Appendix A

Blackburn with Darwen Better Care Fund – Quarter 4 report narrative submission

Scheme one: Voluntary Community and Faith Sector (VCFS)

i. Phase 1: Information Advice and Guidance

Our commissioning intention for a consortium based delivery mechanism for third sector services has been described in our Phase 1 service specification. This covers the approach through which information, advice and guidance services will be provided within the Blackburn with Darwen Borough going forward. The Consortium operate on a prime provider acting as an umbrella for a diverse range of providers and services.

A collaborative review of existing performance indicators and specified outcomes was undertaken in autumn 2017 and new performance and activity reporting arrangements are now in place. This is starting to inform future commissioning intentions for services beyond March 2019.

ii. Phase 2 Integrated Carer Services

There has been a need to review existing arrangements to support non- paid carers in the Borough (or those carers who support an elderly or disabled person living in the Borough) to provide greater integration and economy and efficiency. The focus has been on the delivery of information, advice and guidance to carers across client and age groups.

As the complexity of the health and social care needs of the population increases, we have seen an increase in the support needs of their carers.

Integration of what were separate services continues to evolve with joint meetings and co-located services. The number of carers' champions in organisations in the Borough continue to grow and there is active work to increase financial support to carers through targeted benefits initiatives.

There is evidence that early economies of scale are being achieved as a result of increased shared resources as well as opportunities to develop joint approaches to identified needs within the carer community e.g. supporting carers on issues of drug and alcohol use. Carer numbers identified and supported continue to increase.

ii. Phase 3 Keeping Well and Healthy Homes

Keeping Well:

The delivery of the Keeping Well project began in June 2017 and aligns the Age UK 'Here to Help', MIND 'Achieving Self Care' and Care Networks 'care navigator' service to support growth in community capacity and resilience, improve wellbeing through self-care and offer targeted approaches to reduce the demand on formal health and social care services.

This strand of the VCFS strategy seeks to improve people's actual health and their perception of feeling well. Key to this is improving people's social networks, decreasing people's sense of isolation, increasing opportunities for people to become involved through volunteering opportunities.

Ease of access through coordinated support and the availability of community resources is central to our integrated model of neighbourhood support and success will be measured by reductions in reduce unnecessary GP

consultations and reduction in medication prescription rates. It also envisaged that this will reduce unnecessary hospital attendances, unplanned admissions/re-admissions and presentations to specialist statutory services. Services are linked into Neighbourhood teams and the sector will be represented in the governance arrangements for the new models of care integrating health and social care at the neighbourhood level.

Multi agency working continues to thrive, with closer links for Transforming Lives cases made to Great Places Floating support and STEP services. A number of people are working on the range of Building Better Opportunities projects, accessing specialist support to help move closer to employment

Volunteers have provided over 300 hours of support across the programme

Healthy Homes:
The Healthy Homes service has now been extended to two years to align with the wider VCFS offer. Staff are now in post and are providing awareness raising, advice and signposting to reduce housing related health harms. Referrals have continued in quarter four to expected levels given the time of year and the interdependent work with Care Network Hub (previously known as Your Support Your Choice) is being embedded. Partnership approach is particularly strong in this phase and the use of Care Network Hub as the ‘hub’ has been a really positive catalyst for a strong delivery model from the outset.

Some further work is required around activity and performance reporting to ensure we have the correct intelligence to consider future delivery models by this sector.

Co-ordination of Dementia services
A review of the service is to be completed by Pennine Lancashire Clinical Commissioning Groups and Lancashire Care Foundation Trust Memory Assessment Service to address identified issues, e.g. an inconsistent offer of support across the Pennine Lancashire footprint. This will need to inform the range of commissioning intentions relating to this section of the population and there is great opportunity to further develop the interface between formal services and the support that can be delivered through our VCFS partners.

Scheme Two: Integrated Neighbourhood Teams

Membership of the four weekly Integrated Neighbourhood Team meetings across Blackburn with Darwen continues to grow. Organisations including the Care Network Hub, the Lancashire Women’s Centre and MacMillan Nurses will shortly be joining the weekly INTs to develop the community offer to local residents. It is envisaged that access and participation into Improving Access to Psychological Therapies (IAPT) programmes, Healthy Home services and Cancer support services will increase as a result of the partnership work.

Blackburn with Darwen’s Joint Commissioning Recommendations Group (JCRG) has approved the request to update the Borough wide Integrated Neighbourhood Team data set. A detailed exercise is now underway to identify an additional set of INT outcomes and measures which will help provide an evidence base for the new model of care going forward and enable bespoke, high quality data reports to be produced and shared.

A 12 month INT development plan has been produced following a detailed analysis of the four Integrated Neighbourhood Teams. The plan highlights over 25 priority actions such as the development of an INT partnership agreement, improved partnerships with mental health services and increasing the number of high quality case studies. The plan is discussed at the monthly Integrated Locality Team Co-ordinator Team meetings and overseen by the Integration and Neighbourhood Leads for Blackburn with Darwen Borough Council and Lancashire Care Foundation Trust.

The Integrated Care Data Sharing Agreement is currently being updated to ensure compliance of the General Data Protection Regulation and include the new attendees of the Integrated Neighbourhood Teams. Work continues to progress the IT infrastructure for the four neighbourhood teams including EMIS and ECR laptop access for the Integrated Locality Co-ordinators.

The West Integrated Neighbourhood Team has now co-located into their new office at Barbara Castle Way Health Centre. Staff briefing sessions have taken place to help build rapport between staff members and a West neighbourhood wide lunchtime networking drop in took place at lunchtime on Wednesday 28th February in the Integrated Team Office. Over 25 West based integrated neighbourhood staff members attended the networking session to meet with colleagues and find out more about each other's roles. A schedule of regular INT lunchtime networking drop ins are planned for the rest of the year for each of the four Integrated Neighbourhood Teams as part of the 12 month development plan.

Pennine Lancashire's Together A Healthier Future Programme have commissioned Rothwell Douglas to provide a Pennine Lancashire training programme known locally as 'Making It Happen', to develop the links between the emerging Primary Care Networks and the Integrated Neighbourhood Teams across all 13 neighbourhoods. Integrated Neighbourhood Team members throughout Blackburn with Darwen are currently being identified to attend the training on behalf of the four Integrated Neighbourhood Teams.

Representatives include Social Worker Team Leaders, GP's, District Nurses, Therapists, the Voluntary Sector, Practice Managers, Mental Health Practitioners, Neighbourhood Managers, Rapid Assessment Team members, Well-being Service colleagues and Lancashire Fire & Rescue Services. The training commences in mid-April and consists of four one day modules over a four month period.

Blackburn with Darwen Borough Council's Public Health Specialists are currently supporting the neighbourhood baseline assessment as part of Pennine Lancashire's Together a Healthier Future Programme. To help develop their awareness of the INTs and capture ideas for the neighbourhood profiling work Public Health Specialists have undertaken a number of visits to the Integrated Neighbourhood Teams.

Excellent partnership working continues between East Lancashire Hospice, the Clinical Commissioning Group, GP's and the four Integrated Neighbourhood Teams to increase the support for local residents who are accessing supportive/palliative care. As part of the Quality and Outcomes Enhanced Services Transformation (QOEST) scheme local residents who are accessing supportive/palliative care will be referred into the four Integrated Neighbourhood Teams via an identified principle contact from 1st April onwards. The work will be overseen by the Blackburn with Darwen Palliative / Supportive Care Project Group.

Scheme Three: Intermediate Care

The development at Albion Mill is progressing as planned and represents an innovative approach towards bed based intermediate care. The legal agreement is now in place and the build start date has been delayed until May 2018, with completion by November 2019. The project is well supported with a representative steering group that will drive progress, monitor risks and report through the appropriate governance processes. A procurement timescale has been developed for the care, nursing and therapy element of the model and a local vision has been developed that will be used to launch a soft market test with potential providers. The aim is to appoint a care provider by July 2019 to allow mobilisation and staff recruitment prior to go live date. This model includes principles that are detailed within the Pennine Lancashire Out of Hospital Business Case and will readdress the balance of step up and step down support, focusing on supporting patients to regain their independence and return home with additional wrap around care if required. The intermediate care model will deliver the whole spectrum of care, for example to those being discharged home with minimal care, to a person living at home with a time limited package of care that will facilitate early discharge and/or prevent an admission, to a person needing step up or step down into bed based care with wrap around support.

The local model includes a 'community hub' that will be used by all members of the community, residents of the intermediate care facility and their family members. This will include an offer of advice and guidance, the opportunity to build personal resilience and the opportunity to increase confidence in the range of support services and equipment available to promote independence and self-care. There has been staff and provider consultation over the usage of the hub and how it will operate to the benefit of residents and the wider community.

The existing provider of intermediate care in BwD has agreed to a contract extension in line with the new build timescales to ensure continuity of care. The existing provider has agreed to test some of the principles agreed in the new service model and have been trailing the Trusted Assessment model. An effective feedback loop is in situ to help ensure that the most appropriate individuals are referred to the service.

Scheme Four: Integrated discharge service & Home first

The newly developed Integrated Leadership Post within the Integrated Discharge Service has been successfully recruited to and the post holder has been inducted across all partner agencies. The post holder Chairs strategic partnership meetings set up to ensure all pathways are streamlined and all parties are adhering to the Discharge to Assess Principles. This group will also ensure an alignment of data collection and outcomes, enhance partnership working and retain a focus on reducing delayed transfers of care.

The simple Home First pathway is very well embedded and continues to perform well. This pathway supports an early discharge into home based therapy via the Early Supported Discharge service and the Reablement service and into residential rehab beds via the Trusted Assessment. This is now mirrored by the Enhanced Home First pathway which is fully established and able to support people with more complex needs. The Enhanced Home First offer is optimising outcomes for people by offering a holistic and strength based assessment in their own home with wrap around access to personal care, reablement, therapy and social care. This service is consistently promoting a safe and timely discharge with a more accurate assessment of longer term needs.

All Home First pathways enable discharge from hospital either same day or next day, once a Trusted Assessment has been received and validated. The weekly discharge figures for this pathway have increased and consistently achieve the targets set. Outcomes for service users after five days have varied according to individual need. Some people have been discharged from social care services as they have become independent, others have been referred on to universal community services and some people have required a domiciliary care package that meets their assessed needs.

The Integrated Step Down Team that co-ordinates all pathways using the Trusted Assessment, has now been relocated from the Hospital Team to the Home First Team to ensure excellent communication and collaboration, an approach which is proving highly successful.

Scheme Five Intensive Home Support Service (IHSS)

The IHSS model is operating as a step up model of care with the aim of preventing hospital admissions by providing time limited intensive care within a person's home, prior to referral to core community services. The link between the IHSS complex case managers and Integrated Neighbourhood Teams and GP practices is robust. This role supports the community teams in identifying patients at risk of a hospital admission and facilitating wrap around care. The role continues to develop as a means to further improve the step up and step down pathways.

The Chronic Obstructive Pulmonary Disease (COPD) team is working with the Acute Respiratory Assessment Unit to support patients with both COPD and asthma. The team will carry out community reviews and promote self-care

strategies. Referrals are increasing with the team acting above baseline with strengthened links between pulmonary rehabilitation and oxygen services.

Work has commenced to look at developing a Pennine Lancashire Intensive Home Support Service offer. This will include step up and step down services that will proactively manage patients health needs within the community. It is envisaged that this offer will include medical oversight and will align to the Intermediate Care offer within Blackburn with Darwen.

Scheme Six Directory of Service / Navigation Hub

BwD CCG are working across Pennine Lancashire to develop an Integrated Urgent Care model based on the National documentation and directives. Part of the requirement is to develop a local 24/7 Clinical Advice Service with a booking management function. BwD have been working with the existing provider of the Navigation Hub to redefine the specification and objectives to ensure that the service is better utilised and becomes part of the integrated offer with NHS 111. This specification has been approved by the CCG and will be implemented with effect from 2 April 2018 for a 12 month period. The process has been tested with a small number of NHS 111 calls being redirected to the Navigation Hub for local triaging, signposting and booking into local services. Feedback from the testing has been used to inform this specification.