Lancashire Health and Wellbeing Board

Lancashire County Council

Lancashire Health and Wellbeing Board
Thursday, 28 April 2016, 2.00 pm,
Cabinet Room 'D' - The Henry Bolingbroke Room, County Hall, Preston

SUPPLEMENTARY AGENDA

Part I (Open to Press and Public)

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
4. Better Care Fund 2016/17 Submission	Decision		Paul Robinson (Lancashire BCF, Senior Programme Manager, NHS Midlands and Lancashire Commissioning Support Unit)	(Pages 1 - 458)	14:10

I Young
County Secretary and Solicitor

County Hall
Preston

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Lancashire Health and Wellbeing Board
Meeting to be held on 28th April 2016

Lancashire Better Care Fund (BCF) Plan for 2016/17

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Executive Summary

The purpose of this report is to inform the Lancashire Health and Wellbeing Board on the progress of and rationale around the development of the Lancashire Better Care Fund (BCF) Plan for 2016/17 and to seek the Board's approval of the plan.

The Lancashire BCF Plan for 2016 /17 will build upon that for 2015/16 and take an approach that ensures stability and consolidation. The schemes within the plan will vary little in outward appearance from those seen in 15/16 but will be stronger in how they deliver.
This is an approach agreed across all BCF partners. It reflects the changing planning environment, and a central government desire for BCF focus on addressing the issues around hospital admission avoidance and safe, timely discharge. It also enables partners to best manage resources at a time of continuing financial uncertainty and increased system pressures.
The Lancashire BCF plan 2016/17 aligns with all CCG (Clinical Commissioning Group) and Lancashire County Council operating plans being now part of "business as usual" planning.

Further ambitions expressed for the BCF have not been lost but redirected into the Healthier Lancashire and Lancashire and South Cumbria Sustainability Transformation Plan work programmes. The BCF will continue to be a core part of the move to greater integration and as part of the work within the BCF plan in 2016/17 lay the ground for a plan for integration of Health and Social Care.

The BCF plan 2016/17 sees significant strengthening of the input of the City and Borough Councils and Voluntary sector that will bring a whole new set of skills and resources into delivering its priorities and schemes. Built into the plan is the early refresh of delivery plans for schemes and this will reflect that wider view of who can contribute and the prospect of greater coordination /integration.

The financial requirements for the plan have changed little. The total Lancashire BCF pooled fund in 2016/17 will be £91,419,000 compared to £89,219,000.
The centrally prescribed format of the BCF plan for 2016/17 has been slimmed down to a high level narrative, which refers to supporting documents, and a spreadsheet template submission of management information and financial plan detail.

Recommendation/s

As the Lancashire Better Care Fund accountable body the Health and Wellbeing Board is recommended to:

- Endorse the approach taken in developing the Lancashire Better Care Fund plan 2016/17
- Approve the Lancashire Better Care Fund Plan 2016/17 and its submission to NHS England
- Agree a BCF reporting schedule to the board based upon that required by NHS England

Lancashire County Council

Background

It was confirmed in the Comprehensive Spending Review (November 2015) that the Better Care Fund (BCF) would continue into 2016/17.

NHS planning guidance set the scene for 2016/17 to be a period of stability and consolidation for Better Care Funds with clear emphasis upon addressing the issues around hospital admission avoidance and safe, timely discharge. This was reinforced in further guidance as requirements for plans were slimmed down to a high level narrative and a spreadsheet template submission of management information and financial plan detail.

Development work carried out late in 2015, including that within a Health and Wellbeing Board workshop, produced a number of new priorities for the Lancashire BCF:

1. Residential and Nursing Home care
2. Children and Adolescent Mental Health Services.
3. Transforming Care (Learning Disability)
4. Public Health /Prevention

The acceleration of the Heathier Lancashire programme and the introduction of the Sustainability and Transformation Plans has changed the planning environment and enabled these to become distinct work streams within those. For 1 and 4, especially, there is much potential for BCF scheme delivery to now have crossover benefits and early gains. These will be explored in the early stages of 2016/17 as part of review of delivery and impact. This will reinforce the view of the BCF role as an enabler that can be utilised as all programmes develop.

Against this background, and in a continuing position of financial uncertainty and high system pressures, all BCF partners agreed that the best approach was to replicate the BCF plan of 2015/16 in terms of schemes and investment in the pooled fund.

The plan therefore includes all schemes of the 2015/16 plan, with some minor name changes, along with an additional scheme of Carer support in Fylde and Wyre.

Format of the Plan
NHS England has taken a lighter touch in requirements for the format of the plan in 2016/7. While this is now a “high level” narrative plan and a spreadsheet template submission of management information and financial plan detail there is a requirement in the plan assurance process for a detailed response to a significant number of key lines of enquiry (KLOES), *see appendix A (BCF Planning 2016-17, Approach to regional assurance of Better Care Fund plans)*.
In addition the narrative plan refers to source documents. This approach is part of demonstrating that the BCF is an enabler in a wider health and social care planning system and connects into “business as usual”.

National conditions
The requirements for the BCF plan 2016/17 include 2 new national conditions.
These are:
Requiring local areas to agree to fund NHS commissioned out of hospital services. This follows the removal of the pay for performance element of the BCF pooled fund.
Agreement on local action plan to reduce Delayed Transfers of Care (DTOC)
Both of these are covered in the plan. DTOC is specifically referred to below.

Delayed Transfers of Care (DTOC)
A DTOC plan and target is required for inclusion in the plan. The approach taken in Lancashire and agreed by the Lancashire and South Cumbria Urgent and Emergency Care Network is for plans to be developed at System Resilience Group (SRG) level i.e. focussed around the acute health care providers. The creation of these plans will be staged with stage 1 plans ready for the time of plan submission and a 12 month programme of further development. The plans will recognise and include existing planning activity and integrate with that. Three of the plans will be developed and

agreed with partners outside the Lancashire boundaries i.e. Blackpool, Blackburn with Darwen and Sefton.

Target setting
There are four prescribed national metrics within the plan:

1. Non elective admissions
2. Delayed Transfers of Care
3. Permanent admissions to Residential and Nursing Care
4. Effectiveness of Reablement

Target setting for these is directly linked to the targets set in CCG and Lancashire County Council operating plans. The approach taken is in line with national guidelines, reflects a joint approach to sustainability of NHS providers, and being within a “credible ask” while retaining some stretch based upon past performance and analysis of trajectories and annual profiles.

Finance
The financial arrangements for the Better Care Fund are based around a centrally defined level of minimum contributions that CCGs will make to the BCF pooled fund. In addition Lancashire County Council contributes against agreed schemes. Also added to the pooled fund is an amount for the provision of Disabled Facilities Grants which is then distributed to City and Borough Councils so that they can fulfil their statutory duties. This is £11,476,00 in 2016/17.
The total BCF pooled fund for 2016/17 is £91,419,000. The detailed allocation of this is set out in the BCF plan.

The agreement to pool these funds is set out in a Section 75 agreement between Lancashire County Council and all Lancashire CCGs. Lancashire County Council has agreed to host the pooled fund and manages the financial processes required.

Reporting requirements
NHS England has set out a quarterly reporting schedule for all Better Care Fund Plans for 2016/17. It is recommended that the board receives reports on the same schedule subject to meeting timings.

BCF Partners and governance
Lancashire County Council and the Lancashire CCGs are the formal partners to the Better Care Fund. The Lancashire Health and Wellbeing Board is the accountable body for the BCF and plan. There is in place a robust BCF governance structure based around a steering group and programme managers group.

The governance arrangements have recently been significantly strengthened by the addition of voluntary sector and district council senior officer representation. This is a major step in taking the BCF to the next level as it will, in 2016/17, explore and take opportunities to tap into what each of these sectors can offer especially around prevention and supporting independence in peoples’ own communities.
It will also lay the ground for some of the wider conversations that need to happen in Healthier Lancashire programmes and delivery of the Sustainability and Transformation Plans. Joint work is already taking place across boundaries in the BCF. Most notably, now, that is around Delayed Transfers of Care but as relationships grow that will expand to other areas of mutual benefit.

NHS England BCF plan assurance
Following approval by the Health and Wellbeing Board the Lancashire Better Care Fund Plan will be submitted to NHS England for assurance the detail of which is set out in Appendix A. The result of that assurance process will be communicated to the board at the earliest opportunity.

NHS England has committed resources to the support of BCF planning through regional BCF managers and also through allocation of some funds for use of BCFs for specific development work. Lancashire BCF has recently received £24,000 to assist in developing evaluation tools and an additional £37,000 to be used to develop DTOC planning across the STP footprint.

Department of Health

Department for Communities and Local Government

Local Government Association

NHS England

BCF Planning 2016-17

Approach to regional assurance of Better Care Fund plans

MARCH 2016

The Better Care Fund

Overall approach to assurance: what's different?

- For 2016-17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process.
- The first stage of the overall assurance of plans will be local sign-off by the relevant local authority and CCG(s).
- The policy framework signals the need for stability in 2016-17, and a reduction in the overall planning and assurance requirements on local areas. This includes a shorter narrative plan requirement, reduced detailed requirements on the scheme level data, and for plan assurance to be owned by NHS England and local government regional teams, rather than through the national assurance and resubmission process that existed for 2015-16.
- There will be no national assurance process for BCF Plans for 2016-17. Instead regional teams will work with the Better Care Support Team to provide assurance to the national Integration Partnership Board (jointly chaired by DH and DCLG whose membership includes NHS England, Local Government Association and the Association of Directors of Adult Social Services) that the above process has been implemented to ensure that high quality plans are in place which meet national policy requirements.
- The regional process will be supported by a cross-regional calibration exercise coordinated by the national team
- A report will be provided to the national Integration Partnership Board, including areas that do not have an approved plan.
- Health and Wellbeing Boards are expected to sign off the final version of plans submitted

This will require DCOs, working with regional LG and NHS teams, with support from Better Care Managers to:

- Agree the process for assuring and moderating plans in line with the guidance and timetable, using the key lines of enquiry and other nationally available materials
- Agree how DCOs and NHS regions will work with LG regional colleagues and over what footprint to avoid duplication, and put in place a timetable for delivery
- It will also require Local Government regional chief executives and directors of adult social services to put in place appropriate additional regional capacity to ensure local government regions are fully undertaking their role in

Plan requirements

The following components are the requirements for Better Care Fund plans in 2016-17:

i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;

ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.

iii. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;

iv. Better data sharing between health and social care, based on the NHS number;

v. A joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;

vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

vii. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

viii. Agreement on a local action plan to reduce delayed transfers of care.

Local partners will need to develop a joint spending plan that is approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. In developing BCF plans for 2016-17 local partners will be required to develop, and agree, through the relevant Health and Wellbeing Board:

- A short, jointly agreed narrative plan including details of how they are addressing the national conditions
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes
- A scheme level spending plan demonstrating how the fund will be spent
- Quarterly plan figures for the national metrics

Plan elements and assurance approach

The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured. These will be the only planning requirements for the Better Care Fund in 2016-17.

Requirement	Collection method	Assurance approach
Narrative plans	Submitted to NHS England regional / DCO teams in an agreed format	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Confirmation of funding contributions	Submitted through CCG Finance Template and through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through a nationally developed high level BCF planning return (spreadsheet)	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Scheme level spending plan	Submitted to NHS England regional / DCO teams through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Metrics	Submitted through UNIFY and through a nationally developed high level BCF template return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process

These are the planning requirements for the BCF for 2016-17. The assurance process will focus on ensuring that Better Care Fund plans are set in a manner that supports financial stability in local systems.

Reporting requirements for 2016-17 will be confirmed in due course as part of a refresh of the Operationalisation Guidance for the Better Care Fund, originally published in March 2015.

BCF Assurance timetable

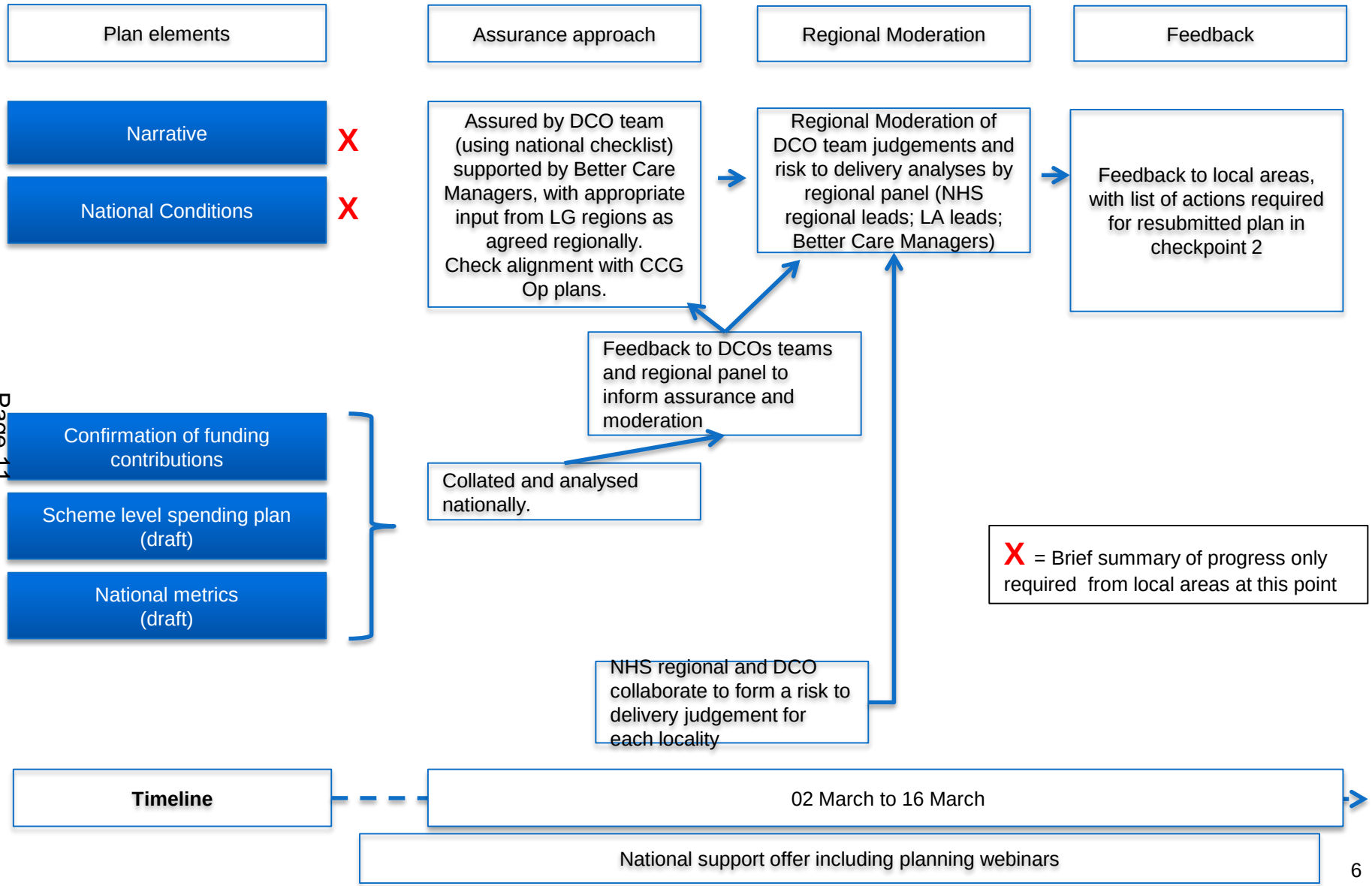
Proposed timeline	Dates (all 2016)
Planning guidance and planning template issued	22 February
Submission 1 BCF Planning Return submitted by HWB areas to DCO teams, copied to the national team. This will detail the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.	**2nd March**
National team provide analysis of BCF planning returns in a single spreadsheet and send to DCOs and BCMs, highlighting any potential issues in the information provided	7th March
Feedback from regions, DCOs and BCMs to the national team on any outstanding issues or support needs arising from the first submission. To be coordinated regionally.	16 March
Submission 2 Full BCF plan submitted by HWBs to DCO teams, including BCF Planning Return version 2, which is to be copied to the national team for analysis	**21st March**
National team provide analysis of BCF planning returns in a single spreadsheet and send to DCOs and BCMs, highlighting any potential issues in the information provided	24th March
Deadline for regional confirmation of draft assurance ratings for all BCF plans to the **national team**	6th April
National calibration exercise carried out across regions to ensure consistency	7th – 8th April
Deadlines for feedback from DCO teams and BCMs **to local area**s to confirm draft assurance status and actions required	11th April
Submission 3 Final plans submitted, having been formally signed off by HWBs	**25th April**
Deadline for regional confirmation of final assurance rating to BCST and local area	13th May
Deadline for signed Section 75 agreements to be in place in every area	30th June

Key: Action for regions, DCO teams and BCMs | Action for local systems | Action for the Better Care Support Team

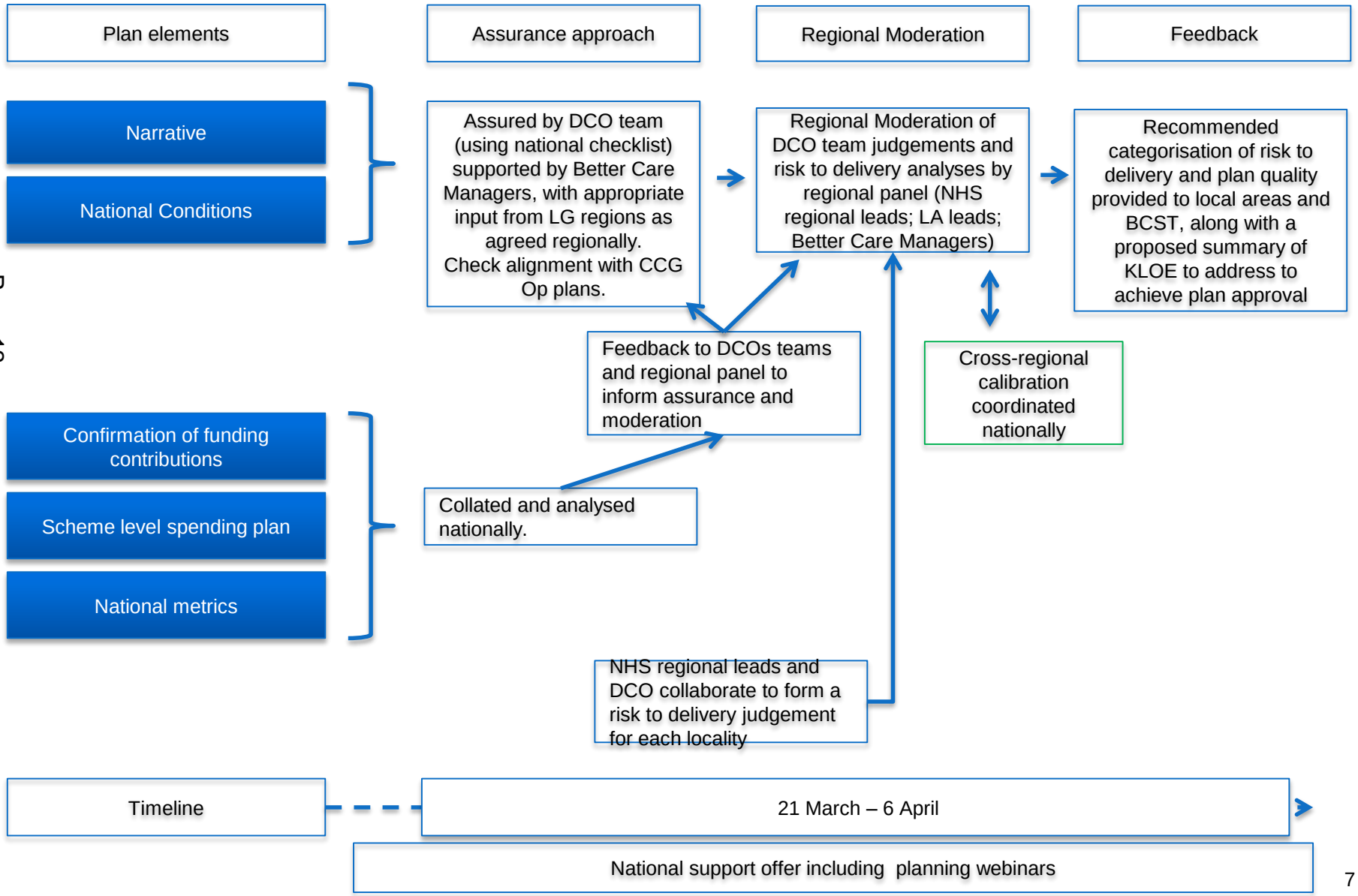
Key regional assurance activities

Date	Action
By 19 February	• National assurance approach and key lines of enquiry for assurance shared with DCOs, BCMs, NHS England and LG regional teams to support assurance process
Before 19 February	Regional LG leads and NHS England DCOs to • Agree their roles in moderation and assurance of finance plans, and key milestones • Identify local areas that may need support with the development of their plans
02 March to 20 March	• **Stage 1** regional assurance arrangements operational for first BCF submission • National team provide analysis of first submissions to identify areas for follow up • DCO teams and BCMs follow up with individual systems where issues appear and identify areas requiring further support • Regional level return to the national team setting out any areas of concern and support needs, using template provided • High level summary report from the national team to the Integration Partnership Board and NHS England leadership
21 March to 24 April	• **Stage 2** regional assurance and moderation operational • National team provide analysis of the BCF planning returns and identify areas for follow up • DCO teams, BCMs and LG leads review plans and give each plan a draft assurance rating • Regional moderation of draft assurance ratings and identification of support needs, ensuring financial stability is maintained through BCF plans. Submission to national team using template provided • Nationally coordinated calibration exercise across regions, with any proposed adjustments to draft assurance ratings confirmed back to regions, DCOs and BCMs • Full feedback provided by DCOs and BCMs to local areas on assurance ratings and actions required to address KLOEs and move to fully approved, where necessary • High level summary report to the national Integration Partnership Board and NHS England leadership
25 April to 13th May	• **Stage 3:** Final plans signed off by Health and Wellbeing Boards and submitted to DCOs and national team • National team provide analysis of final planning return submission to regions, DCOs and BCMs • All plans assigned an assurance category following review of progress made from last submission • Formal escalation to the national Integration Partnership Board for any plans not approved

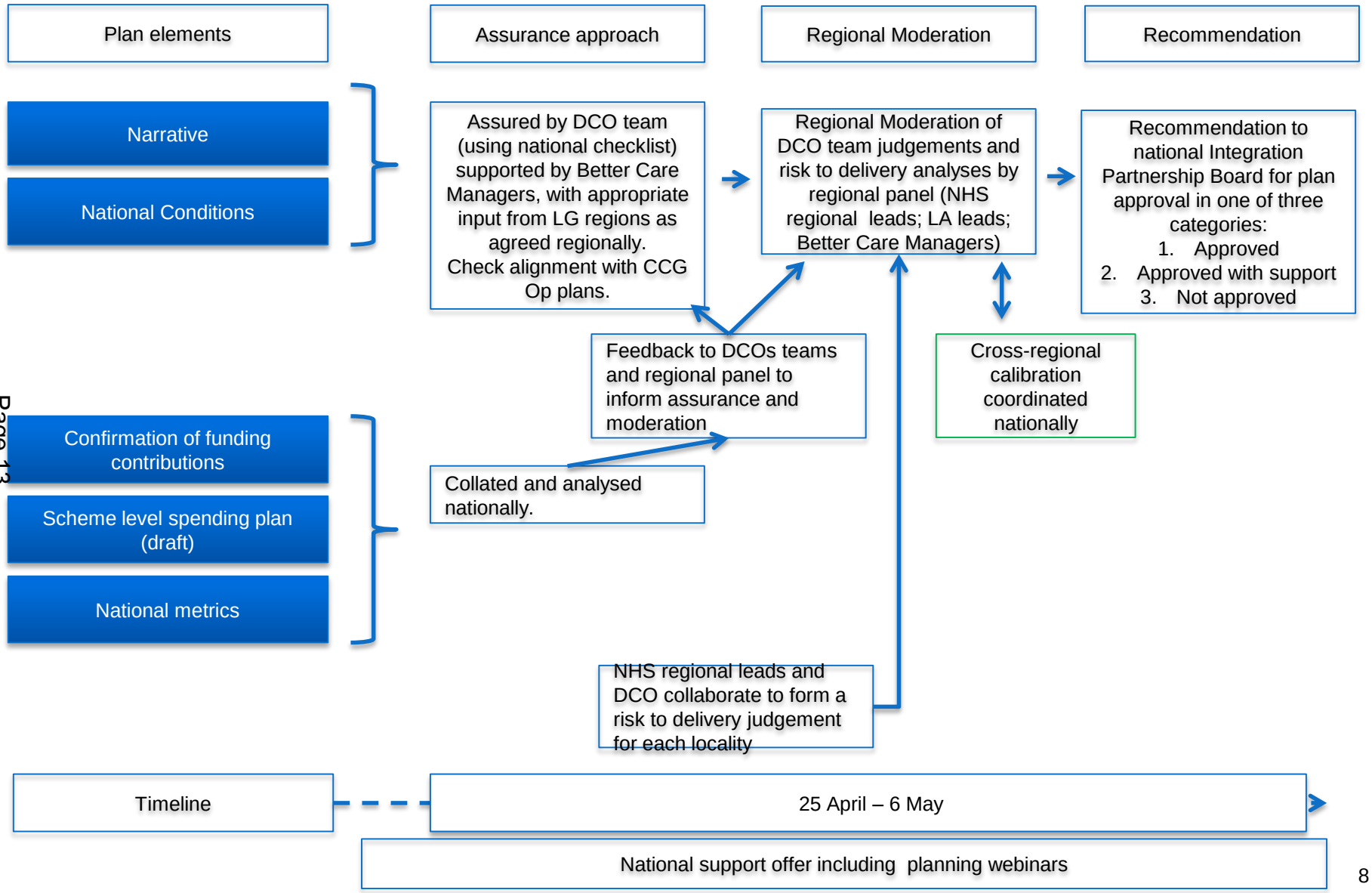
Assurance: Checkpoint 1 (2nd March)



Assurance: Checkpoint 2 (21st March)

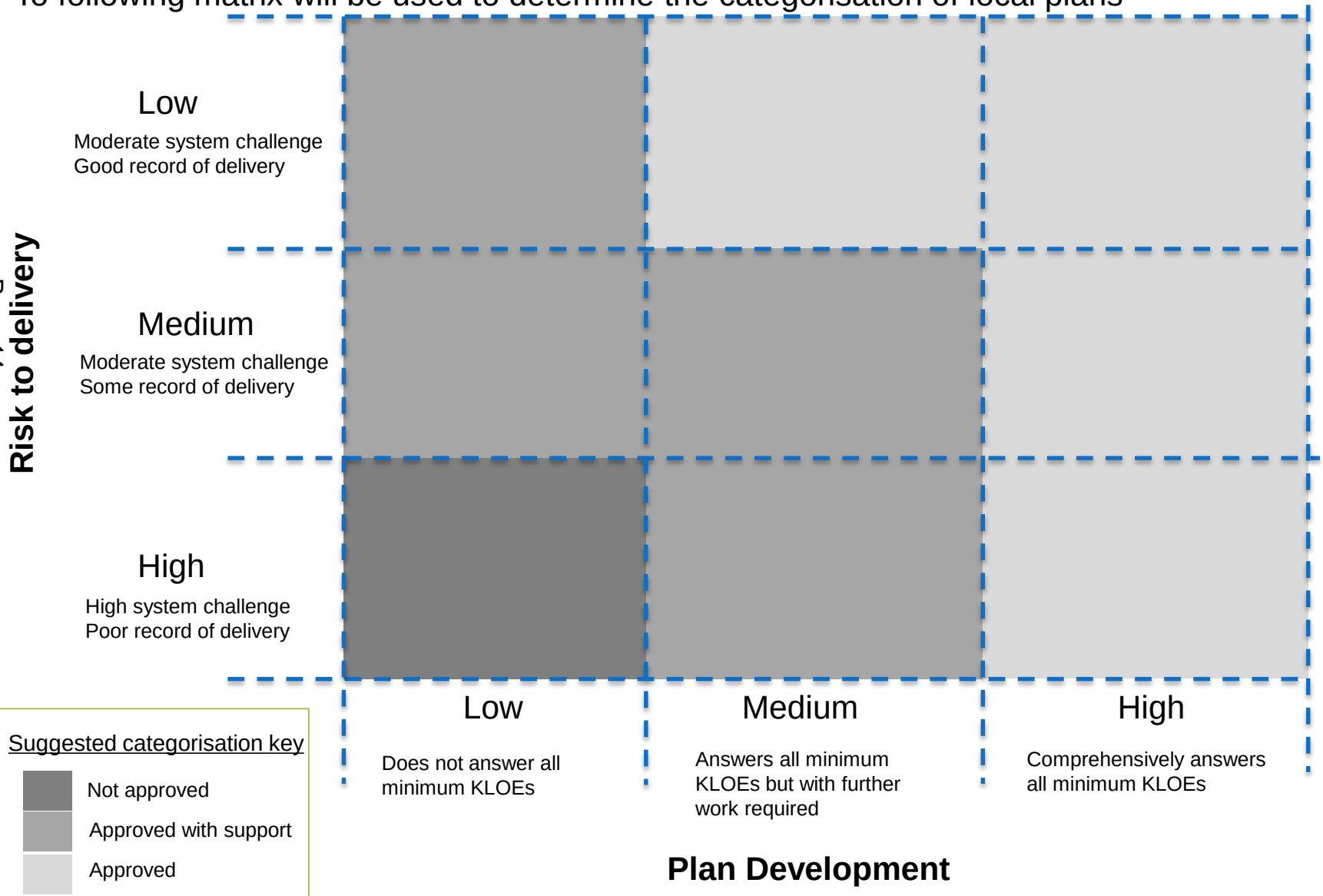


Assurance: Checkpoint 3 (25th April)



Moderation matrix and assurance categories

To following matrix will be used to determine the categorisation of local plans



Assessing delivery risk for moderation

To support regional moderation and feedback to local systems, regions are encouraged to consider risks to delivery alongside plan quality ratings, using a moderation matrix (see previous slide). This will be used to determine whether a plan is recommended.

In addition to plan quality, based on the key lines of enquiry, an assessment of risk to delivery should review, and make a judgement of

- Commissioner and provider financial and quality performance
- BCF Quarterly reporting risks
- Other local/regional intelligence

The assessment of delivery risk **should be:**

- An opportunity to assess the delivery context within which a BCF plan sits
- An opportunity to be clear about the delivery challenges faced locally
- An assessment built on existing measures that provides a fair and agreed view of risk across health and social care in a local area

The assessment of delivery risk **should not be:**

- A judgment on the quality of the plan itself
- An attempt to pass a new judgment on the health and social care system in a local area
- A reflection of the level of partnership working in an area

Assessing plan development

As part of the regional assurance, moderation, and feedback to local systems, regions will need to consider the level of development of the plan.

In order to ensure consistency a national set of key lines of enquiry (KLOE) have been developed (see Appendix 1) to support the assessment for each of the plan elements (set out on slide 3). Where appropriate, these are consistent with both the ‘risk assessment checklist’ used by reviewers during the nationally consistent review of plans, and the ‘what good looks like’ criteria set out in for BCF planning guidance for 2015-16. These have been updated and revised to take account of changes to policy and context.

In a departure from the framework used last year the plan quality assessment will no longer be based on an assessment of risk represented by the quality of the plan. Instead, the assessment will focus on the degree to which the KLOEs have been met. As follows:

- High – answers all the minimum requirement KLOEs comprehensively and addresses the further requirement KLOEs;
- Medium quality – answers the minimum requirement KLOEs for all plan elements, but with further work required to strengthen these and/or meet further KLOEs;
- Low – fails to answer some or all of the minimum requirement KLOEs for one or more of the plan elements.

A template beencreated to aid both the delivery risk and plan development assessments.

Ensuring consistency

Whilst the assurance process for 2016-17 BCF planning is to be regionally run and owned, there is a need for consistency in the assessment of plans and the placing of those plans into an assurance category. This is a government requirement.

The assurance framework described within this pack sets out to achieve this through:

- The agreement of a consistent approach to assurance across regions;
- Agreement on the criteria used for the assessment of delivery risk within a system;
- Development of a standard set of questions (KLOEs) which underpin the assessment of a plan's development;
- Agreement of a common approach to how each plan is categorised based on the basis of its delivery risk and plan development rating.

This will be reinforced through the development of a standard template to be used in assessing an individual plan. This has been developed nationally but completed and owned by DCO teams. This should also form the basis of consistent feedback to local areas.

In addition, to check that there is consistency in the regional interpretation of the framework, the national team will facilitate a calibration exercise. This will include:

- Aa template, to be completed regionally, which will provide an overview of assurance ratings for individual plans in the region, and a summary of how they have been reached;
- The coordination of a teleconference with leads from each region to compare scores for a selection of areas within each assurance category
- Scrutiny of assurance outcomes for systems identified as high risk.

Roles and responsibilities

NHS England Directors of Commissioning Operations (DCOs)

- Work with LG regions and BCMs to agree and deliver the approach to assurance
- Ensure that the BCF assurance template is completed for each Health and Wellbeing Board within their area

Regional Local Government Leads (Directors and/or Chief Executives)

- To oversee the LG input to BCF plan assurance and moderation, working with DCOs, BCMs and NHS England regions
- To ensure that additional operational capacity is provided to LG leads to deliver the approach to assurance and moderation from a local government perspective

Better Care Managers (BCMs)

- To provide additional capacity to DCOs and LG regional leads as agreed to support the overall approach to assurance and moderation across both health and social care

NHS England regional leads

- To work with LG regional leads to provide a moderated view of BCF plans which aligns with wider moderation of NHS plans for 2016-17
- To coordinate and submit regional level returns providing an overview of plan assurance outcomes for each HWB in the region

The Better Care Support Team

- To develop a consistent framework for assurance and moderation agreed by partners
- To develop a HWB level BCF assurance template to aid consistency
- To develop a regional level return template and collate these when submitted to establish a national picture of plan assurance

Appendices

Appendix 1 – Key Lines Of Enquiry for assessing plan quality

Appendix 2 – Framework for assessing the risk to delivery

Appendix 3 – Overview of planning support materials and guidance [to follow]

Appendix 1

BCF Planning 2016-17:

Key lines of enquiry for use in the regional assurance of BCF plans

Introduction

This document sets out the content to be covered in Better Care Fund plans for 2016-17. This should be read in conjunction with the BCF Policy Framework for 2016-17 published by the Department of Health and Department of Communities and Local Government, and Annex 4 of the NHS Technical Planning Guidance: 'BCF Planning Requirements 2016-17' published by NHS England.

The 'Key Lines Of Enquiry' (or KLOE) set out here are intended as a guide to local areas in developing their plans, as well as to the teams that will be carrying out the assurance of BCF plans for 2016-17. This assurance will be led regionally, with the aim of reducing the burden of national bureaucracy borne by local areas during planning for the BCF in 2015-6. As part of this, the KLOEs set out in this document will provide a single, transparent set of requirements for local areas in approaching BCF planning.

The KLOEs will then provide the framework for the review of plans at a regional level, with assurance based on the degree to which they are met (alongside a view of the level of risk delivery posed by the context within which the plan sits). Feedback will then be provided to local areas following their first full plan submission on any KLOEs that requires further action to meet. By the end of the assurance process all plans will need to demonstrate that they are meeting, or have plans in place to meet, the minimum requirement in order to be approved and therefore gain access of the Better Care Fund.

The KLOEs here are drawn from the BCF policy framework, planning guidance and the criteria used within the national assurance of plans for 2015-16. The minimum KLOEs are those which all local areas will need to answer through the assurance process for 2016-17.

The further KLOE are providing a guide for going beyond the minimum.

Answering Key Lines of Enquiry

The approach to BCF planning for 2016-17 seeks to simplify the requirement for local areas, whilst still ensuring that the conditions of access to the fund are met and local plans for furthering the integration of health and social care services through the use of the fund are in place.

In light of this it is important to note that it is not a requirement to confirm, describe or demonstrate compliance with all KLOEs within a single planning document. Instead, plans submitted by Health and Wellbeing Boards should either include the information required to meet each KLOE or set out where this information is already available within existing strategies or documents.

Within this plans will be expected to build on those already in place for 2015-16. Where appropriate signposting to the existing plan whilst providing any updates required will also be a suitable approach to answering the KLOEs.

No set template is to be issued nationally for BCF plans for 2016-17 but in order to simplify both the planning and the assurance processes the structure of this document can be used as a guide. A template has been issued for a BCF Planning Return in excel format to provide key information for analysis at a national level. This is not intended as a planning template or plan in itself but the information provided within it will need to match back to information provided within BCF plan submissions. In cases where a KLOE should be met by information provided within the BCF Planning Return template then this is indicated.

Compliance checks

Requirement	Source	Minimum KLOE	Further KLOE
1. Narrative plan submitted for assurance at a regional level	✓ Narrative plan submission ✓ Supporting documents submitted	i. First submission of narrative plan to the DCO team on date requested ii. Submission signed by the local CCG(s) and local authority iii. Final submission of narrative plan to the DCO team on date requested iv. Submission signed off by local CCG(s), local authority, and the Health and Wellbeing Board	
2. BCF planning return template submitted to the national team	✓ BCF Planning Return Submission	i. First submission of planning return template to national team on date requested ii. Submission signed by the local CCG(s) and local authority iii. Final submission of planning return template on date requested iv. Submission signed by the local CCG(s) and local authority	

A. Confirmation of funding contributions

Requirement	Source	Minimum KLOE	Further KLOE
1. All minimum funding contributions met	✓ BCF Planning Return Submission ✓ Narrative plan submission	Does the BCF planning return confirm that the local area has met its minimum contributions for: i. CCG minimum contributions ii. Disabled Facilities Grant iii. Care Act 2014 Monies iv. Former Carers' Breaks funding v. Reablement funding Full BCF allocations have been published here: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/	Does the narrative plan also: vi. Set out how each element of the minimum funding contributions which has a specific purpose is being used? vii. Include an agreed plan for use of DFG monies across both tiers of local government (where applicable), that meets both the statutory requirements of housing authorities and those of the BCF plan??
2. Detail provided of any additional funding contributions	✓ BCF Planning Return Submission	Does the BCF planning return confirm: i. Any additional local authority contributions to the pooled budget? ii. Any additional CCG contributions to the pooled budget?	Does the narrative plan also: iii. Set out the additional contributions for 2016-17 in the context of those provided for 2015-16, articulating the impact of any changes?
3. Local agreement on funding arrangements	✓ BCF Planning Return Submission ✓ Narrative plan submission	i. Has the BCF planning return template been signed off by all parties? ii. Has the narrative plan submission been signed off by all parties? iii. Does the narrative plan provide a full overview of funding contributions for 2016-17? iv. Does this set out any changes from funding levels in 2015-16, and how these have been agreed? v. Does this include an assessment of the impact of these changes on services?	vi. Does the assessment of the impact of any changes include an immediate and medium term view of the impact on patients and service users? vii. Have any changes to funding arrangements been set within the context of longer term integration, sustainability and transformation plans?

B. Narrative plan requirements

Requirement	Source	Minimum KLOE	Further KLOE
1. The local vision for health and social care services	✓ Narrative plan submission ✓ Supporting documents submitted	Does the narrative plan include? i. A clear articulation of the local vision for health and social care services, including changes to patient and service user experience and outcomes? ii. A description of how the BCF plan contributes to the local implementation of the vision of the Five Year Forward View and the move towards fully integrated health and social care services by 2020? iii. A description of the aspects of the change the local area is intending to deliver using the BCF?	iv. Is there reference to the JSNA and JHWS, and any other locally relevant strategic plans? v. Does it describe how these changes effectively respond to changes to the local public health needs and the broader demographic, and socio-economic changes in the local area? vi. Is there evidence of the input of service users and public engagement? vii. Does it describe a set of concrete changes to service delivery that will help to bring about this vision for the future? viii. Reference to the relationship between the BCF plan for 2016-17 and longer term Sustainability and Transformation Plans? ix. Does it describe how BCF plans will contribute to the ongoing delivery of the aims and changes set out in the Care Act 2014?
2. An evidence base supporting the case for change;	✓ Narrative plan submission ✓ Supporting documents submitted	Does this local area's case for change include: i. A clear and quantified understanding of the precise issues that the BCF will be used to address in the local area? ii. Identification of the opportunity to improve quality and reduce costs, based on segmented risk stratification? iii. A narrative that is bespoke to the local area and articulates how integration will be used to improve the issues identified? iv. Data that supports the case for change, including quantifying levels of unmet need, issues of service quality, and inefficiencies in service delivery?	There are no further KLOEs for this section.

B. Narrative plan requirements

Requirement	Source	Minimum KLOE	Further KLOE
3. A coordinated and integrated plan of action for delivering that change;	✓ Narrative plan submission ✓ Supporting documents submitted	Does the local area's plan of action include: i. A description of the specifics of the overarching governance and accountability structures in place locally to support integrated care? ii. A description of the specifics of the management and oversight in place to support the delivery of the BCF plan? iii. An articulation of the arrangements in place to support joint working? iv. Key milestones associated with the delivery of the plan of action in 2016-17? v. A fully populated and comprehensive risk log, with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally?	Does the local area's plan of action also include: vi. How governance and accountability structures support joint accountability? vii. The level at which strategic issues will be dealt with within structures? viii. Diagrams to explain structures for decision making and governance? ix. A process for regular monitoring of performance of schemes and issue resolution?
4. A clear articulation of how they plan to meet each national condition;	✓ Narrative plan submission	See section C.	See section C.
5. An agreed approach to financial risk sharing and contingency.	✓ Narrative plan submission ✓ Supporting documents submitted	Does the local area's risk sharing plan include: i. Quantification of what proportion of the pooled funding is 'at risk', if any, and how this has been calculated? ii. An agreed approach to sharing risk on NEAs and DTOCs in line with national conditions 7 and 8? iii. An articulation of any other risks associated with not meeting BCF targets in 2016-17? iv. An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and	Does the local area's risk sharing plan also include: v. A clear articulation of how CCG plans have been set, and how these relate to BCF risk sharing arrangements? vi. An agreed plan for how any funding that is released will be spent, including: • What services or development will be funded? • Which quarter the fund will be received and the implications this has for how it might be used? • How the Health and Wellbeing Board will be consulted on this plan and made aware of the

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
1. Plans to be jointly agreed	✓ Narrative plan submission ✓ Supporting documents submitted	Does the area's plan demonstrate that: i. The BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the HWB area, is signed off by the HWB itself, and by the constituent Councils and CCGs? ii. In agreeing the plan, CCGs and local authorities have engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people? iii. The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences? iv. As the Disabled Facilities Grant (DFG) will again be allocated through the BCF, local housing authority representatives have been involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing?	v. There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan? vi. This includes an assessment of future capacity and workforce requirements across the system?

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
2. Maintain provision of social care services	✓ Narrative plan submission ✓ Supporting documents submitted ✓ BCF Planning Return Template	Does the planning return template confirm: i. The total amount from the Better Care Fund that has been allocated for supporting of adult social care services? ii. That the total amount allocated for social care from the mandated BCF minimum allocation has been, as a minimum, maintained in real terms compared to 15/16 iii. That at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? iv. The amount of funding that will be dedicated to carer-specific support from within the BCF pool? Does the narrative plan demonstrate that: i. Local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16? ii. The definition of support has been agreed locally and, as a minimum, maintains in real terms the level of protection as provided through the mandated minimum element of local BCF agreements of 2015-16? iii. In setting the level of protection for social care the local area has ensured that any change does not destabilise the local social and health care system as a whole? iv. The local area has included a comparison to the approach and figures set out in 2015-16 plans? v. The approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14?	Does the local area's plan also include: vi. An explanation of how the proposed local schemes and spending will support this commitment, and how this will achieve the desired outcome of supporting social care services? vii. A demonstration that the local area has considered how local demographic change will impact upon social care demand? viii. A quantified allocation within Better Care Fund which is for the implementation of the Care Act? ix. An articulation of what the requirements of the Care Act mean in terms of changes to the delivery of local services? x. An articulation of any interdependencies between this work stream and the delivery of the Better Care Fund plan? xi. An articulation of how funding dedicated for carer-specific support will be used to support improved outcomes for carers, including: • A reflection on the effectiveness of services commissioned in 2015-16? • Confirmation of services being commissioned in 2016-17, and how these will impact on the experience of carers? vi. Evidence based consideration of how carer support will impact on patient level outcomes?

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
3. Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.	✓ Narrative plan submission ✓ Supporting documents submitted	Does the area's plan demonstrate that: i. They will provide, or have a plan in place to provide, 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care? ii. This approach will prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week? iii. Their approach will support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care? iv. The approach is underpinned by a delivery plan for the move to seven-day services, which includes key milestones and priority actions for 2016-17.	Does the local area's plan also include: v. Evidence of progress towards implementation of the four key 7DS standards locally during 2016/17 as set out in the Service Development and Improvement Plan section of NHS local contracts between CCG and providers? vi. An indication of how local partners will work together to ensure that NHS providers meet the milestones for inclusion of the Clinical Standards for 7DS in 2014/15, 2015/16 and 2016/17? vii. Detail of any risks relating to the move to seven day services?

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
4. Better data sharing between health and social care, based on the NHS number	✓ Narrative plan submission ✓ Supporting documents submitted	Does the area's plan demonstrate that: i. That the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care? ii. They are using the NHS Number as the consistent identifier for health and care services, and if they are not, that they have a plan to do so? iii. They are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls? iv. They have the appropriate Information Governance controls 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, when they plan for it to be in place? v. They have ensured that 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)? vi. How these changes will impact upon the integration of services?	Does the local area's plan also include: vii. An articulation of the progress made to date in relation to the use of the NHS number as the primary identifier, based on either real time retrieval or timely batch processing? viii. Plans to use the NHS number as early as possible in the clinical process / care pathway as opposed to solely at end for payment purposes? ix. Details of the remaining key phases of work required to ensure that this becomes part of business as usual, including x. Key milestones associated with this xi. Priority actions and next steps to ensure progress can be made xii. Detail of the risks relating to using move to the use of the NHS number as the primary identifier? xiii. Evidence of the progress made to date in adopting Open APIs and Open Standards, and how close to delivery of this the local area is? xiv. The remaining key phases of work required to ensure that this becomes part of business as usual, including: xv. Key milestones xvi. Priority actions and next steps to ensure progress can be made xvii. Highlighting any risks relating to using Open APIs and Open Standards and ensure that these are cross referenced in the risk log alongside appropriate mitigating actions [Continued on next slide]

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
4. Better data sharing between health and social care, based on the NHS number (continued)	✓ Narrative plan submission ✓ Supporting documents submitted		xviii. Demonstrating commitment within the scope of the plan (be it procured/developed) that: • systems will provide interfaces that are accessible to those that need to use them? • all significant business functionality provided by the host system should be available via an API? • to clearly publish and document their provided interfaces? xix. An articulation of the progress made to date in developing and implementing appropriate IG controls, include documentation demonstrating local IG protocols and agreements are in place? xx. Details of the remaining phases of work (particularly in relation to procurement of technical systems, development of guidance and protocols, delivery of training) to ensure IG controls are observed? xxi. Detail of any risks relating to IG controls? xxii. A declaration of compliance?

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
5. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	✓ Narrative plan submission ✓ Supporting documents submitted	Does the area's plan demonstrate that: i. Identify which proportion of the local population will be receiving case management and named care coordinator? ii. Identify dementia services as a particularly important priority for better integrated health and social care services, supported by care coordinators (for example dementia advisors)? iii. A description of plans for health and social care teams to use a joint process to assess and plan care? iv. A plan with milestones demonstrating how and when this condition will be fully complied with?	Does the local area's plan also include: v. A description of any action being taken to remove barriers to joint assessments and planning? vi. A description of the role of accountable lead professional as it is envisaged, such that the patient knows who to contact when they need to and can get timely decisions about their care? vii. How GPs will be supported in being accountable for co-ordinating patient centred care for older people and those with complex needs? viii. Consideration of the impact of these systems for people with Dementia and mental health problems?
6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	✓ Narrative plan submission ✓ Supporting documents submitted ✓ Signed provider return	Does the area's plan demonstrate that: i. The impact of local plans has been agreed with relevant health and social care providers? ii. There has been public and patient and service user engagement in this planning, as well as plans for political buy-in? iii. These align to provider plans and the longer term vision for sustainable services? iv. 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? v. Demonstration of clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans?	Does the local area's plan also include: vi. Confirmation of detailed and meaningful provider involvement in the development of the plans? vii. Triangulation to provide reassurance that any projected reductions in planned emergency activity are feasible? viii. Confirmation that this provider is implementing their own risk management and action plans to respond to any planned change in activity? ix. Demonstration of a shared understanding of the critical path to successful delivery? x. An articulation of local risks and how these are being managed / shared?

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
7. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	✓ Narrative plan submission ✓ Supporting documents submitted ✓ BCF Planning Return Template	Does the area's plan demonstrate that: i. The local area has agreed how they will use their full 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? ii. This is clearly set out within the summary and expenditure plan tabs of their BCF planning return template? iii. In reaching agreement they have considered whether a local risk sharing arrangement is required, supported by analysis of the likely risk of unplanned activity in the area based on their track record of performance? iv. This analysis is data driven and includes consideration of the long term trend in admissions and the successful of schemes implemented to date? v. Where a risk sharing arrangement has been agreed this is, where appropriate, consistent with guidance? vi. NHS commissioned out-of-hospital services and services that were previously paid for from funding made available as a result of achieving their non-elective ambition, continue in a manner consistent with 15-16.?	Does the local area's plan also include: vi. An analysis of the value of NHS Commissioned Out of Hospital Services in 2015-16, compared to plans for 2016-17? vii. An analysis of the impact of any changes to the level of investment in NHS Commissioned Out of Hospital Services? viii. An analysis of P4P performance in 2015-16 and a clear articulation of how this has been used to drive the local decision on how to use this portion of the fund?

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
8. Agreement on local action plan to reduce delayed transfers of care (DTOC)	✓ Narrative plan submission ✓ BCF Planning Return ✓ Supporting documents submitted	Does the area's plan demonstrate that: i. The local area has developed a local action plan for managing DTOC? ii. The local area has established their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts? iii. The plan is within the context of the System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management, and timely and safe discharge)? iv. This target is reflected in CCG operational plans? v. The local area has considered the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and best practice? vi. In agreeing the plan, CCGs and local authorities have engaged with the relevant acute and community trusts and are able to demonstrate that the plan has been agreed with the providers? vii. Clear lines of responsibility, accountabilities, and measures of assurance and monitoring? viii. They have taken account of national guidance and best practice, including the eight 'high impact interventions' that were agreed by ECIP ix. There has been engagement with the independent and voluntary sector providers?	Does the local area's plan also include: x. A situation analysis which includes: • Detailed analysis of current performance , trends, and the causes of delays? • An assessment of current schemes in place to reduce delays and improve patient flow across the system, and how effective these are? • A gap analysis comparing local measures to the best practice interventions (see below)? • A consideration of whether additional measures are required where rates of delay are very high, including whether a risk sharing arrangement may be appropriate? xi. A Target and Action Plan, that includes: • A clear articulation of how the target has been set, with reference to the situation analysis? • A trajectory for reducing the number of delays, which is aligned to CCG plans? • A set of clear actions to deliver improvement that builds both on successful local initiatives and on the nationally agreed best practice interventions? xii. Detailed accountability arrangements, with all actions clearly owned, so the plan sets out lines of responsibility and accountability for delivering each element of the plan? xiii. Read across to other local plans which will improve patient flow and support local performance? [continued on next slide)

C. Narrative plan – national conditions

Requirement	Source	Minimum KLOE	Further KLOE
8. Agreement on local action plan to reduce delayed transfers of care (DTOC) [Continued]	✓ Narrative plan submission ✓ BCF Planning Return ✓ Supporting documents submitted		Does the local area's plan also include: xiii. Analysis of local capacity and requirements? xiv. Analysis of how that capacity can best be used across health and social care to minimise DTOC and meet evolving need? Including a joint commissioning approach between health and care and consideration of the long-term sustainability of the market for both health and social care? xv. Consideration of the role that the voluntary and community sector can play in supporting patients to remain in their own home or return there more quickly following a period in hospital? xvi. Consideration of what measures are proportionate to address local levels of performance. Including demonstrating, where DTOCs are high and rising, how they have considered all options for addressing this, including the potential use of risk sharing arrangements? xvii. If there is local agreement that a risk sharing arrangement is appropriate, that the local area has: • Considered the use of existing mechanisms? • Confirmed their approach takes account of the legal framework on payments set out in the Care Act and that they are content that they are not acting in any way which goes against current legislation? • Agreed collectively on the approach and assured themselves that it will lead to resources being spent in the best interest of the local population and with a positive impact on the performance of the local health and care system?

D. Scheme level spending plan

Requirement	Source	Minimum KLOE	Further KLOE
1. Scheme level spending plan provided	✓ BCF Planning Return Template ✓ Narrative plan submission ✓ Supporting documents submitted	i. Has a scheme level spending plan been submitted as part of the BCF Planning Return template? ii. Does this plan account for the use of the full value of the budgets pooled through the BCF? iii. Have all columns of the spending plan template been completed for every scheme? iv. Has confirmation been provided on the summary tab of the planning return of the amount identified for the protection of social care, with any variance from the automatic calculation from the spending plan explained?	vi. Does the narrative plan provide sufficient assurance that detailed plans are in place for each of the schemes set out in the spending plan? vii. Does this include reference to how these plans are aligned with, and included in, CCG operating plans for 2016-17?

E. National Metrics

Requirement	Source	Minimum KLOE	Further KLOE
1. Non-elective admissions (General and Acute)	✓ BCF Planning Return Template ✓ Narrative plan submission	i. Has a target been set for this metric as part of the BCF Planning Return template? ii. Does the narrative plan include an explanation for how this target has been reached? iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17? iv. Is there demonstration of triangulation with other plans – e.g. acute contracts and CCG plans?	v. Has this analysis been supported by a view of longer terms trend? vi. Does this include consideration of service change and demographic factors that are likely to impact on performance?
2. Admissions to residential and care homes;	✓ BCF Planning Return Template ✓ Narrative plan submission	i. Has a target been set for this metric as part of the BCF Planning Return template? ii. Does the narrative plan include an explanation for how this target has been reached? iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	iv. Has this analysis been supported by a view of longer terms trend? v. Does this include consideration of service change and demographic factors that are likely to impact on performance?
3. Effectiveness of reablement;	✓ BCF Planning Return Template ✓ Narrative plan submission	i. Has a target been set for this metric as part of the BCF Planning Return template? ii. Does the narrative plan include an explanation for how this target has been reached? iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	iv. Has this analysis been supported by a view of longer terms trend? v. Does this include consideration of service change and demographic factors that are likely to impact on performance?
4. Delayed transfers of care;	✓ BCF Planning Return Template ✓ Narrative plan submission	i. Has a target been set for this metric as part of the BCF Planning Return template? ii. Does the narrative plan include an explanation for how this target has been reached? iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17? iv. Is there demonstration of triangulation with other plans – e.g. acute contracts and CCG plans?	v. Has this analysis been supported by a view of longer terms trend? vi. Does this include consideration of service change and demographic factors that are likely to impact on performance?

Appendix 2

BCF Planning 2016-17:

Framework for assessing delivery risk

Introduction

Rationale / Purpose for assessing delivery risk

Assurance of BCF plans must be done within the local context that each plan is seeking to address. As a result, the qualitative review of the plans needs to be accompanied with a view of how challenging the local context is.

Assumptions

- Plans are only deliverable if they are appropriate to their local context
- The most telling and measurable contextual factor that impacts a local area's ability to deliver is the financial stability of the local health and social care economy
- A commissioner or provider in financial difficult will find it more difficult to deliver the changes required by BCF plans
- There may also be other local factors that influence the delivery risk, and these should be considered too
- The knowledge required to make these assessments (financially and otherwise) will be held by NHS England, Local Government, TDA and Monitor colleagues at an DCO and Regional Team level.
- There will be a clear link in plans between the level of risk identified here and the approach to risk sharing

Principles for assessing delivery risk

- The measures are simple and easy to understand
- They are built on pre-existing information in the system
- They are agreed by NHS, Local Government, Monitor and TDA colleagues

Objectives in assessing delivery risk

1. To review health commissioner stability now and for the duration of the plan
2. To review social care commissioner stability now and for the duration of the plan
3. To review local provider stability now and for the duration of the plan
4. To consider any other evidence that impacts on delivery risk

Approach

- Joint assessment by NHS England Regions and Local Government regional leads working with partners from TDA and Monitor.
- Data-based assessments will be conducted on health and social care commissioner and provider stability to generate an automated guideline risk rating.
- Narrative assessment to be conducted to establish of there are any other factors that affect this risk rating
- Based on guideline rating and narrative assessment, NHS England Regional and Local Government regional leads should determine the riskiness of the local health and social care context for the HWB.

Methodology

NHS Commissioners: weighting 0.25	✓ Assessors are asked to include all CCGs that are part of the BCF plans. ✓ The responses for each CCG are weighted equally in generating a rating for NHS Commissioners. The questions are also weighted equally. ✓ If the CCGs exert different levels of influence over the plans, this should be recorded in the narrative assessment and the end risk rating adjusted accordingly ✓ A link should be demonstrated between the level of commissioner risk indicated here and the approach to risk sharing described in the plan.
Local Authority Commissioners: weighting 0.25	✓ Assessors are asked to include all Local Authorities that are part of the BCF plans. ✓ Each Local Authority is equally weighted in calculating the level of social care commissioning risk. The questions are also weighted equally. ✓ If the LAs exert different levels of influence over the plans, this should be recorded in the narrative assessment and the end risk rating adjusted accordingly
Provider finances: weighting 0.25	✓ Assessors are asked to include those trusts that are most affected by a reduction in Emergency admissions or otherwise likely to be impacted by BCF plans. Do not include providers who have a negligible or insignificant share of provision, unless they exert a significant influence on plans in another way. ✓ Each provider is weighted equally in calculating the provider financial risk. If the providers exert different levels of influence over the plans, this should be recorded in the narrative assessment and the end risk rating adjusted accordingly
Special measures and licence breaches: weighting 0.25	✓ If there are any Trusts that are either FTs in breach of their licence conditions or NHS Trusts in Special Measures, this should be recorded here.
Automatically generated guideline risk score	Based on answers to the above four sections, an automatically generated guideline score will be produced. This is based on an equal weighting across the four sections and an equal weighting of questions within each section. If there are any commissioners or providers that exert a particular influence this should be noted in the narrative section and the score moderated to reflect this
Moderated risk score	Assessors are asked to complete the narrative section identifying any other factors that influence the overall delivery risk for the local health and social care economy. If these factors are material enough to adjust the risk score, this should be done in the Proposed Risk Rating section of the template.

Lancashire Better Care Fund Plan

2016 – 2017

Lancashire Health and Wellbeing Board

NHS East Lancashire Clinical Commissioning Group

NHS Chorley and South Ribble Clinical Commissioning Group

NHS Fylde and Wyre Clinical Commissioning Group

NHS Greater Preston Clinical Commissioning Group

NHS Lancashire North Clinical Commissioning Group

NHS West Lancashire Clinical Commissioning Group

Lancashire County Council

Contents

1. Summary

Health and Wellbeing Board	**Lancashire**
Local Authority	**Lancashire County Council**
Clinical Commissioning Groups	**Chorley and South Ribble** **Greater Preston** **Lancashire North** **West Lancashire** **East Lancashire** **Fylde and Wyre**
Boundaries	**Lancashire County Council upper tier authority** **12 District Councils** **Burnley Borough Council** **Chorley Borough Council** **Fylde Borough Council** **Hyndburn Borough Council** **Lancaster City Council** **Pendle Borough Council** **Preston City Council** **Ribble Valley Borough Council** **Rossendale Borough Council** **South Ribble Borough Council** **West Lancashire Borough Council** **Wyre Borough Council** **Borders with 2 Unitary Authorities within the Lancashire footprint:** **Blackburn with Darwen Council** **Blackpool Council**

Minimum required value of Better Care Fund pooled fund:	**£91,419,000**
Total agreed value of Better Care Fund pooled fund:	**£91,419,000**
Date agreed at Health and Well Being Board:	**28th April 2016**
Date submitted:	**29th April 2016**

2. Authorisation and sign off

Signed on behalf of **Lancashire Health and Wellbeing Board**	
By	
Position	
Date	

Signed on behalf of **East Lancashire Clinical Commissioning Group**	
By	
Position	
Date	

Signed on behalf of **Fylde and Wyre Clinical Commissioning Group**	
By	
Position	
Date	

Signed on behalf of **Greater Preston Clinical Commissioning Group and Chorley and South Ribble Clinical Commissioning Group**	
By	
Position	
Date	

Signed on behalf of **Lancashire North Clinical Commissioning Group**	
By	
Position	
Date	

Signed on behalf of **West Lancashire Clinical Commissioning Group**	
By	
Position	
Date	

Signed on behalf of **Lancashire County Council**	
By	
Position	
Date	

3. Introduction

The Lancashire BCF Plan for 2016 /17 will build upon that for 2015/16 and take an approach that ensures stability and consolidation. The schemes within the plan will vary little in outward appearance from those seen in 15/16. However the lessons learned in the year will be applied to ensure that, they will be better set up in terms of measurable outcomes, formal review and demonstrable impact upon the metrics.

The plan reflects the growth in engagement with partners, shared ambitions and common goals.

The Lancashire BCF has proved to be a significant enabler across the health and social care environment. It has supported the change in approach to working together across Lancashire and is now placed as a key element in taking forward the Healthier Lancashire programme and contributing to the development and delivery of the Lancashire and South Cumbria Sustainability and Transformation Plan. Within this it will provide the building blocks for the development of an Integration Plan to be in place by March 2017 and enable the move towards the integration of health and social care by 2020.

4. Vision

The Lancashire vision for health and social care services keeps at its core the aims expressed in the 2015/16 plan:

That in 3-5 years Health and Social Care will have created a fully person centred approach, with seamless integrated services and pathways and that there will be emphasis on the key themes of:

- Out of hospital care with integrated neighbourhood teams
- Re-ablement services
- Intermediate care services – community based 24x7 step up & step down
- Supporting carers
- Integrated care shaped around individuals and delivered in care settings close to home.

This vision has been further enhanced by the development of a set of guiding principles that grew out of the desire of the Lancashire Health and Wellbeing Board, a multi partner BCF workshop and ongoing multi partner conversations to deepen the impact of the BCF.

- Using the Better Care Fund as a tool to move towards achieving integration by 2020 including:

    - Underpinning further integration of operational teams and joint posts to achieve new care delivery models.
    - Pooling resources to maximise value and efficiencies
    - Facilitating joined up care outside hospital across sectors and, importantly, including the 3rd sector and City and Borough Councils.
- The reduction of the number of BCF schemes to a smaller number of clear priority areas having BCF wide targets and work streams to allow for local variation.
- Aligning with and supporting the Healthier Lancashire programme
- Aligning with and supporting the development and delivery of the Sustainability and Transformation Plan (STP), adopting the appropriate planning footprint at the right time and working cooperatively across boundaries.
- Using the Better Care Fund pragmatically pooling funds in areas of joint activity that would benefit but don't immediately fit with the priorities of reducing avoidable hospital admissions and facilitating early discharge.
- Developing an emphasis on prevention and how the BCF can help the Start Well agenda.
- Being clear on the outcomes that are expected and building in measurement and evaluation from the start.

As can be seen there is a growing emphasis on the role that BCF will play in the development of the Lancashire and South Cumbria STP. Its role as an enabler has been recognised as it is included as a distinct work-stream within the Healthier Lancashire/ Lancashire and South Cumbria STP collaborative schemes. See *appendices A and B*.

While not all elements of the principles will be applied in BCF 2016/17 they will feed into the longer term planning processes for integration and STP.

BCF development work carried out in December 2015 encouraged participants to be ambitious in their expectations of what the BCF could be used to achieve. Along with existing priorities around supporting independence, prevention, admission avoidance and safe and timely discharge additional priorities for further consideration were identified:

1. Residential and Nursing Home care… Continuing Health Care, Quality, Safety, Managing the market
2. Children and Adolescent Mental Health Services...using the BCF Pooled fund arrangement to support integration
3. Transforming Care (Learning Disability) … using the BCF Pooled fund arrangement to support integration
4. Public Health /Prevention… Identify across existing Lancashire County Council and CCG spend on prevention and wellbeing areas of congruence and potential for improved outcomes and greater efficiency.

As the planning environment has changed it has enabled these to become distinct work streams within the accelerating Healthier Lancashire and Lancashire and South Cumbria Sustainability and Transformation plan programmes. For 1 and 4, however, there is much potential for BCF scheme delivery to now have crossover benefits and early gains. These will be explored in the early stages of 2016/17 as part of review of delivery and impact. This will reinforce the view of the BCF role as an enabler that can be utilised as all programmes develop.

A strong message that the BCF vision seeks to promote is that health and social care alone will not achieve the best outcomes around integration but need the wider involvement of the voluntary sector and district councils and the special and local knowledge, skills and resources that they can bring.

This BCF plan includes a commitment to use the coming 12 months to explore and pilot new models of shared delivery in support of the BCF outcomes. This initial 12 month commitment is a first step in a broader commitment that will see the Voluntary sector in Lancashire as a co-production and delivery partner in Lancashire by 2021. This will see:

- A positive shift in relationships and networks which will bring the BCF network and key strategic voluntary sectors together
- A joint understanding and shared commitment to progressing key priorities for BCF
- Market testing of the viability and robustness of the voluntary sector to deliver BCF priorities
- Insight and learning from 12 months of joint activity to inform work to achieve our 5 year commitment to work with the voluntary sector. This will align and then merge with the drive for integration and the Healthier Lancashire and STP programmes.

A statement from the voluntary sector setting out the intent to engage with the BCF is included at *appendix C*.

Similarly the 2016/17 BCF plan will introduce a programme of closer working with City and District Councils so as to have, in year, aspects of BCF plan delivery having strong district council input.

“In Lancashire we have seen that the Better Care Fund has started conversations that needed to happen - conversations that increasingly see housing as an essential part of health and care planning. BCF has provided a platform for meaningful engagement and partnership working between our District Councils, Lancashire County Council (Public Health and Social Care) and Clinical Commissioning Groups.”

See *appendix D* for full statement.

5. The Case for Change

The full case for change set out in the 2015/16 plan remains as relevant.

- The financial position across Health and social care partners has become increasingly challenging and is likely to worsen. Recent work carried out under the Healthier Lancashire programme identified a potential £800m financial gap by 2020 across the NHS and social care in Lancashire.
- The demographic pressures remain with the older population continuing to increase. Lancashire is showing higher populations than the England average in all age bands over 60 by 2021.
- Although Life expectancy overall is increasing there are still health inequalities across Lancashire, with areas within all districts were ill health is experienced at an earlier age and outcomes are worse than more affluent areas.
- Pressures on health and care systems have increased as more people with greater complexity of needs enter those systems challenging capacity and sustainability.
- The care sector across Lancashire requires support to improve quality, consistency, safety and capacity. There is a challenge to ensure that the right care is available at the right place at the right time.
- No one organisation is able to respond effectively, or even health and social care together. A full system approach is required which this plan seeks to enable.
- The BCF metrics in 2015/16 have shown some aspects of improvement but not achieved target for either Delayed Transfers of Care or Non- elective admissions.

6. Governance

There remain strong Lancashire BCF governance structure and processes that were put in place for BCF15-16. Details of these, including a structure and accountability diagram are within schedules 2, 3, 4 and 5 of the Lancashire BCF 2015/17 S75 agreement. See *appendix E.*

The terms of reference to both the Lancashire BCF Steering group and Programme managers group are attached at *appendices F and G*. Membership of these groups has been strengthened for 2016-17 by the recruitment of senior representatives of the voluntary sector and of the City and Borough councils within the county.

The Lancashire Health and Wellbeing board has taken the BCF as a priority within its work plan. It receives regular reports and takes a robust approach to the scrutiny of delivery. See *appendices H and I*.

So as to better manage the development and delivery of the BCF in Lancashire the BCF partners jointly funded a Senior Programme Manager post, hosted by Midlands and Lancashire CSU. The post-holder reports into the steering group, chairs the programme managers group and supports the partners' commitment to joint and coordinated working across the county and with neighbours in Blackburn with Darwen and Blackpool. See appendix J.

7. National Conditions

a. Plans to be jointly agreed

The final version of the BCF plan 2106/17 will be jointly agreed and signed off by the Health and Wellbeing board.

Providers of both health and social care have been involved with BCF workshops and fed into the process through the Health and Wellbeing board. *See appendices K and L.*

Providers are involved in all individual improvement areas e.g. all acute providers are key partners in the development of the DTOC plans and targets.

The CCG and Local Authority have as part of their wider planning and commissioning processes informed and engaged providers on the impact and expected outcomes of the use of the BCF.

b. Disabled Facilities Grant

There is an increasing level of involvement of districts councils in the BCF. Initially focussed on the mechanics of allocating DFG monies it is growing into a meaningful input into the wider plan development. District councils were significantly involved in the BCF development workshop and are now formally involved in the BCF governance structure at senior officer and housing policy level. *See appendix M.*

Lancashire County Council is leading the specific engagement of districts around DFGs. That arrangement has had success in redesigning pathways, improving consistency and piloting new shared assessment /working methods. It is focussing on the potential of more creative uses of DFGs especially in the initial stages of the assessment process.

c. Supporting Adult Social Care Services

The BCF plan will continue to support social care services as it did in 15/16. This is seen in the commitment to fund the same services, at the same level, as set out in the submission template. This includes a commitment to supporting the continued delivery of the Care Act requirements.

Continued contribution to Care support services is in line with the Lancashire Multi Agency Carers Strategy. This details the priorities for carers between 2016 and 2018. *See appendix N.*

The balance achieved in 15/16 in supporting financially challenged social care services while avoiding over stretching CCG support will continue. CCG operating plans reflect this approach.

The approach has to be seen in the context of the response of Lancashire County Council to the continuing challenges. The council has begun a programme of transformation under the banner of “Passport to Independence” working in partnership with the Newton Europe consultancy. This work is likely to result in radical changes in how social care services are delivered that will reshape the need for support.

The health transfer to social care revenue amount of £ 26.852m has been allocated to protect social care services within the BCF during 20161/7. £3.173m of this transfer is to continue to support delivery against Care Act duties. This is in line with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14.

The developing shared view of the desire to support social care can be seen in the approach to the allocation of the original S256 monies and an acceptance of there being benefit to the system that doesn’t necessarily sit in the originating CCG.

d. 7 Day Services

While 2015/16 saw the early form of a Lancashire wide 7 day delivery plan the approach taken in 2016/17 has been to enable that planning to take place at CCG and acute provider level so as best to reflect local and organisational circumstances**.**

CCG operating plans reflect this intent and how it will be overseen by the local SRGs so that the wider partnership elements of 7 day service delivery can be actively explored, and implemented. In turn the intent is to work to the Lancashire and South Cumbria Urgent and Emergency Care Network (UECN) so as to best address issues affecting achieving the four key 7DS standards such as workforce development. Resources available through the NHS Improving Quality Team, Health Education England are supporting this activity.

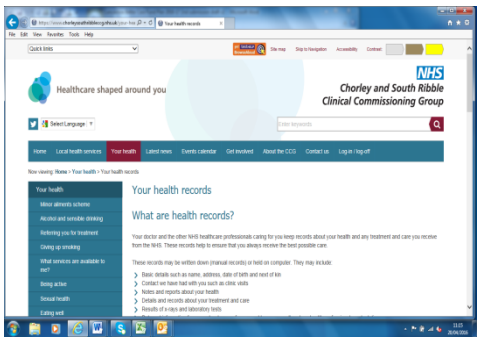
The BCF plan incorporates and supports this local and Pan- Lancashire activity.

e. Better Data Sharing

The plan for better data sharing is based around the Lancashire Digital Health Roadmap, (Enabling Work streams Chapter 7) *See appendix O.* A revised deployment plan for this is currently under development.

The roadmap and deployment plan cover the development of open APIs but not specifically the use of the NHS number. This is being managed under a separate programme by Lancashire County Council that has commissioned its IT support providers, BTLS, to complete the final stages of enabling the NHS number to be populated into all social care records. Once this is complete the Local Person

Record Exchange Service (LPRES) will be enabled and effective sharing of the right level of data in place.



Robust Information Governance arrangements are in place in all BCF partner organisations. All have in place clear processes and procedures that ensure patients, service users and the wider population are clear about how data about them is collected and used. These are proactive processes informing at the point of collection and accessible through the full range of channels. (Leaflets, web sites, posters, face to face etc.) Information is also provided across organisational boundaries i.e. covering health and social care in a single source.

f. Joint approach to assessments

There are joint developments of Integrated Neighbourhood Teams / Care Teams in slightly different guises in each CCG area across the county. Their importance to integration is reflected in their inclusion in this plan. All are developing joint assessment processes across health and social care, some creating trusted assessor roles and care coordinators.

This applies equally to people living with dementia, but there is also a different specific pathway for dementia is available with dementia advisers operating across the county working closely with integrated mental health teams. This approach is to continue and strengthen in 2016/17.

Each CCG uses Risk Stratification tools within overall population analyses to target its resources within the community and specifically in the emerging Integrated Neighbourhood Teams (INTs). Five of the CCGs use a risk stratification tool based on the Combined Predictive Model available through the *Aristotle* system provide by Midlands and Lancashire Commissioning Support Unit.

Use of the tool varies from identification of the top 2% high risk patients for case finding to stratification of the whole population to support needs assessment and service design (e.g. the Fylde Coast Vanguard). Whatever approach taken risk stratification tools are used to identify levels of support required including case management.

As a minimum 2% is maintained across all CCGs as the proportion of the population that will be receiving case management and named care coordinator. A more sophisticated approach will be articulated in a delivery plan, to be developed through BCF programme management group, early in the BCF plan 2016/17, setting out milestones and targets.

This will include such activity as the planned implementation of a trusted assessor model across the county to access Intermediate Care, Reablement and Community beds negating the need for social work assessment to gain access to these services. This has been built into contracts with social care providers as integral to access processes.

The BCF plan will coordinate with the work programme of the NHS England Lancashire Primary Care Transformation Team. Initial scoping has been carried out and synergies identified. Joint programmes and activity will be defined early in 2016/17. The resources of the team will be invaluable in work across all CCGs including building support for GPs and achieving consistency/ quality. *See appendix P*

g. Consequential impact of the changes

The consequential impact of the BCF on providers has been considered in deciding to retain the schemes from the 2015/16 plan.

Each CCG in its operational planning and contract management has, both internally and in dialogue with providers, confirmed that the planned levels of emergency activity are feasible and sustainable, minimising risk to commissioners and providers. These activity level targets, expressed both in the Operational Plans and the BCF plan, are ambitious, in that context.

As part of contractual arrangements and their own business sustainability model each provider actively monitors changes in activity and has in place risk management process and the ability to implement action plans.

The health economy level system resilience groups (SRG), centred on the providers of acute health care in Lancashire, provide the local forums for multi-agency oversight of activity and actions on local priorities. Along with the overarching Lancashire and South Cumbria Urgent Care Network these SRGs are the points of increasing inclusion of Lancashire BCF plan activity and that of the neighbouring authorities.

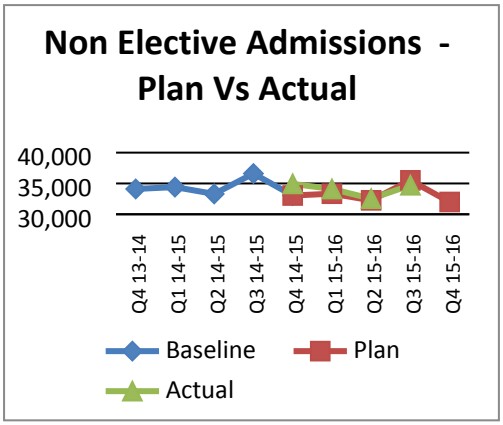
The recently submitted Lancashire and South Cumbria Urgent and Emergency Care Network delivery plan shows how the BCF will contribute to delivering the Urgent and Emergency Care priorities in each Network, and enable planning at a local SRG level. *See appendix Q*

h. Agreement to invest in NHS commissioned out of hospital services

The significant level of investment in NHS commissioned out of hospital services seen in the Lancashire 2015/16 BCF plan will be replicated at least in the 2016/17 plan. There has been some adjustment across schemes to reflect changes in minimum contributions and broader CCG planning priorities.

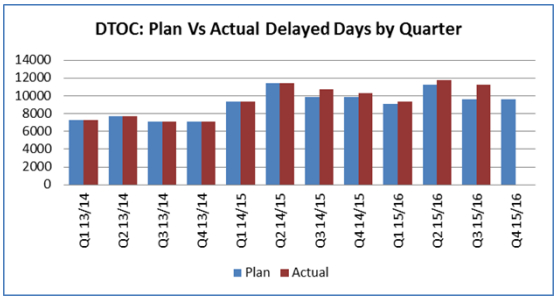
The approach to risk in operation of the BCF pooled budget in 2015/16 was one of individual organisations managing that around their own contribution and local performance against the metrics. This allowed for significant local differences, demographic, provider, geographic and historical performance to be safely managed across a complex planning footprint.

Performance in 2015/16 did not achieve planned levels in Lancashire. However the level of underperformance in both Non Elective Admissions and Delayed Transfers of Care metrics was relatively low and with some local variations against a backdrop of sustained high and complex demand.



Non elective admissions at Q3 2015/16 were 2.9% less against the 2015/16 reduction target of 3.1% from baseline.

Delayed Transfers of Care – 1.2% higher than same period during 2014/15.



All CCGs are in agreement that continuation in the "self-management" approach to risk should continue given the narrow gap. It is acknowledged that the "gap" needs to be closely and jointly monitored throughout the life of the BCF plan and management plans initiated as required. High quality and timely data is provided to the BCF steering and programme manager groups in the form of a *dashboard* that provides monthly performance and trend analysis. *See appendix R*

The out of hospital NHS commissioned schemes within this plan cover prevention, admission avoidance, supported discharge and a range of step up / down services and reablement/rehabilitation. They are

CCG commissioned services:

East Lancashire
• Services through its partnership with the voluntary sector to focussed on building community assets to provide tailored information and signposting.
• A primary care base model of Dementia Diagnosis including pre and post diagnostic support.
• Redesigned intermediate care services supported by an integrated discharge function.

• Intensive Home Support
Fylde and Wyre

• Intermediate Care redesign to include 4 components
  o Residential Recuperation and Rehabilitation
  o Rehabilitation Beds
  o Recuperation Beds
  o Dementia Residential Rehabilitation

Greater Preston and Chorley and South Ribble
• Community Beds / Intermediate Care • Effective Discharge
Lancashire North

A sub set of the *Better Care Together* Transformation programme
• Intermediate Care Services supporting a Care Coordinating Centre
• Self-Care… Self-care Lancashire North
• Specialist Community Services…within an out of hospital model
  o Provide specialist support to core teams in planned management of patients
  o Provide fast access to support if a patient's condition deteriorates to stabilise their heath and prevent avoidable admissions

West Lancashire
Within the Building the Future Together initiative • Single point of access • Integrated Neighbourhood teams • Integrated Out of hospital Urgent Care services • Improved community management of ambulatory care sensitive conditions • Extended treatment room services

All are retained at the same level of investment as 2015/16. P4P performance in 2015/16 was such that there was no significant release of funds to support any change in funding levels.

i. Delayed Transfers of Care (DTOC)

The Lancashire and Cumbria Urgent Care Network has supported the approach to develop SRG foot print based plans that will then be drawn together into a Lancashire compendium of plans for DTOC. At Lancashire level commonalities will be highlighted and best practice shared. This will include plans operating across local authority boundaries, working collaboratively with Blackpool and Blackburn with Darwen, and cover such additional issues as managing transfers of care from centralised specialist provision.

Delayed Transfers of Care are currently the focus of a number of improvement collaborative workshops across Lancashire based around the acute providers. There are also a number of existing work-streams and programmes considering DTOC led by a range of partners and with differing priorities. All of these are being

mapped so that each SRG can draw activity together under the BCF DTOC plan umbrella with consistent aims and coordinated activity.

In addition BCF DTOC plans will create links and identify synergies with a parallel piece of work now underway to create a collaborative approach to managing DTOC in mental health settings in Lancashire.

Targets for DTOC have been set within CCG operating plans and are the basis for the BCF targets. The level of stretch agreed within the BCF reflects the opportunities offered by improved planning and coordination across patient flows but also reflects the profile of quarterly performance in the last 2 years so as to be realistic.

All SRG level stage 1 DTOC plans are complete and incorporate local short term action plans based upon analysis of local circumstances, capacity and effective experience. *See appendices S,T,U,V,W.*

A further 12 month period of development will now follow. Subject to confirmation this will be "owned" by the Lancashire and Cumbria Urgent Care Network supported by the BCF programme.

April 2016	**Stage 1 SRG level DTOC plans in place**
May 2016	Lancashire and South Cumbria "compendium of plans in place
June /July 2016	UECN review of all DTOC plans and effectiveness of local actions
July 2016	Lancashire and South Cumbria DTOC planning events / workshops to develop sustainable models
August to October 2016	Support to all SRGs to further develop plans and delivery
December 2016	Stage 2 SRG level DTOC plans in place
January to March 2017	Ongoing review of plans including peer review
March 2017	Lancashire and South Cumbria DTOC planning event
April 2017	Stage 3 (Final) SRG level DTOC plans in place with final Lancashire and South
April 2017	Ongoing development process to be agreed

8. Scheme planning and delivery

All schemes as set out in the Lancashire BCF plan 2015/16 are to be retained for the plan 2016/17.

The rationale for this approach is that they are the priority activities for each partner that offer the most impact upon the BCF outcomes and metrics, they offer further opportunities for development and refinement and provide the stability for commissioners and providers.

The opportunity will then exist to review all against good outcome measures using tools such as Logic Modelling.

Part of the review(s) will be to look at the potential to streamline the number of schemes on the basis that they provide the same or very similar services and have similar aims. Combining schemes, where local considerations allow, may ease administrative and planning burdens and be real examples of how joint working and integration can progress. The plan will be flexible to allow “shadow” combination of schemes to happen in year.

The schemes are seen as the basis and test bed for greater integration and so help the BCF plan 16/17 be a step towards the overall integration plan.

Delivery of schemes will remain the responsibility of the identified lead organisation that will also be responsible for leading reviews, reporting on performance and sharing learning and good practice.

9. Scheme level spending plan

Each scheme is set out in terms of planned spend and individual CCG and /or LCC contribution in the submission template and sections 12. and13. of this plan.

Each scheme has in place an existing detailed plan for its delivery. See Lancashire BCF plan 2015/16. These plans will be reviewed and new plans put in place early in the first quarter of the 2016/17.

Where possible plans will be aligned as part of the streamlining described above.

The CCG operating plans make appropriate reference to the new BCF plans.

10. National metrics

a. Non elective admissions

The target has been set through direct reference to CCG operating plan targets. No additional performance has been associated with BCF as to go beyond a “credible ask” would represent a non- viable approach.

This ask reflects consideration of performance during 2015/16 which while improving year on year did not achieve planned target and so underlined the need to avoid any overstretching.

The target is set in the context of delivering while maintain provider sustainability.

b. Admissions to Residential and Nursing Care Homes

The plan for 2016/17 is a 3% reduction on the forecast 2015/16 outturn i.e. from716.4 to 682.7 admissions per 100,000 population over 65 years.

The target has been set so as to be achievable within a period of challenging finances, structural changes in social care and high system pressures while still seeking to move toward the England average. It is also based upon a continuing downward trajectory seen over the last two years but tempered by the recognition that the demographic factors set out in the case for change will see an increase in upward pressures.

The analysis done, to define the target, indicated that recent significant improvements would be difficult to maintain year on year due to pressures in the system linked to demographic changes and the ‘credible ask’ being requested for individual CCG planning.

c. Effectiveness of Reablement

The 2016/17 target has been set at 2015/16 levels i.e. 82% (Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services).

Setting of this target has been done against a background of a great increase in demand for the service and overall throughput. While this is in itself a success it also represents greater numbers of people with more complex needs going through the service with a differing, less positive, set of likely outcomes than previous cohorts.

d. Delayed Transfers of Care

The final quarterly plan will be confirmed once all data for 15/16 becomes available. Q3 15/16 showed a significant worsening and system feedback indicated that Q4 would show an at least equal challenge.

The 16/17 plan reflects the trajectory seen in 15/16 and profile across the year. It refers back to CCG operating plans and is expressed at SRG level in the DTOC plans.

11. Funding Contributions

The planning return template sets out the allocation of the minimum contributions for 2016/17. This has been signed off by all parties.

The application of the Relative Needs Formula has resulted in some shifts, in 2016/17, from 2015/16 CCG minimum contributions as set out below.

	£
Chorley and South Ribble and Greater Preston CCGs	+ 503,000
Fylde and Wyre CCG	- 68,000
East Lancashire CCG	- 46,000
Lancashire North CCG	+ 64,000
West Lancashire CCG	- 5,000

These changes have been managed within the individual CCG planning process and are reflected in the planned BCF scheme spends.

The £11,476,000 Disabled Facilities Grant (DFG) funding is being distributed as required across the 12 district councils, within Lancashire, with the financial process for this well established. In 2016/17 the allocations will be directed towards delivery through the DFG process. However District Councils are actively considering, through the health leads group and BCF steering and programme manager group involvement, the potential for more flexible approaches that can have more immediate impact upon such issues as safe hospital discharge. It is anticipated that this will come together as a DFG/BCF action plan during the life of this plan.

Care Act, former Carers Break and Reablement monies have been clearly identified within the template submission.

There are to be no additional contributions to the pooled budget in 2016/17 by Lancashire County Council or any of the 6 CCGs.

Each CCG has proportionally* contributed an increased amount to the support of Care Act delivery based upon the “ready reckoner” indicative amount. (* based upon total minimum contributions).

12. Lancashire Better Care Fund Schemes 2016/17

		£ ,000s
Scheme	**East Lancashire CCG**	
BCF01	• Transforming Lives, Strengthening communities - Building capacity in the voluntary sector	204
BCF02	• Re-design of Dementia Services East Lancashire	1,588
	• Redesigned Intermediate Care supported by	
BCF03	○ Integrated Discharge Function,	
BCF04	○ Intensive Home Support,	
BCF05	○ Navigation Hub/Directory of Services	13,883
	Fylde and Wyre CCG	
BCF06	• Intermediate Care Redesign	1,935
BCF07	• Admissions Avoidance	3,714
	Greater Preston, Chorley and South Ribble CCG	
BCF08	• Lancashire health economy whole system urgent care transformation programme – Community Beds / Intermediate Care	5,972
BCF09	• Lancashire health economy whole system urgent care transformation programme – Effective Discharge	446
	Lancashire County Council	
BCF10	• Development of Extra Care Schemes (Housing) (No additional funding in 2016/17 but scheme remains within BCF to end of planned development)	0
	Lancashire wide	
BCF11	• Integrated Offer for Carers – Support and Respite	7,511
BCF12	• Reablement	6,444
BCF13	• Transforming Community Equipment Services	9,768
	Lancashire County Council	
BCF14	• Telecare services Lancashire CC	548
BCF15	• Care Act	3,173
BCF16	• Disabled Facilities Grant	11,478
	Lancashire North CCG	
BCF17	• Intermediate Care Services to support Care Coordination Centre	3,845
BCF18	• Self-care Lancashire North	43
BCF19	• Specialist community services Lancashire North	2,766
	Lancashire wide	
BCF20	• Integrated Neighbourhood / Care Teams Lancashire-wide	13,134
	West Lancashire CCG	
BCF21	• Building the future together West Lancashire	4,967
	Total	91,419

13. Lancashire BCF scheme CCG and Lancashire County Council breakdown

£ ,000s

BCF scheme	Total	EL	F&W	CSR/GP	LN	WL	LCC
1.	204	204					
2.	1,588	1,588					
3. – 5.	13,883	13,883					
6.	1,935		1,935				
7.	3,714		3,714				
8.	5,972			5,972			
9.	446			446			
10.	0						0
11.	7,511	2,536	1,012	2,366	925	672	
12.	6,444	1,741	1,059	2,454	487	703	
13.	9,768	3,619	805	3,589	1,221	534	
14.	548	254	115		103	76	
15.	3,173	1,024	461	966	415	307	
16.	11,478						11,478
17.	3,845				3,845		
18.	43				43		
19.	2,766				2,766		
20.	13,134	1,200	1,791	9,267	720	156	
21.	4,967					4,967	
Total	91,419	26,049	10,892	25,060	10,525	7,415	11,478

14. Appendices

Page	Appendix	Document
9	A	Lancashire Collaborative Programmes
9	B	STP Submission
10	C	Voluntary sector statement
10	D	City and Borough Council Statement
11	E	Section 75 agreement
11	F	BCF Steering Group Terms of Reference
11	G	BCF Programme Managers Group Terms of Reference
11	H	Lancashire Health and Wellbeing Board Agenda 22nd February 2016
11	I	Lancashire Health and Wellbeing Board Action Planning
12	J	Senior Programme Manager Job Description
13	K	BCF workshop programme
13	L	BCF workshop report
13	M	Local Authority Health Leads agenda
13	N	Lancashire Carers Strategy summary 2016 18
14	O	Lancashire's Digital Health Roadmap 2015-2018
16	P	NHSE Lancashire Primary Care Transformation Plan on a Page

Page	Appendix	Document
16	Q	Lancashire and South Cumbria Urgent and Emergency Care Network delivery plan
17	R	Lancashire BCF Performance Dashboard
19	S	Stage 1 DTOC Plan East Lancashire
19	T	Stage 1 DTOC Plan Fylde Coast
19	U	Stage 1 DTOC Plan, Greater Preston and Chorley and South Ribble
19	V	Stage 1 DTOC Plan Lancashire North
19	W	Stage 1 DTOC Plan West Lancashire

Mapping Current Lancashire Collaborative Programmes

Primary care | Secondary and Tertiary | U&E care | Elective & maternity | Diabetes | End of Life | MH & dementia | LD | C&YPMH | Care Sector | BCF

1. Stroke
2. Vascular

Stroke /TIA
Deliverables
New model of care in acute services
Improved stroke prevention
End to end stroke dashboard
Improved post stroke support
Improved patient information across pathway

Team resource
Senior Programme Manager - 2-3 days /week; Programme Manager – 3-4 days/week; Band 7 - 2 days/week ; Band 6 - 2-3 days/week; Band 5 - 2-3 days/week General project support; Clinical associate support – 1-2 days/month

Vascular
Deliverables
Standardised out of hospital pathway
Gap analysis against pathway
Training and education plan for primary care

Team resource
Programme Manager - 1-2 days per week; Band 5 - 1 day/week General project support; Clinical associate support – 1-2 days/month

3. U&E care plans

Urgent & Emergency Care
Deliverables
Support the development of the U&EC Network plan for submission by 30th June 2016
Engage with NWAS/NHS111 and NHS England locality teams to support the development of the plan.
Link with Lancashire Digital Strategy.
Link with other U&EC Networks

Team resource
Senior Programme Manager – 2-3 days/week

KEY

HL AOP priority

Other STP priority

Senior Programme Manager – Band 8b
Programme Manager – Band 8a

4. MH & Dementia
5. Learning Disability
6. C&YPMH

Mental Health & Dementia
Deliverables
Mental Health Crisis Care Concordat
Mental Health Unscheduled Care
EIS, IAPT, MAS, USC
Review of service specifications

Team resource
Senior Programme Manager – 2-3 days/week ; Programme Manager – 5 days/week; Band 7 - 2 days/week; Band 6 - 2 days/week ; Band 5 -1-2/days week – General project support

Learning Disability
Deliverables
Resettlement of current long term hospital in-patients
Develop new community service model
Develop housing strategy/market stimulation/workforce/prevention /Crisis/forensic programmes
Calderstones closure programme

Team resource per week
Programme Director – 5days/week; Band 6 – 5 days/week; Band 3 – 5 days/week Administration

C&YP Emotional Wellbeing and Mental Health
Deliverables
Implementation of the CYPEWMH transformation programme objectives
Engagement with schools and third sector providers
Links with Adult Mental health and Learning Disabilities programmes

Team resource
Programme Director (8d) – 4-5 days /week; Senior Programme Manager – 2-3 days/week; Band 6 – 5 days/week; Band 5 - 2-3 days/week General project support

7. BCF
8. MH rehab

Better Care Fund
Deliverables
Identification of good practice in integration across health and social care
Production of a 2016/17 plan
Support the integration of health and social care
Alignment of BCF plans
Evaluating the impact of the 2015/16 Lancashire BCF plan.

Team resource
Senior Programme Manager – 5 days/week

MH Rehab
Deliverables
Evaluation of, and future recommendations for, the gateway Pilot in BwD.
Production of a joint health & LA resource that offers an updated picture of MH bed and support service availability pan Lancashire.
Work with LCFT to develop a project to review all BwD MH rehab cases currently in funded placements.

Team resource
Senior Programme Manager – 1-2 days/week; Programme Manager – 4 days/week; Band 6 – 1-2 days per week

Lancashire & South Cumbria STP
April 15 template submission

FINAL v 4.2

Key information on the footprint

Name of footprint: 4. Lancashire & South Cumbria
Region: North
Nominated lead of the footprint: Dr Amanda Doyle, Clinical Accountable Officer, Blackpool CCG
Contact details: Amanda.Doyle@blackpool.nhs.uk 01253-951227
Organisations within footprint:

Organisations by Local Delivery Plan footprints

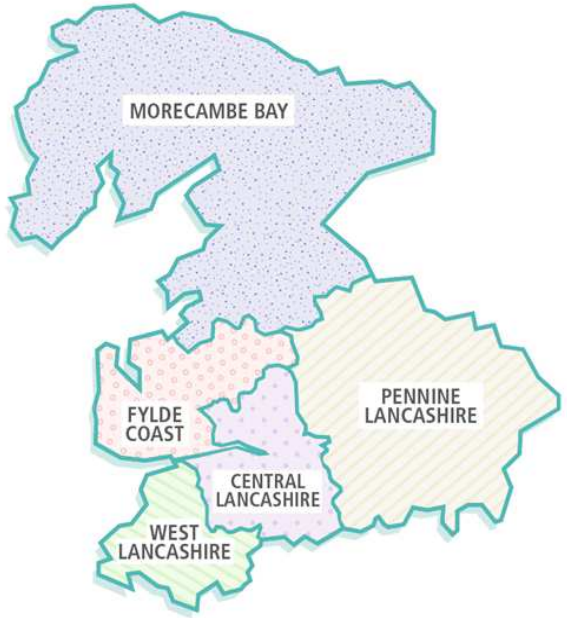
Central
Greater Preston CCG
Chorley & South Ribble CCG
Preston City Council
Chorley Council
South Ribble Council
Lancashire Teaching Hospitals FT

Fylde Coast
Blackpool CCG
Fylde & Wyre CCG
Blackpool Teaching Hospitals FT
Blackpool Council
Fylde Council
Wyre Council

West
Southport & Ormskirk Hospitals
West Lancs CCG
West Lancashire Council

North
University Hospitals Morecambe Bay FT
Cumbria Partnership FT
Lancashire North CCG
Cumbria CCG (South)
Cumbria County Council
Barrow-in-Furness Council
Lancaster City Council
South Lakeland Council

Pennine
Blackburn with Darwen CCG
Blackburn with Darwen Council
East Lancashire CCG
East Lancashire Hospitals Trust
Burnley Council
Hyndburn Council
Pendle Council
Ribble Valley Council
Rossendale Council



Overarching Organisations
Lancashire County Council
Calderstones/Merseycare Trust
Lancashire Care FT
NHS England
North West Ambulance Service

Section 1: Leadership, governance & engagement (1)

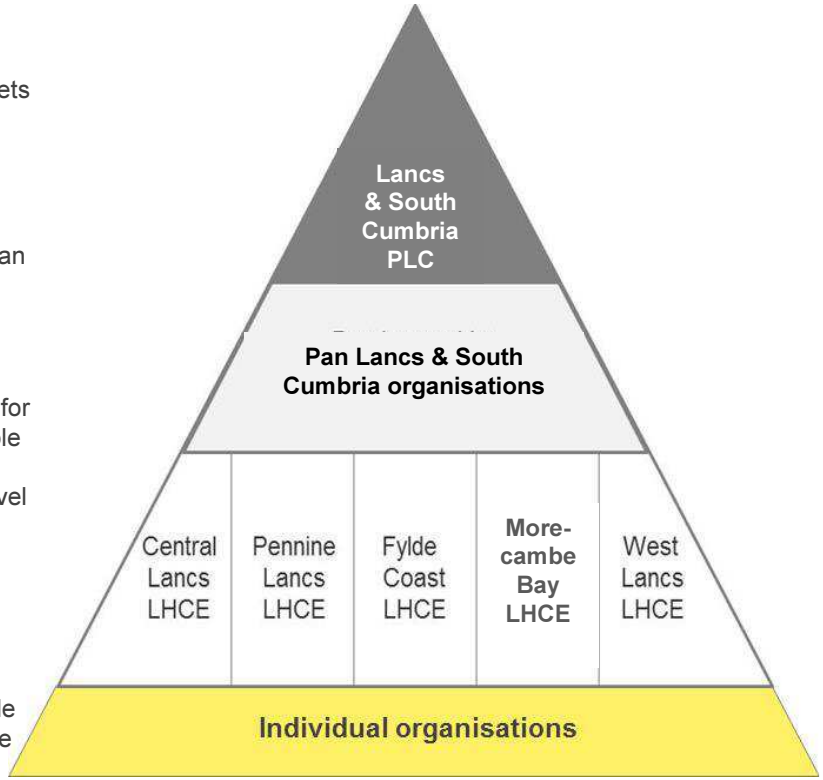
Collaborative leadership and decision-making

Healthier Lancashire & South Cumbria

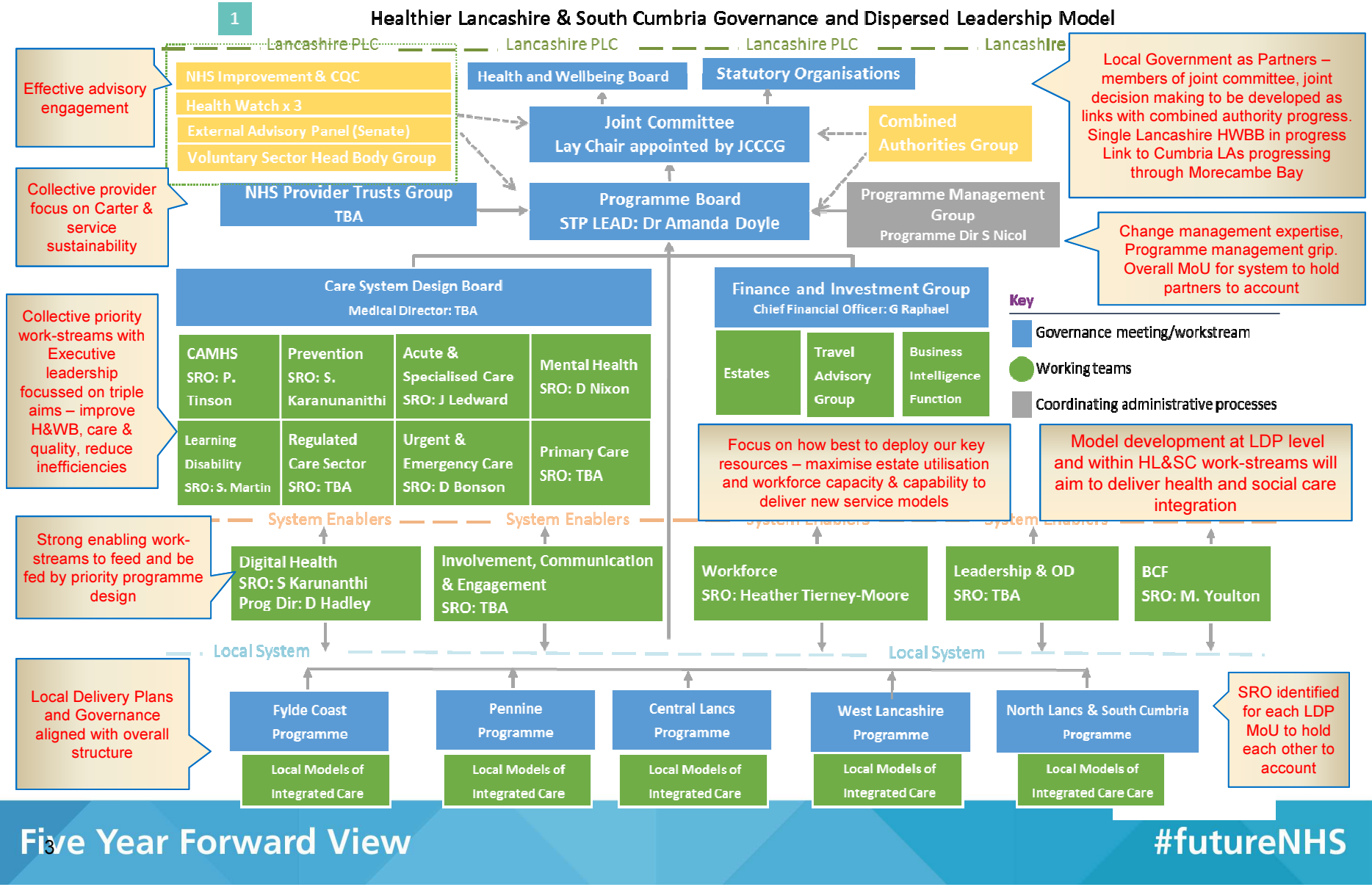
As health and care organisations across Lancashire and South Cumbria (L&SC) we have organised ourselves to work in an unprecedented collaboration to co-design, implement and deliver the changes required to transform the health and care services; to ensure services are delivered to meet the needs of our local populations, and actually ensure improved health outcomes, but that are prioritised within existing financial allocations. Our ambition is to see a radical large scale system change in health and care in L&SC, underpinned by the combined long-term commitment of organisational leaders across L&SC. We're doing this to deal with the financial, demographic and outcome challenges being felt more acutely in our area than elsewhere in England and consequently needing urgent, unified attention.

The L&SC Sustainability and Transformation Plan 2016-21 will be an early output of the Healthier Lancashire & South Cumbria programme, setting out the case for change, priorities for collective action and plans for mobilisation of the solution design phase of the HL&SC programme. HL&SC will need to be built upon the commitment of the providers, commissioners, local government and other partners within each of our five localities to deliver the change required to better meet local needs through their local delivery plans (LDPs). The success of the L&SC STP will depend upon the alignment of its vision, ambition and priorities with the opportunities for collective action within the LDPs, and the effective focus of our combined efforts at the right level of the HL&SC triangle.

- **At a L&SC PLC level:** Seeking new opportunities for truly transformational change and leveraging system wide assets and influence
- **At a Pan L&SC level:** Accepting compromise and agreeing consistent service models to enable efficiency for pan Lancashire organisations and make the system navigable for patients and care providers
- **At a LHCE level:** Having a framework for commonality so system remains navigable and learning can happen across LHCEs and encouraging innovation at a local level as addressing truly local challenges and piloting at scale to the benefit of Lancashire. Working collaboratively between neighbours rather than against
- **At an individual organisation level:** Ongoing relentless delivery of sustainable CIPs, QIPP and cost reduction will still be required



Our governance arrangements recognise the importance of working through distributed leadership. Dr Amanda Doyle is lead for the L&SC STP and SRO for the HL&SC programme, supported by an experienced senior team; Gary Raphael as Finance Director and Sam Nicol as the Programme Director. Each HL&SC work-stream has an identified SRO drawn from across member organisations, supported by a dedicated senior programme manager. Similarly, each LDP has an SRO and Programme Director, with local governance and work-stream arrangements aligned to the structure below.



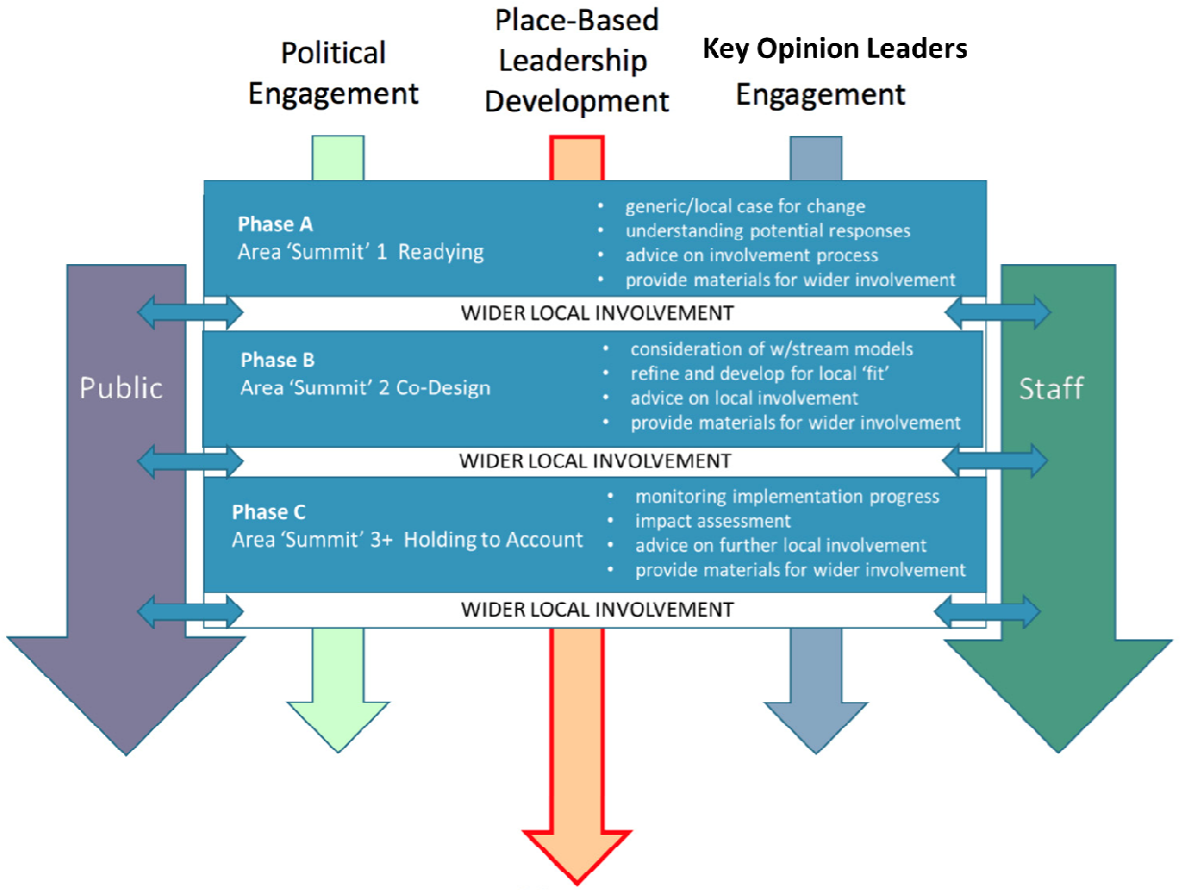
Section 1: Leadership, governance & engagement (3)

An inclusive process

Everything we will do together will be for the benefit of all of the people of Lancashire. We will build upon the collaborative change programmes that we are already delivering, within which we have undertaken extensive engagement on planning changes to service delivery. However, we are now looking for a step-change in that involvement so that our people become part of the change. Collectively we will co-design strategies, working towards a radically different, people-centric preventive system, addressing the wider determinants of health and so less reliant on costly infrastructure.

We recognise that changes over the next five years can only be made by common consent with patients, the public, staff, local media and system partners – so everyone will need to be fully engaged to collectively develop the system-wide solutions needed to tackle system-wide problems. Consequently, we have designed a HL&SC involvement communications and engagement (ICE) programme.

Our ICE programme will create widespread understanding of the need for radical change; raise awareness of what individuals and communities can do to improve their health, resilience and behaviours; and ensure that change proposals are developed through co-design with clinicians, the public and service users. Our approach will be fundamental in demonstrating that we have met statutory requirements for robust evidence of inclusive engagement to facilitate implementation; convince politicians we are listening to local people; and withstand any legal challenge to the process. Therefore, we are appointing a Director of Involvement, Communications and Engagement to oversee delivery of this programme, supported by strong C&E lead network across L&SC.

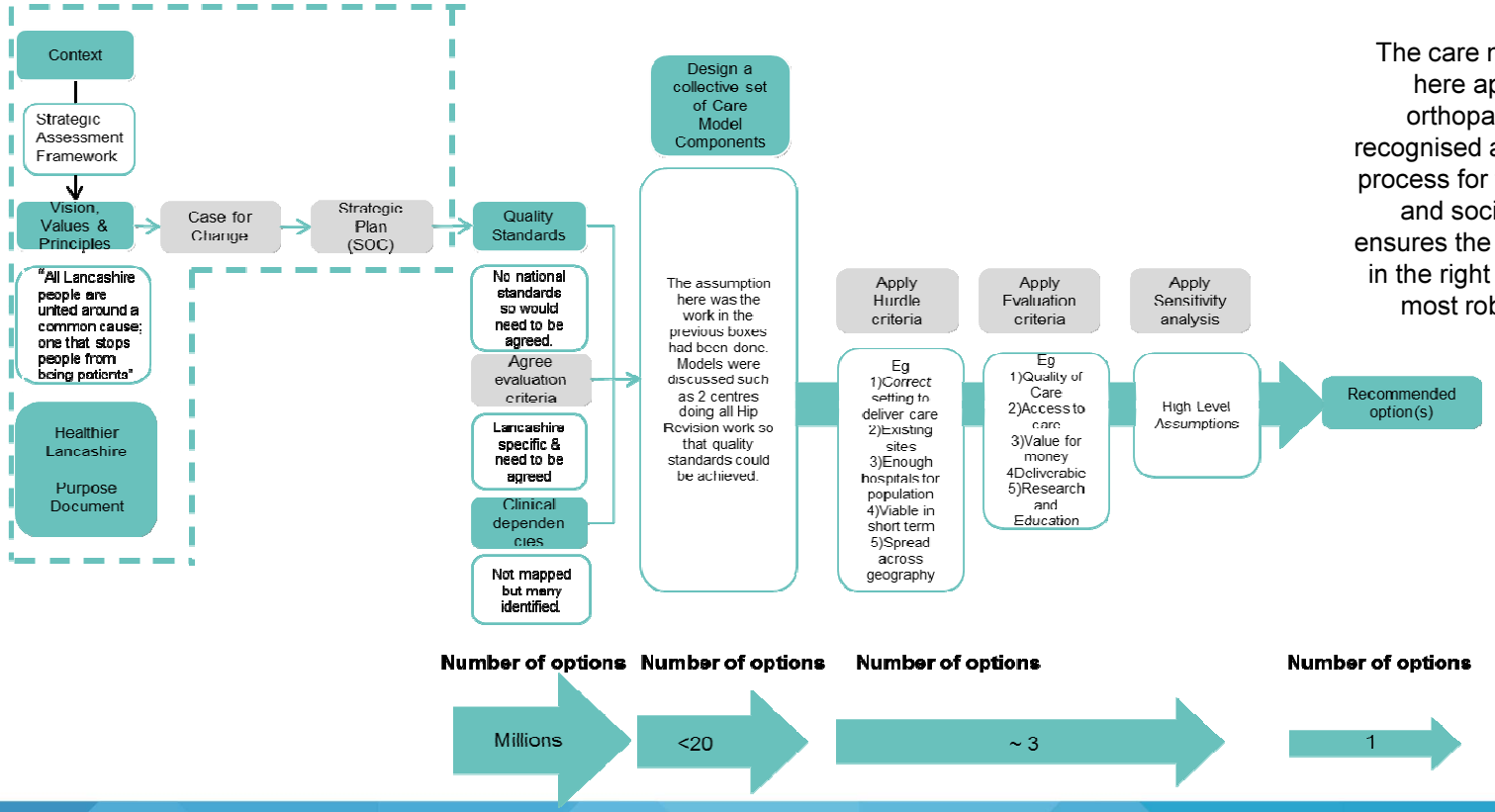


Section 1: Leadership, governance & engagement (4)

Engaging clinicians and other NHS staff

Within the HL&SC governance arrangements, the System Model Design Group will be made up of senior clinicians and care professionals. All the identified work-streams and project groups will include hospital and community based clinicians and care professionals on the principle that frontline staff have to be involved in designing the solutions to make them deliverable. We will provide expert guidance on opportunities, interventions and evidence in support of our solution design process (example below)

Lancashire Elective Orthopaedic Update: Care Model Design Process Flow Chart



The care model design process – here applied to the elective orthopaedics pathway - is a recognised and tested gold standard process for the redesigning of health and social care systems. and ensures the right decisions are made in the right sequence to ensure the most robust option is agreed.

Section 2a: Improving the health of people in our area

We understand what is driving the excess mortality and ill health across our area. We have developed this understanding through a detailed analysis of health profiles in each of our five health economy foot prints and of the variation that exists across our area. In summary:

1. We have an ageing population - we have added years to life but not necessarily life to years. Healthy life expectancy is plateauing and in some cases, particularly in males, it is starting to decline. Socioeconomic and environmental factors play a significant role in determining the health outcomes.
2. We have a high prevalence of damaging behaviours - smoking, poor diet, increased alcohol use
3. The major reasons for the gap in life expectancy between Lancashire and England are due to circulatory diseases (includes coronary heart disease and stroke), cancer, respiratory and digestive diseases (includes alcohol-related conditions such as chronic liver disease and cirrhosis). There is a significantly higher proportion of external causes for men (includes deaths from injury, poisoning and suicide) compared to women. Circulatory diseases and mental and behavioural disorders for women (includes dementia and Alzheimer's disease) affect a higher proportion of women compared to men as the major reasons for the gap in life expectancy between Lancashire and England.
4. We also have pockets of higher infant mortality, low birth weight, tooth decay, under 18 conceptions, overweight and obesity at reception and year 6, and unplanned admissions due to injuries, asthma, diabetes and epilepsy in our children and young people compared to the England average.

Our hospital-centred model is increasingly unable to meet the needs of a modern healthcare system – we must prevent new cases of avoidable disease arising; improve community resilience and citizen independence; and manage the quality of life for people with multiple long term conditions. Keeping people safe and well, leading socially and economically active lives in their own homes and communities for as long as possible has to be the focus for the future of our sustainable L&SC health and care system. We need a **'population health system'** , with more health and social care focussed on preventing disease and promoting health. We need more of it delivered in homes, localities and neighbourhoods where we know early intervention can best stop problems becoming more serious and expensive to deal with. We will move from a hospital and illness based approach to a person centred and health based approach with a different and lower cost infra-structure.

Working with local authorities and the wider public, third sector and businesses, our population health system will make L&SC a safer, fairer and healthier place to be born, live, work and retire, and will improve health across all ages, building upon our existing programmes (see next page), sharing what works and implementing locally across Lancashire at pace and scale.

Aims and Objectives	Our initial hypothesis for improving health and wellbeing
1. Promoting Wellbeing and addressing socioeconomic and environmental determinants of health	
1.1 Fully engaging and activating the resourcefulness/assets of our residents and communities to improve wellbeing and resilience (grass roots third sector). We will also work in partnership with other public sector agencies.	We have numerous examples of exemplar initiatives within our STP area. Our key focus is on scaling up and spread of initiatives and to learn from other areas to implement best practice. The following examples demonstrate our thinking so far. We will further refine and prioritise these and also identify success measures to monitor and evaluate progress. • Scale up our work with the VCFS sector to develop grass roots community resilience • Spread initiatives like Well Skelmersdale, Spice Time Credits and the learning from Carnforth and Millom experience • Maximise the role of Health champions/Health Trainers that already exist in our communities
1.2 Breaking the link between poverty and ill health by improving early childhood development, health related unemployment, housing standards including fuel poverty and social isolation.	• Achieve the key standards in the Better Births, the Healthy Child Programme and the National Troubled Families programme
1.3 Maximise the role of LAs and public services in improving health outcomes	• Further develop our Walking and Cycling Strategies across the STP area • Spatial planning policies to promote health and wellbeing (e.g Healthy New Towns) • Continue to improve road safety and community safety initiatives to address excess mortality and morbidity
2. Preventing Illness and addressing variation in quality of care	
2.1 Promote healthier lifestyles and maintaining independence by taking a place based and whole life course approach.	• Focus on behaviour change and a healthy settings approach (e.g healthy cities, smoke free, dementia friendly) to achieve a step change in childhood obesity, smoking, alcohol, and physical inactivity
2.2 Early identification and management of risk factors that cause the excess deaths and ill health.	• Continue to improve uptake on NHS Health Checks and the roll out of the next phase of diabetes prevention programme • Improving quality of primary care in detecting and managing long term conditions • Improving screening uptake (breast and colon in particular) and early diagnosis of cancer
2.3 Address variation in the quality of care across our area by learning from the right care approach and sharing good practice	• Refer to right care opportunities for improvement in the 'Improving Quality Section' of this template
2.4 Workplace health	• Promote workplace wellbeing charter and spread good practice like Flourish at Work staff fitness programme in Morecambe Bay • Embed making every contact count across the workforce and the use of digital technology as key enablers of our transformation
3. Prolonging quality of life	
3.1 Improve the quality of life for people with complex long term conditions through a strengths based self-management support and a community orientated integrated team working across the health and care sectors.	Systematic identification of the 2% complex patients through risk stratification People with complex comorbidities to have an integrated health and care plan Further enhance the self-management support for people with long term conditions

Section 2b: Improving care and quality of services (1)

Understanding our care and quality gaps

We have poorer outcomes in L&SC – we are amongst the worst in the country on premature mortality. Our elective hospitalisation rates are much higher than both the England and North Region average. There are acute shortages of hospital doctors across some specialties and difficulties recruiting GPs to work in disadvantaged areas. Our regulated care sector market – vital to receive patients ready for discharge from hospital – needs urgent attention, and resources available for adult social care are falling. As health and social care becomes more integrated out of hospital, there is a need to make progress with the reconfiguration of hospital services at a time of financial pressures.

We are using the Right Care data packs to develop our understanding on the unwarranted variation in the cost and quality of our local services to identify key opportunities for collective action to avoid 'postcode lotteries'. Where appropriate, we will use our ethical framework to review ineffective services to inform disinvestment opportunities. The table below provides a list of common areas of improvement across a range of disease pathways in Lancashire which will inform our work-streams.

Disease pathway	Common themes for improvement across Lancashire
Cancer (Breast, Colorectal and Lung)	Breast screening, Bowel Cancer screening, early diagnosis and starting definitive treatment within 2 months.
Diabetes	Control of blood pressure and cholesterol Retinal screening
Common mental health conditions	Improving access to psychological therapy completion and demonstrating reliable improvement
Heart disease	Control of hypertension and high cholesterol
Stroke	Treatment of TIA within 24 hours Patients with stroke spending 90% of the stay in a stroke unit Emergency readmissions within 28 days of discharge
COPD	Improving the identification of people with COPD on GP registers Measuring FEV1 to assess COPD
Asthma	Emergency admissions for children and young people (0-18)
Musculoskeletal	Management of osteoporosis EQ5D health gain for people undergoing hip and knee replacement Emergency readmissions within 28 days of discharge following hip replacement
Trauma	Falls in elderly, emergency readmissions within 28 days of discharge following hip fracture
Renal	Percentage of people with chronic kidney disease on home dialysis Percentage of people with renal replacement therapy who have renal transplant
Maternity and early years	Many areas have worse outcomes e.g. under 18 pregnancy, smoking during pregnancy, breast feeding at 6-8 weeks, childhood obesity at reception age, AE attendances for under 5s,

Section 2b: Improving care and quality of services (2)

Our emerging hypotheses for tackling the care and quality gap

We will improve significantly the care and the quality of services at a locality level through the integration of health and social care, and L&SC-wide we will improve quality, outcomes and safety through the achievement and maintenance of core standards across all hospital services accessed by our populations. We will reduce fragmentation through standardised approaches; implementation of evidence based components of care at scale and pace; and basing the design of services on agreed and evidence based standards (see slide 5 for an example of our care model design process).

We are already developing, implementing and testing new models of care within LDP footprints, and ensuring that learning from local and national vanguards is shared across the system to support implementation at scale as appropriate:

Central – Primary care at scale; MSCP across 3 localities
Fylde coast – Extensive care Vanguard; enhanced primary care; episodic care model across neighbourhoods
Morecambe Bay – Better Care Together - shadow accountable care system
West Lancs – Integrated health and social care at neighbourhood level via MCP model; community service procurement
Pennine Lancs – Accountable care system; Care sector (NH) Vanguard (Airedale)

We are establishing a provider group to focus on networking and collaborative opportunities across Lancashire providers, particularly the delivery of recommendations from the Carter review to deliver improvements in the quality and cost efficiency of care. The work of the group will also include the significant third sector providers who are seen as vital to the future delivery of care services.

A key driver is the workforce challenge already experienced across L&SC. We recognise that this will necessitate health and care services to be consolidated and require new roles and flexible working. We have established a work stream to not only look at supporting the existing workforce to be more effective, but working in partnership with schools and colleges to encourage the workforce of the future to choose health and care professions. We also have a significant digital health programme, establishing the infrastructure for sharing information across the system, and to enable the use of new technologies in supporting individuals to more proactively manage their own conditions. Our estates work-stream will look at estate utilisation across sectors and partners in the L&SC system to maximise support to delivery of new models of care; shifts of service provisions; and minimise spend on poor quality, under-used buildings.

Section 2b: Improving care and quality of services (3)

Our emerging actions on clinical priorities

We have already undertaken an alignment of plans exercise and through the case for change we will have a further level of detail against the identified opportunities for improvement. These include:

Primary care – building upon development of GP quality contracts, we will develop contracting support for new models of care; we will support delivery of 7 day access; workforce development, including advice on working at scale & opportunities for utilising pharmacy services; and we will develop a Lancashire primary care estates plan

Acute & specialised – we will build initially upon the collaborative work already undertaken on Stroke/TIA services across L&SC, implementing our end to end specification, focussing on prevention & self management and shaping the hyper-acute/acute/ rehab provider system. For Cancer & other specialised services, we will align our consideration of service configuration with the NHSE spec services outcomes work and its potential impact on the provider landscape.

Adult MH/Dementia – we will build upon the continued implementation of our MH hospital service reconfiguration, which has to date generated £13m of savings, by developing a new model of MH care and a reframed case for change to improve local diagnosis and early treatment, focussing on crisis care, parity of esteem and operational resilience

Urgent & emergency care – we will continue to develop our new system architecture model, including urgent & emergency care centres; paramedic at home services; MH crisis; self care; and support for care sector & primary care

Regulated care sector – we will work closely across health and social care to develop new models of care; funding system rewards; workforce resilience; in-reach to home; hospice model; self care; and market stimulation

CAMHS – We will continue our whole system transformation plan implementation, focusing on children in crisis and eating disorder services, improving access, effectiveness, pathways, and VFM

Learning disabilities – we will implement our Transforming Care plan, improving estates; engagement; community; service model; crisis support; positive behaviour support; and workforce development/training

Better Care Funds – we will continue to drive the BCF approach as a means to deliver integrated health & social care

Section 2c: Improving productivity and closing the local financial gap

Tackling our efficiency and financial gaps

An assessment of the health, quality and financial gaps in the STP footprint was undertaken by EY Consulting in the summer of 2015. It concluded that by 2020/21 the financial shortfall for adult services would be of the order of £805m or 23% of the combined turnovers of health and social care services organisations if no action was taken to address and resolve the potential financial shortfall arising from the growth in demand.

We are planning to transform health and social care services to better meet the needs of our populations in a clinically and financially sustainable way. We will develop transformation plans that enable the sustainability of services to be assessed across the following dimensions:

- improved efficiencies (reduction in unit costs) resulting from substantial rationalisation within clinical and non clinical support services to release resources for front line services
- standardisation of best practice clinical pathways, underpinned by integrated care records, to deliver more effective and efficient services and reduced unit costs
- transformation of out of hospital services to deliver more cost effective responses to the needs of local people and reduce demand for acute services
- development of staff with both generic and specialised skills and competencies that are better able to meet people's needs and generate the synergies among public services necessary to make the best use of more scarce resources

We have yet to model the extent to which our prevention and care model improvements will deliver reductions in anticipated levels of demand and the technical and allocative efficiencies that will be generated. However, overall we are not expecting to spend less on the population but to use the resources that we hold on their behalf more effectively and efficiently to meet and contain rising demand over the strategic timeframe. Overall NHS commissioner total place-based allocations will rise from £2,934m in 2016/17 to £3,267m by 2020/21, an increase of £333m or 11.3% over the five year period. However, the resources available for social care services will fall over the period. Therefore we will look at all measures that may be available to mitigate the impact of these reductions through the synergies expected to be generated in our joint work on new care models.

Section 2c: Improving productivity and closing the local financial gap (2)

Using our Transformation Funding

We anticipate that Transformation funding will be required in order to underpin delivery of the STP by covering the gap and unlocking transformation:

- provide double running costs associated with the migration from existing to more cost effective service provision. This will include rationalisation of clinical and non clinical support services and centralisation of back office functions
- provide pump priming money to enable new support services models to be implemented alongside existing services to ensure service continuity
- provide support to staff (training costs and back fill) as they acquire the new skills necessary to meet the needs of local people while providing more cost effective services
- invest in key enabling strategies, such as ICT, estates and transport, that support the patient empowerment programme and underpin integrated records for improved service provision

The focus will be on collaboration amongst all stakeholders to drive the changes required. A consistent and fair approach will be taken to the ways in which savings, mitigation and funding is managed across the STP footprint amongst all participating organisations. We will establish a robust process and principles against which bids for allocation of the Transformation Fund will be made to ensure fair effective and best-value utilisation of the fund.

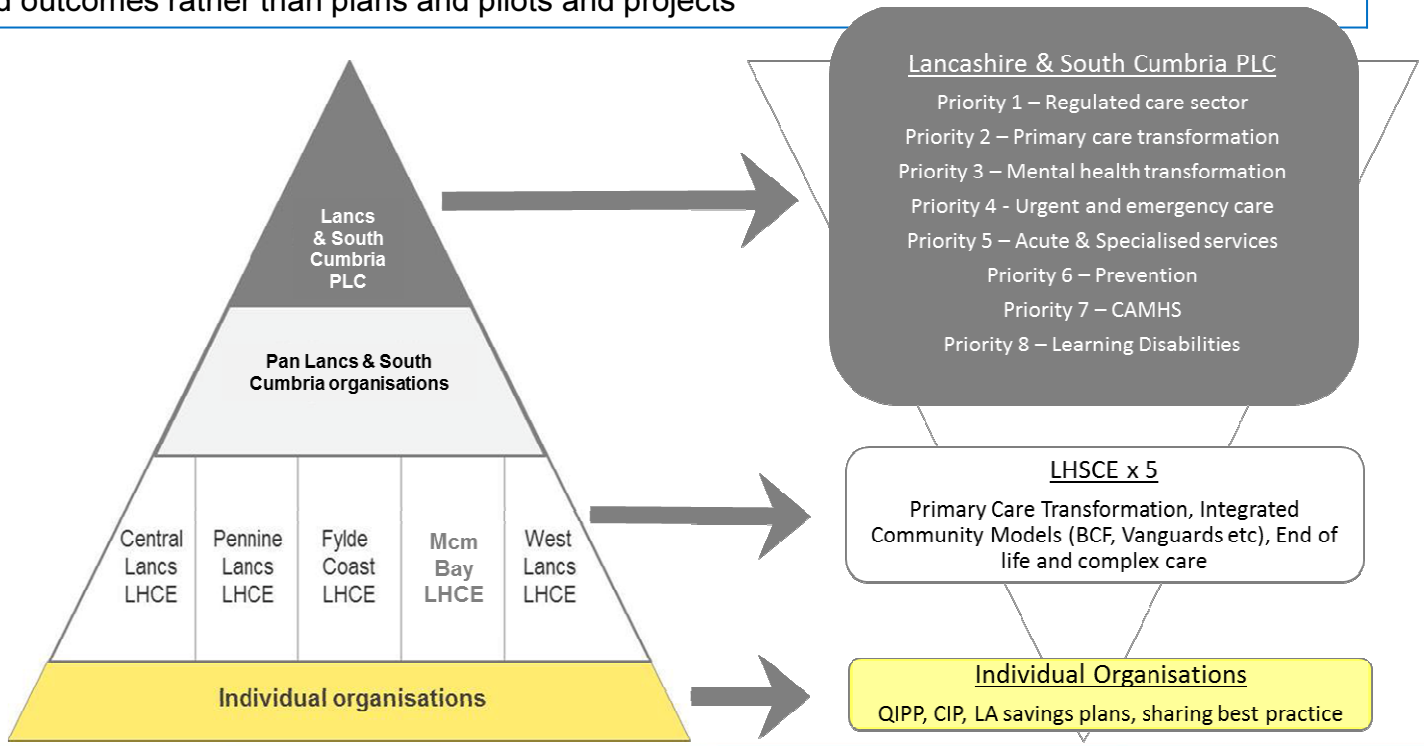
Section 3: Our emerging priorities

Emerging thinking on key priorities

We recognise that there are some big decisions that we will need to make *as a system* to drive transformation – our governance is designed to ensure that all members of that system are actively involved in the effective generation of innovative and impactful evidence-based solutions. Big decisions are likely to include:

- Acute services reconfiguration – all trusts to ensure all impacts, implications and interdependencies are managed
- Designing services to meet agreed standards and standardisation across Local Health and Care Economies and the Lancashire and South Cumbria footprint
- Resource allocations (transformation and sustainability), with new funding/contracting models
- Potential centralisation of specialist services in a designated hub
- Implementing and holding providers to agreements on solutions designed and commissioned
- Focus on agreed and shared outcomes rather than plans and pilots and projects

We have built the HL&SC governance and workstream structure around the priorities for action identified in the Healthier Lancashire Alignment of Plans analysis.



Section 4: Support we would like

Support/barriers/risks/good practice
• **Regional or national support** Vanguards rapid evaluation outputs and learning from these; advice on new funding and contractual arrangements; alignment of work with NHSE, NHSI, CQC re navigating choice and competition issues • **National barriers or actions** – more around the use of money or the regulations e.g. the use of the 1%, and about the appropriate footprint i.e recognising it's both a local approach and a L&SC wide one too. Consistent messages and approaches. • **Share good practice from other footprints**. National database of solutions that are truly radical and evidence based • **Key risks** We have a risk register detailing the key risks to delivery of the STP, including resource limitations which may impact on time taken, availability of resource to double run to test at scale and pace before implementing, any one of the participating partners choosing to not commit to the L&SC footprint and the programme

Voluntary Sector Lancashire

Contribution to Health and Social Care outcomes

Background

The Lancashire Better Care Fund Plan (2016/17) will include in its narrative a commitment to engage with the voluntary sector over the coming 12 months to explore and pilot new models of shared delivery in support of the BCF outcomes. This initial 12 month commitment is a first step in a broader commitment that will see the Voluntary sector in Lancashire as a co-production and delivery partner in Lancashire by 2021.

It is proposed that if this model can be established within BCF (as an enabling programme), there would be the potential to advocate for the commitment to be integrated within the wider Healthier Lancashire model, the Lancashire and South Cumbria Sustainability and Transformation Plan and programmes of delivery.

Proposed 5 year commitment within the Lancashire BCF Plan:

"By 2021 Lancashire BCF will enable its networks and our voluntary sector partners to work collaboratively to understand and jointly respond to gaps and risks within services (particularly prevention), working cooperatively to identify and resource models of shared delivery which improve outcomes for service users".

Proposed 12 months actions to feature in the BCF plan:

"Over the coming 12 months, Lancashire Better Care will engage with our networks and the voluntary sector to:

- Build positive relationships and an understanding of potential benefits of joint work
- Explore specific opportunities where there are gaps and risks within planned services (with a particular focus on prevention)
- Examine opportunities to support voluntary sector partners to access resources from wider funders and the NHS in support of BCF priorities
- Pilot joint delivery to build confidence and cohesion in our aligned networks
- Evaluate the impact and report back to the BCF Steering Group on the cost / benefits of work with the voluntary sector
- Advocate for the Voluntary sector within the BCF network and Healthier Lancashire Sustainability and Transformation Plan programmes."

Anticipated outcomes:

"12 months outcomes for BCF are anticipated as:

- A positive shift in relationships and networks which will bring the BCF network and key strategic voluntary sectors together
- A joint understanding and shared commitment to progressing key priorities for BCF
- Market testing of the viability and robustness of the voluntary sector to deliver BCF priorities
- Insight and learning from 12 months of joint activity to inform work to achieve our 5 year commitment to work with the voluntary sector"

Lancashire District Councils – Better Care Fund Statement

District Councils are critical partners in the move towards integrated place-based public services.

In the provision of core local services including housing, economic development, planning, leisure, parks and open spaces, wellbeing and environmental services District Councils are vital components of population health systems.

District Councils and housing organisations have long argued the importance of good housing to better health and wellbeing but historically three way links between health, social care and housing have not been strong. The inclusion of the delivery of Disabled Facilities Grants within the Better Care Fund has started to change this.

In Lancashire we have seen that the Better Care Fund has started conversations that needed to happen - conversations that increasingly see housing as an essential part of health and care planning. BCF has provided a platform for meaningful engagement and partnership working between our District Councils, Lancashire County Council (Public Health and Social Care) and Clinical Commissioning Groups.

Partnership working in the delivery of DFGs across our two tier structure has improved. We have a better understanding of local drivers – housing needs, demand, systems and workforce issues. We have seen better integration with equipment services and minor adaptations and importantly the start of the harmonisation of processes is underway.

There are many challenges and barriers to the tasks we are faced with including the complexity of our local systems, workforce issues and supporting IT systems. Difficult conversations have taken place between Lancashire District Councils and Social Care regarding referral processes and assessments and capacity within OT and assessment teams but these challenges underline the importance of continuing to develop closer working relationships. BCF continues to help us to build these relationships.

There is a shared appetite to explore all of the flexibilities and opportunities offered by BCF relating to DFGs including ensuring that we maximise the role of assisted technology, telehealth and telecare alongside traditional adaptations. We need to explore links between DFGs and delayed transfers of care and flexibilities to facilitate more effective hospital discharge.

BCF provides a further opportunity for District Councils to engage with health and social care on the developing integrated neighbourhood models of health. Here the contribution of District Councils to BCF outcomes will be far wider than DFGs alone. Better links between health, social care and housing will help to future proof population healthcare.

New housing will be designed with older people in mind, more specialist housing will be built to address local needs, advice will be available on housing options ensuring that housing needs are assessed alongside needs for care and support. Preventative services such as Home Improvement Agencies and Handyperson Schemes will deliver upstream interventions that prevent emergency hospital admissions caused by falls and cold homes. Patients will have their housing needs assessed more effectively as part of hospital discharge.

Lancashire District Councils look forward to continuing engagement with health and social care colleagues as Lancashire takes BCF planning to the next stage.

Dated 27th March 2015

LANCASHIRE COUNTY COUNCIL

And

NHS CHORLEY & SOUTH RIBBLE CLINICAL COMMISSIONING GROUP

NHS EAST LANCASHIRE CLINICAL COMMISSIONING GROUP

NHS FYLDE & WYRE CLINICAL COMMISSIONING GROUP

NHS GREATER PRESTON CLINICAL COMMISSIONING GROUP

NHS LANCASHIRE NORTH CLINICAL COMMISSIONING GROUP

NHS WEST LANCASHIRE CLINICAL COMMISSIONING GROUP

PARTNERSHIP AGREEMENT

Pooled Budget for Integrated Health and Social Care Services Relating to the Better Care Fund

1st April 2015 to 31st March 2016

Contents

THIS AGREEMENT is made on 27th March 2015

PARTIES

LANCASHIRE COUNTY COUNCIL of County Hall, Preston, Lancashire, PR1 OLD (hereinafter called the **"Council"**)

And

NHS CHORLEY AND SOUTH RIBBLE CLINICAL COMMISSIONING GROUP of Chorley House, Lancashire Business Park, Centurion Way, Leyland, Lancashire PR26 6TT

NHS FYLDE AND WYRE CLINICAL COMMISSIONING GROUP of Derby Road, Wesham, Lancashire PR4 3AL

NHS GREATER PRESTON CLINICAL COMMISSIONING GROUP of Chorley House, Lancashire Business Park, Centurion Way, Leyland, Lancashire PR26 6TT

NHS EAST LANCASHIRE CLINICAL COMMISSIONING GROUP of Walshaw House Regent street, Nelson, Lancashire BB9 8AS

NHS WEST LANCASHIRE CLINICAL COMMISSIONING GROUP of Hilldale , Wigan Road, Ormskirk, Lancashire L39 2JW

NHS LANCASHIRE NORTH CLINICAL COMMISSIONING GROUP of Moor Lane Mill, Moor Lane, Lancashire LA1 1QD]

(Hereinafter referred to collectively as the "**NHS Body**". Where an individual Clinical Commissioning Group **("CCG")** is referred to, it shall be named**)**

BACKGROUND

A. In furtherance of the objectives of this Agreement to secure and advance the welfare of the citizens of Lancashire (excluding Blackburn with Darwen and Blackpool) in accordance with the 2006 Act, the Partners have agreed to enter a prescribed arrangement in relation to the exercise of the prescribed functions of the NHS Body and the prescribed health related functions of the Council pursuant to the Regulations.

B. This Agreement is a partnership prescribed arrangement for contribution, establishment and maintenance of a Pooled Fund by the Partners for the purpose of commissioning Integrated NHS and Social Care Services as detailed in the Schedules.

1. DEFINITIONS

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 23 the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agent means any party the host may delegate administrative duties to in respect of reporting the Better Care Fund

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners and references to the **"BCF"** shall be construed accordingly.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners' plan for the use of the Better Care Fund.

Board means the Lancashire Health and Wellbeing Board

CCG Statutory Duties means the duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 1st April 2015

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history; or
(b) which does not constitute Personal Data or Sensitive Personal Data but which relates to any patient or his treatment or medical history;
(c) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or
(d) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) (in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other

supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner is the organisation providing administrative support under this Agreement. In the case of this Agreement, the Host Partner is the Council

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Integrated Commissioning means arrangements by which Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the NHS Body as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 6.3.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the NHS Body(s) and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board means the Steering Group responsible for review of performance and oversight of this Agreement

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner, being a member of a specified accountancy body in accordance with section 113 of the Local Government Finance Act 1988 for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund.

Previous Section 75 Agreements means previous agreements entered into by the Partners or their predecessor bodies under section 75 NHS Act 2006 or the Health Act 1999,

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

Quarter 1 1 April to 30 June

Quarter 2 1 July to 30 September

Quarter 3 1 October to 31 December

Quarter 4 1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme. The individual schemes are shown at Appendix 1

Service Users means those individuals to whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Steering Group means the governance group responsible for review of performance and oversight of this Agreement

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Steering Group.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a statutory bank holiday (in England) under the Banking & Financial Dealings Act 1971.

2. AGREEMENT PERIOD

2.1 This Agreement shall come into force on the Commencement Date and shall continue for a period of 12 months

3. AIMS AND OBJECTIVES OF THE AGREEMENT

3.1 This Agreement is a prescribed arrangement for the establishment and contribution of funds by the Partners into a single Pooled Fund for the purpose of commissioning Services for the benefit of the citizens of Lancashire, excluding Blackburn with Darwen and Blackpool, in accordance with Section 75 of the 2006 Act.

4. SERVICE COMMISSIONING UNDER THIS AGREEMENT

4.1 The Services are set out in the individual scheme specifications shown at Appendix 1 of this Agreement.

4.2 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

4.3 Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

4.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

4.5 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall exercise the Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification and comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned and with all due skill, care and attention.

4.6 Procurement and contracting will be carried out in accordance with the Lead Commissioners procurement procedure and all contracts and service level agreements (SLA) must be in writing.

4.7 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.8

The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.9

Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.]

5. GOVERNANCE AND MANAGEMENT

5.1 The governance structure of this partnership arrangement is set out in the diagram at Schedule 2.

5.2 The Partners' responsibilities are set out at Schedule 3

5.3 The responsibilities of the Steering Group are set out at Schedule4

5.4 The responsibilities of the Board are set out at Schedule 5

6. FINANCIAL CONTRIBUTIONS AND FINANCIAL MANAGEMENT ARRANGEMENTS

6.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such Pooled Funds for expenditure as set out in the Scheme specifications shown at Appendix 1. The table below shows the Financial Contributions made by the Partners into the Pooled Fund:

Partner Organisation	Financial Contribution 2015/16 £"000
Lancashire County Council	9,438
Chorley & South Ribble and Greater Preston CCG (combined)	24,556
East Lancashire	26,384
Fylde & Wyre	10,960
Lancashire North	10,461
West Lancashire	7,420
Total Contribution	**89,219**

The Financial Contributions will be adjusted in line with national pay for performance conditions.

6.2 The Council shall act as the Host Partner for the Pooled Fund. The Council will account for the Contributions and will invoice each Partner at the end of each Quarter for one quarter of their Contribution. Each Partner shall charge back to the Pooled Fund any expenditure incurred directly, up to the maximum amount that they have contributed to the Pooled Fund. The Pooled Fund will record the actual expenditure incurred in relation to the Services

6.3 In the event that additional Financial Contributions are proposed to be made into the Pooled Fund, a business case proposal should be developed, proportionate to the scale of funding requested. The business case will be submitted to the Partners for consideration and decision. Partners will usually agree any additional contributions as part of their annual investment planning rounds.

6.4 The Pooled Fund will be used solely for commissioning Services set out in Appendix 1.

6.5 Each Partner will be responsible for adhering to its own standing orders and

financial regulations in respect of the Contributions and expenditure charged back to the Pooled Fund. The Host Partner is under no obligation to ensure the other Partners' compliance in this regard.

6.6 Lead commissioning arrangements outlined in Schedule 1 will continue for the duration of this Agreement. The responsibility for financial payments to Providers will remain with the Lead Commissioner.

6.7 The Steering Group shall have overall responsibility for performance managing and monitoring of actual income and expenditure in relation to the Pooled Fund. The Host Partner (or its delegated agent) will provide regular financial reports to the Steering Group and each Partner (at least Quarterly), using information from its accounting system and/or information provided by each Partner or Agent, where appropriate. The Steering Group shall recommend that any cost pressures and mitigating actions are reported through the appropriate governance structures in each Partner organisation. Financial information should be supported by appropriate and proportionate activity reports. From the Second Quarter onwards, financial reporting should include a forecast of the year end position.

6.8 Each Partner shall bear the full costs incurred in respect of non-Pooled Fund services/activity including, but not limited to, overheads, internal recharges, incidental expenses and damages). For the avoidance of doubt, non-Pooled Fund services/activities shall not be paid out of the Pooled Fund.

6.9 Each Partner shall comply with its reporting requirements, using the formats for finance and performance illustrated at Schedule 1, part 2 along with a performance management framework.

6.10 The Host Partner will provide the information required for the year end accounts to each Partner and its auditors, where appropriate.

6.11 The internal auditor of the Host Partner will be responsible for the internal audit of the Pooled Fund. It will agree its audit plans in relation to the Pooled Fund with the Audit Committee of the Host Partner.

6.12 The external auditor of the Host Partner will be responsible for the external audit of the Pooled Fund. It will agree its audit plans in relation to the Pooled Fund with the Audit Committee of the Host Partner.

6.13 Copies of all audit reports in relation to the pool budget will be made available to the Lancashire Health and Wellbeing Board.

6.14 The Partners shall co-operate in the prompt provision of information, and access to premises and staff, to ensure compliance with any statutory inspection requirements, or other monitoring or scrutiny functions. The Partners shall implement recommendations arising from these inspections, where appropriate.

7. RISK AND INDEMNITIES

7.1 The Lead Commissioner will manage the risk in accordance with current contractual arrangements, including any financial overspend or underspend.

7.2 The Host and other Partners shall be required to inform the Steering Group of any likely risks in relation to the Pooled Fund. Partners shall also be required to develop a recovery plan for resolving risks and bringing the plan back into balance.

7.3 Each Partner (the "**Indemnifying Partner"**) shall indemnify and keep indemnified the other Partner (the "**Indemnified Partner"**) against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses whatsoever, whether arising in tort (including negligence), default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, wilful default or fraud of itself, the Indemnifying Partner's employees, or any of its Representatives or sub-contractors, except to the extent that the loss or claim is directly caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the Indemnified Partner or its Representatives.

8. LIABILITIES

8.1 Subject to clause 8.2, neither Partner shall be liable to the other Partner for claims by third parties arising from any acts or omissions of the other Partner in connection with the Services before the Commencement Date.

8.2 Liabilities arising from Services provided or commissioned under the Previous Section 75 Agreements shall remain with the Host Partner for the Service under the relevant agreement.

8.3 Each Partner shall, at all times, take all reasonable steps to minimise and mitigate any loss or damage for which the relevant Partner is entitled to bring a claim against the other Partner under this Agreement.

9. TERMINATION & DEFAULT

9.1 This Agreement may be terminated by any Partner giving not less than 6 (six) Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

9.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

9.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 10.

9.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners‟ rights in respect of any antecedent breach.

9.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

9.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

9.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

9.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

9.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

9.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

9.6.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

9.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

10. DISPUTE RESOLUTION

10.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

10.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 10.1, at a meeting convened for the purpose of resolving the dispute.

10.3 If the dispute remains after the meeting detailed in Clause 10.2 has taken place, the Partners' respective chief executives or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

10.4 If the dispute remains after the meeting detailed in Clause 10.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

10.5 Nothing in the procedure set out in this Clause shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action

11. NOTICES

11.1 Notices shall be in writing and shall be sent to the other Partner marked for the attention of the chief executive (or equivalent) or another person duly notified by

the Partner for the purposes of serving notices on that Partner, at the address set out for the Partner in this Agreement.

11.2 Notices may be sent by first class mail. Correctly addressed notices sent by first class mail shall be deemed to have been delivered 72 hours after posting.

12. FORCE MAJEURE

12.1 No Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by any other Partners or incur any liability to the other Partners for any Losses incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

12.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partners as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner.

12.3 If the Force Majeure Event continues for a period of more than sixty (60) days, any Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination review to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause 12.3.

13. CONFIDENTIALITY

13.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 13, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

13.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

13.1.2 he provisions of this Clause 13 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

13.2 Nothing in this Clause 13 shall prevent the Recipient from disclosing Confidential

Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

13.3 Each Partner:

13.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

13.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 13.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 13;

13.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

14. EQUALITY DUTIES

14.1 The Partners acknowledge their respective duties under equality legislation to eliminate unlawful discrimination, harassment and victimisation, and to advance equality of opportunity and foster good relations between different groups.

15. FREEDOM OF INFORMATION

15.1 The Partners acknowledge that each is subject to the requirements of FOIA and the EIR, and shall assist and co-operate with one another to enable each Partner to comply with these information disclosure requirements, where necessary.

16. DATA PROTECTION AND INFORMATION SHARING

16.1 Each Partner shall (and shall procure that any of its Representatives involved in the provision of the Services shall) comply with any notification requirements under Data Protection Legislation. Partners shall duly observe all their obligations under Data Protection Legislation, which arise in connection with this Agreement.

16.2 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and

responding to any requests by the Partner receiving a request for comments or other assistance.

16.3 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

17. INSURANCE

17.1 The Partners shall effect and maintain a policy or policies of insurance, providing an adequate level of cover for liabilities arising under any indemnity in this Agreement.

18. PUBLICITY

18.1 The Partners shall use reasonable endeavours to consult one another before making any press announcements concerning the Services or the discharge of either Partner's Functions under this Agreement.

19. NO PARTNERSHIP

19.1 Nothing in this Agreement shall be construed as constituting a legal partnership between the Partners or as constituting either Partner as the agent of the other for any purpose whatsoever, except as specified by the terms of this Agreement.

20. THIRD PARTY RIGHTS

20.1 No one other than a party to this agreement, their successors and permitted assignees, shall have any right to enforce any of its terms.

21. ASSIGNMENT AND SUBCONTRACTING

21.1 Neither party shall assign, transfer, mortgage, charge, subcontract, declare a trust over or deal in any other manner with any or all of its rights and obligations under this agreement without the prior written consent of the other party.

22. SEVERABILITY

22.1 If any provision or part-provision of this Agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this clause shall not affect the validity and enforceability of the rest of this agreement.

23. WAIVER

23.1 The failure of either Partner to enforce any of the provisions of this Agreement at any time or for any period of time shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Partner thereafter to enforce such provision.

23.2 No waiver in any one or more instances of a breach of any provision of this Agreement shall be deemed to be a further or continuing waiver of such provision in other instances.

24. ENTIRE AGREEMENT

24.1 This Agreement, the Schedules and the documents annexed to it or otherwise referred to in it contain the whole agreement between the parties relating to the subject matter of it and supersede all prior agreements, arrangements and understandings between the parties relating to that subject matter.

25. GOVERNING LAW AND JURISDICTION

25.1 Subject to clause 10, this Agreement and any dispute or claim arising out of or in connection with it or its subject matter shall be governed by and construed in accordance with the law of England and Wales, and the Partners irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

26. FAIR DEALINGS

26.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon

such action as may be necessary to remove the cause or causes of such unfairness.

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE COMMON SEAL of **THE LANCASHIRE COUNTY COUNCIL** was affixed to this Deed pursuant to the Scheme of Delegation to Chief Officers in the presence of:

Steve Gross

Authorised Signatory

THE COMMON SEAL of **THE NHS CHORLEY & SOUTH RIBBLE CLINICAL COMMISSIONING GROUP** was affixed to this Deed……

Authorised Signatory

THE COMMON SEAL of **THE NHS EAST LANCASHIRE CLINICAL COMMISSIONING GROUP** was affixed to this Deed……

Authorised Signatory

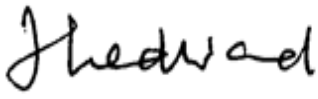
THE COMMON SEAL of **THE NHS FYLDE & WYRE CLINICAL COMMISSIONING GROUP**

was affixed to this Deed……

Authorised Signatory

THE COMMON SEAL of **THE NHS GREATER PRESTON CLINICAL COMMISSIONING GROUP**

was affixed to this Deed……



Authorised Signatory

THE COMMON SEAL of **THE NHS LANCASHIRE**

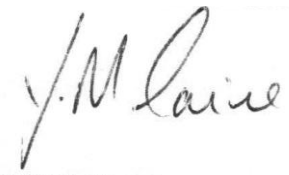
NORTH CLINICAL COMMISSIONING GROUP
was affixed to this Deed……

Authorised Signatory

THE COMMON SEAL of **THE NHS WEST LANCASHIRE**

CLINICAL COMMISSIONING GROUP

was affixed to this Deed……



Authorised Signatory

SCHEDULE 1 PART 1

FINANCIAL CONTRIBUTIONS AND COMMISSIONING ARRANGEMENTS

Schemes to be commissioned under this Agreement

Table 1 lists the 21 Individual Schemes that will be commissioned under this Agreement and the Partner responsible for commissioning the Individual Scheme.

Table 1

Ref	Name of the scheme	Footprint
BCF01	Transforming Lives, Strengthening communities - Building capacity in the voluntary sector	East Lancashire
BCF02	Re-design of Dementia Services	East Lancashire
BCF03 **BCF04** **BCF05**	Redesigned Intermediate Care supported by an Integrated Discharge Function, Intensive Home Support, Navigation Hub/Directory of Services	East Lancashire
BCF06	Intermediate Care Redesign	Fylde and Wyre

BCF07	Admissions Avoidance	Fylde and Wyre
BCF08	Lancashire health economy whole system urgent care transformation programme – Step up/Step down beds	GP / SR&C
BCF09	Lancashire health economy whole system urgent care transformation programme – Ambulatory Care	GP / SR&C
BCF10	Development of Extra Care Schemes (Housing)	Lancashire CC
BCF11	Integrated Offer for Carers – Support and Respite	Lancashire-wide
BCF12	Reablement	Lancashire-wide
BCF13	Transforming Community Equipment Services	Lancashire-wide
BCF14	Telecare services	Lancashire CC
BCF15	Care Act	Lancashire CC
BCF16	Disabled Facilities Grant	Lancashire CC
BCF17	Intermediate Care Services to support Care Co-ordination Centre	Lancashire North
BCF18	Self-care	Lancashire North
BCF19	Specialist community services	Lancashire North
BCF20	Integrated Neighbourhood / Care Teams	Lancashire-wide
BCF21	Facing the future together	West Lancashire

Details of the Services commissioned for each scheme are contained in the detailed specifications at Appendix 1.

Although the Partners have made the financial contributions set out in Clause 6 to the Host Partner of the Pooled Fund, the Host Partner may use commissioning flexibilities to delegate lead commissioning responsibility for certain schemes back to the Partners, as shown in the Table below. The financial responsibility for the payments to providers will also follow.

Table 2 shows the financial contribution by each Partner by scheme and the proposed commissioning arrangement that could be delegated back to the Partners for expediency.

Table 2

Scheme	**Scheme Value £"000**	**Financial Contribution made by each Partner £"000**	**Proposed Commissioning arrangement to be delegated**

								by the Host Partner
		CSR & GP	F & Y	EL	LN	WL	LCC	
BCF01	273			273				East Lancs CCG Lead
BCF02	1,481			1481				East Lancs CCG Lead
BCF03 BCF04 BCF05	13,999			13,999				East Lancs CCG Lead
BCF06	1,935		1,935					Fylde & Wyre CCG Lead
BCF07	3,789		3,789					Fylde & Wyre CCG Lead
BCF08	6,393	6,393						Chorley & South Ribble and Greater Preston CCG Lead
BCF09	343	343						Chorley & South Ribble and Greater Preston CCG Lead
BCF10	1,924						1,923	Council Lead
BCF11	7,518	2,366	1,012	2,543	925	672		Joint
BCF12	5,637	1,647	1,059	1,741	487	703		Joint
BCF13	9,976	3,589	805	3,885	1,163	534		Joint
BCF14	548		115	254	103	76		Joint
BCF15	4,273	951	454	1,008	409	302	1,150	Joint
BCF16	6,365						6,365	Council Lead
BCF17	3,845				3,845			Lancs North CCG Lead
BCF18	43				43			Lancs North CCG Lead
BCF19	2,766				2,766			Lancs North CCG Lead
BCF20	13,134	9,267	1,791	1,200	720	156		Joint

BCF21	4,977					4,977		East Lancs CCG Lead
OTAL FINANCIAL CONTRIBUTION	**89,219**	**4,556**	**10,960**	**26,384**	**0,461**	**7,420**	**9,438**	

Table 3 shows the sub pools that each Partner shall manage if the Host decides to use its flexibility to delegate commissioning arrangements back to the Partners.

TABLE 3

Delegated scheme	**CSR & GP**	**F & Y**	**EL**	**LN**	**WL**	**LCC**	**General Pool**
	Sub Pool A £"000	Sub pool B £"000	Sub Pool C £"000	Sub Pool D £"000	Sub Pool E £"000	Sub Pool F £"000	£"000
BCF01			273				
BCF02			1481				
BCF03/4/5 BCF04 BCF05			13,999				
BCF06		1,935					

BCF07		3,789					
BCF08	6,393						
BCF09	343						
BCF10						1,923	
BCF 11							7,518
BCF 12							5,637
BCF 13							9,976
BCF 14							548
BCF 15							4,273
BCF16						6,365	
BCF17				3,845			
BCF18				43			
BCF19				2,766			
BCF 20							13,134
BCF21					4,977		
Total of each Pool and sub Pool	6,736	5,724	15,753	6,654	4,977	8,288	41,087

The Council shall retain lead commissioning responsibility for Schemes 10 and 16 with the values of £1,923k and £6,365k respectively.

BCF Schemes 11, 12, 13, 14, 15 and 20 have multiple partners. Partners will need to agree how a joint commissioning arrangement will work with five or more partners.

SCHEDULE 1 PART 2

FINANCIAL AND PERFORMANCE REPORTING

Finance and Performance reporting will be managed by each Partner to provide assurance for that organisation's Governing Body and Local Partnership that each scheme within the BCF is operating as envisaged within the scheme plan and delivering the outcome gains anticipated. Where the scheme requires additional actions to mitigate shortcomings in, either;

· the original scheme design or implementation,

· or outcome performance,

- that organisation's Governing Body will agree, execute and report against those actions.

The Finance and Performance reporting managed by each organisation for its locality, which sets out the forgoing information, will be consolidated into a BCF Performance Report to the Steering Group. This consolidation process will be overseen by the Programme Managers Group. Once consolidated the BCF Performance Report will be presented at the Steering Group to enable the Steering Group:

1. to be assured that scheme performance is on track and if not on track appropriate mitigating actions are being managed at the locality level;

2. agree key points for discussion with the Lancashire Health and Well Being Board.

The Steering Group Chair will present the Report to the Lancashire Health and Wellbeing Board highlighting exceptions, performance variation and action taken, significant risks and mitigation plans. The BCF Performance Report will be produced monthly.

The Lancashire Health and Wellbeing Board will receive the BCF Performance Report from the Steering Group and advise/act on non -performance and hold to account the constituent Governing Bodies and Local Partnerships for delivery. This will be delegated to the Steering Group which will ensure appropriate onward communication.

The aim is to provide a finance and performance reporting format that is suitable for both locality reporting and County wide reporting. Thus a single reporting format can be used to serve more than one audience. Standardising the reporting formats will also make consolidation easier for reporting the County wide position.

The proposed financial reporting format is as follows:

Health and Wellbeing Board Expenditure Plan

Lancashire

MONTH **1**

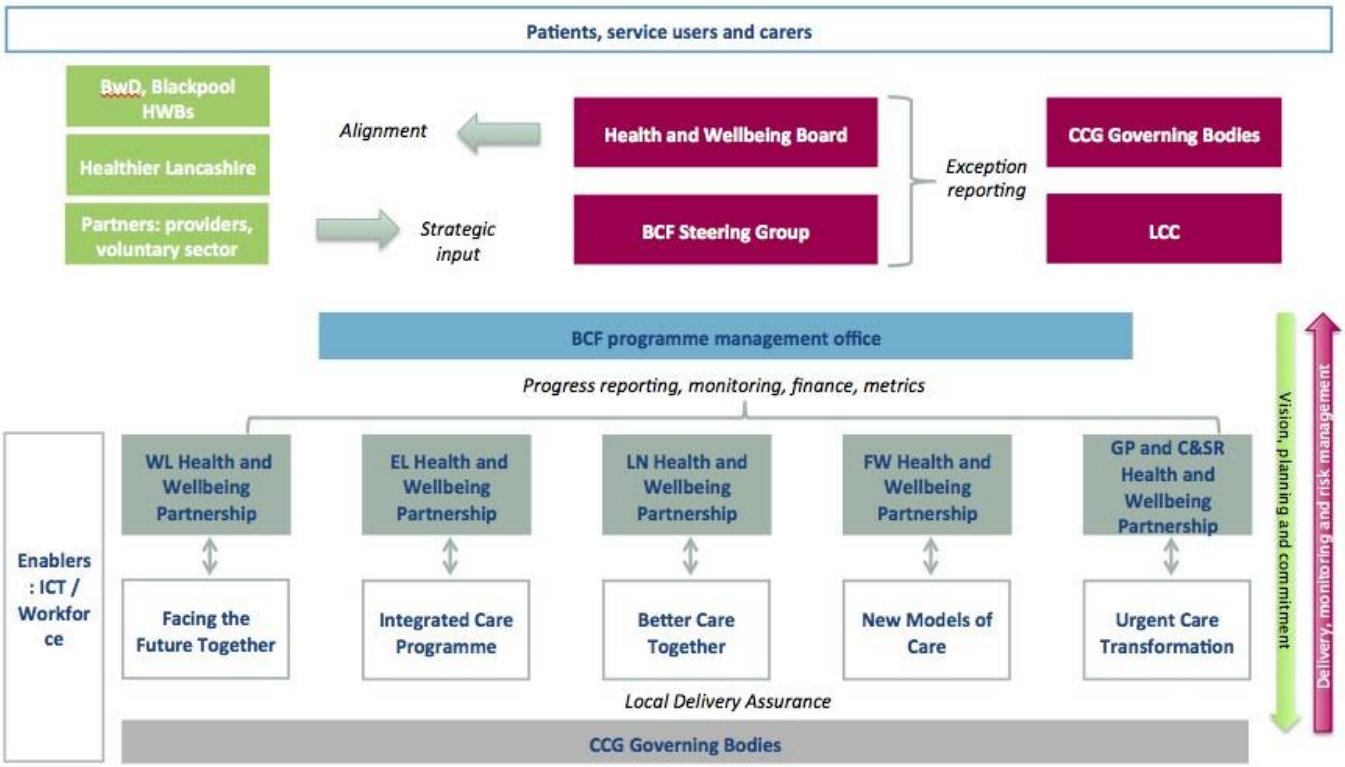
Scheme Number	Scheme Title	2015/16 Plan as at 1 April 2015 (£000)	2015/16 Revised Plan (£000)	2015/16 Forecast Outturn (£000)	2015/16 Variance (£000)	2015/16 Original Plan YTD (£000)	2015/16 Revised Plan YTD (£000)	2015/16 Expenditure YTD (£000)	2015/16 Variance (£000)
BCF01	Transforming Lives, Strengthening communities - Building capacity in the voluntary sector	273	273		(273)	3	3		(3)
BCF02	Re-design of Dementia Services	1,481	1,481		(1,481)	15	15		(15)
BCF03	Redesigned Intermediate Care supported by	10,356	10,356		(10,356)	104	104		(104)
BCF04	Intensive Home Support (across Pennine	3,284	3,284		(3,284)	33	33		(33)
BCF05	Navigation Hub/Directory of Services	359	359		(359)	4	4		(4)
BCF06	Intermediate Care Redesign	1,935	1,935		(1,935)	19	19		(19)
BCF07	Admissions Avoidance	3,789	3,789		(3,789)	38	38		(38)
BCF08	Lancashire health economy whole system urgent care transformation programme – Step up/Step down beds	6,393	6,393		(6,393)	64	64		(64)
BCF09	Lancashire health economy whole system urgent care transformation programme – Ambulatory Care	343	343		(343)	3	3		(3)
BCF10	Development of Extra Care Schemes (Housing)	1,924	1,924		(1,924)	19	19		(19)
BCF11	Integrated Offer for Carers – Support and Respite	7,518	7,518		(7,518)	75	75		(75)
BCF12	Reablement	5,637	5,637		(5,637)	56	56		(56)
BCF13	Transforming Community Equipment Services	9,976	9,976		(9,976)	100	100		(100)
BCF14	Telecare services	548	548		(548)	5	5		(5)
BCF15	Care Act	4,273	4,273		(4,273)	43	43		(43)
BCF16	Disabled Facilities Grant	6,365	6,365		(6,365)	64	64		(64)
BCF17	Intermediate Care Services to support Care Co-ordination Centre	3,845	3,845		(3,845)	38	38		(38)
BCF18	Self-care	43	43		(43)	0	0		(0)
BCF19	Specialist community services	2,766	2,766		(2,766)	28	28		(28)
BCF20	Integrated Neighbourhood teams	13,134	13,134		(13,134)	131	131		(131)
BCF21	Facing the future together	4,977	4,977		(4,977)	50	50		(50)
Total		**89,219**	**89,219**	**-**	**(89,219)**	**892**	**892**	**-**	**(892)**

The proposed example of the reporting framework for KPIs is as follows:

KPIs (Better Care Fund)

Code	Short Name	Short Trend	Long Trend	Current Target	Icon	2012/13	2013/14	2014/15	2015/16	Latest Note
						Value	Value	Value	Value	
BCF 91 days SAH	Proportion of people 65+ who were still at home 91 days after discharge	Improving	Improving	82%		76.8%	78.8%			
BCF Ad Nur Homes	Permanent admissions of older people (65+) to Residential and Nursing Homes per 100,00	Getting Worse	Getting Worse	850		1,031	796.4			
BCF Non Ele LTH	Non Elective Admissions Change at LTH			-0.5%				6%		
BCF_Avd EmAd CSR	Avoidable Emergency Admissions Composite Measure per 100,000 CSR	Improving	Improving	2,068		2,110.5				
BCF_Avd EmAd GP	Avoidable Emergency Admissions Composite Measure per 100,000 GP	Getting Worse	Improving	2,344		2,396				
BCF_DTOC	Delayed transfer of care from hospital per 100,000 Lancashire	Improving	Improving			3,025	8.8			

Schedule 2 – Governance Structure



Schedule 3 – Partners' Aims/Responsibilities

- Drive transformation and collaborative working across the County
- Drive shared learning and opportunities to work at pace and scale
- Ensure communication and engagement with all stakeholders, patients and public
- Be responsible for ensuring frequent engagement with patients and populations to ensure their priority areas are captured in our strategic plans and translate into our Better Care Plan to deliver them
- Be responsible for ensuring both County wide and local engagement
- Collectively assess any changes to commissioned services should be commissioned as a result of BCF delivery
- Promote collaborative, integrated working and services
- Promote activities that bring about sharing of best practice, delivery of quality standards and improved performance

Schedule 4 - Steering Group/Partnership Board Responsibilities

Underpinning and accountable to the Health and Wellbeing Board is a Steering Group which receives regular updates on progress and reporting information and identification of risks and appropriate mitigating actions.

Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions in accordance with the aims/responsibilities set out in Schedule 3.

Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

The Steering Group will work in accordance with its agreed terms of reference which are subject to ongoing review.

The Steering group is a focused group of senior executive leaders, bringing together key commissioners and the county council. It has delegated authority to drive forward implementation of the BCF on behalf of its representative organisations, agreeing plans and overseeing delivery. This is a platform local organisations have confidence in from successful experience and from which they can build further.

The group will manage the delivery of Better Care Fund schemes, review progress against plan, scrutinise performance and finances and raise exceptions to the HWB. Through strong interfaces to its constituent organisations, it will ensure remedial action is taken should the plan not be delivering. The Steering Group will be supported by a **dedicated Programme Management Office**, who will:

- Provide a common and consistent framework for monitoring and reporting
- Work to and develop an industry standard programme methodology tailored to suit local circumstances
- Build and maintain relationships across the Lancashire system
- Manage plan activities
- Report and escalate risks
- Create a positive and efficient environment for people to work together

The **Health and Wellbeing Partnerships at local level** will provide strategic input to the BCF Steering Group and HWB, ensuring that local needs and priorities fit within the overall Lancashire governance and delivery structure. These will interface with the **5 transformation programmes**, which will report progress against BCF scheme delivery.

Schedule 5 – Health and Wellbeing Board Responsibilities

The Lancashire Health and Wellbeing Board will take overall accountability and strategic oversight of the implementation of the BCF, operating within the structure illustrated at Schedule 2, which brings together the delivery of transformation and integrated care across the county. The Health and Wellbeing Board shall make recommendations to the Partners in respect of any action it considers necessary.

Schedule 6 – The Better Care Fund Plan.

The Better Care Fund Plan is at Appendix 2.

APPENDIX 1 – SCHEME DETAILED SPECIFICATIONS

SCHEME SPECIFICATIONS:

Scheme ref no.
BCF001
Scheme name
Transforming Lives, Strengthening communities - Building capacity in the voluntary sector
What is the strategic objective of this scheme?
We will work with partner public sector agencies and the voluntary sector to develop a coordinated approach to earlier intervention support to prevent and/or delay demand on statutory health and care services and wider public services. In addition the scheme will: • Improve access to support in people's neighbourhoods linking to the wider development of Integrated Neighbourhood teams • Promote a collaborative approach to provision of information, advice, guidance and support • Encourage a coordinated, lead professional approach supported by voluntary sector partners to developing provision to meet the requirements of those with more complex needs • Reduce replication of activity across agencies • Improve quality of life and experience of services within East Lancashire • Maximise potential to bring inward investment into East Lancashire
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Current model This scheme builds on a strong and long standing partnership locally with partner agencies and the Voluntary, Community and Faith (VCF) sector, focused on building community assets and resilience providing tailored information, signposting and partnership approaches to statutory provision. It includes:

- "**Help Direct"** - maintains accredited trades and services lists to support vulnerable older people to access help around home, maintenance and safety and is an information and signposting service for the public.
- **Green Dreams** - supports individuals with primarily social needs that are impacting on the use of the primary care system, including mental health debt, relationship problems, housing, isolation and worklessness.
- **Stroke Association** - offers follow up support to individuals and their families / carer supports post-Stroke (761 contacts in Quarter 2 14-15 for 437 people who have had a stroke and 32 carers)
- **Alzheimer's Society** - offer Dementia Advisor and Support Worker input post-diagnosis and hold a current caseload of 1339 people with Dementia across Pennine Lancashire, receiving 97 new referrals in Q1 2014-15 and supporting 140 attendees at Dementia cafes (there are 5 Carer support meetings and 7 Dementia cafes are held each month in East Lancashire).
- East Lancashire commissioners are working with 5 local VCF sector counselling services to build capacity within the community in relation to the **Improving Access to Psychological Therapies (IAPT) programme**.

Future expansion

The CCG, County Council and District council partners are underway with plans to much more significantly extend the development of community resilience through an integrated commissioning and delivery model. The key principles are:

- Identify opportunities early with people (individuals, families, cohorts) who are vulnerable
- Commit to working together across organisations as a single approach to ensure delivery of Transforming Lives; Strengthening Communities ethos and achievement of improved outcomes
- People are central to defining and addressing their challenges and are key partners in the solutions (co-production)
- Work with people and evidence based provision to overcome barriers to achieve better outcomes and to understand those barriers
- Test the principle that upstream intervention (primary, secondary & tertiary prevention) is investment that reduces demand on public sector as a whole

The approach is characterised by:

- Families and individuals identified and targeted earlier for support- proactive not reactive
- Named single key worker/lead professional for individual/family to coordinate all interventions and support
- Share information across agencies to identify the population at greatest risk – this could include „frequent flyers/users", those identified as having multiple risk factors.
- Utilising enhanced VCF capacity to support the on-the-ground delivery of the early

action approach to these „at risk" populations.

- Build a collaborative approach across the VCF sector, encouraging these organisations to work in partnership.
- Dealing with individual/families problems as a whole rather than responding to each problem or person separately
- Joining up local services with a shared plan - one SMART Action Plan
- Persistence with individual/families can be backed up with sanctions "common endeavour" where this is appropriate to the individual's need
- All agencies operating within agreed structures in the neighbourhood
- Meaningful activity is a consistent aim – aspiration and practical support to get adults back into work, volunteering or meaningful community engagement
- Work with all individual/families regardless of age including adult only families

Key to the delivery of this ambitious plan is the ability to increase the capacity of the voluntary sector and to embed them as equal partners in the delivery of the approach. We will enhance locality-based support through the remodeling of the existing provision outlined above and by commissioning further capacity within the sector in crucial elements that will underpin this early action approach. These include:

- The County Council is undertaking a r**e-procurement of „Help Direct"** and the Public Health commissioned supports it inherited when the function transferred to local government. This will be within an „Integrated well-being" service on the East Lancashire footprint aimed specifically at early action support to the 20% of the population deemed at highest risk. This process will be completed by April 2015.
- In collaboration with Lancashire Fire and Rescue and Age UK Lancashire, the CCG and Council have been liaising with colleagues in Cheshire around their **Springboard service** aimed at the „Ageing well" element of integrated well-being. This service integrates health data with wider mosaic databases to identify the population 65 and over who are at greatest risk. Using the Fire service as a "trusted brand" to contact and undertake an initial cross-agency assessment with this potentially „hard to reach" population, early action follow-up is then delivered by Age UK by consent to support the key risk elements identified.
- An **extended "healthyminds"** approach is being undertaken by the CCG and Council, which will continue to support the development of the Green Dreams project connecting to Primary care and the VCF consortium delivering IAPT level support, utilising the learning we derive from these test models to determine the overall final model.
- The **Age UK Integrated Care** service brings together voluntary organisations and health and care services to provide a combination of medical and non-medical support for older people who are living with multiple long-term conditions at risk of recurring hospital admissions. **East Lancashire has just been accepted as one of 4 pilot areas across the country looking to scale up the work undertaken by Age UK in Newquay around integrated care** with an expected level of support 1,000 older adults. This pilot will be formally evaluated by the Nuffield Trust as part of an overall national model of support. The service will link to the development of Integrated Neighbourhood teams, where they will feed into MDT processes, but also link back to the Springboard development with Lancashire Fire and Rescue service. The results above form the basis of the expected benefits from the transforming lives new schemes in 2015/16.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners: East Lancashire CCG, Lancashire County Council

Partner commissioners: Blackburn with Darwen Clinical Commissioning Group & Blackburn with Darwen Borough Council.

Public sector partners: Lancashire Fire and Rescue, Lancashire Police, NWAS

Providers: Age UK, Green Dreams.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

UK exemplars

- **Age UK Integrated pathfinder**: Early results from the Age UK Integrated Care Pathfinder site in Newquay shows that out of 106 people that took part in the pilot there was a:
  - 23% improvement in people's self-reported wellbeing
  - 30% reduction in non-elective admission cost
  - 40% drop in acute admissions for long term conditions
  - 5.7% cost reduction and reduction in demand for adult social care
- **Cumbria neighbourhood care independence programme**: In April 2013, Cumbria County Council and CCG launched a new Neighbourhood Care Independence Programme in partnership with the VCF sector to develop an asset-based community development approach. It worked at a local and neighbourhood level to support over three thousand people in six months through focusing on community solutions leading to a reduction in hospital admissions and reliance on residential and statutory care provision.
- **Springboard, Cheshire:** early indications from the Cheshire work is that it is supporting a deflection of acute admissions and the reduction in the acute bed base but further analysis of this work is on-going and we are working closely with Cheshire to further understand their impacts as we look to develop the service locally.

Local context

- We are auditing and analyzing the Green Dreams pilot service, which links at present to 10 surgeries across East Lancashire covering 30% of the CCG population (115,000

people) to test this approach. It has an open caseload of 224 people (September 2014) and is receiving 30+ new referrals a month to the service.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total Investment:

Scheme Name	2014/15 (£000)	2015/16 (£000)
Springboard		100
Hospital aftercare	147	147
Police Liaison in A&E	26	26
TOTAL	**173**	**273**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Estimated Diagnosis Rate for Dementia	☑
patient experience: Proportion of people feeling support to manage their LTC	☑

Based upon the Age UK Newquay model, this identified that by targeting high-risk patients with at least two long term conditions, excluding end of life, that there was a 40% reduction in

admissions for these patients.

The modelling here includes the cohort of patients that have multiple admissions of more than 4 each year, excluding those cohorts of patients identified in other schemes (e.g. falls, ambulatory care and dementia) as the target for this scheme.

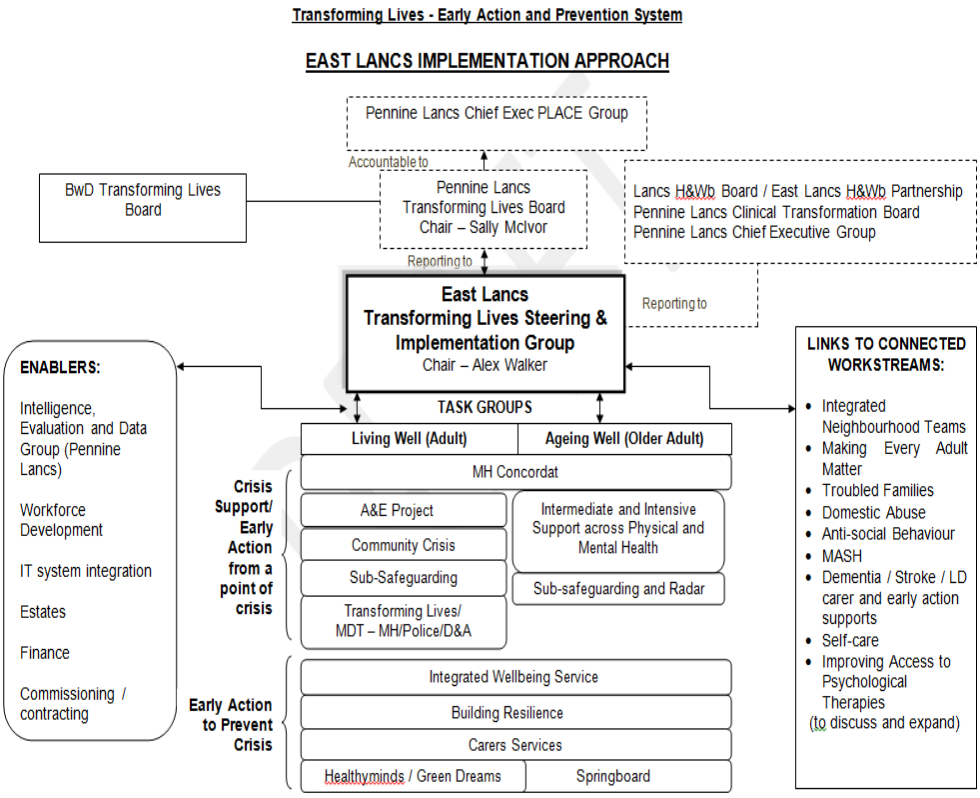
Therefore quantified benefits in 2015/16 are **a reduction in non-elective admissions of 166**.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is a complex programme with multiple key stakeholders and partners and a robust governance plan has been established to ensure that we manage coherence across the programme, eliminating any potential for replication and ensuring a clear understanding across both Pennine and Lancashire systems.

The overall programme area, its key linkages and connections and governance structure is shown in the diagram below:



There will also be formal evaluation of the Age UK Integrated Care pilot by Nuffield Trust.

What are the key success factors for implementation of this scheme?
• Partnership working, there are a range of existing schemes that nurture this way of working, which needs to be continued. • Successful LCC re-procurement of „Help Direct" service • Ability to demonstrate multi-agency impact to enable mainstreaming of traditional short term grant funding to VCFS • Ability of VCFS to respond and work both differently and flexibly

Scheme ref no.
BCF002
Scheme name
Re-design of Dementia Services
What is the strategic objective of this scheme?
his scheme will involve the redesign of memory assessment services (MAS) in order to: • Develop an improved open access route to the local population on a neighbourhood basis, connected to Primary care • Improve and sustain dementia diagnosis rates, by having stream-lined processes for screening and diagnosis that deliver prompt decision making, enabling early access to co-ordinated care • To deliver a comprehensive post-diagnostic support structure aligned to a re-designed Memory service • Deliver information and support to enable decision making for people with dementia and their carers, leading to extended independence for people with dementia and their carers. Our approach is centred on the principle of building „dementia friendly communities" to provide a supportive environment for dementia care in the community.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will deliver a **primary care based model of Dementia diagnosis**

including pre and post diagnostic support that will continue to reduce the dementia diagnostic gap and improve access to support for people with suspected and diagnosed dementia and their carers in East Lancashire.

This will be through a **more efficient and open access into Memory Assessment Services (MAS)**, which will:

- Result in all people starting the diagnostic process within 4 weeks if this is their choice
- Improve access to diagnosis and support from the bottom up, with open access to people in their communities, meaning that less formal referral processes become the main route into services.
- Deliver a new model, which will be spread across the 13 neighbourhoods within Pennine Lancashire (9 in East Lancashire and 4 in Blackburn with Darwen), providing services at neighbourhood level in line with plans to develop a wider integrated neighbourhood team approach wrapped round Primary care for all community health and care supports.

Within the new model, we are **working closely with two external companies (Cambridge Cognition and IXICO)** and Rowlands Pharmacies in testing out two further specific areas of diagnostic approach to dementia in order to see if we can widen access to services with a particular emphasis on our BEM communities and to improve the accuracy of decision making, which could inform the optimum approach to post-diagnostic support.

These approaches are around:

- Screening, using the CANTAB mobile app (developed by Cambridge Cognition) within the neighbourhood MAS teams and local Rowlands pharmacies. This is a non-language based screening test supported with in-built instructions in 19 languages.

- Diagnosis, we are undertaking a 12 month scanning pilot with IXICO to use the ASSESSA reporting system post-scan (works with MRI scans) to see if this supports quicker and more accurate diagnosis, particularly in earlier and more complex cases in order to ensure the right treatments and support can be offered individuals.

The new model of support is scheduled to be rolled out in three neighbourhood clusters within East Lancashire from late November 2014 and will progress to all 13 neighbourhoods across Pennine Lancashire within the following 6 months.

The **VCF sector is already a significant component of the Memory service delivery with 3 Dementia Advisers and a Dementia Support Worker from the Alzheimer's Society working within the MAS service**. Further investment as part of the re-design will:

- Expand the capacity significantly to develop a wrap-around pre and post-diagnostic element to the neighbourhood MAS model
- Sign-post people into their local neighbourhood assets, supporting the development of Dementia Friendly communities within each neighbourhood /

locality area, supporting the maintenance of independence within a community based setting of this vulnerable group.

The plan is to **merge the current resources within MAS and the VCF sector** along with the additional levels of investment to develop a combined multi-agency model in primary care allied to cutting edge innovation, which will:

- Provide quicker throughput and case identification but also the most suitable pathway for assessment based on more individual need.
- Build capacity in General Practice in order to move the 2.500 patients on annual MAS review back in to annual QOF reviews, thus creating increased diagnostic capacity
- Create a softer front end approach, which will encourage people to self-refer, so assisting diagnosis levels, whilst at the same time reducing stigma
- Improve awareness within local communities through a neighbourhood presence, thus helping communities to become more aware of dementia and equipping them with the skills to take greater ownership for supporting local people with dementia and their carers.
- Encourage more people to become dementia champions.
- Create a collaborative, multi agency approach, which will improve services, reduce duplication and lead to better outcomes for people living with dementia and their carers.
- Overcome the perception within some elements of Primary care that diagnosis is futile, due to perceived long waiting times for assessment and diagnosis and a lack of treatment and support options by having a responsive and systematic service locally.

The post diagnostic element of the pathway will utilise the five pillars of dementia support designed by Alzheimer's Scotland. The service will systematically offer this level of support in the first year post-diagnosis.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners: East Lancashire Clinical Commissioning Group and Lancashire County Council.

Providers: Alzheimer's Society, Crossroads, Lancashire Care Foundation Trust, Cambridge Cognition, IXICO.

To facilitate this scheme we are also working with Age UK, Innovations in Dementia (a national CIC) and the evolving Dementia Voices group in Lancashire (a group of people diagnosed with dementia who are working to influence the development of services and supports across the County) to shape the service offer over the coming year.

We have an on-going Dementia Strategy group for Pennine Lancashire, which oversees the specific Memory Assessment re-design task group. These governance arrangements link in to the local Governing Body and also to the Lancashire wide dementia Expert reference Group, linked to the NW Strategic Clinical Network.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

UK evidence

- The early diagnosis of dementia is a national priority, as identified in the National Dementia Strategy and the Prime Minister's challenge on Dementia.
- It is crucial that dementia is diagnosed and treated in a timely manner to prevent and delay admissions to residential and nursing care, as well as avoid unnecessary hospital admissions. Moreover, earlier identification and treatment will improve citizen experience.
- Evidence suggests that early diagnosis leads to better outcomes for citizens with dementia and their carers, enabling them to be better prepared and more resilient thus reducing the number of unplanned acute admissions, an increase in the need for formal care support and wider demand on health and social care services.
- It is estimated that 70%+ of Residential home placements have a co-morbidity of Dementia as well as poor outcomes from general acute unplanned admission.

Local context - dementia

- 2013/14 data from hospital admissions identifies that in East Lancashire we recorded 1453 unplanned hospital admissions for patients with a coding of Dementia, which cost a total of £3.860m at an average cost of £2,656 per admissions.
- This means that 39 beds were occupied by people with dementia for unplanned care on each day. The above activity probably only captures around half of the actual activity given the diagnosis rate in 2013-14, so in reality double this activity and impact occurred.
- In 2018/19 it is predicted that this will increase in line with population projections and will cost £4.330million each year from over 1,600 admissions and nearly 16,000 bed days. It is however, important to note again that this does not account for the increased work being undertaken to improve dementia diagnosis in the community and is likely to be higher when we get to 2018-19 as we should have a better recognition of our dementia population at that point.
- In 2013, there were 593 LCC funded long term care admissions (this excludes self-funded admissions), with 16.5% of these admissions taking place directly from hospital National evidence suggests at least a 70% incidence of Dementia within long term care settings for people 65 and over.
- If this applies in East Lancashire, it would suggest that 415 people with dementia a year are admitted to long term care. Social care colleagues confirm that the likely incidence is at least at that level but again until we have more accurate levels of diagnosis, it is difficult to confirm this figure accurately.

Local context – Memory Assessment Service

- The Memory Assessment Service (MAS) has been under immense pressure in the last 24 months and the waiting list consisted of 355 patients with the longest wait at 39 weeks (the figure now stands in October 2014 at 152 patients on the waiting list with the longest wait being 8 weeks).
- There is an acknowledgment that with a current referral rate of 140 per month, that there will always be up to 140 patients in the 0-4 weeks bracket, but this referral rate is anticipated to grow as the population demographic changes, so plans are being predicated on a referral rate of 200 people a month to the service. There has already been a 40% rise in the referral rate to MAS over the last 4 years.
- At an expected referral rate of 2400 people a year living within the Pennine Lancashire CCG footprints (1,680 from East Lancashire / 720 from Blackburn with Darwen) it was recognised by all partners that the existing system in MAS would not cope with this level of demand and therefore we either had the option of either finding greater levels of resource or to comprehensively re-design the service to cope with increasing demand.
- Given that the support for people post-diagnosis was the area highlighted by Primary care, people with Dementia and their carers as requiring the most development and investment, it was agreed that capacity in the diagnostic element of the pathway should be delivered through re-design and linked more systematically to post-diagnostic support.

International evidence

- The World Alzheimer's Report 2011 demonstrates that earlier diagnosis with a holistic response including prescribing, and more importantly, clear and comprehensive programmes of support to people with dementia and their carers can impact significantly on quality of life, potential institutionalisation or the point at which this happens.
- The report suggests „The beneficial effects of caregiver interventions upon institutionalisation rates have been much more robustly and directly demonstrated. In addition to the long-term Mittelman trial, used in the US economic modelling analysis, a systematic review of 10 RCTs has indicated a 40% reduction in the pooled odds of institutionalisation; the effective interventions were structured, intensive and multicomponent, offering a choice of services and supports to carers. The Mittelman trial suggested a greater benefit as regards institutionalisation when the interventions were commenced earlier in the disease course. The difference in predicted time to placement between those receiving and not receiving the caregiver intervention was 557 days.‟
- Furthermore, the evidence base clearly identifies the improved quality of life delivered by more substantial post-diagnostic support and the plans to link this support in Lancashire to „Peace of Mind‟ plans for Carers that would initiate crisis support to a person with dementia should the ability of their carer to be compromised for any reason, would also suggest an impact on the potential admission of people with Dementia to hospital support at a point of crisis.
- Because of this, the lead clinicians believe that the plan outlined would quickly

support significant improvements in Quality of Life, as well as maintain and further improve the level of diagnosis of Dementia against predicted prevalence at a minimum of 67% in 2015-16.

- Impacts on admission to long-term care may begin to be experienced in 2015-16 but this is likely to be at an extremely modest level influenced to a greater degree by the RAID approach around liaison within acute settings in 2015-16, with the greater impacts from early diagnosis growing year by year from 2016-17.‟ (Dr. Prashant Kukkadapu / Dr. Ian Leonard - Consultant Psychiatrists, LCFT and Dr. Rakesh Sharma (Lead GP for Dementia, East Lancashire CCG)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment:

Scheme Name	2014/15	2015/16
Memory assessment service	£1,260,000	£1,260,000
CANTAB and LCFT	£325,000	
Increase in Dementia Advisor and Support Worker capacity		£124,000
Respite support for Dementia carers		£97,000
TOTAL	£1,585,000	£1,481,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

lease provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metric	
Emergency admissions	☑
Estimated Diagnosis Rate for Dementia	☑

Patient experience: Proportion of people feeling support to manage their LTC	☑

EL CCG has already seen an increase in the diagnosis rate from 53% in April 2014 to 1% in October 2014 and is on trajectory to achieve the 67% target in March 2015. The aim is to increase this to 70% by 2019. A further 1 % increase from 67% to 68% in 15/16 would equal another 44 diagnosed.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Regular Dementia diagnosis rates review
- Assessment of dementia admissions hospital admissions (however needs to take into account previous underreporting.
- Assessment of dementia admissions to care homes

What are the key success factors for implementation of this scheme?

- Successful implementation of new MAS model in neighbourhoods
- Estate availability for neighbourhood teams
- Recruitment of new workforce
- Improved access to post-diagnostic support, including increased levels of engagement in peer support programmes, increased number of peace of mind plans, increase in use of advance directives.
- Increased diagnosis rate in hard-to-reach communities such as BEM communities, people with Learning Disability and people in care settings.
- Increased involvement of people with dementia in social activities and wider community engagement.
- Improved understanding and awareness of dementia across East Lancashire.
- Development of Dementia Friendly Communities within each District Council area.

Scheme ref no.
BCF003, BCF004, BCF005
Scheme name
Scheme 3 - Redesigned Intermediate Care supported by an Integrated Discharge Function Scheme 4 - Intensive Home Support Scheme 5 - Navigation Hub/Directory of Services
What is the strategic objective of this scheme?
The strategic objectives are: • Delivery of a responsive proactive step up option to reduction avoidable admissions available 7 days a week. • Utilise trusted assessment to reduce duplication and offer seamless transfer between community and acute bed and non-based bed provision. • Deliver efficiency and effectiveness compared to current system to ensure quality and value for money, reducing length of stay and improving patient outcomes/achievement of goals. • Improve quality of care and in particular patient experience for this service redesign. These objectives are supplemented by a set of principles as agreed by the Chief Executives from a number of organisations across Pennine Lancashire. These principles, or strategic intentions, support the implementation of the Better Care Fund Plan and are summarised as: • Initial focus for service redesign will be on complex frail elderly people. • Simplification of the system is vital leading to a minimal number of options with simple, single access points. • Step up as well as step down as a feature of all Out of Hospital services. • Discharge to assess long term care needs, allowing time outside of the acute setting to develop appropriate care plan for patients, relatives and carers. • Management of flow and capacity of the system needs to be coordinated and managed as a whole system. • Trust in the robustness of the Out of Hospital system has to be established.

- Capacity has to be consistent and greater flexibility of the system is required, specific to the needs of the person.
- Full spectrum of need will be addressed, with responses varying from light touch through to intensive support.
- Changes to the system must build on existing provision, and not duplicate or introduce complexity.
- System changes will be responsive to our ongoing development of integrated locality/neighbourhood teams.
- Alignment of the emerging integrated intermediate care system with the CCG strategic and operational plans as well as planned Local Authority activity

Overview of the scheme

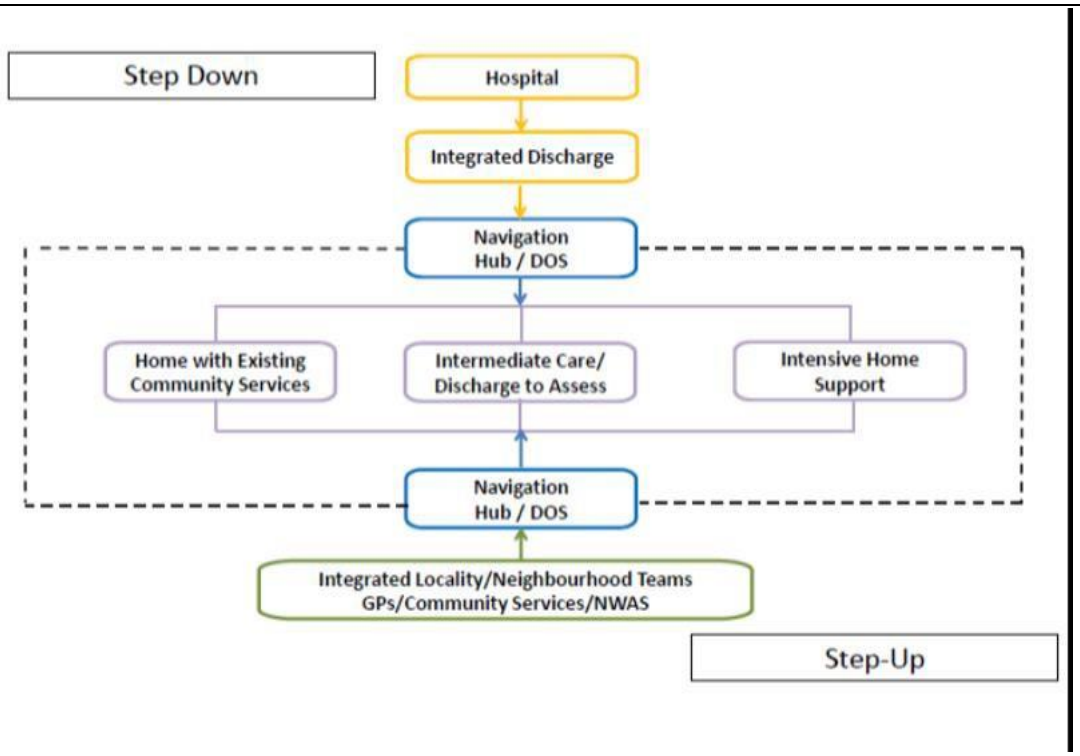
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The programme relates to services for complex frail adults and will initially focus on 3 specific areas:

- Integrated intermediate care supported by integrated discharge function and enhanced falls service
- Intensive Home Support
- Navigation Hub and Directory of Services

The diagram below outlines how the scheme elements will work together to support the delivery of an integrated whole system and the needs of complex frail elderly patients.



i.

Integrated Intermediate Care System

Current system

An analysis of our current hospital system highlights that the unplanned care pathway produces a significant amount of admissions for older adults, frequently risking the potential for over-intervention and the undertaking of risk-averse practices. This also results in inefficient and complex discharge processes that can actually increase frailty and dependence rather than supporting recovery and future independence. This is not a criticism of staff but more a reflection of a system that has developed over time.

Model

<u>Remodel the current Community Hospital and Intermediate Care provision</u>

Our intention is to re-balance community integrated intermediate care services and short term bed based services to provide each individual the opportunity to recover and achieve their optimal level of skills, confidence and independence. We will devise a system where people are able to step up into intermediate care and sub-acute beds to avoid an unplanned admission thus ensuring that at least 1/3rd of the capacity of the system is used for step up need. The beds can also be used as step down from an acute setting where necessary. The project will include:

- **Re-model a planned East Lancashire wide system following a detailed analysis of the sub-acute bed base required (employing the methodology Birmingham used to define their need) and delivering**

the following:

- **Capacity in each locality of East Lancashire relative to local population needs (Rossendale, Pendle, Ribble Valley, Hyndburn, and Burnley).**
- **A mix of Extra Care Housing based provision (25%) and more traditional 24/7 oversight (75%).**
- **Agree the future plan for a revised Intermediate Care model for people who cannot remain in their own homes for a short period.**
- **Create a flexible specification for community beds to include a range of care from sub-acute to intermediate care.**
- **Make use of short term recovery/recuperation beds before patients move to intermediate care**
- **Establish a co-located Integrated Discharge Team with the ability to flex between community and acute bed base**
- **Provide locality or neighbourhood capacity to meet the needs of the local population in each district council area of East Lancashire.**
- **Delivery of a wider step up/down sub-acute bed base for intermediate or sub-acute care that supports the full range of needs.**
- **Overseen by an agreed model of medical management.**
- **Include support to people with dementia and delirium on a parity of esteem basis.**
- **Inclusive of individual housing based support to offer step up/down care in settings that can include existing carers on a 24/7 basis, as well as giving people the opportunity to test alternative longer term support options (extra care housing).**

<u>Falls Pick-up Service (FPS)</u>

The service will provide an alternative to the deployment of an ambulance and will support citizens through care closer to home, reducing the need for unnecessary conveyance to Hospital and therefore reducing admissions.

Key outcomes for people include:

- **Providing a quick, effective qualitative service for rapid access to clinical intervention, community services or equipment that would improve their quality of life and allow them to remain independent and continue living at home.**
- **Reducing conveyance, admissions to emergency departments and other acute admissions.**
- **Increasing the number of ELCCG patients that are seen and treated by the Falls Service.**
- **Ensuring appropriate onward referral to other health and social care services.**
- **Providing safe appropriate admission avoidance solutions;**
- **Promoting falls prevention;**
- **Providing simple and complex case management in conjunction with Integrated Neighbourhood Teams and ICAT**
- **Providing a specialised dedicated response to patients (>50yrs) who have fallen at home or their usual place of residence in the ELCCG**

area
Timescales
The review and redesign of the intermediate care system will commence in January 2015 and be completed by December 2017. The remodelling of the integrated care system is a long term plan therefore it is expected that the CCG will only see a small proportion of impact and savings during 2015/16, with full effect and impact as a long term vision.
Intensive Home Support
Proposal
The Intensive Home Support (IHS) Service will be a community based, medically-led multidisciplinary team that focuses on patients with the highest risk of a hospital admission or requiring intensive support following a hospital admission. It provides sub- acute care to support patients to remain in their own home. Discharge from the service will be planned such that more patients can rapidly flow through the system back to main stream services and home. The health and social care economy will work in partnership and in collaborative teams to deliver services. Referrals will be able to be made direct by hospital and community through the Integrated Neighbourhood Teams or the Navigation Hub
Model
The basis for implementation of an IHS in East Lancashire will be a remodelled Virtual Ward service including direct commissioning of Crisis Support. **The service will focus on frail elderly patients in the first instance and:** • **Enable clinically stable patients to start or complete their care pathway in the home.** • **Provide „medical lead" working with skilled multi-disciplinary team, supporting patients at home 7 days a week 24 hour with support from GP, community nursing, acute clinicians and social care services. Medical oversight will provided by an integrated model of consultant support and primary care.** • **Facilitate medicines management reconciliation to avoid negative poly-pharmacy and pill burden.** • **Provide support to both step up and step down patients out of the hospital and community based services.** • **Integrate with existing health and social care provision including direct commissioning of reablement and crisis offer and integrated locality or neighbourhood team development.**

The point of access into the service in East Lancashire will be through the Intermediate Care Allocation Team (ICAT). ICAT is a small multi-disciplinary team that takes referrals from a range of health and social care disciplines in the community and acute sector and allocate short term community care. This can be both step up and step down. It is the lynchpin of our integration strategy for all adults in East Lancashire.

Performance is strong with an average 165 referrals per month (case load of 30 per worker) and all referrals are dealt with within a two hour period providing piece of mind for patients, carers and referrers. Around 91% of referrals into ICAT mean a patient stay in their own home; it is estimated that 1 5 referrals avoids a hospital admission. Trends in re-admission rates for the rust have declined which in part can be attributed to ICAT. It is estimated that for every assessment received, ICAT saves an assessment with its MDT approach. The team currently operate 9am-5pm Monday to Friday not including bank holidays. These opening times will be extended to 8am – 10pm seven days per week.

The model proposes that ICAT keeps its current MDT approach as its core principle. This means that:

- **More staff will be required.**
- **All social care, therapy and coordinator resource will be based directly in the team (employment contracts will sit in LCC). No rise in nursing requirements is factored in as this will be planned within the development of the Intensive Home Support service closely aligned / integrated with ICAT.**
- **The service will offer a minimum of three duty team at any one time, an ICAT mailbox, telephone referrals and monitoring of flow to residential rehabilitation (24 beds)**

The model also proposes the development of a rapid assessment resource in AT, delivered jointly with Blackburn with Darwen. It has been estimated that within the new model, ICAT could deliver around 3-5 "rapid response" assessments per day if:

- **No other service is able to assess.**
- **it can't be determined what the needs are from the telephone referral**
- **A triage would be beneficial for the assessment**
- **The patient/service user needs a further specialist opinion for a holistic assessment.**

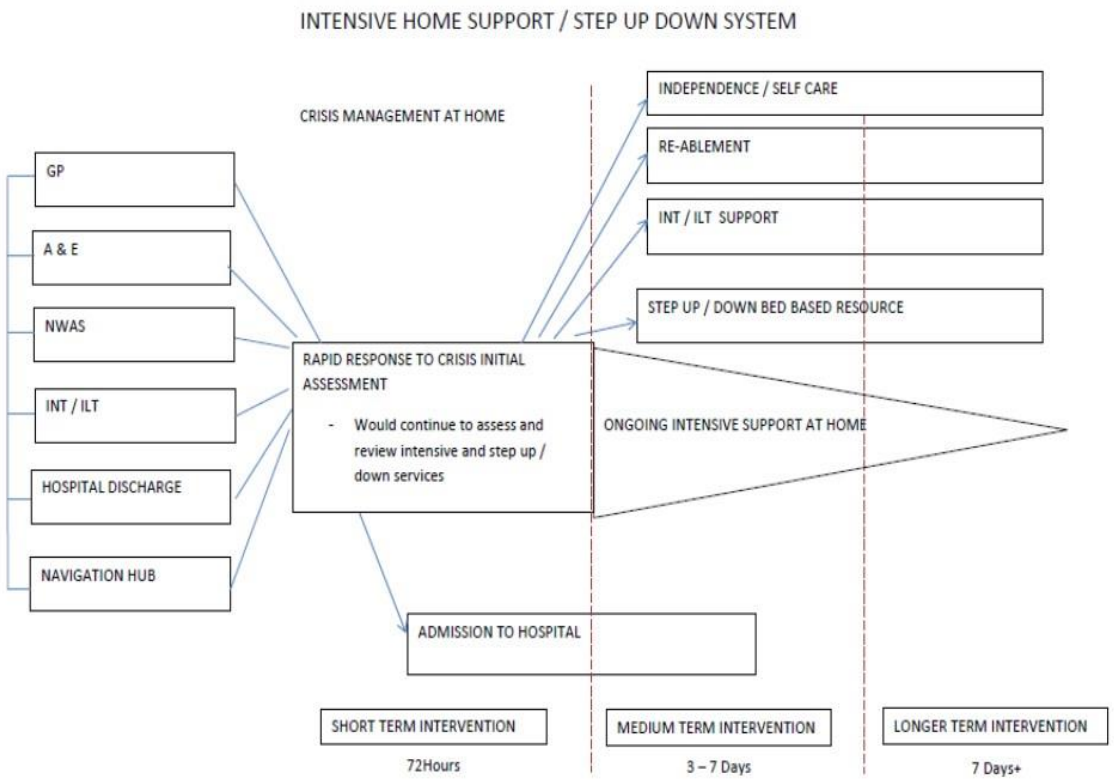
Timescales
The implementation of IHS will commence February 2015 with initial focus on re-design of existing Virtual Ward model to support those who are at highest risk of emergency hospital admissions and patients discharged from hospital to remain in own home.

Co-ordination hub and Directory of Services

Model

The Care Navigation hub will provide a key interface with the Intensive Home Support and the Integrated Discharge Team. It will also provide a capacity management system for out of hospital care enabling full use of resource and ensuring flow across the community bed based system.

The diagram below outlines the DOS and navigation hub interface with the wider system.



Alongside the hub a comprehensive Directory of Services (DOS) advice and brokerage for health and care professionals to enable them to access the appropriate services for frail elderly patients. It will also have a capacity monitoring function to help referrers understand their options to make best use of resources within the local health and care economy. The DOS will

include service information relating to:

- **Primary care including pharmacy**
- **Secondary care**
- **Social care**
- **Mental health services**
- **Community health services**
- **Hospital discharge**
- **Voluntary sector**
- **North West Ambulance Service**

Timescales

The implementation of the Directory of Services will commence from December 2014. The Co- ordination hub will be established by March 2015.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Pennine Lancashire Health Economy is a natural footprint covering the boroughs of Blackburn with Darwen, Burnley, Hyndburn, Pendle and the Ribble Valley and Rossendale. Acute Services are provided on a Pennine Lancashire footprint by East Lancashire Hospitals Trust.

Service	Commissioner	Provider
Integrated Intermediate Care and Discharge Function	East Lancashire CCG, Lancashire County Council	Lancashire County Council, Care Agencies, East Lancashire Hospitals Trust, Lancashire Care Foundation Trust
Intensive Home Support	Blackburn with Darwen CCG and Local Authority aligned with East Lancashire CCG, Lancashire County Council support),	Lancashire Care Foundation Trust, East Lancashire Hospital Trust (community & secondary are via consultant Blackburn with Darwen local Authority, Lancashire County Council, East Lancashire

		North West Ambulance Service
Care coordination hub/ DOS	Blackburn with Darwen CCG & Local Authority, East Lancashire CCG, Lancashire County Council	East Lancashire Medical Services (ELMS)

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Emergency admissions are rising in East Lancashire, particularly in over 65‟s. Older people stay in hospital longer than average and costs of admissions increase with age. Blackburn with Darwen is an outlier for long term residential care admissions. The current system is complex and often difficult to navigate.

Intermediate Care Services

Local evidence for Intermediate Care Services

All three schemes will have an impact on delayed transfers of care but cannot be split into individual schemes. The delayed transfers of care modelling at the Lancashire level, calculates a reduction of 3.06% i.e. 384 on current activity for ELCCG. Evidence from Doncaster that their schemes have had an impact on reducing LOS by 2 days, which will contribute to a reduction in DTOC.

To validate this the Pennine Lancashire economy has undertaken two 'perfect week' events. These were done in October 2013, and more recently October 2014, with another one planned for January 2015. These schemes concentrated on the flow of patients through the hospital system and highlighted a number of areas, which require improvement to improve flow and have provided evidence to support the schemes that have been included in these BCF schemes.

Academic research for Intermediate Care Services

IC Services have the potential to reduce length of stay by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up) (The King's Fund, 2014).

Reablement can enable people to stay in their own homes for longer, reduce the need for home care and improve outcomes for users. Reablement costs slightly more

than traditional home care, but there is a strong probability of cost savings in the long term Rehabilitation and reablement provided at home is cheaper than rehabilitation and reablement when it is provided as bed-based care, and in many cases services provided at home are preferred by service users (Social Care Institute for Excellence, 2013).

We know from the work undertaken within the National Audit of Intermediate Care that:

- Prof. John Young (National Clinical Director for Integration and Frail Elderly) suggests that for frail older adults, 30% of people at the admission point to hospital could be deflected from admission and 25% of people could benefit from earlier discharge.
- Intermediate care should be step up as well as step down. National Intermediate Care data shows that for a Bed base service 2/3 is usually step down from hospital and 1/3 step up, for Home based services 1/3 is usually step down and 2/3 step up.

Local evidence for Falls Pick-up Service

- In Burnley, Hyndburn, Pendle and Rossendale the rate (12/13) of emergency hospital admissions for falls injuries in 65+ persons is significantly higher than the England rate during 2011/12, 2012/13 & 2013/14 68% of ambulance call outs were for falls in 65+ persons
- Between 2011/2012 and 2012/13, the rate of emergency hospital admissions for injuries due to falls in 65+ persons has considerably increased in Burnley, Hyndburn and Pendle
- In Hyndburn, Pendle and Rossendale the rate of emergency hospital admissions for Injuries due to falls in persons aged 65-79 years is significantly worse than the England rate
- In Burnley and Rossendale, the rate (12/13) of emergency hospital admissions for injuries due to falls in 80+ persons is significantly worse than the England rate.
- During 2011/12, 2012/13 & 2013/14 68% of ambulance call outs were for falls in 65+ persons
- In the 20% most affluent areas of Lancashire, emergency hospital admissions for injuries due to falls in people aged 65 and over are significantly better than England; in the 10% most deprived areas they are significantly worse than England

UK best practice for Falls Pick-up Service

Hardwick Clinical Commissioning Group commissioned a Falls Partnership Service (FPS) working collaboratively with Derbyshire Community Healthcare Services (DCHS) and East Midlands Ambulance Service (EMAS). The FPS provides a 50/50 primary/secondary response to people over 50 years who have fallen at home.

- Using the Kings Fund evaluation which indicates a cost of £2.8k for each patient fall x (n= 84) hospital admissions avoided following an intervention by the FPS team between 6th November and 28th February 2014 equates to a potential saving of £239.4k
- In addition to this HCCG can evidence that (n= 14) patients who were not re-admitted back into hospital 30 days post fall and using the Kings Fund

evaluation the potential cost saving is £16.17k per patient, demonstrating significant savings per patient across both health and social care.

Academic research for Falls Pick-up Service

Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs. *NICE Clinical Guideline 161 Falls: assessment and prevention of falls in older people (June 2013)*

- 10% of all > 65yrs who fracture their hips will die within 30 days
- 30% of all > 65yrs who fracture their hips will die within 1 year
- 50% of fragility fractures go onto fracture their hips.
- 50% never regain their current mobility
- Ageing population means that incidence will increase by 50% by 2030

Local evidence for Integrated Discharge Services

In June 2013, BwD CCG and Local Authority established an East Enhanced Integrated Community Service (EICS) Pilot in the East of the Borough. The University of Liverpool, Institute of Psychology, Health and Society, have been collecting data; interim results have identified:

- 81 patients received Intensive Home Support or case management and 231 patients were seen by the ASC project between June 2013 and June 2014.
- There is some evidence to suggest that the pilot prevented emergency admissions is and access to GP consultations for each person receiving the intervention over 6 months of follow up.
- Following a full 6 months of follow up it is estimated that the 81 people who had received the IHS during between June 2013 and June 2014 will have had 90 fewer emergency admissions and the 231 people receiving the ASC intervention would have consulted their GP 460 more times if these interventions were not in place.
- The modelling provided by BWDCCG within its BCF submission identified that the impact of this scheme was a reduction in NEL admissions of 8.4%
- The commentary provided detail of the patient groups i.e. ambulatory care and falls, therefore over 65s in these cohorts have been used within the modelling only.

Evidence from current Intermediate Care Allocation Tem (ICAT) service has been collected locally over recent months (June 14 – Oct 14) which has captured where an admission has been avoided by their intervention. The avoidable admissions for this period, with these operational hours was 140.

Intensive Home Support (also known as „Virtual Ward" or „Hospital at Home")

Local evidence

Modelling provided by BWDCCG identifies that the impact of this scheme was a reduction in NEL admissions of 8.4% for specific patient cohorts (i.e. ambulatory care

and falls patients).

Academic research

A systematic review of trials comparing „hospital at home" schemes with inpatient care found that, for selected patients, avoiding admission through provision of hospital care at home yielded similar outcomes to inpatient care, at a similar or lower cost. (Sheppard et al, 2010).

A Nuffield Trust Study (June 2013) of 3 current virtual ward programmes, has shown an overall reduction in electives, outpatients, A&E and emergency costs for the first 6 months post discharge to the ward of around 5% overall, compared to the costs of patients pre- referral. In relation to specific schemes, the evidence suggests that:

- In Devon, emergency admissions were reduced by 25.7%
- In Wandsworth there was a 45% reduction in the first 6 months
- In North East Essex they expect a 25% reduction over the first year

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The provisional BCF allocations are subject to agreed business cases for investment areas. This significant non-repetitive investment will be made during 14/15 and 15/16 to support the re-design of the Intermediate Care System and allow the opportunity to test the change and gather evidence for long-term repetitive investment.

Service	2015/16
ntensive Home support (new resources)	£1,168,000
DOS/Coordination Hub (new resources)	£359,000
Reablement	£2,116,000
ntermediate Care/ Discharge to assess (part new resources)	£10,356,000
TOTAL	**£13,999,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

These schemes are expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Delayed transfers of care	☑
atient experience: Proportion of people feeling support to manage their LTC	☑

The quantified impact is calculated as:

- A reduction of **612 non-elective admissions** in 2015/16
- A **reduction of 10 permanent residential admissions** by 2015/16
- **420 fewer delayed transfers of care** compared to the prior year

Other benefits of the IHS Service (and ICAT specifically) include:

- a more responsive crisis service
- reduction to hospital admissions
- support for community and hospital social workers to focus on more complex and long term packages of care.
- increased capacity to deal with an estimated number of referrals as follows: 386 (ICAT current number per year) + 1374 = 1760 or 32 per month to 115.
- support out of hours services to commission crisis directly.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- We will implement routine patient satisfaction surveying from GP Practices to enable the capture and tracking of the experience of care.
- We will collapse the current number of service specification associated with community services to align to an integrated model of care, and this will be

underpinned by a robust performance management framework which will measure benefits at a neighbourhood, practice and patient level.

- We will adopt a programme management approach to the delivery of integrated care to ensure, leadership, accountability and reporting processes are rigorous and robust.
- All Integrated Care projects delivered in East Lancashire are accountable to the following governance structure:
  - Senior Management Team
  - Executive Team
  - East Lancashire Partnership Delivery Group
  - Pennine Lancashire Executive Officers Group
  - Lancashire Health and Wellbeing Partnership
  - Lancashire Health and Wellbeing Board

What are the key success factors for implementation of this scheme?

- Interoperable IT systems including capacity management
- Workforce development plan to support multi professional skills aligned to IHS
- Co-located discharge teams utilising single assessment document
- Estates review to support Intermediate Care facilities
- Continuous stakeholder engagement

Scheme ref no.
BCF006
Scheme name
Intermediate Care Redesign – Fylde and Wyre
What is the strategic objective of this scheme?
he strategic objectives of this scheme are to build on existing individual good practice to expand and integrate all intermediate care provision, establishing a single pathway and range of time limited interventions provisions that: • Maximise individual independence • Offer a seamless transfer between bed and non-bed based provision • Improve the health and wellbeing of patients who are pivotal in agreeing goals and outcomes • Focus on and enable early supported discharge and reduce length of stay • ensure a quality service that provides value for money. • Provide proactive step up options to reduce avoidable emergency admissions. he service model will be developed to ensure sufficient community capacity to ensure at assessments outside of the acute setting are the default position, providing a „Time to Think" model and wherever possible ensuring that patients are discharged directly to a new permanent residential placement
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
By re-designing, enhancing existing services and developing new provision the future model for intermediate care in Fylde and Wyre will ensure: • patient hand offs are minimized • individuals" rehabilitative pathway will be co-ordinated and managed by one lead professional, • a seamless transition through both residential and home based services as appropriate.

Increased community capacity and step up access will directly impact:

- a reduction in non-elective admissions,
- a reduction in delayed transfers of care,
- a reduction in admissions to care homes
- an increase in patients remaining at home 91 days after a hospital admission.

The community based step up and step down services will continue to work in a proactive way, ensuring people are supported to remain in their own homes and dependent for as long as possible. A range of options are available to support people to recover following a hospital stay or health related difficulty. The options aim to ensure:

- the right level of care and services are available to individuals, at the right time and place.
- timely discharge from hospital with reducing lengths of stay, helping avoid admissions to long term residential care as well as readmissions to acute care.

This service model has evolved over time with pockets of integrated practice and provision already established, but some historical ad-hoc provision in place. The intermediate care model of care includes the following 4 components:

1. Residential Recuperation and Rehabilitation

- **Rehabilitation Beds** are designed to support people to either accommodate their illness by learning or re-learning the skills necessary for daily living or regaining skills and abilities following illness or fall.

- **Recuperation Beds** are designed to support people who are not able to return home following a stay in hospital or a period of illness. These patients will not require nursing care but need time to fully recuperate before returning home either independently or to continue their rehabilitative journey.

In Fylde and Wyre there are 12 rehabilitation and 6 recuperation beds based at Thornton House (a 44 bedded residential home). These beds are currently commissioned by Lancashire County Council with the CCG commissioning the therapy and nursing provision inputting to the service via separate contracting arrangements.

Rehabilitation beds should be used for a period of up to 6 weeks and recuperation beds for up to 4 weeks. These beds provide an opportunity for individuals who:

- Would not be able to immediately manage at home following a hospital stay
- Require therapies to support their physical recovery
- Require support to relearn lost skills and gain confidence
- Require support to return to good general health and general wellbeing

those using the beds have access to a small domestic kitchen and a communal area. The home has no therapy room so any therapy has to take place on the communal stairs and in bedrooms.

2. Dementia Residential Rehabilitation

Dolphinlee offers a specialist dementia residential rehabilitation in Lancaster, outside of the Fylde and Wyre CCG footprint. The service provides 10 residential rehabilitation
beds with dedicated therapeutic intervention for up to 6 weeks to individuals with dementia who have suffered an episode of physical ill health or injury. The service aims to prevent or delay admission to long terms care, prevent admission or re-admission to hospital and facilitate early hospital discharge. Given the location the service is accessed with relative infrequency by Fylde and Wyre patients.

3. Day services (Community Brain Injury Rehab Service / Richmond Fellowship)

Day time support services are provided for specialist rehabilitation such as brain injury and acute mental health episodes. These services are accessed over a much longer period of time to enable patients to recover from periods of complex mental health need in order to reach their full potential.

4. Home based provision

A range of home based provision services are available to individuals as part of the Intermediate Care Pathway which include occupational therapy and physiotherapy, reablement with therapy, Short Term Intense Support (STIS) and a variety of equipment and adaptations.

Service redesign and specific commissioning activity in 2015/16 will include:

- Develop and expand the current integrated access point to include all

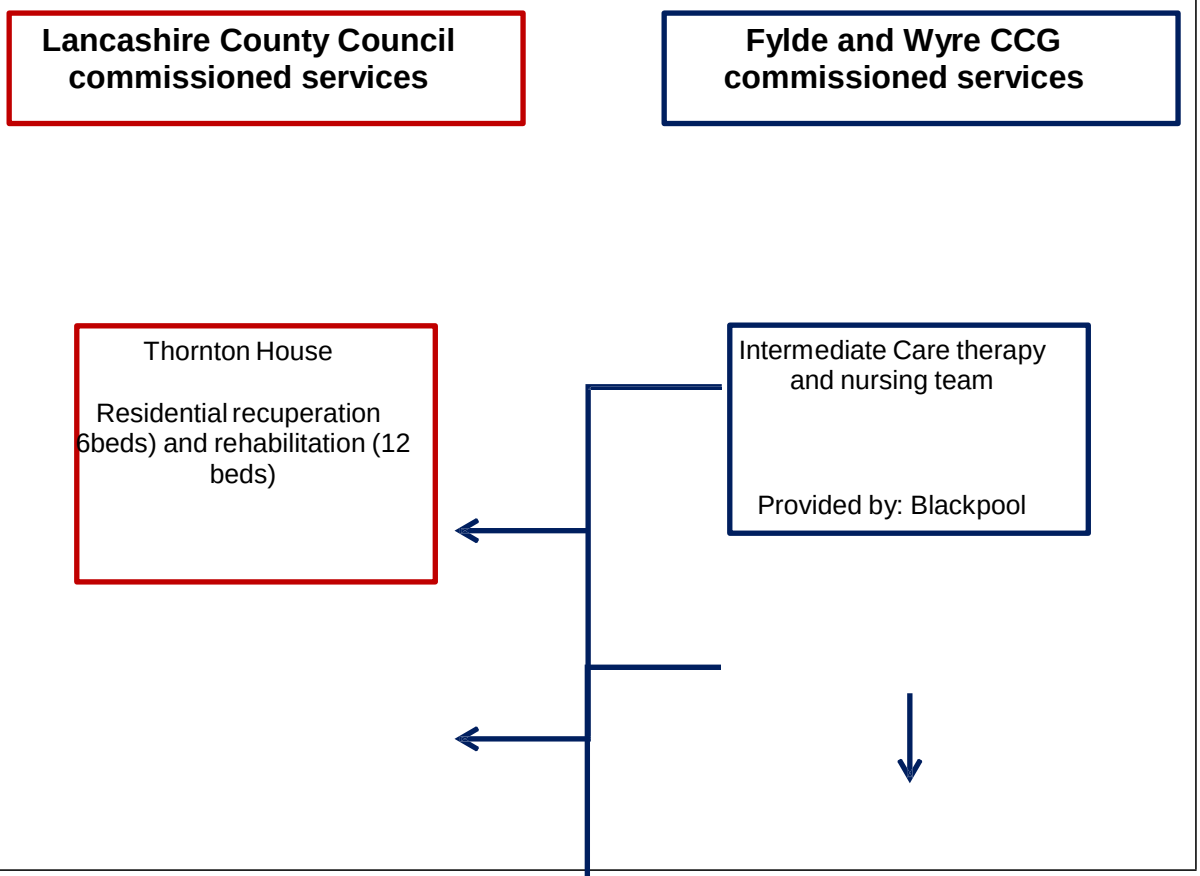
intermediate care referrals

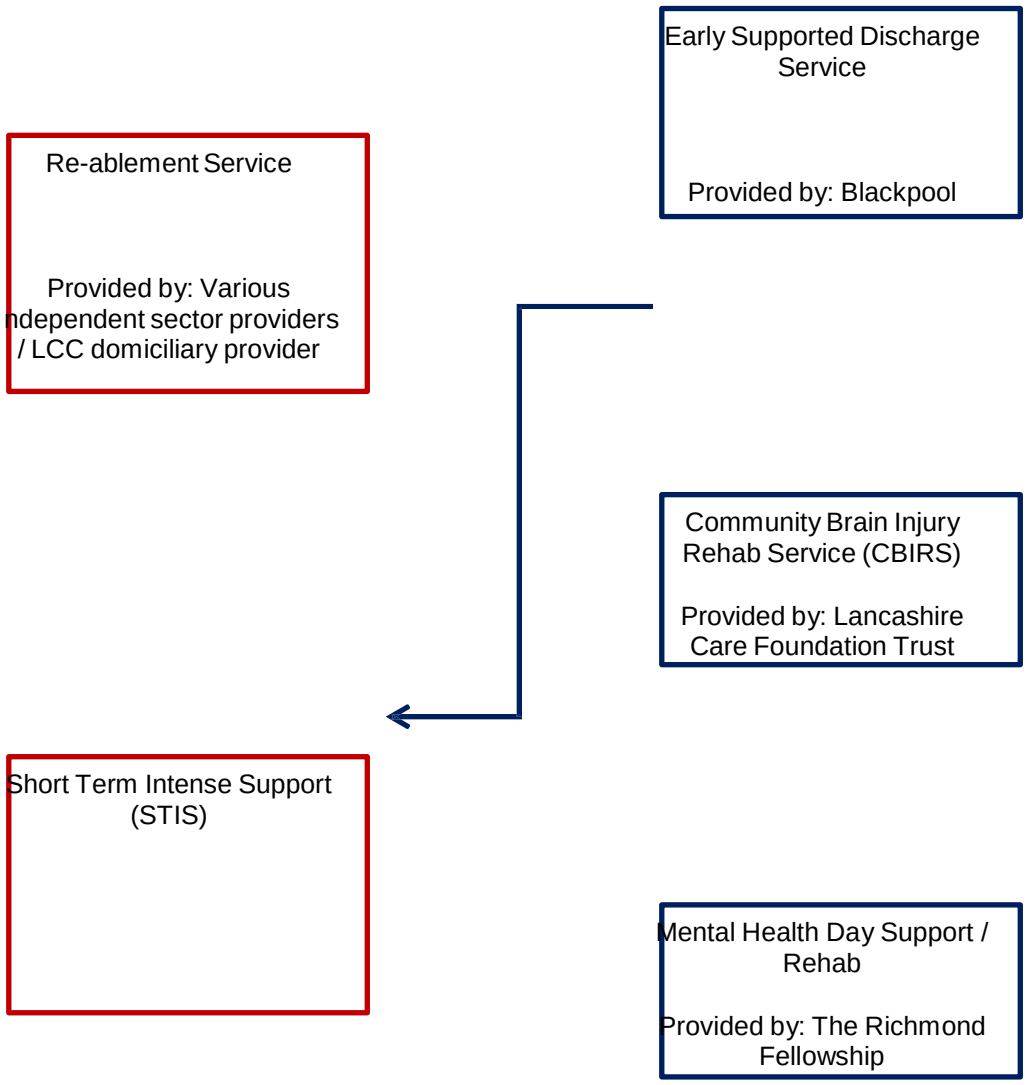
- Further integration of health and social care community based intermediate care services in the form of a new Early Supported Discharge / Discharge to Assess service
- Enhance therapy and nursing input into non-nurse lead residential beds and community therapy team to improve the patient journey and optimize independence
- Provide integrated 7 day discharge services to increase intermediate care step down
- Jointly commission specialist dementia rehabilitation in Fylde and Wyre, both residential and community based provision.

The patient cohort targeted in this scheme will be primarily older people (over 65s) and people with multiple long terms conditions

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved





The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

NHSE Emergency Care Intense Support Team (ECIST) (July 2014) recommended that focus be placed on early supported discharge / discharge to assess model due to concerns with high number of blocked beds.

Fylde Coast Intermediate Care Review (July 2013) undertaken by Benchmark Management Consultancy Ltd recommendations included;

- Implement a simplified and improved intermediate care pathway,
- Review and identify opportunities to re-balance intermediate care capacity over time,
- Refine the existing plans for a single point of access for intermediate care,

- Develop an intermediate care at home team,
- Develop a single standardised assessment process for intermediate care.

Fylde Coast Unscheduled Care Strategy – highlights the complexity of current provision of intermediate care services commissioned with some potential duplication and apparent fragmentation of services. Initial investigations confirmed that there is no single coherent intermediate care pathway and many referral routes into the system.

Department of Health: Intermediate Care – Halfway Home July 2009 - makes it clear that intermediate care must involve multi-disciplinary team working, often offering a spectrum of care including both health and social care professionals.

The National Audit of Intermediate Care, Prof. John Young (National Clinical Director for Integration and Frail Elderly) suggests that for frail older adults, 30% of people at the admission point to hospital could be deflected from admission and 25% of people could benefit from earlier discharge and that intermediate care should:

- not look like (or operate like) a hospital ward but be domestic in feel with a key message that community hospitals managed by acute hospitals are not usually a true part of the Intermediate care system as they tend to be managed to deal with the flow issues within the main hospital site. They suggest a clear need for step up/down services to be separated out and run from a community perspective.
- be step up as well as step down. National Intermediate Care data shows that for a Bed base service 2/3 is usually step down from hospital and 1/3 step up, for Home based services 1/3 is usually step down and 2/3 step up.
- have multiple staff types involved in IC for a better outcome. The evidence shows that outcomes are improved if more than 5 different work disciplines are part of the multi-disciplinary team working within an Intermediate care service, Key areas often not active within such teams include medical cover (Consultant or GP), Medicines management and wider therapy support such as speech and language therapy.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Metrics	Intermediate Care Redesign
Early Supported Discharge	£544,000
Intermediate Care Nursing & Therapies	£809,000
Hospital Discharge Services	£249,000
MH & CBIRS Day rehab	£266,000
Dementia	£67,000
TOTAL	**£1,935,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

lease provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Delayed transfers of care	☑

The quantified impact is calculated as **a reduction of 39 Non-Elective admissions.** The team supporting early discharge will actively manage a caseload of circa 200 patients per annum on a rolling caseload basis. This caseload will be targeted based upon a strict set of criteria that focuses on most at risk of readmission and based upon analysis of past activity. This translates as 10% of the overall reductions that Fylde & Wyre CCG are working towards in 2015/16.

hese schemes will also have a positive effect upon delayed transfers of care – analysis of the current patient cohort who are encountering delays in their discharge

has identified that **reductions of 28 days in 2015/16** are potentially achievable. This activity will also contribute to maintaining current performance across metrics within social care.

The key qualitative benefits are:

- Improved integration of services across primary, community and secondary care.
- More informed decision making re: long term care planning coupled with holistic provision of care
- Improved communication between providers of care
- Eliminate duplication of services
- More appropriate referrals resulting in service users receiving the most suitable care to meet their needs
- Improved patient experience through patient self-care and involvement in managing own health needs.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

All of Fylde & Wyre's contracts with Providers have agreed inbuilt reporting mechanisms to ensure that the commissioner is able to monitor the performance and activity levels of the services that it procures for its registered patient population. This is also supplemented with robust key performance indicators and a quality reporting schedule to allow the commissioner to maintain service assurance.

Specifically the scheme impact will be monitored through the following governance arrangements:

- Overall progress will be monitored through local governance, senior management and executive structures at Fylde and Wyre CCG.
- These structures include provider, commissioner and wider stakeholder representation and report into the BCF governance including to the Lancashire Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

The key success factors of this scheme are the:

- continuation of partnership working between health and social care front line staff
- integrated systems which front line staff rely on such as single assessment, shared records, monthly MDT‟s.
- robust workforce development strategy which is pivotal in ensuring the right level of skilled community based staff are recruited in order to deliver the new pathway.
- development of the Market place to ensure the role of private sector residential and domiciliary provision is met.

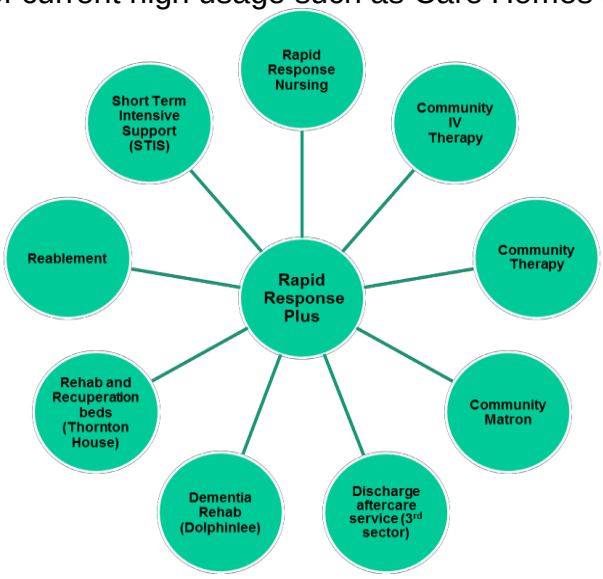
Scheme ref no.
BCF007
Scheme name
Admission Avoidance
What is the strategic objective of this scheme?
The strategic objective is to provide a cohesive and integrated approach to admission avoidance, building on existing good practice. The scheme will: • Embed integrated interventions for frequent users of 999, A&E, police and local authority urgent services. • Ensure an integrated pathway delivered by responsive services is in place to meet the needs of individuals in crisis or with chaotic lifestyles. • Ensure bespoke support is available to all residential care and nursing homes in order to reduce 999 calls and acute admissions. • Embed an equitable falls pathway that provides training, lifting services and avoidance / education scheme.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

By re-designing and enhancing existing services and developing new provision there will be a more coherent and systematic integrated approach to hospital admission avoidance in Fylde and Wyre. Patients will receive an equitable service with specialist input and provision being targeted at areas of current high usage such as Care Homes and Falls.



The main service that will support admission avoidance is the Rapid Response Plus service. It, in turn, is supported by a number of services as depicted in the above diagram. Detail of the Rapid Response Plus and the more major services follows.

Rapid Response Plus – single point of access

An integrated 7 day service aimed at admission avoidance for people with a diagnosed health AND/OR urgent social care need. The team will be accessed via one telephone number and provide a rapid assessment in order to mobilise appropriate support, refer onwards and signpost to relevant services.

The key features are:

- Calls answered by a health or social care professional
- Trained assessors and clinicians working within the team
- Simplified referral pathway and availability of advice
- Senior clinician always available
- Implementation of mobile IT devices
- Remote access to patient notes on PCIS
- Lab results and x-rays in the near future.

Short Term Intense Support (STIS)

An LCC commissioned crisis intervention service which providing a quick response to a social care crisis that allows a person to be supported at home safely and avoids an unnecessary admission to hospital or residential care. A critical success factor is the ease and speed of access, usually within one hour, so that service users, carers and other health and social care professionals can have trust and confidence in the service. There are 230 contracted hours per week allocated to Fylde and Wyre with these hours increasing during winter months to support winter pressures across the health and social care system.

Rapid Response Nursing

Team of highly skilled professionals who have a solution focused approach and are empowered to work with referrers by promoting a culture of helpfulness and actively work to manage risk creatively and innovatively.

Community IV Therapy

Intravenous therapy administered in the home or alternative community setting in order to avoid an acute admission.

Other service provision:

- Frequent callers pilot
- Targeted intervention supporting those individuals with extremely high levels of 999 calls
- Acute Visiting scheme (NWAS & Out of Hours)
- Mental Health Crisis Support & Reablement
- Falls provision
- Care Home Support Team
- Hospice at Home

Service redesign and specific commissioning activity in 2015/16 will include:

- Embed and expand the pilot frequent 999 callers service to meet the needs of frequent Police, A&E and Local Authority users.
- Develop an integrated community pathway to meet the needs of individuals and families with chaotic lifestyles using third sector supports, health coaching and asset based approaches
- Commission an integrated Care Home Support Team to work with all residential care providers in Fylde and Wyre
- Establish an integrated seamless falls pathway which encompasses all elements from

prevention to rehabilitation.

- Broaden scope of Rapid response Plus to function as a single access point for all hospital avoidance services and provision

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Currently most services are commissioned by Fylde and Wyre CCG and provided by a range of providers including:

- Blackpool Teaching Hospitals Trust (Acute and Community)
  - Northwest Ambulance Service
  - FCMS – Out of hours Provider
- Lancashire Care Foundation Trust
  - Trinity Hospice
- Community Integrated Care (CIC provide Short Term Intense Support (STIS)). Directly commissioned and performance managed by Lancashire County Council however the service can be accessed by both health and social care professionals and is currently part funded by F&WCCG.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local support

Local evidence in relation to high prevalence of falls and falls conveyances.

Area	Fylde and Wyre CCG	Lancashire CCG Cluster	WAS
Total Incidents	**21,997**	**207,852**	**68,098**
17 – Falls	**3,157**	**23,187**	**06,217**
% of all incidents	14.4%	11.6%	1.5%
Falls Conveyed	**2,171**	**16,322**	**6,818**

% of fall incidents	68.8%	70.4%	2.3%	
Falls Not Conveyed	**986**	**6,865**	**9,399**	
% of fall incidents	31.2%	29.6%	7.7%	

This data shows the total number of falls conveyed equates to 6 calls a day. By utilising a previous analysis of data from other schemes, such as the East Midlands Ambulance Falls Service, the targeted falls reductions shows a minimum of 40% of these would not travel. Therefore 868 less patients would be transported to Emergency Departments. Admittedly not all conveyances would lead to a non-elective admission but it is felt that due to the frail and vulnerable nature of many patients, admissions would be avoided by both falls prevention and non-conveyance schemes.

Peer evidence

A pilot scheme targeting 15 Care homes in our neighboring Blackpool CCG evidenced the following outcomes:

- 20% reduction in the number of A&E transfers by NWAS in 1 year
- 20% reduction in unnecessary A&E attendances in 1 year
- 20% reduction in the number of unnecessary non-elective admissions to hospital in 1 year
- 95% of Care home Residents in the pilot group to have Community Care Plans in place in 1st year
- An education and training plan is developed and delivered for Care Home Staff

International best practice

The Veterans Health Administration, in the United States, shows they reduced bed day use by over 50% when it was transformed from a hospital-centred system to a series of regional integrated service networks[1] and Kaiser Permanente uses one-third of the bed days the NHS does for comparable conditions for people aged 65 and over[2].

Academic research

1 [1] Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data; BMJ; 2003; Ham C, York N, Sutch s, Shaw R.

[2] Avoiding hospital admissions: Lessons from evidence and experience; Kings Fund; 2010; Ham C, Imison C, Jennings M.

Our proposed service redesign is based on recommendations and principles of best practice outlined in:

- NHSE Emergency Care Intense Support Team (ECIST) recommendations July 2014
- Fylde Coast Unscheduled Care Strategy
- Implementing the End of Life Care strategy – Kings Fund
- Avoiding hospital admissions: Lessons from evidence and experience; Kings Fund; 2010; Ham C, Imison C, Jennings M.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Community Matrons	£834,000
COPD rehabilitation/nursing	£84,000
End of Life	£231,000
Hospital Liaison Service (BTH)	£165,000
Mental Health Crisis and Reablement	£1,451,000
IV Therapy	£245,000
Frequent Attenders	£100,000
Falls	£150,000
Rapid Response +	£349,000
Care Home Support Team	£180,000
TOTAL	**£3,789,000**

*****only a portion of this is currently spent across Fylde & Wyre.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in

headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Delay transfers of care	☑

The quantified impact is a **reduction in non-elective admissions of 306** resulting from the activities of this scheme and its related services. This translates into 75% of the overall reductions that Fylde & Wyre CCG are working towards in 2015/16.

his scheme and its related services will also have a **positive effect upon delayed transfers of are and are expected to demonstrate a reduction of 19 days** across 2014/15 **increasing to 28 in 2015/16** whilst also contributing to maintaining the current performance across metrics within social care.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

All of Fylde & Wyre's contracts with Providers have agreed inbuilt reporting mechanisms to ensure that the commissioner is able to monitor the performance and activity levels of the services that it procures for its registered patient population. This is also supplemented with robust key performance indicators and a quality reporting schedule to allow the commissioner to maintain service assurance.

What are the key success factors for implementation of this scheme?

Critical success factors to these services to be implemented successfully and our goals to be achieved include:

- Training staff to the right level of skill
- Changes in patient behavior are critical

- Robust communications required to manage expectations and channel patient behaviors appropriately.

Scheme ref no.
BCF008
Scheme name:
Lancashire health economy whole system urgent care transformation programme – Step up/Step down beds
What is the strategic objective of this scheme?
Step up/Step down beds is one of five high impact changes that need to be delivered to improve the quality of, and access to the urgent care system. There is significant need for a fundamental change in the way that services are commissioned and provided in Greater Preston CCG and Chorley & South Ribble CCG, with significant opportunities to improve patient care, outcomes, patient experience and value for money. The aim of this scheme is to improve access to the right level of care in a timely manner for those patients who need intermediate care, thereby: • Avoiding unnecessary admission to acute care • Promoting faster recovery (or discharge if admitted) • Reducing the need for residential or domiciliary care in the longer term. The overall strategic objective is to enable patients and their carers to lead the most independent and fulfilling lives as possible, delivered through: ● Effective joined up health and social care; ● Coordinated Multi-Disciplinary Team assessment, goal setting and goal follow-up; ● Stretching and maximising rehabilitation and reablement interventions; ● Supporting and maximising independence wherever possible;

● Making long-term care decisions outside the acute setting ● Care delivered as close as possible to home, in a positive environment that maximises efficiencies in reaching goals. To accomplish this, there is a need to invest in the development of community health and social care services in partnership to support people outside institutional care, ideally in their own homes.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?

The proposed Intermediate Care service will support and enable patients and their carers to live productive and independent lives in their own homes for as long as possible. This will be achieved through mutually agreed goals as part of a personalised and co-ordinated service, driven by one single assessment and active case management.

Models of care and support

Access to the range of intermediate care services will be coordinated through a **single point of access**. An **individualised plan of care** will be identified to provide support through the continuum of services with the intention of maximising independence and facilitating a return to their own home, wherever possible. It will deliver:

- An end to end service provided by one multi-disciplinary team, with one management structure
- We will **incentivise one provider to manage the balance and flow between bed-based and community services** to provide much greater flexibility and support to patients with different levels of needs. This joined up incentivised approach is highly likely to generate further efficiencies by reducing hand-offs and maximising utilisation of services.
- Patients will be **referred** to services determined by their needs via a **Single Point of Access**, to be used regardless of the referring agency. This will enable professionals to make referrals through just one point of entry and will facilitate more integrated and coordinated care.
- **Decisions will be made using a „single assessment process"** and will be dependent on specific criteria (including whether an individual can be supported at home, where therapy and/or care should be provided and by whom).This „single assessment process" will provide reassurance to the referrer regarding transfer of care, patient safety and governance arrangements.
- **Short stay „Assessment" beds** for people who need a period of assessment to identify the most appropriate onward care (patients may or may not need therapy; this service will be designed to accommodate both „Step Up" and „Step Down" patients)
- **Short stay „Recuperation"** (including transitional care) beds for people who may or may not need therapy but are unable to return home or participate in a programme of rehabilitation immediately for a variety of reasons (e.g. plaster of Paris in-situ);
- A **bed-based rehabilitation service** for people discharged from hospital that are medically stable but have a short-term need for Residential rehabilitation;
- A **non-bed based „Reablement service" (with or without therapy), to accommodate both „Step Up" and „Step Down" patients**, preventing unnecessary admission/re-admission to acute care services through provision of support in the patient's own home;
- **Domiciliary Care in the community quickly** (2 hour response time) to prevent unnecessary conveyance to the Emergency Department and/or admission to acute care services;

- Provision of a time-bound community service providing care in the patient's own home assisting them to be as independent as possible for as long as possible;
- Telecare service to support provision of care in a less acute environment, such as **"Skype" clinics**;
- Access to 24/7 nursing and/or social care (as required) in a non-acute setting;
- **Access to up to 72 consecutive hours of domiciliary social care support** allowing patients/service users to remain in their own homes for a period of assessment to accurately assess and establish needs and/or requirement for additional support or services.
- The social care element of intermediate care services is non-chargeable for a total period of up to 6 weeks (although there is some flexibility with this period for a small number of therapists) After 6 weeks, a **financial assessment should be undertaken by social care** to determine if an individual is required to contribute to the cost of any further care. Within the new model, robust monitoring and measurement of services being utilised will ensure that local resources are maximised and used in the most cost effective manner in order to benefit more individuals.
- *Appendix 1 and 2 to this scheme show the flow diagrams below demonstrate the pathway into and out of the individual 'Step Up' and 'Step Down' services.*

Target patient cohorts

The patient profile for the proposed model is adults of all ages with functional impairment as a result of either a short or long-term illness who will benefit from a period of assessment, recuperation, rehabilitation or transitional care. Most, but not all, patients will be elderly. Those with Mental Health needs will not be excluded, with the exception of patients detained or under consideration to be detained under a section of the Mental Health Act.

The types of patients who will be supported within Step Up/Step Down Care include the following:

- Acutely unwell but medically stable patients, e.g. UTI "off legs", Not eating and drinking/dehydration (Step Up);
- Post fall (Step Up or Step Down);
- Post-acute medical, orthopaedic or surgical episode (Step Down);
- Patients considering/being considered for long-term care;
- Patients awaiting further assessment (e.g. CHC MDT, completion of Social care assessment, further assessment/input from therapists).

This service will be provided in line with all the latest guidance and standards pertaining to intermediate care services. These include the following –

- High Quality Care for all; Delivering Care Closer to Home: Meeting the Challenge; Our Health, Our Care, Our Say – A New Direction for Community Services (DoH, 2008)
- National Audit of Intermediate Care (2012)
- National Audit of Intermediate Care (2013)

- Intermediate Care – Halfway Home
- Updated Guidance for the NHS and Local Authorities, (DoH, 2009)
- Reablement: a cost effective route to better outcomes (scie, 2011)

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The expectation is that it will be possible to commission the entire service from one provider with beds appropriately situated, supported by the re-shaped Integrated Transitional Care team. A procurement exercise will be necessary to seek one provider to deliver this service in its entirety, across the 3 localities (Preston, South Ribble, and Chorley).It will also stimulate the Health and Social care economy to work in partnership with an independent provider and the third sector

The key deliverables for implementation are:

Deliverable	Responsibility
Delivery of the new model	Integrated Transitional Care Team
	GPs Providers of health and care services
• **Identify what populations will most benefit from integrated commissioning and provision** • **determine the outcomes for these populations** • **Identify the budgets that will be contributed and the whole care payment that will be made for each person requiring care** • **Performance management and governance arrangements**	Greater Preston CCG Chorley and South Ribble CCG Lancashire County Council NHS England (in partnership where necessary)
• **Local area coordination with the Voluntary Community and Faith Sector.**	Greater Preston CCG Chorley & South Ribble CCG Lancashire County Council
• **Co-design the care models that will deliver these outcomes** • **Transition resources into these models to deliver outcomes** • **Ensure governance and organisational**	Lancashire Care Trust Lancashire Teaching Hospital public, private and voluntary and

arrangements are in place to manage these resources • **Agree the process for managing risks and savings achieved through improving outcomes** • **Establish information flows to support delivery** • **Ensure effective alignment of responsibilities and accountability across all the organisations concerned.**	community sector groups

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

We have taken into account UK evidence, the local context and academic research when developing this scheme.

UK evidence

In totality we are experiencing similar challenges to health and social care systems throughout the country:

- Local public health statistics indicate that the over 65‟s age group is expected to increase by approximately 10% over the next 5 years.
- The over 65 years age group made up 19% of attendances at Lancashire Teaching Hospitals Emergency department during 2012/13; a rise of approximately 0.9% per year over the past 4yrs.
- Local intelligence suggests that the over 65 years age group will have an increased demand for substantive social care services of approximately 4000 people between 2013 and 2018, with the biggest projected increase for domiciliary based services as opposed to residential care.
- Increasing regulation in health and social care is increasing quality but also reducing freedom to act atypically – this means having to do more with less;
- The general ethos of both health and social care services is shifting from treatment - to prevention and promoting independence and self-care.

We have also drawn on key guidance in prioritising and developing this scheme:

- Our plans are in line with the strong emphasis on health maintenance and prevention in the DoH document „NHS 2010 – 2015: from good to great. Preventative, people-centred, productive‟.
- The National Audit Commission briefing “Reablement: a cost-effective route to better outcomes” (Social Care institute for excellence, 2011) declares there is “good evidence that reablement removes or reduces the need for ongoing conventional home care” and that it “improves outcomes for people who use services”.
- The National Audit for Intermediate Care 2012 placed strong focus on the positive patient impact of focused home based rehabilitation, delivered at the

earliest opportunity

- The results of the recently produced National Audit for Intermediate Care 2013 indicate that „the current provision of intermediate care remains around half of that which is required to avoid inappropriate admissions and provide adequate post-acute care for older people".

Local context

Due to the fragmentation of the current system in Greater Preston and Chorley & South Ribble, National benchmarking data indicates that intervention time for both bed and community based Intermediate Care services is generally higher than the national average.

Intermediate Care Usage	National	Local	Variance
Average occupancy rates in residential rehab	85%	80%	**5%**
Average Length of Stay in residential rehab bed	26.9	34.1	**7.2**
Average Length of domiciliary rehabilitation services	28.5	34.8	**6.3**
Average Length of domiciliary reablement services	32.4	42	**9.6**
Average Length of crisis care	5.7	4.41	**1.29**
Intermediate Care Costs	**National**	**Local**	**Variance**
Average cost per patient in ICT bed/res rehab	£5,218	£3,737	**£1,481**
Average cost per hospital bed day (rehab)	£169	£195	**£26**
Average cost per patient - home based services	£1,134	£402	**£732**
Average cost per patient - reablement services	£1,850	£2,000	**£150**
Average cost per patient – crisis care	£1,019	£402	**£617**

A reasonable interpretation might be that:

- The balance of intermediate care beds and home based intermediate care is inconsistent with the national picture;
- Patients who do receive home based care are retained within the system for too long;
- There is significant scope for improving access, throughput and thus value for money in the local Intermediate care system.

Lancashire Teaching Hospitals is considered to be an outlier in relation to Delayed Transfers of Care (DToC) having „lost" 6325 bed days in 12/13 to patients who were deemed medically well enough to leave the acute setting but were unable to be discharged for a variety of reasons.

Establishment	National	NW	Comparator Group	Top Quartile	Local (12/13)	Variance (Comparator)	Variance (Top Quartile)
Patients admitted to	690.3	772.4	716.3	574.8	876.8	160.5	302

long-term care (≥65 yrs.) per 100,000 population							

Our local health economy is also an outlier both regionally and Nationally in relation to the number of patients admitted to long-term care with 161 patients more (per 100,000 population) being admitted to long-term care than a comparator health economy (187 more per 100,000 population than the national average).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment requirements are as follows

Urgent Care Budgets	S 256 £'000	NHS £'000	Total £'000
Step Up/Step Down	1,814	4,579	6,393

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

lease provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑

Delayed transfers of care	☑
Patient experience: Proportion of people feeling support to manage their LTC	☑

The quantified impact on **reduction in non-elective admissions is calculated as 1,126**.

A reduction of 10 permanent residential admissions by 2015/16.

- The medium-term aim would be to reduce admissions to long-term care by 12% to bring the local health economy in line with the North West average.
- The long-term aim would be to reduce admissions to long-term care by 21% to bring us in line with the national average.
- However, the aspiration and ambition would be to reduce admissions to long-term care by 34% to bring us in line with the Top Quartile.

Other benefits will be:

- Improved outcomes and experience for patients and carers as the service becomes seamless and provides greater flexibility in managing the transition through bed based and home based services;
- Realisation of savings across the Health Economy from improved integration and efficiency in intermediate care services;
- Provision of services which are more aligned with current local and national strategies
- Maximising the use of community care, including robust admission criteria and exit strategies for all patients to ensure resources (bed based service in particular) are used appropriately.
- Reduction of Delayed Transfers of Care
- Providing care (both clinical and therapy) closer to home for individuals, in a non-acute environment, preferably their own home.

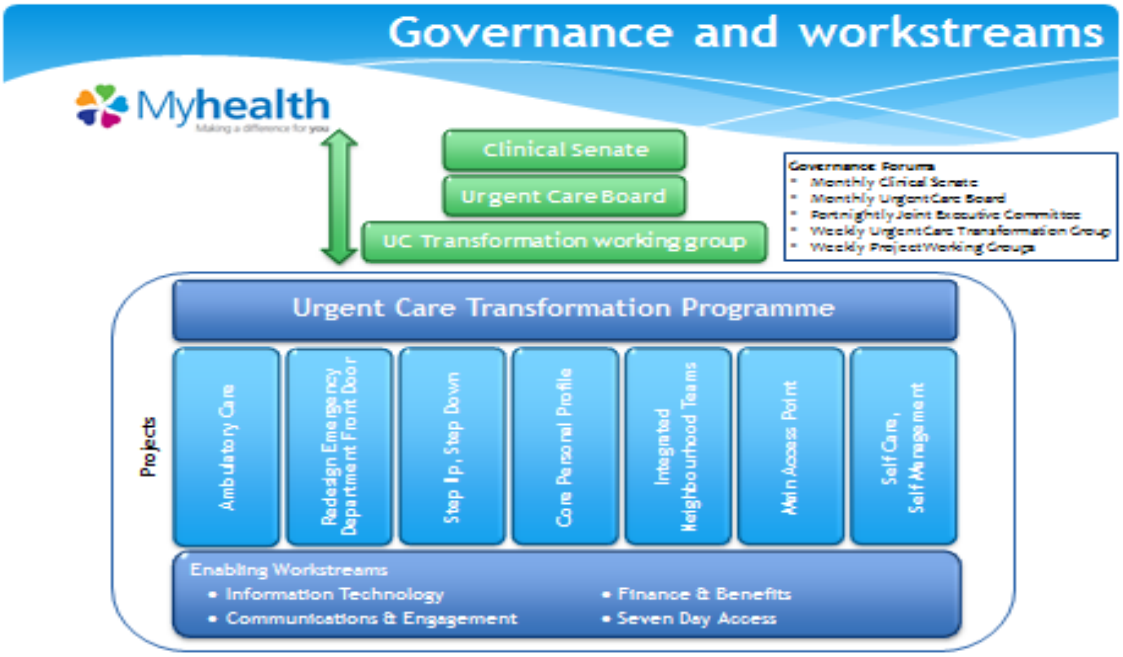
Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The data we have used to support the implementation of the Step up/step down beds scheme will act as the initial baseline for the KPIs listed below. These KPIs will then be monitored on monthly basis through our governance processes (see the Governance diagram at the end of this section) and programme leads are held accountable for delivery through this structure.

KPI	Description	Target

Delayed Transfers of Care	Delayed transfers of care will be transferred out of the acute setting under the new model of care.	Reduction in delayed transfers of care of 80% by the end of Year One
Admission Avoidance	Increase in the number of patients „stepped up" from the ED/MAU to avoid an unnecessary hospital admission	Not currently measured – aim to avoid a minimum of 2 admissions per week
Care closer to home	Appropriate current in-patient rehabilitation activity will be transferred out of the acute setting under the new model of care. Increase numbers in receipt of domiciliary intermediate care	Reduction of 70% current in-patient rehabilitation activity by the end of Year One Increase usage of social care element (domi/crisis care) from 67% to >/= 95% (assuming demand exists. (NB: 67% includes West Lancashire)) and increase domiciliary therapy by >/= 20% (currently 399 per annum, would become 479 per annum)
Bed utilisation Discharge destinations at various intervals Change in functional capacity before and after intervention	Increased bed occupancy rate in Longridge Community Hospital Reduction in average length of stay in Longridge Community Hospital Reduced average length of stay across all the hospital rehabilitation wards Increased bed occupancy rate in bed based services Reduction in average length of stay in bed based intermediate care services Increase in the proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services Reduction in the rate of admissions to long-term residential care Monitoring of Barthel ADL scores and Elderly Mobility Scale to demonstrate increased functional ability Monitoring of patient perceived improvement	Increase occupancy rate from 71% to 95% Reduction in average LoS of 27% from 19.2 days to 14 days 12% reduction in average LoS (from 17.1 to 15 days) All bed based services will have an average occupancy rate of 95% (assuming demand exists) 12% reduction in average LoS (from 34.1 days to 30 days Increase current average of 78.2% to >/= 80% Reduction of 12% in 2 years to bring the Health Economy in line with the North West Average Improved average score from 9% to 7% using BADL scale (low is good); 5% improvement in average EMS scores (from 23% to 28%); 5% improvement in average Barthel ADL index scores (from 21.1% to 25%); Target of >/=90% patients to have a perceived improvement compared with their pre-admission functional ability



In order to evaluate and continually improve success, a range of outcome measures is proposed. This will be supported by a robust, commissioner led, system of performance management.

Measures will include the following:

- Source, case mix and number of referrals into each element of the service;
- Time lapse between referral and transfer into a service;
- Audit of reasons for refusal of/for a service;
- Length of stay in each case (including mean and median data) for all elements of the service;
- Discharge destination and/or package of care required after discharge;
- Number of readmissions to Step Up or A&E within 14 days;
- Audit of any/all incidents (e.g. accidents, unexpected death);
- Audit of any „exceptions" (e.g. decision made to provide longer than 6 weeks bed based service);
- Monitoring and reporting of response times (e.g. specialist social care assessment etc.);
- Audit of the number of patients receiving a comprehensive geriatric assessment (CGA);
- Audit of compliance with the providers „Safeguarding" Policy;
- Audit of staffing ratios based on RCN guidance, 2012;
- Number of cases from acute hospital discharged directly to residential care (e.g. self-funders);
- Documentation, including audit of documented care pathways; documented achievement of individual goals;
- Change in functional capacity before and after intervention: Monitoring of Barthel ADL scores and Monitoring of Elderly Mobility Scale;

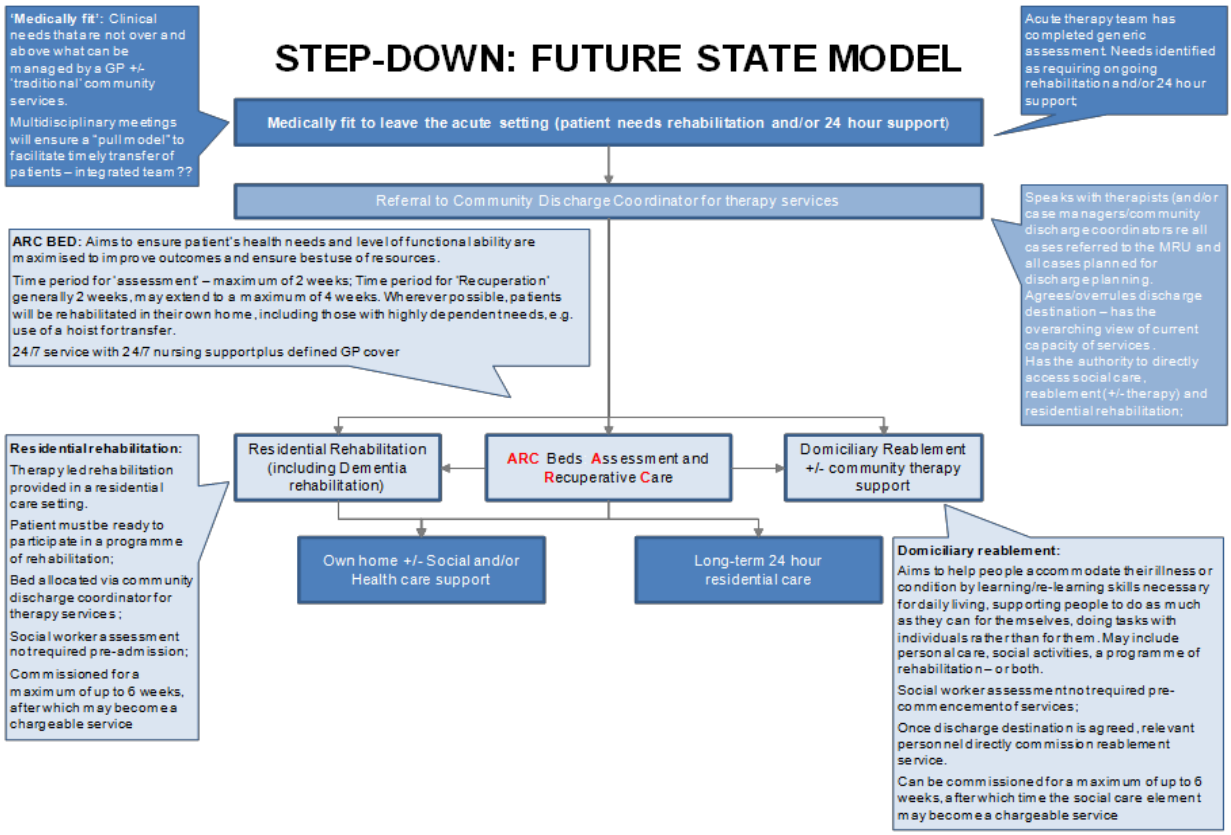
- Patient/Service user experience measured via PREM form (a new development proposed by the National Audit for Intermediate Care for 2013, aimed at providing standardised quality measurements for intermediate care);
- Patient perceived improvement measures

All KPIs are monitored through the Urgent Care Transformation governance structure.

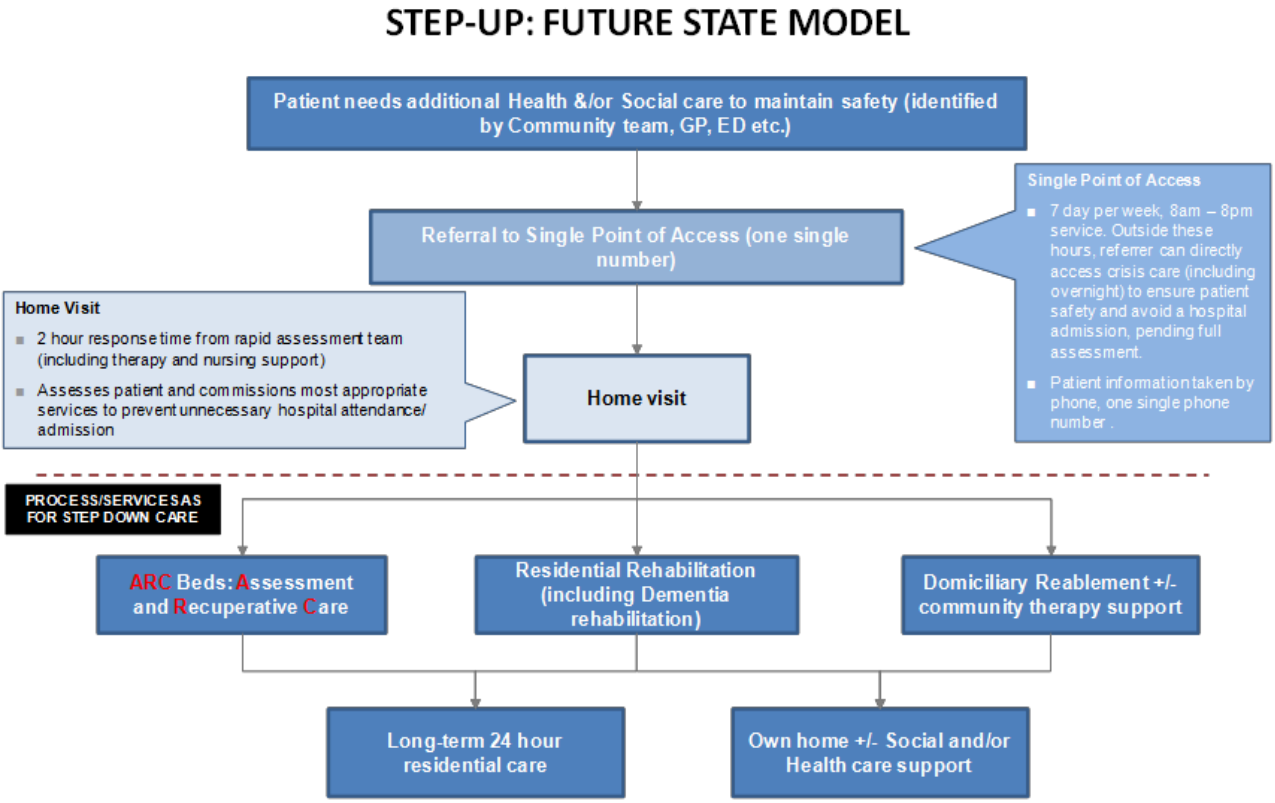
What are the key success factors for implementation of this scheme?

- Further developments with regards „Step Up" Care will need to be closely linked to (and are greatly reliant on) both the „Ambulatory Care" and „Integrated Neighbourhood Teams" project work and strategies (e.g. provision of „step up" support to include the management of ambulatory sensitive conditions such as COPD in a non-acute environment).
- Support and enable patients/service users and their carers to live productive and independent lives in their own homes for as long as possible. They will receive a personalised and co-ordinated service, driven by one single assessment (currently being developed as part of the Improving Urgent Care programme of work) and active case management.

Appendix 1: Proposed model of step-down beds



Appendix 2: Proposed model of step-up beds



Scheme ref no.
BCF009
Scheme name:
Lancashire health economy whole system urgent care transformation programme – Ambulatory Care
What is the strategic objective of this scheme?
Ambulatory Care Sensitive Conditions is one of five high impact changes that need to be delivered to improve the quality of, and access to, the urgent care system. An integrated model of ambulatory care services will be redesigned and implemented across the Chorley and South Ribble and Greater Preston CCGs footprint within Central Lancashire.

VISION OF URGENT CARE

Local people who need access to urgent and emergency care should receive care which fit for purpose in a timely manner. The system will need to achieve a balance between patient experience, quality outcomes, access and cost. To achieve this we will develop a simplified, proactive, robust system for patients that will promote health and wellbeing, and redirect current levels of urgent care into planned or managed care within the managed health and social care system 24/7.

The strategic objective of the Ambulatory Care scheme is to provide a comprehensive approach to meet the growing demand and needs of patients with ambulatory care sensitive conditions and minimise the risk of hospital admissions,

It is critical that we deliver an effective, integrated ambulatory care strategy which benefits our patients and their carer's and ensures that:

- The identified cohorts of patients will be managed safely and effectively across the primary/ secondary care interface and would therefore not require an admission
- Patients receive appropriate access to diagnostics and treatment
- By delivering ambulatory care we will provide better quality and cost effective treatments, closer to home
- By avoiding hospital admissions it minimises the risk of patients experiencing complications that can occur as a consequence of admission; such as infection and functional deterioration of underlying co-morbidities, particularly in the frail elderly
- By considerable coordination and joint working we will ensure the quality of patient outcomes and patient experience is improved in the future.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This strategy will promote the delivery of high quality services that offer:

- Fully integrated clinical pathways incorporating primary, secondary and social care
- Prevention of disease through primary prevention activities
- Improving the health and well-being of the Central Lancashire population
- Ensuring full engagement and empowerment of service users and carers
- Self-care and self-management practices
- Increased patient education
- Appropriately trained multi-disciplinary workforce delivering high quality care to patient

Models of care and support

AMBULATORY CARE

Clinical care which may include diagnosis, observation, treatment and rehabilitation that is not provided within the traditional hospital bed base or within traditional out-patient services, and that can be provided across the primary/secondary care interface. *(DH, PbR guidance 2013)*

There are three models of care that will be followed to meet our ambulatory care objectives.

1. **Proactive case management of ACSC by multidisciplinary teams**
   - This will enable primary, community and secondary care teams to work in an integrated manner and proactively manage patients with ACSC
   - This will minimise the risk of acute events, thereby reducing 999 calls, ED attendances and non-elective admissions

2. **Implementation of new pathways of care for ACSC**
   - These new pathways will be supported through community-based services which will provide alternatives to hospital admission and where appropriate, will provide early supported discharge services

3. **Improve outcomes for people with an ACSCs**
   - Patient outcomes will be at the centre of the pathway redesign, and all new pathways will be monitored to ensure effectiveness, experience and safety

Target patient cohorts

Initially our focus will be on those deemed most at risk of hospital admission for COPD (900 patients), and expand this over time. Therefore for planned deliverables are:

- To evaluate the COPD admission avoidance pathway undertaken at Q1
- To agree the outline the integrated COPD service model with GP directors
- To inform and outline the integrated COPD service model;
- To scope the opportunities for redesign of acute end of Diabetes pathway;
- To scope the opportunities for Quadramed markers for ambulatory care pathway covering Cellulitis, Diabetes, Asthma and Epilepsy

Proposed Service Model for COPD Ambulatory Care

To enable the delivery of the anticipated outcomes and benefits required, we believe a fully integrated, fully resourced COPD service incorporating primary, secondary and social care is necessary to deliver:

- Prevention of COPD through primary prevention activities and pro-actively screen at "risk" patients (i.e. smokers over 35) to identify undiagnosed patients. Promotion of flu and pneumococcal vaccination strategies
- Existing registers validated, and newly diagnosed patients rated (mild, moderate, severe). Patients to receive recommended number of reviews per annum as per DH guidance and the National COPD Strategy
- Increase patient education (i.e. self-awareness, care and management)
- Improve communications and engagement across the health economy to promote the services available for people with COPD
- Appropriately trained multi-disciplinary workforce delivering high quality care to patients across care pathways
- COPD services aligned with existing oxygen services
- Develop or improve on joint working with community pharmacy services and voluntary sector organisations where appropriate
- Utilising new technologies such as telemedicine will be key to the service delivery
- Ensuring support is offered throughout the patient care pathway and through implementation of personalised care planning
- Shared health and social care information, should be integral to this pathway thus ensuring smooth transition for service users across organisational/professional boundaries and also supporting care providers in the delivery of holistic care
- To develop a proactive, collaborative management model of care following agreed protocols, guidelines and pathways for COPD

Proposed changes to the service

Designing the new service we will investigate access, service specifications, expanding the use of the community COPD service and response times:

- Expanding the current 300 of 900 patients admitted to LTH with COPD who are referred on to the COPD service, as re-admission rates for COPD are low where known to the COPD service.
- Current service specification includes only 300 pulmonary rehabilitation (PR) places per year. As a minimum enough places should be commissioned to allow all patients admitted with COPD to be offered a place
- If services were resourced to run 8-8 every day and 9-5 weekends rather than office house then additional admissions would be avoided. Further analysis of admissions times needs to be undertaken to offer the most complete picture of admissions for COPD.
- If the number of clinician was expanded for the Heart Failure service it would be able to contact patients within 48 hours of referral.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain comprises the following commissioners and providers:

- Commissioners – Greater Preston CCG, Chorley and South Ribble CCG, Lancashire Care Trust

The key deliverables for implementation are:

Care pathways development and redesign	
COPD Service Review • Pathway mapping activity ○ Training shortfalls ○ Team capacity ○ Access to patient records ○ Communication ○ Collaboration and joint working opportunities ○ Standardisation • Implementation • Delivery • Monitoring	Joint initiative between commissioners and provider

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are a number of drivers, both nationally and locally, that have promoted a thorough review of ambulatory care services within Central Lancashire and the development of a high quality model of care that is owned across all relevant organisations.

Central Lancashire has taken into account UK evidence, the local Lancashire context and academic research when developing this scheme.

UK evidence

Different sets of ACSCs are used for research and health policy analysis (Purdy et al 2009). In England, the most frequently used set are the 19 ACSC conditions provided by

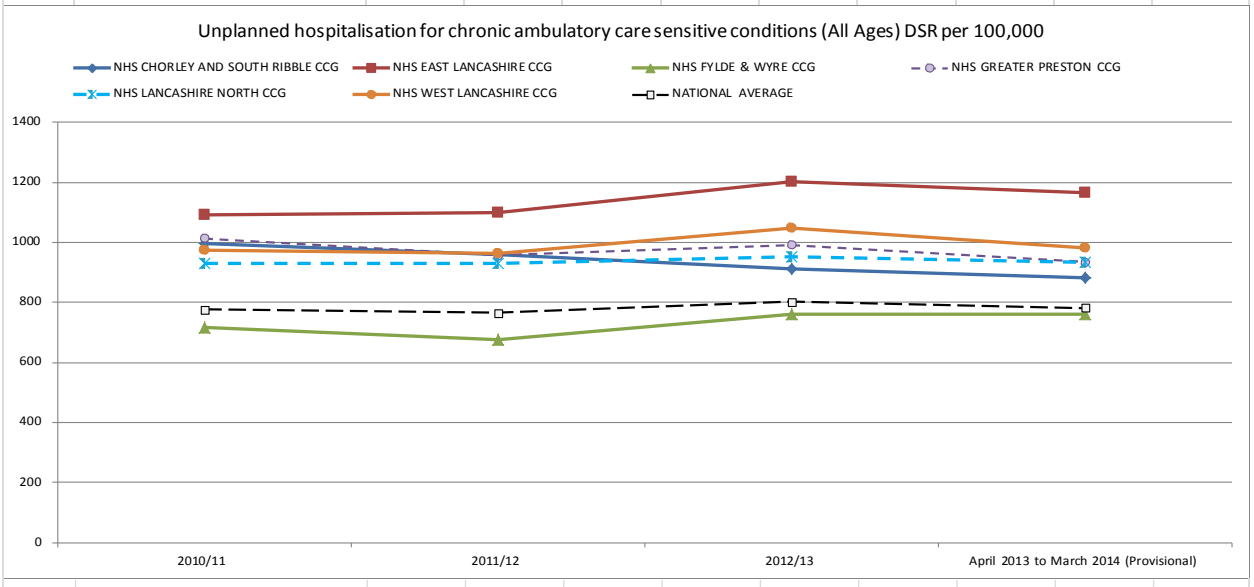
The NHS Instituted for Innovation and Improvement (2007). Improving the management of
these conditions is important for the following reasons:

- Ambulatory care-sensitive conditions (ACSCs) account for one in every six emergency hospital admissions in England.
- The proportion of emergency admissions for ACSCs is larger in under-5s and over-75s. Children are predominantly admitted for acute conditions, older people for chronic conditions, and both groups for vaccine-preventable conditions.
- The rate of emergency admissions for ACSCs varies among local authorities from 9 to 22 per 1,000 population.
- The rate in the most deprived areas is more than twice the rate in the least deprived areas in England.
- Emergency admissions for ACSCs cost the NHS £1.42 billion annually. Influenza, pneumonia, chronic obstructive pulmonary disease (COPD), congestive heart failure, dehydration and gastroenteritis account for more than half of the cost.
- Older people (aged 75 years and over) account for 40 per cent (£563 million) of total spend.
- Influenza and pneumonia account for the largest proportion of admissions (13 per cent) and expenditure (£286 million).

Local Lancashire context

- Both NHS Chorley and South Ribble CCG and NHS Greater Preston CCG show a rate of hospital admissions for patients with ACSCs greater than the national average, see below. Improvement to the ambulatory care pathways would have a positive impact on the hospital admissions rate for ACSCs.

CCG Code	CCG Name	2010/11	2011/12	2012/13	July 2012 to June 2013	October 2012 to September 2013	January 2013 to December 2013	April 2013 to March 2014 (Provisional)	2010-11 to 2013-14	% Movement
00X	NHS CHORLEY AND SOUTH RIBBLE CCG	996.3	958.8	912.5	874	849.9	834.7	880.6	-115.7	-11.6%
01A	NHS EAST LANCASHIRE CCG	1090.5	1099.2	1203.1	1191.4	1156.9	1145.9	1167.2	76.7	7.0%
02M	NHS FYLDE & WYRE CCG	714.9	677.3	759.9	793.9	762.4	759	759.9	45	6.3%
01E	NHS GREATER PRESTON CCG	1013	957.3	991	936.1	908	896.5	935.4	-77.6	-7.7%
01K	NHS LANCASHIRE NORTH CCG	929.5	929.6	952.6	950	973.5	937	932.1	2.6	0.3%
02G	NHS WEST LANCASHIRE CCG	972.6	964	1048.6	1018.9	989.4	955.5	979.8	7.2	0.7%
	NATIONAL AVERAGE	775.9	765.8	802.8	796.5	787.7	780	780.9	5	0.6%
	Lancashire 'Range' (Max - Min)	375.6	421.9	443.2	397.5	394.5	386.9	407.3		



Unplanned hospitalisation for chronic ambulatory care sensitive conditions (All Ages) DSR per 100,000[3]

- The 2012 Lancashire Teaching Hospital (LTH) non elective admissions data was analysed and identified the following (2012/13 data):
  - ACSC patients cost over £12.5m from 6,774 admissions with COPD being the highest
  - this accounted for 18% of non-elective admissions and 17% of occupied bed days
  - the over 65s counted for 37%of admissions but 66% of occupied bed days

This data supports the selection of the scheme in that, there are service improvements and cost savings (specifically in reducing the number of non-elective admissions) to be made. The majority of ACSCs admitted to hospital are those people over 65 years of age.

Academic research

Research by the Kings Fund, April 2012[4], states that high levels of admissions for ACSCs often indicate poor coordination between different elements of the healthcare system, particularly between primary and secondary care. An emergency admission for an ACSC is a sign of the poor overall quality of care (even if the ACSC episode is managed well). The wide variation of emergency hospital admissions for ACSCs implies that they, and the associated costs for commissioners, can be reduced.

he research also points out the substantial difference in cost to treating conditions (£734 for ENT to £4002 for gangrene) and that the cost of emergency admissions for ACSCs was strongly associated with patients‟ age (40% of expenditure on patients who were 75 years old and over). Finally, the research also notes that nearly 80% of patients who stayed in hospital for more than two weeks were those over the age of 65.

The analysis showed that the number of emergency hospital admissions for ACSCs could be reduced by 18% (150,373 per year; potential cost reduction £238 million) if all local authorities performed at a level of the best-performing quintile local authorities; by 8% (63,214 per year; potential cost reduction £96 million) if each quintile local authorities performed at the level of the next best quintile local authorities; 11% (90,471 per year; potential cost reduction £136 million a year) if the poorer (than the average) performing local

[3] **Emergency Admissions** Benchmarking and Trends LANCASHIRE CCGs. Source: http://nww.indicators.ic.nhs.uk/webview/

[4] Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions

authorities performed at the level of the better (than the average) ones.

The analysis also showed Influenza, pneumonia, COPD, congestive heart failure, dehydration and gastroenteritis account for more than half (53 per cent) of the cost of emergency ACSCs admissions.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment = £343,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑

The quantified **reduction in emergency admissions is calculated as 260** in 2015/16.

This takes into account UK evidence,(Effing & Cochrane (2009) Self-Management with Education works for COPD and Puhan and Cochrane (2011) Rehab for COPD), Thomas Heart Specialist Clinic for heart failure reduce admissions after 12 months 2013), the local context and academic research in developing this scheme.

Both Chorley South Ribble and Greater Preston CCGs show a rate of admissions above the national average and therefore improvement to these pathways will have a positive impact on the non-elective admission rate for ACSC. Evidence shows that over the last two months NEL activity for COPD, Upper GI and Cellutis has reduced by 12% by pulling out 0 - 1 day. The Urgent Care Centre at Chorley is expected to further reduce ACSC when it comes on stream next year.

Feedback loop

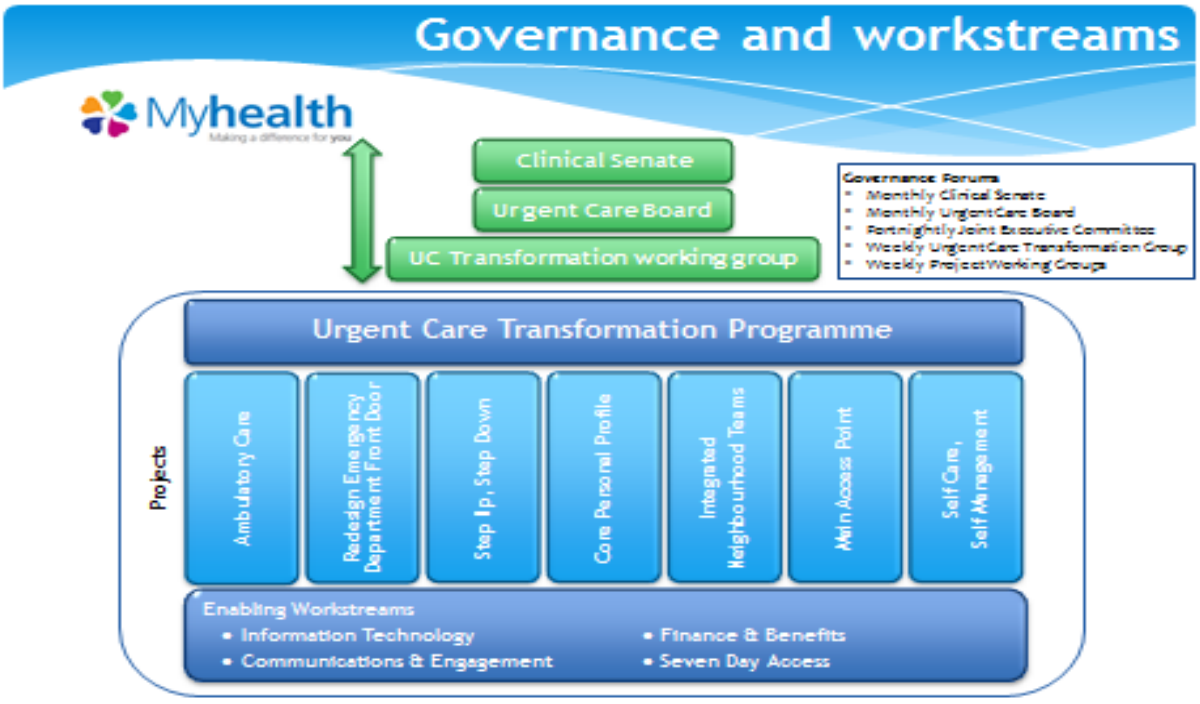
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The data we have used to support the implementation of the ambulatory care scheme will act as the initial baseline for the KPIs listed below. These KPIs will then be monitored on monthly basis through our governance processes (see the Governance diagram at the end of this section) and programme leads are held accountable for delivery through this structure.

KPI	Description	Target
Success Factor	**Indicator**	**Target/ Trajectory**
Clearly defined ambulatory pathways	Quality – efficiency & effectiveness	● Reduction in length of stay ● Reduction in admissions to care homes ● Improved patient and carer experience ● Reduction in readmission rates ● No's of ACS pathways and protocols in place for timely referral to appropriate services
Reduced ED attendances	Quality – patient care & clinical outcomes	● Reduction in overall ED attendance ● Reduction in people attending with ACSCs
Care in least intensive setting	Reduction in admissions with ACSCs	● Number of patients with an integrated care plan and named coordinator ● % of patients admitted to acute hospitals and entering on the ACS COPD care pathway ● % of patients admitted to acute hospitals and referred to early supported discharge teams ● % of patients admitted to acute

		hospitals seen by Respiratory Team ● % of patients admitted to acute hospitals referred to INTs
Reduced length of stay in acute and community hospitals	Reduced admission to LTH	● Reduced bed days
Improved patient and carer experience	Quality – stakeholder satisfaction	● Patient and carer satisfaction rates ● Friends and family testing
A successful whole system approach is delivered	Quality – strategic benefits	● Positive outcomes from this COPD exemplar model will drive further changes in relation to each ACS condition.
New pathways enable proactive response to demand	Cash releasing	● Reduction in length of stay ● Reduction in admissions to care homes ● Reduction in readmission rates ● Reduction in bed days

Governance structure and accountability model for the Urgent Care Transformation programme and in particular, the Ambulatory Care project:



What are the key success factors for implementation of this scheme?
Demonstrate an understanding of the **key success factors** for the scheme that you are proposing. E.g. expertise, staff, demographics, history of partnership working? • Do these also exist within your area? • If not - what action is required to put those in place? • Or what impact will the absence of those supporting factors have on the outcomes that can be achieved? • Outline a stepped approach to implementation which draws on i) learning from either local evaluation or other areas where this has been implemented, and ii) engagement with partners about the deliverability of the proposal
• Systems need to be put in place at CCG level to feed back to GPs which of their patients are presenting at A&E as a result of one of these ACS conditions. Existing Risk Stratification methodology to be used to easily identify these patients • Systems need to be in place to identify which conditions account for a disproportionate level of hospital admissions to focus resources in their area • Enable access to other services (e.g. Rapid Access clinics, In-reach and out-reach teams, intermediate care) for practices to support the management of these patients. • Develop A&E assessment procedures. Gaps in communication, joint working, technology, data collection and analysis, information sharing, capacity etc.

Scheme ref no.
BCF10
Scheme name
Development of Extra Care Schemes
What is the strategic objective of this scheme?
An Extra Care and Specialist Housing Strategy was recently developed in order to address The low level of current provision of extra care with a view to reducing the level of demand for social care and health care services amongst older people. The strategic objectives of the scheme are to: • Enable the development of an extra care scheme in each district

- Reduce admissions to residential care
- Provide an additional housing option for older people and people with disabilities
- Promote health and wellbeing and reduce the need for health and social care services

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme aims to provide a home for life through:

- Ensuring that the design of the building can meet the needs of people with increasing care and support requirements
- The provision of a basic level of on-site domiciliary care which will be available to all residents 24 hours per day.

Extra Care Housing is targeted at:

- People at risk of being admitted to residential care
- People in receipt of reablement who have been assessed as requiring extra care housing
- People who have low or no immediate care needs but would benefit from the extra care environment in order to promote wellbeing

The strategy estimated an immediate need for an additional 988 units of extra care for older people across the county. This level of provision would enable Lancashire to reduce its current reliance of residential care. A more ambitious target of around 2,600 units has been identified which is predicted to grow to 3,725 by 2033.

The core components of the scheme are:

- The delivery of at least one extra care scheme for older people in each district of the County.
- An initial requirement for 10 centres given facilities already exist in Rossendale and West Lancashire.
- Ultimately more than one scheme in many districts will be considered, as local communities and housing markets often don't recognise or coincide with district boundaries, but a scheme per district is considered a reasonable starting point.
- A flexible approach to differing and changing funding and support requirements, enabling LCC to increase or reduce its financial exposure according to what can be achieved with other partners including health, developers and registered housing providers.
- Where the market is not able to develop services without financial assistance from LCC, the

County Council will look to provide financial input to schemes, including any land value, not representing more than 30% of the total cost of a project. However, in most cases the contribution of LCC would be expected to be significantly less.

- The programme will be delivered through strong partnership working between County Council, District Council, NHS Clinical Commissioning Groups and providers and operators
- It is envisaged that joint working between all partners could enable the development of around 600 units, which represents two thirds of the original target of 900 units.
- We are also proposing a core wellbeing, unplanned care and sleep in service which will be commissioned by LCC. The tenant will be required to use the onsite provider for this element of the care, but will be able to use their personal budget for all planned care.

The development of extra care schemes can arise as a result of:

- LCC identifying a site, or a need, in a particular area and then seeking expressions of interest from the market. LCC would decide in conjunction with the district as to whether to advertise or to target particular landlords already working in a district
- A landlord approaching commissioners either with a site, or with funding, or the intention to bid for funding and contribute own resources if successful. Landlords may also request additional funding from LCC to make the finances stack up.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Lancashire County Council, District Councils, CCGs, Regeneration Partners and landlords will be involved in taking forward the Extra Care Strategy.

All agencies are keen to make sure that extra care is developed, consequently we are seeking to combine a strategic direction with a pragmatic approach, whilst always ensuring that we comply with procurement rules

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local evidence and context

The evidence base is elaborated in the attached strategy document and the key aspects have been included in the Overview section:

Extra Care Strategy 2014 v7 2 FINAL.pdf

Pages 25-27 which explain the methodologies used below to project the number of units of extra care required.

The key driver is **an over admission into residential care of 442 people per year in Lancashire** when compared to the comparator group average, as calculated in the following table:

	65+ residential admissions only	Population 65+ based on 2012 pop estimates	Admissions needed to achieve comparator group average	Over admissions	Extra Care Units Required to remove over admissions
Lancaster	166	26,356	130	36	79
Fylde	106	19,104	95	11	26
Wyre	159	27,550	136	23	51
Preston	150	19,785	98	52	116
South Ribble	157	20,521	102	55	124
Chorley	117	19,253	95	22	49
West Lancs	127	21,968	109	18	41
Hyndburn	114	13,425	66	48	106
Ribble Valley	75	12,135	60	15	33
Burnley	134	14,751	73	61	136
Pendle	132	15,048	74	58	129
Rossendale	99	11,138	55	44	98
	1,536	**221,034**	**1,094**	**442**	**988**

The demand on residential care homes can be reduced by providing **appropriate additional extra care beds, calculated to be 988** (the final column). It is this figure, which is subsequently used to calculate the base level of potential savings on residential care spend, through investment in extra care.

Using a simplified version of the HGP methodology for calculating extra care numbers, we estimated the number of people who could be better supported in extra care. We segmented the 75 year old population using the principles from the Wanless Review, assuming those classified as Group 3 and 4 are most amendable to extra care, less a proportion that we assume still requires registered care. This amounts to 10.14% of the older person population.

Converting these numbers into households and then using the study of Strategic Housing Market Assessments to estimate the proportion of this household population that we think would choose an extra care service, amounts to 25% of the population, being:

- 2013 – 2,597
- 2023 – 3,102
- 2033 – 3,725

UK research and exemplars

Improving housing with care choices for older people: an evaluation of extra care housing. This report summarises the results of a Department of Health (DH) funded valuation of 19 extra care housing schemes that opened between April 2006 and November 2008, and which received capital funding from the Department's Extra Care Housing Fund. Its key findings were improved outcomes and quality of life for those involved and when matched with a group of equivalent people moving into residential care, costs were the same or lower in extra care housing.

Aston University Research/Extra Care Charitable Trust

This comprehensive study, looking at 17 of the Extra Care Charitable Trust extra care developments, shows early indication of the following

- Planned NHS admissions in the Extra Care Housing group reduced from 0.298 to 0.115, a 60% drop in activity;
- Unplanned admissions in the Extra Care Housing group reduced from 0.225 to 0.154, a 32% drop in activity;
- Drop in GP activity planned (36.4%)and unplanned of (19.4)%;
- Reduction in mean depression scores
- Increase in mean memory scores.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment = £1,924,000

Where the market is not able to develop services without financial assistance from LCC, the County Council will look to provide financial input to schemes, including land value, not representing more than 30% of the total cost of a project. However, in most cases the contribution of LCC would be expected to be significantly less.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delayed transfers of care	☑

Other expected benefits include:

- Keep people healthier and active longer and more able to contribute to society;
- Reduce loneliness thereby improving mental health
- Enable hospital discharge as some form of intermediate care/ rehab will be included within extra care provision

- Improved efficiency in relation to the delivery of domiciliary care
- Release of general housing (family housing) as provides alternative option for over 65"s.
- Number of units of extra care housing developed
- Reduction in number of people accessing A&E

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Is part of the development of new services, an outcomes framework will be jointly developed by LCC, CCGs and Districts. Due to the long lead-in time, the timeframe for this is sometime in 2015/16.

What are the key success factors for implementation of this scheme?

- Develop better pathways into extra care
- Need to better understand the population stratification to identify those who would benefit from this scheme
- Partnership working will be crucial to ensure then best financial benefits and health & Wellbeing outcomes.
- There are sites available that would be suitable for extra care and there are no insurmountable barriers from a town planning perspective to delivering a step change in extra care provision.
- There are willing operators and providers although many have constraints on their ability to raise capital to invest at risk in the development of the extra care market.

Scheme ref no.
BCF11

Scheme name
Integrated Offer for Carers – Support and Respite
What is the strategic objective of this scheme?
One of the key outcomes of the BCF programme is „Improved quality of life for people with support needs and for their carers". Through the Lancashire Multi Agency Carers Strategy, 2012-2015 we intend to increase the number of unpaid and informal carers who receive an assessment and support to develop a personalised support plan, in order to implement the duties within the Care Act 14. The aim of the scheme is to provide and develop good quality local support for carers tailored to their individual needs, promoting the carers general health and wellbeing, preventing, reducing or delaying their need for support. To achieve the aim, the strategic objectives of the scheme will be to: • Work in partnership across Lancashire to ensure a common identity and consistent offer to carers across Lancashire • Work collaboratively with condition or age specific VCF organisations offering a carer support offer locally • Widely promote the service and identify and support hidden carers • Develop high quality, person centred support for carers • Support and co-ordinate consultation and involvement between carers, Lancashire County Council and the NHS • Develop comprehensive, co-ordinated information and advice for carers and former carers • Develop knowledge by the provision of timely and appropriate information and support which will help link carers into the services they need • Help Lancashire County Council and the NHS to develop responsive cultures and services which see carers as individuals with unique needs • Provide opportunities for carers to have a break from their caring role via a range of services, including the provision of a sitting in service and Time for Me grants • Support carers to develop their Peace of Mind 4 Carers Contingency plan • Undertake carers assessments and support plans with carers with the potential to commission carers personal budgets.
Overview of the scheme

There are two key components to this scheme, Carers Support and Carers Respite.

Carers support

This scheme will redesign and re-commission carers services across Lancashire, delivering an integrated service specification built around a suite of key outcomes:

1. **Emergency planning service** (Peace of Mind for Carers): The service will provide up to 72 hours of replacement care in situations where the carer can no longer provide the care due to an unplanned/unforeseen circumstance. The service will develop a plan of emergency are with the carer and the cared for person and be ready to be activated 24/7, 365 days per year. It is anticipated that around 600 new emergency plans will be completed per month across the county.

2. **Carers Assessments:** The service will offer carers the opportunity to have a carers assessment where the carer requests a separate assessment to the person they care for. It is anticipated that around 600 carers assessments will be completed monthly.

. **Time for Me:** The service will provide grants of around £350 to carers who are not eligible for a carers Direct payment. The grant can be spent on anything that will give the carer a break from their caring role. It is anticipated that around 700 carers will access a Time for Me Grant.

. **Specialist workers:** The service will have a range of specialist workers including BME and Dementia workers.

5. **Information, support, signposting and advice and forums:** The service will offer an 8am-6pm telephone helpline, a 24/7 volunteer peer support line, range of social media and offer face to face visits. The service will provide a range of support groups developed in response to carer request/need. The carers service will facilitate local and Lancashire wide carers forums. It is estimated that by 2017/18 around 25,000 carers will be registered with carers services.

6. **Sitting in Service:** A volunteer manned sitting in service will be available to carers to

enable them to have a break. The sitting in service will support at least 200 carers per month to have a break.

7. **Former carer support:** Former carers will be supported for up to two years after their caring role ends. This is in recognition of the fact that carers at the end of their caring role can ace bereavement, financial difficulties, housing issues, lowered confidence, unemployment etc.

8. **Trips, activities and courses**: A range of courses, trips and activities will be offered to carers to enable them to have a break.

9. **Carers Awareness Training** - All organisations who come into contact with carers will have access to carers awareness training delivered by the carers service. The training will be tailored to the organisation's needs. At least 20 carers awareness sessions will be delivered per month.

10. **Forums** - There will be a range of local forums feeding into a Lancashire wide carers forum facilitated by the carers service:

- Pukar: a BME specific resource centre located in Central Preston. The service provides a range of courses, including IT and ESOL, translation support, case work with BME families and drop in facility for carers and people with disabilities
- Carers Mental Health specific service: the Lancashire wide carers service is specifically to support the needs of carers caring for someone with significant mental health problems. The service offers a range of support to this group of carers via a team of specialist workers, including:

  - CHIT service – The carers Help & Information Team is available Monday to Friday 8:00 am until 6:00 pm offering information, support and signposting
  - CHAT service - The Carers Help And Talk line is available 24 hours a day 365 days per year, the line is manned by carers who have an understanding of caring for a person with a mental health condition
  - 1:1 intensive support that can be provided in a crisis
  - Support groups and forums

<u>Carers Respite</u>

- Carers, regardless of their level of need will have a carers assessment which will

identify the level of support they require to enable them to maintain their caring role.

- A budget will be allocated to eligible carers to enable the carer to have a break from their caring role which they can use to access to a range of domiciliary, daytime and residential respite. The majority of carers will be issued with a pre-paid card, which will enable them to purchase a short break flexibly to suit their needs, however, carers can choose to have their break directly commissioned where a pre-paid card is not suitable.
- In addition, eligible carers will receive a personal budget to be spent in a flexible way, for example to purchase gym membership, therapies, leisure activities. The budget allocation will be based on a resource allocation system.
- In particular and in response to feedback from carers we have commissioned two dedicated short break beds across the County that carers are able to book in advance using their Direct Payment. The beds will be for the use of adults 18+ no matter what the level of need.

The delivery chain

Programme & Project Manager – Carers Strategy Officer Lancashire County Council

Commissioners: Chorley, South Ribble and Greater Preston CCG, West Lancashire CCG, orth Lancashire CCG, Fylde and Wyre CCG, East Lancashire & Lancashire County Council.

Providers:

Central and West Lancashire Carers

n-compass

Carers Link Lancashire

The evidence base

UK exemplars

- In Lancashire, we have focused on early intervention and prevention in line with the direction provided nationally through the Care Act.
- The Integrated Offer for Carers will drive forward activity to meet the requirements set out in the Care Act 2014, to recognise the wellbeing of carers in their own right, as well as the people they care for.
- Carers need preventative health and care services that build their resilience and

focus on carers‟ own health as well as supporting the people they care for, to enable them to sustain their caring role.

- Support must be in place for carers to have time away from caring, allowing them to have a healthy lifestyle, address their own health needs and look after their own mental well-being.
- Much of the research by Beverly Castleton has identified the importance of carers in supporting patients, in particular those with Parkinson's and early research from 1998 / 99 attributed as much as 20% of emergency admissions to “carer breakdown”.

Local context

- There are 133,213 self-identifying carers (including parent carers and young carers) in Lancashire. 32,164 of these provide more than 50 hours per week in the caring role and 17,672 provide more than 19 hours a week. The census indicated that 9,500 (just over 7%) of carers indicated that they themselves were in bad or very bad health.

Reports

Supporting Carers: The Case for Change

This report demonstrates how increasing support for carers benefits the people being cared for, CCGs, health commissioners, general practitioners (GPs) and councils. It provides evidence from randomised controlled trials (RCTs) and peer reviewed journals to show that increasing support for carers:

- Improves health and wellbeing outcomes for patients and recipients of care;
- Improves health and wellbeing outcomes for carers, who suffer disproportionately high levels of ill-health;
- Reduces unwanted admissions, readmissions and delayed discharges in hospital settings;
- Reduces unwanted residential care admissions and length of stays

Please refer to section 6 of the report, available at
http://www.carers.org/sites/default/files/supporting_carers_the_case_for_change.pdf

Carers Support Centre, Bristol and South Gloucestershire: This report presents the impact

related to the outcomes reached by a number of projects delivered by Carers Support Centre,
Bristol and South Gloucestershire (CSC).

Investment requirements

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment: £7,518,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delayed transfers of care	☑
Estimated Diagnosis Rate for Dementia	☑
atient experience: Proportion of people feeling support to manage their LTC	☑

The quantified impact of this scheme has been calculated as:

- A reduction of 61 non-elective admissions in 2015/16
- A reduction of 5 permanent residential admissions by 2015/16
- A 9% improvement in reablement rates in 2015/16

In addition the following outcomes for the Carers scheme have been agreed:

- Reduce the need for health and social care services and improve wellbeing of carers by ensuring an integrated approach to accessing help and guidance.
- To ensure that we commission and provide assessment and support planning to carers, ensure assessment and support planning processes are personalised and provided by skilled staff within the local authority, health services and trusted assessors from the Voluntary, Community and Faith sectors.
- To provide all carers with effective advice, guidance and signposting support.
- Increase number of carers assessed in line with the Care Act expectations.
- Establish what works for carers and what produces sustainable savings locally by understanding the impact of carer support on delayed discharges, the need for social care and emergency hospital admissions, and by evaluating the range of carer support packages.
- To ensure carers have a „Peace of Mind" plan (emergency plan) that delivers a crisis response to ensure that a crisis for a carer does not result in a crisis for the person being cared for.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The re-procurement of carers services will be co-ordinated by a cross agency steering group reporting to the Lancashire Multi Agency Carers Steering Group.

Outcomes will be reported into the HWBB partnership, which in return reports into the Lancashire HWBB, to monitor the implementation of BCF schemes.

The following metrics and outcome measures will be agreed and reported through the governance arrangements, detailed above:

- Feedback from Carers as part of the statutory carers survey

- Qualitative measures of outcomes for carers co-ordinated and reported by Carers Services
- Monitor the patient experience.
- Ensure outcomes are included in the contracting of carers services.
- Commission Services based on outcomes and monitor at quarterly intervals through the financial year.
- Work will also be undertaken to ensure that accurate recording of admissions is taking place to enable real time impacts to be monitored.

What are the key success factors for implementation of this scheme?

- Improved personalised planning processes.
- All carers have access to effective advice, guidance and signposting support.
- Increased number of carers assessed in line with the Care Act care reform models.
- Carers feel more supported and know how to access help and guidance.
- Reduced breakdowns due to carer stress.
- Improved well-being of carers.

Scheme ref no.
BCF12
Scheme name
Reablement
What is the strategic objective of this scheme?

The purpose of reablement is to help people re-learn valuable life skills that may have been lost or reduced due to a period of illness or incapacity such as through a hospital admission. people are supported and encouraged to gradually do more for themselves with the ultimate aim of maximising their independence. The strategic objectives of the scheme are to:

- Maximise the numbers of people accessing reablement
- Reduce the need for ongoing home care support
- Reduce the hours of support required
- Delay the need for residential/nursing care

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The scheme will see the existing reablement service redesigned so that anyone referred to the Council for social care, whether a new customer or an existing customer whose social care needs have increased and who has the potential to benefit from reablement, will be offered a period of up to six weeks reablement. This will help them increase their level of independence and reduce demand for ongoing social care support.

- **Personal Social Care (PSC) will assess the person** and, as long as they have the potential to benefit from reablement, will agree with the person a **reablement plan** setting out the goals they will be supported to work towards. If appropriate NHS therapy colleagues such as Occupational Therapy and Physiotherapy will contribute to the development and implementation of the reablement plan.
- Through the domiciliary framework, a **provider will be sought to work with the person** over a period of up to six weeks to deliver the plan during which time the plan will be continuously reviewed and the amount of support will reduce as the person's skills and confidence increase.
- At the end of the period of reablement, PSC will work with the person and if appropriate, any therapist involved, to **review the person's progress against their reablement plan** and determine whether they have any ongoing needs. These will then be addressed in line with the Council's eligibility criteria.

Currently just under 4,000 service users benefit from reablement per annum. It is intended that by redesigning the service in line with the model described above, this will increase incrementally to approximately 7,000 per annum by 2017.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Lancashire County Council: will provide the assessment function through its personal Social Care service. Colleagues within Personal Social Care will following assessment develop a Reablement Support Plan with the individual setting out their goals. They will also oversee and review the plan throughout the process and undertake a review or re-assessment at the end of reablement to identify and address and remaining needs.

Clinical Commissioning Groups: will commission Community Therapy Support such as Occupational Therapy and Physiotherapy to work alongside the Council's Personal Social are teams to assess people accessing the service and to contribute to the development and implementation of individual reablement plans.

Lancashire County Council: will commission support through its domiciliary framework from independent sector providers.

Independent sector providers: will provide support to individuals in their own homes to implement their reablement support plans using staff who have been trained to deliver reablement.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

UK exemplars

- National research has shown that reablement can generate both positive outcomes for citizens and significant savings for Local Authorities.
- The University of York (2010)[5] reported a 60% reduction in ongoing social care costs following a period of reablement. Similarly Gerald Pilkington Associates[6] report that "*the financial benefit is a significant reduction in ongoing care hours, compared to conventional homecare packages*".
- They go on to say that the "*focus should be on how to get there as cost effectively as possible*". They conclude that "*councils need to focus on minimising the cost of delivering reablement whilst maximising the benefit and duration of benefit gained*".

Local context

- Analyses around predicted demand, both of the Councils current referral patterns and national data relating to population size and reablement, indicate that we should

[5] *Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study), University of York (2010)*

[6] *The Cost-Effectiveness of Homecare reablement – Gerald Pilkington Associates*

be providing reablement for approximately 7,000 people per year across Lancashire.

- A review of the current model of reablement in Lancashire has shown that whilst it is highly effective in delivering positive outcomes for individuals and reducing demand for ongoing social care.
- However, the complexity of the current model is limiting the numbers of people who are able to benefit from the service. Also that the costs of the current delivery model largely outweigh the savings that the service generates in terms of reduced demand for social care support.
- An analysis of a sample of individuals accessing the reablement service has identified that c68% did not need ongoing social care post reablement and the 32% that did received care packages c14% lower than would have needed to be in place without the reablement intervention.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment: £5,637,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑

The quantified impact of this scheme has been calculated as:

- A reduction of 123 non-elective admissions in 2015/16
- A reduction of 10 permanent residential admissions by 2015/16
- An 18% improvement in reablement rates in 2015/16 *

* Based on the analysis of individuals accessing reablement outlined in the evidence base, he expansion of the reablement service is expected to both reduce the level of new demand for long-term care and contribute towards reducing the unit cost of those who do require ongoing support:

- Currently in Lancashire our 2013/14 performance is 78.8% against the national Reablement metric: (2B1) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
- This equates to 446 individuals still at home out of 566 who were provided with reablement /rehabilitation in the quarterly sample exercise.
- For the 2013/14 full year calculation this is equivalent to 1,784 still at home out of 2,264 who were provided with reablement /rehabilitation.
- Our aim is to increase reablement delivery from the 2014/15 current level of just under 4,000 per annum to 7,000 per annum by 2016/17 by redesigning the current service.
- On this basis we are projecting that in 2015/16 and 2016/17 we will increase the numbers of people remaining at home following a period of reablement provided by the redesigned reablement service to 1,968 and 3,501 respectively. These estimates are based on a target metric outcome figure of 82.0% still at home 91 days later.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

dashboard of metrics for the scheme is being developed and will be reported monthly to the Steering Group which will in turn report performance and progress to the Health & Wellbeing Board through the agreed performance and governance process and structure. The metrics

are currently being finalised and are likely to include:

- Number of new reablement support plans created each month.
- Number of people receiving a reablement package of care
- Number of hours of reablement packages of care commissioned/provided by district

per 1000 population aged 65+'.

- Range of length of reablement package of care in each district
- Number of reablement episodes per person in a year by district.
- Percentage of people receiving a reablement package of care who have no long term (ongoing) services at the completion of the package.
- Percentage of people receiving a reablement package of care who have a prior request for short term services to maximise independence (national measure)
- Percentage of people receiving reablement who have no long term (ongoing) services at the completion of the package who have not requested further support at 6 months/12 months.
- The percentage of people who have received a reablement package of care who demonstrate a reduction in need from the start of reablement to the completion of reablement

What are the key success factors for implementation of this scheme?

successfully delivering the scheme relies on delivering the following things on the critical path
over the next 3 years:

2015/16

- Assessment function transferred into PSC, guidance produced and published, staff fully trained, required system changes in place and fully operational.
- LCCG reablement support staff redeployed within the Council or taken VR.
- Commence transfer of reablement business to providers within domiciliary framework
- Commence growth in reablement delivery capacity amongst domiciliary framework providers towards target capacity for 7,055 people per year.

2016/17

- Complete transfer of reablement business into domiciliary framework
- Training for domiciliary framework providers around reablement delivery
- Growth in reablement delivery capacity amongst domiciliary providers to achieve target capacity for 7,055 people per year.

2017/18

- Operation of new service model, delivery of projected savings

Scheme ref no.
BCF13
Scheme name
Transforming Community Equipment Services
What is the strategic objective of this scheme?
The strategic objective of this scheme is: • To deliver a single high quality service based on a Lancashire wide service specification and contract • To undertake market testing to ensure value for money as agreed in the community strategy • To achieve best value through the buying power of a single Community Equipment Services (CES) provider • To deliver improved value for money resulting from improvements across the whole service, delivered through the procurement process, for example the ability to re-use and re-purpose high cost equipment (e.g. children's equipment) • To develop streamlined pathways for the provision of high cost equipment
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The provision of community equipment plays a vital role across Lancashire by promoting and enabling: • the independence of thousands of people with disabilities of all ages • children and adults who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live as full a life as possible. • individuals to manage independently and prevent the need for other care services. • the safe and effective delivery of care usually in a person's home environment often

Following a stay in hospital.

Community equipment can be categorised into three main areas:

1. **Simple Aids to Daily Living (SADLs)** are products that support people with day-to-day tasks e.g. walking frames, raised toilet seats and bath seats. These have the potential to benefit the whole population, not just those eligible for statutory support. These items are low value and high volume with most often costing less than £50.
2. **Complex Aids to Daily Living (CADLs)** are products that are largely provided by the state to support care in the home setting e.g. profiling beds, hoists and bath lifts. These items often have electrical or hydraulic components. They are high cost and so are provided on a loan basis and are reused as appropriate.
3. **Bespoke equipment** is uniquely specified by the prescriber and sourced for an individual service user. This is a relatively small amount of the total equipment provided, but is more commonly provided to children with complex needs e.g. specialist seating.

In Lancashire, there are two distinct supply chains for the provision of community equipment:

- **Retail Model** – the vast majority of SADLs are provided on prescription via the retail marketplace. Approximately 62,000 simple aids each year are supplied through this service in Lancashire.

- **Community Equipment Services (CES)** – all complex aids, bespoke equipment and a limited range of simple aids are provided on a loan basis by these services, supplying about 42,000 items of equipment a year in Lancashire.

This scheme specifically covers the CES support services:

- procure, deliver, collect, decontaminate and, where appropriate, service and recycle equipment, which has been prescribed by clinicians or social care staff for individuals residing throughout Lancashire
- are funded collaboratively between the relevant NHS CCG and the Council with an agreed local delineation of the funding of different equipment between organisations.

Through this scheme we are aiming to (as part of this agreement) establish a common approach across the county to address **the variation that exists due to historical arrangements for the CES services**. The following has been completed to develop the approach:

- The former Primary Care Trusts (PCTs) worked together under a Collaborative Working Group to review a number of services across Lancashire including Community Equipment.

- NHS Shared Business Service (SBS) Commercial Procurement Solutions was commissioned in 2010 (completed in 2011) to undertake an options appraisal on behalf of partners in relation to the reduction of the number of CES stores across Lancashire. This was commissioned in anticipation of a significant decrease in activity through the stores, following the implementation of the nationally supported Retail Model for the provision of SADLs.
- The expected reduction in CES store activity has since been fully realised with about 60% of all equipment now provided through the Retail Model. The resulting surplus capacity within CES stores offered commissioners the opportunity of consolidating the current stores facilities to a single solution able to serve the whole of Lancashire delivering consistency, quality and best value.
- The six CCG"s in collaboration with Lancashire CSU Service Redesign team have continued working in partnership with LCC"s Adult Services and the Children and Young People Directorates to develop new commissioning and service delivery arrangements for CES across the County.
- The intention is that a single service will be tendered through what is likely to be a complex procurement. It is proposed that Lancashire North CCG lead the process under clear governance arrangements set out in the Section 75. The aim is to complete the procurement and begin service mobilisation during the second or third quarter of 2015/16.

The joint procurement arrangements present the CCG"s and Local Authority with the best opportunity of achieving consistency of service provision and delivering best value within a suitable legal framework for managing the local requirements and complexities.

The CES main service components are:

- Procuring equipment (Standard Stock and Special/Bespoke equipment) including paediatric and sensory equipment
- Providing on-site technical advice, working with practitioners/clinicians, attending joint visits and advising clinicians on all aspects of minor adaptations and technicalities around equipment
- Delivering appropriate items of equipment for daily living or nursing equipment to Service Users on short or long term loan basis to Service Users" homes
- Delivering items to peripheral stores, hospitals, schools and day centres
- Collecting equipment (avoiding contamination with equipment being delivered) from the Service User's home or community setting when no longer required;
- Providing and maintaining a virtual Equipment Catalogue;
- Servicing, maintenance and repair of all items of equipment supplied in accordance with the manufacturer's recommendations,
- Establishing close working links with clinicians and prescribers in acute, primary, secondary, community teams and other health/social care establishments;
- Administering, over-seeing and quality checking any minor modifications/adaptations undertaken by subcontractors;
- Recycling of equipment
- Storing a range of equipment, including returned Specials that have been purchased

via stores processes to Commissioners;

- Agreeing and maintaining minimum service stock for Standard Stock items;
- Cleaning and refurbishment of returned equipment to enable its re-use as quickly as reasonably practicable;
- Fitting, adjusting and/or assembling equipment and providing safety instructions to Service Users,
- Safe disposal of all equipment collected from or returned by Service Users where the equipment is unsuitable for re-use and beyond economic repair;
- Producing management reports and keeping of all records; and
- Providing an efficient web based Information Technology System, to carry out all the above activities as well as providing management information and a Service Users database to provide information regarding special equipment in stores for prescriber information.

The patient cohorts being targeted are children and adults of all ages who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live as full a life as possible.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The current delivery chain is detailed below. Post procurement the commissioners will remain the same however there will be a single provider for the service.

Commissioners	Providers
Lancashire County Council	East Lancashire Hospital Trust Lancashire Care Foundation Trust
Chorley & South Ribble CCG	Blackpool Teaching Hospitals Foundation Trust Lancashire Care Foundation Trust
East Lancashire CCG **Fylde & Wyre CCG**	East Lancashire Hospital Trust Blackpool Teaching Hospitals Foundation Trust
Greater Preston CCG	Lancashire Care Foundation Trust
Lancashire North CCG	Blackpool Teaching Hospitals Foundation Trust

West Lancashire CCG	Lancashire Care Foundation Trust

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This scheme has been selected based on the evidence relating to:

- the prevention agenda, where the evidence supporting use of equipment to provide a vital gateway to independence, dignity and well-being for many people living in the community is well documented.
- operational efficiencies / improvement evidence in terms of smarter procurement of goods, good stock management and logistics.

The use of Community Equipment is a cost effective way of preventing further disability and maintaining independence for people.

- **The Audit Commission** (2000) reported that the use of such equipment can prevent the higher costs associated with other parts of the Health and Social care system
- **London School of Economics and Political Science** (PSSRU) reported in *Building a business case for investing in adaptive technologies in England*, July 2012 that (under the central scenario), the results suggest that equipment and adaptations lead to reductions in the demand for other health and social care services worth on average £579 per recipient per annum (including both state and private costs). In addition, the services lead to improvements in the quality of life of the dependent person worth £1,522 per annum.'

The evidence suggests significant operational efficiencies can be realised.

- In Lancashire, approximately £7.3m per annum is spent on community equipment services collectively by the CCGs and LCC.
- Benchmarking analysis against other community equipment services suggests there is scope to reduce costs.
- It has been estimated by up to £2.2m, but caution is needed, as the investment requirement will not be known until the procurement has been completed, or is at least at an advanced stage.

The Service will contribute to the implementation of the following national policy guidance:

- Our Health, Our Care, Our Say (2006)
- Improving the Life Chances of Disabled People (2005)
- NSF for Children, Young People and Maternity Services (2004)
- Healthy Lives, Brighter Futures (2009)
- Working Together to Safeguard Children (2013)
- Every Child Matters: Change for Children (2005)
- Aiming High for Disabled Children (2007)
- National Service Framework for Older People (2001)
- National Service Framework for Long Term Conditions (2005)
- A Vision for Adult Social Care: capable communities and active citizens (2010)
- Healthy Lives, Healthy People: our strategy for public health in England (2010)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment = £9,976,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delayed transfers of care	☑
Patient experience: Proportion of people feeling support to manage their LTC	☑

The quantified impact of this scheme has been calculated as:

- A reduction of 5 permanent residential admissions by 2015/16
- A 9% improvement in reablement rates in 2015/16
- 61 fewer delayed transfers of care compared to the prior year
- A reduction of 123 non-elective admissions in 2015/16

Other benefits include

- Savings due to improved economies of scale and value for money through the procurement process
- Preventing falls, maintaining independence and supporting carers
- End of life pathway and preferred place of care

Non-financial benefits include:

- To help people to maximise their ability to live independently
- To help reduce the escalation of disability
- To enable timely hospital discharge and reduce delayed transfers of care
- To facilitate intermediate and community care
- To support carers in their caring role
- To provide a responsive service to people of all ages irrespective of where they

live
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The outcomes of the scheme will be measured via the quality and performance schedules of the NHS Standard Contract which have been developed as part of the procurement process. Please see details below:

The providers performance will be measured against performance standards in eight performance sections as set out below.

Required Performance Area	Indicator/s	Target/s	Reporting Frequency
Priority/Timelines: All Orders shall be completed in a timely fashion. If these performance targets are not met, the Provider shall waive all Service charges for all Out of Time (OOT)	1. Emergency Orders 2. Urgent Orders 3. Premium Orders 4. Standard Orders	1. 100% within 4 hours of receipt of order notification. 2. 100% within 1 day of receipt of order notification. 3. 100% within 2 days of receipt of order notification 4. 100% within 7 days of receipt of order notification Where performance is below the 100% target, providers must report by exception.	Monthly By exception
Effectiveness: activities are completed within specified times.	1. Completion of Orders 2. Joint Visits	1. 97% completed within one visit to Service User's residence. 2. 99% attendance of Joint Visits as requested and scheduled by the Prescriber.	Monthly
Maintenance: equipment shall be fully maintained within the manufacturers" guidelines and repaired as specified where necessary. Maintenance Report	1. Equipment maintenance carried out as schedule in Pre-Planned Programme. 2. Timescale for repairs including electrical items (e.g. hoists, pressure relieving mattresses) (i) Critical (ii) Non Critical Identifies maintenance activities and may serve to highlight product deficiencies.	100% completed within 10 days of the date set out in the Pre-Planned Maintenance schedule. Repairs completed within the timescales: (i) 100% same Day (ii) 100 % within 5 Days	Monthly
Special Equipment: Special Equipment shall be delivered/installed in a timely fashion once the equipment has been received by the service provider.	Completion of Special Equipment Service Orders	100% completed within 7 days. The remaining 15% within 20 days.	Monthly
Complaints: Complaints shall be minimised and resolved swiftly.	Number of Complaints received.	The number of complaints in each month is less than 0.25% of total activity (deliveries, collections,	Monthly

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme are:

- Procurement expertise and management is required to ensure effective and successful management of the complex procurement process through to service delivery from a single provider.
- Partnership working; there are a range of existing forums that have been used to progress the service review and redesign work. There is also clear governance arrangements for the scheme which will report through Lancs North CCG (as the Lead commissioner for CES) and the BCF governance arrangements
- Transition from the current multiple service providers and CES providers to a single service provider following the procurement process to ensure seamless contract and service provider change process with positive impact for end users

Scheme ref no.
BCF14
Scheme name
Telecare Services
What is the strategic objective of this scheme?

- **Ensure Cost Effectiveness:** Develop an affordable and effective service that enables substantial growth in the number of people using the service. This means ensuring ready access to Telecare for those who will benefit most from the service.
- **Integrate services around the individual:** Integrate Telecare within the mainstream assessment, support planning and review processes for adult social care and reablement services, in order to maximise people's ability to continue to live independently with the minimum level of support to safely meet their needs.
- **Work in Partnership:** Work with our partners to ensure that Telecare is widely understood and accessible to service users, carers, housing, health, emergency services and social care professionals. Specifically with our NHS partners to embed Telecare within integrated locality based services, so people get the right care, in the right place at the right time.
- **Quality assurance and ethically based:** Develop a high quality and ethically based Telecare service that strikes a reasonable balance between the individual's right to autonomy, choice and control and wider strategic priorities to achieve better outcomes

and financial savings

- **Provide Leadership:** Commission a Telecare service where the service provider(s) play a major leadership role in driving the changes essential to achieving the council's strategic aims.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Description

The strategy aims to achieve a connected model of Telecare supported by an integrated Lancashire wide therapy and response service that can deliver a swift and timely service through a single point of access within social care, health and housing services in Lancashire

The Telecare service will provide technological equipment, aids and adaptations to enable people with a) long term conditions, b) life limiting illnesses and c) the elderly to overcome key environment barriers and maintain independence and health.

Lancashire are implementing a new strategy for this service and re-commissioning Telecare at present. Our key messages are:

- **Improve Outcomes:** Telecare has a significant role in helping people to maintain their independence and stay safe.

- **Make Cash Savings:** Telecare will contribute to the delivery of financial savings by reducing the demand for more costly and intensive services across the Lancashire health and social care economy.

- **Grow the Service:** The intention in re-commissioning the Telecare service is to achieve sustained growth, with the ambition of having 7,000 people receiving Telecare by the end of 2017/18.

- **Maximise the benefits:** We want to reach individuals who will benefit most from Telecare. Review and change our access arrangements, eligibility criteria and the charging policy to support our intentions.

- **Develop the workforce:** Set ambitious Learning and Development goals to ensure sound understanding of the purpose and benefits of Telecare across the health and social care workforce.

- **Deliver in Partnership:** Statutory, voluntary, private and community organisations must play a leadership role with the County Council to support the growth of the service, and to ensure Telecare is embedded within locality based care services.

- **Evaluate the impact:** External research bodies and our own business intelligence services will be commissioned to ensure there is robust evaluation of the Telecare Service.

Model

Below is our cyclical model for Telecare services.

Targeting

We will promote and encourage the take up of Telecare by groups who are at risk of hospital admissions. They are:

- People who are frail
- People with dementia
- People who fall or who are at risk of falling
- People with learning disabilities
- People with physical or sensory disabilities

- People with informal carers who need extra support.

We also expect to target people who are eligible for care and support, who have received reablement or who are entitled to receive Telecare under a new preventative offer.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The current Telecare service is commissioned by Lancashire County Council and provided by four housing providers that each cover a geographical area of Lancashire.

However, the service is currently being retendered. We are currently procuring a 'Development Partner' that will lead and drive the strategic development and expansion of Telecare in partnership with Lancashire County Council; suitably package and subcontract the range of services to organisations that are experienced and capable of providing high quality and cost effective services; and manage the whole system effectively by coordinating and bonding the services together so the end-to-end system functions seamlessly as one for the end user.

One of our strategic intentions is to work in partnership with key stakeholders, including the CCGs and NHS Trusts in Lancashire to embed Telecare into other health and social care pathways and neighbourhood care teams.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

UK Exemplars

To help develop our understanding and strategy we have engaged with Telecare providers through a soft market testing exercise, met with other councils that have successfully implemented Telecare, held discussions with industry experts, considered a range of publications and attended specific Telecare conferences and events.

There is a range of research evidence regarding the financial benefits of Telecare with a number of local authorities having invested significantly in Telecare on the basis of being confident of the subsequent delivery of financial savings as well as improved outcomes for

individuals. As examples:

- Evidence supporting the development of Telecare from Essex County Council has indicated that the financial benefits of Telecare are for every £1 spent on Telecare £3.80 is saved on traditional care.
- Hillingdon council saw the number of admissions to residential care reduce by half within 18 months of the implementation of their Telecare offer.

Telecare is also of increasing importance in Government policy on health and social care provision. It is now widely accepted that it has a major role to play in delivering a transformed and personalised social care system. Nationally, a vision is emerging of a more cost- effective, assistive technology-supported, health and social care system that is able to deliver care where it is most appropriate, increasing the flexibility of care packages and improving the quality of peoples‟ lives. Telecare has huge potential to support a diverse range of individuals to live at home. It can also give carers more personal freedom, meet potential shortfalls in the workforce and complement the work of health, social care and housing providers to achieve outcomes that improve the health and well-being of people using services.

The Department of Health's Whole System Demonstrator Programme found that Telehealth had a:

- 20% reduction in emergency admissions
- 15% reduction in A&E visits
- 14% reduction in elective admissions
- 14% reduction in bed days
- 8% reduction in tariff costs

Local context

The estimated potential savings in Lancashire is based on benefits resulting from reductions in domiciliary care (for 60% of new Telecare service users) and delays in admissions to residential care (for 15% of new Telecare service users).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment = £548,000 with the intention that the cost will increase as the number of people receiving telecare grows from the current c1,100 up to the planned c7,000.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delay transfers of care	☑
patient experience: Proportion of people feeling support to manage their LTC	☑

The quantified impact of this scheme has been calculated as:

- 61 fewer delayed transfers of care compared to the prior year
- A reduction of 123 non-elective admissions in 2015/16

We expect the new Telecare service to help vulnerable people achieve these outcomes:

- Enable better self-care
- Enable them to stay in their own homes
- Increase their choice and independence
- Improve their quality of life
- Reduce risk and make them feel safer
- Provide carers with support and peace of mind
- Promote early intervention and prevent a crisis
- Prevent admissions to hospital

- Enable timely and safe discharge from hospital.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We are involved in the ATTILA trial: assistive technology and Telecare to maintain independent at home for people with dementia and we are working in partnership with Lancaster University on a three year PhD studentship and evaluation study of our new service funded by the Economic and Social Research Council.

We will also work with our Development Partner to design a benefits realisation framework that will include measuring outcomes and return on investment of the new service. We will place an emphasis on reviewing individuals and their patterns of Telecare use, in order to understand if the service is meeting their needs or not.

What are the key success factors for implementation of this scheme?

For out Telecare service to be implemented successfully and allow us the opportunity to achieve our goals and strategic ambitions, the following needs to be in place and/or achieved:

- Successfully tender for a Telecare service provider(s)
- Partnership working with other key stakeholders (CCGs and NHS Trusts) to embed Telecare into other health and social care pathways and neighbourhood care teams.
- The development of our workforce to promote and support the Telecare service
- The availability of strong and effective communication channels
- The availability and access to a suite of equipment (alarms, sensors and detectors)
- The availability and access to equipment to support remote monitoring of a patient's long term condition(s)
- The implementation of structural capabilities including:
  - Joint assessment and care management of patients that spans both health and social care
  - Therapy services that perform comprehensive needs assessment for technological aids and adaptations
  - Access to on-call support services in cases of emergency
  - Access to integrated community and primary care services

Scheme ref no.
BCF15
Scheme name
Care Act Implementation
What is the strategic objective of this scheme?
The primary objective of the scheme is to contribute to the delivery of the requirements of the Care Act 2014. The Care Act modernises the legal basis for adult care and support in England. This will make the law easier to understand and apply, and will bring greater clarity, consistency and equality of access to care and support. The intended effect is also to improve the outcomes and experience of care, and secure a more effective use of public and community resources by improving the personalisation of services, giving people more choice and control over how their desired outcomes are achieved.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The aims of reforming the law relating to care and support are to: • Modernise the legal basis to reflect the Government's ambitions for personalised adult care and support • Refocus the law around the person, not the service, by enshrining new statutory principles that place the wellbeing of the individual at the heart of individual decisions about care, • Simplify the law into one single statute for adult social care, supported by clear regulations and a reformed bank of statutory guidance in one place, • Develop a more transparent framework, which simplifies practice for care professionals, reduces burdens, and empowers individuals to better understand their rights and responsibilities.

he investment from the Better Care Fund will contribute to the implementation of the Care Act, which in particular proposes to:

- Enhance systems to ensure that a duty to secure the provision of information and advice on care and support for adults and carers is in place
- Implement clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need;
- Support transition into adult care
- Review Lancashire County Council's eligibility criteria for Adult Social Care to ensure that they are at a national standard
- Implement the extension of responsibilities towards carers ensuring that carers will have a right to an assessment and maintaining their health and wellbeing; and a national eligibility threshold for carers will be introduced
- Implement the responsibility to provide a care and support plan (or a support plan in the case of a carer)
- Embed the legal entitlement to a personal budget
- Develop and strengthen the role of Safeguarding Adult Boards and putting them on a statutory basis
- Fulfil requirements that have made deferred payments a statutory requirement - as a way of enabling self-funders, or those required to make a financial contribution, to meet their care and support costs when moving into residential care without having to sell their own homes
- Ensure that commissioning is focused away from activity towards value-based services that focus on delivering improved outcomes for people
- Implement the national minimum training standards for care workers with dignity and respect at heart of the code of conduct
- Promote diversity and quality in the care and support provider market

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

These projects have been commissioned by Lancashire County Council's Adult Services, overseen by the Care Act Board (including the Executive Director of Adult Services, Health & Wellbeing; Deputy County Treasurer; Director of Personal Social Care and the County Secretary and Solicitor).

The projects are to be delivered by the Care Act Implementation team lead by the Head of Care Act Implementation.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This scheme is designed in response to the new legislation which governs how adult care and support is defined and delivered. It will help Lancashire County Council transition from the requirements of the current legislative, which is opaque, complex and anachronistic.

The new law provides the underpinning framework for care and support and is critical to the way care it is delivered on a day-to-day basis to people who need it and will far better provide:

- Clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need
- Focus on and support for local authority relationships with other organisations and the need to join up services
- Improving access to universal information and advice on care and support
- Reflect local authority responsibilities to promote diversity and quality in the care and support provider market
- Support the cultural and systemic change needed for personalisation and self-directed support; and,
- Support transition into adult care and support for children.

These are discussed in turn below.

Clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need

As set out in the Government's A Vision for Adult Social Care, a considerable proportion of are needs could be avoided, reduced or delayed as a result of earlier intervention. However the current system is geared too much towards intervention at the point of crisis rather than helping individuals to postpone or prevent the onset of illness or loss of independence.

A recent DH survey suggested that around 80% of local authorities currently set their eligibility criteria threshold at substantial or critical levels of need, meaning that they do not make support available to people who are assessed as having moderate or low needs.

Only 2% provide funding at "low" levels, indicating that investment is not focused on avoiding people's needs from getting worse.

Focus on and support for local authority relationships with other organisations and the need to join up services

There is a need to facilitate increased joint commissioning across health, social care and public health and allow for the implementation of services that use the “whole person” approach. Incentives for individuals to take preventative steps should also be improved – for example by linking duties to integrate explicitly to a focus on preventing or reducing needs.

Improving universal access to universal information and advice on care and support

The availability of information and its quality is a critical enabler for both consumers and commissioners to make choices and drive up quality.

However, rather than being shaped around the needs of individuals, services have tended to develop based on systems, structures and funding flows. There are still significant barriers preventing people from having choice and control over how they are supported to achieve their desired outcomes. This has affected the extent to which care and support is personalised and integrated with other public services, with consequential implications for quality of outcomes, user experience and efficient use of public resource.

Reflect local authority responsibilities to promote diversity and quality in the care and support provider market

The Caring for our Future White Paper set out the government's intention to promote a diverse market of high quality care and support services, to improve service quality through individual choice and control and address some of the current key issues:

- Carers have consistently highlighted a lack of suitable, high quality services. Carers have said that a paucity of suitable services can mean that they can have to care for more hours than they would ideally like too.
- Feedback from the Caring for our future engagement suggested that even when people are given access to a personal budget, many struggle to find services to meet their needs.

- In December 2009, a Care Quality Commission (CQC) analysis found that the proportion of council-supported residents in care homes rated good or excellent varied by authority from 45% to 97%, indicating a wide variety in the quality of care received.
- The variation implies inconsistency in the effectiveness of commissioning strategies. In some areas at least, providers are not sufficiently incentivised to improve service quality.
- Users and carers are not sufficiently empowered to make informed choices at a time when individuals are becoming increasingly responsible for buying their own care. Care providers do not have an incentive to improve the quality of the care they offer, as they cannot demonstrate to potential customers what improvements have been made.

Support the cultural and systemic change needed for personalisation and self-directed support

There are a number of cultural and organisational barriers to progress in local authorities making a universal offer of self-directed support to people using care and support. Reasons might include: perceived higher costs; low priority given to this principle by councils; inertia; vested interest; or the perception by individuals that a higher workload is required by a more responsive and flexible service:

- The current legal framework does not require councils to provide personal budgets.
- Individuals may be put off by the perceived potential complexities of decision-making in relation to personal budgets and personalised support planning
- Not all groups of users are able to access personal budgets and direct payments. Current regulations do not allow those in long-term residential care to access direct payments.
- Evidence suggests that there is inadequate provision of information to both state-funded care users and in particular to people funding their own care. Many self-funders do not access local authority information or take up assessments as they receive no support due to their financial position.
- Evidence from the Caring for our future engagement, supported by research from the Personal Outcomes Evaluation Tool, showed that people were much more likely to take control of their care and support funding through a direct payment if they had received support with making choices about the care they wanted, and with articulating how that care should help them achieve their goals.

Lack of provisions to support transition into adult care and support for children

There are well-documented issues associated with the transition between children's services and adult services. One such issue is a gap in provision often described as the „cliff edge". An independent report commissioned by the Department of Health referred to the

Considerable evidence from research that for most young people with disabilities the process of transition
from child to adult services is problematic".

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment

£3,123,000 in 2014/15 and
£3,123,000 in 2015/16 (revenue)
£1,149,000 in 2015/16 (capital)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Patient measure: Proportion of people feeling support to manage their LTC	☑

The financial benefits are:

- Quality of life gains for carers from improved legal rights and improved access to support.
- Benefits to local authorities through better coordination, more proactive, preventative measures and planning of care and support functions, for example preventing crisis and escalation of need, including via improving information,

personalisation, and assessment of carer need.

Other key non-financial benefits:

- People with care and support needs will benefit from improved wellbeing, better prevention of care and support need, greater clarity, consistency and equality of access to care and support and reduction of unmet need.
- Improved information, advice and cooperation between organisations will help people to navigate the system more easily and with greater freedom, flexibility and choice.
- This will improve the outcomes and experiences of people who use care and support services, carers and their families.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The County Council has set up a Corporate Programme Board to oversee the development of Lancashire's response to the requirements of the Care Act.

Recommendations are being developed based on a continuing analysis of the Care Act guidance and regulations.

What are the key success factors for implementation of this scheme?

The key factors to successful implementation are workforce, informatics, communications and understanding the cost of the reforms.

- *Workforce:* Pressure on workforce capacity, the need for change to existing working practices, new roles, and learning and development needs will need to be closely considered. The Act is an opportunity to develop and promote a change in workforce culture, not just within social care practice, but also more widely as part of the increasing integration of health and social care.

- *Informatics:* Investment is required to drive efficiency, deliver more joined-up, safer

and higher quality care and support preventative services. The Council needs the right technological capabilities to support integration and manage case records.

- *Communications:* Activity relating to the following is critical to successful implementation:

- The provision of information for affected individuals (care and support service users, carers, care workers and people approaching point of need).
- A broader programme of marketing activity to inspire behaviour change at a societal level, so that it becomes the norm for people to prepare for potential care and support needs as part of their wider financial planning.

- *Understanding the cost of reforms:* Both the reforms to care and support commencing April 2015, and the subsequent funding reforms taking effect in 2016 will have a significant financial impact on councils. Both sets of reforms will have financial implications beyond the year they are introduced.

Scheme ref no.
BCF16
Scheme name
Disabled Facilities Grant (Capital Scheme)
What is the strategic objective of this scheme?
Enabling vulnerable disabled people to remain as independent as possible in their own homes through provision of adaptations to the dwelling. Adaptations delivered via Disabled Facilities Grants deliver on a range of key policy objectives, including: • Helping prevent hospital admissions • Speeding up hospital discharge • Reducing strain on carers • Assisting community care • Promoting social inclusion • Improving quality of life

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The scheme will provide capital funding for home adaptation grants, delivered by the district councils in their statutory role under Part I of the Housing Grants, Construction and Regeneration Act 1996. The types of work covered include:

- Making it easier to get into and out of the dwelling by, for example, widening doors and installing ramps
- Ensuring the safety of the disabled person and other occupants by, for example, installing hoists to assist in getting out of bed
- Providing or improving access to the living room, bedroom, and kitchen, toilet, washbasin, bath and/or shower facilities; for example, by installing a stair lift / through floor lift or providing a downstairs bathroom
- Improving access and movement around the home to enable the disabled person to care for another person who lives in the property, such as a spouse, child or another person for whom the disabled person cares.
- Preventative home based risk assessments in the homes of vulnerable clients

The scheme supports independence in the home for disabled people (children and adults), ith grants mandatory and means tested for adults. The patient cohort includes older people with higher needs at heightened risk of hospital admission.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Initially an **Occupational Therapist** will determine what works are “necessary and appropriate” to meet the disabled person's needs. The grants are **managed and delivered by the district councils in Lancashire**, either by direct provision or through Home Improvement Agency arrangements, determining what works are “reasonable and practicable”, and producing a schedule of works which forms the basis of the grant aided work. The client is supported throughout in commissioning the works with private contractors, managing delivery and ensuring timely completion to the required standard and budget.

CCGs to further develop a shared approach to provision of adaptations, improving the interface and integration with other support services, improving the customer experience and reducing the demand on health & social care services.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Adapting the homes of citizens with disabilities enables independent in the community, reducing the risk of social isolation and deterioration of conditions associated with a move to a different/less independent setting. It also facilitates discharge from a hospital setting and through improving the safety and appropriateness of the home environment reduces the risk of further admissions.

A research review by Heywood and Turner (2007) reported that there is evidence that adaptations can produce significant savings in the following areas:

- Prevention of falls;
- Reduction in the need for home care services;
- Reductions in the use of residential care (including nursing care);
- Enhancements in the quality of life of people in receipt of adaptations, improving well-being and contributing to the sustainability and extent of their independent living.
- Improvements in the health and well-being of carers, whose health can be improved because the people they are caring for are able to live more independent lives.

The savings, i.e. cost offsets to other services, produced by adaptations can be extensive and enduring. In 2009, the Home Adaptations Consortium estimated that 20 level access showers installed in the London Borough of Newham at a cost of some £110,000 had produced a five year saving of £1.86 million13 (Home Adaptations Consortium, 2009).

Work carried out at Neath Port Talbot Council in Wales, and appraised by the Lean Enterprise Research Centre at Cardiff University for the Welsh Audit Office, showed a strong correlation between the average age of admittance into residential care and the provision of a DFG. Those who received a DFG went into residential care on average 4 years later than those who did not receive a DFG. The Council identified 189 people who went into residential care where there had been a request for a DFG but the work had not been completed sufficiently quickly. At an average cost of £380 per week in residential care, the potential saving which would have arisen from timely provision of the DFG was £12.7m (i.e.

x 52 x 4), less the £1.2m cost of the DFG (at an average of £7,000).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Local Authority	2015/16 Minimum Allocation
Burnley	£961,000
Chorley	£370,000
Fylde	£468,000
Hyndburn	£449,000
Lancaster	£783,000
Pendle	£455,000
Preston	£625,000
Ribble Valley	£161,000
Rossendale	£424,000
South Ribble	£334,000
West Lancs	£543,000
Wyre	£792,000
Lancashire Total	**£6,365,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delayed transfers of care	☑

The quantified impact of this scheme has been calculated as:

- A reduction of 14 permanent residential admissions by 2015/16
- An 18% improvement in reablement rates in 2015/16 *
- 61 fewer delayed transfers of care compared to the prior year
- A reduction of 245 non-elective admissions in 2015/16

The scheme will contribute directly to BCF outcomes of reduced residential and nursing care admissions, and reduced delayed transfers of care. The scheme will also contribute to BCF metrics concerning improved patient and service user experience by enabling citizens to stay living independently in their own home for longer.

DFGs provide a mechanism to:

- Reduce A&E attendances and admissions
- Facilitate care closer to home
- Help to develop a more socio-medical model of care where social and environmental factors are considered as well as medical ones
- Help facilitate better care at home and in the community for at-risk patients
- Help support carers
- Improve end of life choices

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

level of integration & what's working / not working. Performance measure (not currently agreed with districts) – timeliness of completions and customer satisfaction levels?
What are the key success factors for implementation of this scheme?
or successful implementation, close and effective partnership working between LCC, district councils and CCGs is needed. Need to build trust across all sectors & timely open communication as a prerequisite.

Scheme ref no.
BCF17
Scheme name
Intermediate Care Services to support Care Co-ordination Centre (Lancashire North CCG)
What is the strategic objective of this scheme?
This scheme is one of the Lancashire North CCG BCF schemes which are a sub-set of a larger health economy transformation programme called Better Care Together. The **Intermediate Care Services scheme** contributes to the following strategic objectives of the Better Care Together programme: • To design and implement new integrated models of care across the local health economy • To design and implement a system which recognises the specific geographic and demographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times • To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable

- To enable the development of a flexible, integrated and productive workforce across our health economy.
- To design and implement a future healthcare system for our area that makes best use of the money and resources available
- **Within the Better Care Together Programme the following model of care will be implemented:**
- A **Care Co-ordination Centre** will provide a single health and social care hub for both professionals and patients, with the aim of ensuring patients are in the right place within the health economy, at the right time. The Care Co-ordination Centre is supported by:
  - An **integrated community care service**: a wrap-around multidisciplinary team who can be deployed to supplement the core team, with the aim of reducing unnecessary hospital admissions and reducing the number of handoffs patients currently experience. The appropriate clinical team will make a rapid assessment of the patients‟ medical, nursing and care needs, delivering a package of care before handing the patient back to the core team for recovery.
  - **Intermediate care services.** These services provide a range of interventions which:
    - Reduce avoidable emergency admissions
    - Reduce length of stay in hospital
- Provide an integrated urgent care interface to co-ordinate packages of care which keep people as independent as possible, in the best interests of their health and well-being.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

What is the model of care and support?

Which patient cohorts are being targeted?

The **Care Co-Ordination Centre** has a number of I**ntermediate Care Services** which form the intermediate integrated model of care. They are:

- **CRISIS** – A short term intensive support service providing upto 72 hours of free social care support. The service:
  - Enables a person to be supported at home safely
  - Supports avoidance of an unnecessary admission to hospital or residential care.
  - Has rapid response times (usually within one hour)
  - is integrated with mental health services
- **Transitional Care Pathway (Rapid Response, React, Pulmonary Rehab)** This integrated service acts as an access and assessment point for patients on the Transitional Care Pathway. Referrals are then allocated to the most appropriate member of the team or signposted to other services. The service comprises of:
  - **REACT:** a multi-disciplinary co-located virtual team (nurses, physiotherapists, OT‟s and social care staff)

- Implementation of **rapid response** individual pathways for patients including NHS staff being able to commission social care services as „trusted assessors".
- **Pulmonary Rehabilitation** providing patients with chronic respiratory / chronic heart failure a structured multidisciplinary group or home programme of exercise and education.

- **Alcohol Liaison Service** –aims to improve the management of patients, attending and/or admitted to the hospital, who are alcohol dependant or drinking at levels that are harmful or likely to damage their health. The service:
  - Provides a dedicated nurse within the acute setting with the aim of improving alcohol misuse management within a „whole integrated system" approach.
  - Targets intervention and support for frequent flyers and priority service users.
  - Offers access 7 days a week
  - Supports patients to address their alcohol consumption and therefore improve their health outcomes, particularly in cases where the condition is wholly or partially caused by alcohol consumption.
  - Has a strong workforce development component to raise awareness of the impacts of alcohol and promote the use of screening tools to maximise referrals.

- **Stroke – Early Supported Discharge – An interdisciplinary neuro-rehabilitation service for patients who have suffered a stroke**. The service is community based, and delivered in the patient's home. There are close links to secondary care working to an integrated model with social services and third sector (Stroke Association) to deliver optimal rehabilitation for people with stroke as they transfer from hospital to home.

- **Ripley Suite –An intermediate nurse-led 24/7 step up/step down facility** to enable admission for patients who would benefit from acute nursing care but who do not require a secondary care environment or require significant diagnostic input to provide a diagnosis. This facility is an alternative model of care to a general medical elderly ward.

- **Residential Recuperation and Rehabilitation** -The provision of rehabilitation beds and recuperation beds.

  - **Recuperation beds are offered for a period of up to 4 weeks** to support people who are not able to return home following a stay in hospital or a period of illness. Service users will not require nursing care but need additional time to fully recuperate prior to being able to live independently.
  - **Rehabilitation beds are offered for up to 6 weeks** to support people to either accommodate their illness by learning or re-learning the skills necessary for daily living or regaining skills and abilities following illness or fall. These beds are supported by community therapy staff who work into the unit. There is also provision for **specialist dementia residential rehabilitation** with dedicated therapeutic interventions who have suffered an episode of physical ill health or injury.

- **Therapy (Rehab)** - Community therapeutic services provide assessment and treatment

of physical conditions. The service promotes independence via planned specialist input with patients, their carers and where appropriate social care.

Falls Assessment Service – An early intervention service which:

- Aims to restore independence, through falls care pathways,
- Assessment covers motor and sensory function, environmental factors, cognitive ability and screening for medication that may have side effects that increase falls.
- Provides simple pieces of equipment and adaptations (e.g. grab rails)
- Provides programmes of rehabilitation
- Whole system focus on developing the knowledge of fall prevention in the wider community.

The intermediate care services overall will:

- Create a single point of entry into the urgent care system
- Interface with core teams to co-ordinate across existing services to produce the best package of care for individual patients
- Reduce presentations at A&E by responding to patients needs proactively
- Reduce emergency admissions by ensuring the most appropriate package of care is provided and communicated to patients within a community setting
- Review and re-design services to provide an integrated, efficient and responsive intermediate care service.

The patient cohort targeted in this scheme will be primarily older people (over 65s) and people with multiple long terms conditions

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners include Lancashire North CCG and Lancashire County Council.

Providers include:

- Community Integrated Care
- Blackpool Teaching Hospitals Foundation Trust
- University Hospitals Morecambe Bay Foundation Trust
- Stroke Association
- Four Seasons Health Care
- Lancashire County Commercial Group

The evidence base

Please reference the evidence base which you have drawn on

to support the selection and design of this scheme

to drive assumptions about impact and outcomes

The Morecambe Bay Better Care Together Strategy, volume 2, version 5.0, 22nd August 014, provides clear rationale and option appraisals as to the overarching vison of which the BCF schemes are a sub-set.

UK evidence

The overarching vision and the principles of the Better Care Fund align with the **NSF for long term conditions**[7]. That is, to improve health outcomes for people with long term conditions by providing personalised care plans, reduce emergency admissions, improved care in primary care and community settings, improve access to services. The NSF provides strong underpinning for the focus on this scheme:

- The number of people over the age of 80 is set to increase by almost a half with those over 90 doubling in the same period.
- Older people tend to have a much greater need for health and social services, so the bulk of health and social care resources are directed at their needs.
- Almost two thirds of general and acute hospital beds are used by people over 65.
- Conditions prevalent among older people are stroke, falls and mental health as stroke, falls and mental health (including dementia and depression).

Other relevant metrics:

- Around 63% of older people permanently entering nursing home care and around 43% of those entering residential care homes come direct from hospital.
- Around 30% of patients die in the first month after a stroke, most in the first ten days. Although after a year, 65% of surviving stroke patients can live independently, 35% are significantly disabled and many need considerable help with daily tasks or visits from a district nurse. Around 5% are admitted to long-term residential care
- Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK, accounting for over 400,000 A&E attendances
- Up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture

7 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf

Academic Research

- The Kings Fund summit and subsequent report „The Care of Frail Older People with Complex Needs: Time for a revolution‟ 2012 concluded that a revolution is needed in the care and treatment of older people.
- Care Closer to Home – University of Cumbria Review 2010. The objective is ultimately to deliver a more integrated service. Key to its success is to address the whole health economy with local priorities defined to maximise the strategic benefits.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Project	Total Investment (£000)
CRISIS	£211,000
Transitional Care Pathway	£1,258,000
Alcohol Liaison	£126,000
Stroke ESD	£419,000
Ripley Suite	£500,000
Therapy staff	£566,000
Residential rehab	£580,000
Falls	£185,000
Total	**£3,845,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Delayed transfers of care	☑
Patient experience: Proportion of people feeling support to manage their LTC	☑

The out of hospital model is expected to achieve **1.8% reduction in non-elective admissions** in year 1 and a reduction in delayed transfers of care of 1.8% in year 1. Detailed activity forecasts are attached outlining the 1 – 5 year impact.

This scheme is expected to achieve 43% of the target reduction, calculated as follows:

Metric	Target reduction
Reduction in emergency admissions	146
Reduction in delayed transfers of care	80

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Board who will manage project development, performance against activity / impact trajectories, risks and mitigation plans and evaluation and outcomes.

In addition to this each individual scheme has key expected outcomes in the form of KPIs which are monitored regularly in line with contractual requirements.

Detailed formal reviews are planned as part of the transformation programme to ensure maximum efficiency and integration across health and social care to deliver an effective out of hospital model.


Community Therapy Case Study.docx


LTCT Case Study 2.docx


LTCT Case Study.docx


Rapid Response Case Study.docx


Stroke Case Study.docx

What are the key success factors for implementation of this scheme?

The key success factors for this scheme are tabled below:

Inter-dependency	Outputs required	Effect on Delivery
IT	Estates strategy will need to deliver integration for understanding real time demand / capacity and sharing patient information. There may also be a requirement for a solution to deliver digital health virtually.	Critical for the overall transformation Not critical for current service provision
Workforce	Re-alignment of existing workforce for services that are currently in operation but which may be re-designed.	Critical for the overall transformation Not critical for current service provision
OD	Engagement from all staff across the health economy to deliver this – organisational change strategy.	Required
Engagement	Continued partnership working	Critical

Scheme ref no.
BCF18

Scheme name
Self-care (Lancashire North CCG)
What is the strategic objective of this scheme?

This scheme is one of the Lancashire North CCG BCF schemes which are a sub-set of a larger health economy transformation programme called Better Care Together. The **Self Care scheme** contributes to the following strategic objectives of the Better Care Together programme:

- To design and implement new integrated models of care across the local health economy
- To design and implement a system which recognises the specific geographic and demographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times
- To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable
- To enable the development of a flexible, integrated and productive workforce across our health economy.
- To design and implement a future healthcare system for our area that makes best use of the money and resources available

The Out of Hospital Model for Better Care Together recognises the importance of empowering the population:

- to take action to care for themselves, their children, their families and others to stay fit and maintain good physical and mental health,
- meet their social and psychological needs, prevent illness or accidents,
- care for minor ailments and long term conditions,
- maintain health and wellbeing after an acute illness or discharge from hospital.

This is termed **"self-care"** and is an integral part of both in and out of hospital care. The self-

care scheme will:

- Reduce avoidable emergency admissions

- Reduce people's dependence on health professionals and increasing their sense of control and wellbeing

- Equip clinicians and other health care professionals and staff to support and enable the general population and patients to self-care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Help Direct is designed to help people get the right practical support or the right information and advice they need before a small problem becomes a crisis. The service is aimed at people who want more practical, everyday type of support to help them get the most out of fe and supports people to make their own choices and decisions about what works for them.

This scheme puts Help Direct advisors within a general practice setting to:

- Work with General Practice to identify people who are in need of further help and support to prevent a problem becoming a crisis
- Work with people who are at risk of becoming isolated and marginalised
- Act as a conduit into further social care services for patients
- Coordinate health and social issues by assisting the patient on a one to one level
- Act as a support mechanism for practice staff for a whole range of social care issues allowing staff to concentrate on more conventional health needs of their patients
- Help people gain confidence and make a contribution to their local community, for example through volunteering or through time-banks. These could either be the long term unemployed or those on incapacity benefit
- Increase take-up of referrals to Help Direct
- Provide greater added value for services offered to patients within the practice
- Save GP time by targeting patients with long term health issues or low level mental health problems. Clients can be referred to specialist support services which could reduce the number of GP appointments
- Provide easier access to Help Direct as face to face appointments are available in a location that is convenient and familiar to the patient

The **Help Direct GP Advisors are a key success criteria, in the context of the Better Care Together transformation programme** through:

- Increased capacity, confidence and efficacy of individuals to self-care

- A Change in the behaviour of the general population in relation to the way they use health care services.
- A change in the behaviour of the health care economy in how they empower patients to care for themselves.
- To develop and deliver effective, integrated self-care support services that will offer the public appropriate support, largely provided by the community and voluntary sectors, and reduce reliance on mainstream NHS services.
- Improve the health and wellbeing of the population.
- Reduce presentations at A&E by responding to patients needs proactively

The patient cohort is primarily patients with one or more long term conditions within Lancs North CCG population.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners include:

- Lancashire North CCG
- Lancashire County Council.

The **provider** is Age UK.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Morecambe Bay Better Care Together Strategy, volume 2, version 5.0, 22nd August 014, provides clear rationale and option appraisals as to the overarching vison of which the BCF schemes are a sub-set. Other project specific examples include:

- In England and Wales, **the King's Fund** has stipulated the provision of active support for self-care, followed by a focus on primary and secondary prevention, as the top three priorities for NHS commissioners. Involving patients and carers more fully in managing their own health and care is one of six underlying objectives in NHS England's call to action for general practice.
- The King's Fund also identifies ten priorities for commissioners with active support

for self-management[8] being number one. Self-management support can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours: and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership (de Silva 2011). (Help Direct meets both those definitions). The reason self-management is so important is because:

- Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years (Department of Health 2011c).
- People with long-term conditions are the most frequent users of health care services, accounting for 50% of all GP appointments and 70% of all inpatient bed days.
- Treatment and care of those with long-term conditions accounts for 70% of the primary and acute care budget in England (Department of Health 2011c).
- At the heart of the chronic disease management model (Wagner *et al* 1996) is the informed, empowered patient with access to continuous self-management support.
- Around 70-80% of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).

The impact of self-management has the potential to improved health outcomes, the patient experience, improve adherence to treatment and medication (Challis et al 2010) and reduced unplanned hospital admissions (Purdy 2010). Evidence that this translates into cost savings is more equivocal although a cost analysis performed in the United States indicated expenditure in other parts of the system can be reduced (Stearns el al 2000).

- Recent work conducted by the Richmond Group of Charities and The King's Fund (2012) called for patients to be offered the opportunity to co-create a personalised self-management plan which could include the following:
  - patient and carer education programmes
  - medicines management advice and support
  - advice and support about diet and exercise
  - use of telecare and telehealth to aid self-monitoring
  - psychological interventions (e.g., coaching)
  - telephone-based health coaching
  - pain management
  - patient access to their own records.

Most of these points are covered within this proposed Self-Care scheme.

- The NHS Constitution enshrines the patient's responsibility to play a more active role in care and to lead informed decision-making around their health. As such, the home, rather than the surgery, should become the default place for care. Home permits patients the immediacy and convenience of care, in a safe environment that allows them to develop their confidence in self-care, whilst being fully aware that their healthcare professional remains available for advice when it is required.
- Help Direct uses the principles of Telehealth and Telecare in giving patients information and support about their conditions and minor ailments but in a face to

[8] http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/self-management

face settings as opposed to a solely technological solutions. The Department of Health's Whole System Demonstrator Programme[9] advocates patient involvement in their own care thus the need for access to information about their conditions. The first set of initial findings from this complex trial show that, if delivered properly, telehealth can substantially reduce mortality, reduce the need for admission to hospital, lower the number of bed days spent in hospital and reduce the time spent in A&E. The study itself took at least a year's worth of data that was then evaluated by six major academic institutions under five themes (service utilisation, participant reported outcomes such as quality of life; cost effectiveness; user and professionals‟ experience; and influence of organisational factors to adoption). The early indications show that if used correctly telehealth can deliver a 15% reduction in A&E visits, a 20% reduction in emergency admissions, a 14% reduction in elective admissions, a 14% reduction in bed days and an 8% reduction in tariff costs. More strikingly they also demonstrate a 45% reduction in mortality rates.

- Systematic application of strategies which involve patients, their families and communities more directly in the management of long term health conditions. These savings represent a 7% reduction in spending in terms of reduced A&E attendances, planned and unplanned admissions, and outpatient admissions.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment = £43,320

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
patient experience: Proportion of people feeling support to manage their LTC	☑

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215264/dh_131689.pdf

The Self Care BCF scheme is a sub-set of the overarching North Lancashire CCG transformation strategy. The out of hospital model is expected to achieve 1.8% reduction in on-elective admissions in year 1 and a 1.8% reduction in delayed transfers of care in year 1.

The Self-care scheme is not directly attributable to a reduction in emergency admissions or reduction in delayed transfers of care. It is, however, part of an holistic whole system approach and is expected to deliver the following added benefits / outcomes:

- Decrease the number of visits to GP practices for minor ailments
- Decrease the number of visits to A&E for inappropriate visits
- Increase the number of patients who feel able to make decisions about their health and care
- Increase the use of community based pharmacy services
- Better symptom management
- Improved quality of life
- Decrease prescribing of over the counter medication
- Improved patient experience
- More effective use of consultations
- Improved social capital and community cohesion
- Improved community health knowledge i.e. better health literacy
- Increased number of consultations using Shared Decision Making
- Increased use of self-care programmes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are formal governance arrangements in place through the transformation programme board who will manage project development, performance against activity / impact trajectories, risks and mitigation plans and evaluation and outcomes.

In addition to this the scheme has key expected outcomes which are monitored regularly including the impact on the use of GP and clinical service time as a result of the intervention qualitative data assessing the impact and experiences of service users is also collected and assessed.

Detailed formal reviews are planned as part of the transformation programme to ensure maximum efficiency and integration across health and social care to deliver an effective out of hospital model.

What are the key success factors for implementation of this scheme?

The key success factors of this scheme are:

Inter-dependency	Outputs required	Effect on Delivery
Organisational Development	As self-care is a behaviour change approach then an investment in change management will be required.	Required
Communication and engagement	Health education programmes Continued partnership working	Critical
Workforce	There will need to be a focus on training staff to encourage the use of assistive technologies, access to community support, self-care and to ensure they can guide patients to the relevant services available to them. • Consideration must be given to capacity for staff to have on-going training and interaction with the relevant professionals so their skills are gained, maintained and updated – this needs to include self-care training and awareness along with Every Contact counts. • General training should be provided to current staff and integrated into training and	Critical

	induction programmes to ensure they a) know how they fit into the integrated health and social care model and b) are able to provide guidance to patients on accessing the variety of support and services available to them.		
IT	▪ To support the Help Direct model, Web-based signposting and resource provision to encourage self-care: ▪ Ability to provide users with information online, to encourage self-support without dependency on care services ▪ Ability to provide users with an inventory of all community assets (e.g. hospitals, clinics, third sector activities) with a Directory of Community Assets ▪ Development of mobile technology e.g. apps ▪ telehealth	Critical	

Scheme ref no.
BCF19
Scheme name
Community Specialist Services (Lancashire North CCG)
What is the strategic objective of this scheme?
This scheme is one of the Lancashire North CCG BCF schemes which are a sub-set of a larger health economy transformation programme called Better Care Together. The **Community Specialist Services scheme** contributes to the following strategic objectives of the Better Care Together programme:

- To design and implement new integrated models of care across the local health economy
- To design and implement a system which recognises the specific geographic and demographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times
- To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable
- To enable the development of a flexible, integrated and productive workforce across our health economy.
- To design and implement a future healthcare system for our area that makes best use of the money and resources available

Community specialist services will have two roles within the Out of Hospital Model;

- to provide **specialist support** to the core teams in the planned management of patients
- to provide **fast access** to support if a patient's condition deteriorates, to stabilise their health and **prevent avoidable admissions** to hospital.

These services are key to the functioning of the out of hospital model and provide the specialist expertise to complement the more generalist knowledge of the core team in supporting the overall health of the population.

his scheme will see the start of a change to a more community focused provision supporting patients where they live and undertake their daily lives so that expertise is provided more in context with the patient's situation. There will also be a significant focus on supporting:

- and interacting with the health care professional who understands the patient's wider context
- the patient to become an "expert" in their own situation and management.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The **Community Specialist Services** has a number of **specific services** which support

delivery of the **Out of Hospital Care Model**. They are:

- **Dementia Support & Outreach Service: Providing in-home support**. This is provided flexibly in terms of times and duration and is integrated with the household's daily rhythms of life so the:
  - Carer's lifestyle is supported and they are supported in maintaining their community presence and social networks.
  - people living with dementia are supported with the development or maintenance of social networks, daily living skills, and the enjoyment of life.
  - Networking with other services to support these groups of people in maintaining their independence in the community is provided.

The service provider will promote access to support services for people living with dementia who may be hard to reach or reluctant to seek or accept advice or support.

- **Dementia Advisors: Providing personalised information, advice and signposting services** to people in the process of getting a diagnosis or from diagnosis of dementia onwards. This will include:
  - accurate, accessible information to help people with dementia make informed decisions
  - a point of contact for all information and advice
  - signposting and where appropriate referral or signposting to one-to-one dementia support, peer support, and education services.

The service should aim to maintain and develop abilities and work directly with the person with dementia to promote independence and enable people with dementia to remain active and social citizens.

- **Solutions Plus: Supporting people aged over 16 with mental health needs within the community to promote recovery, wellbeing and greater independence.**

The service provides a range of mental health day time support in partnership with a wide range of agencies and community groups which help individuals develop their:

- own personal strengths
  - coping abilities,
  - social networks
- natural support systems

The service supports anyone over 16 who is:

- In need of support and guidance

- At risk of social isolation
- At risk of developing mental health problems
- Recovering from severe mental health problems

Service users have an allocated care–coordinator to support them for a time limited period to achieve their goals; and (FACS Eligible) long term support which provides service users with access to a range of specialist services designed to meet their needs such as employment and volunteering.

- **Care Homes Team Service is a multi-disciplinary team with skills specifically combined to provide support and advice to Care Home providers to address specific health needs e.g. wound management, continence, therapy and falls assessment**.

The team will work together in a co-ordinated way to provide a first point of contact for staff in Care Homes that require support and advice about the care of their residents. The team will offer advice, triage and face to face assessment as a first response, they will not routinely provide direct care, it is accepted that it is the care homes responsibility and wish to provide he care to the patient as stipulated under their CQC registration. The team may support the staff by:

- Providing advice about the development of specific care plans
- demonstrating techniques to support delivery of the specific care plans
- providing advice about the development of written guidelines,
- attending review meetings and joint visits with other professionals.

The team will develop relationships with all care homes with nursing in the Lancashire North area, undertake the aspects set out above to assist Care Homes with nursing care requirements to support the identification and planning for residents whose needs are changing and may need to facilitate a transition into a Care Home with nursing care provision.

These key services form part of the wider Community Specialist Services workstream within the Better Care Together Transformation Programme). The workstream will increase opportunities to:

- significantly reduce the amount of unnecessary hospital outpatient activity
- reduce avoidable non-elective admissions by increasing access when deterioration occurs

In order to fully realise the benefits from the workstream **Specialist Community Services will need to be developed to meet the local demographics,** for example, an area with a high prevalence of diabetes as opposed to COPD may have a co-located diabetes team. It

is likely that the first Community Specialist Services to be reviewed will be:

- Respiratory;
- Cardiology;
- Orthopaedic MSK;
- Palliative care; and
- Rehabilitation and Therapies.

As each pathway is developed it will need to include an end to end approach from prevention through to end of life care where appropriate and each specialist service will need to be considered within that context. For each of the areas agreed upon a separate sub-project will be developed.

The Community Specialist Services overall will:

- Improve quality of life for patients and their families through more focused use of specialist advice.
- Enable patients of all ages to have greater control over care plans, more managed personalised care and support delivery of improved health outcomes
- Help ensure a more joined-up approach amongst staff as they work together in integrated teams
- Empower clinicians to take overarching responsibility for the care aims of their designated demographic in their speciality.
- Enable healthcare professionals to be actively involved in the training and support of other professionals.
- Reduce the number of hospital outpatient appointments particularly in the number of follow up hospital outpatient appointments where appointments do not add value
- Support better planning of care, thus less „crisis management", reduced A&E attendances and emergency admissions with a reduction in anxiety that this causes for patients and their families.
- Reduction in patients revolving between acute and primary care and not finding resolution to their need
- Greater job satisfaction and more satisfying roles for staff, resulting in improvements in recruitment and retention of staff.

The patient cohort targeted in this scheme will be primarily older people with one or more LTCs, dementia, and people aged 16 and over with mental health needs.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and

providers involved
Commissioners include: • Lancashire North CCG • Lancashire County Council. The providers are: • Alzheimer's Society • Creative Solutions • Blackpool Teaching Hospitals NHS Foundation Trust
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The Morecambe Bay Better Care Together Strategy, volume 2, version 5.0, 22nd August 014, provides clear rationale and option appraisals as to the overarching vison of which the BCF schemes are a sub-set. Other project specific examples include: The **NSF for older people**[10] document defines the service of care for older people. It notes that, currently, over 20% of the population is over 60 and that between 1995 and 2025, the number of people over the age of 80 is set to increase by almost a half with those over 90 doubling in the same period. It states that older people tend to have a much greater need for health and social services than the young, so the bulk of health and social care resources are directed at their needs. For example, almost two thirds of general and acute hospital beds are used by people over 65. It determines the conditions prevalent among older people as stroke, falls and mental health (including dementia and depression). **Everybody's Business**[11] is a set of free e-learning material about the mental health of children and young people. It is aimed at people who work with children, young people and their families who are not mental health professionals. Everybody's Business was commissioned & funded by the National CAMHS Support Service (NCSS) and developed by a number of trainers across the country, originally in 2006 and then re-launched in 2009. These tools will be an integral part of our **Solutions Plus** module.

10 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

11 http://learning.camhs.org.uk/

Dementia – Supporting people with dementia and their carers in health and social care[12] produced by NICE state that dementia is associated with complex needs and, especially in the later stages, high levels of dependency and morbidity. These care needs often challenge the skills and capacity of carers and services. As the condition progresses, people with dementia can present carers and social care staff with complex problems including aggressive behaviour, restlessness and wandering, eating problems, incontinence, delusions and hallucinations, and mobility difficulties that can lead to falls and fractures. This NICE guideline offers best-practice advice on the care of people with dementia and on support for their carers. There is broad consensus that the principles of person-centred care underpin good practice in the field of dementia care and they are reflected in many of the recommendations made. The principles assert:

- the human value of people with dementia, regardless of age or cognitive impairment, and those who care for them
- the individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia
- the importance of the perspective of the person with dementia
- the importance of relationships and interactions with others to the person with dementia, and their potential for promoting well-being.

Living well with dementia – a national dementia strategy[13] produced by the Department of Health state that recent reports and research has highlighted the shortcomings in the current provision of dementia services in the UK. Dementia presents a huge challenge to society since:

- There are currently 700,000 people in the UK with dementia, 570,000 of whom live in England.
- Dementia costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

The strategy covers 17 key objectives including improving awareness and understanding, providing good quality early diagnosis and care, developing structured peer support and learning networks, improving community personal support services and support for care homes in managing residents with dementia.

The Department of Health produced **Quality Outcomes for people with dementia: building on the work of the National Dementia Strategy**[14]. It states that although dementia is primarily associated with older people, there are also a significant number of people (around
15,000) who develop dementia earlier in life. The direct cost of dementia to the NHS and Social Care is estimated at £8.2bn annually.

[12] https://www.nice.org.uk/guidance/cg42/resources/guidance-dementia-pdf
[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf
[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213811/dh_119828.pdf

Integrated whole system services for people with dementia at Mersey Care NHS Trust: By redistributing resources from acute care settings to locally-based and home-based services, the study aimed to keep people with dementia independent for longer and, where they require hospital treatments, to get them back into the community as swiftly and as well prepared for independent life as possible. The literature suggests a 40% reduction of both elective and non-elective inpatient admission for dementia.

The Prime Ministers Challenge Fund[15].

Nationally there is evidence that care home providers would appreciate more support in terms of contact with Primary and Community Care services when they need it for individual patients, particularly to deal with difficult clinical situations. This might be at the end of a patient's life, when they have wound problems, falls or nutritional problems. It is at these times that patients often end up in hospital because the care home cannot obtain the support it needs.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Project	Total Investment
Dementia Carer Support	**£9,000**
Dementia Advisors	**£70,000**
Solutions Plus	**£48,000**
Care Homes	**£500,000**
Better Care Together Development	**£2,139,000**
Total	**£2,766,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in

[15] http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑
Delayed transfers of care	☑
patient experience: Proportion of people feeling support to manage their LTC	☑

This BCF scheme is a sub-set of the overarching North Lancs CCG transformation strategy. The out of hospital model is expected to achieve **1.8% reduction in non-elective admissions** in year 1 and a reduction in delayed transfers of care of 1.8% in year 1. Detailed activity forecasts are attached outlining the 1 – 5 year impact.

This scheme is expected to achieve 29% of the target reduction, calculated as follows:

Metric	Target reduction
Reduction in emergency admissions	95
Reduction in delayed transfers of care	54

Some of the other benefits of Community Specialist Services include:

- Patient / carer experience survey as part of care planning review showing higher satisfaction rates;
- Reduction in A&E attendances rate compared to peers;
- Admission rates for long term conditions reduced; and
- Reduction in outpatient appointments and follow up appointments compared to peers.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are formal governance arrangements in place through the transformation programme

board who will manage project development, performance against activity / impact trajectories, risks and mitigation plans and evaluation and outcomes.

In addition to this each individual scheme has key expected outcomes in the form of KPIs which are monitored regularly in line with contractual requirements.

Detailed formal reviews are planned as part of the transformation programme to ensure maximum efficiency and integration across health and social care to deliver an effective out of hospital model.

What are the key success factors for implementation of this scheme?

The key success factors for this scheme are tabled below:

Inter-dependency	Outputs required	effect on Delivery
IT	IT strategy will need to deliver integration for understanding real time demand / capacity and sharing patient information. There may also be a requirement for a solution to deliver digital health virtually.	Critical for overall transformation, not critical for this scheme
Engagement	Continued partnership working	Critical
Pathways work stream	The re-design of specific pathways in different tranches to effectively move care out of the acute trust.	Critical

Scheme ref no.

BCF20

Scheme name

Lancashire Integrated Neighbourhood / Care Teams

(relevant to Greater Preston CCG, Chorley & South Ribble CCCG, Fylde & Wyre CCG,

Lancashire North and East Lancashire CCGs)

What is the strategic objective of this scheme?

This scheme will provide a new model of care, which coordinates the activities of health, social care and voluntary sector partners around the needs of some of our most complex patients:

- Provide integrated care for which is best suited to each locality and neighbourhood
- Increase patient satisfaction levels by providing community based care which is tailored to meet their needs
- Increase staff satisfaction levels through training/education and provision of autonomy to deliver the care required within that neighbourhood and at an individual patient level
- Reduce non-elective and emergency admissions to acute care
- Promote health and wellbeing through a focus on self-care and self-support
- Deliver effective processes to identify individuals who will most benefit from earlier intervention as well as those requiring support from health and social care services
- Build our existing multi-disciplinary work so that care reviews take place regularly and systematically
- Support the improved use of community resources
- Workforce development/skill mix (new types of worker)
- Working with care homes and domiciliary care to build capacity and skills (these mainly independent sector organisations support the most complex people and if not part of the 'system' will potentially be the weak link that leads to the high levels of unscheduled admissions).
- Potential to build preventative and wellbeing services into INT's

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Model of care and support

This scheme will see the establishment of case managed, multi-disciplinary teams based on GP practice populations, utilising risk stratification. Initially our focus will be on those deemed most at risk of hospital admission, including those with long-term conditions and frail, elderly people.

The key elements of the model

- Utilising **risk stratification** tools and local knowledge to identify high risk patients
- Regular **Integrated Care Team Meetings**, which facilitate the sharing of knowledge of patients and identify the most suitable approach to patient care.
- **Case managers** will work with individuals, their carers and other health and social care professionals to develop or review personalised care plans.
- Case managers will have responsibility for **planning, monitoring and anticipating** the changing needs of these individuals, and coordinating their care across all parts of the health and social care system.

Working in an integrated way across the system

- Work in **partnership with Secondary Care, NWAS, GPs and the voluntary** Sector to help prevent hospital admissions
- Integrating with **Connect 4 Life** type of schemes, which are the basis of the integrated wellness service currently being procured by LCC which will align with integrated care teams.
- Embed **strong links with the local community** to promote and develop self-care and independence, the identification and support of carers and vulnerable Groups, and building on existing community assets.
- **Information sharing**/shared care plans
- Regular Integrated Care Team Meetings that will involve GP Practices.

Interdependencies

Target patient cohorts

- The model currently being implemented supports citizens with long-term conditions including the frail elderly.
- In year 1, this will particularly focus on those deemed most at risk of hospital admission, including those with long term conditions, mental health problems,

substance misusers and the frail, elderly populations.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery chain comprises CCG level governance and engagement, involving providers and commissioners. Sitting above that is the BCF

Commissioners	Providers
Lancashire County Council	Lancashire County Council Adult Social Services
Greater Preston / Chorley & South Ribble CCG	66 GP practices Lancashire Care Trust
Fylde & Wyre CCG	1 GP practices, organised into four neighbourhoods (each having an integrated care team) Blackpool Teaching Hospitals Trust Ncompass NWAS FCMS (OOH and care co-ord) Red Cross Chloe Care Lancashire County Council
East Lancashire CCG	64 GP Practices East Lancashire Hospitals Trust (community provider) East Lancashire Hospitals Trust

	Acute provider) Lancashire Care Foundation Trust (Primary Care Mental Health and Memory Assessment Services) Lancashire County Council (Adult Social Care) Lancashire County Council (Public Health) Age UK
Lancashire North CCG	Blackpool Teaching Hospitals FT HS England are also commissioners of GP practices 13 GP practices
Districts Councils are also important partners in the development of neighbourhood models of care	

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In developing this scheme we have taken into account international best practice, UK exemplars, academic research and the local Lancashire context.

International best practice

There is a growing body of international evidence, systematically analysed by Richardson nd Dorling. Their findings from 34 systematic reviews of integrated care published in the last 10 years, included:

- 81% (13 of 16 reviews) assessed MDTs and found a positive impact
- All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalization
- Hospitalisations reduced by 15- 30% (inter-quartile range)

The Buurtzorg service in particular has established some critical principles for delivery of integrated community care services:

- Small teams comprising generalist professionals
- The service is provided to small discrete communities
- The promotion of self-care is central to the service delivery model

- Strong focus on maximising the time spent caring for individual patients
- Integrated communication systems
- Total staff autonomy

The service outcomes included far greater patient satisfaction, lower overhead costs, reduced sickness rates and staff turnover.

UK exemplars

- Inner North West London Integrated Care Pilot have shown that patients who had a care plan reported improved access to NHS services (64%), that they now had to spend less time booking appointments to see their GP and other health professionals (55%), and that health care staff asked them fewer questions about their medical history (67%).
- In South Devon and Torbay the introduction of integrated care teams has led to over 50% reduction in occupied beds over 11 years, emergency bed day use in the population aged 65 and over is the lowest in the region and emergency bed day use for people aged 75 and over fell by 24 per cent between 2003 and 2008 and by 32 per cent for people aged 85 and over in the same period.
- Learning and information has been taken from the 14 National Integrated Care Pioneer, including:
  - Greenwich – Focus on prevention, early identification and care coordination. In the first year of integrated services there was a 35% reduction in care home admissions
  - South Tyneside – Plans to transform the local care and support system organised around the needs of individuals.
  - Waltham Forest, East London and City – Putting the patient in control of their health and wellbeing, with a focus on reducing hospital admissions.

Academic research

- Research by Ross et all 2011, states that case management works best as part of a wider programme to integrate care, including good access to primary care services, supporting health promotion and primary prevention, and co-ordinating
- community-based packages for rehabilitation and re-ablement (Challis and Hughes no date; Ross et al 2011; Goodwin et al 2012)

Local Context

- Compared to the England average, Lancashire has a higher proportion of people in

all age bands above 50 years old. Between 2014 and 2021, all eight of Lancashire's CCGs will see growth of at least 13% in their populations aged 70 or over.

- Three of the six CCGs are in the bottom 25% in England for percentage of people with 3 or more Long-Term Conditions, and all are below the England average.
- 5 CCGs are above the England average for both unplanned hospitalisation for chronic ambulatory care sensitive conditions and Emergency admissions for acute conditions that should not usually require hospital admission

DN: is there anything relevant from any patient surveys we could add in here

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Greater Preston / Chorley & South Ribble - £9,267,000

Fylde & Wyre - £1,791,000

East Lancashire – £1,200,000

Lancashire North – £720,000

West Lancashire - £ 156,000

TOTAL = £13,134,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	
Emergency admissions	☑

Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delay transfers of care	☑
Estimated Diagnosis Rate for Dementia	☑
patient experience: Proportion of people feeling support to manage their LTC	☑

The **total quantified benefit** from this scheme across Lancashire is calculated as:

- 114 fewer delayed transfers of care compared to the prior year
- A reduction of 533 non-elective admissions in 2015/16

The key qualitative benefits are:

- Improved integration of services across primary, community and secondary care.
- More informed decision making re: long term care planning couple with holistic provision of care
- Improved communication between providers of care
- Eliminate duplication of services and better use of scarce resources
- More appropriate referrals resulting in service users receiving the most suitable care to meet their needs
- Improved patient experience through patient self-care and involvement in managing own health needs.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are three key components for monitoring the impact of the scheme:

<u>Governance</u>

- Overall progress will be monitored through local governance, senior management and executive structures at each CCG locality.

- These structures include provider, commissioner and wider stakeholder representation and report into the BCF governance across the county, including to the Lancashire Health and Wellbeing Board.
- A programme approach will be taken to ensure effective management of performance, risks and mitigation plans in accordance with the agreed evaluation and outcome measures.

Bespoke data collection and analysis

- We will Implement routine patient satisfaction surveying from GP Practices to enable the capture and tracking of the experience of care, assessing in particular:
  - Increase in contacts dealt with positively near or at point of contact
  - Increase in self-reported wellbeing and quality of life
  - Reducing depression and isolation

- Robust performance management framework of associated contracts, which will measure benefits at a neighbourhood, practice and patient level.
- We will establish a mechanism by which we will track hospital admission and GP attendances for each patient who goes through the Integrated Care Team Meeting process.
- We will also work to monitor patients through weekly clinical Integrated Care Team Meetings and ensure that data is recorded accurately and collectively monitored.

Analysis of routinely collected data

The following information which is collected under existing processes will also be used to appraise the impact of the scheme:

- Admissions to hospital and re-admissions to hospital within 30 days
- Emergency admissions to hospitals for conditions not usually requiring hospital care
- For those in receipt of reablement, % reduction in hours support required
- Closing the life expectancy and inequality gaps that exist in the borough

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme are:

- Implementation of appropriate 7 days services
- Training and upskilling of the workforce, empowering them to make decisions locally about care provided
- Commitment to collaborative working between commissioning and provider organisations
- A commitment from all providers of care to operate across organisational boundaries
- Risk profiling is implemented and data can be linked across disparate systems to facilitate sharing of patient information
- Appropriate information governance in place
- Strong engagement from patients, public and staff
- Linkages with other elements of transformation programmes including Intermediate Care, discharge schemes
- Developing an effective IT infrastructure supporting the single assessment process, specialist assessment and care planning across both acute and community services.

Scheme ref no.
BCF21
Scheme name
Facing the Future Together
What is the strategic objective of this scheme?
The strategic objective of this scheme is to implement a whole systems approach to integrated care in West Lancashire through a number of coordinated initiatives to meet the strategic objectives of providing high quality care that: • Adds value for patients (defined as quality outcome per £ spent) • Supports GPs as providers and commissioners • Improves population health • Reduces avoidable non-elective admissions The achievement of these strategic objectives requires Clinical and Service integration. This

means:

- Co-ordinating care for individual service users and carers
- Supporting more integrated working with primary care by organising community services around GP practices and population
- Working jointly with social care
- Transforming communication between GPs, specialists and generic services
- Collaborating with other healthcare providers
- Measuring outcomes and costs and making this information widely available
- Providing comprehensive disease management and preventive services to our population, including the promotion of self-care
- VCFS and community assets utilised to best efforts

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Our vision is to ensure the best possible care and health outcomes for our population and to empower our population to be in control of their own health.

Our model of Integrated care, as set out in our clinical commissioning strategy and shown in Figure 1, is based on a whole system approach with the outcome being to provide high quality care to whole populations with an initial focus on older people and people with multiple long terms conditions.

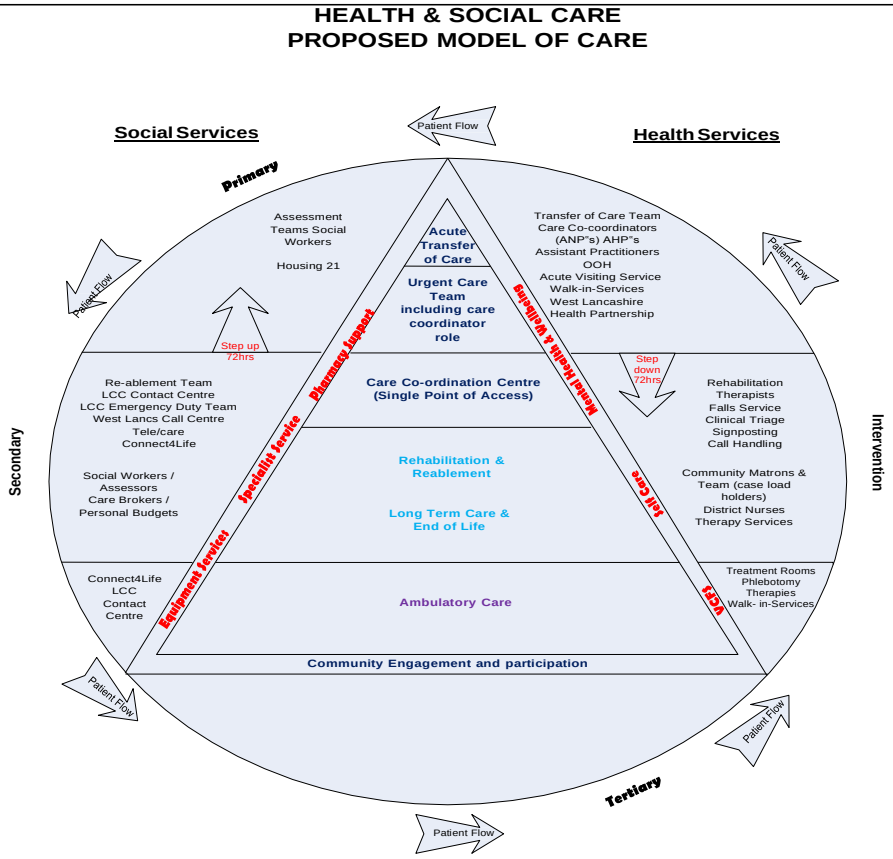


Figure 1: Facing the Future Together Health and Social Care: Model of Care

The model of integrated care we will commission should:

- Deliver continuity of care, smoothing transitions between care settings, aligning adult social care to health teams to support integration and co-ordinated care and providing services that are responsive to patients needs
- Provide proactive management of population health through a system wide approach to data sharing and population stratification, which will enable targeting of services to the populations and areas of greatest need;
- Be delivered through five neighbourhood teams working in local GP practices in an integrated health and social care infrastructure, supported by our community assets. This will bring together existing components in primary, community, social and acute care into one comprehensive framework
- Focus all parts of system together on admission avoidance to hospital and or residential care, early supported discharge and care outside of hospital

The component parts of the model of care are:

- Single point of access / care co-ordination
- Neighbourhood generic and complex care teams
- Dedicated hospital transfer of care team (discharge)
- Urgent care services

- Access to timely consultant option and community geriatrician support
- Improved community management of ambulatory care sensitive conditions
- Extended treatment room services

as previously articulated, the patient cohort targeted in this scheme will be older people (over 65s) and people with multiple long terms conditions (Phase 1 of the Facing the Future Together Programme)).

The difference this will mean for a patient within the cohort is shown below:

Barry's story

What happens now?

Barry is a 65 year old father of two from Skelmersdale. He is a smoker and can easily get through 30 cigarettes a day. He has a bad chest but puts it down to a bit of a smoker's cough and none of his friends or family have ever said anything about it. He's noticed a bit of chest pain walking upstairs recently but, despite its reoccurrence, he dismisses it straight away as some kind of indigestion after a couple of pints down his local the night before. He lives within a minute's walk of his GP but he doesn't like to bother him unless he is „really ill". He can't even remember the last time he was there, but that's partly because every time he used to go he'd have to change shifts at work and lose money as a result. These days, if he needs anything he'll swing by the local A&E or walk-in centre.

For Barry, co-ordinated, person-centred care which promotes self-care means...

- Contributing to the design of services
- Easy access to information on services through an on-line portal
- Regular medicine reviews
- Access to social care and other disciplines, within one team- a team which works together and all know Barry's position. Barry came to their attention through a risk stratification exercise.
- That he is supported in self-care and confident in doing so
- He knows who is accountable for his care- his local GP. However, the GP works closely with the specialist at the local hospital to ensure Barry has specialist support, when needed.
- He receives the care he needs, in a clinic setting, near to his home
- He has a care plan

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

NHS West Lancashire CCG has a complex strategic position across a number of planning units and organisations, with our patient flows and provider network facing into Merseyside and our CCG network and collaboration, including BCF, facing into Lancashire. We have worked with our delivery chain partners through the design of the Facing the Future Together

Programme.

There is a particularly strong third sector presence in West Lancashire, which has informed the opportunity analysis in relation to the future care landscape. The Facing the Future programme draws all the key partners together to work towards whole system transformation. The commissioners and providers for this BCF scheme are:

Commissioners	Providers
Lancashire County Council	Adult Social Services 3rd sector providers
West Lancashire CCG	Southport & Ormskirk Hospital NHS Trust Lancashire Care NHS Foundation Trust 3rd sector providers
NHS England	GP practices

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is clear national policy direction for integrated care in the:

- NHS Constitution (Dept. of Health 2010)
- NHS Future Forum Report (2011)
- The NHS Five Year Forward View “High quality care for all, now and for future generations” (NHS England October 2014) which again confirms the move to integrated care and the increased importance of prevention and shift to out of hospital care.

Alongside this national policy direction the basis for this work largely comes from the national evidence base on the implementation of integrated care. We have used this to support selection and design of the scheme. The evidence supporting the scheme is primarily:

- Clinical and service integration: The route to improved outcomes. **The King's Fund** (Curry and Ham, 2010 ;). http://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf

- Accountable care organisations in the United States and England Testing, evaluating and learning what works. The Kings Fund (Aldicott, Walsh et al 2014) http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/accountable-care-organisations-united-states-england-shortell-mar14.pdf

- Principles for Integrated Care: **National Voices** (2011). http://www.nationalvoices.org.uk/principles-integrated-care

- An evaluation of the impact of community based interventions on hospital use: a case study of eight Partnership for Older People Projects (POPP). **The Nuffield Trust,** London (Steventon, A , Bardsley, M, Billlings, J, Georghiou, T, and Lewis, G. 2011)) http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/An-evaluation-of-the-impact-of-community-based-interventions-on-hospital-use-summary-Mar11.pdf

- Learning has also been taken from the following international and national, models of integrated care:
  - **Canterbury, New Zealand** – „right care, right place, right time by the right person"
  - **Torbay and Southern Devon Care Trust** - elderly care vertical pathway work
  - **Veterans Health Administration** - remote monitoring of patients
  - **Trafford PCT** - vertical integration of primary care, community services & social services
  - **Jonkoping, Sweden** - vertical and horizontal integration of health social and departments focusing on the wider determinants

The evidence indicates a number of key principles:

- Take a whole system approach to integration and organising clinical services around populations, for example older people and children, with definable sets of needs. The evidence discourages disease-based integration of services that "*just replace the old silos with the new silos"*
- Have collective accountability to engender integrated working and can lead to improved outcomes for patients.
- Define integrated care from the patient or service user's perspectives. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together.
- Care closer to home is better value for money - as well as being the preference of patients and carers, we also know that delivering care within the community, can be less costly and better value for money. Research from the Kings Fund suggests

care provided by community teams can reduce costs to £1 for every £1.20 being spent currently in acute settings.

- Creating a coherent service framework, that crosses organisations, with resources being shared, will reduce costs and improve patient experience. Examples from other areas show this to be the case with some organisation reporting extensive savings as a consequence (some suggest savings of up to 20%).

Applying the evidence to West Lancashire

A key part of our design process has been to use the wider national evidence base and assess applicability and alignment to our locality health and social care needs.

The five neighbourhood areas have different profiles as summarised in Figure 2 below. This local difference is addressed through the design of locality neighbourhood teams.

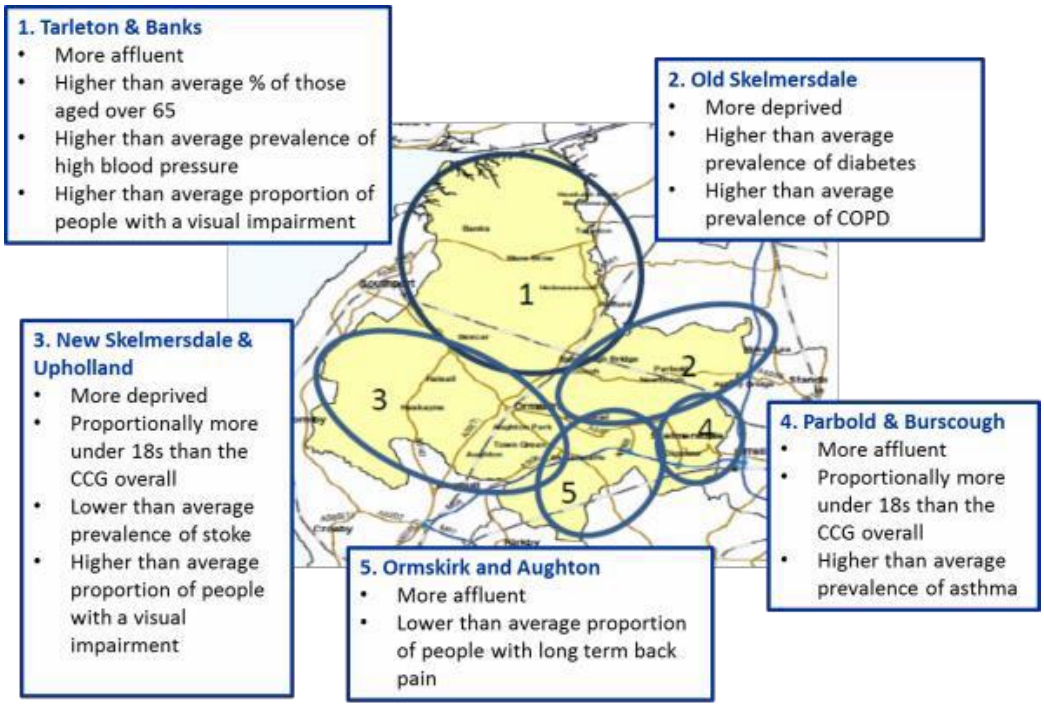


Figure 2: Facing the Future Together: Neighbourhood Profile summaries

Common to all areas are that West Lancashire population has:

- More 65 year olds compared to England where 16.7 % of the population are over 65 years old. The proportion of over 65s is set to rise to 27% of the population by 2035 for West Lancashire.
- A higher prevalence of dementia than the national average. Recent data shows West Lancashire has diagnosed 58% of the expected dementia prevalence and that there are approx. 126 patients missing from registers. Localities 2, 3 and 5 have the highest dementia rates compared to other localities.
- Most areas have over 17% of their population reporting living with a limiting illness, but that this increases to over 20% in areas of Skelmersdale and the North and West of West Lancashire.

There is also **variation** in the local rates of admission by neighbourhood, which is not aligned to disease prevalence. For example Locality 1 had the highest rate of unplanned admissions for respiratory conditions when compared with other localities and the CCG average. Locality 2 had significantly fewer admissions for Respiratory and Cardiac conditions than the CCG average, despite having high prevalence of asthma and average prevalence for CHD, Stroke and high blood pressure. This is illustrated in the following table:

13/14 FOT Crude Rate per 1000 under 65s

Practice	Respiratory NEL	Cardiac NEL	Digestive NEL
Locality 1	5.1	7.8	10.0
Locality 2	2.1	4.0	7.2
Locality 3	2.4	5.2	7.8
Locality 4	3.5	5.7	8.8
Locailty 5	4.5	7.4	10.6
WL CCG	3.3	5.9	8.7

Significant difference from CCG average

Using the evidence to develop the business case

Further local research and design has been undertaken with support from GE Finnamore. This has concluded that the integrated care model will release greatest benefits if it is geared specifically to target the reduction of avoidable non- elective admissions and on a whole system model of provision, with patient centred coordinated community and primary care, supported by the social and voluntary sectors.

Conclusions

Based on neighbourhood pilot models in other areas of country including North West London pioneer, which suggested 15% non-elective reductions. We have assumed 5% of the +65 age cohort in year 1, and this will then expand to wider non-elective baseline in year 2 and 3. The target we are eventually aiming for in the CCG is for each of the 5 neighbourhood teams to save at least 1 non elective admission per day:

Neighbourhood	Population	Age 65+	Age 75+	Reduction per Day NELs
Tarleton, Hesketh Bank and Banks	13,322	3,067	1,265	1
Burscough and Parbold	19,642	4,446	1,872	1
Ormskirk and Aughton	29,595	6,819	3,217	2
New Skelmersdale and Upholland	25,981	3,931	1,599	1.5
Old Skelmersdale and Beacon	23,406	3,947	1,701	1.5

This target will be achieved over 3 years so that the cumulative total of "avoided"

admissions will be at least 1752 by the end of 2017/18.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Total investment = £4,977,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme is expected to have a positive impact on the following BCF metrics:

Metrics	Facing the Future together Integrated Model of Care
Emergency admissions	☑
patient experience: Proportion of people feeling support to manage their LTC	☑

In 2015/16 we calculate a **reduction in non-elective admissions of 276**.

This is based on neighbourhood pilot models in other areas of country including North West London pioneer, which suggested 15% non-elective reductions.

we have assumed 5% of the +65 age cohort in year 1 and this will then expand to wider non- elective baseline in year 2 and 3. The target we are eventually aiming for in the CCG is for

each of the 5 neighbourhood teams to save 1 non-elective admission per day.

The key qualitative benefits are:

- Improved integration of services across primary, community and secondary care.
- Improved communication between providers of care
- Eliminate duplication of services and better use of scarce resources
- More appropriate referrals resulting in service users receiving the most suitable care to meet their needs
- More informed decision making re: long term care planning couple with holistic provision of care
- Improved overall quality of care provision
- Increased accessibility to services based on need
- Improved patient experience.
- Improved staff satisfaction

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Our approach to measuring outcomes is through both quantitative and qualitative analysis. Critical to our success is also how we respond to the findings. This is coordinated through our governance arrangements which are outlined below:

Governance

- Local delivery of this scheme will be controlled through the Facing the Future Together Programme Board, which has accountability to West Lancs CCG Governing Body. The Facing the Future Together Programme Board is responsible for assurance of the overall direction and management of the programme. Membership includes West Lancashire CCG‟s Clinical Executive Committee and a senior representative from Southport and Ormskirk Hospital NHS Trust.
- The Facing the Future Together Programme also reports into the BCF governance, including to the Lancashire Health and Wellbeing Board
- A programme approach will be taken to ensure effective management of performance, risks and mitigation plans in accordance with the agreed evaluation and outcome measures.
- There is also a comprehensive communications and engagement plan which underpins the programme and ensures we share our measurement of outcomes so that local people continue to be made aware of the impact the programme is having and that the „together‟ element of „Facing the Future‟ is truly realised.

Data collection and analysis

A number of formal KPIs will be developed to demonstrate the „success‟ of this service.

These will be formulated around 3 key themes:

- Patient experience
- Staff experience
- Improvement in the quality of self-care

The following will be used to measure the outcomes from the scheme:

- Increase in contacts dealt with positively near or at point of contact
- Increase in self-reported wellbeing and quality of life
- Closing the life expectancy and inequality gaps that exist in the borough
- Using surveys to capture patients" experience of care
- The proportion of people who use services who have control over their daily life
- Admissions to hospital and re-admissions to hospital within 30 days
- Emergency admissions to hospitals for conditions not usually requiring hospital care

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme are:

- **Strong engagement from patients, public and staff:** throughout the design process we have engaged and involved patients, public and staff across West Lancashire. We will build on these foundations through the programmes engagement and communication to feedback how we are progressing and ensure ongoing user involvement in design and review of our initiatives and implementation of the integrated model of care
- **Achieving collective accountability for care:** the local integrated care model is based on population needs - this forms the basis to work with partners to establish collective accountability for care, local management arrangements built around practice populations and best use of technology and estates to support this.
- **Southport and Ormskirk Hospital NHS Trust achieving synergy from vertical integration:** the business case is predicated on Southport and Ormskirk Hospital NHS Trust achieving synergy from vertical integration. Quality and productivity should improve through clinicians working in a different way that reflects true integration of services.
- **Establishing a new financial and payment model:** Southport and Ormskirk Hospital NHS Trust The Trust is expected to measure the actual costs of each component of care and to share this information with commissioners so that jointly we can establish the new financial and payment model. By 2017/18 it is expected that the financial model will be implemented in shadow form. Commissioning from

this point will be based on real cost data generated from the revised pathways – and there will be a gain sharing agreement in place taking into account legislative and policy arrangements (known and emergent).

- **Re-investing in Primary Care:** GP commissioners will be offered a range of options to use their freed up resources in ways that will improve the capacity of general practice to deliver high quality primary care.
- **Workforce Development:** training and upskilling of the workforce so frontline staff have the skills and resources required to deliver the model. Empowering staff to make decisions locally about care provided with confidence.
- **Using information systems to target and streamline care:** the local integrated care model is dependent on developing an effective IT infrastructure supporting the single assessment process, specialist assessment and care planning across the system. In addition use of risk profiling tools, accurate disease registers, practice profiles and real time reporting are key to success

Lancashire Better Care Fund – Steering Group

Terms of Reference

1.0 Introduction

1.1 The Steering Group is responsible for overseeing the ongoing strategic planning and for assuring the delivery of the Better Care Fund (BCF). It will oversee the progress of delivery against agreed plans and report on progress on a regular basis to the Lancashire Health and Wellbeing Board.

2.0 Objectives for the Steering Group will:

2.1 Responsible to the Health and Wellbeing Board for ensuring the delivery of the BCF within the context of the overall health and wellbeing agenda (i.e. progress against the health and wellbeing strategy/plans 3-5 year) and for upholding the vision, values and principles as set out in the Health and Wellbeing Board's Terms of Reference

2.2 Receive BCF progress reports from the Programme Managers Group and advise on non–performance ensuring appropriate action taken, providing guidance and a steer

2.3 Exception report to the Health and Wellbeing Board reporting variation and action taken, significant risks and mitigation plans

2.3 Request, receive, review performance reports and advise on variations and required actions

2.4 Delegate responsibility for delivery of the BCF plan to the Programme Managers Group This will be done through the Local Partnership arrangements and other individual scheme project management resources in line with the terms of the Section 75 agreement

2.5 Through its role in BCF to help drive transformation and collaborative working across the County

2.6 Ensure that there are opportunities to share learning and opportunities to work at pace and scale

2.7 Ensure continuous, consistent and clear communication and engagement with all stakeholders

2.8 Collectively assess whether additional services should be commissioned as a result of BCF performance

2.9 Promote and role model collaborative, integrated working

2.10 Promote activities that bring about sharing of best practice, delivery of quality standards and improved performance

2.11 Ensure the BCF Plan resources are secured and committed and their utilisation monitored in line with the BCF Plan

3.0 Membership

3.1 Steering Group members are required to attend at least 80% of meetings per annum and in the event of a member of the Group not being able to attend their views must be communicated to the Group Chair prior to the day of the meeting as deputies are not expected.

3.2 The membership of the Group will be made up of the following members, plus any other representatives that are required to attend as determined by the Group. The tenure of any one member will be for a period of 12 months.

Membership (suggested, still to be confirmed by the group)
Chairman – Mark Youlton
Vice Chairman – Mike Kirby
CCG Representation x 6 - (one from each CCG) East Lancashire – Mark Youlton, Chief Financial Officer (CFO) West Lancashire – Paul Kingan, CFO North Lancashire – Kevin Parkinson, CFO Fylde and Wyre – Peter Tinson, Chief Operating Officer Greater Preston – Matt Gaunt, Deputy CFO Chorley & South Ribble – Matt Gaunt, Deputy CFO
LCC Representation – Mike Kirby, Director of Corporate Commissioning
NHS England – Helen Crombie, Head of Assurance and Delivery
In attendance
Healthy Lancashire Director – Samantha Nicol
CSU Service Director – Carl Ashworth
Chairman of the Programme Managers Group - tbc
Other stakeholders as required on an adhoc basis

4.0 Meeting Arrangements

4.1 The Lancashire Better Care Fund Steering Group will be held on a Friday morning, at 0900,fortnightly for a maximum of 2 hours and will be scheduled in accordance with the dates for the national performance report return. Meetings will be held at Jubilee House.

5.0 Membership Responsibilities

5.1 The Steering Group shall have responsibility for ensuring that all the BCF performance metrics are managed and monitored across the schemes within the BCF.

5.2 The Steering Group shall have overall responsibility for performance managing and monitoring of actual income and expenditure in relation to the Pooled Fund. The Host Partner (or its delegated agent) will provide regular financial reports to the Steering Group and each Partner (at least quarterly), using information from its accounting system and/or information provided by each Partner or Agent, where appropriate. The

Steering Group must ensure that any cost pressures and mitigating actions, are reported through the appropriate governance structures in each Partner organisation. Financial information should be supported by appropriate and proportionate activity reports. From month three onwards financial reporting should include a forecast of the year end position.

5.3 The Steering Group must be able to trigger or prompt and necessary or required action within their organisations and across the BCF plan footprint in relation to the delivery of the BCF.

5.4 Focussed leadership, robust project management and process control to ensure the successful deliver of the Better Care Fund

5.5 Maintain the pace to deliver the BCF within agreed timescales

5.6 Demonstrate that the patient voice is heard using existing organisational systems during all parts of the strategy development and implementation phases.

5.7 The Steering Group Chairman must be a member of the Health and Wellbeing Board and should present and recommend the quarterly national performance report to the Health and Wellbeing Board for their acceptance and sign off prior to submission to the Department of Health.

6.0 Meeting Frequency

6.1 The Lancashire Better Care Fund Steering Group will meet fortnightly from 1st June 2015 to fit in with the national report framework:

Year	Month	Dates (Friday)
2015	June	5, 19
	July	3, 17, 31
	August	14, 28
	September	11, 25
	October	2, 16, 30
	November	13, 27
	December	11, 25
2016	January	8, 22
	February	5, 19
	March	4, 18
	April	1, 15, 29
	May	13,27

6.2 This schedule of dates will be reviewed in December following two full reporting cycles.

7.0 Declarations of Interest

7.1 Individuals contracted to work with or appointed to the Steering Group will comply with Lancashire County Council's standard of business conduct policy including the requirements for declaring conflicts of interest. (These are appended).

7.2 In order to facilitate this process, “Declaration of Interests” will be a standing item on all agendas and copies of the minutes will be sent to the Better Care Fund Steering Group for the purposes of maintaining the register of interests.

7.3 All new declarations of interest must be notified to the Chair of the Steering Group within 28 days of a member taking office of any interests requiring registrations, or within 28 days of a change to a member’s registered interests. Copies of these notifications should be sent to the Better Care Fund Steering Group.

8.0 The Lancashire Better Care Fund Steering Group will report to:

8.1 The Lancashire Health and Wellbeing Board.

8.2 The Steering Group will provide the Health and Wellbeing Board with the quarterly performance report which they are required to receive and sign off and submit.

9.0 Review of Terms of Reference

9.1 Terms of Reference will be reviewed on 11th December 2015.

Lancashire Better Care Fund – Programme Managers Group

Terms of Reference – June 2015

1.0 Introduction

1.1 The function and purpose of the Programme Managers Group (PMG) is to ensure the delivery of the Better Care Fund (BCF) as guided by the Steering Group (SG), to receive direction from the Steering Group and to make recommendations to the Steering Group.

1.2 The PMG will provide the SG with the quarterly performance report which they are required to provide to the Lancashire Health & Wellbeing Board (LHWB)

2.0 Objectives for the Programme Managers Group:

2.1 The Programme Managers Group and the individuals representing each Clinical Commissioning Group area will be expected to advise the Steering Group on delivery acting as the main link to the local partnership arrangements and other individual scheme project management resources in line with the terms of the Section 75 agreement

2.2 To help drive transformation through its role in BCF as a lever for further developing collaborative working across the County and be responsible for helping to co-ordinate discussions around ambition and making recommendations about ambition to the SG

2.3 To ensure that there are opportunities to share learning and opportunities to work at pace and scale across the Lancashire BCF

2.4 To ensure continuous, consistent and clear communication and engagement with all stakeholders as deemed appropriate through an agreed framework and depending on the subject matter

2.5 To receive performance reports from the member organisations via the agreed reporting mechanisms, and modify, provide interpretation and required changes before approving for the steering group

2.6 To manage risks locally and provide mitigation

2.7 To promote and role-model collaborative, integrated working across the BCF

2.8 To promote activities that bring about sharing of best practice, delivery of quality standards and improved performance

2.9 To ensure the BCF Plan resources are monitored and managed appropriately in line with the BCF Plan and Section 75 Agreement, through the statutory functions of the BCF partners

2.10 To ensure that the 12 month work plan is managed successfully and to assure the Steering group of this.

3.0 Membership

3.1 Programme Managers ~~Steering~~ Group members are required to attend at least 80% of meetings per annum. This may be in-person or by phoning-in.

3.2 The membership of the Group will be made up of a single, nominated, representative from the following members, plus any other representatives that are required to attend as determined by the Group.

Membership
Chairman and Senior Programme Manager
Vice Chairman – TBD
CCG Representation x 5 - (one from each CCG) East Lancashire West Lancashire North Lancashire Fylde and Wyre Greater Preston and Chorley & South Ribble (two CCGs with a single management team)
LCC Representative
NHS England Representative
Healthier Lancashire Representative
CSU Service Representative
By invitation
Others as required

3.3 In the event of any nominated member not being able to attend a meeting then they are expected to either:

i) ensure that their views or comments about any of the agenda items is communicated to the Chairman prior to the meeting by email to be shared with the Group or

ii) provide a nominated deputy that is fully briefed and is able to act in the same capacity. The Chairman should be advised of the arrangements prior to the meeting.

3.4 In the event of any existing member representative being incapacitated or resigning then it will be the responsibility of the organisation they represent to confirm a replacement member of equal status.

3.5 Representatives who are "in attendance" members and those there by invitation will be able to participate in the Programme Managers ~~PM~~~~Steering~~ Group discussion and business and their opinions to be heard, but they will not have any voting rights.

3.6 Members and invitees will have the option of using teleconference facilities and dialling in to the meeting when it is not possible for them to physically attend the meeting place.

4.0 Quorate

4.1 The Programme Managers ~~PM~~~~Steering~~ Group will only be deemed as quorate if 50% of the members are physically present – including at least 2 CCGs.

5.0 Meeting Arrangements

5.1 The Lancashire Better Care Fund PMG will be fortnightly for a maximum of 2 hours and will be scheduled in accordance with the dates for the SG

5.2 The PMG will be held to account by the SG.

5.3 Recommendations will be ratified by a majority vote taken by those members who attend the meeting. This may be in-person attendance or by phoning-in.The Chairman will not have a vote

5.4 A Risk Log will be maintained by the PMG and which will be reported to the SG and back to the individual organisation's own governing bodies as deemed appropriate by those organisation's own constitutions.

5.5 The Chairman may at any time convene extraordinary meetings to consider business that required urgent attention or when required to manage significant risks as advised by the SG SRO.

5.6 The Steering Group Administration is as follows:

- Minutes and action log will be sent out three working days after the meeting
- Agenda and papers will be sent out two working days before the meeting
- Agenda and papers to be agreed with the Chairman three working days before the meeting
- All papers agreed by the Chairman should be received by the Administrator three working days in advance of the meeting

6.0 Membership Responsibilities

6.1 The PMG shall have responsibility for ensuring that all the BCF performance metrics are monitored, managed and reported across the schemes within the BCF.

6.2 The PMG shall have overall responsibility for performance managing and monitoring of actual income and expenditure in relation to the Pooled Fund. The Host Partner (or its delegated agent) will provide regular financial reports to the Steering Group and

each Partner (at least quarterly), using information from its accounting system and/or information provided by each Partner or Agent, where appropriate Financial information should be supported by appropriate and proportionate activity reports. From month three onwards financial reporting should include a forecast of the year end position.

6.3 The PMG will provide focussed leadership, robust project management and process control to ensure the successful delivery of the Better Care Fund

6.4 The PMG will maintain the pace to deliver the BCF within agreed timescales

6.5 The PMG will demonstrate that the patient voice is heard using existing organisational systems during all parts of the strategy development and implementation phases.

6.6 The Chairman of the PMG will attend the SG meetings.

7.0 Declarations of Interest

7.1 Individuals contracted to work with or appointed to the group's committees will comply with the group's standard of business conduct policy including the requirements for declaring conflicts of interest.

7.2 In order to facilitate this process, "Declaration of Interests" will be a standing item on all agendas and copies of the minutes will be sent to the Better Care Fund Programme Managers Group for the purposes of maintaining the register of interests.

7.3 All new declarations of interest must be notified to the "Accountable Officer" within 28 days of a member taking office of any interests requiring registrations, or within 28 days of a change to a member's registered interests. Copies of these notifications should be sent to the Better Care Fund Programme Managers Group.

Lancashire Health and Wellbeing Board

Lancashire County Council

Lancashire Health and Wellbeing Board
Monday, 22 February 2016, 10.00 am,
Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

AGENDA

Part I (Open to Press and Public)

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
1. Election of Chair for the Meeting	Action	To elect the Chair for the meeting.			10.00am - 10.05am
2. Welcome, introductions and apologies	Action	To welcome all to the meeting, introduction and receive apologies.	Chair		10.05am - 10.10am
3. Disclosure of Pecuniary and Non-Pecuniary Interests	Action	Members of the Board are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	Chair		10.10am - 10.15am

Sam Gorton: sam.gorton@lancashire.gov.uk 01772 534271

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
4. Minutes of the Last Meeting	Action	To agree the minutes of the previous meeting.	Chair	(Pages 1 - 8)	10:15am - 10:20am
5. Better Care Fund (BCF)	Action	i) Performance report ii) Future scope and planning 2016/17	Mark Youlton	(To Follow)	10.20am - 10.50am
6. Health and Wellbeing Board Action Plan	Action	To provide the focus of activity in 2016/17 for the Board.	Dr Sakthi Karunanithi	(To Follow)	10.50am - 11.20am
7. Joint Strategic Needs Assessment (JSNA) Work Programme	Action	To inform and support future work programmes.	Gemma Jones	(To Follow)	11.20am - 11.40am
8. Health and Wellbeing in Care Homes	Action	To promote the resource and improve the health and wellbeing of care home residents.	Dr Sakthi Karunanithi	(Pages 9 - 14)	11.40am - 11.50am
9. Urgent Business	Action	An item of Urgent Business may only be considered under this heading, where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading.	Chair		11.50am - 11.55am

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
10. Date of Next Meeting	Information	The next scheduled meeting of the Board will be a development session, held at 2pm on 28 April 2016 in the Henry Bollinbroke Room, (former Cabinet Room 'D'), County Hall, Preston, PR1 8RJ.	Chair		

I Young
County Secretary and Solicitor

County Hall
Preston

Appendix A

Health and Wellbeing Board
Plans and Priorities Workshop
8 December 2015

Introduction

As part of the recent review of the Health and Wellbeing Board (HWBB) a number of proposals were agreed and many of these have now been implemented. One of these proposals was the development of a clear and concise action plan. This action plan would support the delivery of the aspirations and intentions within the Health and Wellbeing Strategy but would articulate these as tangible activity for 2016/17. The role of the HWBB would then be to own the actions within the plan and provide leadership, support and challenge to enable its delivery.

The purpose of this workshop was to allow the discussion and dialogue across Board members to agree the short term goals, priorities and activity that will populate the Boards action plan.

Who was involved?

All members of the HWBB were invited to the workshop and there was good representation from all sectors. A full list of participants can be found at **Appendix A**. In addition colleagues from Healthier Lancashire, the Better Care Fund Steering Group and Lancashire County Council's commissioning team provided expert input and facilitation.

What happened?

Setting the scene

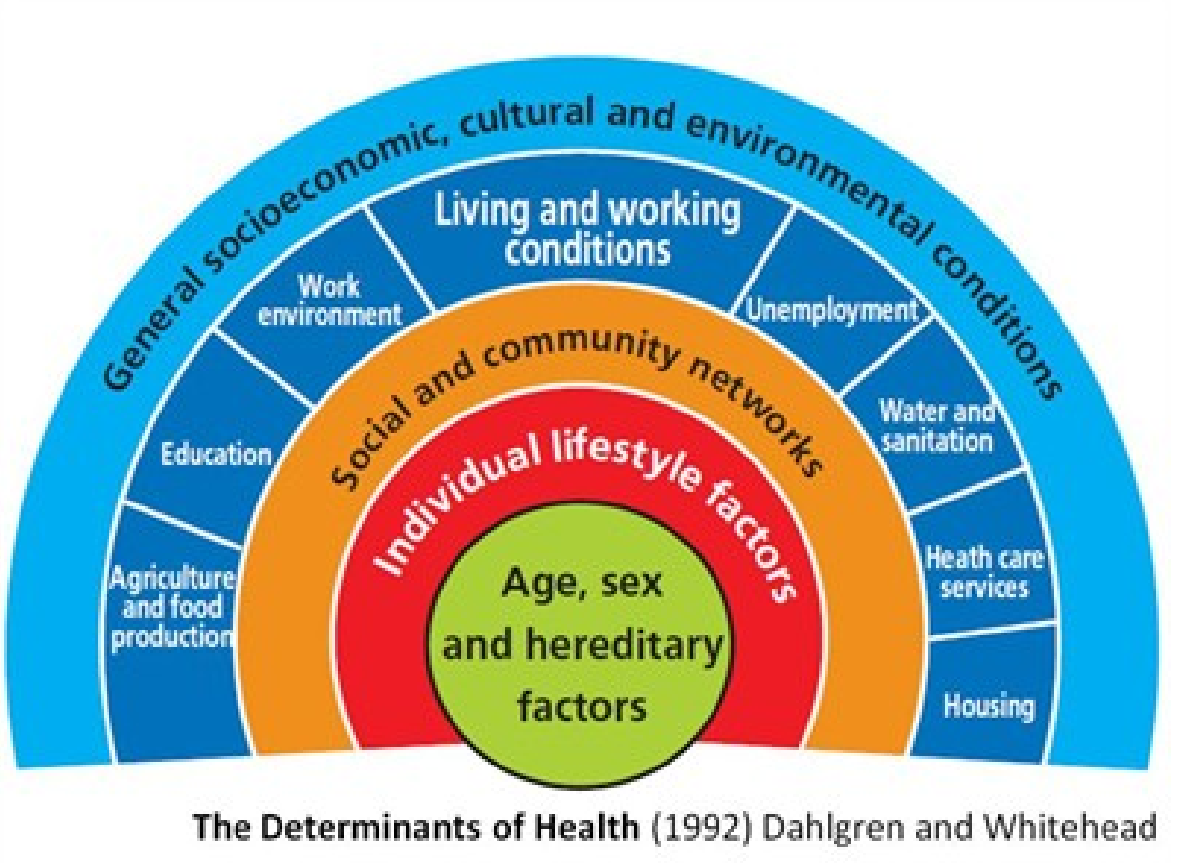
Key note inputs were provided by Dr Mike Ions (East Lancashire Clinical Commissioning Group), Gary Hall (Chorley Council) and Dr Sakthi Karunanithi (Lancashire County Council). These inputs provided an overview of the current challenges across the health and wellbeing system and some of the ongoing developments

The primary messages delivered through the presentations were as follows:

- There are significant challenges now but reducing resources and increasing demand for services will mean that over the next five years some of these challenges will become unmanageable unless we do something substantially different
- Any response to future health and wellbeing challenges needs to be a whole system response not just an NHS response
- The way we work now is not sustainable, we need to focus our efforts on developing place based systems of care
- Healthier Lancashire provides a vehicle for addressing some of the issues in the system
- At the moment there are lots of discussions, planning and work, but fundamentally decisions are still made by individual organisations
- The 15 Local Authorities in Lancashire are having positive discussions about coming together as a Combined Authority. This will not be a new authority but a way of

working together and the focus will be on skills, housing, transport, economic growth and public service reform

- There is a need to focus on prevention and early intervention – refocussing the services already provided to address the cause of issues before they arise
- How do we focus better on the prevention, early help and the socio economic determinants?
- The Board has already agreed the evidence base (JSNA) and the Strategy (framed around Start Well, Live Well, Age Well) but there is a need to be clear about the priorities needed to deliver the Strategy and how this aligns with other developments ie Healthier Lancashire, Combined Authorities, LCC Corporate Strategy
- In all the developments and challenges around the health and wellbeing systems, where is there a focus on children and young people?
- Is the Board committed to addressing wider socio economic determinants? At the moment the focus of the Board is predominantly around health care services



The Determinants of Health (1992) Dahlgren and Whitehead

Workshop 1 - improving health and wellbeing outcomes

Board members engaged in a facilitated discussion on tables to identify future priorities for the HWBB. Information was provided to inform this discussion and included summaries of previously agreed areas of focus and themes of work drawn from needs assessments, strategies and actions from past Board meetings (see **Appendix B**).

Through this discussion, Board members identified the following key themes as areas of focus and development:

Better engagement with the third sector – maximising their contribution, developing community assets, a coherent VCFS structure to work with, understand the VCFS offer

Making every contact - using the workforce more effectively, single care records, mutual trust/support

Develop and embed place based integrated teams – implement a model; develop shared estates strategy; effective engagement in planning and design; address information sharing challenges

Digital First – develop the infrastructure, getting people digitally literate, an approach where digital is the default option, explore the potential to develop the economy

Childhood Obesity – working with schools, planning services and the private sector; simple steps; lobbying locally, regionally and nationally

Reducing Alcohol Harm – oversight of the Alcohol Harm Reduction Strategy; including focus on behaviours, licensing, intervention, education

Developing the prevention agenda – where is the potential for pooled budgets; Shared agenda; do we understand the focus (the most vulnerable)

Strategic leadership and direction – bringing together plans and priorities,;shared vision/principles; promoting/enabling collaboration; holding organisations to account; influencing; alignment of resources; challenging systems

Addressing health inequalities - what action is the Board taking to address health inequalities? where is the focus on the wider determinants of health? This should be a focus within the work of Healthier Lancashire

Adult Care Market - care homes; health and social care collaboration and integration; is the Health and Wellbeing Board clear of expectations of the system?

Workshop 2 – governance and leadership

The second workshop allowed all Board members to discuss three different areas of governance and leadership that have been identified as key in recent Health and Wellbeing Board meeting. These areas were Better Care Fund; Healthier Lancashire; and Health and Wellbeing Structures.

Better Care Fund

Within this discussion the Board focussed on three key questions and a summary of this can be found below:

- What does the Board need to know to ensure the effective use of the Better Care Fund (BCF)?
- What are the strategic challenges to making the most of the Better Care Fund that the Board could provide?
- What opportunities are there to broaden the scope of the application of the Better Care Fund to enable other pooled budget arrangements?

Better understanding of BCF – what is the progress being made? Where are the challenges? What are the future opportunities? simplify the reporting – what are the key messages?

Prevention – how will BCF support an approach that is focussed around prevention?

Ambition - to use the BCF to achieve big ambitions. What is the role of BCF in developing place based systems? Using BCF as a platform to drive cultural change – sharing risk, building trust?

2020 – a model/process to deliver integrated social care and health services by 2020, a plan needs to be in place for 2017

Strategic alignment – is there potential for a pan Lancs BCF? Needs to ensure that BCF is working towards HWBB priorities, how is BCF aligned with HL workstreams?

Future opportunities – obesity; children's mental health services (children); starting well; transforming care; linking in with third sector; other pooled budget arrangements.

Healthier Lancashire

Within this discussion the Board focussed on three key questions and a summary of this can be found below:

- What could the Health and Wellbeing Board offer to Healthier Lancashire (HL)?

- What are the requirements of the Health and the Wellbeing Board of Healthier Lancashire?
- What might the role of the Health and Wellbeing Board be in Healthier Lancashire?

Formalise the relationship between the HWBB and HL – needs a formal agreement, regular flow of information and dialogue between the two bodies, the Health and Wellbeing Board holding the joint committee accountable?

Strategic alignment – there is a need to ensure that there is a shared vision that supports strategies, priorities and workstreams to be fully aligned

What does good look like? – need to develop a shared understanding (and then shared ownership and leadership) of what we are working towards – what do we want the health and social care system to look like; what is the model that we are working towards, can we describe this?

Missing focus – HL needs to develop a focus around children and prevention and early help.

Provide oversight, challenge and support – HWBB to hold HL accountable for delivery; ensure duplication is removed; provide strategic direction and enable alignment with other key agendas and programmes

Wider determinants – challenge HL to ensure that activity to address the wider determinants of health are addressed

Systems Leadership – HWBB to provide a focal point for driving change across the whole of the whole of the health and wellbeing system; to ensure synergy between the NHS and the rest of the public sector; to focus on health outcomes

Health and Wellbeing Structures

Within this discussion the Board focussed on three key questions and a summary of this can be found below:

- What needs to happen to strengthen the links between the H&WB Board and the five local partnerships?
- How do we ensure coherence and alignment across the three HWB Board in Lancashire?
- Are there other groups and partnerships that should be better aligned with the H&WB? What do we need to do to make this happen?

Clear responsibility – Health and Wellbeing Partnerships (HWBPs) to identify what needs to be delivered at local level and how these complement countywide priorities, better sharing information/knowledge between the Board and HWBPs; HWBPs reporting progress to the Board; HWBPs challenging the Board and providing a local perspective

Strategic alignment – when the HWBB has set its priorities the local Health and Wellbeing Partnerships need respond and detail how they will support the delivery of these priorities; all priorities and plans across the structure need to align with the Health and wellbeing Strategy

Pan Lancashire Approach – to work with Blackpool and Blackburn with Darwen to embed a single HWBB across Lancashire

Local structures – HWBPs to lead on ensuring local health and wellbeing structures are streamlined, coherent, effective and sustainable; examples include discussion between BwD HWBB and East Lancs HWBP or merging Central Lancs Clinical Senate and the Preston, Chorley and South Ribble HWBP.

Effective approach across partnerships – need to further develop the links across the HWBB, Children's Trust, Community Safety, Safeguarding Board; commit to not developing new Board structures as new agendas/funding come into place but use what we already have; ensure the starting point is how we support vulnerable people and then make sure partnership we have are delivering this.

Oversight and leadership of existing programmes – children and young people's mental health services; transforming care for people with disabilities

Next steps

Following this workshop of Board members the next steps are as follows:

- This report will be shared widely, specifically with Health and Wellbeing Board members and members of the five local Health and Wellbeing Partnerships report produced and shared widely, but also including the membership of other strategic partnerships and with colleagues in Blackburn with Darwen and Blackpool
- A small task and finish group of board members to meet in January 2016 to turn the discussion that have been capture in this report into an action plan for the Board for 2016/17
- This action plan will be taken to the February meeting of the Health and Wellbeing Board for agreement.

Appendix A

Health and Wellbeing Board - Plans and Priorities Workshop Participants

Name	Attendance	Representing
CC David Whipp	Attended	Lancashire County Council
CC Jennifer Mein	Attended	Lancashire County Council
CC Matthew Tomlinson	Attended	Lancashire County Council
Clare Platt	Attended	Lancashire County Council
Cllr Delma Collins	Attended	Fylde Borough Council
Councillor Bridget Hilton	Attended	Central Lancs District Councils
Councillor Hasina Khan	Attended	Preston, Chorley, South Ribble HWB Partnership
Dave Carr	Attended	Lancashire County Council
David Tilleray	Attended	West Lancs HWB Partnership
Dee Roach	Attended	Lancashire Care Foundation Trust
Dr Alex Gaw	Attended	Lancashire North CCG
Dr Dinesh Patel	Attended	Greater Preston CCG
Dr Mike Ions	Attended	East Lancs CCG
Dr Sakthi Karunanithi	Attended	Lancashire County Council
Gary Hall	Attended	Lancashire District Councils
Ian Crabtree	Attended	Lancashire County Council
Jane Booth	Attended	LSCB
Karen Partington	Attended	Lancashire Teaching Hospitals Foundation Trust
Louise Taylor	Attended	Lancashire County Council
Margaret Flynn	Attended	LSAB
Mark Bates	Attended	Lancashire Constabulary
Mark Youlton	Attended	East Lancs CCG
Michael Wedgeworth	Attended	Healthwatch Lancashire
Paul Robinson	Attended	Commissioning Support Unit
Phil Huxley	Attended	East Lancs CCG
Richard Cooke	Attended	Lancashire County Council
Sally Nightingale	Attended	Lancashire County Council
Sam Nicol	Attended	Healthier Lancashire
Sarah Swindley	Attended	Lancashire Women's Centres
Stuart Aspin	Attended	Healthier Lancashire
Tony Pounder	Attended	Lancashire County Council

Appendix B

Health and Wellbeing Board Workshop - an overview of existing evidence, commitments and priorities

December 2015

The following provides a summary of some of the evidence, commitments and priorities that have featured through recent Board agendas. Whilst the context we are working within is constantly evolving, and in some respects the pace of change is quickening, it is important when we consider future priorities for the Board that this is framed and builds upon evidence that has already been recognised, considered and agreed as being important.

Lancashire Health and Wellbeing Strategy

The JSNA makes it clear that we need to focus our work to deliver the strategy across the whole life course, intervening in a coordinated way in childhood, adulthood and old age. Three distinctive programmes of work have been identified, reflecting the different support people need at different stages of their life. Below are the work programmes with the desired objective for each of the work programmes:

Starting well

- To promote healthy pregnancy
- To reduce infant mortality
- To reduce childhood obesity
- To support children with long term conditions
- To support vulnerable families and children

Living Well

- To promote healthy settings, healthy workforce and economic development
- To promote mental wellbeing and healthy lifestyles
- To reduce avoidable deaths
- To improve outcomes for people with learning disabilities

Ageing well

- To promote independence
- To reduce social isolation and loneliness
- To better manage long term conditions
- To reduce emergency admissions and direct admissions to residential care
- To support carers and families who care for family members

Health Inequalities JSNA (2014)

The diversity of the county is reflected in the health and wellbeing needs and assets of the population. There are large inequalities in health and in the causes of poor health between different areas and groups of people in the county. Inequalities in health in the county are a significant concern and JSNA analysis has identified the 10 largest gaps in health outcomes between the least and most deprived areas of the county and the priorities for addressing these inequalities.

Top Ten Goals for Health Equity

Narrow the gap in:

- diabetes
- respiratory disease
- digestive disease
- mental health problems
- lung cancer
- circulatory disease
- accidental deaths
- quality of life
- unplanned hospital admissions
- infant mortality

Priorities for addressing health inequalities

Priority 1 Develop the local economy

Recommendations to JSNA partners:

• consider how economic development strategies can support growth in sectors that employ high numbers of people from deprived areas as well as increase investment in high growth sectors;

• support local businesses to become accredited healthy workplaces that use evidence-based approaches to keep people well at work and enable those with health problems to stay in employment;

• promote access to welfare rights advice within health care settings;

• work with GPs and local employers to better understand the 'fit note';

• encourage the local public sector and partners to increase social value though employment of local people, purchasing from local businesses, commissioning from the third sector and employee volunteering;

• identify ways to increase digital inclusion;

• encourage local employers to pay the Living Wage.

Priority 2 Increase social connectedness

Recommendations to JSNA partners:

• take opportunities provided by infrastructure programmes such as the Preston, South Ribble and Lancashire City Deal to design the built environment to facilitate social connectedness;

• commission the third sector to bring local communities together to improve quality of life, using community assets approaches;

• increase opportunities to bring people together for group activities, sports and games;

• support local authority elected members to undertake community development and to connect local people to community assets;

• establish networks of mentors/buddies in the most vulnerable communities;

• increase digital inclusion to help address loneliness and social isolation;

• make use of Lancashire Economic Partnership's influence, connections with big businesses, skills and financial resources to increase social connectedness

Priority 3 Promote and enforce health-related legislation

Recommendations to JSNA partners:

• encourage local lobbying for evidence-based health-related legislation by JSNA partner organisations such as local authorities, clinical commissioning groups, health and care providers, police and the third sector;

• enforce health-related legislation (e.g. licensing, food hygiene, alcohol and tobacco sales) proportionately according to intelligence about non-compliant businesses;

• lobby for a minimum unit pricing for alcohol;

• promote health and safety in the workplace as a more positive concept that focuses on promoting the health and wellbeing of employees, their work-life balance and fulfilment rather than purely risk management;

• enforce building regulations to ensure the quality of housing;

• explore the introduction of 'exclusion zones' to limit the number of unhealthy food outlets and alcohol-licensed premises near schools;

• consider opportunities for increasing physical activity and social interaction, and improving access to green space and leisure facilities when planning the built environment;

• increase the number and quality of cycle and walking routes when developing the transport network;

• make health impact assessment mandatory for local authority planning, contracting and commissioning.

Priority 4 Allocate public sector service resources according to need

Recommendations to JSNA partners:

• explore the development of resource allocation formulae that reflect need for services;

• promote the use of equity audit in the commissioning of services to ensure that access, use and outcomes of services are proportionate to the level of need across the social gradient;

• introduce local area co-ordination approaches to join up services around groups of general practices and to enable people experiencing challenge to be connected to assets in the local community;

• commission integrated prevention services focused on achieving a small number of key outcomes;

• apply the concept of proportionate universalism within the commissioning process.

Health Behaviours JSNA (2015)

Whether a person is healthy or not is a combination of many factors including the wider determinants of health and the availability of health enabling resources across the region. A deeper understanding of health behaviours has allowed the identification of the health behaviours across population groups, and the characteristics of people with different health behaviours. It has also allowed an understanding of emerging issues. The JSNA produced a number of evidence-based strategic recommendations:

- Increase people's health-enabling behaviours and health literacy levels to reduce health-compromising behaviours.
- Reduce harmful drinking among identified high-risk groups and promoting sensible drinking.
- Enforcement, advocacy and legislative work around alcohol sales and minimum unit pricing.
- Promote harm reduction and recovery services for substance users.
- Support and develop work around substance misuse, dual diagnosis, and collaborative working between partner organisations.
- Address and reduce levels of obesity in adults and children.
- Increase knowledge, skills and abilities around healthy eating and nutrition.
- Challenge societal attitudes towards mental health, develop opportunities for social inclusion, social capital and mentally healthier communities.
- Increase physical activity levels among children, young people and adults by making physical activity more available/accessible.
- Improve sexual health through increasing testing and screening rates and reduce rates of under-18 conceptions and abortions.
- Reduce smoking rates in the adult population whilst preventing children and young people from smoking (including e-cigarette use).

Six Shifts

The Board has committed to making a number of important changes or 'shifts' in the way that we work together for the benefit of our citizens and their communities. These shifts will fundamentally challenge the way that we currently work and are essential if we are to successfully improve health, wellbeing and the determinants of heath on a sustainable basis and within the resources that will be available to us in the coming years:

1. Shift resources towards interventions
2. Build and utilise the assets, skill and resources of our citizens and communities
3. Promote and support greater individual self-care and responsibility for health
4. Commit to delivering accessible services within communities
5. Make joint working the default option
6. Work to narrow the gap in health and wellbeing and its determinants

An overview of themes and priorities taken from the notes of the last 12 months of Health and Wellbeing Board meetings:

Children's emotional health and wellbeing services
Infant mortality
Tobacco control
Governance and effective ness of the Board
Alcohol harm reduction
Domestic abuse
Dementia
Transforming care for people with learning disabilities
Understanding of health and wellbeing needs in Lancashire
Affordable warmth
Health and Wellbeing system leadership and oversight
Transforming care for people with learning disabilities
Better Care Fund
#hello, my names is…
Healthier Lancashire – alignment of plans

Midlands and Lancashire
Commissioning Support Unit

JOB DESCRIPTION

HOSTED BY:	MIDLANDS & LANCASHIRE CSU		
DEPARTMENT:			
JOB TITLE:	LANCASHIRE BETTER CARE FUND (BCF) SENIOR PROGRAMME MANAGER		
BASE:	LEYLAND (with travel around Lancashire)		
REPORTS TO:	LANCASHIRE BCF SENIOR RESPONSIBLE OFFICER		
ACCOUNTABLE TO:	LANCASHIRE BCF STEERING GROUP		
DISCLOSURE & BARRING CHECK REQUIRED:	**YES** ☐	**NO** ✓	**Standard** ☐ **Enhanced** ☐

Job Summary

The Better Care Programme is the most ambitious of its kind - a mandatory programme of health and care integration with National Conditions and Requirements. In addition, the Lancashire Better Care Plan has a complex footprint involving multiple commissioning and provider partners. It is political, sensitive and dynamic work, driving local transformations in healthcare systems. The post holder will be expected to work constructively and proactively to understand complex motivations and manage the inherent challenges with experience and expertise. S/he will be expected to contribute to the wider collaboration and system development in Lancashire.

Job Purpose

The role of the Senior Programme Manager will be to support the Senior Responsible Officer and the BCF Steering Group to provide clear and visible programme leadership. They will have specific responsibility for co-ordinating the Programme Management Office functions and resources and ensuring that there is frequent assessment and appropriate challenge of progress.

The Senior Programme Manager will act as a Strategic Advisor and drive the programme in accordance with the collective ambition and national aspirations for the Better Care Programme as a whole. The post holder will lead the ongoing implementation for 2015 – 2016, proactively identifying the support required from partners and developing solutions. S/he will also lead the planning / submission process for the Better Care Plan for 2016 – 2017. This will include working with all partners to specify any new areas for inclusion as schemes or any amendments to existing schemes.

The post holder will also work closely with the Steering group to ensure the links between Healthier Lancashire; the Lancashire-wide collaborative programmes; the Partners' own Strategic and

Operational Plans and the Better Care Plan - as well as responding to emerging national requirements in both the technical and strategic aspects of the programme.

The Senior Programme Manager will be responsible for compiling all the required monitoring reports and providing assurance to the Steering Group on delivery of the BCF Plan, managing the risk register and being a key link between related strands of work.

KEY RESONSIBILITIES:

Leadership and Co-Production:

- Build on the momentum to date and drive the Programme forward
- Act as a Strategic and Technical Advisor, identifying support and development needs and working across organisations to solve problems and generate solutions
- Build on the collective model of leadership in Lancashire, engaging and developing relationships at a Lancashire-wide level (especially Healthier Lancashire and the Lancashire collaborative programmes) and locally at health and wellbeing partnership level, providing or securing expert inputs as needed to strengthen partnership working
- Develop and deliver an effective communications strategy for the BCF
- Support wider engagement with stakeholders including NHS and Care Providers, to embed the Better Care Plan goals and schemes and enable further co-production

Assurance and Reporting

- To assess and ensure that the Programme meets National Conditions and Requirements, as per the Section 75 preconditions and any emerging legislation such as the Care Act
- Maintain oversight of the BCF's progress and act as a single point of contact, establishing strong links and working relationships with Programme Managers within Partner organisations, to understand the macro and local level actions, progress, enablers and challenges which contextualise the technical indicators of performance
- Co-ordinate the PMO resources across the various partners, which will involve matrix and collective management rather than direct organisational line management
- Work with the Senior Analyst, Finance Lead and Administrative support to develop an assurance and reporting process (for NHSE; HWBB, Steering Group, Programme Managers Group) with the associated schedule of products, to include an exception report; schedule of technical indicators as required by NHSE; a meaningful and consistent narrative HWBB and remedial or action planning
- Lead on the collective reporting cycle, presenting the above as required in support of the SRO, providing assurance locally to the HWBB and regionally / nationally to NHSE and DH
- Interpret and present sensitive and complex information to other audiences and stakeholders as required and develop feedback mechanisms to evidence action(s) taken as a result of listening and participation exercises (centrally or locally collated)
- Track implementation progress against the agreed annual work plan, updating and refreshing this weekly/ monthly as required. Use this as a basis for the preparation of updates and facilitation to the Steering and Programme Groups.
- Co-ordinate the collation of the information and compile the quarterly monitoring and assurance reports
- Co-ordinate and compile the papers for the Steering Group

Planning and Development

- Lead by co-ordinating across partners, the implementation and further planning processes, providing subject matter expertise in strategic planning and change management
- Ensure the key products are updated and refreshed as required for 2016/2017 including the Plan document and the Section 75, accessing appropriate legal and technical support
- Act as the Chairman of the BCF Programme Managers Group, ensuring proactive engagement and challenge both within this group as good working practice but also on a 360 cycle raising any system blocks or challenges back to the Steering Group and NHSE as appropriate
- Ensure that there are appropriate risk management and mitigation plans in place and these are being delivered with the appropriate governance between Steering Group and PMs
- Regularly review BCF governance arrangements with Health and Wellbeing Board, Steering Group and Programme Managers Group, ensuring alignment with national good practice advice and / or requirements, updating the Section 75 agreement if changes are material
- Ensure that any decisions taken are commensurate with the Terms of Reference for the group and the requirements of the Better Care Programme nationally / Care Act
- Develop mechanisms for impact assessment working with Partners to regularly assess impacts and interdependencies of related schemes and activities and implement agreed scenario / arbitration mechanisms in line with the agreed Section 75
- Identify and exploit opportunities for shared learning and information sharing and access support from regional and national sources as they become available

Working Arrangements

The post will be hosted by the CSU, with a base at Jubilee House in Leyland - however in order to establish the working relationships with partners it is expected that multiple bases / hot desking options will be necessary, to fulfil the requirements of the role.

The post holder will therefore be required to be highly mobile and flexible with regular travel and use of remote working where possible, to meet the challenges of the job.

This is a complex job with competing demands for time and prioritisation of the postholder's resources and focus. The post holder will need to be resilient and able to establish positive working relationships with clear boundaries.

There are political and locally sensitive issues involved in this work and the post holder will be expected to work confidently at all levels of seniority and with local politicians and elected members as appropriate, in support of and in line with the SRO overall direction.

The post holder will be expected to work with a high level of autonomy and self-direction – in addition s/he will be acting as a strategic advisor at a senior level and will be expected to generate solutions to problems and proactively take these forward, with minimal supervision.

PERSON SPECIFICATION

Knowledge Training and Experience required for the post	Essential at Recruitment ✓	Developed within the role ✓	How Assessed A – Application I – Interview P - Presentation T – Test
Knowledge, Training and Experience			
Educated to masters level or equivalent level of experience of working at a senior level in specialist area.	✓		A/I
Extensive knowledge of specialist areas, acquired through post graduate diploma or equivalent experience or training plus further specialist knowledge or experience to master's level equivalent	✓		A/I
Evidence of post qualifying and continuing professional development. Must have an understanding of the background to and aims of current health and social care policy and appreciate the implications of this on engagement	✓		A/I
Should have an appreciation of the relationship between Health and Social Care and individual provider and commissioning organisations	✓		A/I
Understanding of and commitment to the principles underlying the Better Care Fund and the ability to ensure that the implications are reflected in all developments	✓		A/I
Communication Skills			
Must be able to provide and receive highly complex, sensitive or contentious information, negotiate with senior stakeholders on difficult and controversial issues, and present complex and sensitive information to large and influential groups	✓		A/I
Negotiate on difficult and controversial issues including performance and change	✓		A/I
Analytical skills			
Problem solving skills and ability to respond to sudden unexpected demands	✓		A/I

Ability to analyse complex facts and situations and develop a range of options	✓		A/I
Takes decisions on difficult and contentious issues where there may be a number of courses of action.	✓		A/I
Strategic thinking			
Ability to anticipate and resolve problems before they arise	✓		A/I
Demonstrated capability to plan over short, medium and long-term timeframes and adjust plans and resource requirements accordingly	✓		A/I
Comprehensive experience of project principles techniques and tools such as Prince 2 and Managing Successful Projects	✓		A/I
Management Skills			
Ability to work as part of a multi-agency team as well as undertaking complex work on own initiative	✓		A/I
Must be able to prioritise own work effectively and be able to direct activities of others.	✓		A/I
Experience of managing and motivating a team and reviewing performance of the individuals.	✓		A/I
Experience of managing complex projects	✓		A/I
Autonomy			
Freedom to Act	✓		A/I
Must be able to use initiative to decide relevant actions and make recommendations to Sponsor/ Manager, with the aim of improving deliverables and compliance to policies.	✓		A/I
Ability to make decisions autonomously, when required, on difficult issues, working to tight and often changing timescales	✓		A/I
Experience of identifying and interpreting National policy.	✓		A/I
Experience of researching best practice (globally, private and public sector), interpreting its relevance and processes/ practices which could be implemented successfully to achieve system reform	✓		A/I

(advising on policy implementation)			
Physical Skills Working knowledge of Microsoft Office with intermediate keyboard skills	✓		A/I
Equality and Diversity Needs to have a thorough understanding of and commitment to equality of opportunity and good working relationships	✓		A/I
Financial and Physical Resources Previously responsible for a budget, involved in budget setting and working knowledge of financial processes	✓		A/I
Other Used to working in a busy environment	✓		A/I
Adaptability, flexibility and ability to cope with uncertainty and change	✓		A/I
Willing to engage with and learn from peers, other professionals and colleagues in the desire to provide or support the most appropriate interventions	✓		A/I
Professional calm and efficient manner	✓		A/I
Effective organizer, influencer and networker	✓		A/I
Demonstrates a strong desire to improve performance and make a difference by focusing on goals.	✓		A/I
Completer/Finisher	✓		A/I
Ability to travel around the county as required	✓		A/I
Some evenings	✓		A/I

Employment Acts and Codes of Practice

All employees are required to comply with employment legislation and codes of good practice.

- **Equality and Diversity**

We are an Equal Opportunities employer and will do all we can to make sure that job applicants and employees do not receive less favourable treatment because of their age, sex, marital status, faith, race, disability or sexual orientation, or for any other reason that is not justified.

- **Health and Safety**

In accordance with the Health and Safety at Work Act 1974, and other supplementary legislation, all employees are required to follow Trust Health and Safety policies and safe working procedures, take reasonable care to avoid injury during the course of their work, and co-operate with the Trust and others in meeting statutory requirements.

All employees must comply with Prevention and Control of Infection polices and attend any related mandatory training.

- **Risk Management**

Employees are required to report every incident where the health and safety of self or others has been jeopardised (including near misses) and to carry out or participate in investigations into such incidents as required.

- **Safeguarding Children and Vulnerable Adults**

All CSU employees and volunteers are required to act in such a way that at all times safeguards the health and well being of children and vulnerable adults. Familiarisation with and adherence to CUS and Lancashire County Council Safeguarding policies is an essential requirement of all employees and volunteers, as is participation in related mandatory training and safeguarding supervision.

- **Data Protection Act**

All members of staff are bound by the requirements of the Data Protection Act 1998.

- **Rules, Regulations, Policies, Standing Orders and Financial Instructions**

All employees are required to comply with the rules, regulations, policies, standing orders and financial instructions of the Trust.

- **Research and Development Projects**

Whenever you decide to undertake a piece of research, either as a Principal Investigator or Local Researcher, or Assistant Researcher, you must comply with the principles of Clinical Governance and the Research Governance Framework.

- **Development Review**

Key performance objectives, development needs and compilation of a Personal Development Plan will be discussed and agreed at Annual Development Review meetings.

- **Training**

Postholders are required to attend any relevant and mandatory training for the post.

- **Outside Employment / Outside Interests**

Any other work or outside interests must not conflict with the duties and responsibilities of your attendance for work as an employee of the CSU. In accordance with legislation on working time, it is a condition of employment that all staff must inform their line manager before taking up any private practice, work for outside agencies or other employers, other work for this CSU (including bank work) and / or voluntary work. This is to ensure there is no conflict of interest with your NHS duties.

- **Review of Job Description**

This is not intended to be a comprehensive description of the duties of the post. Due to the Trusts commitment to continuous improvement it is likely that the post will develop over time. These duties will be subject to regular review and any amendments to this job description will be made in consultation and agreement with the post holder

- The Trust operates a Smoke Free Policy

ACCEPTANCE OF JOB DESCRIPTION

I confirm I accept the duties contained in the above job description.

Name: _____ **(PRINT)**

Post holder Signature: _____ **Date:** _____

Line Manager: _____ **Date:** _____

Lancashire Better Care Fund Workshop

Thursday 10th December 2015, 9.00 am to 1.00 pm

Rowan Room, Woodlands Conference Centre

Chorley PR7 1QR

Programme

8.45 Arrival…tea and coffee.

9.00 Welcome and introductions

9.15 The Lancashire Better Care Fund so far…

- The process, The plan, The performance

9.45 What has it meant to you? ....group session

- What outcomes have been achieved?
- How has it made a difference to patients and service users?
- What challenges have been overcome?
- What have we learned?

10.45 Coffee

11.00 What next?...taking into account:

- National requirements / guidance
- Lancashire Heath and Well Being Strategy
- LCC Corporate Strategy
- Healthier Lancashire alignment of plans
- Lancashire CCB work programme
- Proposed combined authority

11.15 What are our ambitions for the Better Care Fund in Lancashire? ...group session

- How do we use it?
- What opportunities does it present?
- What else needs to happen?

12.30 You told us…plenary session / summary / questions

12.45 Next steps

1.00 Close and light lunch

Midlands and Lancashire Commissioning Support Unit

Lancashire Better Care Fund Workshop
Woodlands Conference Centre, Chorley
Thursday 10th December 2015

Lancashire Better Care Fund Workshop
Thursday 10th December 2015

1.0 Introduction

The Better Care Fund (originally known as the Integration Transformation Fund) was announced by the Government in June 2013. The main aim of the Better Care Fund was to transform efforts to integrate health and social care across England, by placing well-being as the focus of both entities with a shared plan and a single pooled resource.

The Lancashire Better Care Fund (BCF) workshop was arranged to provide an update to key stakeholders around the progress so far in terms of the process, the plan and performance, and to obtain their views around outcomes, challenges and ambitions for the BCF. The workshop was facilitated by John Berwick OBE and in attendance were representatives from Lancashire's Clinical Commissioning Groups, district councils, Lancashire County Council and the Voluntary Community and Faith Sector (VCFS). A full list of the attendees is available in Appendix 1 (page 7)

2.0 Method

Attendees were assigned to four groups to ensure complementary representation for the two breakout sessions and encourage a productive mix of contributions. The group breakout sessions were facilitated by Lancashire BCF Programme Managers and looked at:

1) What the BCF meant to them in terms of:
- What outcomes have been achieved?
- How has it made a difference to patients and service users?
- What challenges have been overcome?
- What have we learned?

2) What they felt their ambitions were for using the Better Care Fund in Lancashire in terms of:
- How do we use it?
- What opportunities does it present?
- What else needs to happen?

A full list of the speakers and facilitators is available in Appendix 2 (page 8).
The complete workshop programme is available in Appendix 3 (page 9).

3.0 Findings

The full set of feedback provided by the attendees is available in Appendix 4 (page 10), but in summary the feedback from the groups is as follows:

3.1 Breakout session one:

The main discussion points from the groups during the first break out session that focused on what BCF meant to the attendees were:

3.1.1 More engagement was needed with district councils and the VCFS as these organisations did not feel involved in or informed of the BCF process or plans.

3.1.2 More could be done to work together on pieces of work where there could be agreed principles and a standardised approach across Lancashire, specific examples given around this were:
- The Disabled Facilities Grant (DFG): more could be done around adaptions for patients and improving waiting times and the delays with residential care
- Local Health and Wellbeing Partnerships and Health and Wellbeing Boards could be more joined up and linked to the BCF work programme
- Engagement with the VCFS around BCF is variable and patchy; shared learning could be arranged to ascertain what has worked well in working with and involving the third sector
- Standardisation and co-ordination of the links to neighbourhood teams; it was recognised that some locality individuality could be necessary in some areas, but it was important to understand what was working well and what was not

3.1.3 Much of the groundwork had been done in that the governance structure and reporting mechanism were in place, and now it was on to phase two which was to establish a programme of work that would result in the outcomes of integrated care and standardised offers.

3.1.4 Relationships were being built between organisations, and going forwards there would be benefits in involving service users and support organisations, such as Mind and Age UK. Another suggestion was to include representatives from the district council and the VCFS on the BCF steering group and programme managers' group.

3.1.5 Relationships are being created at a local level between commissioners and also between commissioners and providers, and having the BCF senior leads working together helps with delivery. It was felt that the relationships between commissioners and providers had vastly improved; they were working as a team, with the presence of healthy challenge. Some of the benefits of this approach are that a joint vision can be articulated, staff are being recruited, processes and new teams have been developed.

3.1.6 There was currently an emphasis on "age well", and there was a general query as to whether there should be more of a shift to "start well", but the group felt that ultimately more emphasis should be assigned to the "live well" aspect and to provide more support for people to live well in the community. It was identified that this focus would result in more integrated working with the VCFS and district councils and also a reduction in duplication of funding arrangements.

3.1.7 From a patient perspective, it is not the BCF per se that has made a difference but the individual work streams that are taking place, and especially in areas where learning is being shared and areas for joint working are being identified. It was suggested that a cultural change was needed to alter patients' perceptions of their "right" to see a

consultant as this may not always be necessary and another appropriately skilled health specialist may be able to provide a better quality service, experience and better outcome to meet the patient's needs.

3.1.8 With regards to social care it was felt that there were quicker links within a unitary authority as opposed to within Lancashire County Council that covered the majority of the county.

3.2 Breakout session two:

The main discussion points from the groups during the second break out session that focused on what the attendees felt their ambitions were for using the Better Care Fund in Lancashire were:

3.2.1 There was a need to bring more funding streams together, particularly in areas of shared risk, shared ambition and shared opportunity; but this needed to be done on a larger scale, rather than in silos, with areas that transcend health and social care across geographical locations and organisations. It was recognised that a wider understanding was needed of what can be pooled together, and these may be areas that have traditionally been kept apart.

3.2.2 An element of flexibility was needed from all organisations involved, as when organisations are trying to reduce spending it can result in a gap in services when each organisation removes an amount of funding. One solution suggested was to see funding as one whole amount and then prioritise in terms of what areas need the most investment and where it is essential to always absolutely deliver, and which areas a patient/family may have to fund themselves. It was suggested that despite joint commissioning and working very closely together, there may currently be mixed messages and confusion for patients and families, around what health services provide, what social care services provide and what patients must provide for themselves.

3.2.3 The benefits of prevention rather than crisis management were discussed along with the pressures of trying to ensure the right balance and spectrum of spend across the end of life care, for people in nursing home care, for people with multiple needs and morbidities right through to the early help and intervention for young people. It was highlighted that prevention does not deliver much for social care services over a two year period, instead it was the long term investment around prevention that would assist in ensuring people have healthier lives for as long as possible. Projects need to be longer term so that any outcomes and achievements from investments made with young people can be seen later in adulthood. In summary shorter term preventative measures are necessary to promote independence as quickly as possible and a longer term investment cycle is needed in order to see any benefits and outcomes. An example was given around "frequent flyers" often having chaotic lives and issues such as poor housing and what could be done to really target things and see the A&E attendance rate drop. A possible solution could be to move to something that is traditionally out of scope.

3.2.4 There was a need for a consistent vision across the whole of the patch with a local vision to underpin it all. Communication with the public and stakeholders was crucial, along with a need for honest discussions to take place where a service cannot continue to be provided. Having sign up to and belief in the vision from workforce

was also felt to be essential – frontline people need the knowledge. It was also important to benchmark what is done today so that 12 months later any effects can be demonstrated, as changes are not always seen on a day to day basis due to pressures in the system. Being able to demonstrate positive change could be one way to enthuse the workforce. Consistency in the workforce was also felt to be important as there was a sense that organisations were "all fishing in the same pond" for staff and there was a tendency to use agency staff too.

3.2.5 It was felt to be beneficial to have a consistent evidence base across Lancashire and clarity around how we link in with organisations such as AQuA, public health, universities etc. to underpin any business cases that are produced. It was queried whether going forward there would be multiple business cases produced or a single Lancashire business case but with local flavour. The latter option could reduce duplication and demonstrate where there is going to be impact.

3.2.6 Other points mentioned were the need for patient education and having consistency in language, for example being able to articulate to the public what the offer is from a neighbourhood team or a primary care service and reduce the number of terms for the same service.

3.2.7 The group described how behaviour change was needed in terms of:

- within organisations and also how they interact with each other
- in the communities so that they seek different interventions
- the community assets that operate on the front line so that they see themselves as part of the health economy with the common aim of what is trying to be achieved

3.2.8 The need to involve partners who can become part of the delivery chain - individuals, community based organisations, voluntary sector, local authorities, and different component parts of NHS. It was suggested there needs to be investment through Healthier Lancashire to facilitate this, to coordinate effectively, to produce research of evidence of why a business case is effective in terms of return of investment and ultimately leadership.

3.2.9 It was recognised that what was missing, not just in Lancashire, but across the country, is defining what actions need to take place to make the vision a reality. An attendee from Healthier Lancashire explained that the next step for this programme was to describe what it is that is being built, from both a professional and the public perspective. The workforce and the public would need to be involved in these discussions to ascertain what good looks like from different perspectives.

3.2.10 There was a brief discussion around the possibility of Healthier Lancashire and the BCF work stream coming together due to the similar aims and intentions. Overall it was felt though that the programmes needed to remain separate in order for the BCF to give a ring fenced fund, enable the planned changes to happen and hopefully illustrate there was a business case, a return on investment and allow for further growth. The longer term plan needed to be protected from the more immediate pressures.

4.0 Conclusion

4.1 In summary it was felt that:

- there were opportunities to look at different funding and commissioning arrangements – bringing monies together in a different way and addressing priority areas.
- it was beneficial to continue to build relationships and it was recognised that it is a long journey to do things differently. Wider engagement was needed with district councils and the VCFS.
- there may be a version of Devolution Manchester to be developed in Lancashire. This still needed to be worked through but it could be a combined authority or some other version. Health and social care are a major aspect of this initiative.
- working more collaboratively could help to drive difficult discussions as challenging decisions and explanations to the public can be carried out collectively. When this is done separately it can sometimes result in a cost shunt between health and social care.
- ambitions needed to be bigger, bolder and longer term in ambition. A clear definition of what is being built and the actions needed to achieve this was also essential.

4.2 The attendees were asked to complete a workshop evaluation form. The attendees who completed the evaluation had found the workshop worthwhile and overall felt the objectives of the workshop had been achieved. The full evaluation findings report are in Appendix 5 (page 16).

Appendix 1

Attendees at the Lancashire Better Care Fund Workshop

Name	Organisation
Barbara Ashworth	Rossendale Borough Council
Mike Banks	Fylde and Wyre CCG
Paul Beech	East Lancashire CCG
Tom Birtwistle	Fylde Borough Council
Richard Cooke	Lancashire County Council
Cath Corcoran	Lancashire Teaching Hospitals
Ian Crabtree	Lancashire County Council
Alan Crowther	East Lancashire Hospital Trust
Gill Dickson	Pendle Borough Council
Sarah Eccles	Lancashire North CCG
Cathy Gardener	East Lancashire CCG
Tony Harrison	Burnley Borough Council
Paul Hegarty	Blackburn with Darwen Council
Sue Hird	Lancashire County Council
Deborah Howe	Lancashire Care NHS Trust
Justine Howe	NHS England
Paul Kingan	West Lancashire CCG
Adrian Leather	Lancashire Sport
Charlotte McAllister	West Lancashire CCG
Jennifer Mullin	South Ribble Borough Council
Sam Nicol	Healthier Lancashire
Alison Patterson	Lancashire County Council
Tony Pounder	Lancashire County Council
Kirsty Slinger	East Lancashire CCG
Mike Smith	NHS England
Mike Walker	Hyndburn Borough Council
Kathryn Woods	Lancashire Care Foundation Trust
Mark Youlton	East Lancashire CCG

Appendix 2

Speakers and facilitators

Mark Youlton	Chief Finance Officer, East Lancashire Clinical Commissioning Group. Chair, Lancashire Better Care Fund Steering Group
John Bewick OBE	Workshop Facilitator
Paul Robinson	Senior Programme Manager, Lancashire Better Care Fund
Justine Howe	Better Care Coordinator (Lancashire, Greater Manchester, Cheshire and Mersey), NHS England
Sam Nicol	Director, Healthier Lancashire
Richard Cooke	Health Equity, Welfare and Partnerships Manager, Lancashire County Council.

Lancashire Better Care Fund Programme Managers

Sarah Eccles	Senior Manager – Contracts and Delivery Lancashire North CCG
Mike Banks	Consultant, New Models of Care, Fylde and Wyre CCG
Jane Kitchen	Jane Kitchen, Transformation Manager - Urgent Care NHS Chorley & South Ribble Clinical Commissioning Group and Greater Preston Clinical Commissioning Group
Charlotte McAllister	Charlotte McAllister, Urgent Care Commissioning Lead West Lancashire CCG
Alison Patterson	Programme Manager, Lancashire County Council

Workshop Support

Sharon Walkden	Service Redesign Officer, Midlands and Lancashire CSU
Heather Symons	Service Redesign Project Support Officer, Midlands and Lancashire CSU

Appendix 3

Programme

8.45 Arrival…tea and coffee.

9.00 Welcome and introduction…John Bewick and Mark Youlton

9.15 The Lancashire Better Care Fund so far… Paul Robinson,

- The process, The plan, The performance

9.45 What has it meant to you?
....group session…Better Care Fund Programme Managers

- What outcomes have been achieved?
- How has it made a difference to patients and service users?
- What challenges have been overcome?
- What have we learned?

10.35 Coffee

10.50 What next? Considering:

- National requirements / guidance
  …Justine Howe,
- Lancashire Health and Well Being Board, Priorities and Plans
  …Richard Cooke
- Healthier Lancashire alignment of plans
  …Sam Nicol

11.20 What are our ambitions for using the Better Care Fund in Lancashire?
...group session…Better Care Fund programme managers

- How do we use it?
- What opportunities does it present?
- What else needs to happen?

12.30 You told us…plenary session / summary / questions

12.45 Next steps …Mark Youlton

1.00 Close and light lunch

Appendix 4

Session 1 – BCF - What has it meant to you?

Question 1 – What outcomes have been achieved?

Metrics still developing	Complex health and social care system – Lancashire
Successful partnership working plus continue to develop between hospital trust and CCG	Maintained executive ownership and delivery – CCB become more functional
Facilitated move integrated working	Building effective relationships
More impact at a Lancashire level – implementation at local level – BCF as enabler at local level	BCF is a vehicle for delivering integrated care – both at a local and Lancashire level
Risk averse	Lancashire as an entity
Different priorities, different means	Buy in to IT
Reduce duplication e.g. with rehab, domiciliary care	Unclear how patients affected - how has BCF impacted locally
Strategic and operational split – influence on strategy	Steering Group – CCGs and County Council – how do wider partners influence?
Grown relationships, joined up working o In a better place to deliver o Consolidation of schemes – focus	

Question 2 – How has it made a difference to patients and service users?

Early days in terms of measurement	Development of INTs and MDTs
'Falls' car	Intensive integrated care teams
Increased partnership working between providers	Redesigned virtual ward – increased access, seven day service
Wellbeing service aligned closely to integrated teams	Reducing duplication and creating a simple system
Has the pooled budget made a difference?	Greater focus on people's wellbeing
Re-configured voluntary sector	Longer term development
Reablement brought to fore for CCG	People want smooth transition
Not yet in large sense, maybe individually	Shouldn't matter which organisation, wrap services around patient/res – it's about quality of life
Support services making difference but not consistent across patch e.g. IV services and bridging support.	Intensive home support team in East Lancashire deflected 66% of patients who would otherwise have been admitted through ED.

Session 1 – BCF - What has it meant to you? continued

Question 3 – What challenges have been overcome?

Overcome complexity of 'Lancashire Plan' and dispersed areas within	Governance arrangements around finance and impact of schemes ('local' versus 'Lancashire' impact)
Tackling underpinning issues i.e. workforce	Change in culture
Workforce – agency staff/rates	Missed opportunity for joint commissioning
Quick wins really important	Pace of integrated commissioning
Internal focus of the council	Reorganisation – loss of staff/workforce
Leadership from CFOs important	
Districts – involvement of local health & wellbeing limited • East Lancs • Fylde DFG involvement • Programme Manager level involvement from districts? • Thought it was to happen • Work mainly around DFG	
Voluntary Sector • One place on H&WBB – Limited involvement • New rep on local H&WBB partnerships • Tokenistic maybe working at local level but not strategic led	
CCG • Policy, tick boxes, get plan together • Reflects what was happening locally • Relationships, enablers • Performance metrics – acute trust focus – is this driving activity? • Complexity of system • Older people focus • Duplication around health and wellbeing function and services - needs to be more joined up - CVS • Consistency of offer - not all areas have same services - patches of work - How do we make this consistent across Lancashire?	

Question 4 – What have we learned?

Working together is the way forward!	Commissioners and providers working together as a team
Voluntary sector	Look at now BCF is
Need a standardised offer	Governance – formal process
Decision making	District and voluntary sector involvement
Living well: Keep people well Join up services Prevention Quality of life	Social isolation: Growing issue Impact on system
Learning from other parts of the country e.g. Plymouth and public sector review Chorley/Central	

Session 1 – BCF - What has it meant to you? continued

Session 1 - Summary of feedback from groups recorded by Paul Robinson

Built relationships (team challenge, not 'cosy')	Patients/service users seen benefits - but not BCF made a difference for patients
Not enough district and third sector involvement	Perceptions and expectations challenge change
Groundwork is done (Phase 1)	Emphasis on Age Well but Live Well
Still much duplication	Unitary position +ve
Relationships at local level – Coms/providers	Need to change perception/expectations
Lancs wide 'many partners'	Joint vision – developed
Challenges differ	Hard metrics E.L. – deflection
Different relationship: Coms and provider – team Healthy challenge – not cosy	How far have we come? JB – headline
Not much DC involvement?	HWBB - ?Governance – links/communication
DFGs	Patchy engagement – learning
Using community assets	Reflects experience
Building relationships	
Voluntary sector - involvement?Big orgs - dialogue? Service users' experience - mobilise Community assets	

Session 2 – What are our ambitions for using the BCF in Lancashire?

Question 1 – How do we use it?

Vehicle to bring all strands together	Prevention not crisis management
Flexibility how funding is allocated/spent	Healthier Lancashire co-ordinating role
Use mass media for common themes	Provide evidence bases for schemes
Using that learning across Lancashire	Enabler
Not just money – about developing initiatives	Involve system – vision
Not just elderly focussed	To investigate a cultural shift
Build partnerships – working together to meet budget challenges	Shared outcome and service delivery – Health/Social Care/Voluntary Sector
Sharing information, sharing local delivery and management	Bring funding streams together - shared risk shared ambition/opportunities
What is the commonality – what do patients expect?	What is BCF and what is Healthier Lancashire? Become one and the same in the future
Wider detriments - Housing, employment, opportunities, education - Use fund to promote - Broaden budgets and engagement – or else will always be driven by acute end and patching up/support – focus on quality of life and living well	Total place - Mechanism to drive - Integrated neighbourhoods – Plus!

- Long term benefits for population - Public health outcomes – but broader, good place to live	

Session 2 – What are our ambitions for using the BCF in Lancashire? continued

Question 2 – What opportunities does it present?

Opportunity to look at different commissioning and funding arrangements	To enable and drive potential 'difficult' discussions - opportunity to stop doing things?
Building relationships – strengthen on last 12months	Comms & engagement – better campaigns supporting Healthier Lancashire
Devolution Lancashire	Prevention – rather than crisis management
All age – not just frail/elderly	Sharing of schemes across Lancashire
Easier access for patients in terms of navigating services	Being able to work closer with districts – share knowledge and information
Common platform, one voice	Use a different process to develop options
Library of evidence/more evidence based approach	Having the mechanisms to effectively joint commission
'Healthier Lancashire University'	To facilitate behaviour change
Not just financial – sharing lessons learned	Partnership working – reduce duplication
To invest more in preventative services	Public Health involvement
Risk – stop the hospital always being the main focus	Collective mobilisation of resource and assets
Way to protect budgets - Danger of mistrust, but need honest conversations – shared risk - Joint responsibility - System approach	Digital enablers - Record sharing - Technical issues
Sustainable change – needs earlier intervention – acute is too late!	Start with individual and work back – quick, easy to navigate support. - Coordination of service offer.

Question 3 – What else needs to happen?

Improved communications – patient expectations	Bigger and bolder - 'All Age'
Longer term	Detailed prioritisation
Organisationally need to align to deliver	Build on the platform of civil responsibility
Better Lancashire leadership	Consistent messages and terminology
Better public consultation and engagement	Unified Lancashire vision
Bottom up approach not top down	Health and Wellbeing Boards are pivotal
Compromise on sovereignty - HL joint committee	Primary care development needs to be aligned signed up to
Develop a delivery chain	Enables voluntary sector to bid for monies
Include Public Health	Pool initiatives not just money
Expert patient – digital	Information share with districts
Broader partners – bottom up approach	Wider involvement and engagement - District councils - Voluntary sector – grow - Managing politics
BCF managers group to be more closely in	Housing and social care sharing information

touch with Healthier Lancashire development	and working with each other

Session 2 – What are our ambitions for using the BCF in Lancashire? continued

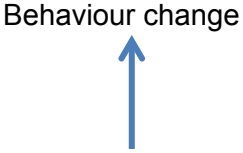
Examples:	
What does good look like?	Where things haven't gone well, opportunities missed
Focus – main agency working	Link to combined authority
What does BCF look like elsewhere? - Good practice - Other 2 tier areas - Other examples which could be adopted in Lancashire - Don't be restricted by geography – what works? - Use existing good local structures/processes	Vulnerable groups - Cohorts known as high users of services – prevention - Build support early - Joint approaches

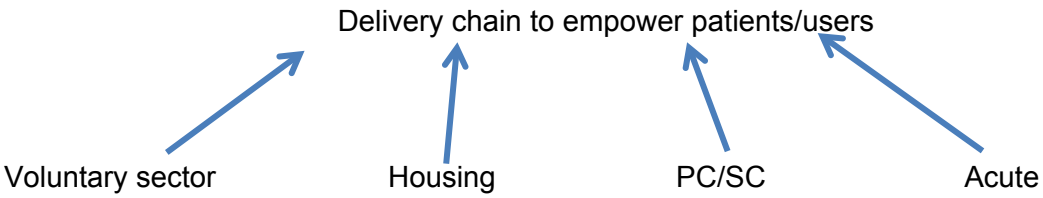
Session 2 - Summary of feedback from groups recorded by John Bewick

1. Increase funding streams together, wider pooling connections e.g. Res nursing home. Honesty about financial shortfall now	2. Wider – prevention/indep! (Spec top % impact) Longer term investment cycle
3. Flexibility = pool and see as one £ = personalisation = people focused	4. Opportunities Increase finance and relationships Devo Lanc of which health and social care increases Reality of stopping some services Look outward to other systems
What more? Voluntary sector District Councils	Bolder longer term: Consistent vision, local identity, public engagement in vision, stakeholder, workforce, vision: to build what?, enablers – workforce/IT, evidence base, business case, patient education, consistent language
Bring together with Healthier Lancashire but ring fence the prevention/resilience Place based, wider	

What are we building?

Example:





Session 2 – What are our ambitions for using the BCF in Lancashire? continued

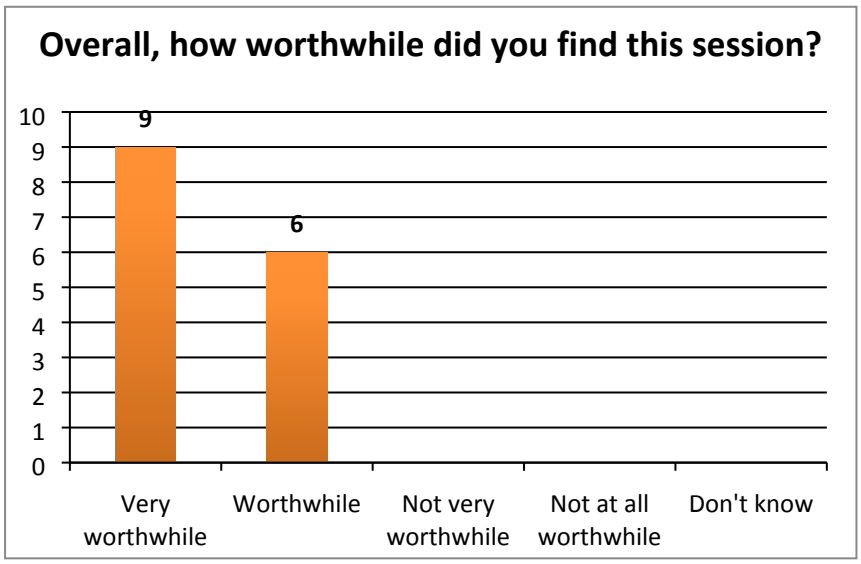
Session 2 - Summary of feedback from groups recorded by Paul Robinson

What would BCF look like?	PQ Map Spend on BCF priority areas
Care system – TP? Longer term – TP?	Offer to district councils and third sector
Care homes – 2 x funding streams	Move on Residential/Nursing Sector/PHE
MY - INT	?Timescale
Stop people getting ill BCF contribute to community resilience e.g. COPD – address route causes e.g. housing Children's obesity – Children run a mile a day, the GPs measure obesity	PH – pool it Get and jointly deliver Around table to deliver best for Lancs
	16/17 – have to do? HWBB – BCF – looks like e.g. Resi/Care PH
	BCF to jointly commission services - model

Appendix 5

Attendees' evaluation of workshop

1. Overall, how worthwhile did you find this session?



2. Please tell us more about how worthwhile you found the session, what were your main reasons for the answer given above?

It was worthwhile in that it brought together a very wide perspective/participant, but that also presented some difficulties for me.
Great to have the discussion and positive movement
Very good discussion about current and future
Getting pragmatic people in the room who do want to look at implementing what we need to build
Really good to hear what's going on in respect of delivery. Good ideas coming out to improve things.
I was able to build on my knowledge base of BCF and understand strategic view
Bringing partners together
Opportunity to consider and reflect key future challenges and way through them
Very worthwhile getting all partners together to explore future for BCF
Voluntary sector profile and engagement Build networks and knowledge of the CCG network
Worthwhile as it is part of he process of shaping and driving future BCF
Maintaining and growing momentum, broader remit, new partners Starting to plan early

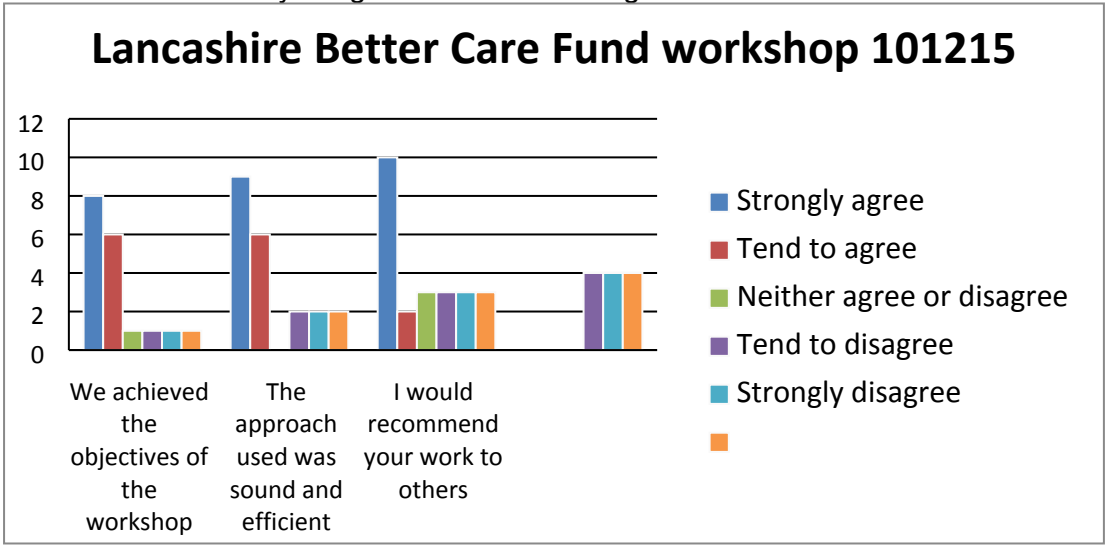
3. What part of the workshop was the most useful and why?

The workshops/group sessions - honest conversations - being listened to and understood
All
Forward planning including wider Lancashire partners - links to Healthier Lancashire
The work on tables and networking
Ambition session
Discussion on tables to hear a range of perspectives
Group sessions and context - big picture
Conversations with partners
Second workshop, discussing future model and acknowledgement of role of districts and voluntary sector and pooling public health resources/outcomes. Very encouraging
All well structured and informative

4. What part of the workshop was the least useful and why?

The middle section - too rushed and hard for me to follow as I know little about any of these three areas - needed background papers beforehand.
First part as I haven't really been involved to date on BCF delivery

5. To what extent do you agree with the following statements?



6. Any other comments?

Need to implement what has been agreed today
John Bewick is very positive as a facilitator.
Engagement with districts - would be useful to brief council leaders to get this support/engagement

Local Authority Health Leads

Wednesday 9th March

10am-12pm

Cabinet Room B County Hall Preston

Agenda

1.	Welcome and Introductions	Clare Platt	LCC
2.	Minutes and matters arising from last meeting	Clare Platt	
3.	Health and Wellbeing Board		
	Link to Board papers 22nd February – See Items 5 & 6		
	• Sustainability Transformation Plan	Clare Platt	
	• Better Care Fund	Paul Robinson	NHS CSU
4.	Disabled Facilities Grant	Chris Calvert	LCC
5.	A Strategy for Physical Activity and Sport	Caroline Holtom	PHE
6.	Crisis and Support Fund	Clare Platt	
7.	AOB		
8.	Date of next meeting		

Lancashire County Council

Lancashire Care NHS Foundation Trust

NHS Lancashire North Clinical Commissioning Group

NHS Chorley and South Ribble Clinical Commissioning Group

NHS Greater Preston Clinical Commissioning Group

NHS East Lancashire Clinical Commissioning Group

NHS West Lancashire Clinical Commissioning Group

NHS Fylde and Wyre Clinical Commissioning Group

The Multi-Agency Carers Strategy Summary Lancashire 2016-18

Working together for carers

Carers Lancashire Supporting carers locally

Believe in children Barnardo's

It is widely recognised that carers make an invaluable contribution to society but that the cost to the carer can be high in terms of their personal health and general well-being. There have been real steps forward over the past few years in relation to support for carers in Lancashire. The commissioning intentions below build on these positive steps and will improve and develop existing services. The commissioning intentions are based on the evidence detailed within the full strategy. The intentions are grouped under themes that carers tell us capture the fundamental issues that they face as a result of their caring responsibility.

The vision for carers in Lancashire

The vision for carers in Lancashire is informed by what carers have told us is important to them and based on the four priority areas identified in the Government's Carers Strategy Refresh (2010), 'Recognised, Valued and Supported'.

We are committed to ensuring that carers in Lancashire:

1. **Are identified and recognised**
2. **Realise and achieve their potential**
3. **Have a life outside of their caring role**
4. **Are supported to stay healthy**

Quality of services and support

We Will…….

- Analyse available carers data to enable resources to be targeted in the areas where support is most needed in Lancashire
- Explore the options of offering extended carers service opening hours
- Explore ways of creating greater consistency in the allocation of social workers and improve communication
- Drive up the quality of services and support through considering quality in all aspects of commissioning and by effective service monitoring
- Review carers service contracts by March 2016
- Develop a charter detailing carer involvement principles with the aim of achieving sign up from Lancashire County Council, Lancashire Care Foundation Trust and Clinical Commissioning Groups to ensure staff have guiding principles in supporting carers
- Update the Better Care Fund Plan to ensure it reflects the commissioning intentions within this strategy

Getting a Break

We Will……..

- Evaluate the new system that has been introduced to replace the short break voucher scheme to ensure that the options carers now have to pay for their short break are working for them
- Evaluate the new system introduced to offer carers a personal budget to ensure its working for carers
- Develop systems and processes for carers to enable them to have the option to do their carers assessment themselves via an on line self assessment portal
- Scope out opportunities to extend the sitting in service to include a volunteer buddying scheme, which will

provide support to carers experiencing difficult situations
- Ensure that there are bookable short break beds and that they are promoted via carers services and the Care Navigation services
- Drive up the numbers of carers who care for someone with a mental health problem who are referred to the carers mental health service and for a carers assessment

Health and emotional well-being

We Will……

- Scope out ways to support carers who want to plan for the future for when they may not be in a position to provide care anymore
- Offer carers caring for someone with a mental health problem courses to help with coping strategies
- Explore the options around offering carers mindfulness courses

Getting the Right Information

We Will……...

- Review all the information promoted on carers services, Lancashire County Council, Lancashire Care Foundation Trusts and Clinical Commissioning Groups websites to ensure its consistent and appropriate
- Ensure that the following is promoted on carers service websites, via carers assessments, support groups and via social media:
  - The Care Navigation Service
  - Peace of Mind 4 Carers
  - Carers assessments
  - The options around having a break
  - Carers courses
  - Benefit information, including links to services that can support form filling

Income and employment

We Will……..

- Identify services that offer support to individuals to complete forms and promote them to carers
- Ensure carers service workers receive basic training to inform them about available benefits and ensure this knowledge is kept up to date

Carer Recognition

We Will……...

- Work with hospitals in the area to increase the number who adopt a hospital passport which includes a robust section about the carer
- Develop targeted support for young adult carers within carers services working in partnership with young carers service providers
- Offer all professionals who may come into contact with a carer free carer awareness briefings, specifically targeting mental health teams across Lancashire
- Work with colleges in Lancashire to identify and support parent carers who are going through a transitions process with the young person they care for and ensure support is provided through carers services for them

- Increase the numbers of carers supported by carers services to 19% of the 133,000 carers identified by the 2011 census in Lancashire, a rise of 5% by 2018
- Scope out the possibility of GPs adopting a Lancashire wide form that carers can complete to report issues/changes with the person they care for
- Work with home care providers to ensure they recognise and refer carers into carers services

Young carers

We Will……..

- Promote a positive culture of supporting young carers
- Improve the identification of young carers
- Use a whole family approach to assessment and service delivery
- Support young carers and their families in order to reduce the number of young carers whose caring responsibilities have increased. It is our aim to improve the health and wellbeing of young carers
- Raise awareness about young carers and their issues amongst organisations and professionals
- Encourage designated young carer champions in schools;
- Ensure that young carers in educational settings such as short stay schools, colleges or home educated are identified and have access to support
- Ensure all young carers have access to an assessment of their need
- Continue to develop an integrated approach, working in partnership with other agencies, to allow young carers to learn, develop, thrive and reach their full potential
- Where possible, jointly commission, design and deliver young carer services with our partners, making the best use of resources
- Support young carers at key transitional stages throughout their childhood, including from children's to adult services
- Continue to support young carers to have their voices heard

Parent carers

We Will…….

- Improve transition for young people moving into adult services
- Ensure parent carers have access to information to support them in their caring role, this will include face to face, hard copy and electronic information
- Continue to work with parent carers to develop parental participation
- Work jointly to ensure Lancashire County Council and Clinical Commissioning Groups have increased recognition and support of parent carers

Next steps

To ensure that this strategy is making a positive difference to carers, it is important that developments are monitored and reviewed. The responsibility for delivery of the commissioning intentions will lie with all those signed up to the strategy and more specifically carers services. .

If you would like a copy of the full strategy or more information about support to carers in Lancashire, please call: 0345 688 7113

Working Title:

A Unified Lancashire Digital Health Roadmap

2016-2020

DRAFT VERSION (1.3)

Note to the reader:

This version of document encapsulates comments from stakeholders. Going forward it is anticipated that the output from the Healthier Lancashire Alignment of the Plans Report and additional roadmap resources from NHS England will lead to further iterations of this roadmap.

Index

Foreword

For completion on approval of the outline roadmap with stakeholders.

Executive Summary

The NHS is undoubtedly in the midst of a formidable challenge brought about by a combination of reduced investment, increasing demand and new technological innovations. Lancashire, like many others parts of the country will see significant demographic and public health changes over the next five years. There will be a 13% increase in the number of people aged over 70, whilst at the same time the health inequalities gap will rise. Meaning that more people in Lancashire are likely to die prematurely from chronic illness, in part caused by the wider determinants of health, such as low income, poor education and housing. This gives us a sense of urgency in responding to the challenges set out in the Five Year Forward View and in reforming our public services for the future.

All across the country, communities are digitally transforming to respond to increasing demand and less money. In Lancashire, this transformation has started with the introduction of a new approach to electronic record sharing, as part of the Healthier Lancashire Programme. However, going forward more will need to be done to meet local need and the expectations of Government[1], who set out a clear direction for the healthcare system to:

- Improve local partnerships with greater integration across the system
- Seek a radical upgrade in public health
- Put patients in control of their own care
- Use technology to improve patient experience and access

In October 2015, NHS England issued new guidance to Clinical Commissioning Groups (CCGs) to establish Digital Roadmaps[2], which will map out how communities move towards paper free at the point of care by 2020. For Lancashire, the CCGs have agreed to create a single countywide Roadmap, coordinated through the Healthier Lancashire Digital Health Board. This new roadmap will build on the established programme to:

- Improve the digital maturity of healthcare providers to enable them to be paper-free at the point of care by 2020

[1] https://www.england.nhs.uk/ourwork/futurenhs/
[2] https://www.england.nhs.uk/digitaltechnology/info-revolution/digital-roadmaps/

- Share electronic records across organisations to support effective & efficient care
- Empower the patient to be an active participant in their care by giving them access to their health records
- Enable citizens to harness the power of assistive technology to live independent, healthy lives
- Make better use of our data to predict need and inform future service delivery
- Create opportunities for economic growth within the region in the digital health sector
- Create a robust, affordable IT infrastructure that supports integrated working across the public sector workforce

{summary of key actions}

1. Introduction

1.1. The NHS is undoubtedly in the midst of a formidable challenge brought about by a combination of reduced investment, increasing demand and new technological innovations. The scale of this challenge has been documented by Simon Stevens, CEO for NHS England, who paints a clear picture on what we all need to do if we want to continue having a universal healthcare service that offers high quality care for all. In the Five Year Forward View[3], he sets out a clear direction for the healthcare system to:

- Improve local partnerships with greater integration across the system
- Seek a radical upgrade in public health
- Put patients in control of their own care
- Use technology to improve patient experience and access

1.2. For Lancashire, the challenge is manifesting itself in the form of a financial gap; the exact scale of which is yet to be determined. However, it could be in excess of £800m by 2020, if left unchecked. Tackling this mammoth problem is going to require bold solutions, effective leadership and purposeful collaboration across health, social care and the third sector. In response to the Five Year Forward View, NHS England have published a framework called 'Personalised Health and Care 2020: a framework for action'[4] , which outlines examples of how the application of technology can improve health outcomes, transform quality and reduce costs. Also contained within the framework are proposals to help, such as:

- Increasing the use of remote diagnostics and telecare
- Increasing the use of consumer health technology
- Empowering citizens to use their own health data

1.3. Stemming from the 2016/17 NHS planning guidance, there is now a requirement for Clinical Commissioning Groups (CCGs) to develop digital roadmaps and define a collaborative footprint in which organisations will work together on delivering fully interoperable digital records.

3 http://www.england.nhs.uk/wp-content/uploads/2014/09/nxt-stps-to-co-comms-fin.pdf
4 https://www.gov.uk/government/publications/personalised-health-and-care-2020/using-data-and-technology-to-transform-outcomes-for-patients-and-citizens

1.4. Consequently, the purpose of this paper is to define the characteristics of a digital roadmap that will underpin a comprehensive system-wide transformation programme that supports the community in meeting the challenges that lie ahead.

1.5. This new roadmap will build on the endorsed initiatives that were agreed by the Digital Health Board in late 2014 – see below:

1.5.1. Table A – Digital Health Board Scope:

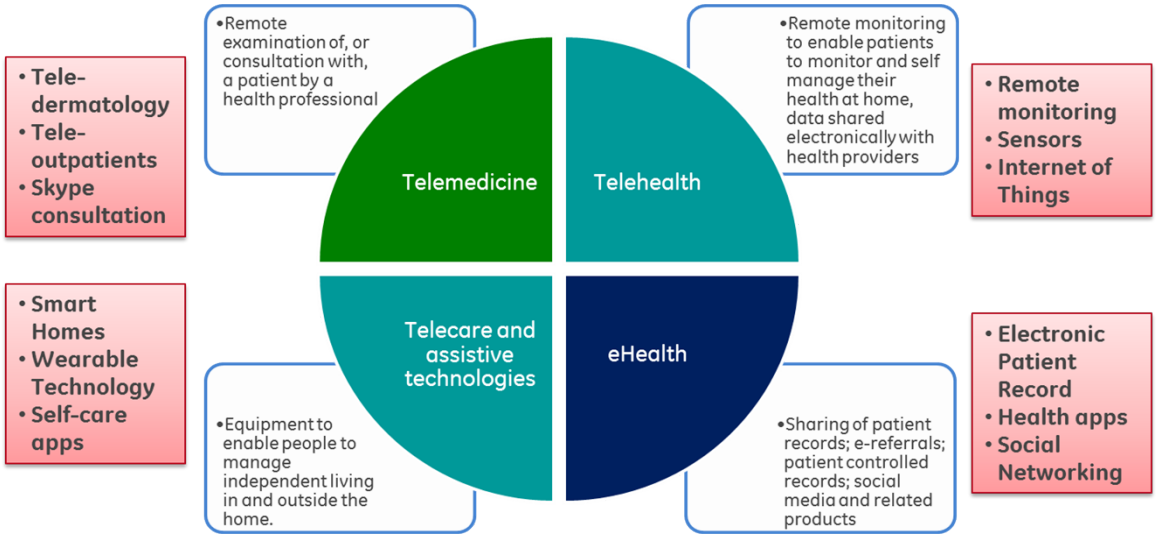
Enabling outcomes, experience, empowerment, efficiency, sustainability and innovation			
SIS stakeholder board	E prescribing	Online access	Shared records platform
Sharing good practice	Exploring patient held records	Promoting a digital first approach	Assisted independent living
E-Growth & commercial partnerships	Promoting digital literacy	Infrastructure	Telehealth/Telecare

1.6. This is a first iteration of the roadmap with the intention that it will adapt and grow over time in conjunction with stakeholder plans. The primary objectives here are to:

- Refine and reframe the current Digital Health Board agenda based on the feedback and insight gained from stakeholders over past 12 months.
- Ensure there is mechanism to allow the roadmap to respond to the emerging transformation agenda
- Identify opportunities within digital health to address the wider determinants of health, including economic growth in the digital sector across the region
- Align the Digital Health Board's agenda with emerging CCG's Digital Roadmap with the intention of creating a unified approach across Lancashire
- Enable Digital Health Board members to effectively prioritise initiatives going forward
- Ensure there is a shared understand of what digital health is and the opportunities it presents to transform the system

2. What is digital health

2.1. Technology is constantly changing and so are the words the industry uses to explain it. There are many definitions of what digital health is, however for the purpose of this document we will build on the work of Alison Marshall from University of Cumbria, see below:



2.1.1. Diagram A – The components of digital health

2.2. Building on the diagram above, Paul Sonnier digital entrepreneur, describes digital health as the convergence of the digital and genomic revolutions with health, healthcare, living, and society. Digital health is empowering people to better track, manage, and improve their own and their family's health, live better, more productive lives, and improve society[5].

2.3. Broadening these perspectives on digital health to a regional footprint leads to the concept of a digital health ecosystem[6], which encompasses a whole range of stakeholders within the digital health agenda to:

- Breakdown silos
- Develop lasting collaboration across the public, private and third sectors
- Improve patient care
- Improve efficiency

[5] http://storyofdigitalhealth.com/
[6] http://www.echalliance.com/ecosystems/

- Drive economic growth

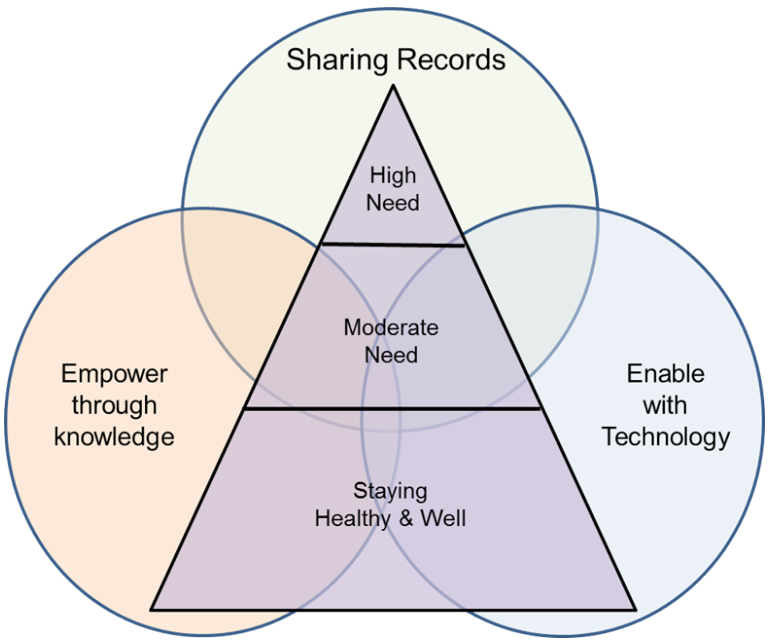
2.4. In context of this roadmap, there are three broad themes a digital health ecosystem aims to deliver for the citizens of Lancashire. The Venn diagram below outlines how these initiatives will be aligned to population health need.

2.4.1. ***Sharing*** of electronic records is primarily focused around supporting safe, integrated care for those with the highest need. Typically, this is the same group of people who have the most interaction with and across healthcare services. In a more general sense, record sharing underpins the whole healthcare system.

2.4.2. ***Empowering*** people through the sharing of knowledge is aimed at helping those people with moderate to low need. These people may have one or more long-term condition but are otherwise well. Here technology is used to give them access to information about their condition and allow them to be actively involved in managing their own care.

2.4.3. ***Enabling*** people with technology is utilising a range of technologies, including lifestyle and consumer devices to help people stay healthy and well, access services in new ways and to bring care closer to home. Whilst there will be many scenarios for technology to support those with the highest need, the transformational priority here will be to use technology to promote health literacy, prevent illness and improve the accessibility of care.

2.4.4. Diagram B - The alignment of digital health technology to population need



3. Strategic & Economic Context

3.1. Lancashire, like many others parts of the country will see significant demographic and public health changes over the next five years. There will be a 13% increase in the number of people aged over 70, whilst at the same time the health inequalities gap will rise[7]. Meaning that more people in Lancashire are likely to die prematurely from chronic illness, in part caused by the wider determinants of health, such as low income, poor education and housing. Unfortunately, parts of the county demonstrate some of worst deprivation in the country[8]. This gives a sense of urgency in responding to the challenges set out in the Five Year Forward View. For Lancashire this will mean finding effective solutions to respond to:

- Twice as many people with cancer
- A 70% increase in obesity
- 175,000 more people with diabetes

3.2. Across the public sector, organisations are digitally transforming to meet the challenges of increasing demand and less money. Deloitte recently reported that over 80% of public sector leaders are developing digital strategies that aim to:

- Increase efficiency
- Improve customer experience
- Drive organisational success

3.3. Yet the respondents had concerns about their organisation's capability to deliver against their digital plans[9]. The NHS in particular, has been slow to develop its digital channel[10], however the new policy framework aims to radically improve digital maturity over the next five years. Technology alone will not bring about the desired change, there are many other factors that need to be considered on our digital transformation journey. Deloitte sets out five questions for leaders to consider in accelerating their digital transformation:

3.3.1. Do we have a digital strategy that is clear, coherent and central to our leadership narrative?

3.3.2. Is our strategy genuinely digital or are we bolting-on to our existing business?

[7] http://www.eastlancsccg.nhs.uk/download/governing_body_papers/6.4%20%20Healthier%20Lancashire%20Programme%20-%20Purpose%20Document.pdf
[8] http://www3.lancashire.gov.uk/corporate/web/?siteid=6120&pageid=41357&e=e
[9] http://www2.deloitte.com/content/dam/Deloitte/uk/Documents/public-sector/deloitte-uk-ascent-of-digital.pdf
[10] https://www.gov.uk/service-manual/communications/increasing-digital-takeup.html

3.3.3. How are citizens and service-users going to be part of our digital transformation?

3.3.4. Have we looked at our talent pool and planned where skills are coming from?

3.3.5. Do we have a coherent business case that monetises our digital transformation?

3.4. So what might the future look like? Nesta recently published a vision for the NHS in 2030[11] that sets out how technology might underpin delivery of healthcare in the future. The report highlights key themes, such as:

- Precision care from precision medicine, using genome mapping to deliver more precise interventions
- Real-time telemetry from biometric and passive sensors, which constantly monitor people for signs of disease
- Patients and their carers actively involved in their care, using easily accessible knowledge to inform their decision making
- More health professionals actively engaged in research, utilising automated diagnostics tests and health analytical tools to inform their practice

3.5. Whilst the healthcare system in 2030 might seem intangible, there are clear indicators emerging today that suggest Nesta's predictions maybe a reality sooner than we think. For example, the use of mobile and tablet technology is growing exponentially in the UK. This year Ofcom reported[12] that 93% of UK adults have a mobile phone, of which 73% are smartphones. This has increased 27% since 2012. This year the smartphone has overtaken the tablet or PC as the preferred device to access the Internet. With this proliferation of access, public attitudes and behaviours are changing:

- Seven in ten (69%) internet users say that technology has changed the way they communicate and six in ten (59%) say these new communications methods have made life easier
- More than seven in ten adult internet users (72%) have a social media profile
- A quarter of adults with a Twitter account use it to air complaints or frustration
- 85% of households have access to the internet, with 30% being superfast

[11] http://www.nesta.org.uk/publications/nhs-2030-people-powered-and-knowledge-powered-health-system
[12] http://stakeholders.ofcom.org.uk/binaries/research/cmr/cmr15/CMR_UK_2015.pdf

3.6. Undoubtedly citizens are becoming digitally enabled and subsequently expectations around digital services in the public sector are growing. Accordingly, Lancashire's digital roadmap needs to address the ongoing societal change and the anticipated exponential technical convergence that is anticipated over the next 10-15 years.

3.7. The Lancashire health and care system spends in excess of £3 billion annually to provide services for its citizens. Included within this huge sum of money, will be investment going into traditional information communication technology (ICT) and into new digital health tools. The ICT spend in NHS organisations is typically going to be between 1-3% of revenue, although this figure is based on historical data collected in the latter part of the Connecting for Health programme.

3.8. Local spend on new digital technology is even more difficult to assess. Globally the mobile health market alone was estimated to be worth $2.4 billion in 2013 and forecast to reach $21.5 billion by 2018, with the largest predicted growth in the UK and across Europe[13]. Life sciences and health technologies as a UK industrial sector employs over 180,000 people and generates a turnover of £56 billion[14]. The Department of UK Trade & Industry predicts digital health will increasing become a significant part of the UK economy with the largest anticipated growth area in Population Health Analytics[15]. This builds on the NHS' position as a universal service for all and as the most efficient health system in the world[16].

3.9. Across the North West and in Lancashire in particular, we are well placed to capitalise on digital health revolution. We have strengths in clinical innovation, academic research and in our technical infrastructure. Individually, these strengths represent value to the healthcare system. However, if taken together and combined they represent a strategic economic asset.

3.10. To harness this potential asset for both economic purposes and to help address our systemic challenge we need to collaborate and bring together the public and private sector. This approach has proved successful in other parts of the world.

3.11. In the United States, research has found that where industry activities are brought together within a regional footprint they achieve a critical mass that drives

[13] http://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/connected-health.html
[14] https://www.gov.uk/government/publications/bioscience-and-health-technology-database-annual-report-2014
[15] https://www.gov.uk/government/publications/digital-health-industry-uk-market-analysis
[16] https://www.gov.uk/government/publications/the-uk-your-partner-for-digital-health-solutions

competiveness and economic growth[17]. For our region, a first step towards this kind of clustering has already been started.

3.12. An initial cluster mapping exercise was completed in July 2015, identifying key stakeholder strengths and mapping out high-level regional assets across South Cumbria and Lancashire. Whilst it is acknowledged that further detailed mapping is required, the asset profile does give a sense of the depth and breadth of the potential opportunity. In summary, the process identified the following:

- Strong clinical engagement and leadership in digital health, supporting new innovation and service redesign
- Directors of Public Health committed to a 'digital first' approach to their service delivery and utilising the technology to improve health outcomes
- Strategic development work undertaken in Cumbria on utilising technology to deliver services in rural areas - http://www.ruralhealthlink.co.uk/
- University of Cumbria's academic research on workforce technology adoption
- Cumbria CCG's pioneering work on patient capacity and demand
- Lancaster University's centre of excellence for computing, data science and security
- Lancaster University's Health Innovation Campus, Science Park & Health Hub which is creating an innovation infrastructure and attracting inward investment into the region
- The University of Central Lancashire's Research and Innovation partnership with West Lakes Enterprise Park, which is turning ideas into commercial opportunities
- New models of care being developed in two Vanguard[18] sites across Blackpool & North Lancashire and in two primary care demonstrators (PMCF[19]) in Fleetwood and Blackburn with Darwen
- Chorley Borough Council's Digital Health Park, which is creating a campus for existing businesses and new start-ups looking to produce new digital health technology
- Lancashire County Council's Business BOOST, which is seeking out new businesses in the digital health space and helping them to grow

[17] http://www.clustermapping.us/content/clusters-101
[18] http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/
[19] http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

- Blackburn and Darwen Council's Making Rooms, which is a new facility for designers and technology firms in Blackburn, acting as a hub for art and digital technology development
- Healthcare providers who are leading on the development of new clinical APPs, electronic healthcare records and a range of innovative online self-care tools
- A state-of-the-art network infrastructure with a wide range of collaborative services sitting on top of it, including the implementation of a Lancashire-wide citizen's record exchange
- A single community information system covering Primary Care, Child Health and Community Services
- A collaborative and dynamic approach to meeting the challenges of information governance

3.13. Connecting and developing these regional assets will create the environment for a digital health ecosystem to thrive, which in turn will address aspects of the systemic challenges described in section 3.1.

3.14. Transforming services through the use of digital health presents a credible opportunity for the Lancashire community to meet the financial challenges that lie ahead and also support economic growth across the region, in effect creating a virtuous circle:

"Digital health is a fast growing industry and it has great potential to improve access to healthcare. Wide scale deployment/adoption also has the potential to improve efficiency, productivity and cost-effectiveness of healthcare delivery. Digital health is central to the delivery of the Government's NHS policy agenda and is a key enabler for realising the Five Year Forward View"

Digital Health in the UK: An industry study for the Office of Life Sciences

4. Why have a Lancashire-wide Digital Health Roadmap

"*The structure of the health and social care health informatics 'family' has meant that Lancashire has been able to draw on the skills and knowledge of experienced individuals from a variety of organisations around the county. This has resulted in a shared vision of how we should use information technology to help deliver care and support health to the citizens of our county. I have also been lucky to work alongside and learn from experienced and helpful colleagues in health informatics to support my role as Chief Clinical Information Officer. This collaborative approach is echoed in the attitude to delivering a solution to record sharing in our health and social care economy*."

Nick Wood, Consultant Gynaecological Oncologist & CCIO, Lancashire Teaching Hospitals

4.1. In September 2015, the National Information Board published outline guidance for CCGs on developing their digital roadmap[20]. Although detailed further guidance has yet to be released, the centre is expecting CCGs to map out their collaborative footprint, engage stakeholders and then work up a detailed roadmap, encompassing such things as:

- Implementing record sharing across organisations
- Improving clinical digital maturity
- Deploying technology enabled care
- Increasing remote consultations

4.2. The process for defining the footprint has to be submitted to the centre by the 30th October, followed by a full submission in April 2016. The CCGs are also required to publish a digital maturity self-assessment towards the end of the 2015.

4.3. Within Lancashire there is a long history of collaboration within the technical community that led to tangible benefits for patients and staff alike. Building on this, the ambition here is that CCGs will agree to establish a Lancashire-wide footprint that will leverage our previous collaborative success. Consequently, the plan set out in this document will eventually be subsumed into the template that is required for submission next year on behalf of the CCGs.

[20] http://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/09/digi-roadmaps-guid.pdf

4.4. Beyond the emerging commissioner requirement described above, there are many other reasons why public and third sector organisations in Lancashire might want to work together, not least the scale of the looming financial gap.

4.5. The most obvious of rationale for any collaboration is the desire to provide safe, holistic and integrated care that is centred on an individual's need. To do this effectively organisations will need to coordinate delivery of their services, share records and empower individuals to be more active participants in their care. This requires a multidisciplinary, cross-sector approach to tackle the demographic factors and the wider determinants of health that are creating such insatiable demand for our services.

4.6. Technology on its own will not bring about the desired change; due consideration has to be given to people and process. As such, it is acknowledged that a standalone digital health programme will not deliver the system-wide transformation that is required to meet the future challenge. There is a need to align the digital ambitions of individual commissioners and providers with the overarching Healthier Lancashire Transformation Programme. Thus, effectively making the pan-Lancashire Digital Roadmap a work stream within that programme.

4.7. Furthermore, analysis of current (both provider and commissioner) strategic plans highlights a number of common themes that are relevant to the digital health agenda and a pan-Lancashire Roadmap, they are:

- Holistic person-centred care, in-part utilising personal budgets
- Supporting a broad health and wellbeing agenda
- Ensuring right care, first time, every time
- Self-management with care closer to home or available digitally from home
- Seamless care, shared records and partnerships across agencies
- Enabling 7-day services and extended services
- Easy access to the most services, using signposting and information
- Telehealth, remote diagnostics / consultations and patient decision aids
- Simple processes and systems to improve productivity
- Using data to target resources, improve quality and reduce variation
- Creating safer communities

4.8. In summary, working together on a Lancashire footprint not only meets the requirements of the centre, it also:

- Leads to safer, seamless care for the citizens of Lancashire
- Builds on our collaborative success in technology infrastructure
- Supports a consistent approach to digital health for patients
- Harnesses our limited technical resource for the benefit of all
- Reduces duplication and unnecessary costs

"Healthcare organisations cannot continue to do more of the same and remain viable. Clinical transformation of clinical services and cross-organisational care pathways need to be transformed and linked up across organisations. This should be a clinically-led planning process:

- *Clinical information needs to be presented at different care points along those clinical pathways, so that we have "Better Information" to support "Better Decisions" at point of care or other clinical decision points such as MDT's, and lead to Better Outcomes for patients.*
- *We need better electronic records, connected up and supporting pathways of care.*
- *We need organisations to be brave, with collaborative, strategic leadership to put patients first and not persist in organisation-centric thinking.*

All of this will support safer patient care, good clinical decisions and lead to more affordable care across a large footprint.

Agreeing on a digital Roadmap Strategy will support the development of cohesive electronic health and social care records, which are securely linked and underpinned by IT infrastructure which supports sharing and helps to break down technological and electronic 'walls' "

Colin Brown, Consultant Gastroenterologist & CCIO, University Hospitals of Morecambe Bay

5. The pan-Lancashire approach

5.1. Across Lancashire most organisations have some form of Information Technology strategy or plan in place, which has delivered significant progress in moving towards electronic health and social care records. This roadmap is intended to complement those plans not replace them.

5.2. The preferred collaborative approach for the Lancashire Digital Health Board can be defined as:

- **Supporting** local organisations to drive forward their plans
- **Facilitating** collaboration across organisational boundaries on common issues
- **Leading** pan-Lancashire initiatives where there is a clear mandate from stakeholders

5.3. Overarching this approach is a firm commitment to ensure that this roadmap embeds a principal of co-production[21] with citizens, clinicians and the wider workforce from the outset. Whilst some mechanisms are already in place to fulfil this principle, further work is required over the coming year to really achieve meaningful engagement.

5.4. As previously stated, there is an expectation that this roadmap will be a part of a system-wide transformation programme which is being developed under the banner of Healthier Lancashire. However, at this point in time the exact themes contained within that transformation agenda are still to be determined. Furthermore at a borough level, mature cross-organisational transformation plans are already in place and, in some cases being delivered. Accordingly, this roadmap will need to respond to those initiatives and the pan-Lancashire programme as it develops in line with approach set out in 5.2.

5.5. Over the last year the Digital Health Board, through its various stakeholders, have made progress in a number of areas:

- Developed stakeholder engagement and involvement in both the Digital Health Board and Digital Health CCIO & CIO
- Successfully secured investment to support record sharing across the county

[21] http://www.stakeholderdesign.com/co-production-versus-co-design-what-is-the-difference/

- Implemented an innovative and effective mechanism to allow organisations to share relevant data for the benefit of front line staff and all citizens
- Created a new information governance tool that improves the transparency of record sharing and reduces bureaucracy
- Maintained and developed a sustainable infrastructure to support all forms of digital technology
- Established a number of proof of concepts to test new digital health tools for managing remote and complex care
- Mapped out the digital health assets that exist across South Cumbria and Lancashire and supported the development of regional growth schemes

6. Developing a framework for a Digital Health Roadmap

6.1. Going forward into the next three years this roadmap will create a number of work streams that will support the strategic ambitions of the stakeholders. The exact definition and scope of these will form through continued discourse with stakeholders. At this stage in the process, the foundation of the roadmap is based on the following broad themes:

6.1.1. Sharing records across organisations to support care giving:

- Working with stakeholders to build the capability and coverage of systems that capture healthcare data.
- Establishing standards that enable the flow of data between organisations and to the patient
- Ensuring record sharing meets legislative standards and that the citizen is actively involved in any decision to share
- Seeking out opportunities to reduce unnecessary administration for our workforce

6.1.2. Empowering the patient to be an active participant in their care:

- Creating a mechanism for patients to readily access and contribute to their electronic health records in a consistent and meaningful way
- Promoting the use of patient health applications in a standardise way using both mobile and web technologies

- Exploring how technology can be used to help improve health literacy across the population
- Utilising digital health technologies to support the prevention and health promotion agenda

6.1.3. Enabling citizens through the use of technology to live independent, healthy lives:

- Developing care professionals' skills in designing and delivering technology enables care
- Engaging the public and service users of health & social care in service design of technology enables care services
- Expanding the use of technology enables care in a safe and consistent manner
- Encouraging peer to peer support amongst patients in a social online environment, supported by clinicians

6.1.4. Creating a health learning system that uses the data to inform practice and predict need:

- Building skills and capability in the analysis and interpretation of healthcare data
- Increasing the breadth and scope of patient decision aids and clinical decision support tools
- Working with academic partners to accelerate the diffusion of new insight
- Developing a citizen consent to share model that supports appropriate secondary uses for healthcare data

6.1.5. Exploring how the digital roadmap can support economic growth within the region:

- Connecting and aligning our regional digital health assists as described in section 3.12
- Exploring opportunities for collaboration between the public sector in Lancashire and local businesses
- Creating an environment for digital innovation to flourish in the region
- Working collaboratively across public, private and third sectors to seek out digital solutions that address the wider determinants for health

"A specific example of how digital health can support economic growth in the region is the proposed Digital Health Village development at Chorley. This innovative project, aimed at creating over 700 jobs, will bring together office and data centre provision with a 40 bed step down care home, a mix of 125 affordable and private houses, and the adjacent district hospital to create a hub focused on supporting start-ups and small companies developing and testing digital health solutions. The development will also have an integrated digital health partnership with Lancaster University. The University development will be both a catalyst and an R&D support for start-ups on the Chorley Digital Health Village, creating a direct and supported infrastructure for start-ups from R&D through to product testing and implementation"

Gary Hall, Chief Executive, Chorley Council

6.1.6. Creating a robust, affordable technical infrastructure that supports the clinical and operational workforce:

- Ensuring stakeholders exploit opportunities to reduce costs on ICT infrastructure
- Designing ICT that allows the workforce to deliver care closer to home and across organisational boundaries
- Exploiting technology to improve communications between organisations and to the patient

7. Enabling work streams within the Roadmap

7.1. As stated above, this roadmap will require further iterations over the coming months as new requirements emerge from the Healthier Lancashire programme and elsewhere. Nevertheless, there are enabling activities already taking place and being planned that will underpin these emergent requirements. Principally, these activities have been initiated under the banner of the Digital Health Board to either tackle current operational issues or develop new approaches for future transformation. Consequently, the funding for these activities is either in place or set out in the financial schedule in Section 10.

7.2. Once this draft roadmap is finalised and approved the activities below will form a baseline programme. As such, any alterations or amendments to the roadmap will be subject to a change control process.

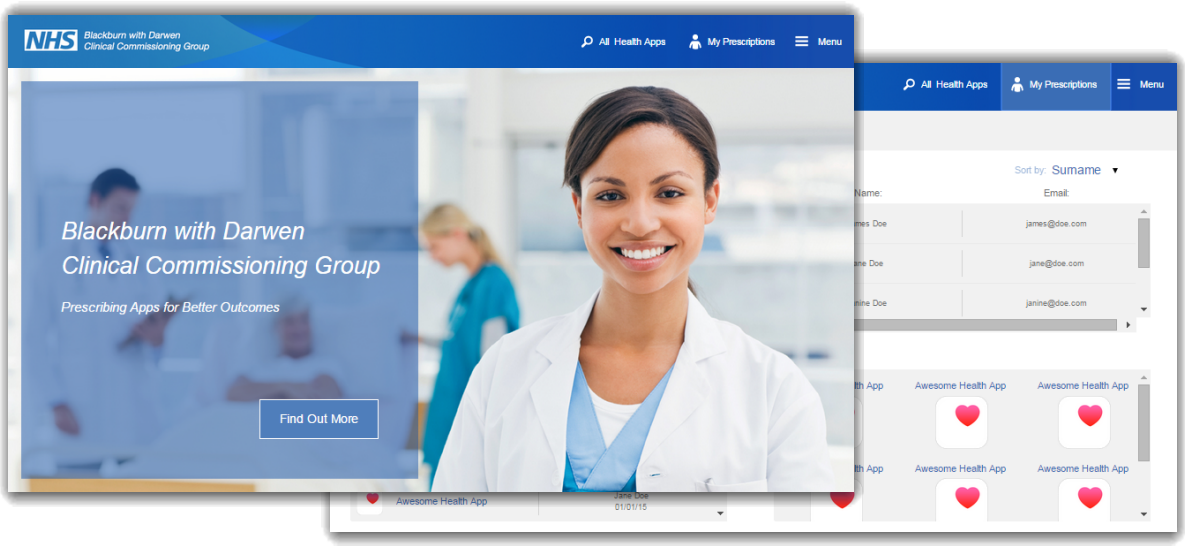
7.2.1. Record Sharing

- Continue to roll out Local Person Record Exchange Service (LPRES) to stakeholders, expanding the portfolio of standardised documents for exchange within the system
- Work with stakeholders to seek opportunities for clinical systems consolidation and to expand the breadth / depth of digital records
- Continue to support collaboration and further development of the Cumbria & Lancashire Information Governance Tool
- Explore opportunities to develop a federated data sharing model that allows data to be shared with tertiary and specialised services outside of Lancashire

7.2.2. Empowering Patients / Citizens

- Explore an approach to use LPRES as a mechanism to provide citizens with unified access to their care records
- Map out clinical App usage and identify any common approaches.
- Explore mechanisms to standardise App usage in clinical pathways (see portal mock-up below)
- Establish a common set of clinical standards and protocols for App usage
- Learn from others and test out solutions with patients, clinicians and citizens

7.2.3. Screenshot A – Example of a Clinical App Portal



7.2.4. Enable Patients / Citizens

- Develop care professionals' skills in delivering digital care in partnership with Lancashire's workforce development network
- Create a 'digital first' resource kit for teams seeking to transform their services, based on a proof of concept with sexual health and obesity services
- Promote digital literacy for citizens by supporting go-on.org.uk and similar
- Support stakeholders developing digital channels for generating, collating and acting on patient feedback (Twitter, Facebook & Skype etc.)
- Engage the public, patients and staff in testing new digitally enabled services, particularly solutions that harness third sector community-based assets. Test out with Rallyround[22]
- Develop digital solutions that improve health literacy and empower patients to be active participants in their care. Engage with Public Health leads to develop the design principles
- Encourage peer to peer support amongst patients in a social online environment, supported by clinicians.
- Exploit new technologies that help deliver care closer to home and near patient testing. Test, evaluate and where appropriate link to transformation initiatives

7.2.5. Population Health Analytics

- Map out the use of patient decision aids and clinical decision support tools with a view to sharing good practice across Lancashire
- Coordinate / integrate with regional initiatives and groups, such as the Connected Health Cities programme[23]
- Work with the Information Governance network to develop a consent to share model with citizens that supports secondary uses
- Work with Lancashire's workforce development network to improve the informatics skills within the workforce

7.2.6. Enabling Infrastructure

- Continue to expand the availability of public access Wifi across Lancashire

[22] https://www.rallyroundme.com/welcome
[23] http://www.ahsn-nenc.org.uk/wp-content/uploads/2015/04/Health-North-Connected-Health-Cities-submitted.pdf

- Collaborate and optimise across the stakeholder's IT estate, to reduce cost and share expertise. In particular, collaborate on solutions that support workforce mobility, such as:
    - Simple, fast logons using shared Wifi
    - Consolidated data centre compute & store facilities
    - Expand the use of open source solutions
    - Expand the use of cloud-based solutions (ie Office 365)
    - Link telephone, instant message and video solutions
- Expand the use of solutions that allow multidisciplinary teams to work seamlessly, ie the Advice & Guidance App developed in North Lancashire
- Create a common catalogue of telehealth / care solutions for stakeholders

7.3. The list above contains a mix of projects, large and small. As stated in paragraph 5.2, some projects will be delivered at an organisational level, others across a community and a few at a Lancashire level and beyond. The resources outlined in Section 10 will only pump-prime projects unless otherwise stated. Further work will be required to define specific resource requirements and to align investment being made elsewhere in the system. The primary output for the majority of the projects above will be to:

- Share knowledge and experience
- Co-create design principles and common standards
- Create capacity for innovation and service redesign in the digital space
- Build relationships and trust around digital innovation
- Reduce cost where possible

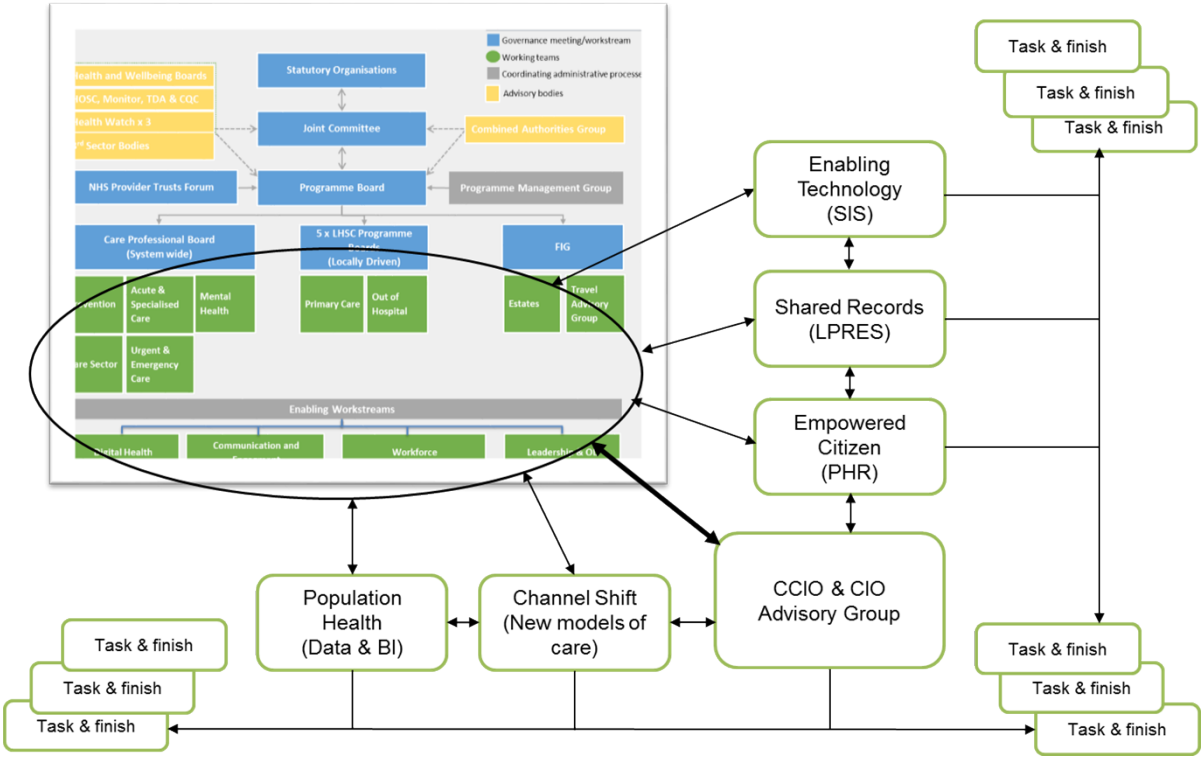
8. Governance

8.1. The proposed governance structure supporting delivery of the roadmap will be integrated into Healthier Lancashire's governance model. There will be two primary governance mechanisms for this roadmap:

- The Digital Health Board – providing oversight of the whole programme. Ensuring there is alignment across Lancashire and local community transformation programmes. Managing resources and risk.
- The Digital Health CCIO & CIO group– providing creativity, design and purpose for the whole programme. Ensuring the philosophy of co-production described in Section 5.3 is upheld.

8.2. The Digital Health CCIO & CIO Group will also act as the aggregation point for work stream activities led at a Lancashire level, delivered through a series of task and finish groups, which should be led by clinical representatives wherever possible (see Diagram C).

8.2.1. Diagram C - Proposed governance structure



8.3. Implementation work which is relevant to the digital roadmap but not delivered at a pan-Lancashire level will report into the Digital Health Board as appropriate and in line with the leadership approach outlined in paragraph 5.2.

8.4. Both the Digital Health Board and the Digital Health CCIO & CIO Group will aim to meet quarterly and be constituted with representatives from:

- Health & Local Authority Commissioners

- Service Providers
- Third Sector representation
- Local Academic institutions including the North West Coast AHSN
- Local Enterprise Partnership representation

8.5. The terms of reference and membership of both committees will be reviewed annually. The constitution of task and finish groups will be determined on a case-by-case basis by the two governing committees above.

8.6. The implementation of pan-Lancashire activities within the roadmap will be coordinated and managed through a Digital Programme Team aligned / integrated with the Healthier Lancashire Programme Management Office.

9. Making it happen

9.1. Having a roadmap document alone will not bring about change. What it can do is act as a catalyst to bring people together to start the dialogue about what the future could look like. The scale of the challenge that lies ahead requires us all to commit to bold, effective large-scale change. However, first and foremost we need to achieve a common understanding of what we want to change and why.

9.2. Alongside our commitment to change, we also need to be united in our desire to use technology, which has the potential to transform the way we do things. If we choose to embrace it, it will improve services and empower our citizens to live longer, healthier lives.

9.3. To succeed in bringing about change, Helen Bevan suggests ten key principles[24]:

- Move towards a future vision that is fundamentally different from the status quo
- Identify and communicate key themes that people can relate to and that will make a big difference
- Do lots of things and seek to amplify these small changes ('lots of lots')
- Frame the issues in ways that engage and mobilise a lot of different people
- Mutually reinforce change across different parts of the system
- Continually refresh the story and attract new, active supporters
- Adopt an emergent planning and design process, adapting as you go

[24] http://www.institute.nhs.uk/leading_large_scale_change/general/leading_large_scale_change_homepage.html

- Enable many people to contribute to the leadership of change, moving beyond organisational boundaries
- Transform mind-sets to deliver sustainable change
- Maintain and refresh leaders energy to sustain them over the long-haul

9.4. Applying this to the implementation of the roadmap and building on Deloitte's findings outlined in Section 3, to make it happen we need to:

9.4.1. Continue to develop the vision for the future and closely align it with stakeholder strategies

9.4.2. Determine the scope and scale of our collaboration

9.4.3. Endorse the roadmap and establish a clear mandate for delivery with stakeholders. Ensure participating organisations are committed to the change

9.4.4. Have a shared understanding of what activities are best done at scale and those that are best delivered locally

9.4.5. Ensure we invest time and resources across our partnership to achieve true and meaningful co-production

9.4.6. Frame and reframe the roadmap communicating the vision in a clear and concise way to the citizens and the workforce

9.4.7. Build partnerships with business that maximise our investment and sustain regional growth

9.4.8. Seek out a diverse range of stakeholders with a view to incorporating and aligning our transformational agendas

9.4.9. Be bold in our ambition and harness the creativity and diversity of our workforce

9.4.10. Make sure we have a clear case for change, including a shared understanding of the realisable benefits, and ultimately ensure that the programme is financially viable

10. Financial Commitment

10.1. As this is the first iteration of our digital roadmap the financial schedule below only provides an indicative outline of costs to illustrate the scale of investment to stakeholders.

10.2. At the point where we have achieved a consensus around the scope and content of the roadmap, we will then be in a position to provide a more detailed financial schedule.

10.3. It is envisaged that this roadmap and the associated investment profile will be incorporated into the overarching Healthier Lancashire Case for Change. This alignment will avoid the potential to double count benefits and maximise opportunities for technology driven change.

10.4. Taking account of the fact that several elements of the programme are underway, the financial schedule is split into two parts. The first is mostly funded and is delivering the LPRES solution. The second is currently unfunded and creates a basic infrastructure to underpin the delivery of this roadmap.

10.4.1. Table B – [DRAFT] Financial Schedule (Part 1)

Ref No.	A	B	C	D	E	F
1	**Program**	**Programme Work stream**	**15/16**	**16/17**	**17/18**	**Totals**
2						
3		**Staffing requirements**				
4	Part 1 - Enabling the Digital Roadmap	**Core Team**				
5		**Head of SiS**	£71,195	£71,195	£71,195	£213,585
6		Admin Support to WAN contract	£24,278	£24,278	£24,278	£72,833
7		Active Directory support	£25,000	£25,000	£25,000	£75,000
8			**£120,473**	**£120,473**	**£120,473**	**£361,418**
9		**Head of LPRES**	£70,000	£70,000	£70,000	£210,000
10		Project Manager	£59,331	£59,331	£59,331	£177,993
11		Technical support	£25,000	£25,000	£25,000	£75,000
12		Information Governance	£50,000	£25,000	£25,000	£100,000
13		Project and business change manage	£20,000	£59,331	£59,331	£138,662
14			**£465,276**	**£479,607**	**£479,607**	**£1,424,491**
15		**Licencing and supplier support**				
16		Supplier support	£150,000	£150,000	£150,000	£450,000
17		HIE License costs	£460,000			£460,000
18		MAINTENANCE		£80,000	£80,000	£160,000
19		HIE Hardware	£60,000	£2,000	£2,000	£64,000
20		New routers to enable image transfer		£90,000		£90,000
21			**£670,000**	**£322,000**	**£232,000**	**£1,224,000**
22						
23		**Sub total -LPRES costs**	**£1,255,749**	**£922,080**	**£832,080**	**£3,009,909**
24						
25		**Resources in place**	**15/16**	**16/17**	**17/18**	
26		Tech Fund monies	£700,000	£300,000		£1,000,000
27		NWCAHSN	£200,000			£200,000
28		CCG's	£150,000			£150,000
29		SIS Funding	£90,000	£90,000	£90,000	£270,000
30		Expected funding from Providers	£390,000	£600,000	£600,000	£1,590,000
31		**Total**	**£1,530,000**	**£990,000**	**£690,000**	**£3,210,000**
32						
33		**Funding gap/contingency**	**£274,251**	**£67,920**	**-£142,080**	**£200,091**

10.4.2. Table C – [DRAFT] Financial Schedule (Part 2)

[To Be Completed}

10.5. Potentially large elements of the investment could be met by stakeholders through "in kind" contributions, typically releasing clinical or technical staff to work on local and pan-Lancashire projects.

11. Summary

11.1. The Lancashire care system is facing a formidable challenge, one which leaders must rise up to. New technology and specifically digital health, has the potential to transform the way we deliver services and fulfil the ambition of the Five Year Forward View.

11.2. Across our community we have a wealth of expertise and a rich asset base to harness digital health if we choose to work together. Having now identified the scale of Lancashire's financial problems we must work collectively to describe how technology can help and set about to transform the system. To quote Rosabeth Moss Kanter from Harvard Business School:

> ''*Leaders must wake people out of inertia. They must get people excited about something they've never seen before, something that does not yet exist'.*

11.3. This first iteration of the document aims to refine and reframe the existing digital health agenda and move us forward towards a unified digital roadmap for Lancashire. One that leads to a true digital transformation not just another bolt-on to existing services.

Primary Care Transformation Team
Plan on a Page 2016/17

The Primary Care Transformation Teams aim is to support all CCGs to achieve their aspirations by tailoring the Lancashire wide priorities to CCGs intentions. The team will inform and support the CCGs to achieve their aspirations and move towards placed based systems of care and accelerate the implementation of the Five Year Forward View and ultimately new models of care.

SUSTAINABLE PRIMARY CARE
Health and Well Being | Care and Quality | Funding and Efficiency

Priorities	Work Streams and Innovation	Alignment with 5 Year Forward
Contracting and New Models of Care	• Multispecialty Community Providers • CCG Quality Contracts • New Models of Care	Delivery of the Five Year Forward View and CCGs aspirations. Creation of integrated out-of-hospital care provided by Multispecialty Community providers and new models of care tailored to suit the local population
Access	• 7 day access • Integration of Health & Social Care • Integration Urgent & Emergency Care • Electronic Record Sharing	Improved access to GP Services including evening and weekend access and same day appointments for all over 75s who need them. Significant progress in health and social care integration, urgent and emergency care and electronic health record sharing.
Quality	• Practice level data on quality of & access to GP Practices. • Improve the quality of care as judged by CQC	Published practice level metrics on quality of and access to GP services. Improved quality of care and safety
Workforce	• Support practices to form federations to enable Primary Care to be delivered at scale. • Support implementation of the 10 point plan • Share learnings from Clinical Pharmacy Programme and wider initiatives • New Workforce Roles	Improved GP workforce through recruitment into general practice, retaining doctors within general practice and supporting those who wish to return to general practice Clinical Pharmacists in post providing additional capacity in GP practices
Estates	• Improve Primary Care Infrastructure • Support development of estate strategies	Robust estate strategies in place. Improvement of Primary Care infrastructure
Technology	• Access to Primary Care services via apps • Data security	Minimum 10% of patients actively accessing primary care services online and through apps. Robust data security standards in place and being enforced for patient confidential data. Effective data sharing.

Ambitions 16/17	Outcomes 2020/21
1. 20% increase in formation of providers capable of delivering primary care at scale (>30,000 pop) 2. 50% population have access to routine Primary Medical Care Services 7 days a week* 3. 20% of federations actually delivering services. 4. 100% of providers providing access to online services. 5. % of uptake in utilisation of online services by patients 6. Technology Applications available (Florence ,Skype and video consultations) 7. Benefits realisation for self-care apps 8. Achievement of CCGs primary care strategies 9. Benefits realisation of workforce initiatives from within the 10 point plan. Workforce planning under taken with 20% of providers 10. Cost Analysis and Review of Quality Contracts to identify best practice, innovation and variation 11. 10% improvement in quality & reduction in unwarranted variation as measured through QOF exception reporting, targeted KPIs and practices identified for review (GPOS). 12. Support and inform CCGs estates strategies to help secure transformation funding for fit for purpose premises	• New Care Model Programme covering 50% population • 100% population have access to routine Primary Medical Care Services 7 days a week* • Significant measurable progress in electronic health record sharing, in areas covered by the New Care Model programme. • No GP practice to have an overall inadequate rating from the CQC. • 95% of GP patients to be offered e consultations and other digital services. • Increase in the number of doctors in general practice in line with the national ambition. • Fully integrated models of care wrapped around patients including all Primary Care and social care services

Patient Engagement

***Lancashire agreed definition of 7 day primary medical services** - Offer additional capacity Monday to Friday e.g. 8am-8pm, Offer minimum of 6 hours on Saturday and some Sunday provision dependent on local analysis of demand in the system, Provide a mixture of same day and pre bookable appointments, Have shared access to patient records with appropriate IM&T / IG infrastructure in place

Urgent and Emergency Care

Network delivery plan: supporting guidance and template

Lancashire and South Cumbria

DRAFT Plan

Submission Date: 11 April 2016

~~December 2015~~

~~For completion by end January 2016~~

Guidance on completing this document

Guidance on completing this document: Purpose and process

Purpose of this document

- This document is to be completed by each Urgent and Emergency Care Network
- It forms the plan for delivering the Urgent and Emergency Care priorities in each Network, and enables planning at a local level
- It will be reviewed by the Director of Assurance and Delivery for each region, and oversight will be maintained by the regional teams

Submitting the plan

Once they have completed the delivery plan, Networks should submit this document to their regional lead by 31 January 2016.

Guidance on completing this document: Information provided and to be completed

National and programme-level information provided

National-level information has been included throughout the document. This provides the context for the Network plans and sets out the national programmes in place. An Appendix of planned publications is set out on pp 55-57.

Sections to be completed

All Networks should complete the following:

Section 1: Executive Summary
Section 2: Implementing the U&EC routemap deliverables
Note: The Contents tables on pp13-15 provide further clarity on pages within Section 2 which are to be completed by Networks.
Section 3: Enablers to implementation

Some of these pages have been pre-populated with specific pieces of information, such as where there are national inputs to the regional/Network activities required.

Additional guidance on using the logic model structure to complete Section 2 is provided on p5.

Children and Young People

Throughout the plan, Networks should consider the specific needs of children and young people, as well as adults, within urgent and emergency care.

Optional additional content

Section 4 also provides space for any additional information the Network would like to include.

Using the 'logic model' structure

The logic model structure

- Section 2 of the planning template sets out a logic model structure for each theme of the U&EC Routemap
- This is divided into five interlinking sections (see table to right)
- Each 'level' informs the next 'level' – e.g. the 'inputs' section identifies the resources needed to deliver the 'activities'. These 'activities' then deliver the 'outcomes' or effects.

Inputs	Activities	Outcomes	Impacts	Vision
Resources used *e.g. £, people, technology*	*Activities undertaken*	*Effects of the activities*	*Broader changes or benefits that result from the work*	*Overall vision achieved by the impacts*

How should this structure be used?

Start at the end. The vision for each theme has been included, as identified by the national U&EC Routemap. These must be achieved within each Network.

The first step is therefore for each U&EC Network to consider the impacts to be achieved at a local level, and the outcomes at a local level which will achieve these impacts.

Once these outcomes have been identified, the Network should consider the activities needed to deliver them. Finally, the U&EC Networks should look at the inputs required for these activities to take place, such as funding, people and technology.

What level of detail needs to be included?

The logic model captures a relatively high level of detail across each theme, and the inputs and activities required to deliver its outcomes and impacts. These inputs and activities will be defined in more detail in local programme and implementation plans, and should simply be summarised in this document.

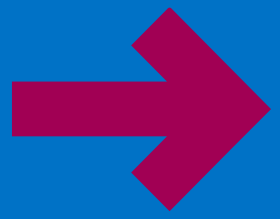
Additional guidance on using logic models

http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf
WK Kellogg Foundation Program Logic Workbook (2001/04)

http://www.thcu.ca/infoandresources
The Health Communication Unit of the Centre for Health Promotion, Uni of Toronto, Program Logic Manual

Section 1

Executive Summary



Executive Summary

Vision of U&EC across England	• For adults and children with urgent care needs, we should provide a **highly responsive service that delivers care as close to home as possible**, minimising disruption and inconvenience for patients, carers and families. • For those people with more serious or life-threatening emergency care needs, we should ensure they are treated in centres with the **right expertise, processes and facilities** to maximise the prospects of survival and a good recovery.
Five key changes to deliver the U&EC Vision	• Providing better support for people and their families to **self-care or care for their dependants** • Helping people who need urgent care to get the **right advice in the right place, first time**. • Providing responsive, urgent physical and mental health services **outside of hospital every day of the week**, so people no longer choose to queue in hospital emergency departments. • Ensuring that adults and children with more serious or life threatening emergency needs receive treatment in centres with the **right facilities, processes and expertise** in order to maximise their chances of survival and a good recovery. • **Connecting all urgent and emergency care services** together so the overall physical and mental health and social care system becomes more than just the sum of its parts
Five Year Forward View	• Across the NHS, urgent and emergency care services will be redesigned to **integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services**. Smaller hospitals will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity services** they offer. The NHS will provide more support for **frail older people living in care homes**.

Note: a further update on Urgent and Emergency Care and the implementation of the above priorities will be provided in the 2016-17 planning guidance (operational and strategic).

Network vision and high-level strategy	The Lancashire and South Cumbria Urgent and Emergency Care Network aims to provide highly responsive services, for adults and children with urgent care needs, that delivers care as close to home as possible and are safe, sustainable and of a consistent high quality. We wish to minimise the disruption and inconvenience for patients, carers and families by supporting the patient to remain or return to a maximum level of independence at the earliest possible opportunity. For people with more serious or life-threatening emergency care needs, we will ensure they are treated in a timely way with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery. To do this, we will, where possible, use the information and expertise already known, to shape the response that takes place and to avoid any urgent need escalating into a life-threatening or emergency event. The Network will ensure that the information, IT and workforce strategies across Lancashire and South Cumbria are linked into its planning processes to support the delivery of its ambitions.

For ease of cross referencing, ‘side tabs’ have been added to the following pages, showing the link to the relevant Routemap Workstream:

The key for these is as follows:

Sys – System Architecture
Acc – Accessing the System
Uec – Urgent and Emergency Care
Esc – Emergency and Specialist Care
Pah – Paramedic at Home
MH- MH Crisis
Self – Self Care
Ind – Independent Care Sector
PC – Primary Care

Summary of activities and deliverables

Include key activities linked to section 2

	Activity/deliverable	Date of delivery	Outcome(s) it will achieve	Support needed	Challenges
Sys	Completion and review of Stocktake at SRG and Network level, to inform final Plan and detailed work programmes	June 2016	System Architecture Outcomes: Key Enabler for all outcomes; Greater effectiveness of Network and connectivity with, and between, SRGs to drive final Plan and Work Programme	Feedback on the Draft Plan; sharing of learning from other areas especially good/ innovative practice 'what works'	Capacity across the system for planning and programme work; tension with short term requirements and pressures
Sys	Review of ToR and Governance in line with STP / Healthier Lancs	From June 2016 (dependent on STP timescales)	As above	As above	As above
Sys	Agree work programmes and shared learning process at SRG and Network level to progress Pathway reviews, metrics etc Implementation stages	June – Dec 2016 17/18 – 18/19	As above As above (specific outcomes would be further defined at implementation stages)	As above As above with greater focus on implementation support	Capacity and resources required for implementation stages; concurrent resource demands from STP / LDPs / immediate operational pressures
Sys	Review electronic access needs and support requirements Development of systems (Part of wider STP Programme)	June 16 17/18 – 19/20	As above (specific outcomes would be further defined at implementation stages)	As above – also reliant on National and Regional technology infrastructure developments / opportunities	Investment requirements; project management of ICT developments; Provider buy in and associated workforce dev.
Sys	Payment system / model – being progressed within Morecambe Bay Vanguard; wider learning and consideration of models from National practice	Delivery being monitored separately under Vanguard Reviews of National guidance / learning as published	As above (Vanguard has separately defined outcomes)	National guidance and publications; reviews of Standard Contracts and Tarff arrangements, engagement and negotiation with providers	Major challenge to move from existing costing bases for providers who must show financial stability to Monitor; phased / supporting investment
Acc Esc	Agree principles and process across system to move to 7DS and ensure compliance to mortality standards / constitution Implementation stages	16/17 17/18 – 18/20	All 3 of the 'Top Outcomes for 2020/2' in NHSE Guidance; Further outcomes would be defined at implementation(s)	Sharing of learning, best practice and 'what works'; provider / clinical engagement in solution design including National/ Regional expert inputs	Capacity and resources required for implementation stages
Acc Self	Review SRG DTOC Work Programmes in line with BCF Plans and building on Rapid Improvement Processes (30/60/90 Day Plans)	16/17	Provide highly responsive urgent care; reduce delays (with linked care/ value outcomes)	Sharing of learning and best practice – what works/ lessons	Concurrent need to deliver against short term rapid plans and longer term system change

Continued Overleaf

Summary of activities and deliverables

Include key activities linked to section 2

	Activity/deliverable	Date of delivery	Outcome(s) it will achieve	Support needed	Challenges
Acc	Clinical Hub proposal – consideration by SRGs Next stages to be informed by SRG responses – likely to involve local alignments and functionality	June 16 16/17 – 17/18	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance	As before in relation to national learning and requirements	Capacity and resources to rollout in accordance with detailed local functionality / fit
Acc Uec	Continued implementation of 111; evaluation of booking pilot and further rollout based on findings, SRG consideration and alignment	16 – 17 17/18	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance	As before in relation to national learning and requirements	Capacity and resources for evaluation / blueprinting and rollout in accordance with detailed local functionality / fit
Uec Esc	Review Nat Principles against Local UECs and EDs/ Spec care (and nat specification, if expected?) Implementation arising from above of any C&D approaches/ nomenclature/ discharge and escalation / associated specs	16/17 16/17/18	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance	Clarification of whether a National Specification is expected as noted in previous communications, in addition to the Principles	Capacity and resources for implementation stages Challenges for providers to operationalise any C&D system changes / nomenclature
Uec	Continued maintenance / development of DoS	16/17	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance	As before in relation to national learning and requirements	Cross organisational/ IT system alignment and functionality
Pah	Continued implementation of Paramedic at Home; inclusion into 16/17 commissioning intentions; actions including assessment and tools to support hear and treat and see and treat; delivery in line with National standards and local reqs	16/17	Provide highly responsive urgent care services so people no longer choose to go to A&E; Single call access to clinical advice for public &professionals	Sharing learning/ clinical models for ambulance services	As above
Esc	Network/STP level discussion(s) and actions regarding future shape of Emergency and Specialist care and components / designations	Aligned with interdependent STP discussions and Acute Workstream 16/17 – 18/19/20	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance particularly 3 (emergency needs)	Network / STP level support, subject matter expertise and clincial/ provider engagement; stakeholder / public engagement	Capacity and resources for whole system work (linked to STP challenges)

Continued Overleaf

Summary of activities and deliverables

Include key activities linked to section 2

	Activity/deliverable	Date of delivery	Outcome(s) it will achieve	Support needed	Challenges
MH	Interdependent activities in MH (STP) Workstream including continuing implementation of Crisis concordat, 24/7 MH crisis services	Delivery via interdependent MH Workstream/ Collaborative Programme 16/17/18/19/20	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance MH Outcomes including Access/ crisis standards, place of safety	Alignment of reporting and assurance requirements so that these are not duplicated	Challenge of concurrent short term operational pressures and actions, with longer term requirements for transformation
MH	Interdependent activities in CYPEWMH (STP) Workstream (agreed Transformation Plan in place) inc. Care of Vulnerable CYP	Delivery via interdependent CYPEWMH Workstream/ Collaborative Programme 16/17/18/19/20	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance CYP Outcomes as per agreed Transformation Plan	Alignment of reporting and assurance requirements so that these are not duplicated	Capacity and resources required for whole system transformation; challenge of short term operational pressures as above
MH	Ensuring MH needs are incorporated into SRG or Network level discussions and developments/ work progs and ToR	16/17	All 3 of the 'Top Outcomes for 2020/21' in NHSE Guidance	As above	Ensuring alignment across complex multiple STP workstreams and organisations
Self Self	Interdependent activities in STP Prevention Workstream for Self Care regarding personalisation (evidence based approaches, care planning and budgeting) Interdependent activities in Vanguards and LHE Transformation programmes including Neighbourhood teams, care co-ordinators, support to most vulnerable / frail/ targeted cohorts	Delivery via interdependent STP Prevention Workstream/ LHE and Vanguard Programmes 16/17/18/19/20	Specific outcomes defined within interdependent workstreams	Alignment of reporting and assurance requirements so that these are not duplicated	Ensuring alignment across complex multiple STP workstreams, LHE Transformation Programmes, Vanguards, LDP and organisational level plans (the Lancs & Sth Cumbria 'Triangle')
Ind Ind Ind	Interdependent activities in Independent Care Sector (STP) Workstream SRG level care home liaison/ discharge teams and planning Airedale Vanguard (with Pennine Lancs link) for Care Home Devmt	Case for Change Jun 2016 Solution Design from Dec 16 Implementation 17/18/19 Ongoing "	Specific outcomes defined within interdependent workstream All 3 of Top Outcomes "	As above	As above

Continued Overleaf

Summary of activities and deliverables

Include key activities linked to section 2

	Activity/deliverable	Date of delivery	Outcome(s) it will achieve	Support needed	Challenges
PC	Interdependent activities in the Primary Care (STP) workstream and particularly the work programme of the Primary Care Transformation Team (NHSE): - Models of care inc. MSPs - Quality Contract - 7 Day Access - Integration of H&SC and UEC - Electronic record sharing - Practice level data on quality and access - Estates, technology and workforce Linked into the above work programme – establish principles across SRGs and Network for out of/ extended hours, access, triage and assessment models – to agree and align with local service footprints and clarify roles of GPs, community pharmacy and dental	As per NHSE PCTT Plan (16/17 to Five Year)	All 3 of the 'Top Outcomes for 2020/2' in NHSE Guidance Specific Primary Care Outcomes as per NHSE PCTT Plan	Alignment of reporting and assurance requirements so that these are not duplicated	Ensuring alignment across complex multiple STP workstreams, LHE Transformation Programmes, Vanguards, LDP and organisational level plans (the Lancs & Sth Cumbria 'Triangle')
Wk	Workforce – engagement and guidance from HEE to progress with relevant auditing and plans	Engagement for June 2016 Plan submission Regular engagement beyond	All 3 of the 'Top Outcomes for 2020/2' in NHSE Guidance	Engagement from HEE with clarification of their role and alignment with SRG/ Network	Clarification of resources / role of HEE and expectations of capacity from SRG/ Network

Summary of resource requirements

Include key resources linked to section 2 and costed in the finance template

Resource required	Date resource required	Activity/ies resource will support	Cost	Challenges
To be completed at final draft stage				

Engagement to develop and deliver the plan

Stakeholder group	Engagement (engagement to date AND planned engagement)	Timings
STP/ Healthier Lancashire	❑ Director level post being recruited ❑ A Programme of engagement to be established for the whole and individual workstreams which includes U&E	
Vanguards	❑ Wide range of engagement being carried out by Vanguards which has interdependencies with U&E work	
UECN	❑ Engagement at point of scheme/ initiative development or rollout out – for example System workshop planned on Clinical Hub; UECN Event planned in May 2016	
BCF	❑ Engagement at BCF Footprint level for whole Better Care programmes and schemes within this	
SRG	❑ Workstream level engagement at SRG level as appropriate eg. Our Health Our Care in CSR GP	

Financial modelling

A separate template is being circulated alongside this document to capture the costs of implementation.

The front page of this template calculates the totals against each work programme for 2016-17, 2017-18, 2018-19 and 2019-20. **Please copy these totals into the table below.**

	Total implementation cost	Total 16-17	Total 17-18	Total 18-19	Total 19-20
i. System Architecture					
ii. Accessing the Urgent and Emergency Care system					
iii. Urgent and Emergency Care Centres					
iv. Paramedic at Home					
v. Emergency Centres and Specialist Services					
vi. Mental Health Crisis					
vii. Supporting Self Care					
viii. Independent Care Sector					
ix. Primary Care					
TOTAL					

Will be completed at final Plan stage – guidance on criteria to cost these sections would be welcomed

Section 2

Implementing the U&EC review

Contents (1/3)

Note: maroon highlights in Contents table indicate sections to be completed by Networks

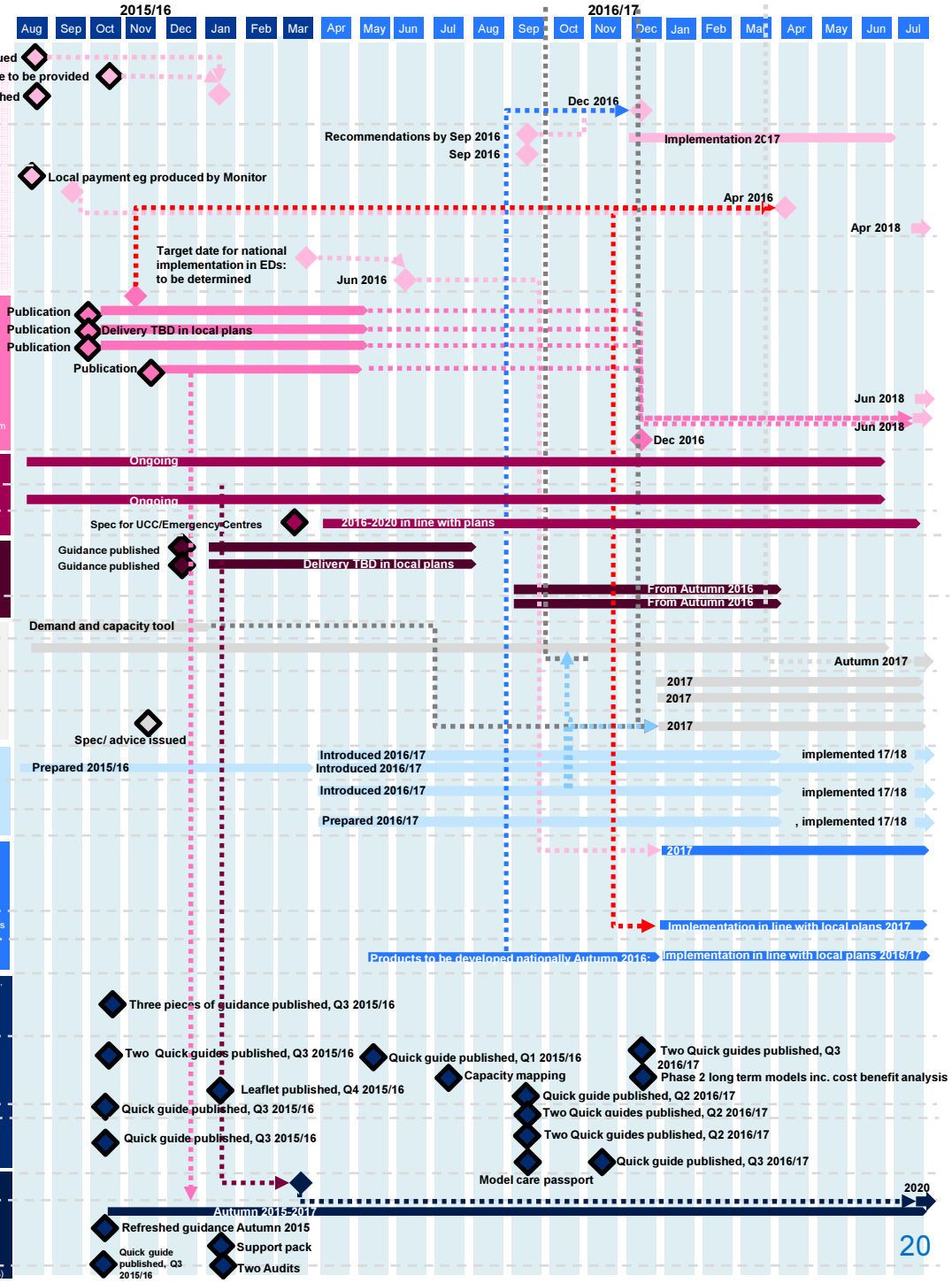
Contents (2/3)

Note: maroon highlights in Contents table indicate sections to be completed by Networks

Contents (3/3)

Note: maroon highlights in Contents table indicate sections to be completed by Networks

U&EC Routemap critical path



i. System architecture	Establishing U&EC Networks	• Principles of governance to support membership structure and ToRs • Stocktake of U&EC services • Support for overarching U&EC review plan • Networks to define consistent pathways for urgent care with equitable access
	Identifying/piloting system wide outcome metrics	• Development of a single framework for measuring and reporting on system outcomes • Toolkit to support measurement
	Develop a new payment system	• Local payment model for pilot sites, taking into account mental health outcomes • Shadow testing payments systems in pilot areas • Roll-out of shadow testing model • Implementation
	Enhanced summary care record	• All NHS 111, 999 and EDs will have access to SCR, local implementation supported by national workstream • U&EC services to have greater electronic access to records, inc summary care record, end of life plans, and mental health crisis plans (inc patient held plans)\
ii. Accessing Urgent and Emergency Care system	Accessing Urgent and Emergency system	• Align/ novate NHS111/ OOH contracts to deliver integrated UC access, or plan for migration to full integration • NHS 111 commissioning standards published nationally • Guidance on the establishment of clinical hubs (within standards) • Guidance on specialist advice (within standards) • Greater access to patient care plans and SCRs • Trial of clinical triage of green ambulance calls established (within standards) • Development of Access to Service Information (next generation of the DoS) for timely access to service information and the technical links with ERS to support booking across the urgent care system • Deliver the Clinical Triage Platform (next generation of clinical decision support) to reflect integrated UC system • NHS 111 digital platform integrated into NHS Choices, with a clear expectation of digital first
iii. Urgent and Emergency Care Centres	Direct booking from 111 to UCCs	• SRG to drive adoption/ greater provision of direct appointment booking to UCCs, ED and primary care.
	Local Directory of Services	• Networks/ SRGs to ensure maintenance of local DoS
	Ensure UCCs provide consistent service	• Specification to support ensuring local care centres are consistently called UCCs and offer consistent service
iv. Paramedic at Home	More patients appropriately dealt with at home by paramedics	• Clinical models to support increase in proportion of calls to 999 dealt with via 'see and treat' • Referral pathways set between paramedics and other providers
	Ensure clinically appropriate response by ambulance to 999	• ~~Ambulance dispatch on disposition evaluated and national standards reviewed~~ • Implementation of recommendations
v. Emergency Centre and Specialised Services	Analytical activity	• Analysis of non-elective activity and capacity
	7 day services across ten identified specialties	• Compliant with 7DS clinical standards as per NHS Standard Contract • All urgent network specialist services compliant with four mortality clinical standards on every day of the week
	Discharge from hospital	• DTOC plans submitted • Support packages for CCGs and SRGs
	Ensure patients are treated in right networked facilities	• Facility specifications/ advice to support designation of network facilities and definition of care pathways
vi. Mental Health Crisis	Access/waiting time standard for 24/7 crisis assessment	• Access and waiting time standard for 24/7 crisis assessment response (community based) • Improving access to health-based places of safety following Section 136
	Access/ waiting time standard for mental health services in A&E	• Access and waiting time standard for assessment by liaison MH services in A&E (as per 7DS standard)
	An assessment standard for those with Mental Health needs	• A next generation clinical assessment system specifically designed to support mental health needs and crisis. This will cover multi-channel access; i.e voice, face-to-face/ telephone and outline

vii. Supporting self-care	Personalised care and support planning	• Those most at risk of needing UEC, incl mental health care, will have a person centred care and support plan
		  • Evidence based approaches to support people to manage their own health and care
		  • Tools to support self-management across the NHS
		  • Tools and training to support professionals

	Personalised Health Budgets	• All CCGs will be offering personal health budgets beyond NHS continuing healthcare in line with their local plans
	Support for self management	• U&ECNs/CCGs should work in partnership with other emergency services, voluntary/ community sector organisations to measure what matters, and use levers/ incentives which help embed effective mgt support
viii. Independent Care Sector	Local Commissioning Practice	• Guidance to CCGs/ LAs on working with ICS, incl. encouraging joint winter and future capacity planning / tools, including case studies and best commissioning practice • Clarification guidance to be made available on Continuing Healthcare funding/ processes • Guidance for acute trusts on how to support self-funders (choice protocols)
	Better use of care homes	• Guidance for best practice clinical input required for care homes (quick guide and long term models) • Series of quick guides: Identifying local care home placements, Technology in care homes, Improving resilience in care homes, Using secure email in care homes, Using data in care homes • Leaflet: Better understanding of housing for healthcare professionals, report on mental health delays due to housing and local capacity mapping product
	Improving hospital discharge	• Quick Guides: Improving hospital discharge, Sharing Patient Information, Discharge to assess
	Better use of care at home	• Quick guides: Better use of care at home, Identifying local care at home packages, Continuing healthcare assessment, Care coordinator role for discharge home • Model care passport
ix. Primary care	Improved access to primary care	• 18 m people will have access to weekend appointments, and/or different modes of accessing general practice • Routine access to GP appointments at evenings and weekends
	Increased role for pharmacy in urgent care	• Pharmacy to have access to Summary Care Record • Seasonal Influenza Vaccination Advanced Service for community pharmacy • Quick guide: Extending the role of Community Pharmacy in UEC • Support pack for urgent medicines service, summary care record read access, COPD rescue pack
	Improving oral & dental health	• Quick guide: Best use of unscheduled dental care services, Audits of urgent dental (NHS Choices and 111 Dos)

Note: workforce

Context

NHS England is working with Health Education England to review the UEC workforce and make sure that it is fit for purpose and there is a clear supply of staff to meet future demands. This includes describing and ensuring the supply of a trained alternative workforce out of hospital and on the interface with emergency departments to support the urgent and emergency care agenda. This involves the development and promotion of roles such as: physician associates, paramedics, pharmacists, and advanced clinical practitioners.

We are working to enhance the role of paramedics to support the ambulance service as a treatment service, in line with the paramedic evidence-based education project (PEEP) report. A new single accredited curriculum for paramedics is in development, which academic institutions will begin to deliver from 2016, and will markedly enhance skills for paramedics to 'hear and treat', 'see and treat', as well as to work independently and in wider urgent care, such as primary care, as an alternative to A&E and ambulance conveyance.

HEE are working closely with NHS England, RCGP and BMA on the 10 point plan for primary care which is equally important in increasing the workforce capacity of not just general practice but the wider primary and community care workforce and the implications of this in supporting the urgent care agenda.

Identifying workforce requirements

The following section includes a high-level template for the workforce requirements against each workstream. These templates provide an initial opportunity to review baseline workforce requirements, to get a sense of local requirements for that on-going discussion for your Networks' thinking around workforce needs.

There will be ongoing opportunities for each Network to work with Health Education England, through your Network LETB leads, to develop further thinking and plans to support these requirements and challenges.

i. System Architecture: National context and work programmes (1/3)

Urgent and Emergency Care Networks (UECNs)

Urgent and Emergency Care Networks (UECNs) are taking the strategic role in coordinating, integrating and overseeing urgent and emergency care across wide geographical areas and populations.

- They have a particular focus on pathways and access protocols to specialist urgent and emergency care (such as those for heart attack, stroke, major trauma, vascular surgery and critically ill children) and setting shared objectives for the network where there is clear advantage in achieving commonality for delivery of efficient patient care wider than at SRG level (ambulance transfer protocols, NHS111 services, clinical decision support).

- Further information on this is available in the Networks advice issued at the end of May 2015.

- Networks have been asked to develop overarching delivery plans for the objectives of the Urgent and Emergency Care review, which will inform the plans of local commissioners.

- A crucial ask of Networks is to define consistent pathways of care and equitable access to diagnostics and services across large geographies.

i. System Architecture: National context and work programmes (2/3)

Identifying and piloting system wide outcome metrics

Current measures of performance are not reflective of outcomes and performance across the whole urgent and emergency care system. They have been effective in many areas at driving improvements but do not help us to measure the performance of a joined-up system providing improved clinical outcomes for patients.

NHS England is therefore working to develop a single framework for measuring and reporting on system outcomes for urgent and emergency care.

These measures would give System Resilience Groups and U&EC Networks a high level assessment of whether a particular urgent and emergency care network was delivering for patients. They will meet the following principles:

- They should be used to measure the performance of a UEC system over time, and highlight achievement that was significantly different from accepted variables. It is not intended that they be used to compare networks or services against one another.

- As well as demonstrating the effectiveness of individual networks, the indicators will encourage behaviour to ensure in particular the smooth flow of patients and patient information across the different components that comprise the total "UEC system"; and innovative thinking about how best to commission and deliver a seamless local urgent and emergency care system to improve outcomes for their populations

- The measures would be an "alert" system, to make individual networks aware that there were potential issues about their effectiveness. They will focus on outcomes and therefore not necessarily provide an indication of where any problems lay, nor where remedial action should be focused.

The measures might be supported by a "toolkit", which would help networks understand what the measures were and weren't demonstrating; and what other data networks could use to investigate changes in achievement. This work, and the extent to which it is supported nationally, will be scoped as the project progresses. NHS England proposes to test the developing metrics with Vanguards and other interested health communities.

i. System Architecture: National context and work programmes (3/3)

Payment reform

NHS England and Monitor recognise that current forms of payment may create a barrier to co-ordination and collaboration, and that a new approach to payment may play a valuable role in enabling a networked model of care. For this reason, we published a discussion document in August 2014 setting out how a new approach to payment could better support the service reform and drive improved quality, co-ordinated care for patients within the budget available.

We have outlined potential payment options and are providing detailed guidance on how a new payment approach might be implemented in practice - https://www.gov.uk/government/publications/local-payment-example-3-part-payment-for-urgent-and-emergency-care.

The options described are at the development stage, and we are working in 2015/16 with UEC vanguards to design and cost new payments in order to understand the activity, flows and fixed costs in 2016/17, ready for implementation in 2017/18.

Updated versions of the new payment approach document will be published as what we learn from this work, including how the proposed UEC payment approach will work alongside other payment models such as capitation, informs refinement of the payment design.

i. System Architecture: Summary of Network delivery plan

Vision	Urgent and emergency care networks connect all services together into a cohesive whole, becoming more than the sum of their parts. This is underpinned by national development of system-wide outcome metrics, a new payment system, greater electronic access to records and an urgent and emergency care workforce fit for purpose.

Inputs

Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*
People	- Lancashire UECN Members - SRGs and SRG Leads - Interdependent Workstream leads (eg. Mental Health leads) - Delivery and commissioning workforce (see next slide) - End users / patients, carers, public, local stakeholders
Technology	• Additional information will be provided in STP with regards to Digital developments at system architecture level • At SRG level systems will be developed to support pilot payment models
Other	• National template and documentation for Network governance and stocktake • Roll out of system wide outcome metrics and supporting toolkit following trial. • Roll out of new payment model following trial • HEE deliver an underpinning workforce development programme at a national and local level • Local financial modelling methodology

Activities

Activity	Date
Completion of Stocktake and review of outputs	June 2016
Agree role, TOR and governance for UECN aligned with Healthier Lancs / STP emerging governance including cross boundary / cross organisational/ cross STP and U&E workstream and neighbouring Networks	From June 2016
Agree work programmes/ shared learning process at LSC and SRGs level to incorporate pathway, metrics/ outcome sets and principles development	June - Dec 2016
Implementation stages resulting from above	2017/ 18 / 19
Review electronic access needs and support requirements (U&EC in particular NHS 111, 999 and EDs, access to SCR).	June 16
Development of systems will be implemented in line with wider STP agreements	2017/ 18 / 19
Payment system / model: local Vanguards piloting accountable care/ capitation Network review National and local learning and further develop plans / rollout	2016 – 17 / 18 17/18 18/19

Outcomes

System Architecture will contribute as an enabler to all 3 of the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016

1. Provide highly responsive urgent care services outside of hospital so people no longer choose to go in A&E
2. Single call to access clinical advice for public and community healthcare professionals
3. Ensure people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and recovery

Network governance and development will also lead to greater and more effective collaboration, reducing duplication of the same efforts in each footprint, genuinely sharing learning and moving towards system wide consistency.

"the more we do together, the less we are all reinventing the wheel"

Impacts

- Networks are in place to define, develop and deliver local U&EC plans
- They are supported by defined governance and ToRs
- Networks have the support and guidance to develop their plans
- All NHS 111, 999 and EDs have access to SCR, enabling more informed clinical and treatment decisions
- Urgent and emergency care services have greater electronic access to records including summary care record, end of life care records, special patient notes and mental health crisis plans (including patient held plans)

i. System Architecture: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	UECN Membership/ SRG Membership and Workstream lead membership SRG Level Urgent Care Networks, Provider and Clinical Engagement	UECN Membership / SRG Membership and Workstream lead membership
Number of vacancies (role type and FTE)	Analysis of workforce requirements of the system architecture is being carried out at STP level.	Analysis of workforce requirements of the system architecture is being carried out at STP level.

Please provide a short summary of the following:	
Actions required to meet establishment	Analysis of workforce requirements of the system architecture is being carried out at STP level. For Urgent and Emergency Care there are leads at SRG and workstream level but no substantive programme management or support at system level currently. Similarly to other STP areas, to progress the full plan it will be necessary to have programme leadership / SRO; Programme Director/ Manager and support roles at the Lancs/ Sth Cumbria level, to progress the necessary discussions about the future shape of UE care.
Current or planned workforce transformation programmes	As above
Requirements for new programmes to upskill existing staff	As above

ii. Accessing the Urgent & Emergency Care system: National context and work programmes

The core vision for a more closely Integrated Urgent Care service builds upon the success of NHS 111 in simplifying access for patients and increasing the confidence that they, local commissioners and the public have in their services.

The offer for the public will be a single entry point - NHS 111 - to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership.

Central to this will be the development of a 'Clinical Hub' offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. The clinicians in the hub will be supported by the availability of clinical records such as 'Special Notes', Summary Care Record (SCR) as well as locally available systems. In time, increasing IT system interoperability will support cross-referral and the direct booking of appointments into other services.

A plan for online provision in the future will make it easier for the public to access urgent health advice and care.

Further information is available in the recently published commissioning standards for integrated urgent care.

ii. Accessing the Urgent & Emergency Care system: Summary of Network delivery plan

Vision	The offer for the public will be a single entry point - NHS 111 - to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership

Inputs

Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*
People	- Lancashire UECN Members - SRGs and SRG Leads - Interdependent Workstream leads (eg. 111 and Digital) - Delivery and commissioning workforce (see next slide) - End users / patients, carers, public, local stakeholders
Technology	*NB - Cross Ref to STP* NHS 111 Digital platform integration into NHS Choices – 'digital first' Development of DoS Booking systems associated with any further rollouts and technical links ERS Development of next generation of integrated clinical decision support
Other	

Activities

Activity	Date
Review Stocktake and agree process to move to standards for 7DS and Mortality and benchmark providers	16/17
Implementation arising from above review	16/17 - 18
Review SRG DTOC Work Progs; align with BCF DTOC and build on Rapid Improvement Process and plans	16/17
Clinical Hub inc. access and triage proposal worked up at NW level, being considered by SRGs	Apr: Jun 16
Further alignment with local service reqs and local implementation as staged rollout	16/17 / 18
Continue implementation of 111 Plan (including evaluation of booking scheme); SRG level consideration of rollout options aligned with local requirements	As above

Outcomes

Activities within this Workstream will contribute to all 3 of the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016

1. Provide highly responsive urgent care services outside of hospital so people no longer choose to go in A&E
2. Single call to access clinical advice for public and community healthcare professionals
3. Ensure people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and recovery

"Patients conveyed and treated, better, in the right place, first time"

Linked to key metrics such as DTOCs, A&E presentation, Four Hours, readmission etc

Impacts

- There is a more functionally integrated Urgent Care Access, Treatment and Clinical Advice Service model (**or** plan for migration to full integration when contracts allow) – through aligned or novated NHS111 and OOH contracts.
- Integrated Urgent Care service, supported by an Integrated Clinical Advice Service (Clinical Hub) will assess the needs of people and advise on or access the most appropriate course of action
- Greater levels of clinical input into NHS 111 service (mental health, dental heath, paramedic, pharmacist, GP)
- The clinical triage of green ambulance calls is established (within standards)

ii. Accessing the Urgent & Emergency Care system: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	Clinical advisors 111 Hub – System wide ranging multi disciplinary eg. Pharmacists, GPs, community / specialist nursing, Paramedics, Dental nurses, mental health, social care, hospices, specialist consultants	Call handlers/ health advisors 111 Hub – range of multi disciplinary support roles Commissioners/ programme leads and co-ordinators
Number of vacancies (role type and FTE)	Further guidance would be welcomed on how to scope this as the workstream contains several elements (which overlap with others) including 111, Clinical Hub and shared data – which all have different workforces.	As previous box
Please provide a short summary of the following:		
Actions required to meet establishment	Formal audit not carried out at this stage (further guidance/ assistance from HEE would be helpful to identify best approach) but it is known that the roles exist currently but are not yet linked in as such to the clinical hub, in particular. Actions are required to progress from existing workforce to a new model of working which integrates the clinical / professional roles listed above. Need to consider the overall programme management, leadership and support (as per system architecture).	
Current or planned workforce transformation programmes	As above – part of the 111 and clinical hub development	
Requirements for new programmes to upskill existing staff	Telephone triage and assessment – to move from call handling and transfer to service to a more hear and assess mode of working. For all professionals, not only call handlers. Eg. Part of community nursing education. Despatcher training requirements. Green ambulance training requirements.	

iii. Urgent and Emergency Care Centres: National context and work programmes

Urgent Care Centres are community and primary care facilities providing access to urgent care for a local population. They encompass Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as “Type 3 A&E Departments”. A consistent nomenclature should be accompanied by a consistent service, so that patients are clear about what they can expect from all Urgent Care Centres, anywhere in England. To achieve this two important principles underpin the development of Urgent Care Centres:

1. Urgent Care Centres offer access to a full range of urgent care services
2. Urgent Care Centres provide 24/7 access to the Urgent and Emergency Care Network

Urgent and Emergency Care Networks should work to develop all Urgent Care Centres so that they are able to provide access to a broad range of physical and mental illness and injury care, in both adults and children.

This will be achieved by a team of on-site healthcare professionals, integrated diagnostic facilities and agreed pathways into other community-based and primary care services. It is the responsibility of the network to ensure these services are provided consistently; it is not acceptable to simply default to a higher level of care.

Ambulance services may convey patients to Urgent Care Centres within agreed pathways where the patient’s condition is suitable for primary care management. Where patients with more serious illness or injury walk into an Urgent Care Centre, clear protocols, agreed with the ambulance service, will facilitate rapid transfer to an Emergency Centre or Emergency Centre with specialist services.

For callers to NHS 111, direct booking will be offered into UCCs where this is appropriate.

Guidance has been developed and will be published once approved.

iii. Urgent and Emergency Care Centres: Summary of Network delivery plan

Vision	Urgent care centres are community and primary services offering consistent access to the full range of urgent care services

Inputs

Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*
People	- Lancashire UECN Members - SRGs and SRG Leads - Interdependent Workstream leads (eg. 111, Digital lead) - Delivery and commissioning workforce (see next slide) - End users / patients, carers, public, local stakeholders
Technology	• Cross Ref STP • Appointment booking systems for any rollout of 111 scheme at SRG levels • Continued DoS maintenance • Review websites for consistent nomenclature
Other	• Guidance for Commissioners regarding Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services

Activities

Activity	Date
Review Stocktake and National Principles / Best Practice (Query National Specification to follow? If so, further review)	16/17
Implementation arising from above – SRG level and Pan Lancs / SC level where standardisation / at scale /cross boundary working is beneficial	16/17 – 18 “
Unify nomenclature including signage / web linked to above review	16/17
Review of Capacity and Demand/ Flow processes and best practice / tools Implementation following	1718
Continued maintenance and development of DoS Include any review findings from above to inform future plans	Cont
Evaluate Pilot of 111 Appointment Booking - further implementation based on findings	2016 16/17

Outcomes..

Activities within this Workstream will contribute to all 3 of the ‘Top Outcomes for 2020/21’ in NHSE STP How To Guide_ UEC published in Draft April 2016

1. Provide highly responsive urgent care services outside of hospital so people no longer choose to go in A&E
2. Single call to access clinical advice for public and community healthcare professionals
3. Ensure people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and recovery

There are expected to be care, quality and value related outcomes resulting from greater efficiency and effectiveness, inc. DTOCs and Four Hours

Agreements on protocols and standards across the system will also improve consistency and reduce confusion, leading to better patient choices and appropriacy of care usage

Impacts

- Local care centres are consistently referred to as Urgent Care Centres, and there is a consistent service delivered across these, enabling access to a local service that is more responsive to individual needs and circumstances
- All providers have access to DoS and an updating methodology is in place, ensuring that providers (including NHS 111) can refer to appropriate services in a timely manner.
- There is adoption and greater provision of direct appointment booking into UCC, ED and primary care, driven by SRGs, allowing patients to access urgent care services conveniently

iii. Urgent and Emergency Care Centres: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	Role Types: Range of UEC staffing/ associated staffing includes nurse practitioners, GPs, consultants, paramedic liaison/ handover roles, paediatric roles, MH nurses, phlebotomy.	Management and support/ admin/ reception roles
Number of vacancies (role type and FTE)	Audit started in some SRG areas but full data not available at Draft stage. Further guidance would be welcomed on how to scope this (core UEC roles? Associated services? Against current establishment or future intentions etc).	As previous box
Please provide a short summary of the following:		
Actions required to meet establishment	Audit not yet undertaken however there are known difficulties with recruitment particularly of medical staffing – eg nurse practitioners. Difficulties attracting candidates into consultant roles (as nationally). This causes a reliance on temporary posts to respond to activity requirements.	
Current or planned workforce transformation programmes	Part of overall programmes – further discussion with HEE would be welcomed about a fuller audit of current and future state and their workforce planning capacity / capability to take forward necessary transformation.	
Requirements for new programmes to upskill existing staff	Wraparound / fluid staffing models becoming part and parcel of mainstream training would be helpful to support aspirations for joined up physical and mental health care.	

iv. Paramedic at Home: National context and work programmes

Research has shown that only a small percentage of ambulance conveyances are the result of serious life-threatening illness and injury, requiring treatment at a specialist emergency centre. The remainder of cases have been classed for the purposes of this document as “urgent care”, and whilst care needs are urgent, they could be better managed in a care setting which is more appropriate to the patients’ needs.

Guidance has been produced which proposes a number of pathways as an alternative to the current default conveyance to Accident and Emergency (A&E). Commissioners should utilise Urgent Care Centres, staffed by a multi-disciplinary team, and ensure that these accept patients conveyed to them by ambulance under agreed protocols and care pathways: other alternative care pathways are described later in the document.

This guidance also proposes two pathways as an alternative to conveyance of any kind, for selected patients contacting the 999 service: “hear and treat” and “see and treat”. The detail of these two treatment pathways and how commissioners might wish to deal with them are described in the guidance.

iv. Paramedic at Home: Summary of Network delivery plan

Vision	Ambulance services increasingly mobile urgent community treatment services, not just urgent transport services, offering more treatment at the scene, including at home.

Inputs

Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*
People	- Lancashire UECN Members - SRGs and SRG Leads - Interdependent Workstream leads (eg. 111, Paramedic) - Delivery and commissioning workforce (see next slide) - End users / patients, carers, public, local stakeholders
Technology	• Review and update "on board" technology to enable paramedic fast response vehicles to better assess and treat locally • Better mobile access to patients ' care records and dedicated care plans
Other	• Clinical models for ambulance services and Improving referral pathways • Recommendations on ensuring a more clinically appropriate response to 999 calls are implemented following trial • CQUIN 16/17 (TBC)

Activities

Activity	Date
Existing plan for Paramedic at Home is evidencing results – inclusion into Commissioning Intentions for 16/17 and assumption that this will be further developed beyond this SRG to review current arrangements against local system needs and input into 16/17 Commissioning Intentions and further development Organisation level actions (NWAS): Assessment and support approaches / tools to support see &treat / hear &treat clinical models Carrying out reviews and providing information against national standards including dispatch / deposition Delivery in line with National and local referral pathways	16/ 17 and cont.

Outcomes

Activities within this Workstream will contribute to all 3 of the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016, but particularly have a measurable impact on:

1. Provide highly responsive urgent care services outside of hospital so people no longer choose to go in A&E
2. Single call to access clinical advice for public and community healthcare professionals

It is also intended that there will be outcomes in relation to efficiency / value and effectiveness – for example reduction of DTOCs, meeting four hour target, reducing duplication / handover, greater appropriacy of service usage

In the longer term it is anticipated that patient experience and involvement in their care will be greater

Impacts

- Clinical models support an increase in proportion of calls to 999 dealt with via 'see and treat' and 'hear and treat'
- Fewer unnecessary conveyances to Type 1 or Type 2 A&E when this may not be the best place to meet patient's needs
- Referral pathways are set between paramedics and other providers
- Recommendations on referral pathways are implemented
- Increased convenience for patients as they are treated closer to home
- Reduced pressure on A&E

iv. Paramedic at Home: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	Paramedics (have already had training for at home based work), other related professionals on referral pathway – health and care	Range of support and administrative staff Technicians Commissioning roles
Number of vacancies (role type and FTE)	Not available at Draft Plan stage – guidance would be welcomed on scoping this (just the Paramedic service or the interdependent services?).	As previous box

Please provide a short summary of the following:	
Actions required to meet establishment	Data not available at Draft plan stage. It is considered that the workforce in this area benefits from having already been trained in the relevant competencies for the Paramedic at Home service and isn't experiencing any unusual vacancy issues. Issues are rather more related to the interdependent services who are not yet working in ways that 'accept' the operational change such as supporting referral requests coming from paramedics.
Current or planned workforce transformation programmes	For the core service, the workforce development is already in place and core staff are trained. In terms of the interdependent services, further discussion would be welcomed with HEE.
Requirements for new programmes to upskill existing staff	Change in way of working for other professionals, to understand the new at home based model and gear up to associated changes in referrals – eg. From a paramedic at scene rather than a GP • Training requirements for all mobile staff to ensure they have the correct skills to treat without conveying • Training requirements for despatchers to better assess type of response required

v. Emergency Centre and Specialised Services: National context and work programmes

Certain hospitals within trusts which are able to receive, assess, treat and refer all patients (both adults and children) with urgent and emergency care needs would be designated as Emergency Centres. Because the successful functioning of an Emergency Centre relies on a range of integrated services it should be noted that the entire hospital is designated as an Emergency Centre, including the Emergency Department (also known as an Accident and Emergency Department) that is located within it. Following initial stabilisation some patients who require specialist care will be transferred to a different Emergency Centre with specialist services; this transfer capability is integral to the functioning of an Emergency Centre and the network in which it operates.

Emergency Centres will contain some facilities and beds to admit and investigate patients' illnesses and injuries as well as having a range of outpatient and supporting services (see below). In rural areas Emergency Centres will be the initial receiving destination for almost all emergency and ambulance patients. These patients will undergo initial treatment and stabilisation prior to admission to that centre, or onward transfer, under agreed protocols and through a designated transfer and retrieval service, to more specialist care at Emergency Centre with specialist services. In more urban environments when the patient has an identified specialist need and the increase in journey time is clinically justified, ambulance staff may bypass an Emergency Centres in favour of an Emergency Centre with specialist services.

An Emergency Centre with specialist services has all the features of an Emergency Centre, but also includes 24/7 access to some specialist facilities that receive patients from Emergency Centres, or directly from an ambulance which has bypassed an Emergency Centre. Such facilities should include a grouping of identifiable specialist services that support a network, current examples include:

- major trauma management including neurosciences, plastic surgery, burns
- primary percutaneous angiography for ST-segment elevation myocardial infarction
- stroke thrombolysis
- emergency vascular surgery
- Specialist paediatric services

- all supported on-site by level three critical care and interventional radiology.

Guidance is under development and awaiting approval.

v. Emergency Centre and Specialised Services: Summary of Network delivery plan

Vision	Networks designate available services in hospital based emergency centres, ensuring that for those people with more serious or life threatening emergency needs We should ensure they are treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery in hospital.

Inputs

Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*
People	- Lancashire UECN Members - SRGs and SRG Leads - Interdependent Workstream leads (eg. 111, MH, STP) - Delivery and commissioning workforce (see next slide) - End users / patients, carers, public, local stakeholders
Technology	• Cross reference with STP • Cross reference with Accessing system/ UCC workstream earlier with regards to booking / capacity systems and tools
Other	• Guidance for Commissioners regarding Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services • National analysis of non-elective activity and capacity, further local analysis will be delivered to support this following trial. • 7DS Clinical standards • Safer Faster Better

Activities

Activity	Date
Review Stocktake and National Principles / Best Practice (Query National Specification to follow? If so, further review) – to ensure compliance with national standards for 7DS and Mortality; standard discharge protocols and escalation	16/17
Network level discussion about future shape of Emergency and specialist care and components of this such as EDs and designation (with links to interdependent STP discussions)	16/17
Implementation arising from above – SRG level and Pan Lancs / SC level where standardisation / at scale /cross boundary working is beneficial	17/18
Cross reference to UCC workstream – particularly with regard to capacity and flow systems and tools; booking systems	18/19

Outcomes

Activities within this Workstream will contribute to all 3 of the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016 but particularly:

- Ensure people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and recovery

It is intended that a range of care, quality and value outcomes will be improved by these activities, to be defined with more precision (in line with the above publication and any further guidance) at implementation stages

Amongst these will be fewer DTOCs, meeting Four Hours etc as those with the more serious or life threatening needs will be treated in appropriate centres of expertise and experience better outcomes and care

Impacts

- Improving referral pathways between emergency centres and emergency centres with specialist services avoids unnecessary and inappropriate delays to definitive care
- Providers are compliant with 7DS clinical standards, as per the NHS Standard Contract
- All urgent network specialist services are compliant with four mortality clinical standards, on every day of the week
- DTOC plans are submitted to support timely discharge.
- Support packages are in place for CCGs and SRGs.
- Facility specifications, network facilities and care pathways are implemented.

v. Emergency Centre and Specialised Services: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	Medical staff will vary according to type of specialities/ designation, with specialist consultants and nursing staff and a range of paediatric, adult and older people focused workforce – making up the core staff of emergency centres/ departments. There are associated / interdependent staff within the same setting and externally (cross reference previous workforce notes on UCCs for list of types of roles)	Similarly to previous sections – a range of management and support functions Commissioning / planning/ leadership roles
Please provide a short summary of the following:		
Actions required to meet establishment	Cross ref to UCCs – recruitment difficulty varies according to specialty. Known issues across the board – particular example would be Respiratory Consultant cover in A&E. Changes in social care provision to be considered in relation to care inputs at emergency contact points and for handovers / discharges. Similarly cross reference to MH Crisis care.	
Current or planned workforce transformation programmes	Individual provider actions regarding recruitment eg. encouraging overtime where appropriate, efforts to extent recruitment range and pull. Current focus in provider landscape necessarily includes resilience responses to strike action and therefore shorter term but important immediate operational matters are high priority currently. Further discussion would be welcomed with HEE.	
Requirements for new programmes to upskill existing staff	Interest in new role development such as Advanced Nurse Practitioners trialled elsewhere Support with any newly introduced systems / capacity and flow tools or changes in pathways / referral criteria and practices associated with this internally within hospital settings or in wider health and care professional practice.	

vi. Mental Health Crisis: National context and work programmes

NHS England is developing clinically informed access and quality standards for mental health crisis care, underpinned by referral to treatment pathways (including waiting time standards), nationally specified datasets, commissioning guidance, quality improvement schemes, payment systems and transparent publishing of key metrics.

While these standards are in development nationally, urgent and emergency care networks should have a focus on the following priorities :

1. Ensuring that **crisis resolution and home treatment teams** able to provide a 24/7 gatekeeping function for acute mental health beds and a 24/7 intensive home-based alternative to admission in line with fidelity standards http://www.ucl.ac.uk/core-resource-pack/fidelity-scale

2. Ensuring acute hospitals have an effective on-site 24/7 urgent and emergency **liaison mental health** service covering all ages http://mentalhealthpartnerships.com/resource/developing-models-for-liaison-psychiatry-services/

3. Ensure adequate provision of **health based places of safety** for people detained under S136 of the Mental Health Act. This includes working with police to improve local protocols for detaining people under s.136 and ensuring that places of safety adhere to clinical, operational and physical standards set out by the Royal College of Psychiatrists, and chapter 16 of the revised Mental Health Act Code of Practice.

4. Local **directories of services** must include complete, accurate and continuously updated information regarding mental health crisis services (for CYP as well as adults). All NHS and local-authority funded mental health services should be required as part of their contracts to provide and maintain a detailed listing on NHS Choices of the services they provide, details of access arrangements, contact details and arrangements for referral or self-referrals.

UEC networks should **work with their local Crisis Care Concordat groups,** multi-agency partnerships who are already established and will have much of the necessary expertise to progress these priorities.

vi. Mental Health Crisis: Summary of Network delivery plan

Vision	People of all ages experiencing mental health crisis will have timely access to compassionate, expert , NICE Concordant care and support.

Inputs	Activities		Outcomes	Impacts
Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*	Activity: Cross reference with STP MH Workstream and CYPEWMH for further detail Key activities: - Continued implementation of Crisis Concordat - Development of sustainable 24/7 MH liaison / crisis service for UEC - Continued implementation of CYPEWMH Transformation Plan (Care of Vulnerable in partic) - Ensuring MH needs are included into all system wide or SRG level developments such as UCC / ESC principles and specs, 111 and appointment booking; care record schemes etc	Date	Activities within this Workstream will contribute to all 3 of the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016, in particular: 1. Provide highly responsive urgent care services outside of hospital so people no longer choose to go in A&E 2. Single call to access clinical advice for public and community healthcare professionals This workstream is also a workstream in the STP and works to specific MH outcomes and Crisis Concordat requirements including Access/ Waiting Time standards for crisis assessment; improved access to health based places of safety (s136); A&E access to MH services in line with 7DS	• People received timely, evidence based crisis response in community, and are able to receive intensive home-based treatment as an alternative to admission. • People receive skilled, compassionate care for mental health needs when they present at emergency departments • There is access to health-based places of safety following detention under Section 136 of the Mental Health Act, so that people are not held in police cells. • Local directories of service for mental health are up to date so that health and care staff are able to refer people to the most appropriate services, and prevent them from attending A&E or being admitted as an emergency inpatient where this is not necessary .
People	- Lancashire UECN Members - SRGs and SRG Leads - Interdependent Workstream leads (eg. Mental Health leads) - Delivery and commissioning workforce (see next slide) - End users / patients, carers, public, local stakeholders			
Technology	Cross reference with STP and with Accessing the System workstream – it is expected that the next generation 111/ clinical assessment systems will include support for mental health needs This covers multi –channel access; i.e. voice, face to face/ telephone and online.			
Other	Access and quality standards developed for crisis care including: • clinically informed referral to treatment pathway (including waiting time) • new crisis care metrics in national datasets • Commissioning guides • National accreditation and			

vi. Mental Health Crisis: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	This audit has been completed and shared with NHSE already. It is too detailed to fit in this template but is available on request. The MH Lead has provided the information to inform this UECN Plan.	
Number of vacancies (role type and FTE)		

Please provide a short summary of the following:	
Actions required to meet establishment	Included within MH Programme (Workstream of STP) – proposals have been made and accepted to increase capacity in known vacancy areas in EDs for example, to allow for the increase in referrals and meet the spec for the MAU. Increases in capacity have also been made as required at acute sites in addition to contracted activity.
Current or planned workforce transformation programmes	Driven via the MH Workstream of the STP and informed by audit noted above.
Requirements for new programmes to upskill existing staff	Training for all the associated organisations including within the acute sector itself is already underway although it would be helpful to consider greater MH awareness and assessment capability at front end service points, avoiding some less appropriate use of MH Crisis and enabling this to be used for the most serious presentations.

vii. Supporting Self Care: National context and work programmes (1/3)

The context for Supporting Self Care is set out in a series of NHS England documents:

Mandate 2015/16 - Chapter 2: para 2.3

NHS England's objective is to make measurable progress towards making the NHS among the best in Europe at supporting people with ongoing health problems to live healthily and independently, with much better control over the care they receive.

NHS Constitution (updated Jul 2015) – 3a Rights of individuals, patients & carers

"You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate."

5YFV Oct 2014 – Chapter 1 Empowering patients

5YFV sets out the need to introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs.

As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

vii. Supporting Self Care: National context and work programmes (2/3)

NHS England Business Plan Priorities 2015/16 – Supporting Patient &Public participation

The Business Plan Priorities include the need to:

- empower people by improving the information to which they have access - not only clinical advice, but also information about their condition and history
- support people to manage their own health and stay healthy, through the 'Realising the Value' programme, work with voluntary sector partners to support commissioning of evidence based approaches such as self-management educational courses, and through encouraging independent peer-to-peer communities to emerge
- promote the value and importance of personalised care and support planning and increase the direct control patients have over the care that is provided, including at the end of life
    - Note that CCGs also have a duty in relation to this under the Health & Social Care Act 2012
- support CCGs to develop their capacity and capability to deliver Personal Health Budgets (PHBs) and develop their local offer to introduce them beyond NHS Continuing Healthcare

LTCs Strategy for LTCs EoLC & Older People programme

The Strategy highlights the requirement to:

- Improve the evidence and insight into best practice for commissioning LTC care
- Improve enablers to support change and measure care across the life course (for example, use of joined-up incentives and data)
- Embed holistic care and support planning to deliver person-centred goals and outcomes
- Improve co-ordination and continuity of care by supporting development and testing of community based care models
- Focus on specific population groups to tackle inequality in outcomes (currently residents in care homes, neurology, paediatric asthma, MSK, older people living with frailty)
- Improve professional and public awareness and engagement around person-centred care for people with LTCs

vii. Supporting Self Care: National context and work programmes (3/3)

A Self-Care programme is underway to:

- Deliver a clear narrative describing the aims and benefits – tailored for patients and professionals
- Promote the implementation of specific self-care interventions based on five themes (see diagram), through connections to existing change and delivery models
- Provide advice and information for all CCGs to draw from, supported by cross-cutting enablers

The programme will be measured and evaluated to provide learning for the future.

vii. Supporting Self Care: Summary of Network delivery plan

Vision	There is personalised care and support planning, as part of a system which provides support for self-management. This includes the use of Personal Health Budgets.

Inputs

Resources (£)

Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section

People

- LTC / planned care and PHB leads in CCGs, CSU and LAs
- PPI / engagement leads
- Condition specific leads with responsibility for expert patient type progs
- Lancashire UECN Members / SRGs Leads
- Interdependent Workstream leads (eg. Mental Health leads)
- Delivery and commissioning workforce (see next slide)
- End users / patients, carers, public, local stakeholders

Technology

Cross ref to STP

- Guidance on personalised care planning (published January 2015)
- Supported self-management guide
- Consensus statement and practical guidance to support commissioners and Fire and Rescue Services to work together to keep people safe and well

Activities

Activity	Date
Cross reference to STP Prevention workstream for more detail (rather than duplication of this within the UEC plan) (This will cover evidence based approaches, personalised care support and budgets). There are also linkages via Vanguard and LHE Programmes for Neighbourhood working / teams / care co-ordination etc	
Specifically for UEC there will be a review of SRG DTOC Work Programmes, as noted in earlier workstream; aligned with BCF DTOC planning and build on Rapid Improvement Process and plans	16/ 17

Outcomes

Activities within this Workstream will contribute at some level to the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016 although not specifically.

Self care is driven in planned care rather than urgent and emergency care although there are clear interdependencies.

Self care outcomes therefore will be about enabling and prevention – upstream benefits which have an impact on the UEC system.

In the round, improvements in self care and personalised care will reduce inappropriate care usage and reliance on emergency care options (those which are attributable as such).

Impacts

- People who are most at risk of needing emergency care, including mental health crisis care, have the option of a person centred care and support plan
- Services are developed and delivered in line with the supported self-management guide
- Work is delivered in line with the guidance d issued by commissioners and Fire and Rescue Services, to use the 670k home visits carried our annually by the FRS to keep people 'safe and well'
- Teams use the new tools developed to support implementation of key approaches, including self-management education and peer support
- Teams use the new tools / training support culture change for health and care professionals
- There is an assessment of the levers, barriers and enablers of person-centred care – and a set of recommendations for the future
- CCGs develop local personal health budgets offer. They introduce PHBs beyond NHS continuing healthcare in line with the 2015/16 planning guidance.

vii. Supporting Self Care: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	Role types very broad as self cover spans across all conditions, specialities, services and modes of delivery as well as featuring in initiatives targeted at frail and vulnerable etc. Particular roles are played by specialist nurses, PPI Leads, pharmacists, neighbourhood teams and care co-ordinators, GPs and practice nurses, community nurses, social care, voluntary sector etc…	As previous box – so broadly scoped that the list of role types is extensive. It includes programme leads for self care related initiatives eg. Expert patient programmes, condition/ LTC specific programmes; LTC commissioners, PPI and engagement leads, PHB Leads, CSU staff, BCF leads, neighbourhood leads…
Number of vacancies (role type and FTE)	Detailed audit in this area potentially not viable as the scope is too broad and overlapping with non UEC areas of work – insufficient benefit vs effort. Suggest discussion with HEE at high level via STP process.	As previous box

Please provide a short summary of the following:	
Actions required to meet establishment	Issues in relation to behavioural / cultural and institutional practice rather than establishment figures. Variation in competencies and developments dependent on condition specific programmes.
Current or planned workforce transformation programmes	Cross ref to STP
Requirements for new programmes to upskill existing staff	Training/ coaching in person centred planning and budgeting integrated into mainstream professional training in all disciplines. Requirement to standardise what person centred care and self care support means across all specialities. Patient and professional education – medication advice and compliance. Integrated care networks for LTCs. Collaborative working

viii. Independent Care Sector: National context and work programmes

The national Independent Care Sector Programme's overall objective is to support the health and care sectors to work together effectively to:

- reduce delayed transfers of care from hospitals;
- improve discharge to care home and home care settings;
- reduce A&E admissions; and
- prevent avoidable admissions to hospitals.

These providers are a key part of the urgent care system, with approximately 80% of care being provided by independent and voluntary sector. A core objective is therefore to connect the Independent Care Sector with the wider Urgent and Emergency Care system, so that the sector can play a role in market shaping and enabling the wider U&EC goals.

The programme has 4 work streams:

- Better use of care homes
- Better use of care at home (domiciliary and housing providers)
- Improving hospital discharge to the care sector
- Local Commissioning Practice (CCGs and local authorities)

viii. Independent Care Sector: Summary of Network delivery plan

Vision	There is better use of care homes, care at home (domiciliary and housing providers), improved hospital discharge to the care sector, and enhanced Local Commissioning Practice by CCGS with local authorities.

Inputs		Activities		Outcomes	Impacts
Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*	Activity	Date	Activities within this Workstream will contribute as an enabler rather than directly correlating to the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016 (as these are focused on delivery of UEC). This workstream will be partly within the scope (and therefore intended outcomes) of the Healthier Lancashire/ STP Independent Care workstream (see STP for further detail) - including system wide long term solutions for sustainable high quality care provision (meeting known demographic needs now and in future) SRGs also have outcomes they expect from local work programmes particularly around admission avoidance and DTOC reductions	Based on guidance and clarification guidance issued… • CCGs and LAs deliver enhanced work with the ICS, including encouraging joint capacity planning • There is enhanced support for self-funders (choice protocols) • There are enhanced Continuing Healthcare processes • There is best-practice clinical input for care homes, including local care home placements and technology in care homes • Local systems consider the best use of care coordinator roles • Local systems are able to better manage care home resilience • Local systems consider discharge-to-assess models to reduce DToCs • There is greater consideration and involvement with domiciliary care and housing organisations to support discharge and prevent admission.
People	- STP Independent Care Sector Workstream lead(s) - UECN and SRGs Leads - Interdependent Workstream leads (eg. Mental Health) - Delivery and commissioning workforce (see next slide) - Care sector employers/ workers/ collaboratives - End users / patients, carers, public, local stakeholders	This is partly in the scope of the Healthier Lancashire/ STP Independent Care workstream (see STP for further detail). This is at Case for Change stage, with Solution Design to follow to Dec 2016. Extensive stakeholder engagement is planned detailed implementation including finance, workforce, estates and capital plans 2017 /20. SRGs also have commitments existing and planned in relation to care homes liaison, teams and contracting. Pennine Lancs have links with the Airedale Vanguard focused on Care Homes Also cross ref to DoS in earlier section	See STP 16/ 17 and beyo nd		
	• Cross ref to STP particularly Independent Care Sector Workstream				
Technology	• Quick Guides Suite www.nhs.uk/quickguides			A pan-Lancashire and South Cumbria, system-wide solution for system-wide issues	

viii. Independent Care Sector: Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	Audit not carried out of this sector but typical roles will include nursing, care workers and management (not necessarily 'medical'). Also more specialist type roles such as EMI / challenging behaviour support workers. Liaison roles and teams dealing with discharge and including AHPS in some areas.	Management and support roles in care homes Programme leads/ commissioners/ contracting support staff, procurement support staff – CCGS, CSU, Local Authorities
Number of vacancies (role type and FTE)	Not audited for this sector	As previous box

Please provide a short summary of the following:	
Actions required to meet establishment	Audit / stakeholder views not yet specifically sought although this will be part of STP Workstream. UECN aware of issues to be considered including implications of living wage, EMI and Challenging Behaviour beds / associated staffing, physical health care to prevent admissions. Actions could include recruitment / employment standards and qualification criteria; CPD training requirements; NVQ type training, Care Home Workers License/ accreditation; review minimum staffing requirements for nos and qualifications
Current or planned workforce transformation programmes	• Healthier Lancashire / STP Programme will progress with some of this – scope currently being agreed
Requirements for new programmes to	• Review existing skills-mix for workforce/ design skills-mix requirements for accredited Care Homes • Design training programmes / CPD to bridge the skills gap • Best practise reviews for staff competencies/ accreditation/ specialist training to avoid 111 / 999 / A&E

ix. Primary Care:
National context and work programmes

Work is ongoing to support:

- Extending the role of community pharmacy in urgent care;
- Ensuring best use of unscheduled dental care services.

National work includes:

- Uptake of Summary Care Record
- Improvement of Directory of Services information – urgent care dental and pharmacy
- Improvement of NHS Choices entries/information – urgent care dental and pharmacy
- Support packs for Urgent medicines services
- Standardisation of minor illness services
- COPD rescue pack guide
- Referral from hospital to community pharmacy guidance
- Review of medication reviews in care homes
- Management of dental pain and referral pathways
- The role of pharmacy in the new Integrated Urgent Care Model
- Sharing good practice of repeat dispensing
- Collating evidence of how pharmacy can support people with LTCs
- Guidance on how community pharmacy can prevent admissions from care homes
- Review of unscheduled dental care
- Commissioning guide on specialist dentistry for vulnerable groups
- 5 year forward view of dentistry and commissioning guide
- Pilot work on community dental services
- Urgent dental public campaign

ix. Primary Care
Summary of Network delivery plan

Vision	There is improved access to primary care, including an increased role for pharmacy in urgent care, and improved oral and dental health

Inputs		Activities		Outcomes	Impacts
Resources (£)	*Will be completed for full submission – further guidance would be welcomed on scope / costing criteria for this section*	Activity	Date	This workstream will contribute to all 3 of the 'Top Outcomes for 2020/21' in NHSE STP How To Guide_ UEC published in Draft April 2016, 1. Provide highly responsive urgent care services outside of hospital so people no longer choose to go in A&E 2. Single call to access clinical advice for public and community healthcare professionals 3. Ensure people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and recovery	• Pharmacies can access Summary Care Record; • There is a greater use of community pharmacy to support minor illness; • There is a transformation of how urgent care dental services are embedded and commissioned within urgent care systems; • There is a Seasonal Influenza Vaccination Advanced Service for community pharmacy; • CCGs consider commissioning minor ailments services and other community pharmacy offers; • Based on guidance issued, work is delivered to extend the role of Community Pharmacy in UEC; • Best-practice use of unscheduled dental care services is implemented. This is based on guidance issued.
People Technology	- NHSE Primary Care Transformation Team - Lancashire UECN and SRGs - Interdependent Workstream leads (eg. STP, MH) - Delivery and commissioning workforce (see next slide) - GP practices, consortia, practice nursing and associated services/ support - GP commissioners - End users / patients, carers, public, local stakeholders, practice patient groups	NHSE Primary Care Transformation Team Plan includes: - Models of care to implement the 5YFV, Quality Contract and MSPs - 7 Day Access - Integration of Health and Social care and UEC - Electronic record sharing - Practice level data on quality and access - Estates, technology and workforce	16/ 17 Plan with 5Yr view	PCTT Plan on a page sets out specific Outcomes for Primary Care – please cross refer to this document	
	See earlier sections on UCCs and UEC and cross ref with STP	Priority for urgent care is to establish the principles / outcomes required across SRGs for out of/ extended hours. Integrate access, triage and hear and treat models; agree/ align roles of GP and community services including pharmacy and dental	16 17 – 17/ 18 on		
Other	• Quick guides and other guidance documents				

ix. Primary Care Workforce requirements

See p17 for guidance on completing the workforce requirements section. Health Education England colleagues are keen to understand the level of support which you require, and this template provides an initial opportunity to review baseline workforce requirements to get a sense of local requirements for that ongoing discussion.

	Medical workforce	Non-medical workforce
Current establishment (role type and FTE)	Typical roles include GP and Practice Nurses, community nurses / teams, case managers Community pharmacy and dental roles GP A&E Roles; Primary Care liaison roles including specific roles for vulnerable people / mental health Linked roles eg. social care	Practice management and support roles Commissioning roles Primary Care Transformation Team
Number of vacancies (role type and FTE)	NHSE / PCTT to provide further detail if held ?	As previous box
Please provide a short summary of the following:		
Actions required to meet establishment	NHSE / PCTT to advise	
Current or planned workforce transformation programmes	Ref. Primary Care Transformation Team	
Requirements for new programmes to upskill existing staff	NHSE /PCTT to advise	

Section 3

Enablers to implementation

Delivery dependencies, challenges and risks

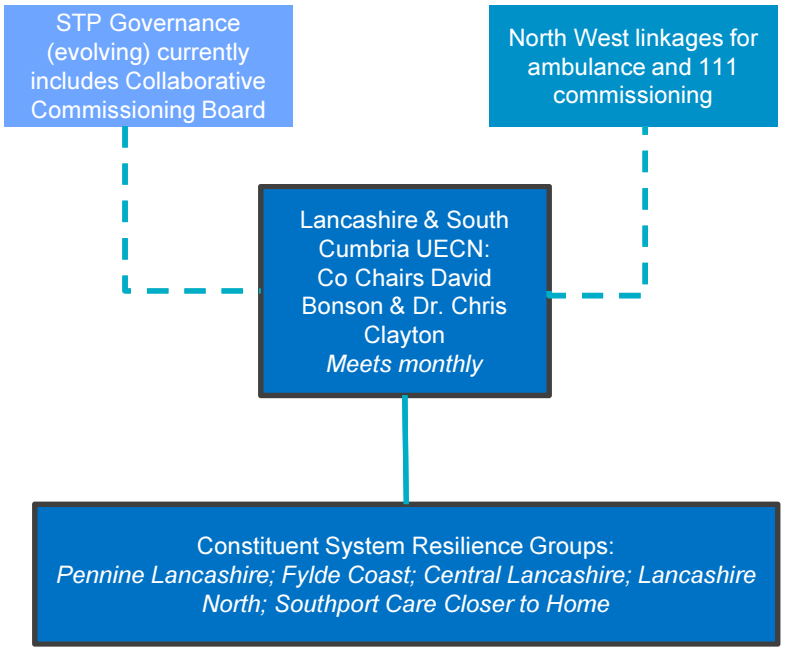
	Description	Mitigating action
Dependencies	1. Three Vanguard programmes: a. Fylde Coast b. Morecambe Bay c. Airedale 2. Links to neighbouring U&EC Networks: a. North East (South Cumbria) b. Cheshire and Merseyside (West Lancashire) 3. Links to other digital footprints 4. Links to community pharmacy and dental services commissioning arrangements. 5. Engagement with HEE around workforce planning and training 6. BCF programmes 7. Healthier Lancashire/ STP 8. NHS111/999 regional programmes 9. Ability to agree a plan that reflects the needs of local areas, Lancashire as a whole and the other interdependencies within the timescale	• The Lancashire UEC Network will maintain close liaison with the Vanguard sites into to ensure best practise is shared accordingly and reduce the risk of conflicting project developments. • The Lancashire UEC Network will seek an alliance with neighbouring UEC Networks, for mutual gain. • The Lancashire UEC Network has members from NHS 111 Lead Commissioners to link into regional NHS 111 programme.
Risks	1. NHS111/999 regional programmes 2. Workforce, capacity 3. Resources, financial and technological	The Lancashire UEC Network has members from NHS 111 Lead Commissioners to link into regional NHS 111 programme.
Challenges	1. Links to neighbouring U&EC Networks: 2. Links to other digital footprints 3. Scale and pace of change within the system	

Governance

Overview of governance
Refer to Governance template previously sent

Summary of regional forum attendees and frequency		
Forum	**Attendees**	**Frequency**
System Resilience Groups (see diagram) CCGS Community pharmacy services GP out-of-hours Providers Health & Wellbeing Boards HEE Healthwatch Local Authorities NHS 111 Providers NHS Acute Trusts Urgent care providers NHS Ambulance Trusts NHS Community Health providers NHS England NHS mental health providers	Chairs (Executive Directors and Senior Clinical Leaders)	Routine attendance from SRG members As there are multiple member organisations it is not expected that every organisation attends every meeting and a 'lead' arrangement by sector has been agreed instead (eg. acute, local authorities) with the role to feedback to the wider sector and collate sector views / information as appropriate

Governance structure



Key performance indicators

Key performance indicator	Definition	How KPI will be monitored	Baseline (15/16)	16/17 target	17/18 target	18/19 target	19/20 target
Core constitution KPIs including Four Hours	As per NHS Constitution	Via existing NHS Constitution performance measurement frameworks and assurance process between NHSE and CCGs; footprint monitoring at SRG					
Contractual measures eg. NWAS, 111, Acute provider performance/ activity measures	As per contracts	Via contracting arrangements					
BCF measures including Delayed Transfers of Care, Non Elective Admissions	As per DTOC / BCF guidance	Via commissioning organisations, provider organisations and collaboratively via SRGs and BCF					
Primary Care measures including access / A&E rates	NHSE / PCTT have set out Ambition and Outcomes in their Plan	Via NHSE PCTT primarily with links as appropriate to SRGs					

Section 4

Additional information

Additional information

If you have any additional information you would like to include, please use this section. Examples might include:

- Details of existing plans or documents
- Links to these documents
- Other Network workstreams or activities not captured in this template

Appendix: Planned publications

Publications (1/2)

The list of planned publications below is taken from the forward plans for 2016/17 developed by within the programme, subject to funding and ongoing review. Further publications may be added to the list below as the year progresses and work is further refined.

Title of Publication	Publication Date	Aim of Publication
National Policy/ Enablers		
System wide outcome indicators		
Evaluation of project to develop and trial indicators	Summer 2016	Set out findings from the trialling of system wide UEC outcomes measures with UEC vanguards and volunteer sites.
National set of outcome indicators	Summer 2016	Set out a recommended list of system wide UEC outcomes measures for use by networks locally in including guidance on how they could be used and how the measures will be made available to them.
National patient satisfaction survey.	Tbc 2017/18	Proposals for or results from a national UEC patient experience survey subject to development in partnership with stakeholders. This is to support improved UEC outcome measurement.
Updates to Transforming Urgent and Emergency Care documents		
Emergency Centre and Urgent Care Workforce Guidance	Q1 2016	To give guidance to Local Education Training Boards (LETBs) workforce development leads on basic work force planning / use of competency frameworks for the new offer for UEC. Guidance will be supported by case studies signposting to effective workforce models.
Refresh of evidence base	Q 2 2016	Refresh of existing evidence base for UEC – latest guidance and research, academic research, new terminology, statistics.
Updates to safer faster better.	Tbc	Updated to existing document to bring in refreshed evidence, update to links, terminology, latest guidelines and statistics.
Update to route map for delivery.	Q 2 2016	Update to dates and enablers to support UEC networks following year one into implementation.
Integrated Urgent Care (IUC)		
Clinical Governance, Clinical Hubs and inter-operability guidance	April 2016	Guidance on how clinical hubs can work together to ensure consistent and safe clinical standards are applied nationally.
IUC High Level Metrics	April 2017	First phase high level list of new metrics aligned to new commissioning standards for IUC to enable commissioners to manage performance of whole IUC system and capture patient insight.
Revision of High Level IUC Metrics	September 2017	Second phase granular list of new metrics for IUC.
Staff insight report	April 2016	Report on existing satisfaction levels and morale of staff working within IUC services plus perceptions of staff working in the wider NHS and necessary action to improve.
Learning and Development Programme Report March 2017	March 2017	To share learning and outcomes of the Phase III Learning and Development project to support and inform the integration of Urgent and Emergency Care. This will enable sharing of best practice and give the necessary evidence for the wider Integrated Urgent Care Programme.
NHS England IUC (NHS 111 Telephony) National Business Continuity Policy	Q2 2016	Updated version of existing policy for integrated urgent care. (https://www.england.nhs.uk/ourwork/pe/nhs-111/resources/).
Procurement Guidance	Q1 2016	Guidance on procurement of new NHS 111 contracts and on moving existing contracts to the new model for IUC.
Integrated Urgent Care Payment annex	Q2 2016	New payment model for IUC to support IUC Commissioning Standards
Integrated Urgent Care Contract Alignment Plan	Q2 2016	Provide guidance on approaches CCGs might take in managing the multiple provider contracts which collectively provide an integrated urgent care service.
Integrated Urgent Care Model (Financial Model Tool)	Q2 2016	Tool to support commissioners in understanding the whole system potential cost and to circulate a summary at CCG level comparing the costs prior to September 2015 of 111 and GP Out of Hours services.
DoS/A2SI Profiling Principles	30 June 2016	To provide best practice guidance of how each area should set up information on their Directory of Services, ensuring better consistency of approach and methodology
DoS/A2SI Roles and Responsibilities	30 June 2016	To provide supplementary information to the IUC commissioning standards on the expected tasks, activities and competencies of those managing and maintaining the Directory of Services in each area
DoS/A2SI Quality Review	30 June 2016	To provide a baseline of data quality in the current Directory of Services by region across three domains: profiling, validation and outcomes

Publications (2/2)

Title of Publication	Publication Date	Aim of Publication
Integrated Urgent Care/ NHS 111 Workforce		
NHS 111 Workforce Investment Fund		
Phase 1 - summary Report of Projects	June/ July 2016	To share learning and outcomes of the Phase 1 project to support and inform the NHS 111 IUC call-centre workforce development. This will enable sharing of best practice and give the necessary evidence for the wider NHS 111 IUC Workforce Development Programme.
Phase 2 Call for Proposals	July/ August 2016	To continue the development of the NHS 111/ IUC call-centre workforce through further pilot, testing and evaluation projects using the NHS 111 Workforce Investment Fund and will raise awareness of the work supporting the NHS 111 workforce.
Phase 2 –Workforce Investment Fund summary report of projects and testing	March 2017	To share learnings and outcomes from the projects to that inform the help inform the work of the NHS 111 Integrated Urgent Care Workforce Development Programme.
NHS 111 Integrated Urgent Care Workforce Development Programme		
Interim Report – including emerging competency frameworks, scope of practice and career frameworks, education/training/curriculum	July / August 2016	To provide an understanding and learning of the work underway to evidence and develop career frameworks, education/training/curriculum guidance.
Competency Frameworks to support the development of the NHS 111 / Integrated Urgent Care call-centre workforce.	Autumn / winter 2016	To provide awareness and information about the work being commissioned by Health Education England (HEE) to identify and develop scope of practice, the competencies and associated education and training requirements of the existing and future NHS 111 and IUC telephone workforce. The publication will support providers, commissioners, networks and HEE locally in providing the best possible workforce whilst the wider programme continues to progress towards a 'Workforce Blueprint'.
NHS 111 Integrated Urgent Care Mental Health Report	Autumn / Winter 2016	This report will review the specific developments tested and implemented for the existing and future workforce in partnership with NHS Digital Urgent Care Programme, based on patient experience and parity of esteem.
Independent Care Sector Programme		
Quick Guide: Supporting self-funders' decisions at discharge	February 2016	Self-funders often have a delayed discharge when they are not funded by the NHS or the Local Authority (LA) and therefore not prioritised or given the information they need. This guidance will provide local health economies (LHEs) with best practice examples.
Quick Guide: Improving resilience in care homes	April 2016	This guidance will outline standard operating procedures for CCGs regarding care home closures, plus advice for early identification of quality issues
Quick guide: identifying local care at home packages	July 2016	To provide guidance and a template for capturing information about available care at home packages
Quick Guide: Continuing healthcare assessment	September 2016	To provide clarity across the sector about the Continuing Health Care (CHC) process and funding arrangements, including trusted assessor arrangements
Quick Guide: Discharge to assess	September 2016	To provide more detailed information on setting up successful discharge to assess schemes, including models and template specifications
Quick Guide: Out of hours services in care homes	September 2016	To highlight best practice examples and practical tips on how out of hours health services work with care homes
Quick Guide: Using secure email in care homes	September 2016	To showcase the findings of the pilots of using secure email in care homes to solve information sharing issues
Quick Guide: Upskilling staff in care homes	September 2016	To provide practical examples and tips to upskill care home staff, both in terms of training to deliver simple health procedures and in how to best use existing infrastructure
Quick Guide: Building social capital	September 2016	To showcase how the voluntary sector and social capital can be harnessed to prevent hospital admissions and improve hospital discharge, including findings from Cabinet Office research
Model care passport	September 2016	Model care passport
Quick Guide: Care coordinators	October 2016	To provide detailed guidance on how best to use 'care coordinators' within the community
Quick Guide: Using data in care homes	November 2016	To provide clarity to care homes on data sharing and usage, including an Information Governance Toolkit and template dashboard
Keeping People Well and Stable		
Five Year Forward View on Dentistry: Views from the system	June 2016	To share feedback gathered during the Call to Action on dentistry and to set the scene for the publication of the commissioning guide
Unscheduled Dental Care Commissioning Guide	March 2017	To provide a clear commissioning framework for the commissioning of unscheduled dental services
Chronic obstructive pulmonary disease (COPD rescue pack).	May 2016	To provide guidance to community pharmacies
Self Care		
Documents to support self care to follow	TBC	

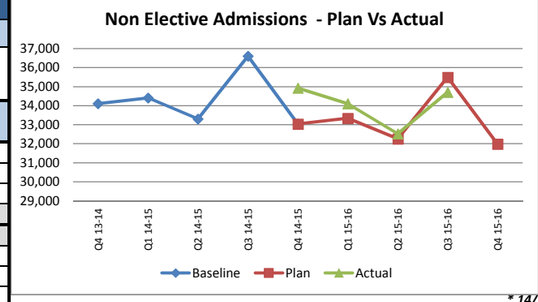
Better Care Fund Monitoring Dashboard

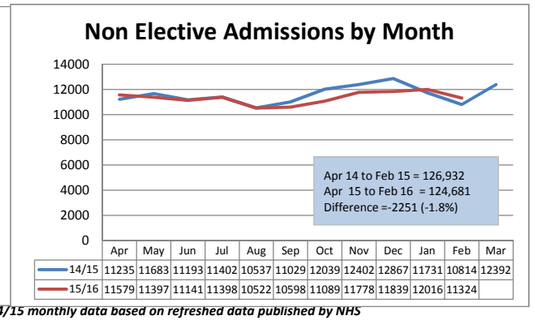
Lancashire Summary: April 2016 (Version 1)

Reducing Emergency Admissions

Source	Reporting Frequency	Latest Update	Next Update
http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/	Quarterly (Performance Against Plan) Monthly (Comparison to Previous Year)	April 2015 to February 2016 (provisional)	Full year provisional data available end April 2016
Measures	**Numerator (Non elective admissions)**	**Denominator (Populations)**	**Metric (Non elective admissions per 100,000 population)**
Target Q3 (Oct 15 to Dec 15)	35,501	1,184,155	2,998
Actual Q3 (Oct 15 to Dec 15)	34,706	1,184,155	2,931
Variance	*-795*		*-67*
% Variance	*-2.2%*		
Baseline (Apr 14 to Dec 14)*	104,387		
Target YTD (Apr 15 to Dec 15) *reduction of 3.1% from baseline*	101,103	1,184,155	8,538
Actual YTD (Apr 15 to Dec 15) *reduction of 2.9% from baseline*	101,342	1,184,155	8,558
Variance	*239*		*20*
% Variance	*0.2%*		

Lower is better





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
14/15	11235	11683	11193	11402	10537	11029	12039	12402	12867	11731	10814	12392
15/16	11579	11397	11141	11398	10522	10598	11089	11778	11839	12016	11324	

**** 14/15 monthly data based on refreshed data published by NHS England in July 2015***

Dementia Diagnosis Rate

Source	Reporting Frequency	Latest Update	Next Update
http://www.hscic.gov.uk/catalogue/PUB15696	Monthly	Feb-2016	March data available mid April 2016
Measures	**Numerator (Number on QOF Dementia Register)**	**Denominator (Estimated Prevalence)**	**Metric (Diagnosis Rate)**
Target 2014-15	10,169	15,170	67.0%
Actual 2014-15	10,070	15,332	65.7%
Feb-16	9,974	14,795	67.4%

Higher is better

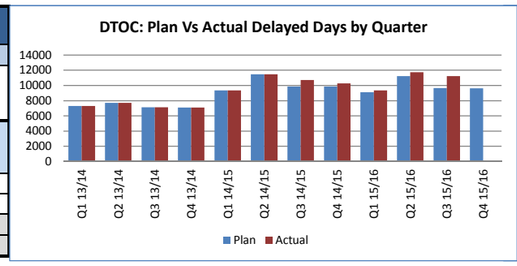
The definition for this indicator changed from 1 April 2015 to reflect expected prevalence rates using the second cohort Cognitive Function and Ageing Study (CFAS II) . The 67% target remains. For further information on new definitions please refer to http://www.england.nhs.uk/wp-content/uploads/2015/02/6-tech-defi-comms-0215.pdf. Trend line will be added when data for April to July 2015 is published (Aug 15 data published already).

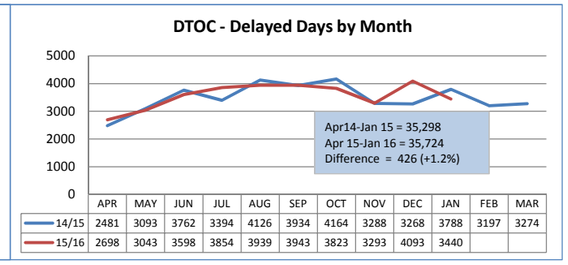
England Figure for February is 67.4%

Delayed Transfers of Care

Source	Reporting Frequency	Latest Update	Next Update
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2014-15/	Quarterly (Performance Against Plan) Monthly (Comparison to Previous Year)	Jan-2016	Feb data available mid April 2016
Measures	**Numerator (Delayed transfers of care - delayed days)**	**Denominator (Population 18+)**	**Metric (Rate per 100,000 Population 18+)**
Target YTD Q3 (Apr 15 to Dec 15)	30,002	940,626	3,189.6
Actual YTD Q3 (Apr 15 to Dec 15)	32,284	940,626	3,432.2
Variance	2,282		
% Variance	7.6%		

Lower is better





	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
14/15	2481	3093	3762	3394	4126	3934	4164	3288	3268	3788	3197	3274
15/16	2698	3043	3598	3854	3939	3943	3823	3293	4093	3440		

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

Source	Reporting Frequency	Latest Update	Next Update
http://ascof.hscic.gov.uk/Outcome/323/2A(2)	Annual (National), Local proxy data available quarterly	Sep -2015 (provisional)	to be confirmed
Measures	**Numerator** **Permanent admissions to residential and nursing care homes (age 65+)**	**Denominator** **Population 65+**	**Metric** **Permanent admissions per 100,000 population 65+**
Actual 14-15	1,805	232,929	774.9
Plan 15-16	1,741	237,289	733.7
Latest 12 months (Oct 2014 to Sept 2015)	1,649	232,929	707.9

Lower is better

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Source	Reporting Frequency	Latest Update	Next Update
http://ascof.hscic.gov.uk/Outcome/323/2B(1)	Annual (National)	2014-15	2015-16 available July 2016
Measures	**Numerator**	**Denominator**	**Metric**
	Those who are at home or in extra care housing 91 days after discharge from hospital	**Those discharged from hospital with a clear intention that they will move on/back to home**	**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**
Actual 14/15	842	1,062	79.3%

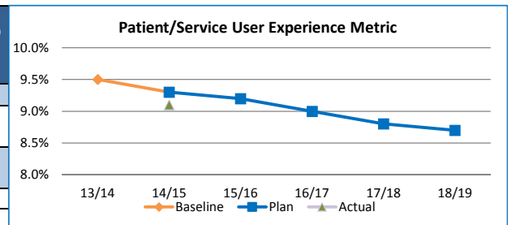
Higher is better

Next reporting period is Oct to December 2015 with results expected July 2016.

Patient Experience Metric - Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? [UNWEIGHTED FIGURES]

Source	Reporting Frequency	Latest Update	Next Update
https://gp-patient.co.uk/surveys-and-reports#july-2015	Bi-Annual	Jan 16 (based on Jan-Mar 15 and Jul-Sep 15)	Jul-16
Measures	**Numerator (Responded 'No')**	**Denominator (Number of Responses with Long Standing Health Condition)**	**Metric (% No)**
Target 2014-15	1,101	11,834	9.3%
Actual 2014-15	1,067	11,729	9.1%
Jan-16	1,020	11,240	9.1%

Lower is better



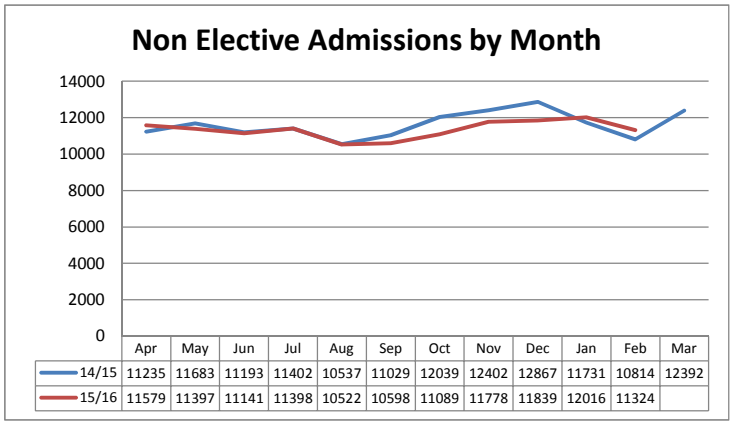
Better Care Fund Monitoring Dashboard

Lancashire Emergency Admissions: February 2015
2014-15 compared to 2015-16

Reducing Emergency Admissions			
Source	**Reporting Frequency**	**Latest Update**	**Next Update**
http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/	Monthly	April 2015 to February 2016 (provisional)	Full year provisional data available end April

CCG	CCG Non Elective Admissions		% Population Resident in Lancashire	Lancashire Non Elective Admissions			
	Apr 2014 to Feb 2015*	Apr 2015 to Feb 2016		Apr 2014 to Feb 2015	Apr 2015 to Feb 2016	Variance	% Variance
NHS Chorley and South Ribble CCG	16,452	17,417	99.8%	16,415	17,378	963	5.9%
NHS East Lancashire CCG	39,690	38,897	98.9%	39,256	38,472	-784	-2.0%
NHS Fylde & Wyre CCG	15,448	14,674	97.4%	15,040	14,286	-754	-5.0%
NHS Greater Preston CCG	20,855	21,199	100.0%	20,855	21,199	344	1.6%
NHS Lancashire North CCG	16,534	16,656	99.8%	16,500	16,622	122	0.7%
NHS West Lancashire CCG	12,372	10,254	97.2%	12,020	9,963	-2057	-17.1%
Other				6,846	6,761	-85	-1.2%
Total	**121,351**	**119,097**		**126,932**	**124,681**	**-2251**	**-1.8%**

** 14/15 monthly data based on refreshed data published by NHS England in July 2015*



Better Care Fund Monitoring Dashboard

Lancashire

Dementia Diagnosis Rate			
Source	**Reporting Frequency**	**Latest Update**	**Next Update**
http://www.hscic.gov.uk/catalogue/PUB15696	Monthly	Feb-2016	March 16 available mid April 16
Measures	**Numerator**	**Denominator**	**Metric**
	(Number on QOF Dementia Register)	**(CFAS II Estimated Prevalence*)**	**(Diagnosis Rate)**
Target 2014-15	10,169	15,170	67.0%
Actual 2014-15	10,070	15,332	65.7%
Sep-15	10,008	14,799	67.6%
Oct-15	10,007	14,793	67.6%
Nov-15	10,095	14,802	68.2%
Dec-15	10,064	14,797	68.0%
Jan-16	10,008	14,797	67.6%
Feb-16	**9,974**	**14,795**	**67.4%**

CCG			**Feb-16**
NHS Chorley and South Ribble CCG			72.0%
NHS East Lancashire CCG			67.4%
NHS Fylde & Wyre CCG			60.6%
NHS Greater Preston CCG			67.5%
NHS Lancashire North CCG			72.5%
NHS West Lancashire CCG			67.8%
Lancashire			**67.4%**
England			**67.4%**

The definition for this indicator changed from 1 April 2015 to reflect expected prevalence rates using the second cohort **Cognitive Function and Ageing Study (CFAS II)**. The 67% target remains. For further information on new definitions please refer to http://www.england.nhs.uk/wp-content/uploads/2015/02/6-tech-defi-comms-0215.pdf.

Better Care Fund Monitoring Dashboard

Lancashire

Patient Experience Metric - Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? [UNWEIGHTED FIGURES]

Source	Reporting Frequency	Latest Update	Next Update
https://gp-patient.co.uk/surveys-and-reports#july-2015	Bi-Annual	Jan 16 (based on Jan-Mar 15 and Jul-Sep 15)	Jul-16

Measures	Numerator (Responded 'No')	Denominator (Number of Responses with Long Standing Health Condition)	Metric (% No)
Baseline 2013-14	1,120	11,834	9.5%
Target 2014-15	1,101	11,834	9.3%
Actual 2014-15	1,067	11,729	9.1%
Target 2015/16	1,083	11,834	9.2%
Latest 2015/16	**1,020**	**11,240**	**9.1%**

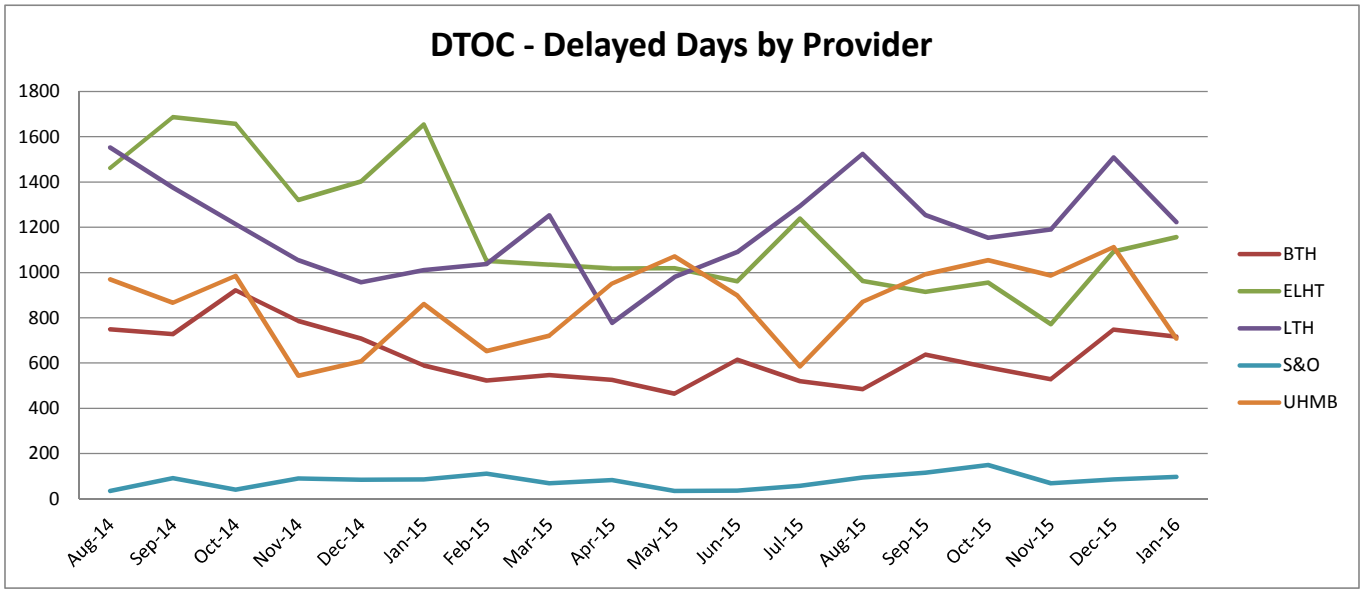
CCG	Baseline	15/16 Target	Jan 16 (based on Jan-Mar 15 and Jul-Sep 15)
NHS CHORLEY AND SOUTH RIBBLE CCG	9.2%	8.8%	7.2%
NHS EAST LANCASHIRE CCG	8.9%	8.7%	9.4%
NHS GREATER PRESTON CCG	11.6%	11.1%	11.1%
NHS LANCASHIRE NORTH CCG	8.0%	8.0%	8.7%
NHS WEST LANCASHIRE CCG	8.8%	8.6%	8.5%
NHS FYLDE & WYRE CCG	10.1%	9.4%	9.2%
Lancashire	**9.5%**	**9.2%**	**9.1%**

Better Care Fund Monitoring Dashboard

Lancashire

Delayed transfers of Care : Delayed Days by Provider

Provider	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
BTH	749	727	922	785	708	589	523	547	526	465	614	519	484	637	581	528	748	717
ELHT	1,462	1,687	1,657	1,320	1,402	1,655	1,051	1,034	1,018	1,019	961	1,238	962	914	955	771	1,093	1,157
LTH	1,552	1,376	1,215	1,055	957	1,010	1,037	1,252	777	980	1,090	1,293	1,524	1,254	1,154	1,190	1,509	1,223
S&O	34	91	40	90	84	85	111	68	82	34	36	57	94	115	149	69	86	97
UHMB	969	866	985	544	607	861	652	721	951	1,071	899	585	870	992	1,054	986	1,112	708
Total	**4766**	**4747**	**4819**	**3794**	**3758**	**4200**	**3374**	**3622**	**3354**	**3569**	**3600**	**3692**	**3934**	**3,912**	**3,893**	**3,544**	**4,548**	**3,902**



Better Care Fund Monitoring Dashboard

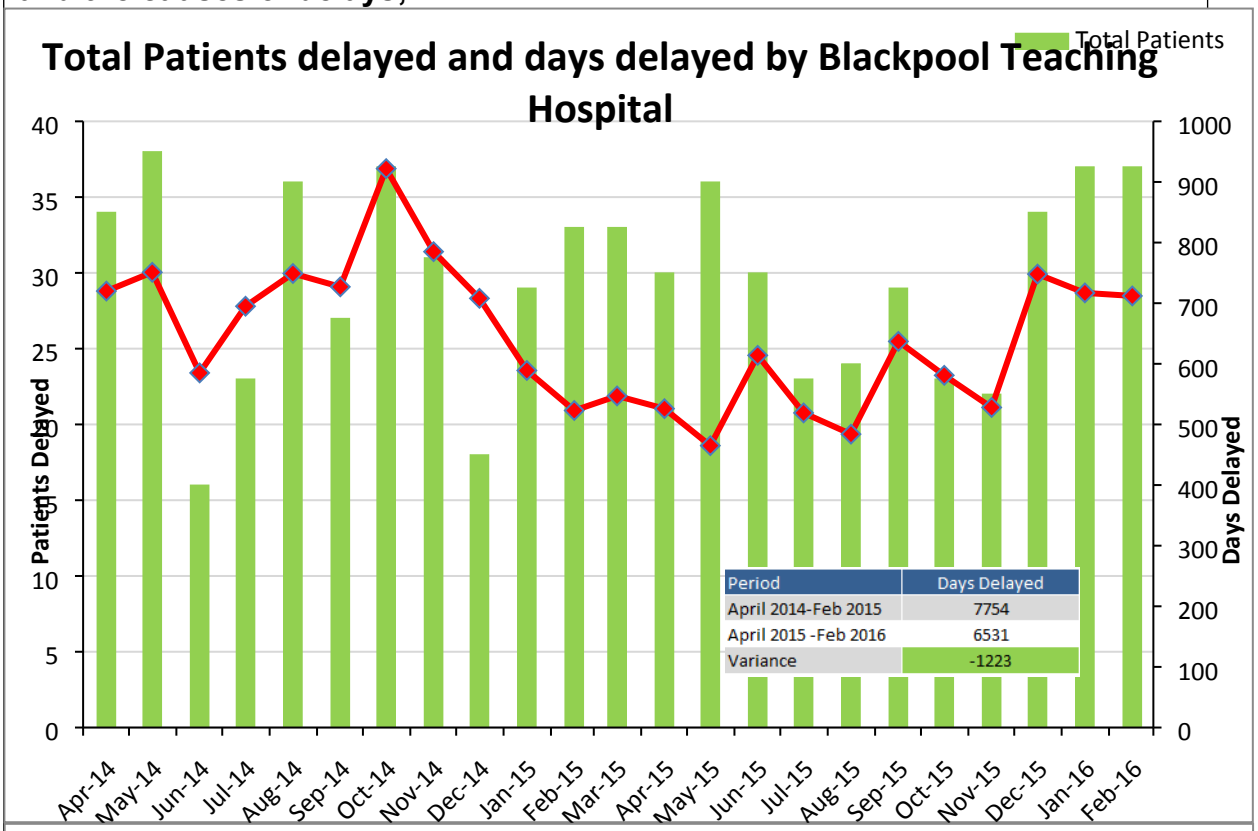
Reporting Sources and Timescales (Lancashire)

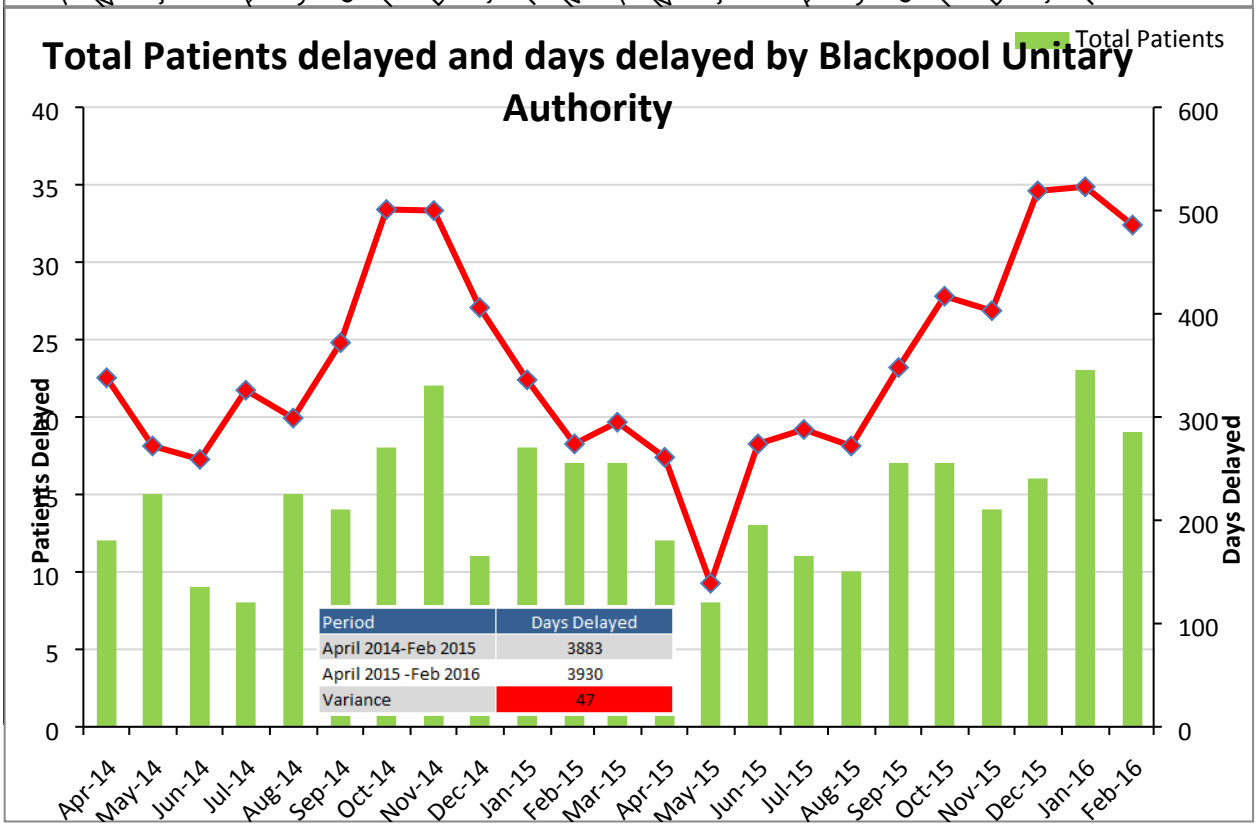
Measure	Source	Reporting Frequency	Reporting Level	Data Availablity
Reducing Emergency Admissions	Monthly Activity Return http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/	Monthly	CCG	Approx 3 weeks after month end (Lancs). Approx 7 weeks after month end (Non Lancs)
Dementia Diagnosis Rate	http://www.hscic.gov.uk/catalogue/PUB15696	Monthly	CCG (by practice)	Approx 3 weeks after month end
Delayed Transfers of Care	http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2014-15/	Monthly	Lancashire (and Provider level)	Approx 6 weeks after month end
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	National Data http://ascof.hscic.gov.uk/Outcome/323/2A(2)	Annually	District	TBC
	Local data from LCC	Quarterly	District	TBC
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	http://ascof.hscic.gov.uk/Outcome/323/2B(1)	Annually	District	TBC
GP Survey Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? [UNWEIGHTED FIGURES]	https://gp-patient.co.uk/surveys-and-reports#july-2015	Bi-annually	CCG	Approx 4 months after reporting period

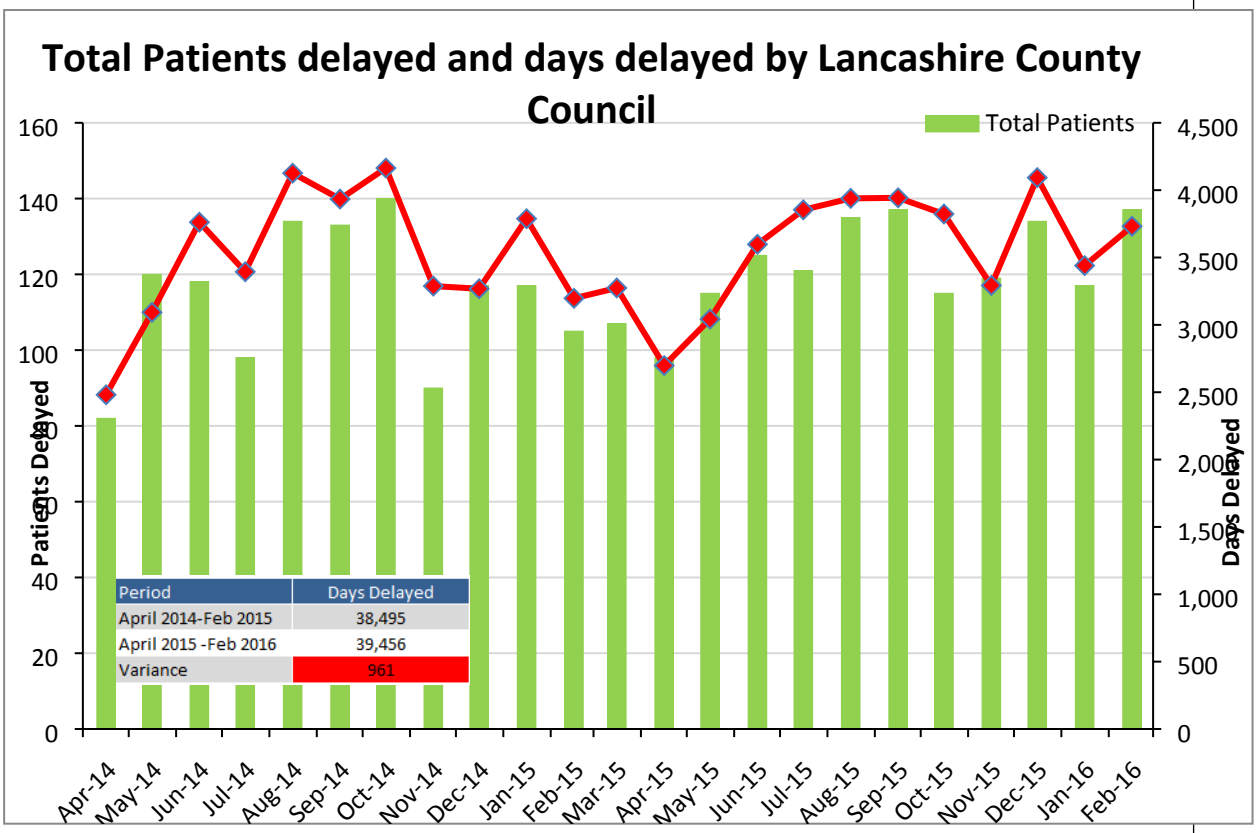
BCF DTOC planning template

Fylde Coast SRG

Situational analysis
Detailed analysis of current performance levels (including trend analysis) and the causes of delays;







CURRENT SCHEMES TO REDUCE DELAYS AND IMPROVE TRANSFERS OF CARE

There have been a number of developments put in place and that are also planned to support the reduction of delayed Transfers of Care locally. These are discussed in more detail in the Operational Plan for DTOC:

- Intermediate Care Services have been reviewed and redesigned across the Fylde Coast to enable more effective signposting. This is a fully integrated pathway working with both Lancashire County Council and Blackpool Council, Blackpool Teaching Hospital, and both Blackpool and Fylde and Wyre CCGs.
- Regular weekly teleconferences are held with all stakeholders to facilitate and expedite discharges.
- Blackpool Teaching Hospital have organised a further multi-disciplinary project group to look at DTOC and those patients that are not always included on the DTOC list but are delayed from being discharged for other reasons.
- An electronic system for patient management is being considered within Blackpool Teaching Hospital which will allow better management of discharges and referrals.
- The Admissions, discharges and transfers policy has been updated
- A Discharge to Assess model is being considered.

GAP ANALYSIS

There has been an ECIST review undertaken in 2015 and Intermediate care has been reviewed and consequently redesigned in 2015/16.
Recommendations of these reviews were used to reduce gaps in the system and are now part of ongoing monitoring of how effective these services are. Services that have needed it to assist in best practice have been invested in, for example NWAS deflection.

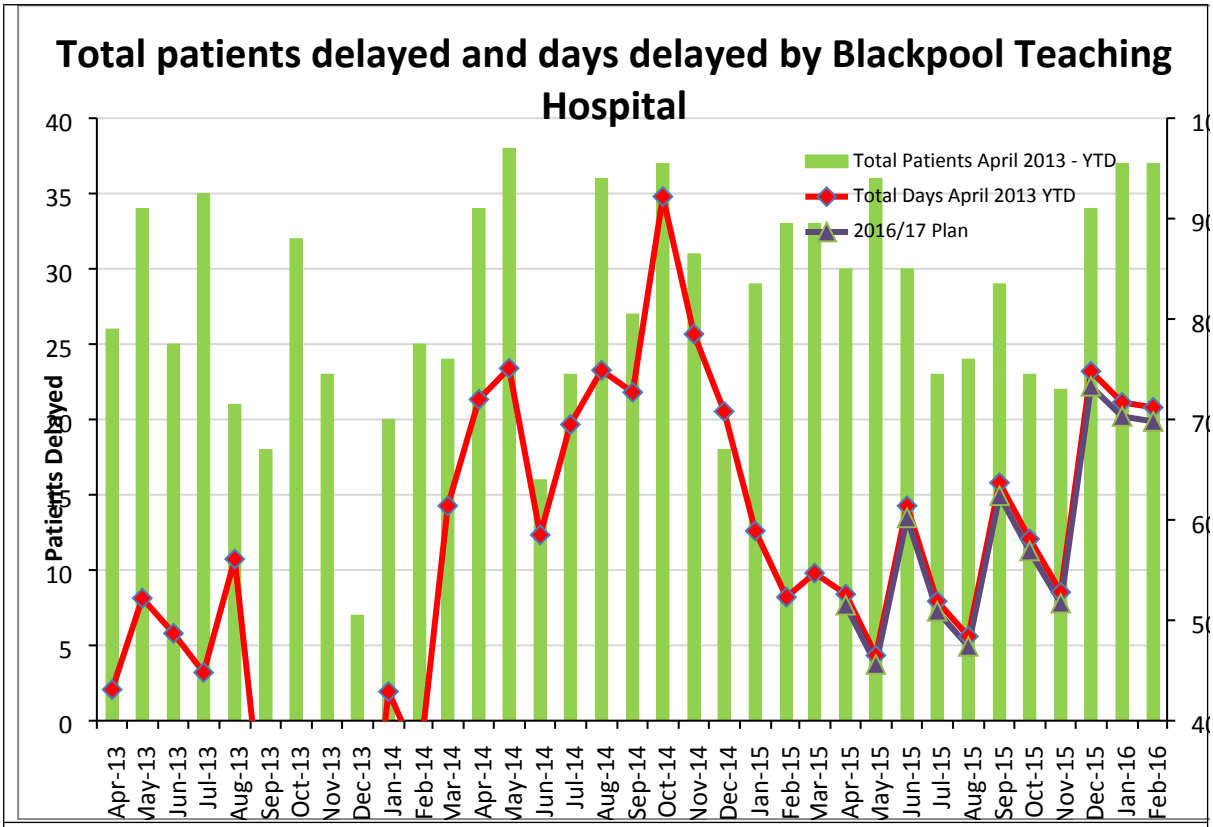
RISKS

A multi organisation risk log is being developed by the Project Group where risks will be identified and mitigated accordingly. Weekly teleconferences take place to identify early actions that need taking to reduce delays.

TARGETS

There has been a significant amount of work undertaken to address DTOC across the Fylde Coast. As part of the analysis, a number of key issues have been identified which have impacted locally on delayed discharges. These include waiting for residential placement and for packages of care in the patients own home. This data informs the project group to ensure we deliver consistent support to the Trust from all organisations. Mental Health DTOC also has an action plan which will be considered within this wider document.

Targets are still being discussed within the project group however an initial reduction of 2% reduction every year has been initially deliberated. This equates to a reduction in 145 bed days over a 12 month period. The graph below is profiled to 15/16 trend.



OTHER METRICS USED TO MONITOR PATIENT FLOW

The main areas of delay monitoring are identified on a monthly basis, although there is a detailed report that is received on a daily basis. Managers pro-actively move people and issues are discussed on the local teleconferences.

ACTION PLAN

MH DTOC plan.docx

DELAYED TRANSFERS OF CARE

ACCOUNTABILITY ARRANGEMENTS

The Fylde Coast SRG will take accountability for the DTOC and reports on the target and delivery of the plan will be made available at each meeting.

The SRG is chaired by the Chief Operating Officer with senior managers with lead responsibility for Urgent Care type services in attendance for their respective organisations. Independent and voluntary sector providers are also engaged.

The list of organisations represented:

- Blackpool CCG
- Fylde and Wyre CCG
- Blackpool Teaching Hospitals
- Lancashire Care Foundation Trust
- Lancashire County Council
- Blackpool Council
- North West Ambulance Service
- Fylde Coast Medical Services
- NHS England

There is also a Lancashire wide Mental Health Operational Resilience group chaired by Blackburn with Darwen which will monitor the Mental Health DTOCs. There are also twice weekly teleconferences and a daily sitrep report covering the Mental health patients.

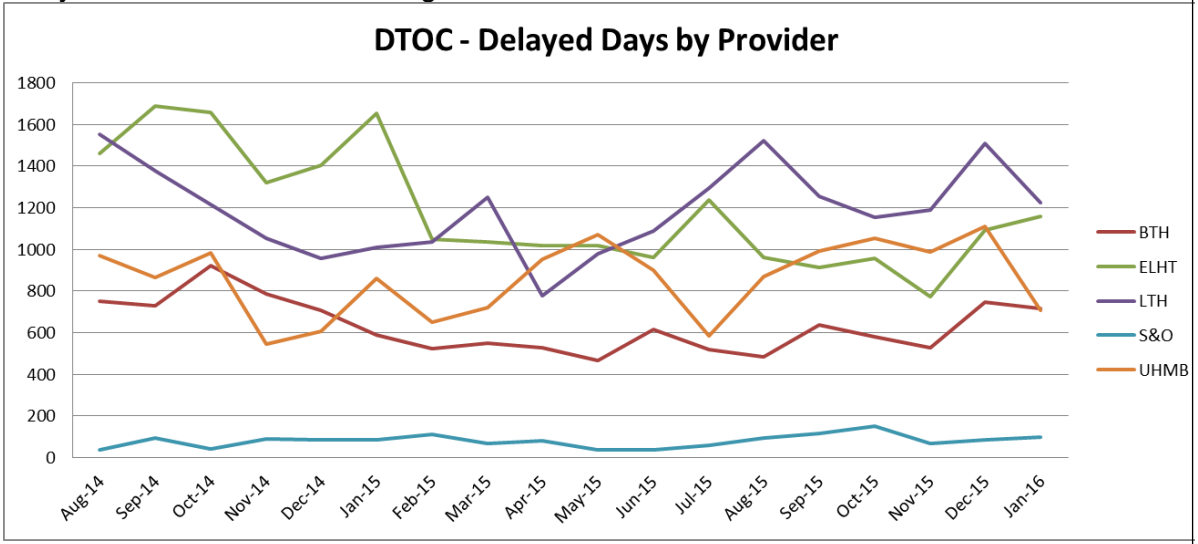
BCF DTOC planning template

Southport SRG

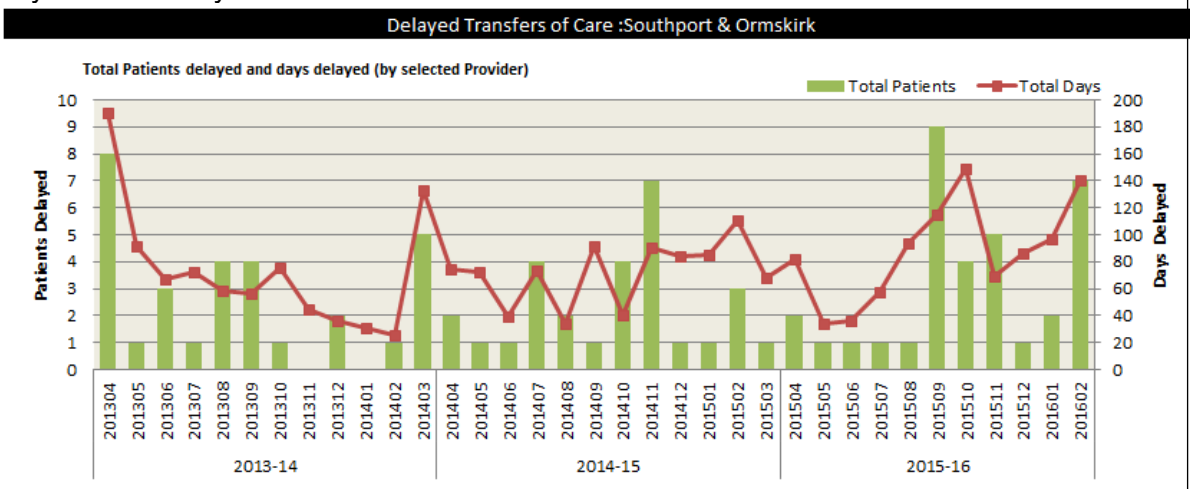
Situational analysis

Detailed analysis of current performance levels (including trend analysis) and the causes of delays is shown below:

Southport and Ormskirk Trust have relatively small numbers of DTOC compared with other Trusts locally. However, the Trust have experienced issues with flow and A&E delays due to ineffective discharges.



Although number of patient delayed has been falling (with a few exceptions) the total bed days due to delays has increased in 2015/16.



If discharges of clinically optimised patients are slow or even late in the day, this quickly impacts upon A&E, which then struggles to meet the 4 hour standard target. The SRG recognise this has a key area for improvement and have formed a sub-group with the aim of standardising discharge processes and to develop a range of schemes to help improve discharge.

An assessment of current schemes in place to reduce delays and improve transfers of care and how effective these are;

A Community Emergency Response Team (CERT) was established using winter funding in 2014/15, the team works across the Southport Health Economy which is made up of West Lancashire and Southport and Formby CCGs. The team in-reach to the Trust and can facilitate discharge by putting in place intensive nursing and/or therapy support to enable step down or return home with support. In West Lancashire the Team are trusted assessors and can assess social care support and work closely with the local domiciliary and care provider. The team can support patients into intermediate care placements and offer rehabilitation in partnership with local care homes. The team are also able to rapidly support patients at home and prevent admission to acute services.

The success of this service has been in the support to patients at home and rapid interventions which enables hospital avoidance. West Lancashire has had a 6% reduction in non-elective admissions 2015/16 (YTD). However, while the team are active at the Trust on the Frail Elderly ward, there is still some work to be done, on other wards, to improve understanding of the team's role and the pathways to step patients down.

A gap analysis comparing local measures to the best practice interventions (see below);

In Southport and Ormskirk Hospital NHS Trust (S&O) there are symptoms of discharge planning having become a specialist function. The ward-based workforce are disengaged with the process of discharge and rely heavily upon the Discharge Planning Team (DPT) facilitating this, which impacts upon the timing of discharges, the quality of patient experience, communication with patients and families and the management of patient expectation.

Discharge planning has complete whole system relevance if the system is looking to ensure patients are receiving the right intensity of service for their needs, to achieve flow and meet targets. This will require a shift in thinking operationally: rather than it being a specialist role carried out by a specialist team, discharge planning has to be owned by ward-based staff and fully supported by medical teams.

To introduce a standardised approach will require the involvement and engagement of the whole system having interdependencies for Southport and Ormskirk across two CCGS and two Local Authorities alongside the pending possible re-procurement of community health services. This calls for a collaborative approach to discharge planning with a shared vision because, collectively, there is a responsibility to ensure that patients are in hospital for the shortest time needed for their acute condition.

o A consideration of whether additional measures are required where rates of delay are very high, including whether a risk sharing arrangement may be appropriate. The SRG are looking to ensure that there is good internal hospital discharge planning in line with the Department of Health's 'Ten Steps to Discharge'. Discharge needs to be everyone's business and planning for discharge needs to start earlier in the patients journey. Monitoring will be needed at ward level to ensure that the ten steps are implemented. There will be ward level targets for discharge for all wards at the Acute Trust.
Target and Action Plan
a clear articulation of how the target has been set, with reference to the situation analysis Given that the changes needed to deliver the target are cultural at the acute trust and there will need to be engagement with staff, the target will be modest to allow schemes to be implemented. Target of 1% reduction in 2016/17. [To be agreed at SRG operational meeting 27th April 16]
The DTOC target and CCG planning assumption should be in alignment and include a trajectory for reducing the number of delays. The DTOC plan is modest to allow time for change management at the Acute Trust. This means that the initial impact on the CCG planning assumptions for 2016/17 will not be significant. However, this will need to be reviewed for 2017/18.

Other metrics used to monitor patient flow

A&E 4 hour target
Ambulance turnaround times
Average LOS

Action Plan

1/Move the role of assessment and discharge planning to ward level, utilising a single assessment completed at the start of the patient's journey.

2/Implement the SAFER patient flow bundle to ensure it is used routinely on all ward to improve patient flow, patient experience and reduce length of stay across adult inpatient wards.

3/ Implement the ECIST recommend 4 basic questions that staff and patients should know:

- What is going to happen to me today?
- What is going to happen to me tomorrow?
- What do I need to achieve to go home?
- When can I expect to go home?

4/ For discharge planning to be successful and achieve patient flow, discharge needs to become the responsibility of everybody across the organisation. Therefore, every profession involved in patient care should be driving the patient journey towards discharge.

5/ Fully implement MADE process across the Health Economy.

6/ Analysis of the lessons learned from MADE and development of schemes to facilitate discharge processes e.g. support services for resolving delirium patients.

Accountability Arrangements:
All actions need to be clearly owned, so the plan should set out lines of responsibility and accountability for delivering each element of the plan, as well as an agreed process for local assurance and escalation where any issue cannot readily be resolved.

The SRG Discharge Sub-group is still being formed; however, it will have representation from Acute Trust, CCGs, Mental Health, Social Care and Community Care. The Terms of Reference are being developed, but the group will be accountable to the Southport SRG.

Also, progress will also be monitored via the BCF Programme Managers group for Lancashire. This is a sub group of the Lancashire BCF steering group.

Using Local Capacity

The Discharge SRG sub-group will be using data and intelligence for the MADE process to inform what out-of-hospital schemes could be developed to support the acute trust to discharge in a more timely way.

For example, West Lancashire CCG is developing a Night support service which could help patients with resolving delirium to return home sooner with a 24 hour support package. CERT would support patients in the daytime and the night time service would either sit in or drop in depending on the level of need. This would mean that patients with confusion could return to their home, which has been shown to improve outcomes by reducing confusion in a familiar environment. This would be a pilot, but if successful it could be rolled out across the health economy. At the moment the CCG is in discussion with CERT to determine the best delivery model, it may be that using the voluntary sector may be the most appropriate and fastest way to implement the service.

Additional measures

See section above on other metrics.