HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Claire Jackson Programme Director Integrated Commissioning
DATE:	27th September 2016

SUBJECT: Better Care Fund Q1 Submission 2016/17 and Commissioning Intentions 2017/18.

1. PURPOSE

The purpose of this report is to provide Health and Wellbeing Board (HWBB) members with :

- an update on 2016/17 BCF plan approval status from NHS England
- an overview of Better Care Fund (BCF) performance reporting for quarter 1 (April-July 2016) including progress in relation to delivery of the plan since the previous report to Board members in June 2016
- an outline of CCG and joint commissioning intentions to support integrated care for 2017/18

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- note the fully approved status of the 2016/17 Better Care Fund plan from NHS England
- note the BCF quarter 1 submission and progress made against delivering the BCF plan, including performance metrics
- note the CCG and joint commissioning intentions to support integrated care for 2017/18.

3. BACKGROUND

As outlined in previous reports, the Health and Wellbeing Board is accountable for the delivery of the Better Care Fund plan. The management of the plan is undertaken by Executive Joint Commissioning Group.

The Blackburn with Darwen BCF plan for 2016/17 was submitted on 3rd May 2016, following an update on planning requirements to HWBB members in March.

4. RATIONALE

Better Care Fund

As outlined within previous reports to the HWBB, the case for integrated care as an approach is well evidenced. Rising demand for services, coupled with the need to reduce public expenditure, provides a compelling argument for greater collaboration across health, care and the voluntary sector.

The Spending Review set out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. This is reflected in the NHS Planning Guidance 2016/17-2020/21 Delivering the Forward View. The Better Care Fund remains a key policy driver to support integration of health and care services at a local level.

Commissioning Intentions

Commissioning Intentions form part of the annual NHS planning cycle, indicating to current and potential providers how services will be shaped to meet the needs of the local population. Commissioning Intentions for 2017/18 build on plans previously presented to HWBB members to support delivery of the Integrated Care plans, including the Better Care Fund plan, evolving Lancashire and South Cumbria Sustainability and Transformation plan and Pennine Lancashire Transformation programme.

5. KEY ISSUES

2016/17 BCF plan

The Blackburn with Darwen Better Care Fund plan for 2016/17 was made on behalf of the Health and Wellbeing Board on 3rd May 2016. The plan was fully 'assured' by NHS England on 4th August 2016, an improvement on last years 'approved with support' status.

The narrative outlines the alignment of BCF delivery plans with Pennine Lancashire Transformation to provide a consistent out of hospital offer to support residents across a wider health and care footprint, whilst ensuring that localities and general practice receive the support required to reflect population need.
The final narrative report is attached in appendix 1.

Finance

As outlined in previous reports to HWBB members, the 2016/17 BCF budget is £12,433,000. The budget has been allocated into:

- Spend on Social Care - £5,544,332
- Spend on Health Care - £4,119,224
- Spend on Integration - £2,139,836
- Contingency - £629,608

It has been agreed that the contingency budget will be held until later in the financial year to enable a wider understanding of system requirements. This will be monitored by the Executive Joint Commissioning Group during quarters 1 and 2.

Quarter 1 2016/17 submission

The quarter 1 submission was made on 9th September following sign off by the Chair of the Health and Wellbeing Board. The submission included an update on performance against national metrics between April and June 2016, as outlined below.

- Non-elective admissions have reduced by 213 in the 1st quarter of 2016 compared to same period in 2015/16, which is on track to deliver against target, however, acuity is increasing
- We are currently on track to deliver against target set for residential care admissions
- Further work is required to meet the re-ablement target due to the very challenging target we have been set nationally, as Blackburn with Darwen is already one of the best performing authorities in England
- Slightly above target for Delayed Transfers of Care by 22 bed days
- We are ahead of plan for the local dementia diagnosis target

Local patient experience metric 'In the last 6 months have you had enough support from local services to manage your long term condition' is reported annually.

Good progress has been made to mobilise local plans which includes;

- Building capacity within the voluntary sector, with alignment of Age UK and Mind services within localities
- Improved offer for local carers resulting from more aligned service provision
- Extending Decent and Safe Homes Scheme to focus on falls prevention as part of the locality offer and developing a telehealth scheme to deliver enhanced support within residential and nursing

homes
- Consistent Trusted Assessment to support more timely discharge from hospital into community services building on our principle of 'telling your story only once'

A full summary update of service delivery during quarter 1 is outlined within appendix 2.

Further submissions will be required on a quarterly basis and will be reported to Health and Wellbeing Board members at subsequent meetings.

Commissioning Intentions

A number of joint principles for joint commissioning were supported by HWBB in September 2015. The principles have been reviewed to consider national and local context and remain aligned to the local direction of travel for integration. They include;

- Deliver a programme of integration across Blackburn with Darwen, Pennine and Pan Lancashire
- Support delivery across 4 locality footprints
- Ensure parity of esteem across physical and mental health
- Support overall system resilience and reduce unnecessary demand including the delivery of services to support early intervention and prevention, supporting independence and promoting self care
- Support 7 day provision of services where appropriate
- Involve and engage with public and stakeholders in development of plans
- Services are provided in co-operation and collaboration with other professionals and co-ordinated across organisations (health, care and voluntary sector) to support a seamless experience by the service user

Commissioning Intentions for 2017/18 build on previous year's plans to support delivery of priorities for integrated care. They include;

Start Well

- Agreed and consistent pathways for asthma
- Delivery of the Children and Young Peoples Improving Access to Psychological Therapies (IAPT) through increasing staff trained in psychological therapies and improved recording of patient outcomes

Live Well - Learning Disabilities

- Integrated model of care for people with Learning Disabilities including single workforce, assessment, diagnosis, formulation and intervention

Live Well - Mental Health

- Evaluate effectiveness of fully configured Early Intervention Psychosis service
- Remodel mental health promotion services to support public health model of care
- Develop consistent care models and pathways for community re-start across Pennine Lancashire
- Continue to develop IAPT models through increased utilisation of Voluntary Sector providers
- Development of virtual ward in the community through remodelling of existing services including community mental health teams

Age Well

- A consistent Intensive Home Support Service model of care across Pennine Lancashire
- Agreed and consistent pathways for Falls and Frailty across Pennine Lancashire
- Memory assessment services delivered in localities with increased GP involvement

A number of joint commissioning intentions cut across start, live and age well cohorts, they include;
- Enhanced locality model of care, fully incorporating community mental health services and the Voluntary Sector offer, extending to include Transforming Lives and children and young peoples

services
- Remodelled home and bed base intermediate care including recovery and recuperation, rehabilitation and sub-acute provision to enable the delivery of a discharge to assess approach

CCG specific commissioning intentions for 2017/18 include;
- Paediatric pathway redesign that focusses on 'assess to admit'
- Improve patient outcomes by recovering the Urgent Care quality standards including the remodelling of Urgent Care and Emergency Departments in line with national requirements
- Improve access, quality and reduce variation in Primary Care, improving sustainability
- Develop lead health professionals to case manage individual personal health care cases in the community
- Agreed and consistent pathways for Diabetes, Chronic Obstructive Pulmonary Disease, Deep Vein Thrombosis and Cellulitis across Pennine Lancashire

Commissioning intentions have been re-reviewed against the priorities within the Joint Health and Wellbeing Strategy (JHWS) and there remains good alignment.

High level commissioning intentions will be issued, jointly where appropriate, to providers by 30th September 2016. Timescales for delivery, finance and activity impact will be developed and agreed by December 2016 as part of contract negotiations for 2017/18. Where possible commissioning intentions will align across Pennine Lancashire and Lancashire and South Cumbria footprints.

6. POLICY IMPLICATIONS

The key policy drivers are outlined within the main body of this report and within previous BCF papers presented to HWBB members. Local areas are expected to fulfil these requirements. Any further impact due to changes in National Policy or planning guidance will be reported as they arise.

7. FINANCIAL IMPLICATIONS

Financial implications for 2016/17 were reported in the June 2016 update to HWBB members. Financial impact of commissioning intentions will be aligned to CCG Quality, Innovation, Prevention and Productivity (QIPP) plans, Better Care Fund requirements and wider system efficiency requirements.

8. LEGAL IMPLICATIONS

Legal implications associated with the Better Care Fund governance and delivery have been presented to Health and Wellbeing Board members in previous reports. A Section 75 agreement is in place between the Local Authority and CCG which outlines risk sharing arrangements associated with the Better Care Fund and other funding streams aligned to integrated delivery locally. The agreement has been reviewed to reflect joint arrangements in 2016/17.

Legal and contractual implications associated with commissioning intentions will be considered as part of implementation plans. Any issues identified will be reported to Executive Joint Commissioning Group and escalated to HWBB members if required.

9. RESOURCE IMPLICATIONS

Resource implications relating to the Better Care Fund plan have been considered and reported to Health and Wellbeing Board members as part of the initial plan submission. Any further resource implications will be reported as they arise.

10. EQUALITY AND HEALTH IMPLICATIONS

Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.

Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care schemes, including new business cases, and are integral to service transformation plans.

11. CONSULTATIONS

The details of engagement and consultation with service providers, patients, service users and the public have been reported to Health and Wellbeing Board members throughout development of the local BCF plan. Consultation and engagement will form part of business case development for any new BCF schemes.

VERSION:	**V5**

CONTACT OFFICER:	Claire Jackson
DATE:	9th September 2016
BACKGROUND PAPER:	Previous BCF reports to HWBB members

Appendix 1 – Better Care Fund Plan 2016/17

Blackburn with Darwen

Better Care Fund Plan 2016/17

Narrative overview

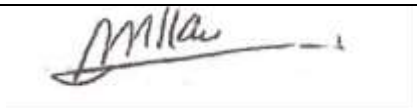
Summary of Plan

Local Authority	Blackburn with Darwen Borough Council
Clinical Commissioning Groups	Blackburn with Darwen CCG
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.

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Blackburn with Darwen CCG 
By	Roger Parr
Position	Chief Finance Officer
Date	29/04/16

Signed on behalf of the Council	Blackburn with Darwen 
By	Steve Tingle
Position	Director of Adults
Date	29/04/16

Signed on behalf of the Health and Wellbeing Board	

By Chair of Health and Wellbeing Board	Cllr Khan
Date	29/04/16

1) Local Vision for health and social care services

The Blackburn with Darwen Better Care Fund (BCF) plan for 2016/17 builds on our development and delivery of integration set out in the 2015/16 BCF plan (the 2015/16 plan is available online). The plan has been agreed through the local joint commissioning group and Health and Wellbeing Board, with formal sign off planned to take place before the end of April submission date. The pooled budget allocation of £12.433 million for 2016/17 fulfils the national requirements.

The BCF is considered locally to be the vehicle for integration in Blackburn with Darwen and the learning and best practice will continue to the identified to inform the emerging Pennine Lancashire plans. The 2016/17 BCF plan will continue to build on the 2015/16 vision for integrated care:

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. In 2014 Blackburn with Darwen CCG and Borough Council completed an Integrated Strategic Needs Assessment (ISNA) on behalf of the Health and Wellbeing Board and captures our shared understanding of health needs and assets in Blackburn with Darwen. The Borough wide ISNA is supported by a detailed analysis of the 4 localities, which are based on General Practice registered population.

There is clear alignment across the BCF and Blackburn with Darwen CCG Operating and Strategic Plans. This is evidenced through the recent CCG submissions to NHS England where there is clear synergy across both narrative and data trajectories. Consideration is currently being given to Quality Premium targets for the CCG and further alignment with the BCF plan.

The delivery of the 5 Year Forward Plan is aligned to Lancashire wide CCG planning and is reflected in the emerging Healthier Lancashire Transformation Plans which will inform the development of the Sustainability and Transformation Plan (STP) across Lancashire and South Cumbria. The STP will outline the move towards integrated health and social care services by 2020. Over the coming months there will be clear communication and engagement proposals across the health and care system on the process and timeline for the development of the STP. This will include liaising with the Health and Wellbeing Boards in respect of the process to sign off the STP and ensuring alignment where appropriate with BCF plans. Delivery of BCF in 2015/16 and planning for 2016/17 has played a significant role in the development of the STP. In particular, Prevention, person centred coordinated care and the roll out of full 7 day services by 2020 delivering the four priority clinical

standards, where out of hospital services are being developed.

Delivery of integrated services across localities will be supported by the Pennine Lancashire Transformation Programme. Blackburn with Darwen and East Lancashire CCGs, Local Authorities and providers are working closely to develop the Locality Delivery Plan which will be built on BCF plans to date and widen scope to include start well and live well cohorts. This includes a range of workstreams to support system transformation including workforce and organisational development.

2) An evidence base supporting the Case for Change

The Blackburn with Darwen BCF Case for Change remains the foundation for the integration of services across Blackburn with Darwen.

Our case for change identified that within our current system;

- Too many people have unnecessary hospitalisation
- Too many people stay in hospital too long
- Too many people are discharged into long term care
- Our system is complicated.

The 2015/16 Blackburn with Darwen BCF plan was based on an in depth analysis of non-elective (NEL) admissions in BwD and a full risk stratification of the GP practice population. Further detail outlining the evidence of our analysis can be found in the 2015/16 plan.

In October 2015 a detailed review of NEL admissions and risk stratification care planning arrangements across Blackburn with Darwen was completed. The review identified;

- A number of GP practices performing above the CCG averages for emergency admissions linked to Chronic Obstructive Pulmonary Disease (COPD), frailty and falls. Bespoke action plans have been developed with primary care and officers assigned to support reduction inactivity to CCG average (or below).
- GP practices with high numbers of frequent flyers have been supported to better utilise Multi-Disciplinary Teams (MDTs).

This review has further supported the prioritisation and transformation of health and social care services to better meet the needs of the local population. It has informed the redesign of community nursing and therapy services and the Intensive Home Support Offer, including a more specialist COPD service to meet the needs of acute patients in the community.

In addition, Newton Europe has been working with Blackburn with Darwen Borough Council since 2014 to review a number of areas and identify efficiencies, these areas include:

- Demand management
- Pathways to placement
- Reablement capacity
- Telecare and promoting independence reviews.

As outlined in section 5, significant work has been undertaken to analyse the local position in relation to delayed transfers of care and plans are progressing across the system to support a reduction.

Newton Europe is currently undertaking an Integration Diagnostic across the Pennine Lancashire system, as part of a national evaluation funded through the Local Government Association (LGA). The outcomes of the review will further inform the transformation and integration of health and care services.

There remain significant pressures locally across the health and care system, linked to deprivation,

demographic growth and an ageing population.

Copies of all the documents referenced are available upon request from BCF leads in Blackburn with Darwen.

3) Scheme narrative – progress during 2015-16 and next steps

During 2015/16 a number of individual integrated care schemes have been mobilised involving health, social care and voluntary sector services. During 2016/17 we will build on progress to date, supporting further alignment of schemes to support wider system change. The same Joint Commissioning Governance arrangements will be in place for 2016/17 and will be aligned to Pennine Lancashire Transformation Programme, where possible.

The majority of schemes developed, to date, will continue to evolve and provide a more targeted focus on Falls, the development of the Intermediate Care system and specific pathways including COPD and Frailty.

Building capacity within the voluntary sector (VCF)

- A joint model of Information, Advice and Guidance has been procured and is fully operational. There is now a single route of access into VCF services and shared assessment process to accelerate support. Data shows the number of people supported through this integrated offer has increased.
- Age UK ' Here to Help' Integrated Care Programme has been operational across Pennine Lancashire since July 2015. The programme works alongside health and social care services, providing voluntary support through working as part of Integrated Locality Teams and included the piloting of in reach into hospital to identify patients awaiting discharge who may be appropriate for the programme. The impact of this programme will be formally evaluated by the Nuffield Trust.

Co-ordination of Dementia services

- A dedicated Dementia Co-ordinator has been leading the delivery of a joint plan to develop a Dementia Friendly Community in BwD.

Integrated offer for carers

- A review of existing Carers' services has been undertaken, joint service specification developed and delivery has commenced. Engagement work with carers and professionals working with carers has taken place to inform these developments.

Next steps

- The next phase in the single point of contract approach is currently being tendered and will see the integration of services for carers, information and support for isolated older people, and services to build resilience and empower vulnerable young people and adults such as those with substance misuse problems. Services are planned to be in place from July 2016.
- The coordination of Dementia services is being reviewed in line with developments in Adult Mental Health and will be aligned to ensure that there is no duplication and improved patient experience.
- An integrated life course approach to Carers' services will be in place from July 2016 as part of the phase 2 VCF redesign with the aim of fully integrating the carers' offer with wider VCF services, reducing duplication and increasing reach. The service will specifically;
    - Increase the number of assessments of carers and personalised support plans developed for carers in line with the requirements of the Care Act 2014 to ensure carers receive the support they require to maintain their caring role.
    - Improve the integration of information, advice and support to Carers, to ensure that any

additional needs of the carer are met independently either by universal services, carers' specific services or other service providers to avoid breakdown of the caring role and unnecessary hospital admission or residential care of the carer and/or the cared for.
    - Liaison service for key professionals such as GPs and hospitals, raising awareness and providing education and training to key professionals about carer issues and carers' needs in order to encourage professionals to identify carers, record on their register, undertake carers' health checks and provide information and preventative measures to reduce the need for support. Awareness raising will also ensure that the experience of carers is positive when accessing all services.
    - Ensure carers are represented in relevant developments of the service.
- Further developments are being proposed for 2016/17 with the aim of implementing a fully integrated offer of voluntary sector services in localities by July 2016.
- Review of the impact of Here to Help will inform future commissioning of voluntary sector services.

Integrated Locality Teams (ILTs)

- 4 Integrated Health and Social Care teams (with links to Specialist Services, Mental Health and VCF services) have been established and continue to build relationships with Primary Care teams. A process has been established to review existing care plans and use an agreed risk stratification tool to identify service users who require proactive care planning and intervention.
- Work is underway to develop a common case management framework that is underpinned by a single assessment and discharge process.
- Considerable work has been undertaken to identify suitable office accommodation for the ILTs across localities and Darwen Locality is on course to co-locate before the end of March 2016.
- Memory assessment services are now offering scheduled appointments in GP surgeries across the localities and are aligning to ILT working to improve access and quality of services offered to patients living with dementia.
- BwD CCG and Borough Council are working together to link the 4 ILT's housing interventions that will potentially deliver health and wider social improvements. The interventions will be delivered by the Borough's DASH (Decent and Safe Homes) service.

Next steps

- Develop Pennine Lancashire wide Standard Operating Procedure (SOP). Ongoing development of single integrated care plan and refinement of a case management framework.
- Refine locality data packs and engage GPs and wider system to gain feedback and establish monitoring framework. Data will be used to inform GP locality decision making process and identify what support is required to provide a system wide offer across each locality.
- Review of current locality offer across Pennine Lancashire, with regards to team make up and wider system relationships and referral processes.

Intermediate Care including integrated discharge and discharge to assess model

- An Integrated Discharge Service (IDS) model commenced operation in September 2015. The emerging model supports the role of trusted assessor, aligning health and care assessment activity.
- Health and social care capacity is in place to support 7 day discharge and prevent unnecessary hospital admissions. This includes additional social care and community nursing capacity. Further details can be found within the national conditions section of this plan.

- Additional health and care capacity has been commissioned to support hospital front door deflection from mid November 2015.
- Intermediate care provision has been reviewed and the model of care has been aligned for sub-acute, intermediate care and discharge to assess beds commissioned by CCG and the Local Authority. Flexible use beds have been commissioned, that can offer a more responsive approach to the delivery of sub-acute and intermediate care dependant on need.

Next steps

- A review of intermediate care and proposals for a future model will be developed across Pennine Lancashire as part of the Local Transformation Programme. The model will mean that all commissioned beds can be utilised flexibly and align other community provision to support patients during their intermediate phase of care.
- The Integrated Discharge model will continue to be developed and aligned across the wider system. Navigation and care co-ordination will be aligned across Pennine Lancashire to further support streamlined and timely discharge.

Intensive Home Support (IHS)

- Intensive Home Support model has been operational since February 2015.
- The service was reviewed in November 2015 to encourage greater utilisation and has been further developed to promote a more streamlined pathway supporting 7 day discharge and admission avoidance.
- Plans are in place to blend the IHS model with ILTs in the community, to utilise the Rapid Assessment Teams within the hospital to deflect admissions, make greater use of the community intravenous antibiotic team to deliver in the community, and supporting early discharge.
- A specialist COPD team is in place and complex case managers are being recruited to proactively identify patients at risk of hospital admission and manage their care in the community.

Next steps

- Redesign of BwD IHS model in line with wider developments in out of hospital services.
- Development of Pennine Lancashire medical oversight model to support IHS.
- Step down from hospital pathway to be standardised across Pennine Lancashire.
- Continue to monitor and streamline Pennine Lancashire's model to support system resilience.
- Communications between step up and step down between Integrated Care Teams, IHS and IDS to be improved and relationships strengthened with key leadership.
- BwD to identify replicable Integrated Care Assessment and Triage (ICAT) model within existing resources (satellite office) and relationship with EL team strengthened.

Care Navigation Hub/Directory of Services (DoS)

- Launched December 2014 and provides a single contact point to support Health and Social Care services across Pennine Lancashire, working with ILTs in local delivery of services through detailed DoS, including more than 800 services, to identify service options or make referrals as required.
- The navigation hub provides prompt, clinical advice to support navigation through out of hospital services and is being utilised by health and social care services to mobilise services and triage and carry out assessment for access into Intensive Home Support services.

Next steps

- Current model to be reviewed in line with 7 day service review and as part of Pennine

Lancashire system wide review. Service will also be reviewed in line with NHS England Urgent Care Standards.

4) A clear articulation of how we plan to meet each national condition

4. 1) Signed off by H&WB and other CCG/LA committees

Updates on progress towards delivery of the Better Care Fund are provided to BwD Health and Wellbeing Board (HWB) on a quarterly basis. Regular briefings, including performance, finance and delivery are provided to the HWB Chair by the BCF Programme Lead to further support assurance. More detailed updates are provided to Joint Commissioning and Recommendations Group monthly and Blackburn with Darwen BC Senior Policy Team and CCG Commissioning Business Group as required. Governance, programme support, operational risk management and joint working arrangements are outlined within the 2015/16 BCF plan (section 4b & c).

BwD HWB agreed to delegate the sign off of 2016/17 BCF plans to the Chair of the HWB at the meeting on 8th March 2016. The full submission, including any feedback from NHS England will be reported to HWB members at the next meeting on 21st June. Arrangements are in place to ensure the plan is signed off by the CCG and LA Executive Leads prior to 3RD May deadline.

Blackburn Health and Wellbeing Members

Board Members

- Leader of the Council – Councilor Mohammed Khan
- Executive Member for Adult Social Care – Councilor Mustafa Desai
- Executive Member for Children's Services – Councilor Maureen Bateson
- Leader of the Opposition – Councilor Michael Lee
- Director of Adult Services – Steven Tingle
- Director of Children's Services – Linda Clegg
- Director of Public Health – Dominic Harrison
- A representative of NHS England – Graham Urwin
- A representative of Healthwatch – Sir Bill Taylor
- A representative of East Lancashire Hospital Trust – Kevin McGee
- A representative of Lancashire Care Foundation Trust – Max Marshall
- Two representatives of the Clinical Commissioning Group – Dr Penny Morris and Graham Burgess
- Two representatives of the Voluntary sector – Vicky Shepherd (Age UK) and Angela Allen (Families, Health and Wellbeing Consortia)
- Two representatives of the Community (Lay Members) – vacant

Non-voting members

- Chief Executive, Blackburn with Darwen Borough Council – Harry Catherall
- Executive Director People, Blackburn with Darwen Borough Council – Sally McIvor
- Clinical Chief Officer, Blackburn with Darwen Clinical Commissioning Group – Dr Chris Clayton
- Chair of the Blackburn with Darwen Live Well Board – Sayyed Osman, Director Housing; Localities and Prevention, Blackburn with Darwen Borough Council

4. 2) A demonstration of how the area will maintain the provision of social care services in 2016/17

There is local agreement of the definition for the protection of social care services (not spend)

across the LA and CCG as follows.

Some protection of social care services (not spending) has been enabled through the BCF pooled budget arrangement. There has been no reduction in health funding allocated to jointly supporting reablement, intermediate care services, social work, provision of Information, Advice and Guidance, and support to carers. Some contribution has been made to support the impact of implementing the Care Act as required nationally. The anticipated financial pressure of demographic growth and the Care Act, which are significant locally, is not included within the Better Care Fund. This definition is consistent with the 2012 Department of Health guidance.

The total funding allocated to maintain social care services is included within the BCF planning Return Template. The total amount for 2015/16 has been maintained in real terms for 2016/17. Further detail of how local schemes will impact on protection of social care services is outlined within the 2015/16 BCF plan.

There has been agreement across health and care partners that the risk share arrangement for 2016/17 will include the impact of demographic pressures and cost of living increases which are likely to have a significant impact on the care system. The well documented financial pressures in the care system (leading to capacity challenges in home care and nursing care locally) will continue in 2016/17 in in doing so may put elements of the wider transformation of the health and care system at risk. In light of this the level of protection for adult social care services within the better care fund will be kept under regular review during the year in relation to potential draw down of monies held within the risk sharing element of the fund.

The following funding streams have been fully incorporated into the BCF plan for 2016/17 at the required amounts.

Disabled Facilities Grant (DFG) continues to be included within the BCF plan at £1.461m for 2016/17. The grant is utilised to support the delivery of home adaptations for both Adults and Children in Blackburn with Darwen. The grant will continue to be managed jointly through the BCF via an allocation to both Adults and Children's Local Authority Capital Programme. The grant has been increased in 2016/17 to support the use of technological solutions to promote further independence and improve outcomes e.g. telecare.

Care Act funding has been allocated within the BCF plan to enhance assessment capacity within Adult Social care to undertake the new Statutory responsibility to assess carers' needs separately. The funding also supports the additional commissioning costs to meet the assessed eligible needs including support for carers and preventative services. An element of funding will continue to support the ongoing costs of implementing Deferred Payment Agreements for service users who opt to use this.

Former carers' break funding remains within the BCF plan. The commissioning of carers' services has been aligned across the CCG and Local Authority in 2015/16 and is currently being tendered. The new service offer will support the key priorities of the BCF plan including reducing DToC.

Reablement funding is clearly outlined within the BCF budget and agreed jointly. The 2016/17 plan will maintain existing levels of reablement support and align where possible, the health and care offer.

4. 3) Confirmation of agreement on how plans will support progress on meeting 2020 standards for 7 day services, to prevent unnecessary non-elective admissions and support timely discharge

There are a number of services in place which support the 7 day prevention of unnecessary non-elective admissions and support timely discharge. They include;

Initiative	7 day Status	Key milestone
Integrated Discharge Service (IDS)	Live 7 days – business case being developed by Providers	July 2016
Care Navigation through a single point of access	Live 7 days – to be reviewed in line with system change in 2016	September 2016
Hospital front door health and care team	Live – work to be aligned to IDS business case	July 2016
7 day social work provision to support the admission avoidance within the acute trust	Live – work to be aligned to IDS business case	July 2016
Integrated Locality Teams	Ongoing development of consistent 7 day offer	September 2016
Intensive Home Support Service including COPD, frailty and IVAB.	Majority of service live 7 days – recruiting to new posts.	June 2016

The CCG and LA are completing a review of current 7 day services to identify gaps and duplication.

More broadly, BwD are delivering a 7 day Primary Care 'spoke model' funded through Prime Minister Challenge Fund. The spokes provide additional emergency GP appointments in each of the 4 localities to allow GPs to prioritise patients with long term conditions who need emergency appointments.

Work is ongoing with the Acute provider to support the implementation of the 4 priority standards for 7 day working. Implementation of the standards by 2017 is being worked towards by the health and care community in Pennine Lancashire supported by NHS Improving Quality Team (NHS IQ).

Blackburn with Darwen CCG is the lead for Mental Health across all 8 Lancashire CCGs and is key to the delivery and development of mental health services. Across Lancashire the Crisis Care Concordat provides strong partnership working across numerous Stakeholder organisations in Lancashire including Health and Social Care, Police, NWAS, Voluntary sector and Criminal Justice Liaison Team. The unique needs of children and young people and people with Learning Disabilities have been considered and incorporated into plans. The Crisis Care Concordat action plan is monitored via a Lancashire wide multi-agency Steering group and has provided Pennine Lancashire with the opportunity to benefit from Lancashire wide leeway.

Various redesign programmes looking at a 7 day offer are underway it Pennie Lancashire:

- Crisis Support Unit (CSU) – is providing a safe non-clinical environment in which people experiencing crisis or pre-crisis and facilitates 'de-escalate', therefore avoiding admission.
- Mental Health Assessment Units – a unit providing clinical assessment for a maximum of 3 days in order to divert admissions away from the Emergency Department and step service users up and down accordingly.
- Street Triage – MH nurse & police officer working as a team, avoiding unnecessary escalation to a crisis situation and/or attendance at Emergency Departments/136 suites.
- Criminal Justice Liaison (CJL) – providing 'front loaded' 7 day service within all the police custody suites, provides direct access to mental health workers for persons who are arrested.
- MH Helpline / 111 – to be expanded to support and provide advice to MH professionals and other organisations when dealing with people experiencing MH crisis (all age) improving signposting
- Vulnerable people Emergency Department Liaison - Ensure that 'Core 24' liaison mental health services are available 24/7 in acute hospitals across all ages and departments

The development of Primary Care Mental Health Services is at the heart of the Local Development Plan in Pennine Lancs. This will include a fully integrated Health and Wellbeing offer to manage the needs of people with both, mental health and long term physical health issues. The redesign of the current IAPT services will be central to this transformation and scope for a 7 day offer will be explored during development, this work will commence in 2016.

4. 4) Better data sharing between health and social care, based on the NHS number

Across the Lancashire health care organisations, there is over 98% usage of the NHS number as the prime identifier. Across Lancashire the North West Shared Infrastructure Service (NWSIS) has a dedicated programme office delivering Lancashire Patient Record Exchange Service (LPRES), which is developing a common approach to exchanging information for the benefit of residents and care planning. A condition of linking to the 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.

Blackburn with Darwen LA IT system, Mosaic, provided by Corelogic, currently allows the user to input a NHS number and retrieve relevant patient data. Further developments to integrate directly from Mosaic to NHS Personal Demographic Service (PDS) were completed in December 2015 and will require additional training for front line staff to utilise this feature. The implementation of Corelogic has been delayed due to unforeseen circumstances, BwD BC is working to complete the transfer as a corporate priority and the 'go live' date is imminent.

As reported through quarterly BCF returns, Open Application Programming Interfaces (APIs) and appropriate Information Governance controls are in place.

The Pennine Lancashire Transformation Programme will lead the further development of system wide sharing of data supported by appropriate governance across health and care.

4. 5) A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional

A joint approach to assessments and care planning is in place through the ILTs who work alongside GP practices to identify patients at risk of hospital admissions or who have been recently discharged to co-ordinate care. This will enable patients to know who to contact when they need to get a timely decision about their care. The ILTs include community, primary care, social care and voluntary sector representation. Work is ongoing to engage with wider professionals including mental health,

dementia and acute services.

A risk stratification analysis has been completed across the whole population; Table 1 provides an overview of people in Blackburn with Darwen with a risk score +80% to identify if people are at high risk or very high risk of further hospital admission. Table 2 identifies people at moderate risk of hospital admission with risk score between 30% and 80%, meaning there is potential for preventative interventions in the community to reduce the likelihood of unplanned hospital admissions. The cases identified are reviewed by General Practice and the Integrated Locality Teams and case management and care planning arrangements are established.

Table 1 – Risk stratification results +80%

Age group	Number in risk cohort	Number of NEL	Total population in cohort
16-64	93	535	109,176
65-74	21	110	13,617
75-84	60	270	7,664
85+	24	88	2,932
Total	198	1003	133,389*

Table 2 – Risk stratification results 30% - 80%

Age group	Number in risk cohort	Number of NEL	Total population in cohort
16-64	1473	2142	109,176
65-74	559	805	13,617
75-84	839	1081	7,664
85+	465	671	2,932
Total	3336	4699	133,389*

*total population of BwD GP registered population (all ages) 171,128.

A trusted assessment process is well established in Blackburn with Darwen and mechanisms are in place to support a joint approach to assessments and care planning across health and care through Integrated Discharge Service and the Integrated Locality Teams. (Further information outlining progress and next steps for these projects is outlined in section 3). This supports an emerging case management and care planning framework which will be aligned to community services to transition patients from hospital to place of residence. The requirement for an accountable professional where a package of care is being funded is being discussed locally with providers to ensure a consistent offer is in place.

The Local Authority has a well-established Complex Case Management Panel with representation from health, mental health and local authority representatives. The Panel meets regularly to consider jointly funded packages of care and reviews cases presented by a single summary document as part of an assessment bundle (work is planned to develop a single assessment

document – which already exists in Mental Health Services). Following Panel assessment a professional is allocated to manage the case.

Mental Health services are also developing a shared plan care for people with severe and enduring mental health issues will have a significant impact on reducing the life expectancy gap for people with long term mental health problems. A number of options are being developed and will be agreed across Pennine Lancashire to ensure the maximum health benefits for this vulnerable client group, in 2016.

High level joint milestone plan:

Initiative	Status	Key milestone
MDT Risk Stratification in General Practice and ILTs	Commenced June 2014	Review September 2016
Integrated Discharge Service – Trusted Assessment	Commenced Sept 2015	September 2016
Complex Cased Management Panel	Live	On-going
Mental Health, Learning Disabilities and Dementia	Live – across number of providers (Coordinated by MLCSU)	Review May – September 2016

4. 6) Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans

The consequential impact of changes in the health and social care sectors in Blackburn with Darwen are monitored through the Pennine Lancashire System Resilience Group (PL SRG). PL SRG is a whole system group of partners working together to co-develop strategies and collaboratively plan to improve the provision of urgent and elective care services across the health and social care economy. Membership of the group:

- Blackburn with Darwen Clinical Commissioning Group (BWDCCG)
- East Lancashire Clinical Commissioning Group (ELCCG)
- East Lancashire Hospitals Trust (ELHT)
- Lancashire Care NHS Foundation Trust (LCFT)
- Blackburn with Darwen Borough Council (BWDBC)
- Lancashire County Council (LCC)
- North West Ambulance Service (NWAS)
- East Lancashire Medical Services (ELMS)
- NHS England (NHSE)
- Airedale NHS Foundation Trust (AFT)
- Age UK (AUK)

The Group has identified the need to work collaboratively in a commitment to improve the resourcing, financial and contracting arrangements between partners to deliver the desired improvements in urgent and elective care in Pennine Lancashire.

The Pennine Lancashire System Resilience Group builds on existing work, to ensure the delivery of the joint agenda for system wide efficiency savings and a programme of improvement bringing about a system of services which enable patients to receive effective, high quality care in the most

appropriate setting.

Both acute and community health providers were engaged in the development of the 2015/16 BCF plan and provided commentary to support local integration. East Lancashire NHS Hospitals Trust and Lancashire Care Foundation Trust have recently become members of the Health and Wellbeing Board and involved in the development and sign off of local plans. Both providers are also members of the Pennine Lancashire Transformation Programme which will align BCF, CCG operating plans and provider plans across a wide geographic area. As part of the Transformation Programme there will be consultation and public engagement to inform future developments. Mental health and physical health are equally reflected in the priorities of this programme.

Commissioning Intentions have been issued to providers in September 2015 that reflect future plans for integration across health and care and mobilisation plans are progressing with providers. Progress is being made towards the signing of 2016/17 contracts that will reflect activity trajectories.

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 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.

4. 7) Agreement to invest in NHS commissioned out of hospital services, or retained pending release as part of the local risk sharing agreement

The minimum required investment in NHS commissioned out of hospital services for Blackburn with Darwen is £3.118 million. Over £5 million of the revenue budget will be commissioned by the CCG on out of hospital services. Of this, £4.4 million will be commissioned from NHS providers. This exceeds the minimum requirement. Further details relating to individual schemes and providers are included within section 3 and in the 2015/16 Annex 1 Detailed Scheme Descriptions.

At the end of Q3 2015/16 BwD emergency admissions target of 2.2% has been achieved, however the cost of activity has increased due to the acuity of the patients presenting.

It has been agreed through joint governance processes, including Health and Wellbeing Board, to retain £634,000 in a risk share arrangement for 2016/17. This funding will be utilised to support increased cost of NELs and increased pressures on social care due to demographic changes activity and complexity of packages being commissioned.

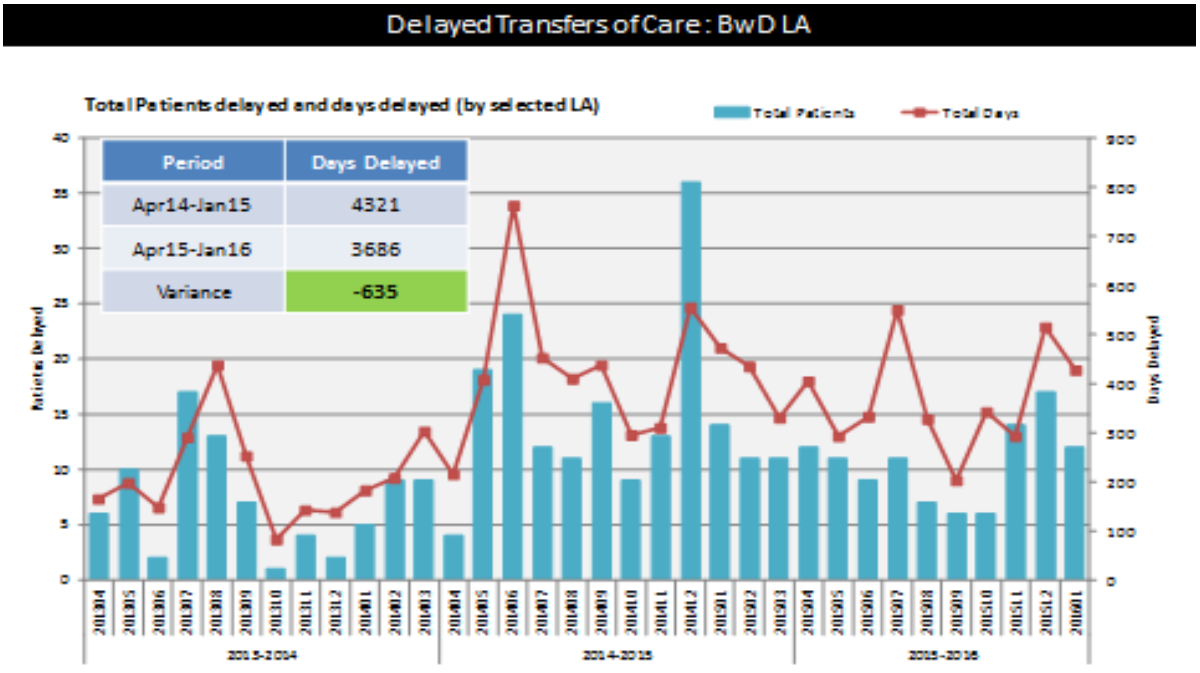
The Section 75 agreement outlines how any funding that is released due to improved performance will be allocated. Performance and budgets are reviewed quarterly and funding support jointly

agreed services or developments for out of hospital system resilience in line with Section 75. Quarterly reports will be provided to Health and Wellbeing Board members with any updates on variance of spend.

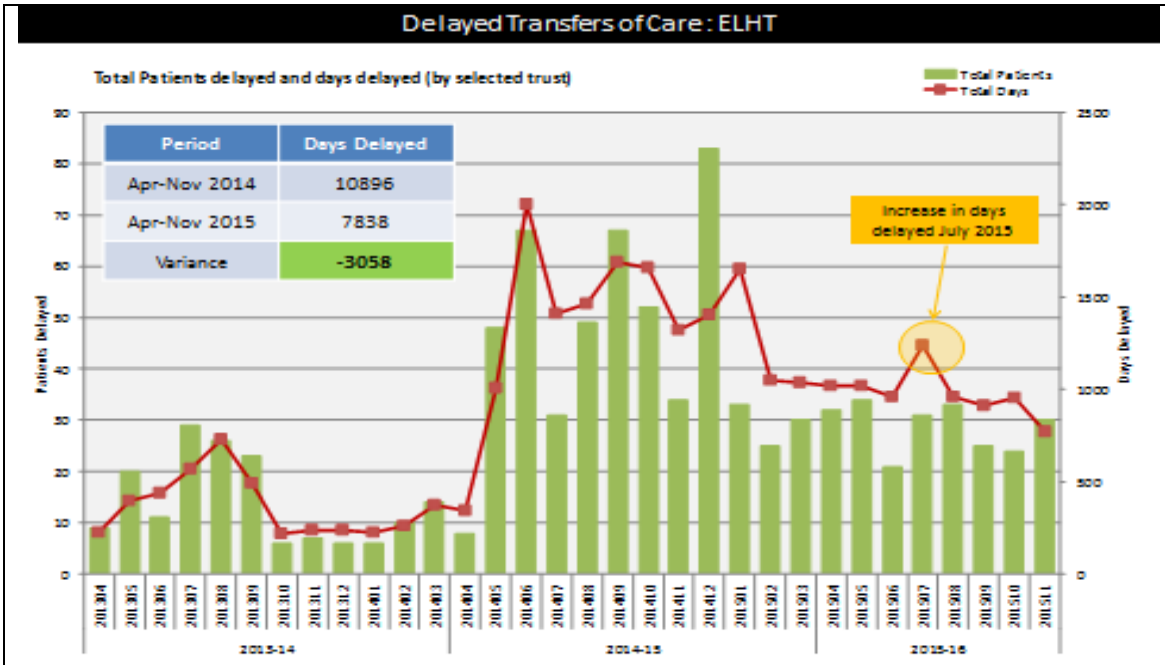
5) Agreement on a local action plan to reduce Delayed Transfers of Care (DTOC) and improve patient flow

Situation analysis

Significant work has been undertaken to address DTOC across Pennine Lancashire. Graph 1 shows the overall position for Blackburn with Darwen and demonstrates a steady decline in DToC over the last 12 months.



Graph 2 shows the Acute Provider position.



As part of the analysis, a number of key issues have been identified which impact locally on Delayed Transfers of Care. These include Continuing Health Care, patient and family decision and awaiting other assessment. This data has informed our emerging plan which will be aligned across Pennine Lancashire to deliver consistent support to the acute provider. This includes the need to introduce discharge to assess as CHC discharge processes from hospital and home of choice are having a significant in terms of numbers of DToCs. Mental Health DToCs are being monitored as part of wider plans.

Target and Action Plan

A 3% reduction in DToC is proposed as part of the 2016/17 plan. This equates to a reduction of 134 days over a 12 month period.

A number of developments have been put in place and are planned to support the reduction of DToC locally. They include:

Action	**Key milestone**	**Owner**
The development of an Integrated Discharge Service across Pennine Lancashire which commenced in September 2015.	September 2016	Blackburn with Darwen and East Lancashire CCG's
The redesign of intermediate care services, including Discharge to Assess, supported by Intensive Home Support and Integrated Locality Teams. The redesign is supported by the Local Authority and CCG commissioners and providers.	1. October 2016 2. March 2017	Pennine Lancashire Integrated Care Group (PLICG)
Commissioners engaging in daily teleconferences with all stakeholders to	On-going	Pennine Lancashire

support flow.		Urgent Care Team
Weekly DToC meetings to identify and resolve any system wide issues.	On-going	Pennine Lancashire Urgent Care Team
Multi-disciplinary accelerated discharge events have been held over winter and there is a Trust Development Agency (TDA) led delayed discharge programme across Pennine Lancashire that will further support our plans for integration.	August 2016	East Lancashire Hospitals Trust

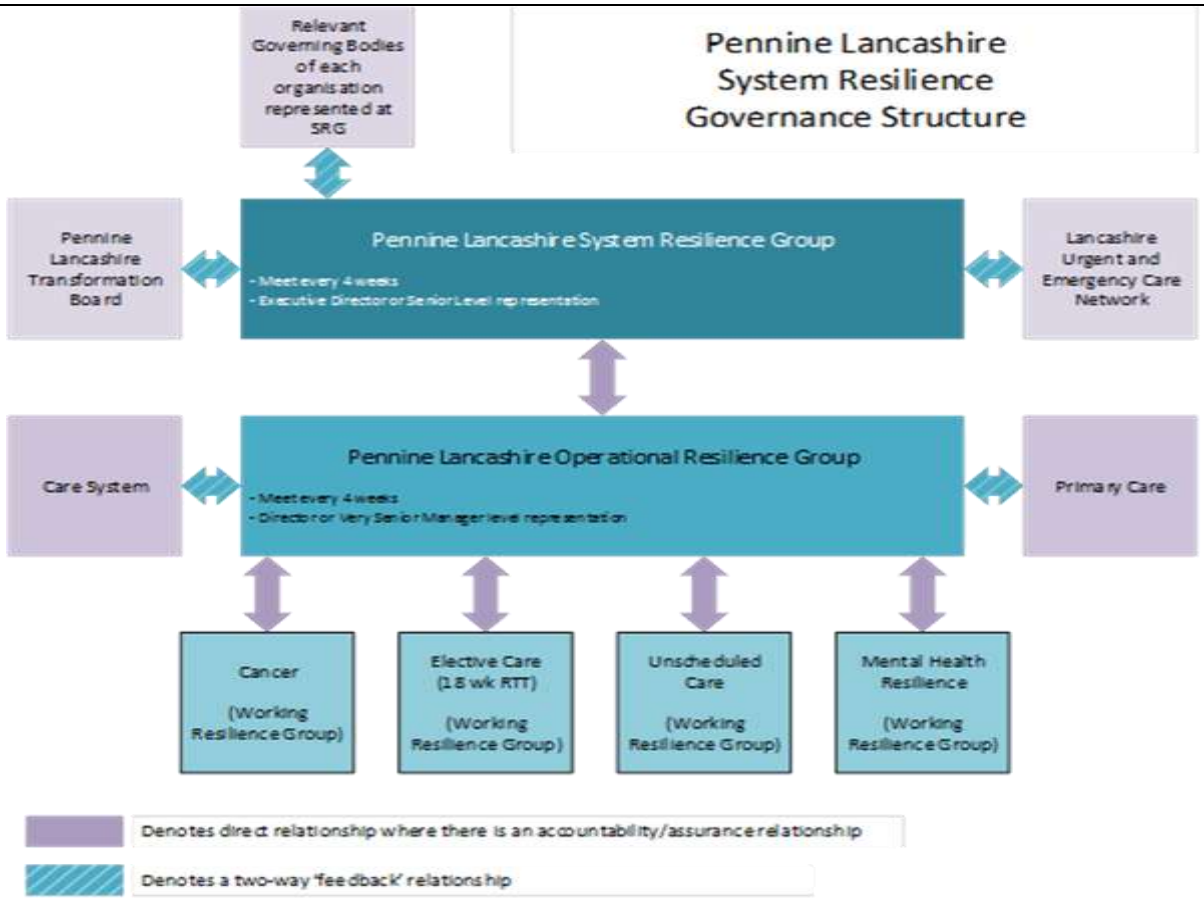
Accountability Arrangements

Accountability for DToC is with the Pennine Lancashire System Resilience Group (PL SRG), attended by CCG, LA and Acute, Community and mental health providers. Formal reports on progress against target and delivery of the plan will be made to BwD HWB quarterly.

Members of the SRG are a designated Executive Director or of senior level with lead responsibility for emergency and urgent care services/elective care for their respective organisations. Independent and voluntary sector providers are fully engaged and are represented on the SRG by Age UK. Full list of organisations represented:

- Blackburn with Darwen Clinical Commissioning Group (BWDCCG)
- East Lancashire Clinical Commissioning Group (ELCCG)
- East Lancashire Hospitals Trust (ELHT)
- Lancashire Care NHS Foundation Trust (LCFT)
- Blackburn with Darwen Borough Council (BWDBC)
- Lancashire County Council (LCC)
- North West Ambulance Service (NWAS)
- East Lancashire Medical Services (ELMS)
- NHS England (NHSE)
- Airedale NHS Foundation Trust (AFT)
- Age UK (AUK)

The SRG Governance structure (ToR available, if required):



6) An agreed approach to financial risk sharing and contingency

A Section 75 agreement has been in place since 1st April 2015. The Section 75 finance schedule will be updated in line with BCF 2016/17 expenditure plan. Risk sharing arrangements are also being reviewed to reflect agreement to support the potential impact of both NEL admissions and increased social care pressure, going forward this will also include risks associated with DTOC. A copy of the Section 75 agreement is available for review if required.

It has been agreed through joint governance routes that the 2015/16 arrangement to release Pay for Performance monies will continue in 2016/17 to support the contingency budget. Performance and system resilience will be reviewed quarterly, in line with BCF Quarterly reporting, through a BCF Performance report to the Exec Joint Commissioning Group and the Health and Wellbeing Board.

7) Funding contributions to Better Care Fund

The funding contributions for BCF 2016/17 will increase as detailed in table 2. The 2015/16 BCF plan has been evaluated by a group of stakeholders using the BCF self-assessment framework and informed the development of the 2016/17 plan.

2016/17 funding has been agreed through an established joint governance process and will be monitored as per arrangements established in 2015/16. For further details please see BwD 2016/17 BCF Planning Template. The pooled budget allocation of £12.433 million for 2016/17 fulfils the national requirements.

Table 2: BCF Funding contributions

	2015/16	**2016/17**
Blackburn with Darwen Borough Council	1,232,000	£1,460,815

NHS Blackburn with Darwen CCG	10,806,000	£10,972,310
Total BCF pooled budget for 2016-17	**12,038,000**	**£12,433,125**

8) A Coordination and integrated plan of action for delivering change

The CCG and Local Authority uses a well-established 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.

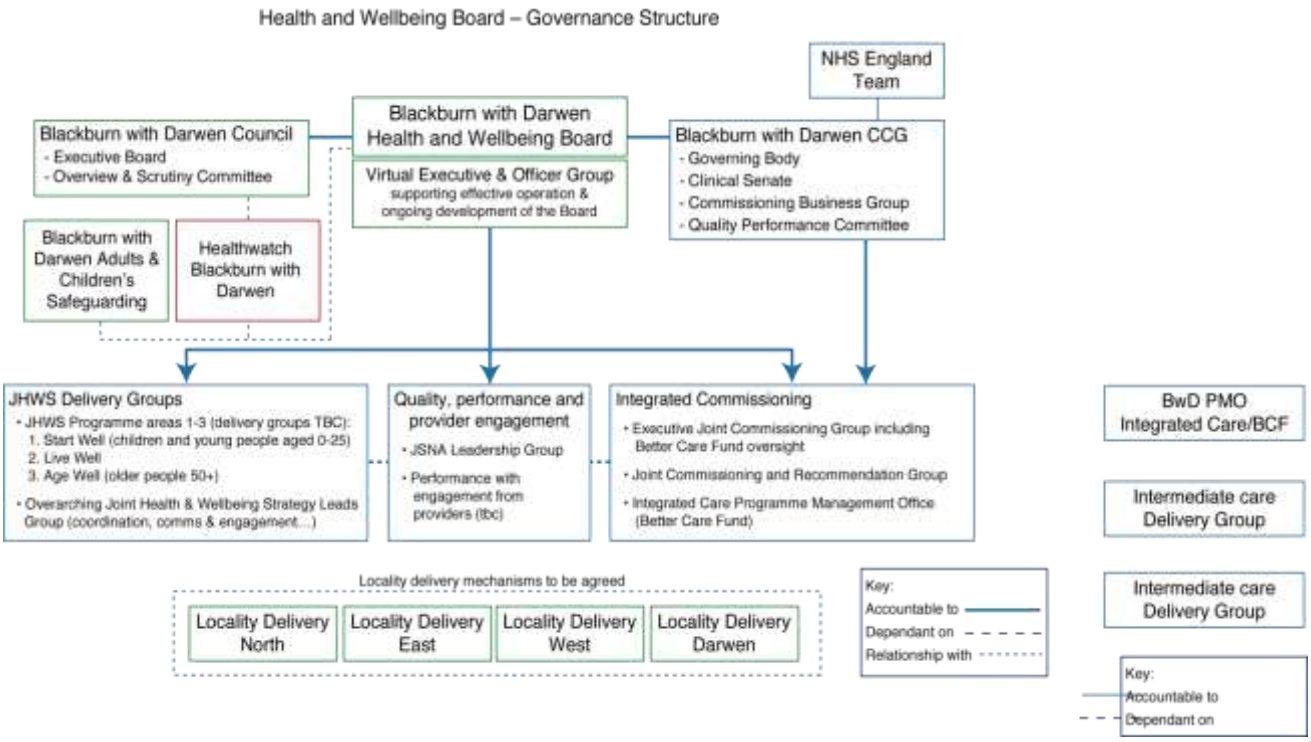


Diagram (i) – Health and Wellbeing Board governance structure

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 HWB 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 HWB 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 who will include progress against metrics, BCF Plan delivery and financial information.

Pennine Lancashire Leadership Forum (PLLF) is accountable for delivery of the Pennine Lancashire Transformation Programme and leads system redesign, transformation and develops

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.

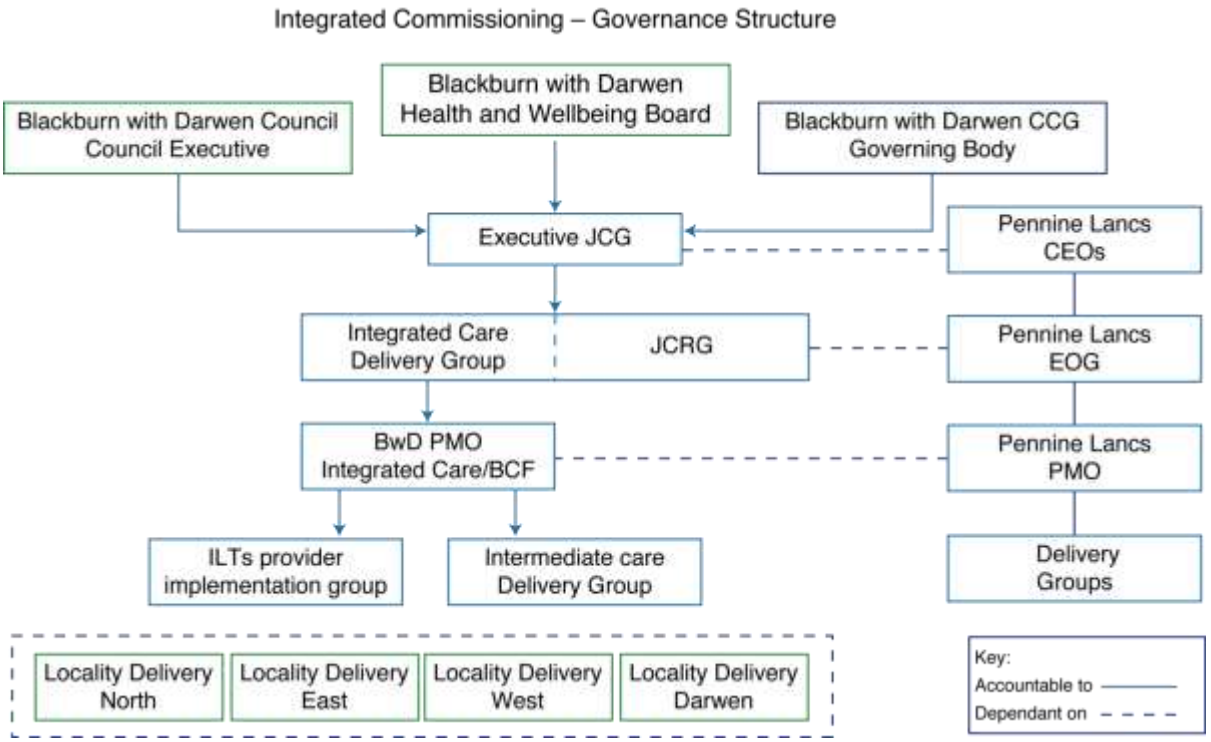


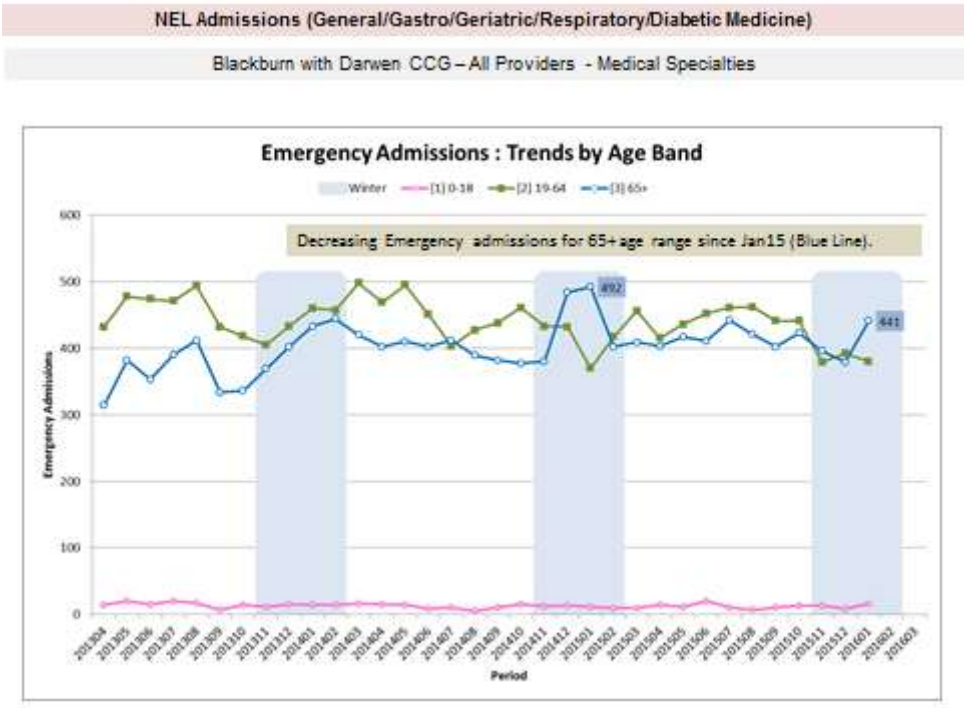
Diagram (ii) – Integrated Commissioning governance structure

9) National Conditions

9.1 Non Elective Admissions (NELs)

The BCF target for NEL is based on a composition calculation from CCG planning application. Blackburn with Darwen (and East Lancashire) shows a 0.2% increase on 2015/16 due to Demographic pressure in financial allocation and we have therefore factored this into the calculations. The target is triangulated against all CCG plans and is reflected in the CCG Planning submission for 2016/17.

NELs are tracked on a monthly basis and a 3 year month on month analysis completed, as evidenced by Graph 3.



Graph 3 – NEL admissions (Medical Specialities)

9.2 Admission to residential and care homes

Forecast performance is close to planned performance in 2015/16. Maintaining the number entering residential care, as the over 65 population increases will present in year challenges that will be considered as part of the wider health and care system.

9.3 Effectiveness of Reablement

The target for reablement is based on a full analysis of 2015/16 activity and the significant increase in numbers of older people discharged into reablement during 2015/16. Performance remains strong in a challenging environment and increasing demographic pressure.

9.4 Delayed Transfers of Care (DToC)

The BCF target for DToC is referenced in section 5. The target has been agreed through joint governance routes and is based on past performance, the considerable work undertaken in the last 12 months and the subsequent improvement in 2015/16; however, we also recognise the challenges and believe we have set an ambitious but realistic plan for reduction. DToC plans submitted in BCF have been replicated as a metric of the CCG Quality Premium Measure.

Appendix 2 - Better Care Fund 2016/17 Quarter 1 narrative

A summary of the schemes that will continue to be supported by BCF is outlined below.

Building capacity within the voluntary sector

The Families Health and Wellbeing Consortium deliver a consortium based model that provides people in Blackburn with Darwen with information relating to care and support for adults and support for carers. The consortium works with statutory partners, voluntary, community and faith (VCF) sector organisations and community based organisations to ensure that information and advice is available and accessible to the whole population. Through a co-ordinated partnership approach across partner agencies we are committed to develop:

- a consortium approach to the delivery of information, advice and guidance services to vulnerable adults and older people in Blackburn with Darwen
- a coordinated approach to early intervention and prevention
- improved access to support in people's neighbourhoods and localities

Building on our successful partnerships with the VCF, we are developing innovative approaches to integrated locality care through remodelling of existing provision and capitalising on opportunities to grow inward investments. This includes the alignment of services provided by Age UK and MIND to support integrated care planning in localities. The services directly support reactive and proactive care planning in localities and are aligned to population need and GP practice demographics.

Integrated Offer for Carers

As part of strategic intention to increase and align capacity within the voluntary sector, Blackburn with Darwen procured an integrated carers offer, delivered through the Families, Health and Wellbeing Consortium. The Consortium is working collaboratively to reach out to particularly disadvantaged carers and hard to reach carers, to make sure they all have equal access to services that are right for them.

In 2016/17 the consortium is delivering an agreed action plan that includes:

- Delivering information, advice and guidance to carers who live in Blackburn with Darwen, or (by arrangement) who care for someone who does
- Increasing awareness and understanding of the protocol for joint assessments between Adult and Children's Social Services so that it works as it should
- Facilitating support to young carers who live in Blackburn with Darwen
- Where carers or the cared for are no longer eligible for services from the Council, they will be shown how to obtain other help to meet their needs through the growing universal offer available in BwD
- Working with all carers to ensure they have a support plan in place to meet their needs and the needs of those they care for

Integrated Locality Teams

Integrated Locality Teams (ILTs) have seen the establishment of case managed, multi-disciplinary teams based on GP practice populations, utilising risk stratification and other relevant local data. The focus of ILT work remains on those deemed most at risk of hospital admission, including those with long term conditions, and frail, elderly people.

- Utilising an agreed risk stratification tool and GP knowledge, high risk patients are identified and their care planning and management reviewed at regular Integrated Care Team meetings. The aim is to share knowledge of patients and identify the most suitable approach to patient care.
- Case managers work with individuals, their carers and in partnership with Secondary Care, NWAS, GPs and the voluntary sector to help prevent hospital admissions to develop or review a personalised care plan. Case managers are identified to develop care plans at weekly team meetings and monthly Integrated Care Team meetings that involve GP Practices. Case managers

have responsibility for planning, monitoring and anticipating the changing needs of these individuals, and co-ordinating their care across all parts of the health and social care system.
- The Integrated Locality Teams are strongly linked with the local community to promote and develop self-care and independence, the identification and support of carers and vulnerable groups, and building on existing community assets.

In partnership with East Lancashire CCG we have developed a Pennine Lancashire Standard Operating Procedure for integrated teams and are working to develop a robust impact and monitoring framework.

Prevention of falls has been identified as a priority area in Blackburn with Darwen and the Borough Decent and Safe Homes (DASH) scheme has been funded through BCF to look at improving the proactive intervention to reduce falls and offer a reactive service to reduce the reoccurrence of falls amongst the population. This work will be aligned to the remodelling of wider falls and frailty pathways.

In 2016/17 we will be implementing a telehealth project which will introduce assistive technology into the integrated model of care within Blackburn with Darwen. The project will support patients and carers to access the right level of care in a timely manner; ensure that care is effective in meeting needs and will avoid an unnecessary admission to acute care, promoting faster recovery and/or discharge where an admission was required. Technology will be installed in 8 care homes as a pilot. The care homes have been selected to participate in the telehealth pilot on the basis of growing A&E attendances, increasing emergency admissions and number of beds, as this is where the biggest impact could be made.

The development of ILTs and a revised case management approach to patient care has identified significant interdependencies with the wider Integrated Care programme. This includes Intermediate Care, Integrated Discharge Intensive Home Support (IHS) service, building capacity in the voluntary sector and BwD Transforming Lives programme.

Intensive Home Support

The service was reviewed in November 2015 to ensure greater utilisation and has been further developed to promote a more streamlined pathway supporting 7 day discharge and admission avoidance. Plans are now in place to blend the IHS model with ILTs in the community, to utilise the Rapid Assessment Teams within the hospital to deflect admissions, make greater use of the community Intravenous antibiotic team to deliver in the community and support early discharge. A specialist Chronic Obstructive Pulmonary Disease team is in place and complex case managers have been recruited to proactively identify patients at risk of hospital admission and manage in the community. GP Medical oversight model for Intensive Home Support is in place and access to the service is via the Care Navigation Hub. We are working with colleagues from East Lancashire CCG to identify best practice, from the work undertaken to date, to implement an aligned service specification. The aim is to prevent unnecessary hospital admissions by providing a community service response and at the front door of the hospital. The service also supports people across Pennine Lancashire when they leave hospital following an admission, providing support to the integrated discharge service.

Intermediate Care including integrated discharge and discharge to assess

An Integrated Discharge Service model commenced operation in September 2015. The emerging model supports the role of trusted assessor, aligning health and care assessment activity. Work has commenced in BwD to develop an out of hospital single point of access to enable more timely discharges and increase capacity in the hospital.

Additional health and social care capacity is in place to support 7 day discharge. The capacity is being utilised to support discharges and to prevent admissions. Intermediate care provision has been reviewed and the model of care has been aligned for sub-acute, intermediate care and discharges to assess beds commissioned by CCG and Local Authority. Flexible use beds have been commissioned, which can offer a more responsive approach to the delivery of sub-acute and intermediate care dependant on need. The new model of care will ensure that all commissioned beds can be utilised flexibly. The main principle for intermediate care will be that a patient's own bed be the first option considered and care be provided in a residential setting.

Care Navigation Hub/Directory of Services (DoS)

The 'Hub' provides a single contact point to support Health and Social Care services across Pennine

Lancashire, working with ILT's in local delivery of services through detailed DoS, including more than 800 services, to identify service options or make referrals as required. The navigation hub provides prompt, clinical advice to support navigation through out of hospital services and is being utilised by health and social care services to mobilise services and triage and carry out assessment for access into Intensive Home Support Services.