Lancashire County Council

Lancashire Health and Wellbeing Board

Tuesday, 29th April, 2014 at 2.00 pm in Cabinet Room 'D' - The Henry Bolingbroke Room, County Hall, Preston

Agenda

Part 1 (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members of the Board are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Last Meeting.**	(Pages 1 - 6)
4.	**Better Care Fund for Lancashire**	(Pages 7 - 68)
5.	**Police Crime Commissioner Priorities and linkages with Health and Wellbeing** The Board will received a presentation in connection with the above.	(Pages 69 - 88)
6.	**Taking a Partnership Approach in Addressing Health Inequalities in Lancashire 2013 to 2020**	(Pages 89 - 92)
7.	**Contribution of the Third Sector in Health and Wellbeing**	(Pages 93 - 108)
8.	**Improving outcomes for children and young people with Special Educational Needs and Disabilities (SEND): implications for health services and local authorities implementing the Children and Families Act (SEN) 2014**	(Pages 109 - 120)
9.	**Pharmaceutical Needs Assessment**	(Pages 121 - 124)
10.	**Clinical Commissioning Group 5 year strategic plans**	(Pages 125 - 128)

Lancashire County Council

11. Urgent Business

An item of Urgent Business may only be considered under this heading where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading.

12. Date of Next Meeting

The next scheduled meeting of the Board will be held at 2pm on the 16th July 2014 in Cabinet Room 'C' – The Duke of Lancaster Room at County Hall, Preston.

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Tuesday, 28th January, 2014 at 2.00 pm in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

Chair

County Councillor A Ali, Cabinet Member for Health And Wellbeing (LCC)

Committee Members

County Councillor M Tomlinson, Cabinet Member for Children,Young People and Schools (LCC)
County Councillor D Whipp, Lancashire County Council
Dr A Bowman, Greater Preston Clinical Commissioning Group (CCG)
Dr S Karunanithi, Director of Public Health, Public Health Lancashire
Mr S Gross, Executive Director for Adult Services, Health and Wellbeing (LCC)
Ms L Taylor, Interim Executive Director for Children and Young People (LCC)
Dr S Frampton, West Lancashire Clinical Commissioning Group (CCG)
Dr P Benett, Fylde and Wyre Clinical Commissioning Group (CCG)
Dr M Ions, East Lancashire Clinical Commissioning Group (CCG)
Dr D Wrigley, Lancashire North Clinical Commissioning Group (CCG)
Mr R Jones, Director NHS England – Lancashire
Councillor J Cooper, Pennine Lancashire District Councils
Councillor B Hilton, Central Lancashire District Councils
Councillor C Little, Fylde Coast District Councils
Canon M Wedgeworth, Chair Third Sector Lancashire

1. Appointment of the Director of Public Health

Resolved: The appointment in October, 2013 of Dr Sakthi Karunanithi as the County Councils Director of Public Health and his consequent membership of the Board was noted.

2. Apologies

Apologies for absence were received from Dr G Bangi (Chorley and South Ribble CCG), Mrs G Stanley (Chairperson of Healthwatch) Mrs K Partington, - Chief Executive of Lancashire Teaching Hospitals Foundation Trust and Professor H Tierney-Moore, - Chief Executive of Lancashire Care Foundation Trust.

3. Disclosure of Pecuniary and Non-Pecuniary Interests

County Councillor Whipp declared a non pecuniary interest in connection with item 5 on the agenda as he was a member of Pendle Borough Council which had a statutory duty to provide funding via the Disabled Facilities Grant which would in the future be included within the Better Care Fund.

4. Minutes of the last Meeting.

Resolved: That the Minutes of the meeting held on the 15th October, 2014 are confirmed as an accurate record and signed by the Chair.

5. Better Care Fund Templates

Mr Mansfield, Chief Operating Officer from the East Lancashire CCG, gave a brief presentation regarding the background to the Better Care Fund, including the necessary governance arrangements and the timescales involved in considering and approving submissions to NHS England.

It was noted that for 2014/15 a further £214m would transfer from the NHS to adult social care in addition to the £859m transfer which was already planned. For 2015/16 the Better Care Fund was estimated as being £1.9bn and would comprise of £130m Carer's Break Funding, £300m CCG reablement funding, £354m capital funding (including £220m Disabled Facilities Grant) and £1.1bn of funding transferred from health to adult social care.

The Chair recognised the considerable amount of work which had been undertaken within a short timescale in order to prepare the templates presented in the report and invited the members of the Board to make comments on the templates so that they could be further developed ahead of the initial deadline for submission.

When considering the report members of the Board made the following general comments regarding the Better Care Fund (BCF).

- It was recognised that the BCF presented an opportunity to transform services and build a more integrated health and social care system which would be flexible and built around the needs of the individual.

- It was suggested that at present the BCF was focussed on acute hospitals and adults with serious medical conditions and in the future consideration would need to be given to both the wider population and the integration of wellbeing services.

- The Voluntary Community Faith Sector was recognised as having an important role in the delivery of services, through in the future such organisations would be faced with challenges and would need to be prepared to rationalise and find innovative ways of working.

- There was some concern regarding cross boundary working in those parts of the County where residents travelled outside Lancashire to a neighbouring authority in order to access health care. It was suggested that more work needed to be done to ensure there was effective communication and data sharing between CCGs and hospitals in those situations and that this should be reflected with the CCG templates.

- It was noted that some templates referred to the extended scope of the Disabled Facilities Grant in relation to aids and adaptations and it was suggested that consideration be given as to how the Grant would be distributed across Lancashire in order to ensure that District Councils received an appropriate level of funding.

- Several members of the Board acknowledged that the BCF did not represent new funding but was instead a reallocation of existing funding from acute health services to community services and that as a result great care would need to be taken to ensure that resources were used as efficiently and effectively as possible.

- It was suggested that care needed to be taken to ensure appropriate community services were in place so that there were no significant gaps in service provision following the transfer of funding from health services via the BCF.

- The need to ensure that GPs and other front line practitioners were fully engaged was discussed and it was noted that in each CCG new arrangements were being developed in conjunction with clinicians and representatives of other agencies. It was also recognised that increasingly GPs were signposting the public to other service providers and that this role would continue to develop in the future.

- A suggestion was made that consideration be given to the administration and governance of the BCF being resourced from within the Fund rather than by allocations from partners. It was noted that the Health and Wellbeing Board could consider possible additional funding beyond the national mandate and enhance the BCF or develop a separate Wellbeing Fund.

- Performance measurement was discussed and it was reported that in the future NHS England would want to negotiate with individual CCGs and the Health and Wellbeing Board in order to set targets that would be both realistic and achievable but also challenging.

The following additional comments were made in relation to the content of specific templates.

A. Greater Preston CCG and Chorley and South Ribble CCG

It was noted that a Clinical Senate had been established, with representatives from the two CCGs, Lancashire Teaching Hospital Foundation Trust, the Lancashire Care Foundation Trust and the County Council in order to develop collaborative working and risk sharing through effective partnership arrangements.

It was recognised that the value of community assets had initially been underestimated and that role of the VCFS in providing services which would help to keep people safe and well within their own homes would be vital in the future.

B. Lancashire North

It was reported that in March 2014 the CCG and Lancashire LINk would be holding a second event to explore how communication and engagement with partner organisations working in health and social care could be improved which would inform future developments.

With regard to the cross boundary issue it was reported that the CCG had developed a good relationship with providers in Cumbria.

C. West Lancashire

It was noted that whilst much of the content of the individual templates was similar in terms of what was to be delivered the West Lancashire CCG template was a good example of how information could he presented in a clear, easy to read format and it was suggested that each CCG look at the other templates in order to identify examples of best practice when finalising their 'first cut' templates.

D. Wyre and Fylde

An updated version of the CCG template was circulated at the meeting and it was suggested that the content be discussed further at the next Fylde and Wyre partnership in order that a 'first cut' template could be finalised ahead of the 14th February 2014 deadline.

E. East Lancashire

It was reported that as many people in East Lancashire travelled to Airedale Hospital in West Yorkshire for health care it was important to ensure there was effective communication and data sharing between the CCG and hospital. In response the Chair reported that he had been involved in a recent meeting with representatives from Airedale Hospital where this issue had been highlighted. It was also noted that the CCG was engaged in discussions with other agencies in Blackburn and Rochdale in relation to the improved integration of services.

It was recognised that IT systems used by different providers may not be compatible and so further work would need to be done in order to identify ways in which organisations could better integrate so that communications and data sharing can be improved.

Resolved:

1. That the comments of the Board as set out above be taken into account by the Clinical Commissioning Groups (CCGs) when finalising their 'first cut' templates.

2. That the content of the Fylde and Wyre CCG template be presented to the next meeting of the Fylde and Wyre Partnership for discussion in order that a 'first cut' template can be finalised.

3. That the Chair and Deputy Chair are given delegated authority to formally sign off the final versions of the 'first cut' templates from each CCG on behalf of the Board by the 14th February 2014 deadline and also in relation to any further amendments which may need to be made before the templates are submitted to NHS England by the 4th April 2014.

4. That an update regarding the submission of the templates be presented to the next meeting of the Board.

6. 2014/15 Programme of Meetings for the Board.

Resolved: That the following programme of meetings for the Board, as approved by the full County Council on 12th December, 2013 is noted, with all meetings to be held at 2.00pm in Cabinet Room C – The Duke of Lancaster Room at County Hall, Preston.

16th July 2014.
16th October 2014.
29th January 2015.
29th April 2015.

7. Urgent Business

There were no items of urgent business for discussion at the meeting.

8. Date of Next Meeting

It was noted that the next scheduled meeting of the Board would be held at 2.00pm on the 29th April, 2014 in Cabinet Room 'D' – the Henry Bollingbroke Room at County Hall, Preston.

I M Fisher
County Secretary and Solicitor

Lancashire County Council
County Hall
Preston

Lancashire health and Wellbeing Board
Meeting to be held on 29th April 2014

Electoral Division affected:
All

Lancashire Better Care Fund Plan
(Appendix A refers)

Contact for further information: Mike Banks, tel. 01772 536287, Adult Services, Health and Wellbeing Directorate. mike.banks@lancashire.gov.uk

Executive Summary

Increases in demand for health and social care services, an ageing population widening health and social inequalities, and financial constraints require transformational change for all agencies working in Lancashire to shift resources to where they will make the biggest positive difference.

The Government will introduce a £3.8 billion pooled budget for health and social care services, known as the Better Care Fund to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people. The Fund will largely not provide new money but require a pooling of existing resources to be managed under a section 75 agreement with individual Clinical Commissioning Groups (CCGs). The allocations denote the minimum contribution that CCGs and Local Authorities must contribute but more can be added over time to facilitate the required strategic shifts. The requirement to have a Better Care pooled fund is now being enshrined in legislation through the Care Bill.

In Lancashire the allocations for the Better Care Fund 2015/16 amount to £88.930m and include allocations for Disabled Facilities Grant, and some elements of the Care Bill implementation.

The Fund requires joint plans that focus on key high impact changes that will support sustainable integrated working and service delivery to shift activity away from the Acute Hospital sector to enhanced supports being available in the Community. At the same time emphasis should be on improving the health, capacity and resilience of individuals, families and communities to avoid or delay hospital admissions and long-term care. Importantly, plans will build on existing work streams across Lancashire, which already include changing the system for long term conditions and urgent care, with the aim of using the Fund to accelerate the transformational changes already being planned.

The Health & Wellbeing Board delegated responsibility of signing-off and submitting the plans to the Chair and Deputy Chair.

Lancashire County Council

Initially the Health & Wellbeing Board, via the Chair and Deputy Chair, submitted draft plans at CCG level which had been agreed by LCC and the CCGs to NHSE in accordance of our understanding of the submission requirements. These first drafts were submitted by the Health and Wellbeing Board (HWB) to NHS England on 14 February 2014. Since then it has been clarified that Lancashire County Council and its CCG partners are required to submit one plan which covers Lancashire. After close liaison with the CCGs, the CSU and LCC and through the Joint Officers Group (JOG) we submitted our Lancashire plan to NHSE on April 4th.

The Health & Wellbeing Board expects further dialogue with NHSE around areas within the BCF plans which are still to be fully agreed upon. These will include Section 75 agreements, risk sharing, hosting arrangements and performance management.

In 2014/15 additional funds will be allocated to promote integration and delivery of the national conditions.

Plans must deliver:

- Protection for social care services; this includes preventative services that may have otherwise had to be cut, but also by reducing on-going care costs via rehabilitation and reablement, use of community assets and reduction in the use of long term residential care.
- 7-day services to support discharge from hospital
- Data sharing and the use of the NHS number
- Joint assessments and lead professionals for people with complex needs

Approximately 25% pooled funds will be performance related and expected to deliver improvements in

- Reducing delayed transfers of care
- Reducing emergency admissions
- The effectiveness of reablement
- Reducing admissions to residential and nursing care
- Patient and service-user experience – national guidance awaited
- The impact of a locally determined performance outcome measure – this will focus on levels of diagnosis for dementia.

CCGs are required to submit 5-year strategic, operational & financial plans, with the first two years at an operational level of detail and the timing for the Better Care Fund is aligned with the CCG 2-year operational plans.

Recommendation

The Health & Wellbeing Board is asked to:

i) Note the BCF submission, which has been signed off by the Chair and Deputy Chair of the Health and Wellbeing Board.

ii) Note the potential performance and financial risks to partners and the approach being taken to mitigate those risks.

Background and Advice

The Better Care Fund (BCF) plan focuses on those high impact changes that will be delivered through integrated service delivery and sustainable shifts in activity from the Acute Hospitals to the care and health interventions and support being delivered in the community. These shifts are predicated on the need to provide comprehensive and accessible universal and targeted everyday supports to people in their neighbourhoods that tackle the wider determinants of health and well-being e.g. advice and information, housing, nutrition, loneliness etc.

The emphasis will continue to be on improving the capacity and resilience of individuals, carers and families to thrive in their communities, and where people have ill-health or disability for them to receive care and support that wherever possible helps them to manage their condition.

Existing work streams will continue and there is a real opportunity to use the Fund to accelerate the transformational changes already planned. The Fund includes specific allocations for carers and provides an opportunity to review the way services support carers in the major contribution they make, which reduces the impact on statutory services significantly.

The focus of the Better Care Fund plan is on integration which is consistent with direction and requirements of the Care Bill. At this stage the focus of the required plan is on frail elderly populations and those with long term conditions such as respiratory disease and dementia. Plans have to demonstrate that people with mental health problems have equal access to the reviewed services and support structures. In future years the Lancashire BCF plan will be developed to address specific areas of mental health, children's health, and drug and alcohol issues, (although it should be noted that work continues to address these areas through individual partner strategic plans).

Although the individual CCG plans that have been produced are clearly tailored to localities in terms of delivery, there are consistent themes around the way that we need to work in the future which has implications for how some of the functions of the council may need to be structured in the future.

The Lancashire plan provides the following narrative:

Increasingly localities or neighbourhoods will be identified around registered populations for a number of GP practices. Typically, this means natural communities of 35000-50000 people.

As part of the integration, wrap around support to promote the determinants of good health and well-being will need to be developed and strengthened around existing community assets. This will be delivered by the Integrated Health and Well-being

Framework being developed which will look to remodel current services and spend across Help direct, Supporting People, and VCFS etc. at a local level.

Those populations will be supported by neighbourhood teams, compromised of health and social care professionals with easy access to this everyday support for their health and well-being (predominantly asset based) and access to reablement and rehabilitative support as a first response to people not coping with their personal care.

Neighbourhood teams working with these populations will identify those most at risk of deterioration in their health and at risk of being admitted to hospital, or long-term residential care unnecessarily. They will help them manage their long term conditions and plan appropriate and flexible responses to crises or deterioration.

Teams will need to develop new roles, skills and trusted relationships that reduce duplication of assessment, allow speedy shared access to the support people in their neighbourhood/locality need and be able to pull in more specialist services as and when needed. Those people with the most complex needs and risks will have case managers or coordinators so that individuals, carers and families have a consistent and reliable point of contact. Teams will need to be skilled in clinical areas that will be carried out in the future outside of the hospital environment, to develop the virtual ward type supports available at home.

When people are in crisis there are coordinated and accessible services to maintain people in their own home wherever possible. Out of hours GPs, Emergency Departments and crisis services will be able to access people's information via web services so that they are aware of the support already in place, can make sure they respond in a way that respects people's wishes and is compliant with people's agreed contingency plans.

For those that do require admission, early planning and safe and integrated and streamlined discharge facilities will be available across 7 days so that people stay in hospital for the least amount of time necessary. People will not be required to make long term decisions about their future from a hospital bed but can be given access to rehabilitation/recuperation services from where the next steps can be planned.

For people with complex needs the neighbourhood team will "reach into" the hospital to coordinate the discharge as they will know the person well.

The neighbourhood teams will develop more integrated practices with social care providers in their neighbourhoods. This will mean that care homes and domiciliary providers will become extended members of the team and will have access to professional support to help people maintain their independence, avoid deterioration in their health and social circumstances and avoid unnecessary hospital admission.

The range of current initiatives and functions that support care homes will be coordinated and targeted to improve quality and help reduce the amount of activity escalated under safeguarding procedures.

Funds for Disabled Facilities Grants (DFGs) will be channelled through this BCF fund. This provides an opportunity through redesign with the district councils to ensure equity of access and secure the links between the provision of adaptations and maintaining people's independence. This support will contribute to the outcomes described below.

These integrated arrangements described in the BCF are meant to reduce the reliance on inpatient hospital care and achieve:

- A reduction in delayed transfers of care from hospital
- A reduction in emergency admissions
- The demonstrable effectiveness of reablement in reducing long term care costs
- A reduction in admissions to long term residential and nursing care
- Improved patient and service-user experience
- The impact of a locally determined performance outcome measure

Sign off of the Better Care Plan for Lancashire rests with the Health and Wellbeing Board Chair and Deputy Chair and was submitted by 4th April 2014 to NHS England.

In the 1st-cut submission, LCC and the CCGs had not yet agreed the performance metrics and targets. Since then, with help from the CSU and NHSE, partners have agreed which performance metrics we will use to help to measure progress and performance and we have also agreed targets for those metrics.
The plans themselves now include agreements on certain key performance indicators (metrics), targets for those metrics at a CCG level and Lancashire level and a draft performance management and governance framework. This framework describes how performance will be reported through the host organisation and will be managed by the Health & Wellbeing Board through JOG. The Board will receive regular performance updates – on an exceptions basis – and recommendations from JOG.

Understandably, given the embryonic nature of this complicated landscape, accountability of performance, risk sharing, Section 75 agreements and the hosting of the BCF are still to be agreed and further engagement with the affected stakeholders will continue until we reach agreement. We await guidance from NHSE but will continue to engage in anticipation.

Consultations

As part of the BCF planning processes at an individual CCG level and at a county level a wide range of consultation has been undertaken. This is described in the plan but includes Health and Wellbeing Board and Partnerships, Health and Social Care Providers, VCFS, Health Watch, CCG Governing Bodies, and Patient and carers forums.

Implications:

This item has the following implications, as indicated:

Financial

For each contributing organisation, the table below lists any spending on BCF schemes in 2014/15 and also identifies the minimum and actual contributions to the pooled budgets from 2015/16.

Organisation	**Spending on BCF schemes in 2014/15 £000**	**Minimum Contribution (2015/16) £000**	**Actual Contribution (2015/16) £000**
Lancashire County Council	5,541	9,438	9,438
NHS West Lancashire CCG		7,419	7,419
NHS Lancashire North CCG		10,462	10,462
NHS Greater Preston CCG		13,223	13,223
NHS Fylde and Wyre CCG		10,961	10,961
NHS East Lancashire CCG		26,095	26,095
NHS Chorley and South Ribble CCG		11,332	11,332
BCF Total	**5,541**	**88,930**	**88,930**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. The partners are required to outline plans for maintain services if planned improvements are not achieved.

The plan for Lancashire includes two main elements i.e. planning for the effect of the holding back of any proportion of the c25% of the BCF to be paid for improving outcomes itself and the potential dual-funding required if existing services need to be maintained at the same time as the investments made in new schemes and services. The partners have agreed to collaboratively develop measures to mitigate the financial impact of these risks. These measures may include:

- A formal risk-share agreement;

- An initial contingency reserve that could be utilised to part-maintain existing services;

- On-going detailed performance management and finance monitoring to enable decisions to be taken at the earliest opportunity to enable actions to be put in place quickly which will either reduce the financial impact of any under-delivery of planned improvements or enable a re-prioritisation of available resource into those areas which are having the most significant impact on performance.

Discussions with partners to date indicate that the above measures would be actioned under five separate section 75 pooled arrangements, one for each CCG (with Chorley and South Ribble CCGs combined), however, these pools would operate under a single Lancashire framework.

Additionally, partners have recognised that the wider context of considerable reductions in Local Government funding in the medium term has the potential to adversely affect the performance indicators upon which BCF performance payments are to be based. Also, the inclusion of the funding for some elements of the impact of the Care Bill in the BCF has the potential to put additional financial pressure on the pooled finances if the allocations for these impacts are not sufficient to meet the requirements. Partners will need to keep these issues under review, and agree mitigating actions as appropriate.

Risk management

In 2015/16 the Better Care Fund (BCF) will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and the Council. A condition of accessing the money in the Fund is that CCGs and Councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

The BCF is intended to provide a means for joint investment in integrated care, which ought to reduce the pressure on social care and hospitals by providing treatment before a crisis. CCGs will have to make significant efficiencies to generate the money to invest in the BCF, and there is a risk that if BCF plans do not deliver the anticipated results, e.g. reductions in residential care admissions or reductions in emergency hospital admissions. Resources will be needed to meet this excess demand, e.g. funding care packages or extra staff for A&E.

Approximately 29% of the revenue funding in the BCF is paid for improving outcomes. Plans for maintaining services will need to be outlined for the scenario where planned improvements are not achieved. The official BCF template will capture these contingency plans.

Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be coordinated by NHS England, with the support of the Local Government Association (LGA).

If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

In addition to meeting the conditions of the fund, and achievement of performance targets, the BCF includes NHS funding for carers' breaks therefore local plans are expected to set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement.

Legal

In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and councils.

Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local Government Act 2003. This will ensure that the DFG can be included in the Fund

Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

The Department of Health (DH) and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m nationally of which £3.073m relates to Lancashire) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

Personnel

The development of neighbourhood teams and wider workforce development will potentially change individual roles and responsibilities of some Lancashire County Council Employees. There is not yet a consistent view on how social work roles will relate to these teams and whether teams will be co-located or whether there will be integrated management arrangements. The requirement for hospital discharge to be facilitated over a seven day period will also require potential changes to working patterns and potentially terms and conditions.

Property Asset Management

The development of neighbourhood teams may mean that staff needs to be co-located with other professional groups.

Procurement

Changes in pathways and the range of out of hospital services will require ongoing commissioning and procurement activity.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
The Better care Fund for Lancashire templates 1 and 2	April 2014	Mike Banks, Adult Services, Health and Wellbeing Directorate 01772 536287

Reason for inclusion in Part II, if appropriate

N/A

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lancashire County Council**
Clinical Commissioning Groups	**Chorley & South Ribble**
	Greater Preston
	Lancashire North
	West Lancashire
	East Lancashire
	Fylde & Wyre
Lancashire Context	In terms of Local Authorities, Lancashire is made up of one County Council and 12 district councils (Lancashire 12). However, there are also 2 unitary authorities within the wider Lancashire area (Lancashire 14). These are Blackpool and Blackburn with Darwen. The 2011 Census usual resident population figure for PAN Lancashire represented an increase of 46,166 people or a population growth rate of 3.3% since the last census in 2001. That was well below the England and Wales increase of 7.8%. The usual resident population of the county council area was 1,171,339, an increase of 36,365 people or a population growth rate of 3.2%. In addition, it is recognised that the South Lancashire City Deal is looking

	to deliver 17,420 new homes between 2014/15 and 2023/24. It is likely that this will create large changes to population numbers. In the North West region, the population grew by 4.8% between 2001 and 2011 to 7.1 million. The English Indices of Deprivation 2010 was published in March 2010 by the Department for Communities and Local Government. The indices measures seven different aspects (or domains) of deprivation for lower level super output areas across England. Six district level summary measures are also produced. Burnley is the most deprived in Lancashire (12) with its ranking falling from 31st to 21st. The percentage of Lancashire LSOAs falling into the most deprived 10% in the country has increased from 15.5% to 17.4% (2007 to 2010). The percentage of Lancashire LSOAs falling into the most affluent 10% has increased, from 4.0% to 5.4% suggesting that the gap is widening between the most and least deprived areas. The average percentile of LSOAs in seven districts has worsened; the biggest deterioration being Chorley which has seen a 5.69% change for the worse between 2007 and 2010. Wyre has seen a corresponding 5.34% improvement. Lancashire (12) currently has approximately 469 residential and nursing care homes across the county. Nationally, BMC Health Services Research estimates an average of 544.5 days for permanent residential placements. In Lancashire during 2011/12, Residential length of stay had decreased by 8.7% from the previous year at a median number of days of 344. Nursing home stays decreased by 28.9% in the same period to 147 days. Lancashire source data includes all long term residents supported in permanent residential and nursing care aged 65+ at their admission date but excludes all self-funders.
Boundary Context for the Plan	The boundary issues are complex and are being managed by the use of component Better Care Fund Plans on a locality basis – aggregating up to the overall Plan. This is necessary because two thirds of the CCGs

	on the local authority footprint (4 out of 6) have significant patient flows/ demand and capacity drivers falling outside the area. These CCGs are therefore an integral part of 2 BCF footprints each, whilst only signatories formally to this one, despite the LCC footprint being the least significant strategically for these CCGs. Therefore it has been agreed locally between partners including the Local Area Team and Health and Wellbeing Board that locality BCF Plans would be developed. This decision was taken acknowledging the complex boundaries and 'natural' health and care footprints – which cross over into three other Better Care boundaries in a statistically significant way. This BCF submission is therefore an overarching plan that aggregates 6 local positions and 5 local plans (as two CCGs have agreed a joint planning footprint to reflect their strategic plans). Due to this complexity and the timescales, the Chair of the Health and Wellbeing Board has been given delegated authority by the Board to sign off the BCF submission. Further work will be carried out post submission to agree system roles and mechanisms, taking into account the Lancashire specifics.
Date agreed at Health and Well-Being Board:	**28 January 2014**
Date submitted:	**04/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£5,541,000**
2015/16	**£88,930,000**
Total agreed value of pooled budget: 2014/15	**£ 5,541,000**
2015/16	**88,930,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Chorley and South Ribble**
By	Jan Ledward
Position	Chief Officer
Date	2nd April 2014

Signed on behalf of the Clinical Commissioning Group	**Greater Preston**
By	Jan Ledward
Position	Chief Officer
Date	2nd April 2014
Signed on behalf of the Clinical Commissioning Group	**Lancashire North**
By	Andrew Bennett
Position	Chief Officer
Date	2nd April 2014
Signed on behalf of the Clinical Commissioning Group	**West Lancashire**
By	Mike Maguire
Position	Chief Officer
Date	2nd April 2014
Signed on behalf of the Clinical Commissioning Group	**East Lancashire**
By	Mike Ions
Position	Chief Clinical Officer
Date	2nd April 2014
Signed on behalf of the Clinical Commissioning Group	**Fylde and Wyre**
By	Tony Naughton
Position	Chief Clinical Officer
Date	2nd April 2014

Signed on behalf of the Council	Lancashire County Council
By	Steve Gross
Position	Executive Director Adult Services, Health and Wellbeing
Date	2nd April 2014

Signed on behalf of the Health and Wellbeing Board	Lancashire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	County Councillor A Ali
Date	2nd April 2014

c) Service provider engagement

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

There is a firm commitment to engagement to ensure the delivery of the Better Care Fund Plan for Lancashire. All commissioning partners across health and social care have worked together to develop this plan and sign off this version. Engagement with providers continues to take place at a number of tiers to ensure the

right conversations are taking place in the right way at the right time. Key to the success of this plan will be a combination of delivery on a locality footprint – and co-ordination and leadership across the County. This includes dialogue with neighbouring commissioners to understand and manage impacts on providers and flows of patients/service users. Key healthcare providers are engaged at locality level to ensure alignment of plans and a shared understanding of their impact – they include Blackpool Victoria Hospital NHS Foundation Trust; East Lancashire Hospitals NHS Foundation Trust; Lancashire Care Foundation Trust; Lancashire Teaching Hospitals NHS Foundation Trust; Southport and Ormskirk Acute Hospital NHS Trust; and University Hospitals of Morecambe Bay NHS Trust and Airedale NHS Foundation Trust.

Change programmes are in progress and are being supported through established consultancies such as KPMG (urgent care in Greater Preston/Chorley & South Ribble); Price Waterhouse Cooper (Better Care Together in Lancashire North); and Capita (urgent care for Pennine Lancashire). These programmes are identifying the required capacity and investment required for future provision that focuses on integrated care close to home.

Plans have been co-produced with partners, through workshops and planning events – with steer through local Health and Wellbeing Partnership arrangements.

It is recognised that further work will be required in the implementation process – both at locality and county level to build on the consultation to date and ensure the complexity of provider arrangements is taken into account. The Lancashire Leadership Forum through its developing Health and Care Strategy will provide an important resource in developing the enablers to integration and is developing approaches to wider public consultation through a series of "Big Conversions" around the future health and social care landscape.

Engagement to date has informed the development of the plan's priorities via consultation or on-going mechanisms as summarised below:

- Consultation with local providers on Urgent Care and neighbourhood working
- Discussion with Voluntary and Community Sector regarding models and priorities
- Views of service users and patients sought from forums and Healthwatch representatives
- Better Care Together is a key driver for developing a transformed health and Care economy for the Lancashire North area – this continues to engage a wide range of stakeholders across comprehensive work streams to ensure clinically led transformation change.
- Pennine Lancashire Integrated Care Delivery Group – with provider representation at a senior level
- East Lancashire Integrated Care Board – CVS and Healthwatch representation
- East Lancashire Development session for BCF held on 21st November 2013 – identification of priorities, visioning, delivery sequencing and resources
- Pennine Lancashire – Development of integrated care Stakeholder Event 8 January 2014 – including all local provider organisations across third and independent sector, housing, district councils – to share plans and receive feedback and shape plan for accelerated transformation

- East Lancashire commissioned NHS IQ to run a change programme relating to integrated neighbourhood teams, including providers of health and care services
- East Lancashire Community Assets/ Building Individual Resilience Steering Group
- Transfers of Care Programme and Project Group established hosted by Acute Provider with hub to provide integrated assessment and allocation
- Adult Social Care Service Provider Forum received an update in January 2014 on the Better Care Fund Plan with opportunity to comment and contribute
- Fylde & Wyre have established a BCF Engagement Group with a focus on impact and interdependencies with providers – monthly meetings scheduled in
- BCF features regularly at the Fylde Coast Commissioning Advisory Board and Unscheduled Care Board since August 2013
- Fylde Coast consultation on Health and Care Strategy 2030 included range of consultation with stakeholders including providers, third and independent sector – future service provision modelling has informed the BCF
- Fylde & Wyre CCG held Commissioning Intentions Events with representation from Healthwatch and third sector – these have informed planned changes
- Greater Preston / Chorley and South Ribble – District Council engagement in Work Stream Implementation and Steering Groups
- Greater Preston / Chorley and South Ribble Health and Wellbeing Partnership informed of progress and have a role to hold the statutory bodies to account
- VCFS and independent providers engaged in Greater Preston / Chorley South Ribble Workshops and Planning Events
- Providers involved in Urgent Care Review / High Impact Change Programme within Chorley and Preston
- Strong partnership approach in West Lancashire involving cross-boundary working with Southport and Formby and South Sefton CCGs and Sefton Council and the Integrated Care Organisation
- Care Closer to Home Programme in place in West Lancashire with a Programme Board overseeing provider engagement from both statutory and VCFS sectors
- Shared Programme Management Office covering the above Care Closer to Home work across West Lancashire, Southport and Formby and Sefton

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Engagement and empowerment are key values for all partners – and are reflected in both the approach taken to the development of this Plan and the commitment to future implementation.

Improving people's lives – working with people and enabling the changes that will make

the most difference – then testing and refining these in a continuous process of improvement – provides a framework for the implementation. (Informed by the 'Call to Action' and 'Commissioning for Prevention – 5 Steps' NHS England).

There are clear messages that we should deliver health and social care services in a way that involves the least possible disruption to people's lives and as close to home as possible. When people have to go to hospital, they want to be able to return home – and become as independent as possible again quickly. The continuity of a key professional – telling the story once and treating the person as expert are all common messages. We know delays in discharges or packages of care are distressing and detrimental to patients and their carers. This has promoted the principle that

"Everybody has a bed – it is in their own home"

The recognition and understanding of the need to engage with people affected by change – and enable people to make their own changes to their health and care – are reflected in the CCG's own Strategies and the Council's Commissioning Intentions.

The principles of Prevention and Self Care underpin the schemes and interventions that lie at the heart of this Better Care Fund Plan. Colleagues from Public Health have been closely involved at both a County and Locality level informing the 'policy' and evidence base for the wider determinants of health.

Engagement is being carried out by partners in their localities in line with the strategic footprints– this is an on-going process of patient, service user and public engagement.

Further detail of this can be found in the Locality Plans and will also be cross referenced in CCG 5 Year Plans. Highlights are given below:

- Views of service users and patients sought from Forums and Healthwatch
- The Better Care Together programme has carried out pre-consultation engagement work with residents, patients, clinicians, health professionals and key stakeholders to help ensure local views are at the centre of the review of services
- East Lancashire Development session for BCF held on 21st November 2013 – identification of priorities, visioning, delivery sequencing and resources
- Pennine Lancashire – development of integrated care – Stakeholder Event 8 January 2014 – including all local provider organisations across third and independent sector, housing, district councils – to share plans and receive feedback and shape plan for accelerated transformation
- East champions for the elderly to share plans for integration and out of hospital care – including a session on what a 'good outcome' looks like for residents
- East Lancashire are using the opportunity of the Patient Engagement DES to ask patients what quality of life means to them and what experiences are important – with findings informing integrated care and transformation programmes
- Pendle Health and Social Care Scrutiny Panel in relation to quality improvement in domiciliary and care home provision
- Fylde Coast consultation on Health and Care Strategy 2030 included focus groups with public, telephone based survey and events to inform prioritisation and choice

- Fylde & Wyre CCG held Commissioning Intentions Events with representation from Healthwatch and third sector – these have informed planned changes
- Engagement is a key feature of the development of the Fylde Coast Unscheduled Care Strategy – defining the foundations of the planned transformations
- CCGs have public and patient membership programmes –Fylde & Wyre are actively developing its Affiliate Scheme – with 840 members who receive regular updates on commissioning strategy
- Lancashire Carers Forum has received a summary of the Better Care Fund Plan for comment and feedback prior to submission
- Chorley and South Ribble & Greater Preston CCGs have held a series of engagement workshops including citizens, carers and expert patients based on principles of 'Working Together for Change' and 'I' statements
- Patient Forums and local partnerships in Chorley and South Ribble & Greater Preston regularly kept informed and asked for feedback
- Strong embedded engagement approach in West Lancashire involving cross-boundary working with Southport and Formby and South Sefton CCGs and Sefton Council and the Integrated Care Organisation
- Care Closer to Home Programme in place in West Lancashire with a Programme Board – extensive public, patient and clinical engagement carried out
- Patient stories developed and used from inauguration of West Lancashire CCG – part of the authorisation journey and refreshed and used by Executive regularly as part of strategic planning – included in the local BCF Plan to illustrate the difference that this will mean for the people living in different areas of the patch

, Carers and Public Event on 21 January – with health

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Lancashire Health and Wellbeing Strategy Health and Wellbeing Board Minutes	**http://www.lancashire.gov.uk/corporate/health/index.asp?siteid=6715&pageid=40272&e=e**
Lancashire County Council Commissioning Intentions	**Available on request**
Dementia Strategy	**There are three Joint Dementia Commissioning Strategies. One per former PCT footprint available on request.**
The 5 CCG level submissions which form	These have previously been submitted and latest versions are available on request from the appropriate CCG

part of the Lancashire submission.	
The 6 CCG 2 Year Operational Plans	These were being submitted as first drafts to the Local Area Team on Friday 14th February and demonstrate alignment within CCG localities to the Better Care Fund assumptions and activity implications.
CCG 5 Year Strategic Plans	These are in development – to be submitted as first drafts by 4 April 2014. They will reflect the strategic footprints agreed for Lancashire – which align across 3 separate Better Care Fund Plans.
Locality specific plans / reviews / strategies/ commissioning intentions	There are supporting plans, either existing or in development, underpinning delivery of the key material activities and developments in each locality area – these are referenced in each Locality Plan. The CCGs wish to outline their current performance in respect of the metrics and to identify the local targets for these metrics. These are included in the plan.
Lancashire Multi Agency Carers Strategy	Strategy 2013 – 2015 available on request
Lancashire JSNA	Available on request
Commissioning for Value CCG Packs	Published by NHS England
NHS England Planning Guidance 'Everybody Counts' and Various additional guidance documents and tools including Commissioning for Prevention; Call to Action; Transforming Participation; Outcome and Atlas Tools; Anytown Tool.	Available on NHS England website
CSU Lancashire Diagnostic to support emergent Health and Care Strategy / Collaborative Programme Development CSU Demographic and Activity Packs (Per CCG and Pan Lancashire)	Available on request

CSU QIPP Opportunity Packs (Per CCG and Pan Lancashire)	

VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Vision

The Lancashire Health and Wellbeing Strategy Vision is:

The Better Care Fund (BCF) plan focuses on those high impact changes that will be delivered through integrated service delivery and sustainable shifts in activity from the Acute Hospitals to the care and health interventions and support being delivered in the community. These shifts are predicated on the need to provide comprehensive and accessible universal supports to people in their neighbourhoods through asset based approaches that tackle the wider determinants of health and well-being, e.g. advice and information, housing, nutrition and loneliness.

The emphasis will continue to be on improving the capacity and resilience of individuals, carers, and families to thrive in their communities and where people have ill-health or

disability, for them to receive care and support that, wherever possible helps them to manage their condition and remain at home.

Existing work streams with CCGs and other partners will continue and there is a real opportunity to use the Fund to accelerate the transformational changes already planned. The Fund provides an opportunity to review the support to carers and families who are often pivotal to frail and disabled people remaining at home.

The focus is on integration is consistent with the direction and requirements of the Care Bill. At this stage the focus of the required plan is on frail elderly populations and those with long term conditions such as respiratory disease and dementia. Our plans demonstrate that people with mental health problems and other client groups have equal access to the reviewed services and support structures. Concepts of personalised planning and coordination will support this. In future years the Lancashire BCF plan will be developed to address specific areas of mental health, children's health, and drug and alcohol issues, (although it should be noted that work continues to address these areas through joint strategies at a Locality level).

Each Locality area has an individual vision that is meaningful to their population and needs – this is included in the Table within the Planned Changes section, which gives an excerpt of each local plan. There are of course consistent themes around the way that we need to work in the future which has implications for how some of the functions of the council will need to be structured in the future.

By 2018…

Localities or neighbourhoods will be identified around registered populations for a number of GP practices. Typically, this means natural communities of 25000 - 50000 people.

Wrap around support to promote the determinants of good health and well-being will be developed and strengthened around existing community assets. This will be delivered by the Integrated Health and Well-being Framework that is in development which will look to remodel current services and spend at both a local and county level. Local area coordination models will build the capacity of neighbourhoods to support their populations. This may include the development of dementia friendly environments and design, and support to people diagnosed with dementia from Dementia Friends and Advisors.

Those populations will be supported by neighbourhood teams, comprised of health and social care professionals. They will have access to a raft of universal support for health and wellbeing which is predominantly asset based. Where people are at risk or not coping, the teams will have direct access to interventions such as reablement and rehabilitative support. This will become the "preferred model" for people not coping with their personal or daily care.

Neighbourhood teams working with these populations will identify those most at risk of deterioration in their health and at risk of being admitted to hospital or long-term residential care unnecessarily. They will help people manage their long term conditions and co-produce appropriate and flexible responses to crises or deterioration.

Teams will have developed new roles, skills and established relationships that reduce duplication of assessment, allow speedy shared access to the support people in their neighbourhood/locality need and are able to pull in more specialist services (including access to mental health and psychological services) as and when needed. Those people with the most complex needs and risks have case managers or coordinators so that individuals, carers and families have a consistent and reliable point of contact.

Teams will be skilled in clinical areas that have traditionally been carried out in hospital environments, and intensive health supports will be available at home or in other nurse led facilities. Increasingly clinical teams will reach in and out of hospitals.

When people are in crisis there are coordinated and accessible services to maintain people in their own home wherever possible. Out of hours GPs, Emergency Departments and crisis services will be able to access people's information via web services so that they are aware of the support already in place, can make sure they respond in a way that respects people's wishes and is line with people's agreed contingency plans and preferred places of care.

For those that do require an admission, early planning and safe, integrated and streamlined discharge facilities will be available across 7 days so that people stay in hospital for the least amount of time necessary. People will not be required to make long term decisions about their future from a hospital bed but can be given access to rehabilitation/ recuperation services from where the next steps can be planned.

For people with complex needs, the neighbourhood team will "reach into" the hospital to coordinate the discharge as they will know the person well.

The neighbourhood teams will have developed more integrated practices with social care providers in their neighbourhoods. This will mean that care homes and domiciliary providers will become extended members of the team and will have access to professional support to help people maintain their independence, avoid deterioration in their health and social circumstances and avoid unnecessary hospital admission.

The range of current initiatives and functions that support care homes will be coordinated and targeted to improve quality and help reduce the amount of activity escalated under safeguarding procedures.

Funds for Disabled Facilities Grants (DFGs) will be channelled through this BCF. This provides an opportunity through redesign with the district councils to ensure equity of access and secure the links between the provision of adaptations and maintaining people's independence. This support will contribute to the outcomes described below.

These integrated arrangements described in the BCF will reduce the reliance and growth in inpatient hospital care and achieve the following outcomes;

- People will not face unnecessary delays in leaving hospital, and will not be required to make life changing decisions in those settings.
- People will have the opportunity, support and control to maintain, regain or improve how they manage their condition and daily lives in a way that helps them achieve their own goals.
- People will have access to teams and individuals that are familiar, communicate well

and help people navigate their way through the health and social care system.

- The everyday basics for good health and well-being are given equal importance to clinical interventions.
- People with complex needs will have real alternative support to long term residential and nursing care, through intensive packages of care, wrap around community supports and increasing choice in terms of extra care sheltered housing.
- Patients and service-users experience of our systems will improve

The Better Care Fund Plan provides the opportunity to accelerate and maximise locality models – ensuring that benefits of the 'at scale' approach are inputted across the whole system and risks are understood and mitigated in partnership. However, it is recognised that the BCF plan is a component part of the 5 year CCG strategic plans and without synchronisation cannot deliver required change.

Four of the six CCGs who are located in the area have significant strategic footprints that lie outside this Better Care Fund Plan – therefore these localities have to take into account two differing 'whole systems' with their own visions, roles and risks.

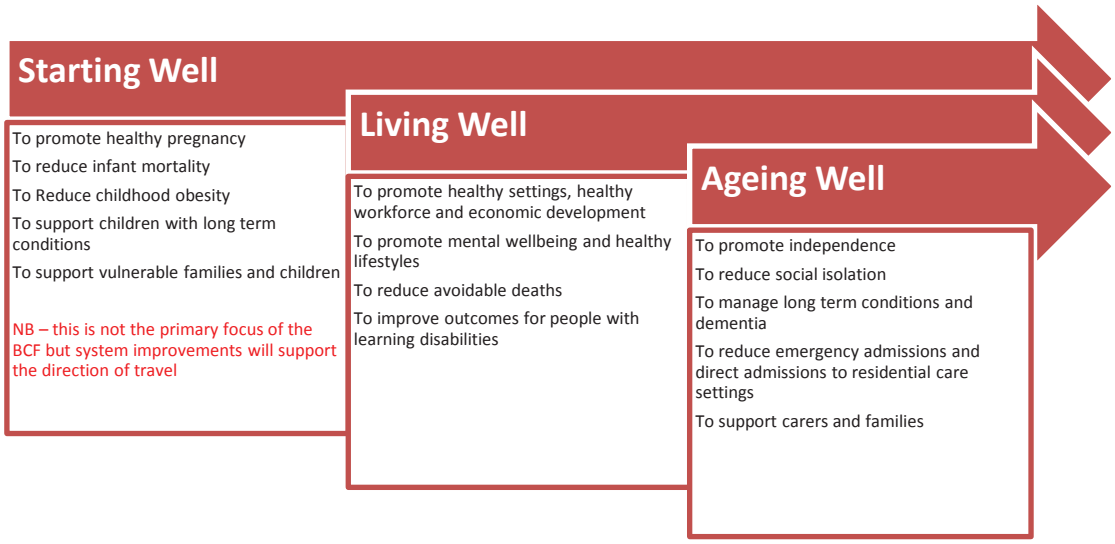
This complexity is mitigated with the use of the locality delivery plans which focus the strategic interventions at the levels that are most likely to succeed – addressing the realities of patient flows and capacity and demand management factors – whilst building a common approach to community infrastructure across the system.

Schemes

There is great commonality in schemes across the Health and Wellbeing area which build on the principles and objectives in the Health and Wellbeing Strategy and ensure that the overall strengthening of community and primary infrastructure is consistent in terms of direction and ambition. The implementation of these, determine success for everyone involved – and most importantly for the people who we will engage with on this journey – our residents and service users. A focus on wellbeing and increasing resiliencies is a shared principle reflected in all Locality Plans.

We will focus on the needs of residents using a whole life approach rather than simply on services. All partners are taking this person-centred approach and aim to create seamless, integrated services and pathways.

The Health & Wellbeing Board have, though the Health & Wellbeing Strategy agreed three overarching programmes of work as part of this whole-life approach. These are Starting Well, Living Well, Ageing Well.



There are shifts in both activity and investment that will be required to achieve the step change in outcomes – and these are planned into CCG and Council trajectories. Fundamental to this is the shift to care closer to home.

Scheme Plans – below is the summary of the plans that will be delivered and tracked in detail in Locality Delivery Plans – taking into account local population need, provider landscape and configurations, demand and capacity flows, outcome analysis and clinical modelling potentialities.

- There are phased plans in each area for integrated care – and these are demonstrated in the CCG 5 Year Strategic Plans on their 'Unit of Planning' footprints. For the Local Authority, integration of services is a key driver for the delivery of the Care Bill's ambitions. This will share the same ambition to deliver as many of its functions as possible at the locality level. Whilst the exact shape of this differs according to the local demography, economy and political factors – there is a common drive to strengthen community and neighbourhood infrastructure so the fundamentals are given priority in the promotion of good health and wellbeing. The deliverables and milestones for these will be tracked at the appropriate Locality level with the impacts on aggregated performance and wider transformation being overseen by the Health and Wellbeing Board.

- All partners have actions in place to improve early intervention and anticipate care needs – preventing the escalation of demand and deterioration of recovery and survival rates Partners are now able to stratify and identify those individuals "at risk" and target care planning and co-ordination to prevent further admissions and crises. The other side of this coin is also important – joining up the plans for post-acute episodes and reablement. This will be delivered as part of each Locality and CCG Plan.

- CCGs are taking forward wider primary care at scale and ensuring that GP Practices are involved in the commissioning of community services and enabled to

play a wider role in personalised care. The actions will be delivered in Locality plans – and include – clustering neighbourhood teams around practices; unifying assessment and case management processes, self-care models, identification of those at risk of admission and improved hand off management within defined care pathways, whole care payments and offers.

- We will invest significant resources in person-centred re-ablement and rehabilitation support, underpinned with home equipment and adaptations, designed to ensure that people can recover and recuperate from illness in their own homes.

- There are important levers for change across co-commissioners and Lancashire is strengthening its collaborative and transformational arrangements – to support the agenda for Specialised Services concentrated in Centres of Excellence.

- Similarly, the NHS requirements for step changes in the productivity of elective care will also have system benefits and encourage provider engagement in new and more innovative ways of working – both at a micro level in relation to patient care and at the macro level in adopting and diffusing new models of care.

- Access remains a key feature in the vision of the new infrastructure required to deliver these aims. We will create efficiencies by locating and providing the right service in the right place, at the right time. Equity will be delivered by universal convenient access. There are commissioner and provider plans to deliver 7 day working to support access to out of hospital care and improve (single or multiple) points of access. Within this will be a redesign of access points and systems for social care 24/7.

- The Better Care Fund Plan chimes with the Locality Strategic Plans – aiming to reduce inequalities by recognising the determinants rather than simply the effects of inequality and inequity. Each locality will have specific actions to identify their most vulnerable populations and target action to make health improvements. As part of the review of the Council's structures and resources, there is a will to identify and align spend on prevention and well-being to provide a coordinated and asset-based "wrap around" infrastructure for local communities and neighbourhoods in line with Marmot approaches.

- Similarly, this builds on Council Plans and Commissioning Intentions – to promote better quality of care in care homes and appropriate use of residential settings. Working in a more integrated way with NHS partners will maximise opportunities to provide support within residential settings – where these are the right place for that person. This will include work to improve safeguarding and the quality of interventions and crisis prevention – to reduce avoidable admissions.

- Parity of esteem will be assured – with plans addressing long term conditions and associated co-morbidities related to mental health and wellbeing. Again, this directly relates to the requirements in 5 Year plans to roll out psychological therapies, preventing crisis but ensuring services are geared up to respond sufficiently where necessary to both adults and children.

- All partners are gearing up more sophisticated – but nonetheless more usable –

capacity and demand trackers. This underpins not only the Better Care Fund Plan but system and individual plans for urgent and emergency care – and the necessary converse of this – community capacity. Actions in Locality Plans include improvements to allocation systems; demand monitoring and pressure warning systems, and capacity planning.

Enablers

There are also common enablers – key to the implementation will be a new approach to collaboration. Integration of care is a means by which we can co-ordinate around the needs of the individuals in our communities – to better meet these needs – which will reduce 'failure demand'; readmissions and inappropriate use of services.

There are community assets available across health and care which can be better utilised as part of the shared vision and integrated in the developing infrastructure towards a common goal. Asset Based Community Development (ABCD) is part of Lancashire's approach to building resilience by placing communities at the heart of decision making processes and strengthening community connections. This is also a design approach which will be used to ensure synergy with Better Care Fund Plan developments.

Lancashire County Council and the CCGs continue to work with the district councils to further develop the delivery of a comprehensive range of aids and adaptations, utilising disabled facility grants and other funding to support independence and improve outcomes for service users. There is a commitment to work in accordance with the Annex to the NHS England Planning Guidance, delegating the indicative minimum district budget allocations (as published by the DCLG for 2015/16), to support delivery of the statutory duty of the strategic housing authorities in relation to adaptations for the disabled. There is a recognition and a commitment from all partners to work together to further improve integration and co-ordination of services which promote independence and equity, enhancing outcomes for customers and maximising value for money. There is also a commitment at a pragmatic level to work together to support delivery. Lancashire County Council and the CCGs continue to work with the district councils on key areas of responsibility across the bodies – for example to further develop the delivery of a comprehensive range of aids and adaptations, utilising disabled facility grants and other funding to support independence and improve outcomes for service users. Chief Executives of the District Council have agreed that this programme of work will be delivered through the Joint Officers Group (JOG) of the Health and Well-being Board

Traditional workforce roles are no longer sufficient to deliver a new system of health and social care, with its greater emphasis integration, community and prevention. Any system for service redesign should be aligned with workforce planning and the systematic development of a competent and flexible workforce. Health Education North West, the organisation responsible for commissioning the Education and Training of all healthcare and public health staff, has brought together its functions to support an integrated approach to education commissioning and workforce development, including piloting a single unified system for collating workforce data across health and social care. There is Regional agreement to support investment in an integrated health and social care workforce.

On a practical level, partners are identifying that support is required in changing some of our cultures, e.g. in working in community settings rather than hospital, our approach to risk and positive risk taking, person-centred approaches including safeguarding and effective case coordination etc. This is being fed into the work being led by the Lancashire Leadership Forum.

At a local level, organisations, including education providers, research bodies, Clinical Networks and Senate, AHSNs, Public Health, Observatories and Early Warning Systems – will need to work together to horizon scan, adapt and support sustainable change.

Partners are also progressing IT and Technology initiatives and digital strategies that will enable change across multiple organisations – with further work to develop data sharing and infrastructure, use of technology for e.g. email and text and Skype to overcome unnecessary delays in the system, provide viable alternatives to face to face appointments and sharing of patient information to facilitate joint care.

The Better Care Fund Plan is being developed in a challenging and emergent context – it will take hard work to become more agile and collaborative – and the outcomes will be greater for being hard earned. The first year will test and stretch the new relationships being forged on a never-tried-before footprint for this area. All partners are striving to understand and assimilate the conditions, requirements and critical success factors in this new context and therefore it is expected that whilst the mechanics of system working will need to be built over the year – the vision expressed above will provide the anchor for this innovative approach in Lancashire.

b) Aims and objectives

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

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

We aim to achieve:

- **System Transformation** – includes cultural shifts, asset management, third sector stimulation, co-production and testing models of care such as the Extensivist approach which is already being considered in parts of County. (Actions included in more detail in Locality Plans).

- **Integration** – all areas have schemes and actions to progress the greater integration of care; neighbourhood working; wider primary care at scale; case management and risk stratification.

- **Strengthened community infrastructure and asset base** – beginning with the assumption that the best bed is our own bed – and facilities and services are built around this premise based on matching expertise to need – from local service level all the way up to Specialised services in Centres of Excellence. Tackling the triggers that can tip people into care – loneliness, poor nutrition, isolation.

- **High Quality, Safe Urgent and Emergency Care** – in the context of the shifts above – care that is appropriately delivered in this specialist setting with the best practice in admission and discharge planning and compassionate care as standard.

- **Greater co-ordination and unification of the assessment and care planning** processes for all patients – and across condition boundaries such as physical and mental health – allocation of care co-ordinators and lead professionals according to needs rather than rotas to promote best practitioner led interventions.

- **A focus on frail elderly populations or those with long-term conditions** – with schemes at each local level taking forward targeted care for people at risk. In future years there will be increased focus on people with **mental health** problems and **dementia**.

- Ways of working that promote the necessary **empowerment for self-care** and real involvement in decision making – about our own care – and about our services. Commissioners and providers need to make cultural shifts to enable these behaviours to become part of the health and care infrastructure.

- **Capacity and demand planning** – all CCG Plans for the next 5 Years include more real time tracking and commissioning of capacity in response to a more granular knowledge of demand.

Performance Management:
We will robustly performance manage the work of the BCF.

It is anticipated that we will report and manage performance through the Health & Wellbeing Board, through local partnerships and through individual stakeholders own organisational management. We will do this though analysis of the following areas:

- Metrics
- Progress of aims, objectives, schemes and actions
- Risk
- Financial management
- Issues management

As part of the performance management framework and aligned to the fact that we intend to have 5 separate Section 75 Agreements, we will further manage performance though 5 performance boards – one for each S75. These boards will sit below the Health & Wellbeing Board and Joint Officer Group (JOG) but will meet more often that the Board and the JOG. They will manage performance in a timely manner and will feed into the JOG and Board.

This process will evolve to remain fit for purpose.

Please see Section on Governance for diagrammatic representation of Framework for Governance and Performance, based on Health and Wellbeing Structure.

To ensure that we were able to agree robust SMART targets for the metrics at a Lancashire level, we have agreed targets at CCG level and used these smaller geographical area targets to inform the Lancashire level targets. This is critical to ensure both accountability within and across the system – and to enable the sharing of good practice, remedial support to areas where delivery is not as expected and further modelling/ impact analysis and adaption of schemes as a continuous loop. The targets are detailed below:

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /rehabilitation services

2013/14 actual denominators used, but 2013/14 numerators not yet known	***2014/15 target*** *Those who are at home or in extra care housing 91 days after the date of their discharge from hospital*	**2014/15 denominator** Those discharged with a clear intention that they will move on/back to their own home (using 2013/14 value)	**2014/15 outcome** Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	% num	% denom
CCGs	Numerator	Denominator	Metric value	% num	% denom
Lancashire North	98	119	82.0%	21.0%	21.0%
West Lancashire	34	42	82.0%	7.4%	7.4%
Fylde & Wyre	82	100	82.0%	17.7%	17.7%
Greater Preston	55	67	82.0%	11.8%	11.8%
East Lancashire	116	141	82.0%	24.9%	24.9%
Chorley & South Ribble	80	97	82.0%	17.1%	17.1%
County	**464**	**566**	**82.0%**	100.0%	100.0 %

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

Potential Targets for 2014-15					
CCGs	Denominator 2014 projected population	Numerator Target of 1939 admissions	Metric value calculated for 1939 numerator	2012/13 Metric value	% change 2012/13 to 2014/15
Lancashire North	27512	232	843.7	880.3	-4.2%
West Lancashire	23260	160	688.2	728.3	-5.5%
Fylde & Wyre	48819	348	713.2	745.9	-4.4%
Greater Preston	20345	204	1003.2	1031.1	-2.7%
East Lancashire	70557	633	897.6	951.9	-5.7%
Chorley & South Ribble	42574	361	848.4	907.6	-6.5%
County	**233067**	**1939**	**831.9**	**876.8**	**-5.1%**

Delayed transfers of care from hospital per 100,000 population (average per month)

Baseline

Metric value		255.6
Numerator	Average monthly proposed to be used for the BCF plan submission rolling 12 months dec'12-nov'13	2,400
Denominator		939,134

Performance under-pinning April 2015 payment

Metric value		243.6
Numerator	Calculated minimum using the bcf-read-reckoner	2,300
Denominator		944,096

Performance under-pinning October 2015 payment

Metric value		243.7
Numerator	Calculated minimum using the bcf-read-reckoner	2,313
Denominator		949,260

Population Proportioned Split	Numerator	Effective proportioned population
East Lancashire CCG	737.93	288,758
Chorley & South Ribble CCG	360.18	140,941
Fylde and Wyre CCG	309.66	121,171
West Lancashire CCG	224.17	87,720
Lancashire North CCG	338.53	132,469
Greater Preston CCG	429.52	168,076

Avoidable emergency admissions (composite measure)

Baseline

Metric value	208.2
Numerator	29573
Denominator	1,183,764

Performance under-pinning April 2015 payment

Metric value	190.3
Numerator	13586
Denominator	1,189,735

Performance under-pinning October 2015 payment

Metric value	217.4
Numerator	15955
Denominator	1,195,652

Population Proportioned Split	Metric (rate per 100,000 month)	Effective proportioned population
East Lancashire CCG	228	372110
Chorley & South Ribble CCG	158	177632
Fylde and Wyre CCG	137	148476
West Lancashire CCG	208	110105
Lancashire North CCG	191	162625
Greater Preston CCG	179	212816

Estimated diagnosis rate for people with dementia.

CCG Code	CCG Name	Sum of Dementia Register (QoF 12/13)	Estimated cases (number)*	Difference between QoF12/13 register and estimated cases	% Diagnosed	Target Numerator to achieve March' 15 67% target	Register increase required
00X	NHS CHORLEY AND SOUTH RIBBLE CCG	1,050	1949	899	54%	1306	256
01A	NHS EAST LANCASHIRE CCG	2,197	4129	1,932	53%	2766	569
02M	NHS FYLDE & WYRE CCG	1,251	2644	1,393	47%	1771	520
01E	NHS GREATER PRESTON CCG	1,169	2239	1,070	52%	1500	331
01K	NHS LANCASHIRE NORTH CCG	1,189	2037	848	58%	1365	176
02G	NHS WEST LANCASHIRE CCG	748	1325	577	56%	888	140
Lancashire		**7,604**	**14323**	**6,719**	**53%**	**9596**	**1992**

Further discussions are required during the year – to ensure that this new system builds the most effective and efficient way of working together – without introducing new layers of complexity and bureaucracy. The partners share a goal to be the change they wish to see in the world – the most productive and agile partnership possible.

Linked to this will be further discussions on Risk Management and Sharing Framework.

The Locality Plans are clear about how success will be measured and how delivery will be assured on their own footprints. There is now a careful dialogue and set of agreements to be achieved to understand and build the right at scale accountability and assurance for success.

The Health and Wellbeing Board is a ‘constant’ in this emergent partnership – and there is a Joint Officers Group, attended at a senior level by all partners – working on the detail and impacts of transformation and implementation.

All partners are committed to the partnership agreement and use of the Section 75 to maximise the opportunities and use of resources for better care.

The Clinical Senates will also be an important touchstone in relation to the changing clinical models and assurance on safe, sustainable service change.

Within the fund are allocations for implementation of the Care Bill of which the move to the Safeguarding Board having a statutory footing is included. The Safeguarding Board is reviewing its arrangements to monitor and quality assure through individual agencies the provision across Lancashire. They will continue to review the progress on quality improvement the integration plans afford through local RADAR arrangements, and monitor the frequency and severity of future safeguarding concerns.

c) Description of planned changes

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

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

Strategic Review to Identify Planned Changes

The priorities for planned changes echo the 'schemes' noted in the previous section and the 'aims' above. These have been identified following review at both Locality and Whole System level of the key areas for improvement. This has included:

- Consideration of the impact of demographic, social and economic changes in each area and the whole footprint – as per the Joint Strategic Needs Assessment and local strategic reviews carried out by both CCGs for their planning purposes and Council as part of local intelligence and profiling

- Analysis of health outcomes – use of Outcomes Tools; NHS Atlas tools providing spend versus outcome intelligence; Analysis packs provided by the CSU on Demographic & Activity Trends and QIPP opportunities

- A Pan-Lancashire Diagnostic carried out in 2013 to identify the key areas of health opportunity – this was also later triangulated with the NHSE Commissioning for Value Packs

- Modelling work which has been carried out in several Locality areas and is informing the shaping of models and interventions in more detail (including use of the Anytown Tool and other datasets including Primary Care / Referral / Capacity and Demand flows). This work will continue as part of the continuous planning cycle.
- Application and assimilation of National Direction and Thought Leadership / Best Practice and Benchmarking guidance – such as the Urgent and Emergency Care Phase 1 Report; Commissioning for Prevention; Parity of Esteem, NAO High Impact Interventions, Think Tank / Academic research eg. Kings Fund/ HSMC

There is an obvious system challenge and an undeniable case for change which emerges from the review of the above – the planned changes to meet this challenge as described here and in Template 2 of this submission are split into **Lancashire wide themes** below – and Locality specific actions which follow:

Admission avoidance by:

- Increasing access and availability of step up & crisis support via points of access
- Increased capacity and responses of integrated community services wrapped around primary care
- Re-design of Emergency Department "front doors", that offer supportive alternatives to accident and emergency
- Better self-management of long-term conditions/ambulatory case sensitive conditions with the offer of accessible alternative responses to crises over 7 days. We will maximise the opportunities for people to control flexibly their support through health and social care individual budgets
- enhanced re-ablement and rehabilitation services to support care at home and avoid admissions/re-admissions
- Targeted work with ambulance pathways, care homes, alcohol interventions
- Wrap around services from District Councils and Well-being services, sometimes known as Local Area Coordination that tackle the triggers that can result in admissions; loneliness, poverty, falls, poor nutrition , mental well-being etc.
- More consistent, better quality zoned home care that can work closely with the neighbourhood teams to support individuals in their own homes
- Helping people to plan their end of life care to make sure the important things to them are addressed and are accessible to key professionals and mortality in hospitals is reduced / people dying in usual residence is increased

Reduced length of hospital stays / delayed discharges / transfers of care by:

- Improved patient flows, reduced waiting and duplication of assessment
- Increased multi-professional access to intermediate/short-term social care
- Integrated 7 day discharge with accessible shared plans around NHS number
- Complex discharges managed by neighbourhood teams that know the patient
- Reducing readmissions by improving quality of interventions at point of delivery

Reduced reliance on long-term domiciliary and residential care:

- Support for carers in line with the Lancashire Multi-agency carers strategy
- Expansion and mainstreaming of reablement responses to maximise people's independence, confidence and resilience
- Moving the assessment function for complex cases out of acute hospital settings to recovery, rehab and recuperation environments.
- Enhanced equipment and adaptations
- Addressing continuity and quality of care by recommissioning and zoning of domiciliary home care and integrated working with providers
- Consideration of housing need alongside other factors and as part of hospital discharge planning and work with housing associations and councils
- The growth of extra-care sheltered housing as a viable and sustainable alternative

Key Actions by Locality (Further detail on Delivery including Timescales and Mechanisms – in Locality Plans).

West Lancashire

The vision for health and social care services for the West Lancashire local community is allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, **citizen**/ patient centred, accessible and seamless services.

The case for change and vision for true integration is well understood in West Lancashire and illustrated through patient stories (contained in the Locality Plan). "I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me".

The Care Closer to Home programme, which aligns both commissioner and provider priorities for whole system transformation, is a cross boundary partnership with a broad range of partners and agencies including Southport and Formby CCG, Southport and Ormskirk Integrated Care Organisation (ICO) and Lancashire County Council. Building on an existing strong foundation, the Better Care Fund will serve as an accelerator to this strategic programme which has true integration at its core.

From a governance perspective, the Care Closer to Home Programme Board sits underneath the Strategic Partnership Board for both the West Lancashire and Southport and Formby areas. A Primary Care Transformation Group and Redesign / New Ways of Working Group oversee the various workstreams and projects underneath this and are supported by the Programme Management Offices (PMO) from the respective organisations working collaboratively to ensure delivery. The BCF actions will similarly be incorporated into this existing structure to ensure progress on shared ambitions. Local Health and Wellbeing Partnerships will be host to strategic planning forums – enabling both the 'hard' governance and 'soft', but equally important, continuous dialogue.

Inextricably linked to the work of Care Closer to Home, the BCF will be used to further progress the West Lancashire Neighbourhood Team model and associated enablers which include workforce, IT, public health and wellbeing, self-care and community assets, amongst others.

Areas of focus to achieve the vision for system wide transformation:

- Further development of 5 local neighbourhood teams wrapped around clusters of GP practices.
- This model will provide effective local area co-ordination and use of VCFS capacity, which is a particular strength in West Lancashire
- A shift in culture, behaviour, practice, spend and activity to ensure sustained reductions in acute admissions, length of stay, readmissions within 30 days, readmissions within 6 months and reduced episodes of end of life in acute settings, which will result in a reduction in acute hospital beds by 2018
- Co-production of services and support across the community through the whole spectrum of needs – through an inclusive planning process and commissioning that utilises resources to address demographic needs and requirements.

- Every person who requires ongoing support post an acute admission or crisis in their life will have a core personal profile that will be visible across acute and community clinicians – a nucleus live document to inform joint health and social assessment and planning
- Implementation of the West Lancashire IT strategy which has clear linkages to BCF, Care Closer to Home and the West Lancashire Primary Care Transformation Plan and is a key enabler.
- Completion of detailed planning including a review of all existing arrangements and services including Section 256, Psychiatric Core 24 Services and Safeguarding – followed by re-procurement as necessary to implement concepts developed during co-design and preparation of specifications / plans for Joint Commissioning.
- Management of implementation and benefits tracking of newly integrated services and develop next tranche of commissioning plans in line with local needs and overall transformation programme from April 2015.
- Implementation of new models of care at scale from April 2015 based on learning and testing from Year 1.
- Investment in priority areas including 7 Day Social Care Provision in Hospitals, 7 Day GP Access, Personalised Health and Care Budgets and Reablement to deliver the new joint approach to Community Independence.
- Transition resources into the new models – with a key milestone to finalise actual budgets for implementation from April 2015.
- Continued close alignment with neighbouring CCGs and the ICO in co-designing approaches, sharing learning and mitigating provider impact.
- Use of 'Working Together for Change' to check the experience of citizens, patients, clinicians and practitioners with reference to 'I' Statements

By 2018 – fully integrated seven day services across acute and community services together with specialist assessment / parity of esteem for people with mental health problems, dementia and other complex needs. By offering time and opportunity to people, we will enable people to recover, recuperate and maximise their life opportunities through person centred reablement, planning and support. "Everyone has a bed – it is in their own home".

Lancashire North

The vision for this area is that the population of Lancashire North will receive the right care, in the right place, at the right time that promotes faster recovery from illness and enables people to live as independent and productive a life as possible within their local community. This will be delivered through person centred integrated services that follow clear pathways of care that have a single point of access, supported by compatible connected information technology.

The aim of an integrated system is to deliver positive outcomes for individuals as close to home as possible, responding to changing needs of the local population by encouraging greater ownership of care. Long term sustainability will be developed through more seamless person centred services embedded in the community.

The CCG and its predecessor have a long history of working and commissioning together to integrate health and care – and the current Strategic Programme for developing a transformed health and care economy for the Lancashire North area is called 'Better Care Together'. This strategy straddles the UHMB and, as such, overlaps with Cumbria County Council as a unit of planning.

This involves the commissioners – Lancashire North CCG, Cumbria CCG, NHS England and Lancashire County Council – working with providers including GP Practices, North West Ambulance, University Hospitals Morecambe Bay NHS Foundation Trust and Blackpool Hospitals NHS Foundation Trust. The work is supported by a Clinical Reference Group.

The Locality Plan gives further detail and case studies of successful joint commissioning – which this plan builds on – including the REACT Team – a multi-professional integrated team and the IST (Intermediate Support Team) for people with Dementia. Lancashire North have been able to stabilise non-elective admissions due to these interventions and support end of life care. However, there have been quality of services issues identified in local providers and significant work already underway to develop future models of provision which address these challenges.

Building on this strong foundation – the partners will use the Better Care Together programme to develop, redesign and transform existing services. There will be a focus initially on the frail elderly and carers.

- Development of single point of access for the transitional care pathway (Step up/ Step Down)
- Reablement and community beds offering rehabilitation and recuperation with therapy and support workers
- An integrated case management approach
- Utilisation of risk stratification and self-care within natural communities based around GP Practice lists, underpinned by case finding and an assets based approach to community development (including Lancaster District HWB Partnership)
- Pathways offering alternatives to hospital admission with community rehabilitation

from minimal to maximal input

- Multi-disciplinary Rapid Response Service in A&E and MAUs to triage and avoid admission
- End of life care and mental health capacity within the Transitional Pathway building on current provision and integration of elderly mental health services already underway
- Increased liaison between health and care commissioners in relation to care home provision, recommissioning and zoning of domiciliary care and extended hours domiciliary care response service
- Continuing to work across partners including the District and Country Councils to further integrate, co-ordinate and develop the range of aids and adaptations using Disabled Facility Grants and other funding to enable independent living
- Joint investment in Telecare to ensure it is funded for growth and health and care staff are fully deploying its potential
- Commitment to the Lancashire Carers Strategy and agreed areas of work (assessments; breaks; wellbeing; information)

There are 14 specific actions identified against the BCF Fund – with milestones and expected benefits (in Locality Plan in detail):

1. Fully implement alcohol liaison service – by April 2014
2. Fully embed Falls Service – April 2014
3. Fully embed Early Supported Discharge and Community Stroke Rehabilitation Service – June 2014
4. Commission Care Homes Support Team – June 2014
5. Review all Urgent, Emergency and Supportive services to assess 7 Day availability and draw up future plans – June 2014
6. Improved Case Finding and realignment where necessary of Long Term Condition teams – December 2014
7. Review services for Carers and develop programme of improvement – December 2014
8. Implement actions from review of Transitional Care OAMH/ Dementia Pathway – April 2015
9. Develop and embed frail elderly pathway within acute trust to link with Transitional Pathway – April 2015
10. Re-commission Community Equipment Services – June 2015
11. Review all equipment and aids and adaptations provision to ensure smooth pathway – June 2015
12. Increase Reablement capacity as primary offer prior to long term care package – September 2015
13. Review access to, throughflow and usage of recuperation and rehabilitation beds and recommission – September 2015
14. Develop plans for integrated bed and community based rehabilitation services – December 2015

There will be joint governance and commissioning arrangements and a Programme Management approach with links to Monitor and NHS England – to report in context of severely challenging financial issues for UHMB – the Programme itself is at Strategic Outline Case stage and contains details of expected changes and impacts. The BCF will deliver a sub-set of this programme.

Fylde & Wyre

The vision is that the population of Fylde and Wyre will receive the right care, in the right place, at the right time that promotes self-care and faster recovery from illness enabling people to live as independent and productive a life as possible within their local community.

The aim of an integrated system is to deliver positive outcomes for individuals as close to home as possible, responding to changing needs of the local population by encouraging greater ownership of care. Long term sustainability will be developed through more seamless person centred services embedded in the community. There is a long history of health and care integration – examples are given in detail in the locality plan including the Rapid Response Nursing Team commissioning of 72 Hour crisis response and admission prevention. This itself built on the joint commissioning of the Transitional Care Pathway and Intermediate Support Team for patients with Dementia. There is an Unscheduled Care Pathway already in place (diagram in Locality Plan).

The CCG currently works to 3 Planning Units – CCG; Fylde Coast and Lancashire. The CCG's 2030 Strategy creates a long term vision for its population and has a focus on out of hospital care integration. There is work across the neighbouring boundary on a Fylde Coast footprint to transform the acute provision – recognising the significant patient flows to Blackpool Teaching Hospital. The Fylde Coast Unscheduled Care Strategy and Intermediate Care Review are both drivers for transformation and inform the models and planned changes in this Plan. The Lancashire wide work includes the Specialised Services commissioning and wider hospital and social care transformation.

The Better Care Fund is a sub set of these plans – with a particular focus on the opportunity for longer term transformation taking the lead from the sound basis noted above – moving from the often single agency developments to a co-ordination of interventions via an integrated team approach.

Central to the transformation in Fylde and Wyre is the Neighbourhood Model

- A single point of access to Intermediate Care and Urgent Intervention services including re-ablement, rehabilitation, COPD specialist services, IV therapy, Rapid Response Nursing, Mental Health and Residential rehabilitation / recuperation
- Multi-disciplinary Rapid Response Plus Service in A&E and MAUs to avoid admission via triage and referral
- End of life and mental health capacity within intermediate care services
- The integrated case management approach building on current pilots eg. AQuA Neighbourhood Integrated Self Care Model and Care Co-ordinated Scheme
- Holistic risk stratification and self-care within natural communities based around GP Practice lists
- Case Finding and an assets based approach to community development
- Recommissioning and zoning of domiciliary care, with improved management of complex needs

- Links forged via neighbourhood model with relevant council / other Housing providers including Third Sector
- Partnership work across CCG, County and District Council to further develop, integrate and co-ordinate the range of aids and adaptations using the Disabled Facilities Grant and other funding

Specific actions are set out in more detail in the Locality Plan and summarised below:

- Implementation of Electronic Palliative Care Co-ordination system – Q1 2014
- Development and implementation of Care plans for all patients at End of Life – 2014 /2015
- Design (April 2014) and implementation of Care Homes Commissioning and Support Plan – 2014 / 2015
- Commission pilot for Community Palliative Care Inc. Rapid Response, Hospice at Home and Sitting Services – April 14
- Commission pilot for expansion of Falls Advice and Assessment Service – April 14
- Commission pilot for Falls Lifting Service linked to Lifeline Pendant Scheme – April 14
- Implement recommendations of hospital discharge review – September 14
- Review all urgent and emergency services to assess 7 day availability and draw up commissioning plans – Sept 14
- Review services for carers and develop programme for improvement – December 14
- Use risk stratification in Care Co-ordination pilot with social care risk factors and Anticipatory Care Plans – December 14
- Fully embed Early Supported Discharge and Community Stroke Rehabilitation Service – March 15
- Broaden scope of 999 Frequent Callers Pilot to increase anticipatory approach – March 15
- Recommission Community Equipment Services – June 15
- Review all equipment, aids and adaptations to ensure smooth pathway – June 15
- Increase Reablement capacity as primary offer prior to receiving long term care service – September 15
- Implement recommendations from Benchmark Intermediate Care Review – September 15
- Consider development of plans to integrate bed and community based rehabilitation – December 15
- Re-shape and maximise community assets and third sector provision – detail to be developed

There are local governance arrangements currently being strengthened and partners are engaged via the Fylde Coast Commissioning Board and Unscheduled Care Board and include Lancashire County Council, Blackpool CCG, Blackpool Council and Blackpool Teaching Hospitals.

Chorley & South Ribble and Greater Preston

Chorley & South Ribble and Greater Preston CCGs serve a population of just under half a million – covering three District Council boundaries – and have agreed with partners to re-focus services on the needs of residents not the convenience of providers or commissioners.

The vision is to provide health and social care which is seamless, patient centred, high quality and efficient.

The Locality Plan provides supporting examples to illustrate what this vision will mean – patient stories and I Statements demonstrating how the changes will impact on the people living in the area.

The approach to integration, self-care and case management has been being co-produced four the past four years, with the input of NHS, VCFS and independent providers, workshops and planning events. District Council partners have also been engaged.

A review of urgent care has also been conducted in the past year with several high impact changes developed through inclusive work streams with a partner lead on each one:

- Ambulatory Care Strategy – system wide pathways
- Better Care, Better Value – Step up/ down/ core personal profile/ shared care/ integrated teams/ self-care
- System wide capacity planning and 7 Day access
- Redesign ED Front Door – improving streaming and access

All the projects are supported by enabler workstreams including IT infrastructure to ensure delivery which together comprise a complex whole system transformation in Central Lancashire. It is currently in the design phase with implementation in April / May 2014.

This is now being joined up with the neighbourhood team work. It is overseen by a collaborative programme office. There is a new BCF Steering Group taking forward local discussion through to action – linking to the above workstreams. GPs will be at the centre of organising and co-ordinating people's care within a collaborative system including pooled budgets and less visible organisational boundaries – shifting resource to allow investment in primary care and securing the best possible outcomes.

The BCF is an accelerator to this local ambition and vision forged from four years of working and listening and planning. From January to March 2014 integration plans will be developed to scope the target population, outcomes and budgets – with provider responses. Detailed specifications and plans to be developed for 2014/ 2015 as per priority areas.

Specifically, the BCF will be used to:

- Develop the Local Area Co-ordination offer, linking and connecting people to local assets including themselves

- Roll out Integrated Neighbourhood Teams building on multi-disciplinary care planning, co-ordination, risk stratification
- Invest in developing personalised health and care budgets to empower people to make informed decisions
- Invest in key areas – Reablement through a joint approach to community independence, reducing hospital admissions and nursing and residential care costs; services to reduce delayed discharges/ residential care admissions and strengthen 7 day social care provision in hospitals; 7 day GP Access in each locality and deliver the new provision of the GMS
- Implement routine patient satisfaction surveying from GP Practices to enable the tracking of experiences of care
- Use Working Together for Change to check the experience of citizens, patients, clinicians and practitioners
- Co-design care models to deliver these outcomes – transitioning resources and agreeing the process for managing risk
- Integrate NHS and social care systems around the NHS Number
- Undertake a full review of technology use to support primary and secondary prevention, enable self-management, improve customer experience and access and free up professional resource to focus on individuals in greatest need
- Establish a Joint Integration Team across local authorities and CCGs for commissioning of health and social care – review all existing services and agreements including VFS and low level/ universal services and re-procure where necessary
- Create a Care home Commissioning Team focussed on improving outcomes – quality, consistency and co-ordination
- Review and support commitment to safeguarding to be on a statutory footing
- Review psychiatric core 24 services for Lancashire Teaching Hospitals and input into Neighbourhood Teams

In the first year (2014/15) detailed planning to implement concepts developed during co-design phase to include monitoring of financial flows in shadow budgets to evaluate financial impact of models. Benefits tracking for 'live' integrated services and development of next tranche.

From April 2015 – implementation of new models of care at scale with budgets attached. Working in close collaboration with other Lancashire CCGs to co-design approaches to integrated care and ensure consistency / sharing learning and accelerate progress.

East Lancashire

The strategic intention for East Lancashire is to transform services to support people to live safely and live well.

Integrated care has long been recognised as the means by which care can be co-ordinated around the needs of the individual – reducing inappropriate demand, improving quality and productivity and increasing utilisation of community assets. "To plan my care with people who work together to understand me and my carer(s), allow me to control and bring together services to achieve the outcomes important to me".

East Lancashire is a large CCG with complex and interlinked infrastructure and an important role in many planning footprints – the wider pan-Lancashire area; the County Council area, Pennine Lancashire and the East Lancashire area itself. East Lancashire has 5 localities – on the District Council boundaries of Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale. These organisations come together in the East Lancashire Health & Wellbeing Partnership.
Further detailed accounts of the demographic, socio-economic and epidemiological factors are contained in the Locality Plan.

The Integrated Care Model has three main elements (detailed scope in Locality Plan):

- Locality based Integrated Care System (East Lancashire specific)
- Transitional System (Pennine Lancashire)
- Transfers of Care (Pennine Lancashire)

The BCF will be used to accelerate the high impact work streams:

- Transfers of Care
- Access and Flow
- End of Life Care
- Transitional Care
- Housing support and developments
- Support for Carers
- Development of Community Assets
- Care Home Improvement
- Access to Technology
- Mental Health & Dementia

The Planned Changes specified against the local Better Care Fund Plan are as follows:

- Development of fully integrated 7 day 365 days a year Transfers of Care Hub – linked to wider development of neighbourhood teams
- Identification of pro-active support for residential and nursing homes through the development of care home improvement teams
- Scope and remodel / re-commission if appropriate existing Crisis, reablement, rehabilitation offers (domiciliary and bed based) – to jointly commission as part of a wider fully integrated 7 day service and linked to LCC re-commissioning Home Care services for older people and people with a physical disability
- Building on the above – scope potential for strategic and operational partnership

with Neighbourhood teams
- Jointly remodel existing investments in Third sector preventative services to maintain Local Area Co-ordination offer, support neighbourhood teams, self-care, case monitoring and asset development
- Jointly develop a framework agreement for residential and nursing care that meets the Eden Alternative's principle-based philosophy to transform institutional approaches into caring communities
- Develop single GP Practice link for residential and nursing homes
- Jointly remodel carer support services to ensure carer's offer including 'Peace of Mind' emergency planning for carers
- Jointly scope and commission existing LCC community brokerage to include personal health budget (CHC) Activity
- Build on Pennine Lancashire End of Life Strategy and jointly commission person centred care
- Scope potential for joint investment and expansion of Telecare services with County Council
- Workforce planning to underpin the new health and care system
- Work with County and District Councils to further develop, integrate and co-ordinate the delivery of aids and adaptations using Disabled Facility Grants and other funding

Scoping and business cases will be developed January to April 2014 – which will inform specification and impact analysis / outcome framework development. Remodelling and re-procurement will take place from May 2014. November 2014 to March 2015 is identified as the Transition phase for new service developments measurement and analysis.

In Year 2 it is expected that there will be operational Neighbourhood teams across 10 neighbourhoods in East Lancashire, including mental health provision – operating a care-coordination approach using a shared electronic record. Supported by Transfers of Care Hub and new model for community bed based care/ crisis care and reablement.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Lancashire's Case for Change

The 'no change' scenario is well known and modelled and it is recognised that expected demand growth necessitates a trajectory from the current baseline that exceeds demographic factors alone. It will not be possible even to standstill given the known pressures including ageing population and associated growth in long term conditions, co-morbidity, frailty and dementia. Improvements in life expectation also have an impact on the intensity of some presentations of health problems and co-morbidities particularly for those who are most vulnerable, people with learning disabilities, mental health problems

and physical disabilities. Therefore the skills and resources required to meet these challenges in the future will also need to be more specialised and intensive.

It is anticipated that there will need to be increased community and primary care to sustain the required shifts in activity at around the 25% investment level (with local variations) – particularly in crisis, reablement and rehabilitation. As noted above – this isn't simply a 'like for like' capacity increase – as the cases presenting in these environments will be more complex and multi-factoral. This will require integrated working and workforce development – sharing learning and skill mix creation across primary care, allied health professionalisms, social care and specialist teams.

It will also require different ways of working – using tools and techniques that are 'best in class' and evidenced to provide the most impact in terms of clinical care, recovery and survival. For example, this may include the increased use of emerging technologies for both communications and care.

Detailed Provider Impact assessment and planning is being carried out by lead contractor CCGs for the providers, in association with the County Council. This work will be continued throughout 2014 to test and refine models and levels of understanding.

The Expected **shifts in activity** are:

- Increased diversion rate from A&E
- Reduction in admissions from top ten Ambulatory care sensitive conditions
- Reduction in average length of stay
- Reduction in delayed transfer of care
- Reduction in avoidable emergency admissions

The **expected benefits** are:

- Reduction in mortality rates
- Improvement in access
- Improvement in survival rates
- Improvement in recovery rates
- Reduction in complications and poor outcomes
- Improvement in prognosis
- Increased opportunity for people with a long term condition to remain at home?
- Improved self-care alignment with recovery
- A broader range of support where and when needed

Activity plans and associated contractual agreements are currently being agreed – with details drafted for the 2 Year Operational Plans of CCGs and Provider Plans submitted to Monitor. Further work for April and then June 2014 will produce the 5 Year picture and enable greater depth of discussion with providers.

The shifts of spend from acute to integrated community care as described at Template 2 assumes that, initially, the system will manage anticipated increases in demand rather than make reductions in acute care spend.

There is on-going modelling work to understand in detail the capacity and demand and future requirement for bed provision and bed-based care, supported by consultancies

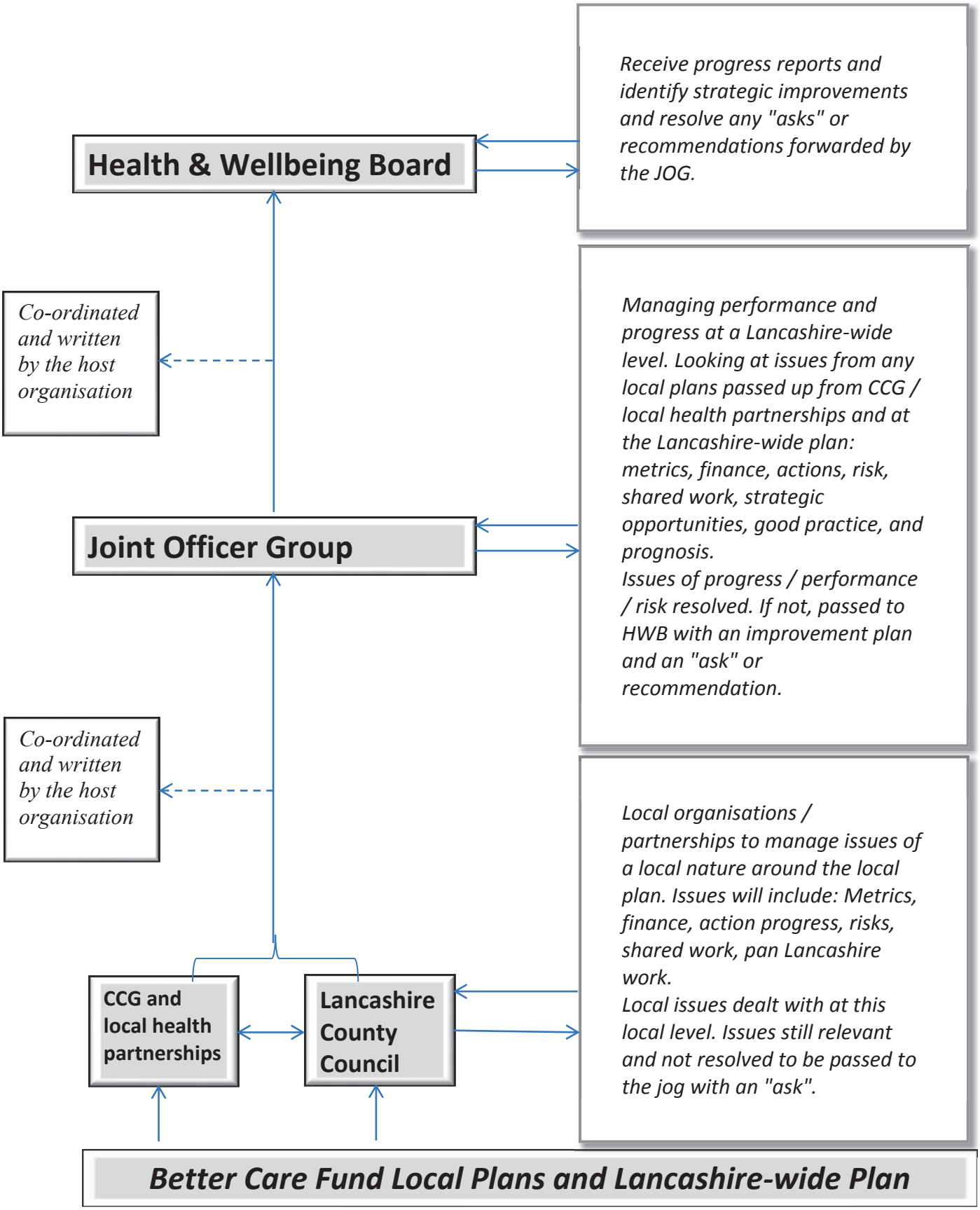
such as KPMG, Price Waterhouse Cooper and Capita. This analysis will inform the re-configuration of hospital and community resources and continue to refine the shape of the system ambition in relation to the acute bed base versus community provision in the longer term.

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

Whole System Governance

The Lancashire Better Care Footprint is a partnership base that has not yet been used for formalised collaborative working. Therefore the whole system governance for this grouping is emergent and embryonic. The Better Care Governance will build upon the agreed Health and Wellbeing infrastructure. Furthermore, the CEOs of the Lancashire District Councils have agreed that the aspirations and outcomes of the DFG will be overseen as part of the BCF via the JOG.

Governance and Performance Management Framework



2) NATIONAL CONDITIONS

a) Protecting social care services

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

Lancashire County Council commissions and provides a range of adult social care and community health services which make a major contribution to the high impact changes, necessary for transforming the whole system. These services have been included within the BCF and partners have agreed that they will be protected, in line with their effectiveness in delivering the agreed vision, aims and objectives of the plan.

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

Where social care services, are effectively supporting the delivery of the BCF, enabling sustained shifts in the activity required, they will continue to be protected. However, where they are not, work to transform and redesign services will be undertaken jointly in light of the evidence from reviews of the services themselves, feedback from individuals and their carers, national research and best practice, alongside the JSNA and the existing commissioning plans of the partners.

b) 7 day services to support discharge

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

Partners are committed to developing integrated 7-day services which support people to be discharged and prevent unnecessary admissions to hospital at weekends; this will be part of the wider 7 day structure which CCGs are expected to commission and providers have to demonstrate in terms of delivery plans.

A number of services have already been established to support this commitment such as the Virtual Ward type arrangements and Intermediate Care Allocation Team (ICAT).

All new services which are developed will be considered as to whether they should have 7 day access – in particular the integrated teams described above which will have 7 day working as part of their ethos.

The overarching intention of the areas as described above is to establish integrated working practices across health and social care. This will include further broadening direct access by health professionals to a range of social care service, such as re-ablement and crisis support which prevent admissions and support discharge.

This will improve patient experience by introducing the concept of a single named professional and will create efficiencies by eliminating duplication of assessments.
The area will work with providers of services to develop community based responsive

services that are able to accept referrals 7 days per week.

The area is also looking to better integrate the use of technology into its working practices so that care plans are more widely available when patients access care; particularly those who are the most vulnerable. We will be looking to ensure that the NHS 111 service and NWAS has access to the care plans for the most vulnerable so that if they call for help the information is readily available, not only 7 days per week, but 24 hours per day.

c) Data sharing

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

Currently NHS Number is used as the primary identifier in health services but this is not the case within the current social care management system for a proportion of social care service users.

See below for plan to implement this commitment

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

We are replacing our current system and implementing Liquid Logic Protocol, with a planned go live of the end of June 2014.

As part of this implementation, we will populate all of the migrated service user records with their NHS number, via the NHS Spine, and implemented a means to capture and populate the NHS number for any new service users.

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

We can confirm our commitment to the above and ensure that we up-to-date with current system integration approaches

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

We can confirm that we are committed to ensuring all appropriate IG controls will be in place. We are aware of all of the above requirements, we are making good progress in

putting in place all that is required to attain a satisfactory accreditation against Version 11 of toolkit by the deadline of April 2014.

d) Joint assessment and accountable lead professional

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

There will be an agreed accountable lead professional for people at high risk of hospital admission. There are plans in place in each Locality to develop methods to identify people at risk and tailor support.

There is a common principle that the increased community and primary care infrastructure is not a 'like for like' increase – the expected increase in complexity and co-morbidity of long term conditions and mental as well as physical health necessitates integrated working to deliver care.

A guiding principle will be the allocation of lead professionals – and the carrying out of assessments – in the way that best meets the needs of the individual – rather than using pre-determined rota type allocations.

All partners are committed to person centred care and empowerment to enable self-care where possible – with service users and carers fully involved in decisions about their care. Whoever is the lead professional or assessor will be expected to work in a way that enables this outcome to be realised.

The Locality delivery plans will action these principles in the most appropriate way in each area – for example:

- Improvements to existing Integrated Teams
- Care Co-ordination Schemes
- Use of Risk stratification tools – commissioning and care delivery
- Use of GP Registers for example Palliative Care
- Electronic Care Co-ordination
- Self-Care Pilot based on AQuA LTC Model
- Community Provider role and assessment developments
- Clear responsibility for vulnerable patients
- Joining up of assessment processes and frameworks
- Changing and supporting the relationship with domiciliary and residential care providers so that they also become a resource to the neighbourhood team

MDT processes will be maintained as a core component – to allocate resources according to the needs of the individual – and ensure appropriate hand offs and clear point of delivery assignments.

The new GMS Contract will also be introduced locally by CCGs – securing arrangements

for patients aged 75 and over to have an accountable medical professional GP lead who oversees a comprehensive and co-ordinated package of care.

National guidance also requires that GP practices are involved in the commissioning of community services – to ensure that they are able to influence the way the packages of care for their population are delivered and co-ordinated.

3) RISKS

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

Risk	Risk rating	Mitigating Actions
Maintaining the integrity of the partnership, with competing financial pressures and performance indictors amongst the key partners, and a political agenda and context to change.	Medium	Robust governance framework and systems in place which are transparent in nature and parties are signed up to. Continued active engagement of, and leadership from, the Health & Wellbeing Board.
Existing funding tied up in a variety of contractual arrangements that may reduce the ability to re-commission in a timely and effective manner	Medium	Contract lengths and terms known so any changes to existing contract arrangements can be planned
The scale of change and interdependency of work streams could be overwhelming at a time of reducing workforce capacity within the County Council	Medium	Clear project plans will be developed which will indicate if implementation of schemes are beginning to miss deadlines
Operational capacity to maintain day to day integrity of the business, safely, whilst delivering change and new models of working	Medium	BCF is intrinsically interlinked with the organisation's strategic plans – all operational capacity is working towards the same vision and goals.
The agreement of the Lancashire wide BCF and the process of agreement become the focus rather than local community requirements	Medium	Clear robust governance arrangements will be agreed early to underpin development of the implementation plan
Workforce culture and development, processional	Medium	Staff briefing systems in place

boundaries and identities will be challenged		
Shift in emphasis to community care, wellness and prevention will not sufficiently impact on acute hospital activity	Medium	Ensure all partners are working towards the same goal of care closer to home.
Integration of staff will require changes to working practices, education and training – appropriate educational packages may not be available	Low	Early focus on gaps in skills and capacity will ensure that personal and organisational development are synchronised. Workforce development is, and will remain, a key component to Lancashire's BCF
Organisational culture and development, professional boundaries and identities will be challenged	Medium	Early focus on gaps in skills and capacity will ensure that personal and organisational development are synchronised. Workforce planning and development is, and will remain, a key component to Lancashire's BCF
Lack of integrated IT infrastructure to underpin the changes in culture practice and shifts in activity will drastically reduce impact.	Medium	Individual CCG IM&T strategy developed which includes inter-operability. Lancs-wide Digital Health Strategy
Reliability of the funding year-on-year to be able to build a sustainable delivery model while organisations have to make savings and fund not identified beyond 2015/16	Medium	A risk from NHS England that the funding is not sustained making is difficult to forward plan and putting intervention services at risk. Continue to make this position/ risk known to government
CCG/LA working relations tested in debates over which part of the system funds what part of the service – e.g. when is it a health cost, when is it a care cost etc.	Medium	Strengthening relations through regular meetings, workshops and 1:1 numbers to establish positive working relationships Move to a more mature funding position that evaluates whole system spend and moves funds flexibly according to need

		and where the money can achieve the best outcomes. Maintain the critical role of the Health & Wellbeing Board in terms of leadership, co-operation, accountability and agreement
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	Medium	An initial impact assessment of the effects of the Care Bill is being undertaken and we will continue to refine our assumptions around this as we develop our final BCF response.
That the success of the services in the BCF will not have the desired effect of moving resources out into the community and spend is not be freed up from acute care and nursing care	High	The Whole Systems transformation programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes	High	We have modelled our assumptions using a range of available data, including metrics from other health economies. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.

Working assumption that the NHSE LAT will expand GP Primary Care to cope with the expansion of new residents; otherwise the Integrated Teams will be overwhelmed particularly in the City Deals areas	Medium	Ongoing dialogue with DC team at AT to ensure synchronisation of primary care strategies with BCF and CCG operational & strategic plans
The interaction between the BCF, Integrated Teams and Personal Health Budgets is difficult to predict and hence is a risk to delivery	Medium	Ensure robust accountability and monitoring and evaluation processes are built into performance and risk management framework to ensure early warning that anticipated models and interactions are not borne out in reality, allowing early mitigating
Populating used for metrics don't match populations used at CCG level	Low	Identify and discrepancies and agree correct numbers

This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1 . Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Lancashire County Council	Y	5,541,000	9,438,000	9,438,000
NHS West Lancashire CCG	Y		7,419,000	7,419,000
NHS Lancashire North CCG	Y		10,462,000	10,462,000
NHS Greater Preston CCG	Y		13,223,000	13,223,000
NHS Fylde & Wyre CCG	Y		10,961,000	10,961,000
NHS East Lancashire CCG	Y		26,095,000	26,095,000
NHS Chorley and South Ribble CCG	Y		11,332,000	11,332,000
BCF Total		**£ 5,541,000**	**£ 88,930,000**	**£ 88,930,000**

***NOTE: Although £5.5m has been identified as the Lancashire County Council spend on BCF schemes ir

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

The plan for maintaining services if planned improvements are not achieved, as a result of the underperformance of schemes, includes two main elements i.e. Planning for the effect of the holding back of any proportion of the c.25% of the BCF to be paid for improving outcomes itself and the potential dual-funding required if existing services need to be maintained at the same time as the investments made in new schemes and services. This includes planning for the risk of insufficient funds being available for investment. The partners have agreed to collaboratively develop measures to mitigate the financial impact of these risks. These measures may include:

• A formal risk-share agreement;
• An initial contingency reserve that could be utilised to part-maintain existing services;
• On-going detailed performance management and finance monitoring to enable decisions to be taken at the earliest opportunity to enable actions to be put in place quickly which will either reduce the financial impact of any under-delivery of planned improvements or enable a re-prioritisation of available resource into those areas which are having the most significant impact on performance.

Discussions with partners to date indicate that the above measures would be actioned under five separate section 75 pooled arrangements, one for each CCG (with Greater Preston CCG and Chorley and South Ribble CCG combined), however, these pools would operate under a single Lancashire framework. Significant progress is expected to be made on delivering the completed section 75 agreements by June 2014.

The risk of not achieving savings is that we may not have sustainable solutions to match forecast demand. The level of potential saving is still being quantified as we work together with stakeholders in monitoring the data and quantifying the financial benefits. The 2014/15 assumptions are based on modest reductions in acute activity, however this will increase in later years as the integrated working evolves.

Risk mitigation will include the involvement of providers in sharing risk. For example, in relation to the East Lancashire community contract there is agreed that the 2014/15 contract includes a local incentive scheme (non-recurrent), valued at 0.5% of the total contract for NHSELCCG. This payment will be made on the understanding that ELHT will work with commissioners to review and redesign the community services element of the contract in line with proposals for the development of integrated neighbourhood teams.

Additionally, involving providers in sharing risk works particularly well for an ICO which has the ability to shift activity from an acute to community setting without losing the funding.

The service budgets forming the BCF will be part of a wider strategic plan to deliver efficiencies across the health economy through the programmes of work taking place such as the "Care Closer to Home" programme in West Lancashire and the "Better Care Together" programme in Lancashire North. These are well-established programmes that involve key stakeholders including the local Acute Trusts, neighbouring CCGs and local authority representation.

In East Lancashire, Capita and the CCG's in-house business intelligence team have recently coordinated consultation exercises across a number of stakeholders and have also provided scenario modelling. This will form the basis of how this agenda is taken forward within East Lancashire including the discussions with acute providers.

Additionally, partners have recognised that the wider context of considerable reductions in Local Government funding in the medium term has the potential to adversely affect the performance indicators upon which BCF performance payments are to be based. Also, the inclusion of the funding for some elements of the impact of the Care Bill in the BCF has the potential to put additional financial pressure on the pooled finances if the allocations for these impacts are not sufficient to meet the requirements. Partners will need to keep these issues under review, and agree mitigating actions as appropriate.

Contingency plan:		2015/16	Ongoing (annual)
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Planned savings (if targets fully achieved)	£1,383,300	£1,383,300
	Maximum support needed for other services (if targets not achieved)	£1,383,300	£1,383,300
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Planned savings (if targets fully achieved)	£164,000	£164,000
	Maximum support needed for other services (if targets not achieved)	£164,000	£164,000
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	£176,400	£176,400
	Maximum support needed for other services (if targets not achieved)	£176,400	£176,400
Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	no expected savings	To be determined
	Maximum support needed for other services (if targets not achieved)	no expected savings	To be determined
Local measure Estimated Diagnosis Rate for Dementia Numbers on QOF registers and dementia prevalence rates by CCG	Planned savings (if targets fully achieved)	no expected savings	no expected savings
	Maximum support needed for other services (if targets not achieved)	no expected savings	no expected savings
*****NOTE: THE SAVINGS FIGURES SHOWN IN THIS TABLE DO NOT INCLUDE THE COST OF THE SERVICES REQUIRED TO DELIVER THESE SAVINGS**			

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
Care Bill implementation funding in the Better Care Fund		£ 3,111,000				£ 3,111,000			
Additional investment in reablement		£ 2,430,000							
Community Emergency Response						£ 250,000		£ -	
Falls Service						£ 196,000		£ -	
Identification of at risk patients/service users						£ 720,000		£ -	
Community Teams (incl Nursing & Mental Health)						£ 6,601,000		£ -	
Care Home/Nursing/Hospice based health interventions						£ 930,000		£ -	
Long term conditions (including dementia schemes)						£ 2,005,000		£ -	
Integrated Neighbourhood Teams (Greater Preston)						£ 4,509,450		£ -	
Integrated Neighbourhood Teams (Chorley South Ribble)						£ 3,689,550		£ -	
Intermediate Care						£ 677,000		£ 6,525	
Discharge Planning						£ 1,506,000		£ 14,515	
Equipment & Adaptations (Health Based)						£ 5,277,000		£ 50,860	
Crisis services including acute crisis services for the Frail elderly						£ 2,809,000		£ 27,073	
OT services						£ 3,914,000		£ 37,723	
OAMH Hospital Liaison team						£ 459,000		£ 4,424	
Carers Support						£ 2,615,000		£ 211,912	
Carers Respite						£ 5,081,000		£ 411,749	
Stroke Services						£ 914,000		£ 74,068	
Equipment & Adaptations (Social Care Based)						£ 4,259,000		£ 345,136	
Telecare						£ 787,000		£ 63,776	
Reablement/Rehabilitation						£ 7,376,000		£ 68,746	
Rehab beds						£ 2,775,000		£ 25,863	
Residential rehab						£ 3,926,000		£ 36,591	
Additional investment in 7 day working						£ 3,447,000		£ 48,418	
End of Life						£ 331,000		£ 4,649	
Inpatient beds						£ 4,456,000		£ 62,591	
Hospital based support						£ 5,229,000		£ 73,448	
Joint funded packages of care						£ 780,000		£ 10,956	
Voluntary sector schemes						£ 403,000		£ 5,661	
Other BCF schemes						£ 459,000		£ 6,447	
Disabilities Facilities Grant						£ 6,365,000		£ 89,405	
Social Care capital							£ 3,073,000	£ 43,164	
***NOTE: The schemes contained within the BCF (shown above) are expected to be developed further by partners in the period leading up to the formal commencement of the pooled arrangements in April 2015. The financial values represent forecasts based on current commitments.									
Total		£ 5,541,000	£ -	£ -	£ -	£ 85,857,000	£ 3,073,000	£ 1,723,700	£ -

Association

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

The successful achievement of the metrics and agreed targets will be managed and maintained through the Performance Management Framework described in Template 1. The local plans and local targets will be managed via the local health and wellbeing partnerships and at organisational level. The performance of the Lancashire-wide metrics will be managed through the Health and Wellbeing Board. The Board will receive regular performance progress reports which will identify areas of underperformance, plans to address this performance, examples of good practice, areas of risk and its mitigation and a prognosis of future performance. Any areas of slow progress or under performance will be addressed through the Board.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We will be using the national metric (currently under development).

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The Social Care Metrics are being assured on a Lancashire wide level. These trajectories, which have been calculated using historical performance data and the BCF statistical significance calculator have been shared and agreed across key shareholders. The Health related metrics, although submitted on a county wide level, have been linked to individual measures detailed within agreed and signed off CCG 2 year Operational plans which are being assured by the Local Area Team.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	876.8	N/A	831.9
	Numerator	1938		1939
	Denominator	221034		233067
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	82.00	N/A	82.00
	Numerator	387		464
	Denominator	472		566
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	255.6	243.6	243.7
	Numerator	2400	2300	2313
	Denominator	939134	944096	949260
		December 2012 -November 2013 12	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	208.2	190.3	217.4
	Numerator	29573	13586	15595
	Denominator	1183764	1189735	1195652
		October 2012 - September 2013 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure it will be the national metric (under development) that is to be used. Awaiting national metric*		*(State time period and select no. of months)* 1	N/A	*(State time period and select no. of months)* 1
Local measure *Estimated Diagnosis Rate for Dementia Numbers on QOF registers and dementia prevalence rates by CCG*	*Metric Value*	53%		67%
	Numerator	7604		9596
	Denominator	14323		14323
		April 2012 - March 2013 12	1	*October 2015* 1

Police and Crime Commissioner priorities and linkages with Health and Wellbeing.

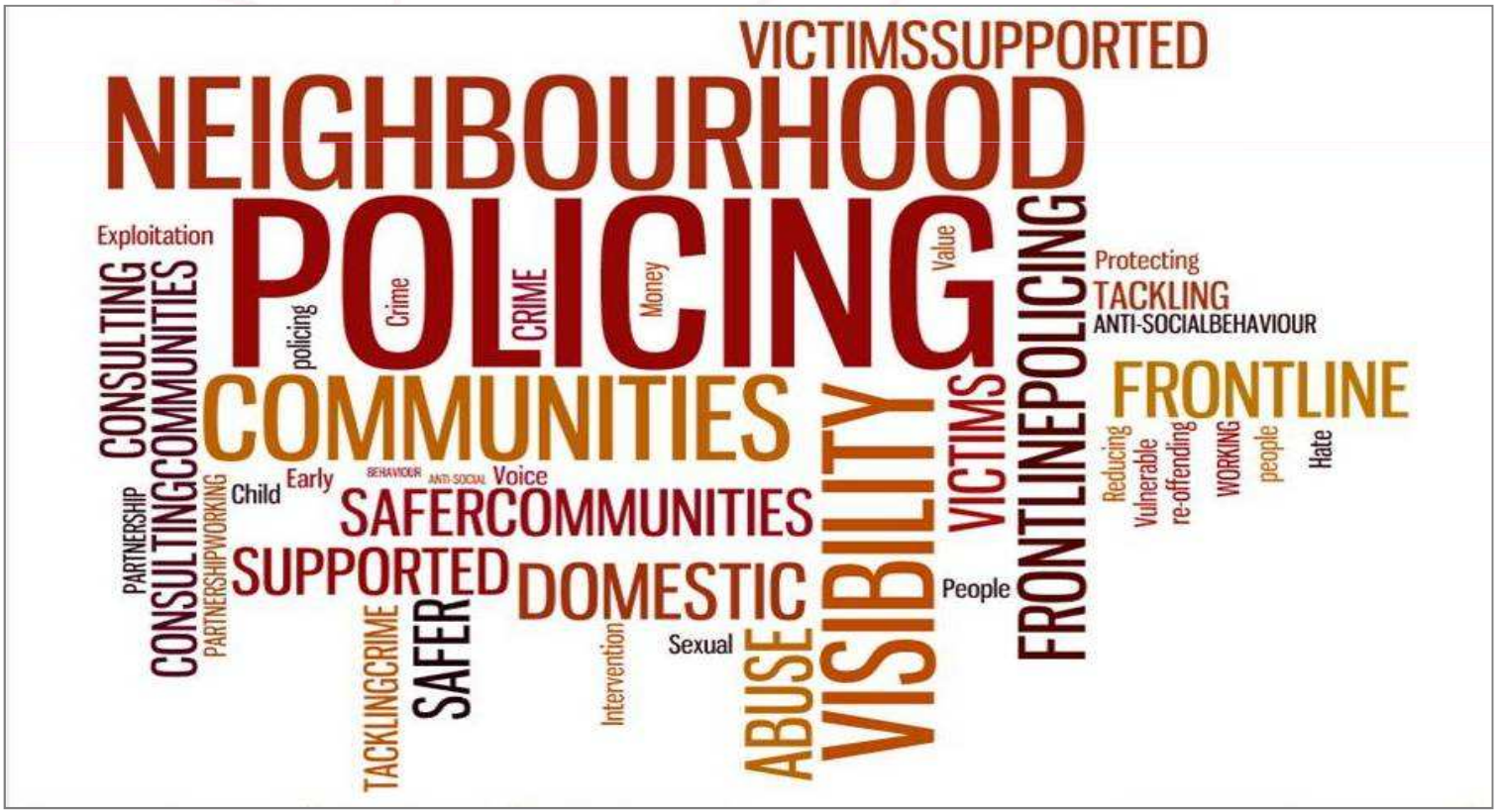
Mike Lock

Senior Strategic Advisor

Role of Commissioner

- Secure the maintenance, efficiency and effectiveness of the constabulary.
- Appoint and dismiss the Chief Constable
- Hold the Chief Constable to account
- Set the precept and to be responsible for the operational policing crime budget
- Set out a five-year Police and Crime Plan
- Contribute to the National Strategic Policing Requirement
- Work with partners to tackle crime and disorder
- Contribute to an efficient and effective criminal justice system.
- Make grants to organisations aside from the police, including but not limited to CSPs.

Police and Crime Plan



Strategic Aims

- **RE-ASSURE** our communities – improve trust and confidence in policing.
- **REDUCE** crime
- **REDUCE** re-offending
- **WORK TOGETHER** with partners to deliver better services and ensure that resources are used effectively.

Strategic Priorities

- **Defend Frontline Policing**
- **Champion the Rights of the Victim**
- **Protect Vulnerable People**
- **Promote Targeted Initiatives to Contribute to Tackling Crime and Re-Offending**

Partner Organisations

- Local Authorities and Public sector bodies
- Lancashire Criminal Justice Board (CPS, HMCTS, Probation, Youth Justice, HMPS, Police, Victim Support)
- Lancashire Community Safety Strategic Group
- Community Safety Partnerships
- Health and Wellbeing Boards
- Children and Young People's Trusts
- Safeguarding Children's and Adults Boards
- Youth Justice Management Boards
- Pan /Lancashire Strategic Boards and Commissioning Groups

Significant health inequalities exist amongst offenders and ex-offenders

In the week following their release:

- - female prisoners are 69 times more likely to die than females in the general population
- -male prisoners are 29 times more likely to die than males in the general population.
- -It is estimated that up to 30 per cent of offenders have a learning difficulty/disability.
- - Among children and young people in custody:
- - over 75 per cent have serious difficulties with literacy and numeracy
- - over 30 per cent have a diagnosed mental health problem
- - more than 30 per cent have experienced homelessness
- - over 30 per cent of young women and over 25 per cent of young men report a long-standing physical complaint

Significant Health Inequalities exist amongst offenders and ex offenders

- 24 per cent of prisoners with a drug problem are injecting drug users. Of these, 20 per cent have hepatitis B, and 30 per cent have hepatitis C.
- Among female prisoners, 40 per cent have a long-standing physical disability, and 90 per cent have a mental
- health or substance misuse problem.
- Less than 1 per cent of ex-offenders living in the community are referred for mental health treatment.
- In prisons, the smoking rate is as high as 80 per cent – almost four times higher than the general population.
- 63 per cent of male prisoners and 39 per cent of female prisoners are hazardous drinkers.

Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.1 Children in poverty 1.2 School readiness1.3 Pupil absence1.4 First time entrants to the youth justice system 1.5 16-18 year olds not in education, employment or training1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H) 1.7 People in prison who have a mental I illness or a significant mental illness 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services *(i-NHSOF 2.2) ††(ii-ASCOF 1E) ** (iii-NHSOF 2.5) †† (iii-ASCOF 1F) 1.9 Sickness absence rate1.10 Killed and seriously injured casualties on England's roads1.11 Domestic abuse 1.12 Violent crime (including sexual violence) 1.13 Re-offending levels1.14 The percentage of the population affected by noise 1.15 Statutory homelessness 1.16 Utilisation of outdoor space for exercise / health reasons 1.17 Fuel poverty1.18 Social isolation † (ASCOF 1I)1.19 Older people's perception of community safety.*

Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.1 Low birth weight of term babies
2.2 Breastfeeding
2.3 Smoking status at time of delivery
2.4 Under 18 conceptions
2.5 Child development at 2 – 2 ½ years
2.6 Excess weight in 4-5 and 10-11 year olds
2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
2.8 Emotional well-being of looked after children
2.9 Smoking prevalence – 15 year olds (Placeholder)
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Successful completion of drug treatment
2.16 People entering prison with substance dependence issues who are previously not known to community treatment
2.17 Recorded diabetes
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2
2.20 Cancer screening coverage
2.21 Access to non-cancer screening programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over.

Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities.

Indicators

3.1 Fraction of mortality attributable to particulate air pollution**3.2** Chlamydia diagnoses (15-24 year olds)**3.3** Population vaccination coverage**3.4** People presenting with HIV at a late stage of infection**3.5** Treatment completion for TB**3.6** Public sector organisations with board approved sustainable development management plan**3.7** Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies.

Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.1 Infant mortality* (NHSOF 1.6i)4.2 Tooth decay in children aged 54.3 Mortality rate from causes considered preventable ** (NHSOF 1a)4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* (NHSOF 1.1)4.5 Under 75 mortality rate from cancer* (NHSOF 1.4i)4.6 Under 75 mortality rate from liver disease* (NHSOF 1.3)4.7 Under 75 mortality rate from respiratory diseases* (NHSOF 1.2)4.8 Mortality rate from communicable diseases4.9 Excess under 75 mortality rate in adults with serious mental illness* (NHSOF 1.5)4.10 Suicide rate4.11 Emergency readmissions within 30 days of discharge from hospital* (NHSOF 3b)4.12 Preventable sight loss4.13 Health-related quality of life for older people4.14 Hip fractures in people aged 65 and over4.15 Excess winter deaths4.16 Estimated diagnosis rate for people with dementia (NHSOF 2.6i)

Improving the wider determinants of health

Objective Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- Pupil absence
- First-time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People in prison who have a mental illness or a significant mental illness
- Killed and seriously injured casualties on England's roads
- Domestic abuse
- Violent crime (including sexual violence)
- Re-offending levels
- The percentage of the population affected by noise
- Statutory homelessness
- Older people's perception of community safety

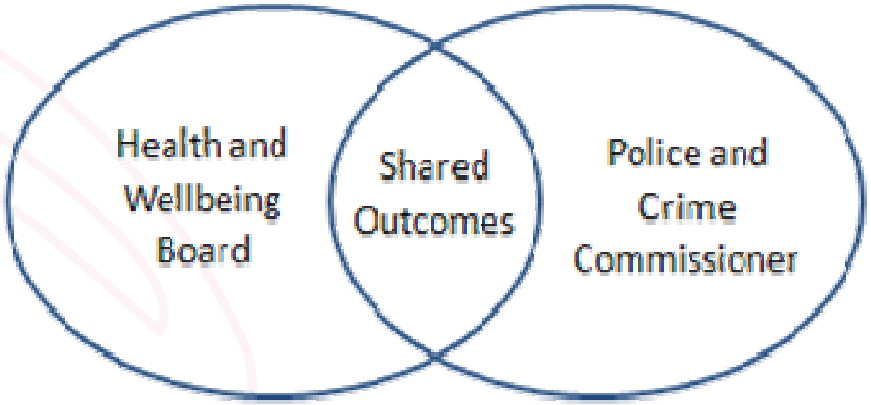
Health Improvement

Objective People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Under 18 conceptions*
- Child development at 2-2½ years (under development)
- Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Emotional well-being of looked after children
- Self-harm
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Alcohol-related admissions to hospital
- Self-reported wellbeing

Potential shared outcomes across the Outcomes Frameworks



- Public health outcomes framework for England, 2013/2016
- NHS Outcomes Framework 2014/15
- Adult Social Care Outcomes Framework2014/15
- Outcomes aimed at Children and Young People

Health and PCC Commissioning functions

Clinical commissioning groups (CCGs)	NHS Commissioning Board (NHSCB)	Local authorities	Police and Crime Commissioner
• health services for adults and young offenders serving community sentences or completing custodial s sentences on licence, supervised by the local probation trust. • emergency care, including 111, A&E and ambulance services, for prisoners and detainees • mental health services, including assessment at arrest and advice to courts (as well as psychological therapies) • treatment services for children, Including child and adolescent mental health services (CAMHS) • treatment for mental ill health, including community sentences with a mental health treatment requirement • alcohol health workers in a variety of healthcare settings • promoting early diagnosis, as part of community health services and outpatient services • drug misuse advice and treatment in the community, which may form part of other healthcare contacts.	• primary care, including mental health, secondary care, drug and alcohol treatment services • health services (excluding emergency care) and public health services for people in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children's homes, secure training centres, immigration removal centres, police custody suites) • public healthcare for people in prison and other places of detention. • sexual assault referral services (SARCs) • mental health interventions provided under GP contract • some specialised mental health services. • secure psychiatric services • brief drug, alcohol misuse and tobacco control interventions in primary care.	• drug misuse services, prevention and treatment • alcohol misuse services, prevention and treatment • local tobacco control a activity, including stop smoking services, prevention activity, enforcement and communications • sexual health advice, prevention and promotion • mental health promotion, mental illness prevention and suicide prevention • local programmes to address inactivity and other interventions to promote physical activity • adult and young people's social care services • vulnerable adult accommodation services.	• Tackling Crime and Reoffending: • Community Victim Services including crime and ASB incidents • Restorative Justice • Community Action Fund

Health Issues for the OPCC

1. Health Inequalities with a particular focus on victims and offenders

2. Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis. Local areas to make sure that:

- Health-based places of safety and beds are available 24/7
- Police custody should not be used because mental health services are not available and police vehicles should also not be used to transfer patients.
- Timescales are put in place response from health and social care workers.
- Information sharing so they can receive the best care possible.
- In areas where black and minority ethnic groups have a higher risk of being detained under the Mental Health Act, this must be
- A 24-hour helpline should be available for people with mental health problems and the crisis resolution team should be accessible 24 hours a day, 7 days a week.

3. Early Intervention and Early Support

4. Addressing unmet physical and mental health needs for young people and adults involved with the criminal justice system.

5.Supporting interventions for adults and young people to address substance misuse use impacting upon crime reduction and reoffending

6. Substance misuse harm reduction (including both legal and illegal drugs and alcohol) and the relationship with crime reduction and the night time economy

7.The provision of improved services for victims who require specialised support services (including domestic abuse, sexual violence, child sexual exploitation and other groups with significant vulnerabilities

8. Sexual Assault Referral Centre, Police Custody Healthcare and Custodial health care provision transfer to NHS England

Moving Forward together

- How we work together
- Identifying and agreeing our joint priorities
- Sharing data and information
- Achieving shared outcomes
- Pan Lancashire / Constabulary wide delivery
- Relative size of budgets
- Commissioning together for Combined effect

Ten questions about working in partnership with PCC and CJS

1. Do board members have an awareness and understanding of the positive local health outcomes linked to improving the health of people in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims?

2. Does the board have a good understanding of how current investment in the health of people in contact with the CJS is deployed, and the levels of access this provides?

3. Is there a local needs assessment incorporated into JSNAs that identifies the health and social care needs of people in contact with the CJS?

4. Do local commissioning plans explicitly recognise the service needs of offenders and ex-offenders including health and re-offending prevention services?

5. Is there a coherent and agreed partnership strategy with CJS agencies for offender and ex-offender health?

6. Do health and wellbeing board members recognise that new ways of partnership working are required and has consideration been given to how partnership links with local CJS agencies can be strengthened?

7. Is integrated care for people in contact with the CJS commissioned through providers and other organisations with clear shared priorities and vision?

8. Are primary care services aware of the wider needs of people in contact with the CJS and are they able to signpost and refer for example, for housing, employment, benefits etc.

9. Are offenders supported to maintain continuity of health and social care from prison to community?

10. Is there active engagement with different local community groups in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims?

Ten questions CJS agencies should ask about working in partnership with health and wellbeing boards

1. Do you understand how JSNAs and JHWSs and commissioning plans fit together in the new local health and care system

2. Do you know how to input into and influence JSNAs and JHWSs?

3. Has the health and wellbeing board been made aware of the responsibilities across the local CJS for delivery of local offender and ex-offender health outcomes?

4. Is key evidence (including quantitative data and analysis, and qualitative information) on health and health inequalities among people in contact with the CJS, shared with the health and wellbeing board and member organisations?

5. Do CJS agencies share an awareness and acceptance of the benefits of integrated planning, commissioning and delivery of health and care services across the CJS?

6. Is there a coherent and agreed partnership vision across local CJS agencies for offender and ex-offender health priorities and outcomes that can be shared with the health and wellbeing board?

7. Are all CJS partners open and willing to explore new ways of partnership working?

8. Are local CJS leaders clear about their roles and responsibilities in terms of fostering joint working between CJS agencies and the health and care system at local level?

9. Are CJS agencies willing and able to align their priorities for delivering improved health outcomes in the CJS with those of JHWSs

10. Is there recognition of the benefits from strong and effective leadership, able to influence and motivate across organisational boundaries to translate locally agreed health and wellbeing priorities into action?

Lancashire Health and Wellbeing Board
Meeting to be held on 29th April 2014

Electoral Division affected:
All

Taking a Partnership Approach in Addressing Health Inequalities in Lancashire 2013 to 2020

Contact for further information: Clare Platt, Specialist in Public Health, Lancashire County Council. Email: Clare.Platt@lancashire.gov.uk Telephone: 07876844627

Executive Summary

Following publication of the Marmot Review, Lancashire was chosen alongside five other authorities to receive bespoke advice and support over a two year period due to the complexities of addressing health inequalities in a two tier area. An event was organised on 13th March 2014, 'hosted' by the Lancashire Health and Wellbeing Board to look at how different partners could work together in addressing health inequalities, utilising the Marmot objectives.

A wide range of partners attended including, members of the Health and Wellbeing Board, Joint Officer Group, District Councils, Lancashire County Council, Registered Social Landlords and Chairs of Locality Health and Wellbeing Partnerships. A total of approximately 40 people attended. Mike Grady from the Institute of health equity gave the keynote speech about aligning strategy and action and included an update on community budgeting. He also facilitated the event, providing challenge to the partners.

Recommendation

The Health and Wellbeing Board is asked to:

1. Note the update from the Health and Wellbeing Hosted Event on 13 March 2014
2. Consider the next steps identified in the report and agree the way forward.

Background and Advice

1. The History of the Marmot Review in Lancashire

The Marmot review, Fair Society, Healthy Lives states that reducing health inequalities is a matter of fairness and social justice. There is a social gradient in health, meaning that those people in the most deprived areas experiencing poorer health than those in the least deprived areas. Action to mitigate this should focus on reducing the gradient in health; this should also consider equity of access for groups who find it difficult to access the resources and services they need to thrive.

Lancashire County Council

2. Support from the Marmot Team

Working with Mike Grady from the Institute of Health Equity, University College London, a series of workshops are currently underway both within Lancashire County Council and externally with wider partners via the Health and Wellbeing Board and the Lancashire Leaders' Group, to help identify key actions to address health inequalities using the Marmot approach, focussing on the social determinants of health.

3. The Partnership Approach in Lancashire

Taking a Marmot approach means tackling the root causes of health inequalities; and specifically the inequalities in life chances. To achieve greater health equity we should focus on the six Marmot policy objectives: maximising the life chances of children, improving access to work, increasing income, strengthening community resilience, improving the quality of the local environment and preventing ill health. The Health and Wellbeing Board has also previously agreed six 'shifts' which will help deliver improved health outcomes.

Six Marmot Policy Objectives	Health and Wellbeing Board Shifts
1. Give every child the best start in life 2. Enable all children, young people and adults to maximise their capabilities and have control over their lives 3. Create fair employment and good work for all 4. Ensure healthy standard of living for all 5. Create and develop healthy and sustainable places and communities 6. Strengthen the role and impact of ill-health prevention	1. Shift resources towards interventions 2. Build and utilise the assets, skills and resources 3. Promote and support greater individual self-care and responsibility 4. Commit to delivering accessible services 5. Make joint working the default option 6. Work to narrow the gap

4. Health and Wellbeing Hosted Event

The Lancashire Health and Wellbeing Board has agreed to facilitate a series of 'hosted' events covering a range of topics. The first 'hosted' event took place on 13th March, with a focus on implementing the Marmot recommendations to address health inequalities in Lancashire. A wide range of partners attended including, members of the Health and Wellbeing Board, Joint Officers Group, District Councils, Lancashire County Council, registered social landlords and chairs of locality Health and Wellbeing Partnerships. A total of approximately 40 people attended. Mike Grady from the Institute of Health Equity gave the keynote speech about aligning strategy and action, and included an update on community budgeting. He also facilitated the event and provided the partners with healthy challenge. Dr Sakthi Karunanithi updated the attendees about progress within Lancashire County Council in developing its strategic approach to implementing the Marmot policy objectives.

The workshop sessions focused on the sphere of influence for individual organisations to improve health outcomes, and also how the different partners could most effectively work together.

5. Developing Partnership Activity and Next Steps

Attendees at the event were subsequently invited to prioritise the actions identified in the workshops that they suggested partners could work together. The key themes for consideration by the Board include:

- To engage with the district council Chief Executives and Leaders on health inequalities agenda; explore how we can communicate this with the public.
- To maximise the opportunities to address health inequalities by identifying specific projects with the registered social landlords.
- Encourage joining up of resources and activities at a neighbourhood level to improve outcomes
- As major employers, commit to provide opportunities for work start and apprenticeships as well as promote workplace health and embed social value principles in our commissioning plans and procurement strategies.
- Develop evidence base and share the learning from developing policies, programmes and activities aimed at reducing health inequalities.

These actions comprise a mixture of activity that has already been initiated (e.g. discussion with Lancashire Leaders) and is on-going, together with new initiatives.

Risk management

The Board is advised that the response to identify future actions was limited, with a total of 12 responses received. The Board is asked to consider whether the actions identified resonate with individual / organisational expectations. If so the actions should be endorsed, or alternatively re-shaped.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
The Marmot Review Fair Society Healthy Lives http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review	2010	Clare Platt, Adult Services & Wellbeing, 07876844627

Reason for inclusion in Part II, if appropriate

N/A

Health & Wellbeing Board
Meeting to be held on 29th April 2014

Electoral Division affected:
All

Contribution of the Third Sector in Health and Wellbeing
(Appendices A, B and C refer)

Contact for further information: Michael Wedgeworth (Director One Lancashire)

Executive Summary

Deeds, not Words

It is universally recognised that voluntary, community and faith groups and social enterprises (which can be embraced under the general title of 'the third sector') can make an important contribution to health and well-being. The benefits of utilising the assets which exist in all local communities are increasingly recognised, a fact underlined by the Marmot report on the Social Determinants of Health.

The King's Fund video, 'Sam's Story', illustrates well the sector's contribution in its description of the principles underlying the Better Care –Better Value programme. Sam, 87 years old and recently widowed, lives with a number of long-term conditions. He avoids frequent hospital stays, and the eventual need to go into residential care, by having a single person (as it happens, a district nurse) who co-ordinates the work of a number of professionals. She also introduces Sam to a lunch club run by a local charity, where he enjoys good meals in company with others and meets friends and volunteers who support him in other ways. This could be said to be the 'well-being' complement to the skills of the health and care professionals, which enables Sam to do exactly what he wants to do: to go on living at home.

However, it has been said that there is too much lip-service paid to the importance of the third sector's contribution and not yet enough ways of making it happen. This report proposes ways of pressing on with translating aspiration into action.

This having been said, the sector appreciates that it is to a degree already involved in partnership arrangements and contracts with public bodies. This is especially true of the larger charities. The thrust of this report is to explore ways in which all third sector bodies, national and local, large and niche might extend their contribution to local health and well-being economies.

Recommendation

1. The partners represented on the Lancashire Health and Well-Being Board re-affirm their commitment to work with the third sector.

Lancashire County Council

2. The Board commits itself to the fundamental principles of the Social Value Act, and to apply them to all contracts, not just those above the EU thresholds.

3. The Board urges commissioners in health and social care to ensure that a clause is inserted in all procurement plans stating that 'the contribution that third sector bodies can make will always be taken into account in awarding contracts'.

4. The Board urges commissioners to enter into negotiations with third sector representatives to enable co-design of contracts

5. The Board refers this report to the Joint Officer for further considerations and report back.

Background and Advice

1. A Snapshot of the Third Sector in Lancashire

1.1. A 'Market Day' event held on the 30th of January 2014 and addressed, among others, by Steve Gross of Lancashire County Council and Mike Barker of the Greater Preston and Chorley and South Ribble Clinical Commissioning Groups, attracted an audience of 160 people, representing 100 third sector bodies working in the Health and Well-Being field. Each was invited to complete an A4 sheet to describe what their organisation does, who are its clients, what paid staff and volunteers are deployed and in which part of the county it operates.

1.2. These following few examples from the responses, chosen more or less at random, illustrate the huge diversity and reach of the sector , as well, perhaps, as its complexity:

- Age UK Lancashire: Employ 300 staff in wide range of services to older people, in particular a hospital after-care service for 1400 people
- Asian Women's Forum, Chorley: Variety of support offered including respite for women carers in the extended family situation
- Homestart: Present in most parts of Lancashire: in Chorley and South Ribble offer support to 378 families with 745 children
- Together Lancashire: A new Church of England project, starting up in Blackburn, but designed to spread through the 250 parishes of Lancashire, which provides a parish nurse to support health needs of people in the locality
- The Stroke Association: Supports 1500 stroke survivors, their families and carers

- Preston Community Transport: Runs Dial-a-Ride, Community Car Schemes, Shopmobility, Day Trips on accessible minibuses and Volunteer Minibus Driver Training. Around 4000 people benefit from the service
- Maundy Relief, Accrington: Runs a drop in centre for food, clothing, advice, assisting 8000 people each year suffering homelessness, alcohol problems and marginalisation. Deploy 25 volunteers

1.3. The event which elicited this information was organised by Third Sector Lancashire (TSL), under the banner of One Lancashire which is now the recognised representative body for the whole sector in the County. Similar bodies exist in Blackpool and Blackburn with Darwen, and they work increasingly together. Third Sector Lancashire works in a strategic alliance with One Lancashire, now concentrating exclusively on Health and Well-Being. It too operates 'pan Lancashire'.

1.4. One Lancashire and Third Sector Lancashire are 'infrastructure' organisations. They do not themselves provide services, but support 'front line' bodies which do so.

1.5. One Lancashire is co-ordinating a portfolio of services for the front line covering business advice, training, funding, employment law, representation, tendering and learning.

1.6. Over the past three years, Third Sector Lancashire has organised a series of hearings for the sector (see Appendix A for the programme for 2014), on the evolving health and care landscape, in which experts (including several members of the Health and Wellbeing Board) have addressed third sector audiences. The next in the series, on "Innovation in Health and Social Care", is to be held in early May, and is designed in part to invite the sector itself to consider how it needs to collaborate and innovate. Future plans, under the umbrella of One Lancashire, include training sessions to prepare front line organisations to become 'commission ready'.

1.7. One Lancashire has established an informal 'Health and Well-Being Group', made up of the chief executives of the larger charities in the County. Its membership is illustrated in Appendix B. This Group meets monthly to share experience and ideas, and receives regular updates on the work of the Board.

1.8. The representative of the sector on the Board (the Chair of the Third Sector Lancashire) reports on its work regularly to the Group, and aims to feed back to the Board ideas and insights from the Group, and also (and most importantly) from the 'front line', via meetings, web-sites, events and regular

e-mail communications.

2. The Sector's Role in Commissioning

2.1. Two important messages are being heard ‘loud and clear’ by the sector. One from Lancashire County Council, that it must move towards fewer larger and more effective contracts, especially in light of the draconian cuts it is facing; the other from Clinical Commissioning Groups, that such is the plethora of voluntary and community groups in their areas that the work of designing commissions in which the sector can play a part (which they desire to do) can become impossibly complex.

2.2. In response to the latter, the Health and Well-Being Group has identified an experienced representative for each of the 8 CCG’s (that is, including Blackburn with Darwen and Blackpool) to work closely with lead commissioners. They are all chief executives of their organisations, or in one case, a deputy.

Blackburn with Darwen	Angela Allen- The Families Health and Wellbeing Consortium
Blackpool	Richard Emmess- Blackpool Fylde and Wyre Council for Voluntary Service
Chorley and South Ribble	Judith Culshaw- Deputy CEO, Age Concern Central Lancs
East Lancashire	Terry Hephrun- Burnley Pendle and Rossendale Council for Voluntary Service
Fylde and Wyre	Richard Emmess
Greater Preston	Judith Culshaw
Lancashire North	Stephanie Tufft- Age UK
West Lancashire	Greg Mitten

3. The Commissioning Climate

3.1. In the early days of the Coalition, the Government enthusiastically endorsed a private member’s bill which became the Public Services (Social Value) Act 2012. It came fully into force on 31 January 2013.

3.2. The Act places a requirement on commissioners to consider the economic, environmental and social benefits of their approach to procuring services before the actual process of procurement starts. This is because of the need to inform the whole shape of the procurement approach and the design of the services required. Commissioners can use the Act to re-think outcomes and the types of services to commission before the procurement process gets underway.

3.3. On the face of it, such a process should give significant opportunities for the sector to both participate in the design of public contracts, and to be in a better position to tender for them.

3.4. Unfortunately, the Act is overlaid by European Union Directives and Public Contract Regulations which mean that is applies only to contracts above certain thresholds, namely

- £113,057 for services contracts awarded by central government and the NHS
- £173,934 for all other contract bids

3.5. This means that only the larger third sector bodies are able to deploy the social value case in tendering for such contracts, although they can in turn 'sub-contract' elements of them to smaller partners. Nevertheless, commissioners can, at their discretion, apply social value clauses to contracts under these thresholds.

3.6. A question of vital importance is whether local authorities and CCGs intend to apply social value just to contracts above the thresholds, which is the mandatory requirement, or whether they also intend to apply them to smaller contracts. This would enable smaller organisations to enter the public service delivery market directly.

3.7. An interesting example of commitment to social value is the work that Oldham Council has done with its partners, including the third sector. It is described in Appendix C**.**

3.8. The National Association for Voluntary and Community Action (NAVCA) says that " Chris White, the MP who proposed the Bill has called the Act 'a work of persuasion'- a way of trying to change a culture. It is not about compliance but about procurement taking risks….. But support for the principles of the Act appears to be waning."

3.9. If true, this is a shame. Of course the third sector understands the pressure that public bodies are under to squeeze every drop of benefit out of every pound they spend. But the extensive use of volunteers by the third sector can, of itself, enable it to compete effectively on price, given the opportunity to do so. But approving all tenders simply on the basis of lowest price can deny to the public benefits which cannot always be measured in financial terms. They include:

- Closeness to communities

- Enabling good understanding of each other with elected representatives and better engagement with community interests
- 'Going beyond the call of duty'
- Working outside 'office hours'
- Agility in finding ways to deliver services, and responding to urgent needs
- Demonstrating 'the heart as well as the head' of community service

4. Obligations upon the Third Sector

4.1. It goes without saying that there are obligations on the part of the third sector itself if it is to extend its role in commissioning.

4.2. These certainly include:

- Gaining a good understanding of the constraints upon the public sector
- Willingness to collaborate with sector partners
- Recognising the need for reform and rationalisation within the sector
- Moving away from a 'culture of entitlement', where grants are being largely replaced by contracts
- A willingness to innovate
- Focussing on good service to the public rather than its own internal machinations.

4.3. One Lancashire, across the whole sector, and Third Sector Lancashire in the Health and Well-Being field, are totally committed to working with the ‘front line’ in fulfilling these principles.

4.4. At the same time, the sector recognises that it cannot be given preferential treatment for contracts regardless of cost. Instead, it seeks to secure a commitment from commissioners always to take into account the distinctive offer it can make.

5. Conclusion

5.1. The thrust of this paper has been to recognise the contribution that the third sector is ready and willing to make to the effective and efficient provision of quality services to the public through the commissioning process in the health and well-being field.

Hopefully, it is a balanced portrayal, recognising especially the work the sector can offer to ‘well-being’, alongside the much greater and more extensive skills of professionals working in health and social care. It is in that spirit that the above recommendations are made.

Consultations

One Lancashire Board members were consulted on this paper

Implications:

The public sector bodies who make up the Health and Wellbeing Board will need to take legal advice on the final recommendations made by the Joint Officer Group:

Risk management

If the recommendations above are not taken on board, then there is a risk that the Marmot Principles of having a vibrant third sector could be jeopardised and the smaller grass root third sector organisations would remain dependent on grants.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper Date Contact/Directorate/Tel

Reason for inclusion in Part II, if appropriate

N/A

Third Sector Lancashire
Working for better Health and Care

ONE NE LANCASHIRE
WORKING BETTER TOGETHER

Hearings Programme 2014

Date	Time	Venue	Theme	Keynote Speakers	Co-Producer
January 30th	10:00 - 13:00	Gujarat Hindu Centre Preston	Market Event for the Third Sector Health and Wellbeing Providers	**Steve Gross**: Executive Director Adult, Community Services and Wellbeing **Mike Barker**: Greater Preston CCG	Neil Coulson-Consulting
May 7th	9:30 - 12:00	St Ambrose Parish Hall Leyland	Innovation in Health and Care	**Richard Jones**: NHS England **Dr James Fleming**: GP **Stephen Sloss**: Salvere **Caroline Sagar**: nCompass	
June 11th		St Cuthbert's Parish Hall Fulwood, Preston	Health and Benefits The Impact of Changes in the Welfare System	**Jim Dickson**: Head of Welfare Rights, LCC The Maundy Project **Austin Staunton:** North Lancashire CAB **Lucy Hardwick:** Maundy Relief Project	Help Direct
July 17th			Fit for Purpose	**Dr William Bird**: GP and Founder of Intelligent Health **Adrian Leather**: Chief Executive Lancashire Sport Public Health LCC	Lancashire Sport
September 9th		Whalley Abbey	Faith, Health and Wellbeing	**Reverend Dr Mike Kirby**: Cancer Therapist,Liverpool University Muslim Chaplain at Blackburn Royal Hospital Psychologist	Blackburn Diocese
October 15th		*Town Hall Accrington*	*Health, Wellbeing and the Private Sector*	*A Private Care Home Provider* *A local industrialist*	*Lancs Economic Partnership*
November 13th		*Abel Street Mosque Burnley*	*Health and Wellbeing Issues in Ethnic Communities*	*Public Health* *Ethnic GP*	*BME Reps*
December 11th			*Working Together*	*Professor Chris Heginbotham: Board Member of Lancashire Care NHS Trust*	*LCFT*

**The text in italics are proposed arrangements that are to be confirmed.*

Health and Wellbeing Group Members

Oldham Council Example

Social value procurement framework

03-05-13 v. 5

1. Introduction

As a Co-operative Council we are committed to acting in a socially responsible way and to influencing the organisations we work with to do the same. Our values and priorities in this respect are detailed in our Ethical Framework, which was agreed by Cabinet in October 2012.

One of the key tools at our disposal in making the Ethical Framework tangible is our approach to commissioning and procurement. We spend in excess of £232million with 5,700 trade suppliers each year, so by formally and consistently considering social value in the decisions we make in spending this money, we can make a major contribution to delivering a Co-operative Borough.

2. How do we plan to use this framework?

• For each procurement exercise, we will identify which of the outcomes in the table below are appropriate for inclusion.

• Appropriate outcomes will be identified from the table below on the basis of what is relevant and proportionate for each contract.

• This means that our approach to social value is a bespoke approach, tailored for each and every contract.

• Every tendering exercise will include at least one of the outcomes listed below.

• Suppliers will be scored on their responses to the question about how they will deliver against these outcomes.

• Suppliers will also be scored on their responses to an accompanying question about how this will be measured and verified.

• The responses of the winning bidder will be incorporated into the contract and the ensuring contract management and monitoring process.

3. Our procurement principles

As we face increasing pressure on resources and increased demand on public services, it is imperative that we achieve the maximum value from every pound that we spend. When we commission and procure, this means that we need to focus on

outcomes rather than outputs to ensure that we achieve the greatest possible impact and, therefore, the best value for money on behalf of Oldham's residents.

Our social value procurement framework seeks to achieve this by ensuring that social, economic and environmental outcomes are systematically incorporated into procurement practices, so that we can achieve greater impact from each and every contract. Tenders will be scored against these outcomes, and contracts will be monitored against them.

In addition to the specific outcomes listed in the table below, we are also committed to a set of principles which guide every commissioning and procurement exercise that we carry out:

We are committed to, and we expect our suppliers to be committed to:

• supporting the local economy, including through any sub-contracting;

• delivering at neighbourhood-level wherever appropriate;

• reducing demand for public services and including appropriate incentives in contracts, such as contract extension opportunities for suppliers who effectively reduce demand;

• supporting the community and voluntary sector through our suppliers and contracts;

• fostering positive relationships between and within different communities (both geographical communities, such as Limeside or Shaw, and communities of interest, such as people in a particular age group or people of a particular faith);

• robust enforcement in cases where suppliers fail to deliver agreed outcomes;
• working positively with suppliers to deliver the maximum possible social value together (e.g. we might offer a supplier discounted use of our buildings in order to enable district-based delivery of services across the borough);

• paying our suppliers promptly;

• engaging our staff and working constructively with trades unions;

• endorsing / promoting suppliers who engage successfully and positively with our social value approach to procurement;

• upholding and maintaining our ISO14001 environmental management system accreditation;

• 100% compliance with environmental legislation and health and safety legislation.

4. Our Social Value Procurement Framework

Theme	Outcomes: What are we trying to achieve?	What could this mean in practice for suppliers? What could they deliver? (NB. These are examples only – not an exhaustive list)
a) Jobs, growth, and productivity	**Outcome 1:** More local people in work	Create x number of new jobs in the local economy (i.e. within the borough of Oldham)
		Create x number of traineeships (including apprenticeships) for Oldham borough residents
		Provide x number of days of meaningful work experience for Oldham borough residents
		Support x number of people back to work by providing career mentoring for job clubs, including mock interviews, CV advice, and careers guidance
		Supporting young people into work by delivering employability support (e.g. CV advice, mock interviews, careers guidance) to x number of school and college students
		Employ x number of ex-offenders (or other group of people who typically face additional challenges in competing in the labour market)
	Outcome 2: A local workforce which is fairly paid and positively supported by employers	Pay staff the Living Wage
		Increase rates of pay for lowest-paid staff by x%
		Improve the skills levels of existing staff by training x% of the workforce to Level 2/3/4 (for example)
		Reduce average sickness absence by x% through an improved health, wellbeing and support package for staff
		Identify all staff who are carers and ensure flexible working practices are implemented to support these responsibilities within x weeks of contract start date
	Outcome 3: Thriving local businesses	Support x number of new business start-ups by running practical workshops with enterprise clubs
		Support the local economy by spending x% of total expenditure in the local supply chain (i.e. within the borough of Oldham) - this could be measured with tools such as LM3
		Support the local supply chain by spending x% of total expenditure in a 10-mile radius / within the borough of Oldham
	Outcome 4: Responsible businesses that do their bit for Oldham	Attract £x worth of inward investment into the borough
		Secure positive profile for Oldham through x number of positive stories in the national media
		Support Oldham's Fairtrade Town status by ensuring that x% of food products in the supply-chain is Fairtrade
		Secure £x-worth of investment in, or in-kind contributions to, fuel poverty initiatives in Oldham
		Support staff, service users and residents to fundraise £x for the Co-operative Oldham Fund (and/or match-fund x% of the total funds raised).
b) Resilient communities and a strong voluntary sector	**Outcome 5:** An effective and resilient third sector	Contribute x number of hours of business planning support / financial advice / legal advice / HR advice to community and voluntary organisations through an Employer-Supported Volunteering scheme
		Provide facilities for use by community and voluntary organisations for x number of hours per year
		Work with community and voluntary organisations to create x number of new volunteering opportunities in the borough
		Support local third sector organisations through the supply chain by spending x% of total expenditure

		with community and voluntary sector providers based in the Oldham borough
	Outcome 6: Individuals and communities enabled and supported to help themselves and each other	x% of service users supported to self-help
		Coordinate and run a befriending scheme to reduce social isolation (and thus prevent the consequences of social isolation) for x number of older people
		x% of customers directed towards lower-cost forms of contact (eg. phone or web rather than face-to-face), including training service users to use IT as necessary
		Support x number of service users to engage in volunteering
		Support x number of service users into work experience / paid work / training
		Work with x number of service users to design / deliver the service
		Deliver the service on a localised basis so that the average distance to travel to access the service is reduced by x miles
		x% of residential social care users supported to live independently
c) Prevention and demand management	**Outcome 7:** Acute problems are avoided and costs are reduced by investing in prevention	x% overall spend disinvested from acute interventions and reinvested in prevention
		Support more people to manage their finances effectively by increasing the number of residents who save with Oldham Credit Union by x
		Support prevention by running education and publicity campaigns with specific targets (e.g. support x number of staff / residents / service users to stop smoking / increase their physical activity / access money advice)

d) A clean and protected physical environment	**Outcome 8:** We are protecting our physical environment and contributing to climate change reduction	Reduce the amount of waste generated by x% compared to previous contract
		Reduce the amount of waste sent to landfill by x% compared to previous contract
		Reduce carbon emissions by x% per year
		Reduce overall energy consumption / water consumption by x% per year
		Increase the use of renewable energy / community-generated renewable energy as a proportion of total energy consumption by x% over the lifetime of the contract (without increasing overall energy consumption)
		Support x number of households to better manage their energy demands through improvements in the fabric of their homes, bringing them out of fuel poverty and contributing to climate change goals

Health and Well Being Board
Meeting to be held on 29 April 2014

Electoral Division affected:
All

Improving outcomes for children and young people with Special Educational Needs and Disabilities (SEND): implications for health services and local authorities implementing the Children and Families Act (SEN) 2014
(Appendix 'A' refers)

Contact for further information: Sally J Riley, 01772 532713, Directorate for Children & Young People, Sally.Riley@lancashire.gov.uk

Executive Summary

The purpose of this report is to provide the Board with an update in respect to the implementation of the Children and Families Act (SEN) 2014. It offers:

- an overview of the key SEND Reforms, and
- outlines the main duties and responsibilities for health services in partnership with the local authority to implement the required changes in legislation.

Recommendation

The Health and Well Being Board are invited to receive, consider and comment upon the report.

Background and Advice

The Children and Families Act 2014 will be implemented from September 2014 and has major implications for how the NHS organises and delivers services to children and young people who have a Special Education Need and/or Disability (SEND) between the ages of 0 and 25. It will reform the system of support across education, health and social care to ensure that services are organised with the needs and preferences of the child and their family firmly at the centre, from birth to the transition to adulthood.

This is an important step forward, children and young people who have a Special Education Need and/or Disability make up a significant proportion of the childhood population, with up to 20% of school age children and young people having SEN. Across this group there are a diverse range of health needs, which include children and young people with long term health conditions, children and young people with autism and children and young people with sensory impairments and children and young people with mental health issues. It will also include children and young

people with multiple and complex needs who may be dependent on technology, children and young people with behaviour that challenges and children and young people with a life-threatening or life-limiting condition.

Meeting these health needs will often require a range of different NHS services, provided by different professionals which often cut across organisational boundaries. Children with SEN and disability are therefore disproportionately disadvantaged by a system that does not integrate services, support them to make decisions about their own care or adequately support them during the transition to adult services. The Children and Young People's Health Outcomes Report highlighted the need to improve services for children and young people in England, and to make sure they work closely alongside education and social care services to provide the right support where and when children, young people and their families need it.

Getting this right will require practical and cultural changes from professionals, clinicians and commissioners working with and for children and young people. While this will present a challenge, the solutions will build on many of the current drivers of change within the NHS and social care, and present an opportunity to reduce costs in the long run.

The focus on person centred care and integration of services that are central elements of the NHS Mandate and NHS England's Everyone Counts strategy and prioritising children and young people's decision making supports the principles and rights set out in the NHS Constitution. The reforms sit alongside the commitments in the Better Health Outcomes for Children and Young People Pledge to improve the health system for children, young people and their families by delivering integrated, person centred health care, and will support the integration agenda being strengthened by the Care Bill.

This report highlights the key reforms in the Children and Families Act 2014 and some of the key issues professionals in health services should be addressing as they prepare for the implementation of the reforms.

The main areas of focus are:

- The new joint commissioning arrangements for local authority and health commissioners
- Health services' role in the identification and assessment of children and young people with SEN and disability
- What the introduction of Education Health and Care plans (EHC plans) for children and young people with SEN mean for health services
- Complaints and redress

The importance of working together

To achieve person centred support across Education Health and Social Care the Children and Families Act 2014 is placing duties on local authorities (LAs), health bodies and other partner organisations to work together to deliver support and

services to the children and young people with SEN and/or disability they are responsible for.

The Children and Families Act requires LAs and their health partners (meaning each CCG with responsibility for commissioning health services in the LA area, and NHS England) to establish joint commissioning arrangements to improve outcomes for children and young people with SEN and disability. Commissioning Support Units may take on an important role in supporting this agenda. In addition NHS Trusts, NHS Foundation Trusts, Health and Wellbeing Boards and service providers must also have regard to the Children and Families Act 2014/Code of Practice to ensure they are able to contribute to the implementation of the new system of support.

Joint working between local authorities and health bodies is not new; there are a range of existing duties on the LA and health bodies requiring them to work together.

The Health and Social Care Act 2012 and the NHS Mandate both make clear that NHS England, CCGs and Health and Wellbeing Boards must promote the integration of services if this will improve services and/or reduce inequality, and they should consider arrangements under section 75 of the National Health Service Act 2006, including the use of pooled budgets. The Children Act 2004 also places a duty on local authorities to make arrangements to promote cooperation with its partners (including the police, health service providers and youth offending teams and the probation services) in promoting the wellbeing of children and young people under 18 which includes safeguarding and the welfare of children.

In order to have the greatest impact the joint commissioning arrangements introduced by the Children and Families Act 2014 should build on examples of existing good practice where possible. It is also important each area looks at the links between the implementation of the reforms and the current drivers of system transformation and integration in each local area. This may include the priorities in the Joint Health and Wellbeing Strategy or work being undertaken as part of the Better Care Fund.

Joint Commissioning arrangements

The Children and Families Act 2014 gives local areas the freedom to meet local challenges flexibly. It does not specify how joint commissioning processes should be structured in each area or how specific services should be commissioned. However there are some specific arrangements that every local partnership must put in place to improve outcomes for children and young people with SEN and disability.

Every local authority areas' SEN and disability joint commissioning arrangements must clearly set out:

- The education, health and social care provision reasonably required by local children and young people with SEN and disability, and how this provision will be secured and by whom
- What advice and information is to be provided about education, health and care provision and who is responsible for providing this advice

- How health services will support the identification of children and young people with SEN and disability
- The process by which local health services (including primary and secondary care) are able to inform the local authority of children, including those under compulsory school age who they think may have SEN and/or disability
- How complaints about education, health and social care provision can be made and are dealt with
- Procedures for ensuring that disputes between local authorities and CCGs are resolved as quickly as possible
- How partners will respond to children and young people who need to access services swiftly
- The joint commissioning must also include arrangements and responsibilities for securing outcomes and personalised services, specifically:
    - Securing Education, Health and Care assessments;
    - Securing the education, health and care provision specified in EHC plans; and
    - Agreeing personal budgets

The joint commissioning arrangements should also take account of the full range of policies that affect the provision of education, health and social care services to children and young people with SEN and disability, which may include:

- The Common Assessment Framework
- Criteria for NHS Continuing Health Care Funding and National Framework for Children and Young People's Continuing Care
- The implementation of the supporting pupils at school with medical conditions guidance
- Individual schools' SEN information reports
- The legal requirements to make reasonable adjustments under the Equality Act

Who is responsible for making this happen?

The Joint Commissioning Duty in the Children and Families Act 2014 specifies that the Local Authority and its partner CCGs and NHS England must establish local governance arrangements which ensure clear ownership and accountability across SEN and disability commissioning with clarity about who is responsible for delivering what, with accountability to named councillors and senior commissioners across education, health and social care. These arrangements should be clear regarding who can make decisions both operationally (e.g. deciding what provision should be put in an EHC plan) and strategically (e.g. what provision will be commissioned locally, exercising statutory duties).

It is important that these arrangements make clear the links between services commissioned by a local CCG and services commissioned by NHS England to ensure that the provision children and young people with SEN and disability receive fits together seamlessly and there are not gaps in provision at critical points.

To coordinate health involvement in the joint commissioning arrangements the Children and Families Act Code of Practice states that a Designated Medical/Clinical Officer should be identified by each CCG. The Designated Medical/Clinical Officer role should be to ensure that the CCG is exercising its statutory functions effectively. They can also function as a point of contact for local partners such as local authorities and schools when making statutory notifications and seeking advice on SEN and disability. The Code of Practice recommends that they are an employee with clinical expertise such as a paediatrician or other health professional who will be able to exercise their functions effectively.

Improving outcomes for children and young people with SEN and disability in Lancashire.

The goal of joint commissioning is to improve outcomes for children and young people and their families with SEN and disability. Local partners will need to develop a shared vision for children and young people with SEN and disability and their families in their area and a clear plan of what needs to be put in place to achieve this. This requires local partners to share a clear understanding of these needs and how they are currently met by education, health and care provision and to identify any gaps in provision that need to be addressed.

Partners must also involve children, young people and their families in this process, they are central to the process of reviewing provision and developing shared outcomes. These outcomes should form the basis of reviewing strategic commissioning decisions and should contain measures for monitoring and evaluating progress.

The local authority and its health partners should monitor the changing needs of children and young people with SEN and disability in their local population and assess whether or not the available provision is improving their outcomes. This process of assessing need, provision and identifying outcomes should be linked to the existing Joint Strategic Needs Assessment (JSNA) carried out by the Health and Wellbeing Board and make full use of the available local data. This is an opportunity for local partners to think about how they can work together to achieve their existing outcomes. This may include how joint commissioning for SEN and disability can help partners meet goals in the Joint Health and Wellbeing Strategy, objectives in the NHS Mandate, or indicators in the NHS Outcomes Framework, the Public Health Outcomes Framework, or the CCG Commissioning Outcome Indicator Set.

Examples of shared joint commissioning outcomes include:

- Improved educational progress and outcomes for children and young people with SEN and disability
- Increasing the proportion of children with SEN and disability whose needs are identified in the early years
- A reduction in avoidable unplanned episodes of care in acute hospital services
- Improved family (or patient) experience feedback.

The Children and Young People's Outcomes Forum Report contains more information on the importance of outcome measures for children and young people.

When these outcomes have been agreed the local authority and health partners will have to agree how they are going to be achieved. This may involve commissioning services in a different way, integrating workforces and involving children and young people with SEN and disability and their parents in the commissioning process. Partners should also consider using their powers to pool budgets to deliver improved outcomes.

Progress against these outcomes should be reviewed on an ongoing basis, and this process must involve the views of children and young people with SEN and disability, and their parents. There must also be clear arrangements that set out how the partners will resolve disputes over commissioning decisions and hold each other to account for delivery of the outcomes.

Any changes in the education health or social care provision commissioned locally as a result of this process should be clearly reflected in the local offer.

The Local Offer

Alongside the joint commissioning arrangements the Children and Families Act 2014 introduces a duty on every local authority to publish and maintain a Local Offer. The Local Offer is a document that sets out the provision the local authority expects to be available for children and young people with SEN and disability, who they are responsible for, including provision outside the local area. The Local Offer must be developed by local authorities and their health partners, together with children and young people with SEN and disability and their families. The Local Offer should build on the JSNA and the analysis of local SEN and disability needs. As well as providing information about the services that the local authority expects to be available the Local Offer should also perform an important function as a tool to improve provision by setting out how services will meet local need and achieve the outcomes set out by the joint commissioning arrangements.

The Local Offer will need to set out the health provision available to children and young people with SEN and disability. The local authority **must** consult with all health authorities, including CCGs, NHS England, NHS Trusts and NHS Foundation Trusts when drawing up the local offer and these organisations **must** cooperate with the local authority by providing information on their services including:

- Clinical treatments and delivery of medications
- Therapies such as speech and language therapy, occupational therapy and physiotherapy
- Services assisting relevant early years providers, schools and post-16 institutions to support children and young people with medical conditions
- Nursing, portage, continence services
- Child and Adolescent Mental Health Services (CAMHS)
- Palliative and respite care and other provision for children with complex health needs; specialist equipment such as wheelchairs, splints and continence supplies
- Emergency healthcare provision

- Information about Continuing Health Care Funding
- Support for young people when moving between healthcare services for children to healthcare services for adults.

It should also include highly specialist services commissioned centrally by NHS England including:

- Alternative communication systems
- Services for rare conditions
- Specialist mental health services
- Provision for young offenders in the secure estate

The Local Offer **must** also meet the following requirements:

- The local authority must involve parents, children and young people in developing and reviewing the local offer, and cooperate with service providers.
- The local offer should be promoted to children and young people with SEN and disability and their families, and the information should be easy to understand and jargon free.
- The local offer must cover available provision across education, health and social care from the ages of 0 to 25, with details of how these services can be accessed and any admission or eligibility criteria. It must also include clear details of where to go for information, advice and support, as well as how to make complaints about provision or appeal against decisions.
- The local offer must be clear about how commissioning decisions and decisions about services are made and who is accountable and responsible for them.

What are health services' responsibilities towards individual children and young people with special educational needs?

In addition to strategic joint commissioning arrangements, the Children and Families Act 2014 also introduces new responsibilities for the health service towards individual children and young people with special educational needs (SEN). This is a different definition and does not cover disabled children and young people who do not have SEN.

The importance of delivering health services as part of an integrated package for children and young people with SEN is underlined by the NHS Mandate objective that children and young people "have access to the services identified in their agreed care plan, and that parents of children who could benefit have the option of a personal budget based on a co-ordinated assessment across health, social care and education."

What is health's role in identifying children and young people with SEN?

The health service has an important role to play in identifying children and young people who may have, or may develop SEN. The joint commissioning arrangements between the local authority and the health service must set out how the health

service will support the identification of children and young people with SEN. This requires clear arrangements, understood by staff, to ensure that:

- Professionals in local health services (including primary and secondary care) understand how they can inform the local authority of children who they think may have SEN

- Identification of children with SEN is a consideration at key points of a child's interaction with the health service, especially health checks in the early years

- There are individuals designated with responsibility for fulfilling this function who provide a clear point of contact for LAs and schools seeking health advice on children who may have SEN and disability.

What is the health service's role in the EHC Plan Assessment process?

Once a child has been brought to the attention of the local authority as potentially having a special educational need the local authority has to decide whether to carry out a statutory assessment for an Education Health and Care Plan, and it must inform the relevant health service of its decision.

Education Health and Care (EHC) Plans are legal documents that set out the education, health and social care support a child or young person with SEN requires when their needs cannot be meet by resources available to mainstream early years providers, schools and post-16 institutions. They are focused on the outcomes the child or young person wants to achieve and set out how services will work together to support these outcomes. They will also set out the details of any personal budget that has been identified to deliver some or all of the provision set out in the EHC Plan.

Information on the number and content of EHC Plans should also be used to inform the review of the joint commissioning arrangements by providing clear information about provision and outcomes relating to children and young people with SEN in each area.

When carrying out a statutory assessment of SEN the local authority must seek medical advice and information from health care professionals with a role in relation to the child or young person's health, and this information must be provided in a clear and specific written submission. The Children and Families Act 2014 makes clear that this assessment process should be well coordinated and result in timely, well informed decisions. All professionals involved should focus on the needs and preferences of the child or young person and their family and support them to be actively involved and make informed decisions regarding the assessment process.

Following this assessment process the local authority will use this information to develop an EHC Plan setting out details of the education, health and social care provision required by the child or young person and who is responsible for securing it.

Who is responsible for provision set out in the EHC Plan?

The relevant health commissioning bodies must agree to the health provision set out in the EHC Plan. If the health commissioning body does not accept the health provision set out in an EHC Plan because it does not agree that the provision is reasonably required to meet the child or young person's health needs then the health provision is not included in the EHC Plan. At this point if agreement can't be reached between the health commissioning body and local authority the partners should engage the dispute resolution process that must be set out in their joint commissioning arrangements.

After an EHC Plan has been agreed the relevant health commissioning bodies must ensure that the services listed as health provision are available to the child or young person until the plan is reviewed. This will involve drawing on the joint commissioning arrangements that set out how EHC Plans will be delivered, including responsibilities for funding arrangements between partners.

NHS England will be responsible for taking action to promote children and young people's access to the health provision set out in their EHC Plans, and will have an important role in supporting CCGs to meet these obligations.

Mediation, complaints and redress

When children, young people and their families are unhappy about the content of their Education Health and Care (EHC) Plan they can challenge decisions in a number of ways.

This involves the mediation and appeals system relating to special educational provision including the Special Educational Needs 1st Tier Tribunal, and the complaints process in health and social care.

The Government has made clear that it wants these processes to be better integrated and more accessible for parents, and have committed to investigating the extension of mediation and redress mechanisms to cover the social care and health elements of an EHC Plan. This involves a review and pilot process that will investigate different mechanisms to achieve this, including extending the authority of the Special Educational Needs 1st Tier Tribunal over health and social care provision.

This will be an ongoing process while the Children and Families Act 2014 is implemented but it is vital that all health bodies consider how they will respond to children, young people and their families who are not happy with the health provision available as part of the Local Offer or decisions relating to an Education Health and Care Plan. This should include thinking about how this information is collected, and how it is used intelligently to improve commissioning and delivery of services. The role of local Healthwatch, working together with local Parent Partnership Services should also be explored.

A timeline for implementation of the SEND reforms, published by the Department for Education, is provided at Appendix A.

Consultations

N/A

Implications:

This item has the following implications, as indicated: N/A

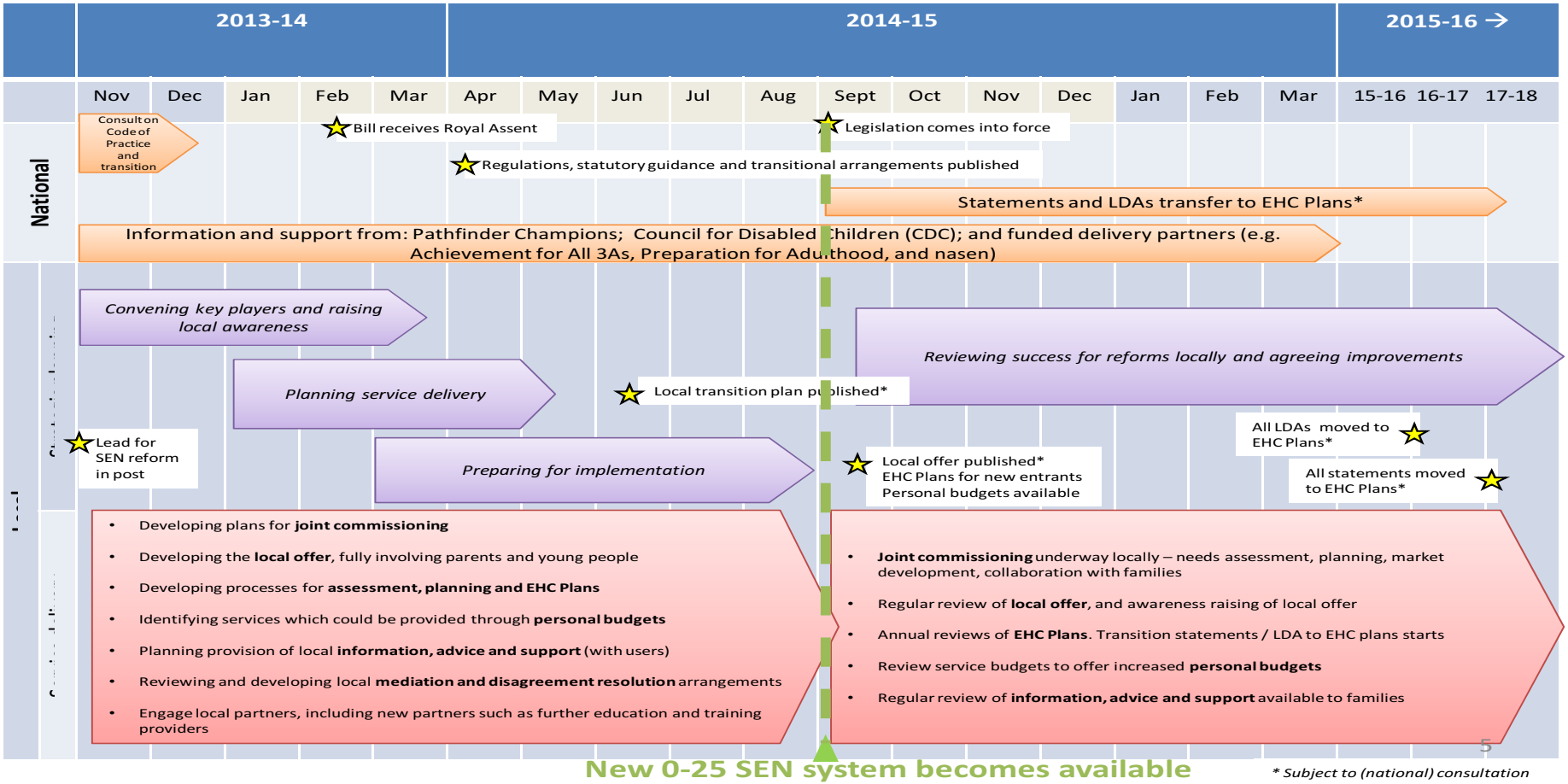
Risk management

N/A

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

Timeline for implementing a new approach



Health & Wellbeing Board
Meeting to be held on 29 April 2014

Electoral Division affected:
All

Pharmaceutical Needs Assessment: the responsibilities of Health & Wellbeing Board

Contact for further information: Peter Lobmayer, 01772539831, Adult Services Health and Wellbeing, peter.lobmayer@lancashire.gov.uk

Executive Summary

The report highlights the responsibility of the Health and Wellbeing Board in relation to producing and publishing a pharmaceutical needs assessment (PNA) by end of March 2015 the latest.

Recommendation

The Board is asked to

1. Consider how relationships between community pharmacies and the Local Pharmaceutical Committee can be strengthened through the Health and Wellbeing Board.

2. Consider the report for future arrangements for Lancashire Pharmaceutical Needs Assessment and responsibilities for the Health and Wellbeing Board.

3. Request an update in 6 months' time in relation to the development of a comprehensive Pharmaceutical Needs Assessment.

Background and Advice

Overview of Community Pharmacies

- Community pharmacies are a major provider of health and wellbeing services within England and 96% of the population, even those living in the most deprived areas, can access a pharmacy within 20 minutes on foot or on public transport.

- They dispense medicines with advice and support for patients with long term conditions, support self-care and appropriate use of purchased medicines and, in many cases, provide health promotion and brief interventions to their customers and patients.

- They make a significant contribution to their local communities, for example by making collections/deliveries for the housebound. Many community pharmacies also provide a range of public health information and advice, e.g. NHS stop smoking services.

- They play a major role in developing a sustainable local community, by delivering services that support people to live independently as well as providing a focus for community health and wellbeing such as directing people to their local carers support group or NHS services.

- There were 269 pharmacies in Lancashire County Council geography in 2010/11, 90 of those were in East Lancashire, 104 in Central Lancashire and 75 in North Lancashire former PCT area.

Pharmaceutical Needs Assessment

The Pharmaceutical Needs Assessment is a comprehensive assessment of the pharmaceutical health needs of the local population and aims to establish the current provision of pharmaceutical services, identify any inequalities in provision and consider the future provision of pharmaceutical services to meet the identified needs.

From 1st April 2013, statutory responsibility for publishing and updating a statement of the need for pharmaceutical services was transferred to Health and Wellbeing Boards. This statement of need is referred to as a Pharmaceutical Needs Assessment (PNA) and Health and Wellbeing Boards must ensure that they have considered the wider role of community pharmacy in supporting people's health and wellbeing.

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, require each Health and Wellbeing Board to:

- Make a revised assessment as soon as is reasonably practicable after identifying changes to the need for pharmaceutical services which are of a significant extent.
- Publish its first Pharmaceutical Needs Assessment by 1st April 2015.

NHS England Lancashire has written to the Chair of each Health and Wellbeing Board in Lancashire highlighting the Board's responsibility for the production of the PNA. The letter highlights a pan Lancashire approach to developing the PNA, via a small working group, and seeks support from the Health and Wellbeing Board in addition to an identified sponsor for this work stream.

Although the deadline is not imminent, there is an immediate responsibility to review the Pharmaceutical Needs Assessments inherited from the three former Primary Care Trusts to identify whether these are fit for purpose. These PNAs were produced in 2010 and 2011 and overall pharmaceutical services were found adequate, though some gaps in services in East and Central Lancashire were identified and major development opportunities highlighted that could improve the health of the population. As part of the needs assessment process there is considerable opportunity to explore the potential of the healthy living pharmacy programme.

Delivering the pan-Lancashire PNA is a major undertaking with an estimated timescale of 12 months which includes a statutory 60 day stakeholder consultation with a required list of organisations that must be consulted, e.g. NHS England; Local Pharmaceutical Committee; HealthWatch; Patient and Public Groups.

The PNA will help inform Local Authority public health commissioning decisions and by being linked to the Joint Strategic Needs Assessment can inform priorities to improve health outcomes and reduce demand for acute health and social services. The PNA should also be used by NHS England when determining whether to open new pharmacies and dispensing appliance contractor premises. Such decisions are appealable and decisions made on appeal can be challenged through the courts. The risk of challenge is significant.

Systems need to be developed to allow the Health and Wellbeing Board to:

- Identify any changes in need for pharmaceutical services within their area.
- Assess whether the changes are significant.
- Decide whether producing a new PNA is a disproportionate response, or decide upon a proportionate response to the need to update and publish the PNA.

The process for developing a PNA involves the Health and Wellbeing Board supported by Local Authorities, Clinical Commissioning Groups, NHS England Lancashire, Public Health England Cumbria and Lancashire Centre.

Issues for consideration

The Board must understand its responsibilities for the PNA, and be assured that there will be a robust engagement process and may want to consider how it will oversee the process and development of the PNA.

Consultations

In relation to the PNA a steering group has been established consisting of representatives from the following areas:

- Public Health from Lancashire County Council, Blackburn with Darwen Council and Blackpool Council
- Local Professional Network (Pharmacy)
- NHS England Lancashire

Wider consultation is part of the needs assessment process and will be delivered in due course.

Implications:

This item has the following implications, as indicated:

- Producing, updating and publishing PNA is a statutory duty of the Health and Wellbeing Board.

- Results of the PNA will be used for decisions over licencing new pharmacies and proposed changes in existing pharmacy licences e.g. for relocations

Risk management

Producing, updating and publishing the PNA is a statutory duty of the Health and Wellbeing Board

Not following the proposal may open the Council to litigation from prospective pharmacies and from those that plan to change their services.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
Pharmaceutical Needs Assessment of Central, North and East Lancashire (separate documents)	15/04/2014	Dr P Lobmayer MD, MSc Adult Services, Health and Wellbeing, 01772 539831

http://www.lancashire.gov.uk/corporate/web/?siteid=6101&pageid=39610&e=e

Reason for inclusion in Part II, if appropriate
N/A

Health & Wellbeing Board
Meeting to be held on 29th April 2014

Electoral Division affected: All

Update on 5 year strategic planning process

Contact for further information: Ann Bowman, Greater Preston CCG, Ann.Bowman@greaterprestonccg.nhs.uk Tim Mansfield, 01282 644687, East Lancashire CCG, Tim.Mansfield@eastlancsccg.nhs.uk

Executive Summary

This paper updates the Health and Well-Being Board on the NHS England strategic planning process and on the development of the 5 year strategic plan across:

Chorley South Ribble CCG
East Lancashire CCG
Fylde & Wyre CCG
Greater Preston CCG
Lancashire North CCG
West Lancashire CCG

The detailed CCG plans will be presented to the Health and Wellbeing Board on the 4th June 2014 and will include more detail on the vision and transformational priorities across the CCGs, and the implications of these plans at a Lancashire level.

Recommendation

The Health and Wellbeing Board is asked to:

1. Note the content of this report
2. Note that individual CCG plans will be presented to the Board on the 4th June 2014 for review as part of the sign off process.
3. Agreed to delegate authority to the Chair and Deputy Chair of the Health and Wellbeing Board if required to approve the final plans ahead of the deadline for submission to NHS England on 20th June 2014.

Background and Advice

Background

In December 2013, NHS England published the Planning Guidance 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' The guidance describes NHS England's ambition for the years ahead and its ongoing commitment to focus on

Lancashire County Council

better outcomes for patients. It describes the vision for transformed, integrated and more convenient services, set within the context of significant financial challenge.

This guidance identifies the need for CCGs to develop strategic plans covering a five year period, with first two years at operating plan level. Templates have been provided to support the completion of NHS England's information requirements, and for the five year strategic plans each CCG is being asked to provide a final 'Plan on a Page' and a completed 'Key Lines of Enquiry' submission by 20th June 2014 (following draft submission on 4th April 2014).

The Health and Wellbeing Board has already been involved in a major element of this strategic planning process through its Better Care Funding Submission on 4th April 2014, relating to increased integration of adult health and social care services. The 5 year plans being developed by CCGs are all written within the framework of the Health and Wellbeing strategy and align with the Better Care Fund submission.

Five year plans

The CCG 5 year plan submissions will be made up of:
- Plan on a Page submission (a one page summary of the key system objectives, interventions, values and principles and governance arrangements)
- Key Lines of Enquiry submission (containing narrative to provide further detail to the Plan on a Page, and following the structure of an NHSE provided template)

Each CCG strategic plan will include the following elements:

- A long term strategic vision
- An assessment of the current state and current opportunities and challenges facing the system
- A clear set of objectives, that include locally set metrics for improvement against the seven outcome ambitions covering all the NHS Outcome Framework domains
- A series of interventions that when implemented move the health system from the current position to achieving the objectives and implementing the vision

NHS England has also asked CCGs to identify the appropriate models of care in their area as part of their commissioning plans for the next five years. It has identified six characteristics that must apply to future models of care:

1. A new approach to ensuring the public is fully included in all aspects of service design and change and that patients are fully empowered in their own care.
2. A broader range of primary care services and an expanded role for GPs.
3. A modern model of integrated care.
4. Access to the highest quality urgent and emergency care.
5. A 'step-change' in the productivity of elective care.
6. Specialised services concentrated in centres of excellence.

Individual CCG Plans have been shaped by the national priorities above, combined with an understanding of current local outcomes and opportunities, and by engagement with local communities, patients and carers, in line with the 'Call to Action' process set out by NHS England in 2013.

Each CCG has completed a draft Plan on a Page and Key Lines of Enquiry Submission based on these elements, and aligned to existing local plans, the Health and Wellbeing Strategy and Better Care Fund submission. The drafts have been submitted to NHSE as part of the assurance process. Following feedback on the level of ambition and risk in each plan, they will be worked up further for final submission in June.

Advice

The Key Lines of Enquiry template requires CCGs to work with the Health and Wellbeing Board in developing and signing off the plans. The CCGs will present their submissions for review at the Health and Wellbeing Board on the 4th June 2014 and request that the Chair and Deputy Chair be authorised to approve the plans following this session. Without this approval, there is a risk that CCG strategic plans would not be signed off by the Health and Wellbeing Board before final submission, which would contradict national guidance and our ethos of local collaborative working.

In partnership with the CSU, each CCG is undertaking a review of their individual draft plans to highlight common themes and ambitions across Lancashire, and areas of common strategic intent which will be the focus for collaborative working and re-design over the coming years. The findings from this review will inform the final submissions and will be presented to the Health and Wellbeing Board in June.

Consultations

Appropriate local consultation has preceded and is ongoing as part of any change programmes which form part of the CCG 5 year plans and ambitions. Where this is appropriate, consultation is taking place on a structured and transparent basis within local CCG footprints.

Implications:

This item has the following implications, as indicated:

Risk management

N/A

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
None		

Reason for inclusion in Part II, if appropriate
N/A