ANNEX A

# LEWISHAM ADULT INTEGRATED CARE PROGRAMME

## Better Care Fund planning template – Part 1

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
|---|---|
| Local Authority | **LB Lewisham** |
| | |
| Clinical Commissioning Groups | **Lewisham Clinical Commissioning Group** |
| | |
| Boundary Differences | **Boundaries are coterminous** |
| | |
| Date agreed at Health and Well-Being Board: | **Proposed areas of spend/activity agreed by HWB on 28 January 2014 Final sign off by HWB scheduled for 25 March 2014** |
| | |
| Date submitted: | |
| | |
| Minimum required value of ITF pooled budget: 2014/15 | **£1.140m** |
| 2015/16 | **£21.114m** |
| | |
| Total agreed value of pooled budget: 2014/15 | **£7.159m** |
| 2015/16 | **£21.843m** |

### b) Authorisation and signoff

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| **Signed on behalf of the Clinical Commissioning Group** | **Lewisham CCG** |
| **By** | **Martin Wilkinson** |
| **Position** | **Chief Officer NHS Lewisham Clinical Commissioning Group** |
| **Date** | |

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| **Signed on behalf of the Council** | **Lewisham** |
| **By** | **Aileen Buckton** |
| **Position** | **Executive Director for Community Services** |
| **Date** | |

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| **Signed on behalf of the Health and Wellbeing Board** | **Lewisham Health and Wellbeing Board** |
| **By Chair of Health and Wellbeing Board** | **Sir Steve Bullock** |
| **Date** | |

**c) Service provider engagement**

Lewisham's Adult Integrated Care Programme, to which BCF will align, builds on work undertaken within the borough since November 2011, when the Council, the CCG (in shadow form), the then PCT and Lewisham Healthcare Trust (the acute and community provider) agreed to develop and deliver an integrated health and social care model.

This work brought together teams of district nurses, all therapies, social workers and care workers, secured by a s75 agreement between the provider and the Council. Building on this, further integration took place through the establishment of multi-disciplinary teams to align with GP neighbourhood clusters.

Subsequently, members of the Health and Wellbeing Board, which includes provider membership, agreed to increase the scale and pace of integration - as set out in the Adult Integrated Care Programme Initiation Document and approved by the Board in November 2013 (see Annex A).

Lewisham and Greenwich NHS Trust and the South London and Maudsley NHS Foundation Trust sit on Lewisham's Adult Integrated Care Programme Board, which oversees the programme, and staff from each organisation contribute to the workstreams within the programme. Wider participation from health and care providers across Lewisham is taking place as detailed plans develop.

Community and voluntary sector providers have also been key to supporting Lewisham's community development plans and have benefited from £1m Council investment to support the development of new community based activities and opportunities to support residents across all four levels of Lewisham's integrated model.

**d) Patient, service user and public engagement**

In developing Lewisham's Health and Wellbeing Strategy, the CCG's Commissioning Strategy and Intentions, and the vision for the Adult Integrated Care Programme, we have been influenced by views expressed by local residents, including service users and their carers. The engagement has focused on gathering views to improve existing services and to identify key priorities and has taken place through workshops, a range of consultation meetings with service users and their carers, and through the Voluntary Sector's Health and Social Care Forum.

Two voluntary sector members sit on the Health and Wellbeing Board. To support the Board in its engagement and consultation activity, a Joint Public Engagement Group has been established which brings together representatives from the voluntary sector and Healthwatch, and officers from the CCG, Council and the acute trusts, to inform the

integrated care agenda.

Further engagement and consultation with patients, service users, the public and key stakeholders - such as the focus group with enablement service users scheduled for February - is taking place as plans develop.

In addition, workstreams will use a range of existing fora, such as Lewisham's Positive Ageing Council and Local Assemblies, to engage with the public more widely.

**e) Related documentation**

| Document or information title | Synopsis and links |
|---|---|
| **Lewisham Health and Wellbeing Strategy** | Published in September 2013. Based on the JSNA evidence the board has identified nine priority outcomes for health & wellbeing in Lewisham, which highlights the commitment to integrated working.<br><br>**http://www.lewisham.gov.uk/myservices/socialcare/health/improving-public-health/Pages/Health-and-wellbeing-strategy.aspx** |
| **Pioneer Bid** | Lewisham's expression of interest in becoming a Pioneer in health and social care integration outlining the history of integrated working in Lewisham and its plans to increase the scale and pace of integration.<br>  <br>Pioneerpaper - version final.doc |
| **Programme Initiation Document** | This document outlines the vision for integrated care, covering all adults in Lewisham. The PID provides more detail on the programme which seeks a step change in the way services are delivered, in patient experience and in performance and outcomes. |
| **Joint Strategic Needs Assessment** | An online information resource for everyone who commissions, provides or uses health, social or children's services in Lewisham. It also provides the evidence base for Lewisham's Joint Health & Wellbeing Strategy.<br><br>**http://www.lewishamjsna.org.uk/** |
| **A Local Health Plan for Lewisham - NHS Lewisham CCG's Commissioning Strategy 2013-18** | The strategy sets out the purpose, vision, and understanding of the health needs of Lewisham residents and the plans to improve their health and wellbeing. |

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| | **http://www.lewishamccg.nhs.uk/about/Our-Plans/Documents/Lewisham%20CCG%20Strategy%202013-18%20v2.pdf** |
| **CCG Commissioning Intentions 2014/15 and 2015/16** | The framework for commissioning local health services over the next two years.<br><br>**http://www.lewishamccg.nhs.uk/about/Our-Plans/Documents/Enc%2010%20Lewisham%20CCG%20Commissioning%20Intentions%202014-2016.pdf** |

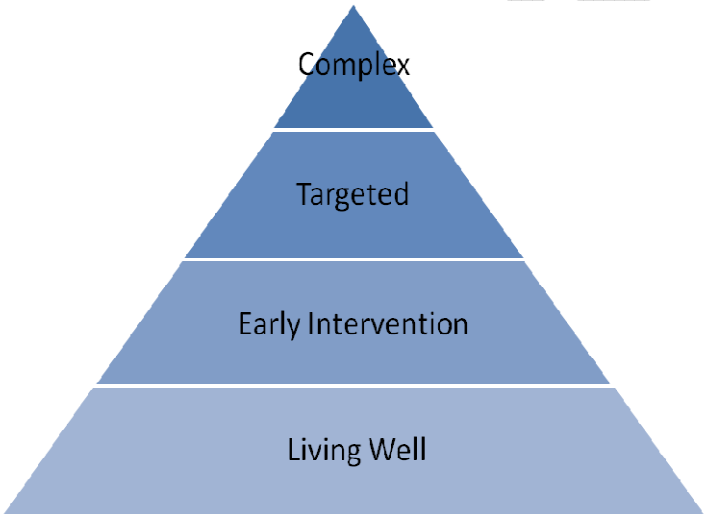
# 2) VISION AND SCHEMES

**Vision for health and care services**

Our vision " Better Health, Better Care, Stronger Communities" drives the pace and scale of the changes Lewisham wants to see in the way in which services are designed, commissioned and delivered to improve health and care and to reduce health inequalities.

Our integration work involves partners within Public Health, Adult Social Care, Lewisham and Greenwich NHS Trust, South London and Maudsley NHS Trust, the voluntary and community sector and Housing, amongst others. As mentioned above, our plans for integration build on work which has already taken place in aligning professionals at the point of first contact, integrating the Council's reablement and Lewisham and Greenwich NHS Trust's intermediate care team to create a single enablement team focusing on both admission avoidance and effective discharges, and establishing multi-disciplinary teams within GP neighbourhood clusters focusing on early intervention and planned support for those with long term conditions.

Our vision is designed to improve outcomes for all adults across the four levels of need shown below.




By using integrated resources to their best effect and by reconfiguring and reshaping the advice, support and care services provided across health and social care, our vision is for all adults in Lewisham, including patients, users and carers to experience:

Better Health, that will be delivered through

- Access to clear and high quality, personalised information
- Receipt of consistent messages and integrated campaigns which raise awareness and encourage people to take action themselves
- Effective advice and support (including advice on benefits entitlement) that promotes healthy living
- Effective advice and support for self-care

- Proactive and consistent management of health and wellbeing by professionals and voluntary sector workers
- Promoting services that sustain active lifestyles and promote wellbeing

Better Care, that will be delivered through

- Professional support to individuals and carers to enable them to exercise choice and control in relation to their health and wellbeing.
- Key pathways coordinated across health and social care e.g. dementia, falls
- A continuum of co-ordinated, flexible, innovative community based care to effectively support and maintain independence and rehabilitation including:
    - Rapid delivery and installation of equipment, technology and housing adaptations
    - Effective support within appropriate settings to enable people to recover quickly
    - 24/7 services that are able to respond quickly to unexpected deterioration and other health or care emergencies or crises
    - Intermediate care services to support a short or long term 'step up' in the level of support at home
- Professionals and voluntary sector workers having the knowledge and confidence to empower and signpost effectively
- A shared approach to care management across health and social care including
    - Shared tools for risk stratification to identify those most at risk
    - Systems and processes which enable safe sharing of information on individuals, so that individuals tell their story only once, through co-produced and jointly agreed single assessments, jointly produced and jointly resourced, and fully implemented care plans, single co-produced health and social care records, and single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible.

Stronger Communities, that will be delivered through:

- Stronger resilient community networks working effectively to support people to live well and stay healthy
- Strong community networks working effectively to identify and support individuals and carers that require additional help.
- Effective links to community and neighbourhood support e.g. social networks to maintain recovery and independence
- Activities and opportunities available locally to promote and support health and well being

**a) Aims and objectives**

Lewisham's Adult Integrated Care Programme has been established to deliver three key strategic objectives:

- Better Health - to make choosing healthy living easier;

- Better Care - to provide the most effective personalised care and support where

and when it is most needed;

- Stronger Communities - to build engaged, resilient and self-directing communities.

A robust Outcomes Framework of measures will be used to demonstrate the level of local ambition of the Adult Integrated Care Programme and to monitor our progress. This will be complemented by the wider Joint Strategic Needs Assessment (JSNA) and the monitoring of the Health and Wellbeing Strategy, which measure the overall health and wellbeing gains for Lewisham's population.

The programme's wider outcomes framework will include the BCF five national metrics and the local indicator on the quality of care for people with long term conditions.

**National Metrics**

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

**Local Metric**

- *Proportion of people feeling supported to manage their (long term) condition*

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**b) Description of planned changes**

The Better Care Fund will be aligned with other resources that have been identified to support the transformation of health and social care across the borough as set out in Lewisham's Adult Integrated Care Programme.

The integrated programme adopts a **population-based approach**, covering all adults in Lewisham. It includes the frail and vulnerable, older people, people with long term conditions and /or mental health problems, people with learning disabilities, carers, as well as the wider adult community. It does not include the under 18 population of Lewisham.

It is also a **whole system approach** covering most services and activities across the health and care sector, including public health. It embraces opportunities and flexibility that can be delivered through the voluntary, community and private sectors. It aligns with universal services such as Supporting People, housing, employment, adult education, culture and leisure.

Given the scale of the programme, a number of workstreams, each overseeing individual projects, have been established to take this work forward.

I. Providing high quality information and advice – involving the co-ordination of health and wellbeing campaigns; health promotion and self- help initiatives; and access to

information and signposting about services;

II. Supporting independence - the development of effective systems and processes for the identification of need and support, diagnosis and management, including enablement, telecare, and equipment, with a specific focus to support admission avoidance and hospital discharge;

III. Transforming care planning – the development of single assessments, including risk profiling, joint care plans, joint reviews, direct payments, personal budgets, personalised health budgets and the development of a single health and care record;

IV. Streamlining care pathways – the streamlining of key pathways across health and social care from initial contact to ongoing care eg dementia, falls, COPD, Heart Failure and Diabetes;

V. Inspiring the workforce – working with patients and local providers to develop new ways of working and culture and behaviour changes to proactively manage health and wellbeing;

VI. Maximising the potential of Information and Communication Technology (ICT) – involving a joint approach to collection, use and sharing information and joint care records;

VII. Building stronger communities – coordinated work to develop vibrant connected local communities and strong neighbourhood networks;

VIII. Creating excellent commissioning – to develop more innovative commissioning approaches and contractual models to support the transformation of services. This will include developing new ways of incentivising market development in the community; implementing transparent processes so that resources can move flexibly around the system and achieve system wide savings, whilst assuring quality and safety standards; creating the right commissioning environment to facilitate transformation change, rather than transactional change

IX. Securing wider partnerships - with an initial focus on the interface with housing and supported accommodation;

X. Managing the programme - including programme support; sources of programme funding; financial modelling and forecasting; risk management, programme consultations and communications.

**c) Implications for the acute sector**

The main provider of acute care services for the borough is Lewisham and Greenwich NHS Trust (which provides services at Lewisham hospital). The latest figures show that the majority of Lewisham CCG's acute spend is as follows:

- Lewisham and Greenwich Healthcare NHS Trust – 58% of the acute budget;
- King's College Hospital NHS Foundation Trust– 17%of the acute budget;
- Guy's and St Thomas's NHS Foundation Trust– 13% of the acute budget.

Lewisham and Greenwich NHS Trust is also Lewisham's community services provider and South London and Maudsley NHS Foundation Trust (SLaM) provides the majority of the borough's mental health services.

The implications for the acute sector in terms of reductions in planned commissioned activity, from a NHS perspective, are set out in Lewisham CCG's Commissioning Intentions 2014/15 and 2015/16 (December 2013) under the Quality Innovation Productivity and Prevention (QIPP) Programme which has been shared with our local acute, community and mental health providers as well as being debated with the public. This includes a planned reduction of over 15% in emergency admissions during 2014/15 and 2015/16.

A main objective of Lewisham's Adult Integrated Care Programme is to support the acute sector by reducing avoidable emergency admissions and attendances. The programme seeks to develop effective risk stratification tools and effective alternatives to admission to hospital, effectively managing those patients who are admitted and ensuring they stay no longer than is necessary.

If we are successful, funding for unplanned admissions to hospital, particularly for people who are 80 and over, will be reduced because people will not need to go to hospital in the same numbers as they do at the moment, and lengths of stay will be shorter.
The key challenges that face local commissioners and providers are:

- Ensuring the provision of high quality, safe care
    - through commissioned services that meet the appropriate quality standards and clinical outcomes, including working towards seven day a week services, which are monitored systematically through the commissioning Quality Assurance Framework
    - ensuring all people have a positive experience of care – people are treated with compassion, respect and dignity – whether at home, in hospital or in a care home - regardless of income, age, gender, ethnicity or any other characteristic
    - through the early identification of mistakes and that lessons learnt are shared quickly.

- Establishing a local workforce which works together in different ways and which empowers service users:
    - by developing innovative ways of working and embedding cultural and behavioural changes
    - by proactively working with residents so that they can manage their own health and wellbeing, with a greater focus on health prevention and self-care and by delivering planned interventions so that 'every contact with a professional counts'.

- Providing personalised co-ordinated care:
    - ensuring that care in and out of hospital remains personalised.

- Maximising the potential of Information and Communication Technology (ICT)

- by having a joint approach to the collection, use and sharing information and joint care records, including the implementation of the Virtual Patient Record (VPR).

- Reducing avoidable emergency admissions, outpatient attendances and A&E attendance and shifting resources towards the provision of community based care
- Risk sharing with providers – through the development of alternative contractual mechanisms for emergency acute and community services.

- Joint demand and capacity modelling of the health and social care system with providers through the Urgent Care network, to ensure appropriate levels of capacity are commissioned both within and outside the hospital.

- Improving productivity and efficiency.

- The acute hospital landscape changed significantly in 2013/14 as a result of the Secretary of State's decisions following the Trust Special Administrator report. For Lewisham the most significant change is the creation of the Lewisham and Greenwich NHS Trust. The new Trust has set out a challenging cost improvement plan (CIP) in its transaction business case. Commissioners in Lewisham are working with other commissioners in South east London on a strategic plan with a view to secure services that are sustainable in the medium to long term in terms of quality and finance across the whole economy of South east London. This includes the need for provider productivity improvements. Engagement on the SEL strategy has commenced over March and April on a draft case for change and emerging strategic opportunities. As part of developing a SEL strategy by June, BCFs across SEL will be factored into overall planning to assess impact on acute providers who cover more than one borough.

**d) Governance**

The following Boards ensure effective governance of Lewisham's adult integrated care programme:

- Health and Well Being Board
- Adult Integrated Care Programme Board (AICPB)
- Individual Project Boards for each workstream

The Health and Wellbeing Board is monitoring the progress of the programme. To ensure that the progress of each individual workstream is more regularly assessed, the Health and Wellbeing Board is supported by the Adult Integrated Care Programme Board (AICPB).

The AICPB sits alongside, and work closely with Lewisham's Health and Wellbeing Delivery Group which ensures progress against the Health and Wellbeing Strategy, the Adult Joint Strategic Commissioning Group and the Joint Public Engagement Group .

The AICPB will be accountable to the Health and Wellbeing Board for the delivery and evaluation of the Adult Integrated Care Programme. It has specific responsibility for overseeing the implementation, monitoring and evaluation of the programme and the

Better Care Fund plans.

# 3) NATIONAL CONDITIONS

### a) Protecting social care services

Lewisham's Adult Integrated Care Programme highlights the crucial role adult social care services will continue to play in ensuring that people receive the right care, at the right time, in the right place. As such the BCF will be used to maintain and, where necessary, enhance the adult social care services that contribute to the achievement of the integrated programme's objectives and desired outcomes.

Lewisham Council needs to make savings of £95m from its revenue budgets between 2014/15 and 2017/18. As the largest service area, adult social care will need to make a substantial contribution to this and has a provisional savings target of £25m over this period (against a base budget of £81m). Integrated working has already delivered efficiency savings and reshaped services. The BCF will play a key role in progressing this work further bringing additional efficiencies and cost effective working.

This includes protecting and delivering high quality, cost effective, flexible adult social care services that have a positive impact on maintaining people's independence, that reduce the need for ongoing intensive health or social care services, that provide effective personalised care and support - including end of life care - as and when needed, and that seek to reduce duplication and that maximise the best use of resources across the health and social care economy.

In terms of eligibility, Lewisham will continue to provide services to those assessed as having critical or substantial needs.

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

Much of the focus of the integrated programme, and therefore of the BCF, is on establishing better co-ordinated and planned care closer to home in the community, thus relieving pressure on acute services and reducing the use of emergency/crisis social care services.

The funding in 14/15 will be used to maintain and build on the social care elements of the integration work undertaken to date and to ensure that the necessary work has been undertaken in anticipation of the changes arising from the Care Bill, including those in relation to carers and self funders.

This includes :

Further developing the single point of access which provides information, guidance and advice and which acts as a gateway into social care services;

Continuing to provide social care resources for the multidisciplinary neighbourhood teams to co-ordinate preventative action and early intervention and to work holistically with those most at risk of deterioration or possible crisis, and with those who need on-going health and care services.

Maintaining social care investment in enablement, helping people to learn or relearn skills to maintain independence and thus reduce their need for ongoing packages of care.

Ensuring that appropriate care and support services can be put in place out of normal office hours and at weekends to avoid unnecessary hospital admissions and to facilitate timely discharges from hospital. This will include development of a Welcome Home Support Service.

The BCF will continue to support all those areas listed above and will be used in addition to further transform services, including addressing the requirements of the Care Bill, and achieve a significant reduction in unplanned admissions to hospital and in the number of patients remaining in hospital unnecessarily.

To achieve this detailed plans are being developed to reduce emergency admissions. These plans will enhance the work already in hand to develop a continuum of advice, support and care which will result in hospital admissions being avoided. These plans will seek to rebalance the overall health and social care spend by reducing the demand for acute and mental health beds thus releasing more resources and shifting those resources into meeting community and social care needs, including using appropriate contractual levers and risk sharing arrangements.

The Better Care Fund will also be used to further improve hospital discharge across health and social care, to expand extra care and rehabilitation facilities and in enabling people's health and care needs to be met wherever possible in or near to their own home.

**b) 7 day services to support discharge**

Lewisham is committed to improving the seven days a week access to urgent and emergency care services, and their supporting diagnostic services, so that they are delivered in a way that meets the clinical standards and are financially sustainable;

NHS Services, Seven Days a Week Forum Summary of Initial Findings (Dec 2013) found that health and social care were missing a significant opportunity, because extending the service would improve clinical outcomes, provide a much more patient focussed service and better patient experience.

Appropriate weekend working will be the initial focus for Lewisham services so that active acute care is delivered at weekends and that community and mental health and social care services are available to deliver weekend discharges and provide support services ensuring local urgent and emergency care services operate effectively and efficiently across the whole week.

The intention is to use local CQUIN monies as an additional incentive to transform the way services are provided to implement the ten evidence-based clinical standards that the NHS Services, Seven Days a Week Forum is recommending should be adopted by the NHS to end current variations in outcomes for patients admitted to our hospitals at the weekend.

As highlighted previously, we will ensure that appropriate social care and support

services can be put in place out of normal office hours and at weekends to facilitate timely discharges from hospital. This will include resources being made available to undertake assessments at weekends and, during 14/15, introducing the ability to set up care packages or restart packages over the weekend. Extra care and an rehabilitation facilities will be further developed so that they can be accessed 7 days a week. In addition, we are developing a Welcome Home Support Service.

**c) Data sharing**

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

The NHS number is used as the primary identifier between Lewisham and Greenwich NHS Trust acute services and social care services (ASC) provided by Lewisham Council. However, NHS number is not, as yet, the primary identifier within social care nor between the South London and Maudsley NHS Trust (SLaM) and the Council. The Adult Integrated Care Programme will look to develop this.

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

Lewisham is working with a range of healthcare providers within the borough, led by Lewisham and Greenwich NHS Trust, to establish a Virtual Patient Record (VPR) which uses the NHS number as an identifier. The VPR has been rolled out within health authorities and work is underway to include SLaM and ASC as part of the database procurement process that will be completed by December 2015.

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

Yes

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

Yes – the Council has achieved compliance with the PSN framework which includes N3 code of connection. We are currently considering the best approach to establishing an RA for connection to the NHS spine for access to Patient Demographic Services.

**d) Joint assessment and accountable lead professional**

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

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

Through existing integration work, Lewisham has already brought together a number of different disciplines into a single team working within four GP neighbourhood clusters. These teams have undertaken a risk stratification of the GP's adult population to identify those who would benefit from early intervention work. The teams also include a community development worker who links users to networks and opportunities within their local areas to support and improve their health and wellbeing. The identification of agreed lead professionals is part of the planned development of the neighbourhood teams.

To build on this work, the workstream on care planning and pathways within the Adult Integrated Care Programme has set the following objectives:

- To establish a single assessment and review framework which takes into consideration health and care outcomes
- To establish a single health and care record system
- To establish a single personalised budget for health and care, with direct payments
- To establish a person centred health and care pathway which wraps around the person and their needs

The workstream objectives were informed by work undertaken by the Inner North West London Integrated Care Pilot (May 2013) which was presented as part of the Programme Initiation Document :

1. **Targeted Intervention** – identifying those specific high risk individuals who would benefit from active intervention to avoid a potential crisis such as an inappropriate admission and re-admissions to hospital. The aim is to mitigate risk through proactive intervention. It is estimated that this cohort is about 4.5% of the total population and accounts for 29% of total spend across health and social care
2. **Complex Care** – coordinating and managing a complex health and social care package in a single care plan which is tailored around the needs of the individual, carer and the family with them at the heart and still in control - 'nothing about me, without me'. For example, the care package to support a person choosing to die at home. Often it is these complex cases that fall through the cracks of a non-integrated care system. It is estimated that this cohort is about 0.5% of the total population and accounts for 11% of total spend across health and social care.

## 4) RISKS

A number of areas have already been identified which present possible risks .

| Risk | Risk rating | Mitigating Actions |
|---|---|---|

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| **Achievement of financial efficiencies** – the timetable to achieve the required efficiencies is challenging and needs to be aligned with the timetables and targets for the local government savings and the CCG's QIPP programmes. Research has indicated that it requires long term sustained multi-organisational focus to achieve maximum efficiencies. Also the levels of financial benefits stated within the PID are based on the best available evidence of good practice, but remain at this point theoretical to Lewisham. | High | Robust ongoing scrutiny through existing governance arrangements.<br><br>Tight programme and project management arrangements.<br><br>Detailed financial mapping to align activity and spend and to assess impact of proposed changes. |
| **Resources** – there may be insufficient resources to invest in new delivery models, new approaches or to build capacity or capability. In addition, the staffing resource may be inadequate to realise the full potential of the programme. | Medium | Prioritisation of resources to support integration plans and particularly those areas which are needed to reduce acute activity.<br><br>Allocation of resources based on where there is evidence of significant positive impact on improving outcomes and quality |
| **IT Systems, Processes and Governance -** systems for effective information sharing across organisations may be difficult due to technical difficulties, governance/confidential issues and/or investment. | Medium | Commitment to Virtual Patient Record.<br><br>Achievement of N3.<br><br>Secured agreement for shared information tool for adult integrated care programme. |
| **Workforce Capacity and Capability** – a different culture and relationship with the users of services and a different way of working across organisations is required. This will require buy in from all organisations involved and commitment from staff. Also the programme will seek to develop generic workers working across health and social care. | Medium | Specific workstream on workforce development.<br><br>Successful bid to HESL to support this work. |
| **Action Research** – it may be difficult to evaluate the specific improvements in quality, patient experience, health outcomes and finance as a result of the programme, due to the interrelated nature of this | Medium | The bringing together of best practice and collaborative working across PH, CCG and LBL to enhance competencies, |

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| programme which interfaces with wider health and social care changes eg Dilnott. | | skills and capacity. |
| **Cross Organisation commitment to the Integration agenda** – is needed to maintain long term sustained multi-organisational focus to achieve maximum efficiencies, despite wider national policy changes and local acute configuration changes. | Low | Continued commitment from partners within the HWB as evidenced to date.<br><br>Partners committed to integrated programme and the adult integrated care programme board has agreed ToR and approved direction of travel. |