Shadow Health and Wellbeing Board

Tuesday, 4th September, 2012 in Rowan Room - Woodlands, at 12.00 pm

Agenda

LUNCH AND REFRESHMENTS

Lunch and refreshments are provided, available from 12 noon with presentations on the Interventions to start at 12.30.

1. Interventions Presentations and Update (Pages 1 - 38)

The remaining groups will present to the Board work undertaken on their Interventions, there will be a series of short presentations for each Intervention with the main meeting to follow.

Affordable Warmth, People at Risk of Emergency Admissions and Alcohol Liaison Intervention documents have been updated since the 10 July 2012 meeting, updated documents are attached.

All of the previously circulated Interventions documents can be accessed from this link: http://council.lancashire.gov.uk/mgAi.aspx?ID=6611#mgDocuments

2. Welcome from the Chair to the formal meeting and overview of the agenda

3. Apologies for absence

4. Minutes of the meeting held on 10 July 2012 (Pages 39 - 46)

To be confirmed by the Board as an accurate record.

5. Health and Wellbeing Conference "Working Together for Change" - 16 November 2012 (Pages 47 - 48)

6. Clinical Commissioning Group (CCG) Priorities (Pages 49 - 54)

7. Public Health Update (Pages 55 - 56)

8. Any Other Urgent Business

9. Date of Next Meeting

The next meeting of the Board will be held on 18 October 2012, 2pm at Woodlands Conference Centre, Chorley.

Update Affordable Warmth Specific Actions

Please see the below for an update re actions to the Affordable Warmth Planning document submitted to the Health and Wellbeing Board on the 4th July 2012 (Please see appendix 1).

Immediate and Key actions for Affordable Warmth
Please see Intervention Planning document for further developing actions, 'current reality', and 'results'.

Shifts most directly tested by the actions below:

- **Resources shift towards preventing ill health and reducing demand for acute services**
- **Make joint working the default option, pooling budgets and resources, commissioning together and sharing service responsibilities**
- **Commitment to deliver accessible services within communities**
- **Narrowing the gap in health and wellbeing and its determinants**

Response	Actions	Next Steps	Actions the Board can support
Referral Districts, HIA, LCC, CCGs and NHS Providers, Voluntary sector to work together to put in place an effective referral system	Further mapping and contact with locality / community health contacts is required – community matrons, occupational health, hospital discharge teams etc, to raise awareness of the new referral mechanisms.	Support the work taking place to make health and social care providers aware of the referral process and interventions available in their district, providing them with a single contact point, for their locality. £6,400 is currently available for the delivery of awareness sessions, paid for from the outstanding funds from the County element of last years' Warm Homes Healthy People Fund, costs are being kept to a minimum by attending	• Promote the awareness and bite size training to providers –especially in areas (geographically and by client group) where there are gaps in the training so far planned for Sept/ Oct 2012 and provide key points of contact who can help identify the appropriate frontline teams and individuals to receive training. • As many awareness / training sessions as possible will be delivered for the funding available but initial feedback from teams &

		existing team meetings & delivering briefings rather than bringing people to an external training session. There is also the option to deliver training the trainer sessions to help promote sustainability.	groups already engaged with suggests that demand will outstrip the available resource quickly. *If additional resources and access to teams (where contact has not yet been made) could be arranged significantly more sessions could be arranged targeting a wider range of professions.*
	Develop referrals from GP practices	Use the disease registers to target high risk groups	• Encourage discussions with CCGs re supporting referrals through GP practices and through commissioning of community/ locality based health services.
	Test evaluate referral system success	Discuss means of monitoring and evaluation with partners involved in referrals and response Evaluate and monitor current referral mechanisms (where the referral comes from, referral rates and the response / outcome to the referrals). Feedback from frontline providers will be crucial to refine and improve the referral mechanism going forward	• Find resources for evaluation and promote monitoring of referrals to partners as necessary.
Assessment and Response Develop and enhance the response to referral	Use referral pathways already developed as basis for the response available in each locality	Develop response to referrals to enable up scaling of successful interventions, including engagement with the following partners: - Senior district housing managers - Lancashire Home Improvement Agency (HIA) Forum	• Wyre and Fylde £17, 000 141 emergency interventions for the most vulnerable individuals, supported by £13, 000 of capital expenditure. In addition to emergency interventions this funding also contributed to cavity wall / loft referrals. - Find resources for similar level of activity in other districts.

		- Commissioners of HIAs - Home Energy Officer Group This is addition to involvement of health commissioners and providers see above.	• Be informed by evaluation of WHHP and PCT funded projects in Lancaster Fylde and Wyre, which includes emergency intervention fund and one additional post for housing enforcement in Wyre and Fylde and one for Lancaster. This evaluation will take place over the next 12 months and be completed by December 2013. • Following discussions with HIAs, where required -support and commission HIAs to respond further to affordable warmth priorities. • Commission locality and community based health and social care services in a way that supports appropriate referrals, from frontline workers.

For details contact: Chris Calvert 01772 533011 or email chris.calvert@lancashire.gov.uk

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Lancashire Shadow Health and Wellbeing Board

Intervention planning

Purpose

This report sets out a template for use in preparation of the work programme for each of the Health and Wellbeing Board's ten interventions. The template is designed to;

- Create clarity on the desired impact of each intervention and on the specific roles of partners in delivering the intervention.
- Make explicit the shifts in ways of working that will allow partners to deliver the intervention.

The planning template

1. Reality

What's the current reality?

- **What is currently working well?**

Lancashire Home Energy Group attended by all Lancashire Districts and the County Council includes a strong officer base with specialist and local knowledge. The Groups remit is to work in partnership to improve the energy efficiency of Lancashire Homes, addressing health inequalities exacerbated by living in cold damp homes, and reducing fuel poverty. The Group has a good track record of working in partnership and establishing appropriate links with the insulation industry and the energy providers.

Existing partnerships have helped to ensure that insulation installation rates in some areas of Lancashire are amongst the highest in the Country. Given this experience Lancashire is in a position to capitalise on existing partnerships to deliver home energy insulation at volume, across other areas of Lancashire, for the remaining duration of CERT.

Last winter Lancashire submitted bids to the Department of Health Warm Homes Healthy People Fund and successfully delivered a number of projects across the County. New partnerships were established and delivered wide-ranging interventions targeted at preventing cold related deaths and illnesses. The interventions included: emergency heating repairs, boiler servicing, draught proofing, fuel poverty training for front line staff, emergency heaters, fuel payments, food parcels, benefit checks, winter warmth packs, referrals to free loft and cavity wall insulation schemes and the gritting of paths.
Building on the initiatives and partnerships established last winter, with the potential for the more effective supply of health related referrals from PCTs and GPs, via this proposed affordable warmth intervention, Lancashire affordable warmth partnerships are primed to

deliver breakthrough results in reduced visits to GPs surgeries, reduced hospital admissions and ultimately reduced excess winter deaths.

Home Improvement Agencies (HIA's) are operating across Lancashire. These agencies provide a range of housing related support to older and/or vulnerable people to maintain, improve and adapt their homes to maintain independence and improve wellbeing. Specific works reduce fuel poverty and tackle poor housing conditions that exacerbate chronic illnesses and reduce the risk of accidents in the home. These agencies could be mobilised into coordinated, health-led, affordable warmth activity.

- **Where are the gaps in service delivery that really matter?**

Energy efficiency measures and other actions that protect people from the effects of cold weather need to be targeted at those that are most at risk of suffering ill health and poor wellbeing from the cold weather. Effective referrals are required from hospitals, GPs and Social Care.

The removal of fuel poverty as a national indicator coupled with reducing local authority financial resources may have led to less emphasis on this area of work in the last 18 months and so a joint approach with Health input could provide the catalyst for affordable warmth to move up the agenda in local authorities.

We need to identify the at risk groups and then get them the right help, in an effective and timely manner, however these measures are not integrated into long term condition care pathways routinely across the county.

Lancashire needs an effective referral pathway with a single point of access that will allow front line health and social care professionals to refer people at risk of ill health due to cold and poorly heated homes, to a range of evidence based affordable warmth measures.

Referrals are currently not routinely made by social care and health services due to confusion of where to refer for particular interventions, initial research shows practitioners want a straight forward referral system and confidence that referrals will be followed up. Most Home Improvement Agencies and housing enforcement teams are working at full capacity and so in some areas we will need to either increase capacity or move capacity from other (lower priority) areas of work.

Emergency funds are required and not huge funds either….. winter 2011/12 Warm Homes Healthy People funding from the Department of Health evidenced what can be delivered with modest, targeted funding (see results section).

- **What are the issues and opportunities that must be addressed if we are to make a breakthrough? i.e. what really matters?**

Systematically offering affordable warmth measures by identifying those at greatest risk of cold related ill health from , GPs through primary care disease registers, social care services

and other hospital services and others working with those with long term conditions – including an effective referral service, see above.

We would like to see hospital/health based Home Improvement Agency staff available to give advice and coordinate home visits, upon or preferably pre-discharge.

Targeted enforcement of private rented sector landlords to provide at least minimum statutory standards in private rented housing. The private rented sector continues to consistently contain the poorest housing conditions.

We need to maximise the uptake of free loft and cavity wall insulation via CERT for the remainder of the scheme (it is anticipated that CERT will finish in December 2012).

We must be ready to maximise the opportunities that may come out of the Governments 'Green Deal' and the associated energy company obligations which is currently a developing area of policy.

2. Results

What does success look like?

2.1 Longer-term impact

- **What will be the 3 to 5 year impact of the intervention?**

The overall goal of the initiative is to reduce the negative impact of cold, damp homes upon the health and well being of our most vulnerable residents.

Reduced demand for NHS services specifically reduced excess unplanned hospital admissions for respiratory and circulatory diseases in the winter, reduced visits to GPs surgeries, reduced excess winter deaths. Reduction in health inequalities.

Improved housing, lower fuel bills for clients, older people better able to maintain independence, support provided will help vulnerable people to maintain their tenancies, individuals mental as well as physical wellbeing will be improved.
Reduced exacerbations of childhood asthma. Reduced isolation (evidenced that particularly older people living in cold, damp homes are not inclined to encourage visitors). Those with long term conditions will be better able to maintain independence at home. Supports healthy maternal health and early years.

Other wider and positive impacts of home improvement agency access to these vulnerable clients will be seen for example, clients will access handy person services and so we will see reduced slips/trips/falls, benefit checks will result in increased household incomes and so additional money for household bills (including fuel). To give an idea of the potential scale of this in Wyre and Fylde for example between April 2011 and March 2012 Care & Repair assisted older and disabled residents in Wyre and Fylde to make £557,585 per annum of new claims for Attendance Allowance and £58,164 per annum in other benefits. That is a massive increase in income for residents of £615,749 per annum, with some couples receiving as much as £8054.80 additional income per year.

What are the longer-term measures of success?

- reduced excess winter deaths
- reduced excess winter hospital admissions (conditions associated with cold weather respiratory, cardiovascular and hypothermia)
- reduced number of visits to GPs
- Improved housing – reduction in category 1 excess cold hazards.
- Reduced Fuel Poverty of high risk groups
- Reduced fuel bills for individuals
- Contribution to achievement of all age all cause mortality targets (and consequently reducing inequalities in life expectancy within the area)
- Improved health, wellbeing and life expectancy of vulnerable groups
- Reduced winter planning pressures on NHS, social care and other relevant organisations
- Reduced non-elective admissions to hospital
- Increased household incomes
- Reduced costs to NHS/health services due to fewer presentations /admissions

2.2 Impact in the year ahead

What specific goals will the intervention achieve in the next year?

Depending on the ability to secure some resources for implementation of a referral system and an emergency fund for minor repairs, it would be possible to deliver a number of affordable warmth interventions to those who need them most.

As an example, for a sum of £17,000 Wyre and Fylde Care and Repair delivered 141 interventions that included: the repair of 11 heating systems, the servicing of 23 boilers, the distribution of 29 emergency heaters, the distribution of 10 food parcels, draught proofing measures for 30 homes, emergency fuel payments, a supply of grit sufficient to grit the paths of 300 homes and clients were referred for free loft and cavity wall insulation via CERT and, for those eligible, heating systems via Warm Front.

In excess of 5,000 Vulnerable individuals across Fylde and Wyre including the elderly, low income groups and disabled people received information and advice on how to cope with the cold weather during the winter months.

52 professionals working with vulnerable groups across Fylde and Wyre were trained on how to identify when people are in fuel poverty; the health impacts of living in fuel poverty; basic energy efficiency advice; low cost / no cost energy efficiency measures; and where to signpost people for help and advice;

If this were to be rolled out across Lancashire, the impact would be significant.

- What are the specific measures of success for the year ahead?
- How will the Health and Wellbeing Board know that the intervention has achieved its goals?

Some possible measures could be

- The delivery of an additional loft and cavity wall insulation across Lancashire
- The number of Category 1 excess cold Hazards in private rented sector homes addressed
- The number of referrals leading to an intervention to improve a households affordable warmth.
- The number of reduced visits to GP's surgeries
- The number of vulnerable households benefiting from affordable warmth interventions.

3. Response

What needs to happen to ensure partners achieve better results?

3.1 Shifts in the way that partners deliver services

- How must partners work to ensure that the 'priority shifts' are applied and the intervention is effectively implemented?

Partners need to work together to support the referral system and identify those most in need, this will require better data sharing, Joint working will also be important e.g. hospital based HIA staff. This will reduce demand for acute and residential services, reduce bed blocking and the return of patients back into the health system due to cold. HIA teams and partners will help to deliver accessible services in the community and maintain individual's independence.

3.2 Programme of work

- Who needs to be involved to develop, commission and deliver the intervention?

HIAs, Districts – Private Sector Housing Teams, LCC, Public health teams, Registered social landlords, Hospitals, CCGs, GP's, Community nurses, Social Care, Trading Standards, Third Sector

- What are the 'milestones' for the Task Group in the year ahead?

Launch and engage partners in an effective referral system with a single point of access, that gets help to people who are most at risk of ill health from cold conditions, and makes the most efficient use of the HIA and other services available. (The design of this should be informed by the current review of the referral process across Lancashire).
Developing an effective information sharing system with health professionals to enable targeting of those with long term health conditions and other vulnerable groups
Increased uptake of energy efficiency measures through CERT funding and /Warm Front

Participation in the 12/13 winter warmth campaigns by Districts, health, CCG's, LCC (Public Health, Social Care), Home Improvement Agencies, CAB, RSL's and third sector partners (inc.

CAB).

Planning and preparation for an effective Green Deal and ECO in Lancashire.

- What are the specific activities to be carried out by each partner?
  - Districts, LCC, CCGs and hospitals to work together to design, launch and to put in place (including awareness raising amongst front line professionals) an effective referral system coordinated by the Lancashire Energy Officers Group?
  - Identify and put in place an effective response to the referral process (referral pathway / establishing what happens next in each locality). For example insulation of energy efficiency measures, income maximisation, and fuel debt advice.
  - Determination of resources available to support Affordable Warmth intervention, in particular funding to be used for emergency winter warmth interventions
  - Coordination of Lancashire wide 12/13 winter warmth programmes – establishment of 'footprint' leads to take local programmes forward.
  - Mapping of local community health contacts is required – community matrons, occupational health, hospital discharge teams etc, to raise awareness of the new referral mechanisms.
  - Engagement with CCG's on developing CCG Business Plans
  - Work to include actions to address affordable warmth as part of discharge planning.
  - Evaluate WHHP projects and the PCT funded projects in Lancaster, Wyre and Fylde for potential roll out.

Lancashire Shadow Health and Wellbeing Board

Identifying People at Risk of Emergency Admissions and Provide Appropriate Interventions

Purpose

This report sets out a template for use in preparation of the work programme for each of the Health and Wellbeing Board's ten interventions. The template is designed to;

- Create clarity on the desired impact of each intervention and on the specific roles of partners in delivering the intervention.
- Make explicit the shifts in ways of working that will allow partners to deliver the intervention.

The planning template

1. Reality

What's the current reality?

• What is currently working well?	Initial mapping exercise suggests that risk stratification and associated interventions is being considered in all CCG areas as part of their LTC/Unscheduled care groups. Most of them have also completed a self assessment of where they are and what needs to be done. The neighbourhood level local area coordination meetings have also been established in Central and West Lancashire. The Lancashire LTC implementation forum that comprises of clinical leads from CCGs, PCTs, Social Care and providers has been established under the Lancashire Improving Outcomes Programme Board. The focus is to collaborate and share good practice and champion the work on LTCs. The members of this group along with input from Children and Young People HWB Group will develop the plan for addressing this intervention. Links are also being established with other regional and local workstreams e.g. Lancashire Improving Outcomes Board, AQUA programmes on LTCs, local urgent care groups, neighbourhood teams, self care intervention of the draft HWB strategy, and other strategy interventions groups

	such as self care, older people and affordable warmth etc.
• What is getting in the way of partners achieving desired impacts?	We need to systematically adapt, scale up and spread of these initiatives across Lancashire to achieve the desired impacts. This includes building capacity in primary care and reforming community services, having a risk sharing agreement to reduce capacity in secondary care, better health and social care integration and systematically engaging people with LTCs in self care and addressing their wider determinants of health e.g. worklessness, fuel poverty etc.
• Where are the gaps in service delivery that really matter?	Systematic risk profiling of the whole population leading to a comprehensive care plan for people at very high and high risk of emergency admissions. Developing neighbourhood level integrated health and social care teams embedded within the local area coordination for improving health wellbeing of citizens and linked to the specialist services. Involving patients and their carers and empowering them for shared decision making and self management support. Appropriate use of information technology including telehealth, telemedicine, telecare, electronic access to patient records and developing integrated IT systems. Delivering on all of the above through a programme that also coordinates actions across all the strategic interventions of the health and well being strategy.
• What are the issues and opportunities that must be addressed if we are to make a breakthrough? i.e. what really matters?	**Opportunities** There are many pockets of excellence in Lancashire. These can be shared across the County. A Joint Strategic Needs Assessment of long term conditions is being planned which will provide opportunities to engage with all the stakeholders in the system to agree common goals. All CCGs have reduction of unplanned admissions as their priority. Identifying common themes they

	are working on could lead to working on them together across Lancashire. Reducing readmissions and excess bed days is also part of the cost improvement plan in hospitals across Lancashire. The districts along with their partners including the third sector are also working on local area coordination and neighbourhood level teams that are aimed at improving the wider determinants related to preventing emergency admissions.

2. Results

What does success look like?

2.1 Longer-term impact

• What will be the 3 to 5 year impact of the intervention?	• An integrated health and social care system for addressing the needs of people with long term conditions. • Reduction in emergency admissions due to chronic ambulatory care sensitive conditions that can be better managed in community and primary care settings • Improved patient experience and quality of life. • A reduction in the demand for social care due to long term conditions (especially crisis and re-admissions).
• What are the longer-term measures of success?	• Health related quality of life for people with long term conditions • Emergency admissions due to long term conditions in both children and adults. • Proportion of people feeling supported to manage their condition

2.2 Impact in the year ahead

• What specific goals will the intervention achieve in the next year?	• GP practices and community services will be using the risk stratification tool to identify people at risk of emergency admissions. • Integrated neighbourhood level health and social care teams to address the needs to patients with complex needs

	including the self management support for them and their carers.
• What are the specific measures of success for the year ahead? • How will the Health and Wellbeing Board know that the intervention has achieved its goals?	Proportion of GP practices using a risk stratification tool to identify people at risk of emergency admissions Number of integrated neighbourhood level health and social care teams HWB Board will be aware of the plans across Lancashire and the progress being made to reduce emergency admissions in Lancashire

3. Response

What needs to happen to ensure partners achieve better results?

3.1 Shifts in the way that partners deliver services

• How must partners work to ensure that the 'priority shifts' are applied and the intervention is effectively implemented?	The Lancashire wide long term conditions operational steering group will also be the task group. This group has agreed to share good practice and work jointly where it is appropriate to apply the shifts identified by the Health and Well Being Strategy.

3.2 Programme of work

• Who needs to be involved to develop commission and deliver the intervention?	CCGs, LCC (including its Public Health Services from 2013), NHS Providers including GP practices, District Councils and Third sector partners
• What are the 'milestones' for the Task Group in the year ahead?	The Task Group has identified a list of issues to work together. They include working on how to implement risk stratification tool, sharing the LTC dashboard, structure of integrated teams and local area coordination.
• What are the specific activities to be carried out by each partner?	This discussion is yet to happen. It is planned for the next Task Group meeting in early October (dates being identified). The activities identified by the task group will be presented to the Board in due course.

Appendix 1

Priority shifts in the ways that partners deliver services

- Shift resources towards interventions that prevent ill health and reduce demand for acute and residential service
- Build the assets, skills and resources of our citizens and communities
- Promote and support greater individual self-care and responsibility for health; making better use of information technology and advice.
- Commit to delivering accessible services within communities; improving the experience of moving between primary, hospital and social care.
- Make joint working the default option; pooling budgets and resources to focus on priority outcomes, commissioning together on the basis of intelligence and evidence; sharing responsibilities for service delivery and combining services in the most effective way; sharing risk.
- Work to narrow the gap in health and wellbeing and its determinants

Intervention planning

Purpose

This report sets out a template for use in preparation of the work programme for each of the Health and Wellbeing Board's ten interventions. The template is designed to;

- Create clarity on the desired impact of each intervention and on the specific roles of partners in delivering the intervention.
- Make explicit the shifts in ways of working that will allow partners to deliver the intervention.

The planning template

1. Reality

What's the current reality?

- Alcohol misuse has a huge impact on the health of the population in Lancashire adversely affecting disadvantaged communities leading to loss of life as well as increasing costs to the NHS. In 2011/12, it is estimated that PCTs in Lancashire spent £71.9 million on PbR tariff alone treating alcohol related conditions, with £15 million in treating conditions wholly attributable to alcohol.
- The increasing costs of alcohol related admissions are not sustainable and the hospital liason services to care for people with alcohol misuse needs to be transformed.
- Addressing alcohol misuse is a priority for many CCGs. It has also been identified as a priority intervention within the draft health and wellbeing strategy for Lancashire.
- The Lancashire improving outcomes board has also identified addressing alcohol related admissions as a service transformation area.
- There is inequity and variation in the service provision, especially the hospital alcohol liaison service and targeted identification and brief advice - two of the seven high impact changes identified by the Department of Health's Alcohol Learning Centre.

- What is currently working well?
- Existing commissioned hospital alcohol liaison HAL schemes exist in Lancashire. Local schemes are bespoke depending on need and circumstance and not 'one size fits all'.
- NHS Central Lancashire have worked through the contracting process with Lancashire Teaching Hospitals NHS Foundation Trust to deliver hospital based IBA for adult admissions
- Public Health Network Alcohol Programme Manager assists coordination and collaboration through the Lancashire Alcohol Network (LAN). LAN input influences effective collaborative working across partnerships at district and County levels.
- Strong evidence base for hospital alcohol liaison (HAL) and Identification and brief advice (IBA) interventions as two of the seven High Impact Changes to reduce alcohol harm. Evidence of alcohol liaison outcomes based on 'invest to save' and cost avoidance principles is strong. NWCEO's .Locality business cases predicated on this.
- Partners involved in alcohol harm reduction partnerships have identified alcohol impacts as a priority.
- Succesful Pan Lancashire business case for transformation funds submitted through the LIO board for hospital alcohol liaison services in the hospital and urgent care settings. ***Please see attached appendices 'A', 'B', and 'C'.***

NHS Evidence (2011): *Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care*

NICE (2010): Alcohol-use disorders: preventing the development of hazardous and harmful drinking

NICE (2010): Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications

NICE (2012): Alcohol Pathways http://pathways.nice.org.uk/pathways/alcohol-use-disorders

- What is getting in the way of partners achieving desired impacts?
- Sustainable funding for alcohol liaison nurse resources. N Lancs has some specific funding, East has improvised a resource and Central has an in-reach service as part of its drug and alcohol services. Business case identified above will 'kick start'.
- Generally, hospitals and urgent care centres lack screening processes to identify alcohol related conditions on presentation and staff lack awareness and training to recognise issues and deliver information and brief advice (IBA).
- Significant progress has already been made in discussing liaison services with partners. However, the need for this service requires constant re-enforcement with colleagues across acute trusts to ensure that a partnership approach to service implementation can be achieved.
- Lack of effective clinical pathways between hospital, primary care and community services to reduce repeat attendance and admission by 'frequent attenders'.

- Where are the gaps in service delivery that really matter?
- Equity of access to alcohol liaison across Lancashire ie in-reach service only in central Lancashire, NL only at BVH, East at RBH. The lack of equitable service delivery across Lancashire impacts on re-admissions and the long term prognosis for patients with chronic conditions caused or exacerbated by alcohol.
- Alcohol related condition screening and identification in hospitals and primary care Urgent Care Centres is inconsistent across Lancashire. Many areas have low levels of professional awareness of alcohol screening tools and IBA techniques. However, some developments are being taken forwards in central Lancashire through use of CQUINs.
- Lack of effective and consistent referral and clinical pathways between hospital, GP and community services.

- What are the issues and opportunities that must be addressed if we are to make a breakthrough? i.e. what really matters?
- Commission hospital alcohol liaison services for Lancashire residents.
- Leadership from senior management in strategic health planning and acute hospital trusts to influence and lead the buy-in to alcohol liaison as a means to health improvement and reducing associated costs to health services and other partners.
- Opportunity to publicise JSNA findings and evidence base for intervention impacts.
- Provision of alcohol awareness, IBA training for appropriate staff and incorporate IBA delivery into primary and secondary care contracts.
- Identify and agree 'best fit' liaison model and target groups ie dependent drinkers (frequent flyers) or dependent + increasing risk or universal whole patient group approach.
- Identify robust data systems and cost benefit tools to demonstrate effectiveness and outcomes.

2. Results

What does success look like?

2.1 Longer-term impact

- What will be the 3 to 5 year impact of the intervention?
- Please see attached business case for outcome details
- Reduction in the rate of increase of alcohol related hospital admissions and A&E repeat attendances.
- A reduction in the number of alcohol specific re-admissions and A&E representations within 30 days.
- A reduction in bed days associated with managing acute alcohol withdrawal (AAW)
- Demonstrable cost savings
- Improvement in Lancashire Alcohol Profiles for England (LAPE) across Lancashire 12 districts.
- Improved quality of care for people admitted to hospital for alcohol specific and alcohol related conditions.
- Reduced health service utilisation (pre and post intervention) by patients supported by the alcohol liaison service.
- Improved treatment pathways between hospital, primary care and access into community treatment services
- Skill development within the acute sector workforce through training in identification and brief advice and management of AAW.
- A reduction in alcohol fuelled violence and aggression against hospital staff.

- What are the longer-term measures of success?
- Contribute to a reduction in the rate of increase of alcohol related hospital admissions
- Contribute to reducing demands on partner services from alcohol related issues.
- With the association alcohol has to other conditions including mental health, cancer and CVD this work should make a contribution to positive impacts on these outcomes over the longer term

2.2 Impact in the year ahead

What specific goals will the intervention achieve in the next year?

- Please see attached business case for outcome details
- Reduce alcohol related hospital admissions by ensuring an equitable level of service is in place across Lancashire.
- To expand capacity of alcohol liaison nursing in acute settings that incorporates assertive outreach and integration with community in reach services.
- To develop skills within primary and secondary care workforce through training in Identification and brief advice
- Produce referral and clinical pathways between hospital, GP and community services appropriate to each locality.
- To support peer to peer learning between organisations
- Establish robust data collection and monitoring systems to evaluate the impact of the changes on alcohol related admissions

- What are the specific measures of success for the year ahead?
- How will the Health and Wellbeing Board know that the intervention has achieved its goals?
- Please see attached business case for outcome details
- Sustainable resources are identified to facilitate alcohol liaison service provision.
- Alcohol liaison established equitably in all A&E and acute hospital settings in Lancashire by September 2013, embedded as part of local alcohol service provision.
- Alcohol liaison established in hospital acute settings and Urgent Care Centres as appropriate.
- Effective clinical pathways are established between hospital, primary care and appropriate community

services.

- Lead officers will produce quarterly progress reports on key deliverables for H&WB responsible members for programme monitoring and feedback to the Board.

3. Response

What needs to happen to ensure partners achieve better results?

3.1 Shifts in the way that partners deliver services

- How must partners work to ensure that the 'priority shifts' are applied and the intervention is effectively implemented?
- Partners must promote awareness of the impacts that alcohol has on services and the benefits of alcohol liaison as a harm reduction intervention to prevent ill health and reduce demand for services.
- Partners must commit to engagement in the work programme and contribute to the implementation of alcohol liaison as a priority objective. ensuring that our alcohol services are working effectively and efficiently to ensure we maximise the impact from alcohol liaison.
- Partners must communicate openly regarding barriers to achieving objectives.
- Partners must commit to pathways and joint working to delivering accessible services within hospital and community settings to improve the experience of moving between primary, hospital and social care.
- Partners must commit to training and raising awareness for frontline staff to facilitate identification of alcohol harms, adopting screening tools for identification, delivering information and brief advice and pathways for signposting.
- Influence of HWB/CCG's to promote planning priorities

3.2 Programme of work

- Who needs to be involved to develop, commission and deliver the intervention?

Engagement and participation of the following partners will be essential for effective implementation of this project. All stakeholders will need to reflect arrangements pan-Lancashire;

- Clinical Commissioning Groups (as future lead commissioners for acute services & for clinical input)
- Community Alcohol Service Providers (ensuring developments are embedded within/aligned to care pathways)
- Drug and Alcohol Action Teams (as current lead commissioners for community alcohol services)
- Finance leads (for modelling financial impact of project delivery)
- Primary care (as the setting for IBA intervention)
- Hospital Trusts (as the setting for HALS intervention)
- Lancashire County Council Adult Social Care (for reducing admissions by frequent attendees and for length of stay for general alcohol related admissions)
- Local alcohol leads (as project managers at local level – often also fulfilling the public health role)
- Patient involvement (appropriate to needs and circumstances of the diverse range of service users)
- Public Health (for evidence base including critical appraisal of scientific evidence and health needs)
- Upper tier and unitary authorities (as future commissioners of drug and alcohol services)

- What are the 'milestones' for the Task Group in the year ahead?
  - Implement schemes locally using available resources and consider recommendations for shifting existing health resources to prevention and early interventions.
  - Engage all key stakeholders in planning alcohol liaison services as per 3.2 above.
  - Develop locality implementation plans including; agreement of liaison model and target groups, specification and performance management indicators, and provider mobilisation plans including staff recruitment and agreed commencement date.
- What are the specific activities to be carried out by each partner?

- Awareness raising and engagement of partners to develop local implementation plans. (Commissioners/partners)
- Negotiate potential for resource shift with partners and providers ie acute trusts'
- Negotiate contracts with acute trusts including finance, service model, performance management framework etc. and ensure service equity across Lancashire (commissioners NL/CL/EL in collaboration with unitaries as required and provider stakeholders)
- Provider mobilisation including recruitment of staff , protocols and pathways, staff training. (providers)
- Develop referral and treatment pathways between hospitals, primary care and community treatment services and signposting to other partners. (all)
- Achieve full implementation of service and evaluation (all)

Appendix 1

Priority shifts in the ways that partners deliver services

• Shift resources towards interventions that prevent ill health and reduce demand for acute and residential service
• Build the assets, skills and resources of our citizens and communities
• Promote and support greater individual self-care and responsibility for health; making better use of information technology and advice.
• Commit to delivering accessible services within communities; improving the experience of moving between primary, hospital and social care.
• Make joint working the default option; pooling budgets and resources to focus on priority outcomes, commissioning together on the basis of intelligence and evidence; sharing responsibilities for service delivery and combining services in the most effective way; sharing risk.
• Work to narrow the gap in health and wellbeing and its determinants

Lancashire Transformation Fund Business Case

NHS Lancashire

Name of proposed project: Hospital Alcohol Liaison Services (HALS)

Business Case developed by:

Andrew Ascroft
Public Health Associate
Child Public Health & Risk Taking Behaviours Team, NHS Central Lancashire

In consultation with local alcohol leads;
Steve Owen – NHS East Lancashire
Vicky Putt – NHS North Lancashire
Helen Lowey – NHS Blackburn with Darwen
Steve Morton – NHS Blackpool

Stephen Boydell – Public Health Intelligence, NHS Central Lancashire

Date: 30th July 2012

CCG:

PROJECT LEADERSHIP:

Lancashire Improving Outcomes Programme Lead: Dr. Sakthi Karunanithi	**Project Manager(s):** Alcohol leads in PCTs
Project Clinical Lead: (Ensure clinical focus throughout)	**Project Lead Accountant:** Chris Ridehalgh

OUTLINE PROPOSAL:

Background to the proposal: (Include the business need, why it is needed now, and existing arrangements – such as current service delivery, technical standards)

1. Alcohol misuse has a huge impact on the health of the population in Lancashire adversely affecting disadvantaged communities leading to loss of life as well as increasing costs to the NHS. In 2011/12, it is estimated that PCTs in Lancashire spent £71.9 million on PbR tariff alone treating alcohol related conditions, with £15 million in treating conditions wholly attributable to alcohol.
2. The increasing costs of alcohol related admissions are not sustainable and the hospital liason services to care for people with alcohol misuse needs to be transformed.
3. Addressing alcohol misuse is a priority for many CCGs. It has also been identified as a priority intervention within the draft health and well being strategy for Lancashire.
4. The Lancashire improving outcomes board has also identified addressing alcohol related admissions as a service transformation area.
5. There is inequity and variation in the hospital alcohol liaison service and targeted identification and brief advice - two of the seven high impact changes identified by the Department of Health's Alcohol Learning Centre.
6. There is an opportunity to halt the rising trend of alcohol related admissions by utilising some of the non recurrent resources to pump prime the transformation of the alcohol services available in the hospitals as well as in primary care with a plan to sustain.

Existing Arrangements: Blackpool has got a Hospital Alcohol Liaison Service (HALS) and Identification and Brief Advice in the community. HALS does not exist in North Lancashire but a recurrent funding source has been identified for HALS and a community in-reach exists. East Lancashire has got a HALS but is not adequate to cover the whole population. Central Lancashire has an in reach model for hospital alcohol liaison as part of the community services. Further details of existing arrangements can be found in annex 1.

This business case specifically focuses on expanding the capacity of HALS in East Lancashire and proposes setting up a HALS in Central Lancashire that incorporates assertive outreach alcohol service to integrate with the community based in-reach services. It also requests resources for training health professionals on identification and brief advice (IBA) in Central, East, BwD and North Lancashire.

The investment proposals should be seen in the context of improving the returns on existing spend on alcohol related admissions, which is approximately £71.9 million per year in Lancashire of which £12m are for conditions wholly attributable to alcohol.

Project Aim(s):

The project **aim** is reduce alcohol related admissions by ensuring an equitable level of service is in place across Lancashire.

Project deliverables:

1. To develop a hospital alcohol liaison service in Lancashire Teaching Hospital and Southport and Ormskirk Hospitals that is sustainable and incorporates assertive outreach and integration with community in reach services.
2. To expand capacity of alcohol liaison nursing in East Lancashire Hospitals Trusts and in urgent care settings that is sustainable and incorporates assertive outreach and integration with community in reach services.
3. To develop skills within primary and secondary care workforce through training in Identification and brief advice
4. To support peer to peer learning between organisations
5. To evaluate the impact of the changes on alcohol related admissions

Clinical evidence base and technical standards:

There is numerous evidence to support the interventions proposed in this project. Some of the key ones are given below

NHS Evidence (2011): *Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care*
NICE (2010): Alcohol-use disorders: preventing the development of hazardous and harmful drinking
NICE (2010): Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications
NICE (2012): Alcohol Pathways http://pathways.nice.org.uk/pathways/alcohol-use-disorders

Robin Touquet and colleagues in the Emergency department at St Mary's Hospital, London have designed the 1-minute Paddington Alcohol Test to identify patients with an alcohol-related problem. This resulted in a 10-fold increase in referrals to an Alcohol Health Worker (AHW). The AHW gave brief intervention and education, which resulted in a reduction of 43% in alcohol consumption. Every two referrals to the AHW resulted in one fewer reattendance during the following year. If patients are offered an appointment with the AHW on the same day, almost two-thirds attend. If the appointment is delayed for longer than 48 hours, only 28% attend. Hence, the intervention needs to be immediate (R Touquet et al, 2009)[i]. This also emphasises the need for the Hospital Alcohol Liaison service to be delivered 7 days a week

Evidence from transferrable case studies

The evidence from modelling using SRFT and WWHT suggests that a combination of alcohol liaison nurse, Identification and Brief Advice, and extended brief intervention could provide a decrease of 7.6% from the increase trajectory, with recognition that at least a one to two year period is required to achieve the activity benefits and a potential reduction of between 4 and 7 beds. The implementation of assertive outreach service will reduce admissions with AAF=1 by 10% in year 1, 20% in second year and 25% in the third.

To be effective evidence from case studies suggest that the HALS needs to an embedded component of

the hospital mutli-agency team. The Royal Bolton Hospital NHS Foundation Trust has an alcohol team, which systematically uses Brief Interventions and has strong links to community teams. The Royal Bolton Hospital collaborative care for alcohol- related liver disease and harm is a multidisciplinary team that consists of a Consultant Gastroenterologist, Liaison Psychiatrist, Psychiatric Alcohol Liaison Nurse, Liver Nurse Practitioner and all relevant health care professionals, including the dedicated social worker (K. J. Moriarty, 2010)[ii]. This is outlined in the 'interdependencies' section of the report.

The Royal Bolton Hospital NHS Foundation Trust for example has reduced inpatient detoxifications, saving the Trust more than 1,000 bed days annually, equating to £250,000 in reduced admissions. Also, in the 6 month pilot, this innovation has facilitated 541 discharges from the gastroenterology ward, compared to 355 in the comparable period last year, a 52% increase.

Note on case studies: Lancashire model is underpinned by Salford Royal and Royal Bolton as most robust evidence from that reviewed to date. Liverpool outcomes not transferrable to Lancashire as the model focusses on detox – have assumed context of limited community alcohol services which is not the case in Lancashire.

Deliverable Benefits/Impact: (quantify the measurable benefits using SMART methodology including benefits to patients)

It is recommended that further calculation of benefits is done using the actual activity levels in hospitals due to alcohol related admissions. The details provided below are conservative estimates from NI39 admission figures only. In reality, the actual activity is estimated to be three times the number of NI39 admissions.

Benefits from the cost reduction would be realised by the PCTs through admission avoidance and could lead to bed based reductions for two categories of patients:

1. Those with conditions partially attributable to alcohol, with a 0-1 LOS
2. Those with conditions wholly attributable to alcohol with a LOS typically >10.

The benefits have been quantified using the national planning tool to reduce alcohol related admissions based on the assumption that the interventions proposed in this business case would reduce the alcohol related admissions by at least 2%. A sensitivity analysis of the impact of this project ranging from 2% to 5% reduction in alcohol related admissions and the associated cost savings are provided in appendix 2.

The case is predicated on national indicators and length of stay costs that assumes on average an alcohol related admission costs a PCT £1,824 per admission.

Detailed graphs illustrating the projected trend and the impact of reducing the admissions by 2% to 5% and the associated cost savings can be found in the financial appraisal section and in appendix 3.

A risk benefit sharing structure would be required to ensure stabilisation within the health economy during the reduction of admissions and the associated bed reduction.

Please see the attached spreadsheet for details of costs involved and the associated savings.

Key Partners: (which partners are essential for delivery/sustainability of project activities/achievements)
Engagement and participation of the following partners will be essential for effective implementation of this project. All stakeholders will need to reflect arrangements pan-Lancashire;

- Clinical Commissioning Groups (as future lead commissioners for acute services & for clinical input)
- Community Alcohol Service Providers (ensuring developments are embedded within/aligned to care pathways)
- Drug and Alcohol Action Teams (as current lead commissioners for community alcohol services)
- Finance leads (for modelling financial impact of project delivery)
- Primary care (as the setting for IBA intervention)
- Hospital Trusts (as the setting for HALS intervention)
- Lancashire County Council Adult Social Care (for reducing admissions by frequent attendees and for length of stay for general alcohol related admissions)
- Local alcohol leads (as project managers at local level – often also fulfilling the public health role)
- Patient involvement (appropriate to needs and circumstances of the diverse range of service users)
- Public Health (for evidence base including critical appraisal of scientific evidence and health needs)
- Upper tier and unitary authorities (as future commissioners of drug and alcohol services)

Which element of QIPP does this scheme relate to?			
Quality	✔	**P**roductivity	
Innovation		**P**revention	✔
Which Lancashire cross-cutting theme does this scheme relate to?			
Prevention			✔
Long-term conditions			
Demand Management			
End of Life Care			
Safer Care			

TIMESCALES- KEY DATES:	
Project Start Date: Implementation from Q4 onwards	**Project End Date:**
Review Date 1:	**Review Date 2:**
Review Date 3:	**Review Date 4:**

Key Milestone Date including any additional reviews: (This forms the basis for the plan so use a timescale and record the major milestones. **NB. In non-recurrent funding request please state the date by which non-recurrent funds will be used.)**

Detailed milestones etc will be developed once the allocation is confirmed. It is expected that some of the funding will used in the next financial year.

FINANCIAL APPRAISAL: Please see Excel Spread Sheet for financials

Funding from Transformation Fund	**Gross (total) cost to deliver the scheme**	**Recurrent savings (Based on reduction in admission)**	**Net savings** (Total cost less total savings)	**Is there a need for non-recurrent set up costs? If so, how much?**	**Will savings be recurrent or non-recurrent?**	**Target year to realise savings**
£512k Includes non recurrent set up costs of £95k		Assuming 2%redn £1089k	£577k yr 1 but £672k recurrently	£95k	recurrent	2013/14
£512k Includes non recurrent set up costs of £95k		Assuming 5%redn £2,723k	£2,222k yr 1 but £2,317 recurrently	£95k	recurrent	2013/14

Activity Implications (-/+)	**Provider**	**Year of implication**	**Impact**
-597 (Assuming 2% reduction)	Pan Lancashire	2013/14	
-1493 (Assuming 5% reduction)	Pan Lancashire	2013/14	

Alternative options: (Have any alternatives been considered? Can this be done another way?)

Alternative options considered are as follows;

1. Do nothing
2. Alcohol liaison service including with IBA in secondary care with training health professionals on IBA (cost and benefits above)
3. Alcohol liaison service with IBA in secondary care plus IBA in primary care for 50% of patients in most deprived practices in Central, East, BwD, North and Blackpool (Add extra costs £1,785,000)
4. Alcohol Liaison service including IBA in primary care for 25% of patients in most deprived practices in Central, East, BwD, North and Blackpool (Add extra cost of £882,000)

It is assumed that the non recurrent funding will be available for at least 12 months from the onset of this project.

IMPLICATIONS and CONSTRAINTS:

Interfaces: (Which other services does this relate to: internal and/or external? What impact will this have on them?)

The key interfaces for this project are as follows;

Internal Interfaces

- Implementation of this service will need local clinical leadership.
- It will lead to increased identification of alcohol misuse in patients attending the hospitals

External Interfaces

- Existing alcohol service providers including community services to take account of the place of HALS within comprehensive alcohol care pathways.
- Training conducted will also help deliver better quality alcohol misuse identification and brief advice that will be done as part of NHS Health Checks in subsequent months.

Interdependencies: (Identify where project progress or successful delivery is dependent on other factors external to the project, or vice-versa)

The key interdependencies that are identified as affecting progress of implementing the project, successful delivery of the project or external factors required for successful delivery are as follows;

Factors affecting implementation progress

- Inability to recruit due to lack of appropriately skilled workforce (for HALS).

Factors impeding successful delivery

- Agreeing a consistent dataset by which to monitor the impact of the intervention so we know the numbers of admissions avoided and length of stays reduced so this can be equated to financial savings.
- Inflexibility of acute contracts so that any financial savings achieved cannot be released.
- Capacity within the emerging local public health services to sustain the input required to develop and deliver against the project.
- 3 month delivery period too short to effectively set up service, embed and deliver reductions in hospital admissions for HALS and demonstrate impact for IBA
- Lack of sustainable funding

External factors required for successful delivery

- Alcohol service provider engagement and buy-in to consider this non recurrent funding in the context of the comprehensive alcohol care pathway (for both IBA and HALS).
- Capacity in community alcohol service providers to effectively manage patients diverted from hospital admission or whose length of stay is appropriately reduced (for HALS).
- Embed HALS as part of multi-agency hospital team with strong links to social work and community substance misuse services

Assumptions: (State any assumptions made in making the Business Case, even if they seem obvious)
It is recommended that a detailed hospital level alcohol related activity is analysed to understand the impact of reducing NI39 admissions and validate the modelling done with SRFT and WWHT data.

The following assumptions have been made in developing the business case;

1. Salford Royal NHS Foundation Trust and Royal Bolton Hospital NHS Foundation Trust outcome data has been used to underpin assumptions for modelling impact for the HALS element of the business case
2. There is an assumption that the average cost of an alcohol related admission is the same in Lancashire as documented nationally
3. There is an assumption that hospital coding practices will remain consistent
4. There is a presumption that the definition of alcohol related hospital admissions will remain consistent
5. Financial modelling relating to use of figures drawn from NHS Evidence apply
6. There is an assumption that secondary care contracting is able to utilise savings associated with this scheme to sustain the model
7.

Risks: (Outline significant risks identified – stating if they relate to proceeding or not proceeding)

- The business case does not take account of local service models and provision and as such does not achieve maximum impact from use of the potential resource.
  - This risk would inform the detail of how the business case could best proceed.
- It is not possible to replicate a single model seen elsewhere to Lancashire that would deliver an agreed percentage reduction in the rate of alcohol related hospital admissions. There is therefore no guarantee that a 1% reduction will be achieved
- Local changes in recording can have significant impacts on the rate of alcohol related hospital admissions documented. This could affect performance monitoring of HALS
- Failure to sustain this approach beyond the 12 months identified will result in failure to deliver the identified % reductions in alcohol related hospital admissions

ADDITIONAL CONSIDERATIONS:

Workforce: (To include consideration of required capability (knowledge, skills & experience) as well as capacity – also training/development needs etc, for delivery of change as well as ongoing post-change implications)

Providers Trusts need to identify the workforce to be trained and delivering the alcohol liaison service.

Estates/Infrastructure: (Consider buildings/transport , IT etc)

Quality: (Including legal implications such as NICE guidelines, specifications, standards, indicators/targets, QIPP/CQUIN links etc)

PROJECT BUSINESS CASE SUMMARY:

Points in favour of this project proceeding:	**Arguments against this project:**

AGREEMENT TO SUBMIT TO RESOURCES SUB-GROUP FOR APPROVAL:

NAME	*SIGNATURE*	*DATE*
Project Senior Lead:		
Project Manager:		
Project Clinical Lead:		
Project Lead Accountant:		

RESOURCES SUB-GROUP AGREEMENT TO PROCEED:

Resources Sub-group Chair Agreement Received: YES/NO	*SIGNATURE*	*DATE*

If no please state reason

COMPLETED FORM TO BE RETURNED TO
ANDREA TRAFFORD, PROJECT OFFICE, JUBILEE HOUSE

[i] Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care (2012): NHS Evidence
[ii] Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care (2012): NHS Evidence

Annex 1: Existing Hospital Alcohol Liaison Services in Lancashire

Trust	Hospital(s)	Current arrangements for Hospital Alcohol Liaison

Blackpool Teaching Hospitals NHS Foundation Trust	Blackpool Victoria Hospital	Hospital Alcohol Liaison Service in place, 4 hospital nurses based in BVH Gastro working across hospital. 1.6 in reach workers from Horizon linking patients to community services. Volunteer Health Mentors working across hospitals providing signposting and basic information. IBA staff training available regularly and built into some JDs. Anticipate need for 1 or 2 additional nurses but would envisage this to be via N Lancs funding.
East Lancashire Hospitals NHS Trust	Royal Blackburn Hospital	HALS in place. Need to extend the hours and presence in urgent care centre
	Burnley General Hospital	No alcohol liaison service
Lancashire Teaching Hospitals NHS Foundation Trust	Royal Preston Hospital	No hospital based alcohol liaison service in place. Community substance misuse service 'Discover' commissioned to deliver an in reach model. IBA being delivered by hospital staff to adult admissions as per quality component of contract
	Chorley and South Ribble Hospital	As above
Southport and Ormskirk Hospital NHS Trust	Southport and Formby District General Hospital	Business case being developed with NHS Sefton and Southport and Ormskirk Hospital NHS Trust to develop Hospital Alcohol Liaison Service although no funding source identified for central Lancashire component of business case. Community substance misuse service 'Discover' commissioned to deliver an in reach model for central Lancashire patients only.
	Ormskirk and District General Hospital	As above
University Hospitals Of Morecambe Bay NHS Foundation Trust	Royal Lancaster Infirmary	Business case and service specification has been agreed by Lancaster, Wyre and Garstang CCG (as was) and the Urgent Care Network. Some recurrent funding has been identified internally but model is dependant on engagement from UHMBT to support a service redesign approach and resource shift in order to complement the recurrent PCT investment. Ongoing discussions with UHMBT regarding this approach have not yet realised an implementation plan. The non-recurrent funding can be utilised to support the proposed model by providing resource to train potential ALN staff and UHMBT medics.
	Furness General Hospital	N/A

Appendix 2: Projected reduction in admissions and savings. This is for illustration purposes only.

Lancashire-14 reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	46139	45277	862	£1,572,560	44846	1293	£2,358,840	44415	1724	£3,145,120	43984	2155	£3,931,400
2013/14	49171	46441	2730	£4,979,326	45102	4069	£7,421,812	43781	5391	£9,832,846	42476	6695	£12,212,430
2014/15	52203	46519	5685	£10,368,907	43824	8379	£15,283,451	41226	10977	£20,021,829	38724	13480	£24,586,873
2015/16	55235	45499	9736	£17,759,119	41111	14125	£25,763,347	37025	18211	£33,216,202	33228	22007	£40,141,251

Central Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	14560	14286	274	£499,252	14149	411	£748,878	14012	547	£998,504	13875	684	£1,248,129
2013/14	15434	14572	862	£1,571,528	14150	1284	£2,342,315	13732	1701	£3,103,116	13321	2113	£3,853,933
2014/15	16308	14523	1785	£3,255,307	13677	2630	£4,797,764	12862	3446	£6,284,621	12077	4231	£7,716,777
2015/16	17182	14140	3042	£5,548,995	12769	4413	£8,048,635	11494	5688	£10,375,194	10309	6873	£12,536,113

North Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	8919	8752	167	£304,703	8668	251	£457,055	8585	334	£609,406	8501	418	£761,758
2013/14	9485	8957	528	£962,567	8698	787	£1,434,709	8443	1042	£1,900,757	8191	1294	£2,360,712
2014/15	10051	8954	1097	£2,000,288	8435	1616	£2,948,253	7934	2117	£3,862,162	7451	2600	£4,742,565
2015/16	10617	8742	1875	£3,419,570	7898	2720	£4,960,481	7111	3506	£6,395,030	6380	4237	£7,727,774

East Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	12292	12062	230	£419,444	11947	345	£629,166	11832	460	£838,888	11717	575	£1,048,610
2013/14	13087	12359	727	£1,326,624	12003	1084	£1,977,353	11651	1436	£2,619,693	11303	1784	£3,253,645
2014/15	13881	12368	1513	£2,759,777	11651	2230	£4,067,753	10960	2921	£5,328,794	10294	3588	£6,543,655
2015/16	14676	12087	2589	£4,722,487	10920	3756	£6,850,745	9833	4842	£8,832,253	8824	5852	£10,673,290

Blackpool PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	5281	5183	98	£178,688	5134	147	£268,032	5085	196	£357,376	5036	245	£446,720
2013/14	5663	5350	312	£569,746	5197	466	£849,258	5046	617	£1,125,196	4897	766	£1,397,561
2014/15	6045	5391	654	£1,193,766	5080	965	£1,759,771	4781	1264	£2,305,618	4493	1552	£2,831,630
2015/16	6427	5300	1127	£2,055,867	4792	1635	£2,983,048	4318	2109	£3,846,742	3878	2549	£4,649,646

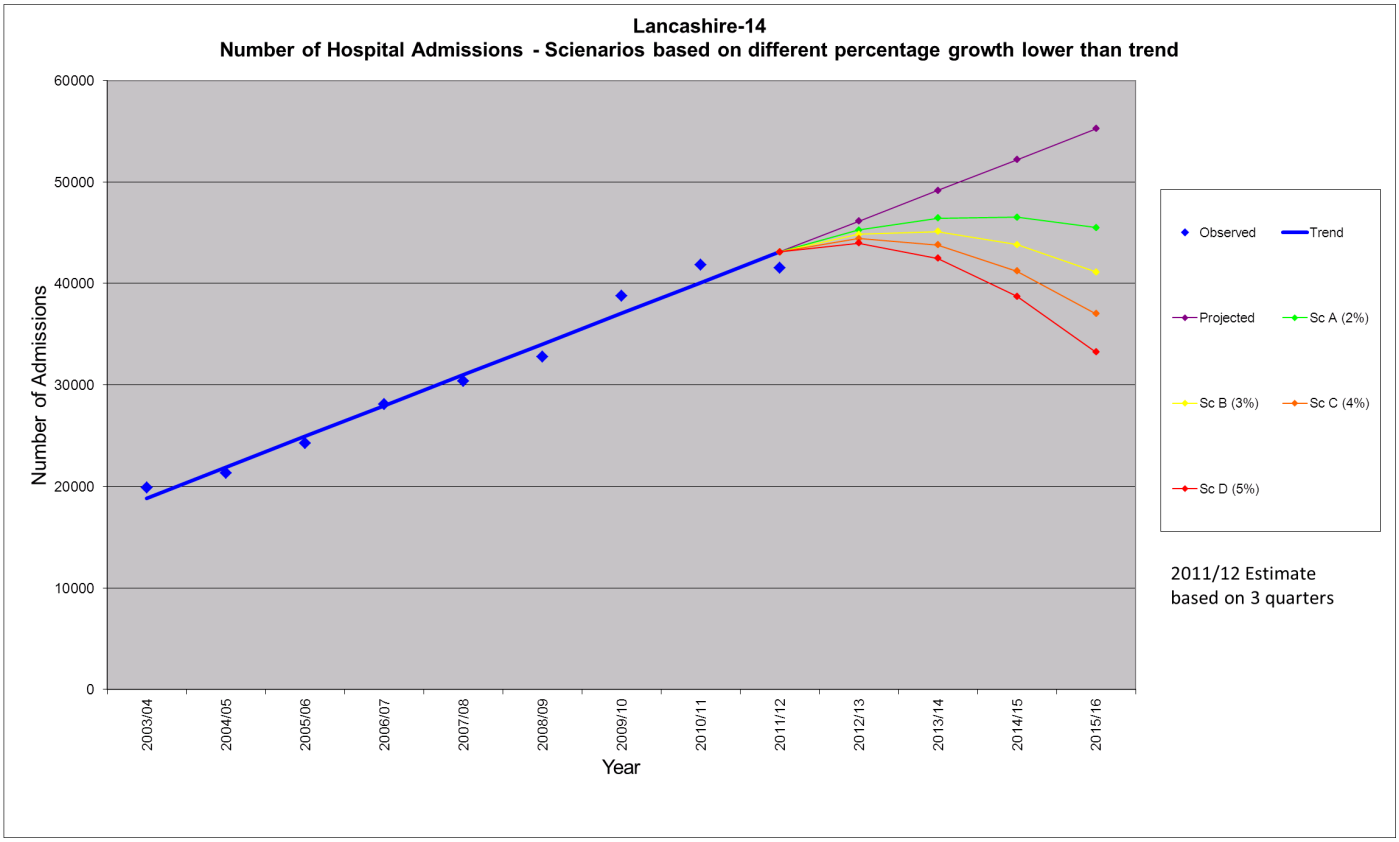
Blackburn with Darwen PCT reduction in number of hospital admissions and subsequent cost saving estimate

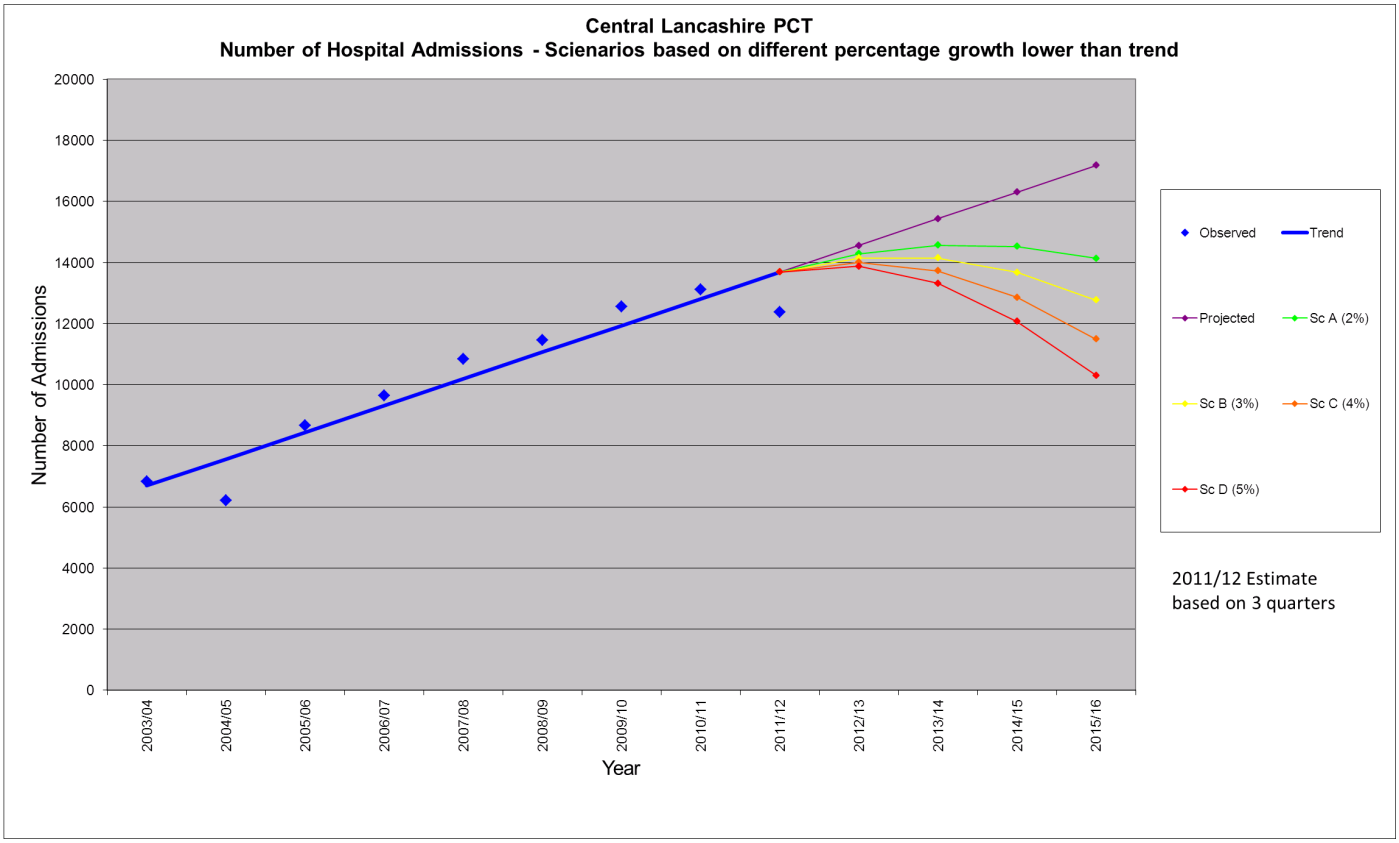
Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	5086	4992	93	£170,514	4945	140	£255,771	4899	187	£341,028	4852	234	£426,285
2013/14	5497	5196	301	£548,538	5049	448	£817,692	4903	594	£1,083,435	4759	738	£1,345,768
2014/15	5909	5274	635	£1,158,289	4972	936	£1,707,712	4682	1227	£2,237,728	4402	1507	£2,748,647
2015/16	6320	5219	1101	£2,008,469	4722	1598	£2,914,980	4259	2061	£3,759,886	3828	2492	£4,545,782

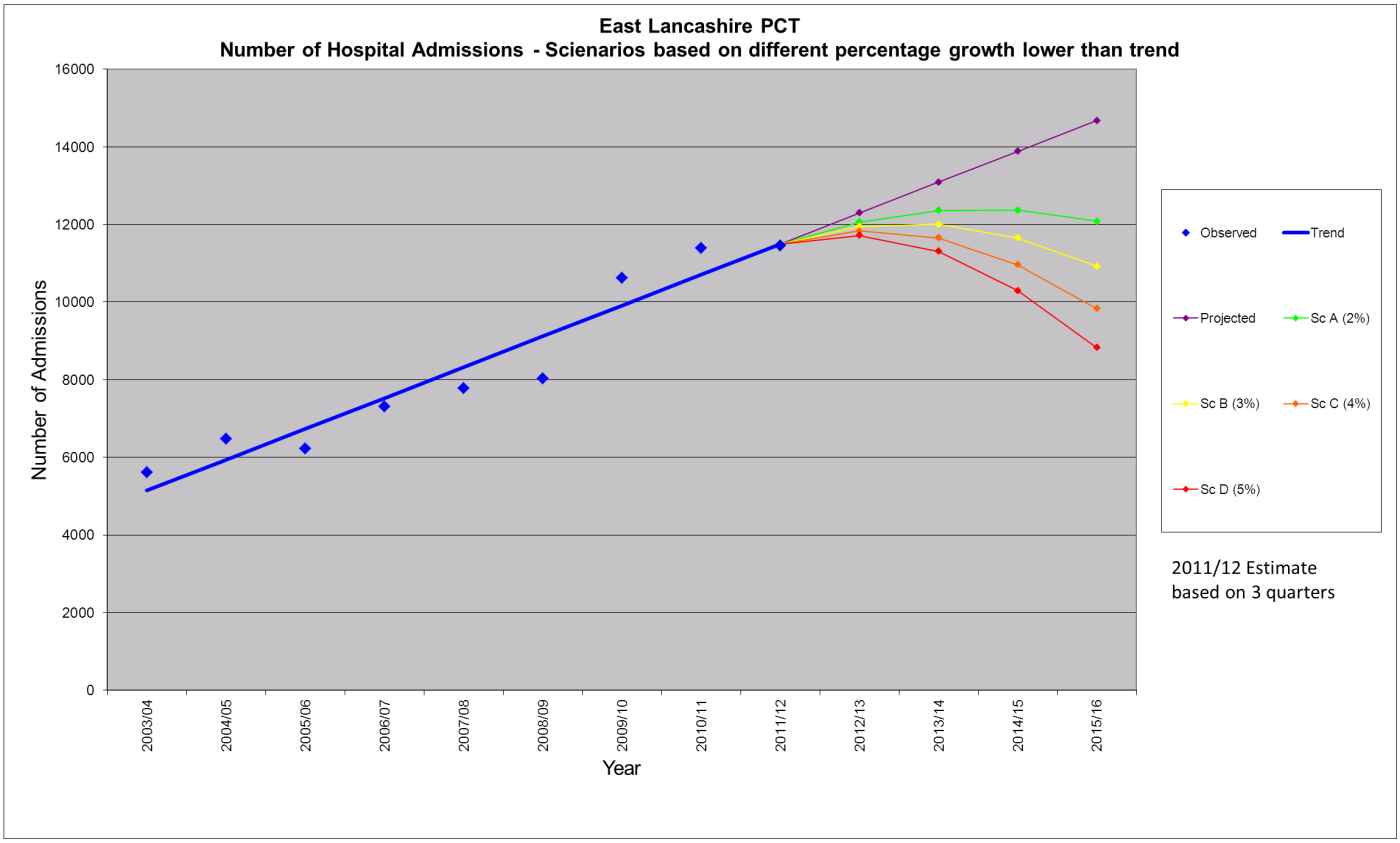
Based on average cost per alcohol related admission of (from business case):

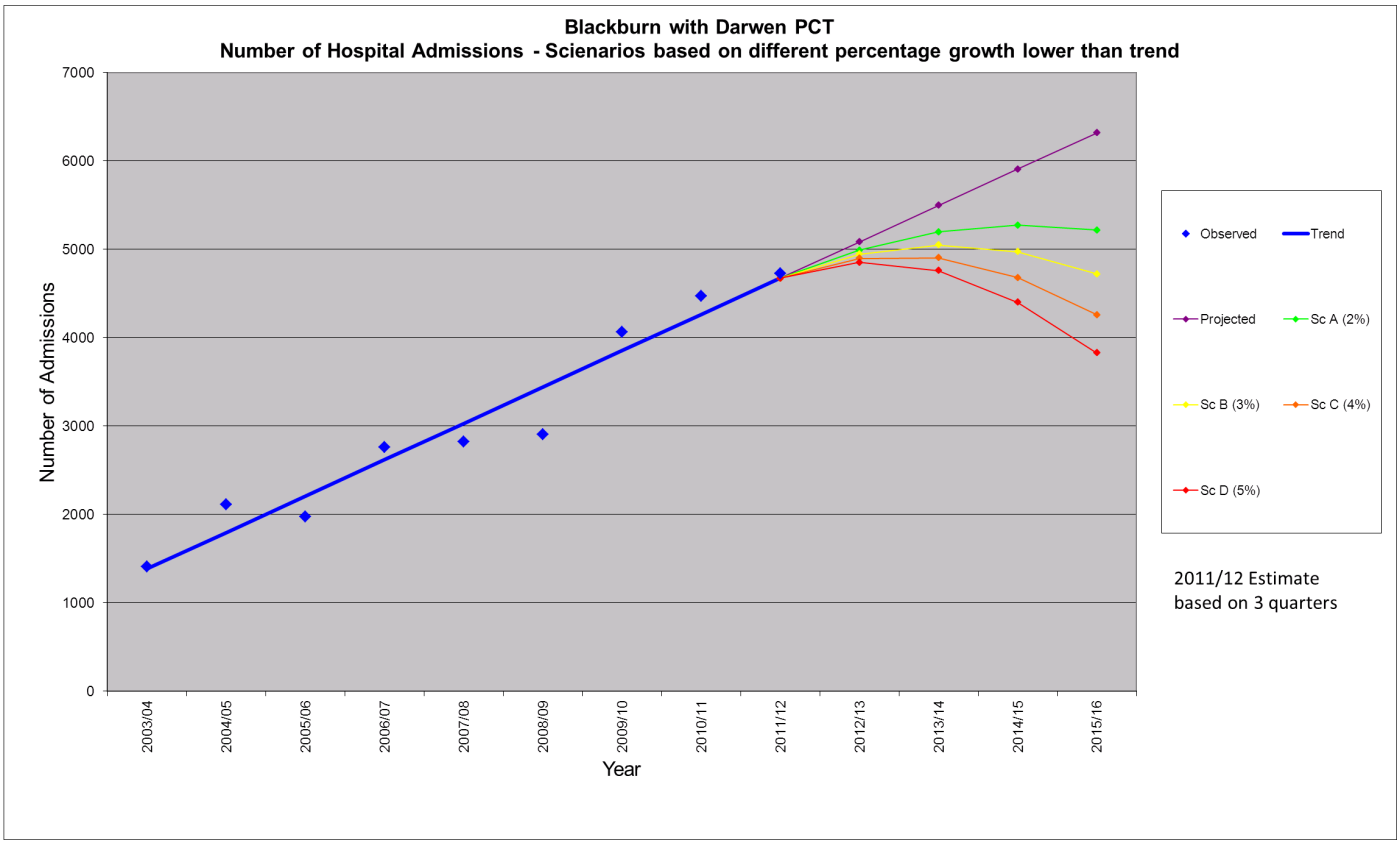
£1,824

Appendix 3 – Projected trend and impact of reducing alcohol related admissions from 2 – 5%






East Lancashire PCT
Number of Hospital Admissions - Scienarios based on different percentage growth lower than trend
Number of Admissions
16000
14000
12000
10000
8000
6000
4000
2000
0
2003/04
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Year
Observed
Trend
Projected
Sc A (2%)
Sc B (3%)
Sc C (4%)
Sc D (5%)
2011/12 Estimate
based on 3 quarters


Blackburn with Darwen PCT
Number of Hospital Admissions - Scienarios based on different percentage growth lower than trend
Number of Admissions
7000
6000
5000
4000
3000
2000
1000
0
2003/04
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
Year
Observed
Trend
Projected
Sc A (2%)
Sc B (3%)
Sc C (4%)
Sc D (5%)
2011/12 Estimate
based on 3 quarters

Appendix 'B'

Lancashire Improving Outcomes Board

Transformation Fund

Business Case Summary Sheet

1. Title of Business Case	**Hospital Alcohol Liaison Service to reduce alcohol related admissions**
2. Business Case developed by	Andrew Ascroft and Dr. Sakthi Karunanithi in conjunction with alcohol leads in other PCTs.
3. Investment summary	£512k Includes non recurrent set up costs of £95k
4. Identifiable Recurrent / non-recurrent savings by year	Range is between £577k yr 1 but £672k (based on 2% reduction) recurrently and £2,222k yr 1 but £2,317 recurrently (based on 5% reduction)
5. Benefits summary	Reduction in admissions in the range of 597 to 1493
6. Notes	The benefits are very conservative figures based on NI39 admissions. The actual hospital admissions are likely to be three times higher than NI39. A detailed hospital level activity analysis might reveal more opportunities for savings. The case is predicated on the sharing of financial risks between commissioners and providers

Local Implementation

The following points must be taken into account in the development of local implementation plans:

- Transition (double running/start up) where appropriate is clearly identified and agreed;
- Ensure that reductions in admissions and beds are explicit and agreed with providers;
- Any recurring costs are clearly identified and agreed;
- Success metrics are defined, baselines agreed and appropriate monitoring systems are established before work commences, and
- A 'get out' clause is established and agreed with provider partners should the project not prove successful in its aims.

Completed by:	Dr Sakthi Karunanithi
Date of completion:	30th July 2012
Date submitted to Resources Subgroup:	14th August 2012
Decision of Resources Subgroup:	Supported by the Resources Subgroup

Hospital Alcohol Liaison Service - Appendix 'C'

Health Economies		Required Funding Recurrent pa £	Non Recurrent £
NHS Blackpool		0	0
NHS Blackburn with Darwen & East Lancashire		141,000	10,000
NHS Central Lancs		276,000	10,000
NHS North Lancs Lancs		0	10,000
Pan Lancs	Marketing/ Community engagement		45,000
	Evaluation		20,000
Total		417,000	95,000

Assuming a 2% reduction in alcohol related admissions

	Admsn redn	Potential Recurrent Savings Yr1 £	Cost Avoidance -cumulative Admsn redn Yr2	£	Admsn redn Yr3	£	Admsn redn Yr4	£
NHS Blackburn with Darwen	93	170,514	207	378,024	542	987,775	1,008	1,837,955
NHS Central Lancs	274	499,252	588	1,072,277	1,511	2,756,055	2,768	5,049,743
NHS East Lancashire	230	419,444	497	907,180	1,283	2,340,333	2,359	4,303,043
	597	1,089,210	1292	2,357,481	3336	6,084,163	6135	11,190,740
NHS Blackpool (Team already in place)	98	178,688	214	391,058	557	1,015,078	1,029	1,877,178
NHS North Lancs Lancs (Team not in place but arrangeme	167	304,703	361	657,864	930	1,695,585	1,708	3,114,867
Total	265	483,391	575	1,048,921	1486	2,710,663	2737	4,992,046

Assuming a 5% reduction in alcohol related admissions

	Admsn redn	Potential Recurrent Savings Yr1 £	Cost Avoidance -cumulative Admsn redn Yr2	£	Admsn redn Yr3	£	Admsn redn Yr4	£
NHS Blackburn with Darwen	234	426,285	738	1,345,768	1,507	2,748,647	2,492	4,545,782
NHS Central Lancs	684	1,248,129	2,113	3,853,933	4,231	7,716,777	6,873	12,536,113
NHS East Lancashire	575	1,048,610	1,784	3,253,645	3,588	6,543,655	5,852	10,673,290
	1493	2,723,025	4635	8,453,346	9325	17,009,079	15217	27,755,185
NHS Blackpool (Team already in place)	245	446,720	766	1,397,561	1,552	2,831,630	2,549	4,649,646
NHS North Lancs Lancs (Team not in place but arrangeme	418	761,758	1,294	2,360,712	2,600	4,742,565	4,237	7,727,774
Total	663	1,208,478	2060	3,758,273	4153	7,574,195	6786	12,377,420

Hospital Alcohol Liaison Service

				Funding		
NHS Blackpool					Non	
			Recurrent		Recurrent	
Primary Care			£	£	£	£
IBA						
Training -already funded						
Blackpool , Fylde & Wyre Hospitals						
Alcohol Liaison Team -already recurrently funded						
Total				0		0
NHS Blackburn with Darwen & East Lancashire						
Primary Care						
IBA						
Training						10,000
East Lancahire Hospitals	Band	wte				
Alcohol Liaison Team						
Specialist Nurses	7	1.00	45,000			
Specialist Nurses	6	2.00	76,000			
Support costs			20,000			
				141,000		
Total				141,000		10,000
NHS Central Lancs						
Primary Care						
IBA						
Training						10,000
Lancashire Teaching Hospitals	Band	wte				
Alcohol Liaison Team						
Specialist Nurses	7	1.00	45,000			
Specialist Nurses	6	3.00	114,000			
Support costs			25,000			
				184,000		
Total				184,000		10,000
Southport & Ormskirk						
Alcohol Liaison Team						
Specialist Nurses	7	1.00	45,000			
Specialist Nurses	6	3.00	114,000			
Support costs			25,000			
			184,000			
50% for Central Lancs				92,000		
Total				92,000		0
NHS North Lancs Lancs						
Primary Care						
IBA						
Training						10,000
University Hospitals Morecambe Bay						
Alcohol Liaison Team -already recurrently funded						
Total				0		10,000

Lancashire- reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	46139	45277	862	£1,572,560	44846	1293	£2,358,840	44415	1724	£3,145,120	43984	2155	£3,931,400
2013/14	49171	46441	2730	£4,979,326	45102	4069	£7,421,812	43781	5391	£9,832,846	42476	6695	£12,212,430
2014/15	52203	46519	5685	£10,368,907	43824	8379	£15,283,451	41226	10977	£20,021,829	38724	13480	£24,586,873
2015/16	55235	45499	9736	£17,759,119	41111	14125	£25,763,347	37025	18211	£33,216,202	33228	22007	£40,141,251

Central Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	14560	14286	274	£499,252	14149	411	£748,878	14012	547	£998,504	13875	684	£1,248,129
2013/14	15434	14572	862	£1,571,528	14150	1284	£2,342,315	13732	1701	£3,103,116	13321	2113	£3,853,933
2014/15	16308	14523	1785	£3,255,307	13677	2630	£4,797,764	12862	3446	£6,284,621	12077	4231	£7,716,777
2015/16	17182	14140	3042	£5,548,995	12769	4413	£8,048,635	11494	5688	£10,375,194	10309	6873	£12,536,113

North Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	8919	8752	167	£304,703	8668	251	£457,055	8585	334	£609,406	8501	418	£761,758
2013/14	9485	8957	528	£962,567	8698	787	£1,434,709	8443	1042	£1,900,757	8191	1294	£2,360,712
2014/15	10051	8954	1097	£2,000,288	8435	1616	£2,948,253	7934	2117	£3,862,162	7451	2600	£4,742,565
2015/16	10617	8742	1875	£3,419,570	7898	2720	£4,960,481	7111	3506	£6,395,030	6380	4237	£7,727,774

East Lancashire PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	12292	12062	230	£419,444	11947	345	£629,166	11832	460	£838,888	11717	575	£1,048,610
2013/14	13087	12359	727	£1,326,624	12003	1084	£1,977,353	11651	1436	£2,619,693	11303	1784	£3,253,645
2014/15	13881	12368	1513	£2,759,777	11651	2230	£4,067,753	10960	2921	£5,328,794	10294	3588	£6,543,655
2015/16	14676	12087	2589	£4,722,487	10920	3756	£6,850,745	9833	4842	£8,832,253	8824	5852	£10,673,290

Blackpool PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	5281	5183	98	£178,688	5134	147	£268,032	5085	196	£357,376	5036	245	£446,720
2013/14	5663	5350	312	£569,746	5197	466	£849,258	5046	617	£1,125,196	4897	766	£1,397,561
2014/15	6045	5391	654	£1,193,766	5080	965	£1,759,771	4781	1264	£2,305,618	4493	1552	£2,831,630
2015/16	6427	5300	1127	£2,055,867	4792	1635	£2,983,048	4318	2109	£3,846,742	3878	2549	£4,649,646

Blackburn with Darwen PCT reduction in number of hospital admissions and subsequent cost saving estimate

Year	Projected rate of alcohol-related admissions based on trend	2% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	3% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	4% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving	5% lower growth relative to trend	Cumulative Reduction in number of admissions	Cumulative Cost Saving
2012/13	5086	4992	93	£170,514	4945	140	£255,771	4899	187	£341,028	4852	234	£426,285
2013/14	5497	5196	301	£548,538	5049	448	£817,692	4903	594	£1,083,435	4759	738	£1,345,768
2014/15	5909	5274	635	£1,158,289	4972	936	£1,707,712	4682	1227	£2,237,728	4402	1507	£2,748,647
2015/16	6320	5219	1101	£2,008,469	4722	1598	£2,914,980	4259	2061	£3,759,886	3828	2492	£4,545,782

Based on average cost per alcohol related admission of (from business case):
£1,824

Shadow Health and Wellbeing Board

Minutes of the Meeting held on Tuesday, 10th July, 2012 at 2.00 pm in Cabinet Room 'D' - County Hall, Preston

Present:

Chair

County Councillor Mrs Val Wilson, Cabinet Member for Health and Wellbeing (LCC)

Committee Members

County Councillor Mike Calvert, Cabinet Member for Adult and Community Services (LCC)
Richard Jones, Executive Director for Adult and Community Services (LCC)
Dr Peter Williams, East Lancashire Clinical Commissioning Group (CCG)
Dr David Wrigley, Lancaster Clinical Commissioning Group (CCG)
Dr Ann Bowman, Greater Preston Clinical Commissioning Group (CCG)
Dr Simon Frampton, West Lancashire Clinical Commissioning Group (CCG)
Peter Kenyon, Chair of Lancashire PCT Cluster Board
Councillor Julie Cooper, East Lancashire District Councils
Councillor Bridget Hilton, Central Lancashire District Councils
Councillor Cheryl Little, Fylde District Councils
Lorraine Norris, Lancashire District Councils (Preston City Council)
Michael Wedgeworth, Chair of Third Sector Lancashire
Walter D Park, Chair of Lancashire LINk

Officers

Deborah Harkins, Lancashire County Council
Habib Patel, Lancashire County Council

Apologies

County Councillor Mrs Susie Charles, Cabinet Member for Children and Schools (LCC)
Helen Denton, Executive Director for Children and Young People (LCC)
Maggi Morris, Director of Public Health (LCC / PCT)
Dr Robert Bennett, Chorley and South Ribble Clinical Commissioning Group (CCG)
Dr Tony Naughton, Fylde and Wyre Clinical Commissioning Group (CCG)
Janet Soo-Chung, Chief Executive of Lancashire PCT Cluster Board
Ian Roberts, Greengage Consulting

1. Welcome from the Chair and overview of the agenda

The Chair, County Councillor Valerie Wilson, welcomed all to the meeting and in particular the guests attending to assist with presenting the Intervention items. County Councillor Wilson also provided an overview of the agenda.

2. Apologies for absence

Apologies were noted.

3. Minutes of the meeting held on 29 May 2012

Resolved: The minutes of the meeting held on 29 May 2012 were agreed as an accurate record.

4. Overview of the Interventions

Habib Patel, Lancashire County Council, opened the presentation by explaining that the Board has been working to a tight timescale but has a bit more time to work on the chosen Interventions. The intention is to agree which Interventions the Board will target with the aim of presenting firm proposals to the September 2012 Board meeting. Habib thanked Board members for their hard work so far on each on the Interventions.

Habib drew the Boards attention to the 10 documents circulated in the agenda papers which give an overview of the work done on each Intervention to date.

Resolved: The Shadow Health and Wellbeing Board noted the presentation and documents circulated with the agenda.

5. Progress on the Three Interventions

Alcohol Liaison Intervention (Board Members County Councillor Mike Calvert and Dr David Wrigley)

Steve Owen, Lead Officer for the Alcohol Liaison Intervention gave a presentation on progress to date on this particular Intervention and what is working well / not well.

The current situation in Lancashire is that there are three distinct projects which follow a best fit model as resources allow. Models are based on local priorities – i.e. reducing alcohol related admission rates and unscheduled care. There is a good evidence base for interventions and some evidence of emerging partnerships between hospital and community services.

Steve explained that the outcomes for Alcohol Liaison had been split into short, medium and long term goals as follows:

Short 1year	• Contracts agreed with providers based on the identified target groups for local projects. • Equitable access to liaison services. • Robust data collection and monitoring systems for evaluation. • Clinical pathways agreed between hospital, GP and community. • Increased clinician awareness of alcohol impacts and skills in Identification and Brief Advice.

Medium 3-5years	• Reduce alcohol specific re-admissions and A&E representations within 30 days. • Reduce bed usage associated with acute alcohol withdrawal. • Improve quality of care for people admitted to hospital for alcohol specific and alcohol related conditions. • Reduce alcohol associated demand and cost burden to NHS and partners.
Long 2020	• Reduction in the rate of increase of alcohol related hospital admissions. • Improvement in Lancashire Alcohol Profiles for England (LAPE) across Lancashire 12 districts. • Positive outcomes over the longer term on other conditions associated with alcohol including mental health, cancer and CVD.

Steve also highlighted some of the shifts or changes required to ensure the Intervention is effectively implemented as follows:

How must partners work to ensure that the 'priority shifts' are applied and the intervention is effectively implemented?	
• Partners need to commit to engagement and contribute to implementing alcohol liaison as a priority objective. • Partners need to commit resources • Partners need to 'buy in' to evidence of the benefits of alcohol liaison as an intervention to improve health and reduce demand for services. • Partners need to communicate openly regarding barriers to achieving objectives. • Partners need to commit to integrated pathways between hospital, community and primary care. • Partners need to commit to workforce training and adopting screening for alcohol related issues. • Influence of HWB/CCG's to promote planning priorities.	
Who needs to be involved to develop, commission and deliver the intervention?	
• Public Health Lancashire • CCG's • Acute Trust • Primary care services	• Community treatment services • Service users • Leverage from HWB
What are the 'milestones' for the Task Group in the year ahead?	
• Resubmit alcohol liaison business case to funding groups and explore potential for 'invest to save' resource shift with providers. • Engage all key stakeholders in planning alcohol liaison services. • Develop locality implementation plans.	

Board members welcomed the presentation and commented that early intervention to educate people on a healthy lifestyle was important to intervention success, and also commented on some of the wider interventions related to alcohol such as enforcement of alcohol licensing.

Loneliness in Older People Intervention (Board Members Michael Wedgeworth and Dr Peter Williams)

Habib Patel began the presentation by highlighting the current situation in Lancashire and the strengths and weaknesses as follows:

Strengths

- Third Sector working with older people in communities.
- Different befriending models.
- Local community groups supporting older people.
- Help Direct – statutory organisations funding older people services.
- Varied choice and provision.
- Lots of good practice and innovation across the county

Weaknesses

- Sharing information between agencies - referral
- Sharing information between intervention service providers
- Duplication and gaps of services
- Not enough good practice sharing across the county
- Not being able to find small amount of resources to get on with projects (sustainability)
- Being clear about what is happening in local areas for lonely older people - for frontline staff to refer
- Lack of holistic approach to health & wellbeing (including loneliness)
- Inconsistent approach to integrating interventions to address loneliness into care pathways

Habib report the desired outcomes for this Intervention as follows:

- Identifying lonely older people by raising awareness amongst all agencies who are involved with older people, identify those who may be vulnerable to loneliness.
- A simple but effective referral process that has capacity and can be monitored and measured for success.
- Local services which meet the need of older people, without them needing to travel far and therefore accessible on the door step or in the home.

Finally, Habib reported to the Board the suggested workstreams for this Intervention and suggestions for how to take this Intervention forward as follows:

- Awareness plan for those at risk and for those who know others are at risk.
- Consider Help Direct as first point of call, identify the grit in referral process.
- Bring together a range of evidence (JSNA) to support us in identifying who/where.
- Effective local directory.

- Need to link referral with outcome.

Board members welcomed the presentation and provided feedback, it was suggested that one possible workstream would be to support to use of Help Direct advisors in GP surgeries.

Joined up Support for Vulnerable Families (First Pregnancy)

Gail Porter, Project Director (Total Family), Lancashire County Council gave a presentation on the work of done on the Support for Vulnerable Families Intervention. Gail explained that there are a wide range of existing strategic commitments with specific action plans in place but highlighted a number of areas that the Intervention could seek to strengthen:

- Consistency of provision and supply of data across geographies varies.
- Awareness and use of established guidance.
- No shared definition of 'vulnerable family'.
- Individuals who do not access any midwifery or antenatal services.
- Progress with Health Visitor Implementation plan.
- Workforce development and engagement of Higher Education providers (HEIs).
- Intensive workstream to support developments in UH Morecambe Bay.

Gail also highlighted a number of "priority shifts" which could build and utilise the assets, skills and resources of our citizens and communities:

- reduce reliance on services;
- increase resilience of families;
- develop community capacity to support families.

Gail explained that another "priority shift" is to shift resources towards prevention and reduce demand on acute services:

- knowledge – who, where, how;
- Understanding – why;
- Delivery – targeted and coordinated;
- Sustainability - what works.

Gail also summarised the programme of work as follows:

Knowing	**Understanding**	**Delivering**	**Sustaining**
Improve the flow of data regarding early notification and live births	Health and social needs - strengthen the pathways for both.	Patient walkthrough using Working Together Family cohort	Role of specialist midwives versus mainstream role

Women who do not access midwifery services by 12 weeks – how many, where and why?	Coordination across (the many) existing programmes of work	Academic involvement to examine lead professional role	Community capacity building i.e. parenting champions
	Opportunities presented by the Health Visitor expansion programme		Academic institutions regarding future workforce planning requirements.

The Board welcomed the presentation and provided feedback.

Resolved: The Shadow Health and Wellbeing Board noted the presentations and it was agreed that further presentations of the remaining seven Interventions would be arranged as soon as possible.

6. Health and Wellbeing Strategy Narrative Draft

Habib Patel presented the report (circulated). The Board provided comments and feedback on the progress to date on the narrative and it was suggested that a small group be formed to review the narrative.

Resolved: The Shadow Health and Wellbeing Board noted the report and agreed to that a small group be formed to review the narrative.

7. Engagement Feedback and comments to date on Strategy

Habib Patel presented the report (circulated) on the Engagement Feedback and comments received to date on the Strategy.

Michael Wedgeworth, Third Sector Lancashire, was invited to comment on the work done by Third Sector Lancashire on collating responses from the Third Sector to the strategy.

Michael reported back on a number of suggested recommendations received from the Third Sector organisations (document circulated) which included addressing inequalities, need for clarity around the role of the Voluntary, Community and Faith Sectors within the Health and Wellbeing Strategy, the need for two way communication and other suggested recommendations.

Resolved: The Shadow Health and Wellbeing Board noted the report and presentation.

8. Role of the Shadow Health and Wellbeing Board in the authorisation of CCG Commissioning Plans

Dr Ann Bowman, Greater Preston Clinical Commissioning Group (CCG), presented the Commissioning Plan (circulated). Dr Bowman explained that the Plan had been written before the Health and Wellbeing Strategy so reference to the Health and Wellbeing Strategy will be included in future editions of the Plan.

Dr Bowman explained that the Shadow Health and Wellbeing Board will play a significant role in informing CCGs of health and social care need, working with CCGs to develop their strategic thinking and shape their developing plans for the future. The Shadow Health and Wellbeing Board plays a part in the authorisation process, key areas were highlighted as follows:

- Taking part in a 360 degree survey on each CCG within its footprint
- Receiving and commenting on the vision and key priorities of each CCG within its footprint.
- Working with CCGs, using refreshed JSNA ,to develop joint health and wellbeing strategy, to enable integrated commissioning where it is most useful on an on-going basis
- Ensuring that Quality, Innovation, Productivity and Prevent ion (QIPP)is integrated within all plans on an on-going basis

The key questions within the 360 degree survey that will be asked of the Shadow Health and Wellbeing Board were circulated at Appendix 2.
Vision and key Priorities of each of the six CCGs within Lancashire's Shadow Health and Wellbeing Board were circulated at Appendix 3.
A copy of Greater Preston's Clear and Credible Plan (CCP) was circulated at Appendix 4.

Resolved: The Shadow Health and Wellbeing Board noted the presentation and noted their role in the future authorisation of CCG Commissioning Plans.

9. Any Other Urgent Business

It was noted that with regard to the HealthWatch item discussed at the previous Board meeting that a contract had now been awarded to a provider. The timescales are to be determined between now and November of how HealthWatch will be implemented.

10. Programme of Meetings 2012 and Date of Next Meeting

The programme of meetings was noted and it was noted that the next Shadow Health and Wellbeing Board meeting would be held on 4 September 2012 at 2pm in the Rowan Room, Woodlands Conference Centre, Chorley.

Andy Milroy
Principal Executive Support Officer

Lancashire County Council
County Hall
Preston

'Working Together for Change'
Lancashire Health & Wellbeing Board Event Overview

Friday 16th November 2012
12.45pm to 4.00pm
Gujarat Centre, Preston

Aim of the event:

This facilitated event forms part of a wider communications plan, for the Lancashire Health & Wellbeing Board. The event is proposed to be a combination of:

1. Information giving - explaining the strategy to interested partners and stakeholders
2. Involvement - giving partners and stakeholders an opportunity to share how they can help to achieve the aims of the strategy and to deliver the interventions.

The emphasis is on giving attendees the opportunity to share ideas and discuss how they can help achieve the aims of the strategy and deliver the interventions. The focus is not a formal launch of the strategy but on how partners and stakeholders can begin to think how they can influence and recognise their own part to play in bring about the changes identified in the strategy.

Audience:

It is proposed to host an event for around 200 delegates made up of:

1. All respondents to the engagement process for the strategy
2. Wider public sector and VFC sector
3. Providers from across the statutory, third and independent sectors – including those providing health, care and wellbeing services
4. Elected Members – both district and county councillors
5. GP's / Primary Care Health Teams – to include dentists and pharmacists etc.
6. Citizens involved in delivering health and wellbeing interventions and those who use services.

Format of the event:

The half day event will begin with lunch giving delegates the chance to get to know each other and relax before the main session begins. The event will include speakers from the Health and Wellbeing Board and be facilitated by Ian Roberts from Greengage Consulting. Following a short presentation about the strategy and an overview of the interventions there will be facilitated group discussions on the ten interventions.

It is suggested that the room be set out 'cabaret style' then each table can give their reaction to the strategy, for example what do they like and what would they change or strengthen? A small panel of the members of the Board would be available to address comments from the tables through the facilitator. Then the discussion can move to the interventions.

It is proposed that the facilitated groups look at a common theme for the ten interventions, and from discussions with intervention leads it is proposed that this theme should be how community assets approaches can be used to deliver improvements to health and wellbeing.
.

The need to identify and develop community assets has been identified by all ten interventions, during planning and design work, to be integral to successfully delivering the priority shifts that the Health and Wellbeing Board wants to see. It is felt that this could be a productive and creative focus for the group sessions.

An initial agenda (speakers to be confirmed) is as follows:

13.30 – 13.45	Introduction
13.45 – 14.15	Presentation of the Strategy
14.15 – 14.30	Our 10 Interventions
14.30 – 14.45	Introduction to community assets approaches – case study
14.45 – 15.45	Group sessions
15.45 – 16.00	Feedback and Close

Follow up work:

In order to make the event as productive as possible it is proposed that delegates are contacted following the event with a list of resources that they may find useful – this could include highlighting other delegates they may it useful to engage with and develop work further or simply contacting them with a reminder about what they said they could do.

Recommendations:

The Health and Wellbeing Board are asked to discuss this proposal and advise on the draft format and content of the event.

Helen Clay & Louise Charnock
Lancashire Public Health network
24 August 2012

Clinical Commissioning Groups (CCG) – emerging priorities

Each CCG is expected to develop a “Clear and Credible” Plan (CCP), which is a three year plan outlining the CCGs vision, strategic direction and commissioning intentions. The CCGs need to integrate with wider planning arrangements such as local authority plans and health and well-being strategies.

Appendix 1 summarises the emerging priorities from the CCGs in Lancashire. These priorities have been taken from CCG websites and their recent consultations. However it must be noted that these are early iterations of the plans which will continue to be refined and developed as the CCGs mature as organisations.

The Health and Wellbeing Board will have an important role to play in advising partners who sit on the Board to provide the robust evidence on which to base their future commissioning priorities and to ensure that they align their priorities with the H&W Strategy.

Recommendation

The Health & Wellbeing Board is asked to note the emerging CCG priorities

CCG	Geographical coverage	Priorities	Population	Number of Practices	Commissioning Budget
EAST LANCASHIRE **CCG Lead officer & Contact Details:** Chairman - Dr Mike Ions	Burnley Pendle Hyndburn Rossendale Ribble Valley (excluding Longridge)	• acute (hospital) planned care • children and young people • mental health services • unplanned (urgent) care • community services • getting the best from medicines	371,073	63	£710 million
LANCASHIRE NORTH **CCG Lead officer & Contact Details:** Chairman – Dr Alex Gaw **Alex.Gaw@gp-Y01008.nhs.uk**	Lancaster and Garstang	Plans for first year, 2011/12 include: • Improvements to Urgent Care, with better integration of GP and Hospital services • Better community nursing support to avoid unnecessary hospital admissions, or help earlier discharge • Alcohol liaison services, to support patients who otherwise have frequent hospital admissions • Improvement of services for patients who have had a stroke • Improvement in rehabilitation services for patients with Chronic chest problems, to help keep them out of hospital • Design of a community cardiology service • Improvement of Cancer Services • More development of services for patient approaching the End of Life • Better consulted advice services to GPs	158,843	13	£183 million

CCG	Geographical coverage	Priorities	Population	Number of Practices	Commissioning Budget
		to reduce unnecessary hospital referrals • Introduction of a community dermatology service to offer patients more choice • Transfer of more diabetic care to GPs with Consultant support • Work with Lancashire Care Trust to redesign the local services for mental health patient			
GREATER PRESTON **CCG Lead officer & Contact Details:** Chairman – Dr Ann Bowman	Preston Longridge Parts of South Ribble including parts of Penwortham, Lostock Hall and Walton-le-Dale	**Improving quality** (by using evidence-based practice); and **Redesigning care pathways** (to reduce waste and improve productivity) Ten priority clinical areas for 2011-13: • Cancer • Cardiovascular disease • Community services • Dementia • Diabetes • End of life • Medicines management • Orthopaedics • Referral management • Urgent care	212,000	34	£202 million
CHORLEY & SOUTH RIBBLE **CCG Lead officer & Contact**	Chorley & South Ribble	**Improving quality** (by using evidence-based practice): and **redesigning care pathways** (to reduce waste and improve productivity). Seven priority clinical areas for 2011/13:	170,000	31	£196 million

CCG	Geographical coverage	Priorities	Population	Number of Practices	Commissioning Budget
Details: Chairman - Dr Gora Bangi		• Stroke and cardiovascular disease (CVD) • Alcohol • End of life care • Mental health • Dementia • Prescribing • Long term conditions Other key areas of work are: • Secondary care • Urgent care • Cancer • Community based care			
WEST LANCASHIRE **CCG Lead officer & Contact Details:** Chairman - Dr John Caine	Co-terminous with District Council	**Short term priorities (until June 2012)** • Stroke/TIA (Transient Ischaemic Attack - known as a mini stroke) • Heart failure • Dementia/Mental health (limited number of elements) • Trauma and orthopaedics • Diabetes • Dermatology **Medium term priorities – (until March 2013)** • Southport & Ormskirk NHS Hospitals Trust/Community Services – contracting and service pathway development and	111,848	23	£120 Million

CCG	Geographical coverage	Priorities	Population	Number of Practices	Commissioning Budget
		redesign • Urgent Care including utilisation of Walk in Centre and West Lancashire Health Centre (continued into longer term) • Sexual Health • Medicines Management • Referral Management • Admission Avoidance including elderly frail/care homes **Longer term priorities – additional to above – (5 year plan)** • Cancer • Lifestyle and risk taking behaviours • CVD (cardio vascular disease) • Respiratory health • End of life • Children's services – linked to LCC children's priorities and CAMHS (child and adolescent mental health services) • Other long term conditions			
FYLDE & WYRE **CCG Lead officer & Contact Details:** Chairman - Dr Tony Naughton	Fylde and Wyre excluding Garstang	1. **Supporting people with long-term health conditions**. This includes: • Developing a more socio-medical model of care (i.e. where social and environmental factors are considered as well as medical ones) • Reducing hospital admissions	251,707	21	£233 million

CCG	Geographical coverage	Priorities	Population	Number of Practices	Commissioning Budget
		• Reducing cancer deaths • Improving outcomes for people who have had a stroke • Improving diabetes services 2. **Preventing ill health**. This includes: • Ensuring a better start in life for children • Reducing the number of children who are obese • Reducing the number of mothers who smoke 3. **Delivering safe, quality services**. This includes: • Improving urgent care services • Providing better care at home and in the community for at-risk patients • Improving access to a GP • Ensuring equality of access and choice to patients undergoing planned procedures • Improving mental health and dementia services • Improving end of life care, with more choice and better information for patients and carers			

Lancashire Shadow Health and Wellbeing Board - Update on the Public Health Transition

From April 2013, responsibility for public health will transfer from the NHS to upper tier local authorities who will be funded by a ring-fenced public health grant to deliver a new duty to take steps to improve the health of the population.

An estimated baseline for the public health grant has been published by the Department of Health and is based on public health spending during 2010/11. The estimated baseline for Lancashire is just under £46 million which equates to £37 per person. This is the minimum guaranteed funding allocation that has been made to Lancashire. A number of adjustments have been made to the baseline and submitted to the Department of Health, however it is not yet clear whether these will result in a greater allocation for Lancashire. A needs-based allocation formula for the public health ring-fenced grant has been developed and consulted on. A number of local partners have responded to the consultation. A final allocation formula along with the actual allocations will be published in December 2012.

While local authority based public health services will be largely free to determine its own priorities and services, it will be required to provide the following mandatory services:

- Appropriate access to sexual health services
- NHS Health Check assessment
- Steps to protect the health of the population
- Weighing and measuring children for the National Child Measurement Programme, and
- Providing public health advice to NHS commissioners

In Lancashire, governance of the public health transition is provided by the Public Health Lancashire Steering Group which is chaired by Richard Jones and includes membership from the County Council, a District Council, NHS Lancashire, the Health Protection Agency and the Strategic Health Authority. The three Lancashire Directors of Public Health are key members of the steering group. A joint Public Health Transition plan has been developed and is being implemented. This includes action to deliver a safe transfer of public health into Lancashire County Council (and other organisations that will take on so some of the PCT public health responsibilities, e.g. Public Health England and the National Commissioning Board), as well as action that capitalises on the opportunities that the reforms provide to transform the way we deliver public health in Lancashire. The plan's objectives are:

1. To ensure effective public health leadership during the transition and beyond
2. To ensure the effective delivery of public health programmes through the transition and beyond
3. To co-design an integrated public health service within Lancashire County Council
4. To ensure the smooth transfer of NHS public health staff to Lancashire County Council
5. To develop and implement a Business Transfer Agreement to guide the transfer of public health responsibility to Lancashire County Council
6. To ensure the effective transfer of financial and physical assets from the NHS to Lancashire County Council

The Director of Public Health in the County Council will have chief officer status and will be an Executive Director reporting to the Chief Executive. NHS Lancashire and Lancashire County Council sought to recruit a county-wide Director of Public Health earlier in the year but did not appoint to the post. Additional leadership capacity for the public health transition has been secured from Aislinn O'Dwyer, an independent public health consultant. The recruitment to the three posts that will directly report to the Director of Public Health is currently underway.

Formal consultation took place earlier in the year on the functions of the local authority public health service. In order to enable the transfer of public health staff to Lancashire County Council, Aislinn O'Dwyer is currently leading work to re-shape the public health workforce to bring the three PCT teams into one. It is intended that a draft re-shaped structure be consulted on with staff for 30 days from mid September. It is also intended that engagement with important partners in public health such as the Clinical Commissioning Groups, District Councils, LCC directorates, Public Health England and the local area teams of the developing National Commissioning Board takes place at the same time to ensure that the local authority public health service is able to provide the necessary support to the wider public health system.

Debs Harkins, Head of the Joint Health Unit