Updated on revised template August 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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
Boundary Differences	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 boundary issues are complex and are being managed by the use of component Better Care Plans on a Locality basis – aggregating up to the overall Plan. This is necessary because half of the CCGs on the Local Authority footprint (3 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 in some cases. 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, to reflect natural patient flows and key strategic partnering relationships. This BCF submission is therefore an overarching plan that aggregates 6 local positions and 5 local plans (as two CCGs have a joint management structure and therefore share a local plan). Work will continue to confirm system roles and mechanisms, taking into account the Lancashire specifics. The local plans form the basis for the Schemes – the delivery plans in each CCG area - and as such locality based measures will be used to gauge success relative to these plans.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF pooled budget: 2014/15	**£5541000**
2015/16	**£88930000**
Total agreed value of pooled budget: 2014/15	**£ 5541000**
2015/16	**88930000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Fylde & Wyre CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Chorley & South Ribble CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical	Greater Preston CCG

Commissioning Group	
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	East Lancashire CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Lancashire North CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	West Lancashire CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Lancashire County Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) 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	www.lancashire.gov.uk/corporate/health/index.asp
Health and Wellbeing Board Minutes Lancashire County Council Commissioning Intentions and annual business plan 2014/15	Available on LCC website

Dementia Strategy	There are three Joint Dementia Commissioning Strategies. One per former PCT footprint available on request.
Locality Better Care Fund Delivery Plans.	The 5 CCG level submissions which form part of the Lancashire submission.
6 CCG 2 Year Operational Plans	CCG Websites / available on request
CCG 5 Year Strategic Plans	CCG Websites / available on request
Lancashire Multi Agency Carers Strategy	Strategy 2013 – 2015 available on Council website
Lancashire JSNA	Available on Council Website
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) CSU QIPP Opportunity Packs (Per CCG and Pan Lancashire)	Available on request

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision:

Every citizen in Lancashire will enjoy a long and healthy life

Lancashire Health and Wellbeing Strategy

Lancashire has an agreed Health and Wellbeing Strategy, which was developed in line with findings from the JSNA about the priorities for the population.

In addition, CCGs have recently completed a period of intensive strategic and analytical review to underpin their Operational and Strategic Plans*.

The current state is well known and the vision is well rehearsed – at all footprints, from the natural Locality based 'health economies' to the wider Lancashire area. There is an obvious system challenge and a compelling case for change.

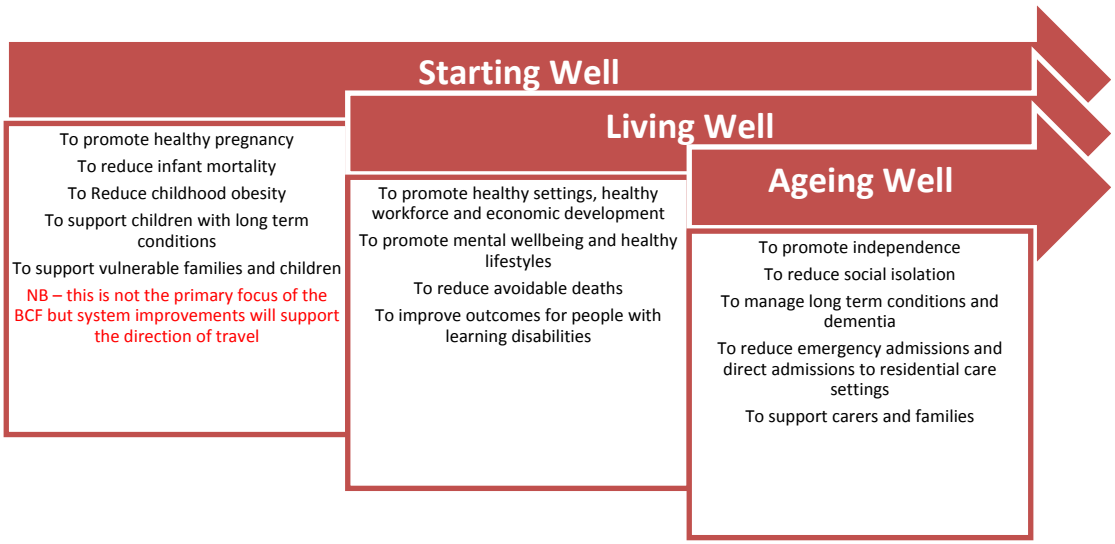
The Better Care Fund (BCF) plan focuses on those high impact changes that will be delivered through integrated service delivery and sustainable shifts in activity from the Acute Hospitals to care and health interventions and support being delivered in the community. These shifts are predicated on the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

Each Locality area has an individual scheme that is meaningful to their population and needs – this is included in Annex 1, which gives an overview of each local scheme.

There are of course consistent themes around the way that we need to work in the future which have implications for how some of the functions of the council will need to be structured in the future.

A focus on wellbeing and resilience 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 has, through 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.



*The Strategic Analysis has included:

- Consideration of the demographic, social and economic challenges - of each area and the whole footprint – as per the Joint Strategic Needs Assessment and local strategic reviews carried out by both CCGs and the 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

- Consideration of care trends/ use including residential and domiciliary care; reablement

- 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 has also 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

b) What difference will this make to patient and service user outcomes?

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.

Local integrated arrangements 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 to 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 support, wrap around community supports and alternative housing availability
 Patients and service-users experience of our systems will improve

By 2018…

People will have robust and routine access to wrap around support to promote the determinants of good health and well-being. This support will be developed and strengthened around existing community assets.

Neighbourhood capacity will be built to support and co-ordinate care – there will be dementia friendly environments and advisors; neighbourhood teams, effective multi-disciplinary assessment and treatment, reablement and rehabilitative support, rapid responses to crisis.

Neighbourhood teams 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. Those people with the most complex needs and risks will have case managers or coordinators identified increasingly through extensivist approaches so that individuals, carers and families have a consistent and reliable point of contact – and specialist care, including mental health or psychological services – will be easier to access. Neighbourhood teams will ‘stay with’ their patients throughout their care – for example assisting with discharge planning if a hospital admission is required, to ensure appropriate transitions and support back home.

Duplication of assessments will be eliminated and people will notice a radical improvement in the speed, continuity and convenience of the system of support.

People will be able to access clinical care locally that used to require a trip to the hospital – with intensive support at home or in other nurse led facilities. For those that do require 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.

When people are in crisis there are coordinated and accessible services to maintain people in their own home wherever possible. Information will be shared across Out of hours GPs, Emergency Departments and crisis services to ensure they respond in a way that respects

people's wishes and maintains agreed contingency plans.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

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 a shift to care closer to home.

We aim to achieve:

- System Transformation – includes cultural shifts, asset management, third sector stimulation, co-production and testing models of care such as the newly emerging Extensivist approach which is already being discussed and planned across the 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. Localities or neighbourhoods will be identified around registered populations for a number of GP practices – working with natural communities of 35000 -50000 people.

- 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. The Integrated Health and Well-being Framework will remodel current services and spend across Help direct, Supporting People, VCFS etc. at a local level.

- 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, including accelerating individualised care and personalised budgets.

- 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

- Funds for Disabled Facilities Grants (DFGs) will be redesigned with the district councils to ensure equity of access and secure the links between the provision of adaptations and maintaining people's independence.

- Care homes and domiciliary providers will become extended members of the team with access

to professional support to help people maintain independence, avoid deterioration. Initiatives will be coordinated and targeted to improve quality and reduce safeguarding escalation.

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 – commissioners, providers and interested stakeholders – which can be better utilised as part of a shared vision and reimagined as 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 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 CCG 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 andsocial 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 bought 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.

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

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.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Lancashire's Case for Change

The past year has been a leap forward in understanding in Lancashire – with new Clinical Commissioning Groups and the County Council taking a fresh approach to understanding, framing and tackling the challenges ahead.

In their first year of existence, CCGs have looked deeper at their own populations, trends and system roles – using expert partners such as KPMG, Price Waterhouse Coopers, Capita and the CSU – to carry out more systematic analysis of the Lancashire current state. A Pan-Lancashire diagnostic has highlighted areas where outcomes are poorer than would be expected given spend and benchmarks; locality analysis has provided more specificity into system blockers and enablers; and modelling has shown the size of the challenge in directly quantifiable terms – the numbers of avoidable admissions to both health and care settings and the consequent optimum shape of the infrastructure if these can be tackled, can now be much more closely visioned.

The 'no change' scenario is well known and modelled – the Lancashire 'system' simply cannot continue as it is – it would be both unaffordable and inappropriate for the people it serves. It is recognised that expected demand growth – not just in simple numbers, but in complexity and intensity - necessitates a change in healthcare responses – and therefore in its infrastructure.

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. There will need to be a wholesale shift – in settings, in specialisms, in expertise and in the cultures and behaviours that underpin them.

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. However, 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, use of emerging technologies for both communications and care.

*If it is decided locally to put forward a case for a trajectory different to the 3.5% - this is where the rationale / case narrative would seem to fit best. Awaiting agreement from partners.

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 longterm 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 have been agreed in the recent contract round and are reflected in CCG and Provider Plans.

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 makes reductions in acute care spend.

There is ongoing 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 vs community provision in the longer term.

The footprint of the Better Care Fund creates a new and unique opportunity for Lancashire – to join up and calibrate benefits 'at scale' across the whole system – to address the challenge as noted above, which is well known and well rehearsed.

Importantly, as the partnership evolves and matures it will generate greater leadership capability and collaborative intent, enabling commissioners to systematise leadership for Lancashire – understanding, managing and mitigating risks in partnership. The BCF plan is a key component part of CCG and Local Authority Strategic Plans and must be synchronised with Strategies for Specialist and Primary Care, Direct Commissioning, Provider Plans – as the required changes impact across the system and are interdependent.

This provides the opportunity to accelerate and maximise transformational change and in particular locality models to shift care closer to home and reduce unnecessary hospitalisation

The scale of the challenge cannot therefore be measured in data alone – certainly not by a crude measure of hospital admissions – but is multi factoral, requiring cultural and institutional change. Nonetheless, the changes will manifest in certain measurable areas:

- Admission avoidance – achieved by increased capacity and responsiveness of community services 7 days a week, wrapping around primary care populations; with access to step up and step down care and crisis support; mechanisms such as points of access and information sharing to streamline transitions and avoid system failures; redesign of ED Front Doors and alternatives to A&E; targeted NHS and Local Authority 'offers' for ambulatory care; reablement, rehabilitation; pathway redesign and service improvement including Ambulance provision, care sector,

intervention offers including for alcohol misuse; neighbourhood capacity to address loneliness, poverty, incapacity and seasonal difficulties (winter and summer).

- Reduced length of hospital stays / delayed discharges – achieved by improved patient flows, reduction of delayed discharges and improved multi-disciplinary assessment processes including elimination of duplication, reduced waiting times, integrated 7 day working, neighbourhood teams reaching into hospital; assessments in recovery and recuperation stages

- Improved transfers of care – achieved by the above – plus remodelling domiciliary and residential care with zoning around neighbourhood and primary care; improved end of life care planning and choice; increased access to intermediate and short term care solutions, improved provision of equipment and adaptations

- Reducing re-admissions – achieved by the above – plus improvement in quality and appropriacy of interventions at point of delivery; personalised care planning and budgeting; improved self care and self management support

- Reduced reliance on long-term domiciliary and residential care - achieved by the above with greater 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; addressing continuity and quality of care by recommissioning and zoning of domiciliary care; consideration of housing need in discharge planning; growth of extra-care sheltered housing as a viable and sustainable alternative.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

As shown in the matrix that follows – the Lancashire Better Care Plan will be delivered through 5 Transformational Schemes – one in each natural healthcare footprint:

- Chorley & South Ribble and Greater Preston Urgent Care Transformation
- East Lancashire Integrated Care Programme
- Fylde & Wyre – Fylde Coast Transformation
- Lancashire North Better Care Together
- West Lancashire Facing the Future Together

The above schemes are major programmes of change to deliver integration in each area – at the heart of each CCG 5 Year Strategic Plan on their 'Unit of Planning' footprints – and similarly central to the Local Authority intentions around the delivery of Care Act Ambitions locally. Whilst the exact shape of this differs in each footprint according to the local demography, economy and political factors, as well as natural patient flows and therefore the potentiality for change – there is a common drive to strengthen community and neighbourhood infrastructure. There is a common aspiration to promote good health and wellbeing.

The Better Care Plan brings these Schemes underneath one overarching system banner for the Lancashire County Council footprint – accelerating and enabling the changes described in the Case for Change.

- 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. CCGs and Public Health are now able to stratify and identify high risk individuals and target care planning

and co-ordination. 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.

- The Fund provides an opportunity to review the way services support carers in the major contribution they make, which reduces the impact on statutory services significantly.

- The Better Care Plan chimes with the CCG 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 improvements with people with the worst health outcomes. 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 management 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 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.

Insert Matrix here

b) Please articulate the overarching governance arrangements for integrated care locally

The Lancashire Better Care Plan is comprised of 5 major programmes of change:

- Chorley & South Ribble and Greater Preston Urgent Care Transformation
- East Lancashire Integrated Care Programme
- Fylde & Wyre – Fylde Coast Transformation
- Lancashire North Better Care Together
- West Lancashire Facing the Future Together

The Governance for integrated care is shown in each Scheme Annex – it is built around the governance necessary to deliver integrated care at each CCG level.

It has a different set of mechanisms to ensure ownership and appropriacy in each locality - determined by the specific local needs and requirements in each area of Lancashire – based on historic, political, demographic and infrastructural factors. This is also important to ensure any Governance is 'hard wired' at CCG Governing Body level.

The section below shows how these local elements are held together at a Lancashire Level through the Health & Wellbeing Board.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

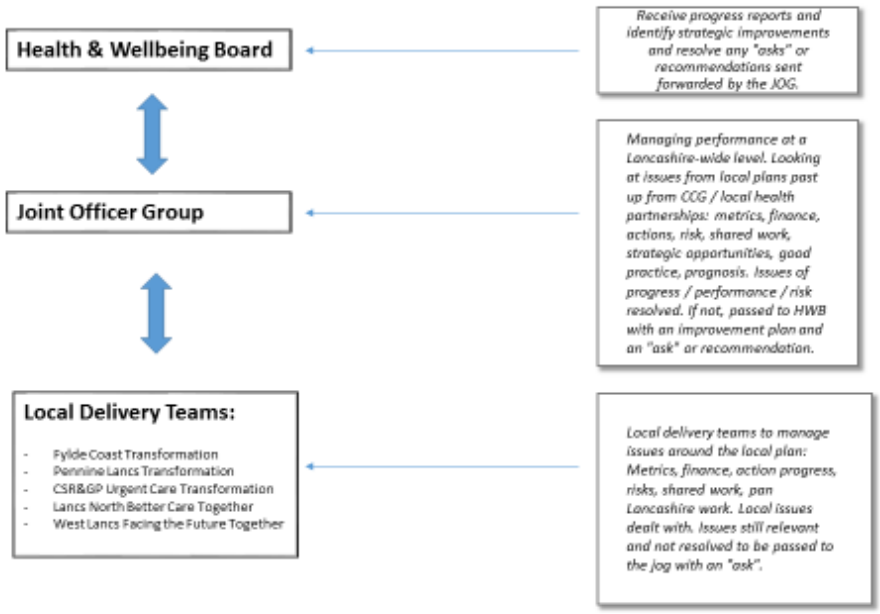
The Better Care Governance will build upon the agreed Health and Wellbeing infrastructure:

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.

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

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

Governance and Performance Management Framework



d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
BCCP	Chorley, South Ribble & Greater Preston - Urgent Care Transformation
BCEL	East Lancashire – Integrated Care Programme
BCFW	Fylde & Wyre – Fylde Coast Transformation Programme
BCLN	Lancashire North - Better Care Together
BCWL	West Lancashire - Facing the Future Together

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

This is an initial risk score. Scores are taken before any mitigating actions are completed.

There is a risk that:	Likeli-hood	Impact	Overall risk	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.	2	5	10	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	1	3	3	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	2	2	4	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	2	2	4	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	1	2	2	Clear robust governance arrangements will be agreed early to underpin development of the implementation plan
Workforce culture and development, processional boundaries and identities will be challenged *	See	Later		Staff briefing systems in place
Shift in emphasis to community care, wellness and prevention will not sufficiently impact on acute hospital activity	4	4	16	Ensure all partners are working towards the same goal of care closer to home. This is part of the Hwb strategy. Also to improve ongoing liaison with acute / provider
Integration of staff will require changes to working practices,	4	4	16	Early focus on gaps in skills and capacity will ensure that personal

There is a risk that:	Likeli-hood	Impact	Overall risk	Mitigating Actions
education and training – appropriate educational packages may not be available				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	5	3	15	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.	4	4	16	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	3	5	15	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.	3	5	15	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 (inc S75?)
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.	3	3	9	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. And work more closely
	3	5	15	The Whole Systems

There is a risk that:	Likeli-hood	Impact	Overall risk	Mitigating Actions
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				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	3	5	15	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. And an increase in engagement (now and ongoing) with acute / providers
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	2	4	8	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	3	4	12	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	5	1	5	Identify and discrepancies and agree correct numbers

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The timescale for the revised Better Care plan submission did not allow sufficient consideration and collective decision making in light of the new Performance Framework and associated risks and benefits. In addition, there remain significant queries regarding the mechanisms and rules which prevent partners from making a full assessment of risks.

All partners are committed to reaching an agreement on contingency and risk sharing prior to the commencement of the formal Performance scheme at which point it is hoped that the mechanisms and rules are clarified nationally and examples / best practice is shared.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

As noted in the sections above – the acceleration and co-ordination of existing initiatives and resources is core to the approach being taken for Better Care in Lancashire. The Plan is in itself a mechanism to achieve greater alignment in both commissioning and the delivery of care.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The BCF was aligned to the CCG Operational and Strategic Plans submitted in June 2014 and also to Local Authority plans at that time

This also fed into and formed the basis for contractual agreements now signed off and forming material legal agreements.

It should be noted that the original trajectory and metric assumptions were used as the basis for these Plans.

The introduction of a new metric with greater scale and pace of ambition came after the above process had been finalised and contracts agreed and therefore the new metric assumption and trajectory is anomalous.

As stated in the technical guidance – any revision of CCG Strategic / Operational Plans will be carried out for next years' submission.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

All CCGs with lead contracting responsibilities in the Lancashire Better Care Fund area have expressed an interest in co-commissioning primary care and are currently working up the detailed plans with the Local Area Team. These will be developed in tandem with the implementation of the major schemes of transformation in the localities and therefore will align with the direction and implementation of the Better Care Fund.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Within Lancashire, the County Council commissions and provides a range of adult social care services which, alongside a range of community health services in the area, making 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, aim and objectives of the plan.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Where local services, health or social care, 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

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The current S256 health transfer to social care amount of £25.291m (i.e. the Council's share of the national £1.1bn) has been allocated to protect social care services. Additionally, £3.1m has been identified within the BCF as the local proportion of the national £135m for the implementation of the new Care Act duties in 15/16.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The County Council has a Corporate Programme Board to oversee the development of Lancashire's response to the requirements of the Care Act. This is still developing proposals based on a continuing analysis of the draft guidance and regulations Priority areas which are being addressed are

- Carers - Additional Assessments and support - some additional in house capacity will be developed, and further work will be undertaken with existing Carers Services to review and develop their capacity

v) Please specify the level of resource that will be dedicated to carer-specific support

NEW – to be developed & agreed (Aidan to chase Dawn Butterfield) - This question can't be completed until all the finance templates are received, they are due 29th august

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

NEW – to be developed & agreed (Khadija? Aidan to chase) – we are not exactly sure what is required for this field. But, if a comparison is required between the current and previously submitted BCF plans, then the forecast effect on the local authority's budget has not changed from the previous version

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to 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 the full 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

i) Please set out the plans you have in place for 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.

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.

ii) Please explain your approach for 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 explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

We can confirm that we are aware of these requirements and committed to ensuring all appropriate IG controls will be in place.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

There are varied approaches to risk stratification across the Lancashire Better Care Plan area – see the Scheme detail for more information on approaches taken and the current state in relation to understanding of proportions of the population. It is not possible to aggregate into

one analysis at this point given the differences in systems and stages of analysis.

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.

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.

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 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

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

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 Locality Schemes 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 in commissioning and delivery of care
- 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, the eyes and ears, arms and legs of the neighbourhood team

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

As stated in the answer to part i) of this question – there is a variety in the approach taken in each Locality to risk stratification. It is not appropriate at this stage to give an overarching view as each area has adopted its own approach to understanding its high risk cohorts. Therefore it is not possible to identify across the whole plan the proportions within the risk stratification in the frame used for this question. See Scheme descriptions in Annex 1 for more detail.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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.

The hard and soft intelligence collected by both health and care consistently tells commissioners that people want to be cared for outside hospital – with the least possible disruption to their 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 – 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.

"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 Commissioning Intentions.

The principle of Prevention and Self Care underpins many of the schemes and interventions that lie at the heart of this Better Care 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 and care agenda.

There are multiple tiers of local government engaged throughout the process – with District Councils as well as Town and Parish Councils playing active roles within their communities. The Locality Delivery Plans will provide one of the mechanisms to ensure that these bodies are kept involved and form part of the learning and feedback loop necessary to guide change for their populations.

Engagement is being carried out by partners in their localities in line with the strategic footprints– this is an ongoing 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
- East Lancashire 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
- Eas 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 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
- Lancashire PPG, Carers and Public Event on 21 January

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

There is a firm commitment to engagement to ensure the delivery of the Better Care 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 at Locality basis – and co-ordination and leadership across the County – including 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

Change programmes are being supported through renowned, 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).

Plans have been co-produced with partners, including the County and District Councils and the CCGs. This has been achieved through workshops and planning events – steered through local Health and Wellbeing Partnerships.

The development of robust Locality Plans at the heart of the Lancashire approach was agreed by the Health and Wellbeing Partnerships and the Board, in liaison with the Local Area Team. 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.

It is recognised that further work will need to be 'written into' the implementation process – both at Locality and County level to build on the extensive consultation to date and ensure the complexity of the provider landscape is being taken into account. The Lancashire Leadership Forum will provide an important resource in developing the enablers to our integration and is developing approaches to wider public consultation through a series of "Big Conversations" around the future health and social care landscape.

Engagement to date has informed the development of the plan 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 transformational 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
- East Lancashire 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
- Safer 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 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

ii) primary care providers

As above

iii) social care and providers from the voluntary and community sector

As above

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

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. However, 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, use of emerging technologies for both communications and care.

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 longterm 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 have been agreed in the recent contract round and are reflected in CCG and Provider Plans.

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 makes reductions in acute care spend.

There is ongoing 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 vs community provision in the longer term.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCCP
Scheme name:
Greater Preston, Chorley & South Ribble Urgent Care Transformation Programme
What is the strategic objective of this scheme?

Greater Preston CCG and Chorley & South Ribble CCG serve a population of just under half a million, covering three District Council boundaries of Preston, Chorley, South Ribble and within the Lancashire County Council boundary. As key partners together with our excellent Community Health and Acute Provider Trusts, we have agreed to re-focus services on the needs of residents, not the convenience of providers or commissioners, reflecting the principles of the Better Care Fund.

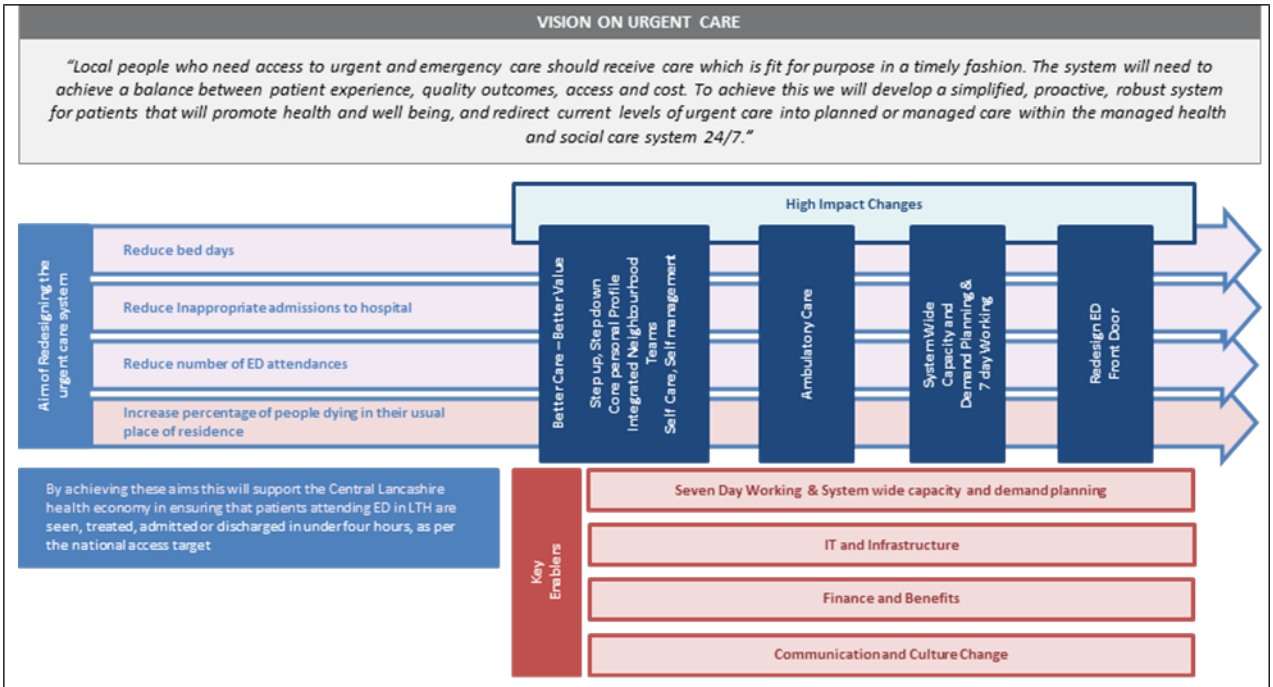
Our strategic vision is to provide health and social care which is:

- **Seamless** – boundaries between commissioning and providing organisations should be, as far as possible, invisible to patients, services users and members of the public.
- **Patient-centred** – the needs, interests and views of patients and local people should be the key determinant of service design.
- **High quality** – all citizens should have access to the best services we can afford, regardless of age, gender, ethnicity or disability.
- **Efficient** – we will manage our resources wisely, eliminate waste and ensure that every pound is well spent.

To achieve the above vision we will improve the quality and cost effectiveness of urgent care provision across the central Lancashire health economy. This will be achieved through our Urgent Care Transformation programme and is currently at the heart of our day to day business across all public sector health organisations. The diagram below shows the vision, aims, the four high impact projects and the supporting enabler workstreams.

We will focus BCF activity for 2014/15 and 2015/16 specifically on 'Better Care Better Value' work stream, however the context is within our wider transformational work, with all elements being interdependent, so it is important to capture the wider ambition.

The BCF will be an accelerator of local ambition and vision that is based on four years of work to date, listening to the experience of people living in the local communities, understanding local population needs and developing key collaborative work streams for long term conditions and urgent care.



Overview of the scheme

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

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

The diagram below highlights the ambitions - in year one and two the Health Economy will be focusing on the Better Care, Better Value workstream to complement the planned changes.

We have unpacked this vision into a series of more specific aims and objectives, as follows:

- Promote independence and help people and their carers better manage their own health and social care needs.
- Identify people's health and social care needs at an early stage and involve them in shaping a personalised care plan to meet those needs.

- Improve team working and co-ordination between professionals and voluntary agencies to deliver seamless care.
- Deliver care in, or close to, home where possible.
- Develop actions that reduce urgent interventions and improve value for money.

The patients benefitting from these changes to services will include the Frail Elderly, patients with long term conditions and patients with complex needs.

All the projects are supported by enabler workstreams to ensure delivery such as seven day access and IT. Collectively they comprise a complex, whole-system transformation to the urgent care pathway in Central Lancashire. The programme is currently in the detailed design phased to ensure implementation will start in April/May. Implementing these changes will require new ways of working across the local health economy.

The programme will make a major difference to the lives of local people by providing co-ordinated, transparent, streamlined services for the community. For example patients will progressively see a single care manager and co-produce a personal care plan over which they feel a real sense of ownership. This process will start with our older patients, who often have the most complex needs. They will be served by integrated teams focused on maintaining them in their homes safely and for as long as is possible. This will have a form of local Area Coordination, utilising local community assets and the VCFS as part of the wider neighbourhood team, supporting those with the most complex needs and those people at tipping points and supporting future community capacity and resilience.

Although we aim to maximise the independence of our older citizens, thereby dealing the need for long-term care, we will continue to require a strong supply of housing and support options, ranging from extra care housing units to high-quality nursing homes, to provide the best possible care towards end of life.

We will need to make investments in skills, capacity and infrastructure to support a more coordinated, integrated and person-centred approach to the delivery of health and social care. This will allow us to develop health and social care professionals who are confident about working outside their precise professional boundaries. This will mean that people are served and supported in a more targeted way by a smaller number of professional staff.

We will achieve more effective co-ordination of delivery by providers through the implementation of a whole-system inclusive approach to commissioning, made possible by the pooling of budgets. This will require a clear focus on outcomes and quality, with organisational boundaries becoming less and less relevant and visible. The result of this collaboration over the next five years will be a substantial shift of resources from emergency, bed-based, secondary health care into community-based health and care services.

GPs will be at the centre of organising and coordinating people's care. Through investing in primary care, we will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

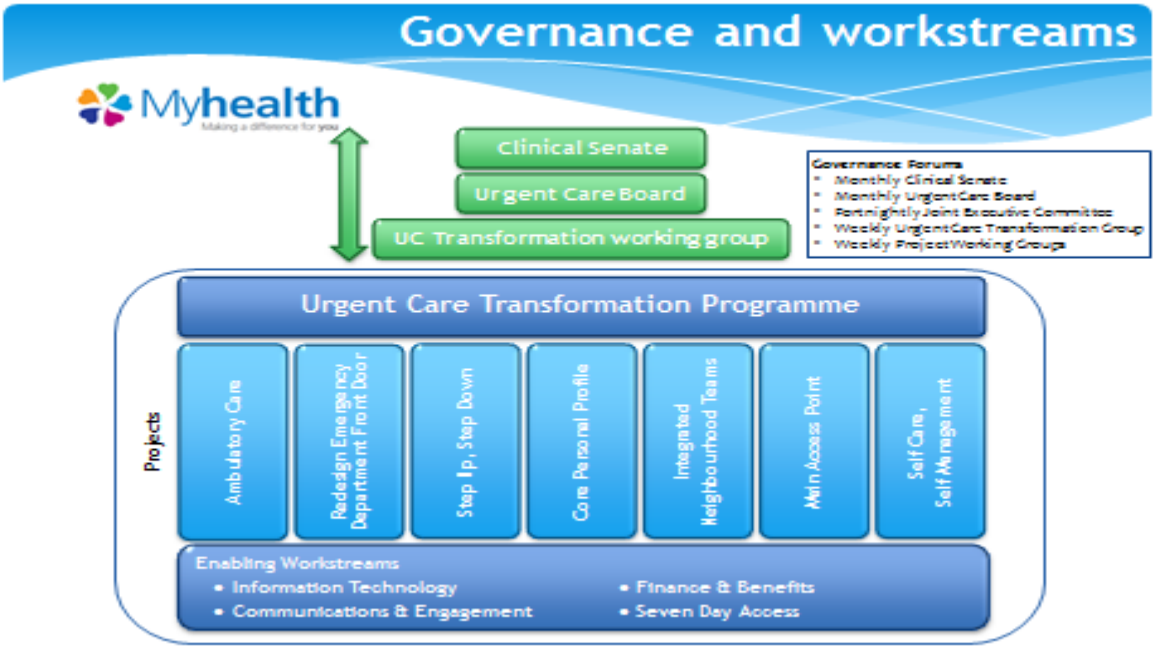
We will deliver on the new provisions of GMS, including names GP for patients aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over seven days will be accompanied by greater integration with mental health services and a closer relationship with pharmacy services. Our GP practices will collaborate in networks focused on populations over at least 20,000 within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing

joined up support for those individuals with long-term conditions and complex health needs.

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

We recognise that achieving our vision will mean significant change across the whole of our current health and care provider landscape**.** Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with citizens, patients and each other. The CCGs and local authority commissioners who make up Central Lancashire are committed to working together to create a marketplace and maximise all the assets including community assets and seeing people and families as assets, and effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

Below is a diagram of the Greater Preston and Chorley and South Ribble CCG Governance Forums. The local governance structure leads into the Lancashire wide governance structure as shown in template 1.



We envisage that both the local authority and the CCG would be held to account for the delivery of the plan by clinical senate and the Health and Wellbeing Board. Reviewing the Terms of Reference of our senate and Health and Wellbeing Boards, and ensuring they are in a position to provide effective governance, will be a priority for the coming months.

We have an established Clinical Senate, with representatives from the Chorley & South Ribble Clinical Commissioning Group, Preston Clinical Commissioning Group, Lancashire Teaching Hospital Foundation Trust, Lancashire Care Foundation Trust and Lancashire County Council. The Clinical Senate is a maturing partnership, committed to collaborative working and risk sharing, through effective partnership arrangements.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The CCG working with the Council and other partners including Public Health and external

agencies such as KPMG has been building its evidence base with a specific focus on the transformation of the urgent care system.

KPMG were commissioned by the CCG and partners across Central Lancashire, with the support of the Clinical Senate, to examine in depth both the Urgent Care and more recently the Primary Care evidence base – not only in quantifiable terms but also looking at enablers and blockers.

Following the diagnostic phase of their work, KPMG identified six high impact changes, together with four 'enabling quick wins' that will support the Central Lancashire health economy to deliver a model of urgent care that enables local people who need access to urgent and emergency care to receive care which is fit for purpose in a timely fashion.

The high impact changes are whole-system changes that redefine how patients will be cared for across their patient journey. As such they will require cross-organisational collaboration in order to achieve the intended outcomes of these changes.

To implement the vision, local health and social care commissioners (Greater Preston CCG, Chorley and South Ribble CCG and Lancashire County Council) in partnership with NHS England where necessary, will continue to strengthen its approach to identifying the populations that will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care.

In tandem with this will be the performance management and governance arrangements to ensure effective delivery of this care, based on an evidenced best practice approach.

Local health and care providers (Lancashire Care Trust, Lancashire Teaching Hospital) and associated public, private and voluntary and community sector groups, will be involved in co-designing the care models that will deliver these outcomes; transitioning resources into these models to deliver the outcomes required; ensuring governance and organisational arrangements are in place to manage these resources; agreeing the process for managing risks and savings achieved through improving outcomes; establishing information flows to support delivery; and ensuring effective alignment of responsibilities and accountability across all the organisations concerned.

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

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

The whole system must transform and shift at the same time, which will require quick cash releases from acute contracts and re-investment in Primary and community care. However there is a risk that if the demand on acute hospital beds does not reduce as anticipated, the system will not cope and there will be significant funding and capacity gaps.

There is a significant need to increase capacity in community and Primary care to sustain the required shifts in activity, and the support of more complex and vulnerable people in the community - with at least 25% further investment in reablement and rehabilitation services. We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce mortality through better access to senior doctors; improve access to GPs and other services so patients can be seen more quickly and at a time convenient to them; reduce complications and poor outcomes for people with long-term conditions by providing more

coordinated care and specialist services in the community; and ensure less time is spent in hospital by providing services in a broader range of settings. There will be a need to invest in a new evolving workforce, based on the cultural and practice shifts required over the next five to ten years.

We will use the BCF to:

- Help people self-manage and develop our Local Area Coordination offer, linking and connecting people to local assets and promote themselves as assets working in partnership with voluntary, community and long-term conditions groups.

- Invest in developing personalised health and care budgets working with patients and service users and frontline professionals to empower people to make informed decisions around their care.
- Implement routine patient satisfaction surveying from GP Practices to enable the capture and tracking of the experience of care.
- Use working together for change to check out the experience of citizens, patients, clinicians and practitioners across the whole system, with reference to the citizen 'I' statements
- Invest in reablement through a new joint approach to community Independence, reducing hospital admissions and nursing and residential care costs.
- Reduce delayed discharges through investment in services and strengthen 7 day social care provision in hospitals and reducing admissions to residential care directly from acute settings
- Integrate NHS and social care systems around the NHS Number to ensure those frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need.
- Undertake a full review of the use of technology to support primary and secondary prevention, enable self-management, improve customer experience and access, and free up professional resources to focus on individuals in greatest need.
- Roll out the whole systems Integrated Neighbour Teams care model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary team, including local Area Coordination – community connecting.
- Invest in 7 day GP access in each locality and deliver on the new GMS.
- Establish a Joint Integration Team working across the local authorities and CCGs to support the implementation of integrated commissioning of health and social care.
- Review all existing services, including services commissioned under existing section 256 agreements, to ensure they represent VFM and re-procure services where necessary to enable integrated working. This will include our current investment in VFS and low level / universal services to continue our commitment to Local Area Coordination and community connecting
- Create a joint Nursing and Care Home Commissioning Team focussed on improving outcomes through transforming the quality, consistency and co-ordination of care across the nursing and care homes.
- Review and support our commitment to safeguarding – supporting changes in Care and Support Bill for the Adult Safeguarding Board to be on a statutory footing
- Review psychiatric core 24 services to cover Lancashire Teaching Hospitals, providing holistic support for physical and mental health needs and input into the Neighbour teams.
- We will include a form of Local Area Coordination to ensure community assets and the VCFS is an integral part of the wider offer of care and support.

Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

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

To deliver the ambition contained in our BCF, we recognise the need to develop further our strategic and operational governance arrangements. We therefore propose to look at, as part of this process, how we start to bring together management responsibilities and accountability across care and health services, for our residents and patients and as whole. We would see our future management team accountable for the commissioning of integrated care, through the Health and Wellbeing Board, to the Local Authorities and the CCGs. In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

Our current proposal is to delegate specific functions between Local Authority and CCGs in areas that facilitate delivery of the BCF. The initial areas that we wish to consider are the commissioning of step up step down care, and the commissioning of care delivered in people's homes. We envisage that these joint arrangements would enable us to deliver the full benefits of reablement and intermediate care services provided in people's homes, and to remove current gaps and duplication in provision.

Regular briefings to the Clinical Senate Cabinet and the CCG Governing body are designed to help to ensure effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities. Across Central Lancashire the Clinical Senate, combining health and local authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography.

Throughout this process, we will ensure that the local Health and Wellbeing Boards for each CCG remain central to the development and oversight of the proposed schemes making up our Better Care Fund, with a principle of pooling as much health and care funding as is sensible to do so, and with a focus on developing our joint commissioning and outcomes frameworks to drive quality and value.

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

The changes we are planning will be comprehensive and transformational in their impact. We will therefore expect to see major shifts in culture, behaviour, activity and spend as well as improved patient experience and health outcomes.

- There will be a significant and measurable reduction in pressure on acute settings. This will be achieved by shifting resources from bed-based care to primary and community-based care.
- There will be a demonstrable shift to whole-system joint commissioning across health and social care.
- People will feel empowered to direct their care and support and to receive the care they need in their homes or local community.
- Carers will feel better supported and that their own needs are better met, thus enabling them to continue their value contribution to the community.
- There will be a demonstrable shift from block contracting to personalisation through co-production of care plans.
- We will have the services in place that will allow people to spend longer in their family homes and less time in secondary care and care homes (including end of life care provision).
- GPs will be at the centre of organising and co-ordinating people's care. At the heart of this will be a form of Local Area Coordination, maximising community assets and universal supports as part of a wider inclusive offer.

- We will have a strong and self-confident group of health and social care providers, working together collaboratively and competing, as appropriate, and meeting the needs of local people. The local market will include strong community provision, delivering a joined-up set of low-level interventions which prevent patients from entering into unnecessary high-cost care packages.

We will set targets and measure our performance in the following areas:

- Level of acute admissions and number of beds and bed days.
- Level of emergency admissions.
- Level of admissions to residential and nursing care and number of beds and bed days.
- Number of whole-system commissioning decisions (i.e. fewer contracts that apply only within a single provider organisation).
- Number of block contracts (i.e. fewer block contracts and an increase in commissioning of personalised care plans).
- Percentage of patients with LTCs who have a personalised care plan.
- Percentage of patients who have a joint health and social care personal budget with a single support plan.
- Feedback from patients and carers about their experience, their involvement in decisions and the extent to which their needs and wishes are met.
- Feedback from GPs about their role in organising and co-ordinating patient care.
- Strength of local providers, as assessed by relevant health and social care regulators.
- Deaths in hospital as a percentage of all deaths.

By 2018-19 we will:

- maximise both public and wider community resources in a way that achieves the best possible outcomes for communities, families and individuals, reducing health and social inequalities and improving life opportunities and experience.
- jointly plan and deliver integrated services and support across partner organisations to achieve the right support, in the right place, at the right time, with the right outcome, at the right cost.
- be mature partnership agreements and risk-sharing arrangements that will support the delivery of safe and timely services that are high quality, offer best value, within the least restrictive environment, that promote wellness, recovery and seek to maximise the resilience and capacity of individuals, families and communities.
- be focussing on reducing the impact of ageing, long term conditions, disability and health inequalities in a proactive manner, as opposed to reactive systemic management

What will this mean for the people of Greater Preston and Chorley & South Ribble?

- They will feel reassured, because their needs and the needs of their carers have been taken fully into account and shared with the professionals involved in supporting them.
- They will know that decisions about their care will be made in consultation with them and will be made more quickly.
- They will know that their personal goals will inform clinical and care decisions and they will have more control over their health, enabling them to live as full and independent a life as possible.
- They will only make trips to the GP and hospital when necessary.

Scheme ref no.
BCEL
Scheme name
East Lancashire Integrated Care Programme
What is the strategic objective of this scheme?

Our strategic intention is to transform services to support the people of East Lancashire to live safely and live well. Integrated care is a means by which we can co-ordinate care around the needs of individuals in our community to enable our goal to be realised. Successful delivery of the integrated care agenda will reduce inappropriate demand, improve quality and productivity and increase utilisation of community assets.

Our vision is described from the perspective of a service user and is "to 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."

East Lancashire is an area with significant deprivation and poor health. Hyndburn is ranked 308 out of 324 lower tier Local Authorities for premature mortality. The consequence of this, is a larger than average proportion of people with multiple conditions and some of the highest rates of unplanned admissions to hospital in the country. Our challenges locally include:

- Ageing population; significant increase in the proportion of people aged 65+, and the number of very elderly (85+) projected to double, in the next 20 years.
- Increasing population diversity; Black and Minority Ethnic (BME) and migrant population groups have increased markedly in the last 10 years and now make up the majority population in many neighbourhoods across East Lancashire.
- Extremes of socioeconomic deprivation and disadvantage in some population groups and areas; overall almost half of the population lives in the 20% most disadvantaged areas nationally.
- Rising expectations for housing, transport and service delivery, including increasing use of technology
- Changes in patterns of behaviour and living; increasing alcohol-related personal and social harm, rising levels of obesity and type 2 diabetes, increasing numbers of chaotic families in frequent contact with multiple public agencies at high cost.
- Wider social impacts of the recession, including higher unemployment, stagnant wages and relatively greater Council budgets cuts.
- Increased prevalence of complex disability

Health and social care services for complex and long term conditions, as currently configured are not sustainable in the face of future projected need and increasing financial constraints.

The case for integrated care as an approach, particularly to meet the needs of the aging population is well evidenced. Rising demand for services, coupled with the need to reduce public expenditure provide compelling arguments for greater collaboration. Additionally, the integration of health and social care services potentially offers further means of supporting people with complex health and social care needs to live independently in the community.

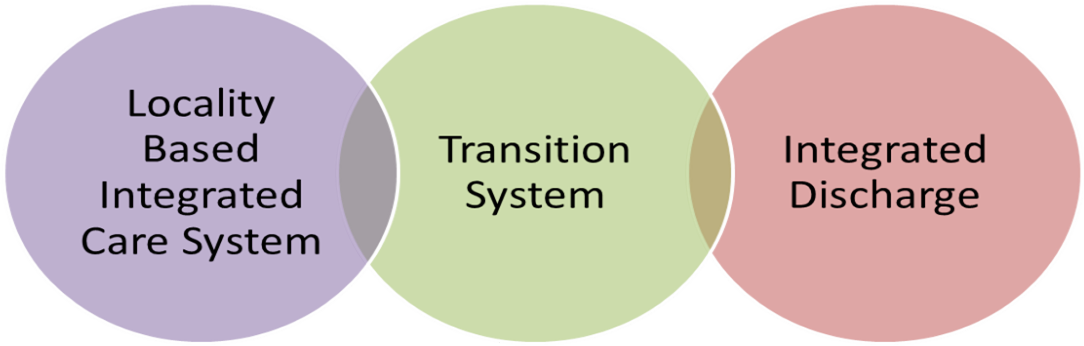
Integrated care is reflected in the development of our plans for the BCF to support the integration of health and social care and shift care from acute sector into community provision from 2014/15, building on an established foundation of integrated working.
Locally, work is underway to establish the foundations for co-ordinated delivery across health, social care, public health, third sector and other local services however more needs to be done to ensure scale and pace of transformation.

Given the complexity of the current pathways and service configuration, a phased approach will be taken to implement integrated care. The proposed timescales are:

- 2013-15 Long Term Conditions/frail elderly/those on End of Life pathway and high intensity users
- 2013-16 Mental health, substance misuse and learning disabilities
- 2013-17 Children and young people – including complex needs, early help and universal service provision

Some neighbourhoods, dependent on locality profile may bring services on-line earlier according to need.

The figure below describes for the main providers of services within scope in the first year of implementation which key teams, services and pathways will be reviewed to enable impact to be scoped and assessed for longer term transformational change.



Overview of the scheme

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

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

Implement a neighbourhood based integrated care system to integrate health and social care teams

The development of integrated neighbourhood teams will see the establishment of case managed, multi-disciplinary teams based on GP practice populations across 10 neighbourhoods in East Lancashire, utilising risk stratification as a tool for planning. In year 1, this will focus on those deemed most at risk of hospital admission, including those with long term conditions, mental health problems, substance misuers and the frail, elderly populations. This will result in the improved integration of primary care, integrated community nursing teams, therapists, social care, virtual ward, rapid response and care home liaison nursing. The integrated locality teams will be strongly linked with the local community to promote and develop self-care and independence, the identification and support of carers and vulnerable groups, developing improved housing options and stock by building on and developing existing community assets.The development of an intensive home support service, including rapid access to crisis and reablement at home will form part of the neighbourhood model.

Transitional/Intermediate Care System Review and Remodel

It is our intention to re-balance community transitional support services and short term bed based services to meet a whole width of patient need and to ensure each individual is given every opportunity to recover and achieve their optimal level of independence, as well as being able to step up into the system to avoid an unplanned admission into hospital where an alternative exists.

This will include the remodelling of Community hospitals, Intermediate Care, Crisis response provision, Re-ablement, end of life care, Take home and settle support and the use of Short term care placements. It is also recognised locally that there are both capacity and integration issues around community based short term and crisis support with multi-agency audits of the transfer system through point prevalence and perfect week studies highlighting patchy timely access into

re-ablement and community therapy teams, as well as a lack of alignment of these services. This was also true of Crisis support for health and social care need, where a disconnect between a joint offer from these services has occurred. We will use the BCF to re-integrate and enhance the capacity of these community transitional and crisis service areas. It is the aim of this workstream to focus on reviewing the existing numer of community intermediate care beds available to EL registered patients and create referral criteria and exclusion criteria for these beds that will improve the discharge pathways for individuals and ensure that they are discharged for assessment in the most appropriate setting, facilitating "home to assess" where ever it is possible and appropriate. This will include detailing the number of each category of beds eg sub-acute and social care intermediate care, step up beds, co-located recovery & 'time to think' and CHC assessment beds. The project will involve carrying out an in depth analysis to review the actual usage of beds and level of services provided for each bed in order to determine numbers required.

It is our intention to to develop a range of initiatives to grow and develop high quality community transitional support services and rehabilitative bed-based and home based services to meet the whole breadth of patient need both for step up and step down provision.

Integrate the existing hospital assessment and transfer teams and develop one single assessment process through organisational co-production to support "Discharge To Assess"

Assessment and discharge services are currently provided by a number of teams across five (ELHT, LCFT, CSU, BwD, LCC) organisations. These teams provide services for all age adults receiving assessment, allocation and continuing care and support services across Pennine Lancashire. The Safer Transfers of Care Programme has promoted the integration of services across health and social care by developing a single on-site hospital assessment and transfer team. This team will facilitate discharge from and support admission avoidance to an acute setting and will be responsible for transferring a patient's care to the most appropriate setting and monitoring the flow to the transitional system, including flexing the system at times of enhanced pressure. It is our intention to review the function and delivery of integarted discharge based on a "discharge to assess" model. Three key objectives have been set for implementation:

Objective 1: Needs Based Assessment: Any patient with an identified need will be transferred to the transitional system via one common assessment framework as efficiently as possible.

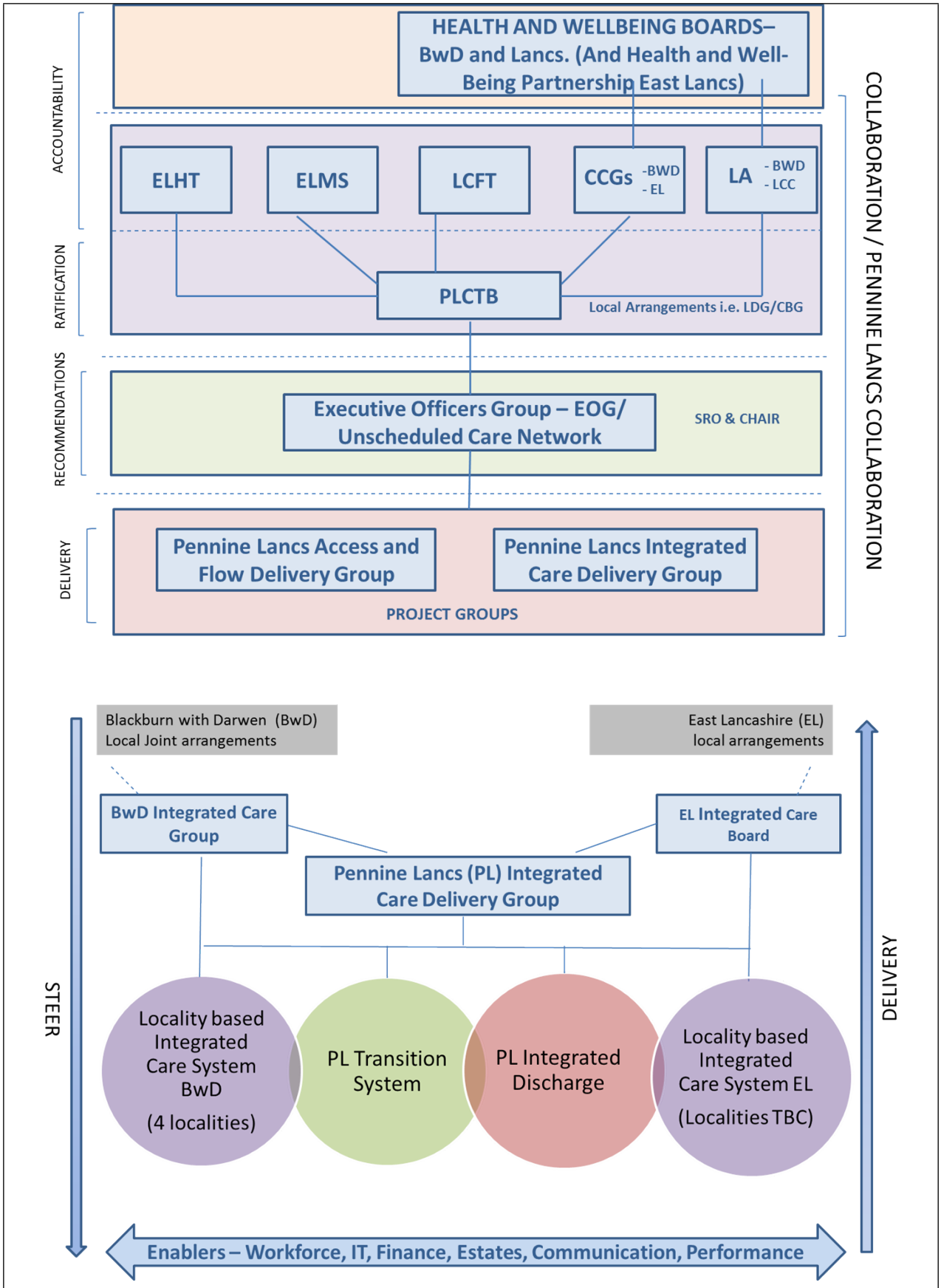
Objective 2: Consistency of Offer: The Hub or Transition or Management Team will operate a 7 days a week service as an integrated team. They will provide a safe, personal and effective patient transfer to the community setting as quickly and efficiently as possible.

Objective 3: Integrated information systems: The Discharge Hub will operate a shared Information system with automised audit systems to improve discharge quality and efficiency

The East Lancashire Heath Economy is in the process of re-defining the post discharge system; this will require discussions around integrated services and intermediate care bed management, assessment, allocation and monitoring. The challenge for the health economy is the provision of enough capacity in the community to accommodate the principle of discharge to assess. This may remodel the location of the hospital social work team, providing more assessment activity within community beds and home based settings.

The delivery chain

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



We remain committed to ensuring close relationships and shared impact assessment with all local providers and continue to work closely between CCG & LCC colleagues on the development and delivery of a shared commissioning plan.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The CCG has worked with colleagues in Public Health, other public sector services such as police, primary care and key local providers to understand the evidence base behind the development of integrated care. We have also commissioned CAPITA to run a point prevalence survey with the acute Trust and more recently a review of community capacity to help quantify intended impact. Colleagues with the CSU business intelligence service have also supported this work.

In November 2013, we were involved in a Perfect week exercise which took place in both acute and community beds and helped to identify common themes in terms of support to discharge patients, particular those frail and elderly who did not need to remain in a bed based system.

In September 2014, Healthcare at Home will run a subsequent ward audit to present further information of level of capacity required in the intermediate care and home based system to facilitate discharge and build community capacity to avoid admission.

Performance management and governance arrangements will be tightened up to ensure effective delivery of integrated care, based on an evidenced best practice approach.

Local health and care providers will be involved in co-designing the care models that will deliver the specified outcomes, ensuring effective alignment of responsibilities and accountability across all the organisations concerned.

East Lancashire CCG are programme members on the AQUA integrated care programme, which in 14/15 focuses on system level change needed to deliver effective integration, this provides an opportunity to share best practice and learn from North West colleagues and pioneer sites.

We have utilised the services of the NHS Improvement Team to facilitate design and delivery of integrated neighbourhood teams and worked with the Design Council to introduce system design principles to our planning. We were also invited to the NHS Benchmarking Group for integrated care and intermediate care and remain committed to this programme.

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

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

- ***Integrated Discharge Function***

Improving outcomes for people

- Patients/ service users/ cares feeling they were fully involved at every stage in their decision making
- Patients/ service users/ cares feeling they were treated with kindness, respect, dignity and their privacy and confidentiality was respected
- Number of complaints around transfer of care services
- Reduction in admission to Long Term residential settings
    - On discharge by a%
    - At 1yr post discharge by a%

- Acceptable number of moves for people with dementia
- Patients receiving a multi-agency assessments/screening prior to admission
- Increase in numbers of people receiving care in their "home" setting

Organisational outcomes

- Referring groups satisfied with communications around transfer of care
- Providers satisfied with communications around transfer of care
- Ratio of assessments in hospital: community
- Patients discharge- improve discharge planning and re-ablement agreed supported in their usual place of residence
- Number of people receiving re-ablement services in their usual place of residence
- Reduction in LOS for patients admitted into an acute bed
- Reduction in the cost of a person's overall support packages- including residential and nursing home
- No increase in 30 day readmissions
- Improved staff satisfaction and sense of empowerment in meeting patient's needs

Standard of service

- Increase in the number of patients flowing into Single point of access services
- 2 hour response to mobilised planned intermediate care
- Decrease in number of inappropriate transfers reported on Datix
- Reduction in ward/bed transfers by x to an average of y/never to exceed z

- ***Intermediate Care System***

- Increased diversion rate from A&E department
- Reduced admissions and re-admissions for avoidable Unplanned care
- Reduced acute length of stay for Unplanned care admissions
- Reduced Long term care placements and packages
- Improvement in recovery rates
- Increased opportunity for people with a long term condition to remain at home
- Improved quality of life for people with support needs and for their carers
- Improved access to support in people's neighbourhoods and localities
- Increased opportunity for End of Life care within a person's chosen setting

Neighbourhood Teams

There is a need to increase capacity in community and Primary care to sustain the required shifts in activity, and the support of more complex and vulnerable people in the community - with further investment in reablement and rehabilitation services and an intensive home support and rapid response service in East Lancashire, we would anticipate the following:

- Reduced Avoidable Admissions based on risk stratification tool (Aristotle and EMIS) to combine both acute and primary care data
- Increased number of patients with a shared care plan and access to a case manager for complex needs (linked to development of increased primary care capacity for over 75's)
- Single point of access with an intuitive directory of services to help primary care and other professionals navigate the out of hospital system
- An increase in patient and professional levels of satisfaction with local community

services using routine experience surveys

- Integrate NHS and social care systems around the NHS Number to ensure those frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need.
- Roll out the Integrated Neighbourhood Teams model building on existing care planning, care co-ordination, risk stratification and multi-disciplinary team, including community connecting, identification of vulnerability (Springboard Approach) and asset development.

Feedback loop

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

To deliver the scale and pace of change as outlined through the BCF and to be able to demonstrate outcomes as specified and measured, we will improve local governance arrangements and ensure regular feedback through the Executive Officers Group and Chief Exec group in Pennine Lancashire.

We will implement routine patient satisfaction surveying from GP Practices to enable the capture and tracking of the experience of care.

We will collapse the current number of service specification associated with community services to align to an integrated model of care, and this will be underpinned by a robust performance management framework which will measure benefits at a neighbourhood, practice and patient level.

We will adopt a programme management approach to the delivery of integrated care to ensure, leadership, accountability and reporting processes are rigorous and robust.

We will ensure that the local Health and Wellbeing Board remain central to the development and oversight of the proposed schemes making up our Better Care Fund to develop our joint commissioning and outcomes frameworks to drive quality and value.

We will continue to engage in the Healthy Lancashire workstreams to ensure consistency of message and alignment to 5 year strategic plans across the Health & Care economy.

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

The major system changes to the health economy over the period of transition would be:

A reduced acute bed base

A clear de-lineation of in and out of hospital services resulting in a complete re-modelling and integration of all Community Hospital and Intermediate care provision into a single model of step up/ down locality based out of hospital provision

A fused model of care between specialist and Primary care for those with intensive need

A greater level of home/housing with care and support options reducing reliance on the residential care system

Shared data allowing for targeted early action across the public sector releasing efficiencies for all organisations around staffing and crisis support costs

Help people to self-manage and develop our local offer, linking and connecting people to local assets and promote themselves as assets working in partnership with voluntary, community. and public health services

Investment in reablement through a joint approach to community provision, reducing hospital admissions and nursing and residential care costs.

Reduce delayed discharges through investment in step down and at home services and strengthen 7 day social care provision, reducing admissions to residential care directly from acute settings.

Increased and improved use of technology to support prevention, enable self-management, improve customer and professional experience and access and share information.

The expected shifts in activity will be as follows:

- Increased diversion rate from existing A&E attendance baseline
- Reduction in admissions from top 10 ambulatory care sensitive conditions from existing baseline
- Reduction in average length of stay
- Reduction in delayed transfer of care from acute hospital
- Reduction in avoidable emergency admissions
- Reduction in on-going packages of care
- Increase in number of clients at home 90 days after reablement intervention
- Reduction in number of short stay POC becoming permanent residential admissions

Scheme ref no.
BCFW
Scheme name
Fylde Coast Transformation
What is the strategic objective of this scheme?
The strategic objective is for the people of Fylde and Wyre to 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 CCG has recently developed a 2030 Strategy following extensive consultation and engagement with stakeholders, clinicians, patients and the public. This sets out a long term vision for the population of Fylde and Wyre with a focus on out of hospital 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 are a key interdependency for our long term strategy and the success of the Better Care Plan and particularly this scheme.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The aim is to create an integrated system to deliver positive outcomes as close to home as possible, responding to the 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 Fylde Coast Unscheduled Care Strategy and Intermediate Care Review are both drivers for transformation and inform the models and planned changes in the scheme. There is a long history of health and care integration – with highlights being the development of Rapid Response nursing and 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. The scheme is being developed with a view across to the Lancashire wide work and the interdependencies with other elements of the system including Specialised Commissioning and the ‘Healthier Lancashire’ hospital and social care transformation. The Better Care Plan – and the Fylde Coast Transformation Scheme – is a sub set of the wider plans, with a particular focus on the opportunity for longer term transformation based on the foundations above. Working in a wider system in this way will enable the Fylde Coast scheme to move from the often single agency developments to a co-ordination of interventions via integrated

commissioning intentions – and ultimately, manifesting in the creation of an integrated team approach at the point of delivery for the end user.

Central to the transformation in Fylde & Wyre is the Neighbourhood Model:

- A single point of access to Intermediate Care and Urgent Intervention services including reablement, rehabilitation, COPD specialist services, IV Therapy, Rapid Response Nursing, Mental Health and Residential Rehabilitation and 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 services

- The Integrated Case Management approach building on current pilots eg. AquA Neighbourhood Integrated Self Care Model and Care Co-ordinated Scheme

- Holisitic 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 the Neighbourhood model with relevant council / other Housing Providers including third sector

- Partnership work across CCG, County and District Councils to further develop, integrate and co-ordinate the range of aids and adaptations using the Disabled Facilities Grant and other funding

Specific actions are summarised below:

- Implementation of Electronic Palliative Care Co-ordination system
- Development and implementation of care plans for all patients at end of life
- Design and implementation of Care Homes Commissioning and Support Plan
- Commission pilot for Community Palliative Care including Rapid Response, Hospice at Home and Sitting Services
- Commission pilot for expansion of Falls Advice and Assessment Service
- Commission pilot for Falls Lifting Service linked to Lifeline Pendant Scheme
- Implement recommendations of hospital discharge review
- Review all urgent and emergency services to assess 7 day availability and draw up commissioning plans
- Review services for carers and develop programme for improvement
- Use risk stratification in Care Co-ordination pilot with social care risk factors and Anticipatory Care Plans
- Fully embed Early Support Discharge and Community Stroke Rehabilitation Service
- Broaden scope of 999 Frequent Callers pilot to increase anticipatory approach
- Recommission Community Equipment Services

- Review all equipment, aids and adaptations to ensure smooth pathway
- Increase Reablement capacity as primary offer prior to receiving long term care
- Implement recommendations from Benchmark Intermediate Care Review
- Consider development of plans to integrate bed and community based rehabilitation
- Re-shape and maximise community assets and third sector provision

GP practices will be at the heart of making these changes happen. As well as coordinating an individual's care, practices will work with patients and other partners to decide how to best tailor services to meet the needs of local people.

We are now working with practices to agree how they will come together in geographical neighbourhoods to coordinate services, and what support they will need to do this.

This will involve practices coordinating doctors, nursing teams, pharmacy, social care, the voluntary sector and other professionals so they deliver a joined-up service in different community settings, including people's homes. It will also involve practices working in partnership to determine what services are needed to meet the needs of their population.

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

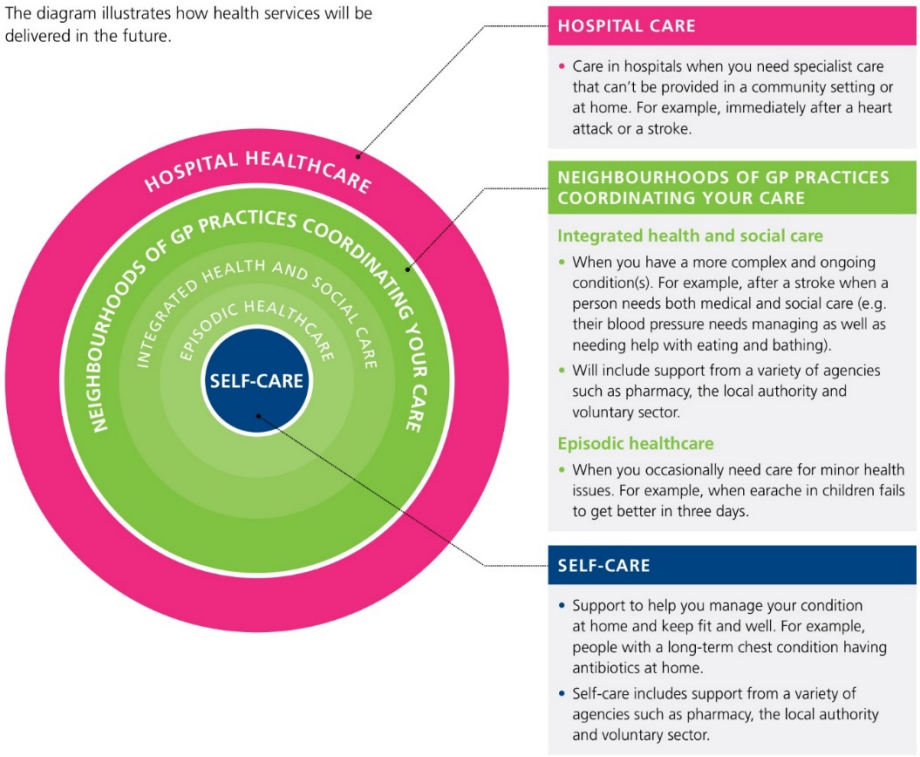
The CCG works in several Planning Units:

- Fylde and Wyre CCG
- Fylde Coast – with Blackpool CCG
- Lancashire Better Care – with CCGs named in this plan
- Pan Lancashire – with the above plus Blackpool CCG and Blackburn with Darwen CCG

Fylde & Wyre CCG has lead contracting responsibility for Blackpool Teaching Hospitals and is therefore engaged in a programme of Transformation across the Fylde Coast with Blackpool CCG as a key commissioning partner.

Partners are engaged via the Fylde Coast Commissioning Board and Unscheduled Care Board – including Lancashire Council, Blackpool Council and providers as above.

The CCG also has significant patient flows within central Lancashire (Lancashire Teaching Hospitals) and northwards into Lancashire North (Morecambe Bay).



The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The purpose of transforming our health and care system is to ensure that the people of Fylde and Wyre receive the best possible care. To identify opportunities, we have used a broad range of national and local information tools to develop our ambitions – against the outcomes and ambitions outlined in NHS England's planning guidance and Better Care guidance.

The tools identified below were instrumental in considering our current position and identifying the opportunities for transformational change.

National tools:
- Commissioning for value packs and explorer tool
- CCG outcomes tool
- Levels of ambition atlas
- Operational planning tool
- Spend and outcomes tool (SPOT)
- Any town

Local tools and analysis:
- Public feedback surveys
- Demographic and non-demographic growth analysis
- Quality, innovation, productivity and prevention (QIPP) benchmarking packs
- CSU Pan Lancashire 'diagnostic'
- Ambition modelling tool
- Health needs analysis

The level of our ambition has been based on current performance against England and the group of CCGs most similar to Fylde and Wyre demographically ('Commissioning for Value' group performance).

We recognise that these performance groups will be striving to improve their outcomes too. We therefore propose to review all trajectories against these performance groups after two years to ensure we continue to be sufficiently ambitious, as part of our Strategic Planning process.

We have also been looking at what works from healthcare systems across the world to assess which new models of care could be successfully implemented locally to improve quality and patient experience and address the challenges we face.

These discussions have been informed by a detailed analysis of our current population comorbities (where someone has more than one long-term condition), age and the associated spend on healthcare.

We know that 48% of Fylde and Wyre's hospital spend is driven by 4,600 patients – just 3% of the population.

The Fylde coast risk stratification tool is used to identify those at highest risk of non-planned admission or excessive use of emergency services. This provides a micro-practitioner level of evidence that is directly applied to clinical care.

Since April 2013, as a direct result of the use of risk stratification, the care coordination scheme has enabled those people identified as being very high intensity users of healthcare to have their needs assessed by a GP, community matron or other appropriate professional. Their care is then jointly and proactively planned to ensure, wherever possible, their needs can be met at home with hospital attendance and admission avoided. The anticipatory care plans are held by the local out-of-hours provider and, when necessary, accessed via a single telephone number in order to mobilise appropriate support.

In addition to the data led exercises above, we have put in significant efforts to understand our communities needs, based on their own views, lifestyles and wishes.

We surveyed more than 1,000 people living in the area – key findings included:

- 88% supported having more advice and support to help them better manage their condition at home
- 42% of those with a long-term condition said they had a specific health professional who coordinated their care
- 25% of those with a long-term condition said they did not know who to contact if they had a question about their care
- 86% said they would like to have their follow-up appointments in a community setting rather than in hospital.

Other engagement mechanisms included a series of focus group, events, surveys, regular drop-in listening sessions held at libraries and health centres, as well as using traditional and new media.

In total, we spoke to nearly 3,000 people over a six month period – some about our vision in-depth, and some about the issues they are currently facing.

We also used traditional and new media, and through the local press there were 368,000

‘opportunities to see’ information about the vision. We also used social media to tap into the communications network across our partner agencies.

We engaged the district and county council scrutiny committees, as well as attending numerous meetings and sessions with our local authority partners.

All of the data gathered was independently analysed and triangulated by the commissioning support unit, and the main themes pulled out. Clinical, commissioning and communication leads at the CCG then spent two days together analysing the data and applying the findings to shape their commissioning plans and the development of this scheme.

In addition to this, to support the development of our commissioning intentions for the next two years, we held two stakeholder engagement events. Approximately 40 people attended each session, including representatives from GP practices and the CCG’s Public and Patient Engagement Group. A panel with patient representation was held to prioritise the intentions. All of the proposed schemes were scored against the public pledges developed as part of the engagement exercise, demonstrating that engagement processes are embedded in decision making.

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

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

We have captured the overall outcomes for the people in Fylde & Wyre as a set of pledges, linked to our long term strategy:

By 2030, you will consistently:

1 Have clear information relevant to your health and wellbeing which is easy to understand.

2 Have the opportunity to live a healthier lifestyle and be supported to keep well both mentally and physically.

3 Be more involved in decisions about health services and your healthcare.

4 Receive safe, high quality healthcare.

5 Have services which are easy to access, timely and appropriate for your needs.

6 Have services tailored to the needs of your neighbourhood.

7 Receive care in a community setting or at home, where appropriate.

8 Be supported by organisations that work together to provide the care and support services you need.

9 Be supported using the most appropriate technology and equipment as it becomes available.

10 Receive value for money from your local health service.

These complement the measurement of ‘formal’ outcome metrics and Performance indicators which are now embedded through the CCG assurance processes and the equivalent Council processes – and which will be jointly reported on a Scheme basis (see Governance).

Feedback loop

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

The Strategic Planning process provides the key opportunity to refresh and test the approach against outcomes – which are now included in the CCG Assurance framework itself.

The Scheme itself will be managed and measured locally – see the section on Governance above.

At the Lancashire plan level see the section in the main plan on Governance and Performance Management – this will link the overall progress and checks back through the Health and Wellbeing Board.

There is a strong history of engagement in Fylde and Wyre and across the Fylde Coast which will continue throughout the Scheme's life and beyond – we have a long term strategy which has been subject to extensive consultation and has an ever increasing sense of local ownership.

In terms of continuous engagement - there are many ways for people to get involved in helping to shape health services in Fylde and Wyre including joining the Affiliate Scheme.

Key plans and documents are available on the CCG Website along with opportunities for engagement and feedback mechanisms.

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

We believe that we will only meet the challenges facing us if people are empowered to make informed decisions about their health and care, and are enabled to participate in shaping the development of health and care services.

Taking on board all of the feedback, we believe the following is crucial if we are to address the challenges we face:

- Supporting people to keep well both mentally and physically to prevent ill health in the first place
- More support to help people manage their condition at home to keep as fit and well as possible
- Better information to support people to make informed choices about their health and healthcare
- More coordinated and integrated health and social care planned around people's needs
- Access to many services seven days a week.
- More community and home-based care
- Care in hospitals for specialist services only
- Better use of technology to improve access to services and improve productivity

We recognise that the way we deliver care across Fylde and Wyre needs to change. We want to make sure that those people who have multiple long-term conditions – the 'sickest of the sick' – have much more intensive support from a team of experts who will coordinate all their care.

We also want to make sure those people with one long-term condition are similarly supported, albeit in a less intensive way.

For this to happen, the CCG will need to work with its partners as well as the public, patients and their carers to ensure people have the knowledge, skills and confidence to be able to take

ownership of their own health and wellbeing.

It will also require the relevant organisations to work together to provide joined-up support and care tailored to the needs of individuals and their communities.

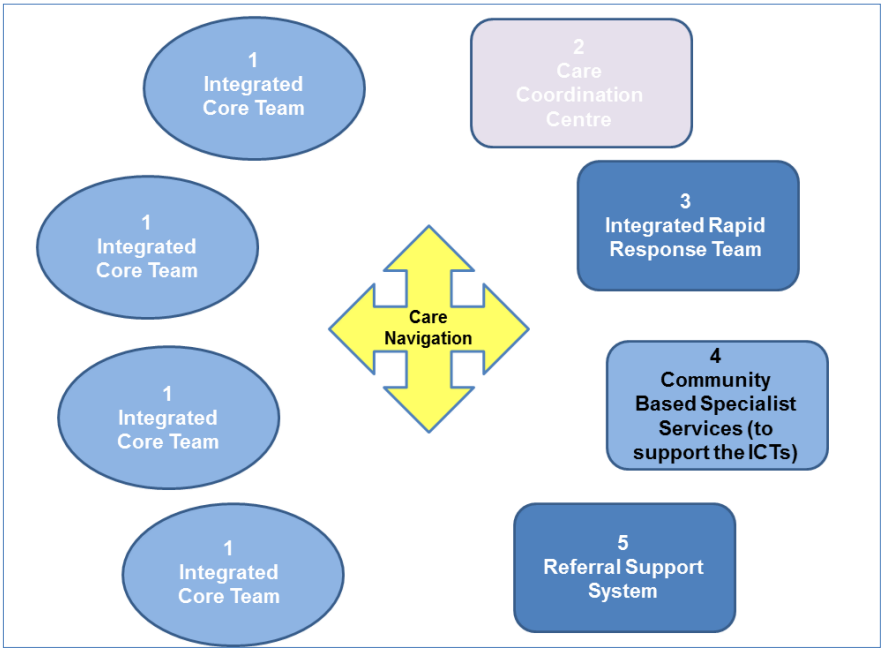
This new way of working has been strongly supported by people living in Fylde and Wyre. We cannot do this alone. We must strengthen how we work with partner organisations such as local authorities, other commissioners, the voluntary sector and advocacy groups in order to make our vision a reality. We also recognise the enormous contribution of carers, who we consider to be key partners.

Scheme ref no.
BCLN
Scheme name
Lancashire North CCG – Better Care Together
What is the strategic objective of this scheme?
Our ambition is to create a sustainable health and social care system (Lancashire North and Morecambe Bay) that provides the best care possible based on five objectives: 1. To design and implement new integrated models of care across the local health economy that meet agreed local and national clinical standards and can deal with changes in our population and their needs 2. To design and implement a system which recognises the specific geographic and demographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times. The emphasis will be on providing these services in, or as close as possible to, people's homes 3. To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable 4. To enable the development of a flexible, integrated and productive workforce across our health economy. This approach will enable staff to develop continuously, realise their potential and achieve greater job satisfaction 5. To design and implement a future healthcare system for our area that makes best use of the money and resources available We know our new model of care needs to be centred around the patient rather than the care setting and to focus on the quality of the services being delivered, rather than the organisation that delivers them. In the past we tried to improve care by concentrating on hospital services. Consequently, we have entered into a vicious circle of spending too much money on in hospital care and leaving insufficient resources to invest in primary and community services. This has led to more people being admitted unnecessarily to hospital, resulting in increased spend in the most expensive part of our system and often poorer experiences for our patients who would prefer to receive care closer to home. This current position is unsustainable for the Bay as our care is costing more to provide than we have available. We recognise that the populations we serve, like those across the country, are likely to see big increases in demand for health care due to factors such as lifestyle, age and the increasing prevalence of long term conditions. Similarly, we understand there are demographic and geographic factors that make Morecambe Bay unique and therefore implementing our ambition is particularly challenging. As a system, we have re-designed how our patients are going to be able to receive care outside of a hospital setting and in turn, then considered what these changes mean for the delivery of services in our three hospitals in the Bay.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
To support the development of our Out of Hospital model of care, our clinicians have

developed design principles and their preferred clinical models for Episodic Care, Complex Care, Unscheduled Care, Children and Young People's Care and Maternity Care. The principles are set out below and the models are described in section four:

1. Our services are of good quality that deliver safety, equity and continuous improvement in outcomes
2. Our system is sustainable both financially and clinically and is flexible to meet future demands
3. Our design will build on what is already working well and recognises that some of what we are currently doing has to change
4. We will encourage our patients to take more responsibility for themselves and we will take account of their views in our service design
5. All design options will be realistic and based on evidence based best practice
6. Care will be provided in the right place and at the right time. There will be more care delivered out of hospital and some small volume specialty work may not be viable to provide locally
7. Services will be provided in an integrated way with shared records, fewer handoffs and easy navigation
8. We will manage patients proactively and patients will know who is responsible for their care
9. Morecambe Bay will be an attractive place to work and our workforce will be developed and encouraged to deliver services which are in the best interests of patients

Out of Hospital model



The five elements of our model are:

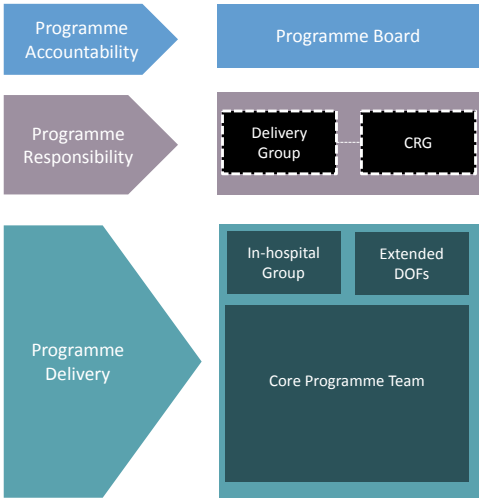
1 - Integrated core teams
2 - Care co-ordination centres (with a menu option to transfer to a children's specific section)
3 - Integrated rapid response teams for adults with separate teams for children
4 - Community specialist services for both adults and children
5 - Referral support system for both adults and children

These elements fit together in a coordinated system of care with the needs of "whole person" (physical, psychological and social) at the centre. The future model of care has at its heart a commitment to support a more integrated health and social care service in the coming years.

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

The programme has deployed a rigorous approach to governance, with groups established to drive programme accountability, responsibility and delivery. For a list of governance group membership please see Supporting Paper 4.3.4.A in Volume 3.

Figure 2d: Our governance structure

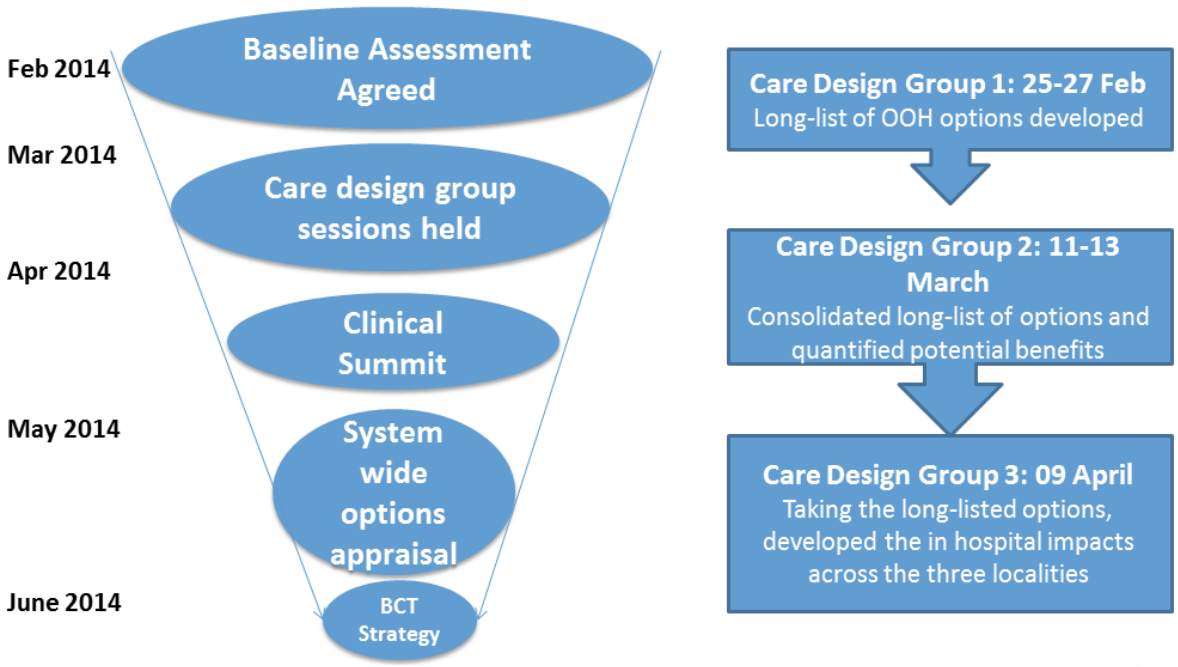


The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The CCG has developed a robust evidence base – building on the extensive situational analysis required for authorisation and subsequent development of Commissioning Strategy/ 2 Year Operational Plan and 5 Year Strategic Plan.

For this programme specifically, a thorough process of analysis has taken place for the development of the strategy. Five principles underpinned the approach:

1. Focussing on patient's experience, rather than organisational interests
2. Engaging our patients and stakeholders from programme conception to identification of the preferred clinical model
3. A clinically led solution from start to finish
4. A robust qualitative and quantitative framework to underpin and evaluate the options
5. A focussed governance process to drive the process and hold it to account



The BCT programme has developed options for improvement by considering the stakes in the ground by locality, the CRS analysis, the out of hospital model and the need to deliver hospital services as efficiently and effectively as possible.

The options development process resulted in a long list of 132 options that was then subsequently prioritised down to a shortlist of 6 options that would be considered for evaluation. All of the shortlisted options contain a consistent offering with regards to Out of hospital (OOH), Urgent care, Womens' and children's care and Planned in-patient care.

A financial analysis of current state and financial modelling of future options has been carried out and informed the detailed business case across Lancashire North and Morecame Bay. The methodology has involved using examples of best practice from other healthcare economies, known benchmarks through peer comparisons, and robust costing methodologies, combined with operational and financial insight of running services in the Bay.

The shortlist of options were qualitatively and quantitatively evaluated by the programme's Clinical Reference Group (CRG) which consists of senior clinical leads across primary and secondary care in Morecambe Bay. Two evaluation sessions were held with the CRG and a three step evaluation process was followed by the programme in order to arrive at a preferred clinical model from the initial six shortlisted options.

The model was also tested through a 'patient experience story' – using her journey through services currently and as it would be once the changes are in place.

What happens now?
Mary, a 68 year old lady with moderately severe chronic lung problems gets occasional chest infections. These cause her to become very short of breath and because she lives alone this can make her very anxious. She sometimes panics and dials 999 for help. The ambulance service arrive to find her fighting for breath and take her to hospital where she spends a day or two before being sent home. (NB links to Mary's Planned care journey).

What will happen in the future?
Mary's GP has identified that Mary is prone to suffering from chest infections that progress rapidly and cause her to be admitted repeatedly and alerts the Integrated Core Team. With the support of the Integrated Core Team, and the Respiratory Clinical Nurse Specialist, Marys GP develops a care plan, with Mary's involvement, that has helped her to identify when she is developing problems at an early stage. She has been given a course of steroid tablets and antibiotics that she can start at the first signs of infection developing. If she does get panicky and call the ambulance service they have been made aware of her care plan and, after checking that she is well enough to stay at home, can involve the rapid response team and her community matron or Respiratory Nurse Specialist via the Care Coordination Centre. Her GP is advised of Mary's condition by the Care Coordination Centre and follows up accordingly.

An analysis of workforce, IM&T and estate implications has also been carried out and the key actions included into the local programme of work.

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

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

The CCG and its predecessor have a long history of working and commissioning together to integrate health and care. 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 UHMB and, as such, overlaps with Cumbria County Council as a unit of planning.

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. The schemes identified in this plan will help to achieve some of the deliverables identified in the Better Care Together Strategy. Partners will use the Better Care Together programme to develop, re-design and transform existing services, with an initial focus on the frail elderly and carers. The Better Care Fund schemes will deliver:

- Person centred integrated services that follow clear pathways of care that have a single point of access, supported by compatible connected information technology
- 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.
- 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
- Pathways offering alternatives to hospital admission with community rehabilitation
- 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
- Increased liaison between health and care commissioners
- Partnership working across partners including the District and Country Councils using Disabled Facility Grants and other funding to enable independent living
- Joint investment in Tele-care
- Commitment to the Lancashire Carers Strategy and agreed areas of work (assessments; breaks; wellbeing; information)
- Alcohol liaison service
- Falls Service
- Early Supported Discharge and Community Stroke Rehabilitation Service
- Care Homes Support Team

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

Internally there will be a programme board monitoring implementation and progress of the Better Care Together strategy (see Governance section above).

In addition there will be a group tasked with monitoring the specific projects funded via the Better Care Fund, which will feed into the Unscheduled Care Board and Health and Well Being Board.

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

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.

Delivering the change is as important as articulating the change. As such we have been through a rigorous process to develop the strategy and we have a clear roadmap that reflects key activity required over the next 5 years to implement the change.

The high level design emphasis is on:

- Building on existing schemes, where possible that are part of the future out of hospital service interventions
- Focusing on the implementation of a series of quick wins to pump prime the programme. We aim to have implemented each of these by end of 15/16.

- Key activity for each workstream will be designed in far greater detail between Q2 14/15 and Q3 14/15. At the end of this detailed design phase there will be a detailed business case, detailed implementation plan, a detailed description of how each enabler will support the workstream and confirmation of quick wins
- Many of the OOH and in-hospital initiatives will be implemented using a phased approach – 3 'tranches'. During the detailed design phase each workstream will establish the activity that will be implemented under each tranche and the process for taking each tranche forward. Taking this approach will allow us to implement in a focused manner at speed whilst having the opportunity to evaluate and act on the lessons learned from each tranche. Each tranche is split into:
  - Pathway re-design (approximately 6 months)
  - Implementation (approximately 6 months)
  - Benefits realisation (approximately one year to reach a point where full benefits will be delivered
- The extent to which elements of the OOH model reflects the 'tranche' approach depends upon the amount of pre-existing work already in place. This is particularly the case with the integrated core teams where a number of localities are already in a position where they can mobilise their teams quickly
- The in-hospital initiatives will also follow the 'tranche' approach. The pace of many elements of the in-hospital changes will be driven by the speed at which benefits are released by the OOH model. In-hospital changes will need to be phased in this way to ensure the full impact of the potential benefits are realised by the health economy

There are 11 specific actions identified against the BCF Fund – with milestones and expected benefits (in Locality Plan in detail).

Scheme ref no.
BCWL
Scheme name
West Lancashire - Facing the Future together (FtFT)
What is the strategic objective of this scheme?

Facing the Future Together (FtFT) is a transformational change programme to deliver the strategic aims and objectives outlined in NHS West Lancashire's five year strategic plan and the Better Care Fund.

It proposes a modern model of integrated care which is seamless and meets the challenges of NHS West Lancashire's case for change.

The vision for the Facing the Future programme, which NHS West Lancashire's GP membership has signed up to, includes the following:

- Co- ordinated, person-centred, wrap-around services targeted at the frail elderly
- Services that are delivered in or as close to the person as possible; in a way that maximises independence and quality of life, throughout their lives
- Clinically-led multi-speciality teams that take responsibility for the continuum of care
- Tapping into and valuing all of our communities assets and talents to offer the best care and support at the most affordable cost

The integration of care and multi- speciality teams closer to peoples homes – in localities that are meaningful to the communities living in them – will help direct healthcare in the most effective way – with planned and non specialist treatment out of hospital – freeing up hospitals to focus on those patients with more complex needs or unavoidable emergencies.

Overview of the scheme

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

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

FtFT is a programme of work in West Lancashire which is striving to achieve the following ambitions:

- **Patient Centred, Coordinated Care**
  (e.g. Enabled people, support for carers, joined up care/ care co-ordination, tell their story once)
- **Reduction of Urgent Care Demand**
  (e.g. Reduced emergency admissions, reduction of A&E attendances, appropriate time in hospital)
- **Quality**
  (e.g. Easy access, to work in partnership, best information and evidence, fully supported by technology, right first time, every time, demonstrate outcomes, high quality care, VFM)

The programme intends to develop wrap around services targeted at people with the highest need, initially focusing on the frail elderly (our intelligence tells us the number of 85 year olds is expected to double over the next 20 years).

This will involve the development of health and social care teams built around the needs of local populations which will be aided by the further development of Integrated Neighbourhood Teams across five localities:

- Tarleton and Banks

- Old Skelmersdale

- New Skelmersdale and Upholland

- Parbold and Burscough

- Ormskirk and Aughton

The Programme aims to build on these natural Localities over the next five years, ensuring the delivery of healthcare is based on a strong understanding of the communities needs, assets and opportunities – to offer tailored, accessible and high quality services.

The approach takes into account differences across the localities – for example support in the rural and sparsely populated areas of West Lancashire which will require a different model of outreach than the more intensively residential commuter belt areas which look southwards onto Liverpool and upwards into Southport – as well as the more urban corridors along the main motorway and trunk routes crossing West Lancashire.

We are working towards the creation of a dynamic and responsive multi-disciplinary workforce providing anticipatory, seamless and co-ordinated care, reducing duplication and keeping people as well as possible and at home for as long as possible, in partnership involving GPs, social care, acute providers, third sector groups, families and carers.

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

NHS West Lancashire CCG has a complex strategic position across a number of planning units and organisations, with our patient flows and provider network facing into Merseyside and our CCG network and collaboration, including BCF, facing into Lancashire.

Commissioners and providers involved include

The Facing the future programme draws all these partners together to work towards whole system transformation.

As there is a ‘golden thread’ across all our programmes and plans e.g. BCF, FtFT, five year plan, roles and responsibilities are clear.

This is evident by the engagement which has already commenced in respect of this programme, be it within the ICO or with our local CVS partners.

The final formal arrangements in relation to delivery for this programme are currently in the process of being agreed as part of the development of a comprehensive business case which is scheduled to go to both the CCG Governing Body and Board in September.

When finalised the delivery will be overseen locally by Strategic Partnership arrangements (detail in the business case).

The programme will then report up to the Lancashire level to the Health and Wellbeing Board as per agreed arrangements, to give assurance on the West Lancashire element of the larger Better Care Plan.

The evidence base

Please reference the evidence base which you have drawn on

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

The CCG has developed an increasingly robust evidence base to draw upon in analysis and strategic planning, including the following:

- 360 stakeholder survey

- Case studies:

  - Virtual Wards

  - Dementia

  - Health and Wellbeing (with Lancashire County Council & the Health and Wellbeing Board)

- Population and Public Health intelligence including the JSNA highlighting life expectancy; mortality and causes of death trends as well as quality of life and wellbeing indicators

- Equality Profiling including Impact Assessment and Safeguarding Framework and Policy

- Clinical Engagement including GP Executive Leads; Governing Body; Membership; Provider engagement and leadership development via our Strategic Partnership mechanisms

- Patient and Public engagement including our ongoing Listening Events; Patient experience and outcome surveys, complaints, compliments and our 'You Said We Did' mechanism

- Stakeholder Feedback

- Application of national models and scenario generation tools including Anytown, Atlases of Spend/Variation and Outcome tools

- Analysis of Key Performance Indicators and Outcomes from Authorisation through a full year of CCG Commissioning in 13/14

- Service usage; benchmarking data and scenarios – including use of 'Patient Profiles' to make the data relate to various cohorts of people living in the West Lancashire area

- Opportunity assessment including infrastructural factors, community resilience and assets, self care and carers support - to optimise potential for healthcare interventions

- Positional analysis including SWOT / PESTLE to identify the CCG optimum system role

- Prioritisation exercises are embedded into the CCG's strategic planning processes for example the refresh of the Integrated Commissioning Plan and the subsequent more recent development of the 2 Year Operational Plan and 5 Year Strategic Plan (with the Better Care Plan now an integral element of the overall strategic landscape).

Throughout the development of this programme, learning has been taken from the following international and national, models of integrated care:

- **Canterbury, New Zealand** – 'right care, right place, right time by the right person'
- **Torbay and Southern Devon Care Trust** - elderly care vertical pathway work
- **Veterans Health Administration** - remote monitoring of patients
- **Trafford PCT** - vertical integration of primary care, community services & social services
- **Jonkoping, Sweden** - vertical and horizontal integration of health social and

departments focusing on the wider determinants

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

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

In summary, the outcomes we are working towards are:

- Non-elective admissions
- Readmissions within 30 days
- Length of stay
- Excess bed days
- Delayed discharges

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

This will be via both a quantitative approach (outcomes previously outlined) and also a qualitative approach (feedback from both patients and frontline staff 'on the ground').

The Programme is in the process of being formalised into a Business Case which is scheduled for formal sign off in September 2014 – this more detailed document includes the approach to measuring success and impact on key outcomes (summarised above).

The programme detail addresses 'what is and is not working' and the key improvements in integrated care – shaping the delivery of integrated care through the development of Neighbourhood Teams based on the 5 Localities in West Lancashire – and harnessing the commissioning capacity of all partners around this Transformational programme of work.

There will be 5 Localities which allow the local population of each area to access quality care offered as locally as possible by an integrated workforce in partnership across GPs, social care, acute providers, third sector groups, families and carers.

Through this mechanism the partners will develop a strong understanding of each communities' needs and will tailor delivery to each local area. This will enable the partners to address inequalities – for example addressing specific weaknesses that we know about or those that get fed back from localities as the programme evolves.

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

These are currently in the process of being agreed as part of the development of a comprehensive business case which is scheduled to go to both the Governing Body and Board in September.

However, key success factors include:

- a stepped approach to implementation of whichever option is agreed and
- robust engagement
- delivery of the infrastructure to achieve greater integration of care
- improvement in services particularly around urgent care, long term conditions and support to people who are the most frail and vulnerable and at risk of admission
- greater collaboration between commissioners and providers to ensure outcomes

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Lancashire Health and Wellbeing Board
Name of Provider organisation	Blackpool Teaching Hospitals NHS FT
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Lancashire Health and Wellbeing Board
Name of Provider organisation	East Lancashire Hospitals NHS Trust
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Lancashire Health and Wellbeing Board
Name of Provider organisation	Lancashire Teaching Hospitals NHS FT
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Lancashire Health and Wellbeing Board
Name of Provider organisation	Southport and Ormskirk Hospital NHS Trust
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Lancashire Health and Wellbeing Board
Name of Provider organisation	University Hospitals of Morecambe Bay NHS FT
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	