Lancashire Health and Wellbeing Board

Lancashire County Council

Lancashire Health and Wellbeing Board
Friday, 2 September 2016, 10.00 am,
Cabinet Room 'D' - The Henry Bolingbroke Room, County Hall, Preston

AGENDA

Part I (Open to Press and Public)

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
1. Welcome, introductions and apologies	Action	To welcome all to the meeting, introduction and receive apologies.	Chair		10.00-10.05am
2. Disclosure of Pecuniary and Non-Pecuniary Interests	Action	Members of the Board are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	Chair		10.05-10.10am
3. Minutes of the Last Meeting	Action	To agree the minutes of the previous meeting.	Chair	(Pages 1 - 6)	10.10-10.15am

Sam Gorton: sam.gorton@lancashire.gov.uk 01772 534271

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
4. Amendments to JSNA Leadership Group terms of reference	Action	To note the amendments and agree the revised terms of reference.	Gemma Jones	(Pages 7 - 10)	10.15-10.20am
5. Q1 Better Care Fund (BCF) Report	Information	To receive a presentation on the report.	Paul Robinson	(Verbal Report)	10.20-10.40am
6. Better Care Fund (BCF) Evaluation	Information	To note the report.	Paul Robinson	(Pages 11 - 26)	10.40-11.00am
7. Lancashire and South Cumbria Change Programme (LSCCP) and Sustainability Transformation Plan (STP) Update	Information	To note the report.	Sam Nicol and Roger Baker	(Pages 27 - 40)	11.00-11.15am
8. Development of Pan Lancashire HWBB	Information	To receive an update from the HWBB Summit meeting held on 26 July 2016.	Clare Platt	(Verbal Report)	11.15-11.45am
9. Urgent Business	Action	An item of Urgent Business may only be considered under this heading, where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading.	Chair		11.45-11.55am

Agenda Item	Item for	Intended Outcome	Lead	Papers	Time
10. Date of Next Meeting	Information	The next scheduled meeting of the Board will be held at 10.00am on Monday, 24 October 2016 in the Duke of Lancaster Room, (Cabinet Room C), County Hall, Preston, PR1 8RJ.	Chair		11.55-12 noon

I Young
County Secretary and Solicitor

County Hall
Preston

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Monday, 13th June, 2016 at 10.00 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

Chair

County Councillor Jennifer Mein, Leader of the County Council

Committee Members

County Councillor Azhar Ali, Cabinet Member for Health And Wellbeing (LCC)
County Councillor Tony Martin, Cabinet Member for Adult and Community Services (LCC)
County Councillor David Whipp, Lancashire County Council
Dr Sakthi Karunanithi, Director of Public Health, Public Health Lancashire
Louise Taylor, Corporate Director Operations and Delivery (LCC)
Bob Stott, Director of Schools, Education and Care
Tony Pounder, Director of Adult Services
Councillor Bridget Hilton, Central Lancashire District Councils
Michael Wedgeworth, Healthwatch Lancashire Interim Chair
Karen Partington, Chief Executive of Lancashire Teaching Hospitals Foundation Trust
Sarah Swindley, Third Sector VCFS Rep
Jane Booth, Independent Chair, Lancashire Safeguarding Children's Board
Councillor Hasina Khan, Chorley Borough Council
Andrew Bennett, Lancashire North CCG
Cllr Viv Willder, Fylde Borough Council
Jan Ledward, Chief Officer - Chorley & South Ribble and Greater Preston CCG
Janet Thomas, Lancashire Care Foundation Trust
Sharon Martin, East Lancs Clinical Commissioning Group

Apologies

County Councillor Matthew Tomlinson	Cabinet Member for Children, Young People and Schools (LCC)
Dr Tony Naughton	Fylde & Wyre CCG
Graham Urwin	NHS England, Lancashire and Greater Manchester
David Tilleray	Chair West Lancs HWB Partnership

1. Appointment of Chair

Resolved: that in accordance with the Terms of Reference, County Councillor Jennifer Mein, as the Leader of the County Council, is appointed as the Chair for the remainder of the 2016/2017 municipal year.

2. Appointment of Deputy Chair

Resolved: that Dr Tony Naughton is appointed as the Deputy Chair of the Board for the remainder of the 2016/2017 municipal year.

3. Membership and Terms of Reference of the Board

A report was presented in connection with the membership and Terms of Reference of the Board.

Resolved: that the Board accept the current Terms of Reference and Membership.

4. Welcome, introductions and apologies

Apologies for absence were noted as above.

Replacements were as follows:

Janet Thomas for Dee Roach (Lancashire NHS Foundation Trust)
Sharon Martin for Mark Youlton – East Lancashire CCG
Jan Ledward for Dr Gora Banghi – Chorley and South Ribble CCG and Dr Dinesh Patel – Greater Preston CCG

5. Disclosure of Pecuniary and Non-Pecuniary Interests

There were no disclosures of interest in relation to items appearing on the agenda.

6. Minutes of the Last Meeting

The Chair informed the meeting that the Better Care Fund evaluation that was due to come to this meeting, be brought to the next meeting as Paul Robinson and Mark Youlton were unable to attend this meeting.

Resolved: i) that the minutes of the meeting held on 28 April 2016 are confirmed as an accurate record.

ii) that the BCF evaluation report is on the next agenda on 2 September 2016.

7. Director of Public Health Annual Report

Dr Sakthi Karunanithi gave a detailed account of the report Securing our Health and Wellbeing, highlighting key points.

The report is aimed at all partnerships and for them to raise awareness of it with the public.

The Board felt the report was excellent and it was clear that partnership working had to be effective in order to deliver the health outcomes needed. The report should also link in with the Sustainability Transformation Plan (STP).

It was noted that telecare/teleaccess to clinicians from the local hospital is available in parts of Lancashire.

Sakthi agreed to update the Board regularly on progress on the report.

Resolved: that the Board noted the Director of Public Health's Annual Report and agreed to support the recommendations within it.

8. Sustainability and Transformation Plan

Sam Nicol, Healthier Lancashire was welcomed to the meeting.

The purpose of the report was to provide the HWBB with an update on the development of the Lancashire and South Cumbria STP. The original NHS England guidance regarding the STP which was published in December 2015, advised that STPs are approved by the HWBB prior to 30 June 2016 submission deadline. However, on Friday 20 May 2016, NHS England issued new guidance as follows:

"The plans that you submit on 30 June will form the basis for a face to face personal conversation with the national leadership in the NHS throughout July, and will be a key part of a subsequent managerial process to inform decisions about the geographical targeting of growth in the intervening years to 2020. Your submissions will therefore be work in progress, and as such we do not anticipate the requirement for formal approval from your boards and/or consultation at this early stage. We will, however, wish to be assured that your plans reflect a shared view from your leadership team where possible, based upon the needs of patients and taxpayers, and a robust plan to engage more formally with boards and partners following the July conversations."

Sam also spoke about the meeting that had taken place recently with Councillors and County Councillors from Lancashire. One clear message that came from the session was that we cannot hold on to what we have – we have to have more joined up working and provide what works and what there is a demand for, within the resources available. The same message came from a session with Blackburn with Darwen also.

Local Delivery Plans (LDPs) have to be accountable to the delivery of local outcomes.

The public need to be aware of what is going on and it needs to be communicated in plain English.

The STP needs to focus on financial sustainability and get people's minds to look to the future and how it will work.

There needs to be a communication plan for the STP for County Councillors, Chief Executives and District HWB Partnerships so they can feed into other groups along with the LDPs.

It is now expected that the third, and final version of the STP will be required in October 2016. The Case for Change will be utilised at pace to agree a future system model and to mobilise the work required, with a strong focus on delivery of our ambitions set out in the STP, and the 10 priority areas.

Sounding Boards will be set up which will include politicians who will meet in September 2016.

Resolved: that the Board:

i) noted the contents of the report
ii) provided relevant comments on the Lancashire and South Cumbria STP

Sam was thanked for her report.

9. Closure of Chorley A & E

Karen Partington tabled and gave a detailed description to the attached Briefing Paper to the HWBB and brought attention to the fact that this item had been discussed as set out in the agenda papers at Health Scrutiny also on a number of occasions.

The Board felt that the public needs to be clearly aware of the position around locums and how that affects the department, when quick decisions are needed.

Karen also expressed her personal thanks for support from various members of the Board around this issue.

10. Lancashire CYP Emotional Wellbeing and Mental Health Transformation

Julie Haywood, Fylde and Wyre CCG and Peter Tinson, Midlands and Lancashire Commissioning Support Unit were welcomed to the meeting.

They took the Board through the presentation attached to these minutes.

If anybody wished to receive any district specific information which can be shared with the Children's Partnership Boards then please contact Julie Haywood, email: Julie julie.haywood1@nhs.net or Peter Tinson, email: Peter.Tinson@fyldeandwyreccg.nhs.uk.

The workstream proposals for 2016/2017 are as follows:

- Promoting Resilience
- Improving Access
- Care of the Most Vulnerable
- Accountability and Transparency
- Developing the Workforce

A digital concept called 'Thrive' is currently being scoped out for Lancashire which is a tool which provides:

i) a system overview
ii) integrated performance reporting
iii) enabling an interactive offer

It was noted that monthly newsletters and an expanded quarterly newsletter will expand on what is and what is not working. A quarterly report will come back to the Board.

Following on from the CQC Inspection and the issues raised, the Board needs to feel confident that everything that is planned in the transformation covers the concerns expressed by the CQC.

Resolved: that the Board receive a quarterly update on the transformation.

11. Development of Pan Lancashire Health and Wellbeing Board

Sakthi gave a brief insight into the development of a Pan Lancashire HWBB working across three Authorities, Lancashire, Blackburn with Darwen and Blackpool.

A workshop will be held to discuss further development. To include the Third Sector and Local HWB Partnerships in these discussions.

12. Urgent Business

CQC Inspection

The Authority has recently undergone a CQC Inspection. A final report will be available mid-August and will bring it to a future Board meeting.

Resolved: that an item on the CQC Inspection is put on the agenda for a future meeting.

13. Date of Next Meeting

The next scheduled meeting of the Board will be held at 10.00am on Friday, 2 September 2016 in the Henry Bollingbroke Room (formerly Cabinet Room 'D' at County Hall, Preston, PR1 8RJ.

I Young
Director of Governance,
Finance and Public Services

County Hall
Preston

Lancashire Health and Wellbeing Board
Meeting to be held on Friday, 2 September 2016

Amendments to JSNA Leadership Group Terms of Reference

Contact for further information:
Gemma Jones, Lancashire County Council, Tel: 01772 536901, gemma.jones@lancashire.gov.uk

Executive Summary

In February 2016 the Board recommended the reestablishment of the Joint Strategic Needs Assessment (JSNA) Leadership Group. This group met for the first time in August 2016 and suggested some amendments to the terms of reference discussed at the Health and Wellbeing Board in February 2016. The group now seek approval of the suggested changes to their terms of reference.

Recommendation/s

The Health and Wellbeing Board is recommended to:

Approve the amendments to the terms of reference for the Joint Strategic Needs Assessment (JSNA) Leadership Group.

Background

In 2016 the Health and Wellbeing Board recommended the re-establishment of the Joint Strategic Needs Assessment (JSNA) Leadership Group and approved draft terms of reference for the group. The JSNA Leadership Group met on 8 August 2016 where some amendments to the group's terms of reference were suggested. These include additional membership representation from the Director of Corporate Commissioning at Lancashire County Council; and representatives from Lancashire Fire and Rescue Service and Healthwatch Lancashire – two organisations considered by the group to be key stakeholders in JSNA. Other small changes include rewording 'Third Sector Lancashire' to just "third sector representative" on the membership list, thus broadening the scope of potential representatives from this sector; further clarification on the frequency and scheduling of meetings; and a simple rephrasing of the sentence about the provision of reports to the group (under 'meetings and other communication'). No changes to the role and responsibilities of the JSNA Leadership Group have been suggested.

List of background papers

Joint Strategic Needs Assessment Leadership Group terms of reference, August 2016.

Reason for inclusion in Part II, if appropriate

N/A

This report should be no more than **two** pages in total but may provide links to more detailed information and papers.

Lancashire County Council

Joint Strategic Needs Assessment
Leadership Group

Purpose

The purpose of the Joint Strategic Needs Assessment (JSNA) Leadership Group is to provide strategic oversight and governance of the JSNA process and products on behalf of partners involved in the health, resilience and safety of Lancashire residents.

Terms of Reference

The group will comprise strategic leads or directors of a range of key partners from across Lancashire-12.

The group may consider additional representatives as appropriate.

Membership

Suggested membership is as follows:

- Director of Public Health and Wellbeing, Lancashire County Council
- Director of Corporate Commissioning, Lancashire County Council
- Clinical Commissioning Group representative
- Lancashire Children's Trust Partnership Board representative
- Third Sector representative
- Lancashire Police and Crime Commissioner or representative
- Elected Member Lancashire County Council
- District council representative
- Director of adults' services or representative
- Director of childrens' services or representative
- Community Safety Partnership representative
- Lancashire Fire and Rescue Service representative
- Healthwatch representative
- Any other member considered appropriate by the Lancashire Health and Wellbeing Board

The chair is to be nominated and agreed by the group on an annual basis.

Support

- JSNA Manager, Lancashire County Council (LCC)
- Information, Intelligence, Quality and Performance Manager, LCC
- Head of Business Intelligence, LCC

Supporting officers will provide information and advice about the JSNA to the leaders as required. The JSNA manager will be responsible for the production of the annual report to the leadership group.

Roles and Responsibilities

The role of the JSNA leadership group is to:

1. steer the future strategic direction of the Lancashire JSNA and the services it delivers;
2. consider the options for the annual programme of work to be delivered by the JSNA team and agree the annual thematic JSNAs and/or other projects for the September to August project year;
3. nominate a sponsor for each thematic JSNA;
4. review the performance of the JSNA by monitoring outcomes of projects previously delivered, their effectiveness and impact on commissioning and outcomes for citizens;
5. sign off and promote reports resulting from the annual work programme and ensure these are considered when revising the joint health and wellbeing strategy;
6. act as JSNA champions in their respective services, organisations and partnerships;
7. regularly report to the Health and Wellbeing Board on development, delivery and outcomes of the JSNA as part of the board's statutory duty for the JSNA; and
8. ensure that there is active engagement of key stakeholders on strategic priorities.

Meetings and other communication

The group shall meet twice a year (in March/April and July/August) each year as a minimum and there shall be a progress update meeting between the JSNA team and the project sponsors in January.
Any emerging priorities to be incorporated into the JSNA work programme between meetings should be discussed and agreed by email, subject to the capacity of the JSNA team.

At Leadership Group meetings, the JSNA team will provide reports on:

- JSNA activity;
- the impact of JSNA activity;
- the progress of JSNA projects; and
- proposals for new JSNA projects.

An annual report will be made available at the meeting at the end of the financial year to be submitted to the Health and Wellbeing Board for consideration.

Revision

This document should be reviewed regularly and any revisions should be agreed by the group.

Lancashire Health and Wellbeing Board
Meeting to be held on 2nd September 2016

Lancashire Better Care Fund (BCF) Plan Evaluation and Update

Contact for further information:
Mark Youlton, East Lancashire Clinical Commissioning Group, 01282 644684
mark.youlton@eastlancsccg.nhs.uk

Executive Summary

The purpose of this report is to inform the Lancashire Health and Wellbeing Board of the findings of an evaluation into the impact of the delivery of the BCF plan 2015/16.

An evaluation of the delivery and impact of the Lancashire Better Care Fund has been carried out that contrasts varied performance against the BCF metrics with a view of good scheme development and delivery.

Performance, across Lancashire, in the areas of Non Elective Admissions (NEA) and Delayed Transfers of Care (DTOC) did not meet the 2015/16 BCF targets. It did however see a reduction of NEAs against the baseline of 2014/15 and performance against both remains better than the overall England level.

The metrics for the reduction in Residential and Nursing Home admissions and the successful impact of Reablement services show a very positive trend across the county.

Savings attributable to BCF activity were apparently lower than anticipated but are unlikely to be accurately measured currently.

There is a need for continued development of the evaluation framework and sets out how that is being developed.

The Lancashire BCF plan for 2016/17 has been approved by NHS England, with go ahead for delivery given. Future reports to the board will advise on progress of delivery of the plan.

Recommendation/s

The Health and Wellbeing Board is recommended to:

1. Note the findings of the BCF evaluation report
2. Support the continued development of a BCF evaluation framework.
3. Receive regular reports on progress of the delivery of the 2016/17 BCF plan

Background

The board has previously received reports on the Lancashire BCF plan 2015/16 and sought an evaluation of the impact of the delivery of that plan.

Lancashire County Council

The Lancashire Better Care Fund Plan for 2016/17 received formal approval on 14th July 2016. This was in line with approval for all BCF plans nationally. The plan was approved, for submission, by the Health and Wellbeing board, as BCF accountable body, at its meeting on 28th April 2016.

The board will receive reports, during the year, on the delivery of the plan, associated developments and more detailed evaluation of its impact.

Evaluation of the BCF 2015/16

A report attached at Appendix A provides an evaluation of the impact of the Lancashire Better Care Fund 2015/16.

The conclusions reached in the evaluation are:

There has been mixed success when measured against the BCF metrics.

- Performance against the Non Elective Admissions and Delayed Transfers of Care worsened towards the end of the year reflecting the national position of increasing demand and complexity of need. Lancashire performance has been better than the national picture.
- The position regarding both residential admissions and the effectiveness of reablement is more positive indicating that there is an impact upon support for the most vulnerable and diversion from long term care is working.
- The dementia diagnosis rate good level of performance is in line with aspirations and priority given to it across the county and the patient satisfaction level shows an overall increasing level of satisfaction despite the challenges in the system.

Potential financial savings to the health and social care system are reduced as a result of the level of performance. This was an expected level of saving in 2015/16 of £6,804,081 against an "actual", £1,625,820. Great caution is needed when considering these figures due to the many other factors affecting the high level performance metrics.

There is a good level of both development and delivery of the outputs of BCF schemes in all areas of the county.
The assessment of the actual impact of the schemes does not go beyond an almost unanimous "moderate" due to the challenge and lack of confidence in identifying the connection between activity and outcome rather than genuine "moderate" performance.

There is an overall indication of significant progress and in terms of the metrics some challenges requiring wider analysis.
To fill any gaps in understanding the impact of the BCF, there is a need for the continued development of a consistent robust, yet simple, evaluation framework.

The report recommends:

- The continued development of the evaluation framework, based around logic modelling, also including the use of proxy indicators giving more immediate sense of progress used alongside the use of patient experience measures.

- Continued sharing with and learning from BCFs of Blackburn with Darwen and Blackpool.

- The alignment of the BCF evaluation framework with the approach being taken in the Lancashire and South Cumbria Change and STP programmes.

Lancashire Better Care Fund Plan 2015/16

Evaluation

1. Background

The Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care.

2015/16 was the first full year of the fund with each Health and Wellbeing Board being required to produce a plan on how the funds would be used and aims achieved

The Lancashire Better Care Fund Plan for 2015/16 was approved in February 2015. It comprised 21 “schemes” that were identified by the Lancashire Clinical Commissioning Groups and Lancashire County Council as supporting the overall vision for health and care services over the next 3 to 5 years of a system that took a person centred approach and had seamless integrated services and pathways. The Better Care Fund Plan would enable:

- People assuming greater responsibility for their health and wellbeing.
- Development of integrated out of hospital services
- Prevention of avoidable hospital admissions and attendances
- Creation of multi skilled health and social care workers
- Enhancement of the role of the voluntary sector in supporting mainstream services
- Remove barriers and demarcation lines between different health and social care services
- Establishment of joint system leadership across the entire health and social care environment.

The schemes focussed on

- Out of Hospital care with integrated neighbourhood teams
- Reablement services
- Intermediate Care Services
- Supporting Carers

Each individual scheme plan set out whether its delivery would impact upon the prescribed measures and gave an anticipated quantitative impact.

Nationally a set of metrics (measures) was defined, for all Better Care Fund plans, so as to give an indication of success against the primary aims of the fund.

In addition each Health and Wellbeing Board was asked to identify a local Patient Satisfaction measure and a further local priority measure.

The table gives the detail of those metrics along with, Lancashire 2015/16 target and actual and 2016/17 target.

Metric	Target 2015/16	Actual 2015/16	Better is
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	733.7	728.5	Lower
Proportion of elderly (65+) who were still at home 91 days after discharge from hospital into rehabilitation/ reablement services.	82%2%	83.2%	Higher
Average daily rate of delayed transfers of care from hospital.	4,212.7	4,685.5	Lower
Non-elective admissions	133,096	136,810	Lower
Patient experience	9.3%	9.1%	Lower
Estimated Diagnosis Rate for Dementia	67%	67.4%	Higher

A quarterly report is provided to NHS England, on behalf of the Lancashire Health and Wellbeing Board, on performance against the metrics.

2. Performance

All BCF metrics are reported through a BCF dashboard. The 2015/16 year end version is available at *Appendix 1.*

a. Non elective admissions

The target for this metric was set as a 3.9% reduction on a 2014/15 baseline that equated to an annual reduction of 5419 admissions across the county.

Actual performance was of a 1.2% reduction against baseline equating to an annual reduction of 1,662 admissions across the county. Nationally there was a 3.3% increase in emergency admissions during 2015/16 when compared against 2014/15.

Performance through the year had followed the profile of 2014/15 until the final quarter when emergency admissions continued to rise where they had fallen in the previous year. This saw a 5.8% increase, 1,937 emergency admissions, over baseline in Quarter 4. This was also evident nationally with a 7.6% increase over baseline seen during the period.

While the target plan was not achieved performance in Lancashire was better than baseline and national performance.

(Data source: http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/)

b. Delayed Transfers of Care (DTOC)

A Lancashire wide target of a reduction of Delayed days of 5.1%, 2,143 days, was set for 2015/16 against the 2014/15 baseline. Actual performance saw an increase of 4,447 delayed days, 11.2% variance from target and 5.5% variance from the 2014/15 baseline.

The profile of performance through the year broadly followed the 2014/15 baseline until the final quarter when a sharp increase was seen significantly contributing to the annual total. This pattern was seen at all acute providers in the county.

Nationally there was a 10% increase in delayed transfers of care in 2015/16 compared to 2014/15 and an 11% increase in the last quarter of 2015/16 over the previous quarter.

Data source: https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2015-16/

The performance against the above two measures has to be seen against a background of high system demand that the national figures reflect.

The range of factors involved is likely to be many and requires further consideration.

Achieving better than baseline and national performance for non-elective admissions in such circumstances should be seen in a positive context.

The challenge around delayed transfers of care seems to be more entrenched with more volatility in the system. County wide improvement activity, including the 2016/17 BCF Delayed Transfers of Care (DTOC) planning programme should reduce this. The DTOC planning includes the requirement for "situational analysis" which will support evaluation.

c. Permanent admissions to residential and nursing home care

A target of 733.7 admissions per 100,000 population 65+ was set for 2015/16. The actual performance was 728.5 achieving target and further stretch from the 2014/15 actual of 774.9. This was based upon a total reduction of 113 admissions against the baseline.

At the time of writing national and comparator authority year end data was not available.

Success seen in achieving this target can be attributed to the level of cooperation and coordination to offer diversionary services and to promote independence. Lancashire has historically been a high user of residential and nursing care but the trajectory shows a move towards national performance. There is an as yet unsubstantiated view that this performance is also due, in some part, to the lack of sufficient and suitable residential and nursing home care in Lancashire.

(Data source: http://ascof.hscic.gov.uk/Outcome/323/2A(2))

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

Lancashire outcome figures for 2015/16 show that 83.2% were still at home after 91 days. This exceeds the Lancashire target of 82%, the Lancashire 2014/15 baseline of 79.3% and the national average of 82.1%. This performance is in the context of a significant increase in the use of reablement and rehabilitation services. 860 people were referred into the services in Quarter 3 of 2015/16, 875 referred in in Quarter 4. The original target was a referral rate of 600 people per quarter. There is also some evidence, anecdotal at present that the increased use coincided with a greater level of complexity of needs of service users.

(Data: http://ascof.hscic.gov.uk/Outcome/323/2B(1))

e. Dementia Diagnosis rate

This locally selected measure had a target of 67% of the expected prevalence of dementia (number of people in Lancashire) receiving a diagnosis of dementia as recorded on QOF (Quality and Outcomes Framework) Dementia register.

This was against a 65.7% actual in 2014/15 and 2013/14 baseline of 55%.

2015/16 performance was 67.4%.

(Data source: http://www.hscic.gov.uk/catalogue/PUB15696)

f. Patient Satisfaction

The latest measure of this is the data from January 2016 that shows that 9.1% of people when asked: "*In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?"* answered "no". This then supported the assumption that the remainder i.e. 90.9% felt that they had received enough support. The target for this of 9.3% was exceeded. The next reporting date for this measure is July 2016.

3. Assessing progress

To give an insight into the overall progress of the BCF the individuals nearest to delivery of BCF schemes, the scheme leads, were asked to translate their overview and experience into an assessment of:

- scheme development
- delivery of scheme outputs
- and an estimate of impact on BCF metrics

This is expressed in a RAG…Red…Amber…Green rating as below.

Scheme development

- **Green = Advanced development**
- **Amber = Good progress**
- **Red = Early in development**

Delivery of outputs

- **Green = Good delivery**
- **Amber = Moderate delivery**
- **Red = low level of delivery**

Impact on BCF metrics

- **Green = High impact**
- **Amber = Moderate impact**
- **Red = low level of impact**

The chart below set out the overall position

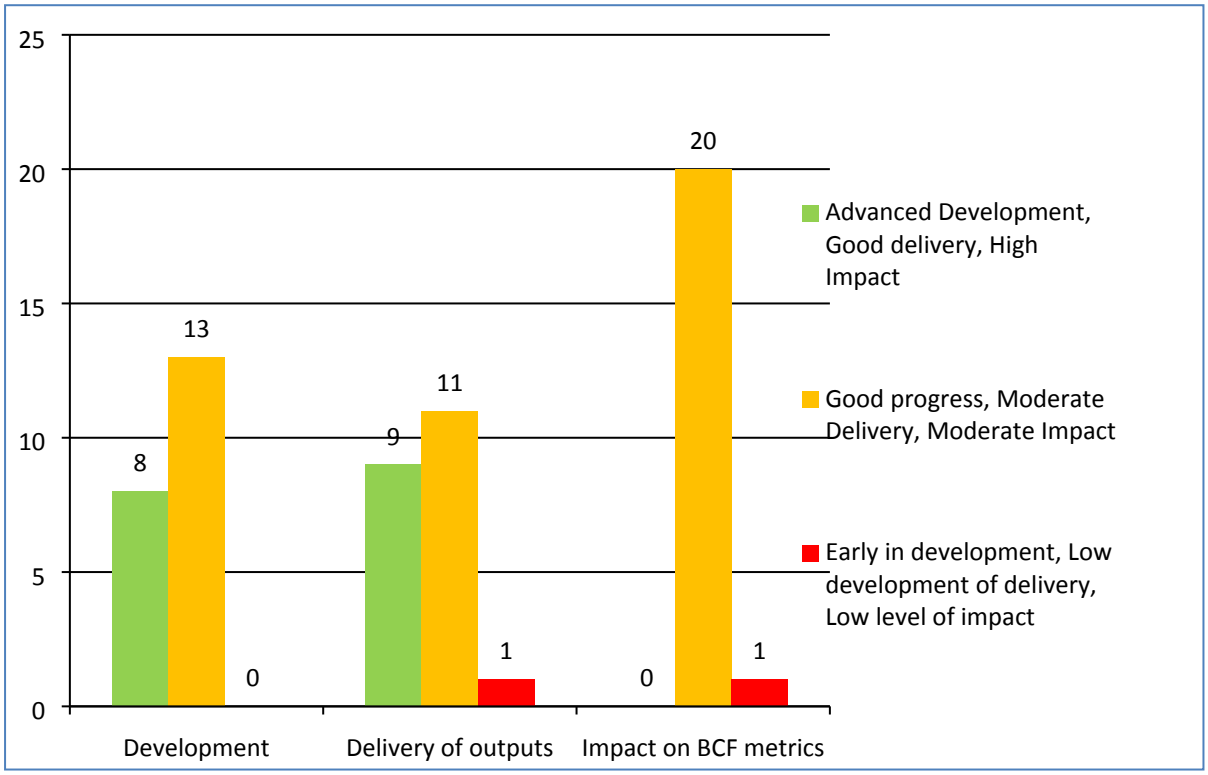


Table 1

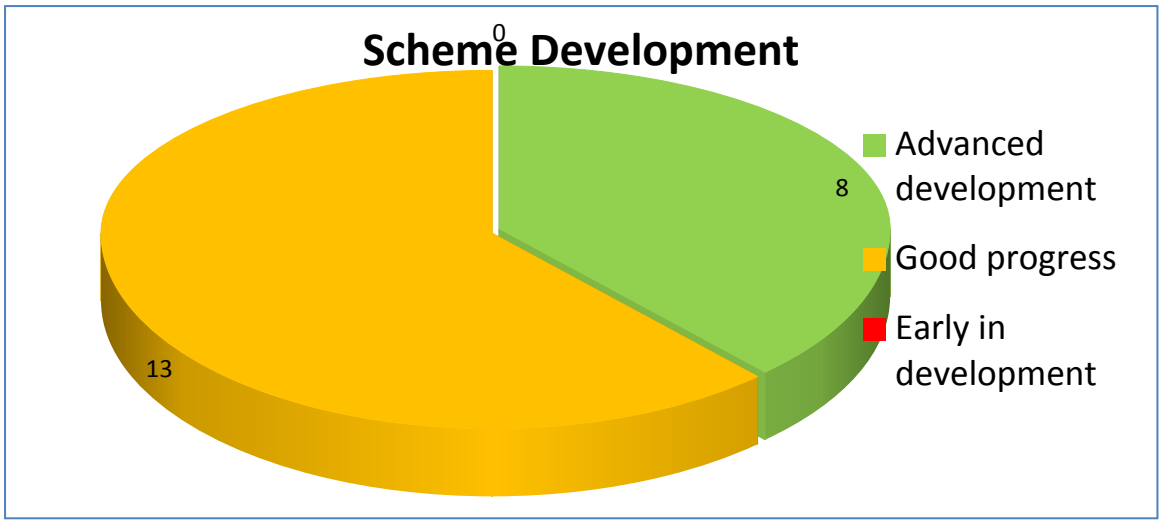


Chart 2

All schemes have developed during 2015/16 with over a 1/3rd in advanced development. The split between advanced and good progress, 38% to 62% shows the differing pace of development across the BCF and can be linked to the starting point of the scheme development, the complexity of planned service and external local factors such as availability of suitable providers.

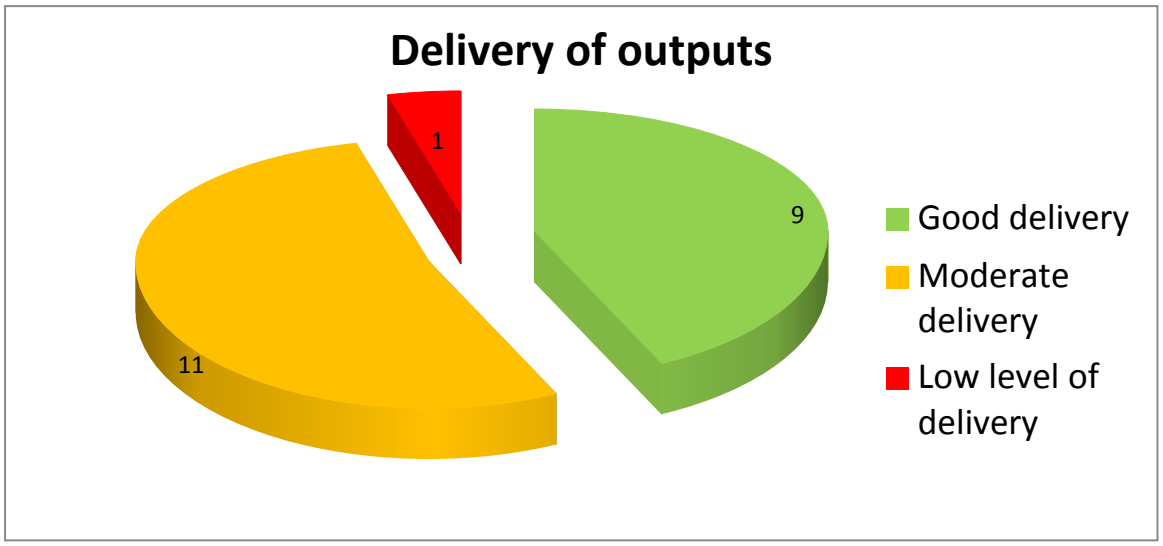


Chart 3

The level of delivery of outputs for the schemes activity to deliver their core services, has grown during the year with good delivery approaching 50% and only one scheme showing a low level of delivery. The delivery of this scheme, Extra Care Housing, has been compromised by changes in national funding arrangements rather than any BCF or organisational related inertia. Except for that one scheme all others are delivering some degree of planned outputs at moderate level or above.

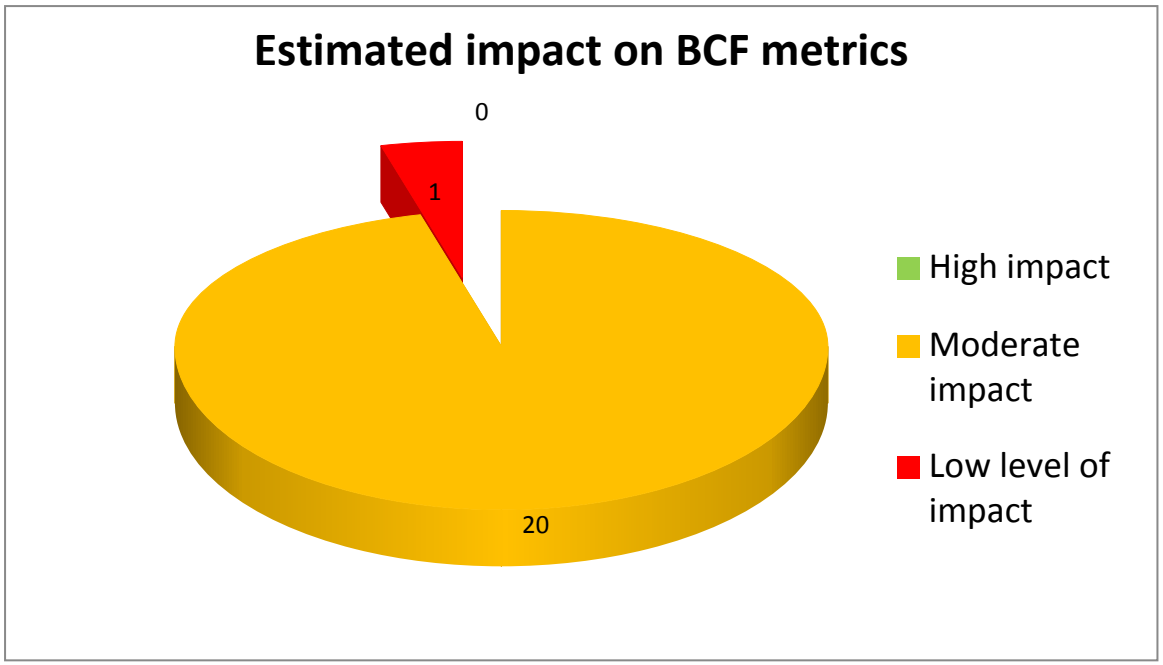


Chart 4

The absence of any scheme indicating a high impact on BCF metrics reflects the difficulty in making the direct connection between scheme activity and overall impact rather than a lack of belief in the scheme effectiveness. The original assumptions of impact for each scheme were based upon informed estimates of the links between inputs, outputs and quantified effect.

4. Making the connection between Better Care Fund Plan and its impact

The schemes within the Better Care Fund Plan were selected and designed as a result of their planned impact upon the aims of the Better Care Fund. This was based upon an evidence base for each, included in the plan that included for example: UK and international exemplars and research, local context and experience, peer experience, international best practice etc. etc. The evidence base also drove assumptions about the impact that schemes could have and the likely outcomes.

The planned impact, against the prescribed metrics of the 21 schemes, brought together at CCG /LA level, within the 2015/16 BCF plan was:

	Residential Admissions	**Reablement**	**Delayed Transfers of Care**	**Non Elective Admissions**
Scheme Footprint	Reductions	Improvement	Reductions	Reductions
East Lancashire	-10	0	-384	-778
Fylde and Wyre	0	0	-64	-345
GP / SR&C	-10	6	0	-1386
Lancashire CC	-43	15	-182	-680
Lancashire North	0	0	-134	-241
Pan Lancashire	0	0	-114	-533
West Lancashire	0	0	0	-276
Total	**-63**	**21**	**-878**	**-4239**
Unit costs £s	2,575	3,596	285	1,490
Savings £s	**162,225**	**75,516**	**250,230**	**6,316,110**
Total savings £s	**6,804,081**			

In addition to showing the quantified impact the table also makes the link to the unit cost of the anticipated “avoided” intervention / support and hence potential savings to the system. The values do take into account the cost of any alternative intervention / support and are adjusted to give a full year value.

If the above is compared with actual performance:

	Residential Admissions	Reablement	Delayed Transfers of Care	Non Elective Admissions
Scheme Footprint	Reductions	Improvement	Reductions	Reductions
Total	**-113**	**35**	**4447**	**-1662**
Unit costs £s	2,575	3,596	285	1,490
Savings £s	**290,975**	**125,860**	**-1,267,395**	**2,476,380**
Total savings £s	**1,625,820**			

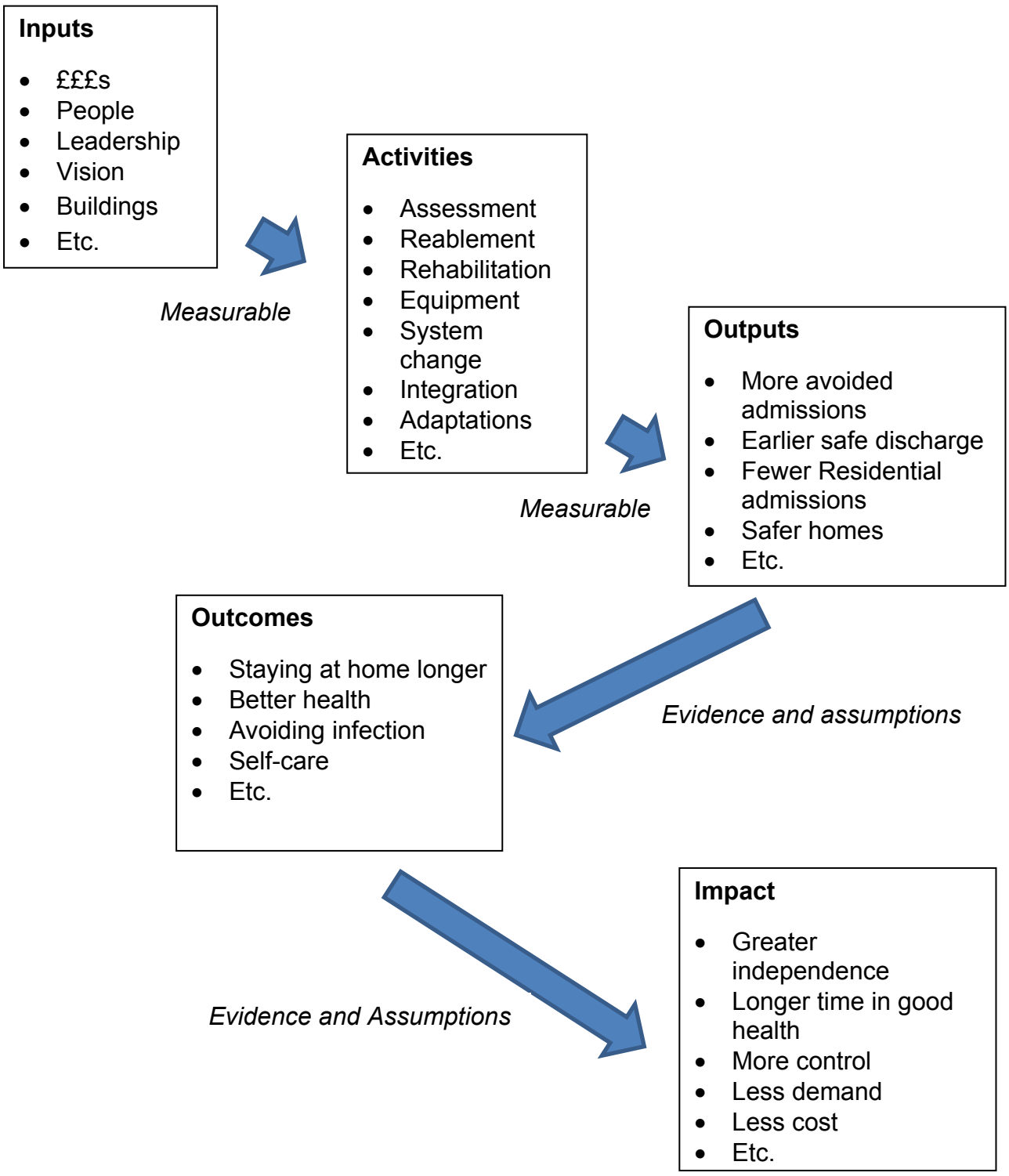
While this appears to demonstrate a reduced level of saving it does not take account of the other factors that have impacted during this period especially the recognised increase in demand and complexity of need. Making a direct, sole, connection would arguably underplay the level of financial savings made through BCF scheme activity.

Perhaps more importantly it does also not give the human dimension of the outcomes for individuals. Assumptions can be made about the impact, and the evidence base supports these, but the above metrics need to be enhanced through the inclusion of more immediate patient experience input and feedback alongside meaningful proxy measures that have a closer link to the actual activity.

5. Developing evaluation

a. Logic modelling

The basis for the evaluation of the BCF, beyond what has been described above, will be the use of Logic modelling. This avoids the complication of attempting to factor in all system variables while providing a connection between the BCF activity and the desired change. For BCF schemes this means:



Each BCF scheme is creating its own model of the above so that each step is clear in terms of what is measured and what is assumed based upon evidence. From that a baseline of each stage is established that is clear on what is to be measured and what assumptions will be made and why.

Through improving systems to measure and record activity a more accurate picture of outcomes and impact will be available.

Each scheme model will be subject to critical review of the BCF programme management team with measuring and recording systems and the assumptions being made tested. This will not only ensure that each is sufficiently robust but also will achieve a common approach across all six CCGs and Lancashire County Council so that comparison can be made across schemes.

b. Proxy measures

It is important that the success of BCF schemes is not only based on a theoretical approach but also on real experience and individual outcomes.

A small suite of proxy measures is being developed initially at scheme level to be able to give the human feel to evaluation. BCF programme managers are currently reviewing what is already in use locally and how this can be used for the BCF.

6. Conclusions

This evaluation has been carried out at a high level so as to better understand the complexities and challenges of the BCF programme and to support the development of an evaluation framework.

a. Performance

The evaluation shows that there has been mixed success when measured against the BCF metrics in 2015/16.

The low performance on NEAs and DTOC appears to be due to a range of factors, many common across the country and linked to higher level of demand and complexity of need. Performance has been better than the national picture.

The position regarding both residential admissions and the effectiveness of reablement is positive indicating that there is an impact on support for the most vulnerable and that diversion from long term care is working.

The dementia diagnosis rate good level of performance is in line with aspirations and priority given to it across the county and the patient satisfaction level shows an overall increasing level of satisfaction despite the challenges in the system.

b. Savings

The tables in section indicate an expected level of saving in 2015/16 of £6,804,081 and an "actual", £1,625,820 based upon the performance against BCF metrics. A more accurate view will be available through the use of the logic modelling approach as described in section 5 when robust assumptions on impact and related costs are built in.

c. Scheme progress

The high level assessment of scheme related development, delivery and impact gives a positive, if measured, view of the overall progress of the BCF in 2015/16.

There is a significant advanced level for both development and delivery with the remainder being at good / moderate so all have moved on in 2015/16.

The "moderate" view expressed for the impact assessment is based on the Scheme leads need to have the confidence through access to the right tools and information to make that link.

d. Evaluation

There is an overall indication of significant progress and in terms of the metrics some challenges requiring wider analysis.

To fill the gap in understanding the impact of the BCF, there is a need for a consistent robust, yet simple, evaluation framework.

Connecting activity to actual performance as set out in section 5 will give an assessment of assumptions made, clarify cause and effect relationships and grow an in depth understanding of how each scheme is intended to deliver results.

The need to continue to develop evaluation techniques is not unique to Lancashire. The Kings Fund has pointed out this in BCF evaluation nationally and the National Audit Office reflects on the time that it can take for any evaluation to identify impact:

"*While projects can be appraised before implementation it takes time for their impact to be established in practice, so there needs to be a strong commitment to monitoring and evaluation over the long term*" (NAO report; *Case Study on integration: Measuring the costs and benefits of Whole-Place Community Budgets*)

7. Recommendations

A robust evaluation framework for the Lancashire Better Care Fund is being created. All BCF partners are involved in this development and will sign off the end product so as to ensure that it aligns with individual organisational evaluation processes.

The framework will include the reporting requirements to Lancashire Health and Wellbeing Board, the BCF steering group and NHS England.

Given its common use, and recognised value, in NHS planning and evaluation e.g. in the new care model vanguards the evaluation framework is based around Logic modelling. It will also retain the monitoring of high level performance and overall progress of scheme development and delivery. In addition it will be given a more human and real time aspect through the inclusion of proxy measures.

So as to give the required level view of impact logic models will be created for each scheme and the BCF plan overall.

Once in place the evaluation framework will be used to report on BCF plan progress. The first report will also provide an update for the approach taken in this evaluation.

The BCF evaluation reporting timing will align with Lancashire Health and Wellbeing Board meeting timetable and NHS England quarterly submissions.

Sharing learning on BCF evaluation and undertaking joint evaluation is being explored with Blackburn with Darwen and Blackpool. This will support the alignment of evaluation methods with those of the Lancashire and South Cumbria Change and STP programmes.

NHS England has allocated £24,000 to Lancashire BCF from its Local Integration Support Fund to enhance the evaluation process and share learning from it. The intention is to use local academic expertise on this detail of which will be shared once confirmed.

It is recommended that all partners to the Lancashire Better Care Fund support the approach being taken and to be further developed as described above.

Lancashire Health and Wellbeing Board
Meeting to be held on *2nd September 2016*

Lancashire and South Cumbria Change Programme and Sustainability and Transformation Programme Update

Contact for further information:
Samantha Nicol, Lancashire and South Cumbria Change Programme, 01253 951630, samanthanicol@nhs.net

Executive Summary

This report summarises the activities of the Lancashire and South Cumbria Change Programme over the last month and includes details on the progress to establishing the governance and programme structure arrangements. The report and the appended Programme Director's Report provides detail on the Programme's work to co-ordinate and support the Lancashire and South Cumbria health and care system the Sustainability and Transformation Plan, required by NHS England and their Delivering the 5 Year Forward View: NHS planning guidance 2017/18-2020/21.

This report aims to assure the Health and Wellbeing Board that the Programme is making good progress and to alert the Board to the activities, products and outcomes that it can expect in the next quarter of the year to inform its work programme.

Recommendation/s

The Health and Wellbeing Board is recommended to:

- Note the progress that the Lancashire and South Cumbria Change Programme has made in establishing the requisite governance and programme structure arrangements.
- Note the requirements of the Sustainability and Transformation Plans NHS and local government organisations and further deadlines of 16th September 2016 for financial plans, and supporting detailed narrative by 30th October to provide assurance that the health and care system can achieve financial sustainability at the end of this year and through to 2018.
- Advise on the requirement for the Programme to report to the Health and Wellbeing Boards or to the Joint Health and Wellbeing Board through the Independent Chairman of the Joint Committee (as set out on the governance structure) and the Senior Responsible Officer and STP Lead who is the Chairman of the Programme Board.
- Confirm its willingness to receive and discuss the Case for Change and its proposed publication at a future meeting.

Background

Attached at Appendix A is the Programme Director's Report which was presented, discussed and its recommendations supported by the Lancashire and South Cumbria

Lancashire County Council

Change Programme Board at its meeting held on 17th August 2016. This provides further detail on the Programme's activities between 20th July and 17th August 2016.

With the publication of the NHS Planning Guidance in December 2015 the Lancashire and South Cumbria footprint was agreed as one of 44 Sustainability and Transformation Plan (STP) areas in England. The Health and Wellbeing Board will note that the STP is a five year strategic plan for health and care focused on the triple aims of improving health and wellbeing, care and quality and through this improve efficiency and the ability to manage within given financial resources. The STP is being developed and it will be implemented and change and improvements delivered through the Lancashire and South Cumbria Change Programme, which was previously known as Healthier Lancashire.

Successful STPs are expected to require an agreement on a common purpose (challenges and opportunities) and through NHS, local government and third sector organisations working together with the public and politicians to collaborate on co-designing solutions and making the most of opportunities to achieve improvements and financial sustainability.

The Health and Wellbeing Board should be assured that the Lancashire and South Cumbria Change Programme (LSCCP) has created a good infrastructure for the STP. The governance arrangements for the LSCCP are now in place. The Programme Board has begun to meet each month, and the Joint Committee, which includes representatives from top tier authorities and district councils, will have its first meeting in October. The Collaborative Commissioning Board which precedes these arrangements is currently considering its role in respect of the Joint Committee and its role in holding the health and care system to account for the implementation, delivery and ongoing monitoring of commissioning decisions. The LSCCP governance arrangements however, is awaiting the confirmation of discussions to form a single Health and Wellbeing Board that will hold the Joint Committee responsible and accountable. The LSCCP has begun the recruitment process for an Independent Chairman and would like the Health and Wellbeing Board's advice on how the LSCCP should report to it, through the Independent Chairman of the Joint Committee and the Programme SRO and STP Lead who chairs the Programme Board.

The Programme Board commenced the discussion about decision making and work has just begun to consider what decisions are taken where and why. This will result in the Programme considering a number of scenarios through which the decision making process can be tested and agreed to ensure that any potential barriers to reaching consensus (such as legal, cultural, constitutional) can be identified and mitigated for.

The supporting programme structure has now been established and with an initial focus on population health, urgent and emergency care and adult mental health; while keeping a strategic oversight on the regulated care sector, primary care and acute and specialised care workstreams. The programme's distributed leadership is now beginning to take shape, with all senior responsible officers in place. There is still however, significant concern about the capacity and capability of the system to support the activities that will be undertaken through the solution design phase. In particular the availability of clinicians and professionals to support the solution design work that is due to commence in September with the publication of the Case for Change. The Board will note from the attached paper, the Case for Change at the moment is still being co-produced with stakeholders. The solution design phase will also require the engagement of the public and local elected representatives. The details of the process, resources and timescale will be presented to the Programme Board in September. It is expected that the Health and Wellbeing Board will receive the Case for Change.

The governance and programme arrangements have been designed to deliver the large scale transformation that is needed to deliver the improvements and remain financially sustainable, but following the second submission of the draft STPs, NHS England (NHSE) has made it clear that STP health and care footprints must assure them of a joined up view of the future and joined up plans that are being delivered and ensure financial sustainability in 2016/17 and 2017/18. By 16th September a revised set of financial plans showing how we expect to achieve financial sustainability will be submitted and a shared narrative describing how this will be done to be agreed and submitted by end of October. Currently the STPs have remained draft working documents and this is expected to be the case in October. The development of the STP is involving all partners and the recently appointed, LSCCP, Involvement, Communications and Engagement Director is currently working with colleagues to develop a robust approach to communications and engagement across the system. It is recommended that the Health and Wellbeing Board has the opportunity to contribute to this and understand how the Case for Change will be used to engage and involve all stakeholders (workforce, public, politicians).

There is well established Digital Health Programme that has had to submit a Digital Road Map alongside the STP and this programme has begun to establish the technical infrastructure to allow the sharing of information across health and social care and which over the solution design phase will consider the appropriate new technologies that can be introduced to support people to look after their own health better or to manage their ill health more effectively.

The LSCCP Team continues to engage with stakeholders on an individual and group basis and has agreed over the coming weeks and months to work more closely with a number of interested parties to develop their understanding of the programme and to involve them in the Programme's activities and solution design.

List of background papers

Delivering the 5 Year Forward View: NHS planning guidance 2016/17-2020/21, published 22nd December 2015.
Joint Committee of Clinical Commissioning Groups Terms of Reference.
Lancashire and South Cumbria Change Programme Board Terms of Reference.

This report should be no more than **two** pages in total but may provide links to more detailed information and papers.

Appendix A

Lancashire and South Cumbria Change Programme (and STP) Director's Report for July and August 2016

1.0 Background:

1.1 Healthier Lancashire was first considered in autumn 2013, with the intention of developing a strategy for improving health outcomes for Greater Lancashire. With the appointment of a Programme Director in September 2014 and resource from NHS England the work to establish a collaborative programme of work to radically change the health and care system commenced in February 2015. Following a piece of work to align the many plans and strategies across Lancashire and the publication of the Lancashire Forward View, there was absolute commitment to establishing and resourcing a programme of work that would not only improve the health outcomes of the population, but would make the radical changes to improve the quality of care, the efficiency and productivity of delivery of health and care and maximise the evidenced benefits of integration with health and social care. In November 2015 the Lancashire Health and Care System agreed to complete the strategic planning phase activities and establish the required governance (decision making) and programme arrangements to do this.

1.2 In December 2015 the NHS England planning guidance required 44 footprints across England to develop plans for sustainability in 2016/17 and 2017/18 as foundation years for transformation of the kind that Lancashire had already agreed was necessary. In January 2016 it was agreed by all stakeholders to include South Cumbria as an important and integral part of the Lancashire footprint, given the close working relationships across Morecambe Bay and patient flows into Lancashire. The Sustainability and Transformation Plan requires the Lancashire and South Cumbria Change Programme (LSCCP) to ensure the development of these plans and their implementation over the next five years.

2.0 Introduction:

2.1 As part of the programme structure supporting the governance structure, a Programme Board has been established for the LSCCP and this Board will also receive the STP as an output of the Programme.

2.2 The formality of the Programme Board will require a Programme Director's Report each month. The meeting on 17th August 2016 is only the second meeting of the Programme Board and this is the first, monthly, Director's Report.

2.3 The Director's Report will set out in a summary form the work of the LSCCP over the previous month, and provide the context and an ongoing developing narrative that will be supported by more detailed Board papers on specific elements of the Programme and the STP.

2.4 These monthly reports will form part of the regular communication across stakeholder organisations and can be used by Programme Board members to brief their organisations or other stakeholder or interested groups.

Lancashire County Council

2.5 For further information on any of the items in the Report please contact Samantha Nicol, Programme Director, either by email on samanthanicol@nhs.net or via the LSCCP Office on 01253 951630.

2.6 This report covers LSCCP activities from 20th July to 11th August 2016 and includes:

2.6.1 Progress on establishing the governance and programme structure and mobilising the Solution Design Phase (SDP)

2.6.2 The Collaborative Commissioning Board – 9th August 2016

2.6.3 Sustainability and Transformation Plan update

2.6.4 Developing the Case for Change

2.6.5 Digital Health Programme update

2.6.6 Involvement, Communication and Engagement

2.6.7 Key risks

3.0 Progress on establishing the governance and programme structure and mobilising the Solution Design Phase (SDP):

3.1 The Joint Committee of Clinical Commissioning Groups (JC CCGs)

3.1.1 A third draft of the Terms of Reference (ToR) of the JC CCGs was circulated to the clinical commissioning groups' (CCGs) governing bodies again during July and August. This followed on from a meeting with Gerard Hanratty, the LSCCP legal advisor, from Capsticks LLP, with the CCGs. Mr Hanratty also reviewed the CCGs' constitutions and along with a revised draft of the JC CCGs' ToR, CCGs who were required to make amendments to their constitutions were advised in writing.

3.1.2 All CCGs have now confirmed that their governing bodies have seen the ToR and confirmed in general their agreement to the ToR. There still remains the requirement for a written Minute of Decision and these will be requested over the next week, although this will not hold up the establishment of a schedule of dates for the JC CCGs.

3.1.3 There are further discussions taking place with the Cumbria CCG in respect of their role on the JC CCGs given the escalated pace of developing the STP.

3.1.4 Non-voting members, NHS England (including specialised commissioning) and local authorities have already confirmed their agreement to the ToR and advised of their representatives. The local authorities have ensured that these representatives cover the footprint and include county, unitary and district councils.

3.1.5 It is expected that the first JC CCGs will be held in October. Following on from the last Programme Board on 20th July, the job description and person specification, for the Independent Chairman, was circulated to Board members and comments received back have been considered and incorporated as appropriate. The advertisement and recruitment process is being supported by the Commissioning Support Unit. The LSCCP will also be requesting the leaders of its partner organisations to consider using their networks to alert prospective suitable candidates to the vacancy. An interview panel will be convened, and this will include an external assessor.

3.2 The Programme Board

3.2.1 As Board members will have seen, following the discussion at the meeting on 20th July and further comments received subsequently, the Programme Board Terms of Reference has been amended. These are subject to a separate paper on the agenda and are presented for agreement and adoption.

3.2.1 Recommendation – the Programme Board considers the agenda item paper on the Programme Board ToR and agrees and adopts these.

3.3 Programme Structure

3.3.1 As Programme Board members are aware the programme structure utilises a dispersed leadership approach, following on from the commitment at the Leadership Summit on 19th November 2015 to utilise existing groups in the Programme and to put resource, including people into it. There was the requirement to develop the clinical leadership for the Programme. It is therefore, with pleasure that we are able to announce the appointment of Dr Malcolm Ridgeway, from Blackburn with Darwen, as the Senior Responsible Officer (SRO) for the Primary Care Transformation Workstream, and he will be further aided by Dr Mark Spencer, from Fylde, as the Clinical Lead. Working alongside Dr Amanda Doyle, SRO for the Programme and the STP Lead, as well, is Mr Andrew Curran, ED Consultant, Lancashire Teaching Hospitals NHS Foundation Trust. Mr Curran has been tasked with setting up the System Design Group, which will include senior medical, nursing and professional colleagues with the remit to oversee the design of proposed options for meeting the health and wellbeing and care and quality gaps.

3.3.2 Recommendation – The Programme Board is asked to note the ongoing efforts to establish clinical and professional leadership for the Programme. An update on progress will be brought back to the next meeting.

3.3.3 In addition the system has also supported Prof. Heather Tierney-Moore's nomination to be the SRO for the Leadership and OD enabling workstream.

3.4 Mobilising the Solution Design Phase (SDP)

3.4.1 On 15th July the senior responsible officers from across the Programme had their first meeting. The SROs are a vital part of the LSCCP, in developing the dispersed leadership approach they have come together to design and agree their role and identify the skills required and to consolidate as a team. The output of this work is an agenda item and separate paper at today's meeting.

3.4.2 It is important that the Programme Board note that in the main the SROs are undertaking these roles on top of their existing 'day jobs'. Most of these individuals do not have any backfill and many are having discussions with their organisations and teams about how their workload is shared or about what doesn't get done. There is without doubt significant risks in terms of capacity and capability.

3.4.3 Recommendation – The Programme Board is asked to consider the separate paper on the agenda today on the SRO role and to note the expectations on the individuals who have agreed to take on these roles and the risk in respect of capacity and capability on the individuals, their organisations and on the Programme.

3.4.4 The SRO group met again on 5th August and invited the local health and care economy programme directors to join them. The objective of the session had been to sign off the role description and to work through what activities or design work was taking place in individual CCG areas, local systems as well as STP footprint level. The intention

had been to then use the results of this to develop scenarios to discuss where decisions were or needed to be taken. The group had planned to look in detail at the proposed solution design process and consider what and how they needed to undertake this, recognising that some workstreams have already been in existence and working prior to the Programme. Interestingly the discussion about what was being done on what level in the system raised the issue of local programme design work versus STP footprint design work. This has raised a critical issue in respect of where decisions are taken and more importantly how they are adhered to.

3.4.5 As yet the governance structure and therefore the decision making process has not been tested. It is however, becoming a constant theme through the local programmes, the Collaborative Commissioning Board and the workstreams, while discussions on the role of the Health and Wellbeing Board(s) continue. In preparation for taking and holding to decisions in the future through the delivery of the Programme and the STP there is a clear need to take a more disciplined approach to testing the decision making arrangements out at this early stage, to minimise disruption or resistance when it might be more mission critical.

3.4.6 The Programme Board today will be asked to contribute to this debate, by considering a couple of scenarios, which the SROs involved in the work have developed. The intention is to build up a picture of the potential issues, barriers or resistance to decisions through these discussions and to then look to ensuring that the governance arrangements are fit for purpose. This might also be related to behaviours, assumptions and mindsets and identifying these will help to inform proposals for leadership development and design of appropriate system interventions.

3.4.7 Recommendation – The Programme Board is asked to participate fully in the discussion on decision making as prompted by the scenarios that will be presented later in today's agenda.

3.4.8 The SRO and Programme Directors have now been asked to consider where their local programmes and workstreams are in relation to it. They will meet again on 9th September and this will be the commencement of the SDP.

4.0 The Collaborative Commissioning Board – 9th August 2016:

4.1. The Director's Report would not normally feedback on the Collaborative Commissioning Board. It is only included here because of several important pieces of work that the Programme Board should be aware of and which have interdependencies with the Programme and the STP.

4.1.1 The work in local systems to develop integrated services between health and social care to support the implementation of new integrated models of care, predicated on community support, but including local hospital services. Together with the work in local authorities, particularly some commissioned work by Lancashire County Council, to develop new approaches to public sector service delivery has raised the desire to consider the requirement for changes in the way services are commissioned. Dr Doyle has agreed to gather together a small group of volunteers to consider what these conversations need to be, who they need to be with and when, with the objective of engaging and involving the right people and organisations in helping to develop options for consideration over the coming months.

4.2 At the last meeting of the Programme Board there was a request to investigate the opportunity to pause expected procurements. This was based on the need to focus

efforts and capacity on the STP, but also to ensure that proposed procurements would not adversely affect or impact on future proposals or necessary decisions.

4.2.1 This request was taken back through the CCB, with the CSU compiling a spreadsheet of current and proposed procurements being undertaken across Lancashire. The CSU also provided advice on the level of risk in relation to pausing these in relation to the stage that the procurement had progressed to.

4.2.2 This exercise raised a number of interesting questions and issues, which the CCB required further exploration on before being able to take a decision in relation to the request to pause.

4.2.3 Not all the CCGs had contributed to the exercise and so the detail on the procurements needed to be completed in full. There were a number of these that were already well progressed and so were considered in the high risk category. So these needed to be considered in relation to the size or value of the tender; the impact or interdependencies across the STP, on other services or organisations; the impact of pausing at an advanced stage of the process. The same was true for those procurements that had not yet commenced. There was also the need to ensure that any of these would not prejudice the co-design of solutions through the Programme or limit future options proposals.

4.2.4 Carl Ashworth, from the CSU, has been asked to set up a small task and finish group to undertake this work and to present back to the CCB at its September meeting.

4.3 Carl Ashworth has also been asked to work with the Programme Director and Dr Doyle to develop a revised ToR for the CCB and a proposal for its role in relation to the LSSCP and the STP going forward. A first iteration of this will be discussed at the CCB at its meeting on 13th September 2016.

4.4 Recommendation – The Board is asked to note that there are several pieces of work being undertaken through the Collaborative Commissioning Board. The output of these are linked to the Programme and the Board, and stakeholder organisations will be contributing to these over the coming months. Updates will be brought back at the appropriate time.

5.0 Sustainability and Transformation Plan (STP) update:

5.1 As Board members are aware the second draft STP was submitted to NHS England on 30th June 2016, this comprised of 30 slides. There was a local assurance meeting with NHS England and colleagues from across the health and care system on 5th July to prepare for a meeting with Simon Stevens and other colleagues from the national teams of NHS England and NHS Improvement on 20th July 2016 in Leeds.

5.1.1 The meeting was structured around service proposals, finance and (political) engagement. This was a 45 minute meeting which focused on the plans that the Lancashire and South Cumbria health and care system had for delivering on its targets, while closing the financial gaps in 2016/17 and 2017/18. Our proposals for the future and our arrangements for working together and taking decisions together were seen as very good there was a significant emphasis on the need to achieve financial sustainability in this year and next to establish the foundations for transformation in years three, four and five of the STP. This was about not waiting until year five to deliver everything, but to spread the work to bridge the gap, avoid cost and take cost out over the whole lifetime of the STP.

5.1.2 Gary Raphael, has summarised the plans in his Finance Director's Report. However, the STP footprints have been asked to submit further detailed financial analysis on the plans for 2016-18 and show how the financial gaps will be bridged, by 16th September 2016. It is expected that these, along with direction in recent financial guidance issued by NHS England, will be used to ensure that contracts with NHS providers are developed during October and November and contracts for two years will be signed by Christmas 2016, bringing forward and truncating the contracting round that usually commences in October to conclude at the end of March.

5.2 Further detail on the expectations of STP footprints in September and October were provided at a meeting of the North Region STP leads and NHS England local directors of commissioning operations from the North, alongside the NHS England North's Director, Richard Barker, colleagues from the Care Quality Commission (CQC), Public Health England (PHE), NHS Improvement (NHSI), National Institute for Health and Care Excellence (NICE); held on 10th August 2016.

5.2.1 NHS England and NHS Improvement described what they had gathered from the 44 STPs so far, the common themes, common enablers, common issues and requests that have been made by STP footprints. The common themes included urgent and emergency care, mental health, elective care. Common issues were delivering at scale and pace, cross boundary issues, fostering a collaborative culture, implementing good practice at scale, and the issue of being transparent and engaging stakeholders in exploring radical solutions. Everyone was clear that an aligned position across the STP footprint was important and that the triple aims were all equally important.

5.2.2 By 16th September 2016 STP footprints have to submit a set of financial returns. By the end of October these financial plans will need to include a clear narrative that sets out how the triple aims will addressed with a coherent story that includes provision and commissioning. The STPs need to show a joined up view of where the system needs to get to by 2020. The STP will set out the journey from sustainability to transformation year on year over its lifetime. The detail of years one and two are expected to be reflected in the operational plans required by December from organisations.

5.3 Chief Executives and Accountable Officers from across the health and care system attended a briefing with Dr Doyle on 22nd July and agreed to come together regularly over the coming weeks to ensure that the work being undertaken to develop the STP is supported. There are four leaders meetings planned. The first one held on 11th August was to set out a number of pieces of work that have been set off and to request further information from organisations and local systems about the detail of their existing plans. The next meeting on 19th August will consider how the local delivery plans and organisational plans meet the triple aims and to consider the impacts across the system and to consolidate performance against plan for this year and consider any remedial actions. The third meeting will then consider the level of transformation that will need to be brought forward to next year for delivery in order to meet the financial challenge.

5.3.1 There is a real desire and an imperative to engage clinicians and others in the development of the STP through to end of October and Roger Baker, ICE Director will be looking to support this with the LSCCP Team.

5.4 Recommendation – the Programme Board takes time to consider the requirements for the next draft of the STP and the proposed approach and its role in developing and agreeing the STP.

6.0 Developing the Case for Change:

6.1 Over the last couple of months, a number of colleagues have been meeting as an Editorial Panel to begin to draft the Case for Change. It is obvious that this needs to support the narrative for the STP too. The Case for Change is should establish a sense of urgency for change. It is often a skipped step in many change programmes or it is assumed that the sense of urgency is already shared broadly among stakeholders in the system, which it rarely is. One of the best ways to cultivate a sense of urgency is to craft a powerful Case for Change.

6.2 Simply put, the Case for Change is a *narrative* that explains the changes coming to the system and why they are necessary. Its objective is to provide a common baseline of awareness and understanding among stakeholders.

6.3 Currently we are working on a fourth draft of the Case for Change, but following the discussion with the STP leads across the North of England and the arm's length bodies there is an opportunity to engage further expertise and involve others in putting this important document together. On the Programme Board agenda today is a paper that sets out the framework for the Case for Change for discussion.

6.3.1 Recommendation – the Programme Board considers the format and content of the Case for Change at this early stage and provides advice and support to ensure this is a robust product.

7.0 Digital Health Programme Update:

7.1 It has been agreed that Declan Hadley, Programme Director and Sakthi Karunanithi, SRO for the Digital Health Programme will present a full update on this at the Programme Board in September. The following is a short summary of work underway.

7.2 A Lancashire and South Cumbria Wide Digital Road Map (LSCDRM) has been created as a key driver to support the better alignment and access of information across health and social care. The LSCDRM is owned by the Digital Health Board who has established a governance structure and a number of key work streams in support of the LSCDRM.

7.2.1 Lancashire Person Record Service (LPRES)

By the end of 2016 all the provider organisations in Lancashire will be able to send and receive any document to any GP anywhere in Lancashire and South Cumbria. It will also be able to provide – subject to Data Sharing and Information Governance agreements – a view of data sets e.g. EpaCCS, urgent care and care plans.

7.2.2 Collaboration across systems for Providers and Primary care

Through the Chief Information and Chief Clinical Information Group all clinical systems are being reviewed and where possible procurement of new systems is co-ordinated to improve collaboration i.e. PACS

7.2.3 Citizen free Wi-Fi

The North West Shared Infrastructure Service (NWSIS) working with Blackpool Council and the Midlands and Lancashire Commissioning Support Unit has rolled out a programme of free public Wi-Fi to most NHS premises across Lancashire (including GP practices). This has been a real success and is now routinely accessed by thousands of patients and staff across Lancashire.

7.2.4 Information Governance and Data Sharing

Information Governance has been an important element within the overall digital agenda and the Cumbria and Lancashire Information Governance Group, which is led by Helen Speed, has created an electronic Information Governance Register which simplifies the creation of data sharing agreements and the provision of Privacy Impact Assessments. It is currently being evaluated by the Information Governance Team at HSCIC to assess its suitability for a national rollout.

8.0 Involvement, Communication and Engagement (ICE):

8.1 Roger Baker, ICE Director, will at a future meeting present the proposed plans for involvement, communication and engagement around the Case for Change, the STP and related to other elements of work across the LSCCP.

8.2 Even in the height of the holiday season however, there have been a number of meetings and discussions with colleagues from across the system. These have included a joint workshop with the communication and engagement partners and the workforce workstream. This was followed by a very productive discussion with union representatives. Both were about developing a good approach to communicating and engaging with staff in and about the Programme, and to understand from the staff's perspective what was important and would be helpful to them going forward.

8.2.1 There have been presentations to the Lancashire's Public Sector Leaders' Group on the STP and a commitment for someone from the LSCCP to attend that meeting on a monthly basis. The Health Watches have come together to also look at how they can support the Programme and will be coming back to the Programme Board with some proposals. The Lancashire Health Scrutiny Committee continues to be actively engaged and the Chairman, County Councillor Steven Holgate and Officer, Wendy Broadley have taken time to give some direction to what they would like the Committee to engage with at their meeting in October.

8.2.2 To continue to develop good relationships with colleagues in Cumbria, Brenda Smith, Director of Adult Social Services, Cumbria County Council has taken time to meet with me and has been invited to be a member of the Programme Board. There have been meetings too with Lindsey Hoyle, MP and council colleagues at Chorley Borough and with Blackpool Council's Adult Care Senior Management Team.

9.0 Key risks:

9.1 Currently the single biggest risk to the LSCCP is capacity and capability of the Programme Team to co-ordinate and facilitate and produce all the required elements of the STP and to mobilise the Solution Design Phase within given timelines. The Team is looking to manage this with some additional capacity to support the Finance Director, and plans to secure further help are being considered.

9.2 Alongside this is the capacity of the system to be able to participate in the activities that are taking place both in local systems and across the Lancashire and South Cumbria footprint. This is being mitigated by ensuring there is prioritisation and good communication to allow people to attend and speak for each other.

9.3 Failure to secure the appropriate commitment to the governance arrangements or to design robust decision making arrangements which will cause decisions to either not be taken or not to be supported and outcomes not delivered. This is why the discussion on decision making and testing this through scenarios is so important.

10.0 Conclusions:

10.1 Despite it being the holiday season, the LSCCP continues to move forward and gather momentum. The last three weeks have been exceptionally busy with work to establish the governance arrangements and mobilise the programme structure and prepare to commence the Solution Design Phase. The Case for Change is a critical element of the Solution Design Phase and this requires further support and development, alongside the push to have a third draft of the STP by the end of October, and financial plans in more detail to be scrutinised by 16th September. Involvement, communication and engagement is a critical part of the LSCCP Team's work and the last few weeks have been no exception.

10.2 It is clear that there is a growing collaboration across health and social care organisations that is focussed on achieving the plans to really impact on health outcomes, while doing so within the given resource envelope. The discussions and commitment to working together is unprecedented and is already ensuring that the complex issues are brought to the fore and activities are focused on looking for solutions together.

11.0 Recommendations:

The Programme Board is asked to note that the following recommendations have been made in this paper:

- Consider the agenda item paper on the Programme Board ToR and agrees and adopts these.
- Note the ongoing efforts to establish clinical and professional leadership for the Programme. An update on progress will be brought back to the next meeting.
- Consider the separate paper on the agenda today on the SRO role and to note the expectations on the individuals who have agreed to take on these roles and the risk in respect of capacity and capability on the individuals, their organisations and on the Programme.
- Participate fully in the discussion on decision making as prompted by the scenarios that will be presented later in today's agenda.
- Note that there are several pieces of work being undertaken through the Collaborative Commissioning Board. The output of these are linked to the Programme and the Board, and stakeholder organisations will be contributing to these over the coming months. Updates will be brought back at the appropriate time.
- Takes time to consider the requirements for the next draft of the STP and the proposed approach and its role in developing and agreeing the STP.
- Considers the format and content of the Case for Change at this early stage and provides advice and support to ensure this is a robust product.