Local Government Association

NHS England

Appendix 'E'

Lancashire Health and Wellbeing Board
28th January 2014

Better Care Fund planning template – Part 1
East Lancashire Version 8: 21 January 2014

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	**East Lancashire CCG**
Boundary Differences	**The CCG is one of six CCGs within the Lancashire County Council area. The boundaries of ELCCG are aligned with five of the twelve District city councils in Lancashire (Burnley, Pendle, Rossendale, Hyndburn and Ribble Valley). The CCG has an acute provider that crosses both Lancashire and Blackburn Borough Council boundaries. The CCG main community provider sits within the neighbouring Blackburn 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	**£26,095,000**

Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

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

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	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

East Lancashire CCG and Lancashire County Council have been working collaboratively with local health, social care, statutory and voluntary providers and partners over the last 6 months on the development of an integrated care strategy, the development of a Pioneer Bid and subsequently as we work towards a new model of health and social care commissioning and delivery through service and system transformation.

However as we reflect on the current position, in order to deliver the ambitious scale and pace of transformation going forward, we must recognise that integrated working across providers and likewise commissioning bodies has been ongoing locally for a number of years.

There is in place a well-established Pennine Lancashire Integrated Care Delivery Group, with senior level representation from provider organisations. In addition, the local CVS and Healthwatch are represented on the East Lancashire Integrated Care Board.

Specifically in the development of the BCF plans, we collectively held a development session on 21st November 2013 with the aim of identifying priority areas for service transformation, using the BCF planning guidance as an enabler and facilitator to these discussions. The objectives were:

- Agree Vision
- Clarity on tasks needing completion – how do we achieve the vision over the next 3 months, 12 months, 2 years, 5 years
- Clarity on role and remit of the Pennine Lancashire Integrated Delivery Group including leadership, direction, key messages.
- Understanding of priorities and sequence of delivery
- Understanding of requirements of Integrated Transformation Fund (ITF)
- Identification of investment needed – resources, equipment etc

On 8th January 2014, a stakeholder event, including all local provider organisations, including the third sector, housing providers and district councils was held; the specific aim of which was to:

- To share Better Care Fund (BCF) initial plans with providers and third sector organisations
- To set strategic context regarding BCF planning process and timescales
- To receive feedback and input on initial plans
- To discuss opportunities for Accelerated Transformation
- To shape the finer detail of the plan working collaboratively with stakeholders

We have commissioned NHS IQ to run a change programme focusing on the development of integrated neighbourhood teams, this encourages active participation for the providers of services who will be responsible for ensuring successful delivery and establishment of the changing systems and services in practice. Health, social care and third sector providers have all been invited to participate and take up has been positive.

Over the last twelve months East Lancashire CCG and Lancashire County Council have jointly been working with local health and social care providers on the development of a Safer Transfers of Care (STOC) Programme, A project group was established with a dedicated programme manager hosted by the acute provider, using shared resource from health and social care. A STOC hub consisting of an Integrated Assessment and Allocation Team will support all people with a need to use short term health and social care services outside of hospital. The hub will oversee and flex the flow and capacity of the transitional system so that it maintains quick access to each element of the system and ensures that the system responds to pressures emerging in the wider health and social care economy.

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

In addition to the specific BCF stakeholder event on 8 January and the Patient Participation Group (PPG) and public event on 21 January, the CCG and LCC have implemented an ongoing coordinated programme of engagement with the public, patients and carers to influence their commissioning decisions and identify views on services on a regular basis.

Within the CCG, the 'Connect' soft intelligence gathering system and locality-based listening events have consistently identified that patients and carers would prefer care out of hospital and closer to home where possible. Hospital discharge, including appropriate

care packages, has also been identified as an issue.

Work though the Better Care Fund and ongoing Cases for Change will be part of the means of addressing these aspects of care delivery.

Communications and engagement are considered integral to the successful delivery of integrated care and the Head of Locality: Communications and Engagement sits on the Integrated Care Board and they liaise closely with their County Council colleague to ensure there are shared communications approaches. A detailed communications and engagement plan is one of the strategic priorities for the CCG during 2014 and beyond, incorporating a robust media strategy.

We will continue to use 'working together for change' principles to co-produce service developments and to review our progress and to understand the impacts on and experiences of people using services.

The development of our case for change for Integrated Care starts with the premise of the National Voices commitment to integrated care in that through our plans we aim from the perspective of the service user "to plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me."

On 21st January 2013, we held an event with representatives of all 62 patient participation groups (PPG), local carers groups and health champions for the elderly. The aim of the event was:

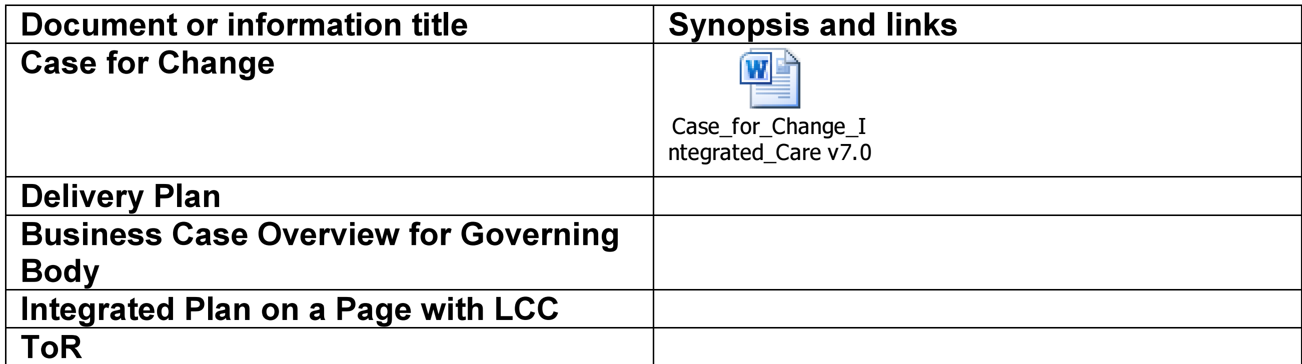
- To share East Lancashire Clinical Commissioning group (EL CCG) and Lancashire County Council plans for integration of health and social care
- To share the plans for delivery of health and social care "Out of Hospital"
- To receive feedback from the public on initial ideas including an update on Better Care Fund
- To discuss what "it" will look and feel like for you and your family
- To discuss current concerns and solutions
- To gain an understanding of what a 'good outcome' is for the residents of East Lancashire to start to firm up citizen defined outcomes as part of our plans

East Lancashire Health Watch are members of the East Lancashire Integrated Care Board, representing patient views.

As part of the patient engagement Direct Enhanced Service (DES) in Health, we are utilising the opportunity to ask patients specific questions in relation to what good quality of life means and what experiences are important to them linked to the development of integrated care and transformation of out of hospital services. This is aligned to National Voices recommendations and the early work regarding patient reported experience measures (PREMs).

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.

Need to include embedded documents.

Document or information title	**Synopsis and links**
Case for Change	 Case_for_Change_I ntegrated_Care v7.0
Delivery Plan	
Business Case Overview for Governing Body	
Integrated Plan on a Page with LCC	
ToR	

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?

Our strategic intention is to transform services to support the people of East Lancashire to live safely and live well. Integrated care is a means by which we can co-ordinate care around the needs of individuals in our community to enable our goal to be realised. Successful delivery of the integrated care agenda will reduce inappropriate demand, improve quality and productivity and increase utilisation of community assets.
Our vision is described from the perspective of a service user and is "to plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me."

East Lancashire is a diverse area but a majority of the areas have significant deprivation and poor health. Ribblesdale is different in its local demography, scoring higher on deprivation but with a significantly older population.

Ranked out of 326 Local Authorities on the Index of Multiple Deprivation (2010) – rank of average score with 1 being worst, East Lancashire ranks as follows:

Burnley – 11
Hyndburn – 34
Pendle – 33
Ribble Valley – 290
Rossendale – 98

And the ranking of All Age All Cause Mortality (2010-2012) with 1 being the best shows:

Burnley – 321
Hyndburn – 317
Pendle – 267
Ribble Valley – 111
Rossendale – 294

The consequence of this, is a larger than average proportion of people with multiple conditions and some of the highest rates of unplanned admissions to hospital in the country.

We are working in a challenging, emergent, and sometimes turbulent context. We need to be agile and adaptive regularly stepping back and scanning for new dynamics which have implications for the local health systems and the lives of our communities. It is clear that the reform and policy agenda presents challenges and ELCCG and Lancashire County Council are part of a wider system working to improve the lives of the people of East Lancashire. There are a number of organisations which commission services, a network of providers of services, and other organisations who play a key role in ensuring

the services provided meet local people's needs, in particular third sector organisations. We recognise the inter-dependencies of these organisations, and the need for all of us to work in a collaborative way whilst acknowledging each other's particular agendas.

We need to work with multiple tiers of local government beyond the County Council including the 5 borough councils of Burnley, Hyndburn, Pendle, Ribblesdale and Rossendale, as well as town and parish councils.

We have a direct part to play in terms of shifting the balance of spending between prevention, primary care, community care and secondary care. We must also challenge ourselves to seek out opportunities throughout every care pathway to build in prevention strategies. And we must 'put our shoulder to the wheel' alongside our partners to influence the wider determinants of health as part of our alignment with and contribution to the Health & Well-being Strategy.

The Lancashire Joint Strategic Needs Assessment (JSNA), and the Local Health Profile for East Lancashire, tells us a great deal about East Lancashire, particularly about the demographics of the local population and about their health needs.
The area is organised into 5 boroughs, and East Lancashire has 5 localities corresponding to the 5 boroughs, except for Ribblesdale where 2 GP practices in Longridge and their patients are part of Greater Preston CCG.

East Lancashire has an ageing population. At the same time, the number of children and young people in the population is higher than the England average, suggesting that we need to be aware of both ends of the age spectrum in commissioning services.
The majority of people in East Lancashire are white British, with a significant BME minority (11%), principally of South Asian origin, which experiences relatively high risk of certain common morbidities (especially cardiovascular disease and diabetes). The BME South Asian population makes up a disproportionate number of those living in the bottom 10% of deprivation, almost three quarters living in the most deprived areas of East Lancashire.

Relatively high levels of socio-economic deprivation in East Lancashire are linked to poor health outcomes. There is evidence that inequalities in the social determinants of health have widened over time.

A significant proportion of the people in East Lancashire experience poorer health than the average for the rest of the North West and England. Although residents live in a mixture of urban and rural settings many of the health, economic, social and educational problems are similar to those found in inner city areas.

Like people in the rest of the country, the health of the people of East Lancashire is affected by risk factors relating to lifestyle behaviours, including smoking, alcohol and drug misuse, diet and exercise.

The health needs of the people of East Lancashire are complex and challenging. The JSNA summary Health Profile for East Lancashire highlights that life expectancy in East Lancashire has improved, but there are wide health inequalities between East Lancashire and the national figure. This is driven by relatively high early death rates from the "big killers", CVD, cancers and respiratory disease, but also by a small number of deaths occurring at a markedly young age e.g. accidents, chronic liver disease, suicides and

infant deaths. Early deaths from cancer, in particular, make an important contribution to overall early death rates, and there is evidence that the local premature cancer death rate has increased over recent years. We also need to ensure that the focus is not simply on life expectancy. Quality of life is also important, and quality of life is associated with the absence of disease and disability. We also need to ensure that people with long-term diseases and disabilities receive the support and care that gives them the most quality of life possible.

The recently published King's Fund paper also summarises the national picture and further highlights the drivers for integrated care and significant service and system wide transformation::

- Over the next 20 years, the number of people aged 85 and over is expected to increase by 106%
- By 2030, the number of older people with care needs is predicted to rise by 61%
- By 2032, more than 40% of households are expected to be people living on their own
- The number of people living with dementia is expected to more than double over the next 30 years
- In the next 20 years, the number of people with some diseases is expected to double
- 58% of people aged over 60 have a LTC and people in the poorest areas have a 60% higher prevalence than those in the most affluent social class
- By 2018, the number of people with 3 or more long term conditions is expected to rise to 2.9 million (from 1.9 million in 2008)

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

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

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

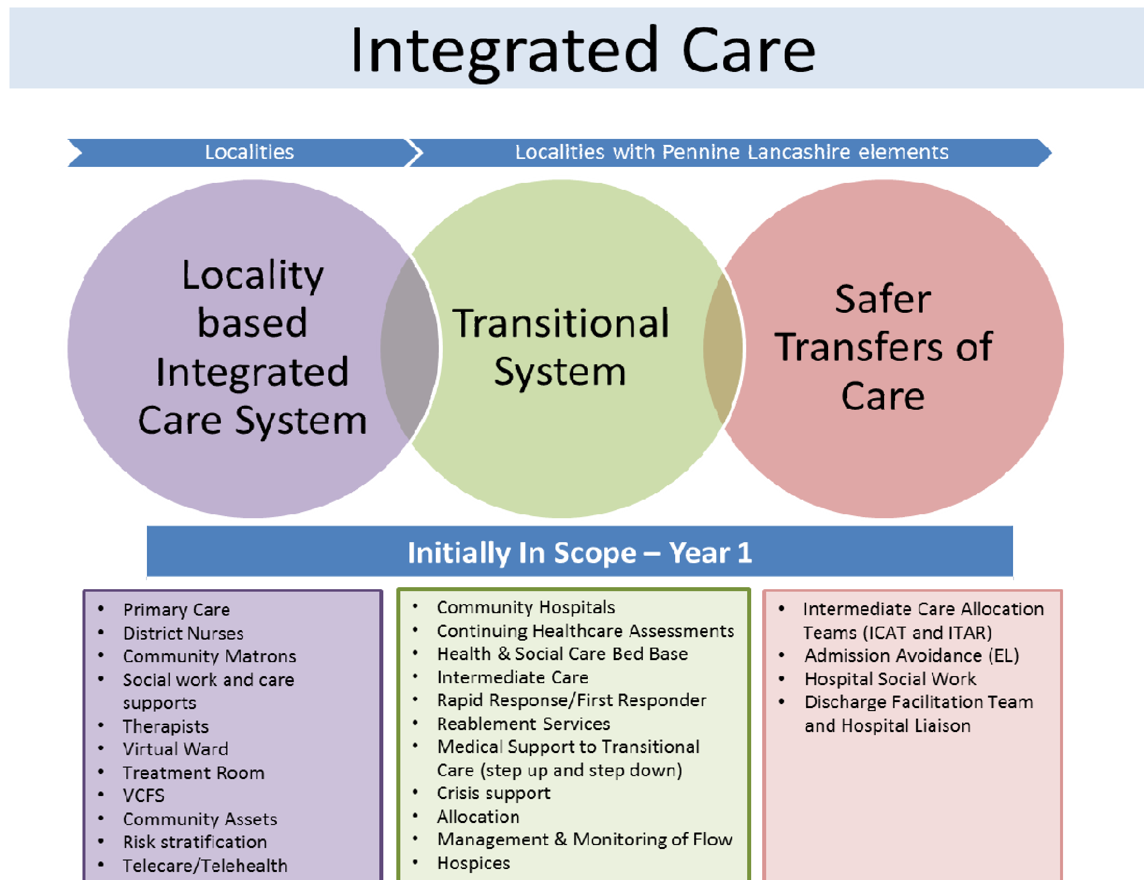
Given the complexity of the current pathways and service configuration, a phased approach will be taken to implement integrated care. The proposed timescales are:

- 2013-15 Long Term Conditions/frail elderly/those on End of Life pathway and high intensity users
- 2013-16 Mental health, substance misuse and learning disabilities

- 2013-17 Children and young people – including complex needs, early help and universal service provision

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

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



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

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

teams, working closley with providers across health, social care and the third sector.

The Community assets approach aims to revitalise how policy makers, commissioners and practitioners think and act to promote a more resourceful approach to tackling health inequities. Lancashire's Health and Wellbeing Board has identified a shift towards recognising and harnessing community assets as one of the 6 priorities 'shifts' in its Health and Wellbeing Strategy. If this is to be achieved a systematic approach to understanding the assets of communities in the county will be needed. Redressing the balance between the assets and deficit models for evidence based public health can help us to unlock some of the existing barriers to effective action on health inequities. This re-balancing helps us better understand the factors that influence health and what can be done about them.

Transitional System Review and Remodel (Right Care, Right Place, Right Time, First Time) It is our intention to re-balance community transitional support services and short term bed based services to meet a whole width of patient need and to ensure each individual is given every opportunity to recover and achieve their optimal level of independence, as well as being able to step up into the system to avoid an unplanned admission into hospital where an alternative exists. This will include the remodelling of Community hospitals, Intermediate Care, Crisis response provision, Re-ablement, end of life care, Take home and settle support and the use of Short term care placements. It is also recognised locally that there are both capacity and integration issues around community based short term and crisis support with multi-agency audits of the transfer system through point prevalence and perfect week studies highlighting patchy timely access into re-ablement and community therapy teams, as well as a lack of alignment of these services. This was also true of Crisis support for health and social care need, where a disconnect between a joint offer from these services has occurred. We will use the BCF to re-integrate and enhance the capacity of these community transitional and crisis service areas.

Integrate the existing assessment and transfer teams and develop one single assessment process through organisational co-production.
Assessment and discharge services are currently provided by a number of teams across five (ELHT, LCFT, CSU, BwD, LCC) organisations. These teams provide services for all age adults receiving assessment, allocation and continuing care and support services across Pennine Lancashire. The Safer Transfers of Care Programme will promote the integration of services across health and social care by creating a single assessment and transfer team. This team will facilitate discharge from and support admission avoidance to an acute setting and will be responsible for transferring a patient’s care to the most appropriate setting and monitoring the flow to the transitional system, including flexing the system at times of enhanced pressure.

Quality outcomes and patient experience to live safely and to live well

- **Co-production with the patient ‘no decision about me without me’** and more planned and systematic management of long term conditions

- **People first, partners will have joint ownership and accountability for enabling people, families and communities to have a good life of their choice, within the resources they have.** Strategic planning and delivery will be an inclusive process, utilising the commissioning process, for a whole population,

with effective utilisation of all the resources, across the community, to shift culture, behaviour, practice, spend and activity, that is sustainable now and for the future, to address the demographic needs going forward. Local Health and Wellbeing Partnerships will be the host to strategic planning forums with robust governance and risk share agreements, focussing on whole population, pre-birth to end of life.

- **Everyone has a bed – it is in their own home, People expect to receive care and support close to their home.** We will shift culture, behaviour, practice, activity and spend to ensure sustained reduction in acute admissions, length of stay, readmissions within 30 days, readmissions within 6 months and reduced episodes of end of life in acute settings. (do not be specific on bed reduction – need to do Capita modelling first) We will see effective utilisation of community assets and universal services delivered by the third sector as part of a wider offer to keep people stable, safe and well. The Accident and Emergency and Urgent Care centres will be fully integrated into the whole system approach, achieving effective diversion of people to appropriate and safe community resources and achieving 95% This will be supported by the development of primary care to provide 7 day access, meaning that the UCC and ED will concentrate on patients who need immediate medical treatment. We have commenced the colocation of primary care with UCC and ED at RBH and this will be rolled out to Burnley when the new UCC opens at the end of January. With a 4 hour wait target for those people needing A&E resources.

- **No person will need to make a decision about long term care and support in a hospital bed.** We aim to significantly reduce admissions to long-term residential care by 2018 by offering time and opportunity to people to recover, recuperate and maximise their life opportunities following an acute illness or life crisis, through person centred re-ablement, planning and support, away from the acute hospital bed.

- **Discharge to Assess not Assess to Discharge** We will have fully integrated seven day services and support, across acute and community services, with flexible capacity to support people outside the acute hospital setting who need further specialist assessment and or assessment for continuing health care. People with very complex needs including Dementia will have an equal consideration of their interests and the same offer of recuperation, reablement and person centred planning in the best and least restrictive environment.

- **People will receive seamless care and support, regardless of the number of clinicians or practitioners involved in their life** Every person who requires on-going support following an acute admission or crisis in their life, will have a core personal profile that will be visible and accessible to acute and community clinicians, that will be a nucleus live document that keeps people safe and well, informs safe and effective clinical decision making and informs further specialist assessment and joint health and social care support planning.

- **People will be supported to stay connected with local family and community networks and resources that keep them safe and well** Through effective local area coordination as an integral part of neighbourhood teams, local community assets and third sector through development of community assets and building

individual resilience capacity will have a focus on keeping people safe and well, through linking and connecting people with what they need, as part of their support plan. There will be an increased focus on people who are at 'tipping points' in their life, so not yet needing statutory offers, but at risk in the near future. There will be an increase in using the core personal profile for those people identified, this will prevent and delay the demand on statutory services for both health and social care.

- **Resources, including third sector support organisations and community assets will be wrapped round local GP surgeries and coordinated through integrated neighbourhood team arrangements.** There will be 10 neighbourhood teams organised round local clusters of GP surgeries, using risk stratification that identifies vulnerable individuals and families, integrated case management, self-care and local area coordination. The neighbourhood teams will include a wider social care offer including the third sector and a model of local area coordination, which will support those most at risk of hospital admission and those at tipping points, with a wider focus on whole population and wellbeing. There will be effective IT infrastructure supporting the core personal profile, specialist assessment and care and support planning across both acute and community services. There will be live and accessible capacity and demand management, with both acute and community resource capacity and utilisation live and accessible to all acute and community clinicians, 7 days 365 days a week. Here will be a multiple access point to coordinate access to the wide range of resources, with delegated authority to an agreed range of acute and community clinicians and practitioners, to avoid unnecessary hand offs. We are also looking at more comprehensive data-sharing opportunities with other sectors such as the Third Sector and the Fire and Police services that will help us proactively work with vulnerable people in the community. There is a common agenda in this work for a number of statutory agencies and we are working with areas such as Cheshire and Merseyside who have found the mechanisms to share health and mosaic data and use the trusted brand of the Fire Service to connect with the vulnerable people identified directly, offering prevention packages of support.

- **We will pro-actively manage capacity and demand as one community of partners, utilising combined resources to ensure right support in the right place at the right time, 7 days a week, 365 days a year.** We will have an integrated allocation system, which will co-ordinate the transitional response system, understanding and predicting peaks in demand or pressures building in the system, facilitate live and accessible capacity and demand to inform day to day and strategic management of the combined resources across the community. Resources will be deployed flexibly to meet existing and predicted future demand, maintaining safe and effective levels of capacity across the community and acute services, which maintain the ambition and vision of partners

- **People will be supported to access housing options, aids, adaptations and equipment to ensure that they can remain living in their own home as safely and independently as *possible*** we will continue to work together with the five district councils in East Lancashire (as the statutory housing authorities) to develop the delivery of a full range of aids and adaptations through aligning disabled facility grant processes within the wider system to support independence and improve the outcomes for service users. We recognise the NHS England

Planning Guidance in this respect and we will have jointly developed plans that address integration, delivery and equity geographically across the County, as covered by the responsibilities of the Health & Wellbeing Board.

- Individually designed patient centred outcomes for each person and their carer(s) will be the norm
- Improve patient access and experience through developing 7 day working where appropriate
- Promotion of prevention, self-care, self-management and early intervention
- Achieving an optimal level of independence for each patient
- To use a multi-disciplinary case management approach for those deemed most at risk with a lead accountable professional to reduce avoidable deterioration and unplanned admission
- Remodelled transitional support services to meet a whole width of patient need and ensure people are given every opportunity to recover
- Exclusion from Rehabilitation and Recovery support should be by exception only (i.e. when there is absolutely no prospect of recovery)
- Delivery of services should always be planned to be as close to a person's home as possible.
- All planning should be made with an emphasis on maximising each individual's level of independence.
- No decision on long term care should be made without first maximising a person's recovery.
- Meeting patients and families preferred place of care at End of Life

For the individual, integrated care will mean:

- **I have access to good information and advice and the opportunity to access local resources that help me live more years without ill-health, pain, stress or anxiety.** Through our pathfinder neighbourhood teams, we will develop a form of local area coordination that brings together numerous resources directories and community asset mapping, that support active and healthy life styles through community connecting and participating. People and their families and carers will be connected with local groups and assets and have a link with the wider neighbourhood team as and when they need it.
- **When I have a period of ill-health or receive a diagnosis of a condition that is likely to affect me for the rest of my life, I can access timely information and advice that keeps me in-control of decision making.** People will have a support plan that is clear about the things important in their life that keep them safe and well and how they access those key supports. Through the urgent care work

streams this will be enhanced by the development of care coordinators and a single care record visible and accessible 24 hours 7 days a week by the wider neighbourhood team and acute teams, that will maintain the integrity of their plan, keep them safe and well in their own home for as long as possible and inform any further specialist assessment or support planning in the future.

- **I am supported to understand and manage my health and wellbeing to the best of my ability.** Through the current programme of work and implementation of neighbourhood teams, self-care is being developed, including the ability to harness local community assets and resources as part of the self-care offer. The single care record will have a profile, that enables people to keep safe and well and will also inform what he may need when things change. A care coordinator will act as a first point of contact to the wider neighbourhood team offer. We will look at the development of on-line resources that will support self-care including videos and game-type programmes that will offer day to day instruction and guidance, as well as making self-care an enjoyable exercise.

- **When I wish or need, my carers (families, friends and supporters) will be included in plans for my care and supported to have the knowledge they need to help keep me and them well.** We will continue to develop access to independent support planners, circles of support and advocacy to enable people to develop their plans with a range of people and support of that they choose.

- **I can stay connected with families, friends and local community networks that help keep me safe and well.** Through our early pathfinder neighbourhood teams, we will develop a form of local area coordination that brings together numerous resources directories and community asset mapping, that support active and healthy life styles through community connecting and participating. People and their families and carers will all been connected with local groups and assets, which will increase their social networks and ability to be seen and heard in their local community.

- **When things change or deteriorate i will have a backup plan that keeps me safe and living in my own home wherever possible.** A person's support plan has a contingency plan that is used to prevent admission to acute hospital or support early discharge, this offers flexibility to increase support for a period of time until things stabilise or support discharge home.

- **If I need to spend time in an acute setting, I know on the day of admission when I can expect to be back home, which will be as soon as possible, with no unnecessary delays.** Through the existing work streams there will be a principle of discharge to assess and no person will make a decision about long term support in an acute setting. The goal will be for sufficient capacity to be commissioned to support both of those principles and ensure people can return to their ordinary residence or a preferred housing and support offer.

- **I am seen for the individual I am, with all of my gifts, talents and inner resources and not as a set of needs or conditions.** The single care record will be the nucleus document used by both community and acute staff, that will focus on the person, enable the person to only have to tell their story once and enhance safe and person centred clinical decision making.

- **I live safely and securely in my home.** quick and safe utilisation of equipment in the family home maintained will main a person's wellbeing and the families' dignity and capacity to cope. Assistive technology will be used as part of a person's support plan, supporting safe and positive life opportunities within the extra care housing scheme.

- **After a short time in hospital I had time to recuperate and receive further support, away from the hospital, with time and emotional space to make decisions about my future care, support and living arrangements.** The new ways of working at the heart of our vision will enable people to have the right care and support needed and deserved. In 2018/19 that offer will be the norm, not the exception.

b) Aims and objectives

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

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

Our aim is to create the circumstances and environment for people, families and communities, to have the best life they can within the resources they have. To achieve that aim we have indentified **High Impact Changes** that will enable us to strategically plan and deliver;

- **Whole system transformation-** wider ambition to strategically plan and deliver for individual, family and community, that shifts culture, behaviour, proactive, activity and spend to a wellness and proactive model, harnessing all the available community resources and assets, including people and families as partners and their best asset. Commissioning for a community through co-production and using Health & Wellbeing Partnerships as a vehicle for delivery.
- **Whole system integration –** people will see one service, seamless care and support. Services and supports will be accessible and operational **7 days a week, 365 days a year.**
- **Whole system capacity and demand management –** flexible utilisation of resources on a day to day basis and strategic planning based on predicted future demands
- **Effective Emergency care as part of wider whole system approach-** simple seamless service that will support principles of right support right place and at right time, effective emergency care navigation and supporting environment to achieve fully integrated urgent care service within wider context of neighbourhood teams.
- **Step up / down –** discharge to assess not assess to discharge. No person making decision about long term support needs in an acute hospital bed. Flexible range of integrated services and supports to meet capacity and demand day to day and future predictions, which reduce delayed transfer of care, admissions, length of stay and admissions to residential care homes.
- **GP led Neighbourhood Teams-** services and supports wrapped round local cluster of GPs including third sector and wider community assets delivered through local area

coordination

- **Integrated care management and case finding-** focus on supporting people in their ordinary residence, maintaining and developing local community networks,
- **Ambulatory Care-** a sustainable, systematic, integrated and personalised approach, linking to wider whole system transformation and neighbourhood teams, shifting activity away from acute setting to the community.
- **Personalised care and support -** people first, individual capacity, resilience gifts and talents respected and included in the ongoing care and support, complementing clinical interventions. Core Personal profile will be nucleus single document supporting personalised care. Keeping people **safe** and well, regardless of where the person is receiving care and support, will be owned by all clinicians, practitioners and support workers.

We will expect to see shifts in culture, behaviour, activity, spend and improved reported experience and outcomes.

To **measure** the intended aims we will need to cross reference a range of information, from multiple sources and multiple organisational form, that must include the **person, family, community and organisational** need and experience.
We will need to cross reference key performance and activity data with actual impact on individual experience, key health and wellbeing measures for the population and the respective organisational key performance indicators.

This will need significant IT infrastructure that will support both the recording and collection of key information, into one place, in order to analyse and monitor the impact.

This will need to be achieved across the whole community and the whole system of integrated working, at the same time, given the high level of interdependency on a number of key work streams.

We will use a person centred process 'Working Together for Change' to fully understand the impact on people, families, communities and clinicians, that is real and meaningful. We will also use the local 'I' statements as themes within the 'Working Together for Change' process, to ensure the integrity of our vision is a reality for people, families, communities and those working in the system.

c) Description of planned changes

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

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

To achieve our vision and ambition we our advocating not just a new fully integrated service across what is traditional health and social care activity, we believe there is a need to fully transform the whole system, that is about whole population, wellness and prevention. This requires a significant shift in culture, behaviour, practice, activity and spends for people, families, communities, practitioners, clinicians and organisations.

We believe that our GP practices will be at the nucleus of the transformational change, however it is fully recognised that our success is totally dependent on our ability to co-produce and create the new ways of working and being across all partners, including the Third Sector and local communities.

We will need effective governance and risk share arrangements that maintain the integrity of the vision and keep respective organisations safe.

We have an established a Pennine Lancashire Clinical Transformation Board, that owns the vision and oversees key work streams to achieve the high impact changes, on behalf of each partners organisation. There is a strong link between the Pennine Lancashire Clinical Transformation Board and the Lancashire wide Health and Wellbeing Board. There is local engagement with local Health and Wellbeing representatives on the Pennine Lancashire Clinical Transformation Board who take ownership of respective organisational governance and decision making.

There is a commitment to use the commissioning process, collaboratively, to strategically plan and deliver for the population needs identified.

There is a commitment from the CCG and County Council to work in partnership, with the Local Area Team, Provider organisations, including district Council partners and the local third sector, to co-produce and implement the agreed commissioning intentions.

We will use the **BCF** to accelerate our existing high impact work streams;

- **Safer Transfers of Care**
- **Access and Flow**
- **End of Life Care**
- **Transitional Care**
- **Housing support and developments**
- **Support for Carers**
- **Development of Community Assets**
- **Care Home Improvement**
- **Access to technology**
- **Mental Health & Dementia**

We will focus on several key developments that will fully support our 9 high impact changes, these will include using the **BCF to;**

- Develop a fully integrated 7 day 365 days a year Safer Transfers of Care Hub, linked to wider development of neighbourhood teams.

- Through the development of care home improvement teams, identify pro-active support for residential and nursing homes.

- Scope and remodel (and or re-commissioning) existing Crisis, reablement, rehabilitation offers (domiciliary and bed based), jointly commissioned as part of a wider fully integrated 7 day service, supporting effective admission avoidance and discharge. 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. 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.

- Scope and Jointly remodel (and or recommission) existing investments in Third sector preventative services to maintain the Local Area Coordination offer, supporting neighbourhood teams, self care, case monitoring and asset based community development. Include current non recurrent funding of Dementia advisors and Stroke Advisors.

- Scope and Jointly develop framework agreement for residential and nursing care that supports neighbourhood team and admission avoidance and discharge activity. Develop single GP practice link for residential and nursing homes.

- Scope and Jointly remodel (and or recommission) range of carer support services to maintain and or increase offer to carers, including 'Peace of Mind for carers.

- Scope and jointly identify joint commissioning of existing LCC community Brokerage model to include provision for supporting health personal budget activity (CHC).

- Scope and jointly commission person centred 'End of Life' care and support that enables people to die in the place they choose.

Integrated Quality Improvement

Increasingly, some of the most vulnerable people with the most complex needs live in our communities in care homes, and it is essential that they are considered as part of the that 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.

We 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.

Care Home owners report that they often receive conflicting messages about best practice and pathways and there is an opportunity to properly agree these across provider managers, clinicians, commissioners and regulators.

There is an 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.

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.

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.

- 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

- 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.

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

The suggested **Time Line** of activity is;

January – April 14

Complete scoping and business cases on high impact changes identified, which will in turn inform specification and expected impact and outcomes of proposals above.

May 14 – October 14

Complete remodelling and re-procurement activity on proposed activity

November 14 – March 15

Transition phase for new service developments, firming up impact and outcome measures, collection and analysis.

Planning first 'Working Together for Change events' for June 15.

Cross reference impact and outcome measuring with wider system high impact changes.

Clarify phase two for BCF, pool budget arrangements and governance for April 2015.

In Year 2, we would expect to see:

- Fully operational neighbourhood teams established across 10 East Lancashire neighbourhoods, including mental health provision and operating through a care co-ordination approach utilising a shared electronic record
- A Safer Transfers of Care hub, co-located and responsible for allocation, assessment, discharge and case management of all complex patients into and out of transitional services, collaboratively managed by health and social care teams
- A new model for provision of community bed based care
- An enhanced crisis care system and an extended reablement offer linked to therapies, delivered on a neighbourhood based approach
- A full commissioning framework to support delivery including service specifications, performance management framework and project plans to support implementation in year 2 following learning in year one.

d) Implications for the acute sector

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

NEO SORT TARGETS

There are several significant work streams that are interdependent and together, will achieve **by 2018;**

The ambition for East Lancashire Hospital Trust (ELHT) is to deliver a range of services across the sites with Blackburn being a major Trauma centre and Burnley developed as an Urgent Care Centre'.

The expected shifts in activity are;

- diversion rate from existing A&E attendance base line
- reduction in admissions from top 10 Ambulatory care sensitive conditions, from existing base line
- reduction in average length of stay, from existing base line
- reduction in delayed transfer of care from acute hospital, from existing base line
- reduction in acute admissions

We are currently working with CAPITA to scope our future requirement for both Acute bed provision and wider bed-abased Transitional (Intermediate) care services. This will

scope the re-configuration of our Community Hospital and Intermediate care resources as well as helping us shape the collective ambition the system can share in reducing the size of the acute bed base in the longer term.

However there will also need to be an increased capacity in community and Primary care to sustain the required shifts in activity, with an estimated 25% further investment in crisis, reablement and rehabilitation services

There will need to be further investment in Primary care, as more complex and vulnerable people are supported in the community. However, a significant element of the development will also result in current acute based services moving to a model of delivery in the community, as well as working in innovative and new ways. East Lancashire has already tested or aims to imminently test this approach through a number of innovations and pilots, including:

- The Airedale Telehealth programme
- The Community Diabetes service
- Medical support to Intermediate care
- Early supported discharge for Stroke
- Virtual Ward

Workforce:

We recognise that this also includes the need to invest in a new evolving workforce, based on the cultural and practice shifts required over the next 5 – 10 years, we have started discussions with providers around this.

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.

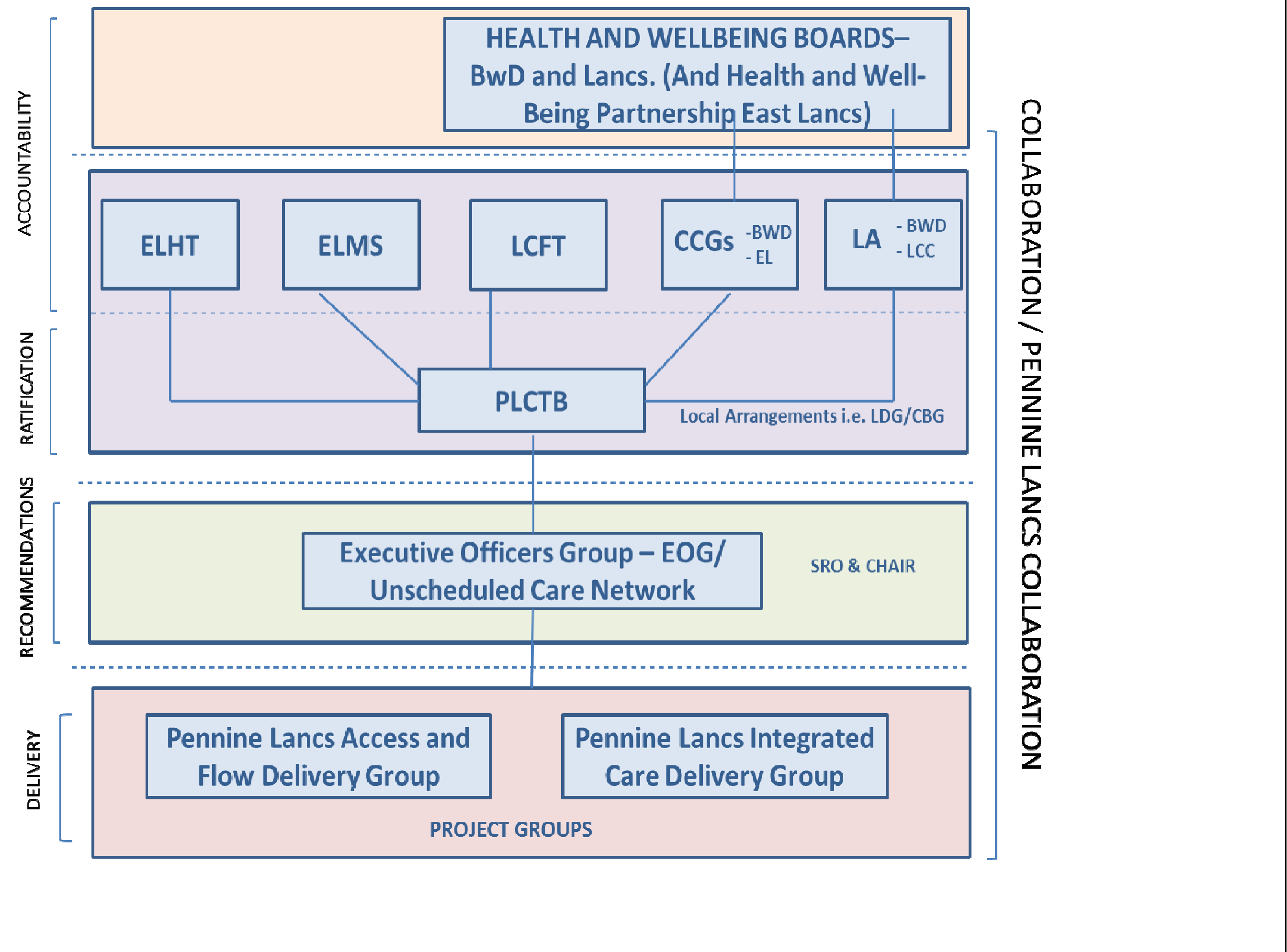
Collaboration

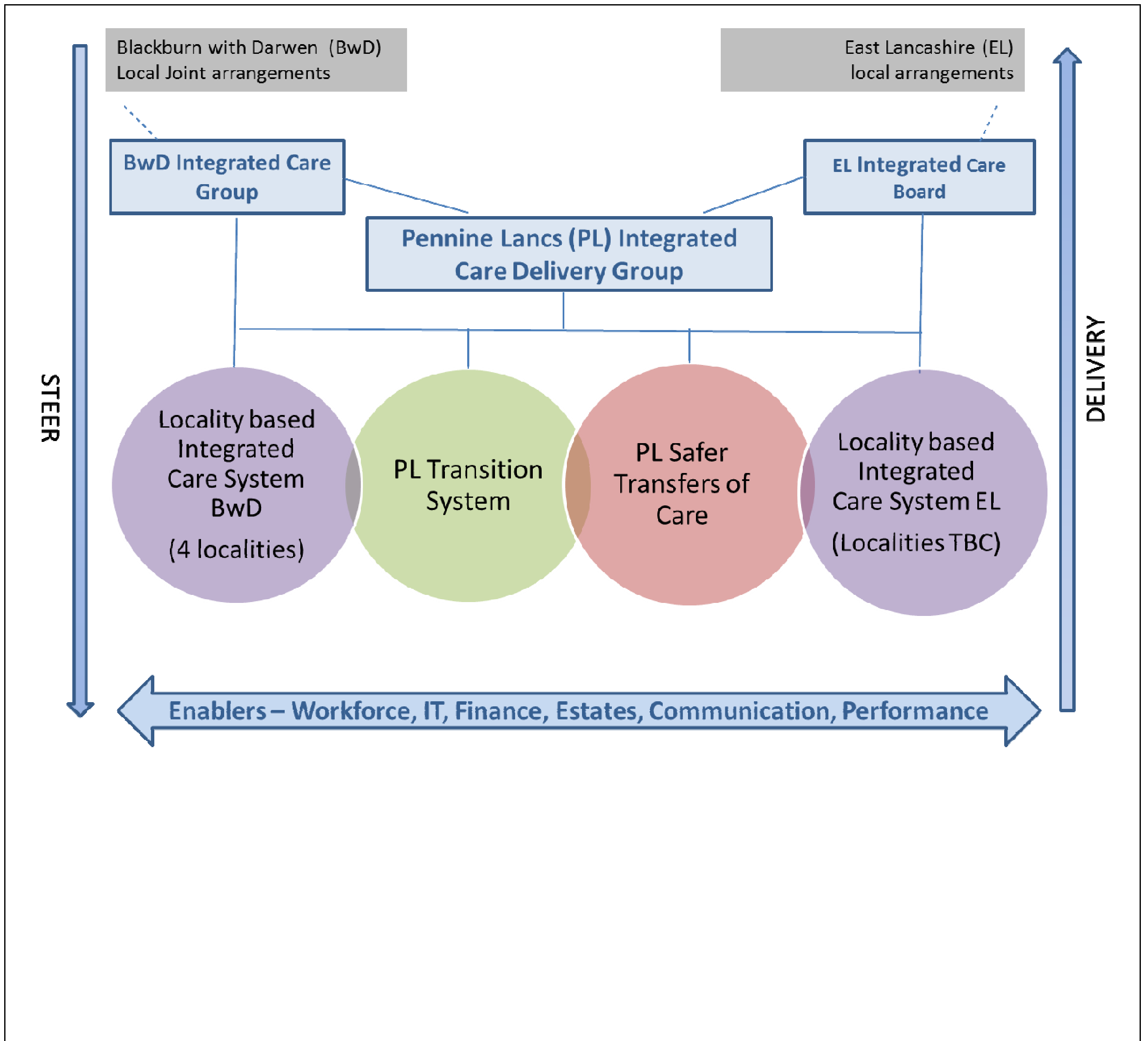
The other further discussion with acute providers has been around developing alliances with other independent and third sector providers to deliver both wider pathways and collaboration within different cost envelopes. Examples of this have already included work with 'Pumping marvellous' around CVD, The Alzheimer's Society around Dementia Advisers and the Stroke Association within the stroke pathway.

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

Programme governance
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 the Local Delivery Group , East Lancashire Integrated Care Board 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.




Blackburn with Darwen (BwD)
Local Joint arrangements
East Lancashire (EL)
local arrangements
BwD Integrated Care Group
EL Integrated Care Board
Pennine Lancs (PL) Integrated Care Delivery Group
STEER
DELIVERY
Locality based Integrated Care System BwD
(4 localities)
PL Transition System
PL Safer Transfers of Care
Locality based Integrated Care System EL
(Localities TBC)
Enablers – Workforce, IT, Finance, Estates, Communication, Performance

3) NATIONAL CONDITIONS

a) Protecting social care services

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

The eligibility for Adult social Care will remain the same, however focus will shift to providing more intermediate care services and preventative services which are not subject to the Councils fair access to care eligibility criteria or the councils charging policy.

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

Within East Lancashire the County Council commissions and provides a range of adult social care services which, alongside a range of community health services in the area, 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. There is an intended shift in investment to grow those services, health or social care that effectively supporting the delivery of the BCF. However, where services are not delivering expected outcomes work to transform and redesign services will be undertaken jointly in light of the evidence from reviews of the services themselves, feedback from individuals and their carers, national research and best practice, alongside the JSNA and the existing commissioning plans of the partners.

b) 7 day services to support discharge

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

Partners are committed to developing integrated 7-day services which 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 Virtual Ward and ICAT. All new services which are developed will be considered as to whether they should have 7 day access. – in particular the integrated teams described above which will have 7 day working as part of their ethos.

The overarching intention of the areas as described above is to establish integrated working practices across health and social care. This will include further broadening direct access by health professionals to the full range of social care service, such as re-ablement and crisis support which prevent admissions and support discharge. This will improve patient experience by introducing the concept of a single named professional

and will create efficiencies by eliminating duplication of assessments.

The area will work with providers of services to develop community based responsive services that are able to accept referrals 7 days per week.

The area is also looking to better integrate the use of technology into its working practices so that care plans are more widely available when patients access care; particularly those who are the most vulnerable. We will be looking to ensure that the NHS 111 service and NWAS has access to the care plans for the most vulnerable so that if they call for help the information is readily available, not only 7 days per week, but 24 hours per day.

c) Data sharing

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

Currently we 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.

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

We are replacing our current system and implementing Liquid Logic Protocol, with a planned go live of the end of June 2013. As part of this implementation, we will populate all of the migrated service user records with their NHS number, via the NHS Spine, and implemented a means to capture and populate the NHS number for any new service users.

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

We can confirm our commitment to the above and ensure that we up-to-date with current system integration approaches.

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

We can confirm that we are committed to ensuring all appropriate IG controls will be in place. We are aware of all of the above requirements, we are making good progress in putting in place all that is required to attain a satisfactory accreditation against Version 11 of toolkit by the deadline of April 2014.

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

The long term vision of the area is that Integrated Community teams will have responsibility for vulnerable patients in a within a defined geographical this named person will support the individual both within the community and throughout any acute episode. 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 patient 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
<Risk 1>	TBC	TBC
<Risk 2>	TBC	TBC
<Risk 3>	TBC	TBC
<Risk 4>	TBC	TBC

We have completed a broad risk profile for integrated care which will be further developed for inclusion.