Public Document Pack

Health & Wellbeing Board

Tuesday, 25th September, 2018
5.30 pm

AGENDA

1.	**Welcome and Apologies**	
2.	**Minutes of the meeting held on 19th June 2018**	
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3.	**Declarations of Interest**	
4.	**Public Questions**	
5.	**Joint Health and Wellbeing Strategy**	
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9.	**Live Well Annual Update (Presentation)**	
10.	**Age Well Annual Update (Presentation)**	

Date Published: 18th September 2018
Harry Catherall, Chief Executive

Blackburn with Darwen Health and Wellbeing Board
Minutes of a Meeting held on Tuesday, 19th June 2018

PRESENT:

Councillors	Mohammed Khan (Chair)
	Maureen Bateson
	John Slater
	Brian Taylor
Clinical Commissioning Group (CCG)	Roger Parr
Lay Members	Joe Slater
Voluntary Sector	Vicky Shepherd
	Angela Allen
Healthwatch	Abbey Mulla
Council	Louise Mattinson
	Gifford Kerr
	Sayyed Osman
	Ismail Hassan
	Wendi Shepherd
	Linda Clegg
Council Officers	Laura Wharton
	Lorraine Price
CCG Officers	Claire Jackson
Midland and Lancashire Commissioning Support Unit	Dawn Haworth

1. WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting especially Cllr John Slater and Cllr Brian Taylor who were attending for the first time. Apologies were received on behalf of Dominic Harrison and Dr Penny Morris.

2. Minutes of the meeting held on 20th March 2018

As an action from the previous minutes a correction was noted that on page 2, Item 2 of the minutes this should read 'Meem Strategy'.

RESOLVED

1. That the minutes of the meeting held on 20th March 2018 be agreed as a correct record subject to the amendment reference to above.

3. Declarations of Interest

Joe Slater outlined his interest in item 7 on the agenda relating to Child Actions.

4. Public Questions.

The Chair informed the Board that no public questions had been received.

5. Universal Credit

The Board received a verbal update from Louise Mattinson, Director of Finance and Customer Services on Universal Credit as requested at the last Board Development Session. Louise had prepared a hand out which was circulated.

Louise highlighted the key points to the Board:

- Country wide role out of Universal Credit - postcodes in Blackburn with Darwen started on 14th February 2018 with online services.
- New claims made on the following; Job Seekers Allowance, Income Support, Employment Support Allowance, Tax Credits, Child Tax Credits and Housing Benefits.
- Reduced waiting time for New Claimants to 5 weeks abolishing the 7 day waiting period and repayment extended from 6 months to 12 months
- Difficult implementation – numbers have exceeded expectations.
- Issues identified and being addressed – claimants with limited digital, poor language and literacy skills.
- Support provided by BWD, Shelter and DWP - Council support system – more work to be completed on this.
    - Provide drop in centres
    - Shortage of English language course
    - Monitoring and working with DWP
    - Currently there are no figures to hand, but looking to monitor where possible and to signposting people to agencies when their needs cannot be met and to ensure the information imputed is correct the first time to avoid delays.

The Board expressed their concerns on the impact on the citizens of the Borough and those finding it difficult to access the new digital system, especially those with mental health and learning difficulties who have been denied benefits. It was noted that Shelter, Healthwatch and Together Housing were already working to support people to avert crisis in poverty, homelessness and drug addiction.

The Board was informed that Darwen Job Centre was closing and this would have a long-term impact on the health and wellbeing of citizens, that there was currently a pilot scheme with partners working together to mitigate issues for vulnerable people:

- The local health centre has opened a drop-in centre to assist with Universal Credit and GPs were looking at how they can support each other linking to agencies.

The Board felt that changes should be made to make this process simpler and that the Government needed to look at this again. Councillor Mohammed Khan noted that Councillor John Slater had already written to the Minister and there would be no changes. The Board asked what could they do in partnership, working together to help Citizens through GP's, CCG's, libraries and neighbourhood working, looking at

how people can be supported.

RESOLVED
1. That the presentation be noted; and
2. That the Sayyed Osman and Louise Mattinson look at the support that can be made available to the community with regard to language, literacy and technology, and to look at the pilot scheme in Darwen.

6. <u>Better Care Fund and Joint Commissioning</u>

Claire Jackson, Interim Director of Commissioning presented the report and explained that the paper had been reviewed in advance of the meeting by the Board. Claire had previously updated the Board at the last meeting on the Financial position at 12 months and final position this year. Claire noted that Section 5.2 of the report outlined the changes and funding to the plan for this year.

The purpose of the report was to:
- Provide the Health and Wellbeing Board members with an overview of Better Care Fund (BCF) performance reporting and finance position at Quarter 4 for 2017/18.
- Request that the Health and Wellbeing Board members approve the developments within the BCF 17–19 plan for 18/19 delivery.
- Provide Health and Wellbeing Board members with the BCF and iBCF Finance schedule for 2018/19.

The Board discussed several key issues:
- Funding and budgets
- 'Home first and discharge' to reduce the lengths of stays in hospital
- Reduction in admissions – this is still being evaluated along with schemes for care homes. These figures are so small that the impact is not currently visible.
- Pharmacies first – Gifford Kerr was assessing this area and concluded that the borough was well provided with pharmacies and would encourage people to use them so that they would remain open. Claire also updated that the Neighbourhood Teams were working closely with pharmacies' and were included in practices to help deliver care and enabling people to remain at home. Claire also updated on online services and home delivery of prescriptions, but noted that the impact, benefits and reduction on wasted medication was difficult to evidence at present.

The Chair thanked Claire for her report and congratulated her on her new role with Pennine Lancashire. Claire confirmed that she would remain in CCG in Blackburn and would still attend these meetings but would not represent Better Care.

RESOLVED

1. That the Health and Wellbeing Board members note the BCF quarter 4 submission and progress made against delivering the BCF plan including the 12 month finance position; and

2. That they also approve the changes made within the BCF Plan for 18/19 delivery.

7. **Lancashire Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan Update**

The Board received a presentation and report from Dawn Haworth, Midland and Lancashire Commissioning Support Unit. The purpose of the report was to provide an update to the Board of progress in delivering the Children and Young People's Emotional Wellbeing and Mental Health Transformation Programme, in particular:

- A summary of the current strategic context and how that is shaping the work of the programme.
- An update on the delivery of the Transformation Plan and its refresh for 2018.
- Challenges that the programme is facing, in particular variation in access, waiting times and investment levels.
- An update on the major project to redesign CAMHS across Lancashire and South Cumbria in line with THRIVE (More evidence based) Think, Risk, Educate
- Ask for the Health and Wellbeing Boards ongoing support for the programme.

Key priorities

- Review Transformation plan
- CAMHS is funded by BWD to ensure we have best possible service.

The Board raised issues with regard to accessing services for both adults and children and comparable statistics. Dawn noted that the data currently was poor, but was seeking to address this, for those who could not access the services and noted that we need to get this right.

- Improving mental and physical wellbeing – via Sport England
- Healthy activity in schools with early intervention
    - Gifford Kerr would liaise with Leisure services to link-in help and support for children and adults are included to access development money.

Actions

- Dawn to provide Cllr John Slater with data to back up evidence via Laura Wharton on
    - THRIVE
    - Data for children carrying mental health issues into adult hood.
- Dawn to liaise with Abbey Mulla - Healthwatch is very interested in encouraging young people to be involved and is commissioning to work with young people and families via workshops. Abbey's group are looking at how this can enhance checkpoint, the experiences and barriers etc.

The Chair thanked Dawn for her presentation noting the challenges that had been met especially in investments. Councillor Maureen Bateson said that the Scrutiny Group were currently working with Young People and would be interested in Dawn presenting to the group.

RESOLVED

1. That the Health and Wellbeing Board noted the current strategic context and how that is shaping the work of the programme.
2. That the Health and Wellbeing Board noted the progress made in delivering against the Transformation Plan and noted the publication of the refreshed Transformation Plan.
3. That the Health and Wellbeing Board noted the challenges that the programme is

facing, in particular variation in access, waiting times and investment levels.
4. That the Health and Wellbeing Board noted the update on the CAMHS Redesign project; and
5. That the Health and Wellbeing Board confirmed that ongoing support for the programme.

8. Review of the Joint Health and Wellbeing Strategy

The Board was due to receive a presentation from Wendi Shepherd from the Public Health Team on the review of the Joint Health and Wellbeing Strategy, but as time was short it was agreed that Wendi would give a quick update. Wendi agreed to email her presentation to the Board and to meet with anyone who wished further information.

Wendi informed the Board that she was leaving in July, but would finalise before she left and would bring the report to the Board in Autumn for continuity.

RESOLVED

1. That Wendi Shepherd bring an update to the Board in Autumn; and
2. That Wendi Shepherd would send a draft report to Members with the notes and presentation.

9. Social Integration
(This item was presented before item 6 on the agenda)

Sayyed Osman, Director of Adults & Prevention (DASS) and Ismail Hasham, Cohesion Advisor on Social Integration attended to present the Social Integration to the Board and covered the following areas:
- Our Vision and Ambitions
- Our Communities
- Volunteering and Your Call
- Civic Events
- Engage in Shared Experience young old and mix enjoying time (photo)
- Workshop Groups and Themes (three key issues) Young People/Social mixing,
- Integration Synopsis
- Access to pathways
- Social mixing
- Local Economy
- Next Steps
    - Stakeholder workshops (Monday 18th June 2018)
    - Update Logic Model
    - Member Workshop (Wednesday 20th June 2018)
    - Shadow Local Integration Partnership
    - National meeting with MHCLG
    - Follow up on key themes, evaluation and feedback
    - Submission of Logic Model to MHCLG

Overview
- BwDBC Approached and delighted to Partner MHCLG given 'Strategic Fit' with our ambitions and Vision.

- MHCLG Announcement – 5 Partnership Areas including BwDBC, Bradford MBC, Peterborough, Waltham Forest, Walsall.
- Context of £50Million announced – (no real money at this stage – working on proposal) Working towards submission in Sept 18.
- This council's leadership is absolutely committed to Integration.
- Our style is to be positive and ambitious, to tackle issues head on. We do this by working closely with lots of different groups and organisations.
- Our young population is one of our biggest assets and is already leading the way on this agenda, which promises real hope for the future.
- We want all communities to prosper, have access to opportunities with no barriers preventing them from being able to engage and thrive.
- This partnership will help trial and pioneer new ways to further advance integration with a sustainable legacy.

Discussions took place following the presentation on how to move forward and the best place to start the journey through young people and through sports. Suggestions were made where people could come together and talk about cultural differences and experiences.

The Chair thanked Sayyed for his presentation and noted this was a very important agenda and that even though some people did not want to integrate the Board could not be complacent and that the Council was a good place to start with strong links to communities.

RESOLVED

1. That the Health and Wellbeing Board notes the information presented; and
2. That Sayyed Osman would send the presentation and video link to the Board Members.

Chair………………………………………..

Meeting at which the minutes were signed………………………………………..

HEALTH AND WELLBEING BOARD

TO:	**Health and Wellbeing Board**
FROM:	**Dominic Harrison, Director of Public Health**
DATE:	**25th September 2018**

SUBJECT: Blackburn with Darwen Joint Health and Wellbeing Strategy 2018 - 2021

1. PURPOSE

The purpose of this report is to present the final Joint Health and Wellbeing Strategy document to the Health and Wellbeing Board for approval and outline the continued arrangements for delivery of the Strategy.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

The Board is recommended to;

- Approve the proposed Joint Health and Wellbeing Strategy for the period 2018 – 2021
- Note the continued arrangements for delivery of the strategy

3. BACKGROUND

A statutory duty under the Health and Social Care Act 2012 requires the Health and Wellbeing Board to produce a Joint Health and Wellbeing Strategy (JHWS) setting out the way in which it will meet the needs identified in the local Integrated Strategic Needs Assessment (ISNA).

The current Joint Health & Wellbeing Strategy (JHWS) produced by the Blackburn with Darwen Health and Wellbeing Board expires in 2018. While much of the evidence, thinking and engagement work upon which the previous strategy is based remains as relevant today it is important to take account of;

- The expanded body of evidence available locally through the Integrated Strategic Needs Assessment (ISNA)
- The changing health, social care and wider public sector landscape as a result of financial pressures and government reform, and role of the Health and Wellbeing Board and JHWS within this.
- Opportunities presented by new ways of working as a result of nationally and locally led programmes for transformation and integration.

Our challenge now is to do more of what has been shown to work from the previous strategy but develop this further within the context of changing service delivery models and increased service demands.

4. RATIONALE

This strategy continues The Board's ambition to ***increase life chances for the residents of Blackburn with Darwen, by improving health and wellbeing; creating healthy places and reducing health inequalities, giving all people the opportunity to Start Well, Live Well and Age Well.***

The "life course" approach of our previous strategy enabled the Health & Wellbeing Board and partners to truly consider the differing health needs that people experience at different points in their lives. Throughout the period of the last strategy, this evidence based approach has been fully embedded into the Health and Wellbeing Boards work.

The life course model consists of three main life phases:

- Start Well: Making sure children and young people get the best start in life
- Live Well: Healthy & prosperous people, places and communities
- Age Well: Ensure older people are supported to remain independent and socially included

Since the launch of our previous JHWS (2015-18), there have been significant developments at a national level which have led to greater integration of services and the development of a Pennine Lancashire footprint for health service planning and delivery. Concurrent with this, we have been developing our "place-based partnership" model in Blackburn with Darwen, which considers the needs of, and delivers integrated prevention, health and care services to our four neighbourhoods.

5. KEY ISSUES

The Joint Health and Wellbeing Strategy for Blackburn with Darwen 2018 -2021 is included in Appendix A of this report.

The key issues requiring decision or agreement by the Board are set out below;

5.1 Priorities:

Continuing the previous strategy, this JHWS seeks to:

- Increase life expectancy year on year for both males and females, and narrow the gap with the rest of England
- Narrow the inequalities in life expectancy within Blackburn with Darwen
- Pursue policies that will maximise the number of years spent in good health
- Improve people's emotional health and wellbeing
- Manage demand and improve outcomes by shifting resources and investments from treatment and care into prevention
- Ensure that Blackburn with Darwen are healthy places to live, work, and play

Over the course of recent months the Health and Wellbeing Board has, through consultation with partners, identified 3 main cross-cutting themes for the new strategy.

- Poverty
- Vulnerable people
- Mental health and wellbeing

5.2 Principles for delivery:

A Place-Based Prevention Framework has been developed for Pennine Lancashire with the aim of embedding prevention across every aspect of our plans and this approach to delivering our priorities has been adopted as part of the new JHWS.

The Framework is based on five key principles:

1. **Place based prevention requires a 'whole of society' approach**: Estimates suggest that health care services contribute only to about 20% of the health of the population. Most of the 'determinants of health' are only amenable to effective preventive actions outside of the health care system.
2. **Place based prevention is a co-operative and collective activity that mobilises support for change**. Creating healthy communities through place based prevention requires collective action aimed at generating a co-operative community resilience to health risks at an individual and community level.
3. **Place based prevention involves mobilising all of societies resources in a 'place'**: Place based prevention and health care systems are the most likely to be effective in mobilising all of societies capacities to improve health and wellbeing
4. **Place based prevention involves creating a culture for health that actively enables citizens to take care of themselves and their communities**: Creating a social movement for health that supports citizen action for wellbeing and re-directs the health and care systems towards prevention is critical to the future sustainability and transformation of health and care systems
5. **Place based prevention is aimed at promoting equity of outcomes and equal life chances for all residents.** Creating equity of outcomes may sometimes involve inequalities of inputs - providing more resources to those whose need is greatest, and actively challenging social inequalities that are unjust, unfair and avoidable.

The Framework is also set out in ten Domains, as shown in the following diagram and described briefly below.

Figure 1: The Pennine Lancashire Place Based Prevention Framework

5.2 Governance and Accountability:

The HWB has previously agreed that lead groups will be tasked with taking ownership of the delivery of the JHWS priorities and wherever possible these have been identified from existing groups already in place. These are referred to as the Life Course Boards.

The key delivery groups for JHWS going forward will, therefore, continue to be;

1. Start Well – Children's Partnership Board
2. Live Well - Live Well Board
3. Age well – Age Well Partnership

Membership of each Board includes a range of relevant stakeholders and organisations and each has a named Chair who is also a member of the Health and Wellbeing Board. Other Health & Wellbeing Board members participate directly in the Life Course Boards as appropriate. Each Board will continue to contribute to the Integrated Strategic Needs Assessment (ISNA) process as relevant to their priority.

Each Life Course Board will develop and implement an annual action plan that reflects the agreed priorities and approach in a way that is responsive to the changing local and national landscape and ensures the best possible health outcomes for residents. The action plans will have specific, measurable milestones that the boards wish to achieve alongside the medium to longer term indicators of progress outlined in national outcomes frameworks. The plans will be shared with the Health & Wellbeing Board and the respective Life Course Chairs will provide an annual update to the Board outlining progress, challenges and plans for the coming year.

6. POLICY IMPLICATIONS

The proposals set out in this paper will have implications for other policies and plans across the health and wellbeing partnership. It is part of the Health and Wellbeing Board's role to ensure that the priorities set out in the JHWS are taken account of by partners, as appropriate.

7. FINANCIAL IMPLICATIONS

There are no direct financial implications of this paper.

8. LEGAL IMPLICATIONS

Health and Wellbeing Boards were established under section 194 of the Health and Social Care Act 2012. The statutory membership is provided for in section 194(2) of the Act. The Board is able to appoint sub-committees and may appoint additional persons to the Board.

The Act details two core functions of Health & Wellbeing Board:

- To prepare an assessment of relevant needs, through the Joint Strategic Needs Assessments (JSNA),
- To prepare a strategy for meeting those needs, through the Joint Health and Wellbeing Strategies (JHWS)

The Board also has a duty to promote integration and involve the public. Other specific powers and responsibilities of the Board include a duty to provide opinion as to whether commissioning plan has taken proper account of the JHWS. The proposals set out in this paper will assist the Board in delivering these functions and responsibilities.

9. RESOURCE IMPLICATIONS

The principle resource implication of this paper is the time of officers from those constituent organisations of the Board to support the implementation of the recommendations.

The priorities set out in the strategy should, along with other national and local plans and guidance influence commissioning decisions made by constituent organisations of the health and wellbeing partnership going forward.

10. EQUALITY AND HEALTH IMPLICATIONS

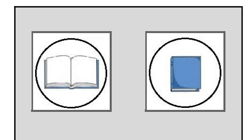
The principle aim of the JHWS is to improve health and wellbeing and reduce inequalities. These principles have been fully embedded and the Strategy has been subject to the relevant impact assessments.

11. CONSULTATIONS

The revised JHWS has been through a process of consultation with relevant stakeholders via the thematic delivery groups (Start Well, Live Well, Age Well) and, via Board Members, with the constituent organisations of the Board.

VERSION:	**1**

CONTACT OFFICER:	Laura Wharton
DATE:	13th September 2018
BACKGROUND PAPER:	



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Sayyed Osman, Director of Adult Services, Neighbourhoods and Community Protection, BwD LA
DATE:	25th September 2018

SUBJECT: Better Care Fund Update

1. PURPOSE

The purpose of this report is to:

- Provide Health and Wellbeing Board (HWBB) members with an overview of Better Care Fund (BCF) performance reporting for Q4 2017/18
- Provide HWBB members with the BCF and iBCF Finance position at Q1 2018/19
- Provide HWBB members with an overview of the forthcoming Local Learning Visit from the National BCF Team

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board members are recommended to:

- Note the BCF Q1 2018/19 finance position
- Note the BCF Q4 2017/18 performance metrics
- Note the planned content of the forthcoming BCF Local Learning Visit

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 through Blackburn with Darwen joint commissioning arrangements.

The Blackburn with Darwen BCF plan for 2017/19 was approved on the 30th of October 2017, with an expectation that planned performance metrics are achieved as described. Quarterly reports have been submitted as per the national schedule, demonstrating the progress made against each scheme. The Q1 return was submitted on 19th July 2018 following sign off by the Chair of the HWBB. Due to the timing of the national returns and year end reporting processes Q4 metrics were captured within the 2018/19 Q1 report.

4. RATIONALE

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 such that by 2020, health and social care is integrated across the country. This is also 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.

5. KEY ISSUES

5.1 BCF Pooled Budget 2018/19

The CCG minimum pooled budget requirement for 2018/19 is £11,381,000. The DCLG have confirmed the DFG capital allocation for 2018/19 at £1,739,476.

The 2018/19 allocations as above plus carry forward amounts from 2017/18 are analysed as:

- Spend on Social Care - £6,501,650 (48.0%)
- Spend on Health Care - £4,252,828 (31.4%)
- Spend on Integration - £2,191,698 (16.2%)
- Contingency - £600,000 (4.4%)

The BCF budget for 2018/19 has been reviewed following further joint planning across LA, CCG finance and social care leads and includes the following:

- Inflationary uplifts
- Capital allocation assigned to INT estates
- The realignment of available monies to fund a reshaped Take Home and Settle service.
- Review of Commissioning Transformation Lead - Integrated Care post with a view to recruitment in Qtr 1 2018.
- The balance of BCF of £600,000, ordinarily held as a contingency, has been allocated to the LA in 2018/19 to meet social care demand and acuity pressures. Any further pressures or savings identified in year will be shared between the LA and CCG in accordance with the S75 agreement.

5.2 iBCF Pooled Fund 2018/19

Central Government consulted on the distribution of the Improved Better Care Fund as part of the Local Government Finance Settlement 2018/19. The spending review set out the expected available revenue for Local Government spending through to 2019/20 and the Core Spending Power information for Local Authorities has now been issued, including the proposed allocations of the Improved Better Care Fund.

Allocations in the Core Spending Power recognised that authorities have varying capacity to raise council tax (including that through the adult social care precept). Further allocations of the Improved Better Care Fund have been made following the Spring Budget. For Blackburn with Darwen the total allocations of Improved Better Care Fund are:

	Original iBCF	Additional iBCF for Social care – Spring Budget	Total
2017/18	£717,301	£3,589,451	£4,306,752
2018/19	£3,714,497	£2,186,064	£5,900,561
2019/20	£6,257,725	£1,081,454	£7,339,179

Allocations will be paid directly to Local Authorities as Section 31 grant and Local Authorities must meet the conditions set out in the grant determination as part of locally agreed plans. The grant must be spent on adult social care and used for the purposes of:

- meeting adult social care needs (£4.074m allocation)
- reducing pressures in the NHS – including supporting more people to be discharged from hospital in a timely way as a means to avoid Delayed Transfers of Care (DToC) (£561k allocation).
- stabilising the social care provider market (£1.265m allocation)

Local Authority Section 151 Officers are required to certify use of the grant and submit quarterly returns to the Secretary of State. Local Authorities must pool the grant funding into the local Better Care Fund and work with CCG's and providers in line with the Better Care Fund Policy Framework and Planning Requirements 2017-19.

5.3 BCF 2017/18 Performance Metrics

Due to the timing of the national returns and year end reporting processes, the metrics described within this report relate to Q4 2017/18 data.
The 6 month 2018/19 position will be reported to the HWBB at the end of Q3.

Reduction in non-elective admissions

There continued to be a reduction in non-elective hospital admissions throughout 2017/18 with integrated working at a neighbourhood level across health, care and the voluntary sector supporting people to avoid hospital admission and remain independent at home. Going forward however, expected increases in 'zero day admissions' due to the inclusion of the Respiratory Assessment Unit and pilot of the Accident and Emergency Care Unit within the reporting figures are likely to impact on the achievement of this metric, as it stands currently, during 2018/19. Discussions are taking place to determine how best to highlight the impact of these initiatives within the BCF return.

Rate of permanent admissions to residential care

The reported number of placements over the 12 month period reflects our approach to ensuring that all suitable alternatives are considered prior to a long term placement being made for any individual resident. The 2017/18 target figure was set at 175 admissions (817.1 per 100,000 population). The final figure at the end of Q4 2017/18 shows an increase of 17 placements. In the vast majority of cases, service users enter short term care in the first instance. Following review, a proportion of placements will become long term and will then be reflected in future figures. Blackburn with Darwen continues to provide a Reablement in-reach service, dedicated social worker support and access to therapy services as a means to maximise the opportunity for service users to return home following a period of short term care. Going forward, our Extra Care Housing schemes will offer increased opportunities for residents to access more enhanced levels of support at home.

Reablement

The reablement target relates to the proportion of people (65 and over) who were still at home 91 days after discharge from hospital into Reablement and /or rehabilitation services. The 2017/18 target was set as 91.4%. This target was met throughout the year with minor fluctuations. The Reablement service continues to provide excellent outcomes for residents and is an integral part of our care pathways. As we continue to expand the Reablement offer across all of our integrated pathways, for example Home First, the service will support residents with increasingly complex needs. This may impact on overall outcomes going forward.

Delayed Transfers of Care (DToC) (delay days in hospital)

By the end of Q4 2017/18 DToC performance was on track to meet targets. This measure is typically subject to fluctuations in response to hospital pressures however the positive trajectory reflects several schemes which have been agreed to support the reduction in DToC and which are progressing as planned:

- The enhanced Home First service within BwD is fully mobilised. Early results are positive with data capture and evaluation ongoing.

- An integrated discharge pathways leadership post has been successfully recruited to and inducted across all agencies. This post leads the current Integrated Discharge function across health and care within Pennine Lancashire

- The Discharge to Assess pathway is established and operating as planned as a means to enable a longer period of recovery outside of the hospital environment and prior to the completion of necessary assessments.

Additionally, there is significant work at hospital level to clearly identify and apportion DToC in line with current guidance. This will also provide consistency across Lancashire and South Cumbria.

5.4 BCF Local Learning Visit

Blackburn with Darwen have accepted the opportunity to participate in a Local Learning visit from the National BCF Team which will take place on Tuesday 9th October. The visit will offer an excellent opportunity to showcase our integrated care developments and receive feedback/learning from other areas. During the day, the BCF Team will be introduced to colleagues from our Home First Service and from one of our Integrated Neighbourhood Teams. This will enable them to hear from our practitioners first hand and discuss the impact of our integrated care developments on ways of working and outcomes for service users. We also intend to provide an opportunity for the team to meet with senior leaders from across the partnership to discuss wider impact and priorities going forward.

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

No further financial implications have been identified for quarter 1. This report outlines the budget position at month 3.

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.

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.

10. EQUALITY AND HEALTH IMPLICATIONS

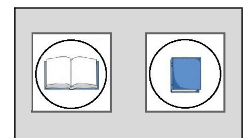
Equality and health implications relating to the Better Care Fund plan were considered and reported to Health and Wellbeing Board members prior to submission of the plan.
Equality Impact Assessments are ongoing as part of the development of all BCF and integrated care schemes, including new business 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.

VERSION:	**2.0**

CONTACT OFFICER:	Katherine White
DATE:	17th September 2018
BACKGROUND PAPER:	



HEALTH AND WELLBEING BOARD

TO:	Health and Wellbeing Board
FROM:	Sayyed Osman
DATE:	25 September 2018

SUBJECT: The Pennine Plan

1. PURPOSE

This paper provides an overview of how the proposals for improving health, care and wellbeing services across Pennine Lancashire have been developed. It recommends the Pennine Plan for consideration and approval (attached in full as appendix A). This report also provides an overview of the engagement approach undertaken to test the Draft Pennine Plan and a summary of responses received during the engagement. These have been used to shape the final version of the Pennine Plan.

The development of a Pennine Lancashire Integrated Care Partnership, within the Lancashire and South Cumbria Integrated Care System, is central to delivering the Pennine Plan. The recently launched Blackburn with Darwen Local Integrated Care Partnership will drive delivery within the 4 Neighbourhoods across the Borough. The Pennine Plan has been developed in collaboration with Blackburn with Darwen Borough Council and impacts upon a number of departments including Adult Social Care, Neighbourhoods, Public Health, Children's Services, Wellbeing Services and Resources. It describes and builds upon the developments within the Council with respect to both developing a place based integrated neighbourhood offer and further developing effective specialist and enhanced services able to meet the future needs of residents.

The Model of Care described within the Pennine Plan comprises of 7 elements which are central to the way in which our services and workforce will develop going forward:

Me and My Family: Putting each of us in control of our own health and wellbeing, enabling us to live in good health for as much of our life as possible and to manage any illnesses we might have.

My Healthy Home: Enabling a positive home environment, wherever we live, including the physical quality, suitability and stability of our homes.

My Healthy Community: Empowering and supporting people within our communities to take more control over their health and lives; strengthening volunteering and support networks to improve the health and wellbeing of others.

Living Happy, Healthy and Well: Encouraging and enabling us all to maintain healthy lifestyles, in environments that promote health and that will help to prevent us from becoming unwell.

Keeping Happy, Healthy and Well: Supporting everyone to stay well and helping people manage their own health and care better.

Joined-Up Care and Support: Bringing services together to improve standards of care and reduce duplication of activity. Providing seamless links between services and linking people into support within local communities.

In-Hospital Care and Support: Ensuring that when we need specialist or acute support, in hospital, we receive the best, most effective care possible.

2. RECOMMENDATIONS FOR THE HEALTH & WELLBEING BOARD

Health and Wellbeing Board is recommended to:

- Note the content of the Pennine Plan
- Note the engagement approach undertaken to test the Draft Pennine Plan and a summary of responses received during the engagement
- Provide any feedback and comments on the Pennine Plan
- Approve the Pennine Plan as the overarching blueprint for health and care transformation in Pennine Lancashire.
- Notes that whilst this plan identifies direction of travel and is for noting, that any key decisions required in the implementation of the plan, relevant and impacting on this council, will be brought forward to the relevant boards for decision.

3. BACKGROUND

In 2016, health and care organisations in Pennine Lancashire agreed to work together to address the greatest issues of challenge in relation to health, care and wellbeing, and to work together as a single public sector economy for Pennine Lancashire.

We believe this is the best approach to improving the health and wellbeing of all who live and work in Pennine Lancashire. The New Model of Care puts people, their families and communities at the heart of everything, aiming to put them in control of their own health and wellbeing, so they can remain as healthy as possible for as long as possible. If people do become ill, the New Model of Care aims to ensure they receive the right level of support within their home or local area. When specialist or enhanced support is needed (for example in hospital), people will receive care that is safe, effective and shaped around their individual needs. In December 2017 the Integrated Health and Care Partnership published a draft of the Pennine Plan, to test proposals for change with a broad range of stakeholders, and gather feedback and insight to inform more detailed service specifications and implementation plans.

4. RATIONALE

Across Pennine Lancashire we face a number of challenges that contribute to increasing demands for service provision and that local people are more likely to experience ill health than people living in other areas of the country:

- Children and young people are not getting the best start in life
- Mental illness is more common than in other areas of the country
- Many people have diseases and health conditions that are preventable
- Many more people attend accident and emergency than in other areas of the country
- People are living longer but with more complex needs
- Increasing pressures are being placed on our services and demand for services is out-stripping the money we have to pay for health and social care.

The Pennine Plan sets out the response to these issues, and has been developed through a Solution Design approach that ensured a wide range of health and care professionals and patient representatives were involved in developing the blueprint for a New Model of Care for Pennine Lancashire. Health and Wellbeing Improvement Priorities have been identified where Pennine Lancashire is performing poorly compared to other similar areas for these issues, either in terms of population outcomes, quality of care, or spend on services. A Prevention Framework has been

developed which will embed prevention across every aspect of our future plans.

5. KEY ISSUES

The Pennine Plan reflects the view that working together is the best way to deliver real improvements for local people, and as a Partnership we have worked with staff and residents to identify how we want our shared future to be. The plan describes shared principles, enablers, workforce development requirements, resource modelling and the emerging new models of care. The Blackburn with Darwen Local Integrated Care Partnership will support (but not be restricted to) the development and delivery of the outcomes described within the Pennine Plan as they relate to Blackburn with Darwen residents.

The Pennine Lancashire Integrated Care Partnership will:

- Take shared responsibility for delivering agreed performance goals and improving shared outcomes
- Manage funding for our population through a financial system 'control total' across Clinical Commissioning Groups (CCGs) and service providers
- Create an effective collective decision making and governance structure, aligning the ongoing and continuing individual statutory accountabilities of partner organisations
- Demonstrate how provider organisations will work together to integrate services in partnership with local GP practices, formed into clinical hubs serving 30,000-50,000 populations
- Ensure an understanding of the health needs of our population and ensure that services are commissioned and delivered to respond to these needs in the most effective way
- Establish clear mechanisms by which residents are able to exercise patient choice
- Take shared responsibility for continuing to improve the efficiency, effectiveness and quality of health and care services.

The final version of the Pennine Plan has now been produced. Key changes from the published draft version are summarised below:

- Updating of terminology such as replacing references to accountable care systems and partnerships with integrated care systems and partnerships
- Simplification of the language used where engagement highlighted particular concerns, for example in relation to food poverty and finance
- Inclusion of further detail which more accurately reflects the scale of opportunities and ambition for Pennine, for example in relation to digital developments
- Explanation of how key areas of work will be taken forward through agreed or developing strategies and framework such as the Pennine Lancashire Volunteer Strategy
- Updating of figures and dates as appropriate
- Inclusion of reference ensuring people are made more aware of what services can support them, to help people to make the right choices, particularly by promoting the NHS Choose Well campaign.

Alongside the Pennine Plan will be a Delivery Plan, which will set out to stakeholders how we are already progressing and delivering key elements of the New Model of Care. This will address queries raised by some stakeholders, regarding the mobilisation and implementation and provide an important opportunity to highlight the significant work already underway across partner organisations to progress the vision.

6. POLICY IMPLICATIONS

The Pennine Plan, Place-Based Integrated Care Partnership, within the Lancashire and South Cumbria Integrated Care System aligns fully with the NHS Five Year Forward View and its 'triple aim' of addressing the current challenges in health and wellbeing, care and quality & funding and efficiency. The approach taken in Pennine Lancashire, as well as in Blackburn with Darwen is fully supported by independent evidence, such as that of the King's Fund (NHS Ten Year Plan, July

2018), which states that 'improving health and reducing health inequalities depends on making further progress in integrating health and social care, building on the development of new care models, and integrated care systems'.

7. FINANCIAL IMPLICATIONS

The Pennine Plan describes the public sector spending on health and social care residents of Pennine Lancashire and the financial challenges of meeting the increasing complexity of health needs and demands for services.

Whilst there is significant financial challenge there are also significant opportunities and work is underway across all partners to ensure we make best use of resources to:

- Improve the efficiency of the services we deliver
- Invest in prevention and population health
- Design and implement new models of care
- Maximise use of One Public Estate
- Utilise Digital and Technological Innovation.

A System Control Total has been agreed on behalf of the Pennine Lancashire Integrated Health and Care Partnership which details how we will manage our money together and a financial strategy to support this is being completed and includes in its core principles delivering the best value for 'the Pennine pound' and 'One Public Estate.'

8. LEGAL IMPLICATIONS

There is a general legal duty on local authorities and other relevant health care bodies to promote integrated working. The Health and Social Care Act 2012 established Health and Wellbeing Boards in each local authority with a 'duty to encourage integrated working.' It also requires the NHS Commissioning Board and individual Clinical Commissioning Groups to promote integration of health services where this would improve quality or reduce inequalities.

Furthermore the Care Act 2014 requires local authorities to promote the integration of health and care provision where this would promote wellbeing, improve quality, or prevent the development of care needs.The decision in principal to work within this local integrated partnership will be subject to the development of an effective collective decision making and governance structure, aligning the ongoing and continuing individual statutory accountabilities of partner organisations and their respective decision making processes. Other matters which will need further consideration include information governance arrangements and procurement of services etc.

9. RESOURCE IMPLICATIONS

Partners from health and social care are already working together to improve how estates are used and where services and workforces can be co-located. The Pennine Plan describes the principle of 'digital first or digital only' as a means to maximise technological developments to give people greater control over their health, care and lifestyle choices.

The Lancashire Local Digital Roadmap identifies 3 broad themes to support delivery and improve efficiency:

- Sharing of electronic records
- Empowerment through the sharing of knowledge
- Enabling resident and workforce with technology.

The Pennine Plan describes the vision of One Workforce in the acknowledgment of the need to work with colleagues across all organisations to support a flexible, resilient and highly skilled workforce. A number of specific workforce priorities have been identified within the New Model of Care which includes:

- Current workforce modelling
- Securing future workforce supply
- Upskilling staff; Developing New Roles
- Consideration of new employment and Contracting Models.

10. EQUALITY AND HEALTH IMPLICATIONS

Equality Impact Assessment (EIA) not required – the EIA checklist has been completed.

11. CONSULTATIONS

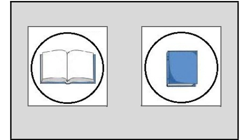
A detailed report of the Communications and Engagement programme is available at www.togetherahealthierfuture.org. Publication of the Draft Pennine Plan was accompanied by a significant programme of communications and engagement to promote, explain and discuss the content of the plan and elicit views from the public, stakeholders and staff about the draft plan. Building on considerable public and stakeholder engagement undertaken since the inception of Together A Healthier Future in 2016, this engagement programme included:

- Promotion of the plan online through social media. The Facebook story about the draft plan reached 44,709 individuals and on Twitter promotion of the draft plan reached 36,127 users. A total of 13,751 visitors visited the Together A Healthier Future website over this period of engagement
- A programme of public relations and media engagement resulting in positive and accurate coverage in all print media of the draft Pennine Plan and our call for views about it
- Workforce engagement via staff newsletters, public bulletins, features on their social media pages, intranet and websites
- A specific targeted engagement exercise with the Traveller community in Pennine Lancashire
- An open invitation from the partnership to every known stakeholder group within the voluntary, community and faith sector, patient interest groups, and staff groups and networks to attend, present and discuss the Draft Pennine Plan
- Market stalls in key locations across Pennine
- Co-production of an “easy read” version of the draft Pennine Plan with representatives of the learning disability community which was well received and accessed by a large number of people.

A significant amount of feedback was received on the Draft Pennine Plan. This included formal responses from 377 individuals, alongside the key messages from the market stalls and meetings attended. The responses and feedback clearly support the proposals set out in the Draft Pennine Plan. While there was some concern expressed about financial viability and sustainability, people recognised the ambitions we have outlined for Pennine Lancashire. This feedback will be used to inform the development of detailed delivery proposals.

VERSION:	

CONTACT OFFICER:	Sayyed Osman / Katherine White
DATE:	6 September 2018
BACKGROUND PAPER:	The Pennine Plan



TOGETHER
A HEALTHIER FUTURE
The Integrated Health and Care Partnership for Pennine Lancashire

The Pennine Plan:

Improving Health, Care and Wellbeing in Pennine Lancashire

Summer

2018

FOREWORD

We are proud of the health and care services we have in Pennine Lancashire. Our doctors, nurses, and wider health and care staff provide high quality care for people who live and work here. We are equally proud of our communities and how residents across the area come together to provide friendship, encouragement and support to each other. Around 114,000 residents volunteer at least once per month, providing support and care to individuals and families across our communities.

People in Pennine Lancashire are more likely to experience ill health compared with people living in other parts of the country. We have high levels of deprivation, poor health outcomes and greater demand for health and care services. The good news is that we can prevent many of our illnesses and, by working together, we can help improve people's health and wellbeing, whilst continuing to provide effective and efficient health and care services.

In delivering Together A Healthier Future we want to harness everything that is good about Pennine Lancashire; our people, our communities, our volunteers, our open spaces and our services. We want to put you and your family at the centre of everything we do and provide health and care around your needs, and not those of organisations.

Over the past 18 months we have worked with residents, volunteers, doctors, nurses, health and care professionals, community workers and others to develop our plans for change. We have listened to what people have had to say and we set out our proposals in our Draft Pennine Plan which we published in December 2017.
Thank you to everyone who has taken the time to let us know what you think of our proposals.

On the whole, you support our drive, ambitions and proposals to improve health and wellbeing in Pennine Lancashire. Many of you recognise the need for everyone to play a role in looking after their own health and using services responsibly. You gave us lots of ideas and food for thought, which will help us shape our services for the future.

We all have a part to play in achieving a Healthier Future and making our services the best they can be. We need everyone to look after their own health as much as they can, to make healthy choices in their lives, use services appropriately and support their families and friends to live healthy lives. Our doctors, nurses, pharmacies and other health care professionals are already working better together in our neighbourhoods and we are continuing to improve hospital and urgent care services.

We are proud of our ambition for Pennine Lancashire, and whilst we acknowledge that the challenges are great, we are committed to improving the health and wellbeing of our residents, transforming the quality of care delivery and ensuring that health and care organisations operate within their financial means. We hope that you will all continue to be involved in helping us achieve these ambitions.

Graham Burgess
Chair, Pennine Lancashire Integrated Health and Care Partnership.

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EXECUTIVE SUMMARY

We know we face a number of challenges that contribute to increasing demands for service provision and mean that local people are more likely to experience ill health than people living in other areas of the country:

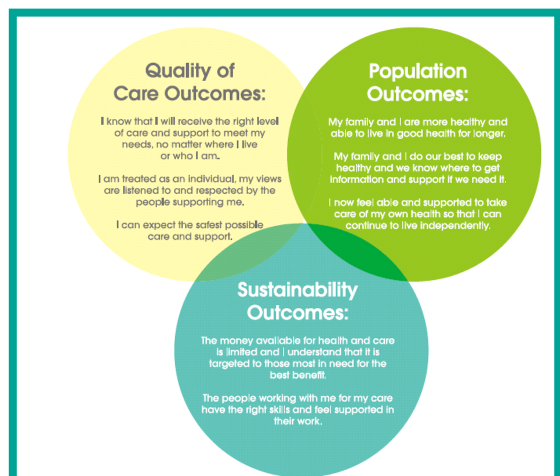
- **Children and young people are not getting the best start in life**
- **Mental illness is more common than in other areas of the country**
- **Many people have diseases and health conditions that are preventable**
- **Many more people attend accident and emergency than in other areas of the country**
- **People are living longer but with more complex needs**
- **Increasing pressures are being placed on our services and demand for services is out-stripping the money we have to pay for health and social care.**

Together A Healthier Future represents all the health and care organisations in Pennine Lancashire, along with local councils and voluntary, community and faith sector services. As organisations who are responsible for, or have an interest in delivering health and care services, we have agreed to work together to take a more preventative approach to health and wellbeing, aiming to ensure people live as healthy as they can for as long as they can. We also want to make health and care services easier for people to access, understand and work with.

We have agreed a shared vision which is:

"For all of us in Pennine Lancashire to live a long and healthy life. Any extra help and support we need will be easy to find, high quality and shaped around our individual needs."

We believe that working together is the best way to deliver real improvements for local people, and we have worked with staff and members of the public to identify eight statements that reflect how we want our shared future to be.



Our Partnership has achieved a lot already, but we want to go further and work together as the Pennine Lancashire Integrated Health and Care Partnership, to ensure we provide care in the right place, at the right time and as one team, to deliver our agreed outcomes. This means we will:

- Take shared responsibility for delivering our agreed performance goals and improving on our shared outcomes
- Manage funding for our population together through a financial system 'control total' across Clinical Commissioning Groups (CCGs) and service providers

- Create an effective collective decision making and governance structure, aligning the ongoing and continuing individual statutory accountabilities of our partner organisations
- Demonstrate how our provider organisations will work together to integrate their services Partner with local GP practices, formed into clinical hubs serving 30,000-50,000 populations
- Ensure we have the skills to understand the health needs of our population and that we are commissioning and delivering services to respond to these needs in the most effective way
- Establish clear mechanisms by which our residents will still be able to exercise patient choice
- Take shared responsibility for continuing to improve the efficiency, effectiveness and quality of our health and care services.

We have identified **Health and Wellbeing Improvement Priorities** where Pennine Lancashire is performing poorly compared to other similar areas for these issues, either in terms of population outcomes, quality of care, or spend on services. We know that a lot of work has taken place in recent years to improve services and outcomes for patients but we need to do more.

Working together with our staff and our communities, we have developed and agreed a **Prevention Framework** which will embed prevention across every aspect of our future plans and a **New Model of Care** which we believe is the best approach to improving the health and wellbeing of all who live and work in Pennine Lancashire.

Our **New Model of Care** puts people, their families and communities at the heart of everything, aiming to put them in control of their own health and wellbeing, so they can remain as healthy as possible for as long as possible. If people do become ill, our New Model of Care aims to ensure they receive the right level of support within their home or local area. When specialist or acute support, in hospital, is needed, people will receive care that is safe, effective and shaped around their individual needs.

The successful delivery of Together A Healthier Future will depend on ensuring we can manage our financial challenges together. We also know that we need to design and provide a workforce equipped to deliver new services, have buildings that are fit for purpose and affordable and use technology to its full potential.

We are focussed on striving to achieve the best health and wellbeing outcomes for our population and making a positive difference to people's lives.

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For more information on how we developed our Pennine Plan please visit:

www.togetherahealthierfuture.org.uk.

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1.0 Introduction

"We are committed to changing our health and care system here in Pennine Lancashire for the better. We have some of the worst health in the country. We can and must do better and we can do this by everyone – staff, residents, businesses, elected representatives, community groups and organisations - working together. Of course, there is not an endless pot of money to achieve this and there is a significant financial challenge but we can change the way things are done for the better."

Dr Phil Huxley, Chair of East Lancashire Clinical Commissioning Group

1.1 Our Pennine Plan sets out how we will work together to transform health and care and improve the health and wellbeing of everyone in Pennine Lancashire.

1.2 Nationally the Government has asked health and care leaders in each area to come together to transform services and ensure they are affordable. These are called Integrated Care Systems. Pennine Lancashire is one of five Integrated Care Partnership (ICP) areas that make up the Healthier Lancashire and South Cumbria Shadow Integrated Care System (SICS). More details about the Lancashire and South Cumbria SICS can be found at www.lancashiresouthcumbria.org.uk.

1.3 We are already working together as an Integrated Health and Care Partnership in Pennine Lancashire, we call it 'Together A Healthier Future.' This means all health and care organisations are working together to achieve the best health and wellbeing outcomes for our population and make a positive difference to people's lives.

1.4 Our Vision for Together A Healthier Future is:

"For all of us in Pennine Lancashire to live a long and healthy life. Any extra help and support we need will be easy to find, high quality and shaped around our individual needs."

1.5 Pennine Lancashire is a large geographical area comprising the six boroughs of Blackburn with Darwen, Burnley, Hyndburn, Pendle, Ribble Valley and Rossendale.

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1.6 We have a resident population of over 531,000, 21% of whom are under 16 years old and more than 17% of residents are from Black or Minority Ethnic Groups. One of the boroughs, Blackburn with Darwen, has one of the youngest populations in England, and half of all school-age children belong to BME communities. The Pennine Lancashire population will grow a little over the next ten years. By 2035 the proportion of people aged 65+ will increase from 13% to 17% and the number of residents aged 85+, currently almost 11,000 people (2.1% of the population), is set to double.

1.7 Pennine Lancashire is a great place to live and work. Public services are of high quality, and have delivered significant improvements to people's lives, but there is always room for improvement. Additionally, there are increasing pressures being placed on these services and demand for services is out-stripping the money we have to pay for health and social care. But we also know about the excellent work that goes on in our neighbourhoods by people and communities working together.

1.8 We know we face a number of challenges that contribute to increasing demands for service provision and mean that local people are more likely to experience ill health than people living in other areas of the country:

- **Children and young people in Pennine Lancashire are not getting the best start in life**
- **Mental illness is more common in Pennine Lancashire than in other areas of the country**
- **Many people in Pennine Lancashire have diseases and health conditions that are preventable**
- **Many more people in Pennine Lancashire attend accident and emergency than in other areas of the country.**
- **People in Pennine are living longer but with more complex needs.**

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48,000
PEOPLE IN PENNINE LANCASHIRE ARE LIKELY TO HAVE A LONG-TERM CONDITION & A MENTAL HEALTH PROBLEM

THE NUMBER OF PEOPLE WITH DIABETES AND CANCER IS EXPECTED TO DOUBLE OVER THE NEXT 5-7 YEARS

It is estimated that over 50% of people living in Pennine Lancashire have one or more long term condition

OVER **33,750** ADULTS IN PENNINE LANCASHIRE ARE RECORDED AS HAVING DEPRESSION

In 2014 an estimated 17.5% of people were aged over 65 years. The number of very elderly residents (aged 85 years plus) is set to double by 2035

THE NUMBER OF CHILDREN AND YOUNG PEOPLE WITH LEARNING DISABILITIES IS SET TO RISE

More than 57,000 people provide informal care for a relative or friend

MORE THAN 2 OUT OF 5 PEOPLE OVER THE AGE OF 70 ADMITTED TO HOSPITAL IN AN EMERGENCY HAVE DEMENTIA

INCREASING DEMAND FOR HEALTH AND CARE SERVICES IS OUTSTRIPPING THE RESOURCES AVAILABLE

500+ ATTENDANCES PER DAY AT A&E

30% OF VISITS COULD HAVE BEEN PREVENTED

People in Pennine Lancashire have some of the worst health in the country and on average, we die earlier than people living elsewhere in the country.

AN ESTIMATED **7,600** CHILDREN AND YOUNG PEOPLE AGED BETWEEN 5 AND 16 IN PENNINE LANCASHIRE EXPERIENCE A MENTAL ILLNESS

Note: An in-depth analysis of the issues which drive our need for change is set out in the Pennine Lancashire Case for Change which is available on our website www.togetherahealthierfuture.org.uk.

1.9 At the core of Together A Healthier Future is a commitment to embed prevention (see section 2.0) right across every aspect of our future plans and a New Model of Care (see section 3.0) which places individuals and families at its heart.

1.10 As we have developed our New Model of Care, we have worked hard to ensure that we deliver on our Commitments to the people of Pennine Lancashire and our Vision for the future.

Pennine Lancashire Commitments
We will create an effective, integrated, person and family centred Locality Services Model, incorporating NHS, Social Care, Primary Care and the voluntary, community and faith sector. This will be capable of managing the escalation of demand in neighbourhood and community settings, keeping people safe and well in their own homes. We will transform urgent and emergency care to ensure that the people of Pennine Lancashire with urgent care needs will receive a highly responsive service that delivers care as close to home as possible. Those with serious or life-threatening conditions will be treated in centres with the very best expertise and facilities in order

to maximise their chances of survival and a good recovery.

We will improve on all of our key 'Variations in Care' through standardisation of pathways and best practice interventions and improve the health and wellbeing outcomes of our population overall.

We will develop a comprehensive health promotion and wellbeing programme focussing on community resilience, disease prevention, citizen empowerment and the development of volunteering, through a single public sector approach working with the voluntary, community and faith sector.

We will deliver the enablers of change for an Integrated Care System:

- Workforce transformation: One workforce
- Better use of technology
- Consistent and clear communication and engagement with our public and workforce
- Optimise the use of public estate across all organisations: one public estate.

1.11 Our Principles are the way in which we will deliver our Vision and Commitments and are aligned with the Lancashire and South Cumbria Shadow Integrated Care System. Our thinking, analysis and design work have all been guided by these principles.

Pennine Lancashire Principles

Place based – transformation will bring about an integrated ‘place based health system’, that shifts the service model to one that spans organisational boundaries and has more health and social care focussed on prevention and promoting wellbeing.

People centred – people are considered in terms of their strengths; they are empowered to improve their own health and wellbeing, and manage their care. Care and support is shaped around individual needs, coordinated, and empowering.

People as partners - in developing services and in providing care and support to others, as carers or volunteers are identified, supported and involved

Health and wellbeing is everyone’s business – health, wellbeing and health improvement is everyone’s business. Whole system transformation requires a ‘whole of society’ approach.

Equity before equality - recognising that some people will need more help and support to ensure they can access the same opportunities as others.

Digital first or digital only – maximising technological developments to give people greater control over their health, care and lifestyle choices.

Safe and effective care – delivery of evidence-based services and interventions which maximise clinical safety and effectiveness.

Shared outcomes – the focus will be on ensuring quality and narrowing inequalities. Voluntary, community and social enterprise and housing sectors are involved as key partners and enablers. People will be given the opportunity to shape their care and support and work towards the outcomes they want to achieve.

One workforce – there will be one workforce, made up of different services, including voluntary; community and faith sector services, who are all working to the same principles and values, to achieve improved outcomes.

Accessible and safeguarded information – for people, patients and professionals when they need it.

1.12 We have identified the Health and Wellbeing Improvement Priorities below because Pennine Lancashire is performing poorly compared to other similar areas for these issues, either in terms of population outcomes, quality of care, or spend on services. We know that a lot of work has taken place in recent years to improve services and outcomes for patients but we need to do more.

Pennine Lancashire Health and Wellbeing Improvement Priorities

Healthy Lungs – including a focus on:
- Chronic Obstructive Pulmonary Disease
- Respiratory illness for children and young people

Healthy Hearts – including a focus on:
- Stroke
- Diabetes

Healthy Minds – including a focus on:
- Crisis mental health
- Mental health and substance misuse
- Psychological support for long term conditions

Cancer – including a focus on:
- Prevention and earlier diagnosis
- Treatment and care
- Living with and beyond cancer
- Patient experience
- Pathway redesign and waiting times

End of life – including a focus on:
- Providing high quality palliative and end of life care

Healthy Children and Young People – including a focus on:
- Accidents and injuries (including road traffic accidents)
- Nutrition and physical activity (incorporating dental health, obesity and low weight)
- 0-25s complex physical needs and long term conditions
- 0-25s complex psychological/social needs
- Infant mortality

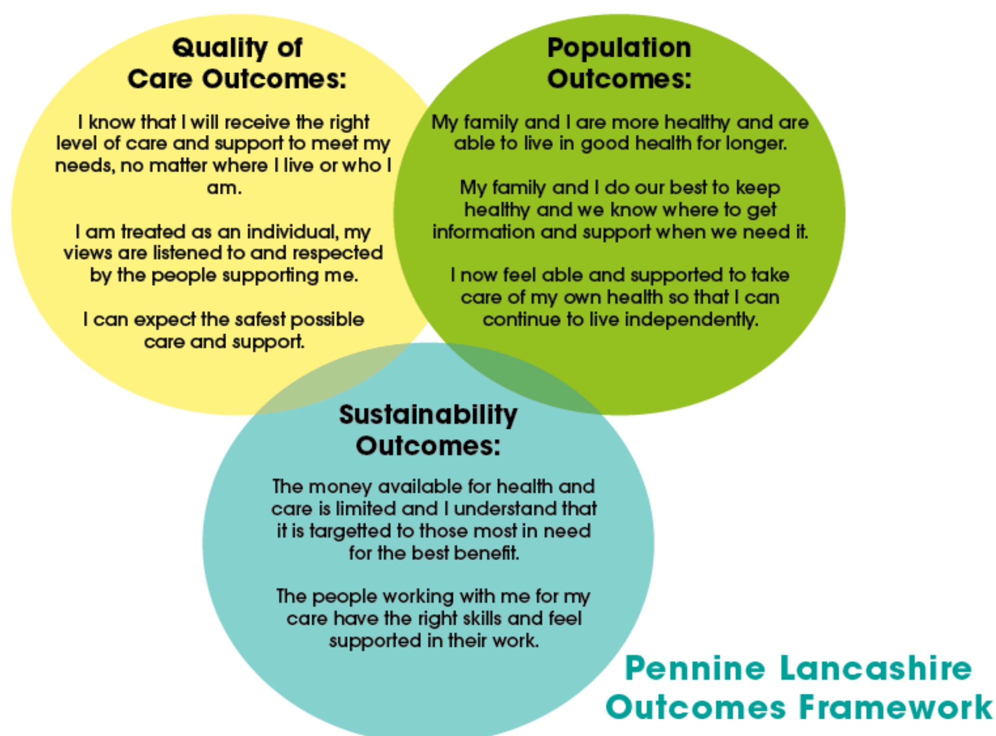
Musculoskeletal – including a focus on:
- Osteoporosis and bone frailty
- Pain Management
- Osteoarthritis

Frailty – including a focus on:
- Falls
- Effectively identifying and supporting people who are frail

1.13 We are proud of our ambition for Pennine Lancashire, and whilst we acknowledge that the challenges are great, we are committed to improving the health and wellbeing of our residents, transforming the quality of care

delivery and ensuring that health and care organisations operate within their financial means.

1.14 At the heart of Together A Healthier Future is the idea that we can all work together as individuals, communities, neighbourhoods, volunteers, health and care workers and organisations to improve our health and wellbeing. We have used a series of events with people and staff, to design and refine eight statements that we believe will help us achieve our vision. These set out both how as individuals we can help ourselves and our families and, as organisations, how health, care and wellbeing services should be delivered in the future. This is shown in the diagram below:



Note: Full details of the how we will measure progress towards achieving these outcomes are set out in our Outcomes Framework which can be viewed at www.togetherahealthierfuture.org.

1.15 We are very proud of the partnership work that has taken place with the public, workforce and partner organisations to produce a joint response to the health and care challenges we face here in Pennine Lancashire and are truly thankful to everyone who has taken the time to work with us, talk to us and offer us their opinions. Our Solution Design approach, engagement work and the feedback we have received and considered in developing our Pennine Plan, is described on our website www.togetherahealthierfuture.org.

1.16 In this Plan we set out our proposals in more detail:

- **Our Prevention Framework:** focuses everyone to take preventive action across our place and our lifetime, to enable us all to lead

healthier lives.

- **Our New Model of Care:** places individuals and their families at its heart and recognises the importance of people living in Healthy Homes and Healthy Communities. The New Model of Care also reflects the different elements of care and support that people need dependent on their circumstances, from when they have no health problems, to when they have multiple health problems and need coordinated support.
- **Finance and Investment:** Outlines the amount of money we currently spend on health and care in Pennine Lancashire, along with the future financial challenges and how we can meet these.
- **System Enablers:** The successful delivery of Together A Healthier Future will depend upon being able to design and provide a workforce equipped to deliver new services, buildings that are fit for purpose and affordable, information and communications technology, and the development of a thriving Pennine Lancashire care culture. We call these elements our 'system enablers' because they are essential to enabling the changes and improvements we need to make in Pennine Lancashire.
- **Next Steps:** Outlines what we want to do next and how you can continue to be involved in Together A Healthier Future.

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2.0 The Pennine Lancashire Place-Based Prevention Framework

> **"Preventing avoidable illness, hospital admissions, long-term loss of independence and poorer quality of life, is not just common sense, in the long run it's the only way to balance the books."**
>
> **Dominic Harrison, Director of Public Health, Blackburn with Darwen**

2.1 If we are serious about achieving our Vision, for all of to us to have healthy and long lives, we must invest significantly in prevention activities which we know work. Our approach is to create healthy communities, both placed-based communities and communities where people share a common identity or like-minded interest. We will also ensure we take preventive action across all stages of life and all stages of both wellness and illness, for us all to lead healthier lives. We will do this through The Pennine Lancashire Prevention Framework (also referred to as The Framework), which underpins the New Model of Care.

2.2 Evidence tells us that if we invest in prevention, we will save money, not just in the health and care system, but across the whole of society including criminal justice, children's services and wider welfare support systems. We know that local prevention activity pays back around £4 for every £1 invested in it.

Place Based Prevention

Healthy Communities are created when:

- Every individual, community group, neighbourhood and locality agree to work together to promote good health

And where:

- Every organisation (voluntary, private and public)
- Every management group, governance system, decision making body and scrutiny organisation
- Every public policy (especially those without a health label)

are mobilised
to support
good health for all

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2.3 The Framework is based on five key principles of Place-Based Prevention which outline that prevention:

1. **Requires a 'whole of society' approach**: Research shows that the biggest impact on people's health and wellbeing comes not from formal health and care services, but from other organisations and the community and environment around them. We need to take action outside of the health and care system to improve the health and wellbeing of our communities.

2. **Is a co-operative and collective activity that mobilises support for change**: Creating healthy communities, through place-based prevention, requires collective action aimed at generating resilience to health risks at both individual and community level.

3. **Involves mobilising all of society's resources in a 'place'**: Healthy communities in healthy places will not happen by themselves. We will need a programme of social mobilisation to get everyone working together for the common good. The health and care system has a key role to play in this but we need everyone to play their part using their own energy, skills, capacities and resources.

4. **Involves creating a culture for health that actively enables individuals to take care of themselves and their communities**: Creating a social movement for health that supports people to act to improve wellbeing and re-directs the health and care systems towards prevention is critical to the future sustainability and transformation of health and care systems.

5. **Is aimed at promoting equity of outcomes and equal life chances for all residents:** Creating equity of outcomes may sometimes involve inequalities of inputs - providing more resources to those whose need is greatest, and actively challenging social inequalities that are unjust, unfair and avoidable.

2.4 The Pennine Lancashire Prevention Framework has ten Domains for Action which will be incorporated into our proposed New Model of Care, these are:

- **Social Movement for Health**
- **Healthy Neighbourhoods and Localities**
- **Health in All Policies**
- **Healthy Settings**
- **A Health Promoting Health and Care System**
- **Healthy Citizens**
- **A Health Promoting Workforce**
- **Health Governance**
- **Volunteering and Building Community Capacity**
- **Digital Health**

Domains and Actions are included visually within final published document.

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3.0 A New Model of Care for Pennine Lancashire

"We want to look at how we change the way we live to improve our health as well as how we work together to improve health and care services. There's never been a more important time to change the way we work in Pennine Lancashire. This is something we can and will change. Together we will find ways of living better and longer lives."

Graham Burgess, Chair of Blackburn with Darwen Clinical Commissioning Group and
Chair Pennine Lancashire Integrated Health and Care Partnership

3.1 Our New Model of Care places individuals and their families at its heart and recognises the importance of people living in Healthy Homes and Healthy Communities.

3.2 There are seven different elements to our New Model of Care, each of which describe how we will work differently to enable people in Pennine Lancashire to live healthier and for longer:

- **Me and My Family:** Putting each of us in control of our own health and wellbeing, enabling us to live in good health for as much of our life as possible and to manage any illnesses we might have.

- **My Healthy Home:** Enabling a positive home environment, wherever we live, including the physical quality, suitability and stability of our homes. Having a healthy home can protect and improve our health and wellbeing, and prevent physical and mental ill-health throughout life.
- **My Healthy Community:** Empowering and supporting people within our communities to take more control over their health and lives and strengthen volunteering and support networks to improve the health and wellbeing of others.
- **Living Happy, Healthy and Well:** Encouraging and enabling us all to maintain healthy lifestyles, in environments that promote health and that will help to prevent us from becoming unwell.
- **Keeping Happy, Healthy and Well:** Supporting everyone to stay well and helping people manage their own health and care better.
- **Joined-Up Care and Support:** Bringing services together to improve standards of care and reduce duplication of activity. Providing seamless links between services, such as hospital and residential care services, and linking people into support within local communities. Ultimately delivering better outcomes for people.
- **In-Hospital Care and Support:** Ensuring that when we need specialist or acute support, in hospital, we receive the best, most effective care possible.

3.3 Our Health and Wellbeing Improvement Priorities look at how our services work at the moment and consider what could be improved through the New Model of Care. In particular, we know we need to do more to prevent people getting these illnesses in the first place, but if people do become ill, we need to provide clear and consistent advice to empower people to manage their own care.

3.4 Hearing from, and working with, people who have experience of these illnesses, either themselves or their family and friends, is a key part of our work. We are involving people, patients and their family/carers in shaping how we address our priorities together.

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4.0 Me and My Family

4.1 Me and My Family lies at the heart of our New Model of Care. We want to put each of us in control of our own health and wellbeing, enabling us to live in good health for as much of our life as possible and to manage any illnesses we might have. You have told us how important it is for all of us to take care of ourselves, make healthier lifestyle choices, use services appropriately and support others around us to live healthier lives. We will support people to do this by:

Encouraging and Promoting the Five Ways to Wellbeing

4.2 We want to encourage everyone to follow the Five Ways to Wellbeing, so that we are able to take simple steps to improve our own health and wellbeing and support others.

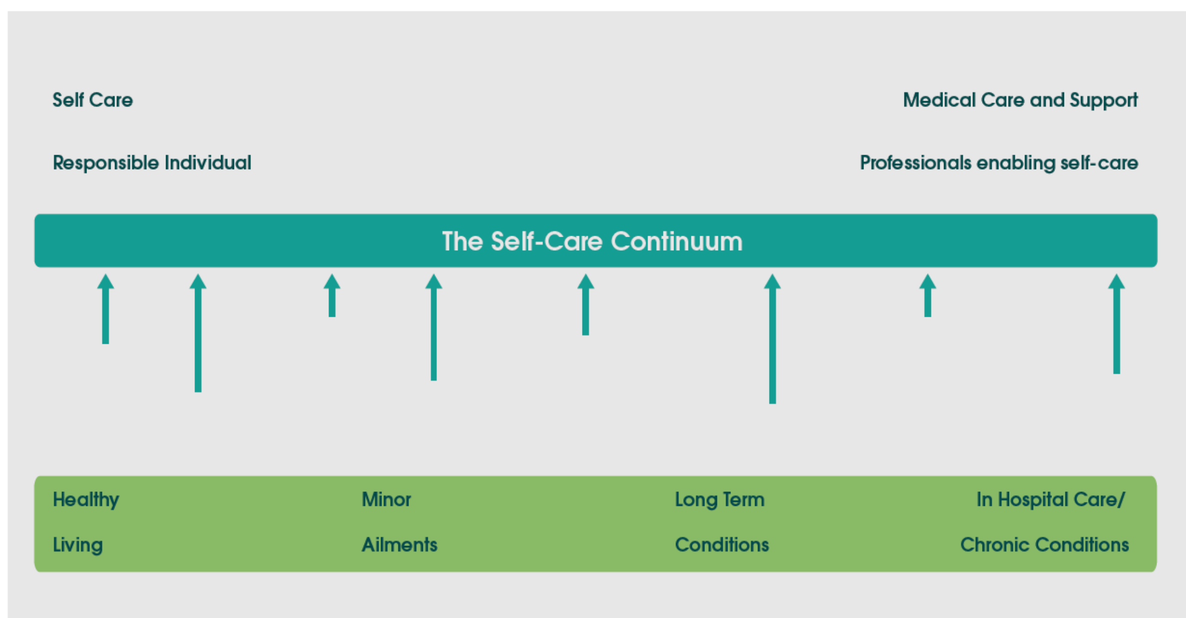
Promoting and Enabling Self Care

4.3 Self-care is so important because it puts people in control of their own health and wellbeing, enabling people to protect their health and manage any illnesses they may have.

4.4 There are plenty of opportunities for people to take care of themselves, by taking responsibility and making daily choices about their health, such as brushing their teeth to prevent cavities or eating healthy options and choosing to be physically active. People can also take care of themselves when they have common symptoms, such as sore throats, and sneezes, many of which can be treated with over-the-counter medicines, and with advice from local pharmacists. Self-management is a way in which people with long term conditions can also self-care and be enabled to deal with their symptoms, treatment and the physical and mental consequences of their illness.

4.5 We want to promote and enable self-care at every opportunity and you will see us talk about self-care throughout our plan.

4.6 The diagram below, which was developed by the Self-Care Forum, helps to show this.



4.7 **Improve Personal Health Literacy:** Health literacy is when we are able to obtain, process and understand basic information about our health and services, so that we can take responsibility and control of our own health. We know that having good personal health literacy encourages healthy behaviours, thereby preventing ill health in the longer term.

4.8 Our whole workforce, whether it be carers, volunteers, or health and social care professionals, is vital to the success of Me and My Family. We will actively involve our workforce in helping us shape new relationships with you, to enable self-care, and improve personal health literacy. To achieve this we will promote:

- Shared values between patients, carers and health care workers
- An acceptance that people have a responsibility for their own health and can positively contribute to improving their health and wellbeing
- An understanding of the benefits of self-care, in particular the preventative and long term approach
- A belief that health behaviours can be changed, that there is a need for motivation and self-discipline and, to know the best advice and support for this change to happen
- Help for people to feel in control of their own health and work together to set self-care goals / pledges. We will enable people to access and utilise digital resources, such as Up and Active, and gain a knowledge and understanding of the range of offers available within communities
- People's self-care pledges as a key part of their care plan if they have one.

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5.0 My Healthy Home

5.1 My Healthy Home is about having a positive home environment, wherever we live, and includes the physical quality, suitability and stability of our homes. Having a healthy home can protect and improve our health and wellbeing, and prevent physical and mental ill-health throughout life.

5.2 My Healthy Home will reduce health risks that are associated with living in a damp, cold or unsafe home by working with those at greatest risk of poor housing and those in the greatest need. We will ensure that people receive timely and relevant information and support to improve their health by improving their home environment.

5.3 Building on existing local services, we will look to provide support across Pennine Lancashire that will:

- Help everyone to understand the effect of housing on health and wellbeing and raise awareness of local support available
- Deliver timely and appropriate advice, signposting and assistance
- Providing home safety risk assessments and advice for the most vulnerable
- Deliver the most cost effective improvements to the poorest housing occupied by the most vulnerable people
- Ensure our workforce makes every contact count for housing and health
- Embed a programme of Health Promoting Care Homes, through our delivery of the Enhanced Health in Care Homes Vanguard
- Support and develop volunteer roles.

5.4 Through My Healthy Home we will also work together to develop:

- Improvements in hospital discharge processes so that we improve the home environment in a timely manner
- Landlord Accreditation and Selective Licensing Schemes as appropriate
- Pre-tenancy and tenancy support to enable people to maintain a tenancy agreement.

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6.0 My Healthy Community

Political, civic and managerial leadership in public services should focus on creating the conditions in which people and communities take control, to lead flourishing lives, increase healthy life expectancy and reduce inequalities across the social gradient".

Professor Sir Michael Marmot, Fair Society Healthy Lives

6.1 We know that community life, social connections and having a voice in local decisions all have a positive impact on health and wellbeing. We want to empower and support people within their communities to take more control over their health and lives, and strengthen volunteering and support networks to improve the health and wellbeing of others.

6.2 Our communities across Pennine Lancashire are full of great people, who really care about each other. They want to do the best they can for each other and their neighbourhoods and there are so many examples of great things happening. We have 114,000 formal volunteers, and we know that there are thousands more informal volunteers and many people who support each other within communities. We want to build on this strong community spirit, and:

- Make sure community-focused approaches, which build on individual and community strengths, become more central to our local plans for health and care
- Improve access to, and funding, for community resources, so that we are able to better connect people to practical help, group activities and volunteering opportunities, to promote good health and wellbeing and increase social participation
- Recognise the excellent work already undertaken by our communities in delivering health improvement and preventative services across our New Model of Care and help grow these further
- Develop new and innovative ways to increase participation and involve individuals and families, particularly those at risk of social exclusion, in designing and delivering solutions that address inequalities in health
- Celebrate, support and develop volunteering
- Work in collaboration and partnership with our local communities and proactively involve them and listen to them at all stages of planning and designing of services.

6.4 Within our communities social movements can be nurtured and grown. They are an integral part of a healthy and thriving society and can enable really positive outcomes. Social movements for health have the potential to:

- Bring about change in the experience and delivery of health care
- Improve people's experience of disability or ill health
- Promote healthy lifestyles

- Address the wider determinants of health
- Democratise the production and dissemination of knowledge
- Change cultural and societal norms
- Bring about new health innovation and policymaking process.

6.5 It is often challenging for established organisations, such as the NHS or local government, to work alongside social movements. Public sector organisations are not always used to more fluid ways of working and may be seen to pressure social movements to change or 'burden them with bureaucracy'. To make sure we can work with, nurture and support social movements we want to:

- **Understand social movements for health and recognise their value.** We will improve our collective understanding of social movements and their potential, so that we are able to generate the necessary appreciation, appetite, enthusiasm and ambition across communities and organisations in Pennine Lancashire

- **Build and support communities of interest which are safe havens for social movement innovation.** It is important that we nurture local activists who will influence their peers and form a critical mass of support for sustained change

- **Develop new models of engagement for Social Movement:** We want to go beyond traditional community development approaches and work outside of our usual geographic and organisational boundaries. We must also seek to understand and work with the desires of our workforce and communities

- **Leadership and culture change for social movement:** We will work together to listen and respond effectively and will be willing to hear new ideas and do things differently. We know that new approaches are required that draw effectively on both the efficiency and scale of institutions and the dynamism and agility of movements.

6.6 We will publish a Community Development Framework setting out how we will work alongside our communities, later in 2018.

6.7 We recognise that, for the health and care system to be able to respond appropriately to emerging social movements, we need to enable and empower our workforce to be able to grow and work with social movements. We will ensure that this is a shared ambition across organisations.

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7.0 LIVING HAPPY, HEALTHY AND WELL

7.1 **Living Happy, Healthy and Well** means encouraging and enabling us all to maintain healthy lifestyles, in health promoting environments that will help to prevent us from becoming unwell. Our Prevention Framework (section 2.0) sets out some of the steps we need to take to achieve this, we will also work to deliver the following:

Early Years, Children and Young People

7.2 Giving every child the best start in life is our highest priority and provides the biggest opportunity for future improvement of health and economic outcomes in Pennine Lancashire. We will improve the life chances for our children by enabling them to grow into healthy and resilient adults.

7.3 Evidence shows that the earlier in life we invest in children, the greater the financial return - for every £1 spent on early years' education, £7 has to be spent to have the same impact in adolescence.

7.4 To give our children the best start in life we want to:

a) Join up health and care provision through the **Healthy Child Programme** to have a positive impact on a wide range of health, education and social care outcomes for children, young people and their families. This will be achieved by expanding programmes that are known to be cost effective and successful and community capacity building across a range of settings, such as children's centres, health centres and GP practices.

b) Ensure parents and carers get the best support possible, through **evidence-based parenting programmes,** as well as through peer support and community groups. This support will be there from before birth through into adolescence.

c) Develop **health promoting education settings**, through delivering activities such as:

- Physical activity in education settings, such as "mile a day"
- Emotional health, wellbeing and resilience for example 'Youth Mental Health First Aid' training
- Life skills such as cooking, financial literacy, citizenship, skills for employment
- Dental health, such as 'smile4health', toothbrush/paste distribution and fluoride varnish.

Physical Activity Promotion, Active Travel and Nutrition

7.5 There is strong and consistent evidence that increasing physical activity will help us live longer and improve our mental wellbeing. It has also been shown

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to reduce the risk of many long term conditions, including heart disease and stroke, diabetes, cancer and dementia.

7.6 We want to support a wide range of initiatives including:

a) Physical Activity and Active Travel

- Physical activity promotion
- Strengthening and expanding subsidised leisure opportunities
- Active Travel and the promotion of walking and cycling.

b) Food and Nutrition

- **Promoting healthy and sustainable food choices for all**: Building on local examples of good practice we will develop an 'Out of Home' food provision action plan

- **Supporting families to have access to healthy and affordable food:**
    - Investing further in ante and postnatal support for breastfeeding, healthy introduction to solid foods and expand nutritional advice in early years settings, to ensure the best nutritional start in life
    - Develop an Affordable Food Network to identify and support families, of all ages, to have access to healthy, affordable food
    - Developing a Pennine-wide food growing programme, accessible for everyone within their local community to support people to access healthy sustainable food, teach life skills and encourage inter-generational activity.

- **Building community food knowledge, skills and resources** – Further investment in cookery clubs, based in community buildings and run by local volunteers, which will target all ages and will include support for vulnerable adults. Investment in achieving 'Sugar Smart Pennine' status using a Pennine-wide campaign, promotions and competitions.

Adverse Childhood Experience

7.7 A public health study in 1998 identified a range of stressful or traumatic experiences that children can be exposed to whilst growing up, collectively termed Adverse Childhood Experiences (ACEs). These ten ACEs range from direct harm to a child, that is physical, verbal and/or sexual abuse and, physical or emotional neglect, to those that affect the environment in which a child grows up, including parental separation, domestic abuse, mental illness, alcohol abuse, drug abuse or incarceration.

7.8 There is a strong relationship between these ten ACEs and the onset of chronic diseases such as diabetes, stroke and heart disease, in adulthood, and health harming behaviours, such as smoking and substance misuse.

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7.9 To address and respond to ACEs we propose to:

a) Build **ACE informed communities** where children have the opportunity to develop intellectually, socially and emotionally. We will ensure that every adult who interacts with children understands ACEs, the impact they can have and knows how to best to provide support.

Pennine Lancashire aims to become the UKs first 'ACE Informed area' by:
- Developing strategies for raising awareness and understanding of ACEs, resilience and the associated science
- Creating environments for people to share and support each other in addressing their own experiences of ACEs
- Creating an ACE informed workforce including education; health and social care; criminal justice; voluntary, community and faith sector
- Strengthening a collective response to ACEs by engaging local community members in developing effective and novel solutions.

b) To build **ACE informed organisations** where we are able to prevent ACEs, mitigate the consequences of ACEs through early identification and intervention and to enable our workforce to take an ACE informed approach to:
- Develop and implement ACE informed training and digital assessment tools to identify children, young people and adults who have increased ACE scores
- Understand the distribution of ACEs across different population groups and understand the potential paths for recovery
- Integrate and incorporate knowledge of ACEs into existing strategies, policies, procedures and practice
- Develop ACE Informed provision, so that there is appropriate support for and management of the consequences of ACEs.

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8.0 KEEPING HAPPY, HEALTHY AND WELL

8.1 Keeping Happy Healthy and Well means supporting everyone to stay well and to help people manage their own care better. We will do this by:

- Creating new relationships between health and care professionals and the public and by having greater integration across primary care (GP practices, dental practices, community pharmacies and optometrists) and within the community
- Ensuring we all know how to access the advice and resources we need to look after ourselves, enabling self-care and scaling up the non-medical advice and support that is available (social prescribing)
- Taking steps to identify and act early on specific health conditions, such as heart disease, diabetes or cancer
- Implementing across all neighbourhoods, preventive interventions that are known to work well.

Creating New Relationships and Integrating Across Primary Care within Communities

8.2 Looking after ourselves, and keeping ourselves as healthy as we can be, helps us from becoming ill and can also prevent existing conditions from worsening. To support self-care and to support healthier lifestyle choices, we must develop better links between our local community and community groups and primary care. This will help us to work together to identify the most appropriate health or social care support when we need it. To do this we will:

- Work together to develop innovative ways of encouraging healthy lifestyles from bump, birth and beyond, which includes improving vaccination uptake, life course skills to support healthy choices and, emotional health and wellbeing
- Ensure children and young people have a voice in, and influence over, service developments, as often their voice is not as prominent as adults
- Support the expansion of a range of community initiatives, such as expert patient programmes, self-management educational programmes for specific conditions, peer-to-peer support and personalised self-management plans
- Ensure that community pharmacies, dental practices and optometrists are aligned to our thirteen neighbourhoods and become integral to our Neighbourhood Health and Wellbeing Teams.

Access to Advice and Resources to Look After Ourselves

8.3 We want to empower people to understand their health and wellbeing and any conditions they may have. We will focus on removing barriers and making health information easier for all to of us to understand. We will work to ensure our services are easier to navigate and that our workforce check that people have understood the information given.

8.4 As described in Me and My Family (Section 4.0), self-care is vitally important to enabling us to Keep Happy, Healthy and well. We will work with primary care, the neighbourhood health and wellbeing teams, community pharmacies and people and patients to provide preventative self-care through a range of measures and interventions. Our proposals for physical activity and healthy nutrition (see Section 7.0) will be important in helping us to self-care.

8.5 We will promote healthy living pharmacies and 'pharmacy first' to enable people to receive safe and effective advice and treatment for non-emergency health matters, such as minor ailments, injuries and self-limiting conditions. We will also support community pharmacies to act as facilitators for personalised care for those of us with long term conditions.

8.6 We will enable more people to access additional advice and support that can enhance their medical care and improve their health and wellbeing. This is known as Social Prescribing. Social Prescribing enables any health and care professional to refer people to a range of local, non-clinical, community-based services, providing the link between medical and social support. Examples of activities that are often linked to social prescribing include volunteering, arts activities and gardening, as well as more formal types of activities, such as exercise referral schemes.

8.8 Through our proposals we will build on the social prescribing models that we have across Pennine Lancashire. This will be strengthened by a digital tool, which will provide links to all of the activities and groups that are available in our neighbourhoods or other places in Pennine Lancashire.

8.9 Community Connectors will form part of our Neighbourhood Health and Wellbeing Teams to assist in providing wellbeing support and helping us to identify and access the activities that they feel will most benefit our health and wellbeing. Connectors will engage across primary care, local community groups and other public services to ensure we get the best support.

Identify and Act Early on Specific Health Conditions

8.10 Screening programmes that detect cancer early are known to be cost-effective if lots of people take-up the service. Unfortunately, take-up of screening services remains low across Pennine Lancashire. We will work to increase the number of people accessing screening services particularly those people who are less likely to use them, incentivise specific schemes and develop intensive targeted programmes.

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8.11 We will continue to support and develop the emotional health and wellbeing programme for children and young people, by improving access to appropriate support and care, working specifically with education and the criminal justice system to reduce mental illness in adults and to improve outcomes for our children and young people.

8.12 We will develop a more targeted approach to the detection and reduction of heart disease risk through NHS Health Checks, with particular focus on hypertension and atrial fibrillation and link to the Type 2 diabetes prevention programme for those at high risk. Access to, and the up-take of, structured patient-education for all patients newly diagnosed with diabetes will be enhanced.

Preventive Interventions That Are Known to Work Well

8.13 In Pennine Lancashire we have already worked together on a range of existing local strategies that aim to support us to make more positive lifestyle choices, such as those that tackle obesity, substance misuse (including alcohol), accidents and falls, child maltreatment and those that improve mental wellbeing, screening, vaccinations, sexual health. But we know we can do more and we will work to expand prevention programmes that are known to be cost effective and successful, such as stop smoking services and support for people with a drug and/or alcohol dependence.

8.14 Through the integrated approach of the Healthy Child Programme, we will support children and young people to have their full course of vaccinations. We want to achieve a 95% uptake for all childhood vaccinations, because this will mean we are able to reduce the associated illnesses and establish an effective level of immunity within all our communities.

8.15 We will work together to understand and capture the impact that various prevention activities have on our health and wellbeing. We will use this information to continually improve our services and help us invest in activities that we know have the best impact.

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9.0 JOINED-UP CARE AND SUPPORT

9.1 Pennine Lancashire has a strong history of delivering integrated health, wellbeing and care services to communities. We have worked with local residents, patient groups and our workforce to develop our ideas about how we can build on our past successes and deliver improved and consistent services across Pennine Lancashire.

9.2 We want to bring more services together to improve care pathways, provide seamless links to other services (such as acute and residential care services) and, importantly into community groups and support. We want to reduce duplication of service provision and the number of times that people have to tell their story. Ultimately we want to deliver better outcomes for people.

9.3 Our proposals for Joined-Up Care and Support are about:

- **Integrating health and wellbeing care at neighbourhood level**, bringing together primary care (GP practices, dental practices, community pharmacists and optometrists), community healthcare, social care, wellbeing services, and the voluntary, community and faith sector

- Keeping people at home for as long as possible by providing a range of **specialised and enhanced community services**. An enhanced offer will be provided to people with long term conditions, bringing additional support to the neighbourhood health and wellbeing led care plans

- Delivering **intermediate care**, which is an extended model of community care which helps people to stay out of hospital following deterioration in their health and circumstances (known as step up services), as well as those that support people to get back home after spending time in hospital (known as step down services)

- **Transforming urgent and emergency care** to ensure that people with urgent care needs receive highly-responsive services that delivers the right care as close to home as possible.

Integrating Health and Wellbeing Care at Neighbourhood Level

9.4 We will bring services together, ensuring that care and support is focused around people's needs and that access to various services is seamless and easy. We want this care to be provided as close to a person's home as possible, whilst ensuring that quality is not compromised.

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9.5 Neighbourhood Health and Wellbeing care will be developed around everyone who is registered with local GP practices, regardless of age. There will be a core level of service delivered across all neighbourhoods, with flexibility to meet the specific needs of local populations. General Practitioners will be the foundation of the neighbourhood-based service, supported by the wider primary care and community teams, including nurses, mental health practitioners, social care, community connectors and a community, voluntary and faith sector lead, who will all work to provide continuity of care.

9.6 Neighbourhood Health and Wellbeing Teams will provide care and support for people in their community to help them stay well and independent for as long as possible. They will also encourage and enable people to play an active role in their own health and wellbeing. This will enable the individual to lead a purposeful and healthy life, maintain their independence, often with a personalised shared support plan and ensure that they have positive mental wellbeing.

9.8 The Neighbourhood Health and Wellbeing Teams will actively seek to support individuals and their families whose situation can be described as complex, and where a co-ordinated approach is required to minimise the risk of deterioration and prevent crisis situations occurring. When a person requires an increase in support rapidly, they will be immediately assessed and an agreed plan will be implemented to prevent an unnecessary hospital stay. Teams will have responsibility for improving communication and connections between hospital inpatient services and with bed and home-based Intermediate Care, to reduce hospital stays and support timely discharges.

9.9 Specifically our Neighbourhood Health and Wellbeing Teams will offer:

- Fully integrated and improved access to psychological therapy (IAPT) services at a neighbourhood level, with specific support for people with long term conditions
- Mental health link workers to provide specialist support for adults
- Universal services for children and young people (aged 0-25), as well as targeted services that are coordinated and integrated, building on the Healthy Child Programme and from the other components within the New Model of Care
- Support, at home wherever possible, for frail older people, and people with complex needs, including those at the end of their lives, to maximise their quality of life
- Improved relationships and communication between primary care and specialist services will enable a more co-ordinated approach to care.

9.10 Enhanced care will be provided to meet the needs of patients residing in short or long term nursing or residential care. This will include access to a named GP and the wider primary care service, comprehensive assessment and care planning support, support for the most vulnerable and those with complex needs, support to promote independence and access to expert and specialist advice.

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Primary Care as the Cornerstone for Our Neighbourhoods

9.11 Primary Care Networks (PCNs) are being promoted by NHS England to develop integrated teams, across primary care, working to support 30,000-50,000 patients, within a specific location. Through our PCNs in Pennine Lancashire we will look to build on our strong history of collaborative working and further develop our offer of support.

9.12 We will align our PCNs to the Neighbourhood Health and Wellbeing teams, and put working arrangements in place to allow them to develop a plan for joined-up delivery of community based services.

9.13 Seven day access to urgent and routine general practice will be supported by wider primary care services including dentistry, pharmacy and optometry.

9.14 System wide information, advice and signposting will be supported in primary care by Primary Care Navigators, which will create capacity within GP Surgery times. This will result in longer appointment times being available for people with long term conditions and/or for those with higher levels of need.

Specialised and Enhanced Community Services

9.15 Whilst the majority of health and care services will be delivered at a neighbourhood level, more specialised and enhanced community services will be available at a wider geographical footprint or district level. These will provide an enhanced offer to people with long term conditions, such as diabetes and heart failure. Our proposals for these services are outlined below.

9.16 Development of **early supported community rehabilitation** across all sectors and conditions to provide assessments and support for people who need it.

9.17 **Intermediate Care services** help people to stay out of hospital following deterioration in their health and circumstances (known as step up services) and they also support people to get back home after spending time in hospital (known as step down services). These services are short-term in nature, providing support for six weeks or less. The services offer a link between hospitals and people's homes, and between community services, hospitals, GPs and social care services. There are three main aims of intermediate care:

- Helping people avoid going into hospital unnecessarily
- Helping people be as independent as possible after a stay in hospital
- Preventing people from having to move into a residential home until they really need to.

9.18 **Specialist therapy, nurses, social workers and doctors.** There is an on-going need for specialist skills to deliver effective care for specific conditions. These specialists will interface with our Neighbourhood Health and Wellbeing

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Teams and provide case management for those people with more complex needs, for short periods of time, until comprehensive support plans are developed. These specialist roles could include for example Gastroenterology services and Diabetes Specialist Nurses.

9.19 We will work closely with the Lancashire and South Cumbria Shadow Integrated Care System to effectively align **specialist services**, currently provided across Lancashire and South Cumbria, to our New Model of Care. This will include:

- Specialist community-based mental health support including access and crisis, community mental health and drug and alcohol services
- Children's mental and emotional health services
- Learning disability specialist support teams.

9.20 We will work with **wider support services**, such as specialist safeguarding, employment support and specialist social work, to consider how these can be developed to provide a specialist response to neighbourhood health and wellbeing care.

Developing a High Quality and Sustainable Urgent and Emergency Care Service

9.21 We often discuss Urgent and Emergency Care as a single part of the health system, but there are two distinct tiers of need:

- **Urgent Care** is treatment for injuries or illnesses requiring immediate or same day care but not serious enough to require an Emergency Department visit or to result in the need for a hospital admission. It can be required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

- **Emergency Care** is treatment for serious or life-threatening conditions and will always require the back up of further hospital services such as in-patient treatment or surgery, though this may not be required for every patient that attends.

9.22 Improving Urgent and Emergency Care is one of the main NHS priorities. There is a clear aim to transform the system into one that allows patients quick and efficient access to the help they need. Patients have often voiced the view that they find the current system confusing and that it is difficult to know how to access the most appropriate sources of help and support, at what, for them, are critical moments in their lives. Therefore both nationally and locally we aim to transform the system across seven key priority areas.

9.23 When you or your family need to access urgent or emergency care services you are able to ring NHS 111 to speak to an advisor, who will quickly be able to direct you to the most appropriate service for your needs. In the future you will still be able to do this, but you will also be able to access a similar system on-line, via your smart phone or computer. Your information will be passed seamlessly, and securely, between all of the services that need to know your

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details eg between 999 and 111 and 111 and your GP. The intention is that one call will do it all and if you need to speak to someone different, you (with your details) will be passed smoothly and swiftly to the correct place.

9.24 Through these proposals, the options for you to receive the help and support you need will be expanded. Access to GP services will be extended so that weekend and evening appointments will be able to be booked directly through your initial call to 111. Urgent Treatment Centres will also be developed that can be booked into as well as being available for walk in treatment. These will operate at least 12 hours a day, be staffed by doctors, nurses and other staff and will have access to key testing and diagnostic services.

9.25 Developments will also take place within ambulance services to enhance the way that they work. Over time their services will be able to deal with more patients over the phone, directing them to appropriate services and they will be able to treat many more patients at home. Key to this will be linking with other services in the community. The result should mean that a lower proportion of people are taken to hospital.

9.26 We will also:

- Put in place Primary Care and Minor Injuries streaming models so that people attending A&E or Urgent Treatment Centres can be directed to the service they need
- Develop a workforce model that will meet both existing and future patient care needs and demand
- Make sure we understand our current demand and capacity requirements
- Consolidate our acute assessment areas within Royal Blackburn Teaching Hospital
- Deliver a Medical Triage Unit which will include an enhanced Ambulatory Emergency Care function which will include a review of the existing Ambulatory Emergency Care model
- Review and improve existing emergency care pathways, particularly for mental health and orthopaedics.

9.27 During our engagement activity in Winter 2017, many people suggested that we should do more to help people make the right choice in relation to urgent and emergency services. We will continue to promote this message particularly through the “NHS Choose Well” campaign.

9.28 All of these improvements should free up A&E to treat only those people who need to be there. The way that people get back out of hospital, if they need care and support at home, will also be a priority for change with joint working across health, social and other sectors being key.

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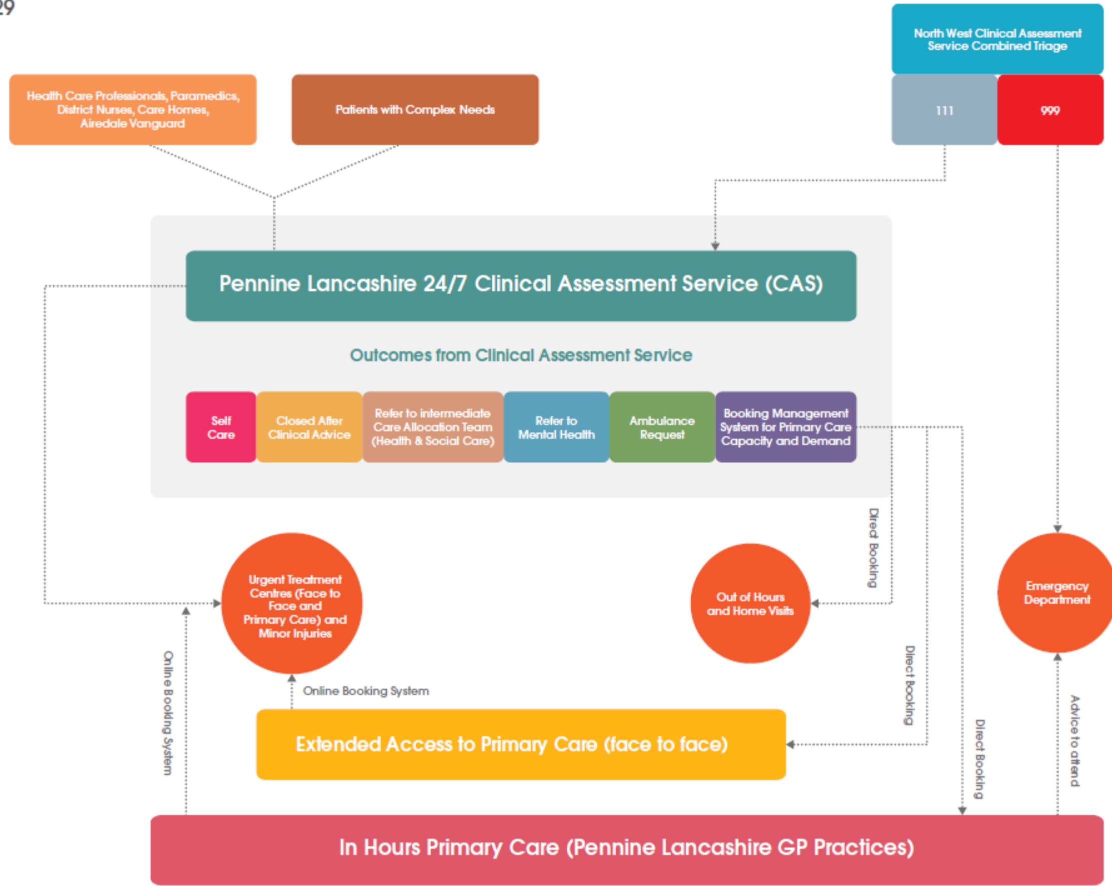

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10.0 IN-HOSPITAL CARE AND SUPPORT

10.1 We all want to know that when we need specialist or acute support, in hospital, that the care we receive will be the best it can be.

10.2 At times we will need access to hospital services in an emergency situation, for example because of an accident, whilst at other times this will be a planned admission to hospital, for example because a routine operation is required.

10.3 We recognise that if we do have to be admitted to hospital, then it is important that we stay there for the shortest time needed and that any after care and support is provided within our home or as close to our home as possible.

10.4 Our proposals below outline, in more detail, what we plan to do to achieve these ambitions.

Emergency Department at the Royal Blackburn Hospital

10.5 Currently there is a single Emergency Department covering Pennine Lancashire situated at the Royal Blackburn Hospital. We don't envisage that this will change. The Emergency Department will continue to be staffed by a highly-skilled workforce delivering life-saving care for our most sick patients. Our proposals for Urgent and Emergency Care (Section 9.29) outline the key steps we are going to take to improve care and support for people in an emergency situation.

Improving Patient Flow

10.6 The Government now requires every hospital and its local health and social care partners to have "adopted good practice to enable appropriate patient flow". This means that people can be admitted to a hospital bed when they need to be, including from the Emergency Department, and that they are discharged from hospital in a timely and safe manner. To do this we will:

- **Optimise Ward Processes** and transform medical, surgical and community wards. The aim is to roll out an improvement programme across all adult wards (post-assessment unit) which will include assessment and diagnostics, care planning, admission, welcome and introduction, delivery and review of care plans (multi-disciplinary working) and transfer of care. This will improve performance and patient experience

- Implement a **Home of Choice** policy. An acute hospital is not an appropriate setting for ongoing care once a patient has completed treatment. Through implementing a Home of Choice Policy, those awaiting a care placement or care provider while in hospital will be

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supported to make a timely choice to minimise the risks associated with remaining longer in hospital

- Develop a **Single Discharge from Hospital Service** which will support people to be discharged from hospital as soon as they can be. Our current Pennine Lancashire Integrated Discharge Service (IDS) commenced in 2015 and brings together a number of disciplines within the hospital setting including complex case managers, social care and therapies. The service supports individuals in discharge planning and arranging care and support needed upon discharge, including social care packages, reablement and rehabilitation, dependant on individual needs. We will strengthen this service and ensure that our Integrated Discharge Service will be responsible for the full implementation of system-wide Trusted Assessment, consistent and effective use of integrated discharge pathways across Pennine Lancashire and the development of a single performance dashboard

- **Discharge to Assess** is a principle of effective intermediate care delivery. It means that future assessments will take place in a community setting, rather than in a hospital setting. This is because it is more effective to assess an individual's needs in their home and surrounding community environment so that the right level of support can be identified and provided. We will ensure a seamless offer of support between hospital and Intermediate Care services to ensure that the assessment of any ongoing support takes place in a suitable environment outside of hospital (preferably in our own homes).

Elective (Scheduled/Planned) Care

10.7 Our proposals aim to ensure the delivery of efficient and effective elective (planned) care services, delivered in a timely manner, as close to the patient as practicable, and that are linked to primary care and community and intermediate services in a seamless manner.

10.8 Some of our elective (planned) care is currently provided at Burnley General Teaching Hospital. In the future we want to provide all our planned care from this site, or others within the community. This will build upon the previous development of Burnley General Teaching Hospital as an elective centre, where the Trust is able to provide a high quality elective experience for patients on a site which has been configured to optimise patient experience and quality and maximise productivity of elective services.

10.9 This innovative unit will see elective work, both medical and surgical carried out side by side in a fit for purpose environment streamlining staffing, resources and skills. The proposal focuses on hospital based services where elective (planned) care centre provision would be desirable and beneficial. It would not involve Gynaecology, Paediatrics, Urgent Care, or Orthopaedic services, and it would not include the care of long stay patients

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10.10 Within Pennine Lancashire we already have successfully transferred a number of other elective services, for example ophthalmology (eye) and dermatology (skin) services out of hospital and into the community, closer to people's homes. Given the success of the work completed to date, we want to deliver more scheduled care within our community settings which could include:

- Providing support closer to home, particularly for people with long term conditions, with specialist nurse/therapist support linked to Primary Care, in particular Gastroenterology
- Services being provided through virtual clinics
- A Single Point of Access for secondary care services within primary care would allow all referrals to be triaged and the most appropriate pathway be sourced reducing the amount of inappropriate referrals and empowering primary care to manage demand in partnership with secondary care
- Providing diagnostic services at district level.

Working within Lancashire and South Cumbria

10.11 The future provision of in-hospital care and support services (acute and specialist) will also be shaped and influenced by discussions across Lancashire and South Cumbria Shadow Integrated Care System.

10.12 East Lancashire Hospitals Trust will be recognised as a centre of excellence for certain key clinical services, taking referrals from a wide geography across the North West (for example certain urology and hepatobiliary surgery and neonatology) and be a networked provider of key specialist services with other Trusts across all of Lancashire (including stroke services, maxillofacial services, vascular services, radiology services and cancer services).

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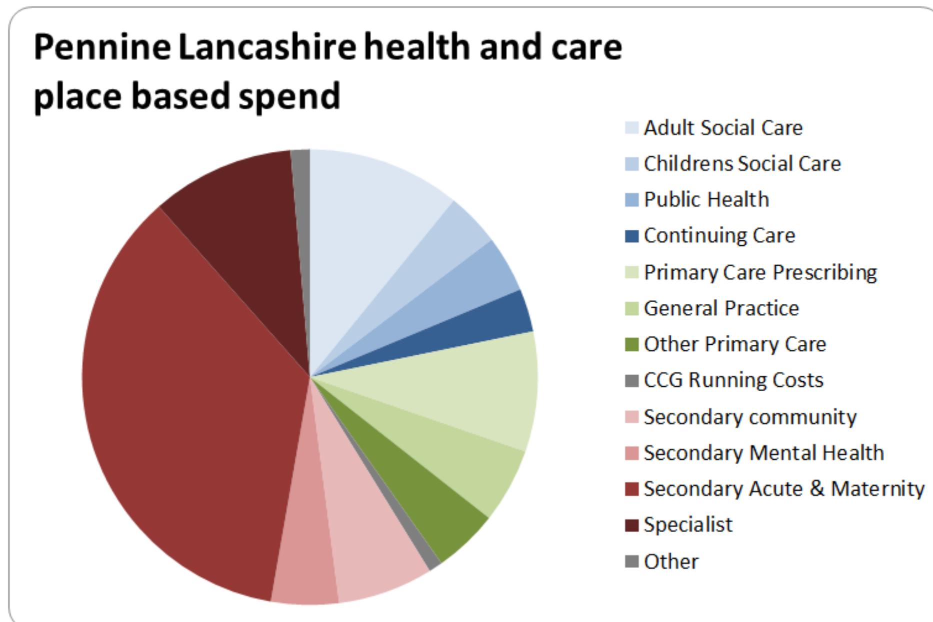
11.0 Finance and Investment

The Challenge

11.1 Each year public sector spending on health and social care for the residents of Pennine Lancashire is around £1.1billion and over the next five years there will continue to be a significant amount of money spent on health and care interventions for the 531,000 people living in Pennine Lancashire. The diagram below shows how this money is spent.



11.2 In June 2018 the Prime Minister announced a new multi-year funding plan for the NHS, which will bring an increase in expected funding available (the financial settlement will be confirmed later in 2018). However, we know that even after taking account of the resources that are likely to be made available, the increasing complexity of people's health needs and demand for services, coupled with the need for a radical uplift in investment in prevention, means we still need to work together to make the best use of our resources.

11.3 Whilst the size of the financial challenge cannot be underestimated, we recognise that there are significant opportunities for us to address this challenge and deliver value for money for every 'Pennine Pound' that is spent.

11.4 Significant work is already underway in developing plans to address how we can do this. These include:

Improving efficiency of services we deliver

11.5 Whilst we always work hard to deliver the best care possible for our population, we know that health and social care providers in Pennine Lancashire can do more to reduce costs and run services more efficiently.

11.6 Benchmarking performance of our services nationally and locally has identified opportunities where savings can be made. Areas identified for

improvement include for example, improving the efficiency of Accident and Emergency and outpatient activity, reducing lengths of stay in hospital for certain procedures and reducing unwanted variation in care through RightCare. Our partner organisations are working hard to deliver efficiencies and productivity improvements to address these challenges.

11.7 A specific programme of work is underway with a team consisting of clinical and specialist expertise, working together to identify areas for improvement specifically related to discharge pathways and community services across Pennine Lancashire. The results of this work will identify the potential capacity which could be released through improved service delivery and inform the development and delivery of improvement plans to realise these savings.

Investment in Prevention and Population Health

11.8 Evidence tells us that, if we invest in prevention, we will save money, not just in the health and care system, but across the whole of society including criminal justice, children's services and wider welfare support systems. We know that local prevention activity pays back around £4 for every £1 invested in it.

11.9 We have a strong foundation of Prevention throughout our New Model of Care as well as some specific new Prevention programmes, which we believe based on evidence of returns on investment, will save money in the long term.

New Model of Care

11.10 The New Model of Care described in detail throughout this document has been, and continues to be, designed to address the triple aim outlined in our Pennine Lancashire Outcomes Framework; to improve population health and wellbeing, provide safe, effective and high quality care and support, and ensure a sustainable health and care system.

11.11 By focussing on and investing in prevention, supporting people and communities to care for themselves and each other, providing high quality out of hospital services and in doing so, freeing capacity in our hospitals to focus on acute and specialist services, we can make best use of our resources and drive real improvements for local people.

One Public Sector Estate

11.12 Savings can be made by making sure we use the buildings we own effectively, across the whole public sector, and where we no longer need some of our buildings, we sell or share these with other organisations. Partners from health and social care, as well as other estate providers, are already working together to improve how our buildings are used and where services and workforces can be co-located.

11.13 The next phase of this work will be to review all of the buildings we own and some of those we don't, across the Pennine Lancashire footprint (public

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sector and wider) with a view to identifying how we can maximise the use of our buildings to deliver the New Model of Care and how we can release some estate to free up valuable funds.

Digital and Technological Innovation

11.14 Digital and technological innovation has the potential to radically empower people to play a more active role in their care and fundamentally change how we deliver services. The Lancashire Local Digital Roadmap identifies three broad themes all of which if delivered effectively will improve care and save money; sharing of electronic records, empowering people through the sharing of knowledge and enabling people with technology.

11.15 Within these themes and to directly address the financial challenge the following commitments have been made:
- Ensuring we exploit technology to manage capacity and demand
- Ensuring we consolidate and share IT systems to reduce cost and complexity
- Ensuring we utilise cost effective cloud-based solutions
- Ensuring we leverage procurement through scale and standardisation
- Ensuring we collectively maximise the benefits of technology.

Next Steps

11.16 Following public engagement the New Model of Care will move into a detailed design phase which will further clarify the benefits and costs of each of the proposals, with a view to decisions being made regarding the affordability of the New Model of Care and any prioritisation that is required.

11.17 A System Control Total has been agreed on behalf of the Pennine Lancashire Integrated Health and Care Partnership which details how we will manage our money together and a financial strategy to support this is being completed and includes in its core principles, delivering the best value for "the Pennine Pound" and "One Public Estate".

11.18 The Estates and Digital opportunities will continue to be refined through the detailed design of the New Model of Care as well through other emerging developments.

11.19 As we continue to move forward as an Integrated Health and Care Partnership and develop our financial strategies and plans to support this, we are also seeking confirmation of Pennine Lancashire's ability to access the following:
- Fair share of the additional transformation funding
- Funding to support social care activity
- Access to capital resources to invest in Information Management and Technology.

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12.0 One Workforce

One Workforce

12.1 We have set our aspiration for One Workforce which is ***"to have in place a workforce which is fit for the future and is able to meet the challenges of a changing health and social care landscape across Pennine Lancashire which will create working conditions that enable the paid workforce to provide care where it is needed irrespective of organisational boundaries"***.

12.2 We have a highly committed and professional health and care workforce across Pennine Lancashire, supporting residents, patients and carers in a range of settings and in a wide range of roles. This workforce is made up of people who are passionate about the jobs they do whether they are providing care in an employed role or whether they are a vital volunteer working on behalf of one of the many charities or community groups in the area.

12.3 Working in health and care is incredibly rewarding, although demanding, and with our vision for One Workforce, we will work with all our colleagues, across all organisations, to shape the delivery of our services and also ensure we make best use of our people and the skills they bring, in delivering these services.

12.4 We know that our ambitions for Together A Healthier Future will mean changes for our workforce – from embedding the principles of self-care, to having the flexibility and agility to deliver care closer to patients' homes. A number of specific workforce priorities have been identified within the New Model of Care, including:

- **Securing future workforce supply** – increase the workforce in specific clinical and nursing roles to ensure safe levels of staffing both in primary and secondary care
- **Upskilling** – upskill staff in particular training to ensure that they are able to make the most of every interaction with a patient whether that be linking to other services or promoting health and wellbeing messages – we call this Making Every Contact Count
- **New roles** – increase in new and different roles to enable individual professional groups to have more time to do the work that only they are trained to do. We will also consider greater and most effective use of the voluntary, community and faith sector to support people in their communities
- **New ways of working** – consider new employment and contracting models to attract future workforce and offer current staff greater flexibility and balance, avoiding burnout and subsequent turnover.

Current Workforce Profile

12.5 Services are provided through a number of organisations including NHS providers, Local Authority, GP Federations, VCF Sector and Care Homes.

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12.6 We estimate that the employed workforce in health and social care, including primary care, stands at around 13,500 and alongside staff working in the 178 local care homes there is a huge volunteer workforce estimated at around 14,000.

12.7 Alongside the New Model of Care, there are a number of other workforce challenges that we need to address. These include significant difficulty in recruiting and retaining certain key roles including medical and nursing roles in both primary and secondary care. An ageing workforce and an expectation of different employment models that offer greater flexibility, means that we face difficulties in maintaining services as they currently are and in realising the ambition of transformation.

12.8 We are planning what our future workfoce needs to look like based on required skills and competencies, enabling exploration of potential new roles, working differently and identification of any upskilling required. We will work with health and care education and training providers to make sure that the number of staff, and the skills and capabilities, we need can be met.

12.9 We know we want our staff to work together across the many different organisations in Pennine Lancashire. This means we will need to think about how we reflect and address differences in culture and practice and differences in the national frameworks for terms and conditions, if we are to achieve true integration.

12.10 There is also a significant unpaid workforce of volunteers and carers who need to be considered to ensure we fully understand how all aspects of care and support is currently delivered and how this supports our drive towards social prescribing and promotion of self-care. Our Volunteer Strategy sets out how we will maximise opportunities for volunteers and organisations to support the health and wellbeing of residents.

Achieving One Workforce

12.11 Workforce design events have taken place with input from colleagues across the system, to shape the One Workforce agenda and develop activity plans for delivering this.

12.12 A comprehensive workforce engagement plan has been developed and has commenced ensuring that colleagues are both kept informed of progress as well as having the opportunity to be meaningfully involved in shaping services. There are many other activities we now need to complete and our proposals are set out below.

12.13 In order to deliver the New Model of Care and meet the gaps in current workforce, significant remodelling will be required in line with population needs, moving away from task and role based provision to needs based. It is likely that there will be a requirement for new roles which are much more generic in nature with the aim of developing the current workforce into these

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roles with new generic competencies, working with education providers to ensure they are able to meet the needs of the future workforce.

12.14 In order to help us attract, recruit and retain staff, we will also develop an education and training approach and organisational development strategy that will enable new and existing staff from across the local health economy to effectively carry out the New Model of Care.

12.15 We have worked with our leaders and our staff to co-design and begin delivery of a comprehensive leadership and organisational development programme, to enable large scale change and a culture that will support transformation. The key elements of this programme are:

- System Leadership Approach - to develop the relationships and behaviours required to work outside organisational boundaries
- Shared Culture, Values and Behaviours
- A culture of innovation and creativity
- Managing and coping with change
- Development of skills, knowledge and experience
- High performing individuals, teams and organisations
- Communication and engagement.

12.16 The key steps we believe we need to take to allow us to achieve our vision of One Workforce are outlined below. We believe these activities will move Pennine Lancashire from collaboration between individual organisations, to a more joined up way of working, with single management arrangements and integrated working:

- **Leadership, Organisational Development (OD) and Workforce Engagement including:**
  - Develop leadership strategy based on compassionate leadership model
  - Build on successful organisation development programme for leaders and Neighbourhood Health and Wellbeing Teams
  - Develop shared values and behaviours
  - Implement joint induction
  - Produce engagement toolkit
  - Identify and train engagement ambassadors
  - Deliver roadshows
  - Undertake a baseline staff survey
  - Engage staff in workforce modelling workshops.

- **Streamlining and Alignment Activities including:**
  - Establish a formal Partnership Forum with Trades Union colleagues
  - Agree a single approach to managing organisational change
  - Establish an agreement for a shared training and development programme
  - Agree a single Occupational Health provision
  - Consider provision of Human Resources and Organisational Development activity, under shared management arrangements

- Develop a single recruitment and retention strategy
- Develop a single health and wellbeing strategy for our workforce.

- **Workforce Transformation Activities including**:
    - Undertake workforce modelling across the New Model of Care and our health and wellbeing improvement priorities
    - Develop use of Insight tool for General Practice
    - Work with education providers to create a Care Academy
    - Appoint a Volunteer Project role to develop volunteer workforce
    - Explore opportunities to utilise new roles such as physician associates, community pharmacists, advanced nurse practitioners
    - Participate in the Global Exchange as part of the Lancashire and South Cumbria Sustainability and Transformation Partnership
    - Create a digital workforce through use of technology
    - Explore new employment models.

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13.0 Conclusion and our Next Steps

"I think, in the future, we've got some challenges, I just think we need to work together we need to look at the social capital, we need to make it work. I think what we need to do now, maybe at a more strategic level, when we're developing these plans we need to make sure everybody is consulted and everyone's getting a say. I just think that times' hard, yes they really are hard, but together we can really make a difference."

Rick Wilson, community leader, Blackburn.

13.1 The Pennine Plan draws to a close our solution design work and reflects the contributions you as our residents, patients and staff have made to the future design of health and care in Pennine Lancashire.

13.2 We've come a long way over the past two years, and we would like to thank all our residents, community and voluntary groups, health care professionals and wider staff who have contributed their support, ideas and opinions to help us get this far. We hope that you will continue to provide us with your thoughts as we move forward in delivering our ambitions.

13.3 As we undertook our detailed engagement, you told us you were keen to hear more details about how and when health and care services will be changing. Alongside this plan we have published a delivery plan to provide more information. This can be found on our website www.togetherahealthierfuture.org.

13.4 We still have a long way to go, but we are confident that together, we can make the difference needed for Pennine Lancashire. If you haven't already joined the conversation about the future for health, care and wellbeing in Pennine Lancashire, then take a look at our website, Twitter and Facebook accounts.

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Join the Conversation

www.togetherahealthierfuture.org.uk

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#ahealthyfuture

together a healthier future

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