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)	

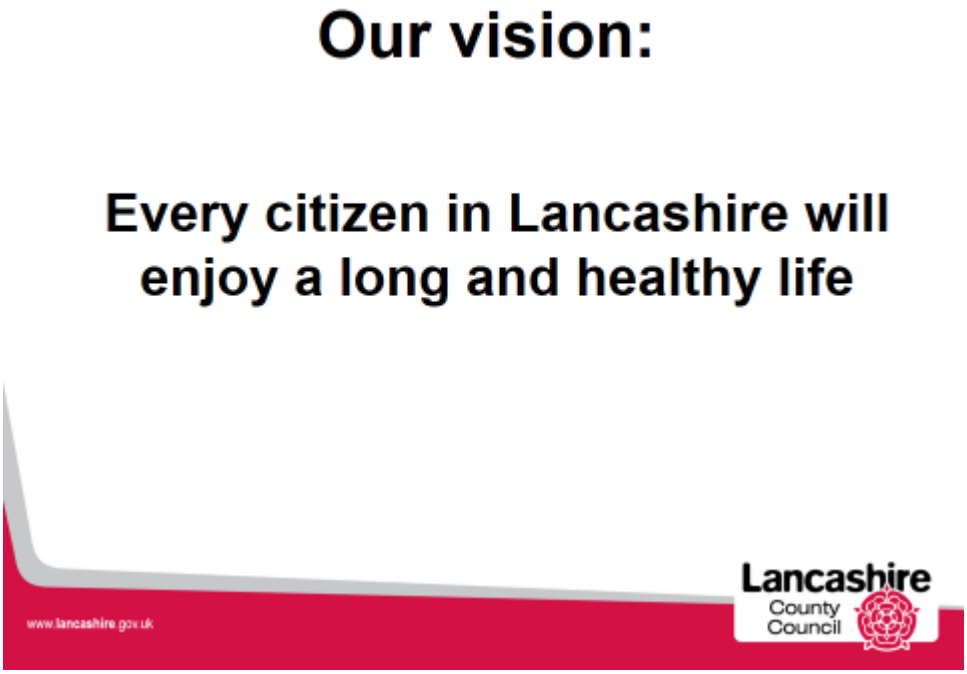
VISION AND SCHEMES

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.

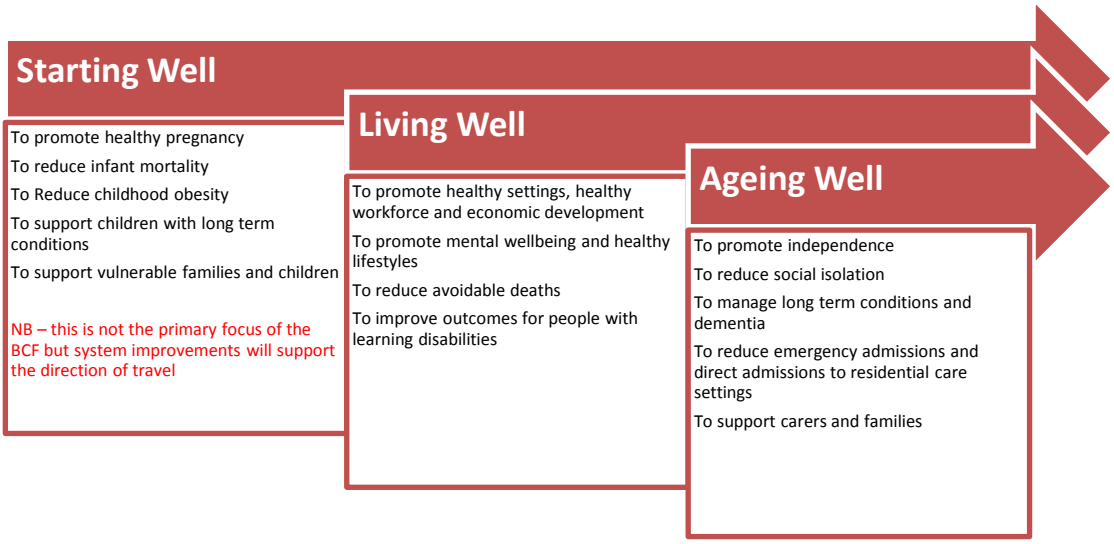
This complexity is mitigated with the use of the locality delivery plans which focus the strategic interventions at the levels that are most likely to succeed – addressing the realities of patient flows and capacity and demand management factors – whilst building a common approach to community infrastructure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

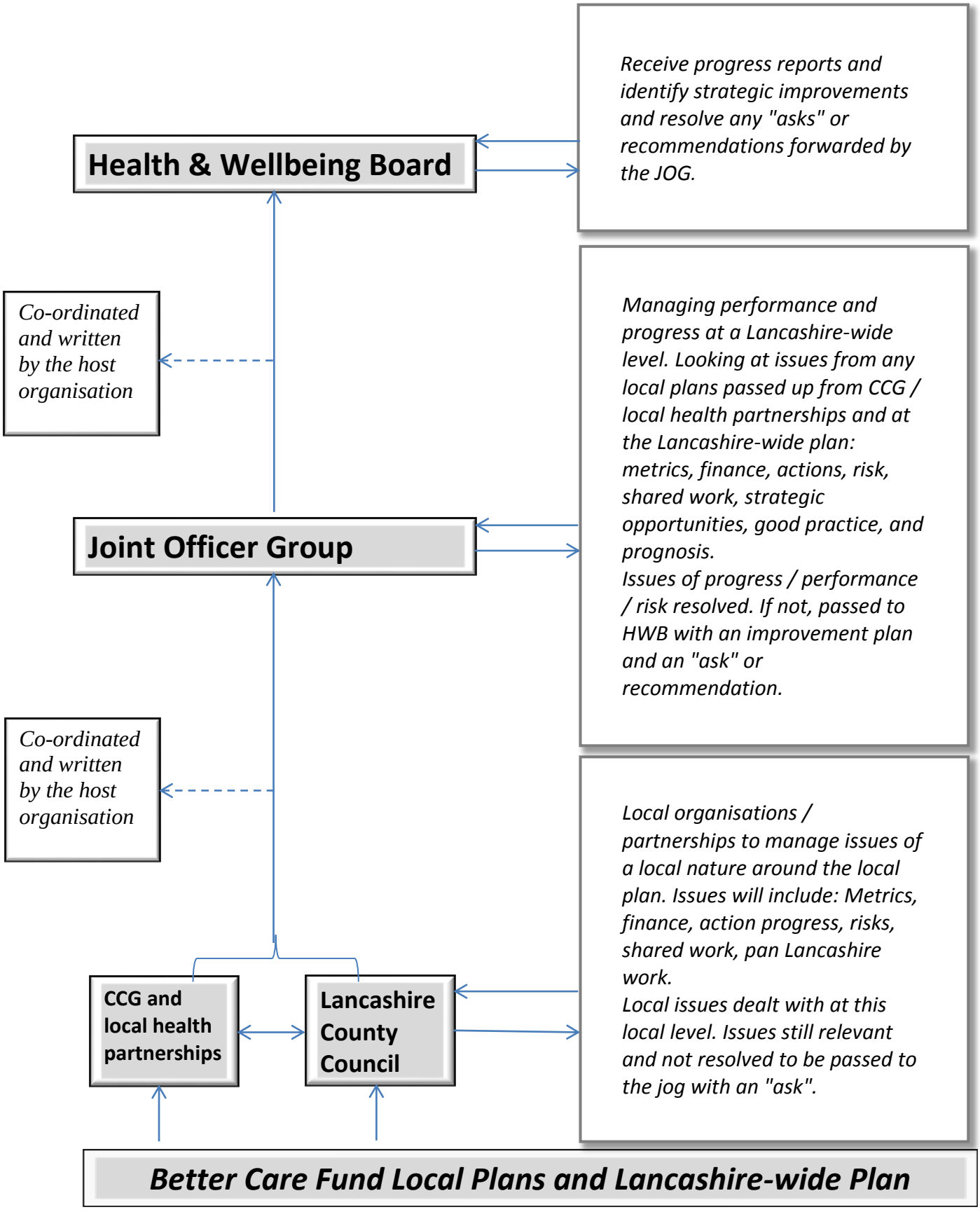
e) Governance

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