APPENDIX 1

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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.

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1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Blackburn with Darwen**
Clinical Commissioning Groups	**Blackburn with Darwen**
Boundary Differences	**The CCG is co-terminous with the Blackburn with Darwen Council, although the CCG has a larger GP registered population. The CCG contracts with an acute provider which has a wider East Lancashire catchment and a Mental Health and Community Health provider which operates across the whole of Lancashire. There is a significant difference between the resident and GP registered population, the latter being circa 170K as opposed to a resident population of around 150K.**
Date agreed at Health and Well-Being	**9th September 2014**

Board:	
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,503,576**
2015/16	**£12,038,000**
Total agreed value of pooled budget: 2014/15	**£3,503,576**
2015/16	**£12,038,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Blackburn with Darwen
By	Joe Slater
Position	Chair
Date	18th September 2014

Signed on behalf of the Council	Blackburn with Darwen
By	Harry Catherall
Position	Chief Executive
Date	19th September 2014

Signed on behalf of the Health and Wellbeing Board	Blackburn with Darwen
By Chair of Health and Wellbeing Board	Cllr Mohammed Khan
Date	19th September 2014

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

Document or information title	Synopsis and links
Blackburn with Darwen CCG 5 Year strategic plan PDF 5 Year Strategy 20 June 14.pdf	Outlines the 5 year strategy for Blackburn with Darwen CCG
Blackburn with Darwen Health and Wellbeing Strategy	Integrated Health and Wellbeing Strategy for Blackburn with Darwen
http://www.blackburn.gov.uk/Lists/DownloadableDocuments/HWBStrategy2012.pdf	
ISNA Story of place	Used to inform the local priorities within Blackburn with Darwen
https://www.blackburn.gov.uk/Lists/DownloadableDocuments/ISNAstory2012.pdf.	
Health and Wellbeing report- HealthTalk summary	Provides a summary of HealthTalk 2013 engagement event
http://94.236.33.182/CmiswebPublic/Binary.ashx?Document=11311	
Director of Public Health annual report	Provides a Public Health perspective on BwD
http://www.blackburn.gov.uk/Pages/Public-health-report-2013.aspx	
Emergency admissions 2013/14 PDF BwD 2013-14 - All Ages - Total.pdf	Used to assist in planning

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision is to deliver effective, efficient, high quality, safe integrated care to enable the residents of Blackburn with Darwen to Live Longer and Live Better.

Our vision will be achieved through building a whole health and care system that:

- Promotes self-care and resilience by building and utilising community assets and the co-production of care
- Manages people's needs in the community unless there is an absolute medical/care need for them to be in hospital/residential care
- Creates integrated care in localities and preventive service teams based on GP registered populations
- Integrates support around the needs of the individual through a personalised approach to care
- Provides high quality evidence based holistic care, continuity of care and a named care co-ordinator for anyone with multi-morbidity and/or aged over 75.

Our vision has been informed by the needs of our local population identified through ongoing needs assessment as part of our ISNA, Health and Wellbeing Strategy and both commissioner and provider plans.

Local population
Blackburn with Darwen has a census population of 147,000 (2011). It is an area of significant deprivation and poor health, ranked 136 out of 150 local authorities for premature mortality and 17th most deprived in the country. As a consequence we have a higher than average proportion of people with multiple conditions and some of the highest rates of unplanned hospital admissions nationally.

Our challenges locally include:

- **Aging population;** significant increase in the proportion of people aged over 65, which is expected to increase from 13% to 17% by 2035 and the number of very elderly residents over 85 expected to double.
- **Diverse population;** the proportion of non-white residents, predominately from Indian and Pakistani backgrounds, amongst the highest in the region.
- **High rates of morbidity and poor life expectancy;** for men and women when compared nationally. The current life expectancy for both men and women in Blackburn with Darwen in 2012 is at national average levels for 2002.

By age 70, 50% of our population has 2 or more long term conditions and experience some of the highest rates of unplanned admissions to hospital in the country (data based on 2012 registered population). Segmentation of our population supports the prioritisation of complex frail adults aged 65 and above to receive integrated care.

Delivering our vision
Our shared principles for the delivery of our vision reflect the 2014 Nuffield Trust/The King's Fund report 'Integrated Care for patients and populations: Improving outcomes by working together' and 'Making best use of the Better Care Fund' (The King's Fund, 2014).

Clear, ambitious and measurable
Our ambition for integration is clearly outlined within the Health and Wellbeing Strategy 2012 - 2015 and CCG 5 Year Strategic Plan 2014-19. This is supported by our wider health economy footprint plans including Pennine Lancashire Annual Resilience plans. Our strategies are underpinned by public and patient participation in the development and delivery of our plans. We intend to transform our system of care around complex frail adults aged 65 plus to deliver robust and integrated alternatives to hospital and long term residential care and streamlined care and case management processes. We have a clear transition plan in place for 2015-16 which sets out required capacity and delivery arrangements.

Offering guarantees to patients with most complex needs
Our Better Care Fund Plan has prioritised those with complex health and social care needs including multiple long term conditions. Historically our system has been organised by pathway rather than focussing on the needs of individuals, impacting on service duplication and delays in interventions. Our Better Care Fund plan will focus on the development of shared care plans, an agreed case manager responsible for co-ordinating care for those with the highest needs, care navigation, self-care and tailored offers of support.

Implementing change at scale and pace
We have full system sign up to implementing our Better Care Fund Plan across health and care commissioners and providers. Our plan to reduce hospital admissions, develop capacity in primary and community services and invest in social care to support rehabilitation and re-ablement at scale and pace has been agreed by the Health and Wellbeing Board. Our Providers and voluntary sector partners are fully engaged and recognise the important role they have in the development and delivery of new models of care. We have agreed dedicated capacity within our integrated care Joint Programme Management Office to lead and support system change. Our strong local and health economy-wide governance will drive alignment of planning and delivery through innovation at scale and pace.

Enhancing primary, community and social care offer
Primary and community care services are key to the delivery of our Better Care Fund Plans. We will support Primary Care to adapt rapidly so that it operates at a scale that can provide a platform for integrated care system leadership. We are exploring a Primary Care model which looks at developing a Federation to provide and develop services collaboratively. Our Primary Care services will extend their offer to 8am-8pm to enable improved access and consistency of care. We are developing 4 integrated locality teams, which will be organised around GP practice populations so that local areas can work together to develop and design local pathways, that meet the specific needs within their communities. Our Reablement offer will support people to stay in their homes for longer.

Our locality offer will build upon the principles of early intervention and self-care supporting people to take more responsibility for their health and wellbeing and make decisions about their own care. Those with more complex needs will be supported by a full intermediate care offer to prevent admissions and support discharge, care navigation and case management. Intensive

Home Support services will provide a medically led multi-disciplinary team approach to meet the needs of the most frail.

Public and patient experience

Service user communications and engagement in relation to our Better Care Fund plans and integrated approach to service delivery, have identified a number of key themes to inform the development of our plans. They include:

They said we need......	We are doing/developing
Co-ordinated information directory and/or advice directory which promotes integrated care delivery	We will develop a Directory of Services and Co-ordination Hub.
Patients and carers to be involved in decisions about them	We will include patients and carers in developing their own care. We will develop an integrated offer across health and social care.
To protect social care services	We will build on the existing Section 256 agreement and develop new and more effective services which will help mitigate rising demand.
Improve communication between different service providers; need for key worker instead of many professionals	We will develop integrated health and care teams based around GP practices in 4 localities.
Third sector are providing good support already	We will build additional capacity within the voluntary sector to enhance the support these services currently provide.
An improvement in Primary Care access/GP appointments	We will develop of integrated health and care teams based around GP practice in 4 localities. We will extend opening in Primary Care to improve access.
To have a better understanding of why people are accessing A&E	We will use risk stratification and segmentation of population to have a better understanding of patients accessing the hospital.
Information when people are discharged from hospital needs to improve – "a lot!"	We will develop a fully Integrated Discharge team to support and provide advice to people during this time.
More support for people at home	We will develop Intensive Home Support for the most complex and frail and offer increased access to reablement support.
People will still need options for residential care if they cannot stay at home	We will publish a market position statement for the care sector which will include residential, extra care, sheltered schemes and life time homes.

b) What difference will this make to patient and service user outcomes?

By April 2020, we expect service users in Blackburn with Darwen will feel more in control and be able to take responsibility of their own care, and will understand what services are available to them. In reality this means people:

- feel like they are dealing with one organisation and they will only have to provide personal information once

- understand that information is shared between those involved in their care
- have access to local teams that are familiar, communicate well and help them navigate the health and care system when they need it
- feel like they receive support from staff who routinely "go the extra mile" to help them
- receive the right treatment quickly without having to deal with lots of people
- will not have to face unnecessary delays in leaving hospital
- will not have to make life changing decisions about their future care from an acute bed
- will have alternative support to long term residential and nursing care, through intensive support delivered in their community, wrap around support and alternative housing availability

Our model of care is designed to:

- Improve people's experience of care
- Avoid hospital admissions
- Reduce lengths of stay in hospital and delayed transfers of care
- Avoid admissions to residential and nursing homes
- Improve early diagnosis of dementia
- Support people to live better and live longer

Figure 1 shows the relationship between our Better Care Fund schemes and metrics.

Metrics / Schemes	Emergency Admissions	Delayed Transfers of Care	Residential Care	Re-ablement	Dementia (Local Measure)	Patient Experience (Local Measure)
Voluntary Sector Capacity Building						
Co-ordination of Dementia Services						
Integrated Offer for Carers						
Integrated Locality Teams						
Integrated Discharge Service						
Intensive Home Support						
Care Co-ordination Hub						

Our plans support us delivering a number of NHS Outcome Ambitions for our population:

Outcome Ambition 1	Securing additional years of life for the people of England with treatable mental and physical conditions
Outcome Ambition 2	Improving the health related quality of life for people with 1 or more long term condition, including mental health conditions
Outcome Ambition 3	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community and outside the hospital
Outcome Ambition 4	Increasing the proportion of people living independently at home following discharge from hospital
Outcome Ambition 5	Increasing the number of people with mental and physical health conditions having a positive experience of care outside the hospital, in general practice and in the community

Our locally agreed patient experience metric will enable us to measure the impact our changes are having, particularly in relation to joint care planning.

'For respondents with a long-standing health condition, in the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health' as this will further support identification of the difference our plans for integration have made to the lives of those experiencing care in their community.

We aim to reduce the percentage of respondents who answer 'no' from 10.6% in July 2014 to 8.3% in 2019. Our trajectory will enable Blackburn with Darwen to be in line with the national average by March 2015 and upper quartile performance by 2018-19.

20th Century Care (Current)

21st Century Care (Our Vision)

20th Century Care (Current)

- Mrs Haworth is an elderly lady living alone in a council flat. The flat is poorly insulated and damp; she often has to turn her gas off to save money.
- She lives near her daughter who is single and supporting 3 young children.
- She suffers from chronic constructive airways disease, heart failure and generalised osteoarthritis and still smokes.
- She is housebound and living purely off the state pension.
- She sees a district nurse from time to time and the GP calls when required.
- She fell a couple of times recently and ended up in A&E where they patched her up and discharged her. On one occasion she had to stay in hospital for 1 week.
- She is on a raft of medication, many of which she does not know what they are for and in reality; her memory isn't as good as it used to be.
- She is a proud lady and desperately wants to retain her independence and remain living in her flat near to her daughter.

21st Century Care (Our Vision)

- Mrs Haworth is an elderly lady living alone in her own council flat which has just been insulated and a new heating system installed and plans to move to a newly built extra care home when she can no longer stay in her own home.
- She lives near her daughter who is single and supporting 3 young children.
- She has a number of health problems and if she needs to go to hospital it tends to be planned
- She is supported by local agencies that are co-ordinated by a single key worker who helps her and her family understand her care plan and identify how to spend her personal budget.
- Her support includes
  - Reablement through which she regained skills and confidence after her falls
  - She accesses tele-healthcare to monitor her medical conditions and uses a pendant alarm which goes through to her daughter and wears a fall detector on her wrist.
  - She attends a luncheon club 3 times a week with her friends and her neighbours call in on other days for a cup of tea and a catch up
  - She goes away to a disabled friendly hotel for a weekend every month which takes the pressure off her daughter
  - Her advocate has helped her and her family to understand her medical conditions and medicines better
  - She's had a memory assessment and is accessing some help from the new community service who attend the luncheon club on Tuesdays.

c) What changes will have been delivered in the pattern and configuration of services over the next 5years, and how will BCF funded work contribute to this?

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

In Blackburn with Darwen we have focused on early intervention and prevention in line with the direction provided nationally through the Care Act. The implementation of the Care Act 2014 puts the wellbeing and outcomes that matter to people at the centre of decision

making. The changes brought about by the Care Act are fundamental in facilitating the shift in leadership and control of decision making to individuals.

We currently rely predominately on an acute hospital and residential care bed system for the care of frail older adults. This is reflected in the high number of hospital admissions, residential placements and frailty related lengths of stay.

Within our current system
Too many people have unnecessary hospitalisation

- Our interactions are often reactive and not proactive
- Our primary, community and social care is not a cohesive system focussed on supporting people in the community
- Our 28 individual GP practices are not fully integrated with the current health and social care offer
- Our alternatives to hospital admissions are not easily accessible or available

Too many people stay in hospital too long

- There is limited early and integrated discharge planning
- There is limited capacity or capability in the community teams to discharge early enough
- There is no single discharge function and the system is complicated, provided through a number of teams, with multiple hand overs

Too many people are discharged into long term residential care

- People are assessed for discharge in an acute hospital setting
- People are discharged into long term care through indirect routes i.e. short term care and are unable to optimise the reablement offer in the Borough
- People experience duplication within the system with no capacity and flow model of community bed availability

Our system is complicated:

- There are multiple points of access with multiple service providers and assessments
- There is underutilised capacity within the community
- There is fragmentation and duplication across services
- Patients and users find the system difficult to understand and find their way through

Over the next 5 years there will be:

Less people admitted to hospital as an emergency

- We will have individual care plans for high risk patients
- We will focus care around the needs of the individual, through the development of 4 clinically led integrated locality teams, ensuring that services and support are wrapped around a local cluster of GPs, including community health, social care and voluntary sector
- We will ensure that effective information, advice and support will be available at times of crisis, delivered in an integrated and systematic way – we will encourage more reliance on self-care and community provision
- We will have an intensive home support service in place

Quicker discharges and people will spend less time in hospital

- We will ensure that every person discharged from hospital will have a full intermediate and reablement package of care where required
- Intensive home support will be available to those who are clinically stable
- We will have a care navigation hub in place to enable co-ordinated and early discharge
- We will develop our intermediate care and rehabilitation beds capacity to provide support for people ready for discharge from hospital

Less people admitted into residential care

- We will implement a 'discharge to assess' model which means that our future assessment will take place in a community setting and no decision will be made on long term care requirements from an acute bed resulting in appropriate time to think and to fully consider all options for patients, relatives and carers
- We will develop greater level of home/housing with care and support options reducing reliance on the residential care system and enabling people to stay in their own homes for longer

A system that can be navigated more easily

- We will develop a care navigation hub enabling people to move through the health and social care system more effectively
- We will have a capacity management system in place to support access to and flow throughout hospital services
- We will ensure that in crisis, people in Blackburn with Darwen will know who to contact, what to do, experience a rapid response where required and have their needs met in an integrated and systematic way

The key outcomes that would be delivered by this programme are reflective of the key aspirations within the Better Care Fund and the maintenance of system resilience and include:

- Increased diversion rate from A&E department
- Reduced admissions and re-admissions for avoidable Unplanned care
- Reduced acute length of stay for Unplanned care admissions
- Reduced Long term care placements and packages
- Improvement in recovery rates
- Increased opportunity for people with a long term condition to remain at home
- Improved quality of life for people with support needs and for their carers
- Improved access to support in people's neighbourhoods and localities
- Increased opportunity for End of Life care within a person's chosen setting

Local measure

In addition, Blackburn with Darwen will measure its performance against an additional local metric of improving diagnosis rates for dementia. Dementia diagnosis rates are currently at 61% and our aim will be to increase this to 70% by 2019. Following the recommendations of the ISNA, improving the support for people with dementia and their carers was made a key priority of the promoting older people's independence and social exclusion theme, of the Health and Wellbeing Strategy. Our vision for dementia services is to enable people with dementia to receive an early and accurate diagnosis, to receive the information and support

they need to make decisions about their life and to lead as full and active life as possible and for their carers to feel well supported. People with dementia will have their individual needs assessed and receive coordinated services, throughout the dementia care pathway, from well trained and skilled practitioners who treat them with dignity and respect.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Our case for change presents a clear understanding of how care can be improved through integration, utilising outcomes of risk stratification, local emergency admissions data, review of service configuration and utilisation and the national evidence base for integrated care.

Blackburn with Darwen Emergency hospital admissions data for 2013/14 shows:

- 30% of all emergency admissions occur in over 65s (yet over 65s account for only 14% of the total population)
- Emergency admissions increase with age. Approximately 1 in 4 of all patients aged 75 and over are likely to have an emergency admission in a 12 month period; and 1 in 6 of the 65s and overs
- The older you are the longer your length of stay in hospital – the average length of stay for 65 and overs is 8.01 days compared to 4.52 days across all ages
- The average cost of admission is higher the older you are – patients aged 65 and over have an average cost per spell of £2,398 compared with £1,616 per spell in all ages
- The greatest population increase in the Borough will be in the over 65s with an expected increase of 9% in the next 5 years to 2019/20

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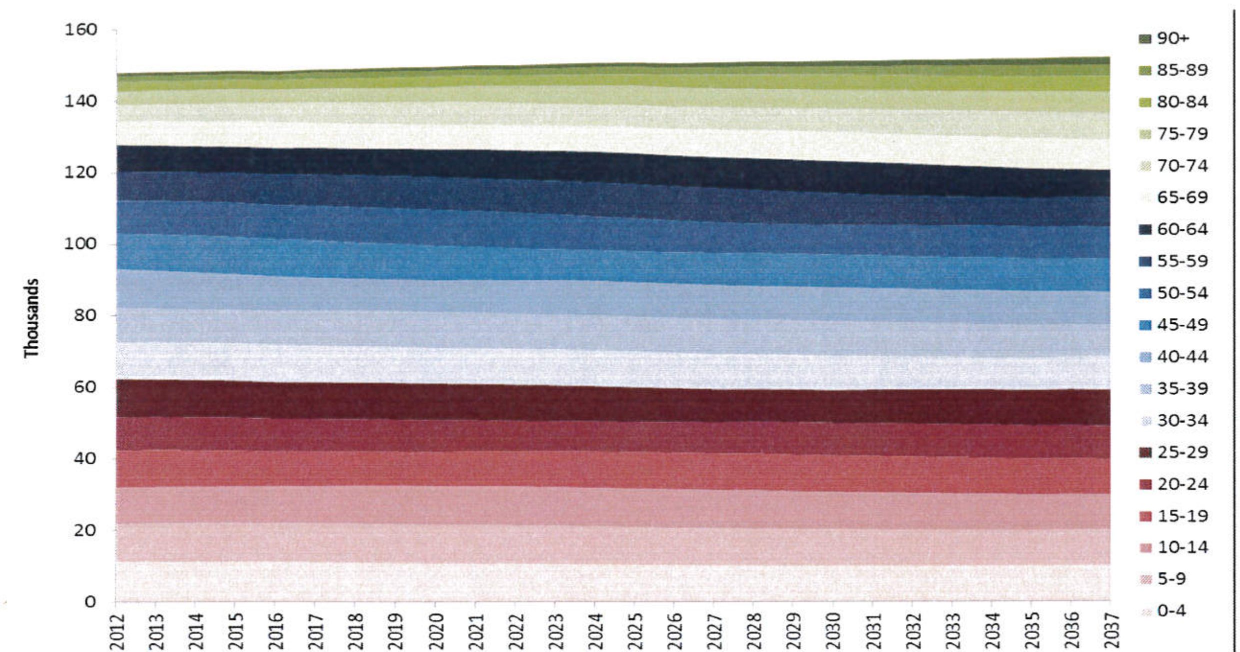
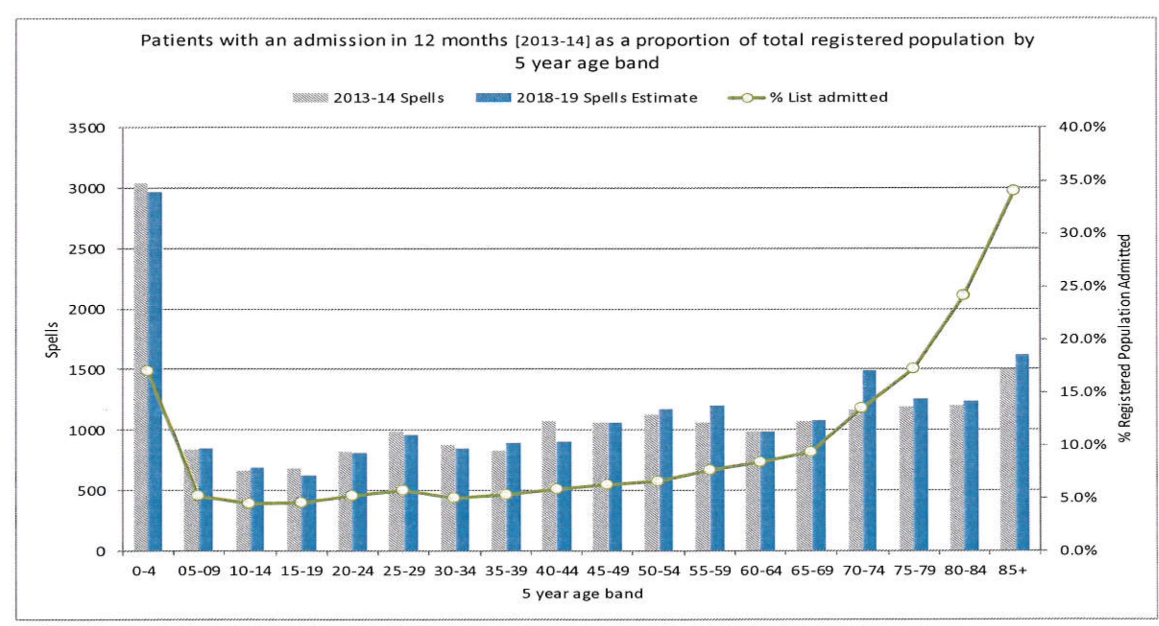
Figure 2 - The graph shows projected age profile of the BwD population from 2012 to 2037, showing an increase in growth in the over 65's.



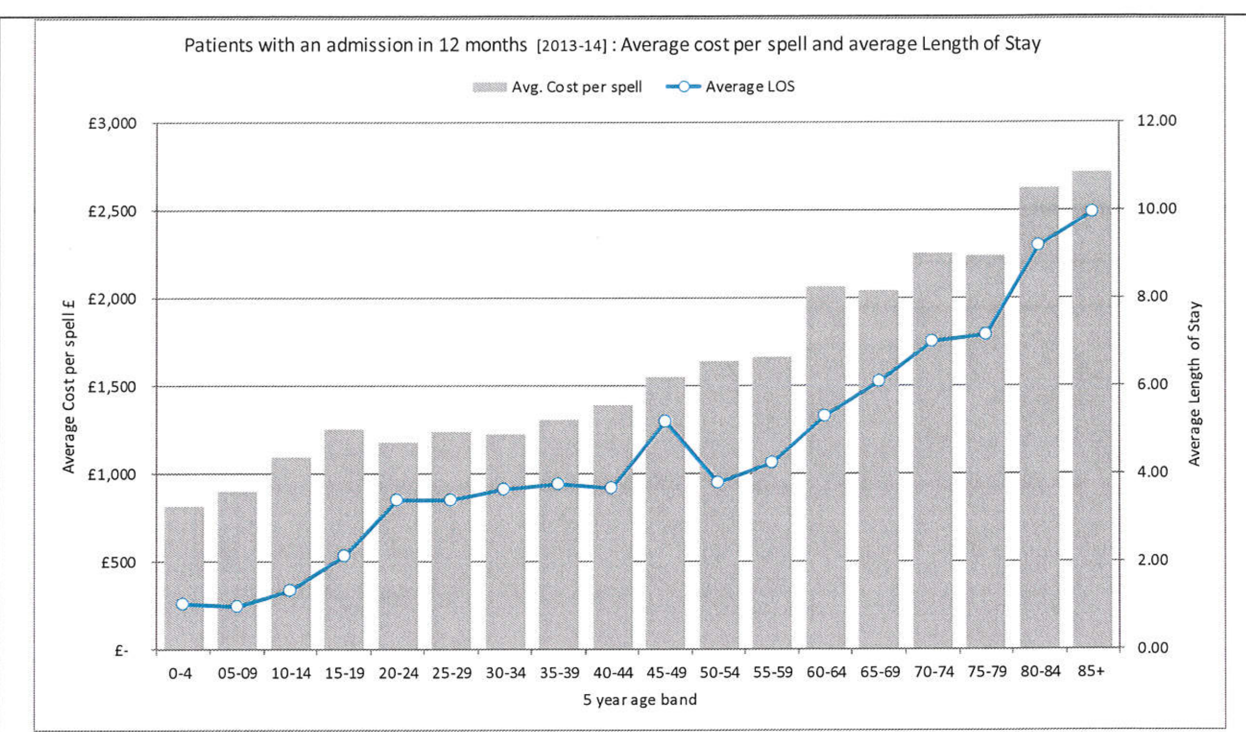
Source: Office of National Statistics

Graph 1 shows the number of emergency admission spells in 2013/14 and estimate by 2019/20 by 5 year age band. It highlights the proportion of registered population that are likely to be admitted as an emergency over a 12 month period. For example, 34% of patients aged 85 and over are likely to have an emergency admission in a 12 month period.



Source: Hospital admissions data 2013/14

Graph 2 shows the average cost per spell and length of stay by 5 year age band. It highlights the interdependency between age and hospital length of stay.



Source: Hospitals Admissions data 2013/14

Adult Social Care services

The Local Authority has undertaken a detailed root cause analysis of the factors driving its current high use of residential care and will be implementing a wide range of changes over the short, medium and long term to address this, including culture/ behaviour change, the interface with health professionals, providing more support at home and in intermediate care to ensure that only exceptional cases (e.g. end of life care) go straight into a long term care home placement. The results of the diagnostic work is as follows:

- The high use of short term residential placements is driving long term admissions.
- The pathway from hospital discharge should be redesigned to ensure service users stay independent in their own home.
- Whilst the Reablement team is demonstrating excellent service user outcomes, there is an opportunity to increase referrals thereby utilising the existing resource more fully.
- Referrals from customer liaison officers could be reduced by improving the pathways and encouraging direct referrals to services such as Reablement, equipment and existing voluntary sector services.
- Assistive technology was identified as a key area for development with a significant opportunity to increase the number of complex telecare packages by ~200%. This will lead to lower reliance on domiciliary care.
- Managing market pressures in Home care and residential placements will yield a significant non-cashable saving.

Current service configuration

A number of reviews across the health and care system have supported our case for change. They included Capita Modelling (2014), Perfect Week (October 2013), Point of Prevalence study (2013). They identified:

- Action is required to improve access to and flows through non-acute services to support the system to continue to deliver.

- There needs to be a raised awareness of access to and capacity within community services, specifically to support discharge from acute services, optimise acute bed utilisation and reduce placements in long term residential and nursing care.
- A recent Blackburn with Darwen study suggested that over 50% of those in an acute bed did not require an acute bed on the day in question, with a significant percentage being over 65.
- Inputs required to expedite discharge for these patients were mainly social, therapy and discharge processes.

Learning from our integrated care pilot

In June 2013, BwD CCG and Local Authority commenced an Enhanced Integrated Community Service (EICS) Pilot in the East area of Blackburn. The pilot identified patients at risk of hospital admissions through risk stratification including primary care expertise. Care planning and case management approaches were delivered to high risk patients through a multi-disciplinary approach. Medium risk patients were offered an innovative voluntary sector led intervention to support self-care and management.

The East EICS Pilot has provided invaluable insight and learning about our patient cohorts and the University of Liverpool Institute of Psychology, Health and Society, has been collecting data to support evaluation to inform roll out. Early indications suggest that the Pilot has led to reductions in hospital admissions and through Achieving Self Care (ASC) a reduction in GP appointments (further information is detailed in Annex 2 Scheme reference 4).

Population risk stratification

To identify people who are most at risk of deterioration or at risk of a significant care event, particularly emergency admissions, risk stratification of our population has been undertaken. Our data is currently only available locally for emergency admissions. Our data supports the national case for targeting integrated care at an aging population and enables us to identify cohorts of our population who are at very high and high risk of hospital admission.

Figure 3 below shows the predicted Risk of Hospital admission by age group in Blackburn with Darwen by whole populations and split by age group. The diagram demonstrates the potential service need of each of the identified population cohorts.

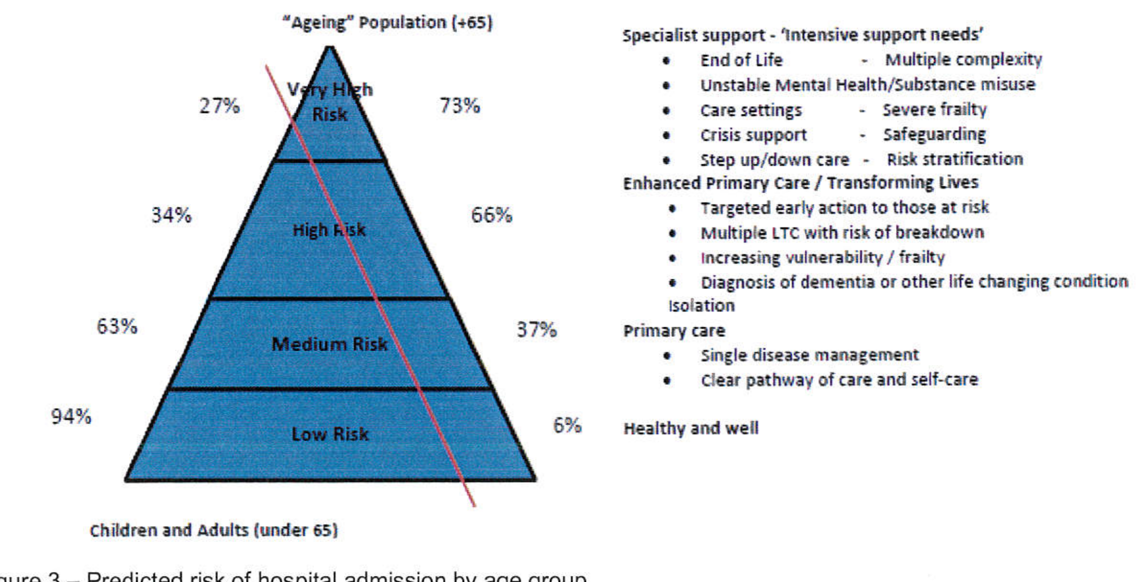


Figure 3 – Predicted risk of hospital admission by age group

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To further support our case for change, Figure 4 shows a significant number of our over 75 population identified at very high and high risk of hospital admissions. Currently 1 in 8 of our over 75s is at high risk compared to only 1 in 37 of our under 15 population.

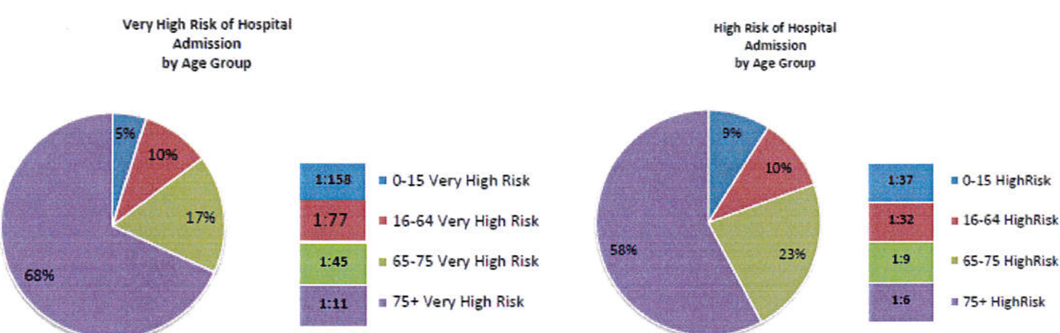

Figure 4 – Very High and High risk of hospital admissions

Better Care Fund Emergency admissions trajectory

The Health and Wellbeing Board has agreed an emergency admissions trajectory for Blackburn with Darwen of 3.5% reduction against current trend, which is made up of:

- 1.3% underlying growth
- 2.2% reduction against BCF baseline

Our rationale for this decision recognises:

- changes in demographics - significant growth predicted in people over 65
- historical patterns and trend - year on year increase of average 1.3% has been experienced between 2009/10 and 2013/14
- deprivation - the national evidence base suggests higher rates of hospital admissions in populations affected by deprivation

The modelling support undertaken by the BCF support team and the national evidence base for integration suggests the need to phase assumptions for benefit delivery and recognise at least an 18 month delay from a standing start to establishment and full impact delivery.

Comparison of our proposed interventions against known national evidence for integration, supported by the national BCF team does indicate that over the next 5 years a scale of reduction equivalent to 10% of the total current emergency admissions (across all ages) may be achievable.

The table below suggests potential impact on emergency admissions for selected cohorts of patients.

	Reduction w/o dbl cnt		Additional reductions Total		CCG funded	Reduction inc dbl cnt
BCF evidence pack	12.5%	-	1,661	-	1,538	12.5%
Integrated community services evidence	8.4%	-	813	-	752	8.4%
MCAP patient flow evidence	4.7%	-	55	-	51	12.5%
Case management evidence	10.5%	-	1,237	-	1,145	28.7%
Total potential	23.5%	-	2,104	-	1,948	

Integrated community services evidence based on published evidence review

Case management evidence based on *Bernabei et al* and *Bird et al*

MCAP evidence based on previous surveys of UK trusts and applied at service level

Source: PA Consulting, 2014

National Evidence

As demonstrated locally, through risk stratification analysis of our population, it is important that we focus our initial plans for integration of care on our over 65 population. National evidence (The King's Fund 2014) suggests that a combined approach to care co-ordination, case management and individualised care plans with input from a multi-disciplinary team of health and social care professionals is supported by proof of impact. National examples of integrated care to address issues with the elderly population include:

Torbay Care Trust
Integrated health and social care teams work alongside GPs to provide a range of intermediate care services. By supporting hospital discharge, older people have been helped to live independently in the community with help from health and social care co-ordinators. The results include reduced use of hospital beds, low rates of emergency admissions for those over 65, and minimal delayed transfers of care.
North Somerset
Implemented 4 fully integrated and co-located multi-disciplinary teams to provide case management and self-care support to older people. The teams are based around clusters of GP practices; the service brings together community health and social care workers, community nurses, adult social care services and mental health professionals.

Next steps: selection of BCF schemes

Our Better Care Fund Plan schemes have been developed to specifically focus on learning from our local population needs, understanding of current system configuration and utilisation and the national evidence base. A number of executive lead workshops and development sessions have been held across Blackburn with Darwen, including Health and Wellbeing Board, and wider Pennine Lancashire to support prioritisation of schemes for inclusion within Better Care Fund.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

We will use Better Care Fund Plan to accelerate and enhance our high impact changes planned across existing work streams. Our programme to support Better Care Fund Plan delivery is developmental and has been co-produced across commissioners and providers, including voluntary sector. Over the next 5 years our plans are likely to change to reflect the changing

needs of the local population, new evidence and impact of scheme evaluation. All schemes are subject to an agreed business case enabling partners to pilot and test that schemes will deliver anticipated benefits and they will be reviewed on an annual basis to inform future planning. Figure 5 highlights the interdependencies we have in Pennine Lancashire with Providers and the Voluntary Sector working across both areas:

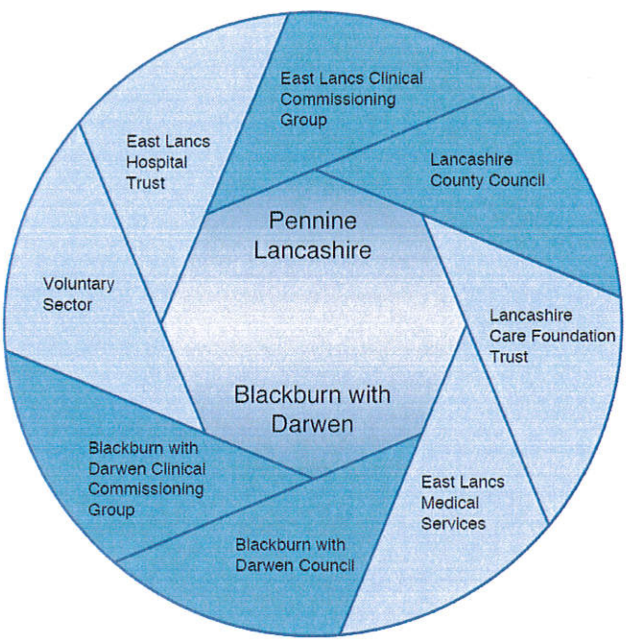

Figure 5 – the Pennine Lancashire Health Economy

Brief outlines of schemes supported by our Better Care Fund Plan and milestones are outlined below. Three detailed scheme descriptions have been developed to demonstrate complex whole system change required to deliver our ambitious plans through:

- Early intervention and prevention
- Development of integrated locality teams
- Providing support to patients with most complex needs

Early intervention and prevention (detailed schemes 1, 2 and 3)

Reducing demand for health and care services, by enabling people to enjoy a healthy and active life within their communities is a key priority within our plans. We will build upon the principles of early intervention and self-care by supporting people to take more responsibility for their health and wellbeing and make decisions about their own care.

BCF scheme	Description	Timescale for delivery
1. Build capacity within the Voluntary Sector	We will build capacity within the voluntary sector through remodelling and growing inward investments using an integrated commissioning and delivery model to drive a more collaborative approach to the co-ordination of advice and information, signposting and locality-based support.	**March 2014-April 2016**
2. Co-ordination of Dementia Services	We will work with Age UK and the 50+ Partnership to support the development of 'dementia friendly communities' and the co-ordination of support for those affected by dementia.	**September 2014 – March 2016**

3. Increase the number of 'recognised' / unpaid and informal carers	We will increase the number of unpaid and informal carers who receive an assessment and access to the wide range of third sector and early help projects underway in Blackburn with Darwen, in line with requirements set out in the Care Act. Additionally, we will ensure that carers are supported to access planned breaks and respite provision to support them in their vital roles.	**February 2014- March 2015**

We will align our BCF plans to existing local developments with the aim of improving access to local services, promoting self-care and increasing access to programmes which encourage lifestyle and behavioural change. They include:

- Blackburn with Darwen Integrated wellbeing service
- Community capacity building
- Falls prevention
- Decent and Safe Housing scheme
- Safe and Well Prevention Plus telecare scheme

Development of 4 locality Primary Care teams (detailed scheme 4)
We are currently working with Providers to develop **integrated health and social care teams** in 4 localities organised around GP surgeries and their practice populations.

BCF scheme	Description	Timescale for delivery
4. Development of 4 locality primary care teams	**We implement fully Integrated Locality teams** bringing together health, social care and third sector across our 4 localities. Care wrapped around the needs of the individual will be provided in a locally co-ordinated structure that includes: **Risk stratification** (using health and social care existing knowledge) in Primary Care to identify vulnerable individuals and review their existing case management as part of a **multi-disciplinary team** meeting with representation from health and social care and other appropriate service, including Mental Health and Drug and Alcohol Services. **Proactive care planning and case management approach** for adults with long term conditions and frail elderly will aim to reduce the number and severity of ill health exacerbations by utilising risk stratification to support segmentation.	**May 2014 - March 2016**
	Plans are in place to incorporate mental health services including IAPT and Memory Assessment Services within our locality offer.	Pilot to commence **October 2014**

We will align our Better Care Fund Plans to existing local developments with the aim of improving access to local services within communities, reducing duplication, supporting medicines optimisation and delivering enhanced primary care offer. They include:

- Medicines Optimisation

- Commissioning Primary Care Enhanced Services
- Proactive Care Direct Enhanced Service

Providing support to patients with most complex needs (detailed schemes 5,6,7)

BCF scheme	Description	Timescale for delivery
5. Intermediate Care/Discharge to assess	We will review the existing number of community intermediate care beds available to Blackburn with Darwen patients and create referral and exclusion criteria. We will improve discharge pathways for individuals and ensure that they are discharged for assessment in the most appropriate setting, facilitating 'discharge to assess', where possible and appropriate.	October 2014-April 2016
6. Intensive Home Support	We will build on the development of our integrated locality teams and existing community provision including Acute Visiting Service and voluntary sector support, to provide an integrated Intensive Home Support offer which will provide dedicated medical lead working with skilled multi-disciplinary team, supporting patients at home 7 days a week.	Phased rollout commence to October 2014
7. Co-ordination hub/Directory of Services	We will develop a directory of services for frail elderly people that is a comprehensive, up to date directory of all health, social care and voluntary sector services to support navigation through the current system. The directory will be supported by a Care Co-ordination Hub, initially focusing on support for clinicians working with frail and elderly patients. The Hub will provide prompt, clinical advice supported by a system that can navigate through the out of hospital system.	DOS in place October 2014 Co-ordination hub established by March 2015

Figure 6 shows the interdependancies and relationships across our schemes to support delivery of transformation for complex frail adults aged 65 and over across Pennine Lancashire, providing clear pathways for admission avoidance and discharge from acute care.

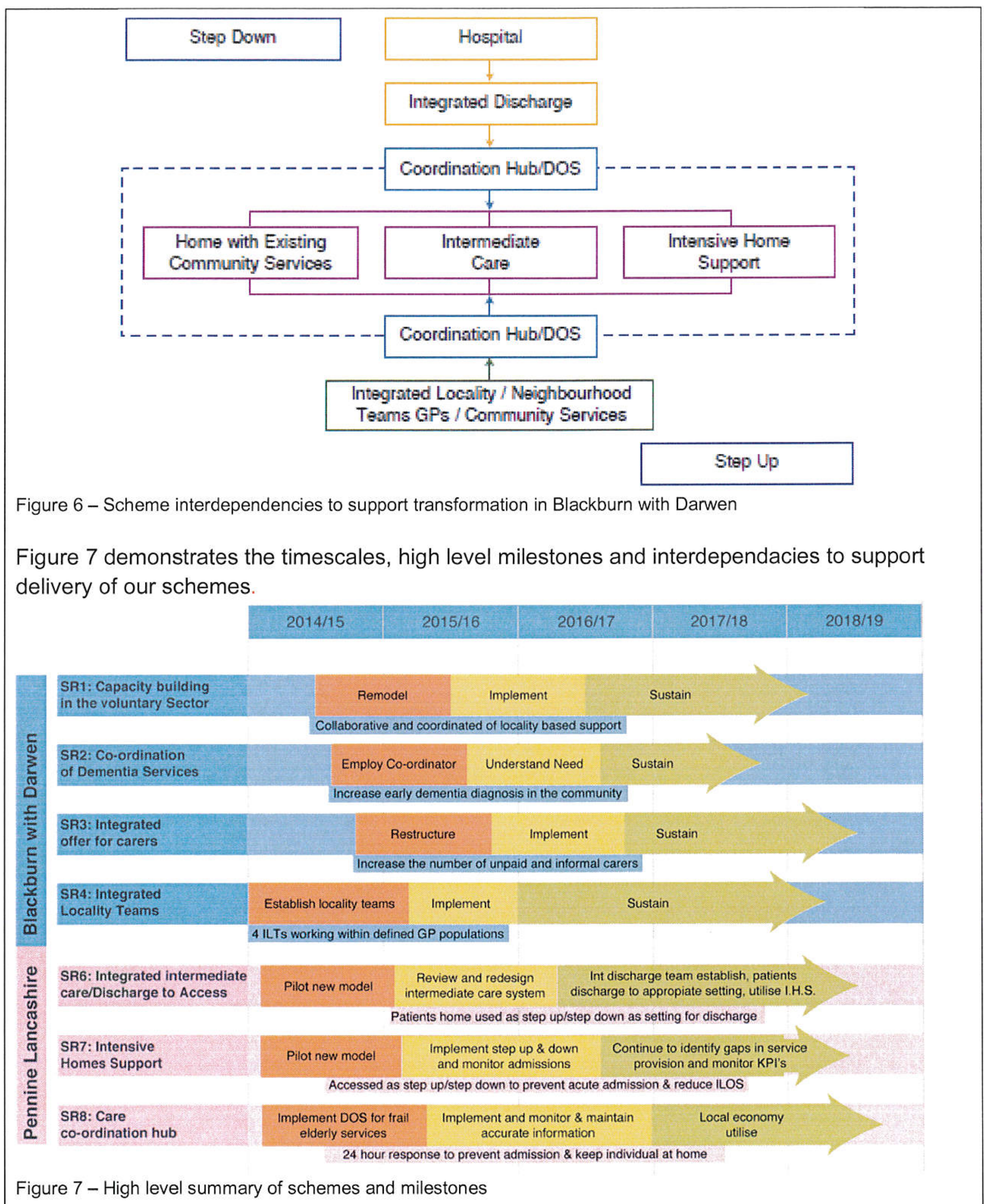

Figure 6 – Scheme interdependencies to support transformation in Blackburn with Darwen

Figure 7 demonstrates the timescales, high level milestones and interdependacies to support delivery of our schemes.

Figure 7 – High level summary of schemes and milestones

b) Please articulate the overarching governance arrangements for integrated care locally

Blackburn with Darwen Health and Wellbeing Board (HWBB) will provide overall ownership of the plan and associated progress and outcomes. Health and Wellbeing Board members have received regular briefs on the development of the Better Care Fund locally, through formal meetings and informal training and development sessions. Below is a summary of when BCF has been presented to HWBB members.

- 23rd September 2013- Health and Wellbeing Board
- 20th January 2014- Health and Wellbeing Board
- 27th February 2014- Health and Wellbeing Board development session- sign off of plan and delegate authority to chair for submission
- 23th June 2014- Health and Wellbeing Board
- 9th September 2014- Health and Wellbeing Board development session (inc. community and acute providers) Board members and providers agreed proposed local emergency admissions indicator, options for patient experience measure, pay for performance and risk, contingency and reporting mechanisms. Board members and providers agreed to sign up to the Better Care Plan for Blackburn with Darwen.

The CCG and Local Authority will make use of an existing governance structure to oversee the delivery of the BCF schemes, with responsibility for strategic decision making resting with the **Health and Wellbeing Board.** Diagram i) outlines Blackburn with Darwen Health and Wellbeing Board system governance structure

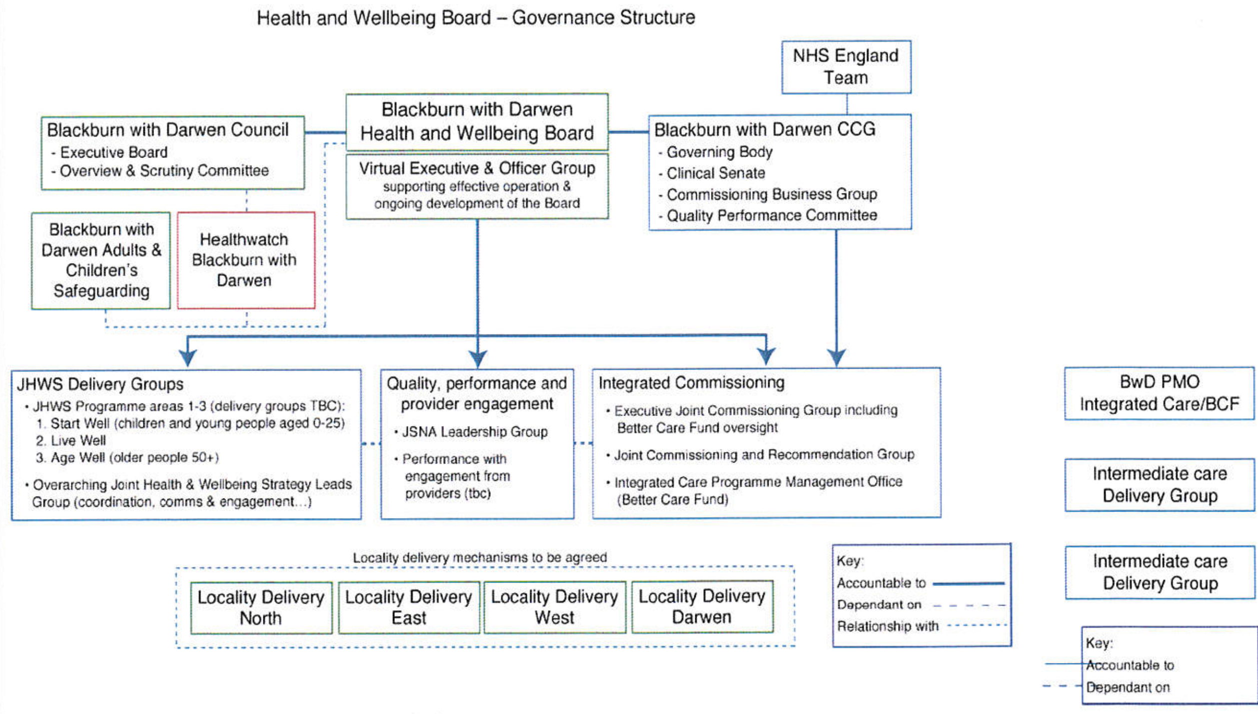

Diagram (i) – Health and Wellbeing Board governance structure

Management of the BCF Plan will be led through Blackburn with Darwen **Executive Joint Commissioning Group (Exec JCG)** which meets monthly and provides regular reports into the local Health and Wellbeing Board, Council Executive Board and CCG Governing Body. Exec JCG delegated powers from Governing Bodies and HWBB are being reviewed to ensure relevant and timely decision making. The Exec JCG membership includes Lead Elected Member, Clinicians, Chief Executives and senior officers across CCG, Local Authority and NHS England Local Area Team. 4 members of the Exec JCG are also members of the HWBB to ensure there is direct communication between both groups.

Exec JCG members receive monthly highlight reports outlining delivery progress across Blackburn with Darwen and Pennine Lancashire schemes and highlighting any strategic risks and issues for escalation to Executives.

Quarterly reports will be provided from Exec JCG to Health and Wellbeing Board members which will include progress against metrics, BCF Plan delivery and financial information.

Pennine Lancashire Chief Executives Group (PLCE) has recently been established to lead system redesign, transformation and develop shared ownership of outcomes across Pennine Lancashire providers and commissioners. The group includes Chief Executive Officers from Lancashire County Council, Blackburn with Darwen Local Authority, East Lancashire CCG, BwD CCG, Lancashire Care Foundation Trust, East Lancashire Hospital Trust and East Lancashire Medical Services. The Executive Officers group supports the integrated delivery of recommendations and decisions through the development of shared business cases, performance and financial planning. Accountability and reporting structures are currently in development to ensure clear alignment of BCF delivery across the Pennine Lancashire footprint where appropriate. Four members of the Blackburn with Darwen Exec JCG are also members of the Pennine Lancashire structure to ensure there is alignment across the Pennine Lancashire system.

Diagram ii) outlines strategic accountability and operational delivery of integrated commissioning and care across Blackburn with Darwen, highlighting interdependencies for delivery across Pennine Lancashire.

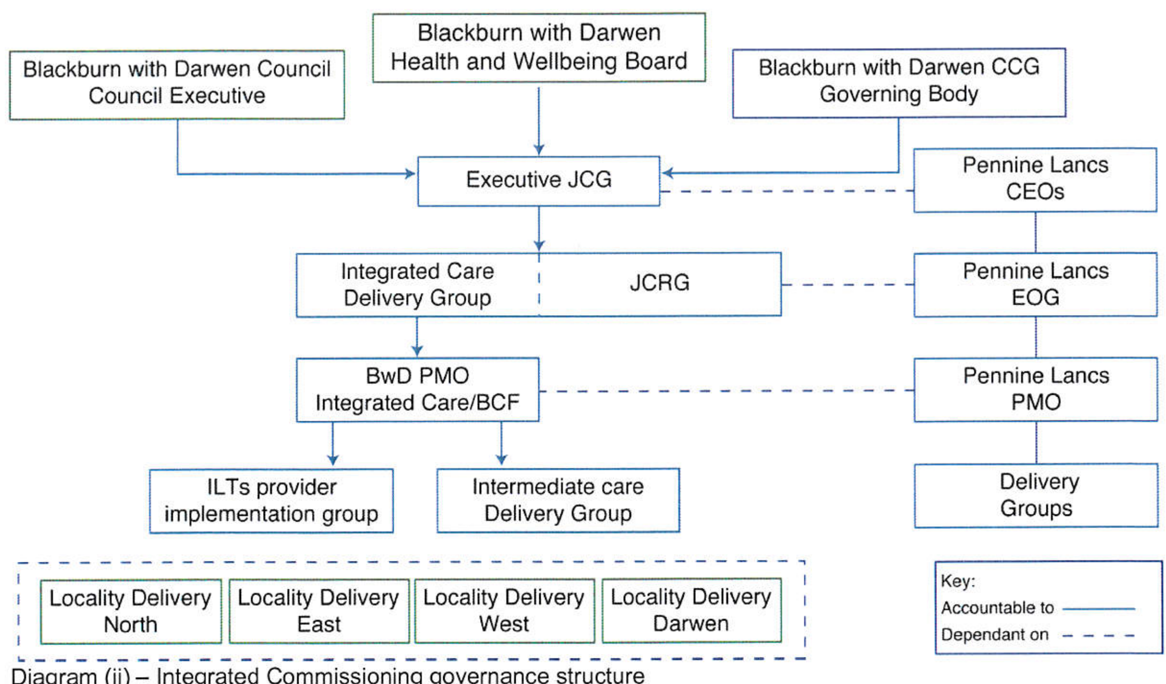

Diagram (ii) – Integrated Commissioning governance structure

A **Section 75** agreement will be established across the health and social care economy to support the governance of the pooled resource and commissioning decisions from April 2015. This will be overseen by the Exec JCG on behalf of the Health and Wellbeing Board.

The Section 75 agreement will establish the Better Care Fund risk sharing principles between the 2 organisations and provide assurance to the Governing Bodies. The Better Care Fund Plan will invest resources into services that impact upon other parts of the health and social care economy, and as such these changes need to be monitored and reported. The pooled budget itself has a minimum value and as such maybe increased if required. The risk sharing principles are:

- The financial position of the pooled budget will be reported on a monthly basis and any

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remedial action agreed by the Exec JCG

- The pooled budget will not fund unrelated demand pressures, or underlying growth in existing services, as these will be funded by the responsible organisation, although the Exec JCG will consider changes in demand arising from BCF interventions
- If there is an increase in service costs, the responsible commissioner will refer to the Exec Joint Commissioning Group for overview of available pooled budget resources
- Any underspend on the BCF will be returned to the pooled budget to support future commissioning intentions

The Section 75 agreement will articulate how the Risk Sharing agreement will work across the health economy. Remedial action for non-delivery of the performance element of the pooled fund will need to be incorporated into the agreement. Forecasting during the year will inform the Exec JCG on progress and risks, and remedial action taken. This may include identifying schemes that are not delivering the expected outcome will be reviewed and possibly disinvested from, and or utilising contingencies set aside in the pooled resource.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

A joint Blackburn with Darwen **Programme Management Office for Integrated Care** has been in place since July 2014 to ensure delivery of planned changes at 'scale and pace'. The Senior Responsible Officer (SRO) holds fortnightly meetings, with senior representation from Blackburn with Darwen CCG, Blackburn with Darwen Local Authority and Lancashire Care Foundation Trust, where delivery progress against the programme plan is considered and discussed along with operational and corporate risks to delivery. The Programme Management Office is led through a jointly funded Programme Director supported by a jointly resourced team.

The Programme Management Office take responsibility for:

- Leading the development of **Better Care Fund integrated care programme and project plans**, including key enablers (i.e. Communications and Engagement plans, IT and Estates)
- **Timely delivery and implementation** of Better Care Fund integrated care programme and project plans
- Identifying **risks, formulating mitigating actions and escalating** to SRO where appropriate
- Reporting and forecasting Better Care Fund **budget spend**
- Leading and supporting the development of **business cases** as and when appropriate
- Collating and reporting Better Care Fund **performance measures** across the Local Authority, CCG and to Health and Wellbeing Board
- Ensuring **inter-dependencies** and opportunities for wider joint working across other programme areas are capitalised and resources shared where appropriate
- Providing programme delivery **assurance** to Exec JCG members

To support delivery, Better Care Fund integrated care is also a standing agenda item at the monthly BwD Joint Commissioning and Recommendations Group and key programme updates are provided by the SRO. Programme risks are escalated and relevant actions agreed accordingly.

We are currently in the process of identifying interdependencies across East Lancashire Hospital

Trust, Lancashire Care Foundation Trust service transformation offices and the wider integrated programme teams across Blackburn with Darwen and Pennine Lancashire to ensure efficient and timely delivery and clear mechanisms for risk identification and mitigation across the Pennine Lancashire system.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Capacity Building in the Voluntary Sector (Blackburn with Darwen)
2	Co-ordination of Dementia Services (Blackburn with Darwen)
3	Integrated Offer for Carers (Blackburn with Darwen)
4	Integrated Locality Teams (Blackburn with Darwen)
5	Intermediate Care and discharge to assess (Pennine Lancashire)
6	Intensive Home Support (Pennine Lancashire)
7	Co-ordination Hub and Directory of Services (Pennine Lancashire)

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

We have not attributed any costs against the potential impact of the risks identified; however, work will be undertaken through the Joint Commissioning governance arrangement in Blackburn with Darwen to understand costs.

There is a risk that:	**How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely***	**Potential impact**	**Overall risk factor *(likelihood *potential impact)***	**Mitigating Actions**
Extreme winter pressures impact on ability to achieve 3.5% emergency admissions reduction target	3	4	12	A cross health and care economy plan has been agreed for 2014/15 annual resilience funding which outlines how the economy will support whole system resilience.
We will not provide an effective IT	2	5	10	A cross organisational group of senior IT and IG officers has been brought together to look at the short term solutions and

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solution or have shared systems				long term resources required to deliver Lancashire Patient Record Exchange Service.
Members of the public fail to engage with change and continue to access health and care services inappropriately	4	2	8	We will continue to engage patients and the public through new and existing forums. A communication and engagement plan is in development.
Performance related payment is reliant on outcomes that may not be sufficiently evidenced or include cohort of patients not targeted by BCF.	3	5	15	BCF Metrics cross organisational group has been brought together to understand the impact of performance payment and will develop a monitoring framework to monitor compliance.
We do not effectively manage the introduction of the Care Bill	3	3	9	Robust planning of impact and implications is being conducted locally and regionally. Financial modelling is being undertaken by ADASS. The Integrated Care Programme has been aligned to emerging workforce development plan at BwD Local Authority.
Improved patient experience and quality of care may not directly translate to the required reductions in acute and nursing home admissions, within required timescale.	3	3	9	Proposal has been developed with the latest information available and will be monitored in the coming 12 months. All data and metrics will inform the development of business cases and commissioning intentions.
Capacity in community care and social care is not sufficient to manage increased demand for care and potential to destabilise existing structure (particularly acute sector)	2	4	8	Providers have been included in the development of the BCF Plans and will allocate resources accordingly to limit impact on patient/user services. A phased approach to the Integration of health and social care teams will limit the negative impact of transition. Further work with acute providers is required.
Population growth and increasing	2	4	8	Proposals are based on available information and will be refined as delivery

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demand for services				progresses. A local ISDA has been produced and will inform the development of our Integrated Locality Teams.
We will not gain agreement from all partners for scale of change required	2	4	8	Our Better Care Fund Plan has been agreed across the Health and Wellbeing Board and wider partnership. We are developing a stakeholder engagement plan to ensure ongoing communication of consistent messages.
We do not have the right workforce with the right skills and capacity to deliver our plans including for 7 day services	4	3	12	Workforce development plans within single agencies and across the partnership are being reviewed and aligned to ensure they meet the requirements set out within plan.
Transformation change is not achieved within planned timescales	4	3	12	The existing governance structure includes providers and risks will be escalated accordingly through shared risk register. A clear performance framework with shared KPI's is in development and will be monitored through existing governance arrangements.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The pooled budget has identified the resource for a contingency reserve to offset the financial impact of not fully delivering the anticipated reduction in non-elective admissions - the payment for performance equates to £635,000. The contingency will be used to either offset the increased costs of emergency admissions or be utilised to bolster services to fully deliver the reduction in activity.

Quarterly reviews associated with Pay for Performance will be undertaken through the programme governance structures.

Investments from the pooled budget will be evaluated to inform decisions of the Exec JCG. Section 4b describes the Risk Sharing Arrangements and further discussions are being held with both the community health provider and the acute provider to agree the risk sharing between commissioners and providers.

All these issues have been discussed with Health and Wellbeing Board members and they have supported this approach. Health and Wellbeing Board members discussed the risk of a severe winter and the impact this could have on emergency admissions as experienced in 2012/13.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The Better Care Fund Plan is part of a whole systems approach to integration, including plans to implement the Care Act.

Integrated care is an approach best suited to frail older people, children and adults with disabilities, people with addictions, and those with multiple chronic and mental health illnesses, for whom care quality is often poor and who consume the highest proportion of resources (Nuffield Trust/The Kings Fund 2014)

To achieve the scale and pace required to deliver our ambitious plans we will use our existing governance arrangements, through local joint commissioning to bring together and ensure consistency between the initiatives funded through Better Care Fund and other key integration work streams. Regular reports will be provided to the Health and Wellbeing Board and any opportunity for shared resource and ongoing communication will be identified through the Integrated Care Programme Office and Joint Commissioning and Recommendations Group.

Given the complexity of the current pathway, service configuration and the complex health and social care needs of our population, a phased approach will be taken to implement integrated care across Blackburn with Darwen.

2014-19- Aging Well
Focus on frail elderly and people with Long Term Conditions, including those on the end of life pathway as part of our Better Care Fund Integrated Care programme

2014-16- Living Better
A number of integrated care programmes are in development to improve outcomes and enhance experience of those affected by mental health, substance misuse, social issues and learning disabilities including:

Transforming Lives
The Transforming Lives approach aims to bring about a whole sector cultural change, shifting focus towards greater early intervention and prevention and getting to the root causes of problems. A phased approach to delivery is being developed with a focus on individuals who are experiencing a number of risk factors and where multi-agency interventions will be beneficial. Risk groups identified include mental health and well-being problems, substance and alcohol misuse, repeat victim or perpetrator of violence and/or aggression and frequent malicious caller to emergency services.
The Making Every Adult Matter
The Making Every Adult Matter project which has been co-produced by a range of partners including the Police, Police Crime Commissioner, Public Health, Blackburn with Darewen CCG, Adult Social Care, Safeguarding Unit, Community Safety Partnership and the Voluntary Community Faith Sector. The aim of the project is to work with the most complex and vulnerable adults in BwD (those facing issues of mental health, homelessness, offending, substance misuse) to improve their wellbeing and support independence.
A & E liaison
The aim of the project is to improve the quality of care for patients (and their carers) who

regularly attend the A&E department at Royal Blackburn Hospital site for violence, alcohol misuse, drug misuse and/or mental health conditions by reducing the amount of inappropriate time that staff spend with this cohort to enable their time to be spent in a more effective and efficient manner, utilising their professional skills. Two police officers have been placed within the A& E department who work closely with a range of internal and external health and other staff and teams to identify and deal with frequent A&E attenders who could be supported in the community and might not necessarily need A&E services. Officers work in close partnership with A&E staff, Mental Health Liaison Team, Hospital and community based drug and alcohol services. Currently officers are compiling a list of frequent A&E attenders who could be supported outside of the A&E department.

Links are being established to develop a referral pathway into Making Every Adult Matter (MEAM) and Transforming Lives initiatives. Officers will also be identifying patients who can be supported via the multi-disciplinary approach within the new Integrated Locality Teams, communicate with the MDTs, initiate referrals to ensure patients do not un-necessarily present at the A&E department and can be supported in their own localities/homes.

2014-17 Start well

Our approach to developing integrated care around the needs of children, young people, families and their carers will initially focus on our Early Help offer, provision for children and young people 0-25 with Complex Needs, and developing a locality offer for children and families.

Early Help

Our Early Help plans incorporate the key principles for an integrated multi-agency approach to the development and implementation of effective Early Help which requires a whole family approach and encompasses all stakeholders working with children, young people and families. The strategy applies to all children and young people in Blackburn with Darwen aged pre-birth to 19 years (and beyond for children in care and those who have a disability). It takes into account children, young people and their families who have specific needs or vulnerabilities and those in family circumstances presenting challenges. We are currently working with the NHS England Area Team to plan the transition of the commissioning of health visiting services into the Local Authority by October 2015. Children's Centres have been identified as the key vehicle for delivering the Early Help work, and the Early Help Strategy has been embedded as part of the core purpose across the network of children's centres. Early Help and Social work services have also been reviewed; structurally integrated and now work across the four local areas, with clear social work links with schools through named social work managers. This integration of services and strengthened locality focus, is ensuring smoother; more seamless and uninterrupted pathways between Early Help and social care for children and families.

0-25 complex needs strategy

We have made good progress locally in developing our integrated Education, Health and Care assessment processes and plans for children, young people with complex needs and their families and carers. Our plans focus on delivering our shared vision to 'work together to support all children and young people aged 0-25 with complex needs, their families and carers to maximise their opportunities, enhance their experiences, promote social inclusion and enable them and their families to live ordinary lives wherever possible in their local community.' We will have processes in place by September 2014 for shared assessments and planning with an initial focus on under 5ablements and young people transitioning into adulthood.

Paediatric admissions

The CCG is outlier for paediatric admissions. The commissioning intentions for 2015/16 will include more accurately classifying paediatric attendances at the acute provider following an external evaluation of the current methodology, including a review of pathways to ensure children are seen in the most appropriate setting. It is envisaged that this will result in the admissions in the health economy moving to the expected rate. We will also work with acute and community health providers to develop specific admission avoidance schemes with a particular focus on respiratory conditions.

Alignment to wider plans

Housing

The Council and its partners have developed a 5 year, older person's housing strategy geared towards delivering greater choice, quality and independence for local people that will:

- Enable older people to feel safe and live in a pleasant environment
- Enable older people to repair, improve or adapt their homes
- Enable older people to live in energy efficient homes
- Improve housing related support
- Promote specialised and affordable housing developments for older people
- Provide appropriate housing choices and advice for older people

Blackburn with Darwen Local Authority has a number of flagship housing developments in train, including 2 large scale extra care developments that will include facilities for intermediate care and dementia. There are also 3 new-build care home facilities being provided to ensure that accommodation for older people is of the highest quality and that residential care homes are of a financially viable size and type to ensure the long term sustainability of care homes in the Borough. The Local Authority has used the Housing Learning Improvement Network Toolkit as well as POPPI/PANSI data to identify its future requirements for the various housing types across sheltered, very sheltered, extra care and residential provision so that older people in Blackburn with Darwen can remain independent for as long as possible.

Assistive Technology

The Borough Council now has approximately 1900 users of Telecare and plans to extend the use of assistive technology and Telehealthcare much further through the next phase of the safe and well programme (prevention plus) to a range of groups, including:

- Self-funders with low, moderate or no Fair Access to Care Services (FACS) needs
- Adults with complex support needs receiving high cost packages
- Informal carers
- Those at risk of falls
- Those with long term conditions
- Socially isolated older people

The development of a retail offer for assistive technology differs considerably from the traditional FACS eligible service, needing to be badged and sold as lifestyle equipment to help people stay independent for longer so as to be attractive enough to purchase.

Personal budgets

Embedding personalised approaches into care and support planning will become the default

assumption in realising our integrated care delivery plan. The implementation of the Care Act will be a significant catalyst in shifting leadership and control of decision making to individuals. An essential element of this process will be ensuring support to individuals where required and ready access to universal services, information, advice and guidance. We are working with key community leaders and partners within the Voluntary, Community and Faith sectors to enhance our local offer around information, advocacy and support to individuals to enhance their wellbeing and improve their connections to family, friends and community.

Blackburn with Darwen has expressed an interest to participate in the Integrated Personal Commissioning Programme which, if successful, will further support our plans to jointly embed a personalised approach to integrated care.

Pennine Lancashire annual resilience plan
The Pennine Lancashire System Resilience Plan has been developed by Unscheduled Care key stakeholders across the system. There is a clear alignment of service developments, particularly Intensive Home Support, Discharge to Assess and Care Navigation.

The Healthier Lancashire Programme
The commissioners of health services across Lancashire are keen to undertake the development of a "Health and Care" strategy across the county which will build upon the work undertaken by the Lancashire Improving Outcomes Board and more recently, the Lancashire Transition Group. Projects include in and out of hospital care, digital health and collaborative leadership.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Integrated Care is central to the achievement of strategic plans across both local government and CCG strategic and operational plans.

For the CCG this is reflected in the CCG 5 Year strategic plan, specifically within:

- Corporate Objective 2 - We will build and maintain successful partnerships so that care for people whether from an individual or organisation in or outside of the NHS is integrated with no gaps and no duplication. We will do this through the implementation and delivery of the Better Care Fund programme, and reducing emergency admissions through urgent care.

- Corporate Objective 4 - We will co-commission and deliver continuous improvement in Primary Care services and tackle inequalities. We will do this working supportively with NHS England improving access to primary care and out of hour's services, improving the quality of life for people with long term conditions, through the implementation and delivery of the Better Care Fund programme and reducing variation in Primary Care services. Six of nine of the High Impact Changes outlined within the CCG 5 year plan reflect the key changes within our Better Care Fund Plan. They are:

High Impact Change 1	Delivering high quality primary care at scale and improving access
High Impact Change 2	Self-care and Early Intervention
High Impact Change 3	Enhanced Integrated Primary Care Services
High Impact Change 4	Access to Reablement and Intermediate Care (and links to Better Care Fund)
High Impact Change 5	Improved Hospital Discharge and Reduced Length of Stay

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High Impact Change 6	Community Based Ambulatory Care for specific conditions (and links to Better Care Fund)

A detailed 2 year operational, financial plan has been developed and extended into a forecast plan for 5 years. This plan supports our joint commissioning intentions for delivery of the 5 year strategy. Investments in the Better Care Fund and the High Impact Changes are planned to deliver these efficiencies. Such investments are designed to improve both quality and patient experience, whilst providing value for money. Reducing avoidable admissions and releasing this resource for care outside of a hospital setting will enable the CCG to deliver a sustainable financial position and by doing so in a planned way must deliver a sustainable health economy.

There is strong alignment between the Better Care Fund Plan of action and the Borough Council's three year Corporate Plan 2012-2015. A pre-existing NHS measure in the Borough Council's Corporate Plan was amended during 2014 as part of a Corporate Plan refresh, to enable alignment with the Better Care Fund measure re 'Unplanned Emergency Admissions'; a further refresh to has now been agreed to align with the new Better Care Fund 'Total Emergency Admissions' measure. Although the Council's 2015-2018 Corporate Plan has not yet been developed it will be aligned to the Better Care Fund Plans.

The Local Authority's Adults and Strategic Commissioning Business Plan aligns closely with Better Care Fund priorities. Local policy drivers for Adults (section 3.2) include integrated commissioning arrangements with the CCG, and a focus on public health and well-being; with partnership working prioritised in section 3.3. Business Plan objectives for 2014/15 include:

- To further extend the use of assistive technology through the Safe and Well Programme; and
- To increase the availability of intermediate care and reablement services.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Blackburn with Darwen CCG has submitted an expression of interest to co-commission Primary Care (General Practice) with NHS England Lancashire Area Team. The CCG believes this will build upon the solid relationship it has with the Local Area Team and enable the development of Primary Care at scale and pace to provide improved quality of services for the population and greatly assist in transforming the local health economy – thereby enabling it to be sustainable in the future.

In taking this collaborative approach to the commissioning of General Practice services, with a stronger focus on local clinical leadership and ownership, will allow more optimal decision making about the balance of investment across primary, community and hospital services. Co-commissioning of Primary, Community and Social Care will support co-ordinated care by enabling commissioners, providers and patients to work together to agree what integrated out of hospital care looks like; develop and negotiate new ways of contracting locally that encourage a shared responsibility for holistic care; deliver patient/population based outcomes and support delivery of the large scale transformation change required.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The Better Care Fund will be used to support the development of a range of social care services which also have a health benefit. In order to protect social care services we will ensure that those in need within our local communities continue to receive the support they require in a time of growing demand and financial pressures. Our primary focus is developing new forms of joined up care which help ensure that individuals remain healthy and have maximum independence.

We will continue to maintain and protect our existing offer of provision whilst enhancing the broader offer across public sector agencies including Housing, Health, Police as well as the Voluntary Sector and communities.

The protection is intended to prevent the diminution of support to vulnerable or needy members of the population not to protect particular services, professions or staff groups or departmental or organisational budgets. This would be consistent with person-centred service and the general duty to promote wellbeing and prevention as part of the Care Act.

We will do this by:

- shifting the current pattern of intensive provision to a more sustainable preventive model for a wider cohort of people, with services which promote independence for as many people for long as possible
- maintaining a focus on person-centred care including support to access universal services
- continuing to provide social care resources for integrated locality teams to co-ordinate preventative action and early intervention; working holistically with those most at risk of deterioration or possible crisis; and those who need ongoing health and care services
- ensuring clear accountability for service delivery and governance so that integration does not mean vagueness about responsibility
- a shared striving for greater equity of outcomes for the population
- further developing relationships across health and social care
- utilising social capital and community assets
- ensuring that our most vulnerable citizens are safeguarded and protected from harm
- supporting self-care and addressing risk through interventions of least intrusion e.g. The Safe and Well programme
- extending our successful housing and support programme to provide additional, high specification , modern facilities that reduce reliance on long term care through a model of rehabilitation, reablement and tenancy based care and support

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Within Blackburn with Darwen, the Local Authority 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 Better Care Fund Plan.

These services have been included within the Better Care Fund Plan and partners have agreed that they will be protected insofar as they make an effective contribution to delivering the agreed vision, aim and objectives of the plan. There is an intended shift in investment to grow those health or social care services that effectively support the delivery of the Better Care Fund Plan. However, where services are not delivering expected outcomes, work to transform and redesign them will be undertaken jointly. This will draw upon 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

Ref no.	Scheme	Impact on social care
1	Capacity Building in the Voluntary Sector	Through the development of a Voluntary, Community and Faith consortium built around an agreed and unifying specification and delivery framework we will improve a broad range of wellbeing outcomes for all citizens.
2	Co-ordination of Dementia Services	We are investing better care fund setup resources in capacity to develop services and improve co-ordination in relation to Dementia. This will assist us to drive up diagnosis rates and provide a range of preventive support services for local people
3	Integrated offer for Carers	Embedding personalised approaches into care and support planning will become the default assumption in realising our integrated care delivery plan. The implementation of the Care Act will be a significant catalyst in shifting leadership and control of decision making to individuals. An essential element of this process will be ensuring support to individuals where required and ready access to universal services, information advice and guidance. We are working with key community leaders and partners within the Voluntary, Community and Faith sectors to enhance our local offer around information, advocacy and support to individuals to enhance their wellbeing and improve their connections to family, friends and community. Increase in numbers of Carer Assessments, greater access to integrated information, advice and guidance services, increased uptake of short breaks, Specific health and wellbeing needs of carers met at a community and Primary Care level.
4	Integrated Locality Teams	Continuing to provide social care resources for integrated locality teams to co-ordinate preventative action and early intervention which will serve to both protect and enhance the social care offer.
5	Integrated Discharge Service (Pennine Lancashire)	Realignment of hospital based social care capacity generating more assessment capacity within the community.
6	Intensive Home Support (Pennine Lancashire)	Realignment of health and social care offer to focus on those with changing levels of need and providing additional reablement and domiciliary care.
7	Care Co-ordination	More effective utilisation of resources reducing

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	Hub (Pennine Lancashire)	duplication across PL health and care provision.

Underpinning these specific schemes we are developing a range of services which will further support social care which include:

- The Safe and Well Programme
- Prevention Plus
- Integrated Health and Wellbeing Service

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

Within our Better Care Fund Plan £4,179,000 has been allocated for the protection of social care services. We can confirm that £423,000 has been allocated to social care for the implementation of the new Care Act duties of which £200,000 is allocated against carers.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Blackburn with Darwen is working with local and regional partners to implement the broad range of duties contained within the Care Act. This far reaching legislation is being delivered through a dedicated project management resource and governance structure.

Specific work streams are being targeted to deliver the key principles of wellbeing, prevention and partnership with wellbeing being the common theme around which care and support is redesigned and delivered. This includes a cultural shift in practice across the public sector landscape that will involve:

- Extending the duty of wellbeing, prevention and demand reduction across all partner organisations through integrated care, support and an enhanced offer of tailored advice, information, guidance and facilitated signposting
- Provision of assessment to users who have previously self-funded
- Investing in additional advocacy support to ensure people are able to participate in care and support planning as owners and leaders of their health and wellbeing
- Enhancing support to unpaid and family carers to ensure the wider take up of assessments and personalised support plans
- Placing the Local Adult's Safeguarding Board on a statutory footing and continuing to embed the key principles of the rights of people to live the lives they wish protected from harm and underpinned by a culture of supportive positive risk taking
- Implementing a co-ordinated communication and workforce management strategy across all sectors to embed the key principles of the Care Act.

The estimated costs of implementing the 2015-16 elements of the Care Act have been calculated using toolkits shared through ADASS, and the proportion of this contained within the BCF (over and above new burdens funding received by the Council from DH) earmarked within the financial template enclosed with this plan. Our cost estimates include: additional social work resources need to undertake assessments, the costs of deferred payments, IT infrastructure, carers'

support and new advocacy provision.

v) Please specify the level of resource that will be dedicated to carer-specific support

A total of £390,000 from the Better Care Fund will be dedicated to carer specific support. This will include:

Delivering carers assessments	£66,000
Carers packages costs	£51,000
Other carers costs	£80,000
Health contribution to carers services	£193,000
Total	**£390,000**

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The financial and resource impacts of implementing the new duties of the Care Act have not yet been fully scoped or agreed at a national and local level, further guidance is awaited from government. However, the new national eligibility criteria, changes in funding for long term care, increased uptake of assessments for carers and self-funders and the extension of the Deferred Payment Agreements will place new burdens on local authorities.

b) **7 day services to support discharge**

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Moving health and care services from 5 to 7 days is a key commitment across the Health and Care system. The day of the week on which a person becomes ill (or recovers from illness) should not be the determinant of the services that someone can receive, or the speed with which they can access services or return home.

Our plans will build on good practice already being delivered to safely discharge patients and prevent admissions and readmissions as part of annual resilience planning. There are a number of existing schemes in place which support 7 day working. They include:

- Co-location of GP service within Primary Care to support a Primary Care pathway across the urgent care system
- Intermediate care including Rapid Assessment and Treatment Service (RATS)
- Domiciliary care services
- Reablement offer
- North West Ambulance Service pathfinder
- Community pharmacy, particularly 100 hour pharmacy
- A&E mental health and police liaison services and Multi- Agency Safeguarding Hub

New developments for 7 day service provision, linked to Better Care Fund Plans will commence between October 2014 and March 2015. They include:

- Development of an Intensive Home Support service (January 2015)
- Integrated discharge service
- Care navigation hub (commence October 2014)

- 7 day discharge into bed based provision

Primary Care (with General Practice at the centre) is being developed to function in an integrated Health and Social Care model which will be accessible on a 24/7 basis through core, extended and out of hours elements. Across Blackburn with Darwen, services will be delivered through a locality model with a wider range of community based, high quality services for patients
Acute and community health providers across Pennine Lancashire are signed up to deliver a quality improvement plan as a result of a recent CQC inspection. The plan outlines actions towards achievement of 7 Day Working: Delivery of NHS England's 10 Standards of Care and includes clear actions to be delivered between 2014 and 2016. They include:

- 2014/15 - there is an expectation that providers will identify short term measures to support delivery of 7 day services
- 2015/16 - expectations around 7 day services will be included within all providers quality schedules as part of NHS Standard Contract

Our commitment to the development of 7 day services will contribute to the achievement of Better Care Fund outcome metrics including:

- Reducing delayed transfers of care
- Reducing emergency admissions
- Effectiveness of reablement
- Reducing admissions to residential and nursing care
- Improving patient and service user experience

Risks associated with delivery of 7 day services (cross referenced with risk log section 5)

- Skill and knowledge of current workforce
- Capacity of workforce to deliver 7 day services
- Financial risk
- Patient safety/experience

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Using NHS numbers as primary patient identifier is a key aim for both health and social care in BwD.

Across the Lancashire health care organisations, there is over 98% usage of the NHS number as the prime identifier, with 2 of the 3 upper tier authorities implementing new Social Care systems and having written into their implementation plans that they will populate these systems with the NHS number. A condition of linking to the **Lancashire Patient Record Exchange Service (LPRES)** will be the ability to have the NHS number as a key identifier within any published data set. By making the NHS number the key identifier and only allowing data sets that have this as their key identifier, LPRES will support the propagation of the NHS patient information across all care settings.

In support of this activity, Blackburn with Darwen Borough Council are in the process of implementing a new Social Care System (Mosaic – Corelogic), which incorporates the use of NHS Number as a primary indicator. The Local Authority has undertaken a data matching

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exercise to allocate NHS numbers to Social Care records. This has been successfully completed for approximately 80% of Social Care Users. The remaining service users will be allocated NHS numbers once a further data matching exercise with the NHS has been completed. Following this, business processes will be updated to ensure compliance with the requirement to include NHS number by ensuring this data is gathered at assessment stage for every new service user.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

All GPs across East Lancashire share a common GP IT System (EMIS Web), providing the ability to integrate, via the Medical Interoperability Gateway (MIG), with local healthcare systems. All GPs are using a secure NHS Mail service.

The current Adult Social Care application, which supports the Better Care Fund Plan, has been confirmed as following open standards and also includes use of the NHS Interoperability Toolkit (ITK) for integration with Health and Social Care systems. This enables the delivery of secure and interoperable application services, while ensuring robust, effective and secure information and data flows across the whole health and care system. Further to this the procurement process for IT solutions within Blackburn with Darwen Local Authority has been updated to include specific requirements around application APIs and open standards, including, where appropriate, interoperability standards within the NHS ITK, to support system integration and data sharing.

All NHS provider organisations across the health economy are working towards ITK compliant messaging and using integration tools and standard messaging to better share data. Initial work has already included the sharing of Admissions, Discharge Transfer messages and feedback to these messages telling the local acute trust when a patient is known to the local community health provider. The usage of LPRES (the Lancashire Patient Record Exchange Service) will only further this intention and the technical ability to move more quickly in seamless sharing and views of data across the Blackburn With Darwen health and social care economy.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

A full IG Framework is already in place across organisations in Blackburn with Darwen for sharing information. This will be used in the initial stages of the programme pending the development of an online wider Information Sharing Portal. Privacy Impact templates are also in place to identify any risks to personal confidential data as per Information Commissioners Office requirements.

IG controls are in place across all organisations demonstrated by IG Toolkit compliance. IG protocols including Tier 0 and Tier1 Information Sharing procedures are available across the partnership.

Information sharing agreements detail the process for securely sharing the information with patient consent. Explicit Patient consent will be used as the basis for sharing information, this will be recorded and the patient may withdraw consent at any time.

A Privacy Impact Assessment is completed as per ICO requirements to ensure that all potential risks are identified and mitigated if possible.

All organisations involved in the Better Care Project submitted a satisfactory IG Toolkit for Version 11 and will be working to ensure that V12 of the IG Toolkit is also compliant. The IG Toolkit encompasses the Caldicott 2 requirements.

In addition Public Services Network (PSN) compliance has been achieved by Blackburn with Darwen Local Authority in addition the IG Toolkit compliance.

The NHS Standard Contract will be used where external contractors are commission, in addition other IG controls will ensure that external contractors are IG Toolkit Compliant or ISO 27001 certified and registered with the ICO as a Data Controller.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

NHS England actively encourages CCGs and GP practices to use risk stratification tools as part of their local strategies for supporting patients with long-term conditions and to help prevent avoidable unplanned admissions. As part of the 2013/14 GP contract, NHS England introduced a new Directed Enhanced Service (DES) that promotes the use of risk stratification tools for identifying and managing patients who are chronically ill or who are at high risk of emergency hospital admission.

Over the last 12 months Blackburn with Darwen has been actively working towards embedding risk stratification in general practice to identify patients at high risk of hospital admissions. Our current approach to risk stratification of patients is predominately primary care led. Significant work has been undertaken to introduce Primary Care data to the risk stratification tool with an ambition to have combined data available to practices by Autumn 2014.

The updated tool will support accountable lead professionals (health and social care) to work proactively with patients before they become unwell and ensure that a tailored care plan is in place.

BwD has a total GP registered population of 169,427 and in the last 12 months recorded 18,183 hospital admissions. To further understand and plan for future service provision we have risk stratified our entire population, the breakdown is as follows:

Age Group	% at high risk of hospital admission	Total population in cohort	Population ratio
0-15	0.7	37,311	1: 30
16-64	2.8	108,440	1: 22
65+	2.3	23,676	1: 6

The evidence is further supported when you consider people over 75 years of age:

Age Group	% at high risk of	Total population in	Population ratio

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	hospital admission	cohort	
75+	1.6	10,418	1: 4

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

In Blackburn with Darwen significant work is underway to align health and social care assessment and joint care planning.

- A joint assessment process has been agreed by Lancashire Care Foundation Trust and Blackburn with Darwen Local Authority and work is underway to embed the document in IT systems.
- A cross organisational IT/IG group has been brought together to support the development of care plans and joint assessment documents and ensure remote capability
- Community Care Pathway (CCPs) plans are currently being used with 11 patients in Blackburn with Darwen East area. The CCPs are the product of ongoing work with North West Ambulance Service (NWAS) to prevent avoidable admissions by offering care pathway options and alternative contact points into community services.
- We have started to pilot the use of a common assessment framework within the Transfers of Care programme across health and social care providers, the learning of which will inform wider integrated care projects.

The most vulnerable individuals will be identified using predictive risk stratification tools and techniques that will provide clear information on population need in each locality. The identification of a patient's health risk category is the first step towards planning, developing and implementing a personalised patient care plan, in collaboration with the patient.

As part of the development of Integrated Health and Social Care Locality Teams (Scheme reference Number 4) we are adopting a case management approach to patient centred care. The integrated care teams will regularly conduct case reviews with input from GPs to improve patient care and address need as early as possible. Multi-disciplinary Teams will operate in the community and be aligned to GP practice groupings across the Borough, with core teams comprising of a social worker, GP, practice nurse, community health practitioners, nurse practitioner and health care support worker, including a mental health practitioner where required. This model of delivery is being implemented on a phased basis across 4 localities and 29 GP practices.

Ongoing activity looks to build on the Integrated Patient care plan which is on GP EMIS system and will be developed and utilised to care plan across all organisations. A review framework and single assessment process has been developed and is being finalised during the development of the integrated locality teams and agreed by LCFT and BwD BC to ensure compliance and consistency.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

We are currently working with our community health provider and Primary Care to identify the proportion of high risk individuals who already have a joint care plan in place. Of the 3400

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patients across Blackburn with Darwen who are at highest risk of an unplanned admission, 4% currently have a joint care plan in place. The remainder of these patients are being jointly assessed by health and social care services and where required, appropriate joint care plans will be developed with the patient.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Blackburn with Darwen CCG and Blackburn with Darwen Local Authority have an ongoing co-ordinated plan of engagement activities. Listening to and learning from the views of patients, carers and the public has been key in informing the priorities for the development of integrated care and the Better Care Fund Plan. The activities to date have included:

- Ongoing public involvement in development and delivery of Health and Wellbeing Strategy priorities.
- Public involvement in the Integrated Strategic Needs Assessment (ISNA) to understand the state of local health.
- Specific Better Care Fund updates provided to Healthwatch members. Healthwatch are also represented on the Health and Wellbeing Board who have received regular updates on Better Care Fund Plans.
- The Health and Wellbeing Board 'HealthTalk' day, which included engagement with local residents and community groups on emotional wellbeing.
- The launch of the digital public health annual report, which features the stories and experiences of local residents and health professional.s
- Ongoing Patients' Voice events, where CCG Chair meets with patients, carers or members of the public individually to hear their stories and feed those into service planning and quality monitoring.
- Engagement prior to, and during, the Enhanced Integrated Community Service (EICS) pilot project, which identified the concerns and needs of patients and carers with Long Term Conditions and co-morbidities, in order to develop patient-centred practice and has been used to influence the development of the plans for the Better Care Fund.
- Meetings with representatives of GP practice patient participation groups.
- A website is currently awaiting approval and a patient survey will be developed in relation to integrated care and the BCF.
- The CCG and Local Authority were involved in the planning of an Age UK event in March 2014, which was specifically aimed at engaging people aged 50+ and focused on the care needs and issues of frail elderly people, those with Long Term conditions and vulnerable people, as the first phase of the Better Care Fund plan.

Specific dates and meetings where Better Care Fund and integrated care have been discussed with members of the public are outlined below.

Date	Forum
29th January 2014	50+ partnership
29th January 2014	Families Health and Wellbeing Consortia
29th January 2014	Healthwatch

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5th February 2014	BCF focus group- residents
31st October 2013	HealthTalk
30th January 2014	Patient representation forum

Children, young people (0-25) with complex needs – Jan 2013/Feb 2014
On-going engagement with parents and carers of children and young people with complex needs has identified a consistent need for integrated service provision. Priorities include:

- Holistic, flexible and integrated services that are preventative and not crisis driven
- Services that focus on family as well as the disabled child and young person, that are individualised and locally based
- The development of Integrated services which are valued; parents and carers dislike multiple and repetitive contacts with services
- Streamlined referral pathways, assessment processes and planning
- More information regarding eligibility criteria for different services across education, health and social care.

Ongoing Engagement
A comprehensive Integrated Communications and Engagement strategy is currently being developed to maximise opportunities to both push and pull information to/from the relevant stakeholder groups. This strategy will also ensure that information is cascaded in a timely fashion in the right places and the right format. This strategy will cover the lifetime of the Better Care Fund and beyond.

The aim of this strategy is to develop a shared vision including key messaging, (potentially) a shared brand, a commonly understood language whilst driving support and buy -in from all partners. The strategy will be developed and implemented in partnership by the Local Authority and CCG communications teams.

The strategy will be both multimedia and multi-layered to maximise engagement opportunities and reach. Emphasis on face to face communications will continue using our networks of health trainers, community wellbeing co-ordinators, Healthy Communities Partnerships, patient involvement groups and neighbourhood teams.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Engaging and co-producing our plans with local health service providers is critical to the success of delivering integrated care in Blackburn with Darwen.

The majority of acute hospital services for our population are provided by East Lancashire Hospitals NHS Trust with community, specialist mental health and dementia services provided though Lancashire Care Foundation Trust.

Blackburn with Darwen CCG and Local Authority have been working closely with health providers

for over 12 months on the development of an integrated care vision and case for change.

Providers of health, social care and voluntary sector have been fully involved in the development of an integrated care vision, the Pennine Lancashire Pioneer proposal and case for change for integrated care and there is clear alignment of strategic plans across both acute and community health providers.

A key driver of ELHT's Integrated Business Plan is its Clinical Strategy. A fundamental element of this Clinical Strategy is for the Trust to enhance its provision of community service. These include services traditionally provided in a community setting, but also more outreach services from the hospital.

Specifically this means delivering care across the whole patient pathway, between home centred, intermediate and hospital based care. Examples include diabetes and respiratory care and particularly services for the frail elderly.

The Trust states in its 5 year plan that there is a shared health and social care vision for reforming the emergency pathway and developing locality based services across the 14 intended neighbourhoods across Pennine Lancashire. In particular the Trust wishes to:

- Improve our integrated discharge arrangements to allow, as much as is possible, our patients to recover in a non – acute setting
- Continue to work in collaboration with our local commissioners to reform the urgent/emergency care pathway and therefore prevent unnecessary attendance/admission to hospital
- Deliver integrated care across acute and community services and particularly develop services for the frail elderly across the full spectrum of care through the Integrated Care Group (a Clinical Division of the Trust which is embracing the recommendations of the Royal College of Physicians Future Hospitals Report)

In recognition of our cross locality interdependencies, we have in place well established partnership forums, with senior level representation, including clinicians from both provider and commissioner organisations. Specifically, we have held development sessions and included BCF and integrated care within the agenda of the following:

PLCTB – Pennine Lancashire Clinical Transformation Board
PLEOG – Pennine Lancashire Executive Officers Group
PLCEO – Pennine Lancashire Chief Executive Officers

Date	Meeting	Integrated care agenda item
3rd July 13	PLCTB	Pennine Lancashire Pioneer proposal – development session
21st November 13	PLCTB	Integrated Transformation Fund - identifying areas for transformation in line with guidance
5th March 14	PLCTB	Better Care Fund Plan development session including feedback from Capita, Clinical presentation (Clinical Director LCFT, Divisional Director Medicine ELHT) and opportunities for joint leadership
2nd April 14	PLCTB	Better Care Fund (BwD/EL CCG) Transforming out of hospital services (Capita) Introduction to the 'Extensivist' model

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5th May 14	PLCTB	Better Care Fund Plan update Developing a Pennine Lancashire Community Intensive Support service (proposal for Area Team support)
16th May 14	PL EOG	Better Care Fund Plan Developing Pennine Lancashire approach to system change
14th June 14	PLCTB	Better Care Fund Plan update Developing a Community Intensive Support (CIS) approach in Pennine Lancs
23rd June 14	PL CEO	Pennine Lancashire programme delivery and governance arrangements to support an integrated vision
14th July 14	PLCTB	Pennine Lancashire Programme Delivery and joint governance arrangements System resilience plan
28th July 14	PL CEO	Early wins for Pennine Lancashire system redesign Annual resilience Better Care Fund Plan update

ii) Primary Care providers

Primary Care and CCG Clinical members have been actively engaged in our plans for integrated care from the development of our Enhanced Integrated Community Service pilot in the East locality to the full roll out of integrated locality teams. Primary Care GPs have been engaged and actively involved through locality workshops, regular discussions and at monthly locality grouping meetings. Regular communication through email briefings, pod casts and events will be planned during 2014/15 and beyond to ensure ongoing engagement of GPs and Primary Care staff.

Other forums where the development of integrated care, Better Care Fund Plans and schemes have been discussed include:

- CCG locality groupings provide an opportunity to develop primary care providers working relationships across 4 locality areas including input into integrated locality teams. Specific Better Care Fund engagement has taken place at the GP Protected Learning Event in June 2014 and Practice Management Forums, providing key updates and identifying practice support requirements.
- At the CCG Clinical Senate held in April 2014, all GP's were invited to attend and discuss the Better Care Fund Plan and integrated care developments. Senate members voted unanimously to support the development of integrated care within localities.
- Local Medical Committee provides scrutiny and challenge to CCG plans at monthly meetings. Agenda items have recently included plans for integrated care and the development of 4 integrated locality teams.
- Locality Patient Participation Group has provided a key forum to discuss plans for integrated care in BwD. PMO representatives have attended 2 sessions so far and have plans to attend more during 2014 and 2015.

CCG Commissioning Business Group (CBG) and CCG Governing Body includes 5 elected GP members plus Chief Clinical and Medical Director who represent GP's in the development and delivery of CCG business. CBG and Governing Body have received and endorsed regular updates, business cases and progress reports on the development of BCF.

We have an identified CCG lead clinician for integrated care, whose role is to provide clinical leadership to the planning and delivery of integrated care across Blackburn with Darwen. The clinical lead has been involved in the development and planning of the ECIS pilot and currently

chairs the integrated care operational group which is leading the roll out of integrated locality teams.

We are ensuring our engagement with primary care aligns with roll out and support of both the proactive care Direct Enhanced Services and over 75 contractual changes to facilitate and support primary care delivery as part of Better Care Fund Plans.

We are currently in the process of reviewing and redefining the locality grouping arrangements to ensure delivery of Better Care Fund Plans and GPs are at the heart of integrated working within their communities.

iii) Social care and providers from the voluntary and community sector

Social care - Commissioned Providers
Blackburn with Darwen has been delivering a detailed programme of service externalisation over the last five years with the vast majority of direct care and support provided by a range of not-for-profit and independent sector organisations. Market shaping and development is a key role for the local authority and partners and close relationships are maintained with sector representatives to align emerging strategies with provider business planning processes.

Quarterly business development fora are held with each of the following sectors to ensure tailored information and guidance:

- Residential and Nursing Care Providers;
- Domiciliary Care Agencies; and
- Supporting People Providers.

Additionally, 2 other structures are in place in to support broader service and workforce development:

- The Blackburn with Darwen Social Care Partnership.
- The Blackburn with Darwen Workforce Strategy Development Group.

As part of all the above we have actively worked with providers to understand better the changing strategic commissioning landscape and support organisations to review business plans and integrated delivery models aligned to our Better Care Fund Plans e.g. the development and implementation of Integrated Triage and Response system out of hours domiciliary care support to enable people to be supported home from hospital or to ensure admission avoidance.

Providers from the voluntary and community sector
The Chief Executives of Age UK Blackburn with Darwen, Carers Service and Families, Health and Wellbeing Consortium were all members of the editorial group for the April 2014 BCF submission and as such had opportunity to influence the priorities, direction and content of the plan and the schemes within it. In addition each of these organisations carried out consultation with either service users or community organisations to support the development of the plan and to test out the priorities in relation to their target beneficiaries. Blackburn with Darwen Age UK and Families, Health and Wellbeing Consortium are named voluntary sector representatives on the Health and Wellbeing Board, and as such have been regularly updated and engaged within Better Care Fund developments.

Age UK BwD, the Carers Service and Care Network have been identified as the current commissioned voluntary organisations providing services for frail elderly (and older people more generally) and carers. For the Carers Service the inclusion of the carers breaks scheme is a direct fit with the operational plan as they are currently commissioned through the organisation, and form part of its wider holistic offer of carers support. This offer focuses on not only crisis intervention, but self-care, prevention and early intervention through providing carers with timely support and information.

Care Network – the current business plan has been shaped and informed by the same drivers that have formed the priorities in the BCF and was developed following a strategic planning session with both health and social care commissioners. Relevant priorities include supporting people to remain independent, improving health and wellbeing, preventative support, and an integrated approach to delivery, as evidenced by its delivery of a Department of Health funded Achieving Self-Care project which works with GPs and other health services to support those identified as at risk of inappropriate use of statutory services through improving individuals' self-care skills and social capital. Care Network's business plan has also been shaped by its role in the delivery of the Your Support Your Choice service which provides information and signposting to improve health and wellbeing for local citizens. The focus of this service is focused on preventative support for local citizens.

Age UK BwD – the current business plan prioritises developing quality services to support older people to remain independent, and improve their health and wellbeing, including a particular focus on supporting those with dementia. Provision of early intervention and re-enabling services, through day care support services which reduce social isolation and support to be healthier and more active along with timely access to information and advice to maintain independence are the priority activities, along with enabling older people's views and voices to be taken into account in service planning and delivery. In addition both Age UK and Care Network are key partners in the local current Safe and Well assistive technology pilot, and Age UK is supporting the development of care plans with GPs for the top 2% of patients.

The Families Health and Wellbeing (FHWB) Consortium - is a member based charity which enables a collaborative approach to service delivery amongst Voluntary Community Faith sector and not-for-profit organisations. The Consortium helps to bring these organisations together in order to provide the best help and support to individuals and communities in the local area through strong partnership working. There are 50 member organisations delivering across the local area.

As such each organisation individually, and collectively, can confirm that the priorities and schemes within the BCF plan are reflective of and align with their own priorities and strategic plans. The opportunity to be involved in strategic planning has been welcomed and there is a keenness and willingness to continue to be involved. They also confirm a commitment and willingness to embed the priorities and work together with commissioners on developing future delivery models which support the BCF plan delivery, and to which, as voluntary sector organisations they can bring much added value.

There is also a commitment to utilise their expertise, for example both Care Network and Age UK are already involved in the implementation of the Integrated Local Teams, offering a voluntary sector perspective and opportunity to maximise the value the sector can bring. The Carers

Service intends to be represented in each of the locality teams to again offer earlier interventions. Each of the organisations were involved in the development of a model to support people to leave hospital in a timely, and appropriate way which is available as a future model of delivery.

There is also opportunity to work with the voluntary sector to develop and agree consistent reporting and outcomes measurements, and to develop a Social Return on Investment model.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The introduction of the BCF integrated care schemes is likely to have far reaching implications in terms of how health and care services are provided in the future. Many of the resultant changes are likely to be felt most by acute providers. East Lancashire Hospitals NHS Trust (ELHT) cares for the vast majority of the non-electives admissions of BwD patients.

Like many acute providers, ELHT has to flex capacity to accommodate the demands of the urgent care system and has to open wards for sustained periods. This means that the workforce has to be complemented by medical and nursing agency staff that results in premium rates/increased costs. The additional capacity under current Payment by Results rules receives only part of the tariff and therefore can cause financial issues for the provider.

When the changes to integrated care are fully implemented, the whole system effects are expected to provide benefits to the local acute provider.

- A reduction in emergency attendances and admissions will relieve pressure on the A&E department, better enabling them to meet the 4 hour target.
- Through reducing delayed transfers of care, patients will be discharged when they are medically fit, meaning only the most appropriate patients remain in hospital and reducing incidences of 'bed blocking'.

It is expected shifts in activity will be:

- Reduction in emergency admissions will be 3.5% against trend by Q3 of 2015/16
- Reduction in delayed transfers of care will be 5% by Q4 of 2015/16

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1- Detailed Scheme Descriptions
Please see attached document titled:

BCF Blackburn with Darwen Annex 1 – Detailed Scheme Descriptions

ANNEX 2 - Provider Commentary
Please see attached document titles:

BCF Blackburn with Darwen Annex 2 – Provider Commentary