Dated 2015

LANCASHIRE COUNTY COUNCIL

And

NHS CHORLEY & SOUTH RIBBLE CLINICAL COMMISSIONING GROUP

NHS EAST LANCASHIRE CLINICAL COMMISSIONING GROUP

NHS FYLDE & WYRE CLINICAL COMMISSIONING GROUP

NHS GREATER PRESTON CLINICAL COMMISSIONING GROUP

NHS LANCASHIRE NORTH CLINICAL COMMISSIONING GROUP

NHS WEST LANCASHIRE CLINICAL COMMISSIONING GROUP

PARTNERSHIP AGREEMENT

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

1st April 2015 to 31st March 2016

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THIS AGREEMENT is made on 2015

PARTIES

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

And

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

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

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

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

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

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

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

BACKGROUND

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

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

1. DEFINITIONS

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

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

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

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

Agreement means this agreement including its Schedules and Appendices.

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

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

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

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

Board means the Lancashire Health and Wellbeing Board

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

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

Commencement Date means 1st April 2015

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

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

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

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

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

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

Force Majeure Event means one or more of the following:

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

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

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

supplies;

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

(h) any other event,

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

Functions means the NHS Functions and the Health Related Functions

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

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

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

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

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

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

Law means:

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

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

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

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

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

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

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

Month means a calendar month.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quarter 1 1 April to 30 June

Quarter 2 1 July to 30 September

Quarter 3 1 October to 31 December

Quarter 4 1 January to 31 March

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

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

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

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

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

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

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

SOSH means the Secretary of State for Health.

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

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

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

2. AGREEMENT PERIOD

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

3. AIMS AND OBJECTIVES OF THE AGREEMENT

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

4. SERVICE COMMISSIONING UNDER THIS AGREEMENT

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

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

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

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

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

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

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

4.8

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

4.9

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

5. GOVERNANCE AND MANAGEMENT

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

5.2 The Partners' responsibilities are set out at Schedule 3

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

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

6. FINANCIAL CONTRIBUTIONS AND FINANCIAL MANAGEMENT ARRANGEMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. RISK AND INDEMNITIES

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

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

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

8. LIABILITIES

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

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

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

9. TERMINATION & DEFAULT

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

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

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

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

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

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

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

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

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

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

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

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

10. DISPUTE RESOLUTION

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

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

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

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

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

11. NOTICES

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

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

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

12. FORCE MAJEURE

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

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

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

13. CONFIDENTIALITY

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

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

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

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

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

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

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

13.3 Each Partner:

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

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

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

14. EQUALITY DUTIES

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

15. FREEDOM OF INFORMATION

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

16. DATA PROTECTION AND INFORMATION SHARING

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

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

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

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

17. INSURANCE

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

18. PUBLICITY

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

19. NO PARTNERSHIP

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

20. THIRD PARTY RIGHTS

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

21. ASSIGNMENT AND SUBCONTRACTING

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

22. SEVERABILITY

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

23. WAIVER

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

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

24. ENTIRE AGREEMENT

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

25. GOVERNING LAW AND JURISDICTION

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

26. FAIR DEALINGS

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

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

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

<u>THE COMMON SEAL</u> of **<u>THE LANCASHIRE COUNTY COUNCIL</u>** was

affixed to this Deed pursuant to the Scheme of Delegation to Chief Officers in the presence of:

Authorised Signatory

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

Authorised Signatory

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

Authorised Signatory

THE COMMON SEAL of **THE** **NHS FYLDE &**

WYRE CLINICAL COMMISSIONING GROUP

was affixed to this Deed………

Authorised Signatory

THE COMMON SEAL of **THE NHS GREATER**

PRESTON CLINICAL COMMISSIONING GROUP

was affixed to this Deed………

Authorised Signatory

THE COMMON SEAL of **THE NHS LANCASHIRE**

NORTH CLINICAL COMMISSIONING GROUP

was affixed to this Deed………

Authorised Signatory

THE COMMON SEAL of **THE NHS WEST**

LANCASHIRE CLINICAL COMMISSIONING GROUP

was affixed to this Deed………

Authorised Signatory

SCHEDULE 1 PART 1

FINANCIALCONTRIBUTIONS AND COMMISSIONING ARRANGEMENTS

Schemes to be commissioned under this Agreement

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

Table 1

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

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

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

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

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

Table 2

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

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

BCF21	4,977					4,977		/est Lancs CCG Lead
TOTAL FINANCIAL CONTRIBUTION	**89,219**	**24,556**	**10,960**	**26,384**	**10,461**	**7,420**	**9,438**	

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

TABLE 3

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

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

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

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

SCHEDULE 1 PART 2

FINANCIAL AND PERFORMANCE REPORTING

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

- the original scheme design or implementation,
- or outcome performance,

  - that organisations Governing Body will agree, execute and report against those actions.

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

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

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

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

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

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

The proposed financial reporting format is as follows:

Health and Wellbeing Board Expenditure Plan

Lancashire

MONTH 1

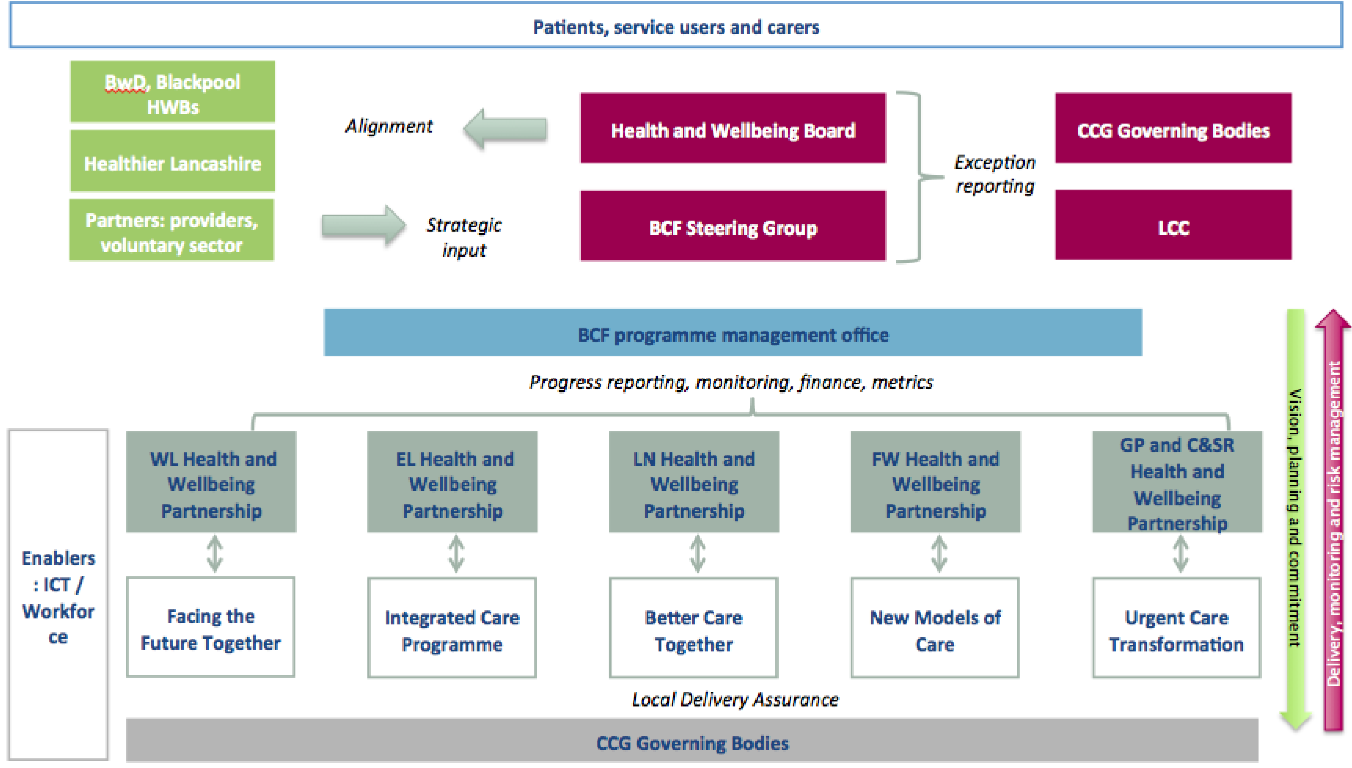
Scheme Number	Scheme Title	2015/16 Plan as at 1 April 2015 (£000)	2015/16 Revised Plan (£000)	2015/16 Forecast Outturn (£000)	2015/16 Variance (£000)	2015/16 Original Plan YTD (£000)	2015/16 Revised Plan YTD (£000)	2015/16 Expenditure YTD (£000)	2015/16 Variance (£000)
BCF01	Transforming Lives, Strengthening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

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

KPIs (Better Care Fund)

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

<u>**Schedule 2 – Governance Structure**</u>



Schedule 3 – Partners' Aims/Responsibilities

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

Schedule 4 - Steering Group/Partnership Board Responsibilities

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

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

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

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

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

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

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

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

Schedule 5 – Health and Wellbeing Board Responsibilities

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

Schedule 6 – The Better Care Fund Plan.

The Better Care Fund Plan is at Appendix 2.

APPENDIX 1 – SCHEME DETAILED SPECIFICATIONS

SCHEME SPECIFICATIONS:

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

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

Future expansion

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

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

The approach is characterised by:

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

action approach to these ‘at risk’ populations.

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

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

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

The delivery chain

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

Commissioners: East Lancashire CCG, Lancashire County Council

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

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

Providers: Age UK, Green Dreams.

The evidence base

Please reference the evidence base which you have drawn on

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

UK exemplars

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

Local context

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

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

Investment requirements

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

Total Investment:

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

Impact of scheme

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

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

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

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

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

admissions for these patients.

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

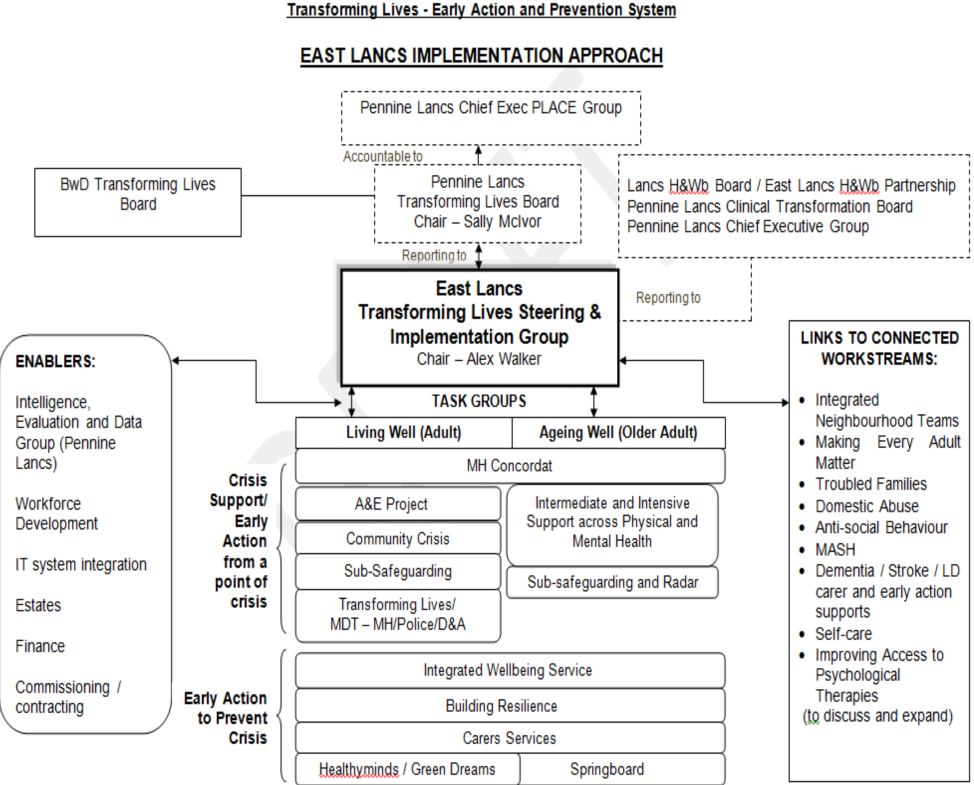
Therefore quantified benefits in 2015/16 are **a reduction in non-elective admissions of 166**.

Feedback loop

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

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

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



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

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

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

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

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

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

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

These approaches are around:

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

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

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

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

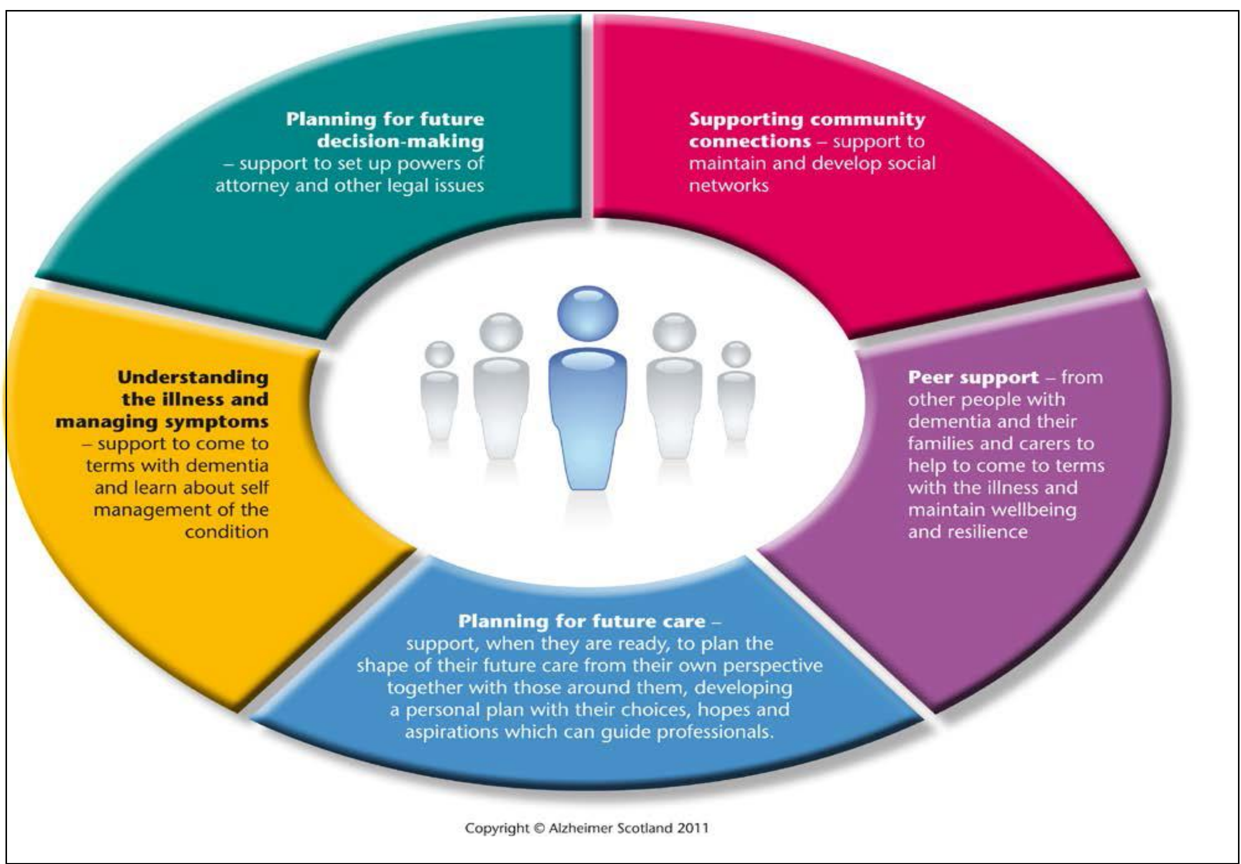
- Expand the capacity significantly to develop a wrap-around pre and post-diagnostic element to the neighbourhood MAS model
- Sign-post people into their local neighbourhood assets, supporting the development of Dementia Friendly communities within each neighbourhood /

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

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

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

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



The delivery chain

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

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

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

UK evidence

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

Local context - dementia

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

Local context – Memory Assessment Service

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

International evidence

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

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

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

Investment requirements

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

Total investment:

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

Impact of scheme

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

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

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

Metric	
Emergency admissions	☑
Estimated Diagnosis Rate for Dementia	☑

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

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

Feedback loop

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

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

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

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

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

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

Overview of the scheme

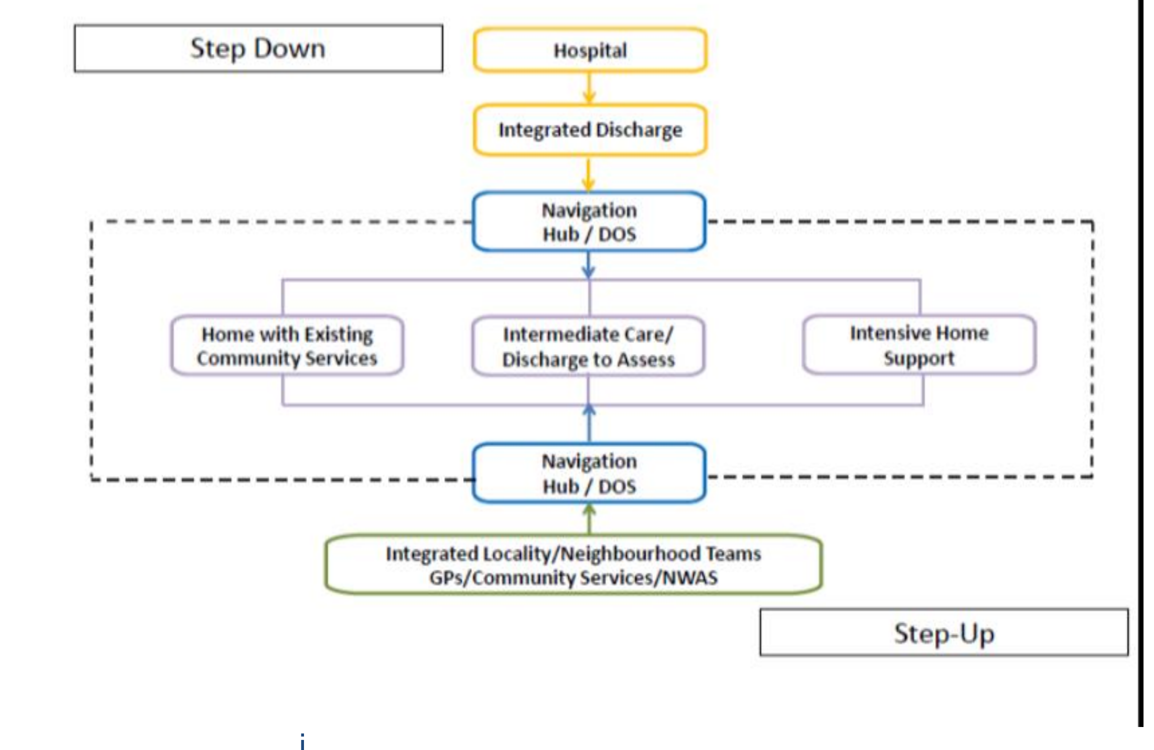
Please provide a brief description of what you are proposing to do including:

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

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

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

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



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Integrated Intermediate Care System
Current system
An analysis of our current hospital system highlights that the unplanned care pathway produces a significant amount of admissions for older adults, frequently risking the potential for over-intervention and the undertaking of risk-averse practices. This also results in inefficient and complex discharge processes that can actually increase frailty and dependence rather than supporting recovery and future independence. This is not a criticism of staff but more a reflection of a system that has developed over time.
Model
<u>Remodel the current Community Hospital and Intermediate Care provision</u> **Our intention is to re-balance community integrated intermediate care services and short term bed based services to provide each individual the opportunity to recover and achieve their optimal level of skills, confidence and independence. We will devise a system where people are able to step up into intermediate care and sub-acute beds to avoid an unplanned admission thus ensuring that at least 1/3rd of the capacity of the system is used for step up need. The beds can also be used as step down from an acute setting where necessary. The project will include:** • **Re-model a planned East Lancashire wide system following a detailed analysis of the sub-acute bed base required (employing the methodology Birmingham used to define their need) and delivering**

the following:

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

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

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

Key outcomes for people include:

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

area
Timescales
The review and redesign of the intermediate care system will commence in January 2015 and be completed by December 2017. The remodelling of the integrated care system is a long term plan therefore it is expected that the CCG will only see a small proportion of impact and savings during 2015/16, with full effect and impact as a long term vision.

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

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

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

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

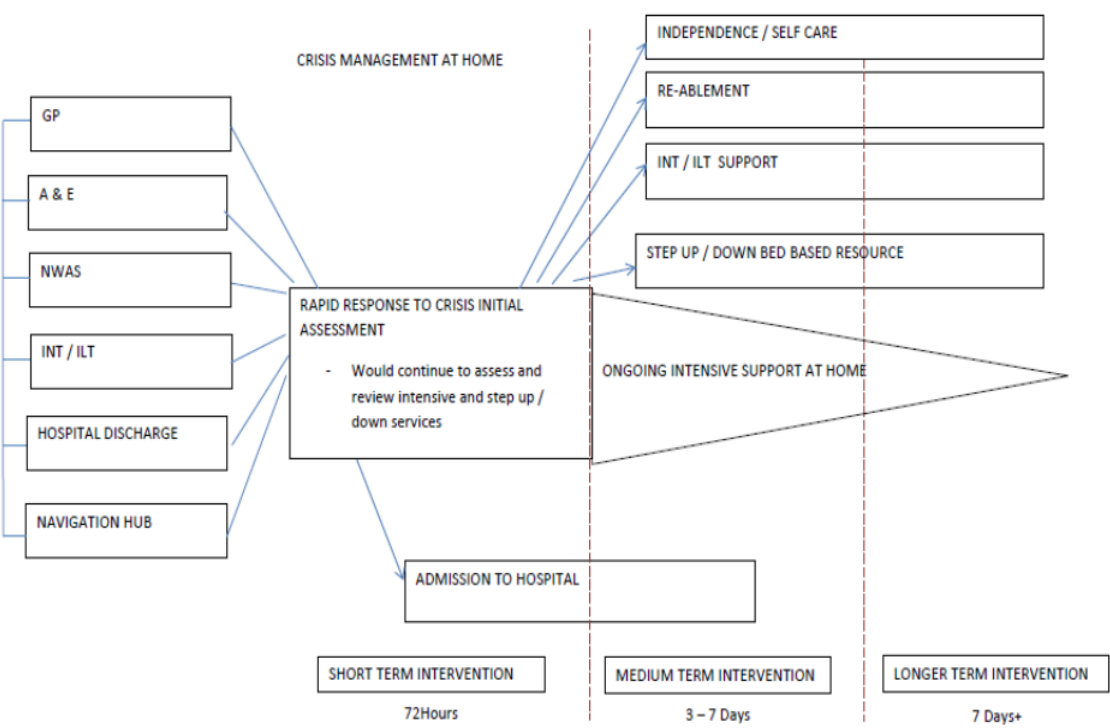
- More staff will be required.
- All social care, therapy and coordinator resource will be based directly in the team (employment contracts will sit in LCC). No rise in nursing requirements is factored in as this will be planned within the development of the Intensive Home Support service closely aligned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

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

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

All crisis referrals will be directed through ICAT for responsiveness and monitoring purposes.

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

Co-ordination hub and Directory of Services
Model
The Care Navigation hub will provide a key interface with the Intensive Home Support and the Integrated Discharge Team. It will also provide a capacity management system for out of hospital care enabling full use of resource and ensuring flow across the community bed based system. **The diagram below outlines the DOS and navigation hub interface with the wider system.**    **Alongside the hub a comprehensive Directory of Services (DOS) advice and brokerage for health and care professionals to enable them to access the appropriate services for frail elderly patients. It will also have a capacity monitoring function to help referrers understand their options to make best use of resources within the local health and care economy. The DOS will**

include service information relating to:

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

Timescales

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

The delivery chain

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

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

Intermediate Care Services

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

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

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

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

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

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

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

Local evidence for Falls Pick-up Service

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

UK best practice for Falls Pick-up Service

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

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

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

Academic research for Falls Pick-up Service

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

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

Local evidence for Integrated Discharge Services

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

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

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

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

Local evidence

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

and falls patients).

Academic research

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

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

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

Investment requirements

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

Expenditure Plan

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

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

Impact of scheme

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

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

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

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

The quantified impact is calculated as:

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

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

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

Feedback loop

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

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

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

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

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

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

Scheme ref no.

BCF006

Scheme name

Intermediate Care Redesign – Fylde and Wyre

What is the strategic objective of this scheme?

The strategic objectives of this scheme are to build on existing individual good practice to expand and integrate all intermediate care provision, establishing a single pathway and range of time limited interventions provisions that:

- Maximise individual independence
- Offer a seamless transfer between bed and non bed based provision
- Improve the health and wellbeing of patients who are pivotal in agreeing goals and outcomes
- Focus on and enable early supported discharge and reduce length of stay
- ensure a quality service that provides value for money.
- Provide proactive step up options to reduce avoidable emergency admissions.

The service model will be developed to ensure sufficient community capacity to ensure that assessments outside of the acute setting are the default position, providing a 'Time to Think' model and wherever possible ensuring that patients are discharged directly to a new permanent residential placement

Overview of the scheme

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

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

By re-designing, enhancing existing services and developing new provision the future model for intermediate care in Fylde and Wyre will ensure:

- patient hand offs are minimized
- individuals' rehabilitative pathway will be co-ordinated and managed by one lead professional,
- a seamless transition through both residential and home based services as appropriate.

Increased community capacity and step up access will directly impact:

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

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

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

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

1. Residential Recuperation and Rehabilitation

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

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

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

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

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

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

2. Dementia Residential Rehabilitation

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

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

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

4. Home based provision

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

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

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

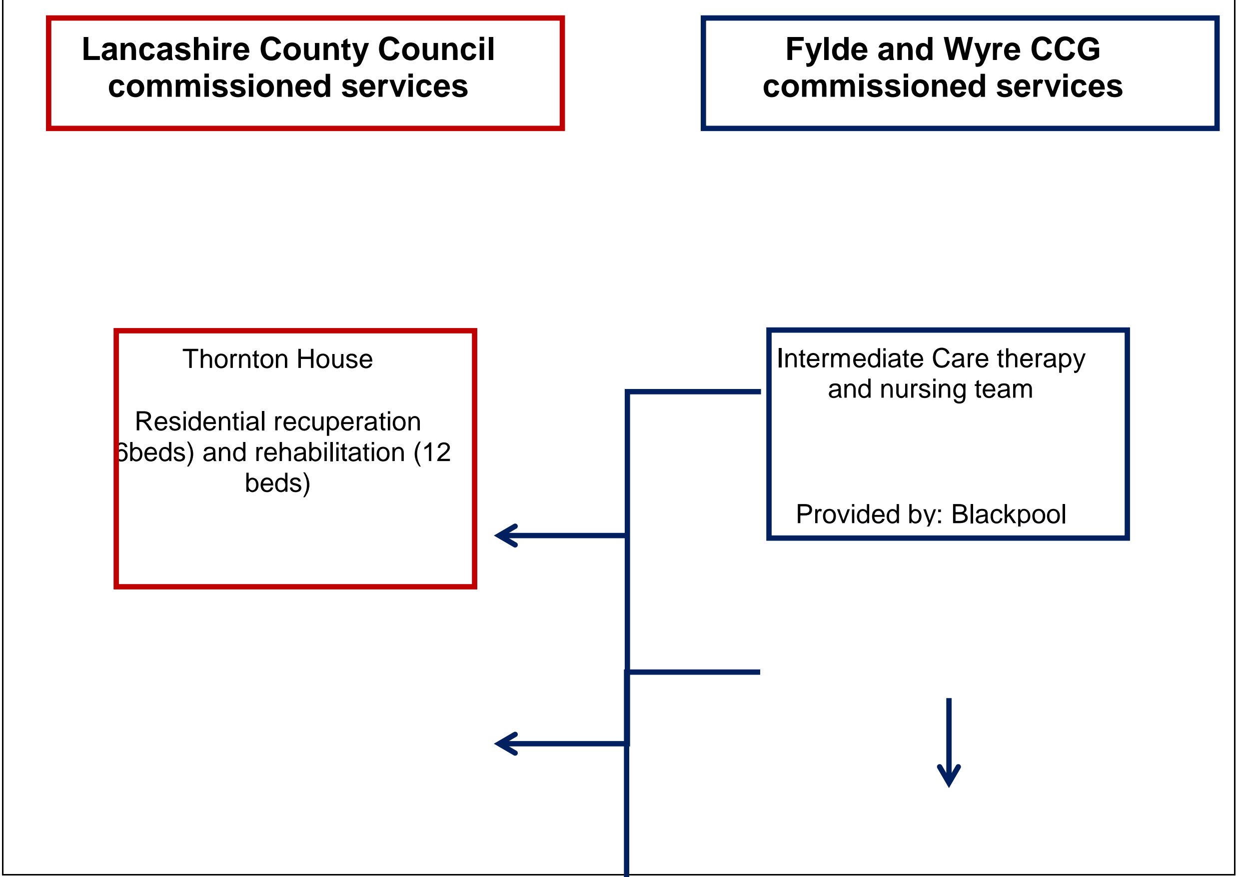
intermediate care referrals

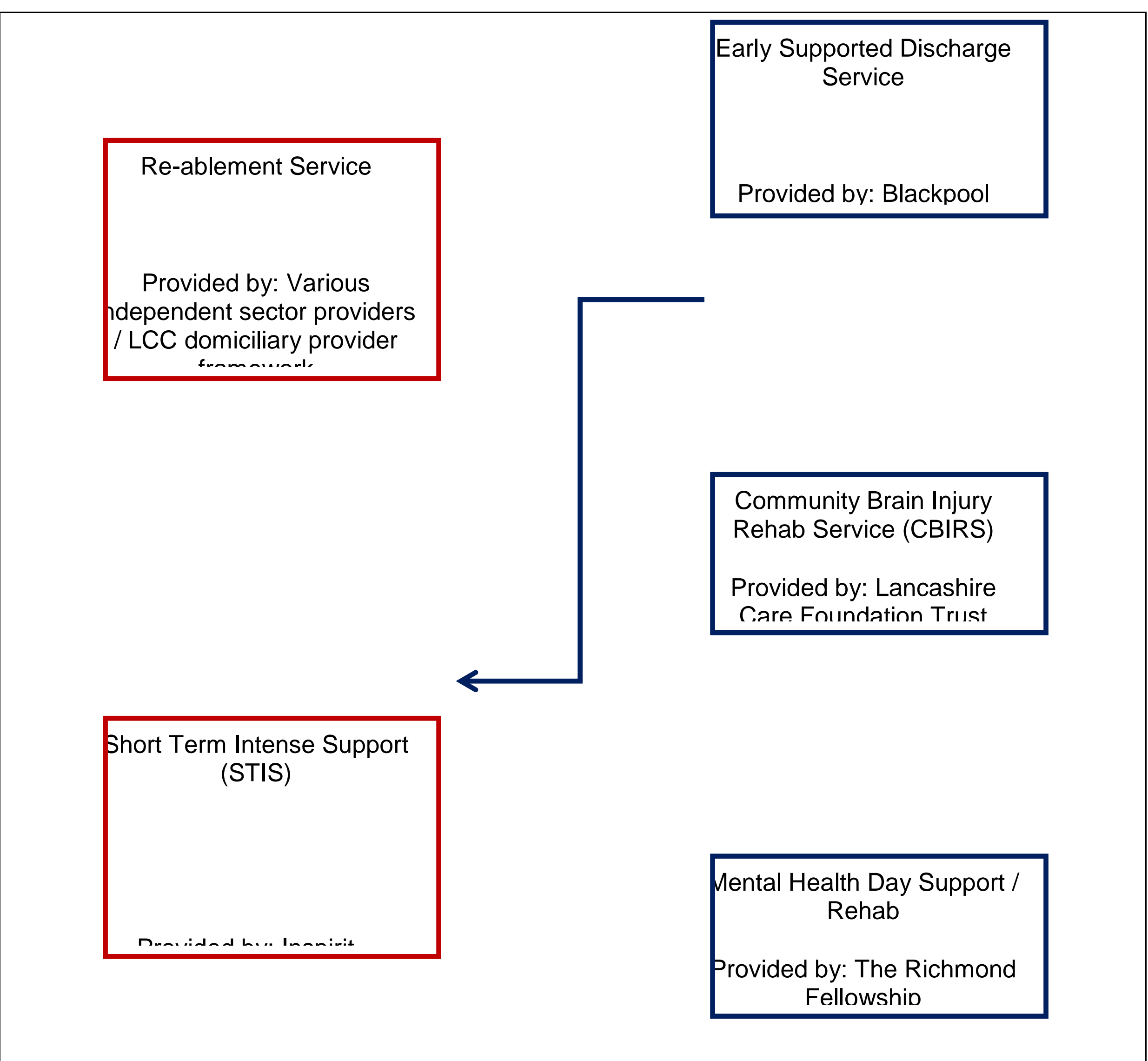
- Further integration of health and social care community based intermediate care services in the form of a new Early Supported Discharge / Discharge to Assess service
- Enhance therapy and nursing input into non-nurse lead residential beds and community therapy team to improve the patient journey and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

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

The delivery chain

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





The evidence base

Please reference the evidence base which you have drawn on

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

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

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

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

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

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

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

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

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

Investment requirements

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

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

Impact of scheme

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

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

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

Metrics	
Emergency admissions	☑
Delayed transfers of care	☑

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

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

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

The key qualitative benefits are:

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

Feedback loop

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

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

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

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

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

The key success factors of this scheme are the :

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

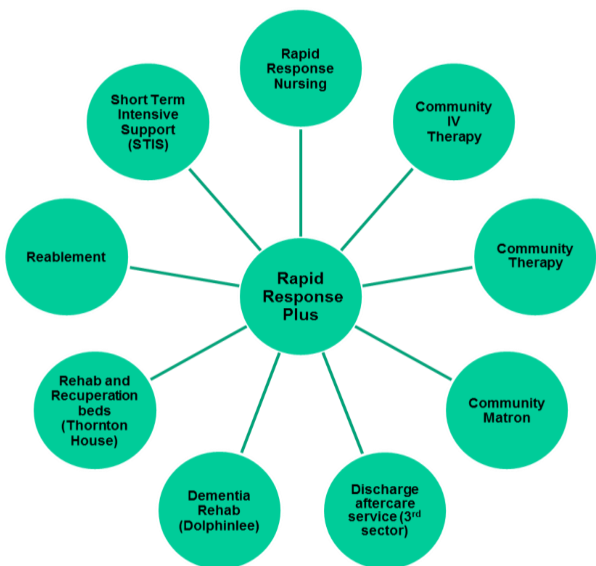
Scheme ref no.
BCF007
Scheme name
Admission Avoidance
What is the strategic objective of this scheme?
The strategic objective is to provide a cohesive and integrated approach to admission avoidance, building on existing good practice. The scheme will: • Embed integrated interventions for frequent users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

Overview of the scheme

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

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

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



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

Rapid Response Plus – single point of access

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

The key features are:

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

Short Term Intense Support (STIS)

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

Rapid Response Nursing

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

Community IV Therapy

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

Other service provision:

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

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

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

prevention to rehabilitation.

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

The delivery chain

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

Local support

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

Area	Fylde and Wyre CCG	ancashire CCG Cluster	IWAS
Total Incidents	**21,997**	**207,852**	**68,098**
17 – Falls	**3,157**	**23,187**	**06,217**
% of all incidents	14.4%	11.6%	11.5%
Falls Conveyed	**2,171**	**16,322**	**'6,818**

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

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

Peer evidence

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

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

International best practice

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

Academic research

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

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

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

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

Investment requirements

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

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

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

Impact of scheme

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

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

headline metrics below

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

Metrics	
Emergency admissions	☑
Delay transfers of care	☑

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

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

Feedback loop

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

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

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

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

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

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

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

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

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

Models of care and support

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

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

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

Target patient cohorts

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

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

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

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

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

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

The delivery chain

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

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

The key deliverables for implementation are:

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

UK evidence

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

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

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

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

earliest opportunity

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

Local context

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

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

A reasonable interpretation might be that:

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

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

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

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

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

Investment requirements

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

The investment requirements are as follows

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

Impact of scheme

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

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

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

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

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

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

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

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

Other benefits will be:

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

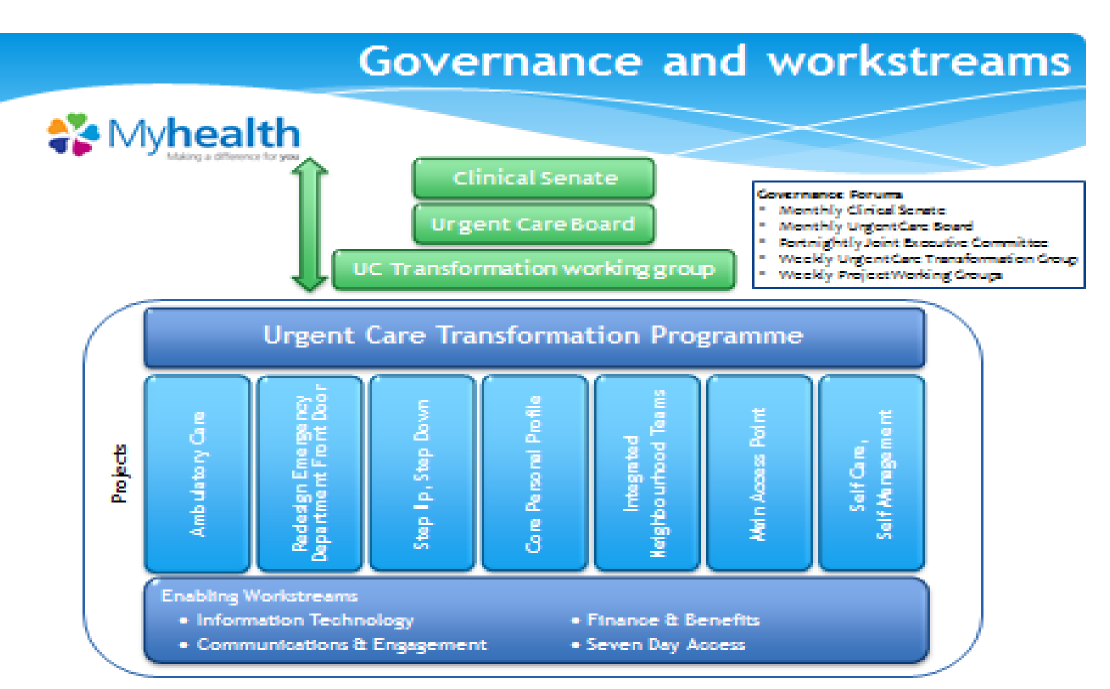
Feedback loop

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

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

KPI	Description	Target

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



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

Measures will include the following:

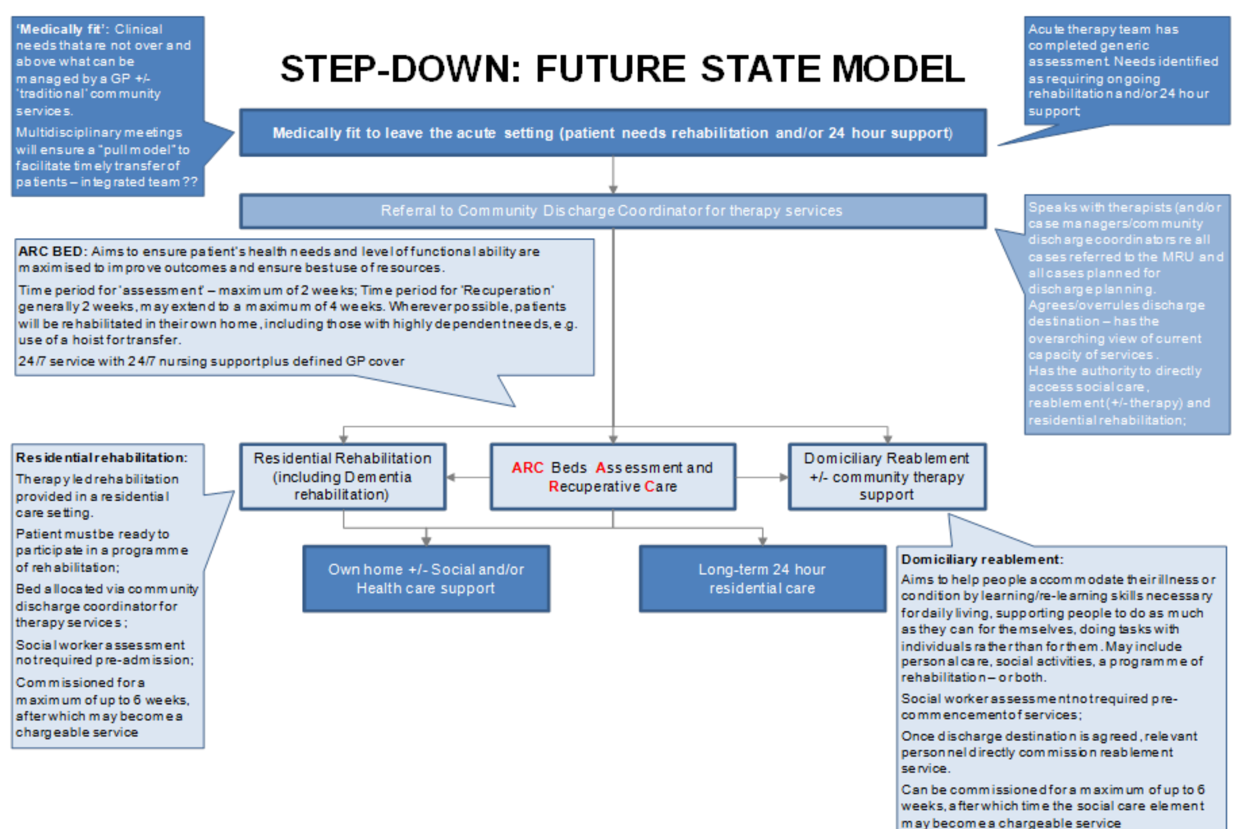
- Source, case mix and number of referrals into each element of the service;
- Time lapse between referral and transfer into a service;
- Audit of reasons for refusal of/for a service;
- Length of stay in each case (including mean and median data) for all elements of the service;
- Discharge destination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

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

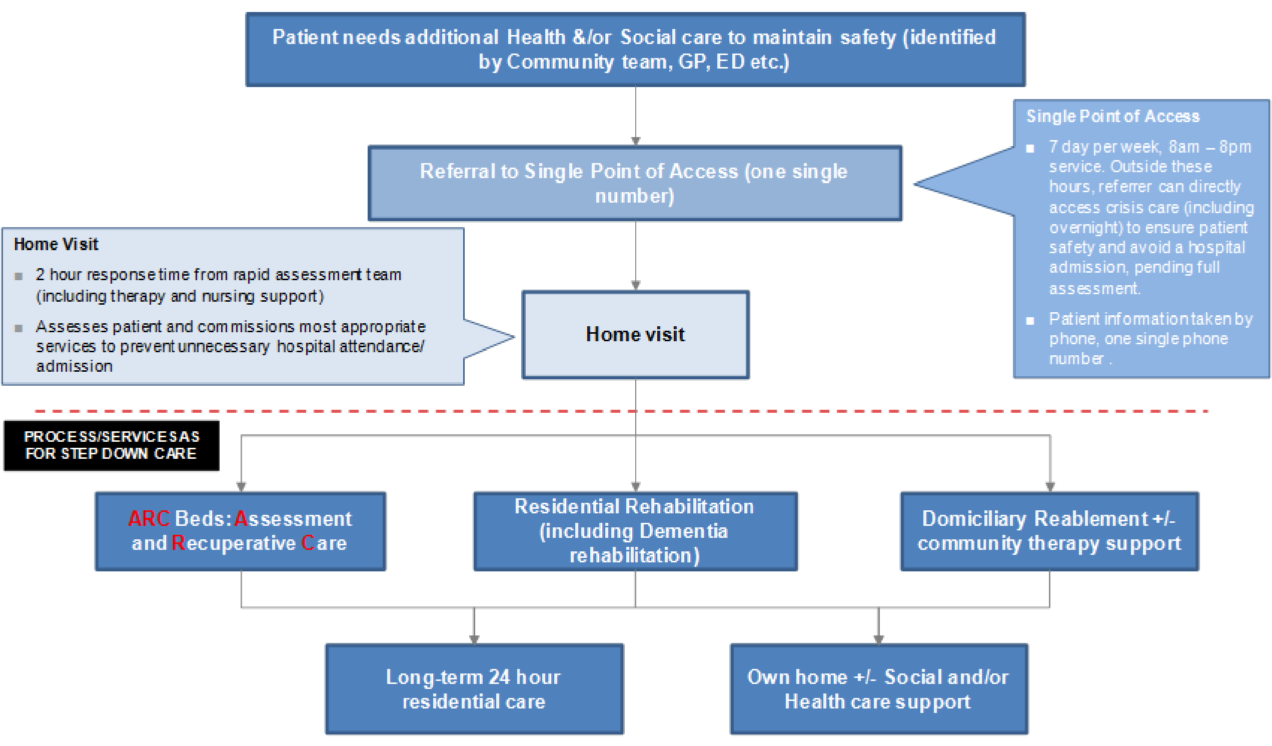
All KPIs are monitored through the Urgent Care Transformation governance structure.

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

Appendix 1: Proposed model of step-down beds



Appendix 2: Proposed model of step-up beds



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

VISION OF URGENT CARE

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

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

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

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

Overview of the scheme

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

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

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

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

Models of care and support

AMBULATORY CARE

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

There are three models of care that will be followed to meet our ambulatory care objectives.

1. **Proactive case management of ACSC by multidisciplinary teams**

- This will enable primary, community and secondary care teams to work in an integrated manner and proactively manage patients with ACSC
- This will minimise the risk of acute events, thereby reducing 999 calls, ED attendances and non-elective admissions

2. **Implementation of new pathways of care for ACSC**

- These new pathways will be supported through community-based services which will provide alternatives to hospital admission and where appropriate, will provide early supported discharge services

3. **Improve outcomes for people with an ACSCs**

- Patient outcomes will be at the centre of the pathway redesign, and all new pathways will be monitored to ensure effectiveness, experience and safety

Target patient cohorts

nitially our focus will be on those deemed most at risk of hospital admission for COPD (900 patients), and expand this over time. Therefore for planned deliverables are:

- To evaluate the COPD admission avoidance pathway undertaken at Q1
- To agree the outline the integrated COPD service model with GP directors
- To inform and outline the integrated COPD service model;
- To scope the opportunities for redesign of acute end of Diabetes pathway;
- To scope the opportunities for Quadramed markers for ambulatory care pathway covering Cellulitis, Diabetes, Asthma and Epilepsy

Proposed Service Model for COPD Ambulatory Care

To enable the delivery of the anticipated outcomes and benefits required, we believe a fully integrated, fully resourced COPD service incorporating primary, secondary and social care is necessary to deliver:

- Prevention of COPD through primary prevention activities and pro-actively screen 'at risk' patients (i.e. smokers over 35) to identify undiagnosed patients. Promotion of flu and pneumococcal vaccination strategies
- Existing registers validated, and newly diagnosed patients rated (mild, moderate, severe). Patients to receive recommended number of reviews per annum as per DH guidance and the National COPD Strategy
- Increase patient education (i.e. self-awareness, care and management)
- Improve communications and engagement across the health economy to promote the services available for people with COPD
- Appropriately trained multi-disciplinary workforce delivering high quality care to patients across care pathways
- COPD services aligned with existing oxygen services
- Develop or improve on joint working with community pharmacy services and voluntary sector organisations where appropriate
- Utilising new technologies such as telemedicine will be key to the service delivery
- Ensuring support is offered throughout the patient care pathway and through implementation of personalised care planning
- Shared health and social care information, should be integral to this pathway thus ensuring smooth transition for service users across organisational/professional boundaries and also supporting care providers in the delivery of holistic care
- To develop a proactive, collaborative management model of care following agreed protocols, guidelines and pathways for COPD

Proposed changes to the service

designing the new service we will investigate access, service specifications, expanding the use of the community COPD service and response times:

- Expanding the current 300 of 900 patients admitted to LTH with COPD who are referred on to the COPD service, as re-admission rates for COPD are low where known to the COPD service.
- Current service specification includes only 300 pulmonary rehabilitation (PR) places per year. As a minimum enough places should be commissioned to allow all patients admitted with COPD to be offered a place
- If services were resourced to run 8-8 every day and 9-5 weekends rather than office house then additional admissions would be avoided. Further analysis of admissions times needs to be undertaken to offer the most complete picture of admissions for COPD.
- If the number of clinician was expanded for the Heart Failure service it would be able to contact patients within 48 hours of referral.

The delivery chain

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

The delivery chain comprises the following commissioners and providers:

- Commissioners – Greater Preston CCG, Chorley and South Ribble CCG, Lancashire Care Trust

The key deliverables for implementation are:

Care pathways development and redesign	
COPD Service Review • Pathway mapping activity ○ Training shortfalls ○ Team capacity ○ Access to patient records ○ Communication ○ Collaboration and joint working opportunities ○ Standardisation • Implementation • Delivery • Monitoring	Joint initiative between commissioners and provider

The evidence base

Please reference the evidence base which you have drawn on

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

There are a number of drivers, both nationally and locally, that have promoted a thorough review of ambulatory care services within Central Lancashire and the development of a high quality model of care that is owned across all relevant organisations.

Central Lancashire has taken into account UK evidence, the local Lancashire context and academic research when developing this scheme.

UK evidence

Different sets of ACSCs are used for research and health policy analysis (Purdy et al 2009). In England, the most frequently used set are the 19 ACSC conditions provided by

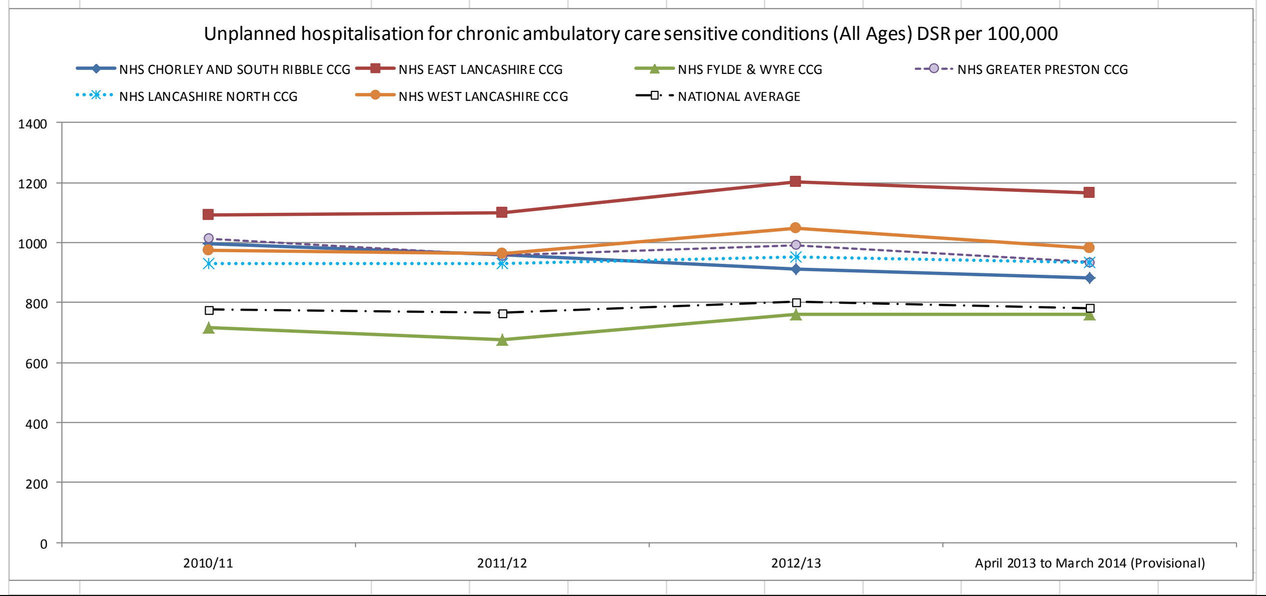
the NHS Instituted for Innovation and Improvement (2007). Improving the management of these conditions is important for the following reasons:

- Ambulatory care-sensitive conditions (ACSCs) account for one in every six emergency hospital admissions in England.
- The proportion of emergency admissions for ACSCs is larger in under-5s and over-75s. Children are predominantly admitted for acute conditions, older people for chronic conditions, and both groups for vaccine-preventable conditions.
- The rate of emergency admissions for ACSCs varies among local authorities from 9 to 22 per 1,000 population.
- The rate in the most deprived areas is more than twice the rate in the least deprived areas in England.
- Emergency admissions for ACSCs cost the NHS £1.42 billion annually. Influenza, pneumonia, chronic obstructive pulmonary disease (COPD), congestive heart failure, dehydration and gastroenteritis account for more than half of the cost.
- Older people (aged 75 years and over) account for 40 per cent (£563 million) of total spend.
- Influenza and pneumonia account for the largest proportion of admissions (13 per cent) and expenditure (£286 million).

Local Lancashire context

- Both NHS Chorley and South Ribble CCG and NHS Greater Preston CCG show a rate of hospital admissions for patients with ACSCs greater than the national average, see below. Improvement to the ambulatory care pathways would have a positive impact on the hospital admissions rate for ACSCs.

CCG Code	CCG Name	2010/11	2011/12	2012/13	July 2012 to June 2013	October 2012 to September 2013	January 2013 to December 2013	April 2013 to March 2014 (Provisional)	2010-11 to 2013-14	% Movement
00X	NHS CHORLEY AND SOUTH RIBBLE CCG	996.3	958.8	912.5	874	849.9	834.7	880.6	-115.7	-11.6%
01A	NHS EAST LANCASHIRE CCG	1090.5	1099.2	1203.1	1191.4	1156.9	1145.9	1167.2	76.7	7.0%
02M	NHS FYLDE & WYRE CCG	714.9	677.3	759.9	793.9	762.4	759	759.9	45	6.3%
01E	NHS GREATER PRESTON CCG	1013	957.3	991	936.1	908	896.5	935.4	-77.6	-7.7%
01K	NHS LANCASHIRE NORTH CCG	929.5	929.6	952.6	950	973.5	937	932.1	2.6	0.3%
02G	NHS WEST LANCASHIRE CCG	972.6	964	1048.6	1018.9	989.4	955.5	979.8	7.2	0.7%
	NATIONAL AVERAGE	775.9	765.8	802.8	796.5	787.7	780	780.9	5	0.6%
	Lancashire 'Range' (Max - Min)	375.6	421.9	443.2	397.5	394.5	386.9	407.3		



Unplanned hospitalisation for chronic ambulatory care sensitive conditions (All Ages) DSR per 100,000[3]

- The 2012 Lancashire Teaching Hospital (LTH) non elective admissions data was analysed and identified the following (2012/13 data):
    - ACSC patients cost over £12.5m from 6,774 admissions with COPD being the highest
    - This accounted for 18% of non-elective admissions and 17% of occupied bed days
    - The over 65s counted for 37%of admissions but 66% of occupied bed days

This data supports the selection of the scheme in that, there are service improvements and cost savings (specifically in reducing the number of non-elective admissions) to be made. The majority of ACSCs admitted to hospital are those people over 65 years of age.

Academic research

Research by the Kings Fund, April 2012[4], states that high levels of admissions for ACSCs often indicate poor coordination between different elements of the healthcare system, articularly between primary and secondary care. An emergency admission for an ACSC is a ign of the poor overall quality of care (even if the ACSC episode is managed well). The wide ariation of emergency hospital admissions for ACSCs implies that they, and the associated costs for commissioners, can be reduced.

he research also points out the substantial difference in cost to treating conditions (£734 for ENT to £4002 for gangrene) and that the cost of emergency admissions for ACSCs was strongly associated with patients' age (40% of expenditure on patients who were 75 years old and over). Finally, the research also notes that nearly 80% of patients who stayed in hospital for more than two weeks were those over the age of 65.

he analysis showed that the number of emergency hospital admissions for ACSCs could be reduced by 18% (150,373 per year; potential cost reduction £238 million) if all local authorities performed at a level of the best-performing quintile local authorities; by 8% (63,214 per year; potential cost reduction £96 million) if each quintile local authorities performed at the level of the next best quintile local authorities; 11% (90,471 per year; otential cost reduction £136 million a year) if the poorer (than the average) performing local

[3] **Emergency Admissions** Benchmarking and Trends LANCASHIRE CCGs. Source: http://nww.indicators.ic.nhs.uk/webview/

[4] Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions

authorities performed at the level of the better (than the average) ones.

The analysis also showed Influenza, pneumonia, COPD, congestive heart failure, dehydration and gastroenteritis account for more than half (53 per cent) of the cost of emergency ACSCs admissions.

Investment requirements

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

Total investment = £343,000

Impact of scheme

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

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

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

Metrics	
Emergency admissions	☑

The quantified **reduction in emergency admissions is calculated as 260** in 2015/16.

This takes into account UK evidence,(Effing & Cochrane (2009) Self Management with Education works for COPD and Puhan and Cochrane (2011) Rehab for COPD), Thomas Heart Specialist Clinic for heart failure reduce admissions after 12 months 2013), the local context and academic research in developing this scheme.

3oth Chorley South Ribble and Greater Preston CCGs show a rate of admissions above the national average and therefore improvement to these pathways will have a positive impact on the non-elective admission rate for ACSC. Evidence shows that over the last two months NEL activity for COPD, Upper GI and Cellutis has reduced by 12% by pulling out 0 - 1 day tays. The Urgent Care Centre at Chorley is expected to further reduce ACSC when it comes on stream next year.

Feedback loop

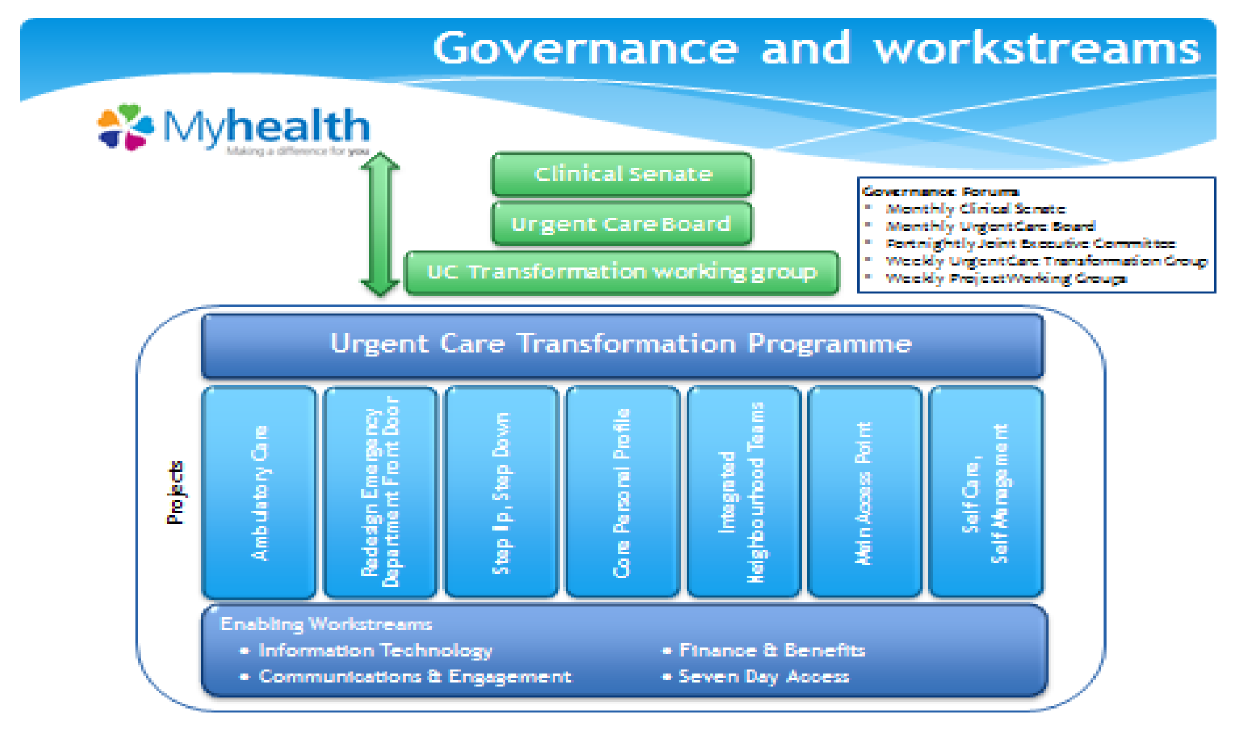
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

he data we have used to support the implementation of the ambulatory care scheme will act s the initial baseline for the KPIs listed below. These KPIs will then be monitored on monthly basis through our governance processes (see the Governance diagram at the end of this section) and programme leads are held accountable for delivery through this structure.

KPI	Description	Target
Success Factor	**Indicator**	**Target/ Trajectory**
Clearly defined ambulatory pathways	Quality – efficiency & effectiveness	• Reduction in length of stay • Reduction in admissions to care homes • Improved patient and carer experience • Reduction in readmission rates • No's of ACS pathways and protocols in place for timely referral to appropriate services
Reduced ED attendances	Quality – patient care & clinical outcomes	• Reduction in overall ED attendance • Reduction in people attending with ACSCs
Care in least intensive setting	Reduction in admissions with ACSCs	• Number of patients with an integrated care plan and named coordinator • % of patients admitted to acute hospitals and entering on the ACS COPD care pathway • % of patients admitted to acute hospitals and referred to early supported discharge teams • % of patients admitted to acute

		hospitals seen by Respiratory Team • % of patients admitted to acute hospitals referred to INTs
Reduced length of stay in acute and community hospitals	Reduced admission to LTH	• Reduced bed days
Improved patient and carer experience	Quality – stakeholder satisfaction	• Patient and carer satisfaction rates • Friends and family testing
A successful whole system approach is delivered	Quality – strategic benefits	• Positive outcomes from this COPD exemplar model will drive further changes in relation to each ACS condition.
New pathways enable proactive response to demand	Cash releasing	• Reduction in length of stay • Reduction in admissions to care homes • Reduction in readmission rates • Reduction in bed days

Governance structure and accountability model for the Urgent Care Transformation programme and in particular, the Ambulatory Care project:



What are the key success factors for implementation of this scheme?
Demonstrate an understanding of the **key success factors** for the scheme that you are proposing. E.g. expertise, staff, demographics, history of partnership working? • Do these also exist within your area? • If not - what action is required to put those in place? • Or what impact will the absence of those supporting factors have on the outcomes that can be achieved? • Outline a stepped approach to implementation which draws on i) learning from either local evaluation or other areas where this has been implemented, and ii) engagement with partners about the deliverability of the proposal
• Systems need to be put in place at CCG level to feed back to GPs which of their patients are presenting at A&E as a result of one of these ACS conditions. Existing Risk Stratification methodology to be used to easily identify these patients • Systems need to be in place to identify which conditions account for a disproportionate level of hospital admissions to focus resources in their area • Enable access to other services (eg Rapid Access clinics, In-reach and out-reach teams, intermediate care) for practices to support the management of these patients. • Develop A&E assessment procedures. Gaps in communication, joint working, technology, data collection and analysis, information sharing, capacity etc

Scheme ref no.
BCF10
Scheme name
Development of Extra Care Schemes
What is the strategic objective of this scheme?
An Extra Care and Specialist Housing Strategy was recently developed in order to address the low level of current provision of extra care with a view to reducing the level of demand for social care and health care services amongst older people. The strategic objectives of the scheme are to: • Enable the development of an extra care scheme in each district

- Reduce admissions to residential care
- Provide an additional housing option for older people and people with disabilities
- Promote health and wellbeing and reduce the need for health and social care services

Overview of the scheme

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

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

This scheme aims to provide a home for life through:

- Ensuring that the design of the building can meet the needs of people with increasing care and support requirements
- The provision of a basic level of on-site domiciliary care which will be available to all residents 24 hours per day.

Extra Care Housing is targeted at:

- People at risk of being admitted to residential care
- People in receipt of reablement who have been assessed as requiring extra care housing
- People who have low or no immediate care needs but would benefit from the extra care environment in order to promote wellbeing

The strategy estimated an immediate need for an additional 988 units of extra care for older people across the county. This level of provision would enable Lancashire to reduce its current reliance of residential care. A more ambitious target of around 2,600 units has been identified which is predicted to grow to 3,725 by 2033.

The core components of the scheme are:

- The delivery of at least one extra care scheme for older people in each district of the County.
- An initial requirement for 10 centres given facilities already exist in Rossendale and West Lancashire.
- Ultimately more than one scheme in many districts will be considered, as local communities and housing markets often don't recognise or coincide with district boundaries, but a scheme per district is considered a reasonable starting point.
- A flexible approach to differing and changing funding and support requirements, enabling LCC to increase or reduce its financial exposure according to what can be achieved with other partners including health, developers and registered housing providers.
- Where the market is not able to develop services without financial assistance from LCC, the

County Council will look to provide financial input to schemes, including any land value, not representing more than 30% of the total cost of a project. However, in most cases the contribution of LCC would be expected to be significantly less.

- The programme will be delivered through strong partnership working between County Council, District Council, NHS Clinical Commissioning Groups and providers and operators
- It is envisaged that joint working between all partners could enable the development of around 600 units, which represents two thirds of the original target of 900 units.
- We are also proposing a core wellbeing, unplanned care and sleep in service which will be commissioned by LCC. The tenant will be required to use the onsite provider for this element of the care, but will be able to use their personal budget for all planned care.

The development of extra care schemes can arise as a result of:

- LCC identifying a site, or a need, in a particular area and then seeking expressions of interest from the market. LCC would decide in conjunction with the district as to whether to advertise or to target particular landlords already working in a district
- A landlord approaching commissioners either with a site, or with funding, or the intention to bid for funding and contribute own resources if successful. Landlords may also request additional funding from LCC to make the finances stack up.

The delivery chain

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

Lancashire County Council, District Councils, CCGs, Regeneration Partners and landlords will be involved in taking forward the Extra Care Strategy.

All agencies are keen to make sure that extra care is developed, consequently we are seeking to combine a strategic direction with a pragmatic approach, whilst always ensuring that we comply with procurement rules

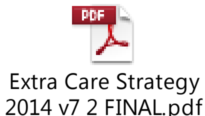
The evidence base

Please reference the evidence base which you have drawn on

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

Local evidence and context

The evidence base is elaborated in the attached strategy document and the key aspects have been included in the Overview section:



Extra Care Strategy 2014 v7 2 FINAL.pdf

Pages 25-27 which explain the methodologies used below to project the number of units of extra care required.

The key driver is **an over admission into residential care of 442 people per year in Lancashire** when compared to the comparator group average, as calculated in the following table:

EXTRA CARE HOUSING CALCULATIONS	65+ residential admissions only	population 65+ based on 2012 pop estimates	Admissions needed to achieve comparator group average	Over admissions	Extra Care Units Required to remove over admissions
Lancaster	166	26,356	130	36	79
Fylde	106	19,104	95	11	26
Wyre	159	27,550	136	23	51
Preston	150	19,785	98	52	116
South Ribble	157	20,521	102	55	124
Chorley	117	19,253	95	22	49
West Lancs	127	21,968	109	18	41
Hyndburn	114	13,425	66	48	106
Ribble Valley	75	12,135	60	15	33
Burnley	134	14,751	73	61	136
Pendle	132	15,048	74	58	129
Rossendale	99	11,138	55	44	98
	1,536	**221,034**	**1,094**	**442**	**988**

The demand on residential care homes can be reduced by providing **appropriate additional extra care beds, calculated to be 988** (the final column). It is this figure, which is subsequently used to calculate the base level of potential savings on residential care spend, through investment in extra care.

Using a simplified version of the HGP methodology for calculating extra care numbers, we stimated the number of people who could be better supported in extra care. We segmented the 75 year old population using the principles from the Wanless Review, assuming those classified as Group 3 and 4 are most amendable to extra care, less a proportion that we ssume still requires registered care. This amounts to 10.14% of the older person population.

Converting these numbers into households and then using the study of Strategic Housing Market Assessments to estimate the proportion of this household population that we think would choose an extra care service, amounts to 25% of the population, being:

- 2013 – 2,597
- 2023 – 3,102
- 2033 – 3,725

UK research and exemplars

Improving housing with care choices for older people: an evaluation of extra care housing. This report summarises the results of a Department of Health (DH) funded valuation of 19 extra care housing schemes that opened between April 2006 and November 2008, and which received capital funding from the Department‘s Extra Care Housing Fund. It’s key findings were improved outcomes and quality of life for those involved and when atched with a group of equivalent people moving into residential care, costs were the same or lower in extra care housing.

Aston University Research/Extra Care Charitable Trust

This comprehensive study, looking at 17 of the Extra Care Charitable Trust extra care developments, shows early indication fo the following

- Planned NHS admissions in the Extra Care Housing group reduced from 0.298 to 0.115, a 60% drop in activity;
- Unplanned admissions in the Extra Care Housing group reduced from 0.225 to 0.154, a 32% drop in activity;
- Drop in GP activity planned (36.4%)and unplanned of (19.4)%;
- Reduction in mean depression scores
- Increase in mean memory scores.

Investment requirements

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

Total investment = £1,924,000

Where the market is not able to develop services without financial assistance from LCC, the County Council will look to provide financial input to schemes, including land value, not representing more than 30% of the total cost of a project. However, in most cases the contribution of LCC would be expected to be significantly less.

Impact of scheme

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

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

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

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

Other expected benefits include:

- Keep people healthier and active longer and more able to contribute to society;
- Reduce loneliness thereby improving mental health
- Enable hospital discharge as some form of intermediate care/ rehab will be included within extra care provision

- Improved efficiency in relation to the delivery of domiciliary care
- Release of general housing (family housing) as provides alternative option for over 65's.
- Number of units of extra care housing developed
- Reduction in number of people accessing A&E

Feedback loop

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

ɩs part of the development of new services, an outcomes framework will be jointly developed ɔy LCC, CCGs and Districts. Due to the long lead-in time, the timeframe for this is sometime in 2015/16.

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

- Develop better pathways into extra care
- Need to better understand the population stratification to identify those who would benefit from this scheme
- Partnership working will be crucial to ensure then best financial benefits and health & Wellbeing outcomes.
- There are sites available that would be suitable for extra care and there are no insurmountable barriers from a town planning perspective to delivering a step change in extra care provision.
- There are willing operators and providers although many have constraints on their ability to raise capital to invest at risk in the development of the extra care market.

Scheme ref no.
BCF11

Scheme name

Integrated Offer for Carers – Support and Respite

What is the strategic objective of this scheme?

One of the key outcomes of the BCF programme is 'Improved quality of life for people with support needs and for their carers'.

Through the Lancashire Multi Agency Carers Strategy, 2012-2015 we intend to increase the number of unpaid and informal carers who receive an assessment and support to develop a personalised support plan, in order to implement the duties within the Care Act 2014. The aim of the scheme is to provide and develop good quality local support for carers tailored to their individual needs, promoting the carers general health and wellbeing, preventing, reducing or delaying their need for support.

To achieve the aim, the strategic objectives of the scheme will be to:

- Work in partnership across Lancashire to ensure a common identity and consistent offer to carers across Lancashire
- Work collaboratively with condition or age specific VCF organisations offering a carer support offer locally
- Widely promote the service and identify and support hidden carers
- Develop high quality, person centred support for carers
- Support and co-ordinate consultation and involvement between carers, Lancashire County Council and the NHS
- Develop comprehensive, co-ordinated information and advice for carers and former carers
- Develop knowledge by the provision of timely and appropriate information and support which will help link carers into the services they need
- Help Lancashire County Council and the NHS to develop responsive cultures and services which see carers as individuals with unique needs
- Provide opportunities for carers to have a break from their caring role via a range of services, including the provision of a sitting in service and Time for Me grants
- Support carers to develop their Peace of Mind 4 Carers Contingency plan
- Undertake carers assessments and support plans with carers with the potential to commission carers personal budgets.

Overview of the scheme

There are two key components to this scheme, Carers Support and Carers Respite.

Carers support

This scheme will redesign and re-commission carers services across Lancashire, delivering an integrated service specification built around a suite of key outcomes:

1. **Emergency planning service** (Peace of Mind for Carers): The service will provide up to 72 hours of replacement care in situations where the carer can no longer provide the care due to an unplanned/unforeseen circumstance. The service will develop a plan of emergency care with the carer and the cared for person and be ready to be activated 24/7, 365 days per year. It is anticipated that around 600 new emergency plans will be completed per month across the county.

2. **Carers Assessments:** The service will offer carers the opportunity to have a carers assessment where the carer requests a separate assessment to the person they care for. It is anticipated that around 600 carers assessments will be completed monthly.

3. **Time for Me:** The service will provide grants of around £350 to carers who are not eligible for a carers Direct payment. The grant can be spent on anything that will give the carer a break from their caring role. It is anticipated that around 700 carers will access a Time for Me Grant.

4. **Specialist workers:** The service will have a range of specialist workers including BME and Dementia workers.

5. **Information, support, signposting and advice and forums:** The service will offer a 8am-6pm telephone helpline, a 24/7 volunteer peer support line, range of social media and offer face to face visits. The service will provide a range of support groups developed in response to carer request/need. The carers service will facilitate local and Lancashire wide carers forums. It is estimated that by 2017/18 around 25,000 carers will be registered with carers services.

6. **Sitting in Service:** A volunteer manned sitting in service will be available to carers to

nable them to have a break. The sitting in service will support at least 200 carers per month to have a break.

7. **Former carer support:** Former carers will be supported for up to two years after their aring role ends. This is in recognition of the fact that carers at the end of their caring role can face bereavement, financial difficulties, housing issues, lowered confidence, unemployment etc.

8. **Trips, activities and courses**: A range of courses, trips and activities will be offered to carers to enable them to have a break.

9. **Carers Awareness Training** - All organisations who come into contact with carers will ave access to carers awareness training delivered by the carers service. The training will be ailored to the organisation's needs. At least 20 carers awareness sessions will be delivered per month.

10. **Forums** - There will be a range of local forums feeding into a Lancashire wide carers forum facilitated by the carers service:

- Pukar: a BME specific resource centre located in Central Preston. The service provides a range of courses, including IT and ESOL, translation support, case work with BME families and drop in facility for carers and people with disabilities
- Carers Mental Health specific service: the Lancashire wide carers service is specifically to support the needs of carers caring for someone with significant mental health problems. The service offers a range of support to this group of carers via a team of specialist workers, including:
  - CHIT service – The carers Help & Information Team is available Monday to Friday 8:00 am until 6:00 pm offering information, support and signposting
  - CHAT service - The Carers Help And Talk line is available 24 hours a day 365 days per year, the line is manned by carers who have an understanding of caring for a person with a mental health condition
  - 1:1 intensive support that can be provided in a crisis
  - Support groups and forums

Carers Respite

- Carers, regardless of their level of need will have a carers assessment which will

identify the level of support they require to enable them to maintain their caring role.

- A budget will be allocated to eligible carers to enable the carer to have a break from their caring role which they can use to access to a range of domiciliary, daytime and residential respite. The majority of carers will be issued with a pre-paid card, which will enable them to purchase a short break flexibly to suit their needs, however, carers can choose to have their break directly commissioned where a pre-paid card is not suitable.
- In addition, eligible carers will receive a personal budget to be spent in a flexible way, for example to purchase gym membership, therapies, leisure activities. The budget allocation will be based on a resource allocation system.
- In particular and in response to feedback from carers we have commissioned two dedicated short break beds across the County that carers are able to book in advance using their Direct Payment. The beds will be for the use of adults 18+ no matter what the level of need.

The delivery chain

Programme & Project Manager – Carers Strategy Officer Lancashire County Council

Commissioners: Chorley, South Ribble and Greater Preston CCG, West Lancashire CCG, North Lancashire CCG, Fylde and Wyre CCG, East Lancashire & Lancashire County Council.

Providers:

Central and West Lancashire Carers

n-compass

Carers Link Lancashire

The evidence base

UK exemplars

- In Lancashire, we have focused on early intervention and prevention in line with the direction provided nationally through the Care Act.
- The Integrated Offer for Carers will drive forward activity to meet the requirements set out in the Care Act 2014, to recognise the wellbeing of carers in their own right, as well as the people they care for.
- Carers need preventative health and care services that build their resilience and

focus on carers' own health as well as supporting the people they care for, to enable them to sustain their caring role.

- Support must be in place for carers to have time away from caring, allowing them to have a healthy lifestyle, address their own health needs and look after their own mental well-being.
- Much of the research by Beverly Castleton has identified the importance of carers in supporting patients, in particular those with Parkinson's and early research from 1998 / 99 attributed as much as 20% of emergency admissions to "carer breakdown".

Local context

- There are 133,213 self-identifying carers (including parent carers and young carers) in Lancashire. 32,164 of these provide more than 50 hours per week in the caring role and 17,672 provide more than 19 hours a week. The census indicated that 9,500 (just over 7%) of carers indicated that they themselves were in bad or very bad health.

Reports

Supporting Carers: The Case for Change

This report demonstrates how increasing support for carers benefits the people being cared for, CCGs, health commissioners, general practitioners (GPs) and councils. It provides evidence from randomised controlled trials (RCTs) and peer reviewed journals to show that increasing support for carers:

- Improves health and wellbeing outcomes for patients and recipients of care;
- Improves health and wellbeing outcomes for carers, who suffer disproportionately high levels of ill-health;
- Reduces unwanted admissions, readmissions and delayed discharges in hospital settings;
- Reduces unwanted residential care admissions and length of stays

Please refer to section 6 of the report, available at
http://www.carers.org/sites/default/files/supporting_carers_the_case_for_change.pdf

Carers Support Centre, Bristol and South Gloucestershire: This report presents the impact

elated to the outcomes reached by a number of projects delivered by Carers Support Centre, Bristol and South Gloucestershire (CSC).

Investment requirements

Investment requirements

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

Total investment: £7,518,000

Impact of scheme

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

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

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

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delayed transfers of care	☑
Estimated Diagnosis Rate for Dementia	☑
Patient experience: Proportion of people feeling support to manage their LTC	☑

The quantified impact of this scheme has been calculated as:

- A reduction of 61 non-elective admissions in 2015/16
- A reduction of 5 permanent residential admissions by 2015/16
- A 9% improvement in reablement rates in 2015/16

In addition the following outcomes for the Carers scheme have been agreed:

- Reduce the need for health and social care services and improve wellbeing of carers by ensuring an integrated approach to accessing help and guidance.
- To ensure that we commission and provide assessment and support planning to carers, ensure assessment and support planning processes are personalised and provided by skilled staff within the local authority, health services and trusted assessors from the Voluntary, Community and Faith sectors..
- To provide all carers with effective advice, guidance and signposting support.
- Increase number of carers assessed in line with the Care Act expectations.
- Establish what works for carers and what produces sustainable savings locally by understanding the impact of carer support on delayed discharges, the need for social care and emergency hospital admissions, and by evaluating the range of carer support packages.
- To ensure carers have a 'Peace of Mind' plan (emergency plan) that delivers a crisis response to ensure that a crisis for a carer does not result in a crisis for the person being cared for.

Feedback loop

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

The re-procurement of carers services will be co-ordinated by a cross agency steering group reporting to the Lancashire Multi Agency Carers Steering Group.

Outcomes will be reported into the HWBB partnership, which in return reports into the Lancashire HWBB, to monitor the implementation of BCF schemes.

The following metrics and outcome measures will be agreed and reported through the governance arrangements, detailed above:

- Feedback from Carers as part of the statutory carers survey

- Qualitative measures of outcomes for carers co-ordinated and reported by Carers Services
- Monitor the patient experience.
- Ensure outcomes are included in the contracting of carers services.
- Commission Services based on outcomes and monitor at quarterly intervals through the financial year.
- Work will also be undertaken to ensure that accurate recording of admissions is taking place to enable real time impacts to be monitored.

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

- Improved personalised planning processes.
- All carers have access to effective advice, guidance and signposting support.
- Increased number of carers assessed in line with the Care Act care reform models.
- Carers feel more supported and know how to access help and guidance.
- Reduced breakdowns due to carer stress.
- Improved well-being of carers.

Scheme ref no.

BCF12

Scheme name

Reablement

What is the strategic objective of this scheme?

The purpose of reablement is to help people re-learn valuable life skills that may have been ost or reduced due to a period of illness or incapacity such as through a hospital admission. eople are supported and encouraged to gradually do more for themselves with the ultimate aim of maximising their independence. The strategic objectives of the scheme are to:

- Maximise the numbers of people accessing reablement
- Reduce the need for ongoing home care support
- Reduce the hours of support required
- Delay the need for residential/nursing care

Overview of the scheme

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

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

The scheme will see the existing reablement service redesigned so that anyone referred to the Council for social care, whether a new customer or an existing customer whose social care needs have increased and who has the potential to benefit from reablement, will be offered a period of up to six weeks reablement. This will help them increase their level of independence and reduce demand for ongoing social care support.

- **Personal Social Care (PSC) will assess the person** and, as long as they have the potential to benefit from reablement, will agree with the person a **reablement plan** setting out the goals they will be supported to work towards. If appropriate NHS therapy colleagues such as Occupational Therapy and Physiotherapy will contribute to the development and implementation of the reablement plan.
- Through the domiciliary framework, a **provider will be sought to work with the person** over a period of up to six weeks to deliver the plan during which time the plan will be continuously reviewed and the amount of support will reduce as the person's skills and confidence increase.
- At the end of the period of reablement, PSC will work with the person and if appropriate, any therapist involved, to **review the person's progress against their reablement plan** and determine whether they have any ongoing needs. These will then be addressed in line with the Council's eligibility criteria.

Currently just under 4,000 service users benefit from reablement per annum. It is intended that by redesigning the service in line with the model described above, this will increase incrementally to approximately 7,000 per annum by 2017.

The delivery chain

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

Lancashire County Council: will provide the assessment function through its personal Social Care service. Colleagues within Personal Social Care will following assessment develop a Reablement Support Plan with the individual setting out their goals. They will also oversee and review the plan throughout the process and undertake a review or re-assessment at the end of reablement to identify and address and remaining needs.

Clinical Commissioning Groups: will commission Community Therapy Support such as Occupational Therapy and Physiotherapy to work alongside the Council's Personal Social :are teams to assess people accessing the service and to contribute to the development and implementation of individual reablement plans.

ancashire County Council: will commission support through its domiciliary framework from independent sector providers.

Independent sector providers: will provide support to individuals in their own homes to implement their reablement support plans using staff who have been trained to deliver reablement.

The evidence base

Please reference the evidence base which you have drawn on

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

UK exemplars

- National research has shown that reablement can generate both positive outcomes for citizens and significant savings for Local Authorities.
- The University of York (2010)[5] reported a 60% reduction in ongoing social care costs following a period of reablement. Similarly Gerald Pilkington Associates[6] report that "*the financial benefit is a significant reduction in ongoing care hours, compared to conventional homecare packages*".
- They go on to say that the "*focus should be on how to get there as cost effectively as possible*". They conclude that "*councils need to focus on minimising the cost of delivering reablement whilst maximising the benefit and duration of benefit gained*".

Local context

- Analyses around predicted demand, both of the Councils current referral patterns and national data relating to population size and reablement, indicate that we should

[5] *Home Care Re-ablement Services: Investigating the longer-term impacts (prospective longitudinal study), University of York (2010)*

[6] *The Cost-Effectiveness of Homecare reablement – Gerald Pilkington Associates*

be providing reablement for approximately 7,000 people per year across Lancashire.

- A review of the current model of reablement in Lancashire has shown that whilst it is highly effective in delivering positive outcomes for individuals and reducing demand for ongoing social care .
- However, the complexity of the current model is limiting the numbers of people who are able to benefit from the service. Also that the costs of the current delivery model largely outweigh the savings that the service generates in terms of reduced demand for social care support.
- An analysis of a sample of individuals accessing the reablement service has identified that c68% did not need ongoing social care post reablement and the 32% that did received care packages c14% lower than would have needed to be in place without the reablement intervention.

Investment requirements

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

Total investment: £5,637,000

Impact of scheme

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

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

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

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

The quantified impact of this scheme has been calculated as:

- A reduction of 123 non-elective admissions in 2015/16
- A reduction of 10 permanent residential admissions by 2015/16
- An 18% improvement in reablement rates in 2015/16 *

* Based on the analysis of individuals accessing reablement outlined in the evidence base, he expansion of the reablement service is expected to both reduce the level of new demand for long-term care and contribute towards reducing the unit cost of those who do require ongoing support:

- Currently in Lancashire our 2013/14 performance is 78.8% against the national Reablement metric: (2B1) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
- This equates to 446 individuals still at home out of 566 who were provided with reablement /rehabilitation in the quarterly sample exercise.
- For the 2013/14 full year calculation this is equivalent to 1,784 still at home out of 2,264 who were provided with reablement /rehabilitation.
- Our aim is to increase reablement delivery from the 2014/15 current level of just under 4,000 per annum to 7,000 per annum by 2016/17 by redesigning the current service.
- On this basis we are projecting that in 2015/16 and 2016/17 we will increase the numbers of people remaining at home following a period of reablement provided by the redesigned reablement service to 1,968 and 3,501 respectively. These estimates are based on a target metric outcome figure of 82.0% still at home 91 days later.

Feedback loop

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

dashboard of metrics for the scheme is being developed and will be reported monthly to the Steering Group which will in turn report performance and progress to the Health & Wellbeing Board through the agreed performance and governance process and structure. The metrics are currently being finalised and are likely to include:

- Number of new reablement support plans created each month.
- Number of people receiving a reablement package of care
- Number of hours of reablement packages of care commissioned/provided by district This can be turned into a more meaningful performance indicator by using a 'rate

per 1000 population aged 65+'.

- Range of length of reablement package of care in each district
- Number of reablement episodes per person in a year by district.
- Percentage of people receiving a reablement package of care who have no long term (ongoing) services at the completion of the package.
- Percentage of people receiving a reablement package of care who have a prior request for short term services to maximise independence (national measure)
- Percentage of people receiving reablement who have no long term (ongoing) services at the completion of the package who have not requested further support at 6 months/12 months.
- The percentage of people who have received a reablement package of care who demonstrate a reduction in need from the start of reablement to the completion of reablement

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

uccessfully delivering the scheme relies on delivering the following things on the critical path over the next 3 years:

2015/16

- Assessment function transferred into PSC, guidance produced and published, staff fully trained, required system changes in place and fully operational.
- LCCG reablement support staff redeployed within the Council or taken VR.
- Commence transfer of reablement business to providers within domiciliary framework
- Commence growth in reablement delivery capacity amongst domiciliary framework providers towards target capacity for 7,055 people per year.

2016/17

- Complete transfer of reablement business into domiciliary framework
- Training for domiciliary framework providers around reablement delivery
- Growth in reablement delivery capacity amongst domiciliary providers to achieve target capacity for 7,055 people per year.

2017/18

- Operation of new service model, delivery of projected savings.

Scheme ref no.
BCF13
Scheme name
Transforming Community Equipment Services
What is the strategic objective of this scheme?
The strategic objective of this scheme is: • To deliver a single high quality service based on a Lancashire wide service specification and contract • To undertake market testing to ensure value for money as agreed in the community strategy • To achieve best value through the buying power of a single Community Equipment Services (CES) provider • To deliver improved value for money resulting from improvements across the whole service, delivered through the procurement process, for example the ability to re-use and re-purpose high cost equipment (e.g. children's equipment) • To develop streamlined pathways for the provision of high cost equipment
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The provision of community equipment plays a vital role across Lancashire by promoting and enabling: • the independence of thousands of people with disabilities of all ages • children and adults who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live as full a life as possible. • individuals to manage independently and prevent the need for other care services. • the safe and effective delivery of care usually in a person's home environment often

following a stay in hospital.

Community equipment can be categorised into three main areas:

1. **Simple Aids to Daily Living (SADLs)** are products that support people with day-to-day tasks e.g. walking frames, raised toilet seats and bath seats. These have the potential to benefit the whole population, not just those eligible for statutory support. These items are low value and high volume with most often costing less than £50.
2. **Complex Aids to Daily Living (CADLs)** are products that are largely provided by the state to support care in the home setting e.g. profiling beds, hoists and bath lifts. These items often have electrical or hydraulic components. They are high cost and so are provided on a loan basis and are reused as appropriate.
3. **Bespoke equipment** is uniquely specified by the prescriber and sourced for an individual service user. This is a relatively small amount of the total equipment provided, but is more commonly provided to children with complex needs e.g. specialist seating.

In Lancashire, there are two distinct supply chains for the provision of community equipment:

- **Retail Model** – the vast majority of SADLs are provided on prescription via the retail marketplace. Approximately 62,000 simple aids each year are supplied througvh this service in Lancashire.

- **Community Equipment Services (CES)** – all complex aids, bespoke equipment and a limited range of simple aids are provided on a loan basis by these services, supplying about 42,000 items of equipment a year in Lancashire.

This scheme specifically covers the CES support services:

- procure, deliver, collect, decontaminate and, where appropriate, service and recycle equipment, which has been prescribed by clinicians or social care staff for individuals residing throughout Lancashire
- are funded collaboratively between the relevant NHS CCG and the Council with an agreed local delineation of the funding of different equipment between organisations.

Through this scheme we are aiming to (as part of this agreement) establish a common approach across the county to address **the variation that exists due to historical arrangements for the CES services**. The following has been completed to develop the approach:

- The former Primary Care Trusts (PCTs) worked together under a Collaborative Working Group to review a number of services across Lancashire including Community Equipment.

- NHS Shared Business Service (SBS) Commercial Procurement Solutions was commissioned in 2010 (completed in 2011) to undertake an options appraisal on behalf of partners in relation to the reduction of the number of CES stores across Lancashire. This was commissioned in anticipation of a significant decrease in activity through the stores, following the implementation of the nationally supported Retail Model for the provision of SADLs.
- The expected reduction in CES store activity has since been fully realised with about 60% of all equipment now provided through the Retail Model. The resulting surplus capacity within CES stores offered commissioners the opportunity of consolidating the current stores facilities to a single solution able to serve the whole of Lancashire delivering consistency, quality and best value.
- The six CCG's in collaboration with Lancashire CSU Service Redesign team have continued working in partnership with LCC's Adult Services and the Children and Young People Directorates to develop new commissioning and service delivery arrangements for CES across the County.
- The intention is that a single service will be tendered through what is likely to be a complex procurement. It is proposed that Lancashire North CCG lead the process under clear governance arrangements set out in the Section 75. The aim is to complete the procurement and begin service mobilisation during the second or third quarter of 2015/16.

The joint procurement arrangements present the CCG's and Local Authority with the best opportunity of achieving consistency of service provision and delivering best value within a suitable legal framework for managing the local requirements and complexities.

The CES main service components are:

- Procuring equipment (Standard Stock and Special/Bespoke equipment) including paediatric and sensory equipment
- Providing on-site technical advice, working with practitioners/clinicians, attending joint visits and advising clinicians on all aspects of minor adaptations and technicalities around equipment
- Delivering appropriate items of equipment for daily living or nursing equipment to Service Users on short or long term loan basis to Service Users' homes
- Delivering items to peripheral stores, hospitals, schools and day centres
- Collecting equipment (avoiding contamination with equipment being delivered) from the Service User's home or community setting when no longer required;
- Providing and maintaining a virtual Equipment Catalogue;
- Servicing, maintenance and repair of all items of equipment supplied in accordance with the manufacturer's recommendations,
- Establishing close working links with clinicians and prescribers in acute, primary, secondary, community teams and other health/social care establishments;
- Administering, over-seeing and quality checking any minor modifications/adaptations undertaken by subcontractors;
- Recycling of equipment
- Storing a range of equipment, including returned Specials that have been purchased

via stores processes to Commissioners;

- Agreeing and maintaining minimum service stock for Standard Stock items;
- Cleaning and refurbishment of returned equipment to enable its re-use as quickly as reasonably practicable;
- Fitting, adjusting and/or assembling equipment and providing safety instructions to Service Users,
- Safe disposal of all equipment collected from or returned by Service Users where the equipment is unsuitable for re-use and beyond economic repair;
- Producing management reports and keeping of all records; and
- Providing an efficient web based Information Technology System, to carry out all the above activities as well as providing management information and a Service Users database to provide information regarding special equipment in stores for prescriber information.

The patient cohorts being targeted are children and adults of all ages who require assistance to perform essential activities of daily living to maintain their health and autonomy and to live as full a life as possible.

The delivery chain

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

The current delivery chain is detailed below. Post procurement the commissioners will remain the same however there will be a single provider for the service.

Commissioners	Providers
Lancashire County Council	East Lancashire Hospital Trust Lancashire Care Foundation Trust
Chorley & South Ribble CCG	Blackpool Teaching Hospitals Foundation Trust Lancashire Care Foundation Trust
East Lancashire CCG	East Lancashire Hospital Trust
Fylde & Wyre CCG	Blackpool Teaching Hospitals Foundation Trust
Greater Preston CCG	Lancashire Care Foundation Trust
Lancashire North CCG	Blackpool Teaching Hospitals Foundation Trust

West Lancashire CCG	Lancashire Care Foundation Trust

The evidence base

Please reference the evidence base which you have drawn on

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

This scheme has been selected based on the evidence relating to:

- the prevention agenda, where the evidence supporting use of equipment to provide a vital gateway to independence, dignity and well-being for many people living in the community is well documented.
- operational efficiencies / improvement evidence in terms of smarter procurement of goods, good stock management and logistics.

The use of Community Equipment is a cost effective way of preventing further disability and maintaining independence for people.

- **The Audit Commission** (2000) reported that the use of such equipment can prevent the higher costs associated with other parts of the Health and Social care system
- **London School of Economics and Political Science** (PSSRU) reported in *Building a business case for investing in adaptive technologies in England*, July 2012 that (under the central scenario), the results suggest that equipment and adaptations lead to reductions in the demand for other health and social care services worth on average £579 per recipient per annum (including both state and private costs). In addition, the services lead to improvements in the quality of life of the dependent person worth £1,522 per annum.'

The evidence suggests significant operational efficiencies can be realised.

- In Lancashire, approximately £7.3m per annum is spent on community equipment services collectively by the CCGs and LCC.
- Benchmarking analysis against other community equipment services suggests there is scope to reduce costs.
- It has been estimated by up to £2.2m, but caution is needed, as the investment requirement will not be known until the procurement has been completed, or is at least at an advanced stage.

The Service will contribute to the implementation of the following national policy guidance:

- Our Health, Our Care, Our Say (2006)
- Improving the Life Chances of Disabled People (2005)
- NSF for Children, Young People and Maternity Services (2004)
- Healthy Lives, Brighter Futures (2009)
- Working Together to Safeguard Children (2013)
- Every Child Matters: Change for Children (2005)
- Aiming High for Disabled Children (2007)
- National Service Framework for Older People (2001)
- National Service Framework for Long Term Conditions (2005)
- A Vision for Adult Social Care: capable communities and active citizens (2010)
- Healthy Lives, Healthy People: our strategy for public health in England (2010)

Investment requirements

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

Total investment = £9,976,000

Impact of scheme

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

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

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

The quantified impact of this scheme has been calculated as:

- A reduction of 5 permanent residential admissions by 2015/16
- A 9% improvement in reablement rates in 2015/16
- 61 fewer delayed transfers of care compared to the prior year
- A reduction of 123 non-elective admissions in 2015/16

Other benefits include

- Savings due to improved economies of scale and value for money through the procurement process
- Preventing falls, maintaining independence and supporting carers
- End of life pathway and preferred place of care

Non-financial benefits include:

- To help people to maximise their ability to live independently
- To help reduce the escalation of disability
- To enable timely hospital discharge and reduce delayed transfers of care
- To facilitate intermediate and community care
- To support carers in their caring role
- To provide a responsive service to people of all ages irrespective of where they

live
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
'he outcomes of the scheme will be measured via the quality and performance schedules of ne NHS Standard Contract which have been developed as part of the procurement process. Please see details below:

The providers performance will be measured against performance standards in eight performance sections as set out below.			
Required Performance Area	**Indicator/s**	**Target/s**	**Reporting Frequency**
Priority/Timelines: All Orders shall be completed in a timely fashion. If these performance targets are not met, the Provider shall waive all Service charges for all Out of Time (OOT)	1. Emergency Orders 2. Urgent Orders 3. Premium Orders 4. Standard Orders	1. 100% within 4 hours of receipt of order notification. 2. 100% within 1 day of receipt of order notification. 3. 100% within 2 days of receipt of order notification 4. 100% within 7 days of receipt of order notification Where performance is below the 100% target, providers must report by exception.	Monthly By exception
Effectiveness: activities are completed within specified times.	1. Completion of Orders 2. Joint Visits	1. 97% completed within one visit to Service User's residence. 2. 99% attendance of Joint Visits as requested and scheduled by the Prescriber.	Monthly
Maintenance: equipment shall be fully maintained within the manufacturers' guidelines and repaired as specified where necessary. Maintenance Report	1. Equipment maintenance carried out as schedule in Pre-Planned Programme. 2. Timescale for repairs including electrical items (e.g. hoists, pressure relieving mattresses) (i) Critical (ii) Non Critical Identifies maintenance activities and may serve to highlight product deficiencies.	100% completed within 10 days of the date set out in the Pre-Planned Maintenance schedule. Repairs completed within the timescales: (i) 100% same Day (ii) 100 % within 5 Days	Monthly
Special Equipment: Special Equipment shall be delivered/installed in a timely fashion once the equipment has been received by the service provider.	Completion of Special Equipment Service Orders	100% completed within 7 days. The remaining 15% within 20 days.	Monthly
Complaints: Complaints shall be minimised and resolved swiftly.	Number of Complaints received.	The number of complaints in each month is less than 0.25% of total activity (deliveries, collections,	Monthly

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

The key success factors for implementation of this scheme are:

- Procurement expertise and management is required to ensure effective and successful management of the complex procurement process through to service delivery from a single provider.
- Partnership working; there are a range of existing forums that have been used to progress the service review and redesign work. There is also clear governance arrangements for the scheme which will report through Lancs North CCG (as the lead commissioner for CES) and the BCF governance arrangements
- Transition from the current multiple service providers and CES providers to a single service provider following the procurement process to ensure seamless contract and service provider change process with positive impact for end users

Scheme ref no.
BCF14
Scheme name
Telecare Services
What is the strategic objective of this scheme?
• **Ensure Cost Effectiveness:** Develop an affordable and effective service that enables substantial growth in the number of people using the service. This means ensuring ready access to Telecare for those who will benefit most from the service. • **Integrate services around the individual:** Integrate Telecare within the mainstream assessment, support planning and review processes for adult social care and reablement services, in order to maximise people's ability to continue to live independently with the minimum level of support to safely meet their needs. • **Work in Partnership:** Work with our partners to ensure that Telecare is widely understood and accessible to service users, carers, housing, health, emergency services and social care professionals. Specifically with our NHS partners to embed Telecare within integrated locality based services, so people get the right care, in the right place at the right time. • **Quality assurance and ethically based:** Develop a high quality and ethically based Telecare service that strikes a reasonable balance between the individual's right to autonomy, choice and control and wider strategic priorities to achieve better outcomes

and financial savings

- **Provide Leadership:** Commission a Telecare service where the service provider(s) play a major leadership role in driving the changes essential to achieving the council's strategic aims.

Overview of the scheme

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

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

Description

The strategy aims to achieve a connected model of Telecare supported by an integrated Lancashire wide therapy and response service that can deliver a swift and timely service hrough a single point of access within social care, health and housing services in Lancashire

The Telecare service will provide technological equipment, aids and adaptations to enable people with a) long term conditions, b) life limiting illnesses and c) the elderly to overcome key environment barriers and maintain independence and health.

ancashire are implementing a new strategy for this service and re-commissioning Telecare at present. Our key messages are:

- **Improve Outcomes:** Telecare has a significant role in helping people to maintain their independence and stay safe.

- **Make Cash Savings:** Telecare will contribute to the delivery of financial savings by reducing the demand for more costly and intensive services across the Lancashire health and social care economy.

- **Grow the Service:** The intention in re-commissioning the Telecare service is to achieve sustained growth, with the ambition of having 7,000 people receiving Telecare by the end of 2017/18.

- **Maximise the benefits:** We want to reach individuals who will benefit most from Telecare. Review and change our access arrangements, eligibility criteria and the charging policy to support our intentions.

- **Develop the workforce:** Set ambitious Learning and Development goals to ensure sound understanding of the purpose and benefits of Telecare across the health and social care workforce.

- **Deliver in Partnership:** Statutory, voluntary, private and community organisations must play a leadership role with the County Council to support the growth of the service, and to ensure Telecare is embedded within locality based care services.

- **Evaluate the impact:** External research bodies and our own business intelligence services will be commissioned to ensure there is robust evaluation of the Telecare Service.

Model

Below is our cyclical model for Telecare services.

Targeting

We will promote and encourage the take up of Telecare by groups who are at risk of hospital admissions. They are:

- People who are frail
- People with dementia
- People who fall or who are at risk of falling
- People with learning disabilities
- People with physical or sensory disabilities

- People with informal carers who need extra support.

We also expect to target people who are eligible for care and support, who have received reablement or who are entitled to receive Telecare under a new preventative offer.

The delivery chain

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

he current Telecare service is commissioned by Lancashire County Council and provided by four housing providers that each cover a geographical area of Lancashire.

However, the service is currently being retendered. We are currently procuring a 'Development Partner' that will lead and drive the strategic development and expansion of Telecare in partnership with Lancashire County Council; suitably package and subcontract the range of services to organisations that are experienced and capable of providing high uality and cost effective services; and manage the whole system effectively by coordinating nd bonding the services together so the end-to-end system functions seamlessly as one for the end user.

One of our strategic intentions is to work in partnership with key stakeholders, including the CCGs and NHS Trusts in Lancashire to embed Telecare into other health and social care pathways and neighbourhood care teams.

The evidence base

Please reference the evidence base which you have drawn on

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

UK Exemplars

To help develop our understanding and strategy we have engaged with Telecare providers through a soft market testing exercise, met with other councils that have successfully implemented Telecare, held discussions with industry experts, considered a range of publications and attended specific Telecare conferences and events.

There is a range of research evidence regarding the financial benefits of Telecare with a number of local authorities having invested significantly in Telecare on the basis of being confident of the subsequent delivery of financial savings as well as improved outcomes for

individuals. As examples:

- Evidence supporting the development of Telecare from Essex County Council has indicated that the financial benefits of Telecare are for every £1 spent on Telecare £3.80 is saved on traditional care.
- Hillingdon council saw the number of admissions to residential care reduce by half within 18 months of the implementation of their Telecare offer.

Telecare is also of increasing importance in Government policy on health and social care rovision. It is now widely accepted that it has a major role to play in delivering a transformed and personalised social care system. Nationally, a vision is emerging of a more cost-ffective, assistive technology-supported, health and social care system that is able to deliver care where it is most appropriate, increasing the flexibility of care packages and improving the quality of peoples' lives. Telecare has huge potential to support a diverse range of individuals to live at home. It can also give carers more personal freedom, meet potential shortfalls in the workforce and complement the work of health, social care and housing providers to achieve outcomes that improve the health and well-being of people using services.

he Department of Health's Whole System Demonstrator Programme found that Telehealth had a:

- 20% reduction in emergency admissions
- 15% reduction in A&E visits
- 14% reduction in elective admissions
- 14% reduction in bed days
- 8% reduction in tariff costs

Local context

he estimated potential savings in Lancashire is based on benefits resulting from reductions in domiciliary care (for 60% of new Telecare service users) and delays in admissions to residential care (for 15% of new Telecare service users).

Investment requirements

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

Total investment = £548,000 with the intention that the cost will increase as the number of people receiving telecare grows from the current c1,100 up to the planned c7,000.

Impact of scheme

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

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

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

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delay transfers of care	☑
Patient experience: Proportion of people feeling support to manage their LTC	☑

The quantified impact of this scheme has been calculated as:

- 61 fewer delayed transfers of care compared to the prior year
- A reduction of 123 non-elective admissions in 2015/16

We expect the new Telecare service to help vulnerable people achieve these outcomes:

- Enable better self-care
- Enable them to stay in their own homes
- Increase their choice and independence
- Improve their quality of life
- Reduce risk and make them feel safer
- Provide carers with support and peace of mind
- Promote early intervention and prevent a crisis
- Prevent admissions to hospital

- Enable timely and safe discharge from hospital.

Feedback loop

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

We are involved in the ATTILA trial: assistive technology and Telecare to maintain independent at home for people with dementia and we are working in partnership with Lancaster University on a three year PhD studentship and evaluation study of our new service funded by the Economic and Social Research Council.

We will also work with our Development Partner to design a benefits realisation framework that will include measuring outcomes and return on investment of the new service. We will place an emphasis on reviewing individuals and their patterns of Telecare use, in order to understand if the service is meeting their needs or not.

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

For out Telecare service to be implemented successfully and allow us the opportunity to achieve our goals and strategic ambitions, the following needs to be in place and/or achieved:

- Successfully tender for a Telecare service provider(s)
- Partnership working with other key stakeholders (CCGs and NHS Trusts) to embed Telecare into other health and social care pathways and neighbourhood care teams.
- The development of our workforce to promote and support the Telecare service
- The availability of strong and effective communication channels
- The availability and access to a suite of equipment (alarms, sensors and detectors)
- The availability and access to equipment to support remote monitoring of a patient's long term condition(s)
- The implementation of structural capabilities including:
    - Joint assessment and care management of patients that spans both health and social care
    - Therapy services that perform comprehensive needs assessment for technological aids and adaptations
    - Access to on-call support services in cases of emergency
    - Access to integrated community and primary care services

Scheme ref no.
BCF15
Scheme name
Care Act Implementation
What is the strategic objective of this scheme?
The primary objective of the scheme is to contribute to the delivery of the requirements of the Care Act 2014. The Care Act modernises the legal basis for adult care and support in England. This will make the law easier to understand and apply, and will bring greater clarity, consistency and equality of access to care and support. The intended effect is also to improve the outcomes and experience of care, and secure a more effective use of public and community resources by improving the personalisation of services, giving people more choice and control over how their desired outcomes are achieved.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The aims of reforming the law relating to care and support are to: • Modernise the legal basis to reflect the Government's ambitions for personalised adult care and support • Refocus the law around the person, not the service, by enshrining new statutory principles that place the wellbeing of the individual at the heart of individual decisions about care, • Simplify the law into one single statute for adult social care, supported by clear regulations and a reformed bank of statutory guidance in one place, • Develop a more transparent framework, which simplifies practice for care professionals, reduces burdens, and empowers individuals to better understand their rights and responsibilities.

The investment from the Better Care Fund will contribute to the implementation of the Care Act, which in particular proposes to:

- Enhance systems to ensure that a duty to secure the provision of information and advice on care and support for adults and carers is in place
- Implement clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need;
- Support transition into adult care
- Review Lancashire County Council's eligibility criteria for Adult Social Care to ensure that they are at a national standard
- Implement the extension of responsibilities towards carers ensuring that carers will have a right to an assessment and maintaining their health and wellbeing; and a national eligibility threshold for carers will be introduced
- Implement the responsibility to provide a care and support plan (or a support plan in the case of a carer)
- Embed the legal entitlement to a personal budget
- Develop and strengthen the role of Safeguarding Adult Boards and putting them on a statutory basis
- Fulfil requirements that have made deferred payments a statutory requirement - as a way of enabling self-funders, or those required to make a financial contribution, to meet their care and support costs when moving into residential care without having to sell their own homes
- Ensure that commissioning is focused away from activity towards value-based services that focus on delivering improved outcomes for people
- Implement the national minimum training standards for care workers with dignity and respect at heart of the code of conduct
- Promote diversity and quality in the care and support provider market

The delivery chain

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

These projects have been commissioned by Lancashire County Council's Adult Services, overseen by the Care Act Board (including the Executive Director of Adult Services, Health & Wellbeing; Deputy County Treasurer; Director of Personal Social Care and the County Secretary and Solicitor).

The projects are to be delivered by the Care Act Implementation team lead by the Head of Care Act Implementation.

The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
This scheme is designed in response to the new legislation which governs how adult care and support is defined and delivered. It will help Lancashire County Council transition from the requirements of the current legislative, which is opaque, complex and anachronistic. **'he new law provides the underpinning framework for care and support and is critical :o the way care it is delivered on a day-to-day basis to people who need it and will far better provide:** • Clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need • Focus on and support for local authority relationships with other organisations and the need to join up services • Improving access to universal information and advice on care and support • Reflect local authority responsibilities to promote diversity and quality in the care and support provider market • Support the cultural and systemic change needed for personalisation and self-directed support; and, • Support transition into adult care and support for children. These are discussed in turn below. ***Clear underlying principles to reflect the modern focus of care and support upon the promotion of individual well-being and prevention of need*** As set out in the Government's A Vision for Adult Social Care, a considerable proportion of :are needs could be avoided, reduced or delayed as a result of earlier intervention. However the current system is geared too much towards intervention at the point of crisis rather than helping individuals to postpone or prevent the onset of illness or loss of independence. A recent DH survey suggested that around 80% of local authorities currently set their eligibility criteria threshold at substantial or critical levels of need, meaning that they do not nake support available to people who are assessed as having moderate or low needs. Only

2% provide funding at "low" levels, indicating that investment is not focused on avoiding people’s needs from getting worse.

Focus on and support for local authority relationships with other organisations and the need to join up services

There is a need to facilitate increased joint commissioning across health, social care and public health and allow for the implementation of services that use the “whole person” approach. Incentives for individuals to take preventative steps should also be improved – for example by linking duties to integrate explicitly to a focus on preventing or reducing needs.

Improving universal access to universal information and advice on care and support

The availability of information and its quality is a critical enabler for both consumers and commissioners to make choices and drive up quality.

However, rather than being shaped around the needs of individuals, services have tended to develop based on systems, structures and funding flows. There are still significant barriers preventing people from having choice and control over how they are supported to achieve their desired outcomes. This has affected the extent to which care and support is personalised and integrated with other public services, with consequential implications for quality of outcomes, user experience and efficient use of public resource.

Reflect local authority responsibilities to promote diversity and quality in the care and support provider market

The Caring for our Future White Paper set out the government’s intention to promote a diverse market of high quality care and support services, to improve service quality through individual choice and control and address some of the current key issues:

- Carers have consistently highlighted a lack of suitable, high quality services. Carers have said that a paucity of suitable services can mean that they can have to care for more hours than they would ideally like too.
- Feedback from the Caring for our future engagement suggested that even when people are given access to a personal budget, many struggle to find services to meet their needs.

- In December 2009, a Care Quality Commission (CQC) analysis found that the proportion of council-supported residents in care homes rated good or excellent varied by authority from 45% to 97%, indicating a wide variety in the quality of care received.
- The variation implies inconsistency in the effectiveness of commissioning strategies. In some areas at least, providers are not sufficiently incentivised to improve service quality.
- Users and carers are not sufficiently empowered to make informed choices at a time when individuals are becoming increasingly responsible for buying their own care. Care providers do not have an incentive to improve the quality of the care they offer, as they cannot demonstrate to potential customers what improvements have been made.

upport the cultural and systemic change needed for personalisation and self-directed support

There are a number of cultural and organisational barriers to progress in local authorities naking a universal offer of self-directed support to people using care and support. Reasons might include: perceived higher costs; low priority given to this principle by councils; inertia; ested interest; or the perception by individuals that a higher workload is required by a more responsive and flexible service:

- The current legal framework does not require councils to provide personal budgets.
- Individuals may be put off by the perceived potential complexities of decision-making in relation to personal budgets and personalised support planning
- Not all groups of users are able to access personal budgets and direct payments. Current regulations do not allow those in long-term residential care to access direct payments.
- Evidence suggests that there is inadequate provision of information to both state-funded care users and in particular to people funding their own care. Many self-funders do not access local authority information or take up assessments as they receive no support due to their financial position.
- Evidence from the Caring for our future engagement, supported by research from the Personal Outcomes Evaluation Tool, showed that people were much more likely to take control of their care and support funding through a direct payment if they had received support with making choices about the care they wanted, and with articulating how that care should help them achieve their goals.

Lack of provisions to support transition into adult care and support for children

here are well-documented issues associated with the transition between children's services nd adult services. One such issue is a gap in provision often described as the 'cliff edge'. An ndependent report commissioned by the Department of Health referred to the "considerable

evidence from research that for most young people with disabilities the process of transition from child to adult services is problematic".

Investment requirements

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

Total investment

£3,123,000 in 2014/15 and
£3,123,000 in 2015/16 (revenue)
£1,149,000 in 2015/16 (capital)

Impact of scheme

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

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

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

Metrics	
Emergency admissions	☑
Admissions to residential and nursing care	☑
Patient measure: Proportion of people feeling support to manage their LTC	☑

The financial benefits are:

- Quality of life gains for carers from improved legal rights and improved access to support.
- Benefits to local authorities through better coordination, more proactive, preventative measures and planning of care and support functions, for example preventing crisis and escalation of need, including via improving information,

personalisation, and assessment of carer need. Other key non-financial benefits: • People with care and support needs will benefit from improved wellbeing, better prevention of care and support need, greater clarity, consistency and equality of access to care and support and reduction of unmet need. • Improved information, advice and cooperation between organisations will help people to navigate the system more easily and with greater freedom, flexibility and choice. • This will improve the outcomes and experiences of people who use care and support services, carers and their families.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The County Council has set up a Corporate Programme Board to oversee the development of Lancashire's response to the requirements of the Care Act. Recommendations are being developed based on a continuing analysis of the Care Act guidance and regulations.
What are the key success factors for implementation of this scheme?
The key factors to successful implementation are workforce, informatics, communications and understanding the cost of the reforms. • *Workforce:* Pressure on workforce capacity, the need for change to existing working practices, new roles, and learning and development needs will need to be closely considered. The Act is an opportunity to develop and promote a change in workforce culture, not just within social care practice, but also more widely as part of the increasing integration of health and social care. • *Informatics:* Investment is required to drive efficiency, deliver more joined-up, safer

and higher quality care and support preventative services. The Council needs the right technological capabilities to support integration and manage case records. • *Communications:* Activity relating to the following is critical to successful implementation: • The provision of information for affected individuals (care and support service users, carers, care workers and people approaching point of need). • A broader programme of marketing activity to inspire behaviour change at a societal level, so that it becomes the norm for people to prepare for potential care and support needs as part of their wider financial planning. • *Understanding the cost of reforms:* Both the reforms to care and support commencing April 2015, and the subsequent funding reforms taking effect in 2016 will have a significant financial impact on councils. Both sets of reforms will have financial implications beyond the year they are introduced.

Scheme ref no.
BCF16
Scheme name
Disabled Facilities Grant (Capital Scheme)
What is the strategic objective of this scheme?
Enabling vulnerable disabled people to remain as independent as possible in their own homes through provision of adaptations to the dwelling. Adaptations delivered via Disabled Facilities Grants deliver on a range of key policy objectives, including: • Helping prevent hospital admissions • Speeding up hospital discharge • Reducing strain on carers • Assisting community care • Promoting social inclusion • Improving quality of life

Overview of the scheme

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

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

The scheme will provide capital funding for home adaptation grants, delivered by the district councils in their statutory role under Part I of the Housing Grants, Construction and Regeneration Act 1996. The types of work covered include:

- Making it easier to get into and out of the dwelling by, for example, widening doors and installing ramps
- Ensuring the safety of the disabled person and other occupants by, for example, installing hoists to assist in getting out of bed
- Providing or improving access to the living room, bedroom, and kitchen, toilet, washbasin, bath and/or shower facilities; for example, by installing a stair lift / through floor lift or providing a downstairs bathroom
- Improving access and movement around the home to enable the disabled person to care for another person who lives in the property, such as a spouse, child or another person for whom the disabled person cares.
- Preventative home based risk assessments in the homes of vulnerable clients

The scheme supports independence in the home for disabled people (children and adults), with grants mandatory and means tested for adults. The patient cohort includes older people with higher needs at heightened risk of hospital admission.

The delivery chain

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

Initially an **Occupational Therapist** will determine what works are "necessary and appropriate" to meet the disabled person's needs. The grants are **managed and delivered by the district councils in Lancashire**, either by direct provision or through Home Improvement Agency arrangements, determining what works are "reasonable and practicable", and producing a schedule of works which forms the basis of the grant aided work. The client is supported throughout in commissioning the works with private contractors, managing delivery and ensuring timely completion to the required standard and budget.

The scheme provides an opportunity for joint working between LCC, district councils and

CCGs to further develop a shared approach to provision of adaptations, improving the nterface and integration with other support services, improving the customer experience and reducing the demand on health & social care services.

The evidence base

Please reference the evidence base which you have drawn on

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

Adapting the homes of citizens with disabilities enables independent in the community, educing the risk of social isolation and deterioration of conditions associated with a move to a different/less independent setting. It also facilitates discharge from a hospital setting and hrough improving the safety and appropriateness of the home environment reduces the risk of further admissions.

A research review by Heywood and Turner (2007) reported that there is evidence that adaptations can produce significant savings in the following areas:

- Prevention of falls;
- Reduction in the need for home care services;
- Reductions in the use of residential care (including nursing care);
- Enhancements in the quality of life of people in receipt of adaptations, improving well-being and contributing to the sustainability and extent of their independent living.
- Improvements in the health and well-being of carers, whose health can be improved because the people they are caring for are able to live more independent lives.

The savings, i.e. cost offsets to other services, produced by adaptations can be extensive and enduring. In 2009, the Home Adaptations Consortium estimated that 20 level access showers installed in the London Borough of Newham at a cost of some £110,000 had produced a five year saving of £1.86 million13 (Home Adaptations Consortium, 2009).

Work carried out at Neath Port Talbot Council in Wales, and appraised by the Lean Enterprise Research Centre at Cardiff University for the Welsh Audit Office, showed a strong orrelation between the average age of admittance into residential care and the provision of a DFG. Those who received a DFG went into residential care on average 4 years later than hose who did not receive a DFG. The Council identified 189 people who went into residential care where there had been a request for a DFG but the work had not been completed sufficiently quickly. At an average cost of £380 per week in residential care, the potential aving which would have arisen from timely provision of the DFG was £12.7m (ie 189 x £380

x 52 x 4), less the £1.2m cost of the DFG (at an average of £7,000).

Investment requirements

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

Local Authority	2015/16 Minimum Allocation
Burnley	£961,000
Chorley	£370,000
Fylde	£468,000
Hyndburn	£449,000
Lancaster	£783,000
Pendle	£455,000
Preston	£625,000
Ribble Valley	£161,000
Rossendale	£424,000
South Ribble	£334,000
West Lancs	£543,000
Wyre	£792,000
Lancashire Total	**£6,365,000**

Impact of scheme

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

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

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

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

The quantified impact of this scheme has been calculated as:

- A reduction of 14 permanent residential admissions by 2015/16
- An 18% improvement in reablement rates in 2015/16 *
- 61 fewer delayed transfers of care compared to the prior year
- A reduction of 245 non-elective admissions in 2015/16

The scheme will contribute directly to BCF outcomes of reduced residential and nursing care admissions, and reduced delayed transfers of care. The scheme will also contribute to BCF Metrics concerning improved patient and service user experience by enabling citizens to stay living independently in their own home for longer.

DFGs provide a mechanism to:

- Reduce A&E attendances and admissions
- Facilitate care closer to home
- Help to develop a more socio-medical model of care where social and environmental factors are considered as well as medical ones
- Help facilitate better care at home and in the community for at-risk patients
- Help support carers
- Improve end of life choices

Feedback loop

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

Work with district council health / housing leads through established group to understand the

level of integration & what's working / not working. Performance measure (not currently agreed with districts) – timeliness of completions and customer satisfaction levels?
What are the key success factors for implementation of this scheme?
or successful implementation, close and effective partnership working between LCC, district councils and CCGs is needed. Need to build trust across all sectors & timely open communication as a prerequisite.

Scheme ref no.
BCF17
Scheme name
Intermediate Care Services to support Care Co-ordination Centre (Lancashire North CCG)
What is the strategic objective of this scheme?
This scheme is one of the Lancashire North CCG BCF schemes which are a sub-set of a larger health economy transformation programme called Better Care Together. The **Intermediate Care Services scheme** contributes to the following strategic objectives of the Better Care Together programme: • To design and implement new integrated models of care across the local health economy • To design and implement a system which recognises the specific geographic and demographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times • To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable

- To enable the development of a flexible, integrated and productive workforce across our health economy.
- To design and implement a future healthcare system for our area that makes best use of the money and resources available
- **Within the Better Care Together Programme the following model of care will be implemented:**
- A **Care Co-ordination Centre** will provide a single health and social care hub for both professionals and patients, with the aim of ensuring patients are in the right place within the health economy, at the right time. The Care Co-ordination Centre is supported by:
  - An **integrated community care service**: a wrap-around multidisciplinary team who can be deployed to supplement the core team, with the aim of reducing unnecessary hospital admissions and reducing the number of handoffs patients currently experience. The appropriate clinical team will make a rapid assessment of the patients' medical, nursing and care needs, delivering a package of care before handing the patient back to the core team for recovery.
  - **Intermediate care services.** These services provide a range of interventions which:
    - Reduce avoidable emergency admissions
    - Reduce length of stay in hospital
- Provide an integrated urgent care interface to co-ordinate packages of care which keep people as independent as possible, in the best interests of their health and well-being.

Overview of the scheme

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

What is the model of care and support?

Which patient cohorts are being targeted?

The **Care Co-Ordination Centre** has a number of **Intermediate Care Services** which form the intermediate integrated model of care. They are:

- **CRISIS** – A short term intensive support service providing upto 72 hours of free social care support. The service:
  - Enables a person to be supported at home safely
  - Supports avoidance of an unnecessary admission to hospital or residential care.
  - Has rapid response times (usually within one hour)
  - is integrated with mental health services
-
- **Transitional Care Pathway (Rapid Response, React, Pulmonary Rehab)** This integrated service acts as an access and assessment point for patients on the Transitional Care Pathway. Referrals are then allocated to the most appropriate member of the team or signposted to other services. The service comprises of:
  - **REACT:** a multi-disciplinary co-located virtual team (nurses, physiotherapists, OT's and social care staff)

- Implementation of **rapid response** individual pathways for patients including NHS staff being able to commission social care services as 'trusted assessors'.
- **Pulmonary Rehabilitation** providing patients with chronic respiratory / chronic heart failure a structured multidisciplinary group or home programme of exercise and education.

- **Alcohol Liaison Service** –aims to improve the management of patients, attending and/or admitted to the hospital, who are alcohol dependant or drinking at levels that are harmful or likely to damage their health. The service:
  - Provides a dedicated nurse within the acute setting with the aim of improving alcohol misuse management within a 'whole integrated system' approach.
  - Targets intervention and support for frequent flyers and priority service users.
  - Offers access 7 days a week
  - Supports patients to address their alcohol consumption and therefore improve their health outcomes, particularly in cases where the condition is wholly or partially caused by alcohol consumption.
  - Has a strong workforce development component to raise awareness of the impacts of alcohol and promote the use of screening tools to maximise referrals.

- **Stroke – Early Supported Discharge – An interdisciplinary neuro-rehabilitation service for patients who have suffered a stroke**. The service is community based, and delivered in the patient's home. There are close links to secondary care working to an integrated model with social services and third sector (Stroke Association) to deliver optimal rehabilitation for people with stroke as they transfer from hospital to home.

- **Ripley Suite –An intermediate nurse-led 24/7 step up/step down facility** to enable admission for patients who would benefit from acute nursing care but who do not require a secondary care environment or require significant diagnostic input to provide a diagnosis. This facility is an alternative model of care to a general medical elderly ward.

- **Residential Recuperation and Rehabilitation** -The provision of rehabilitation beds and recuperation beds.

  - **Recuperation beds are offered for a period of up to 4 weeks** to support people who are not able to return home following a stay in hospital or a period of illness. Service users will not require nursing care but need additional time to fully recuperate prior to being able to live independently.
  - **Rehabilitation beds are offered for up to 6 weeks** to support people to either accommodate their illness by learning or re-learning the skills necessary for daily living or regaining skills and abilities following illness or fall. These beds are supported by community therapy staff who work into the unit. There is also provision for **specialist dementia residential rehabilitation** with dedicated therapeutic interventions who have suffered an episode of physical ill health or injury.

- **Therapy (Rehab)** - Community therapeutic services provide assessment and treatment

of physical conditions. The service promotes independence via planned specialist input with patients, their carers and where appropriate social care.

Falls Assessment Service – An early intervention service which:

- Aims to restore independence, through falls care pathways,
- Assessment covers motor and sensory function, environmental factors, cognitive ability and screening for medication that may have side effects that increase falls.
- Provides simple pieces of equipment and adaptations (e.g. grab rails)
- Provides programmes of rehabilitation
- Whole system focus on developing the knowledge of fall prevention in the wider community.

The intermediate care services overall will:

- Create a single point of entry into the urgent care system
- Interface with core teams to co-ordinate across existing services to produce the best package of care for individual patients
- Reduce presentations at A&E by responding to patients needs proactively
- Reduce emergency admissions by ensuring the most appropriate package of care is provided and communicated to patients within a community setting
- Review and re-design services to provide an integrated, efficient and responsive intermediate care service.

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

The delivery chain

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

Commissioners include Lancashire North CCG and Lancashire County Council.

Providers include:

- Community Integrated Care
- Blackpool Teaching Hospitals Foundation Trust
- University Hospitals Morecambe Bay Foundation Trust
- Stroke Association
- Four Seasons Health Care
- Lancashire County Commercial Group

The evidence base Please reference the evidence base which you have drawn on to support the selection and design of this scheme to drive assumptions about impact and outcomes
The Morecambe Bay Better Care Together Strategy, volume 2, version 5.0, 22nd August 2014, provides clear rationale and option appraisals as to the overarching vison of which the BCF schemes are a sub-set. **UK evidence** The overarching vision and the principles of the Better Care Fund align with the **NSF for long term conditions**[7]. That is, to improve health outcomes for people with long term conditions by providing personalised care plans, reduce emergency admissions, improved care in primary care and community settings, improve access to services. The NSF provides strong underpinning for the focus on this scheme: • The number of people over the age of 80 is set to increase by almost a half with those over 90 doubling in the same period. • Older people tend to have a much greater need for health and social services, so the bulk of health and social care resources are directed at their needs. • Almost two thirds of general and acute hospital beds are used by people over 65. • Conditions prevalent among older people are stroke, falls and mental health as stroke, falls and mental health (including dementia and depression). **Other relevant metrics:** • Around 63% of older people permanently entering nursing home care and around 43% of those entering residential care homes come direct from hospital. • Around 30% of patients die in the first month after a stroke, most in the first ten days. Although after a year, 65% of surviving stroke patients can live independently, 35% are significantly disabled and many need considerable help with daily tasks or visits from a district nurse. Around 5% are admitted to long-term residential care • Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK, accounting for over 400,000 A&E attendances • Up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf

Academic Research

- The Kings Fund summit and subsequent report 'The Care of Frail Older People with Complex Needs: Time for a revolution' 2012 concluded that a revolution is needed in the care and treatment of older people.
- Care Closer to Home – University of Cumbria Review 2010. The objective is ultimately to deliver a more integrated service. Key to its success is to address the whole health economy with local priorities defined to maximise the strategic benefits.

Investment requirements

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

Project	Total Investment (£000)
CRISIS	£211,000
Transitional Care Pathway	£1,258,000
Alcohol Liaison	£126,000
Stroke ESD	£419,000
Ripley Suite	£500,000
Therapy staff	£566,000
Residential rehab	£580,000
Falls	£185,000
Total	**£3,845,000**

Impact of scheme

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

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

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

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

This BCF scheme is a sub-set of the overarching North Lancs CCG transformation strategy. The out of hospital model is expected to achieve **1.8% reduction in non-elective admissions** in year 1 and a reduction in delayed transfers of care of 1.8% in year 1. Detailed activity forecasts are attached outlining the 1 – 5 year impact.

This scheme is expected to achieve 43% of the target reduction, calculated as follows:

Metric	Target reduction
Reduction in emergency admissions	146
Reduction in delayed transfers of care	80

Feedback loop

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

There are formal governance arrangements in place through the transformation programme board who will manage project development, performance against activity / impact trajectories, risks and mitigation plans and evaluation and outcomes.

In addition to this each individual scheme has key expected outcomes in the form of KPIs which are monitored regularly in line with contractual requirements.

Detailed formal reviews are planned as part of the transformation programme to ensure maximum efficiency and integration across health and social care to deliver an effective out of hospital model.

LTCT Case Study 2.docx

LTCT Case Study.docx

Rapid Response Case Study.docx

Stroke Case Study.docx

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

The key success factors for this scheme are tabled below:

Inter-dependency	**Outputs required**	**Effect on Delivery**
IT	Estates strategy will need to deliver integration for understanding real time demand / capacity and sharing patient information. There may also be a requirement for a solution to deliver digital health virtually.	Critical for the overall transformation Not critical for current service provision
Workforce	Re-alignment of existing workforce for services that are currently in operation but which may be re-designed.	Critical for the overall transformation Not critical for current service provision
OD	Engagement from all staff across the health economy to deliver this – organisational change strategy.	Required
Engagement	Continued partnership working	Critical

Scheme ref no.
BCF18

Scheme name
Self-care (Lancashire North CCG)
What is the strategic objective of this scheme?
This scheme is one of the Lancashire North CCG BCF schemes which are a sub-set of a larger health economy transformation programme called Better Care Together. The **Self Care scheme** contributes to the following strategic objectives of the Better Care Together programme: • To design and implement new integrated models of care across the local health economy • To design and implement a system which recognises the specific geographic and demographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times • To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable • To enable the development of a flexible, integrated and productive workforce across our health economy. • To design and implement a future healthcare system for our area that makes best use of the money and resources available The Out of Hospital Model for Better Care Together recognises the importance of empowering the population: • to take action to care for themselves, their children, their families and others to stay fit and maintain good physical and mental health, • meet their social and psychological needs, prevent illness or accidents, • care for minor ailments and long term conditions, • maintain health and wellbeing after an acute illness or discharge from hospital. This is termed **"self-care"** and is an integral part of both in and out of hospital care. The self-care scheme will: • Reduce avoidable emergency admissions • Reduce length of stay in hospital

- Reduce people's dependence on health professionals and increasing their sense of control and wellbeing
- Equip clinicians and other health care professionals and staff to support and enable the general population and patients to self-care.

Overview of the scheme

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

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

Help Direct is designed to help people get the right practical support or the right information and advice they need before a small problem becomes a crisis. The service is aimed at people who want more practical, everyday type of support to help them get the most out of life and supports people to make their own choices and decisions about what works for them.

This scheme puts Help Direct advisors within a general practice setting to:

- Work with General Practice to identify people who are in need of further help and support to prevent a problem becoming a crisis
- Work with people who are at risk of becoming isolated and marginalised
- Act as a conduit into further social care services for patients
- Coordinate health and social issues by assisting the patient on a one to one level
- Act as a support mechanism for practice staff for a whole range of social care issues allowing staff to concentrate on more conventional health needs of their patients
- Help people gain confidence and make a contribution to their local community, for example through volunteering or through time-banks. These could either be the long term unemployed or those on incapacity benefit
- Increase take-up of referrals to Help Direct
- Provide greater added value for services offered to patients within the practice
- Save GP time by targeting patients with long term health issues or low level mental health problems. Clients can be referred to specialist support services which could reduce the number of GP appointments
- Provide easier access to Help Direct as face to face appointments are available in a location that is convenient and familiar to the patient

The **Help Direct GP Advisors are a key success criteria, in the context of the Better Care Together transformation programme** through:

- Increased capacity, confidence and efficacy of individuals to self-care

- A Change in the behaviour of the general population in relation to the way they use health care services.
- A change in the behaviour of the health care economy in how they empower patients to care for themselves.
- To develop and deliver effective, integrated self-care support services that will offer the public appropriate support, largely provided by the community and voluntary sectors, and reduce reliance on mainstream NHS services.
- Improve the health and wellbeing of the population.
- Reduce presentations at A&E by responding to patients needs proactively

The patient cohort is primarily patients with one or more long term conditions within Lancs North CCG population.

The delivery chain

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

Commissioners include:

- Lancashire North CCG
- Lancashire County Council.

The **provider** is Age UK.

The evidence base

Please reference the evidence base which you have drawn on

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

The Morecambe Bay Better Care Together Strategy, volume 2, version 5.0, 22nd August 2014, provides clear rationale and option appraisals as to the overarching vison of which the BCF schemes are a sub-set. Other project specific examples include:

- In England and Wales, **the King's Fund** has stipulated the provision of active support for self-care, followed by a focus on primary and secondary prevention, as the top three priorities for NHS commissioners. Involving patients and carers more fully in managing their own health and care is one of six underlying objectives in NHS England's call to action for general practice.
- The King's Fund also identifies ten priorities for commissioners with active support

for self-management[8] being number one. Self-management support can be viewed in two ways: as a portfolio of techniques and tools to help patients choose healthy behaviours: and as a fundamental transformation of the patient-caregiver relationship into a collaborative partnership (de Silva 2011). (Help Direct meets both those definitions). The reason self-management is so important is because:

- Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years (Department of Health 2011c).
- People with long-term conditions are the most frequent users of health care services, accounting for 50% of all GP appointments and 70% of all inpatient bed days.
- Treatment and care of those with long-term conditions accounts for 70% of the primary and acute care budget in England (Department of Health 2011c).
- At the heart of the chronic disease management model (Wagner *et al* 1996) is the informed, empowered patient with access to continuous self-management support.
- Around 70-80% of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).

The impact of self-management has the potential to improved health outcomes, the patient xperience, improve adherence to treatment and medication (Challis et al 2010) and reduced ınplanned hospital admissions (Purdy 2010). Evidence that this translates into cost savings is more equivocal although a cost analysis performed in the United States indicated expenditure in other parts of the system can be reduced (Stearns el al 2000).

- Recent work conducted by the Richmond Group of Charities and The King's Fund (2012) called for patients to be offered the opportunity to co-create a personalised self-management plan which could include the following:
  - patient and carer education programmes
  - medicines management advice and support
  - advice and support about diet and exercise
  - use of telecare and telehealth to aid self-monitoring
  - psychological interventions (eg, coaching)
  - telephone-based health coaching
  - pain management
  - patient access to their own records.

Most of these points are covered within this proposed Self-Care scheme.

- The NHS Constitution enshrines the patient’s responsibility to play a more active role in care and to lead informed decision-making around their health. As such, the home, rather than the surgery, should become the default place for care. Home permits patients the immediacy and convenience of care, in a safe environment that allows them to develop their confidence in self-care, whilst being fully aware that their healthcare professional remains available for advice when it is required.
- Help Direct uses the principles of Telehealth and Telecare in giving patients information and support about their conditions and minor ailments but in a face to

[8] http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/self-management

face settings as opposed to a solely technological solutions. The Department of Health's Whole System Demonstrator Programme[9] advocates patient involvement in their own care thus the need for access to information about their conditions. The first set of initial findings from this complex trial show that, if delivered properly, telehealth can substantially reduce mortality, reduce the need for admission to hospital, lower the number of bed days spent in hospital and reduce the time spent in A&E. The study itself took at least a year's worth of data that was then evaluated by six major academic institutions under five themes (service utilisation, participant reported outcomes such as quality of life; cost effectiveness; user and professionals' experience; and influence of organisational factors to adoption). The early indications show that if used correctly telehealth can deliver a 15% reduction in A&E visits, a 20% reduction in emergency admissions, a 14% reduction in elective admissions, a 14% reduction in bed days and an 8% reduction in tariff costs. More strikingly they also demonstrate a 45% reduction in mortality rates.

- Systematic application of strategies which involve patients, their families and communities more directly in the management of long term health conditions. These savings represent a 7% reduction in spending in terms of reduced A&E attendances, planned and unplanned admissions, and outpatient admissions.

Investment requirements

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

Total investment = £43,320

Impact of scheme

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

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

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

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215264/dh_131689.pdf

The Self Care BCF scheme is a sub-set of the overarching North Lancashire CCG transformation strategy. The out of hospital model is expected to achieve 1.8% reduction in on-elective admissions in year 1 and a 1.8% reduction in delayed transfers of care in year 1.

The Self-care scheme is not directly attributable to a reduction in emergency admissions or reduction in delayed transfers of care. It is, however, part of an holistic whole system approach and is expected to deliver the following added benefits / outcomes:

- Decrease the number of visits to GP practices for minor ailments
- Decrease the number of visits to A&E for inappropriate visits
- Increase the number of patients who feel able to make decisions about their health and care
- Increase the use of community based pharmacy services
- Better symptom management
- Improved quality of life
- Decrease prescribing of over the counter medication
- Improved patient experience
- More effective use of consultations
- Improved social capital and community cohesion
- Improved community health knowledge i.e. better health literacy
- Increased number of consultations using Shared Decision Making
- Increased use of self-care programmes.

Feedback loop

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

There are formal governance arrangements in place through the transformation programme board who will manage project development, performance against activity / impact trajectories, risks and mitigation plans and evaluation and outcomes.

In addition to this the scheme has key expected outcomes which are monitored regularly ncluding the impact on the use of GP and clinical service time as a result of the intervention. Qualitative data assessing the impact and experiences of service users is also collected and assessed.

Detailed formal reviews are planned as part of the transformation programme to ensure maximum efficiency and integration across health and social care to deliver an effective out of hospital model.

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

The key success factors of this scheme are:

nter-dependency	Outputs required	Effect on Delivery
Organisational Development	As self-care is a behaviour change approach then an investment in change management will be required.	Required
ommunication and engagement	Health education programmes Continued partnership working	Critical
Workforce	There will need to be a focus on training staff to encourage the use of assistive chnologies, access to community support, self-care and to ensure they can guide atients to the relevant services available to them. • Consideration must be given to capacity for staff to have on-going training and interaction with the relevant professionals so their skills are gained, maintained and updated – this needs to include self-care training and awareness along with Every Contact counts. • General training should be provided to current staff and integrated into training and	Critical

	induction programmes to ensure they a) know how they fit into the integrated health and social care model and b) are able to provide guidance to patients on accessing the variety of support and services available to them.		
IT	▪ To support the Help Direct model, Web-based signposting and resource provision to encourage self-care: ▪ Ability to provide users with information online, to encourage self-support without dependency on care services ▪ Ability to provide users with an inventory of all community assets (e.g. hospitals, clinics, third sector activities) with a Directory of Community Assets ▪ Development of mobile technology e.g. apps ▪ telehealth	Critical	

Scheme ref no.
BCF19
Scheme name
Community Specialist Services (Lancashire North CCG)
What is the strategic objective of this scheme?
This scheme is one of the Lancashire North CCG BCF schemes which are a sub-set of a larger health economy transformation programme called Better Care Together. The **Community Specialist Services scheme** contributes to the following strategic objectives of the Better Care Together programme:

- To design and implement new integrated models of care across the local health economy
- To design and implement a system which recognises the specific geographic and demographic characteristics of our area and enables the population to access the most appropriate settings of care for their health needs within reasonable travel times
- To design and implement a system which encourages the improvement of health and wellbeing, clinical outcomes and patient experience, in a way which is sustainable
- To enable the development of a flexible, integrated and productive workforce across our health economy.
- To design and implement a future healthcare system for our area that makes best use of the money and resources available

Community specialist services will have two roles within the Out of Hospital Model;

- to provide **specialist support** to the core teams in the planned management of patients
- to provide **fast access** to support if a patient's condition deteriorates, to stabilise their health and **prevent avoidable admissions** to hospital.

These services are key to the functioning of the out of hospital model and provide the specialist expertise to complement the more generalist knowledge of the core team in supporting the overall health of the population.

his scheme will see the start of a change to a more community focused provision supporting patients where they live and undertake their daily lives so that expertise is provided more in context with the patient's situation. There will also be a significant focus on supporting:

- and interacting with the health care professional who understands the patient's wider context
- the patient to become an 'expert' in their own situation and management.

Overview of the scheme

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

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

The **Community Specialist Services** has a number of **specific services** which support

delivery of the **Out of Hospital Care Model**. They are:

- **Dementia Support & Outreach Service: Providing in-home support**. This is provided flexibly in terms of times and duration and is integrated with the household's daily rhythms of life so the:
- carer's lifestyle is supported and they are supported in maintaining their community presence and social networks.
- people living with dementia are supported with the development or maintenance of social networks, daily living skills, and the enjoyment of life.
- Networking with other services to support these groups of people in maintaining their independence in the community is provided.

The service provider will promote access to support services for people living with dementia who may be hard to reach or reluctant to seek or accept advice or support.

- **Dementia Advisors: Providing personalised information, advice and signposting services** to people in the process of getting a diagnosis or from diagnosis of dementia onwards. This will include:
  - accurate, accessible information to help people with dementia make informed decisions
  - a point of contact for all information and advice
  - signposting and where appropriate referral or signposting to one-to-one dementia support, peer support, and education services.

The service should aim to maintain and develop abilities and work directly with the person with dementia to promote independence and enable people with dementia to remain active and social citizens.

- **Solutions Plus: Supporting people aged over 16 with mental health needs within the community to promote recovery, wellbeing and greater independence.**

The service provides a range of mental health day time support in partnership with a wide range of agencies and community groups which help individuals develop their:

- own personal strengths
- coping abilities,
- social networks
- natural support systems

The service supports anyone over 16 who is:

- In need of support and guidance

- At risk of social isolation
- At risk of developing mental health problems
- Recovering from severe mental health problems

ervice users have an allocated care–coordinator to support them for a time limited period to chieve their goals; and (FACS Eligible) long term support which provides service users with access to a range of specialist services designed to meet their needs such as employment and volunteering.

- **Care Homes Team Service is a multi-disciplinary team with skills specifically combined to provide support and advice to Care Home providers to address specific health needs e.g. wound management, continence, therapy and falls assessment**.

he team will work together in a co-ordinated way to provide a first point of contact for staff in are Homes that require support and advice about the care of their residents. The team will offer advice, triage and face to face assessment as a first response, they will not routinely rovide direct care, it is accepted that it is the care homes responsibility and wish to provide he care to the patient as stipulated under their CQC registration. The team may support the staff by:

- Providing advice about the development of specific care plans
- demonstrating techniques to support delivery of the specific care plans
- providing advice about the development of written guidelines,
- attending review meetings and joint visits with other professionals.

he team will develop relationships with all care homes with nursing in the Lancashire North area, undertake the aspects set out above to assist Care Homes with nursing care requirements to support the identification and planning for residents whose needs are changing and may need to facilitate a transition into a Care Home with nursing care provision.

hese key services form part of the wider Community Specialist Services workstream within the Better Care Together Transformation Programme). The workstream will increase opportunities to:

- significantly reduce the amount of unnecessary hospital outpatient activity
- reduce avoidable non-elective admissions by increasing access when deterioration occurs

In order to fully realise the benefits from the workstream **Specialist Community Services will need to be developed to meet the local demographics,** for example, an area with a igh prevalence of diabetes as opposed to COPD may have a co-located diabetes team. It is

likely that the first Community Specialist Services to be reviewed will be:

- Respiratory;
- Cardiology;
- Orthopaedic MSK;
- Palliative care; and
- Rehabilitation and Therapies.

s each pathway is developed it will need to include an end to end approach from prevention through to end of life care where appropriate and each specialist service will need to be onsidered within that context. For each of the areas agreed upon a separate sub-project will be developed.

The Community Specialist Services overall will:

- Improve quality of life for patients and their families through more focused use of specialist advice.
- Enable patients of all ages to have greater control over care plans, more managed personalised care and support delivery of improved health outcomes
- Help ensure a more joined-up approach amongst staff as they work together in integrated teams
- Empower clinicians to take overarching responsibility for the care aims of their designated demographic in their speciality.
- Enable healthcare professionals to be actively involved in the training and support of other professionals.
- Reduce the number of hospital outpatient appointments particularly in the number of follow up hospital outpatient appointments where appointments do not add value
- Support better planning of care, thus less 'crisis management', reduced A&E attendances and emergency admissions with a reduction in anxiety that this causes for patients and their families.
- Reduction in patients revolving between acute and primary care and not finding resolution to their need
- Greater job satisfaction and more satisfying roles for staff, resulting in improvements in recruitment and retention of staff.

The patient cohort targeted in this scheme will be primarily older people people with one or more LTCs, dementia, and people aged 16 and over with mental health needs.

The delivery chain

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

providers involved
Commissioners include: • Lancashire North CCG • Lancashire County Council. The providers are: • Alzheimer's Society • Creative Solutions • Blackpool Teaching Hospitals NHS Foundation Trust
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
The Morecambe Bay Better Care Together Strategy, volume 2, version 5.0, 22nd August 2014, provides clear rationale and option appraisals as to the overarching vison of which the BCF schemes are a sub-set. Other project specific examples include: The **NSF for older people**[10] document defines the service of care for older people. It notes that, currently, over 20% of the population is over 60 and that between 1995 and 2025, the number of people over the age of 80 is set to increase by almost a half with those over 90 doubling in the same period. It states that older people tend to have a much greater need for health and social services than the young, so the bulk of health and social care resources are directed at their needs. For example, almost two thirds of general and acute hospital beds are used by people over 65. It determines the conditions prevalent among older people as stroke, falls and mental health (including dementia and depression). **Everybody's Business**[11] is a set of free e-learning material about the mental health of children and young people. It is aimed at people who work with children, young people and their families who are not mental health professionals. Everybody's Business was commissioned & funded by the National CAMHS Support Service (NCSS) and developed by a number of trainers across the country, originally in 2006 and then re-launched in 2009. These tools will be an integral part of our **Solutions Plus** module.

[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

[11] http://learning.camhs.org.uk/

Dementia – Supporting people with dementia and their carers in health and social care[12] produced by NICE state that dementia is associated with complex needs and, especially in the later stages, high levels of dependency and morbidity. These care needs often challenge the skills and capacity of carers and services. As the condition progresses, people with dementia can present carers and social care staff with complex problems ncluding aggressive behaviour, restlessness and wandering, eating problems, incontinence, elusions and hallucinations, and mobility difficulties that can lead to falls and fractures. This NICE guideline offers best-practice advice on the care of people with dementia and on upport for their carers. There is broad consensus that the principles of person-centred care underpin good practice in the field of dementia care and they are reflected in many of the recommendations made. The principles assert:

- the human value of people with dementia, regardless of age or cognitive impairment, and those who care for them
- the individuality of people with dementia, with their unique personality and life experiences among the influences on their response to the dementia
- the importance of the perspective of the person with dementia
- the importance of relationships and interactions with others to the person with dementia, and their potential for promoting well-being.

Living well with dementia – a national dementia strategy[13] produced by the Department of Health state that recent reports and research has highlighted the shortcomings in the current provision of dementia services in the UK. Dementia presents a huge challenge to society since:

- There are currently 700,000 people in the UK with dementia, 570,000 of whom live in England.
- Dementia costs the UK economy £17 billion a year and, in the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

The strategy covers 17 key objectives including improving awareness and understanding, providing good quality early diagnosis and care, developing structured peer support and learning networks, improving community personal support services and support for care homes in managing residents with dementia.

he Department of Health produced **Quality Outcomes for people with dementia: building on the work of the National Dementia Strategy**[14]. It states that although dementia is rimarily associated with older people, there are also a significant number of people (around 15,000) who develop dementia earlier in life. The direct cost of dementia to the NHS and Social Care is estimated at £8.2bn annually.

[12] https://www.nice.org.uk/guidance/cg42/resources/guidance-dementia-pdf
[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf
[14] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213811/dh_119828.pdf

ntegrated whole system services for people with dementia at Mersey Care NHS Trust: By redistributing resources from acute care settings to locally-based and home-based services, the study aimed to keep people with dementia independent for longer and, where they require hospital treatments, to get them back into the community as swiftly and as well prepared for independent life as possible. The literature suggests a 40% reduction of both elective and non-elective inpatient admission for dementia.

The Prime Ministers Challenge Fund[15].

Nationally there is evidence that care home providers would appreciate more support in erms of contact with Primary and Community Care services when they need it for individual patients, particularly to deal with difficult clinical situations. This might be at the end of a patient's life, when they have wound problems, falls or nutritional problems. It is at these mes that patients often end up in hospital because the care home cannot obtain the support it needs.

Investment requirements

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

Project	Total Investment
Dementia Carer Support	**£9,000**
Dementia Advisors	**£70,000**
Solutions Plus	**£48,000**
Care Homes	**£500,000**
Better Care Together Development	**£2,139,000**
Total	**£2,766,000**

Impact of scheme

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

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

[15] http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/

headline metrics below

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

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

This BCF scheme is a sub-set of the overarching North Lancs CCG transformation strategy. The out of hospital model is expected to achieve **1.8% reduction in non-elective admissions** in year 1 and a reduction in delayed transfers of care of 1.8% in year 1. Detailed activity forecasts are attached outlining the 1 – 5 year impact.

This scheme is expected to achieve 29% of the target reduction, calculated as follows:

Metric	Target reduction
Reduction in emergency admissions	95
Reduction in delayed transfers of care	54

Some of the other benefits of Community Specialist Services include:

- Patient / carer experience survey as part of care planning review showing higher satisfaction rates;
- Reduction in A&E attendances rate compared to peers;
- Admission rates for long term conditions reduced; and
- Reduction in outpatient appointments and follow up appointments compared to peers.

Feedback loop

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

There are formal governance arrangements in place through the transformation programme

board who will manage project development, performance against activity / impact trajectories, risks and mitigation plans and evaluation and outcomes.

In addition to this each individual scheme has key expected outcomes in the form of KPIs which are monitored regularly in line with contractual requirements.

Detailed formal reviews are planned as part of the transformation programme to ensure maximum efficiency and integration across health and social care to deliver an effective out of hospital model.

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

The key success factors for this scheme are tabled below:

Inter-dependency	Outputs required	Effect on Delivery
IT	IT strategy will need to deliver integration for understanding real time demand / capacity and sharing patient information. There may also be a requirement for a solution to deliver digital health virtually.	Critical for overall transformation, not critical for this scheme
Engagement	Continued partnership working	Critical
Pathways work stream	The re-design of specific pathways in different tranches to effectively move care out of the acute trust.	Critical

Scheme ref no.
BCF20
Scheme name
Lancashire Integrated Neighbourhood / Care Teams *(relevant to Greater Preston CCG, Chorley & South Ribble CCCG, Fylde & Wyre CCG,*

Lancashire North and East Lancashire CCGs)

What is the strategic objective of this scheme?

This scheme will provide a new model of care, which coordinates the activities of health, social care and voluntary sector partners around the needs of some of our most complex patients:

- Provide integrated care for which is best suited to each locality and neighbourhood
- Increase patient satisfaction levels by providing community based care which is tailored to meet their needs
- Increase staff satisfaction levels through training/education and provision of autonomy to deliver the care required within that neighbourhood and at an individual patient level
- Reduce non-elective and emergency admissions to acute care
- Promote health and wellbeing through a focus on self-care and self-support
- Deliver effective processes to identify individuals who will most benefit from earlier intervention as well as those requiring support from health and social care services
- Build out existing multi-disciplinary work so that care reviews take place regularly and systematically
- Support the improved use of community resources
- Workforce development/skill mix (new types of worker)
- Working with care homes and domiciliary care to build capacity and skills (these mainly independent sector organisations support the most complex people and if not part of the 'system' will potentially be the weak link that leads to the high levels of unscheduled admissions).
- Potential to build preventative and wellbeing services into INT's

Overview of the scheme

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

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

Model of care and support

This scheme will see the establishment of case managed, multi-disciplinary teams based on GP practice populations, utilising risk stratification. Initially our focus will be on those deemed most at risk of hospital admission, including those with long-term conditions and frail, elderly people.

The key elements of the model

- Utilising **risk stratification** tools and local knowledge to identify high risk patients
- Regular **Integrated Care Team Meetings**, which facilitate the sharing of knowledge of patients and identify the most suitable approach to patient care.
- **Case managers** will work with individuals, their carers and other health and social care professionals to develop or review personalised care plans.
- Case managers will have responsibility for **planning, monitoring and anticipating** the changing needs of these individuals, and coordinating their care across all parts of the health and social care system.

Working in an integrated way across the system

- Work in **partnership with Secondary Care, NWAS, GPs and the voluntary** sector to help prevent hospital admissions
- Integrating with **Connect 4 Life** type of schemes, which are the basis of the integrated wellness service currently being procured by LCC which will align with integrated care teams.
- Embed **strong links with the local community** to promote and develop self-care and independence, the identification and support of carers and vulnerable groups, and building on existing community assets.
- **Information sharing**/shared care plans
- Regular Integrated Care Team Meetings that will involve GP Practices.

Interdependencies

Target patient cohorts

- The model currently being implemented supports citizens with long-term conditions including the frail elderly.
- In year 1, this will particularly focus on those deemed most at risk of hospital admission, including those with long term conditions, mental health problems,

substance misusers and the frail, elderly populations.

The delivery chain

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

The delivery chain comprises CCG level governance and engagement, involving providers and commissioners. Sitting above that is the BCF

Commissioners	Providers
Lancashire County Council	Lancashire County Council Adult Social Services
Greater Preston / Chorley & South Ribble CCG	66 GP practices Lancashire Care Trust
Fylde & Wyre CCG	21 GP practices, organised into four neighbourhoods (each having an integrated care team) Blackpool Teaching Hospitals Trust Ncompass NWAS FCMS (OOH and care co-ord) Red Cross Chloe Care Lancashire County Council
East Lancashire CCG	64 GP Practices East Lancashire Hospitals Trust (community provider) East Lancashire Hospitals Trust (Intermediate and

	Acute provider) Lancashire Care Foundation Trust (Primary Care Mental Health and Memory Assessment Services) Lancashire County Council (Adult Social Care) Lancashire County Council (Public Health) Age UK
Lancashire North CCG	Blackpool Teaching Hospitals FT IHS England are also commissioners of GP practices 13 GP practices
Districts Councils are also important partners in the development of neighbourhood models of care	

The evidence base

Please reference the evidence base which you have drawn on

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

In developing this scheme we have taken into account international best practice, UK exemplars, academic research and the local Lancashire context.

International best practice

There is a growing body of international evidence, systematically analysed by Richardson nd Dorling. Their findings from 34 systematic reviews of integrated care published in the last 10 years, included:

- 81% (13 of 16 reviews) assessed MDTs and found a positive impact
- All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalization
- Hospitalisations reduced by 15- 30% (inter-quartile range)

The Buurtzorg service in particular has established some critical principles for delivery of integrated community care services:

- Small teams comprising generalist professionals
- The service is provided to small discrete communities
- The promotion of self-care is central to the service delivery model

- Strong focus on maximising the time spent caring for individual patients
- Integrated communication systems
- Total staff autonomy

The service outcomes included far greater patient satisfaction, lower overhead costs, reduced sickness rates and staff turnover.

UK exemplars

- Inner North West London Integrated Care Pilot have shown that patients who had a care plan reported improved access to NHS services (64%), that they now had to spend less time booking appointments to see their GP and other health professionals (55%), and that health care staff asked them fewer questions about their medical history (67%).
- In South Devon and Torbay the introduction of integrated care teams has led to over 50% reduction in occupied beds over 11 years, emergency bed day use in the population aged 65 and over is the lowest in the region and emergency bed day use for people aged 75 and over fell by 24 per cent between 2003 and 2008 and by 32 per cent for people aged 85 and over in the same period.
- Learning and information has been taken from the 14 National Integrated Care Pioneer, including:
  - Greenwich – Focus on prevention, early identification and care coordination. In the first year of integrated services there was a 35% reduction in care home admissions
  - South Tyneside – Plans to transform the local care and support system organised around the needs of individuals.
  - Waltham Forest, East London and City – Putting the patient in control of their health and wellbeing, with a focus on reducing hospital admissions.

Academic research

- Research by Ross et all 2011, states that case management works best as part of a wider programme to integrate care, including good access to primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation and re-ablement (Challis and Hughes no date; Ross et al 2011; Goodwin et al 2012)

Local Context

- Compared to the England average, Lancashire has a higher proportion of people in

all age bands above 50 years old. Between 2014 and 2021, all eight of Lancashire's CCGs will see growth of at least 13% in their populations aged 70 or over.

- Three of the six CCGs are in the bottom 25% in England for percentage of people with 3 or more Long-Term Conditions, and all are below the England average.
- 5 CCGs are above the England average for both unplanned hospitalisation for chronic ambulatory care sensitive conditions and Emergency admissions for acute conditions that should not usually require hospital admission

DN: is there anything relevant from any patient surveys we could add in here

Investment requirements

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

Greater Preston / Chorley & South Ribble - £9,267,000

Fylde & Wyre - £1,791,000

East Lancashire – £1,200,000

Lancashire North – £720,000

West Lancashire - £ 156,000

TOTAL = £13,134,000

Impact of scheme

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

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

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

Metrics	
Emergency admissions	☑

Admissions to residential and nursing care	☑
Effectiveness of reablement	☑
Delay transfers of care	☑
Estimated Diagnosis Rate for Dementia	☑
Patient experience: Proportion of people feeling support to manage their LTC	☑

The **total quantified benefit** from this scheme across Lancashire is calculated as:

- 114 fewer delayed transfers of care compared to the prior year
- A reduction of 533 non-elective admissions in 2015/16

The key qualitative benefits are:

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

Feedback loop

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

There are three key components for monitoring the impact of the scheme:

Governance

- Overall progress will be monitored through local governance, senior management and executive structures at each CCG locality.

- These structures include provider, commissioner and wider stakeholder representation and report into the BCF governance across the county, including to the Lancashire Health and Wellbeing Board.
- A programme approach will be taken to ensure effective management of performance, risks and mitigation plans in accordance with the agreed evaluation and outcome measures.

Bespoke data collection and analysis

- We will Implement routine patient satisfaction surveying from GP Practices to enable the capture and tracking of the experience of care, assessing in particular:
  - Increase in contacts dealt with positively near or at point of contact
  - Increase in self-reported wellbeing and quality of life
  - Reducing depression and isolation

- Robust performance management framework of associated contracts, which will measure benefits at a neighbourhood, practice and patient level.
- We will establish a mechanism by which we will track hospital admission and GP attendances for each patient who goes through the Integrated Care Team Meeting process.
- We will also work to monitor patients through weekly clinical Integrated Care Team Meetings and ensure that data is recorded accurately and collectively monitored.

Analysis of routinely collected data

The following information which is collected under existing processes will also be used to appraise the impact of the scheme:

- Admissions to hospital and re-admissions to hospital within 30 days
- Emergency admissions to hospitals for conditions not usually requiring hospital care
- For those in receipt of reablement, % reduction in hours support required
- Closing the life expectancy and inequality gaps that exist in the borough

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

The key success factors for implementation of this scheme are:

- Implementation of appropriate 7 days services
- Training and upskilling of the workforce, empowering them to make decisions locally about care provided
- Commitment to collaborative working between commissioning and provider organisations
- A commitment from all providers of care to operate across organisational boundaries
- Risk profiling is implemented and data can be linked across disparate systems to facilitate sharing of patient information
- Appropriate information governance in place
- Strong engagement from patients, public and staff
- Linkages with other elements of transformation programmes including Intermediate Care, discharge schemes
- Developing an effective IT infrastructure supporting the single assessment process, specialist assessment and care planning across both acute and community services.

Scheme ref no.
BCF21
Scheme name
Facing the Future Together
What is the strategic objective of this scheme?

The strategic objective of this scheme is to implement a whole systems approach to integrated care in West Lancashire through a number of coordinated initiatives to meet the strategic objectives of providing high quality care that:

- Adds value for patients (defined as quality outcome per £ spent)
- Supports GPs as providers and commissioners
- Improves population health
- Reduces avoidable non-elective admissions

The achievement of these strategic objectives requires Clinical and Service integration. This

means:

- Co-ordinating care for individual service users and carers
- Supporting more integrated working with primary care by organising community services around GP practices and population
- Working jointly with social care
- Transforming communication between GPs, specialists and generic services
- Collaborating with other healthcare providers
- Measuring outcomes and costs and making this information widely available
- Providing comprehensive disease management and preventive services to our population, including the promotion of self-care
- VCFS and community assets utilised to best efforts

Overview of the scheme

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

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

Our vision is to ensure the best possible care and health outcomes for our population and to empower our population to be in control of their own health.

Our model of Integrated care, as set out in our clinical commissioning strategy and shown in Figure 1, is based on a whole system approach with the outcome being to provide high quality care to whole populations with an initial focus on older people and people with multiple long terms conditions.

HEALTH & SOCIAL CARE
PROPOSED MODEL OF CARE

Social Services

Patient Flow

Health Services

Primary

Assesment Teams
Social Workers

Housing 21

Acute Transfer of Care

Urgent Care Team including care co-ordinator role

Transfer of Care Team
Care Co-ordinators (ANP's)
AHP's
Assistant Practitioners
OOH
Acute Visiting Service
Walk-in-Services
West Lancashire
Health Partnership

Patient Flow

Step up 72hrs

Pharmacy Support

Mental Health & Wellbeing

Step down 72hrs

Re-ablement Team
LCC Contact Centre
LCC Emergency Duty Team
West Lancs Call Centre
Tele/care
Connect4Life

Care Co-ordination Centre
(Single Point of Access)

Rehabilitation
Therapists
Falls Service
Clinical Triage
Signposting
Call Handling

Secondary

Specialist Service

Rehabilitation & Reablement

Intervention

Social Workers /
Assessors
Care Brokers /
Personal Budgets

Long Term Care & End of Life

Self Care

Community Matrons &
Team (case load holders)
District Nurses
Therapy Services

Connect4Life
LCC
Contact
Centre

Equipment Services

Ambulatory Care

VCFS

Treatment Rooms
Phlebotomy
Therapies
Walk- in-Services

Community Engagement and participation

Patient Flow

Patient Flow

Tertiary

Patient Flow

Figure 1: Facing the Future Together Health and Social Care: Model of Care

The model of integrated care we will commission should:

- Deliver continuity of care, smoothing transitions between care settings, aligning adult social care to health teams to support integration and co-ordinated care and providing services that are responsive to patients needs
- Provide proactive management of population health through a system wide approach to data sharing and population stratification, which will enable targeting of services to the populations and areas of greatest need;
- Be delivered through five neighbourhood teams working in local GP practices in an integrated health and social care infrastructure, supported by our community assets. This will bring together existing components in primary, community, social and acute care into one comprehensive framework
- Focus all parts of system together on admission avoidance to hospital and or residential care, early supported discharge and care outside of hospital

The component parts of the model of care are:

- Single point of access / care co-ordination
- Neighbourhood generic and complex care teams
- Dedicated hospital transfer of care team (discharge)
- Urgent care services

- Access to timely consultant option and community geriatrician support
- Improved community management of ambulatory care sensitive conditions
- Extended treatment room services

s previously articulated, the patient cohort targeted in this scheme will be older people (over 65s) and people with multiple long terms conditions (Phase 1 of the Facing the Future Together Programme)).

The difference this will mean for a patient within the cohort is shown below:

Barry's story

What happens now?

Barry is a 65 year old father of two from Skelmersdale. He is a smoker and can easily get through 30 cigarettes a day. He has a bad chest but puts it down to a bit of a smoker's cough and none of his friends or family have ever said anything about it. He's noticed a bit of chest pain walking upstairs recently but, despite its reoccurrence, he dismisses it straight away as some kind of indigestion after a couple of pints down his local the night before. He lives within a minute's walk of his GP but he doesn't like to bother him unless he is 'really ill'. He can't even remember the last time he was there, but that's partly because every time he used to go he'd have to change shifts at work and lose money as a result. These days, if he needs anything he'll swing by the local A&E or walk-in centre.

For Barry, co-ordinated, person-centred care which promotes self care means...

- Contributing to the design of services
- Easy access to information on services through an on-line portal
- Regular medicine reviews
- Access to social care and other disciplines, within one team- a team which works together and all know Barry's position. Barry came to their attention through a risk stratification exercise.
- That he is supported in self-care and confident in doing so
- He knows who is accountable for his care- his local GP. However, the GP works closely with the specialist at the local hospital to ensure Barry has specialist support, when needed.
- He receives the care he needs, in a clinic setting, near to his home
- He has a care plan

The delivery chain

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

NHS West Lancashire CCG has a complex strategic position across a number of planning units and organisations, with our patient flows and provider network facing into Merseyside and our CCG network and collaboration, including BCF, facing into Lancashire. We have worked with our delivery chain partners through the design of the Facing the Future Together Programme.

There is a particularly strong third sector presence in West Lancashire, which has informed the opportunity analysis in relation to the future care landscape. The Facing the Future Programme draws all the key partners together to work towards whole system transformation. The commissioners and providers for this BCF scheme are:

Commissioners	Providers
Lancashire County Council	Adult Social Services 3rd sector providers
West Lancashire CCG	Southport & Ormskirk Hospital NHS Trust Lancashire Care NHS Foundation Trust 3rd sector providers
NHS England	GP practices

The evidence base

Please reference the evidence base which you have drawn on

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

There is clear national policy direction for integrated care in the:

- NHS Constitution (Dept of Health 2010)
- NHS Future Forum Report (2011)
- The NHS Five Year Forward View "High quality care for all, now and for future generations" (NHS England October 2014) which again confirms the move to integrated care and the increased importance of prevention and shift to out of hospital care.

Alongside this national policy direction the basis for this work largely comes from the national evidence base on the implementation of integrated care. We have used this to support selection and design of the scheme. The evidence supporting the scheme is primarily:

- Clinical and service integration: The route to improved outcomes. **The King's Fund** (Curry and Ham, 2010;). http://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf

- Accountable care organisations in the United States and England Testing, evaluating and learning what works. The Kings Fund (Aldicott, Walsh et al 2014) http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/accountable-care-organisations-united-states-england-shortell-mar14.pdf

- Principles for Integrated Care: **National Voices** (2011). http://www.nationalvoices.org.uk/principles-integrated-care

- An evaluation of the impact of community based interventions on hospital use: a case study of eight Partnership for Older People Projects (POPP). **The Nuffield Trust,** London (Steventon, A , Bardsley, M, Billlings, J, Georghiou, T, and Lewis, G. 2011)) http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/An-evaluation-of-the-impact-of-community-based-interventions-on-hospital-use-summary-Mar11.pdf

- Learning has also been taken from the following international and national, models of integrated care:
    - **Canterbury, New Zealand** – 'right care, right place, right time by the right person'
    - **Torbay and Southern Devon Care Trust** - elderly care vertical pathway work
    - **Veterans Health Administration** - remote monitoring of patients
    - **Trafford PCT** - vertical integration of primary care, community services & social services
    - **Jonkoping, Sweden** - vertical and horizontal integration of health social and departments focusing on the wider determinants

The evidence indicates a number of key principles:

- Take a whole system approach to integration and organising clinical services around populations, for example older people and children, with definable sets of needs. The evidence discourages disease-based integration of services that "*just replace the old silos with the new silos"*
- Have collective accountability to engender integrated working and can lead to improved outcomes for patients.
- Define integrated care from the patient or service user's perspectives. Patients, service users and carers want continuity of care, smooth transitions between care settings, and services that are responsive to all their needs together.
- Care closer to home is better value for money - as well as being the preference of patients and carers, we also know that delivering care within the community, can be less costly and better value for money. Research from the Kings Fund suggests

care provided by community teams can reduce costs to £1 for every £1.20 being spent currently in acute settings.

- Creating a coherent service framework, that crosses organisations, with resources being shared, will reduce costs and improve patient experience. Examples from other areas show this to be the case with some organisation reporting extensive savings as a consequence (some suggest savings of up to 20%).

Applying the evidence to West Lancashire

A key part of our design process has been to use the wider national evidence base and assess applicability and alignment to our locality health and social care needs.

The five neighbourhood areas have different profiles as summarised in Figure 2 below. This local difference is addressed through the design of locality neighbourhood teams.

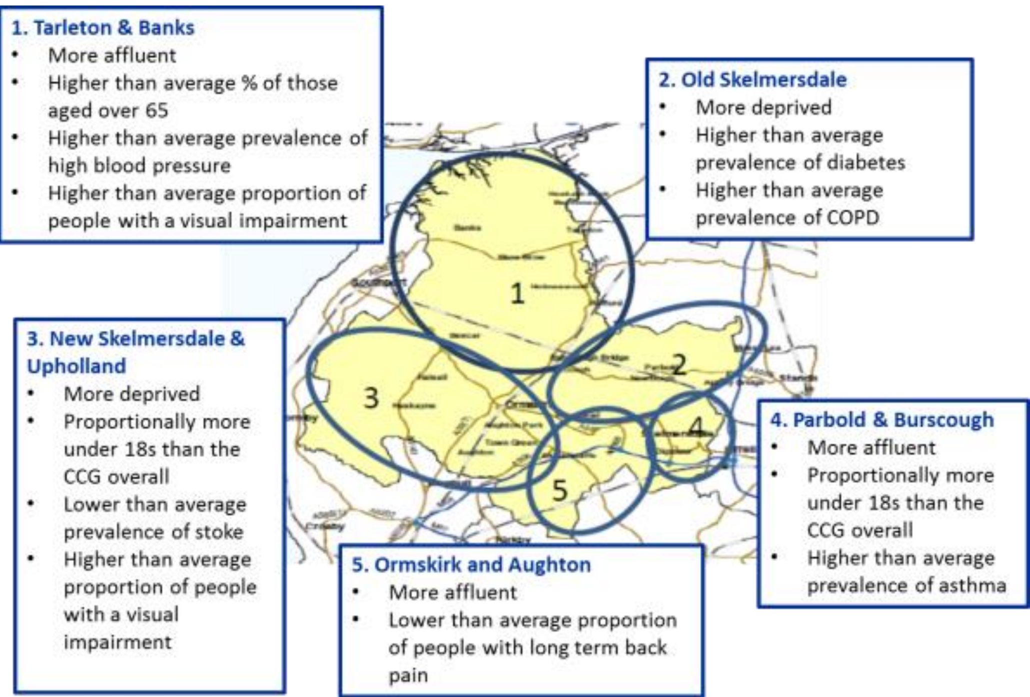


Figure 2: Facing the Future Together: Neighbourhood Profile summaries

Common to all areas are that West Lancashire population has:

- More 65 year olds compared to England where 16.7 % of the population are over 65 years old. The proportion of over 65s is set to rise to 27% of the population by 2035 for West Lancashire.
- A higher prevalence of dementia than the national average. Recent data shows West Lancashire has diagnosed 58% of the expected dementia prevalence and that there are approx. 126 patients missing from registers. Localities 2, 3 and 5 have the highest dementia rates compared to other localities.
- Most areas have over 17% of their population reporting living with a limiting illness, but that this increases to over 20% in areas of Skelmersdale and the North and West of West Lancashire.

There is also **variation** in the local rates of admission by neighbourhood, which is not aligned to disease prevalence. For example Locality 1 had the highest rate of unplanned admissions for respiratory conditions when compared with other localities and the CCG average. Locality 2 had significantly fewer admissions for Respiratory and Cardiac conditions than the CCG average, despite having high prevalence of asthma and average prevalence for CHD, Stroke and high blood pressure. This is illustrated in the following table:

13/14 FOT Crude Rate per 1000 under 65s

Practice	Respiratory NEL	Cardiac NEL	Digestive NEL
Locality 1	5.1	7.8	10.0
Locality 2	2.1	4.0	7.2
Locality 3	2.4	5.2	7.8
Locality 4	3.5	5.7	8.8
Locailty 5	4.5	7.4	10.6
WL CCG	3.3	5.9	8.7

Significant difference from CCG average

Using the evidence to develop the business case

Further local research and design has been undertaken with support from GE Finnamore. This has concluded that the integrated care model will release greatest benefits if it is geared specifically to target the reduction of avoidable non- elective admissions and on a whole system model of provision, with patient centred co-ordinated community and primary care, supported by the social and voluntary sectors.

Conclusions

Based on neighbourhood pilot models in other areas of country including North West London pioneer, which suggested 15% non-elective reductions. We have assumed 5% of the +65 age cohort in year 1, and this will then expand to wider non-elective baseline in year 2 and 3. The target we are eventually aiming for in the CCG is for each of the 5 neighbourhood teams to save at least 1 non elective admission per day:

Neighbourhood	Population	Age 65+	Age 75+	Reduction per Day NELs
Tarleton, Hesketh Bank and Banks	13,322	3,067	1,265	1
Burscough and Parbold	19,642	4,446	1,872	1
Ormskirk and Aughton	29,595	6,819	3,217	2
New Skelmersdale and Upholland	25,981	3,931	1,599	1.5
Old Skelmersdale and Beacon	23,406	3,947	1,701	1.5

This target will be achieved over 3 years so that the cumulative total of "avoided"

admissions will be at least 1752 by the end of 2017/18.

Investment requirements

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

Total investment = £4,977,000

Impact of scheme

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

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

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

Metrics	Facing the Future together Integrated Model of Care
Emergency admissions	☑
Patient experience: Proportion of people feeling support to manage their LTC	☑

In 2015/16 we calculate a **reduction in non-elective admissions of 276**.

This is based on neighbourhood pilot models in other areas of country including North West London pioneer, which suggested 15% non-elective reductions.

We have assumed 5% of the +65 age cohort in year 1 and this will then expand to wider non-elective baseline in year 2 and 3. The target we are eventually aiming for in the CCG is for each of the 5 neighbourhood teams to save 1 non-elective admission per day.

The key qualitative benefits are:

- Improved integration of services across primary, community and secondary care.
- Improved communication between providers of care
- Eliminate duplication of services and better use of scarce resources
- More appropriate referrals resulting in service users receiving the most suitable care to meet their needs
- More informed decision making re: long term care planning couple with holistic provision of care
- Improved overall quality of care provision
- Increased accessibility to services based on need
- Improved patient experience.
- Improved staff satisfaction

Feedback loop

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

Our approach to measuring outcomes is through both quantitative and qualitative analysis. Critical to our success is also how we respond to the findings. This is co-ordinated through our governance arrangements which are outlined below:

Governance

- Local delivery of this scheme will be controlled through the Facing the Future Together Programme Board, which has accountability to West Lancs CCG Governing Body. The Facing the Future Together Programme Board is responsible for assurance of the overall direction and management of the programme. Membership includes West Lancashire CCG's Clinical Executive Committee and a senior representative from Southport and Ormskirk Hospital NHS Trust.
- The Facing the Future Together Programme also reports into the BCF governance, including to the Lancashire Health and Wellbeing Board
- A programme approach will be taken to ensure effective management of performance, risks and mitigation plans in accordance with the agreed evaluation and outcome measures.
- There is also a comprehensive communications and engagement plan which underpins the programme and ensures we share our measurement of outcomes so that local people continue to be made aware of the impact the programme is having and that the 'together' element of 'Facing the Future' is truly realised.

Data collection and analysis

A number of formal KPIs will be developed to demonstrate the 'success' of this service.

These will be formulated around 3 key themes:

- Patient experience
- Staff experience
- Improvement in the quality of self-care

The following will be used to measure the outcomes from the scheme:

- Increase in contacts dealt with positively near or at point of contact
- Increase in self-reported wellbeing and quality of life
- Closing the life expectancy and inequality gaps that exist in the borough
- Using surveys to capture patients' experience of care
- The proportion of people who use services who have control over their daily life
- Admissions to hospital and re-admissions to hospital within 30 days
- Emergency admissions to hospitals for conditions not usually requiring hospital care

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

The key success factors for implementation of this scheme are:

- **Strong engagement from patients, public and staff:** throughout the design process we have engaged and involved patients, public and staff across West Lancashire. We will build on these foundations through the programmes engagement and communication to feedback how we are progressing and ensure ongoing user involvement in design and review of our initiatives and implementation of the integrated model of care
- **Achieving collective accountability for care:** the local integrated care model is based on population needs - this forms the basis to work with partners to establish collective accountability for care, local management arrangements built around practice populations and best use of technology and estates to support this.
- **Southport and Ormskirk Hospital NHS Trust achieving synergy from vertical integration:** the business case is predicated on Southport and Ormskirk Hospital NHS Trust achieving synergy from vertical integration. Quality and productivity should improve through clinicians working in a different way that reflects true integration of services.
- **Establishing a new financial and payment model:** Southport and Ormskirk Hospital NHS Trust The Trust is expected to measure the actual costs of each component of care and to share this information with commissioners so that jointly we can establish the new financial and payment model. By 2017/18 it is expected that the financial model will be implemented in shadow form. Commissioning from

this point will be based on real cost data generated from the revised pathways – and there will be a gain sharing agreement in place taking into account legislative and policy arrangements (known and emergent).

- **Re-investing in Primary Care:** GP commissioners will be offered a range of options to use their freed up resources in ways that will improve the capacity of general practice to deliver high quality primary care.
- **Workforce Development:** training and upskilling of the workforce so frontline staff have the skills and resources required to deliver the model. Empowering staff to make decisions locally about care provided with confidence.
- **Using information systems to target and streamline care:** the local integrated care model is dependent on developing an effective IT infrastructure supporting the single assessment process, specialist assessment and care planning across the system. In addition use of risk profiling tools, accurate disease registers, practice profiles and real time reporting are key to success