Better Care Fund Planning Template
DRAFT version 2

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lancashire County Council**
Clinical Commissioning Groups	**Fylde and Wyre CCG**
Boundary Differences	For the Local Authority Fylde & Wyre area there are 2 GP practices in the Cleveleys area whose responsible commissioner is Blackpool CCG and 1 GP practice in Great Eccleston whose responsible commissioner is Greater Preston CCG.
Date agreed at Health and Well-Being Board:	
Date submitted:	28th Jan 2014
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**(proposed) £10,295.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**(proposed) £10,295.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Fylde and Wyre CCG
By	Tony Naughton
Position	Clinical Chief Officer Fylde and Wyre CCG
Date	21st January 2014
Signed on behalf of the Council	Lancashire County Council
By	Cabinet Member to be Confirmed
Position	Lancashire County Council elected member
Date	
Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	
Date	28th January 2014

Background information

The Fylde Coast Unscheduled Care Strategy (2012) and the Fylde Coast Intermediate Care Review (2013) are both key drivers for developing a transformed health and care economy for Fylde and Wyre. Partners have and continue to be fully engaged in developing and delivering these strategies via the long standing Fylde Coast Unscheduled Care Board and Fylde Coast Commissioning Advisory Board. Fylde and Wyre CCG, Lancashire County Council, Blackpool CCG, Blackpool Council and Blackpool Teaching Hospitals Trust are working together, alongside other stakeholders to ensure that the work streams resulting from this strategy that person-centred, transformational change is delivered. Partners believe that the developments within urgent and transitional care will form a sound basis to the longer term transformation that will be delivered by the Better Care Fund (BCF). More recently the development of the soon to be published Fylde and Wyre CCG Health & Care Strategy (2030) has seen engagement with Wyre and Fylde District Councils, Third Sector providers and members of the public in order to ensure opportunities for integrated working to benefit and meet the needs of our citizens are maximised.

c) Service provider engagement

The Adult Social Care Service provider forum in January received an update on the ongoing development of the BCF plan with an opportunity to comment and contribute. A Fylde and Wyre BCF engagement group (with particular focus on impact on and interdependencies with Blackpool Teaching Hospital Acute and Community) has been established with monthly meetings. Discussion includes progress to date and opportunities for integrated approaches between Fylde and Wyre CCG, Blackpool CCG, Lancashire County Council, Blackpool Council and Blackpool Teaching Hospitals. The BCF has been a featured agenda item on Fylde Coast Commissioning Advisory Board and Fylde Coast Unscheduled Care Board since August 2013 both of which have members from major Fylde Coast urgent care providers. A Health and Care Strategy (2030) engagement event was held in October 2013 and attended by all key stakeholders, including providers from both statutory and third sector representatives. Opinion on future service provision was gleaned and has since been collated to form the basis of both the Better Care Fund and Neighbourhood model development. To support the development of Fylde and Wyre CCG's commissioning intentions; two stakeholder engagement events have been held with representatives from Healthwatch and other Third Sector provision invited to attend. These commissioning intentions are identified in the planned changes section, later in this document.

d) Patient, service user and public engagement

Patient, service user and public engagement has been a key feature of work to support development of the Fylde Coast Unscheduled Care Strategy which forms the foundations of the planned transformation.

As part of the recent development of the Health and Care Strategy 2030, the CCG has to date held six focus groups with the public, with more planned at the end of January 2014. Insight from these will directly inform the strategy. In addition, commissioners have actively incorporated feedback into the commissioning prioritisation process and will continue to engage with individuals on an on-going basis. Further public and partner engagement work to inform Health and Care Strategy (2030) is planned in January, February and March 2014, including a representative telephone survey of 1,000 people living in the area. This survey, being undertaken by Ipsos MORI on the CCG's behalf, will also seek opinion about how people use services, patient choice and people's communications preferences.

To support the development of next year's commissioning intentions, which are incorporated in the planned changes later outlined the CCG has held two stakeholder engagement events. Approximately 40 people attended each session, including representatives from the GP Practice's public and patient engagement group. In addition a commissioning prioritisation panel with patient representation was held to assess proposals for these commissioning intentions.

The CCG has been actively developing its public and patient membership programme, the Affiliate Scheme, and now has 840 members who are contacted to support the CCG to develop plans and services. Members have received updates from the CCG, and attended focus groups contributing to the development of the CCG's draft Health and Care Strategy 2030. A programme to increase participation for affiliate members is being developed including a newsletter, further focus groups and health champion roles. In addition to this, the CCG has supported practices to develop patient participation groups, with 19 out of 21 practices now involved.

A summary of this plan has been shared with the Lancashire Carers Forum for comment and feedback prior to submission.

e) Related documentation

Document or information title	**Synopsis and links**
Review of Crisis, Rapid Response, Intermediate Care, Rehabilitation and Re-ablement For Older Adults in North Lancashire	This report outlines the findings of the Review for Older Adults in North Lancashire (Wilby et al 2010) commissioned by NHS North Lancashire and Lancashire County Council. The recommendations of the report provided the foundation's on which the Fylde Coast Unscheduled Care Strategy and Work streams are built.  older people's rehabillitation
H&C Strategy	To be embedded by 14 Feb 2014
Project Plan	To be embedded by 14 Feb 2014
USC Strategy	To be embedded by 14 Feb 2014
Benchmark Fylde Coast Intermediate Care Review	To be embedded by 14 Feb 2014
Benchmark review of Fylde Coast Discharge Pathway	To be embedded by 14 Feb 2014
HWBB Strategy	http://www.lancashire.gov.uk/corporate/health/index.asp?siteid=6715&pageid=40274&e=e
End of Life Care Strategy 2008	 EOL Care Strategy July 2008.pdf
Lancashire County Council Adult and Community Services Commissioning Intentions	 FINAL Commssioning Intentions 2012-2015

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
JSNA profile	To be embedded by 14 Feb 2014
FYLDE & WYRE CCG FOCUS GROUPS	Questions for F&W Focus Groups 22.11.1 Results to be embedded by 14 Feb 2014

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.

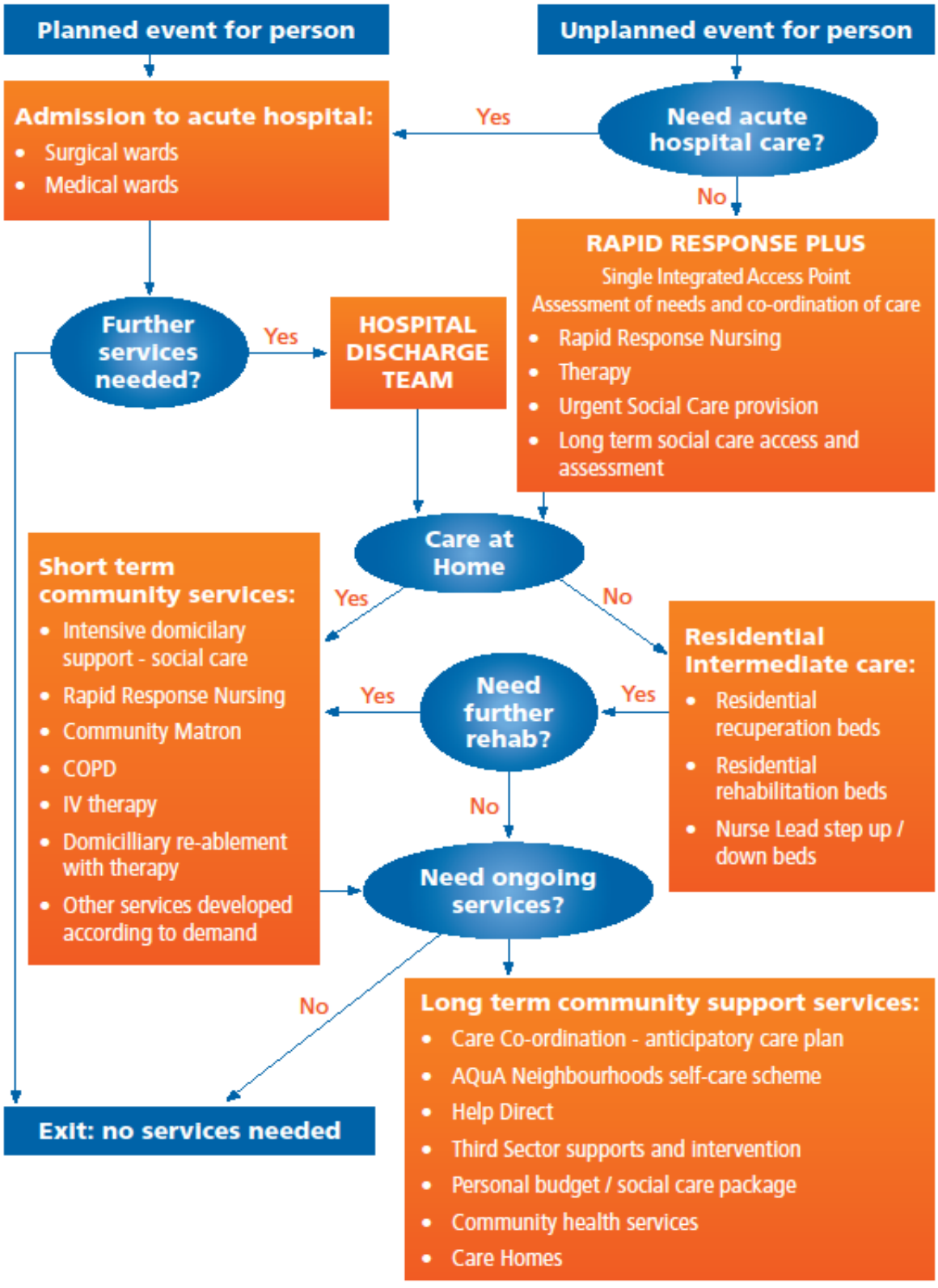
- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The population of Fylde and Wyre will receive the right care, in the right place, at the right time that promotes self-care and faster recovery from illness enabling people to live as independent and productive a life as possible within their local community. This will be delivered through person centred integrated services that follow clear pathways of care that have a single point of access and are supported by compatible connected information technology.

Fylde and Wyre CCG (through its predecessor organisation North Lancashire PCT and the Wylde Practice Based Commissioning Group) 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 2009 when the health commissioned Rapid Response Nursing 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 the joint commissioning of the Transitional Care Pathway, in particular the Rapid Response Plus service, which is a multi-professional integrated team, the Intermediate Support Team (IST) which supports patients with dementia and is again multi-professional and integrated. Other examples exist around Community Equipment, Mental Health Services and Learning Disability Services. The CCG can demonstrate its commitment to prevention through a proactive approach through its development and implementation of the Advancing Quality Alliance (AQuA) Neighbourhood Integrated Self-care model. This targets those patients deemed to be at risk of becoming high dependency users of services and offers proactive support to promote management of their long term conditions.

The current Fylde and Wyre Unscheduled Care Pathway is outlined in the diagram below

Fylde and Wyre Unscheduled Care Pathway



The shared vision for end of life care is to ensure that high quality services are available in hospitals, care homes and all community settings for all patients and carers, irrespective of diagnosis, that offer dignity, choice and support to achieve preferences in the last year of life. Fylde and Wyre CCG and Lancashire County Council will be working collaboratively with a number of stakeholders to ensure that this vision is achieved, including; Acute and Community services, Hospices, and other Third Sector providers.

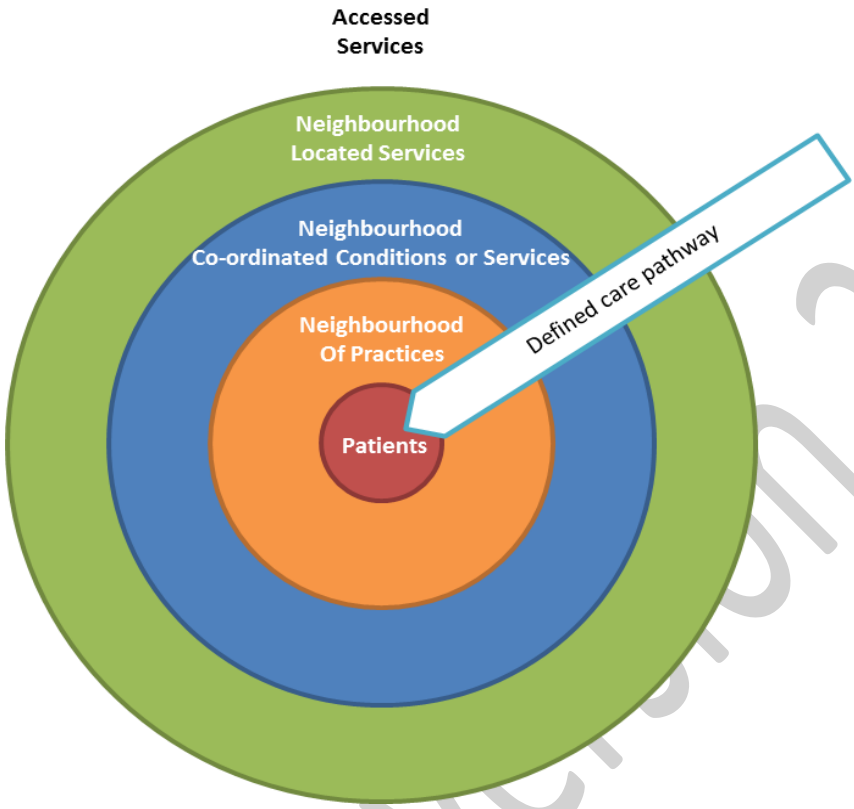
Building on this strong foundation the CCG and LCC will continue to develop, redesign and transform existing services through the Health and Care Strategy (2030) and various work streams within the Fylde Coast Unscheduled Care Strategy. This will result in capacity within both public and wider community resources being maximised such that:

- **person centred care will be delivered closer to home**
- **individuals and their carers will remain at home longer**
- **the need for admission to long term care will be reduced or delayed**
- **admissions to hospital and length of stay will be reduced**

There will be joint governance and commissioning arrangements with an integrated case management approach building on current pilots such as the above mentioned AQuA Neighbourhood Integrated Self-care model and Care Co-ordination Scheme. These will be underpinned by effective holistic risk stratification and the promotion of self-care within natural communities based around GP Practice lists. Alongside such case finding an assets based approach to community development will aim to grow community capacity and support a sustainable shift from acute care.

To deliver the vision, service design and commissioning will be for a defined neighbourhood with provision and supports, including those provided by the Third Sector wrapped round a local cluster of GPs in order to best meet the needs of and maximise the outcomes for those people living in the neighbourhood. We aim to draw on existing strengths within the community including, not just those assets that are land or buildings but also the skills of local residents and the power, knowledge and supportive functions of local associations, organisations and informal networks. This asset based community development approach will support a sustainable shift from hospital care where it is appropriate and safe to do so. This delivery model is broadly out outlined in the diagram below.

Proposed Fylde and Wyre Neighbourhood Model



A single point of access to a range of community based Intermediate Care and urgent intervention services across Fylde and Wyre (including re-ablement, rehabilitation, COPD specialist services, IV therapy, Rapid Response Nursing, Mental Health and residential rehabilitation / recuperation) will mean that more people are treated and supported at home or in a community setting, with appropriately trained therapy and support workers. A&E and Medical Assessment Units will have access to the multi-disciplinary Rapid Response Plus Service in order to focus upon admission avoidance via triage and referral to other appropriate community services. There will be end-of-life care and mental health capacity within intermediate care services.

Carers are an important part of the caring process and provide more care and support to patients than any other group. A more community focused and person centred system will also provide support to carers so that they are enabled and empowered to care for their loved one.

The Better care Fund will therefore support and under pin this well established shared local ambition enabling partners to build on and accelerate the existing collaborative work programmes. It will serve as an enabler, supporting evolving integrated care and future primary care, brought together via a neighbourhood approach.

The table below provides an overview of what the changes mean for:

SERVICES	PARTNERS	RESIDENTS
Staff will work flexibly across traditional boundaries focusing on the needs of their patients rather than the organisation Community health care providers and GPs working closer together and integrating with social care and Third Sector services Better same day and seven day access to general practice and primary care Integrated discharge planning in place from the point of admission to hospital Better management and support in care homes to ensure patients are not admitted to hospital unnecessarily A greater focus on prevention, health promotion and self-care Increased and broader ranging services delivered in the community and primary care, including diagnostics Use of technology to support patients with long term conditions All providers (including care homes, private sector assisted living, hospice care in the home services, domiciliary services, GPs, DNs and hospital staff)	An empowered health and social care partnership that focuses on meeting individual needs and not restricted by organisational boundaries Mutli-disciplinary teams working together to manage urgent needs at the place of residence ensuring patients have an effective alternative to A&E Communities are increasingly empowered and resilient to also facilitate self-help through vibrant volunteering and other services Wrapping health and social care around the patient 24/7 to reduce emergency admission to residential care or acute setting Work with ambulance service on new pathways and models of care, to reduce: - conveyance from care homes to hospital - number of 999 calls by supporting those most at risk of emergency admission in an integrated way to meet their specific needs Understanding of appropriate/alternative multi-agency services or a knowledge of how to access / signpost to appropriate supports Delivery of integrated services in alternative settings to	Care will be delivered to high quality, clear and measurable standards which cover each element of the service and the whole of the patient's journey Services that provide care with the patient not to the patient 24/7 care at home, promoted through early discharge and via services designed to avoid a hospital admission wherever possible Access to integrated rehabilitation and recuperation enabling maximum independence and return to daily living Being aware of alternative services to those in a hospital setting and be able to choose A named person who is familiar with your care needs and responsible for making sure they are met Active support to stay healthy Encouragement to have long term condition screening when invited to do so Care Plan is a source of information to avoid constant repeating of information and high number of appointments Living better, healthier more empowered lives Services in place to provide the necessary support for people,

of care for End of Life are quality assured and have been trained in both the philosophy and best practice Increased identification of patients at end of life Improved communication with patients and carers about death and end of life care including pre and post bereavement support Reduction of deaths in hospital Primary care and GPs working closer together and integrating with Social and Community care Better management in care homes to ensure patients are not admitted to hospital	traditional hospital outpatient setting Integrated neighbourhood teams working together to support patients with long term conditions An increase in active case finding by identifying "at risk" patients/populations Working together in supporting patients to use technology to meet both health and social care need Joined up services, and improved pathways to support rapid discharge for end of life patients from hospital Increase in support available in the community for patients at end of life Increase in specialist end of life care staff to support identification of patients at end of life Increased use of formal End of Life Tools such as Gold Standard framework, and Advance Care Planning Training requirements for health and social care professionals in Advance Care Planning and communication skills 24/7 care through integrated service provision	their families and carers to allow them to be cared for and die at home Patient's family/carers provided with the tools and support to understand the alternative services available for the patient rather than being treated within a hospital setting Highly personalised, holistic and person-centred care and support with individualised care planning Single point of access to manage care through Advance Care Planning Greater control of their choices as well as a preparedness to share risks – a partnership approach Help earlier in their disease trajectories and for longer Better networks for informal carers Faster access to information, new medicines, and technologies to help them adapt and self-manage

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.

The aim of our integrated care 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.

To deliver this aim service design and commissioning will be for a defined neighbourhood with services and supports wrapped round local clusters of GPs including VCFS and wider community assets and delivered through local neighbourhood coordination.

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 patient and population 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 objectives are already measured and monitored via existing work streams within the Fylde Coast Unscheduled Care Strategy.

c) Description of planned changes

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

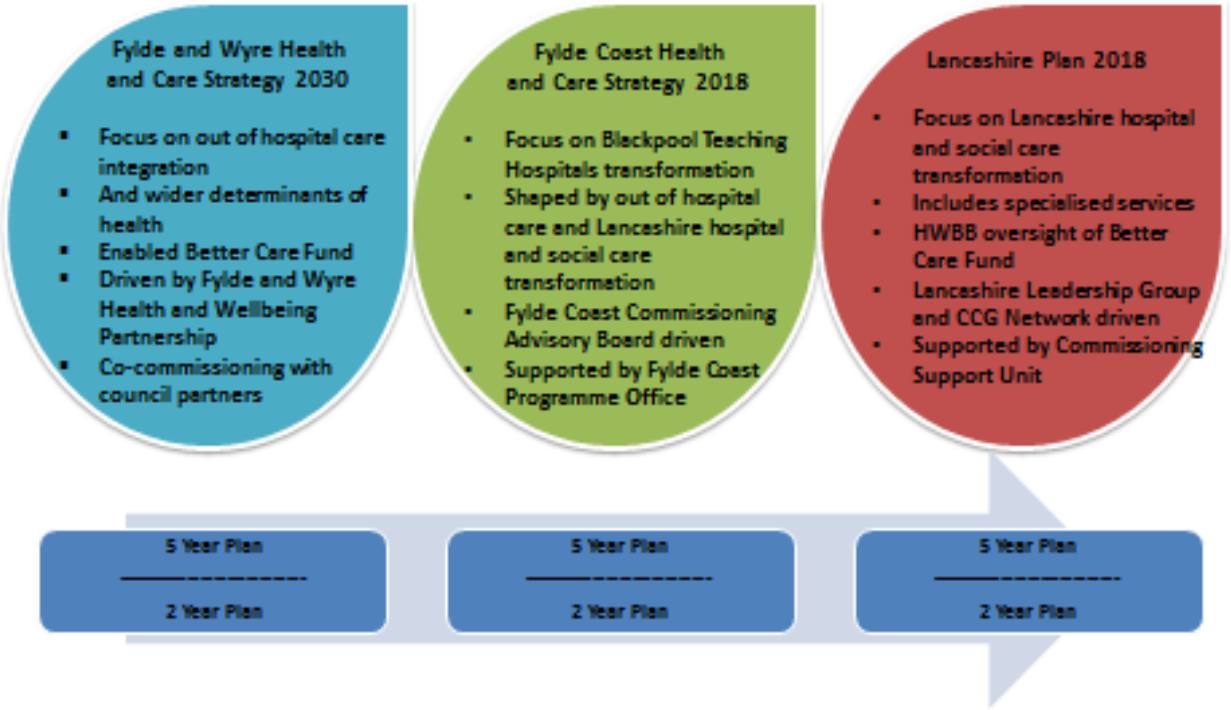
- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

As previously mentioned a well-established programme of transformation and re-design across Fylde and Wyre Health and Care economy is already underway via various work streams sitting within the Fylde Coast Unscheduled Care Strategy.

The Better Care Fund will serve as a lever to accelerate and enable this transformation programme, which fits within the overall significant range of changes needed to ensure a sustainable, high quality health and care economy.

This programme of transformation is supported and influenced by the JSNA, the Joint Health and Well-Being Strategy, Fylde and Wyre Health and Care Strategy (2030), Lancashire County Council Adult Social Care Commissioning Intentions, and the Lancashire Multi-agency Carers Strategy. As outlined in the diagram below Fylde and Wyre CCGs 5 year plan will dovetail with this plan, ensuring that recognition is given to interdependencies and all facets of care, from self-care and support in the patients home to secondary and tertiary care out of area. The plan will highlight interfaces with other commissioners to ensure seamless and streamlined pathways. The CCGs 2 year plan will be a 'sub-set' of the 5 year plan and the Health and Care Strategy 2030, setting out the objectives for the next two years and how services will be re-designed to move towards the aims and objectives of Health and Care Strategy 2030.

Fylde and Wyre CCG Planning Units



The Better Care Fund is then a sub-set of these plans with a particular focus on the intermediate and transitional care pathway, avoiding unnecessary admissions to hospital or long term care, supporting people at home and helping them to manage their own conditions.

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 promote and maintain well-being.

In the interests of vulnerable people in particular and order to ensure the needs of individuals are met, as opposed to responses that serve the system we urgently need to shift to a more proactive, dignified and person approach.

We will 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 ensure an integrated care approach facilitates person led care as opposed to system led care.

There is an opportunity through Lancashire County Council's re-commissioning and zoning of domiciliary home care, for the CCG to work in partnership in order 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.

The zoning of providers in neighbourhoods could foster true integrated working with providers and the integrated neighbourhood team's case managing those people with complex needs.

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. 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 Fylde and Wyre 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 Department for Communities and Local Government 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 table sets out the Planned Changes which have been developed in line with Fylde Coast Unscheduled Care Board and Strategy, Fylde Coast End of life Strategic Group, Fylde and Wyre CCG Clinical Commissioning Committee, Lancashire County Council

Better Care Fund – Planned Changes		
Actions	**By When**	**Expected benefits**
Implementation of Electronic Palliative Care Co-ordination System (EPaCCS)	Q1 2014	Reduce the number of inappropriate admissions to an Acute Setting. All stakeholders involved in the care of the patient will have access to the patients Care Plan which will include details of medication, Preferred Place of Care.
Development and implementation of Care plans for all patients who are identified as End of Life	2014-2015	Reduce the number of inappropriate admissions to an Acute Setting Patient Care will be better managed within the Community.
Design and implement Care Homes Commissioning and Support Plan	Design by April 2014 Implementation from April 2014-Mar 2015	Enhance the quality of care in care homes. Reduce non-elective admissions from care homes. Reducing the episodes of end of life care in Acute settings.
Commission pilot for Community Palliative Care Service including an End of Life Rapid Response Service, Hospice at Home and Sitting Service	April 2014	Reducing the episodes of end of life care in Acute settings. Patients able to remain in their preferred place of care. Patients are able to die in their preferred place of care.
Commission a pilot for the expansion of the existing Falls Advice and Assessment Service to: • Receive referrals from all primary care, community and third sector organisations • Provide community falls prevention events	April 2014	Increase awareness of falls and falls prevention in the community. Reduce the risk of initial and repeat falls within the Wyre and Fylde area. Ensure access to the Falls Advice and Assessment Service for all those who fall. Reduce the number of Ambulance call-outs, A&E attendances, non-elective admissions due to falls. Reduce the admissions to long term care. Improve the long term outcomes for older people.
Commission a pilot for a Falls Lifting Service linked to the Lifeline Pendant Scheme	April 2014	Reduce the number of Ambulance call-outs and conveyances to hospital due to falls (estimated to save 432 ambulance call outs per year). Reduce the number of A&E attendances (estimated to prevent 260 A&E attendances per year), non-elective admissions due to falls.

		Increase referrals into the Falls Advice and Assessment Service. Reduce the risk of repeat falls within the Wyre and Fylde area. Reduce the admissions to long term care. Improve the long term outcomes for older people.
Implement recommendations of hospital discharge review	September 2014	Reduce delayed transfers of care. Improve patient experience.
Review all urgent and emergency services to assess 7 day availability and draw up plans for future commissioning arrangements in line with recent guidance	September 2014	Reduce A&E attendance and Ambulance Calls. Reduce non-elective admissions Increase numbers of people assisted to manage own long term condition.
Review services for carers in light of increasing numbers of carers eligible for assessment and a develop programme for improvement in order to meet demand	December 2014	Improved support for carers Reduced non-elective admissions Reduced admissions to long term care.
Using existing risk stratification tools build on the current Care Co-ordination pilot, broadening scope to include social care risk factors and increase the number of people with an Anticipatory Care Plan	December 2014	Reduced non-elective admissions. Improved self-management of conditions. Provide information to support development of the models to support full implementation of Health and Care Strategy
Fully Embed Early Supported Discharge and Community Stroke rehabilitation service	March 2015	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.
To broaden the scope of existing 999 frequent callers pilot in order to identify more individuals who could benefit from a proactive, person centred anticipatory approach	March 2015	Reduction in calls to 999. Reduction in ambulance conveyances. Reduced non-elective admissions. Improved self-management of conditions. Provide information to support development of the models to support full implementation of Health and Care Strategy.

Re-commission of Community Equipment Services	June 2015	Improved provision of community equipment to support reducing non-elective admissions and increasing discharge.
Review all equipment and aids and adaptations provision to ensure a smooth pathway.	June 2015	Transform the provision of aids, adaptations and equipment.
Increasing re-ablement capacity to ensure that it is the primary offer for the majority of people prior to receiving a long term care service	September 2015	Reduced non-elective admissions. Reduced admissions to long term care. Reducing demand for long term community based care packages. Increased independence and positive outcomes for individuals.
Implement the recommendations from Benchmark intermediate Care Review to ensure sufficient capacity within • Residential Rehabilitation (Nurse and non nurse led) • Residential recuperation • Community therapy	September 2015	Reduced non-elective admissions. Reduced length of stay and delayed transfers of care. Reduced admissions to long term care. Reducing demand for long term community based care packages. Increased independence and positive outcomes for individuals.
In line with Intermediate care review recommendations, consider development of plans to integrate bed and community based rehabilitation services	December 2015	Detail to be confirmed by 14th Feb 2014
In line with the development of a Neighbourhood model scope, re-shape and maximise existing community assets and capacity within Third Sector provision.		Detail to be added by 14th Feb 2014

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.

Response currently being developed with partners.

e) Governance

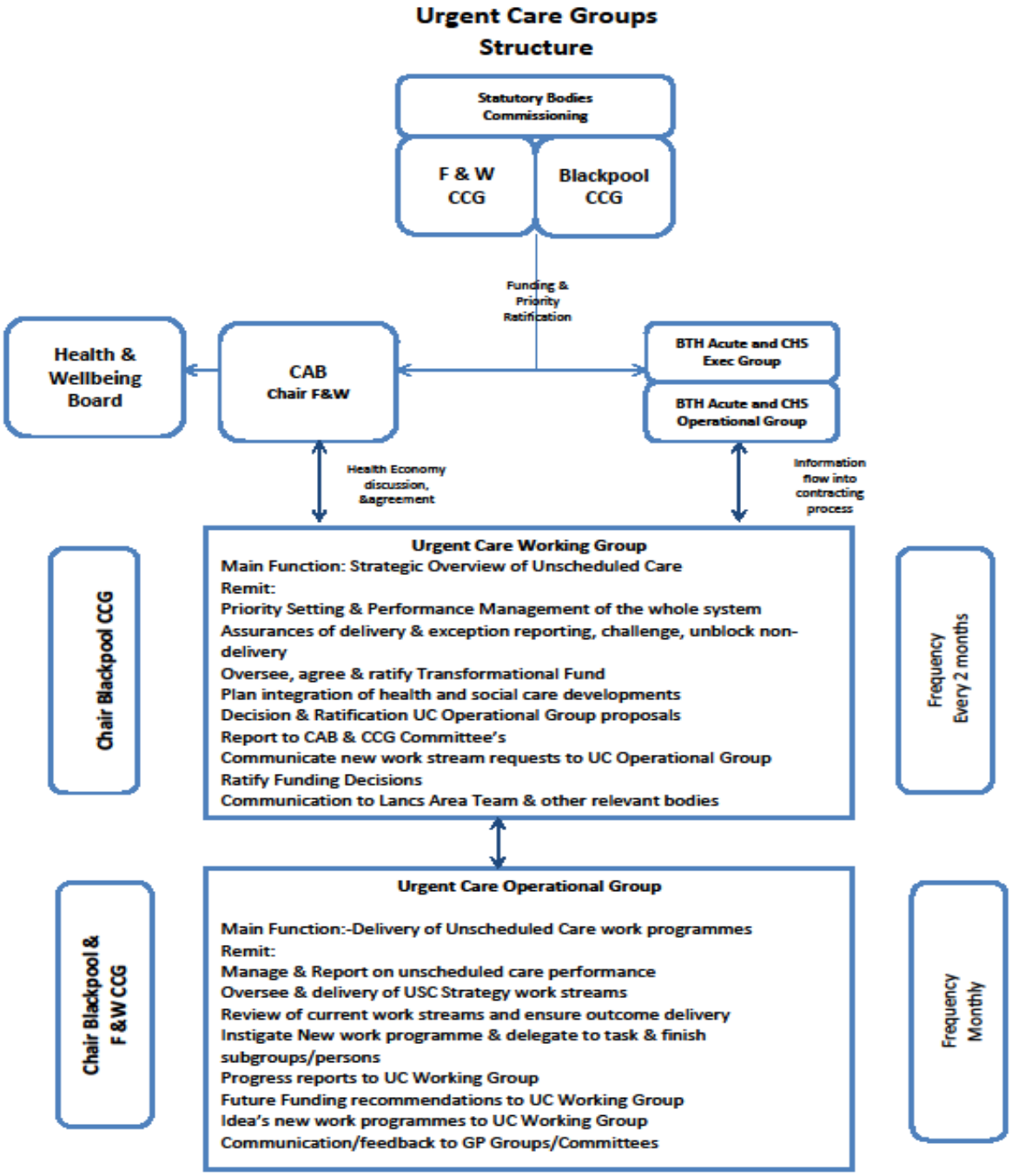
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Lancashire HWBB will receive the initial draft narrative for consideration on the 28th January 2014. This will be following presentation and discussion at appropriate organisational committees and bodies. These being Fylde Coast Urgent Care Working Group, Commissioning Advisory Board, and Fylde and Wyre CCG's Executive Management Team, Clinical Commissioning Committee and Governing Body. Chief Financial Officers will work together to oversee the governance and financial elements of the pooled funding. 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 VCFS, to co-produce and implement the agreed commissioning intentions. Implementation of the plan will be overseen by the Urgent Care Working Group which reports to the Fylde Coast Commissioning Advisory Board. These groups will oversee the implementation of both the Blackpool and Fylde and Wyre BCF plans. Blackpool, Fylde and Wyre are served by a single Acute and Community Trust, Blackpool Teaching Hospitals Trust (BTH). Lancashire County Council with Fylde and Wyre CCG and Blackpool Council with Blackpool CCG work together with BTH to manage the delivery of the range of services included in the BCF.

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.

FYLDE COAST URGENT CARE NETWORK



In addition to the network structure outlined above a short term working group has been set up to ensure individual Fylde and Wyre CCG and Blackpool CCG BCF plans are linked in order to prevent disparate arrangements for the Acute Trust and ad-hoc provision of service.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

Eligibility criteria will remain the same

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

Within the Fylde & Wyre 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 patients being discharged and prevent unnecessary admissions at weekends.

Partners are committed to developing integrated 7-day services which support people to be discharged and prevent unnecessary admissions to hospital at weekends. A number of services have already been established to support this commitment such as the Rapid Response Nursing Service and Rapid Response Plus, both of which have direct access to County Council funded Short Term Intensive Domiciliary Support 7 days per week. The intention is to establish integrated working practices across health and social care by further widening direct access by health professionals, as part of the integrated model of case management, to the full range of social care services 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. There will also be work with providers of services such as reablement, rehabilitation beds and recuperation beds, to ensure their readiness to accept referrals 7 days per week.

Following a recent review of the hospital discharge process recommendations are currently being implemented to ensure the service continues to develop to meet need and working alongside services such as Rapid Response Plus.

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 Lancashire County Council do not use the NHS Number as the primary identifier as the existing 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

NHS number is used as the primary identifier across all health services. In Fylde and Wyre (and across the local health economy) there is a detailed risk stratification tool (Aristotle) information from which is wherever possible shared with social care providers to ensure joined up support for individuals. Examples of this being the AQuA Neighbourhood Integrated Self-care model and Care Co-ordination scheme.

Lancashire County Council are replacing their current system and implementing Liquid Logic Protocol, with a planned go live of the end of June 2014. As part of this implementation, all of the migrated service user records will be populated 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))

Fylde and Wyre CCG support the delivery of IT infrastructure, information systems and standards to ensure information flows efficiently and securely across the health and social care system, in order to improve patient outcomes. All systems, either currently used or planned comply with HSCIC standards including HL7, CDR and Open API. We work closely with HSCIC, suppliers and stakeholders in health and social care to ensure ITK and IGT standards are met and exceeded where possible.

Lancashire County Council can confirm a commitment to the above and ensure that they are 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.

Both Lancashire County Council and Fylde and Wyre CCG are committed to ensuring all appropriate IG controls will be in place. For the CCG these include the requirements set out in the NHS Standard Contracts, professional clinical practice and in particular the Caldicott 2 requirements. Fylde & Wyre CCG are working to compliance in line the Information Governance Toolkit with a target to achieving Level 2 in all requirements resulting in a satisfactory rating. Lancashire County Council are aware of all of the above requirements, and 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.

A number of work streams are already in place that both identify those at risk of hospital admission and provide support to limit unnecessary 999 calls, attendances and non-elective admissions.

The Fylde Coast 'Aristotle' risk stratification tool identifies those at risk of non-elective admission or excessive use of emergency services. Since April 2013 the Care Co-ordination scheme has enabled those people identified of being at highest risk to have had their needs assessed by GP, Community Matron or other appropriate professional. Their and care is then jointly and proactively planned for in order to ensure, wherever possible needs can be met at home and hospital attendance and admission are avoided.

Alongside this, through the CCG's Higher Quality Locally Enhanced Service GP practices are required to implement a Palliative Care Register that is updated on a monthly basis and shared with key stakeholders.

Practices are encouraged to support the implementation and use of the Electronic Palliative Care Co-ordination System (EPaCCs). EPaCCs enable key information about an individual's preferences for care at the end of life to be recorded and accessed by a range of services providing that person's care. By facilitating improved communication and access to information more people should be supported to die in the place of their choosing and with their preferred care package.

There are currently over 1600 people with care plans and this number is continually increasing by linking to schemes such as the 999 frequent caller pilot and other information from health and social care professionals. The Fylde and Wyre health and care economy partners will continue to work together to ensure we plan to meet the care needs of all people with long term conditions with those aged 75 and over having a named health care professional. These lead professional will, via the neighbourhood delivery model have access to a multi-disciplinary team in order to work in a preventative way and promote self-care.

The CCG have also committed to a neighbourhood self-care model based on the AQuA Commissioning guidance for Long Term Conditions. The CCG area has been divided into four pilot neighbourhoods with integrated (health and social care) community teams being allocated to each one. These teams work alongside GP practices to improve coordination. Additional resources have been secured to support the new pathway in the form of a Care Coordinator for each neighbourhood and additional resources for Help Direct to support patients.

Within each neighbourhood, risk profiling data from Aristotle is used as an initial screening tool to identify patients who are most likely to be very high intensity users in the next year (these are patients with a risk score in the 'high risk' category, rather than very high risk. It also offers practices the opportunity to refer patients who may be frequent users of primary care but have a lower risk score but require an element of social care input. The intervention will be time-limited and is expected to cover a period of around 12 weeks.

To build on these two services the CCG and Local Authority have identified that a step change needs to be made to identification of patients / service users by including social care risk factors in the feed. The organisations will work together on this to ensure that information can be shared for the benefit of all citizens, including those at greatest need of integrated support.

Currently a lead professional the GP, community matron or end of life team will have responsibility for the patient. 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, building on the existing Advancing Quality Alliance (AQuA) Neighbourhood Integrated self-care model and Care Co-ordination Scheme a Multi-disciplinary team will have responsibility for vulnerable patients in a natural neighbourhood / 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 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.

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

To be completed by 14th February 2014

Risk	Risk rating	Mitigating Actions
Maintaining the integrity of the partnership, with competing financial pressures and performance indictors amongst the key partners, and a political agenda and context to change.		
Existing funding tied up in a variety of contractual arrangements that may reduce the ability to recommission in a timely and effective manner		
The scale of change and interdependency of work streams could be		

overwhelming at a time of reducing workforce capacity within the County Council		
Operational capacity to maintain day to day integrity of the business, safely, whilst delivering change and new models of working		
Workforce culture and development, processional boundaries and identities will be challenged		
Shift in emphasis to community care, wellness and prevention will not sufficiently impact on acute hospital activity		
Lack of integrated IT infrastructure to underpin the changes in culture practice and shifts in activity will drastically reduce impact.		
Introduction of the Care and Support Bill will bring additional cost pressures to the system which are not fully understood at this time		