covered by Ipswich and East Suffolk and West Suffolk. A service model, known as the Suffolk Health and Care Model, was endorsed by the Health and Wellbeing Board in January 2015 and is being implemented in partnership between providers and commissioners across health and care, along with other partners such as housing providers and the voluntary and community sector. This has included dedicated project groups for health and social care integration at neighbourhood level, known as 'Connect Groups' plus smaller task and finish groups to look at services which are up for contract renewal in the next 18 months and see how they might align both presently and in the future with the Health and Care Model.

3.6.3 Mental and physical health are considered equal, and plans aim to ensure these are better integrated with one another, as well as with other services such as social care

System leaders are fully committed to ensuring an equal focus on improving mental health as physical health and that patients with mental health problems do not suffer inequalities as a result.

[10] Engagement Report: Public perceptions of the changes to the new Health and Care Model http://www.healthwatchsuffolk.co.uk/wp-content/uploads/2015/02/hasci_engagement_report_-_v9.pdf

In **IEWS** the overarching aims for mental health services are that:

- Mental health provision will be open and accessible to all people who need it regardless of their age and the diagnosis and severity of their mental health condition
- No mental health service user should need to be returned to their GP for onward referral for another mental health service
- Commissioned mental health and learning disability services are integrated with the wider health and social system and support the recognition that people's mental health should be seen as part of their overall physical and mental wellbeing. This will apply to all people regardless of their age including those marginalised from society.

The approach to embedding 'parity of esteem' incorporates the following:

- Understanding the needs and barriers for people with MH to access health care and developing our plans accordingly. These include:
    - Learning from the Suffolk Mental Health Joint Strategic Needs Assessment
    - Delivery of the Suffolk Mental Health Strategy Action Plan
    - Co-production with service users

The Mental Health Strategy has been co-produced through a series of eight service user-led workshops which have developed the key themes of prevention and living well, crisis, and recovery.

A Suffolk Youth Ambassador has been commissioned by Health and Social Care to actively seek the views of children and young people particularly about stress experienced by young people.

NHS Great Yarmouth and **Waveney** CCG continues to work in partnership with the Norfolk and Suffolk Foundation Trust (NSFT), Suffolk and Norfolk county councils and a range of third sector organisations to meet the mental health needs of the local population of Great Yarmouth and Waveney.

Access to psychological therapies remains a key priority for both the government and our CCG. In partnership with the Norfolk CCGs, Great Yarmouth and Waveney CCG has procured a new Wellbeing Service which commenced in September 2015. This is provided by NSFT in partnership with MIND and Relate. Performance measures are in place and continued to be monitored to ensure access targets and recovery rates are achieved.

NHS Great Yarmouth and Waveney CCG are working with GP practices and NSFT to increase dementia diagnosis rates. Through joint working we are looking to achieve the national target. In Waveney, the flexible dementia service enables people to remain independent for longer in their own home.

3.6.4 Clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans and an agreement of the impact of plans with local providers

In **IEWS** the BCF plan, Sustainability and Transformation Plan and CCG operating plans are closely aligned. They feed into the same joint and internal PMO functions and have been built up with

system partnership based on the shared vision for integrated health and social care. Development of a single delivery plan through a joint delivery team is in progress.

Joint project charters between Ipswich Hospital and the CCG have been drafted and presented to a fortnightly transformation meeting shared between the CCG and the Trust. This includes information on proposed impact, which (for example in the case of the Crisis Action Team in the Ipswich and East Suffolk area and a related service known as the Frailty Assessment Base) is currently agreed as being six admissions per day.

In **Waveney** all activity contained with the Better care Fund plan for 16/17 will involve consultation with providers so they understand any impact. This is in addition to the wider consultation with providers done by the Local Authorities and the CCG to inform strategic aims which then inform local activity.

As the BCF is not seen as a separate entity but as an integral part of the CCGs and Suffolk County Council in delivering their shared vision, there is clear alignment between the overarching plans. The investment in the Programme Management Office to ensure that all these elements are brought together and clearly aligned is a demonstration of the commitment to ensure that this continues.

3.7 National Condition 7 - Agreement to invest in NHS commissioned out of hospital services

3.7.1 Agreement on the use of the local share of the £1 billion that had previously been used to create the payment for performance element of the fund, in line with the national condition guidance

The use of the element of the BCF previously assigned for payment for performance has been agreed in Suffolk. The non-elective reduction was not achieved through the BCF plan in 15/16 therefore this target reduction will continue to be worked towards in 16/17. However, the reduction has been adjusted slightly to reflect the updated 14/15 baseline from NHSE changes in calculation for 16/17. The risk share costs have been shared between CCG's based on the same methodology as 15/16 where the cost split has been calculated based on CCG average tariff spend.

In practical terms this means that an amount has been set aside for the provision of additional acute sector activity in line with 2015-16. The remainder of the Better Care Fund is allocated to community and out of hospital provision, including the provision of Disabled Facilities Grants, in line with our "shift left" transformation models.

3.7.2 Methodology to determine 2016/17 position

- Updated 14/15 baseline using NHSE pre-populated numbers, this is due to the new reporting methodology for 16/17 and ensure consistency with the 16/17 plans
- As the admission reduction was not achieved in 15/16 the target of 3.5% reduction against the 14/15 actual admissions will continue to be the target for 16/17

- 3.5% reduction against 14/15 baseline is 2434 admissions
- Average tariff of £744 (as provided by NHSE) has been used to calculate the 2434 admissions equates to £1,811,263
- This risk share of £1.8m has been split across our 3 CCG's. The split has been calculated using the average tariff for a Non-Elective admission as paid by each CCG in 14/15. The MRET adjustment has been taken off the IESCCG and WSCCG tariff but not GY&W CCG as they do not apply MRET. This generated a percentage split of cost as follows:
    - 40% - Ipswich and East Suffolk CCG
    - 26% - West Suffolk CCG
    - 34% - Waveney element of Gt Yarmouth and Waveney CCG

NB – impacts re additional adjacent CCGs (x3) have been taken into account.

3.8 National Condition 8 - Local action plan to reduce delayed transfers of care

3.8.1 A local action plan for managing DTOC within the context of the overall SRG plan for improving patient flow and in line with national guidance

In **IEWS** there are action plans for managing Delayed Transfers of Care which have been developed in line with national guidance and best practice (for example adoption of the HII self-assessment tool to provide situational analysis, and benchmarking against national standards). Acute and other NHS providers have been involved and independent and voluntary providers engaged. The plans are aligned to other working initiatives that are associated or have an indirect impact on DTOC eg winter flow projects commissioned in the voluntary and community sector.

The plans are managed locally through multi-agency groups as follows:

- West Suffolk – weekly via the Delays Scrutiny Group
- Ipswich and East Suffolk – fortnightly via the Delays and Winter Resilience Group, with practical action being taken through the Reactive Care Task and Finnish Group
- In both CCG areas there is a daily detailed category breakdown to enable specifically targeted actions, in particular when rates of delay are very high

Results are reported to the System Resilience Groups, and actions owned and shared by all relevant partners. Acute and other providers as well as District and Borough Council representatives are active members of these groups to ensure whole system agreement.

The **West Suffolk** System Resilience Group (SRG) has published a "Managing Delayed Transfers of Care (DTOC)" plan to assist in the management of the reporting and the recovery of the DTOC metric across the 'footprint' of the west Suffolk Health and Care system. The SRG recognises the important role the system collectively plays in providing quality responsive care and support to people who have been in hospital and need support for their transfer of care when they are ready for safe discharge.

The arrangements within this plan will assist the organisations identified within it in meeting the requirements of NHS England to deliver a locally agreed improvement trajectory at WSFT of achieving the tolerance threshold of 2.5%.

The objectives of the Plan are to:

- Identify a flexible and scalable framework which ensures a timely and effective response to fluctuations in the number of people who are reported as experiencing a delay in their transfer of care arrangements
- Identify a shared understanding of what constitutes a 'delay' to transfer of care which is statutorily reportable under the Care Act (2014) and to implement trigger and validation processes between agencies to rapidly improve the data quality in the reporting of the statutory return
- Identify appropriate responses and accountability arrangements within the Suffolk wide System Escalation Policy for when a person is experiencing a delay to transfer of care including escalation and dispute resolution protocols
- Clarify the specific agency responsibilities across the health and care economy footprint in relation to timely managing transfer of care for people who have experienced a period of time in hospital

The Plan focusses on the principles of the 'Safer Bundle' principles outlined below:

- **S**enior Review, all patients will have a Consultant Review before 10am followed by a Ward or Board Round
- **A**ll patients will have a Planned Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by the clinical teams;
- **F**low of patients will commence at the earlier opportunity from assessment units (o inpatient wards. Receiving wards from assessment unites will commence before 10am daily
- **E**arly discharge, 50% of patients will be discharged from base inpatient wards before midday. Information for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge
- **R**eview, a weekly systematic review of patients with extended length of stay (>14 days) to identify the issues and actions required to facilitate discharge. This will be led by senior leaders within the Trust

It is recognised that the west Suffolk system continues to be challenged by the increasing demand from frail elderly people, with complex co-morbidities including dementia and the consequential impact this has on the system in relation to provision of timely assessments and sufficient capacity in the community and the independent sector to meet the complex care needs. The 12-point Plan clearly sets out the collective responsibilities of the local 'system' for supporting delivery of the improvements required.

In the **Ipswich and East Suffolk** area CCG has an up to date system wide plan for reducing delayed transfers of care that is agreed with all partners in the system through the Integrated Care Network. In 2015/16 the key areas driving delays have been:

- Access to domiciliary care (a major overhaul of the way this market operates was implemented by the County Council and CCG and it has taken more time than anticipated for the new providers to consolidate their services resulting in delays)
- Access to care home capacity – the market for care homes in Suffolk is difficult with a paucity of providers willing to meet the CCG and council's price expectations and a growing number of Care Homes being closed to admissions by the CQC. The Council and CCG are undertaking a joint piece of work to review the market conditions and ensure there is a sustainable market going forwards. Part of this work is to step up the joint reviews of the quality of care homes to reduce the numbers of closures
- Continuing healthcare – the CCG has struggled to recruit sufficient capacity to the team despite outsourcing of elements of the work and is part way through a programme to improve the processing efficiencies within the team and within the providers. This has resulted in delayed transfers

The CCG has set a realistic but stretching internal trajectory (shared with NHS England) to end 2015/16 with an official delayed transfer level of 4.5% (the rate has been as high as 6.5%). Current reporting shows this to be on track. Further work will be undertaken with system partners to understand the potential for further reductions in 2016/17 to meet the 2.5% expectation with a view to setting a trajectory to meet this requirement.

The CCG through redesign of reactive model to support the implementation of the Health and Care Review will explore 'Discharge to Assess' models of care with colleagues in Suffolk County Council (Adult Services) and colleagues at Ipswich Hospital.

The Great Yarmouth and **Waveney** CCG Continuing Health Care (CHC) team have been working closely with the James Paget University Hospital and have agreed the best way to record activity so that it is in line with the updated NHS England guidance. The CHC team have also agreed to a five day turnaround for assessments once the checklist has been completed, and to also ensure the full and appropriate use of the twelve 'Discharge to Assess' beds commissioned by the CCG. Given all of these actions we expect to meet the stretch target of 2.5% by the end of the financial year.

This work is further supported by the Urgent Care Board and membership includes; Clinical Commissioning Group, Acute and Community Providers, Local Authorities, Mental Health Trust, District Councils and the Ambulatory and Out of Hours providers. The purpose of the forum for senior representatives from key organisations within the Great Yarmouth and Waveney health and social care system to work together to deliver safe, high quality integrated urgent care.

GYW CCG works in partnership with health and social care providers to both monitor and reduce delayed transfers of care. There is a DTOC plan in place. The current plan requires:

- Daily conference call between providers
- Mon-Fri attendance at the Acute Trust by CHC Lead Nurse
- Day turnaround for CHC assessments
- Regular senior monitoring meetings

Current activity includes;

- The development of an integrated resilience plan which encompasses seasonal pressure points such as winter
- Providing senior decision making to remove obstacles which may affect smooth and timely discharge
- Promoting sustainable change and shared learning, ensuring the integrated use of resources and capacity
- The development of a monthly dashboard including predictive analysis to provide a system wide overview of performance in relation to capacity, constraints and actions
- Continuing the multiagency work for high dependency individuals, especially vulnerable adults (homeless, drug and alcohol related problems, mental health problems), working closely with district councils and voluntary agencies
- Reviewing the effectiveness of community and mental health services, including the role of walk-in centres and minor injury units within Great Yarmouth and Waveney and how they integrate with the James Paget University Hospital NHS Foundation Trust
- Continuing to work with the local ambulance trust and the Great Yarmouth and Waveney NHS 111 and out of hour's provider to ensure effective service delivery to agreed performance standards
- Seeking opportunities to reduce attendance or admission to the James Paget University Hospital NHS Foundation Trust for children, the frail elderly and those patients with long term conditions
- Understanding how the local health and social care economy can support carers

The Urgent Care Board reports quarterly to a Systems Resilience Group and other partner Boards.

The CCG has also commissioned twelve 'Discharge to Assess' beds to enable both rapid transfer from an acute bed and also the provision of a more appropriate environment to assess patients and reach a better decision regarding their long term care needs.

Adult social care developments that feed into each of the three Suffolk plans include:

- The establishment of a Trusted Assessor Role within community groups
- Establishment of a hospital domestic care provider model
- Focused work with residential and nursing care homes to ensure they retain accreditation via the Care Quality Commission
- Development of Discharge to Assess model, including a review of discharge beds
- Best practice pathways for people with delirium and dementia
- Joining up discharge planning teams

3.8.2 The local stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts, and in line with the CCG operational plans.

In **IEWS** and in **Waveney** the system has adopted the stretch target of a 2.5%, alongside the national 3.5% target.

These targets are reflected in the CCG Operational Plans.

3.8.3 *Consideration of the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities*

In **IES** a risk register is maintained and discussion is ongoing across partners. A joint task group has been established involving acute trust & social care to identify shared working and pathways to improve delayed discharges.

In **West Suffolk** data is gathered to ensure reduction of DTOC numbers is fairly aligned to proportionate share of patients alongside reasonable expectation.

3.8.4 Clear lines of responsibility, accountabilities, and measures of assurance and monitoring?

The plans contain clear lines of responsibility, accountabilities and measures of assurance and monitoring. Each action has a designated owner and milestone/timescale for completion.

The plans are managed by the following groups:

- West Suffolk – Delays Scrutiny Group
- Ipswich and East Suffolk – Delays and Winter Resilience Group
- Waveney – Urgent Care Board

There is escalation and reporting to the System Resilience Groups in all areas.

Section 4 – Schemes

This section contains information about the BCF schemes:

1. IEWS Scheme 1 – Proactive Care – Integrated Neighbourhood Teams
2. IEWS Scheme 2 - Reactive Care – Integrated 24/7 urgent care response
3. GWY Scheme 1 – Supporting independence by provision of community based support interventions
4. GWY Scheme 2 – Integrated Community Health and Social Care Teams including Out of Hospital Teams
5. GWY Scheme 3 – Care at Home
6. GYW Scheme 4 – Support for people with dementia and mental health problems

Also attached are scheme level risk logs:

1. Connect East Ipswich
2. Connect Sudbury
3. Waveney Integrated Care schemes

Scheme ref no.
Scheme 1 – IEWS
Scheme name
Proactive Care – Integrated Neighbourhood Teams
What is the strategic objective of this scheme?
To create an integrated locality health and care teams so that: • People manage their own health and social care with the right support when needed • Communities are easy and supportive places to live with a health or care need • The health and care system is coordinated and effective • Higher cost interventions are replaced where possible with lower cost interventions
Overview of the scheme
Integrated Neighbourhood Teams (INTs) are a key building block for the Connect Project which will see the implementation of the Health and Care model developed in 2014. The INT is a multi-agency team, committed to understanding the needs of local people so that it can ensure that services are well co-ordinated around their needs. The ambition is to include a wide range of partners and services, for example, officers assessing and delivering Disabled Facilities Grants working closely with NHS and social care Occupational Therapists, volunteers from local community groups working closely with District Nurses and Social Workers. These multi-agency teams are identifying those patients and customers who have the most complex health or social care service needs, and working together to ensure care and treatment is

anticipated as far as possible, planned and fully co-ordinated across all the agencies involved. The INT will include a core range of generalist services from community health, adult social care, primary care and mental health.

The INTs will enable self-management, support individuals to maintain their independence, support admission prevention activity, support effective hospital discharge and provide an integrated approach to end of life care.

The INTs work to co-ordinate procedures & referral protocols and will provide an uncomplicated access route in for patients, customers and carers alike. There has been a good level of engagement with all operational teams in both Connect pilot areas to support the development of this work programme.

This benefits to local people of this joined up approach is that they will have:

- A simpler route to the support they need.
- Are better informed about what they need and how to get it
- Will have greater control over their lives and treatment

The INT work to date has focused around three key areas:

- Team development e.g. workforce shadowing, lunch and learns, INT directory
- Joining up planning and operational processes e.g. shared care and support plans, referral management
- Co-location of teams and services and hot-desking

The approach for wider roll out of the INTs will be informed by development of an INT checklist focused around key areas of delivery as informed by the learning of the pilot sites.
The checklist will be used by the local INT as a tool to support self- assessment and project planning and to measure success and delivery.

The development of INTs has been driven by multi-agency project groups, which have involved health and care staff, as well as representatives from the police, voluntary and community sector, district and borough councils and Public Health.

Governance for the programme is through the Suffolk Commissioners Group, whilst the practical oversight is through the Health, Care and Safety Joint Commissioning Group. Both of these groups meet on a regular basis and review progress on delivery of the Health and Care model.

Review of progress to date

In 2015/16 the following progress was made:

- Early adopter sites – known as Connect Sudbury and Connect East Ipswich – established to test how the Health and Care model would be implemented in practice
- Connect Sudbury collocated NHS and Adult and Community Services social care staff within the newly opened Health Centre
- A site was identified and commissioned for the Connect East Ipswich Integrated

Neighbourhood Team and work started on building that team

- Workforce development plans included on the ground lunch and learn discussions with the INTs, as well as work shadowing, Big Think strategic sessions and the adoption of shared principles for integrated working
- Evaluation framework developed – being tested

The evidence base

This is a continuation of the scheme 1 in the 2015/16 BCF Plan and the evidence base remains the same.

Scheme ref no.

Scheme 2 - IEWS

Scheme name

Reactive Care 1 – Integrated 24/7 urgent care response

What is the strategic objective of this scheme?

To create an integrated physical health, mental health and care response to people who require **short term intensive support** to :

- Manage them out of a health or care crisis situation, keeping them at home away from acute hospital emergency admission
- Prevent a long hospital stay through the delivery of discharge to assess pathways
- Stabilise an individual's condition before transfer to proactive care

Overview of the scheme

Reactive Care 1 is a key building block for the Connect Project which will see the implementation of the Health and Care model developed in 2014. It supports proactive care delivery by the Integrated Neighbourhood Teams and is seen as a care continuum for managing our complex high demand local population.

Reactive Care 1 will develop a multi-agency team, committed to understanding the needs of local people so that it can ensure that services are well co-ordinated around their needs. The skill mix of the team ensures that the range of presenting conditions and complaints can be managed through a singular response reducing handoffs to other organisations. It is the aim of Reactive Care 1 that from the patients and referrer perspective the service is seen as a single cohesive response; though provision is made up of a number of services provided by partner organisations.

Reactive Care 1 provides a 24/7, single access response supported by clinical triage. A response is agreed within the referrer and delivered within 2 hours from referral. Key to the right response being provided is the information provided in the patients shared care and support plan which is produced in partnership with the Integrated Neighbourhood Team (if not already in place) which ensures the patient/ client receives the appropriate care first time.

Underpinning the delivery model of the team is a focus on reablement and self-management, supporting individuals to regain their independence where this is possible.

This benefits to local people of this joined up approach is that they will have:

- A simpler route to the support they need
- Are better informed about what they need and how to get it
- Will have greater control over their lives and treatment

The Reactive Care 1 work to date has focussed on the following key areas:

- Implementation of shared care and support plans which include urgent care plans which are shared as special patient notes with the ambulance and GP out of hours services
- Team development – implementation of generic skills set so that every member of the team can assess and treat holistically
- Joining up planning and operational processes e.g. shared care and support plans, data sharing and collection
- Co-location of the team

The approach will be under review in 2016/17 to extend the level of response to include other services such as medical support.

Governance for the Connect programme is through the Suffolk Commissioners Group, whilst the practical oversight is through the Health, Care and Safety Joint Commissioning Group. Both of these groups meet on a regular basis and review progress on delivery of the Health and Care model.

Review of progress to date

In 2015/16 the following progress was made:

- Implementation of the core reactive care response in the community bring physical and mental health and care into a single team
- Implementation of the shared care and support plans
- Implementation of generic workers
- Single point of access and clinical triage
- Evaluation framework developed

The evidence base

This is a continuation of the scheme 2 in the 2015/16 BCF Plan and the evidence base remains the same.

Scheme ref no.
Scheme 1 - GYW
Scheme name
Supporting independence by provision of community based support interventions
What is the strategic objective of this scheme?
To deliver community based support interventions, in partnership with the Voluntary and Community Sector to deliver holistic packages of support to individuals to help support and manage their wellbeing. Effective community based support interventions, should enable and support people to maintain or regain their independence. The aim is to help prevent people's needs from escalating and requiring further health and social care interventions.
Overview of the scheme
There are a number of activities that have been identified to support the objective of this scheme. This activity covers three key areas, which include; • Accessing and use of community resources – developed through interventions such as Social Prescribing (see below), or community based services which effectively sign post to community resources. • Supporting the development of voluntary and community resources – ensuring that the voluntary and community sector are supported effectively to develop the necessary community resources. A key element is working with the community to enable them to resilience and solutions to respond to identified need. • Commissioning community based interventions – where need has been identified, and where appropriate, for services/ interventions to be directly commissioned by health and social care.
Review of progress to date
While the Scheme name remains consistent with 2015/16, the activity within it has been updated for 2016/17. A comprehensive evaluation of the schemes revealed that whilst individual work streams should continue to remain live for the CCG the ambitions for BCF required more transformative pieces of work. Key progress during 2015/16 was made in the following areas: • Development of combined service specification for Great Yarmouth and Waveney Adult Social Care and NHS Continuing Health Care universal domiciliary care provision • Deployment of additional nursing resource to support NHS Continuing Health Care, fast track end of life provision • Launch of Aging Well community based support intervention in Lowestoft including

establishment of community navigators

The evidence base

This includes;

Community based support interventions, Self-care & self-management - Patient self-management seems to be beneficial for patients with COPD and asthma. The Cochrane reviews concluded that education with self-management reduced unplanned hospital admissions in adults with asthma, and in chronic obstructive pulmonary disease COPD patients but not in children with asthma. There is evidence for the role of education in reducing unplanned hospital admissions in heart failure patients.

There is some evidence that demonstrates that investment in learning for older people can reduce the costs of medical and social care and improve the quality of life for older people, their families and communities (NIACE, 2010).

Carer Support Services - A systematic review and meta-analysis of cognitive re-framing for carers of people with dementia showed beneficial effects over usual care for carer mental health.

A report assessing the effectiveness and cost-effectiveness of support and services to informal carers of older people by the audit commission in 2004 showed that Day care, Home/help care and Institutional respite care (but not in all cases) may lead to delayed admissions to institutional care (and may be cost-effective).

Respite Care - A report for the Princess Royal Trust for Carers and Crossroads Care (2011) states that investing in respite care results in savings resulting from reduced costs to health and social care: spending more on breaks, training, information, advice and emotional support for carers reduces overall spending on care by more than £1bn per annum, as a result of reductions in unwanted (re)admissions, delayed discharges and residential care stays.

A focused review of the UK literature by the Audit commission looked at the effectiveness and cost effectiveness of respite care of older adults (60+ or 65+) and included cost effectiveness studies from the US literature. Day care, home help/care, institutional respite care and social work/counselling were found to be effective and/or cost-effective for carers in terms of one or more of the outcomes in improving carer welfare and delaying admission to institutional care.

The following evidence base is focused on the research done into Social Prescribing.

Systematic research into SP initiatives is limited and the strongest support for it is qualitative in nature. Due to the variety of initiatives it is also difficult to make comparisons between them (Kimberlee 2013) Branding and House (2009) also note that due to the complexity of the interventions it is very difficult to evaluate the impact of Social Prescribing through research on measuring hard outcomes.

Grant et al (2000) carried out a randomised controlled trial and economic evaluation of such an initiative which took place across 26 GP practices in Avon, comparing patients with psychosocial

problems who were referred to the Amalthea project (a liaison organisation between primary care and a voluntary organisation) and patients receiving routine GP care. They concluded that referral to SP initiative resulted in clinically important benefits such as significantly greater improvements in anxiety, other emotional feelings, ability to carry out everyday activities, feelings about general health and quality of life. Dayson et al (2013) suggests that 18-24 months should be allowed for real changes to be identified including associated costs to commissioning. (6)

The Rotherham Social Prescribing pilot and Age UK Kensington and Chelsea Primary Care Navigator Service have reported outcomes on health services in their evaluations. Their conclusions include the following observations:

1. The CCG, GP practices and the wider NHS benefit from the opportunity to refer patients with LTCs to community based services that complement traditional medical interventions. The pilot provides GPs with a gateway to these services and wider VCS provision. There are a number of signs that these interventions could help reduce demand on costly hospital episodes in the longer term.
2. Other public sector bodies, particularly local authority public health and social care, benefit from additional services that can be accessed by people with complex needs. Wider preventative benefits are likely to emerge over a longer period. There are strong links between the pilot's achievements and the borough's Health and Well-being Strategy.
3. People with LTCs and their carers benefit from an alternative approach to support. There is evidence that social prescribing clients are becoming more independent, have experienced a range of positive outcomes associated with their health and well-being, and are becoming less socially isolated.
4. Funded VCS providers have benefited from the opportunity to broaden and diversify their provision for people with complex needs. It has enabled a number of smaller community level providers to engage with health commissioning for the first time, whilst enabling more established providers to test the effectiveness of new and innovative types of provision.

This potential is increasingly being recognised across the country and there are numerous examples of SP initiatives being set up recently including Luton and Derby.

Marioka et al (2013) putting forward the NESTA Business Case for People Powered Health predict savings of 7% to an average clinical commissioning group based on NHS Level A standards of evidence. However, they suggest this is conservative with the median of all evidence considered suggesting potential savings of 20%. The 7% estimate of savings are predicted to result from reducing expenditure on A&E attendances, planned and unplanned admissions and outpatients admissions and are based on evidence cited by Marioka et al (2013).

Scheme ref no.
GYW2
Scheme name
Integrated Community Health and Social Care Teams including Out of Hospital Team
What is the strategic objective of this scheme?
To continue to develop integrated community health services and the Out of Hospital team to contribute towards the delivery of joined up and quality care. This scheme is very much focused on the delivery of commissioned out of hospital services, in line with the new national condition detailed in the Better Care Fund 2016/17 policy framework. This is focused on enabling GYW CCG to achieve its strategic objectives of: • Care closer to home • Integrated service provision • Reduction in emergency admissions to acute beds Activity will be focused on two main arears for delivery; *Most Capable Provider* We are confident that by 2018/19 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/borough services, from a cohesive integrated care system (ICS). The above excerpt from the Shape of the System Business Case is reflected in one way or another throughout NHSGYWCCG strategic documents which describe moving ever closer to an integrated care system (commissioner and provider). Integral to this is the further implementation of Out of Hospital Teams and associated services, and the optimisation of the acute and community hospital bed base so that care at home becomes increasingly the norm, with care in hospital only used when other means are impossible. *Out of Hospital Team (OHT) Great Yarmouth and Waveney* Continued development of the OHT building on the success of this service in 2015/16. This will continue to contribute towards the aim to provide care at home whenever it is safe, sensible and affordable to do so. The care will be organised around the patient, focusing on individual need and empowering independence.
Overview of the scheme
Most Capable Provider These aspirations are well known to our local providers having been discussed at length through the System Leadership Partnership and featuring in the CCG's commissioning intentions over the past two years.

To this end we will be, in conjunction with NEL CSU, embarking on a process to establish the Most Capable Provider to deliver care and support which is more integrated, better coordinated and sustainable across the locality, with an emphasis on support in the community.

The output from the process will be a new contract with a prime supplier. There will be a 5 year + 2 year commitment for the provision of the required service bundles under an agreed commercial model. There will be a requirement to evidence the cost and service delivery efficiencies gained by the provision of an integrated service model.

The services have been chosen as they are considered to have most impact on the ability to deliver the outcomes and will be greatly improved if the management of the services is streamlined. They are all services which impact on admission prevention and facilitating early discharge and when linked to better patient flow and bed management, will prevent unnecessary admissions to the acute unit and ensure patients are cared for in the most appropriate place. The ability to manage beds across the patch – acute, community, intermediate, beds with care – will improve more appropriate utilisation of available beds.
We also wish to see innovative ideas to utilise our scarce senior professional resource (health and social care) flexibly and for that to include support to primary care.

Out of Hospital Team
The Out of Hospital Team (OHT) is an inter disciplinary team of health and social care professionals for whom the objective of its service is to provide care at home whenever it is safe, sensible and affordable to do so. The care the team provides is organised around the patient, focusing on individual need and empowering independence. The team offers intensive, short term care, reducing as the patient regains health and independence. Care is holistic, co-ordinated, and responsive and goal focused, using a case management approach.

The OHT is made up of key health and social care professionals supported by workers able to perform many types of basic nursing, therapeutic and personal care tasks.

Referrals to the OHT will be accepted for patients registered with a GP. Referrals can be made by any health or social care worker. Patients referred to the service must be 18 years of age and over.

Referrals are only accepted for housebound patients or those who are only able to leave their place of usual residence with substantial support; irrespective of whether the patient, when medically fit, is normally ambulant. Referrals for ambulant, self-caring patients with capacity will not be accepted by the OHT.

Referrals are immediately and automatically directed to the Out of Hospital integrated Triage Team.

Referrals must be for patients for whom it is considered input from the OHT will be of benefit.

Referrals could, for example, include:

- Patients experiencing an acute exacerbation of their Long Term Condition
- Patients experiencing acute symptoms due to chest infection or urinary tract infection
- Patients whose mobilisation has suddenly reduced or is rapidly deteriorating
- Patients for whom the current care package is no longer robust enough and urgent review and amendment is required to prevent a breakdown of carer support
- Patients requiring a supported hospital discharge to their usual place of residence
- Patients presenting at Accident and Emergency who do not require an emergency admission but do require additional short term support to enable them to return home
- Patients who require a short term placement in a bed with care
- Palliative and End of Life patients requiring short term input for example following a fall or an infection

Review of progress to date

Progress to date has included the following;

- The development of South Waveney Out of Hospital Team model following the successful implementation in Lowestoft.
- The Shape of the System consultation made recommendations that will be used to inform the design of the service
- There has been a Cost Benefit Analysis developed that enables system providers to measure the impact of this service going forward. This formula is likely to be used to determine the viability of future projects

The evidence base

This is a continuation of the scheme 2 in the 2015/16 BCF Plan and the evidence base remains the same.

Scheme ref no.

Scheme 3 – GYW

Scheme name

Care at Home

What is the strategic objective of this scheme?

This scheme focuses on the delivery of services and models of support that keep people independent and well for longer, and where possible, regain skills that will prevent, reduce, and delay additional care and support.

This is a key element of the Local Authority strategic aims in their Supporting Lives Connecting Communities transformation programme.

Overview of the scheme

There are a number of activities that have been identified to support the objective of this scheme

including;

Delivery of new models of Home Support

Norfolk and Suffolk County Council and Great Yarmouth and Waveney Clinical Commissioning Group are working towards a jointly commissioned Home Support Service that is focussed on increasing/maintaining independence and on delivering better outcomes in health and social care for our Clients.

Home Support is the delivery of an agreed package of care for adults in their own homes, who have been assessed as having a social care or primary health need, which has arisen as a result of a physical or mental impairment or illness.

This new model addresses the Council's statutory duties as outlined in the Care Act 2014, and the CCGs statutory duties under the National Framework for Continuing Healthcare Services and NHS Funded Nursing Care (2012) through adopting an outcomes-based approach and characterised by the ability to empower local Clients/Carers through activities that promote wellbeing through preventing, reducing or delaying the need for care and support. The Service will promote and encourage Clients to maintain and/or maximise their independence.

Integrated EOL / Palliative Care

Activity will also focus on developing an integrated palliative and end of life care service to provide high quality and consistent palliative care in the patient's preferred place of care. It is crucial that there is co-ordination of a range of flexible health and/or social care packages to support further patients to die within the home care setting; offering a timely and co-ordinated response to crises and ensuring effective information sharing with partner organisations, patients and carers.

Equipment in the home

When people's independence is at risk, it is crucial that they have the right support to restore their wellbeing or at least to minimise their dependency. For example, when someone's mobility is deteriorating ensuring that their home is adapted or getting advice about coping with the early stages of dementia to allow someone to keep living safely at home. Equipment, adaptations and assistive technology can play a crucial part in helping people to manage at home and live independently.

Reablement services

Develop targeted reablement approaches and services that aid the discharge of adults from hospital into the community. This reduces demand for further formal packages of care and supports the implementation of strengths based assessments to identify people's potential for independence.

Rapid/ Crisis response

Develop a clear rapid/ crisis response offer across Great Yarmouth and Waveney which successfully reduces avoidable admissions and supports people appropriately at home. Identify

gaps and opportunities to co-ordinate or commission services needed.

Review of progress to date

While the Scheme name remains consistent with 2015/16, the activity within it has been updated for 2016/17. A comprehensive evaluation of the schemes revealed that whilst individual work streams should continue to remain live for the CCG, the ambitions for BCF required more transformative pieces of work.

Despite this progress was made in the following areas;

- Co-production of Urgent Care Operational Dashboard including; 111, Out of Hours, Ambulance, Community, A&E Attendance and Emergency Admissions with the aim of sharing system information
- Development of Great Yarmouth and Waveney Integrated System Resilience Plan

The evidence base

Care Act 2014

Key drivers of change are the legal duties under the Care Act 2014. They require councils to promote individual wellbeing, to prevent the need for care and support, and where care and support is required to reduce or delay the need for it.

Reablement Services - The evidence base for reablement services is limited by a lack of robust studies. However, there is evidence that reablement can reduce on-going homecare costs to social care. The results showed a reduced use of home care services over time associated with median cost savings per person of approximately AU $12,500 over nearly 5 years when compared with individuals who had received a conventional home care service.

Glendinning et al (2010) showed that there is a 60% reduction in social care costs for those receiving reablement.

Physical Rehabilitation - A Cochrane review of 67 trials, involving 6300 participants showed that physical rehabilitation for long-term care residents may be effective, reducing disability with few adverse events, but effects appear quite small and may not be applicable to all residents. There is insufficient evidence to reach conclusions about improvement sustainability, cost-effectiveness, or which interventions are most appropriate.

Risk Stratification - Statistical models can be used to identify or predict individuals who are at high risk of future hospital admissions in order to target care to prevent emergency admissions. The evaluation of predictive modelling options suggests including GP data in predictive modelling is particularly important, and including all patients in an area rather than just those with prior hospital use was found to improve case-finding. It also suggests using an 'impactability model' to identify high risk patients who are most likely to benefit from preventive care.

Assistive Technology – Tele Health - Tele health is effective in reducing hospital admissions in people with chronic heart failure (meta-analysis of 11 randomised controlled trials showed a significant 21% reduction in hospital admissions in this group of patients.

In addition, the results of a meta-analysis study support the use of telephone-delivered CBT as a tool for improving health in people with chronic illness.

Assistive Technology – Tele Care - Tele care and Falls prevention: There is some evidence from a longitudinal prospective cohort study that a light path plus tele-assistance reduced falls and significantly reduced post-fall hospitalisation.

Tele care and Dementia Care: The British psychological Society (2007) recommends that dementia care plans should include environmental modifications to aid independent functioning.

Two case studies are highlighted below that show the effectiveness of tele care. This is low quality evidence and must be interpreted with caution. Evidence from evaluation of tele care provision in Essex and impact for social care found that for every £1 spent on tele care, £3.82 was saved in traditional care. Tele care in North Yorkshire project evaluation estimates one year savings in care packages of £1 million.

Home Improvement Interventions - There is a range of evidence demonstrating the resultant cost benefits of home repairs, adaptations and hospital discharge housing related help in the Fit for Living Network. This showed that for every £1 spent on handyperson services (which provide fast, low cost help with adaptations and repairs), £1.70 was saved, the majority to social services, health and the police; hospital discharge schemes offering housing help to speed up patient release save local government social care budgets at least £120 a day.

An analysis by Care and Repair Cymru of the outcomes of their Rapid Response Adaptations programmes identified that every £1 spent generated £7.50 cost savings to the NHS. These savings were associated with speeded up hospital discharge, prevention of people going into hospital and prevention of accidents and falls in the home providing an adaptation in a timely fashion can reduce social care costs by up to £4,000 a year.

The cost effectiveness of Home adaptations – a report by The University of Bristol based on a review of case studies revealed:

- Adaptations to the home can reduce the need for Homecare daily visits. In the cases reviewed – between £1,200 and £29,000 saved per year
- Savings in home care costs by home adaptations mainly found in younger disabled people. In older people adaptations are found through prevention of accidents or deferring admission to residential care and improved quality of life
- Home adaptations can reduce the need for residential care in disabled people
- Findings on the impact of adaptations include 70% increased feelings of safety and an increase of 6.2 points on the SF 36 scores for mental health
- Home adaptations that improve the environment for visually impaired people leads to savings through prevention of falls.
- The provision of adaptations and equipment can save money by speeding hospital discharge and preventing hospital admission
- Audit commission stresses effectiveness and value of investment in equipment and

adaptation to prevent unnecessary and wasteful health costs

- Adaptations give support to carers and avoid health care costs for strain and injury

Palliative care – local evidence

- Public health mapping: In July 2013 Public Health Norfolk published the following findings re the palliative care needs of the population of Great Yarmouth and Waveney:
- The number of expected deaths per annum in Great Yarmouth and Waveney is approximately 2,000 patients per annum (Marie Curie EOL Atlas 2010/11), so over 2 years the commissioners (the CCG, and Norfolk and Suffolk County councils) would expect that approximately 80% of these 4,000 patients and their carers would need support from health and social care services.
- Some of the wards in Great Yarmouth and Waveney are amongst the most deprived in England with 27% of the population of Great Yarmouth living in the most deprived postcode areas in the country. This leads to a significant incidence of life limiting illnesses associated with lifestyle issues e.g. cancer, chronic respiratory disease and heart disease. Dementia as a co-morbidity is also an issue in relation to an increasing need for palliative and end of life care services to 2025. This work also shows that 54% of local patients die in hospital, despite their preference being for receiving care in their home care setting (62% EOE wide).
- The development of services in or closer to home will in particular support the needs of the elderly population who are more likely to experience rural isolation and difficulty in accessing services.
- Palliative Care Skills Audit (Norfolk & Suffolk Palliative Care Academy and UEA 2013): The Academy carried out a skills audit with the UEA in 2013 which showed that 63% of staff asked were providing palliative care but had not received any training in the last 3 years to do so.
- Marie Curie Delivering Choice Programme: The Marie Curie Delivering Choice Programme showed a significant variation in the quality of end of life care and also showed a need to improve the education and training for generalist staff providing palliative and end of life care (Marie Curie Delivering Choice Phase 3 report 2011).
- How We Manage Death and Dying in Norfolk (Norfolk County Council and Norfolk and Waveney Cancer Network 2005): showed a significant variation in the quality of local palliative care services.

Scheme ref no.
Scheme 4 – GYW
Scheme name
Support for people with dementia and mental health problems
What is the strategic objective of this scheme?
To deliver specialist support to people with dementia and their cares to avoid/delay admissions to hospital/care and provide assessment of on-going care needs.

Overview of the scheme

Activity within this scheme will cover the following key areas;

- Information advice and advocacy services (including Dementia Advisors)
- Effective, timely and accessible information, advice and advocacy is critical in enabling people to make well informed decisions. It is a core element of the provision of support which helps people manage long term conditions and prevents or delays the need for higher costs, more formal care interventions.
- Dementia Advisors based within community mental health teams can take referrals of people with a new diagnosis of dementia. The support is about helping people to understand the dementia diagnosis including providing information about the impacts and course of the illness.
- Targeted dementia services:
    - Flexible Dementia Service - that enables people with dementia, who are in crisis or potential crisis situations, to remain in, or return to, their homes, which will help prevent inappropriate admissions to acute services, unnecessary admissions to residential/nursing care and avoid Delayed Transfers of Care. This will include giving Family Carers support, advice and guidance in continuing their caring role.
    - Dementia Intensive Support Team - Dementia Intensive Support Teams (DIST) will provide services in the community and in-reach into to acute hospitals to aid safe and early discharge. Service provided daily (7 days per week) 08:00 to 21:00.

Review of progress to date

Progress to date includes the following;

- Improvement in Diagnoses rates for dementia due to local actions being implemented
- New project being implemented on targeting those with LTC and pain management
- Well-being service commencing in Sept 2015
- Enhanced Crisis-Resolution team and Acute Psychiatric Liaison service in place
- All individuals who access Mental health service will have a crisis plan and a named care co-ordinator

The evidence base

This is a continuation of the scheme 4 in the 2015/16 BCF Plan and the evidence base remains the same.

Waveney BCF Risk Log

Ref	Date	Scheme number	Risk	Initial Risk Score	Actions in Place	Current Risk Score	Target Risk Score	Progress Update	Project Manager Responsible	Open/ Closed
1	Dec-15	Savings/ Risk Share	**Significant budget pressures / risks to both NCC and CCG if savings not achieved to fund the identified BCF schemes**	15	Close monitoring required and mitigating actions put in place as required	20	2	Agreed that savings would not be achieved and cost pressure esaclated within the CCG and Local Authorities	Chris Scott/ Bob Purser	Closed
2	Dec-15	7 day services	**Current funding of Social Work team at the James Paget University Hospital is only temporay and available until the end of July. If no sustainable funding can be approved, then this weekend service will be unable to continue**	15	Business Case required tro be presented that clealry outlines activity happening at the weekend and how this is supporting timely discharge of patients	15	2	Meeting held with Social Work team and data requirements agreed. Resource identified to work with Social Work team to collate data, complete analysis and present Business Case	Clare Angel	Open
2	Jan-16	Scheme 2	**Unable to establish clear impact of Out Of Hospital Team to support future development of this servrice**	16	Cost Benefit Analysis tool developed using Treasury approved New Economy Model developed by Manchester University. This has reported clear benefits achieved through this model to both health and social care. Findings presented to BCF Partnership Board in March 16.	9	4	BCF Partnership Board agreed that this tool should be validated. Agreed this validation would be led by the PMO function and reported to the BCF Partnership Board. This validation will also explore the potential uses of this tool in other services to establish cost benefits analysis	PMO	Open
3	Jan-16	Scheme 3	**Delay in Home Support procurement/ re-commissioning for Waveney could result in different types of service being delivered across Great Yarmouth and Waveney**	6	Await outcome of review of roll out of Home Support procurement for the Waveney area. Once timeline is established consider interim arrangements that could be put in place to ensure equitable delivery of this model across the CCG area	6	2	Await outcome of review	Bob Purser	Open
4	Jan-16	Scheme 3	**The re-commissioning of the block contracts for Home Support included an expectation that providers will be approached as the 'preferred provider' for Continuing Health Care universal packages of care at the block rates quoted for social care. Risk that providers will not be able to deliver against this requirement or do not want to due to the lower houlry rate paid for social care packages. Impact is no cost savings realised or improvements to the patient/ service user pathway between health and social care**	16	Briefing session with providers to discuss this key point for their feedback. Ensure robust contract monitoring and management in place to identify areas for discussion with providers	16	6	Briefing sessions held with providers, jointly delivered by Head of CHC and Head of Integrated Commissioning which were well received. Process for effective performance management put in place to ensure we are able to identify where this is happening.	Chris Scott/ Dawn Newman	Open
5	Feb-16	Scheme 4	**Funding for Dementia Advisors for Great Yarmouth area not yet approved**	12	Business Case to be completed and decision by HEX required	12	1	Paper has been drafted and needs to be finalised. To be added to HEX agenda for required decision making	Kim Arber	Open
6	Feb-16	Scheme 4	**Identified that there is a lack of activtiy data for the jointly funded (CCG and Local Authority) Information, Advice and Advocacy services being received by the CCG. Ageed if this continues will be unable to continue to justify funding this service**	15	Commissioning to establish reporting loop between Norfolk County Council and CCG	15	1	Awaiting apointment of Commissioning Support Officer in the Integrated Commissioning Team sp resource can be made available to take this forward	Chris Scott	Open
7	Apr-16	Scheme 1	**Equitable service delivery across Great Yarmouth and Waveney. This is influenced by the funding that the district/ borough councils access and/ or provide to support the development of community resources**	9	Ensure that any funding provided for services by the CCG and/ or Local Authority delivery against agreed strategic principles for community development across Great Yarmouth and Waveney	9	4	Nicole Rickard (Head of Communities) who works in a joint post funded by the CCG and Waveney District Council is involved in the development of the furture support offer to develop community resources within Great Yarmouth	Chris Scott/ Bob Purser	Open
8	Apr-16	Scheme 1	**Lack of awarness of community resources that current exist that support the prevention agenda. This couold result in a lack of being able to support and sign post service users effectively to community resources that are available, impacting on the successful implementation of Community Clinics and Social Prescribing**	12	Within Great Yarmouth, Asset mapping work has started to establish community assets that are available. Need to develop this approach across the whole of Great Yarmouth and Waveney, also need to link resources to depreviation data to inform how commissioners can support the furture development of community resources	12	4	Integrated Commissioning Team to attend presentation on asset mapping work completed by South Norfolk to establish best practice	Chris Scott	Open
9	Apr-16	Scheme 2	**Financial envelope insufficient for new service model/predicted increased demand and the costs associated with transformation. Failure to meet defined process deadlines triggers full procurement exercise.**	15	High quality data in relation to costs should enable discussions with CCG to develop service models to fit the available envelope. If the financial envelope cannot support the proposed service model then further dialogue with the CCG will be required around the next steps. Create plan with clearly defined deadlines, identify both key resources and critical path. Monitor progress once plan established.	12	6	Dialogue Negotiation Phase extended to end of May 2016. Service specification and Cost envelope to be drafted for Governing Body meeting July/August 2016. Contract Managers working to support JV on finalising service line costs.	Fran O'Driscoll	Open
10	Apr-16	N/a	**Resources required to complete data collation/ analysis required to develop market statement concerning commissioning intentions for Care Home market (by the CCG and Local Authorities) across Great Yarmouth and Waveney area**	8	Plan resources required with key people required to complete this work	8	2	Initail conversations held and work postponed until May until resource is available	Bob Purser	Open

Risk Matrix

Consequence (impact)	Likelihood				
	Rare 1	*Unlikely 2*	*Possible 3*	*Likely 4*	*almost certain 5*
Negligible 1	1	2	3	4	5
Minor - 2	2	4	6	8	10
Moderate- 3	3	6	9	12	15
Major - 4	4	8	12	16	20
Catastrophic- 5	5	10	15	20	25

Low risk	normal risks which can be managed by routine procedures, no injuries, low financial loss.
Moderate Risk	responsibility for assessment and action planning allocated to a named individual. Outcomes = first aid
Significant Risk	urgent senior management attention with action plan = significant injury, business interuption, high environmental implications, high financial loss and loss
High Risk	immediate action required by a Director = fatal risks, to life and business, catastrophic loss.

N.B. if controls are inadequate or uncertain, the current risk stays the same as the initial risk rating. If they are perceived as adequate, then the current risk is reduced.

change in status since last report		
→	same	No arrow first reporting of risk
↑	increased risk	Score shows previous reported score
↓	decreased risk	

Connect East Ipswich - RISK REGISTER

Project Title	**#REF!**
Project Reference	#REF!

Number of Risks By Category					
Extreme	**High**	**Moderate**	**Low**	**Closed**	**Total**
1	**6**			**16**	**23**

	Unique Ref. No.	Date Added (A)	Risk Identified (B)	Risk Owner (C)	Risk Response Strategy (D)	Response Strategy Description (E)	Response Owner (F)	Proximity (G)	Likelihood (H)	Consequence (I)	Risk Score	Actual Date Closed (J)	Date Last Reviewed (K)
1	R-01	01/01/14	True integration - different systems, different employers, different locations, which in turn create potential difficulties in communications within teams due to them working in different locations. (previously R01 and R02)	GM/ RB	Reduce	13/1/16 INT principles shared with local area managers on 13/1/16. They will cascade to local teams as part of wider roll out.	MC/Gme/ AT	>12 weeks	3	3	9		15/04/16

#	R-02	08/05/15	Non formation of the information hub and subsequent non development of the metrics so baseline data measures not in place Previously (R03 and R07)	Roy Elmer, Eve Moseley, Rachel Mabb	Reduce	11/2/16 Metrics agreed. Analyst post shortlisted and being interviewed on 15th Feb 2/3/16 - post appointed Closed		9-12 weeks	1	4	4	02/03/16	11/02/16
#	R-03	10/07/15	Limited professional/clinical resource to support roll out of integrated service model and associated organisational development and staff training and development requirements	GM/ Gme/ AT/ SF	Reduce	Closed	GM/ Gme/ AT/ SF		2	2	4	10/12/15	08/01/16
#	R-04	10/07/15	Limited or no availability of suitable property for co-located teams, and insufficient funding to support co-location of health and care teams as part of integrated service model	GM/ MC/Gme / AT	Reduce	11/2/16 Planning permission for change of use submitted.	GM/ MC/Gme/ AT	5-8 weeks	3	5	15		15/04/16

#	R-07	10/07/15	IT and digital cost, time and capability to resource integrated service model developments	GM/ MC/ NR/ JH	Reduce	13/1/16 IT project manager now fully involved in development. WiFi issues still not resolved (Bluebird Lodge and Ravenswood). Progress report being requested from Wendy Corness of ACS 2/3/16 - attended Clinical Information Assurance group (CIAC) and setting up an IT workstream for IT requirements for Sidegate Lane development 30/3/16 Presenting at next CIAC meeting and set up an IT working group for HWRC	Graham Hillson	>12 weeks	2	4	8		15/04/16
#	R-08	10/07/15	Some Information and data sharing protocols not in place to support new service model arrangements around data sharing	RB / GM	Reduce	Closed	RB / GM	>12 weeks	2	3	6	11/02/16	11/02/16
#	R-09	20/08/15	Workforce development lead in post until November 2015. No further funding identified	AL/FD	Reduce	Closed	AL/FD		1	1	1	05/11/15	11/02/16
#	R-10	28/08/15	Proposed shared care and support plan which is under development may	MC/AT/NR	Reduce	Closed	MC/AT/NR		1	1	1	27/11/15	27/11/15

		not ratified/ accepted and used by partner agencies										
#	R-11	06/10/15	Prevention and self care: Delivery partner, Livewell Suffolk has a number of key members of staff leaving before April 2016. New provider will be in place as from April 2016.	LB	Accept	Closed	LB	3-4 weeks	1	2	2	11/02/16	11/02/16
#	R-12	06/10/15	In order to progress the IRR plan, resource needs to be identified.	CB & BL	Reduce	11/2/16 Gillian Clarke to take paper to JCG with proposal to take programme forward 02/03/16 - will be absorbed within wider proactive work Closed	CB & BL	3-4 weeks	5	3	15	02/02/16	02/03/16
#	R-13	09/10/15	Current level of change and uncertainty for staff working within SCH is significant due to transition –further change being implemented may add to staff concerns	MC/GM	Reduce	Closed	AT	< 1 week	3	3	9	11/02/16	11/02/16
#	R-14	13/10/15	Capacity of front-line teams to be part of	RB/ NR/ GM	Reduce	Closed	RB/ NR/ GM	< 1 week	2	3	6	11/02/16	11/02/16

		the INT outcomes e.g. availability to attend lunch and learn sessions/ attend planning meetings etc										
#	R-15	08/05/15	Non or poor attendance by partner agencies at MDTs	GM/ LP		Closed	GM/ LP		2	2	4	28/08/15	28/08/15
#	R-16	10/07/15	Limited professional / clinical input into development of new and integrated service model and tools	GM	Accept	Closed	GM		2	3	6	28/08/15	28/08/15
#	R-17	10/07/15	Insufficient take up of work place shadowing initiative and other training and development schemes to support integration	GM	Reduce	Closed	GM		2	3	6	28/08/15	05/11/15
#	R-18	10/07/15	Limited Councillor, patient/customer and broader stakeholder engagement and input into project to shape deliverables	GM	Reduce	Closed	GM		2	3	6	28/08/15	03/03/15

#	R-19	03/11/15	Commissioing Implementation Manager (CCG MDT Lead) is leaving post, the post is currently out for recruitment, the replacement may have a knowledge gap	GM / RB	Accept	Once post is filled ensure Connect East Ipswich is part of post holders induction 2/3/16 - meeting arranged with new postholder to ensure continuded engagement and understanding of short and long term plans. Closed	GM / RB	9-12 weeks	5	2	10	03/03/16	03/03/16
#	R-20	03/11/15	There is no INT Lead as previous post holders portfolio has changed	GM / RB	Mitigate	Closed	CB / BL	1-2 weeks	5	3	15	11/02/16	11/03/16
#	R-21	03/11/15	Connect East Ipswich is a low priority for SCC CYP Team, meaning there has been limited engagement	GM / RB	Reduce	Closed	GM / RB	< 1 week	3	3	9	02/03/16	03/03/16
#	R-22	03/11/15	Neighbourhood Networks - no resource has been identified to progress pre-retirement planning work - Link to Frailty programme	CB & BL	Mitigate	Discussion at Suffolk Commissioners group to progress	CB / BL	5-8 weeks	4	3	12		15/04/16

#	R-23	11/02/16	Capacity of Connect Co-ordinating resource to roll out INTs in more than one local teams (plan for 7 more areas across Ipswich and East Suffolk)	GM	Mitigate	CCT to assess resource requirement and to raise JCG (link to R-24)	GM/ BL	3-4 weeks	3	3	9		15/04/16
#	R-24	11/02/16	Roll out of LAC to remainder of area - funding	GM	Mitigate	Scale-up numbers of LAC needed with projected costs with proposal to JCG 2/3/16 - with JCG for decision on TCA funding 'virtually' (meeting planned for 3/3/16 cancelled). Proposal and projected costs done. (link to R23) 30/3/16 - going to SCOLT (Suffolk Chief Officers Leadership Team) on 6/4/16	GM/RB	9-12 weeks	3	3	9		15/04/16
#	R-25	13/04/16	HWBC on hold until outcome of capital bid to NHS England and decision on progression of the project. If the project does not progress, the INT teams in East Ipswich will not be co-located.	GM	Mitigate	Ensure that INT development discussions include how non- colocated teams can operate effectively.	GM/RB	5-8 weeks	3	3	9		13/04/16

#													
	R-26												
	R-27												
	R-15												
	R-16												

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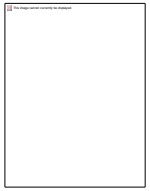

Date	Risk	Mitigating Action	RAG score (C x L) *Before mitigation*	RAG score (C x L) *After mitigation*	Current Status/RAG	Open / Closed
June 15	**Programme -** Information and data sharing protocols not in place to support new service model arrangements around data sharing.	• A protocol has now been developed and is being reviewed by the CCT and INT lead. And that it will be then be shared with SCC and CCG IG and IT leads for feedback. • Data sharing has been on-going across agencies prior to Connect work so there should be organisational preparedness in place.	12	9		Open
June 15	**INT** - Primary care engagement - concern at lack of engagement to date.	• Primary care invited to attend the various workshops and meetings, but only two practice managers have been able to attend. High demand main issue for GPs not being able to engage fully • Attempted to engage in other ways and going to GP clinical meetings to test concept especially in early stages • Siam has commenced MDT meetings • Revised approach for general practice interaction planned for 2016	12	8		Open
June 15	**INT** - Limited professional/clinical input into development of new	• Set up regular meetings with staff from participating agencies • Book location of meetings where staff work to	8	4		Open

Date	Risk	Mitigating Action	RAG score (C x L) *Before mitigation*	RAG score (C x L) *After mitigation*	Current Status/RAG	Open / Closed
	integrated service model and tools	maximise attendance • Give notice for meetings for professionals/clinicians to arrange back fill/cover • Involve staff in designing tools and piloting new approaches e.g. shared care planning				
June 15	**INT** - Limited professional/clinical resource to support roll out of integrated service model and associated organisational development and staff training and development requirements	• Phase roll out of service model aligned to available resource • Seek further resource to support roll out • Second staff to support roll out from participating organisations • Secure additional resource to support roll out	8	4		Open
June 15	**INT** - Insufficient take up of work place shadowing initiative and other training and development schemes to support integration	• Agencies to promote and market within respective organisations using current information communication tools e.g. newsletters • Present information about scheme at existing team meetings and as part of 1-1 meetings	4	2		Open
June 15	**Resource Hub** - failure to assign	• Significant progress made on identifying key metrics to support understanding on the Sudbury				Open

Date	Risk	Mitigating Action	RAG score (C x L) *Before mitigation*	RAG score (C x L) *After mitigation*	Current Status/RAG	Open / Closed
	appropriate resource to support the baseline data and associated analysis	landscape. Planning to fully agree metrics and analyse data are expected throughout November 15 • Specific resource to conduct this work is currently being recruited and will be hosted by SCC.	12	8		
June 15	**Resource Hub** - Resource not identified to support development of co-ordinated approach to setting baseline activity for new service model and monitoring impact of initiatives	• Lead identified from SCC for development of a co-ordinated data and information resource • Set up planning meetings with project leads and data information and analysis leads from different organisations • Agree project and service model outcome linked to metrics/KPIs • Report baseline against metrics/KPIs at start of pilots and monthly thereafter to monitor impact • Set up and record new data lines to monitor integrated service model	12	6		Open
June 15	**Access & Information** - IT and digital cost, time and capability to resource integrated service model developments	• Work streams to specify their IT and digital requirements • Discuss with IT and digital team what is possible and timescales linked to available project resource • Phase roll out of IT and digital initiatives in line with IT project resource	12	6		Open
~~**June 15**~~	~~**Access & Information** – HSCIC shared~~	~~• SCC lead linking closely with HSCIC and WSCCG IT representatives to ensure that a structured plan is agreed for implementation~~				**Closed Initiative not approved**

Date	Risk	Mitigating Action	RAG score (C x L) *Before mitigation*	RAG score (C x L) *After mitigation*	Current Status/RAG	Open / Closed
	~~summary care record implementation. Failure to engage staff and embed across the shared system across the relative teams~~					
June 15	**Comms and Engagement** - Limited Councillor, patient/customer and broader stakeholder engagement and input into project to shape deliverables	• Stakeholder and engagement strategy • Ask to present information about project at existing planned meetings e.g. Cllr Area Committees, patient involvement networks. • Regular briefings to stakeholders on project progress • Communicate a single contact e.g. generic email for project queries • Involve patients/customers in co-production activity • Think Big! Training and development sessions • Cllr visit 12 Nov 15 completed	8	6		Open
June 15	**IRR** - The current limited understanding in the system of how to maximise the outcomes achievable from the reablement	• Ensure a comprehensive plan is developed engaging all key stakeholders are informed and part of the process • Develop key messages and progress updates for release to stakeholders	8	6		Open

Date	Risk	Mitigating Action	RAG score (C x L) *Before mitigation*	RAG score (C x L) *After mitigation*	Current Status/RAG	Open / Closed
	and rehabilitation approaches					
Aug 15	**IRR** – Limited resource available to conduct full IRR development and implementation.	• IRR lead escalated to CCT for discussion at programme level • Plan to embed IRR in the INT approach. To be planned during Feb and March 2016.	12	12		Open
~~**Aug 15**~~	~~**NN** – Local Area Coordination roles may have their allocated funding recalled due to changes in how Care Act monies are allocated. This would result in the pilot being suspended pending alternative funding.~~	~~• Proposal to access pilot funding to be developed through the TCA funding – this has been approved~~ ~~• 1 x candidate appointed~~ ~~• 1 x vacancy, but plan in place to re-recruit~~	~~8~~	~~6~~		**Closed**
~~**Aug 15**~~	~~**NN** – The current Dementia Friendly Communities lead has resigned from the committee resulting in~~	~~• NN lead currently working to recruit new Sudbury based Chair for the steering group. The Chair and Treasurer standing down from the group is continuing to support progress until new appointment made.~~				**Closed – workstream risk**

Date	Risk	Mitigating Action	RAG score (C x L) *Before mitigation*	RAG score (C x L) *After mitigation*	Current Status/RAG	Open / Closed
	~~possible lack of progress for the group.~~					
~~**Aug 15**~~	~~**Prevention self-care model –** The proposed link worker model is designed to operate within the current service provider, but this contract only has 6 months remaining and they may not continue operating the service.~~	• ~~£100k has been agreed from TCA to develop wider workforce to offer self-care / prevention advice, support and interventions where required.~~ • ~~New provider in place from 1 April.~~	~~9~~	~~6~~		**Closed**
Sep 15	**Co-location – Sudbury Health Centre** - the lease has been agreed for 6 months but beyond that the rental needs to be negotiated. The rent has been significantly increased at the	• SCC reviewing the options in conjunction with system stakeholders • SCC continue to pursue with NHS property services	16	16		Open

Date	Risk	Mitigating Action	RAG score (C x L) *Before mitigation*	RAG score (C x L) *After mitigation*	Current Status/RAG	Open / Closed
	last minute (service charges costs not previously reported) and that would not be affordable for ACS beyond 6 months. Lack of response from NHS Property.					
Dec 15	**INT –** workstream lead transferred from central to local ownership – loss of pace and direction risk	• SCC has changed focus on INT leadership resulting in more localised ownership • Connect Coordinating Team is meeting with relevant managers to ensure sound handover of tasks and future requirements • Local INT leadership has been completed with SCC and SCH taking a joint lead.	12	9		Open

RAG Definition

Likelihood score (L) →	1: Rare	2: Unlikely	3: Possible	4: Likely	5: Almost Certain
Consequence (C) score ↓					
5: Catastrophic	5	10	15	20	25
4: Major	4	8	12	16	20
3: Moderate	3	6	9	12	15

2: Minor	2	4	6	8	10
1: Negligible	1	2	3	4	5