Appendix' B'

Lancashire Health and Wellbeing Board
28th January 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lancashire County Council**
Clinical Commissioning Groups	**Lancashire North CCG**
Boundary Differences	The CCG is one of six CCGs within the Lancashire County Council area. The boundaries of LNCCG are aligned with Lancaster City Council (one of the twelve district councils in Lancashire) but also has two member practices that serve the population of Garstang which sits within Wyre Borough Council. The CCG has an acute provider that crosses both Lancashire and Cumbria county boundaries and serves three district council areas, two in Cumbria and Lancaster District. The CCG main community provider sits within the neighbouring Blackpool unitary council.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£10,462,000**

b) Authorisation and signoff

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

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

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

c) Service provider engagement

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

Better Care together (BCT) the CCGs Strategic Programme is the key driver for developing a transformed health and care economy for the Lancashire North area.

Lancashire North CCG, University Hospitals Morecambe Bay NHS Foundation Trust and Cumbria CCG are working together to ensure clinical led transformational change. Lancashire County Council, Blackpool Hospital NHS Foundation Trust Community services, GP Practices, North West Ambulance, NHS England – Lancashire Area Team and Cumbria Area team are all part of the steering group. The programme has a clinical reference group made up of GPs and clinicians from across Morecambe Bay.

Lancaster District health and Wellbeing Partnership is a long standing multi agency partnership that is chaired by LNCCG and has representation from Lancaster City Council, Lancashire County Council, CVS, Healthwatch, Citizen Advice Bureau, Community Futures, Public Health (LCC) Lancashire Fire and Rescue Service and Lancashire Constabulary.

By working together the partnership can provide support and action across a wide range of wellbeing initiatives and facilitates closer working across sectors and organisations. Members of the Partnership will support the wider elements of supporting people in the community and enabling the development of a community asset approach. as set out in this plan.

The UCN is leading the unscheduled care work stream of the Out of Hospital element of BCT to provide a multiagency and multi-disciplinary vision for out of hospital services related to urgent care and older people's services.

Staff engagement across the organisations is a key element of the BCT engagement plan and the Local Authority service provider forum in January received an update of the current work around the BCF and the development of this plan.

The Partnership receives regular updates from the Better care together programme enabling the partnership to provide regular feedback.

Engaging with the third sector. NHS Lancashire North CCG and Lancashire LINk came together for a special event to explore how to improve communications and engagement for all organisations who work in Health and Social Care in Lancaster. The special event which was held in Lancaster in early 2013 was attended by over 80 attendees representing 52 different organisations, with the majority from the voluntary sector.

The event programme included a variety of techniques which were used to facilitate discussion and gain ideas from all participants. This included a pre-event questionnaire, live digital consultation and a technique known as the knowledge café – which involves delegates answering specific questions allocated to set tables, then moving from table to table adding more knowledge and ideas.

On completion of the tasks and throughout the whole event action points were collated. Many of these confirmed the CCG's priorities to focus on commissioning improved hospital and mental health and community health services.

This event will be repeated in March 2014 to ensure further engagement with the third sector.

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

A number of key plans underpin the Better Care Fund for the Lancashire North area and each of these has had significant engagement these are:

- The Better Care Together Programme
- The Transitional Care Pathway
- The Carers Strategy.

The Better Care together programme has carried out pre-consultation engagement work with residents, patients, clinicians, health professionals and key stakeholders to help develop the review of services and ensure that local people's views are at the centre of this review following the "no decision about me, without me" policy (13 Dec 2012).

The better care together team wanted to involve local stakeholders in the pre-consultation phase so that they can actively contribute to the development of future healthcare options rather than solely at a consultation stage. Therefore better care together has engaged with residents and stakeholders from across the Morecambe Bay area of Lancashire North and South Cumbria to feed back their views to those involved with the better care together programme. This pre-consultation public engagement is being used to help inform health professionals who are involved in four clinical work streams: maternity, paediatrics (children and young people), planned care i.e. any care that is arranged in advance and unplanned care (e.g. emergency services). This pre-consultation will support the shaping and development of future service model options.

Patient, service user and public engagement has also been a key feature of work to support development and review of the transitional care pathway - which is the pathway agreed between the former North Lancashire PCT and Lancashire County Council to support people through the urgent care pathway and ensure they access the correct services.

This pathway was supported by the then Practice Based Commissioning Consortia and forerunner of Lancashire North Clinical Commissioning Group. A review of the pathway to assess its functioning and its accessibility for people with dementia or older people with mental

health problems has recently been jointly undertaken by the CCG and Lancashire County Council and the recommendations will be used to inform changes to current services and pathways.
A summary of this plan has been shared with the Lancashire Carers Forum to ensure that it fits with the Carers Strategy.

In addition to the above, the CCG has a communication and engagement strategy that has recently been reviewed and action plan refreshed. The CCG Communication and Engagement Strategy Group is chaired by one of the CCG Governing Body Lay members and the plan will include continued engagement on all relevant topics.

The CCG has regular meetings with Healthwatch to share feedback. Healthwatch is also a member of the CCG Quality Improvement Committee and the Lancaster Health and Wellbeing Partnership.

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

Document or information title	Synopsis and links
HWBB Minutes 15/10/13	**Report re ITF and Lancashire health care strategy.** http://council.lancashire.gov.uk/ieListDocuments.aspx?CId=825&MId=2850&Ver=4
HWBB Minutes 24/07/13	**Report re ITF and Health and Wellbeing Board strategy** http://council.lancashire.gov.uk/ieListDocuments.aspx?CId=825&MId=2657&Ver=4
HWBB Minutes 25/04/13	**Delivery plan for HWBB strategy** http://council.lancashire.gov.uk/ieListDocuments.aspx?CId=825&MId=2385&Ver=4
HWBB Strategy	http://www.lancashire.gov.uk/corporate/health/index.asp?siteid=6715&pageid=40274&e=e
Better care together presentation	**Update (to December 2013) re Better care together update, next steps, details of engagement to date.**  better care together December 2013
Transitional Care Pathway in North Lancashire	**Transitional Care Pathway within North Lancashire**  Transistional care pathway

Review of Crisis, Rapid Response, Intermediate Care, Rehabilitation and Re-ablement For Older Adults in North Lancashire	**This report is based on the findings of the Review of Crisis, Rapid Response, Intermediate Care, rehabilitation and Reablement for Older Adults in North Lancashire (Wilby et al 2010) commissioned by NHS North Lancashire and Lancashire County Council.**  older people's rehabillitation
The Lancashire Multi-agency Carer's Strategy for Working together for carers. 2013-15	**This strategy draws together evidence and information about the needs, issues and priorities for carers reflecting the views and experiences of carers across Lancashire. It sets out key themes, which will influence service development and the quality of support that carers can expect to receive over the next three years.**  Lancashire carer's strategy
Lancashire North CCG JSNA health profile	**This health profile forms part of a Joint Strategic Needs Assessment process for NHS Lancashire North CCG. Specifically it describes the health of the population served by Lancashire North Clinical Commissioning Group (CCG) and identifies local health priorities. Recommends the strategic direction for Lancashire North CCG to improve health and wellbeing in the local resident population**  LNCCG JSNA
Lancashire County Council Adult Social Care commissioning Intentions 2012-15	 LCC adult social care commissioning intentic **This document describes the adult social care commissioning intentions for the coming three years.**
LNCCG Communication and Engagement Strategy	 LNCCG Communication and E

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

Vision: *The population of Lancashire North will receive the right care, in the right place, at the right time that promotes faster recovery from illness and enables people to live as independent and productive a life as possible within their local community*.

This will be delivered through person centred integrated services that follow clear pathways of care that have a single point of access, supported by compatible connected information technology.

Lancashire North CCG (through its predecessor organisation North Lancashire PCT and the Lancaster, Morecambe, Carnforth and Garstang Practice Based Consortia) and Lancashire County Council have a long history of working and commissioning together to integrate health and care services with the aim of supporting people to remain healthy and independent.

Particular examples stretch back to 2003 when the health commissioned Rapid Response Team was enabled to commission social care funded 'crisis support services' to support people in their own homes for 72 hours to prevent hospital admission.

This has been built upon since by the development of joint commissioning of the Transitional Care Pathway, in particular the REACT service which is a multi-professional integrated team, the Intermediate Support Team (IST) which supports peoples with dementia and is again multi-professional and integrated.

REACT

REACT is a team of health and social care professionals who work together to ensure that patients receive the most appropriate care, in the most appropriate place at time of need. Patients are assessed and referred to other professionals for immediate support or treatment.

Case Study 1: *A patient attended A&E with an infection and worsening of their long term condition was seen by the duty doctor in A&E. The doctor referred the patient to REACT due to their problems with poor mobility and the need for bed rest for a few days. REACT were able to assess the patient and arrange for the rapid response team and increased social care to care for the patient at home for a few days. This resulted in the patient being able to be treated and cared for in their own home and the team were able to reassess the patients care package and arrange for rehabilitation to support the patient in their recovery.*

Case Study Two: *An elderly lady attended A&E with injury to right ankle following a fall getting up from a chair. It was suspected that she may have a fracture of her ankle so was put in plaster and kept in hospital overnight to see a consultant and for her mobility to be assessed. On further investigation no fracture was found however the lady was experiencing dizziness and was in danger of further falls. REACT were able to assess and discharge the lady within 24 hours with crisis care and were able to reassess her current care arrangements. After five days the lay was able to be discharged from REACT into the care of the community matrons. This meant that the lady was able to return to her own home without a lengthy stay in hospital.*

Other examples exist around Community Equipment, Mental Health Services and Learning Disability Services. The area has also encouraged the integration of voluntary and statutory services through the commissioning of a 24/7 end of life service which is provided by voluntary and NHS services again through an integrated approach. These examples over recent years have enabled the local health and social economy to stabilise non-elective admissions to hospital

which is in contrast to most other areas which have seen an increase and also to support increasing numbers of people at the end of their life to die in their preferred place of care. In LNCCG the percentage of people dying in their usual residence has risen from 42% to 49% since 2010/11. This is above the England average of 44% and the highest percentage for all CCGs in Lancashire.

Commissioning of Community Palliative Care Services

In 2007, the National End of Life Strategy confirmed that most people prefer to die in their own homes. Currently there are a range of services in the NHS Lancashire North CCG area supporting people at the end of their lives. These include district nursing, care homes and general hospital care as well as more specialist palliative care services including Macmillan nurses and Hospice service. However lead clinicians in the CCG identified opportunities to improve the care of patients by:

1. ***Increasing the co-ordination of existing services***
2. ***Extending services during the evenings, overnight and at weekends to reduce unnecessary hospital admissions***
3. ***Responding more quickly to referrals***
4. ***Helping people to plan their end of life care***
5. ***Increasing the capacity of specialist palliative medical care.***

The CCG commissioning team worked with existing providers to design a model of service that would address these issues and meet the future needs of an ageing population. The new model of care provides a range of co-ordinated services coming together to meet the needs of the patient at the different stages in the last year of life.
In order to achieve this, five additional services have been commissioned;

1. ***The hours and days of operation in the existing Hospice at Home service have been increased to operate from 07.00 to 22.00 over 7 days.***
2. ***An education programme for patients with life limiting illnesses which is designed to support people in considering their future needs and assist local services with planning their care accordingly.***
3. ***Development of a new co-ordination 'hub' with a nursing and administration team that supports co-ordination and rapid deployment of staff to meet planned and un-planned need. The 'hub' also maintains an electronic Locality End of Life register to enable the sharing of real time updates with GPs, Hospital and Community services.***
4. ***Development of a dedicated Palliative Care night time service in the community.***
5. ***A new Palliative Care Consultant working across Hospital, Hospice and community settings.***

The new services complement existing services and enable us to better identify and plan care with patients who are expected to die, deploy our staff resources where they are most needed, prevent avoidable hospital admissions and ensure excellent quality of care for patients and their families.

Mrs B stated: "She felt supported by Hospice at home and the District nurse team."

"Hospice at home staff treated my mother with utmost dignity and respect at all times, and they were a great source of comfort to my wife and me."

Better Care Together

Building on this strong foundation the CCG and LCC will continue to develop, redesign and transform existing services through the Better Care Together (BCT) programme and it's out of hospital work stream that is currently underway.

The BCT programme is described more fully in the attached documents, but was initiated to design future services for the Morecambe Bay Area following the failure in quality of services identified by CQC. Significant work has been undertaken already via multi-agency work streams to develop models for future provision across acute and community health sectors as well as

social care, which will see a complete transformation of many services across the Morecambe Bay area (including Lancashire North) in order to address the underlying problems the area faces.

The Out of Hospital work stream has commenced and will build on this work and extend this to ensure community models are described ready for option appraisal. Some of this re-design is likely to be subject to public consultation and is therefore not ready to be shared in detail.

The work will result in capacity within both public and wider community resources being maximised so that person centred care is delivered closer to home, enabling individuals and their carers to remain at home longer, reducing or delaying the need for admission to long term care, reducing hospital admissions and when hospital admission is necessary, reducing length stay.

There will be joint governance and commissioning arrangements with an integrated case management approach utilising risk stratification and self-care within natural communities based around GP Practice lists. This will be underpinned by case finding and an asset based approach to community development which aims to grow community capacity and support a sustainable shift from acute care. The self care and community asset based approach elements of community development through building skills and knowledge in the community to increase empowerment of communities to self-care, will be supported through the Lancaster District Health and Wellbeing Partnership, a multiagency partnership with a health and wellbeing focus.

For the Lancashire North area, the Better Care Fund is a part of Better Care Together focusing initially on the frail elderly, those patients accessing the Transitional Care Pathway and carers. This plan therefore focuses on those areas of work at present – but the wider programme will support a much bigger transformation across the whole system.

The Better Care Fund will continue to develop and enable a single point of access to a range of community based step up/down services (described locally as the Transitional Care Pathway) including provision of an extended hours domiciliary crisis response service across Lancashire North, reablement and community beds offering rehabilitation and recuperation will mean that more people are treated and supported at home, with appropriately trained therapy & support workers.

Availability of pathways to offer alternatives to hospital admission with clear links to community rehabilitation services ranging from minimal to maximal input, presence of a multi-disciplinary Rapid Response Service in A&E & Medical Assessment Units will focus upon admission avoidance, to triage and access Rapid Response and other appropriate community services.

There will be end-of-life care and mental health capacity within transitional pathway services building on the work of the 24/7 palliative care service and the integration of elderly mental health services into the transitional care pathway which again is already underway.

Care Homes
Increasingly, some of the most vulnerable people with the most complex needs live in our communities in care homes. In Lancashire North there are over 600 nursing home beds and it is essential that the service users within them are considered as part of the community and have equal access to the benefits realised through our vision in terms of access to the right care at the right time, and the wrap around care afforded by using community assets to develop well-being. They will be an integral part of the care system and plans are currently underway to provide greater support into these homes, through links to NHS providers and links into the natural community within which they are situated. This work will include increased liaison between health and social care commissioners as well as health care professionals and social work staff to ensure that care home providers receive consistent messages to help their care provision.

As we look to increase the number of patients who are cared for in their own home there is a need to support domiciliary providers in a similar way to care homes. There is also opportunity through the recommissioning and zoning of domiciliary home care, to address issues of continuity

and improve the quality of the day to day care people receive (that spans basic primary health and social care needs that keep people safe, well and out of hospital). For example, poor hydration and medicines mismanagement often can trigger an admission. The zoning of providers in neighbourhoods and localities should foster true integrated working with providers and the integrated neighbourhood teams case managing those people with complex needs.

Integrated Quality Improvement

We are also aware of the increased activity in terms of safeguarding and avoidable emergency hospital admission from citizens living in these settings. Responding to this demand in the same way is no longer sustainable, affordable and in the interests of vulnerable people and we urgently need to shift to a more proactive approach.

We would wish to build on current (often single agency) developments that take a quality improvement approach to raising standards and the development of best practice within this sector, by coordinating our interventions via an integrated team approach. This will allow us to have more comprehensive assurances of the quality of provision, an opportunity to reduce duplication, and to maximise the opportunities to conduct individual reviews of citizens in the service.

Disabled Facility Grants

Aids, adaptations to homes and equipment to support and enable independent living are essential if patients and service users are to be support effectively. Lancashire County Council, the CCG and Lancaster District Council will continue to work together to develop the delivery of a comprehensive range of aids and adaptations, utilising disabled facility grants and other funding to support independence and improve outcomes for service users. There is a commitment to work in accordance with the Annex to the NHS England Planning Guidance, delegating the indicative minimum district budget allocations (as published by the DCLG for 2015/16), to support delivery of the statutory duty of the strategic housing authorities in relation to adaptations for the disabled. There is a recognition and a commitment from all partners to work together to further improve integration and co-ordination of services which promote independence and equity, enhancing outcomes for customers and maximising value for money.

Home Care

LCC is currently undertaking a major exercise in recommissioning and procurement of its Home Care services for older people and people with a physical disability. Over time this will encompass all the services delivered by registered Home Care providers in Lancashire including mainstream home care, reablement and crisis response services. This work is being managed on a countywide basis and covers about 5000 service users, 4500 staff and about £50M of expenditure per year.

However, at the conclusion of the procurement process later in 2014 and new Home Care contracts are awarded the intention is to develop a much closer collaborative relationship between the group of Home Care Providers and local Commissioners and Providers of both Health and Social Care services. The new commissioning arrangements will involve fewer providers holding contracts for up to 7 years with the county council, organised into zones which are broadly coterminous with the boundaries of Clinical Commissioning Groups. The benefits include, for example, the potential for strategic and operational partnership with emerging Neighbourhood Teams of health and social care staff, leading to a more integrated response to the needs of individuals.

Many people rely on these home care services to support them during times when they are recovering, or need support in a crisis situation or need longer term support and so through the BCF funding we will need as a priority to ensure that the current level of service is protected in

the face of provider's cost pressures and local authority funding reductions. Indeed it would be better if the capacity and capability of these services is increased to ensure more people can be supported at home outside of hospital or residential / nursing homes. Through the BCF process we will start to develop clear plans for this capacity and capability to be grown.

Telecare

LCC will begin to re-commission and procure the key elements of Telecare infrastructure during 2014 to serve the whole of Lancashire. There is considerable scope for expanding and improving Telecare service across Lancashire. The most important potential benefits of Telecare accrue to individuals and their family in terms of improved risk management, peace of mind and responsiveness to emergencies, However the financial benefit from a successful Telecare service will accrue as much to the NHS as to the Council and so it is intended to have a joint investment in the service, ensuring it is funded for growth, and that staff across the local NHS and LCC provider organisations are fully engaged and trained in the deployment of Telecare.

A joint single performance review monitoring process for measuring the impact and efficiency of the services including joint IT services, Incorporation of the utilisation of re-ablement, telecare / telehealth /telerehabilitation, Clear defined links to personal budgets, housing, other services, private and third sector within the pathway These changes will result in people being supported to manage their health and any long term conditions so they are less likely to need to visit A&E and/or be admitted acutely due to an exacerbation of their condition.

Adult Safeguarding

The Lancashire Safeguarding Adults Board has responsibility for ensuring that all of its partner agencies work together to protect those adults at risk due to their disability, frailty or mental health problem from harm, abuse, exploitation and wilful neglect. It has a wide remit across prevention, quality and standards and adult protection and abuse.

The Better Care Fund will provide funding to implement Adult Safeguarding Boards on a statutory funding and Board members are developing proposals for the additional support that will be required to provide Board infrastructure and quality assurance capacity to meet the expectations of the Care Act.

Carers

Carers are an essential part of the caring process and provide more care and support to people than any other group. In order to recognise this contribution and to ensure that carers receive the appropriate support and services LNCCG and Lancashire County Council are committed to the further development of carer services as set out in the Lancashire Carers Strategy around agreed areas of work.

These are:

- Carer's assessments
- Access to breaks
- Health and emotional wellbeing
- Provision of information

In partnership with carers through the various carer forums we will develop a more community focused system which should provide support to carers in the right place at the right time so that they are enabled and empowered to care for their loved one.

Workforce

Traditional workforce roles are no longer sufficient to deliver a new system of health and social care, with its greater emphasis integration, community and prevention. Many of tomorrow's workforce are already here today. Any system for service redesign should be aligned and go hand in hand with workforce planning and the systematic development of a competent and flexible workforce, with the capacity and capability to engage in a world of continuous change with new roles and locations. Key factors to consider will include employment law, professional registration, cultural change, skills development, engagement and the empowerment of frontline staff. The task is immense and will demand action at national and local level which recognises the interdependencies between staff groups and the work they undertake. At a local level, organisations, including education providers, will need to work together to support sustainable change.

As a result of the above, both Better Care Together and the Better Care Fund, more joined up care between the various health and social care organisations means that individuals needs are addressed holistically, improving outcomes for them. People are only in a hospital bed if they need to be. People are treated safely and effectively near to their home, without long waits. Healthcare professionals in the community are supported to make better decisions about where to refer people. Emergency care clinicians can focus on treating serious injury or illness in A&E. Primary care are incentivised to manage minor injury and illness outside of hospital where they can do so safely & effectively. Expert staff and resources are focussed where their skills are needed the most. People access the treatment they need quickly, without unnecessary delays.

a) **Aims and objectives**

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

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

AIM

The aim of our integrated system is to deliver positive outcomes for individuals, which enable people to live as independent and productive a life as possible as part of their local community by bringing care, in its widest sense, as close to home as possible.

The system will respond to the changing needs of the local population, by encouraging the natural community to take greater ownership of their care. Long term sustainability of the health and care economy will be developed through more seamless person centred services and pathways, which are more embedded into the community.

Our objectives are:

- to reduce avoidable emergency hospital admissions and re-admissions,
- to reduce hospital lengths of stay,
- to ensure safe and timely hospital discharge and reduce delayed transfer of care,
- to reduce or delay admissions to long term care,
- increase the proportion of older people living independently at home,

- improve continuity of care by minimising hand-offs between professionals.

Several of these measures are already measured via the Urgent Care Network which oversees the development of the urgent care and community services currently. The remit of the network will be widened to ensure that all these measures are monitored.

b) Description of planned changes

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

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

As described above the whole of the Morecambe Bay Health and Social Economy is involved in an extensive transformation and re-design process – Better Care Together. The Better Care Fund is one part of this which fits within the overall significant range of changes which will need to occur to ensure that health and social care services are sustainable into the future.

Better Care Together is the overall strategic programme for the area and this is supported and influenced by the JSNA, the Joint Health and Well-Being Strategy and the Lancashire County council Adult Social care Commissioning Intentions. The CCGs 5 year plan will be built on this plan, ensuring that recognition is given to all facets of care, from self care and support in the persons home to secondary and tertiary care out of area. The plan will highlight interface with other commissioners to ensure seamless and streamline pathways. The CCGs 2 year plan will be a 'sub-set' of the 5 year plan and BCT, setting out the objectives for the next two years on the above and how services will be re-designed to move towards the aims and objectives of BCT. The Better Care fund is then a sub-set of the 2 year plan with a particular focus on the Transitional Care Pathway, avoiding unnecessary admissions to hospital or long term care, supporting people at home and helping them to manage their own conditions.

The table below sets out the Planned Changes:

	Actions	**By When**	**Expected benefits for patients and services**
1	Fully implement alcohol liaison service.	April 2014	• Improve pathway for service users to enter alcohol management services. • Improve the longer term outcomes for people with alcohol issues. Reduce the number of non-elective admissions for alcohol related reasons.
2	Fully embed Falls service better referral pathways to prevent repeat falls.	April 2014	• Offer of assessment and access to support to prevent people who have fallen from falling again and experiencing further injury – particularly life changing injury such as fractures. • Improve the long term outcomes for older people • Reduce the number of non-elective admissions due to falls. • Reduce the admissions to long term care.

3	Fully Embed Early Supported Discharge and Community Stroke rehabilitation service	June 2014	• Improve the pathway and experience for patients who have experienced a stroke. • Reduce length of stay for people who have experienced a stroke. • Reduce delayed transfers of care. • Reduce non-elective re-admissions for who have experience a stroke. • Improve therapy outcomes for those who have experienced a stroke. • Reduce admissions to long term care.
4	Commission Care homes support team	June 2014	• Improve care in care homes to existing and future patients. • Reduce non-elective admissions from care homes • Smooth transfer pathway from care to nursing homes.
5	Review all urgent, emergency and supportive services to assess 7 day availability and draw up plans for future commissioning arrangements	June 2014	• Enable access for those who require care 7 days per week. • Reduce A/E attendance and Ambulance Calls. • Reduce non-elective admissions • Increase numbers of people assisted to manage own long term condition.
6	Improved Case finding and support to people – through use of improved case finding tools (to include social care risk factors), re-alignment where necessary of Long term conditions teams.	December 2014	• Improved support to patients to manage their own condition, to identify when they need assistance and to seek it in a way which enable prompt support. • Provide information to support development of the models to support full implement of Better Care Together. • Improved case finding of patients likely to be admitted or to access social care services via emergency routes • Reduced non-elective admissions. • Improved self-management of conditions.
7	Review services for carers, in light of the increasing numbers of carers who will be eligible for carers assessments, and a develop programme for improvement	December 2014	• Improved support for carers • Reduced non-elective admissions • Reduced admissions to long term care.
8	Implement actions from the review of the Transitional Care OAMH/Dementia pathway	April 2015	• Improved support to patient who require access to services via the single point of access. • Improved flow of frail older people through the TCP, increased rates of rehabilitation • Ensure that those with dementia or older age mental health issues have access to the pathway and also flow through effectively.

9	Develop and embed frail elderly pathway within acute trust to link with Transitional care pathway	April 2015	• Improve care of patients within the acute hospital and greater emphasis on elderly care needs.
10	Re-commission of Community Equipment Services	June 2015	• Improved provision of community equipment to support reducing non-elective admissions and increasing discharge.
11	Review all equipment and aids and adaptations provision to ensure a smooth pathway.	June 2015	• Transform the provision of aids, adaptations and equipment.
12	Increase reablement capacity to ensure that reablement is the primary offer for everyone who can benefit, prior to commencement of a long term care package.	Sep 2015	• More streamline pathway through re-ablement services. • Reduced non-elective admissions • Reduced admissions to long term care. • Reduced numbers and size of packages of long term domiciliary care
13	Review access to, throughflow and usage of and capacity within recuperation and rehabilitation beds and recommission in line with predicted demand.	Sept 2015	• Improved flow of frail older people through the TCP, increased rates of rehabilitation • Reduced admissions to long term care • Reduced delayed discharges • Reduced lengths of stay
14	Develop plans for integrated bed and community based rehabilitation services	December 2015	• Explore plans to develop an integrated single site for all bed based rehabilitation services and link to community based therapy. • Enable discharge to assess principles to be embedded.

b) Implications for the acute sector

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

University Hospitals Morecambe Bay is currently experiencing severe financial issues. As a response to this and to ensure a sustainable health and social care system moving forward, the CCG, working with UHMB and Cumbria CCG, have initiated the BCT Programme. The thrust of BCT is to increase the management of people in the community and reduce the number of people who require hospital care, this will have a financial impact on the Acute Trust and will be managed via the BCT Programme. This programme has a full Programme Management approach and links to Monitor and the NHS England. The programme has reached the stage of producing a Strategic Outline Case (SOC) which will outline in detail the expected changes and new service models, the financial impacts across the health community and the full engagement

requirements. The timescale for production is June 2014.

The Better Care Fund as described above is a sub-set of the work on BCT and will therefore need to deliver a sub-set of these savings and impacts. Much of the work already undertaken in relation to the TCP has been focused on reducing avoidable hospital admissions however there is still work to be done to reduce the length of stay for those who are admitted, and also to reduce the numbers who stayed longer than necessary in hospital result in a residential stay.

c) Governance

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

The Lancashire HWBB will receive the completed plans for sign off in January after being presented at appropriate organisational committees, bodies. For the CCG this will be Urgent Care Board, Membership Council and LNCCG Governing Body and Cabinet for LCC.

Management of the plan will be through both internal and partnership structures as mentioned above. Chief Financial Officers will work together to oversee the financial elements of the pooled funding.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Yes the eligibility criteria will remain the same

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

Within the Lancashire North area, the County Council commissions and provides a range of adult social care services which, alongside a range of community health services in the area, support the overarching aim and objectives of the BCF. These services have been included within the BCF and partners have agreed that they will be protected, in line with their effectiveness in delivering the agreed vision, aim and objectives of the plan. Where local services, health or social care, are effectively supporting the delivery of the BCF, they will continue to be protected. However, where they are not, work to transform and redesign services will be undertaken jointly in light of the evidence from reviews of the services themselves, feedback from individuals and their carers, national research and best practice, alongside the JSNA and the existing commissioning plans of the partners.

b) 7 day services to support discharge

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

Partners are committed to developing integrated 7-day services which supports people to be discharged and prevent unnecessary admissions to hospital at weekends; this will be part of the wider 7 day structure which CCGs are expected to commission. A number of services have already been established to support this commitment such as the Rapid Response Service, REACT, District Nursing and Community matrons all of which have access to County Council funded Short Term Intensive Domiciliary Support 7 days per week. All new services which are developed will be considered as to whether they should have 7 day access. – in particular the integrated teams described above which will have 7 day working as part of their ethos.

The overarching intention of the areas as described above is to establish integrated working practices across health and social care. This will include further broadening direct access by health professionals to the full range of social care service, such as re-ablement which prevent admissions and support discharge. This will improve patient experience by reducing the number of hand-offs and will create efficiencies by eliminating duplication of assessments.

The area will work with providers of services such as reablement, rehabilitation beds and recuperation beds, to ensure their readiness to accept referrals 7 days per week.

The area is also looking to better integrate the use of technology into its working practices so that care plans are more widely available when people access care; particularly those who are the most vulnerable. We will be looking to ensure that the NHS 111 service and NWAS has access to the care plans for the most vulnerable so that if they call for help the information is readily

available, not only 7 days per week, but 24 hours per day.

c) Data sharing

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

Currently LCC do not use the NHS Number as the primary identifier as our current social care management system does not hold this number for a proportion of our social care service users. All NHS commissioned providers, where activity monitoring is required, are contractually required to use the NHS number as a primary identifier.

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

LCC are replacing their current system and implementing Liquid Logic Protocol, with a planned go live at the end of June 2014. As part of this implementation, LCC will populate all of the migrated service user records with their NHS number, via the NHS Spine, and implement a means to capture and populate the NHS number for any new service users.

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

LCC can confirm their commitment to the above and can ensure that they are up-to-date with current system integration approaches.

As a commissioner of NHS service the CCG are committed to assuring that all system specifications used by our providers, are in line with best practice and NHS standards.

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

LCC can confirm that they are committed to ensuring all appropriate IG controls will be in place. LCC are aware of all of the above requirements, we are making good progress in putting in place all that is required to attain a satisfactory accreditation against Version 11 of toolkit by the deadline of April 2014.
LNCCG can confirm that as part of the NHS contract all our providers conform to the NHS standard contract requirements.

d) Joint assessment and accountable lead professional

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

A number of actions are already in place to identify those at risk and provide support. Three years ago the UCN sponsored the development of a local Urgent Care Dashboard to identity those at risk of non-elective admission or excessive use of emergency services. This takes electronic feeds from a number of sources and Practices in conjunction with the cluster Community Matrons and Long Term Conditions Teams review the lists to identify those that can be supported differently.

The area has also recently developed an area wide end of life register and is using an electronic Palliative Care Coordination System (ePACCs) to enable practices to identify those who may be at risk of entering their last year of life – a factor that is known to increase use of emergency services if not managed. Practices have again been using this to identify these individuals and put in place anticipatory advanced care plans for end of life.

To build on these two services the CCG and Local Authority have identified that a step change needs to be made to identification of individuals by including social care risk factors in the feed. The organisations will work together on this.

Currently a lead professional the GP, community matron or end of life team will have responsibility for the individual The development of the team based approach described below will enable a more sustainable approach to this.

The long term vision of the area is that a Multi-disciplinary team will have responsibility for vulnerable individuals in a natural community. As such the range of professionals will be involved in the care – but as they will be able to commit resources from different providers then joint assessment will only be required when the skills and expertise of the individual can only be provided by that professional. In the majority of cases the most appropriate professional to assess the expected needs will undertake the assessment and care planning process with the person and their carers then liaise as part of an MDT process with colleagues as appropriate. Whilst the GP will maintain the Medical responsibility it will be expected that the most appropriate professional will be the key point of contact and the whole team will have access to the case information to enable 7 day support when required.

4) RISKS

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

Risk	Risk rating	Mitigating Actions
Strategic Risks		
Ability to maintain focus on this Fund whilst the larger goals of Better Care Together have greater resonance and greater impact.		Ensure that Better Care Fund is part of the Better Care Together Programme
That the agreement and process of the agreement become the focus rather than the transformational Change.	TBC	TBC
That Lancashire wide initiatives become the focus rather than the local community requirements.	TBC	TBC
The scale of change and interdependency of work streams could be overwhelming as all organisations manage a number of agendas.	TBC	TBC
Introduction of the Care and Support Bill will bring additional cost pressures to the system which are not fully understood at this time	TBC	TBC
Maintaining the integrity of the partnership, with competing financial pressures and performance indictors amongst the key partners, and a political agenda and context to change.	TBC	TBC
Operational Risks		
Funding within a variety of contractual arrangements that may reduce the ability to re-commission in a timely and effective manner	TBC	TBC
Operational capacity to maintain day to day integrity of the business, safely, whilst delivering change and new models of working	TBC	TBC
The scale of change and interdependency of work streams could be overwhelming at a time of reducing workforce capacity within the County Council and other providers	TBC	TBC
Integration of staff will require changes to working practices, education and training and appropriate educational packages etc may not be available.	TBC	TBC
Culture and development, professional boundaries and identities will be challenged.	TBC	TBC
Shift in emphasis to community care, wellness and prevention will not sufficiently impact on acute hospital activity	TBC	TBC
Lack of integrated IT infrastructure to underpin the changes in culture practice and shifts in activity will drastically reduce impact.	TBC	TBC